Joint Commissioning Panel
for Mental Health

www.jcpmh.info

Guidance for commissioning
public mental
health services

Practical
mental health
commissioning

Updated December 2015

Contents

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[1].

2   Mental disorder affects more than 1 in 4 of the population at any one time[2,3] and costs the English economy an estimated £105 billion a year[4].

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. However, there has been a 1% real reduction in spend on mental health services in the past year[6]. Furthermore, spending on the prevention of mental disorder and promotion of mental health represents less than 0.1% of the annual NHS mental health budget[6].

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[5]. Due to the broad impact of mental disorder and wellbeing, these savings occur in health, social care, criminal justice and other public sectors.

Acknowledgements

Endorsed by:

ASSOCIATION OF DIRECTORS OF PUBLIC HEALTH

Local Government Association

RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (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*[7].

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*,[8] 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)[9], 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 well-being 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[10]

- 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[61] .

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 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[12]. As the title of the Government mental health strategy declares, there is "no health without mental health[7]. 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.

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[7]:

- 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[13]. 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.

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. This compares to 16% for cardiovascular disease and 16% for cancer[1].

The burden is due to the fact that:

Mental disorders are very common

- 10% of 5 to 16 year-olds have a mental disorder[14]

- 18% of adults have a common mental disorder, 6% alcohol dependence and 3% drug dependence[3]

- 25% of older adults have depression requiring intervention[15]

- dementia affects 20% of people aged over 80[16]

- 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[17,18]

- 75% of lifetime mental illness arises by the mid-20's[19]

- 40% of young people experience at least one mental disorder by age 16[20].

Mental disorders result in broad range of impacts

Mental disorder in childhood and adolescence is associated with:

- poorer health, poorer social skills and lower levels of educational attainment[14]

- higher risk of self-harm and suicide[21,22]

- several fold higher levels of health risk behaviour including smoking, alcohol consumption and drug misuse[14]

- higher rates of antisocial and offending behaviour and violence[22,23].

Mental disorder in childhood leads to poorer outcomes and inequalities in adulthood[24]:

- higher levels of unemployment and lower earnings[22]

- higher risk of crime and violence[22]

- higher risk of adult mental disorder[22,25,26].

Mental disorder during adulthood leads to poorer outcomes and inequalities:

- poorer educational achievement[27]

- higher risk of homelessness[28]

- higher unemployment[29]

- higher rates of debt problems[30]

- increased suicide and self harm levels[31]

- increased health risk behaviours, including poor diet, and less exercise

- higher prevalence of smoking, drug and alcohol misuse

- increased risk of physical illness (e.g. depression is associated with an increased risk of coronary heart disease and diabetes)[32,33,34]

- reduced life expectancy – for example, depression is associated with a 50% increased mortality from all disease[35] and reduced life expectancy of around 11 years in men and seven years for women[36]; schizophrenia is associated with increased mortality from all disease[31] and a reduced life expectancy of around 21 years for men and 16 years for women[37].

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[38], which in turn is associated with an increased risk of mental disorder during adulthood[22,25].

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

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[4]. By comparison, the total costs of obesity to the UK economy are £16 billion a year[42] and £31 billion for cardiovascular disease[43].

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

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[45]. 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[46]

- reduced levels of mental disorder in adulthood[47,48]

- reduced suicide risk[49]

- better general health[50]

- 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[53,54]

- healthier lifestyle and reduced health risk behaviour[51] including reduced smoking and harmful levels of drinking[55]

- increased productivity at work[56,57], reduced absenteeism[58,59] and reduced burnout[51]

- higher income[51]

- stronger social relationships[51,52,60]

- increased social/community participation[61]

- reduced antisocial behaviour, crime and violence[62,23].

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.

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

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[12,64,65]:

- 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

- 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.

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[7] highlights the significant economic savings that can be made from public mental health interventions[5,66], 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[5]. 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.

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[3,14,82]. 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[83].

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[84,85]. 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[6].

Important steps towards parity include monitoring and improving access to interventions to:

- treat and prevent mental disorder
- promote mental health.
- address and prevent health risk behaviour in those with mental disorder
- address physical health issues in those with mental disorder.

BOX 3: SELECTED ECONOMIC SAVINGS

Mental health promotion

- £4 saved for every pound spent on debt advice[5]

- £10 saved for every pound spent – work-based mental health promotion after a year[5]

- £17 saved for every pound spent – pre-school educational programmes for 3-4 year olds in low-income families[67,68,69]

- £235 per person – befriending services annual net savings[5]

- £850 per member – timebanks annual net savings[70]

- £5,000 – £12,000 per Quality Adjusted Life Year – walking and physical activity programmes in older people to promote mental wellbeing[71]

- 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[72]

  - £11,000 – £20,000 per person – annual savings from housing schemes for men with enduring mental illness[73]

  - £120,000 per person – annual savings from supported housing for women with multiple complex needs[74].

Economic savings from prevention

- £14 saved for each pound spent – school-based interventions to reduce bullying[5]

- £84 saved for each pound spent – prevention of conduct disorder through school-based social and emotional learning programmes[5]

- £421 saved per person with depression – stigma prevention campaigns[76]

- £829 and £6,446 saved – school-based violence prevention programmes with net savings six and ten years after the programme began[75]

- £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[5,79] and is important to target people with mental disorder, as 42% of adult tobacco consumption is by people with mental disorder[80].

- £568 million – suicide prevention through GP training results in net savings of £44 for every £1 invested[5] (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[77] (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[78]).

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[5]

- £5 for every pound spent – diagnosis and treatment of depression at work after one year[5]

- £8 for every pound spent – training interventions for parents of children with conduct disorder[5]

- £10 for every pound spent – early intervention during the prodromal phase of psychosis (net savings begin from year 2)[5]

- £12 for every pound spent – screening and brief interventions in primary care for alcohol misuse[5].

- £18 for every pound spent – early intervention in psychosis (net savings begin from one year)[5]

- £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[81] .

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[7] highlight the significant economic savings. Savings from public mental health interventions[5,66] 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 and wellbeing

- risk factors for mental disorder and protective factors for mental wellbeing

- 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[14]

  – 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[3]

- this situation is in contrast to cancer, where almost every person receives some form of intervention. Commisioners 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[4], £12 billion was spent on NHS services to treat mental disorder in 2010/11 (11% of the NHS budget[44]). However, only a minority of those with mental disorder except psychosis receive any intervention[3,14,82].

In England in 2011/12, only 3% of adults used hospital or community mental health services with wide variation between regions[86]. 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[6] – equivalent to less than 0.03% 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[59].

Public health policy and mental health

The Public Health White Paper *Healthy Lives, Healthy People*[10] 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*[64] describes a range of effective public mental health interventions to support this policy direction. Further, the Social Care Outcomes Framework[87], NHS Outcomes Framework[88], and the Public Health Outcomes Framework[89] include a large proportion relevant to public mental health.

Since April 2013, public health has had 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 provides 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 is led by Local Authorities, who are legally responsible for public health and will hold a ring-fenced budget to fund this work. It is 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 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[9,90]

- Joint Health and Wellbeing Strategies (JHWSs) which 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[91]. Elected councillors, directors of public health and clinicians all play a part in helping their HWB understand the needs of the whole community and agree collective action to address those needs.

NHS England

CCGs are supported by and held to account by NHS England which became fully operational with full statutory responsibility in April 2013.

National mental health strategy and public mental health

The cross-Government mental health strategy *No Health without Mental Health*[7] takes a twin-track approach as did the previous Government mental health strategy *New Horizons*[92]. 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*[7] 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[66,93] also highlight improving quality and efficiency (QIPP) in the context of a challenging financial climate[93].

Mental health strategy implementation framework

The mental health strategy implementation framework[94] 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[95].

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 higher 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 (JSAAs) 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 heath inequalities[96].

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[3,14].

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

- number and proportion of local people still in need of intervention for:

  – mental disorder, including early intervention

  – prevention of mental disorder

  – mental promotion activities

- 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[95,97].

6 Procurement

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

- ability to deliver the intervention to a high standard

- appropriately trained staff

- 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[98]. 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[258].

HOW CAN A GOOD PUBLIC MENTAL HEALTH SERVICE BE ACHIEVED?

Important factors for a good public mental health service include:

- public mental health information for different groups including commissioners, mental health and public health professionals, patients, carers and the general public

- capacity and coordination
  - ensuring that clinicians dedicate a proportion of their time to public mental health activities
  - local public mental health champions to facilitate and improve communication and coordination between service providers

- local public mental health capability and leadership within the public health department, HWB and CCG

- 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

- training
  - 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[99] and the Five Ways to Wellbeing campaign[100] (this supports improved detection and referral rates)
  - 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

- resources:
  - ensuring that public health departments ring-fence a proportion of their resources to public mental health, particularly in the light of its impact on other priorities such as physical illness and health risk behaviour
  - Payment by Results: investment in public mental health interventions could be incentivised by inclusion in the PbR 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.

BOX 4: PUBLIC HEALTH OUTCOMES FRAMEWORK:
For indicators, see 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[88] 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[88]:

See 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[87] 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[87])
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

Clinical Commissioning Group Outcomes

The CCG Outcomes Indicator Set (formerly known as the Commissioning Outcomes Framework) is an integral part of NHS England's approach to quality improvement[102].

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. It will allow NHS England 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. 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.

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

For further information, please see www.nice.org.uk/aboutnice/cof/mentalhealth.jsp and www.ic.nhs.uk/pubs/mhbmhmds11

Child Outcomes Framework recommendations

The Children and Young People's Health Outcomes Forum have published a report which sets recommendations for a Child Outcomes Framework[103]. 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 improved 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.

Public mental health intelligence

Public mental health intelligence which commissioners need to know includes local:

1   levels of risk and protective factors for wellbeing

2   levels of risk factors for mental disorder and poor wellbeing

3   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   population size

5   levels of mental disorder and numbers affected

6   levels of mental wellbeing

7   level of need for mental health services (estimation of what service provision is required)

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

9   numbers receiving mental health promotion and mental disorder prevention interventions and levels of outstanding unmet need

10   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   economic impact of interventions to treat mental disorder, prevent mental disorder and promote mental health

13   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:

- genetic factors and early environmental factors

- demographic factors such as age (older children and adult middle age)[50,104]

- lower household income[50,55], deprivation and income inequality[105]

- particular types of work such as semi-routine and routine occupations[104]

- mental ill-health[50]

- poor physical health[104]

- poor mobility, poor self-care, difficulties performing daily activities, pain and discomfort[55], as well as work limiting disability[104]

- social isolation, a poor sense of belonging, and reduced ability to influence the local community[55]

- health risk behaviour such as alcohol, smoking and cannabis use[55]

- being a member of a group at greater risk of poor wellbeing such as some BME groups and the unemployed[104].

Protective factors for wellbeing

A range of protective factors are associated with wellbeing:

- genetic and early environmental factors[61]

- socioeconomic factors including higher income and socio-economic status[107,108]

- living environment[106]

- good general health[50,55]

- education[107]

- employment including autonomy, support, security and control in an individual's job[50]

- activities such as socialising, working towards goals, exercising and engaging in meaningful activities[47]

- social engagement and strong personal, social and community networks[104,107,108,109]

- altruism (doing things for others)[110]

- 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[111]

- spirituality is associated with improved well-being[112], self-esteem, personal development and control[113]

- positive self-esteem[114]

- values[115].

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 for local protective factors for wellbeing

Locally available data can be found at the following sources.

- breast feeding and prevalence at 6-8 weeks: 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
  - 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
  - participation in Education, Training and Employment by 16-18 year olds in England 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
  - proportion of adults receiving secondary care mental health services in paid employment[86].

- physical activity:
  - local levels of physical activity www.sportengland.org/research/active_people_survey/aps5.aspx

– local child and adult participation in physical activity 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=tcm%3A77-258850

• housing:

– CLG Live tables on affordable housing supply by Local Authority www.communities.gov.uk/housing/housingresearch/housingstatistics/housingstatisticsby/affordablehousingsupply/livetables/

– 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

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

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%[3].

Data sources for local risk factors

Inequalities and deprivation

• children in poverty www.phoutcomes.info/public-health-outcomes-framework/domain/2

• people living in the 20% most deprived areas 2010 www.nepho.org.uk/cmhp/

• local health inequalities including numbers of adults in poverty 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

Parental factors

• maternal smoking:

– at birth 2011-2012 www.ic.nhs.uk/pubs/wsstd1112q3

– during pregnancy 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

• children in out of work families www.hmrc.gov.uk/stats/personal-tax-credits/ctc-small-areas.htm

• children of parents with mental disorder (box on page 28).

Child factors

• 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=tcm%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=tcm%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

• permanent and fixed period exclusions from school www.education.gov.uk/rsgateway/DB/SFR/s001080/index.shtml

• behaviour in schools 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

• excess winter deaths 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[116].

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

Local numbers experiencing abuse can be estimated from national statistics.

- 25% of 18-24 year-olds and 19% of 11-17 year-olds experience severe maltreatment during childhood[117].
- 3% of women and 0.8% of men experience sexual intercourse during childhood[119]
- 11% of women and 5% of men experienced sexual touching[119].

Local numbers of children:

- assessed with primary need due to abuse or neglect
- with a child protection plan due to sexual, physical or emotional abuse www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-year-ending-march-2012

Abuse of vulnerable adults

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

Domestic violence

Home Office Recorded crime datasets 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. Knowledge about numbers in such groups enables appropriate targeting of prevention and promotion interventions to prevent further widening of inequalities.

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://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

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[121]

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-neet

www.nepho.org.uk/cmhp/

Young offenders

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

First time entrants to the youth justice system should also be considered.

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

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

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

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
- number of working age unemployed adults: www.nepho.org.uk/cmhp/
- long term unemployed 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/
- claimants of incapacity benefit or severe disablement allowance due to alcoholism www.lape.org.uk/data.html

Homelessness

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

- statutory homelessness: homelessness acceptances (1.15i) and households in temporary accommodation (1.15ii) 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

www.justice.gov.uk/statistics/prisons-and-probation/prison-population-figures

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[120]. 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[120].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/
  - 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
  - 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
- percentages of patients on learning disabilities register www.nepho.org.uk/cmhp/

Long term limiting illness

- NEPHO Community Mental Health Profiles 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[125]. However, another survey found a higher proportion, with an estimated 6% of the population as LGB (DTI, 2005)[126]. There are approximately 65,000 to 300,000 transgender people in the UK[127].

People registered deaf or hard of hearing

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=tcm%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
- Projecting Older People Population Information (POPPI) for populations 65 and over www.poppi.org.uk

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

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

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.

Local levels of child and adolescent mental disorder

Local levels of emotional, conduct and hyperkinetic disorders are associated with deprivation[14]:

- 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

BOX 8: PROPORTION OF CHILDREN AND ADOLESCENTS FROM HIGHER RISK GROUPS AFFECTED BY MENTAL DISORDER

Group	Expected prevalence of mental disorders
Looked after children	45%[129]
Children with special educational need requiring statutory assessment	44%
Children with learning disability	36%[130]
Children absent from school more than 15 days in previous term[14]	17% with emotional disorder 14% with conduct disorder 11% with hyperkinetic disorder
Children with a parent with mental illness[14]	Parents of child with conduct disorder • 51% have emotional disorder • 18% have a severe emotional disorder Parents of child with emotional disorder • 48% have emotional disorder
Children from households with no working parent	20%[14]
Children from families receiving disability benefits	24%[14]
Children from household reference person in routine occupational group	15%[14]
Children of parents with no educational qualifications	17%[14]
Children living in 'hard pressed' areas	15%[14]
Children from weekly household income <£100	16%[14]
11-16 year olds from weekly household income <£200	20%[14]
Children living in 'hard pressed' areas	15%[14]
Children in stepfamilies	14%[14]
Children from lone parent families	16%[14]

• 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 is estimated by the Index of Multiple Deprivation: http://webarchive.nationalarchives.gov.uk/20120919132719/http://www.communities.gov.uk/publications/corporate/statistics/indices2010

There are 326 Local Authorities (LAs) with the most deprived LA ranked 1 on the IMD and the least deprived LA ranked 326. The rates of mental disorder for a locality ranked 244 can be estimated as follows[128]:

• emotional disorder: 6% minus (4 multiplied by 244/326)

• conduct disorder: 9% minus (6 multiplied by 244/326)

• hyperkinetic disorder (ADHD): 3% minus (1.5 multiplied by 244/326).

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 self-harm can be estimated by applying national rates and taking into account numbers with emotional, conduct and ADH disorders.

Local levels of alcohol, drug use 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) to the level of increased risk they experience.

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

- IAPT quarterly data uses the NEPHO (2008) report to estimate local numbers of people with depression and/or anxiety disorders http://www.hscic.gov.uk/catalogue/PUB09375

Psychosis

- in previous year, 4/1000 people have psychosis and 1/1000 bipolar affective disorder although rates vary by locality

- number of new cases of psychosis each year is 0.15 per 1000 for schizophrenia and 0.12 for affective psychosis. Rates for schizophrenia are higher in disadvantaged areas but not for affective psychosis. Local number of new cases can be estimated at www.psymaptic.org

- numbers developing a psychosis clinical high risk state (prodrome) each year is at least three times higher than numbers developing psychosis.

Dementia

NHS Dementia Prevalence Calculator enables estimation of local numbers affected by dementia www.dementiaprevalencecalculator.org.uk/

Alcohol use disorder

- Local Alcohol Profiles for England provide data on numbers of abstainers, lower risk, increasing risk, higher risk, binge and dependent drinkers in local authority areas www.lape.org.uk/data.html

- 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)

Drug use disorder

- APHO local levels of drug misuse www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

- NDTMS data on the prevalence of opiate and/or crack use www.ndtms.net

- NDTMS JSNA Support Pack with national and local prevalence estimates 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

- smoking prevalence in adults (over-18s) www.phoutcomes.info/public-health-outcomes-framework/domain/2

- mothers smoking during pregnancy and at delivery www.ic.nhs.uk/pubs/wsstd1112q3 and www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES)

- numbers of smokers with mental disorder is estimated by applying national smoking rates for different mental disorder[80] to local numbers with different mental disorders.

Suicide and undetermined injury

- suicide rate (provisional) www.phoutcomes.info/public-health-outcomes-framework/domain/2

- standardised Mortality Rate for suicide and undetermined injury 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[131]. Particular groups are at higher risk with 42% of immigrant, asylum and refugee women experiencing post-natal depression in developed countries[132].

Adults with learning disability

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

Prisoners

Prisoners experience a several fold increased risk of common mental disorder, suicide, psychosis (10% of prisoners), personality disorder, alcohol and drug problems[134,136] while 80% of prisoners are smokers[137].

Homeless people

Twenty seven percent have probable psychosis, 9% neurotic disorder, 10% alcohol dependence and 15% drug dependence.

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. 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[140]. 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[3].

Refugees and asylum seekers

Rates of mental disorder are several times higher for this group[141,142].

6 Local levels of mental wellbeing

While the Health Survey for England found only small differences in wellbeing across different regions of the country[50], significant variation can occur even within a locality[55].

Wellbeing can be assessed by objective and subjective measures. 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[104] and provides maps showing differences in levels of satisfaction, things being worthwhile and happiness at: 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

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.

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[143], and the Local Index of Need (LIN)[144].

Estimates suggest the following proportions of children and adolescents should be seen by the different tiers of CAMHS services:

- 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[14]

- 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[14].

Observed numbers in the different tiers can be derived from the caseloads of the range of providers and 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

- 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/

- 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

Adults

Nationally, only a minority receive any intervention for mental disorder except psychosis[3]. 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)

- percentage with depression aged 18 and over (on GP depression register) www.nepho.org.uk/cmhp/

- 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

- 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

- 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[86] www.hscic.gov.uk/catalogue/PUB09375

- standardised rate for hospital admission for unipolar disorders www.nepho.org.uk/cmhp/

Psychosis

- Primary care

  Number on and exceptions from QOF SMI register www.ic.nhs.uk/qof

- Secondary care

  Early intervention for psychosis and clinical high risk state (CHRS):

  – number of 15-34 year olds (from census data at ONS 2012 – section 4)

  – number with First Episode Psychosis (FEP) treated by Early Intervention teams Routine Quarterly MHMDS reports: Community Mental Health Activities questions 6 and 786 http://transparency.dh.gov.uk/2012/06/21/mh-community-teams-activity-information/

  – number with CHRS receiving intervention

  – standardised rates for hospital admission for schizophrenia, schizotypal and delusional disorders www.nepho.org.uk/cmhp/

Personality disorder

Numbers receiving interventions for different personality disorders.

Dementia

- ratio of recorded to expected prevalence: % of adults with dementia on GP register www.nepho.org.uk/cmhp/

- maps of dementia prevalence and diagnosis rates http://dementia.dh.gov.uk/map-of-dementia-prevalence-and-diagnosis-rates/

- rates of admission for dementia www.nepho.org.uk/cmhp/

Alcohol use disorder

- alcohol admissions:

  – NHS admissions with a primary diagnosis wholly or partially attributable to alcohol

  – alcohol admissions for alcohol related harm www.hscic.gov.uk/pubs/alcohol12table4

  – hospital stays for alcohol related harm www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

  – hospital admissions for alcohol attributable conditions www.nepho.org.uk/cmhp/ and www.lape.org.uk/data.html

- dependent drinkers in structured treatment www.lape.org.uk/data.html

- details on prescribed drugs for the treatment of alcohol dependence dispensed in the community www.hscic.gov.uk/pubs/alcohol12Table4.12

- JSNA Support Pack for Strategic Partners www.nta.nhs.uk/healthcare-JSNA.aspx

Local data on monthly local numbers in treatment, new presentations, waiting times, treatment outcomes and discharges is at 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

- Numbers of people (aged 18-75) in drug treatment, rate per 1000 population www.nepho.org.uk/cmhp/

- 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.hscic.gov.uk/catalogue/PUB09140

- 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

- "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)

- JSNA Support Pack at www.ndtms. net/ViewIt provides substance misuse statistics at a national and local level. Greater detail from the Needs Assessment reports are accessible from www.ndtms.net via "Outputs" – "Reports" – "Annual" –"Needs Assessment", and also the JSNA Support Pack for Strategic Partners at www.nta. nhs.uk/healthcare-JSNA.aspx

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

- local levels of successful treatment of drug treatment 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

Tobacco dependence

Despite 42% of adult tobacco consumption being by those with mental disorder[80], local information is not 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 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

- NHS Information Centre (2012) Statistics on NHS Stop Smoking Services: England (quarterly data, April to September 2011). 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 (although this has no information on people with mental disorder)

- 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/

Monitoring and 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), QOF indicators at www. ic.nhs.uk/pubs/QOF1112 include the proportion with SMI:

- with check of alcohol consumption (QOF MH11), BMI (QOF MH12), blood pressure (QOF MH13), cholesterol (QOF MH14), blood glucose or HbA1C (QOF MH15) in the preceding 15 months

- whose notes record smoking status in past year (SMOK002)

- who smoke who have received an offer of support of treatment in the past year SMOK005)

- with a review offering routine and appropriate health promotion and prevention advice in previous 15 months (QOF MH9)

- on lithium with serum creatinine and thyroid stimulating hormone in previous 9 months (QOF MH17)

- on lithium where a blood test to check their lithium level has been completed in the previous 4 months (QOF MH18)

- who do not attend for an annual review who are then followed up within 14 days of non-attendance (QOF MH7).

Primary mental health service information

NHS Primary Medical Services Assurance Framework at www.primarycare.nhs.uk provides mental health indicators at GP practice, CCG, area team and regional levels. Indicators can be compared with other data including APHO groupings and IMD.

Secondary mental health service information

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 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

Measures of overall use of secondary mental health services include:

- numbers using adult and elderly secondary mental health services (MHMDS) www.nepho.org.uk/cmhp/

- number of contacts with mental health services per 1000 population (MHMDS) www.nepho.org.uk/cmhp/

- in year bed days for mental disorder per 1000 population (MHMDS) www.nepho.org.uk/cmhp/

- hospital admission rates for mental disorder (HES) www.nepho.org.uk/ cmhp/

- proportion of people in contact with mental health services who are admitted (2010/11) www.ic.nhs.uk/pubs/ mhbmhmds11

- number of people on CPA per 1000 (MHMDS) www.nepho.org.uk/cmhp/

- number of contacts with CPN's per 1000 (MHMDS) www.nepho.org.uk/cmhp/

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. 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, there was a 1% real reduction in spend on adult and older people's mental health services in 2011/12[6]. The following sites provide local spend on mental health, and enable estimation of proportion spent on mental health[148]:

- www.networks.nhs.uk/nhs-networks/health-investment-network/news/2011-12-programme-budgeting-data-now-available

- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/140098/FinMap2012-NatReportAdult-0308212.pdf

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

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

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

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 on pages 20-23.

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

The economic savings of different public mental health interventions 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

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)

- mental disorder is associated with higher rates of physical illness and premature death (page 8)

- physical illness increases risk of mental disorder – those with two or more chronic physical illnesses – are at 7-fold increased risk of depression

- mental disorder and wellbeing influence rates of health risk behaviour. For instance, 43% of smokers under the age of 17 have either conduct or emotional disorder[14] while 42% of adult tobacco consumption in England is by those with mental disorder[80]. Wellbeing is associated with healthier lifestyle and reduced health risk behaviour[51] including reduced smoking and harmful levels of drinking[55]

- 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[62,63].

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

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/

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.

- 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[150]

- breastfeeding is associated with higher intelligence scores and reductions in hypertension, obesity and diabetes in later life[151] and reduced behavioural problems life[152]

- home visiting programmes can improve maternal and child health[153,154]

- parenting programmes can result in improvement in parental mental health[155].

Programmes which provide support to parents are effective in general populations and with high-risk groups[156]. 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[157] and maternal health[153] while SureStart can reduce negative parenting[158].

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[176].

The evidence for parenting programmes is robust including for high-risk parents[159,160] and demonstrates:

- improved parental efficacy and practice[155]

- improved maternal health and reduced maternal depression[155]

- improved child emotional and behavioural adjustment[161,162]

- improved behaviour in children with conduct problems[163]

- prevention of conduct disorder in children with sub-threshold conduct disorder[164]

- improved educational attainment[165]

- promotion of prosocial behaviours[166]

- improved safety at home with reduced unintentional injury[167]

- reduced child abuse[168]

- reduced antisocial behaviour[169,170]

- reduced aggression and violence in children with conduct disorder[163,164]

- reduced re-offending[171]

- effective for ADHD[172] and autistic spectrum disorder[173]

- long term benefits[174,175].

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[171,178]. They are also effective in preventing emotional and conduct disorder[166]. More targeted approaches such as home visiting programmes improve child functioning and reduce behavioural problems[180] (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[54,181,182]. They can also result in reductions in anxiety and depression[182,183,184]. Targeted Mental Health Support in Schools (TaMHS) is also effective.

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[171]. The Penn resiliency programme is a school programme to prevent depression in adolescents which promotes resilience, optimistic thinking and social problem-solving[185,186]. Mentoring has a positive effect on emotional, behavioural, social competence, academic and career outcomes, particularly for high risk groups[187].

1C Living well

A wide range of interventions which help people 'live well' also promote mental health. 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[188,189]

- targeted interventions such as supported housing for high-risk groups, including those with mental disorder[190,191]

- housing support for high-risk families (family intervention projects) associated with reduced eviction rates and improved neighbourhood[192]

- interventions which address fuel poverty and ensure adequate heating are associated with improved mental health[188].

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

Debt advice results in improved mental health[197]. Improved financial capability results in improved mental health as well as reduced anxiety and depression[198].

Physical activity is associated with reductions in depression[199,200], improved wellbeing (including people with

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

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

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

Social capital is associated with improved wellbeing and reduced mental disorder. 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[219], wellbeing[220] and reduces health risk behaviour[221]

- active leisure improves wellbeing[204,205]

- arts and creativity are associated with enhanced well-being[222] and recovery from mental illness[223]. Prescription of arts provides meaningful occupation and participation[224]. Music associated with recovery from mental disorder[225]

- volunteering[226,227,228,229]

- timebanks[230,231,232]

- parental support; Home visiting of peer support[154], parent training[155], child care[233]

- promotion of individual and community empowerment[234]

- enhancing community engagement and participation[235]: Community coalitions can contribute to effectiveness of changing a range of behaviour targeted for change[236]

- 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[237,238,239,240]. 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)[241,242].

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[243,244]

- work-based stress management interventions result in reduced work-related stress/sickness absence[245]

- support for unemployed people results in increased employment and reduced distress[246].

1E Ageing well

Ageing well interventions promote wellbeing in later life.

Interventions to prevent social isolation can improve well-being[247]. Befriending results in reduced depression[248]. *Psychosocial interventions* can promote well-being[249] and prevent depression[250].

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

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

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[254].

- **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[255]. Greater support for caregivers with depression can promote faster recovery[256].

- **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[257]. 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[258].

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[259,260,261]

- breastfeeding which is associated with reduced behavioural problems[152]

- home visiting programmes are associated with reduced behavioural problems[159,180] and exist in the UK as the Nurse Family Partnership and SureStart[158,261] 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[164] and prevention of conduct disorder, anxiety and depression in children and adolescents[180]

- high-quality pre-school programmes, which prevent emotional and conduct disorder[179]

- school-based mental health promotion programmes, which can reduce classroom misbehaviour, anxiety and depression[183,262]. Targeted programmes are effective for those at higher risk of depression[263,264,265] including children with parents who have depression[266,267]

- since 40-70% of those with conduct disorder develop antisocial personality disorder, prevention of conduct disorder in childhood prevents antisocial personality disorder[135] in adult life.

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

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

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

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, prevent mental disorder, and treat it early
- prevention and intervention for abuse
- 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[80] and 43% of smokers under 17 in England have conduct or emotional disorders[14]. 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[279,280,281].

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[282]. It is critical that smokers with mental disorder are identified and supported to stop smoking through improved access to smoking cessation programmes[7]. Since two-thirds of current and ex-smokers started smoking before the age of 18[283], early intervention through school-based cessation programmes can be effective[284,285]. 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[286,287].

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[289,290,291,292] and internet-based interventions[293]. Parental smoking cessation is associated with reduced smoking in their children[294] with parenting programmes to prevent tobacco smoking associated with significant reductions in smoking[295]. 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[296]. Guidelines exist for prevention and reduction of alcohol use in children and young people[297]. Parenting programmes[295] are also effective. Treatment[298] and early intervention for alcohol problems also prevents alcohol associated harm particularly for higher risk groups, such as people with affective and anxiety disorders[299].

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[300].

Drug misuse

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

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[310]. 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[151,311]. Weight loss can also be achieved by promoting a balanced diet and sufficient exercise[312]. Environmental and organisational interventions can also prevent weight gain and facilitate weight loss[196,208,313].

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

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[193,196]. Traffic calming is associated with increased walking and cycling[209], as is improving cycle routes and infrastructure[208]. Walking and cycling can also be increased by coordinated planning with public transport[317]. Workplace physical activity programmes are also effective[318].

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

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[199], as well as improved wellbeing, weight loss and reduced blood pressure in people with schizophrenia[319,320].

Sexual health risk behaviours

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

Sexual abuse prevention programmes in schools can help young people avoid abuse[324] 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 and poor wellbeing. Furthermore, increased levels of income inequality in high income countries are associated with higher prevalence of mental illness and drug misuse[325]. Therefore, addressing and preventing inequality can prevent mental disorder. Marmot and colleagues[326] 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[327,328], social contact between people with mental disorder and members of the public[329] and educational programmes to increase mental health literacy in specific groups[330,331] including Mental Health First Aid[99].

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).

2E   Prevention of suicide

The cross-Government suicide prevention strategy[332] 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. 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. Prevention of child maltreatment could also reduce the prevalence of many common mental disorders[333].

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[334,335,336], sexual abuse[324], bullying[337], and 'date violence'[338].

Parent training programmes result in reductions in unintentional injury[167] and abuse of children[168] by parents, as well as reduced aggression, violence[163,164], offending[171], antisocial behaviour[169] and bullying[166] 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[339,340]. 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[192]. School development programmes also result in reduced violence[341].

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

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[62]. 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[62].

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[135].

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[345]. 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[81,346].

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[347]. Effective interventions include control of availability and density of sales outlets[348], alcohol pricing[296,348], training programmes for owners, servers and door staff[349], community and school policies on alcohol[350], brief interventions with youth involved in violence to reduce hazardous drinking[351,352], and treatment for problem drinkers[348].

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[353]

- children with conduct disorder through parenting programmes results in improved behaviour in their children[25,163] as well as improved educational outcomes, family relationships, child behaviour, reduced crime and reduced mental disorder in adulthood including antisocial personality disorder[135].

- children with ADHD through parenting programmes in the first instance[354] results in better outcomes

- children with emotional disorder[355]

- children with autism can result in improved language, behaviours and cognitive development[356,357]

- adults with common mental disorder reduces duration of illness – for example, early intervention for depression at work can reduce sickness absence[358] (such interventions can be facilitated by the training of managers to recognise symptoms of illness such as depression[359])

- psychosis results in better outcomes, including reduced psychotic symptoms, fewer hospital admissions[360,361], reduced risk of suicide and increased employment[362]. Intervention in the prodromal phase reduces transition to psychosis.

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[17]. 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[296] can reduce alcohol consumption

- borderline personality disorder results in improved functioning in adolescents, reduced psychopathology and parasuicidal behaviour[365]

- antisocial personality disorder improves outcomes[135]

- anorexia nervosa improves outcomes[366].

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[14]

- early promotion of physical health in those with psychosis results in weight loss[315], increased physical activity[319] and smoking cessation[367].

3D Early intervention to promote recovery

Early intervention in terms of supported employment[368], housing support[190,191], and debt advice[30] 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/

  – The Children and Young People Consortium e-portal which will 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[369].

- improved mental health literacy among the population to facilitate prompt help seeking to facilitate prompt help seeking[99,327].

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.

References

1   World Health Organization (2008). Global burden of disease report. WHO.

2   Wittchen HU, Jacobi F, Rehm J, et al (2011) The size and burden of mental disorder and other disorders of the brain in Europe. Eur Neuropsych Pharmacol 21:655–78.

3   McManus S, Meltzer H, Brugha T, et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics.

4   Centre for Mental Health. (2010). The Economic and Social Costs of Mental Health Problems in 2009/10.

5   Knapp M, McDaid D, Parsonage M Eds (2011) Mental health promotion and mental illness prevention: the economic case. Department of Health.

6   Department of Health (2013). 2011/12 National survey of investment in adult mental health services.

7   HM Government (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. HM Government.

8   Bennett, A., Appleton, S., Jackson, C. (eds) (2011) Practical mental health commissioning. London: JCP-MH.

9   Department of Health (2011) Joint Strategic Needs Assessment and joint health and wellbeing strategies explained.

10   Department of Health (2010) Healthy lives, healthy people: our strategy for public health in England.

11   World Health Organization (2001). Fact sheet 220. Geneva: World Health Organization.

12   Royal College of Psychiatrists. (2010). No Health Without Public Mental Health: The Case for Action (Position statement PS4/2010). Royal College of Psychiatrists.

13   Andrews G, Issakidis C, Sanderson K, et al (2004) Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. Br J Psych 184:526–33.

14   Green H, McGinnity A, Meltzer H, et al (2005). Mental health of children and young people in Great Britain, 2004. London: Office of National Statistics.

15   Godfrey M, Townsend J, Surr C, et al. (2005). Prevention and Service Provision: Mental Health Problems in Later Life, Institute of Health Sciences and Public Health Research, Leeds University & Division of Dementia Studies, Bradford University.

16   Knapp M, Prince M, Dementia UK (2007). A report into the prevalence and cost of dementia. London: Alzheimer's Society.

17   Kim-Cohen, J. Caspi A, Moffitt TE et al (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort. Archives of General Psychiatry 60: 709-717.

18   Kessler RC, Berglund P, Demler O et al (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. Archives of General Psychiatry 62: 593-602.

19   Kessler RC, Amminger GP, Aguilar-Gaxiola S et al (2007). Age of onset of mental disorders: a review of recent literature. Current Opinion in Psychiatry 20(4): 359-364.

20   Jaffee SR, Harrington H, Cohen P, Moffitt TE (2005). Cumulative prevalence of psychiatric disorder in youths. Journal of the American Academy of Child and Adolescent Psychiatry 44(5): 406-407.

21   Meltzer H, Harrington R, Goodman R et al (2001) Children and adolescents who try to harm, hurt or kill themselves. A report of further analysis from the national survey of the mental health of children and adolescents in Great Britain in 1999. ONS.

22   Fergusson DM, Horwood LJ, Ridder EM (2005). Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. Journal of Child Psychology 46: 837-849.

23   Sainsbury Centre for Mental Health (2009). The chance of a lifetime: preventing early conduct problems and reducing crime. London: SCMH.

24   Richards M, Abbott R (2009). Childhood mental health and life chances in post-war Britain. Insights from three national birth cohort studies.

25   NICE (2013). Antisocial behaviour and conduct disorders in children and young people. Recognition, intervention and management. National Clinical Guideline 158.

26   Colman I, Murray J, Abbott RA et al (2009). Outcomes of conduct problems in adolescence: 40 year follow-up of national cohort. British Medical Journal 338: a2981.

27   Chevalier A, Feinstein L (2006). Sheepskin or prozac: The causal effect of education on mental health. Discussion paper. London: Centre for Research on the Wider Benefits of Learning.

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

29   Meltzer H, Bebbington P, Brugha T et al. (2010) Job insecurity, socio-economic circumstances and depression. Psychological Medicine 40(8): 1401–1407.

30   Fitch C, Hamilton S, Bassett P, Davey R (2011). The relationship between personal debt and mental health: a systematic review. Mental Health Review Journal16, 4: 153-166.

31   Saha S, Chant D, McGrath JA (2007). Systematic review of mortality in schizophrenia: is the differential mortality gap worsening over time? Arch Gen Psychiatry 64:1123–31.

32   Hemingway H, Marmot M (1999) Evidence based cardiology. Psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies. British Medical Journal, 318, 1460-1467.

33   Nicholson A, Kuper H, Hemingway H (2006) Depression as an aetiologic and prognostic factor in coronary heart disease: a meta-analysis of 6362 events among 146 538 participants in 54 observational studies. Eur Heart J, 27(23), 2763-2774.

34   Fenton WS, Stover ES (2006) Mood disorders: cardiovascular and diabetes comorbidity. Curr Opin Psychiatry,19, 421–7.

35   Mykletun A, Bjerkeset O, Overland S et al (2009) Levels of anxiety and depression as predictors of mortality: the HUNT study. British Journal of Psychiatry, 195, 118-125.

36   Chang C-K, Hayes RD, Perera G et al (2011). Life expectancy at birth for people with serious mental illness and other major disorders form a secondary mental health care case register in London. PLoS ONE 6(5): e19590. doi:10.1371/journal.pone.0019590.

37   Brown S, Kim M, Mitchell C et al (2010) Twenty-five year mortality of a community cohort with schizophrenia. BJPsych, 196, 116-121.

38   Meltzer H, Gatward R, Corbin T et al (2003). Persistence, onset, risk factors and outcomes of childhood mental disorders. London: The Stationery Office.

39   Social Exclusion Unit (2004) Mental Health and Social Exclusion. Social Exclusion Unit.

40   Sainsbury Centre for Mental Health (2002). Breaking the Circles of Fear: A review of the relationship between mental health services and the African and Caribbean communities. London.

41   King M, McKeown E (2003). Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales. London: Mind.

42   Foresight (2007). Tackling obesities: future choices. Project report. London: Government Office for Science.

43   NICE (2010) Prevention of cardiovascular disease at population level.

44   Department of Health (2012). Programme budgeting tools and data. National expenditure data.

45   McCrone P, Dhanasiri S, Patel A, et al (2008) Paying the price. The cost of mental health care in England to 2026. London: The King's Fund.

46   Parry-Langdon N, Fletcher, CA (2008). Three years on: Survey of the development and emotional well-being of children and young people. ONS.

47   Lyubomirsky S, Sheldon KM, Schkade D (2005). Pursuing happiness: the architecture of sustainable change. Rev Gen Psychol 9:111–31.

48   Keyes CLM, Dhingra SS, Simoes EJ (2010) Change in level of positive mental health as a predictor of future risk of mental illness. Am J Public Health 100(12):2366–71.

49   Koivumaa-Honkanen H, Honkanen R, Viinamaeki H, et al (2001) Life satisfaction and suicide: a 20-year follow-up study. Am J Psychiatr 158:433–9.

50   NHS Information Centre (2011) Health Survey for England – 2010. Well-being, health and work.

51   Lyubomirsky S, King LA, Diener E (2005). The benefits of frequent positive affect: Does happiness lead to success. Psychol Bull 131:803–55.

52   Pressman SD, Cohen S. (2005) Does positive affect influence health? Psychol Bull 2005;131(6):925–71.

53   NICE (2009) Promoting young people's social and emotional wellbeing in secondary education. London: NICE.

54   NICE (2008). Promoting children's social and emotional wellbeing in primary education. London: NICE.

55   Deacon L, Carlin H, Spalding J, et al (2009). North West mental well-being survey.North West Public Health Observatory.

56   Boorman S (2009). NHS Health and Wellbeing. Final report. London: Department of Health.

57   NICE (2009) Promoting mental wellbeing at work: full guidance.

58   Keyes CLM, Grzywacz JG (2005) Health as a complete state: the added value in work performance and healthcare costs. J Occup Environ Med 47(5):523–32.

59   Mills P, Kessler R, Cooper J, Sullivan S (2007) Impact of a health promotion program on employee health risks and work productivity. American Journal of Health Promotion, 22(1), 45-53.

60   Dolan P, Peasgood T, White M (2006) Review of research on the influences on personal well-being and application to policy making. London: DEFRA.

61   Huppert FA (2008) Psychological well-being: Evidence regarding its causes and consequences. Foresight State-of-Science Review: SR-X2. Government Office for Science.

62   Coid J, Yang M, Roberts A et al (2006) Violence and psychiatric morbidity in the national household population of Britain: public health implications. British Journal of Psychiatry, 189, 12-19.

63   Bradshaw J, Richardson D (2009). An index of child wellbeing in Europe. Child Indicators Research 2(3): 319-351.

64   HM Government (2010) Confident communities, brighter futures: a framework for developing well-being.

65   Campion J, Bhui K, Bhugra D (2012) European Psychiatric Association (EPA) guidance on prevention of mental disorder. European Psychiatry 27: 68-80.

66   Department of Health (2011) The economic case for improving efficiency and quality in mental health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123739.

67   Karoly LA, Kilburn RA, Cannon JS (2005) Early childhood interventions: proven results, future promises. RAND corporation.

68   Schweinhart LJ, Montie J, Xiang Z et al (2005) The High/Scope. Perry Preschool study through age 40. Summary, conclusions and frequently asked questions. Ypsilanti , High/Scope Research Foundation; 2005.

69   Lynch RG (2004) Exceptional Returns. Economic, Fiscal and Social Benefits of Investment in Early Childhood Development. Washington , Economic Policy Institute.

70   Knapp M, Bauer A, Perkind M, Snell T (2010) Building community capacity: making an economic case. PSSRU Discussion paper 2772.

71   Windle G, Hughes D, Linck P et al (2008) Public health interventions to promote mental well-being in people aged 65 and over: systematic review of effectiveness and cost-effectiveness. NICE.

72   Burns T, Catty J, White S, et al (2009) The impact of supported employment and working on clinical and social functioning: results of an international study of Individual Placement and Support. Schizophrenia Bulletin, 35, 949–958.

73   Care Services Efficiency Delivery (2010) Support related housing: good practice examples.

74   Care Services Efficiency Delivery (2008), Support related housing good practice examples: Hestia Project, DH.

References

75   Beecham J, Baingana F, Bonin E et al (2010) School-based universal violence prevention programmes. PSSRU, London School of Economics and Political Science. Unpublished paper prepared for the Department of Health.

76   McCrone P, Knapp M, Henri M, McDaid D (2010). The economic impact of initiatives to reduce stigma: demonstration of a modelling approach. Epidemiol Psichiatr Soc 18:131–9.

77   NICE (2009) Modelling to assess the effectiveness and cost effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0.

78   Meier PS, Purshouse R, Brennan A (2009) Policy options for alcohol price regulation: the importance of modelling population heterogeneity. Addiction, 105, 383-393

79   Callum C (2008). The cost of smoking to the NHS. Action on Smoking and Health (ASH).

80   McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. London: National Centre for Social Research.

81   Drake EK, Aos S, Miller MG (2009) Evidence-based public policy options to reduce crime and criminal justice costs: Implications in Washington State. Victims and Offenders, 4, 170-196.

82   Russell G, Ford T, Steer C, Golding J (2010). Identification of children with the same level of impairment as children on the autistic spectrum, and analysis of their service use. Journal of Child Psychology & Psychiatry 51(6): 643-651.

83   Reilly S, Planner C, Hann M et al (2012) The role of primary care in service provision for people with severe mental illness in the United Kingdom. PLoS One 7(5):e36468.

84   Mitchell AJ, Lawrence D (2011) Revascularisation and mortality rates following acute coronary syndromes in people with severe mental illness: comparative meta-analysis. Br J Psych 198(6): 434-41

85   Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. Br J Psychiatry 2011; 199: 441-2.

86   NHS Information Centre. NHS specialist mental health services http://www.ic.nhs. uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services

87   Department of Health (2012). Transparency in outcomes: a framework for quality in adult social care The 2012/13 Adult Social Care Outcomes Framework. Department of Health.

88   Department of Health (2011). NHS Outcomes Framework 2012-2013. Department of Health

89   Department of Health (2012). Healthy lives, healthy people: Improving outcomes and supporting transparency. Department of Health

90   NHS Confederation. (2011). The Joint Strategic Needs Assessment. NHS Confederation: London.

91   DH (2012) The functions of clinical commissioning groups (updated to reflect the final Health and Social Care Act 2012)

92   HM Government (2009) New Horizons: a shared vision for mental health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109705

93   Department of Health (2011d). Quality, Innovation, Productivity and Prevention (QIPP). Department of Health.

94   HM Government (2012) No health without mental health: implementation framework

95   DH (2012) JSNAs and joint health and wellbeing strategies – draft guidance

96   Morgan A, Ziglio E (2007) Revitalising the evidence base for public health: an assets model. Promotion and Education 2: 17-22

97   Mental Health Strategic Partnership (2012). No Health Without Mental Health: A guide for community organisations.

98   de Girolamo G, Dagani J, Purcell R, Cocchi A, McGorry PD. (2012) Age of onset of mental disorders and use of mental health services: needs, opportunities and obstacles. Epidemiol Psychiatr Sci. 2012 Mar;21(1):47-57.

99   Zilnyk A (2010) Mental Health First Aid – a life skill we should all have? Perspectives in Public Health 130:61

100   NEF (2011) Five Ways to Wellbeing: New applications, new ways of thinking

101   Department of Health (2012) Adult Social Care Outcomes Framework

102   NICE (2012) Commissioning Outcomes Framework

103   DH (2012) Report of the Children and Young People's Health Forum

104   ONS (2012) First ONS Annual Experimental Subjective Well-being Results

105   Alesina A, Di Tella R, MacCulloch R (2004). Inequality and happiness: are Europeans and Americans different? J Public Econ 88:2009–42.

106   ONS (2012) Measuring National Well-being – Where we Live – 2012 http://www.ons.gov.uk/ons/dcp171766_270690.pdf

107   Dolan P, Peasgood T, White M (2008) Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being. J Econ Psychol 29:94–122.

108   Banks J, Breeze E, Crawford R, et al (2010). Financial circumstances, health and well-being of the older population in England. The 2008 English Longitudinal Study of Ageing (Wave 4).

109   Helliwell J, Putnam RD (2005). The social context of wellbeing. In F.A. , N. Baylis and B. Keverne (Eds). The Science of Wellbeing, 435-459. Oxford: Oxford University Press.

110   Plagnol AC, Huppert FA (2010) Happy to help? Exploring the factors associated with variations in rates of volunteering across Europe. Social Indicators Research, 97, 157–176.

111   Barry MM, Jenkins R (2007). Implementing mental health promotion. Oxford:Churchill Livingstone, Elsevier.

112   Emmons RA. Personal goals, life meaning, and virtue: wellsprings of a positive life. In: Keyes CLM, editor. Flourishing: the positive person and the good life. Washington, DC: American Psychological Association; 2003. p.105–28.

113   Koenig HG, McCullough ME, Larson DB, editors (2001) Handbook of religion and health. New York (NY): Oxford University Press. p. 514–54.

114 Zimmerman SL (2000) Self-esteem, personal control, optimism, extraversion and the subjective wellbeing of midwestern university faculty. Dissertation Abstracts International B: Sciences and Engineering, 60(7-B), 3608.

115 Kasser T (2008). Values and prosperity. London: Sustainable Development Commission. http://www.sd-commission. org.uk/publications.php?id=740

116 Department for Communities and Local Government (DCLG) (2010). English housing survey: headline report 2008-09. London: DCLG.

117 NSPCC (2011) Prevalence and incidence of   child abuse and neglect. London: NSPCC.

118 Radford L, Corral S, Bradley C et al (2011) Child abuse and neglect in the UK today. London: NSPCC.

119 Bebbington PE, Jonas S, Brugha T et al (2011). Child sexual abuse reported by an English national sample: characteristics and demography. Social Psychiatry & Psychiatric Epidemiology 46: 255–262.

120 Emerson E, Hatton C, Robertson J et al (2012) People with learning disabilities in England 2011. Improving Health and Lives: Learning Disabilities Observatory.

121 Niven S, Stewart D (2005). Resettlement outcomes on release from prison in 2003. Home Office research findings 248. London: Home Office.

122 HM Government (2009). Healthy Children, Safer Communities – A strategy to promote the health and wellbeing of children and young people in contact with the youth justice system.

123 Roe, S. & Ashe, J. (2008). Young people and crime: findings from the 2006 Offending, Crime and Justice Survey. London: Home Office

124 Department of Health (2010). Healthcare for single homeless people. London: Office of the Chief Analyst, Department of Health.

125 ONS (2011) Integrated Household Survey April 2010 to March 2011: Experimental Statistcis http://www.ons.gov.uk/ons/ dcp171778_227150.pdf

126 Department for Trade and Industry (2004). Final Regulatory Impact Assessment: Civil Partnership Act 2004.

127 Mitchell M, Howarth C (2009) Trans research review. Research report 27. Equality and Human Rights Commission.

128 Kelvin R (unpublished) A cross trust analysis to inform strategic planning for 2008-2009 and future projections

129 Meltzer H, Corbin T, Gatward R et al (2003). The mental health of young people looked after by local authorities in England. London: Office for National Statistics.

130 Emerson E, Hatton C (2007). Mental health of children and adolescents with intellectual disabilities in Britain. Br J Psychiatry 191:493–9.

131 Gavin NI, Gaynes BN, Lohr KN et al (2005). Perinatal depression: a systematic review of prevalence and incidence. Obstetrics & Gynecology 106: 1071–1083.

132 Collins CH, Zimmerman C, Howard LM (2011). Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. Archives of Women's Mental Health 14(1): 3-11.

133 Smiley E (2005). Epidemiology of mental health problems in adults with learning disability: an update. Adv Psychiatr Treat 11:214–22.

134 Stewart D (2008). The problems and needs of newly sentenced prisoners: results from a national survey. Ministry of Justice Research Series;

135 NICE (2009). Antisocial personality disorder, treatment, management and prevention.

136 Fazel S, Bains P, Doll H (2006) Substance abuse and dependence in prisoners: a systematic review. Society for the Study of Addiction, 101, 181-191

137 Singleton N, Melzer H, Gatward R, et al. Psychiatric morbidity among prisoners in England and Wales. London: Stationery Office; 1998.

138 Chakraborty A, McManus S, Brugha TS et al (2011). Mental health of the non-heterosexual population of England. British Journal of Psychiatry 198: 143-148.

139 Bebbington PE, Bhugra D, Brugha T, et al (2004). Psychosis, victimisation and childhood disadvantage: evidence from the second British National Survey of Psychiatric Morbidity. Br J Psychiatry 185:220–6.

140 Kirkbride JB, Errazuriz A, Croudace TJ et al (2012) Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England. PLoS ONE 7(3): e31660. doi:10.1371/journal. pone.0031660

141 Fazel M, Wheeler J, Danesh J (2005) Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. Lancet 365(9467)1309-14

142 Lindert J, Von Ehrenstein O, Priebe S et al (2009). Depression and anxiety in labor migrants and refugees: a systematic review and meta-analysis. Social Science and Medicine 69: 246-257.

143 Glover G, Arts G, Wooff D (2004). A needs index for mental health care in England based on updatable data. Social Psychiatry and Psychiatric Epidemiology 39:730-738.

144 McCrone P, Thornicroft G, Boyle S et al (2006) The development of a Local Index of Need (LIN) and its use to explain variations in social services expenditure on mental health care in England. Health Soc Care Community 14(3): 254-63

145 North East Public Health Observatory (2012). Mental Health Needs Assessment.

146 McCrone, P and Jacobson, B. Indicators of Mental Health Activity in London: recent developments. 2004. London, Kings Fund.

147 Glover GR,. Robin E. A needs index for mental health care. Social Psychiatry Psychiatry Epidemiology 1998;33:89-96.

148 DH (2012) Programme budgeting tools and data: Commissioner level expenditure data.

149 (39) Cooke A, Friedli L, Coggins T et al (2011) Mental Wellbeing Impact Assessment Toolkit 3rd ed., London: National MWIA Collaborative.

150 (215) Einarson A, Riordan S (2009). Smoking in pregnancy and lactation: a review of risks and cessation strategies. European Journal of Clinical Pharmacology 65: 325-330.

151 (217) Horta BL, Bahl R, Martines JC, Victoria CG (2007) Evidence on the long-term effects of breastfeeding. World Health Organisation.

References

152 Heikkila K, Sacker A, Kelly Y et al (2011) Breast feeding and child behaviour in the Millennium Cohort Study. Arch Dis Child doi: 10.1136/adc.2010.201970

153 Bull J, McCormick G, Swann S, Mulvihill C. Ante- and post-natal homevisiting programmes: a review of reviews. London: Health Development Agency; 2004.

154 Shaw E, Levitt C, Wong S, Kaczorowski J (2006). Systematic review of the literature on postpartum care: effectiveness of postpartum support to improve maternal parenting, mental health, quality of life, and physical health. Birth Issues In Perinatal Care 33(3): 210-220.

155 Barlow J, Coren E, Stewart-Brown S (2003). Parent-training programmes for improving maternal psychosocial health. Cochrane Database of Systematic Reviews. Issue 4. Art. No.: CD002020. doi:10.1002/14651858. CD002020.pub2.

156 Stewart-Brown SL, Scharder-McMillan A (2011) Parenting for mental health: what does the evidence say we need to do? Report of Workpackage 2 of the DataPrev project. Health Promot Int 26(1):i10-28

157 Bakermans-Kranenburg MJ, Van IJzendoorn MH, Juffer F (2003). Less is more: meta-analyses of sensitivity and attachment interventions in early childhood. Psychological Bulletin, 129, 195-215.

158 Melhuish E, Belsky J, Leyland AH et al (2008). Effects of fully-established Sure Start local programmes on 3-year-old children and their families living in England: a quasi-experimental observational study. Lancet 372: 1641-1647.

159 Olds DL, Kitzman H, Hanks C et al (2007). Effects of nurse home visiting on maternal and child functioning: age-9 follow-up of a randomized trial. Pediatrics 120(4): e832–e845.

160 Prinz RJ (2007). Parenting and the prevention of childhood injuries. In LS Doll, SE Bonzo, JA Mercy et al (eds). Handbook of injury and violence prevention. New York: Springer, pp.333–346.

161 Barlow J, Parsons J (2003). Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children. Cochrane Database of Systematic, Issue 2. Art. No.: CD003680. doi:10.1002/14651858. CD003680.

162 Barlow J, Stewart-Brown S (2000). Behaviour problems and group based parent education programs. Developmental and Behavioural Pediatrics 21(3): 356-370.

163 Dretzke J, Davenport C, Frew E, et al (2009) The clinical effectiveness of different parenting programmes for children with conduct problems: a systematic review of randomised controlled trials. Child and Adolescent Psychiatry and Mental Health.

164 De Graaf I, Speetjens P, Smit F et al (2008). Effectiveness of the Triple P Positive Parenting Program on behavioral problems in children: a meta-analysis. Behavior Modification 32(5): 714-735.

165 Scott S, Sylva K, Doolan M et al (2009). Randomised controlled trial of parent groups for child antisocial behaviour targeting multiple risk factors: the SPOKES project. Journal of Child Psychology and Psychiatry 51(1) 48-57.

166 Blank L, Baxter S, Goyder L, et al (2009) Systematic review of universal interventions which aim to promote emotional and social well-being in secondary schools. School of Health and Related Research (ScHARR) University of Sheffield.

167 Kendrick D, Barlow J, Hampshire A, et al (2007) Parenting interventions for the prevention of unintentional injuries in childhood. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD006020. doi:10.1002/14651858. CD006020.pub2.

168 Lundahl BW, Nimer J, Parsons B (2006). Preventing child abuse: a meta-analysis of parent training programme. Research on Social Work Practice 16: 251-262.

169 Hutchings J, Bywater T, Daley D, et al (2007) Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial. BMJ 334:678–82.

170 Scott S (2008). An update on interventions for conduct disorder. Advances in Psychiatric Treatment 14: 61-70.

171 Woolfenden S, Williams KJ, Peat J. (2001). Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17. Cochrane Database of Systematic Reviews, Issue 2. Art. No.: CD003015. doi:10.1002/14651858. CD003015.

172 NICE (2008). Attention deficit hyperactivity disorder: diagnosis and management of ADHD in children, young people and adults. London: NICE. http://www.nice.org.uk/nicemedia/pdf/ CG72NiceGuidelinev3.pdf

173 Whittingham K, Sofronoff K, Sheffield J, Sanders MR (2009). Stepping Stones Triple P: an RCT of a parenting program with parents of a child diagnosed with an autism spectrum disorder. Journal of Abnormal Child Psychology 37(4): 469-480.

174 Lundahl BW, Risser HJ, Lovejoy MC (2006). A meta-analysis of parent training: moderators and follow-up effects. Clinical Psychology Review 26(1): 86-104.

175 Drugli MB, Larsson B, Fossum S et al (2009). Five-to-six-year outcome and its prediction for children with ODD/CD treated with parent training. Journal of child Psychology and Psychiatry 51(5): 559-566.

176 National Centre for Social Research (2010). ASB family intervention projects: monitoring and evaluation. Research report DCSF-RR215. London: Department for Children, Schools and Families. https://www.education.gov.uk/ publications/eOrderingDownload/DFE-RR044.pdf

177 Anderson LM, Shinn C, Fullilove MT, et al (2003). The effectiveness of early childhood development programs: a systematic review. Am J Prev Med 24(3S):32–46.

178 Sylva K, Melhuish E, Sammons P, et al. Effective pre-school and primary education 3-11 project (EPPE 3-11) a longitudinal study funded by the DfES (2003–2008) promoting equality in the early years: report to the Equalities Review. London: Institute of Education; 2007.

179 Tennant R, Goens C, Barlow J, et al (2007). A systematic review of reviews of interventions to promote mental health and prevent mental health problems in children and young people. J Public Ment Health 6(1): 25–32.

180 Waddell C, Hua JM, Garland O et al (2007). Preventing mental disorders in children: a systematic review to inform policy-making. Canadian Journal of Public Health 98(3): 166-173.

181   Weare K, Nind M (2011) Promoting mental health of children and adolescents through schools and school-based interventions: report of workpackage three of the DataPrev Project. DataPrev.

182   NICE (2009). Promoting young people's social and emotional well-being in secondary education.

183   Durlak JA, Weissberg RP, Dymnicki AB, et al (2011) The impact of enhancing students' social and emotional learning: a meta-analysis of school-based universal interventions. Child Dev 82:474–501.

184   Adi Y, Killoran A, Janmohamed K, Stewart-Brown S (2007). Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education. Report 1: Universal approaches – non-violence related outcomes. London: NICE.

185   Brunwasser SM, Gilham JE, Kim ES (2009). A meta-analytic review of the Penn Resiliency Program's effects on depressive symptoms. Journal of Consulting & Clinical Psychology 77(6): 1042-1054.

186   Challen A, Noden P, West A, Machin S (20011). UK resilience programme evaluation: Final report. Research report DFE-RB097. London: London School of Economics and Political Science. https://www.education.gov.uk/publications/eOrderingDownload/DFE-RB097.pdf

187   DuBois DL, Holloway BE, Valentine JC, Cooper H (2002). Effectiveness of mentoring programs for youth: a meta-analytic review. American Journal of Community Psychology 30(2):157-197.

188   Thomson H, Thomas S, Sellstrom E, Petticrew M (2009). The health impacts of housing improvement: a systematic review of intervention studies from 1887 to 2007. American Journal of Public Health 99(S3): S681-S692.

189   NICE (2005). Housing and public health: a review of reviews of interventions for improving health. Evidence briefing. London: NICE.

190   Nelson G, Aubry T, Lafrance A (2007). A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management for persons with mental illness who have been homeless. American Journal of Orthopsychiatry 77: 350-361.

191   Care Services Efficiency Delivery (CSED) (2010). Manchester Methodist Housing Association Next Step Project: resettlement project for men aged 30+ with enduring mental illness. Support related housing. London: Department of Health.

192   National Centre for Social Research (2010). ASB family intervention projects: monitoring and evaluation. Research report DCSF-RR215. London: Department for Children, Schools and Families.

193   Killoran A, Doyle N, Waller S et al (2006). Transport interventions promoting safe cycling and walking. Evidence briefing. London: NICE/HDA.

194   Giles-Corti B, Broomhall MH, Knuiman M et al (2005). Increasing walking: how important is distance to, attractiveness, and size of public open space. American Journal of Preventative Medicine 28: 169-176.

195   Duncan M, Spence J, Mummery W (2005). Perceived environment and physical activity: a meta-analysis of selected environmental characteristics. International Journal of Behavioral Nutrition and Physical Activity 2(11) doi:10.1186/1479-5868-2-11

196   Bauman AE, Bull FC (2007). Environmental correlates of physical activity and walking in adults and children: A review of reviews. Review undertaken for National Institute of Health and Clinical Excellence.

197   Pleasence P, Balmer NJ. (2007) Changing fortunes: results from a randomized trial of the offer of debt advice in England and Wales. J Emp Legal Stud;4(3):465–75.

198   Taylor M, Jenkins S, Sacker A (2009). Financial capability and well-being: evidence from the BHPS. Financial Services Authority, Occasional Paper Series 34.

199   NICE (2009). Depression: the treatment and management of depression in adults.

200   Harvey SB, Hotopf M, Overland S, Mykletun A.(2010) Physical activity and common mental disorders. Br J Psychiatry;197:357–64.

201   Holley J, Crone D, Tyson P, Lovell G (2011). A systematic review: the effects of physical activity on psychological wellbeing for those with schizophrenia. British Journal of Clinical Psychology 50: 84-105.

202   Sibley BA, Etnier JL (2003). The relationship between physical activity and cognition in children: a meta-analysis. Pediatr Exerc Sci;15:243–56.

203   NICE (2008). Public health interventions to promote mental well-being in people aged 65 and over: systematic review of effectiveness and cost-effectiveness.

204   Caldwell LL (2005) Leisure and health: why is leisure therapeutic? Br J Guidance Counsel 33:7–26.

205   Sacker A, Cable N (2005). Do adolescent leisure-time physical activities foster health and wellbeing in adulthood? Evidence from two British birth cohorts. European Journal of Public Health 16(3): 331-335.

206   NICE (2007). Physical activity and children. Review 5: intervention review: children and active travel. London: NICE Public Health Collaborating Centre.

207   NICE (2009). Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings. London: NICE.

208   NICE (2008). Promoting and creating built or natural environments that encourage and support physical activity. London: NICE. http://www.nice.org.uk/nicemedia/pdf/PH008GuidanceWordv2.doc

209   Jacobsen PL, Racioppi F, Rutter H (2009). Who owns the roads? How motorised traffic discourages walking and bicycling. Injury Prevention 15: 369–373.

210   Sin NL, Lyubomirsky S (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: a practice-friendly meta-analysis. J Clin Psychol 65(5):467–87.

211   Grossman P, Niemann L, Schmidt S, Walach H (2004). Mindfulness-based stress reduction and health benefits: a meta-analysis. J Psychosom Res 57:35–43.

212   Chiesa A, Serretti A (2009). Mindfulness-based stress reduction for stress management in healthy people: a review and meta-analysis. J Altern Complement Med 15(5):593–600.

213   Hofmann SG, Sawyer AT, Witt AA, Oh D (2010) The effect of mindfulness-based therapy on anxiety and depression: a meta-analytic review. J Consult Clin Psychol 78:169–83.

References

214   WHOQOL (2006) A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life. Soc Sci Med 62(6):1486–97.

215   Plante TG, Thoresen CE Eds. (2007). Spirit, science and health: how the spiritual mind fuels physical wellness. Westport, Conn/London: Praeger.

216   Smith TB, McCullough ME, Poll J (2003). Religiousness and depression: evidence for a main effect and the moderating influence of stressful life events. Psychology Bulletin 29: 614–636.

217   Koenig HG (2009). Research on religion, spirituality, and mental health: a review. Can J Psychiatr 54(5):283–91.

218   Smith TB, Bartz J, Richards PS (2007) Outcomes of religious and spiritual adaptations to psychotherapy: a meta-analytic review. Psychother Res 17(6):643–55.

219   Schuller T, Preston J, Hammond C et al (2004). The benefits of learning: the impact of education on health, family life and social capital. London: RoutledgeFalmer Press.

220   Feinstein L, Budge D, Vorhaus J, Duckworth K (2008). The social and personal benefits of learning:. A summary of key research findings. London: Institute of Education, University of London. http://www.learningbenefits. net/Publications/FlagshipPubs/Final%20 WBL%20Synthesis%20Report.pdf

221   Sabates R, Feinstein L (2006). Education and the take-up of preventative health care. Social Science and Medicine 62: 2998-3010.

222   Department of Health (2007). Report of the Review of Arts and Health Working Group. Department of Health (

223   Staricoff RL (2004). Arts in health: a review of the medical literature. Research report 36. Arts Council England.

224   Bungay H, Clift S (2010). Arts on prescription: A review of practice in the UK. Perspectives in Public Health 130: 277-281

225   Lin ST, Yang P, Lai CY (2011). Mental health implications of music: insight from neuroscientific and clinical studies. Harv Rev Psychiatry 19(1):34–46.

226   Piliavin JA, Siegl E (2007). Health benefits of volunteering in the Wisconsin Longitudinal Study. Journal of Health and Social Behavior 48(4): 450-464.

227   Brown S, Nesse RM, Vonokur AD, Smith DM (2003). Providing social support may be more beneficial than receiving it: results from a prospective study of mortality. Psychological Science 14(4): 320-327.

228   Greenfield EA, Marks NF (2004). Formal volunteering as a protective factor for older adults' psychological wellbeing. The Journals of Gerontology series B 59(5): S258-S264.

229   Hill M, Russell, Brewis G (2009) Young people, volunteering and youth projects: A rapid review of recent evidence. Institute for Volunteering Research http://vinspired.com/uploads/admin_ assets/datas/282/original/v_formative_ evaluation_rapid_evidence_review_ Dec_2009_x_2.pdf

230   Lasker J, Collom E, Bealer T, et al (2011). Time banking and health: the role of a community currency organization in enhancing well-being. Health Promot Pract 12(1):102–15.

231   Seyfang G (2003). Growing cohesive communities, one favour at a time: social exclusion, active citizenship and time banks. International Journal of Urban and Regional Research 27(3): 699-706.

232   nef (New Economics Foundation) (2008). The new wealth of time: how timebanking helps people build better public services. London: nef.

233   Morgan A, Swann C (Eds.) (2004). Social Capital for Health: issues of definition, measurement and links to health. London: Health Development Agency.

234   Wallerstein N (2006). What is the evidence on effectiveness of empowerment to improve health? Copenhagen, WHO Regional Office or Europe (Health Evidence Network Report).

235   NICE (2008). Community engagement to improve health. Public health guidance 9. London: NICE.

236   Swainton, K and Summerbell, C (2008). The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid Review Phase 3 (including consideration of additional evidence from stakeholders) NICE National Collaborating Centre, University of Teesside.

237   Kuo FE, Sullivan WC (2001). Aggression and violence in the inner city: effects of environment via mental fatigue. Environment and Behaviour 33(4): 543-571.

238   Sullivan WC, Kuo FE, Depooter SF (2004). The fruit of urban nature: vital neighbourhood space. Environ Behav 36(5):678–700.

239   Clark C, Stansfeld SA, Candy B (2006). A systematic review on the effect of the physical environment on mental health. Epidemiology 17(6):S527.

240   Bird W (2007). Natural thinking: a report for the Royal Society for the Protection of Birds, investigating the links between the natural environment, biodiversity and mental health. Sandy: Royal Society for the Protection of Birds.2007. http://www. rspb.org.uk/ourwork/policy/health/index. asp

241   Austin ME (2002). Partnership opportunities in neighbourhood tree planting initiatives: building from local knowledge. Journal of Arboriculture 28:178-186.

242   Mind (2007). Ecotherapy: a green agenda for health. London: Mind.

243   Kuoppala J, Lamminpaa A, Husman P (2008). Work health promotion, job wellbeing and sickness absence – a systematic review and meta-analysis. Journal of Occupational Environmental Medicine 50: 1216-1227

244   Martin A, Sanderson K, Cocker F (2009). Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. Scand J Work Environ Health 35(1):7-18.

245   Richardson KM, Rothstein HR. Effects of occupational stress management intervention programmes: a meta-analysis. J Occup Health Psychol 2008; 13(1):69–93.

246   Audhoe SS, Hoving JL, Sluiter JK et al (2010). Vocational interventions for unemployed. Effects on work participation and mental distress: a systematic review. J Occup Rehab 20(1):1–13.

247   Cattan M, White M, Bond J, Learmouth A (2005) Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. Ageing Society 25:41–67.

248   Mead N, Lester H, Chew-Graham C et al (2010). Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. British Journal of Psychiatry 196: 96-101.

249   Pinquart M, Sorensen S (2001) How effective are psychotherapeutic and other psychosocial interventions with older adults? J Ment Health Aging 7(2):207–43.

250   Forsman AK, Schierenbeck I, Wahlbeck K (2010). Psychosocial interventions for the prevention of depression in older adults: systematic review and meta-analysis. Journal of Aging and Health 23(3): 387 –416.

251   Wheeler J, Gorey K, Greenblatt B (1998) The beneficial effects of volunteering for older volunteers and the people they serve: a meta-analysis. Int J Aging Human Dev 47(1):69–79.

252   Lum TY, Lightfoot E (2005). The effects of volunteering on the physical and mental health of older people. Research on Aging 27(1): 31-55.

253   Chisolm TH, Johnson CE, Danhauer JL et al (2007). A systematic review of health-related quality of life and hearing aids: final report of the American Academy of Audiology Task Force On the Health-Related Quality of Life Benefits of Amplification in Adults. Journal of the American Academy of Audiology 18(2): 151-183.

254   NICE (2010) Promoting the quality of life of looked-after children and young people http://guidance.nice.org.uk/PH28

255   Sorensen S, Pinquart M, Duberstein D (2002). How effective are interventions with caregivers? An updated meta-analysis. The Gerontologist 42(3): 356-372.

256   Thompson A, Fan M-Y, Unutzer J et al (2008) One extra month of depression: the effects of caregiving on depression outcomes in the IMPACT trial. International Journal of Geriatric Psychiatry 23: 511-515.

257   Piachaud D, Bennet F, Nazroo J, Popay J (2009). Social inclusion and social mobility. Report of Task Group 9. London: Marmot Review.

258   NICE (2008). Community engagement to improve health. Public health guidance 9. London: NICE.

259   Button TM, Maughan B, McGuffin P (2007) The relationship of maternal smoking to psychological problems in the offspring. Early Hum Dev 83:727–32.

260   Hutchinson J, Pickett KE, Green J, Wakschlag LS (2010) Smoking in pregnancy and disruptive behaviour in 3-year-old boys and girls: an analysis of the UK Millennium Cohort Study. J Epidemiol Community Health 64(1):82–8.

261   Melhuish, E, Belsky, J., & Barnes, J. (2010). Evaluation and value of Sure Start. Archives of Disease in Childhood, 95, 159-161 .

262   Durlak JA, Wells AM (1997). Primary prevention mental health programs for children and adolescents: a meta-analytic review. Am J Commun Psychol 25(2):115–52.

263   Calear AL, Christensena H (2010). Systematic review of school-based prevention and early intervention programs for depression. Journal of Adolescence 33(3): 429-438.

264   Merry S, McDowell H, Hetrick S et al (2004). Psychological and/or educational interventions for the prevention of depression in children and adolescents. Cochrane Database of Systematic Reviews Issue 2. Art. No.: CD003380. DOI: 10.1002/14651858.CD003380.pub2

265   Horowitz JL, Garber J (2006). The prevention of depressive symptoms in children and adolescents: a meta-analytic review. Journal of Consulting and Clinical Psychology 74(3): 401-415.

266   Garber J, Clarke GN, Weersing R et al (2009). Prevention of depression in at-risk adolescents: a randomised control trial. JAMA301(21): 2215-2224.

267   Beardslee WR, Wright EJ, Gladstone TRG et al (2008). Long-term effects from a randomized trial of two public heath preventive interventions for parental depression. Journal of Family Psychology 21: 703-713.

268   Brugha T, Morrell CJ, Slade P, Walters SJ (2011). Universal prevention of depression postnatally: cluster randomized trial evidence in primary care. Psychological Medicine 41(4): 739-748.

269   Morrell CJ, Slade P, Warner R et al (2009). Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: pragmatic cluster randomised trial in primary care. British Medical Journal 338: a3045.

270   Dennis C-L, Hodnett E, Reisman HM, et al (2009) Effect of peer support on prevention of post-natal depression among high-risk women: multisite randomised controlled trial. BMJ 338:a3064.

271   Chapman DP, Perry GS (2008). Depression as a major component of public health for older adults. Preventing Chronic Disease 5(1).

272   Angevaren M, Aufdemkampe G, Verhaar H et al (2008). Physical activity and enhanced fitness to improve cognitive function in older people without known cognitive impairment, Cochrane Database Systematic Review (2) CD005381.

273   Hamer M, Chida Y (2009). Physical activity and risk of neurodegenerative disease: a systematic review of prospective evidence. Psychological Medicine 39: 3-11.

274   Fratiglioni L, Winblad B, von Strauss E (2007). Prevention of Alzheimer's disease and dementia. Major findings from the Kungsholmen Project. Physiol Behav 92(1–2):98–104.

275   Bennett D, Schneider J, Tang Y, et al (2006). The effect of social networks on the relation between Alzheimer's disease pathology and level of cognitive function in old people: a longitudinal cohort study. Lancet Neurol 5:406–12.

276   Valenzuela M, Perminder S (2009) Can cognitive exercise prevent the onset of dementia? Systematic review of randomized clinical trials with longitudinal follow-up. Am J Geriatr Psychiatry 17(3):179–87.

References

277   Fournier A, Oprisiu-Fournier R, Serot JM, et al (2009) Prevention of dementia by antihypertensive drugs: How AT1-receptor-blockers and dihydropyridines better prevent dementia in hypertensive patients than thiazides and ACEinhibitors. Exp Rev Neurother 9(9):1413–31.

278   Li N, Lee A, Whitmer RA, et al (2010) Use of angiotensin receptor blockers and risk of dementia in a predominantly male population: prospective cohort analysis. BMJ 340:b5465.

279   Campion J, Checinski K, Nurse J, McNeill A (2008). Smoking by people with mental illness and benefits of smoke-free mental health services. Advances in Psychiatric Treatment 14: 217-228.

280   Campion J, Checinski K, Nurse J (2008). Review of smoking cessation treatments for people with mental Illness. Advances in Psychiatric Treatment 14,: 208-16.

281   Campion J, Hewitt J, Shiers D, Taylor D (2010) Pharmacy guidance on smoking and mental health. Forum for Mental Health in Primary Care. Available at: http://www.rcpsych.ac.uk/pdf/Pharmacy_%20guidance%20for%20smoking%20and%20mental%20health%20Feb%202010.pdf

282   HM Government (2011) Healthy Lives, Healthy People: A Tobacco Control Plan for England. HM Government

283   NHS Information Centre (2010b). Smoking, drinking and drug use among young people in England in 2009. Leeds/London: NHS Information Centre. http://www.ic.nhs.uk/webfiles/publications/Health%20and%20Lifestyles/sdd2009/SDD_2009_Report.pdf

284   Joffe A, McNeely C, Colantuoni E et al (2009). Evaluation of school-based smoking-cessation interventions for self-described adolescent smokers. Pediatrics 124(2): e187-e194

285   Peterson AV, Kealey KA, Mann SL et al (2009) Group-Randomized Trial of a Proactive, Personalized Telephone Counseling Intervention for Adolescent Smoking Cessation. J Natl Cancer Inst 101:1378–1392

286   Moolchan ET, Frazier M, Franken FH, Ernst M (2007). Adolescents in smoking cessation treatment: Relationship between externalizing symptoms, smoking history and outcome. Psychiatry Research 152(2-3): 281-285

287   Humfleet GL, Prochaska JJ, Mengis M et al (2005). Preliminary evidence of the association between the history of childhood attention-deficit/hyperactivity disorder and smoking treatment failure. Nicotine and Tobacco Research 7(3): 453-460

288   NICE (2008). Mass-media and point-of¬sales measures to prevent the uptake of smoking by children and young people. http://www.nice.org.uk/nicemedia/pdf/PH14fullguidance.pdf

289   NICE (2010) School-based interventions to prevent the uptake of smoking among children and young people. http://www.nice.org.uk/nicemedia/pdf/PH23Guidance.pdf

290   Ariza C, Nebot M, Tomas Z et al (2008). Longitudinal effects of the European smoking prevention framework approach (ESFA) project in Spanish adolescents. European Journal of Public Health, 18(5): 491-497

291   Conner M, Higgins AR (2010) Long-Term Effects of Implementation Intentions on Prevention of Smoking Uptake Among Adolescents: A Cluster Randomized Controlled Trial. Health Psychology 29(5): 529-538

292   Crone MR, Spruijt R, Dijkstra NS et al (2011).Does a smoking prevention program in elementary schools prepare children for secondary school? Preventive Medicine 52(1): 53-59

293   Thyrian JR, Tagmat D, Wolff J et al (2008). School-based smoking prevention in adolescents via the Internet: Who do we reach and what do they think about it? Family Medicine and Primary Care Review 10(1): 37-44

294   Wyszynski CM, Bricker JB, Comstock BA et al (2011). Parental Smoking Cessation and Child Daily Smoking: A 9-Year Longitudinal Study of Mediation by Child Cognitions About Smoking. Health Psychology 30(2): 171-176

295   Petrie J, Bunn F, Byrne G (2007). Parenting programmes for preventing tobacco, alcohol and drug misuse in children <18 years: a systematic review. Health Education Research 22: 177–191.

296   NICE (2010). Alcohol-use disorders: preventing the development of hazardous and harmful drinking. Public health guidance 24.

297   NICE (2007). Interventions in schools to prevent and reduce alcohol use among children and young people.

298   NICE (2011) Alcohol dependence and harmful alcohol use. London: NICE.

299   Liang W, Chikritzhs T (2011) Affective disorders, anxiety disorder and the risk of alcohol dependence and misuse, Br J Psych 199(3): 219-24

300   NICE (2011). Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults Commissioning guide Implementing NICE guidance.

301   Jones L, Sumnall H, Witty K, et al (2006) A review of community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people.

302   McGrath Y, Sumnall H, McVeigh J, Bellis M (2006) Drug use prevention among young people: a review of reviews.

303   Faggiano F, Vigna-Taglianti FD, Versino E, et al (2005). School-based prevention for illicit drugs' use. Cochrane Database Syst Rev (2) CD003020. doi:10.1002/14651858.CD003020.pub2.

304   Spoth R, Trudeau L, Shin C et al (2008) Long-term effects of universal preventive interventions on prescription drug misuse. Addiction 103; 1160-1168

305   Kellam S, Brown C, Poduska J, et al (2007) Effects of a universal classroom behaviour management program in first and second grades on young adult behavioral, psychiatric, and social outcomes. Drug Alcohol Depend 95(S1):S5–28.

306   Prendergast M, Podus D, Finney J et al (2007). Contingency management for treatment of substance use disorders: a meta-analysis. Addiction 101: 1546-1560.

307   NICE (2007). Drug misuse: psychosocial interventions.

308   NICE (2007). Drug misuse: Opioid detoxification;

309   NICE (2011). Psychosis with coexisting substance misuse: assessment and management in adults and young people.

310   Blaine B, Rodman J, Newman J (2007). Weight loss treatment and psychological well-being: a review and meta-analysis. J Health Psychol. 12(1):66–82.

311   Barker DJP (2007). Obesity and early life. Short science review. Obesity Reviews 8(s1): 45–49.

312   Franz MJ,VanWormer JJ, Crain AL et al (2007). Weight-loss outcomes: a systematic review and meta-analysis of weight-loss clinical trials with a minimum one-year follow-up. Journal of the American Dietetic Association 107(10): 1755-1767.

313   NICE (2006). Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. London: NICE.

314   Griffiths LJ, Parsons TJ, Hill AJ (2010). Self-esteem and quality of life in obese children and adolescents: a systematic review. International Journal of Pediatric Obesity 5(4): 282-304.

315   Alvarez-Jimenez M, Hetrick S, Gonzalez-Blanch C, et al (2008). Non-pharmacological management of antipsychotic-induced weight gain: systematic review and meta-analysis of randomised controlled trials. Br J Psychiatry 193:101–7.

316   NHS Information Centre (2008). Statistics on obesity, physical activity and diet: England, 2008. Leeds/London.

317   Sloman L, Cairns S, Newson C et al (2010). The effects of smarter choice programmes in the sustainable travel towns: summary report. London: Department for Transport.

318   NICE (2008) Promoting physical activity in the workplace.

319   Vancampfort D, Knapen J, De Hert M (2009) Cardiometabolic effects of physical activity interventions for people with schizophrenia. Phys Ther Rev 14(6):388–98.

320   Wu RR, Zhao JP, Jin H et al (2008). Lifestyle intervention and metformin for treatment of antipsychotic-induced weight gain. JAMA 299(2): 185-193.

321   Downing J, Jones L, Cook PA et al (2006) Prevention of sexually transmitted infections (STIs): a review of reviews in the effectiveness of non-clinical interventions. Evidence Briefing Update.

322   Johnson B, Scott-Sheldon L, Smoak Netal (2009). Behavioral interventions for African Americans to reduce sexual risk of HIV: a meta-analysis of randomized controlled trials. Journal of Acquired Immune Deficiency Syndromes 51(4): 492-501.

323   Higgins A, Barker P, Begley CM (2006) Sexual health education for people with mental health problems: what can we learn from the literature? J Psychiatr Ment Health Nurs 13:687–97.

324   Zwi KW, Woolfenden SR, Wheeler DM, et al (2009) School-based education programmes for the prevention of child sexual abuse. Cochrane Database of Systematic Reviews, Issue 3. Art. No: CD004380: a meta-analysis. J Clin Child Psychol. 2000 Jun;29(2):257-65.

325   Pickett KE, Wilkinson RG (2010) Inequality: an underacknowledged source of mental illness and distress. BJ Psych 197:426-8

326   Marmot N, Allen J, Goldblatt P et al (2010). Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010. The Marmot Review

327   Morgan A, Jorm A (2007) Awareness of beyondblue: the national depression initiative in Australian young people. Australas Psychiatry 15: 329 -33

328   Highet NJ, Luscombe GM, Davenport TA, et al (2006). Positive relationships between public awareness activity and recognition of the impacts of depression in Australia. Australian and New Zealand Journal of Psychiatry 40(1): 55-58.

329   Pettigrew TF, Tropp LR (2006). A meta-analytic test of intergroup contact theory. Journal of Personality & Social Psychology 90: 751-783.

330   Pinfold V, Toulmin H, Thornicroft G et al (2003). Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. British Journal of Psychiatry 182: 342-346.

331   Pinfold V, Huxley P, Thornicroft G et al (2003). Reducing psychiatric stigma and discrimination: evaluating an educational intervention with the police force in England. Social Psychiatry & Psychiatric Epidemiology 38: 337-344.

332   HM Government (2012) Preventing suicide in England. A cross-government outcomes strategy to save lives.

333   Keyes KM, Eaton NR, McLaughlin KA et al (2012) Childhood maltreatment and the structure of common psychiatric dosprders. BJPsych 200: 107-115

334   Mytton JA, DiGuiseppi C, Gough D, et al (2006). School-based secondary prevention programmes for preventing violence. Cochrane Database of Systematic Reviews; Issue 3. Art No.: CD004606. doi:10.1002/14651858. CD004606.pub2.

335   Hahn R, Fuqua-Whitley D, Wethington H et al (2007). Effectiveness of universal school-based programs to prevent violent and aggressive behavior: a systematic review. American Journal of Preventive Medicine 33(2): S114-S129

336   Wilson SJ, Lipsey MW (2007). School-based interventions for aggressive and disruptive behavior. American Journal of Preventive Medicine 33(2S): S130-S143.

337   Ttofi MM, Farrington DP, Baldry AC (2008). Effectiveness of programmes to reduce school bullying. Swedish National Council for Crime Prevention.

338   Foshee VA, Bauman KE, Ennett ST et al (2004). Assessing the long-term effects of the Safe Dates Program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. American Journal of Public Health 94: 619-624.

339   Bilukha O et al (2005). The effectiveness of early childhood home visitation in preventing violence. A systematic review. American Journal of Preventive Medicine, 28:11–39.

340   OIds DL, Eckenrode JJ, Henderson CR et al (1997). Long term effects of home visitation on maternal life course and child abuse and neglect: fifteen year follow up of a randomised trial. Journal of the American Medical Association 278(8): 637-643.

References

341   WHO Europe (2010). European report on preventing violence and knife crime among young people. Copenhagen: WHO Europe.

342   Papachristos AV, Meares T, Fagan J. (2007). Attention felons: evaluating Project Safe Neighborhoods in Chicago. Journal of Empirical Legal Studies, 4:223–272.

343   Farrington D, Welsh B (2002). Effects of improved street lighting on crime: a systematic review. Home Office Research Study 251. London: Home Office.

344   Knox K, Litts D, Talcott G, Catalano Feig J et al (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study. British Medical Journal 327:1376.

345   Fazel S, Doll H, Langstrom N (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: a systematic review and metaregression analysis of 25 surveys. Journal of the American Academy of Child and Adolescent Psychiatry 47(9): 1010-1019.

346   Hockenhull JC, Whittington R, Leitner M (2012). A systematic review of prevention and intervention strategies for populations at high risk of engaging in violent behaviour: update 2002-8. Health Technol Assess 16(3):1-152.

347   Flatley J, Kershaw C, Smith K et al (eds) (2010). Crime in England and Wales 2009/10. London: Home Office.

348   World Health Organization (2009). Preventing violence by reducing the availability and harmful use of alcohol. Violence prevention: the evidence. Geneva: WHO.

349   Ker K, Chinnock P (2008). Interventions in the alcohol server setting for preventing injuries. Cochrane Database of Systematic Review, 3:CD005244.

350   Stafström M, Östergren P (2008) A community-based intervention to reduce alcohol-related accidents and violence in 9th grade students in southern Sweden: the example of the Trelleborg Project. Accident Analysis and Prevention 40:920–925.

351   Smith A, Hodgson R, Bridgeman K, Shepherd J (2003). A randomized controlled trial of a brief intervention after alcohol-related facial injury. Addiction 98: 43-52.

352   Oakey F, Ayoub A, Goodall C et al (2008). Delivery of a brief motivational intervention to patients with alcohol-related facial injuries: Role for a specialist nurse. British Journal of Oral and Maxillofacial Surgery. 46(2): 102-106.

353   NICE (2007). Antenatal and postnatal mental health: the NICE guidance on clinical management and service guidance. London: NICE. http://guidance.nice.org.uk/CG45/Guidance/pdf/English

354   NICE (2009). Attention Deficit Hyperactivity Disorder. The NICE guideline on diagnosis and management of ADHD in children, young people and adults.

355   NICE (2005). Depression in children and young people: identification and management in primary, community and secondary care. London: NICE. http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10970

356   Dawson G, Rogers S, Munson J et al (2010). Randomised controlled trial of an intervention for toddlers with autism: the Early Start Denver model. Pediatrics 125: e17-e23.

357   Landa RJ, Holman KC, O'Neill AH et al (2011). Intervention targeting development of socially synchronous engagement in toddlers with autistic spectrum disorder: a randomised controlled trial. Journal of Child Psychology and Psychiatry 52(1): 13-21.

358   Michie S, Williams S (2003) Reducing work-related psychological ill health and sickness absence: a systematic literature review. Occupational and Environmental Medicine 60:3–9.

359   NICE (2009). Promoting mental wellbeing through productive and healthy working conditions. London: NICE.

360   Bird V, Premkumar P, Kendall T et al (2010). Early intervention services, cognitive behavioural therapy and family intervention in early psychosis: systematic review. British Journal of Psychiatry 197: 350-356.

361   Mihalopoulos C, Harris M, Henry M et al (2009). Is early intervention in psychosis cost-effective over the long term? Schizophrenia Bulletin 35: 909-918.

362   Major BS, Hinton MF, Flint A et al (2010). Evidence of the effectiveness of a specialist vocational intervention following first episode psychosis: a naturalistic prospective cohort study. Social Psychiatry & Psychiatric Epidemiology 45(1): 1-8.

363   McGorry PD, Yung AR, Phillips LJ, et al (2002) Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. Arch Gen Psychiatry 59:921–8.

364   McGlashan TH, Zipursky RB, Perkins D, et al (2006) Randomized, double-blind trial of olanzapine versus placebo in patients prodromally symptomatic for psychosis. Am J Psychiatr 163:790–9.

365   Chanen AM, Jackson HJ, McCutcheon L, et al (2008). Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: a randomised controlled trial. Br J Psychiatry 193:477–84.

366   Treasure J, Russell (2011) The case for early intervention in anorexia nervosa: the theoretical exploration of maintaining factors. BJPsych 199: 5-7

367   Tsoi DT, Porwal M, Webster AC (2010). Efficacy and safety of bupropion for smoking cessation and reduction in schizophrenia: systematic review and meta-analysis. British Journal of Psychiatry 196(5): 346-353.

368   (381) Bond G, Drake R, Becker D (2008). An update on randomized controlled trials of evidence-based supported employment. Psychiatric Rehabilitation Journal 3: 280-290.

369   NICE (2009) Depression in adults with a chronic physical health problem: treatment and management.

Joint Commissioning Panel
for Mental Health

www.jcpmh.info

Co-chaired by:

Royal College of General Practitioners

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Membership:

mind
For better mental health

nsun

Rethink Mental Illness.

The British Psychological Society
Promoting excellence in psychology

hfma
MH FINANCE

MENTAL HEALTH PROVIDERS FORUM
Voluntary Agencies Working Together to Improve Mental Health

Mental Health Network
NHS CONFEDERATION

Royal College of Nursing

THE AFIYA TRUST

directors of adass
adult social services

National involvement Partnership

The New Savoy Partnership

A large print version of this document is available from www.jcpmh.info

Published December 2015

Produced by RaffCreative