



champs
public health collaborative service

working together to improve health and
wellbeing in Cheshire & Merseyside

Reducing the burden of mental illness within Cheshire and Merseyside: The role of public health

May 2013

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Acknowledgments

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We would like to thank all those who were interviewed as part of this project for sharing their time and opinions with me.

In addition we would like to thank Dr Elaine Church, Associate Director Public Health NHS Cumbria for sharing her expertise in helping to produce this final report.

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“What we want public health to do is to have a look at the research and the evidence base and tell us what works across populations. I haven’t seen that really in relation to mental health services - let’s look at whole systems, whole populations”

(Mental health commissioner)

Executive Summary

Mental illness is common and is associated with significant individual, social and economic costs. In England, one in six adults and one in ten children will experience a mental illness at any one time. This compares to one in ten people with cardiovascular disease and one in twenty with diabetes. This means that in 2012 across Cheshire and Merseyside around a quarter of a million adults suffered from a common mental disorder and just fewer than 6,000 people had a psychotic disorder. Among people under 65, nearly half of all ill health is due to mental illness. Mental illness represents the single largest cost to the NHS.

At a national level mental health and reducing the burden of mental illness has risen up the policy agenda. The Health and Social Care Act places an explicit duty upon the Secretary of State for Health to promote parity of esteem between mental and physical health care. The government has recently published a cross government mental health strategy *No health without mental health* and a suicide reduction strategy *Preventing suicide in England*.

In order to review the role of Directors of Public Health (DsPH) and their departments within Cheshire and Merseyside to addressing mental illness, interviews were undertaken with key members of staff within the region. A web-based survey was also sent to DsPH, local strategies and reports related to mental illness were reviewed and a literature review to identify evidence based interventions was undertaken.

Key findings:

- There is a lack of senior public health leadership in the area of mental illness. Currently reducing the burden of mental illness is not afforded the same priority as physical disease areas e.g. CVD or cancer by DsPH and their departments across Cheshire and Merseyside.
- Local Health and Wellbeing Boards have identified mental health as a priority area. This provides DsPH and their departments with the opportunity to promote partnership working to reduce the burden of mental illness within their localities.
- Local clinical commissioning groups (CCGs) have identified mental illness as a priority and will benefit from public health advice to commission effective services and address mental health inequalities within the NHS.
- There is a lack of available local data related to the burden of mental illness and mental health services as this is not currently being requested by public health departments.
- Few valid and measurable indicators are being used to measure the impact of interventions related to reducing the burden of mental illness within localities.
- There is a lack of public health expertise within the region related to the availability of evidence based treatments. There has been little public health input into the commissioning of secondary mental health services.
- There is recognition of the need to develop integrated services that promote the physical health needs of people with a mental illness. However, there has been a lack of activity related to achieving this aim in many areas of Cheshire and Merseyside.

Recommendations

In order to reduce the burden of mental illness within Cheshire and Merseyside it is recommended that:

1. There is Consultant leadership for mental illness within the champs collaborative service component 2 (*Advising the NHS*) to champion and co-ordinate action on mental illness, work with the Strategic Clinical Network for mental health and to support local leads in implementing these recommendations.
2. Directors of Public Health work with their Health and Wellbeing Boards to recognise and reduce the burden and impact of mental illness throughout the life-course in their locality and across all sectors, specifically economic and employment, civic and community, housing, criminal justice, education and health and social care.
3. Directors of Public Health provide public health leadership and advocacy across the local system. This should focus upon three priority areas:
 - Achieving parity of esteem between mental health and physical health
 - Reducing the gap in life expectancy between those with severe mental illness and the rest of the population
 - The prevention, early identification and evidence-based treatment of common mental illness, such as anxiety and depression, for children and adults.
4. There is a designated senior public health lead for mental illness who provides leadership to the local mental health system in each local authority area. This should include; support to the Clinical Commissioning Group to commission evidence based services, based on population need; leadership and advocacy on suicide prevention through working with the Cheshire & Merseyside Suicide Reduction Network.
5. Directors of Public Health routinely monitor the Public Health Outcome Framework indicators in relation to mental illness and collaborate with social care and the NHS to set shared targets.
6. Directors of Public Health and their public health intelligence staff identify and make use of appropriate mental health data, indicators and measures - including data on inequalities – to provide up to date mental health needs assessment. (Example in Appendix 3).

Introduction

This report will demonstrate that reducing the burden of mental illness within Cheshire and Merseyside should be a priority for Directors of Public Health (DsPH) and their departments. At a national level, there is recognition that mental illness accounts for the highest burden of all diseases and is the largest area of NHS spending (spending on mental health services accounts for 11 per cent of the NHS secondary health care budget, more than spending on either cardiovascular disease or cancer services). This recognition has seen mental health and illness rise up the national policy agenda.

The higher national priority afforded to mental health and illness is demonstrated by the Government's commitment that equal value is given to physical and mental health care. This is enshrined within the Health and Social Care Bill which places an explicit duty upon the Secretary of State for Health to promote parity of esteem between mental and physical health care¹.

It is the duty of DsPH to follow the national lead and ensure that mental health and illness are given equal priority to physical health. Historically, public health strategies and activity have concentrated on physical health and overlooked the importance of mental health and illness. More recently there has been recognition of the importance of public mental health to promote health and wellbeing and prevent mental illness, with a subsequent increase in public health activity within this area². However, public health activity related to reducing the burden of mental illness has remained limited, despite healthcare public health advice being the third domain of public health.

The report reviews the current public health capacity and activity related to mental illness across Cheshire and Merseyside and makes recommendations as to how DsPH and their departments can reduce the impact of mental illness across the region. The report aims to complement the work being undertaken around the promotion of mental health and wellbeing within the region.

The report focuses on public health activity related to secondary prevention (early identification and treatment) and tertiary prevention (promotion of recovery and relapse prevention) of mental illness and the commissioning of evidence-based treatments that are accessible and equitable. Reflecting the coverage of the *No health without mental health* strategy this report does not cover dementia or drug and alcohol misuse. However, we recognise these are important public health issues which are closely linked to mental health and illness.

¹ For further details see: Whole-person care: from rhetoric to reality: Achieving parity between physical and mental health. Available from: <http://www.rcpsych.ac.uk/pdf/OP88summary.pdf>

² Public mental health focuses on wider prevention of mental illness and promotion of mental health across the life course. For further details see: Royal college of psychiatrists (2010) No health without public mental health <http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf>

Definitions of Mental Health and Illness

Definitions in mental health and illness are subject to debate and are often not used consistently. This inconsistency can lead to confusion and a lack of coordinated action between partners. The World Health Organisation (WHO) defines mental health as:

"A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"³

For the purpose of this report mental illness is defined as:

"A term generally used to refer to more serious mental health problems that often require treatment by specialist services. Such illnesses include depression and anxiety (which may also be referred to as common mental health problems) as well as schizophrenia and bipolar disorder (also sometimes referred to as severe mental illness)⁴".

The two continua model of mental illness and mental health holds that both are related, but distinct dimensions: one continuum indicates the presence or absence of mental health, the other the presence or absence of mental illness, see Figure 1. Therefore the presence of a mental illness does not imply poor mental health: a person with a mental illness may experience high levels of mental health while a person with poor mental health may not suffer from a mental illness⁵.

Figure 1: The two continua model of mental health and illness



³ World Health Organization. (2005). Promoting mental health: Concepts, emerging evidence, practice. Geneva: WHO. Available from: http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf

⁴ Department of Health (2011) No health without mental health http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

⁵ Keyes, C.L.M. (2002) The mental health continuum: from languishing to flourishing in life. J Health Soc Res 43:207-22: <http://tinyurl.com/8ox38p5>

The National Policy Context

Mental health is now near the top of the national policy agenda. This section sets out the key national policies which are shaping future priorities and activity within this area.

The public health white paper *Healthy lives, healthy people*⁶ provides a comprehensive definition of public health, as aiming to improve public mental health and well-being alongside of physical health.

*No health without mental health*⁷ the cross-government mental health strategy sets out the ambition to mainstream mental health, and establish parity of esteem between services for people with a mental and physical illness. The strategy is underpinned by two aims: firstly, to improve the mental health and wellbeing of the population and to keep people well; and secondly, to improve outcomes for people with a mental illness through high quality services that are equally accessible to all. In order to achieve these aims the strategy sets six overarching objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

This report focuses upon the public health role in achieving objectives two to six of the strategy.

Alongside *No health without mental health* the government also published supporting documents; *No health without mental health: Delivering better mental health outcomes for people of all ages*⁸ which explains in detail each objective and outlines effective interventions; and the *No health without mental health: implementation framework*⁹ which aims to ensure that the commitment to parity of esteem between physical and mental health becomes a reality at a local level. The framework sets out what a range of organisations (including local public health teams, Public Health England, clinical commissioning groups, mental health providers, local authorities, and health and wellbeing boards) can do to implement the *No health without mental health strategy*.

A new cross-government strategy *Preventing suicide in England*¹⁰ highlights that local responsibility for coordinating and implementing work on suicide prevention will become, from

⁶ Department of Health (2010) *Healthy Lives, healthy people*. Available from:

<https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england>

⁷ Department of Health (2011) *No health without mental health A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. Available from:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

⁸ Department of Health (2011) *No health without mental health: Delivering better mental health outcomes for people of all ages*. Available from: <https://www.gov.uk/government/publications/delivering-better-mental-health-outcomes-for-people-of-all-ages>

⁹ Department of Health (2012) *No health without mental health: implementation framework*. Available from:

<https://www.gov.uk/government/publications/national-framework-to-improve-mental-health-and-wellbeing>

¹⁰ Department of Health (2012). *Preventing suicide in England: A cross-government outcomes strategy*

April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement. This focus on suicide prevention is reflected within the Public Health Outcomes Framework which includes the suicide rate as an indicator.

Healthcare public health advice

Healthcare public health advice is the third domain of public health, alongside health improvement and health protection, and seen as a critical function to improve population health. In the new structures this means Local Authority Public Health consultants providing advice to local Clinical Commissioning Groups and NHS England. The Department of Health has set out guidance¹¹ for public health input at each stage of the commissioning cycle: strategic planning, assessing need, reviewing service provision, deciding priorities, procuring services, planning capacity and managing demand and monitoring and evaluation.

Within the new champs public health collaborative service the Healthcare public health component will be supporting the public health system to carry out this duty. The newly formed Cheshire and Merseyside Strategic Clinical Network, aligned to NHS England, will be a key partner in this work.

Outcomes related to mental illness

Outcome Frameworks

Outcome measures provide a description of what a good mental health system should aim to achieve, as well as a method of checking progress against achieving these aims. All three of the Outcome Frameworks – Public Health¹², NHS¹³, and Adult Social Care¹⁴ contain objectives related to mental illness, with several of the outcomes being shared across outcome frameworks, see Table 1. This close alignment reflects that in order to improve outcomes for individuals with a mental illness all three sectors must play an effective role. DsPH and their departments must encourage shared ownership of outcomes and prevent silo-working across departments.

to save lives. Available from: <http://tinyurl.com/d34y9d4>

¹¹ Department of Health (2012) Guidance to support the Provision of Healthcare Public Health Advice to Clinical Commissioning Groups, Available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156030/Healthcare-Public-Health-Advice-Service-Guidance-FINAL.pdf

¹² Available from: <http://www.phoutcomes.info/>

¹³ Available from: <https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014>

¹⁴ Available from: <https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014>

Table 1: Outcomes related to mental illness within the three outcome frameworks

Public health outcome framework	NHS outcome framework	Adult social care framework
Employment of people with mental illness*		
People with mental illness and/or disability in settled accommodation	Patient experience of community mental health services	Proportion of adults in contact with secondary mental health services living independently, with or without support
Excess under 75 mortality in adults with serious mental illness**		Overall satisfaction of people who use services with their care and support
People in prison who have a mental illness or significant mental illness		The proportion of people who use services and carers who find it easy to find information about services
Suicide rate		The proportion of service users who say that services have made them feel safe and secure - People are free from physical and emotional abuse, harassment, neglect and self-harm.

* Outcome shared across all three frameworks

** Outcome shared between public health and NHS outcome framework

Commissioning outcome framework (COF)

The NHS England (supported by NICE) has developed a COF¹⁵, which builds upon the NHS Outcome Framework and measure the health outcomes and quality of care provided by Clinical commissioning Groups (CCGs).

COF indicators related to mental illness include:

- 1.30: People with severe mental illness who have received a list of physical checks
- 2.79: People on Care Programme Approach (CPA) followed-up within 7 days of discharge from psychiatric inpatient stay
- 3.26i: Recovery following talking therapies for people of all ages
- 3.26ii: Recovery following talking therapies for people older than 65
- 4.20: Access to community mental health services by people from black and minority ethnic groups
- 4.21: Access to psychological therapies services by people from black and minority ethnic groups

¹⁵ Available from: <http://www.nice.org.uk/aboutnice/ccgois/CCGOIS.jsp>

Children's Outcome Framework

The Children and Young People's Health Outcomes Forum was asked by the Secretary of State to look at how best the health outcomes of children in Britain could be improved. The forum included a Mental Health Sub Group which made recommendations related to promoting mental health and improving outcomes for children with a mental illness¹⁶. In view of the paucity of data on the scale and nature of poor mental health among children and young people, the Forum recommended a new survey to support measurement of outcomes for children with mental health problems. The Department of Health has recently published its response to the Children and Young People's Health Outcomes Forum's recommendations outlining actions the government and partners will take to improve the health of children and young people¹⁷.

¹⁶ Report of the children and young people's health forum – mental health sub group. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156063/CYP-Mental-Health.pdf.pdf

¹⁷ Department of Health (2013). Improving Children and Young People's Health Outcomes. Available from: <http://tinyurl.com/cq43yhg>

The Scale of the Burden of Mental Illness

There is a large burden of mental illness in Cheshire and Merseyside which is associated with significant individual, social and economic costs.

The prevalence of mental illness

Mental illness is common. In England, one in six adults and one in ten children will experience a mental illness at any one time. This compares to one in ten people with cardiovascular disease and one in twenty with diabetes, see Table 1. The most recent estimates on the prevalence of mental illness in England for adults¹⁸ and children¹⁹ are outlined in Appendix 1.

Table 2: Prevalence of common mental disorders, cardiovascular disease and diabetes in males and females

	Males (%)	Females (%)	Total (%)
Common mental disorder (past week) ²⁰	12.5	19.7	16.2
Cardiovascular disease	11.7	10.1	10.9
Diabetes	6.3	5.3	5.5

Applying national prevalence rates to the local population means that in 2012 across Cheshire and Merseyside an estimated 236,609 adults suffered from a common mental disorder and just fewer than 6,000 people had a psychotic disorder. Table 2 displays estimated numbers by locality.

Table 3: Prevalence from the Adult Psychiatric Morbidity Survey in England (2007) applied to the resident population of Cheshire and Merseyside²¹

	Common mental disorder	Psychotic disorder
England	5,285,457	131,308
North West	696,875	17,315
Cheshire and Merseyside	236,609	5,881
Liverpool	47,616	1,183
Sefton	26,362	655
Knowsley	15,074	375
Halton	12,085	301
St Helens	17,716	440
Wirral	29,643	737
Central and Eastern Cheshire	35,519	883
Cheshire West and Chester	32,099	798
Warrington	20,495	509

¹⁸ McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (2009). Adult psychiatric morbidity in England, 2007. Results of a household survey. Available from: <http://www.ic.nhs.uk/pubs/psychiatricmorbidity07>

¹⁹ Green H, McGinnity A, Meltzer H et al (2005) Mental health of children and young people in Great Britain, 2004. Office for national statistics. Available from: <http://www.ic.nhs.uk/pubs/mentalhealth04>

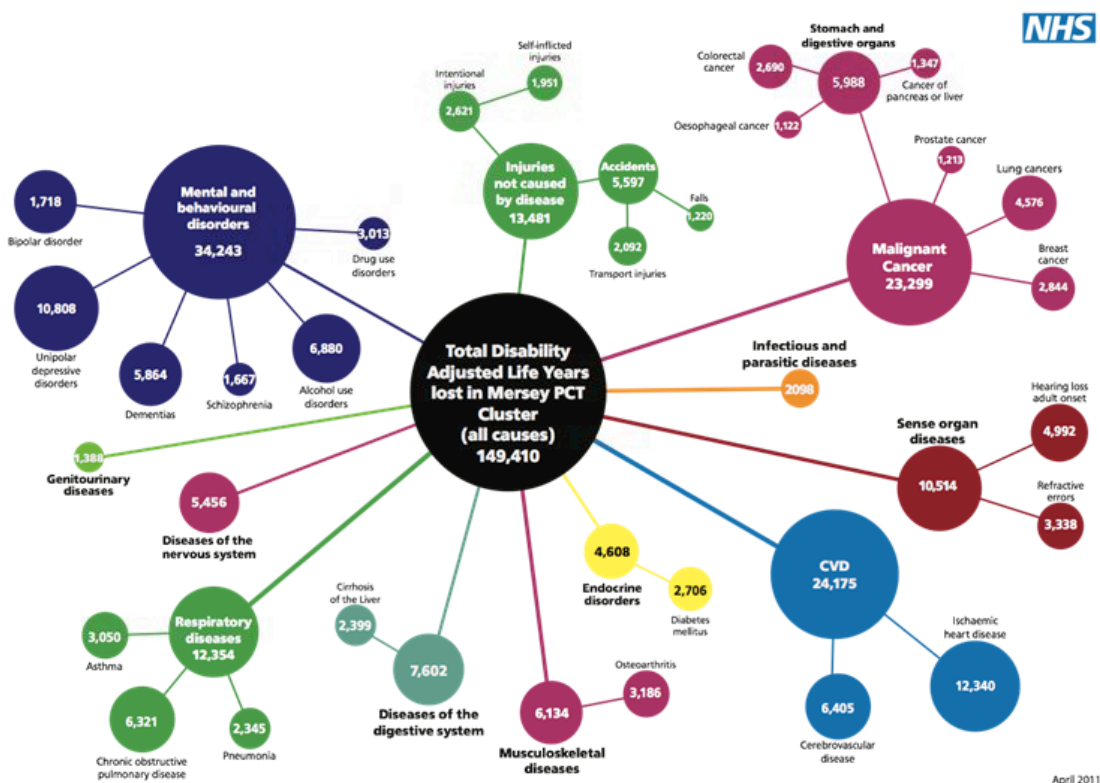
²⁰ The 2007 adult psychiatric survey categorised common mental disorders as follows: generalised anxiety disorder; mixed anxiety and depressive disorder; depressive episode (including mild, moderate and severe); phobias; obsessive-compulsive disorder; and panic disorder.

²¹ Data Source: Projecting Adult Needs and Service Information (PANSI). <http://www.pansi.org.uk/>

Morbidity due to mental illness

As well as being common mental illness also leads to a reduced quality of life. Mental illness is the single largest source of burden of disease in the UK. In 2004, 22.8% of the total burden of disease in the UK was attributable to mental illness, this compares to 16.2% for cardiovascular disease and 15.9% for cancer, as measured by disability adjusted life years (DALYs)²². Figure 2, shows the WHO burden of disease estimates applied to the Merseyside PCT cluster population. Mental and behavioural disorders (including drug and alcohol misuse and dementia) accounted for nearly 35,000 DALYs lost across the PCT cluster.

Figure 2: Estimated DALYs lost in Merseyside PCT Cluster by cause in an average year



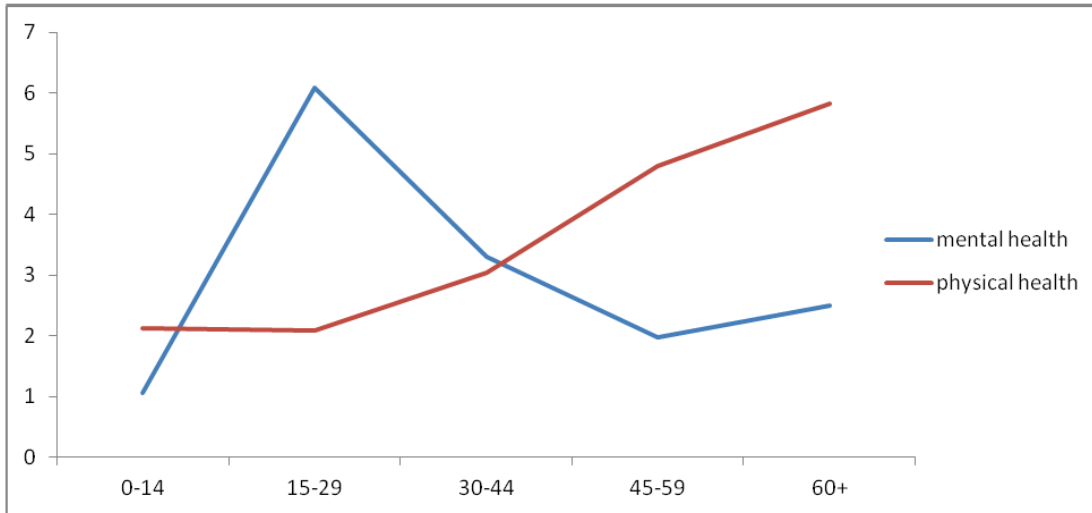
Unlike other health problems such as cardiovascular disease or many cancers mental illness begins early in life and persists over the life course. Half of those suffering from a lifetime mental illness first experience symptoms by age fourteen and three quarters by before their mid twenties²³.

²² A disability adjusted life year (DALY) is a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health. Further information on the Global burden of disease study is available from: http://www.who.int/healthinfo/global_burden_disease/en/index.html

²³ Kim-Cohen J, Caspi T, Moffitt E et al (2003). Prior juvenile diagnosis in adults with a mental disorder: Developmental follow-back of a prospective-longitudinal cohort. Archives in General Psychiatry 60: 709-717. Available from: <http://archpsyc.jamanetwork.com/article.aspx?articleid=207619>

Morbidity due to mental illness peaks at age 15 to 29 and remains higher than or equal to morbidity due to physical illness until age 45 to 59, see Figure 3. This means that among people under 65, nearly half of all ill health is due to mental illness.

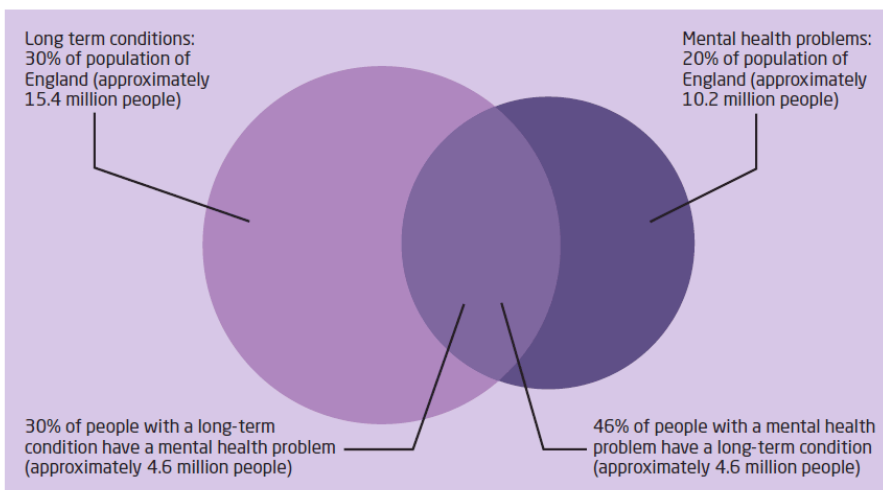
Figure 3: Rate of morbidity from mental and physical illness by age group (equivalent life years lost per 100 people)²⁴



Mental illness and physical ill health

There is a strong interconnection between a person’s mental and physical health and this influence works in both directions; this means many people suffer from a mental illness and a long-term physical health problem, see Figure 4.

Figure 4: The overlap between long-term conditions and mental illness²⁵



People with a mental illness have higher rates of physical illness and die earlier than the general population, largely from treatable conditions associated with modifiable risk factors

²⁴London School of Economics. How mental illness loses out in the NHS. Available from: <http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf>

²⁵ Naylor C et al (2012). Long-term conditions and mental health: The cost of co-morbidities. Available from: <http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health>

such as smoking, obesity, substance abuse, and inadequate medical care. Having depression is associated with a 50% increase in mortality after controlling for confounders²⁶. While in the UK people with schizophrenia die an average of 16 to 20 years earlier than the general population largely due to physical health problems²⁷.

Smoking is a significant cause of morbidity and mortality among those with a mental illness. Smoking is around twice as common among people with a mental illness, and more so in those with more severe disease²⁸. Adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco in England²⁹.

Suicide

Suicide is linked to many issues including mental illness, physical health, social issues and personal relationships. In Cheshire and Merseyside there were 160 suicide deaths in 2010. The suicide rate by locality is displayed in table 4. Cheshire West and Chester, Sefton, St Helens, Halton and Knowsley had suicide rates above the national average.

Table 4: Age standardised suicide rate per 100,000 population³⁰

	2009-11
England	7.87
Cheshire East	7.66
Cheshire West and Chester	8.28
Warrington	6.10
Liverpool	6.21
Sefton	8.22
St Helens	8.34
Halton	8.13
Knowsley	8.28
Wirral	6.24

In Cheshire and Merseyside, in line with national trends, suicide rates have shown a decline since 1980. However the impact of the recent economic recession may reverse this trend. English regions with high rises in unemployment have seen an increase in suicides, particularly among men³¹.

²⁶ Mykletun A, Bjerkeset O, Øverland S, et al (2009) Levels of anxiety and depression as predictors of mortality: the HUNT study. *British Journal of Psychiatry*, 195, 118–125. Available from: <http://bjp.rcpsych.org/content/195/2/118.full>

²⁷ Brown S, Kim M, Mitchell C, et al (2010) Twenty-five year mortality of a community cohort with schizophrenia. *British Journal of Psychiatry*, 196, 116–121. Available from: <http://bjp.rcpsych.org/content/196/2/116.full.pdf+html>

²⁸ The Royal College of Physicians and the Royal College of Psychiatry (2013). Smoking and mental health. Available from: <http://www.rcplondon.ac.uk/publications/smoking-and-mental-health-0>

²⁹ McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research. Available from: <http://www.natcen.ac.uk/study/cigarette-smoking--mental-health>

³⁰ Data source: Public Health Outcome Frameworks Data Tool. Available from: <http://www.phoutcomes.info/search/suicide#gid/1/par/E1200002/ati/102/page/3>

³¹ Barr B, Taylor-Robinson D, Scott-Samuel A, McKee M, Stuckler D (2012) Suicides associated with the 2008-10 economic recession in England: time trend analysis. *BMJ*; 345, e. Available from: <http://www.bmj.com/content/345/bmj.e5142>

Self-harm

Self-harm is a public health issue, particularly among children and young people. It is difficult to measure the extent of the issue in the population, but evidence suggests that self-harm affects at least one in 15 young people and is one of the top five causes of acute hospital admission for people of all ages in the UK. Within Cheshire and Merseyside, rates of emergency hospital admissions for self-harm vary substantially with eight out of nine local authorities having rates that are significantly higher than the England average. Rates for emergency hospital admission for self-harm by locality are outlined in Table 4.

Table 5: Rate of emergency hospital admission for self-harm (0-18 years) per 100,000 population. Cheshire and Merseyside local authorities, 2007/08–2009/10³²

	Rate
North West	179.9
England	137.8
Warrington	226.7
Liverpool	127.6
Sefton	140.7
St Helens	260.7
Halton	373.7
Knowsley	158.6
Wirral	265.5
Cheshire East	178.4
Cheshire West and Chester	164.7

Mental illness and employment

Employment for people with mental illness is important in promoting recovery and social inclusion and can have a positive effect on mental health, although benefits depend on the nature and quality of work. However having a mental illness is associated with an increased risk of unemployment; having a common mental disorder is associated with a three-fold increased risk of unemployment while only one in five specialist mental health service users are either in paid work or full-time education³³.

The economic cost of mental illness

The economic cost of mental illness to the English economy was estimated at £105 billion in 2010. Mental illness is the largest area of NHS spending; spending on mental health services accounts for £11.9 billion (11 per cent) of the NHS secondary health care budget, more than spending on either cardiovascular disease or cancer services³⁴.

³² The North West ChiMatters series. Self-harm among children in the North West: accident and emergency attendances 2007–2009 and emergency hospital admissions 2007/08–2009/10. Available from:

<http://www.nwph.net/nwpho/Publications/SelfharmNW.pdf>

³³ Royal college of psychiatrists (2010) No health without public mental health

<http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf>

³⁴ Department of Health (2011) National expenditure data 2003-04 to 2010-11. Available from:

<https://www.gov.uk/government/publications/2003-04-to-2010-11-programme-budgeting-data>

The Role of Directors of Public Health and their Departments in Reducing the Burden of Mental Illness across Cheshire and Merseyside

In order to review the current activity within local public health departments related to reducing the burden of mental illness the following methods were used:

- interviews were undertaken with key members of staff across the area;
- a web-based survey was sent to DsPH;
- local strategies and reports related to mental illness were reviewed;
- a literature review to identify evidence based interventions was undertaken.

All public health mental health leads, public health intelligence leads and mental health commissioners within the region were invited to be interviewed. Interviews were conducted with six public health mental health leads, six public health intelligence leads and two mental health commissioners. Six of the nine DsPH completed the web-based survey. Interview question guides and web-based survey questions are included in Appendix 2.

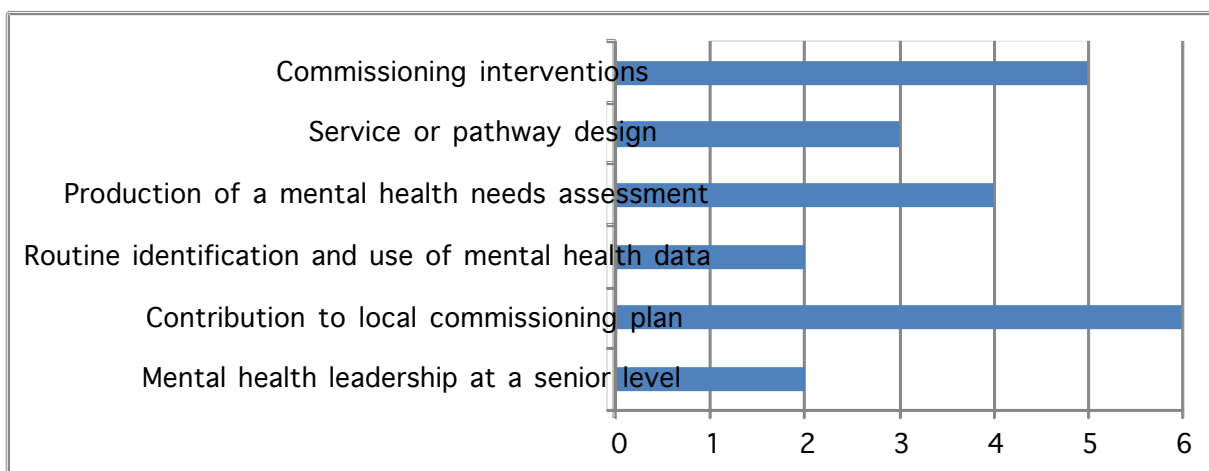
Key themes from these interviews are outlined below, along with examples of good practice and evidence based interventions.

1) *Public health activity and leadership*

DsPH identified reducing the burden of mental illness within their locality as a key priority area; 5 of the 6 DsPH who responded to the web-based survey stating reducing the burden of mental illness in their locality was in their top 5 priority areas.

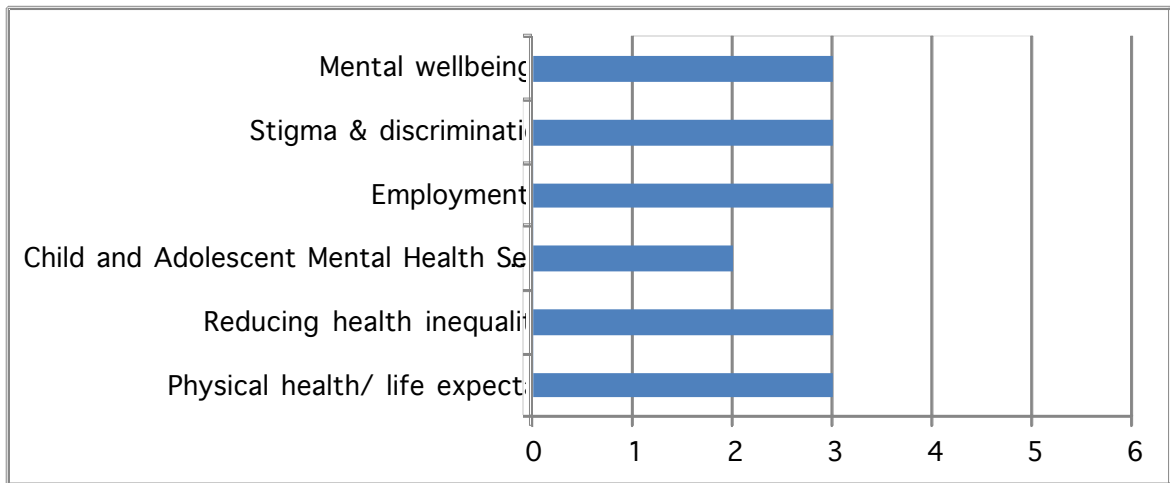
Public health activity that has been undertaken within the region to reduce the burden of mental illness has focused around commissioning; both contributing to local commissioning plans and the commissioning of interventions by public health, see Figure 5.

Figure 5: Activity undertaken by local public health teams in order to reduce the burden of mental illness (Results from DsPH survey)



The focus of public health activity has been the promotion of mental wellbeing, reducing stigma and discrimination, promoting employment, reducing health inequalities and improving the physical health and life expectancy of those with a mental illness, see Figure 6.

Figure 6: The focus of work undertaken by local public health teams in order to reduce the burden of mental illness (Results from DsPH survey)



Four out of six public mental health leads interviewed felt that their public health departments had not prioritised the area of mental illness highly enough and described activity in this area as limited. One public health mental health lead contrasted this with cardiovascular disease (CVD) in which there has been strong public health leadership and influence, see Box 1:

"If you look at the burden mental illness causes society, I don't think that mental health and especially mental illness has had the priority it should have had within public health. So if you say it has more of an impact on people's health and costs more than cardiovascular disease, if people actually took that on board then perhaps there would be a different approach"

(Public health mental health lead)

A lack of capacity and expertise within public health teams were identified by public mental health leads and DsPH as a barrier to activity in this area. Many public mental health leads interviewed led on several areas, with mental health being just one of them.

Public mental health leads interviewed identified a lack of senior leadership within public health departments related to mental illness. No public health consultant with a remit around reducing the burden of mental illness was identified within Cheshire and Merseyside:

"In terms of a senior person leading on mental health there is no one there. They might have mental health under their name, but in terms of doing any work, or strategically delivering anything on that agenda we haven't got anyone"

(Public health mental health lead)

Mental health commissioners interviewed felt that senior public health leadership would be beneficial to push the issue of reducing the burden of mental illness up the agenda across partner organisations:

"What I would like to see is a senior public health mental health lead. Someone who is proactively pushing promoting mental health and reducing mental illness with all and sundry - CCGs, mental health trusts, directors of social care and the wider population. Actually pushing the issue forward and being proactive in terms of driving change rather than waiting for those organisations to suddenly grasp something and move things forward"

(Mental health commissioner)

Box 1: An example of public health activity in the area of CVD which has been a long standing identified public health priority

"In CVD there is significant public health leadership of the issue. There is usually a consultant lead who has a commitment to understanding the epidemiology, the evidence base for interventions and works with commissioners to ensure resources are used effectively. The senior lead ensures public health intelligence teams produce routine data to monitor how mortality and morbidity are progressing. There is an awareness of the issue in the executive team".

(Public health consultant)

2) A whole system approach to reducing the burden of mental illness

Both mental health commissioners interviewed felt that as DsPH work across the local authority, health and wellbeing boards, clinical commissioning groups, providers of health and social care, education, employment and housing they are ideally placed to take a strategic role and support effective partnership working to reduce the burden of mental illness within the region.

The key stages someone with a mental health problem may experience and at which effective interventions may be targeted are outlined in Figure 7. This simplified diagram illustrates that a whole system approach is required in order to reduce the burden of mental illness; a set of unaligned projects will not lead to improved outcomes and recovery.

However, interviews with public mental health leads revealed that currently this whole system working is not happening in all areas of Cheshire and Merseyside:

"There is a lot of silo working and it doesn't get brought together to get that maximum impact" (Public health mental health lead).

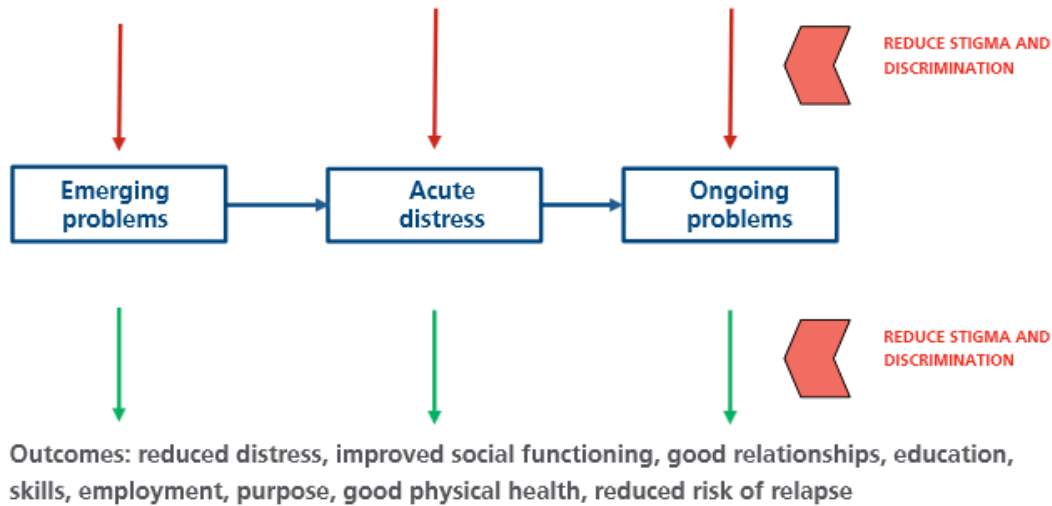
Figure 7: Key stages for intervention to reduce the burden of mental illness³⁵

INTERVENTIONS

Early identification, e.g. primary care, education and criminal justice system

Early intervention, e.g. crisis intervention and home treatment

Ongoing support, e.g. housing and employment



The need for proactive public health input to population healthcare was echoed by mental health commissioners:

“My criticism of public health is that when we have actually got data, they are very good at saying that you have got something wrong. But what we want public health to do is to have a look at the research and the evidence base and tell us what works across populations and I haven’t seen that really in relation to mental health services. You know let’s look at whole systems, whole populations”

(Mental health commissioner)

All of the public health mental health leads interviewed felt that the creation of health and wellbeing boards provides DsPH and their teams the opportunity to promote effective partnership working to reduce the burden of mental illness within their localities.

A desk top review of health and wellbeing strategies within the region was undertaken to identify if mental health and illness had been included as a priority area, results outlined in Table 6. All nine local authority areas have included mental health or the promotion of mental wellbeing as a priority area.

³⁵ Department of Health (2011) No health without mental health: Delivering better mental health outcomes for people of all ages. Available from: <https://www.gov.uk/government/publications/delivering-better-mental-health-outcomes-for-people-of-all-ages>

Table 6: A review of Health and Wellbeing Strategies by locality in Cheshire and Merseyside

Local authority	Health and Wellbeing Strategy priority
Knowsley	Mental health is one of 4 priority areas
Sefton	Mental health is one of six priority areas. To "Support good mental health and wellbeing" is one of 6 priority areas
Liverpool	Mental health is one of 4 priority areas. "More people achieving and maintaining good mental health" is one of 4 priority areas
Wirral	Mental health & wellbeing is one of 9 priority areas
Warrington	"Mental health and wellbeing – personal resilience" identified as a significant challenge that cuts across all identified priorities.
St Helens	Mental health is one of 8 key priority areas
Halton	"Prevention and early detection of mental health conditions" is one of 5 priority areas
Cheshire East	Three strategic priority areas identified based upon life-course approach. Strategic priority area "Starting and developing well" includes aim to "improve the emotional and mental health and wellbeing of our children and young people". Strategic priority area "Working and living well" includes aim to "better meet the needs of those with mental health issues".
Cheshire West and Chester	8 strategic priority areas identified based upon Marmot life-course approach. Focus upon promotion of wellbeing but also includes aim to "Develop more integrated care across health and social care and between physical, mental & community health providers".

It will be vital that DsPH and their departments utilise this new opportunity to lead a whole system approach to reducing the burden of mental illness in their localities³⁶.

3) Needs assessment

Five of the six public health intelligence leads interviewed stated that they do not regularly get requests for local data related to the burden of mental illness or mental health services and that they do not have the capacity to be proactive and provide data that is not requested:

"Data on mental illness and mental health services is available from a wide variety of sources and a lot of these data sources are not held by the public health intelligence team. Therefore when requested we have to scurry away and find it for example to produce the joint strategic needs assessment or public health annual report. However, as public health teams do not request data on mental illness at regular intervals this data set is not kept up to date"

(Public health intelligence lead)

A review of joint strategic needs assessments (JSNAs) was undertaken to identify if local mental health needs are identified, made available and considered as part of the commissioning process. The quality of data relating to mental illness varied between localities. The majority of areas had included a chapter on mental health which outlined the prevalence of mental illness in adults. However, data on the prevalence of mental illness within children and young people was less likely to be included. Identification of unmet need within localities was also not commonly reported and not all areas made recommendations for future commissioning based upon the data presented.

³⁶ MIND (2012). No Health Without Mental Health: a guide for Health and Wellbeing Boards. Available from: [http://www.mind.org.uk/assets/0002/1270/No Health Without Mental Health Health and Wellbeing Boards.pdf](http://www.mind.org.uk/assets/0002/1270/No_Health_Without_Mental_Health_Health_and_Wellbeing_Boards.pdf)

Locally, Warrington JSNA mental health chapter provides an example of good practice, see Box 2. An example of suggested headings for assessment of need and unmet need related to reducing the burden of mental illness within a locality is outlined in Appendix 3.

In addition, a review of local reports related to mental illness was undertaken. Very few recent reports related to mental health and illness were identified within the region. Those that were identified are listed below:

- Liverpool Public Health Observatory, Merseyside Mental Health Needs Assessment, 2011³⁷
- Liverpool Public Health Observatory, Children and young people's emotional health and wellbeing needs assessment: Merseyside, 2012³⁸
- Liverpool Public Health Observatory, Mental Health Equity Profile for the Mersey Care NHS Trust catchment area³⁹
- NHS Warrington, Warrington Mental Health Needs Assessment, 2009⁴⁰

Box 2: Warrington joint strategic needs assessment (JSNA) – mental health chapter

The Warrington JSNA provides an example of good practice in describing the mental health needs of a local area. The chapter was written in partnership with Warrington Council, Warrington public health team and Warrington GPs. The chapter describes available data on the prevalence of mental illness, reviews current services in relation to need and makes recommendations for commissioners. The JSNA chapter is available from:

<http://www.doriconline.org.uk/ViewPage1.aspx?C=Resource&ResourceID=986>

4) Measuring outcomes

Interviews with public health mental health leads and public health intelligence leads revealed that few valid and measurable indicators are currently being used to measure the impact of interventions related to reducing the burden of mental illness within localities. Public health mental health leads, health intelligence leads and commissioners highlighted that in addition to national outcomes within the 3 outcome frameworks there was a need to develop locally agreed outcome measures in order to measure progress.

Public mental health leads interviewed felt that DsPH or a senior public health mental health lead should encourage shared ownership and joint accountability of outcomes across partners in order to incentivise closer partnership working and prevent silo-working across departments:

"We want clear outcomes agreed in partnership so we can demonstrate what we have achieved. Then we can be saying to partners and ourselves how are we going against meeting that target and what more should we be doing?"

(Public health mental health lead).

³⁷ Available from: http://www.liv.ac.uk/PublicHealth/obs/publications/report/obs_report.htm

³⁸ Available from: http://www.liv.ac.uk/PublicHealth/obs/publications/report/obs_report.htm

³⁹ Available from: http://www.liv.ac.uk/PublicHealth/obs/publications/report/obs_report.htm

⁴⁰ Available from: <http://www.doriconline.org.uk/ViewPage1.aspx?C=Resource&ResourceID=986>

An example of a mental health dashboard developed in East Lancashire to monitor performance and inform commissioning is outlined in Box 3.

Interviews with mental health commissioners highlighted that outcome measurement related to mental health services has largely been focused upon the point of entry into a service rather than the journey through it or end outcome. The need to understand whether an episode of care is associated with any improvement was identified:

"When we talk about this in terms of commissioning mental health services, outcomes are the major challenge because trying to determine whether somebody has improved or recovered or changed for the better is difficult in terms of getting a robust measurement tool. There are many social consequences of mental illness so we need to ensure we capture a broad range of outcomes – both psychological such as reduced distress, clinical improvement and social such as employment and improved physical health".

(Mental health commissioner).

The Royal College of Psychiatrists has provided guidance on the use of outcome measures in mental health based on what is of clinical value to patients and clinicians and what is feasible in practice⁴¹. They recommend that outcomes in mental health should cover three domains:

- 1) Effectiveness of treatment – in terms of:
 - achievement of patient-identified goals (in keeping with the recovery model)
 - reduction of symptoms of mental illness
 - achievement of desired social outcomes quality of life.
- 2) Patient safety – the aim should be to ensure that fewer people will suffer avoidable harm, through being treated and cared for in a safe environment and protected from avoidable harm (e.g. suicide).
- 3) Patient and carer experience of care provided – the aim should be that more people will have a positive experience of care, through better processes for delivering personalised care.

Box 3: An example of a mental health dashboard for East Lancashire

This profile provides an overview of readily available mental health indicators for the adult population of East Lancashire and its constituent districts. A dashboard of indicators related to mental health determinants, needs, morbidity and service use are presented for each locality. The profile is designed to support the action being taken by the NHS and its partners to improve mental health services by informing local commissioning plans for mental health and wellbeing services. The profile is available from: <http://tinyurl.com/cb2uexo>

⁴¹ Royal College of Psychiatrists (2011). Outcome measure recommended for use in adult psychiatry. Available from: <http://www.rcpsych.ac.uk/files/pdfversion/op78x.pdf>

5) **Using the evidence base to commission for good outcomes**

While almost £12 billion was spent on NHS services to treat mental illness only a quarter of those with mental illness are in treatment, compared to the vast majority of those with a physical illness⁴². Both DsPH and public health mental health leads identified a lack of evidence as a barrier to improving outcomes. However, the inequality in access to treatment for mental illness occurs despite the existence of evidence based treatments. There are a growing number of effective evidence based approaches to reducing the burden of mental illness within a locality. The National Institute for Clinical Excellence (NICE) have outlined evidence-based interventions that cover the majority of mental illnesses. Ensuring interventions are equitably accessible is key as well as understanding which interventions are effective for different population groups. The currently available NICE guidance is listed in appendix 4.

Around 95% of those with a mental illness are managed in primary care. Public mental health leads interviewed felt that the new mental health commissioning arrangements offer opportunity for increased public health involvement in supporting the commissioning evidence based interventions and supporting integrated commissioning where possible. All of the public mental health leads interviewed stated that the clinical commissioning groups (CCGs) within their locality had identified mental health as a priority area:

“There will be a difference with the CCGs being in charge of commissioning – because they experience people with a mental health problem on a day to day basis and often struggle to access treatments for these patients they have identified mental health as a priority area. What they haven’t got is the data or the evidence to say this is the action you need to take to improve outcomes. I think CCGs will be looking to public health to support them with this and will be pushing for this information which gives us an opportunity to increase our activity in this area”.

(Public health mental health lead)

Five of the six public health mental health leads interviewed described that they have had little input into the commissioning of secondary care mental health services. This was reflected in the interviews with mental health commissioners who felt that public health had not been involved in mental health service planning and needed to increase the support offered to mental health commissioners in this area:

“I have not seen public health get involved in terms of mental health service activity and try to understand the story. There has been more of a general population view rather than getting into what is actually happening in terms of trust activity”.

(Mental health commissioner)

In order to support evidence based mental health commissioning the Joint Commissioning Panel for Mental Health (JCPMH) has published a number of guides; for further details see Box 4.

⁴² London School of Economics. How mental illness loses out in the NHS. Available from: <http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf>

Box 4: Support for evidence based mental health commissioning

The Joint Commissioning Panel for Mental Health (JCPMH) is co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners. It provides practical guidance and a framework for mental health commissioning to support commissioners in commissioning mental health care that delivers the best possible outcomes for health and wellbeing. The JCPMH has produced a series of guides, which provide a description of what a 'good' service configuration should look like, supported by scientific evidence, service user and carer experience, and case studies of best practice. Recently published guidance includes guidance for commissioners of public mental health services and primary mental health care services. More details available at: www.jcpmh.info

6) *Physical and mental health*

As outlined above, individuals with a mental illness experience increased levels of physical illness, have higher rates of smoking, alcohol consumption and drug misuse and a reduced life expectancy. Four of the six public health mental health leads interviewed mentioned that people who have a mental illness (especially a severe mental illness) often experience difficulties accessing services appropriate to their physical health care, prevention and health promotion needs and had identified this as an area for future activity. However, a lack of current activity within this area was identified during interviews.

Nearly half of all people with a mental illness have a long-term condition (around 4.6 million people). The King's Fund has previously argued that developing more integrated forms of care for people with co-morbid mental and physical health problems should be one of the top 10 priorities for clinical commissioning groups and make recommendations as to how this can best be achieved. Reducing excess under 75 mortality in adults with serious mental illness is an outcome indicator shared between public health and the NHS and should be used to promote activity in this area.

Efforts to reduce premature mortality must include focusing on reducing smoking among people with a mental illness. Smokers with a mental illness are just as likely to want to give up as the general population but only a small proportion currently receives effective smoking cessation interventions⁴³. Commissioning for quality and innovation schemes (CQUIN) are a potential way to incentivise activity in this area e.g. the proportion of people with a mental disorder with access to smoking cessation services.

Box 5: The development of an integrated wellness service in Knowsley

⁴³ The Royal College of Physicians and the Royal College of Psychiatry (2013). Smoking and mental health. Available from: <http://www.rcplondon.ac.uk/publications/smoking-and-mental-health-0>

The integrated wellness service that has been developed in Knowsley offers a single point of access to all healthy lifestyle services in the Borough. The services undertakes a person centred, holistic assessment of individuals, encompassing both physical and mental health and supports individuals to make positive changes, including actions upon the wider determinants of health. The service offers a wellbeing and resilience intervention that is targeted at member of the local community known to have low levels of wellbeing and who have or at high risk of developing mental illness identified in conjunction with local partners e.g. those who have recently come off long-term benefits accessing Job Centre Plus or Knowsley works, or those attending substance misuse services to promote recovery. The programme aims to teach people how the choices they make can affect their health and how to enjoy better health.

Conclusion

There is a high burden of mental illness within the Cheshire and Merseyside population that presents an urgent priority. The majority of those interviewed felt that DsPH and their departments have a key role to play in reducing the burden of mental illness within Cheshire and Merseyside. However, there has been a lack of public health involvement in this area. This should be contrasted with physical disease areas such as CVD and cancer in which there has been strong public health leadership and influence. New structures and commitments present opportunities for increasing capacity and capability.

Mental health has been identified as a priority by the newly formed Health and Wellbeing Boards and the Clinical Commissioning Groups. It will be vital that DsPH and their departments utilise this new opportunity to lead a whole system approach to reducing the burden of mental illness in their localities. DsPH and their department will have a key role in providing and utilising intelligence about levels of mental illness within the locality, including data on inequalities; supporting evidence based commissioning of effective interventions; monitoring progress towards agreed outcomes and ensuring that commissioned services address both the physical and mental needs of members of their local community. Clinical Commissioning Groups are now responsible for planning and buying mental health services in England. DsPH and their senior mental health leads must engage with and provide advice and support to the Clinical Commissioning Group in order to ensure the provision of evidence based services, based on population need.

Reducing the burden of mental illness across Cheshire and Merseyside will require the commitment of public health expertise and resources. A lack of public health activity will contribute to and perpetuate the stigma and inequality related to mental illness within society. Public health leadership is critical to ensuring mental and physical health are given equal priority.

Recommendations

In order to reduce the burden of mental illness within Cheshire and Merseyside it is recommended that:

1. There is Consultant leadership for mental illness within the champs collaborative service component 2 (*Advising the NHS*) to champion and co-ordinate public health action on mental illness, work with the Strategic Clinical Network for mental health and to support local leads in implementing these recommendations.
2. Directors of Public Health work with their Health and Wellbeing Boards to recognise and reduce the burden and impact of mental illness throughout the life-course in their locality and across all sectors, specifically economic and employment, civic and community, housing, criminal justice, education and health and social care.
3. Directors of Public Health provide public health leadership and advocacy across the local system. This should focus upon three priority areas:
 - Achieving parity of esteem between mental health and physical health
 - Reducing the gap in life expectancy between those with severe mental illness and the rest of the population

- The prevention, early identification and evidence-based treatment of common mental illness, such as anxiety and depression.
4. There is a designated senior public health lead for mental illness who provides leadership to the local mental health system in each local authority area. This should include; support to the Clinical Commissioning Group to commission evidence based services, based on population need; leadership and advocacy on suicide prevention through working with the Cheshire & Merseyside Suicide Reduction Network.
 5. Directors of Public Health routinely monitor the Public Health Outcome Framework indicators in relation to mental illness and collaborate with social care and the NHS to set shared targets.
 6. Directors of Public Health and their public health intelligence staff identify and make use of appropriate mental health data, indicators and measures - including data on inequalities – to provide up to date mental health needs assessment. (Example in Appendix 3).

Appendices

Appendix 1

Prevalence of mental illness (population aged 16 and over)

	Men (%)	Women (%)	Overall (%)
Common mental disorder			
Mixed anxiety and depressive disorder	6.9	11	9
Generalised anxiety disorder	3.4	5.3	4.4
Depressive episode	1.9	2.8	2.3
All phobias	0.8	2	1.4
Obsessive compulsive disorder	0.9	1.3	1.1
Panic disorder	1.0	1.2	1.1
Any common mental disorder	12.5	19.7	16.2
Posttraumatic stress disorder	2.6	3.3	3
Suicidal thoughts (past year)	3.4	5.2	4.3
Suicide attempts (lifetime)	3.7	5.8	4.8
Self harm (lifetime)	4.4	5.4	4.9
Psychotic episode (past year)	0.3	0.5	0.4
Anti social personality disorder	0.6	0.1	0.3
Borderline personality disorder	0.3	0.6	0.4
Eating disorder	3.5	9.2	6.4
Psychiatric comorbidity (two or more psychiatric disorders)	6.9	7.6	7.2

Prevalence of mental disorders in children and young people

All children Great Britain

	5- to 10-year-olds			11- to 16-year-olds			All children		
	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
<i>Percentage of children with each disorder</i>									
Type of disorder									
Emotional disorders	2.2	2.5	2.4	4.0	6.1	5.0	3.1	4.3	3.7
Conduct disorders	6.9	2.8	4.9	8.1	5.1	6.6	7.5	3.9	5.8
Hyperkinetic disorders	2.7	0.4	1.6	2.4	0.4	1.4	2.6	0.4	1.5
Less common disorders	2.2	0.4	1.3	1.6	1.1	1.4	1.9	0.8	1.3
Any disorder	10.2	5.1	7.7	12.6	10.3	11.5	11.4	7.8	9.6
Base (weighted)	2010	1916	3926	2101	1950	4051	4111	3866	7977

Appendix 2

Question guide for interviews with public health mental health leads:

- 1) What current public health activity is being undertaken related to mental illness?
Consider current public health activity by area:
 1. Operational
 2. Tactical commissioning input/ use of intelligence
 3. Strategic vision (inc. partnership work)
- 2) Have any needs assessments, evaluations/ audits of services and interventions been undertaken?
- 3) Are there any barriers to activity in this area?
- 4) Looking to the future – what could be done differently to reduce the burden of mental illness within locality? What would be a priority focus?
- 5) What is your relationship like with others in this field? e.g. GP's, mental health commissioners, secondary mental health care providers

Question guide for interviews with Public health intelligence leads

- 1) What data is currently collected related to mental illness?
- 2) How is this data currently used? (Review the application of data and responses to intelligence)
- 3) What needs have been identified locally? (including any unmet needs)
- 4) Have any needs assessments, evaluations/ audits of services and interventions been undertaken?

Question guide for interviews with mental health commissioners

- 1) What health intelligence data do you currently use in order to commission services around mental illness?
 - a. Any evidence lacking?
 - b. Any evidence you are aware of that is not being used?
- 2) What outcome indicators are currently in use?
 - a. Are these adequate?
 - b. How could they be improved?
 - c. Performance management – current/ future
- 3) Explore relationship with others:
 - a. Public health – adequate support? What does this look like currently? How could this be improved?
 - b. Providers – What does this look like currently? How could this be improved in the future?
- 4) Have any needs assessments, evaluations/ audits of services and interventions been undertaken?

Questions in web-based survey sent to DsPH

- 1) To what extent is reducing the burden of mental illness within your locality an identified priority for your public health team?
- 2) What activity has been undertaken by your public health team in order to reduce the burden of mental illness within your locality?
- 3) If specific work has been undertaken by your public health team in order to reduce the burden of mental illness within your locality what has been the focus of this work?
- 4) Do you feel there are any barriers to public health working in this area?
- 5) Do you have any additional comments regarding the role of Directors of Public health and their departments in reducing the burden of mental illness within their localities?

Appendix 3

Example of suggested headings for assessment of need and unmet need related to reducing the burden of mental illness within a locality⁴⁴:

- 1) Level of risk factors for mental disorder across the local population, including inequality
- 2) Numbers from different local population groups at higher risk of mental disorder and low well-being who may benefit from prevention and promotion interventions
- 3) Levels of mental illness
 - a. National levels of mental illness
 - b. Local levels of mental illness
- 4) Estimation of required local mental health services
- 5) Assessment of unmet need for prompt treatment of mental disorder
 - a. National proportion receiving intervention
 - b. Local proportion receiving intervention
- 6) Assessment of unmet need for promotion of mental health and prevention of mental disorder
- 7) Assessment of local economic spend on treatment of mental disorder, prevention of mental disorder and promotion of mental health
- 8) Assessment of local economic impact of investment in interventions to treat mental disorder, prevent mental disorder and promote mental health
- 9) Impact of mental disorder and wellbeing on other JSNA priority areas

⁴⁴ Adapted from Joint Commissioning Panel for Mental Health, Guidance for public mental health services. Available from: <http://www.jcpmh.info/good-services/public-mental-health-services/>

Appendix 4

National Institute for Health and Clinical Excellence (NICE) guidelines outlining evidence-based interventions for mental health conditions:

- Common Mental health disorders: Identification and pathways to care. NICE clinical guideline 123 (2011)
- Antisocial personality disorder: treatment, management and prevention. NICE clinical guideline 77 (2009).
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011).
- Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults. NICE clinical guideline 72 (2008).
- The management of bipolar disorder in adults, children and adolescents, in primary and secondary care. NICE clinical guideline 38 (2006).
- Borderline personality disorder: treatment and management. NICE clinical guideline 78 (2009).
- Depression: the treatment and management of depression in adults (update). NICE clinical guideline 90 (2009).
- Depression in children and young people: identification and management in primary, community and secondary care. NICE clinical guidelines 28 (2005).
- The treatment and management of depression in adults with chronic physical health problems (partial update of CG23). NICE clinical guideline 91 (2009).
- Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004).
- Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).
- Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005).
- Psychosis with coexisting substance misuse. NICE clinical guideline 120 (2011).
- Core interventions in the treatment and management of schizophrenia in primary and secondary care (update). NICE clinical guideline 82 (2009).
- Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004).
- Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. NICE clinical guideline 25 (2005).