Cumbria Mental Health Joint Strategic Needs Assessment: Summary Report

Adults
2010

Contents

1 Summary of Findings[1]

Socio-economic determinants of mental health in Cumbria (adult population: 385,500 people aged ≥20)	Compared to England	Trend
Employment and income		
28,600 people out of work claiming benefits	Same	Up
8,700 people claiming incapacity benefits for a mental or behavioural disorder	Same	
3,000 additional people out of work in the last year	Lower	Up
63,300 households on low incomes	Lower	
Education		
32,000 people with no qualifications	Lower	Down
Estimated 9,400 people aged 18 and over with learning disabilities	Same	Up
Family and caring		
63,000 people living alone	Same	
4,100 lone parents claiming benefits	Lower	Down
51,700 people providing unpaid care	Same	
Crime		
12,000 offenders and 20,000 victims in contact with the criminal justice system		
28,200 crimes recorded by Cumbria Police in 2009/10		
5,600 domestic violence incidents reported to Cumbria Police in 2009/10		
Housing		
105 homeless families	Same	

[1] The data included in this report can refer to local authority districts, practice based commissioning (PbC) localities, Cumbria Partnership NHS Foundation Trust (CPFT) footprints, etc. which are not coterminous. Caution should therefore be taken in interpreting all comparisons between estimated and recorded prevalence, referrals and data related to CPFT as geographic footprints may differ.

Throughout this report, where available, 95% confidence intervals (CIs) have been used to describe the precision of estimated rates. A CI is a range of values within which the true value of a quantity has a 95% chance of occurring. CIs are a way of weighing up the likelihood as to whether apparent differences in rates between areas are real or could be due to chance. CIs are shown as vertical lines (or 'error bars') on graphs.

Mental Health Problems in Cumbria (adult population: 385,500 people aged ≥20)	Compared to England	Trend
Estimated 67,000 people with a common mental disorder, 60% of whom are women	Same	Level
Estimated 2,000 people with psychosis, 60% of whom are women	Same	Level
Estimated 6,800 people over 65 with dementia	Higher	Up
Estimated 4% of population aged 16 years and over engage in harmful drinking	Lower	
Estimated 20% of population aged 16 years and over engage in hazardous drinking	Same	
Estimated 22% of population aged 16 years and over engage in binge drinking	Same	
Estimated 26,000 people with eating disorders (19,000 women and 6,000 men) of whom 6,500 are likely to experience a significant negative impact		
Estimated 12,000 people with Post traumatic stress disorder: (7,000 women and 5,000 men)		
Estimated 4,000 people with autistic spectrum disorders: (400 women and 3,600 men)		
Estimated 4,000 people with Bipolar disorders		
Estimated 3,000 people with Personality disorders of whom ~1,300 antisocial disorders and 1,700 borderline PDs		
Estimated 500 women with major post partum depression and 200 with moderate to severe depression in the peri-natal period.		
Estimated 14,000 – 20,000 adults aged 16 years and over had engaged in deliberate self harm in their lifetime with a higher prevalence in females		
50-60 suicides each year	Higher	Down
1,032 admissions for self harm	Higher	
2,200 attendances at A&E departments for self harm each year		
799 men and 570 women in alcohol treatment		
1,242 men and 558 women in drug treatment		
1,830 admissions to hospital for alcohol specific causes	Higher	Up

2 Introduction and Context

In this document we summarise the key findings of an extensive Joint Strategic Adult Mental Health and Wellbeing Needs Assessment for Cumbria which took place in 2009-2010. This Needs Assessment is part of a wider JSNA programme led jointly by NHS Cumbria and Cumbria County Council and is one of its four demonstration projects. It should be read alongside:

- ***The Joint Strategic Needs Assessment to inform the development of a psychological well-being and mental health strategy and commissioning plan for children and adolescents in Cumbria*** (2009) which addresses the needs of children and young people up to and including the age of 19 and is informing commissioning plans of Cumbria's Strategic Partnership Board for Emotional Well-being and Mental Health of Children & Young People.

- ***Cumbria Suicide Prevention Strategy*** and ***Epidemiological Review of Suicide in Cumbria.***

- ***Cumbria's Dementia Strategy***, soon to be launched.

All these documents, as well as the full report of the Joint Strategic Adult Mental Health and Wellbeing Needs Assessment for Cumbria, will shortly be available on the Cumbria Intelligence Observatory website; http://www.cumbriaobservatory.org.uk/ as well as NHS Cumbria's website: http://www.cumbria.nhs.uk/Home.aspx.

The publication of this Joint Strategic Mental Health Needs Assessment for Cumbria comes at a time of major changes affecting the NHS and other agencies which support mental health and well-being. The new Coalition Government has outlined a reform programme which will have implications for the way organisations operate, and for relationships between organisations and society.

This transformational programme is taking place within the context of financial constraints and reductions in public sector spending. The implications of the Government's spending plans will not be fully understood until after the announcement of the Comprehensive Spending Review in October 2010.

What is clear, however, is that the case for investment in mental health and wellbeing is as strong as ever. Wellbeing is crucial to sustainable economic growth and to maintaining community solidarity and social cohesion in the face of economic challenges. Demand for mental health services is likely to increase as a result of stress in the workplace related to organisational change, unemployment, personal debt, home repossession, relationship breakdown and other consequences of changing economic circumstances. Contemporary research corroborates Emile Durkheim's groundbreaking study, ***Suicide*** (1897), which over a century ago showed that suicide rates increase when people become detached from close-knit contacts with others ("egoistic" suicide) and in times of economic crisis ("anomic" suicide).

At the same time, expenditure on mental health services may be particularly vulnerable in the current economic and political climate: '… *services that are cut are often those which lack a strong advocacy base, such as mental health, rather than those lacking a strong evidence-base for improving health'* (Stuckler et al., 2010).

The NHS White Paper ***Equity and Excellence: Liberating the NHS (2010)*** and the series of consultation papers that accompany it set out the Government's vision for transforming health and social care. It signals major changes in the way that health services are

commissioned and provided. Putting patients at the heart of the NHS, it sets out to devolve responsibility for the bulk of the NHS budget in England to general practitioner based consortia. It also proposes the creation of a new national Public Health Service and the transfer of PCT responsibilities for public health to local authorities. A Public Health White Paper is to be published in late 2010. Legislation to underpin these changes will be proposed in the forthcoming Health Bill.

England's new Mental Health policy is also due for publication this autumn. There are early indications that it will retain some of the features of the previous government's reform programme for mental health, set out in ***New Horizons (2009***), in particular, its dual focus on improving population mental heath and well-being and improving mental health services. It is also likely that it will build on the extensive evidence base that has informed policy to date. However, mirroring the NHS White Paper, it is anticipated that it will focus much more strongly on the empowerment of clinicians and patients and on outcomes than the previous national policy framework.

New Horizons sets out a vision to move towards a society where people understand that their mental well-being is as important as their physical health if they are to live their lives to the full. This vision can be achieved by bringing together an alliance across national and local government, the voluntary sector and professionals, as well as local communities and individuals, to work towards a society where **mental health is everybody's business.**

The importance of mental health and well-being is underlined by the following:

- Mental ill-health is common – one in four people will experience a mental health problem at some point in their lives.

- One in six of the UK adult population experiences mental ill health at any one time
- Mental illness accounts for over 20% of the total burden of disease in the UK, more than cardiovascular disease or cancer.

- Mental and physical illness often co-exists, with depression noted in 13-57% of cancers and 30-50% of heart attacks. Co-morbidity can result in sub-optimal treatment of both conditions.

- 10% of children have a mental health problem.

- Half of all mental illness (excluding dementias) starts by age 14.

- Poor mental health has huge costs. The most recent Department of Health programme budgeting information estimates the cost of mental health disorders at £10.4 billion, or 10.8% of the NHS estimated total gross expenditure of £96.8 billion.

- Because the impacts of mental illness on individuals, families, communities and the economy are so wide-ranging – including high levels of sick leave, early retirement and suicide - total costs to society are proportionately higher than for other chronic conditions and are estimated at £105.2 billion in 2009/10 (Centre for Mental Health, 2010).

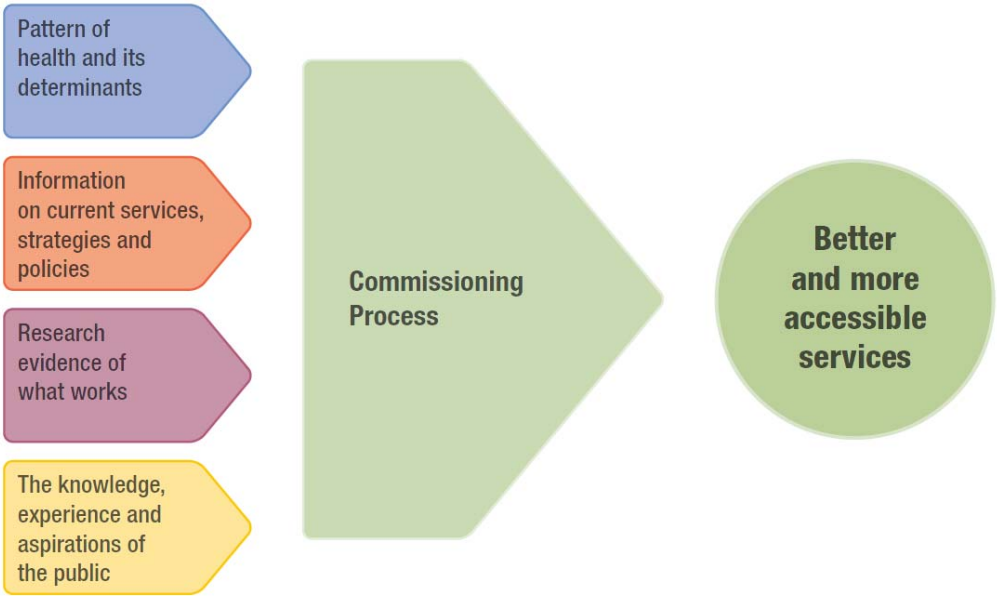
- Mental illness is preventable. It has been calculated that optimal treatment with optimal coverage could avert 28% of the burden of mental illness.

- The economic downturn poses a dual challenge for mental health: a likely increase in demand coupled with potentially reduced funding levels.

3 Objectives of the Needs Assessment

Joint Strategic Needs Assessment (JSNA) is a way of describing the health and well-being of our communities. It involves bringing together relevant data and evidence and working with communities, clinicians, local authorities and other stakeholders including service users and their carers to capture their views and experiences. An effective JSNA should inform future service needs, and predict and anticipate potential new or unmet need. The four main kinds of information used to determine need and decide on commissioning priorities are shown in the **figure 1** below:

Figure 1: The Joint Strategic Needs Assessment process (Source: Cumbria JSNA, 2009)



This JSNA constitutes a baseline against which to measure progress in improving mental health and wellbeing outcomes in Cumbria. Its objectives are:

- To assess the current baseline of mental well-being in Cumbrian adults.
- To describe the numbers of people at increased risk of developing mental problems in Cumbria with reference to the distribution of risk and protective factors for mental health in Cumbria.
- To estimate the number of people with mental disorders in Cumbria.
- To assess strengths, gaps and inefficiencies in existing service provision by identifying people currently not receiving beneficial services (unmet need) and people currently receiving ineffective or inappropriate services.
- To assess the evidence for the delivery of high quality mental health services and interventions.
- To ascertain the views of the public, service users and carers, and other stakeholders, of mental health assets, needs and gaps in services.
- To make recommendations to strategic leads and commissioners of mental health services.

4 Demographic Information

In this section we give an overview of the current population and population trends across Cumbria and its localities, and their implications for mental health. These vary according to the distribution of mental health by age, gender and other determinants.

The current population of Cumbria is about 500,000. Cumbria has a slightly older age profile than the England average (**figure 2**). There is also a significant trend in Cumbria and its localities towards an ageing of the population **(table 1**).

This has implications for the future distribution of mental health and illness in the population, particularly illness affecting older people. It also means that in future, there will be fewer people of working age to take care of those needing additional support.

Figure 2: Mid 2008 population estimates by age and sex for Cumbria and England

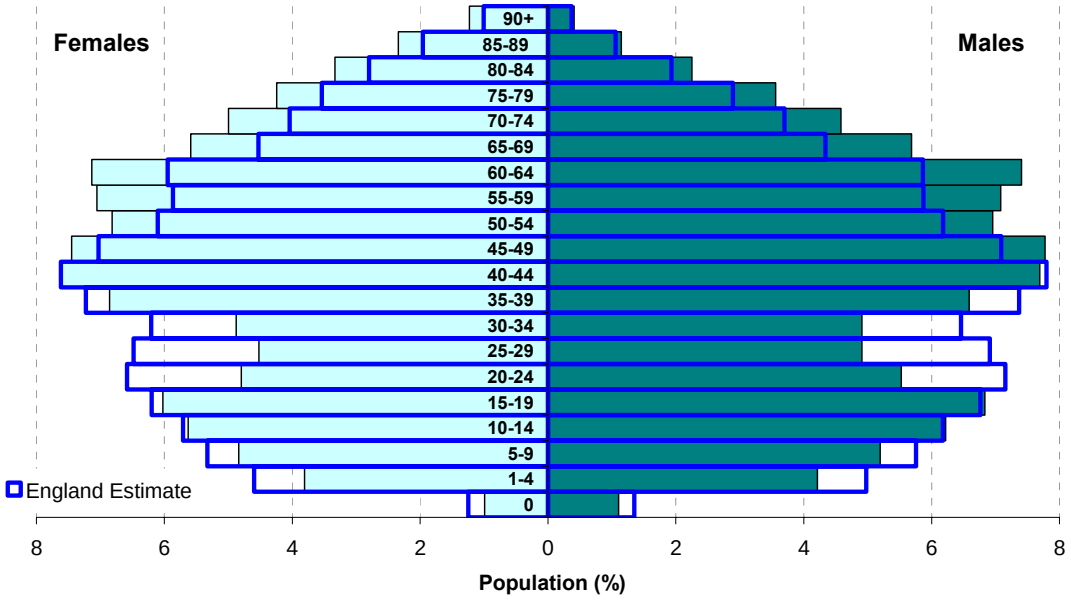


Table 1: Projected population change (2006-2031): actual and % change by age group (Source: ONS)

	Population Change in '000s (%)				
	15-34	**35-64**	**65-74**	**75-84**	**85+**
Allerdale	-0.7 (-3.6%)	-2.8 (-6.8%)	4.7 (48.0%)	4.6 (74.2%)	3.5 (159.1%)
Barrow	-0.1 (-0.6%)	-1.4 (-4.7%)	2.6 (38.2%)	2.5 (61.0%)	1.8 (105.9%)
Carlisle	1.5 (6.0%)	2.4 (5.6%)	5.5 (56.1%)	4.4 (66.7%)	3.1 (134.8%)
Copeland	-0.8 (-5.1%)	-0.8 (-2.6%)	4.4 (63.8%)	3.4 (82.9%)	2.1 (161.5%)
Eden	-0.1 (-1.0%)	-0.5 (-2.1%)	3.8 (69.1%)	3.1 (86.1%)	2.4 (200.0%)
South Lakeland	-0.3 (-1.5%)	-0.9 (-2.0%)	7.1 (60.7%)	6.1 (74.4%)	4.7 (146.9%)
Cumbria	**0 (0%)**	**-4.2 (-2.0%)**	**28.2 (56.2%)**	**24.1 (73.5%)**	**17.5 (147.1%)**

5 Pattern of well-being, mental health and illness and their determinants in Cumbria

5.1 Distribution of mental health and well-being in Cumbria

Some people are at greater risk of experiencing low levels of wellbeing and poor mental health than others. The factors that protect against mental ill-health are often at the opposite end of the same continuum as factors that increase risk. Risk and protective factors are related to individuals and their families and to the communities in which they grow up and live. **Table 2** (over page) outlines the main factors that are associated with different types of mental disorder.

Whether contextual or individual, risk factors are dynamic and interact:

> *'the individual hopelessness a person experiences may be compounded by the similar situation of others in one's neighbourhood and community… this may be in stark contrast to the affluence observed outside the neighbourhood'* (Rehkopf and Buka, 2006).

Equally, individual resilience and the capacity to respond positively to adverse life events are supported by factors ranging from good parenting, positive early life experiences and family and peer relationships to opportunities for life-skill development, educational achievement and meaningful activity and employment, and access to responsive, high quality, co-ordinated services within safe, secure and prosperous environments.

Many of the modifiable risk and protective factors for mental health and well-being are linked to socio-economic status and area deprivation. However, there are some exceptions to this rule, indicating that people are either doing better or worse than expected given their life circumstances. Why certain people or places adapt to adversity and achieve better outcomes is the subject of much current interest in *resilience* and *assets* for health.

Key findings of the needs assessment include:

- A clustering of the key determinants of mental (ill) health in the most deprived parts of Cumbria.
- High numbers of people out of work because of mental ill-health and a general trend towards increased unemployment, especially in more deprived areas, and economic hardship.
- Lower levels of social cohesion in Cumbria's more socially disadvantaged localities, with the exception of Barrow-in-Furness.
- A mean wellbeing score for Cumbria below the North West average, with only South Lakeland scoring above the regional average and Eden having the lowest score.
- Some negative public and professional perceptions of mental health problems.
- A lack of awareness of, as well as gaps in, well-being services and interventions.

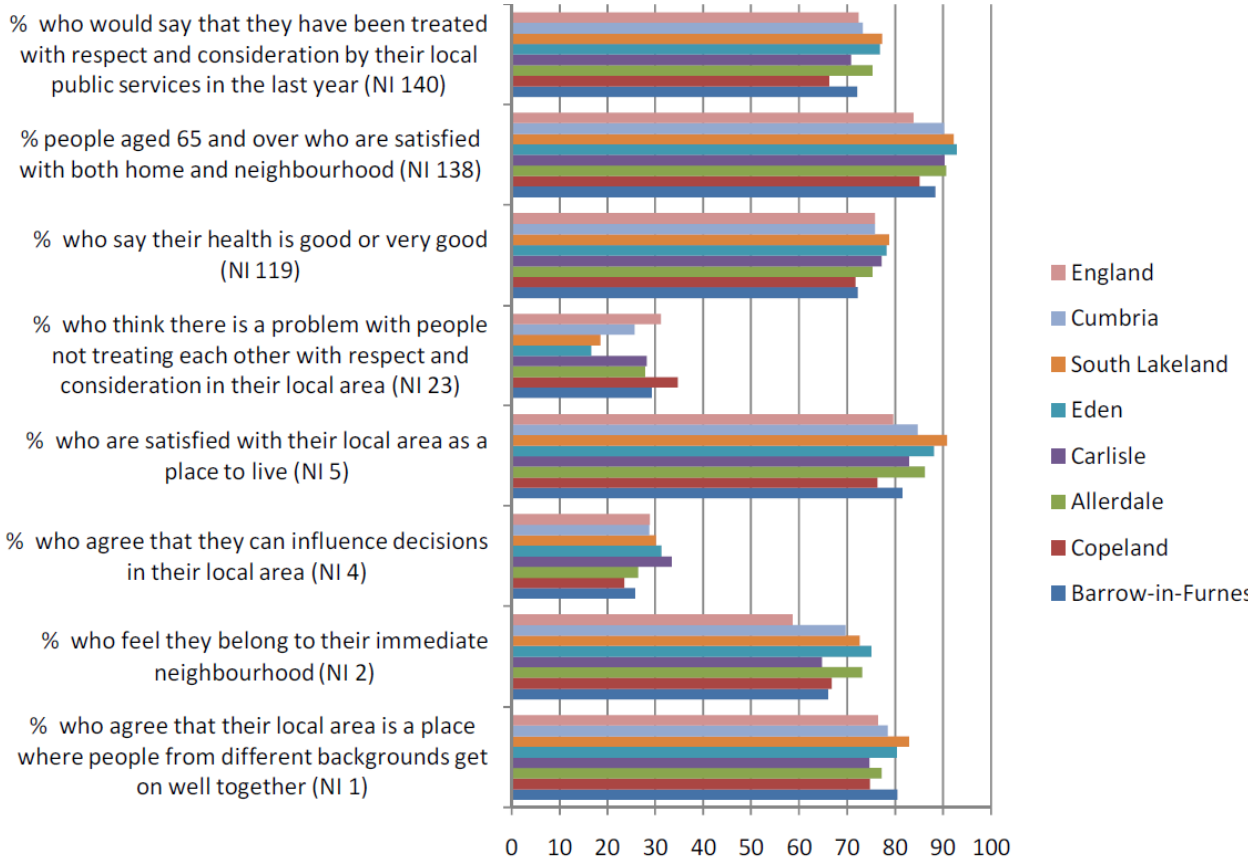
Table 2: Main factors associated with the different types of mental disorders (Source: Jenkins et al, 2008)

	Childhood disorders	Adult common mental disorders	Psychosis	Dementia	Personality disorders	Addictions			Violence	Suicidal thoughts
						Alcohol abuse	Substance abuse	Tobacco		
Age	Increases with increasing age	Highest rates in 35-54 age group	Highest rates 20-34 age group, median age at onset ~3 years later in women than men	Increases with age 5% of over 65s and 20% of over 80s	Increased in younger people	Highest in 16-24 year olds	Highest in 16-24 year olds	Increased onsets in 16-24 year olds, highest rates 25-55	Highest in young adults	Highest in young adults
Gender	M> F	F>M	M>F, but secondary peak in women around 40-45 years	M=F	M>F	M>F	M>F	M=F	M>F	F>M. but actual suicide M>F
Ethnicity	Lower rates in young Indian girls	Higher rates in Irish and Black Caribbean	Higher rates in several BME groups; notably Black Caribbean and Black African populations							
Marital status	N/A	Increased in separated and divorced	Increased in separated and divorced		Increased in single	Increased in single, separated or divorced	Increased in single	Increased in single, separated and divorced	Highest in single	Increased in single, separated and divorced
Family composition	Increased in lone parents, and reconstituted families	Increased in lone parents				Couple with children have lower rates				Increased rates in those living alone
Employment	Increased in poor education of parents, lack of employment and low income of parents	Increased in social class V and unemployed.	Increased in social class IV and V, and in economically inactive. Little evidence that parental social class is influential		Increased in those with lower socio-economic status and poorly educated	Increased in manual occupations	Increased in unemployed	Higher rates with lower educational qualifications, nursing and teaching, lower incomes	Increased in social class III and IV	Higher rates in lower educational qualifications and lower social class

	Childhood disorders	Adult common mental disorders	Psychosis	Dementia	Personality disorders	Addictions			Violence	Suicidal thoughts
						Alcohol abuse	Substance abuse	Tobacco		
Social supports	Increased with psychological distress in mother and family discord	Increased in those with few social supports	Increased in those with few social supports							Increased rates with few social supports
Immigration status			Higher rates in immigrants, probably due to increased stressful life events, urban living, discrimination, social isolation							
Housing tenure		Increased rates in people who rent rather than own home	Increased rates in people who rent			Increased rates in those who rent from LA or housing association and in those with a mortgage	Increased rates in those who rent			Increased rates in those living alone
Urbanisation		Urban>rural	Urban>rural		Urban>rural	Urban>rural	Urban>rural	Urban>rural	Urban>rural	Urban>rural
Deprivation index	Increased rates with neighbourhood deprivation and lack of social cohesion		Increased rates with neighbourhood deprivation and lack of social cohesion, both in childhood neighbourhood and current neighbourhood				Increased rates with neighbourhood deprivation and lack of social cohesion			

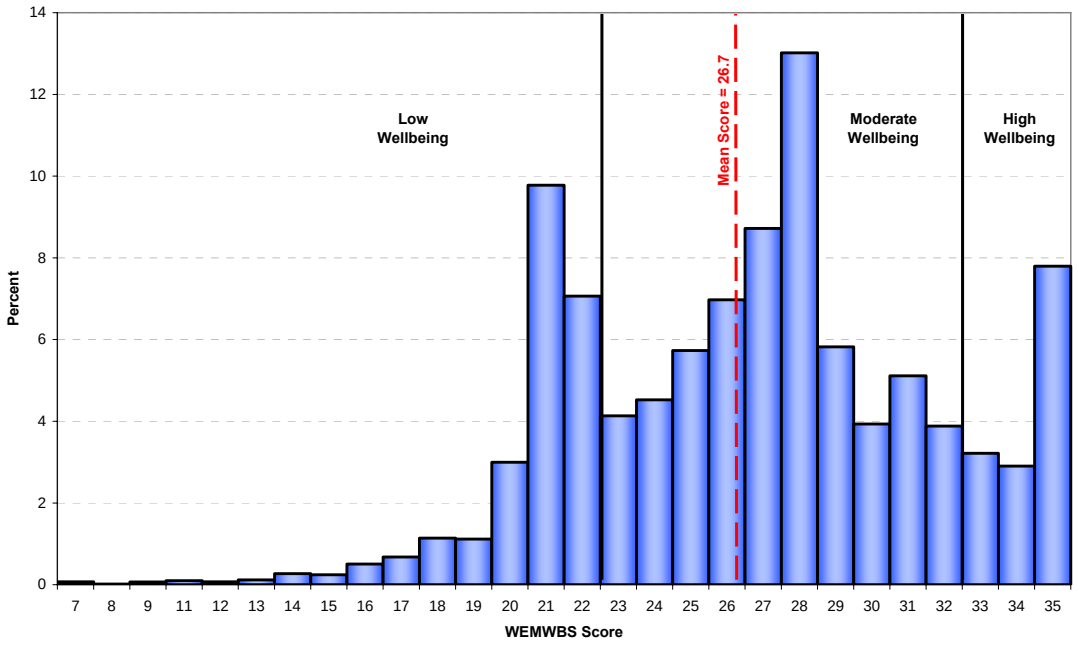
The ***Place Survey*** includes a number of proxy measures of social inclusion, self perceived health and people's perceptions of their community and services they receive. Results show that overall, Cumbria tends to do better than England on these measures (**figure 3**). However within Cumbria there are large differences. The more socially disadvantaged areas tend to fare less well compared to Eden and South Lakeland. Barrow-in-Furness is a noticeable exception. Considering it has the highest level of deprivation in Cumbria, it scores relatively well on most of these measures. Copeland has the lowest reported levels for several indicators including whether people of different backgrounds get on together, whether people feel they can influence decisions, whether people treat each other with respect and overall satisfaction. Why certain people or places adapt to adversity and achieve better outcomes is the subject of much current interest in *resilience* and *assets* for health.

Figure 3: Findings of the 2008 Place survey: NIs 1, 2, 4, 5, 23, 119, 138 and 140



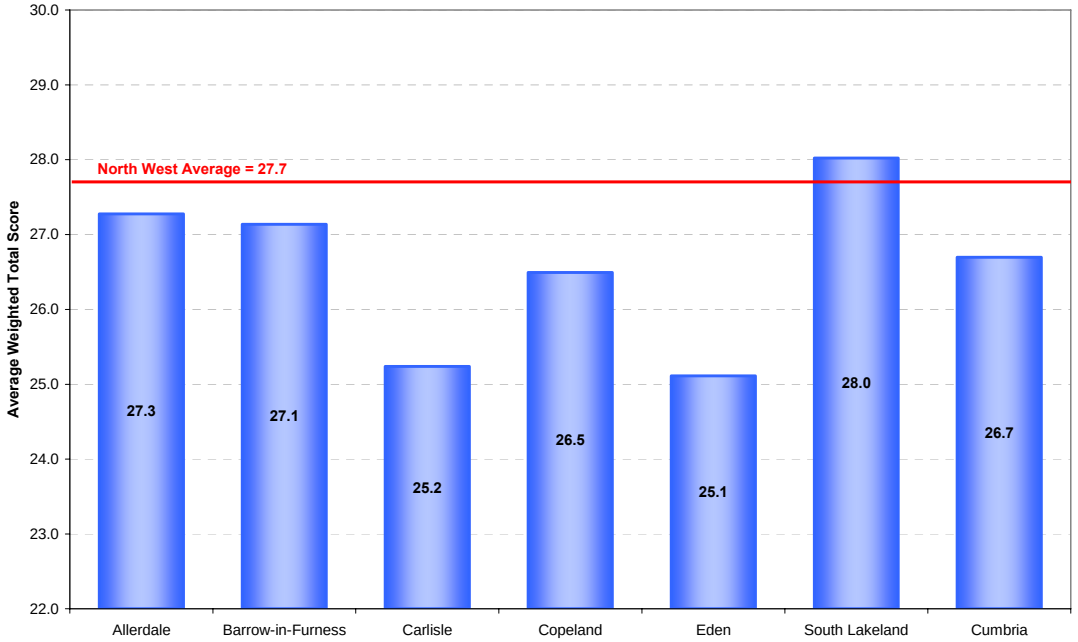
In order to better understand levels of well-being and the factors, or determinants, which may either enhance or reduce well-being, the ***Northwest Mental Wellbeing Survey*** (2009) was undertaken across the North West of England. The survey revealed a mean wellbeing score for the North West of 27.7 out of a maximum score of 35. Cumbria's mean score of 26.7 placed it just below the regional average (**figure 4**).

Figure 4: 2009 Weighted Total WEMWBS Score: Proportion of Cumbrian respondents (Source: Dewa et al, 2010)



Results by district in Cumbria show that only South Lakeland had a mean score above the regional average. Survey participants in Eden had the lowest mean well-being score, at 25.1 out of 35.

Figure 5: Average WEMWBS Score by District (Weighted population) (Source: Dewa et el, 2010)



The North West regional well-being survey (2009) also enabled the following correlations to be made between wellbeing and its determinants:

- Gender – there is no difference between men and women.
- Age – mental wellbeing is highest among 25-39 year olds, then decreases and is significantly lower among 40-54 year olds.
- Deprivation – mental wellbeing decreases as deprivation increases.
- Ethnicity – mental wellbeing is lower amongst white than non-white respondents.
- Health - strong associations between physical health, lifestyle and mental wellbeing.
- Work – mental wellbeing is higher in people in full-time employment or education or self employed and lower in permanently sick or disabled people.
- Place - mental wellbeing is higher in people who have lived 10 years or more in local area; are satisfied with their local area; have a sense of belonging; feel they can affect decisions; and feel safe.
- Relationships - strong relationships and good social networks are strongly associated with high levels of mental wellbeing.
- Money worries - mental wellbeing is lower in respondents with money worries.

Unemployment is a particularly important determinant of mental health. Several studies have identified increased rates of depression in the unemployed, particularly in young men. The overall level of employment in Cumbria is higher than the average of England. However levels of employment in parts of West Cumbria, Barrow and Carlisle are comparable to some of the worst in the country. Between August 2008 and August 2009, the economic down turn resulted in an additional 3,000 Cumbrians being out of work and on benefits. Some areas of Cumbria have particularly high levels of people out of work because of their health. In February 2009, 23,000 Cumbrians were claiming *Incapacity Benefits (IB*), of whom approximately 40% (8,665) for mental and behavioural causes. Barrow-in-Furness had the highest rate of *IB/Severe Disability Allowance (SDA*) claimants for mental and behavioural causes (3.5% of the population aged 16 and over) (**table 3**).

Table 3: Number of people (% of population aged 16 and over) claiming IB/SDA for mental or behavioural disorders as at February 2009 (Source: DWP statistics)

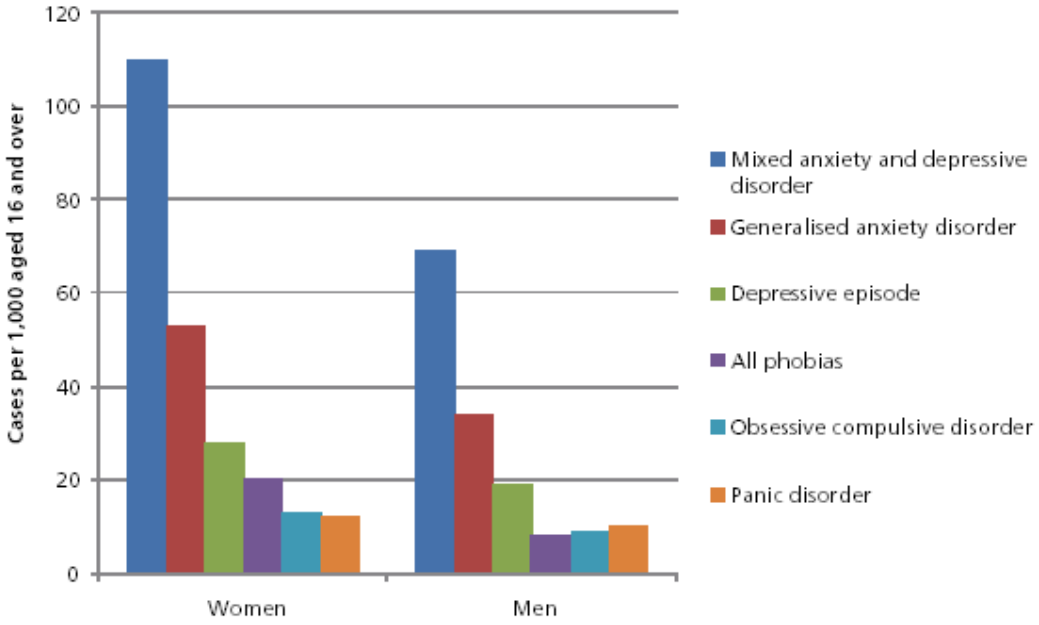
	Number (%)
Allerdale	1,555 (2.0%)
Barrow	2,045 (3.5%)
Carlisle	2,040 (2.4%)
Copeland	1,500 (2.6%)
Eden	465 (1.1%)
South Lakeland	1,060 (1.2%)
Cumbria	**8,665 (2.1%)**
England	**850,465 (2.0%)**

5.2 Estimated prevalence of mental ill-health in Cumbria

This section provides estimates of the prevalence of mental illness in our population. Most of these estimates are derived from national surveys, in particular the ***Adult Psychiatric Morbidity in England Survey*** (APMS) 2007.

According to the APMS, the prevalence of common mental disorders (CMDs) in adults is 17.6% (compared to 15.5% in 1993 and 17.5% in 2000) (**figure 6**).

Figure 6: Numbers of people aged 16 and above with common mental disorders, England, 2007 (Source: APMS, 2007)

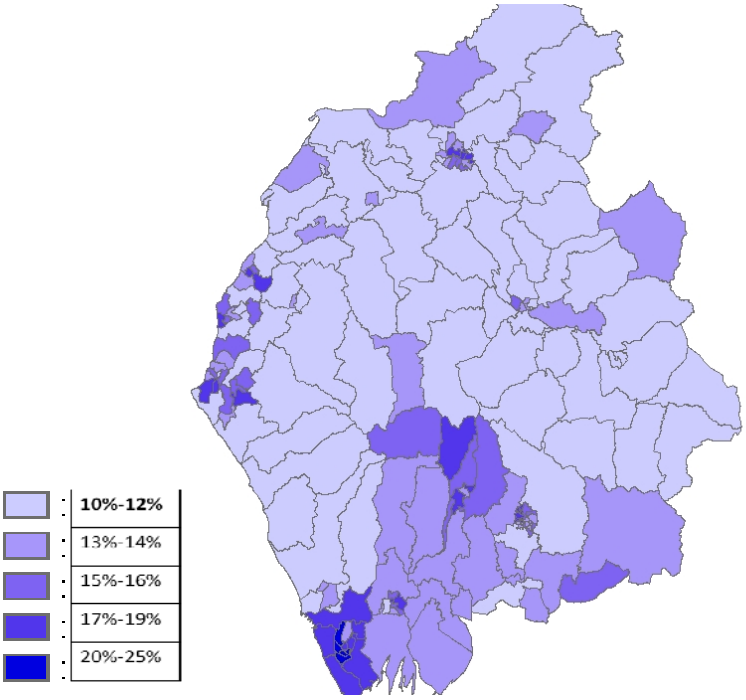


Where possible, we have modelled prevalence in Cumbria based on the findings of the APMS and other surveys adjusted for some of the determinants of mental health. These models are based on various sources and assumptions. They should be used as a guide to how many people are affected by mental illness in Cumbria and its districts. Actual numbers may be different.

According to these estimates:

- About 67,000 adults in Cumbria may have a common mental disorder (CMD), of whom over 60% are likely to be women.
- People living in areas of deprivation are more likely to have a CMD (**Map 1**).
- About 3,500 Cumbrians are likely to experience stress, depression or anxiety caused or made worse by work.
- Each year about 500 new mothers in Cumbria are likely to experience major depression in the peri-natal period

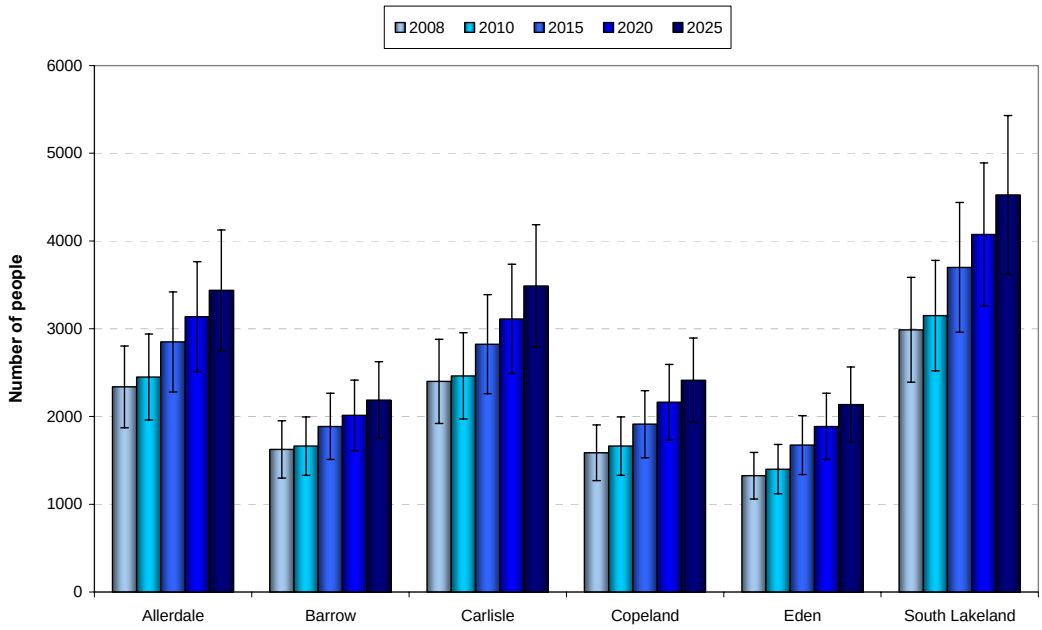
Map 1: Estimated prevalence of any CMD in adults aged 16-74 by ward (Source: NEPHO)



- In men and women, the prevalence of CMDs is highest between ages 35-54 and decreases thereafter.

- Notwithstanding, as Cumbria's population ages, there is likely to be a large increase in numbers of older people with mental illness. By 2025 there are predicted to be 4,700 – 7,100 more people over 65 with depression than in 2008 (**Figure 7**).

Figure 7: Number of people aged 65 and over projected to have depression (estimates based on prevalence rate of 10-15%) (Source: POPPI)



- Estimated prevalence of psychotic disorder is 0.4% (0.3% of men, 0.5% of women).
- In both men and women, prevalence is highest in those aged 35 to 44 years (0.7% and 1.1% respectively).
- Prevalence of psychosis is higher in people with lower household incomes.
- Prevalence is also significantly higher in black men (3.1%) than men from other ethnic groups. There is no variation by ethnicity in women.
- Based on the APMS, there are about 1,600 people with a psychotic disorder and 2,100 people with probable psychosis in Cumbria.

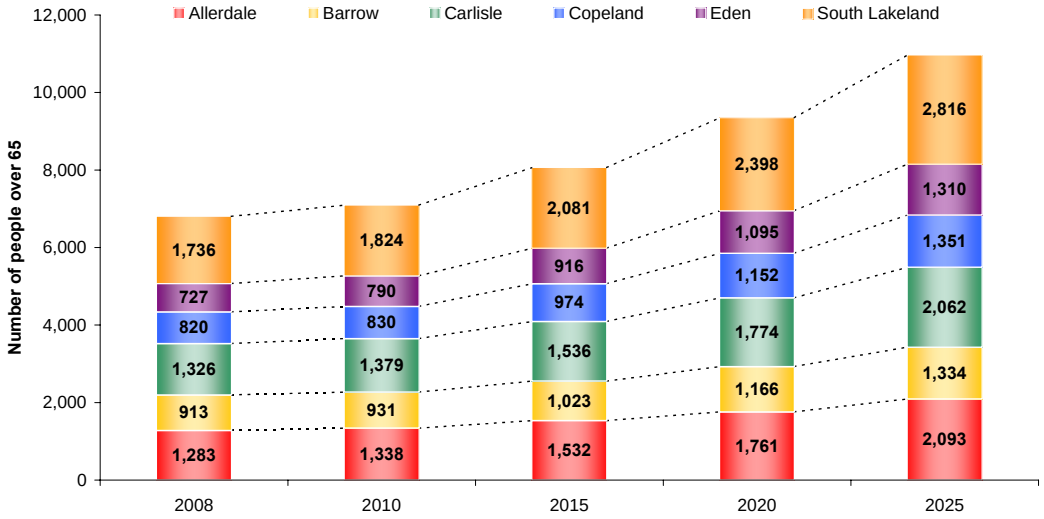
Table 4: Predicted prevalence of probable psychosis adjusted for age, sex and household income: 16-74 age group (Source: McManus et al, 2009)

	Predicted prevalence of probable psychosis (%)	Predicted number of people with probable psychosis	% of total
Allerdale	0.6	414	20%
Barrow-in-Furness	0.7	388	19%
Carlisle	0.6	473	23%
Copeland	0.5	293	14%
Eden	0.4	164	8%
South Lakeland	0.4	325	16%
Cumbria	**0.5**	**2,056**	**100%**

- About 4,000 adults in Cumbria are likely to have bipolar disorder.
- About 12,200 adults are likely to screen positive for post traumatic stress disorder in Cumbria, of whom 5,200 men and 7,000 women.
- There are likely to be about 1,200 people with antisocial personality disorder (1,000 men: 200 women) and 1,600 people with borderline personality disorder (550 men; 1,050 women) in Cumbria.
- There are likely to be about 4,000 adults (3,600 males, 400 females) with autistic spectrum disorder in Cumbria.
- About 6,500 Cumbrians are likely to experience a significant negative impact of an eating disorder.
- There are likely to be about 9,400 people aged 18 and over with learning disabilities in Cumbria about 40% of whom are likely to have a mental health problem. It is important to ensure that people with learning disabilities have equal access to services, including mental health services.
- The number of people aged 65 and over predicted to have a learning disability is expected to increase by over 60% between 2009 and 2030, from about 2,000 to about 3,350.
- About 6,800 people aged 65 and over in Cumbria are estimated to have dementia.
- The number of people aged 65 and over with dementia is expected to increase in Cumbria by over 60% to about 11,000 by 2025 (**figure 8**), a rate of increase greater

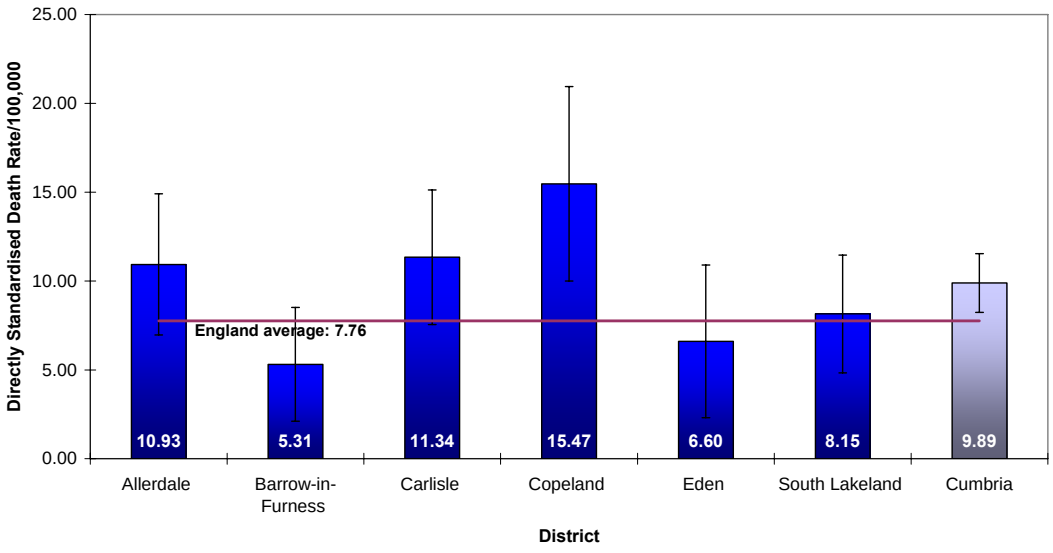
than the England average (51%). Highest increases are expected in Eden and South Lakeland.

Figure 8: 2008-2025: No. aged 65 and over predicted to have dementia (Source: POPPI)



- About 50 people die through suicide each year in Cumbria.
- The suicide rate in Cumbria is significantly higher than the national average (9.89 compared to 7.76 deaths per 100,000 in 2006-08) (see **figure 9**).
- Suicide is less common in women than in men. 71.8% of suicides in Cumbria in 2006-08 were in men, close to the England average (75.9%). Suicide is of particular concern in young males between the ages of 15 – 44 years with a rate in Cumbria of 19.69 deaths per 100,000 in 2006-08.
- Suicide is associated with deprivation: the highest rate of suicide is experienced in the most deprived areas of Cumbria (Quintile 1) and is statically significantly higher than the rate in the least deprived areas (Quintile 5). There is a gradient between the most and least deprived areas. This is comparable to the situation in England and Scotland.

Figure 9: 2006-2008: Directly standardised death rate from suicide and injury of undetermined intent, Cumbria & districts. All ages. (Source: NCHOD)



- One-fifth (20%) of England's adult population has a hazardous pattern of drinking, 6% is dependent on alcohol, 3% on illegal drugs and 21% on tobacco.

- The proportion of Cumbrians aged 16 years and over who binge drink is statistically similar for Cumbria (20.1%) compared to England (20.1%).

- In Cumbria, directly age-standardised alcohol specific mortality rates for both men and women were lower than the national average in 2004-06 (respectively 9.6 compared to 12.3 per 100,000 and 4.9 compared to 5.8 per 100,000). This equates to 81 male deaths and 41 female deaths in Cumbria in 2004-06.

- Alcohol attributable mortality rates follow a similar pattern. In Cumbria, the rate for men in 2004-06 was 36 per 100,000 and for women 19 per 100,000. This was lower than the national average for men but significantly higher than the national average for women.

6 Current Service Provision

In this section we describe the current provision of services to improve mental health in Cumbria. Services to improve mental health in Cumbria are provided by a range of NHS, social care and voluntary sector providers. We map their organisation, infrastructure, expenditure, activity, and where available, outcomes, against the expected prevalence of mental ill-health.

We found many examples of high quality and improving mental health services across the NHS, social care and the voluntary sector. Service mapping was in some instances limited by the quality of available data. However, key issues identified include evidence:

- **Of underinvestment in mental health commissioning.**
- **Of some inefficiencies in service provision:** examples include high cost of older adults' residential care; variations in patterns of GP prescribing and referral; low uptake of specialist personality disorder services; high numbers of out of area placements.
- **Of some gaps and inequities in the distribution and delivery of, and access to, services in relation to need:** examples include transitions to adult services; crisis support and intervention; services for specific population groups and conditions, e.g. eating disorder and personality disorder services; support for people bereaved through suicide; recovery focused support; acute and primary care liaison.
- **That investment could lead to savings elsewhere in the health system and beyond:** examples include improvement of maternal and infant mental health and other investments in the mental health and wellbeing of children, young people and families; support for workplace mental health; integration of physical and mental healthcare to include social prescribing and wider access to psychological therapies for people with physical health as well as mental health problems; mental health support for people in contact with the criminal justice system; pathway development for people who self harm.

6.1 Commissioning for mental health

The report of the NHS North West Mental Health Improvement Programme (2008) found that expenditure on mental health commissioning in Cumbria was among the lowest in the region.

Commissioning for mental health is moving from block contracting arrangements towards mental health payment by results, towards joint approaches to commissioning across the NHS and local authorities, and towards devolving commissioning to GP commissioning localities.

6.2 Overview of activity and expenditure on mental health

- NHS expenditure on mental health (all ages) in Cumbria is marginally higher than expenditure in comparators (£192 per weighted head of population in Cumbria in 2008/09 vs. £188 for the ONS 'coastal and countryside' cluster, £189 across the North West Strategic Health Authority (NW SHA) and £191 for England).

- The value of NHS mental health contracts for 2009/10 was: Cumbria Partnership NHS Foundation Trust (CPFT): £61.4 million; 3 other specialist mental health provider trusts: £2.7 million; other providers: £22.9 million.

- Total (NHS + local authority) expenditure on adult and older adult mental health services in Cumbria is close to £100 million in 2009/10 (adult mental health services: £51,493,000; older adult mental health services: £47,687,000).

- While overall expenditure per head on adult mental health services is relatively close to comparators, direct costs were 65.4% in Cumbria compared to 81.3% for England, 82.7% for the NW SHA and 82.9% for the ONS comparator (**table 5**).

Table 5: Total investment in adult mental health services in Cumbria ('This LIT') and proportion spent on direct and other services compared to NW SHA ('This SHA'), ONS 'coastal and countryside' cluster ('This ONS') and England average ('English LITs') (Source: Mental Health Strategies, 2010)

		Percentage			
Service category	**£'000s**	**This LIT**	**This SHA**	**This ONS**	**English LITs**
DIRECT COSTS:	£33,673	**65.4%**	82.7%	82.9%	81.3%
INDIRECT COST:	£6,547	**12.7%**	6.8%	7.7%	7.0%
OVERHEADS:	£9,222	**17.9%**	8.6%	6.9%	9.0%
CAPITAL CHARGE:	£2,050	**4.0%**	1.8%	2.5%	2.7%
Total adult investment in £'000s	**£51,493**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

- Investment in adult personality disorder services, psychological therapy services, direct payments and home support services was higher in Cumbria than comparators, while expenditure on accommodation, continuing care, services for mentally disordered offenders and health promotion was lower.

- Total weighted investment per head on older people's mental health services appears considerably higher than comparators, at £564.50 in Cumbria compared to an average of £334.60 for England, £312.50 across the NW SHA, and £437.20 for the ONS cluster.

- Investment in direct costs for older adults appears similar to comparators, at 84.8% in Cumbria compared to 83.5% for England, 84.9% for the NW SHA and 87.7% for the ONS comparator (**table 6**).

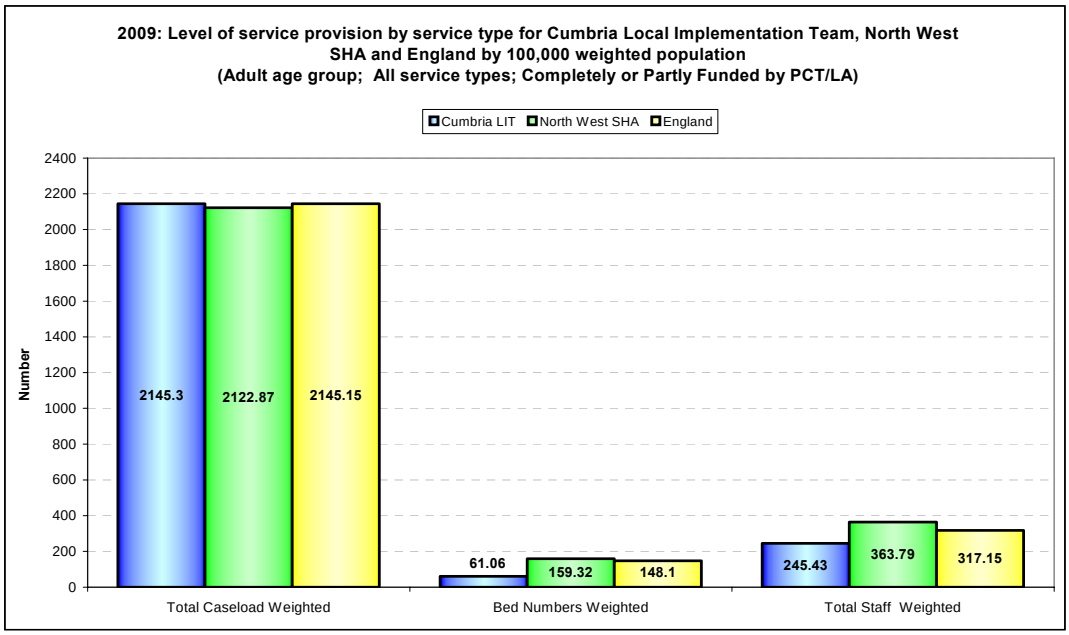
- Investment in older adults' primary and community residential care accounted for over £31 million (of which £21,615,000 non statutory provision). Weighted investment per head in residential care was £370 in Cumbria compared to an average of £116 for England, £122 for the NW SHA and £228 for the ONS comparator.

Table 6: Total investment in older people's mental health services in Cumbria ('This LIT') and proportion spent on direct and other services compared to NW SHA ('This SHA'), ONS 'coastal and countryside' cluster ('This ONS') and England average ('English LITs') (Source: Mental Health Strategies, 2010)

Service category	£'000s	Percentage			
		This LIT	This SHA	This ONS	English LITs
DIRECT COSTS:	£40,426	84.8%	84.9%	87.7%	83.5%
INDIRECT COST:	£2,632	5.5%	6.1%	6.1%	6.6%
OVERHEADS:	£3,932	8.2%	7.3%	4.5%	7.5%
CAPITAL CHARGE:	£698	1.5%	1.7%	1.7%	2.4%
Total OPMHS investment in £'000s	**£47,687**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

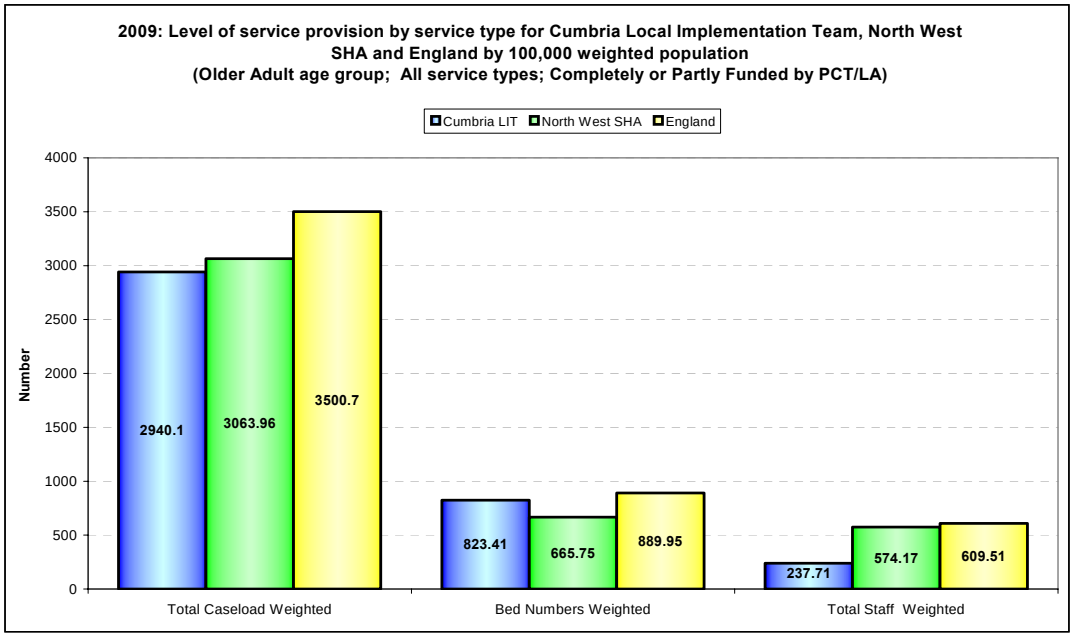
- Mapping of combined NHS and local authority services shows that for adult services, whilst the weighted case load in Cumbria is similar to that found regionally and nationally, contact rates with specialist mental health services, bed numbers and staffing levels are lower in Cumbria than comparators (**figure 10**).

Figure 10: 2009 Level of service provision by service type for Cumbria, NW SHA and England (adult age group) (Source: Mental Health Strategies, 2009)



- For older adults, total weighted caseload was comparable in Cumbria to the North West but lower than the England average. Weighted bed numbers were between levels for the North West and England but total weighted staff levels were less than half the North West and England averages (**figure 11**).

Figure 11: 2009 Level of service provision by service type for Cumbria, NW SHA and England (older adult age group) (Source: Mental Health Strategies, 2009)



6.3 Services and interventions to improve well-being and prevent mental illness: action on determinants of mental health

- A wide range of services and interventions to improve well-being, prevent mental illness and support recovery is available in Cumbria. These include Cumbria County Council Libraries' Well Read books on prescription scheme; and the Condition Management Programme jointly provided by Jobcentre Plus and Cumbria Partnership NHS Foundation Trust CPFT).

- Third sector organisations are a major provider of well-being promoting services. There are an estimated 5,000 such organisations in Cumbria, of which about 30 specifically provide services to people recovering from mental health problems and many others promote well-being – for example services offering advice, volunteering, outdoor pursuits, and skills development.

- There is currently no systematic approach to providing information to professionals and the public about, and signposting to, such services.

6.4 Primary care

- Comparison of expected prevalence of depression and prevalence as estimated by general practice Quality and Outcomes Framework (QOF) registers for 2008/09 suggests over-diagnosis in Eden (and South Lakeland) and under-diagnosis in Cumbria's other districts, especially Barrow-in- Furness (**table 7**).

Table 7: Estimated prevalence and diagnosed prevalence of depression reported in QOF 2008/09 (Source: Glover, 2008; NHS Information Centre)

	Expected prevalence (16-74 year olds)	2008/09 Number of people on QOF register (18 years and over)	2008/09 Diagnosed prevalence on QOF register (% of 18+ population)	2008/09 Diagnosed prevalence on QOF register (% of all ages)
Allerdale	9%	8,014	9.9%	8.0%
Carlisle	10%	10,206	11.7%	9.4%
Copeland	10%	5,120	10.1%	8.1%
Eden	8%	5,026	11.9%	9.7%
Furness	13%	7,412	10.8%	8.6%
South Lakeland	10%	11,141	12.3%	10.2%
Cumbria	**10%**	**46,919**	**11.2%**	**9.0%**
England		**4,373,974**	**10.2%**	**8.1%**

- Most practices scored highly on QOF indicators for the quality of mental health care with the exception of MH6 (documentation of care programme approach), where the score for Cumbria was 2% below the national average, and MH7 (regular review), where the Cumbria score was above the national average but 27 practices scored 0%. There was no significant relationship between deprivation and low practice scores.

- Comparison of expected prevalence of probable psychosis and prevalence as estimated by QOF register MH8 (practice prevalence of people with schizophrenia, bipolar disorder and other psychoses) suggests over-diagnosis Cumbria-wide (**table 8**). However, bipolar affective disorder is included in the QOF figures but not in the APMS estimates so these are not directly comparable.

Table 8: Estimated prevalence of probable psychosis adjusted for age, sex and household income and diagnosed prevalence of psychosis, schizophrenia or bipolar affective disorder (Source: McManus et al, 2009; NHS Information Centre)

	Estimated number of people with probable psychosis (16-74 years)	Estimated prevalence of probable psychosis (%) (16-74 years)	2008/09 Number of people on QOF register MH 8 (all ages)	2008/09 Diagnosed prevalence on QOF register MH8 (all ages)
Allerdale	414	0.6	768	0.8%
Carlisle	473	0.6	1,014	0.9%
Copeland	293	0.5	521	0.8%
Eden	164	0.4	343	0.7%
Furness	388	0.7	740	0.9%
South Lakeland	325	0.4	738	0.7%
Cumbria	**2,056**	**0.5**	**4,124**	**0.8%**
England		**0.5**	**406,075**	**0.7%**

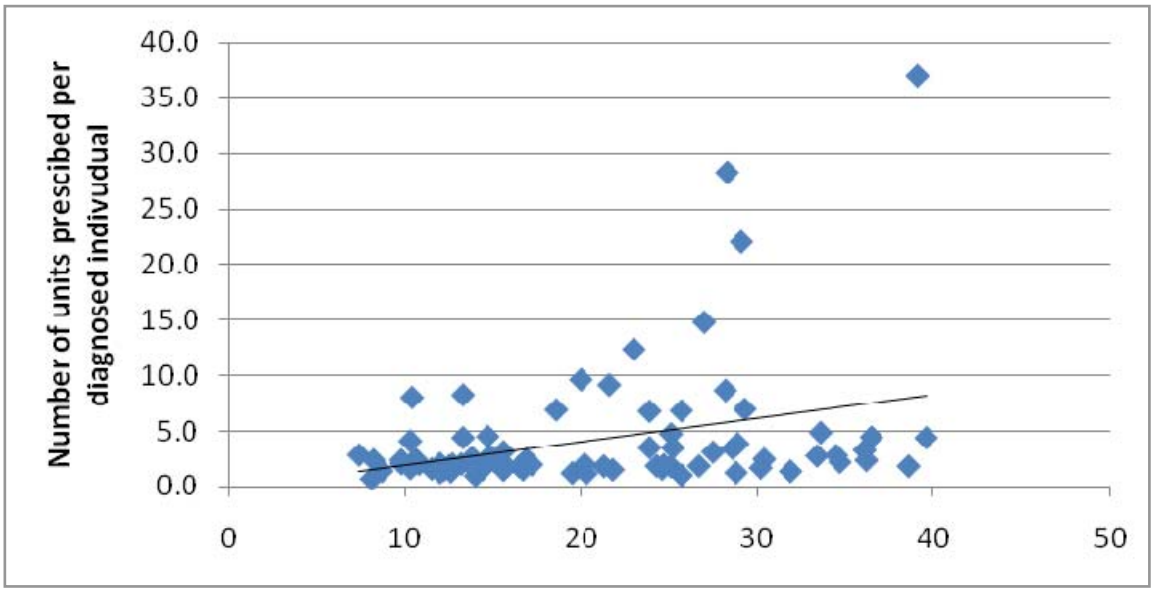
- Comparison of expected prevalence of dementia and prevalence as estimated by QOF registers suggests under-diagnosis Cumbria-wide (**table 9**).

Table 9: 2008/09 Number of dementia cases on QOF register and 2008 expected number (Source: NHS Information Centre; POPPI)

	2008 Estimated number	2008/09 Number of people on QOF register	2008/09 Practice prevalence on QOF register	Percentage QOF register/ expected
Allerdale	1,283	588	0.6%	46%
Carlisle	1,326	662	0.6%	50%
Copeland	820	313	0.5%	38%
Eden	727	284	0.5%	39%
Furness	913	498	0.6%	55%
South Lakeland	1,736	769	0.7%	44%
Cumbria	**6,799**	**3,114**	**0.6%**	**46%**
England	**591,284**	**232,430**	**0.4%**	**39%**

- There are wide variations in prescribing of anti-depressants, anti-psychotics and benzodiazepines across Cumbria, with slightly higher levels of prescribing of anti-depressants in practices with more deprived populations (**figure 12**).

Figure 12: Antidepressant prescribing rate per person with depression compared to deprivation (IMD 2007), by GP practice



6.5 Specialist NHS mental health services

- Cumbria Partnership NHS Foundation Trust (CPFT)'s overall score in the Care Quality Commission's 2008/09 review of the quality of its services was "weak". CPFT has since worked to improve performance and was approved for

registration under the CQC's new system for monitoring standards without conditions on 1st April 2010.

- The quality of data provided by CPFT for the needs assessment was variable, in particular with regards to accuracy and completeness. This is currently being addressed by CPFT. Most data included in the report relates to the period April 2008-March 2009.

- Over 10,000 people were registered as users of NHS specialist mental health services in 2008/09 (**table 10**). Of these, 9.4% received at least one day's inpatient care ('admitted') (compared to the England average of 8.4%), 71.9% had recorded contact with outpatient or community services or a CPA review, but did not spend any time as an inpatient (compared to the England average of 83.8%) ('only non-admitted') and 18.6% had no records of direct contact with services (compared to the England average of 7.6%) ('no care').

Table 10: 2008/09: Number of people using NHS secondary mental health services (Source: MHMDS)

	England		**Cumbria Partnership NHS Foundation Trust**	
	Number (%)	**Rate /100,000 persons (18+ years)**	**Number (%)**	**Rate /100,000 persons (18+ years)**
Admitted	102,153 (8.4)	253	949 (9.4)	249
Only Non-Admitted	1,024,792 (83.8)	2,534	7,252 (71.9)	1,835
No Care	92,992 (7.6)	230	1,880 (18.6)	473
All Care	**1,222,365 (100.0)**	3,023	**10,081 (100.0)**	2,547

- Rates of access to mental health services were lower for Cumbria compared to England in both the adult and older adult age groups (**table 11**).

- 38% of persons accessing specialist services in Cumbria were aged 65 and over, compared to 30% for England.

Table 11: 2008/09: Rates of access to NHS secondary mental health services for all levels of care (Source: MHMDS)

	18-64 years		**65+ years**	
	Number	**Rate /100,000 persons**	**Number**	**Rate /100,000 persons**
England	824,246	2,564	358,235	4,324
Cumbria	6,226	2,079	3,705	3,788

- Assuming that data on contacts with psychiatrists and Community Psychiatric Nurses (CPNs) is accurate, the ratio of psychiatrist to CPN contacts was 0.14 for Cumbria compared to 0.27 for England in 2008/09.

- Referrals to specialist primary and community mental health teams did not follow the expected pattern of need by locality. Referrals for both primary and community mental health services were lower than expected in Furness.

- Only 6% of all referrals to specialist primary mental health services were for people aged 65 and over in 2008/09.

- The majority of referrals to specialist primary (66%) and community (59%) mental health teams in 2008/09 were for women. This broadly reflects expected prevalence by gender. However, only half of admissions were for women.

- Although referrals for community mental health services in South Lakes were higher than in other districts, caseload as a proportion of estimated prevalence was lower.

- Two thirds of referrals for the Early Intervention in Psychosis service and 40% of its caseload were from Carlisle (**table 12**). (NB: Concerns have been expressed by EIS about the accuracy of the data with referral rates appearing to over-emphasise referrals from Carlisle district).

Table 12: Clients receiving early intervention services, number of referrals and expected prevalence of psychosis (Source: Cumbria Partnership NHS Foundation Trust; McManus et al, 2009)

	Clients receiving Early Intervention services (as at 31/7/2009) (% total)	**Number of referrals (2006-08)**	**Referrals per 100 population (>16 years old)**	**Estimated prevalence of psychosis (16-74 years)**
Furness	36 (18%)	32	0.05	0.7%
Carlisle	80 (40%)	241	0.27	0.6%
Eden	17 (8%)	19	0.04	0.4%
South Lakes	25 (12%)	29	0.03	0.4%
West	44 (22%)	38	0.03	0.6%
Cumbria	**202 (100%)**	**359**	**0.08**	**0.5%**

- The distribution of the primary mental health workforce did not match anticipated need or caseload. These findings have been taken into account in the design of the new First Step service (**table 13**).

- Caseload and workforce distribution of community mental health teams did not match anticipated need (**table 14**).

- There were 3,112 referrals to the crisis resolution & home treatment service in 2008 – this is higher than expected numbers of people with psychosis. The exception to this high referral rate was South Lakes (**table 15**).

Table 13: 2008/09: Referrals for common mental disorders and workforce (Source: Cumbria Partnership NHS Foundation Trust; Glover, 2008)

First Step Locality	First Step Locality pop. over 16	Number of referrals	Referral rate per 1,000 pop over 16	Estimated prevalence of CMD (Glover, 2008)	Distribution workforce (2009) according to need		Actual distribution of workforce (2009)	
					WTE	% of total	WTE	% of total
Furness	87,287	1,702	19	18%	11.5	25%	9.4	20%
Allerdale	53,581	1,232	23	14%	5.6	12%	6.9	15%
Copeland	49,046	1,244	25	14%	5	11%	6.2	13%
South Lakes	75,888	1,286	17	14%	8.1	17%	8.9	19%
Carlisle	112,643	2,277	20	13%	11.4	24%	11.5	25%
Eden	53,710	923	17	12%	4.9	10%	3.6	8%
Cumbria	**432,155**	**8,664**	**20**	**14%**	**46.5**	**100%**	**46.5**	**100%**

Table 14: 2008 Estimated number with probable psychosis, 2008/09 number diagnosed with schizophrenia, bipolar disorder and other psychoses and 2008/09 CMHT caseload (Source: McManus et al, 2009; NHS Information Centre; Cumbria Partnership NHS Foundation Trust)

	2008 Est. number of people with probable psychosis (16-74 years)	2008/09 QOF register (MH 8) (All Ages)	Caseload	Caseload per estimated person with probable psychosis	Caseload per person on QOF register MH 8	No. Staff	Case load per WTE staff
Allerdale	414	768	928	2.2	1.2	27.6	34
Carlisle	473	1,014	400	0.9	0.4	32.5	12
Copeland	293	521	310	1.1	0.6	14.7	21
Eden	164	343	279	1.7	0.8	14.3	19
Furness	388	740	554	1.4	0.7	21.6	26
South Lakes	325	738	221	0.7	0.3	18.9	12
Cumbria	**2,056**	**4,124**	**2,692**	**1.3**	**0.7**	**129.6**	**21**

Table 15: Referrals to Crisis Resolution and Home Treatment (Source: Cumbria Partnership NHS Foundation Trust; McManus et al, 2009)

	Number of referrals (2008)	Referrals Rate (>16 years old)	Estimated number of people with probable psychosis (16-74 years)
East	1,369	1.01%	0.5%
Furness	658	1.04%	0.7%
South Lakes	44	0.05%	0.4%
West	1,041	0.74%	0.6%
Cumbria	**3,112**	**0.72%**	**0.5%**

- Waiting times for primary and community mental health services were long, including for assertive outreach (52% over 13 weeks) (**table 16)** and crisis resolution and home treatment (20% over 13 weeks).

Table 16: April 2008 – March 2009: Waiting times of Assertive Outreach services (Source: Cumbria Partnership NHS Foundation Trust)

	Numbers waiting in weeks				Median waiting time	Maximum waiting time	Minimum waiting time
	0 - 4	5 - 8	9 - 13	Over 13			
Assertive Outreach West	22	6	<6	<6	3	27	0
Assertive Outreach East	24	<6	<6	<6	3	26	0
Assertive Outreach Furness	0	<6	0	0	5	5	5
Assertive Outreach South	6	0	0	72	24	44	1
Cumbria Total	**52**	**12**	**8**	**78**	**19.5**	**44**	**0**

- Numbers receiving assertive outreach services were low, particularly in Furness (192 persons, or 5% of persons on QOF register MH8 across Cumbria and 25 persons, or 3% of persons on QOF register MH8 in Furness).

- In November 2009, 6 patients were accessing the Itinerant Therapeutic Community, of whom the majority were in Copeland.

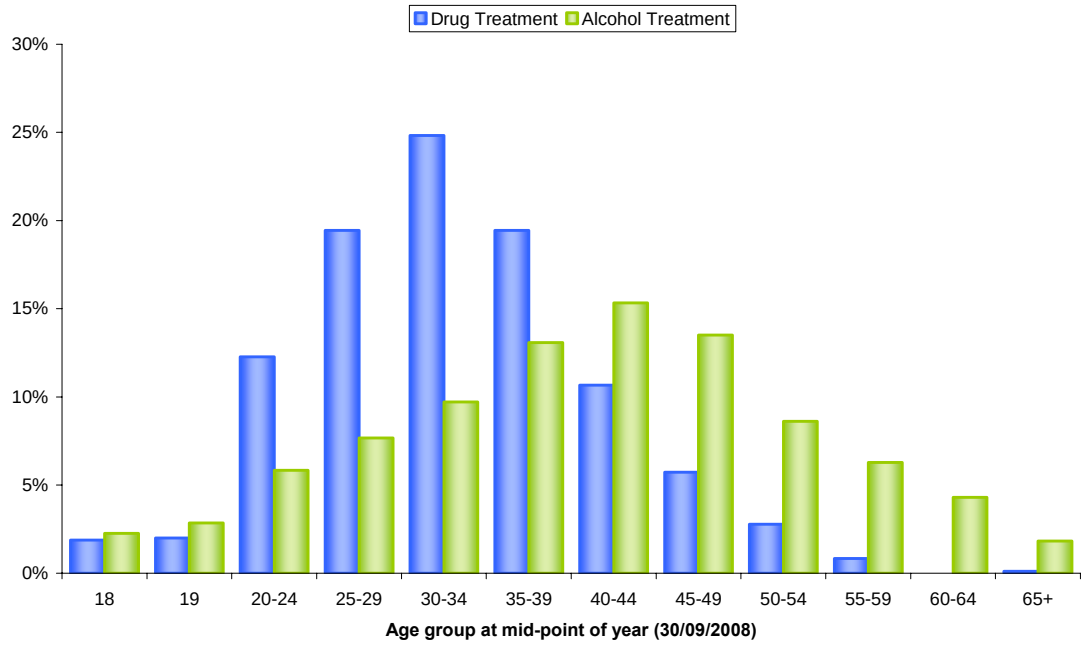
- Very limited data were provided by CPFT concerning older people's services, prison services and services for adults with learning difficulties.

- In 2008/09 there were 1,242 males (69%) and 558 females (31%) aged 18 and over in drug treatment in Cumbria. Of these, 744 were new patients. The 30-34 age group had the highest number of patients, accounting for 25% of all patients. 521 adults exited treatment.

- In 2008/09 there were 799 males (58%) and 570 females (42%) of all ages in alcohol treatment in Cumbria with 1,250 aged 18 and over, 56 aged under 16 and 63 aged 16-17. The 40-44 age group had the highest number of patients, accounting for 15% of the total caseload. 783 exited treatment (**figure 13**).

- Waiting times for alcohol treatment services were on average longer than for drug services.

Figure 13: 2008/09 Adults in drug and alcohol treatment (by age group) as a proportion of all people receiving treatment (Source: Cumbria Drug and Alcohol Recovery Team (DART))



- Numbers of psychiatric in-patient beds decreased from 241 in March 2006 to 179 in March 2009 and there have since been further bed closures. Psychiatric Intensive Care (PICU) beds increased to 10 in January 2010.

- Recording of diagnosis was poor in both community and inpatient services (75% of inpatients had no recorded diagnosis in 2008/09).

- There are over 1,000 admissions to CPFT a year, of which about 30% are repeat admissions and two thirds are emergency admissions (**table 17**).

Table 17: 2008/09 Admissions to CPFT (Source: NHS Cumbria APC Database)

PBC Locality	Number of patients	Total number of spells	Number of emergency spells	% emergency
Allerdale	120	194	159	82.0
Carlisle	186	287	218	76.0
Copeland	93	143	119	83.2
Eden	63	88	58	65.9
Furness	156	191	82	42.9
South Lakeland	169	220	135	61.4
Cumbria	**785**	**1123**	**771**	**68.7**

- The average number of daily occupied beds was 48% in 2008/09.

- Although overall length of stay was comparable to national averages, there were wide variations in length of stay by locality (average duration of spell for dementia: 334 days in Copeland compared to 96 days in Eden in 2008/09).

- The proportion of days lost through delayed transfers of care as a percentage of occupied bed days was 7% in 2008/09.

- 98% of patients were followed up within 7 days of discharge from hospital in 2008/09.

- There were 710 detentions under the Mental Health Act in 2008/09.

- Community treatment orders (CTOs) were introduced in November 2008 following amendments to the Mental Health Act and allow patients to be treated in the community following a period of detention in hospital. As of the end of March 2009, there were 17 CTOs in Cumbria of which 8 were in Carlisle. There were no CTOs in Allerdale, Barrow, or Copeland.

- In the 8 months from April and November 2009, there were 199 out of county placements, at a cost of more than £4.1 million (over £1/2 million each month).

6.6 Acute sector attendances and admissions

- Over 7,800 Cumbrians were admitted to North Cumbria University Hospitals and University Hospitals of Morecambe Bay for mental health and behavioural problems in 2008/09 (**table 18**).

- There were wide variations in admission rates by GP practice and by locality in 2008/09: Carlisle and Copeland had the highest rates and Eden the lowest.

Table 18: 2008/09: Mental and behavioural disorder admissions (F000-F99X) to the acute sector (NCUH and UHMB) by district. Crude rate per 1000 population. Age 20+. (Source: NHS Cumbria APC database)

Local Authority District	Number of episodes	Crude rate per 1000	Directly age standardised rate per 1000	95% Confidence Intervals (DSR)	
				Lower	Upper
Allerdale	1,393	19	15.1	14.2	16.0
Barrow	1,044	19	16.4	15.3	17.5
Carlisle	2,030	25	19.5	18.6	20.4
Copeland	1,189	22	18.2	17.1	19.4
Eden	470	12	8.4	7.5	9.3
South Lakeland	1,553	19	12.5	11.8	13.3
Unknown	131	-	-	-	-
Cumbria	**7,810**	**20**	**15.6**	**15.3**	**16.0**

- Lifetime prevalence of self harm according to the APMS is about 5%. Applying these national prevalence rates to population estimates for Cumbria suggests that approximately 14,000 to 20,000 adults aged 16 years and over self harm in their lifetime, with a higher prevalence in females than males.

- There are about 2,000 A&E attendances and 1,000 admissions (episodes) for self harm/year (all ages) (of which about ~20% are repeat admissions).

- There are high rates of hospitalisation for self harm in Cumbria; rates in Allerdale, Copeland, Barrow and Carlisle local authority districts are all significantly above the national average.

Table 19: 2008/09: Number of episodes and individual admissions for self harm in Cumbria (Source: NHS Cumbria APC Database)

	Males	Females	All Persons
Episodes	429	603	1,032
Individual Admissions*	343	479	822

* 36 admissions had no NHS number

- Rates of male admissions for alcohol specific conditions in Barrow, Carlisle and Copeland and the average for Cumbria are all statistically significantly higher than the England average. For females, rates were statistically significantly higher than England in Allerdale, Barrow, Carlisle and Copeland and for Cumbria overall (**Figure 14**).

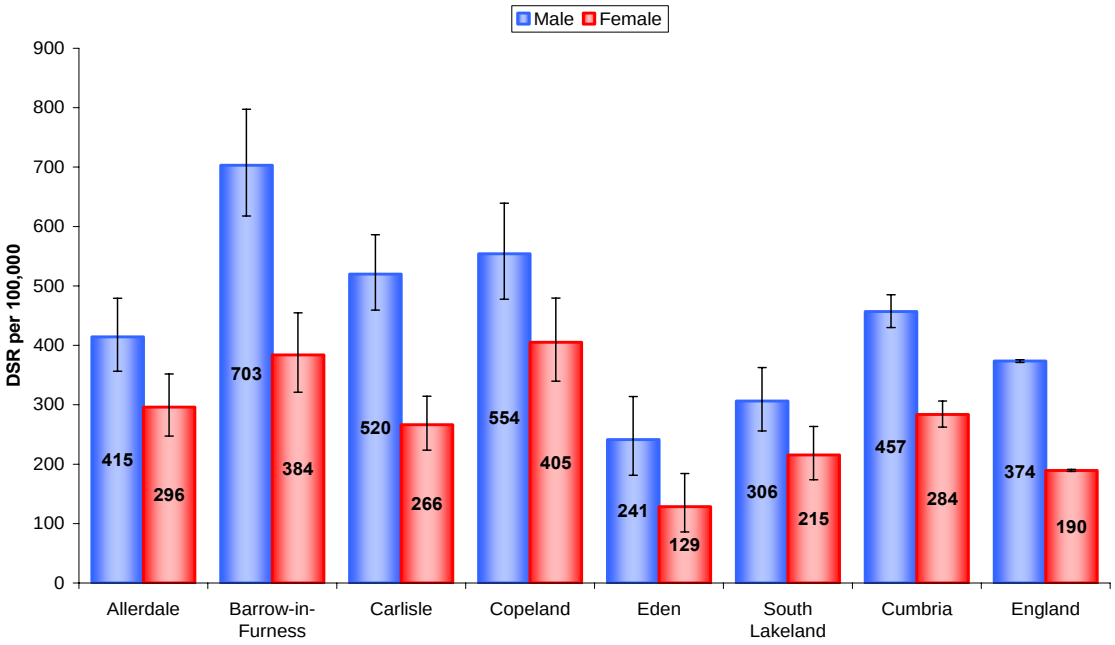


Figure 14: 2007/08: Alcohol specific hospital admissions: DSR per 100,000 (all ages) (Source: NWPHO Local Alcohol Profiles for England, 2009)

6.7 Cumbria County Council Social Care Services

- Cumbria County Council (CCC) commissions and provides a range of services for adults and older people with mental health problems and their carers, subject to assessment of need.

- Adult Social Care services for people aged 16-64 with severe and enduring mental health problems include: information and advice; day care; home care and meals and social work support. Community care support is also provided to people with

autistic spectrum disorders, including getting help with housing, social problems, independent living and health

- Services for adults aged over 65 with a substantial physical and/or mental disability include day care; meals on wheels; home care; occupational therapy; residential homes; nursing homes; telephones; and car badges for people with disabilities.
- Services and support for carers include: information and advice; support to help maintain health and wellbeing; breaks from caring; emotional support.
- CCC also has an Out of Hours Team (OOHT), which provides a generic social work service to children and vulnerable adults when local social care offices are closed.
- In 2008/09, 2,148 people in Cumbria in the under 65 age group received social care services for mental health problems (**table 20**), or 0.54% of the 0-64 years population. Within Cumbria, Barrow-in-Furness had the greatest proportion of clients receiving social care services (1.22%). Analysis of the type of service received reveals that in all districts the vast majority of clients received community services in their own homes.

Table 20: 2008/09 Clients with mental health problems (under 65 years old) receiving social care services (Source: RAP Return)

Locality	Clients receiving social care services	% of population (0-64 years)	Community services in own home	Residential care	Nursing Care
Allerdale	216	0.28%	215	<5	<5
Barrow-in-Furness	718	1.22%	717	18	<5
Carlisle	614	0.73%	610	34	<5
Copeland	172	0.30%	172	<5	<5
Eden	170	0.41%	168	<5	<5
South Lakeland	258	0.32%	249	12	<5
Cumbria	**2,148**	**0.54%**	**2,131**	**74**	**11**

- In the 65 and over age group, 1,094 Cumbrians were receiving social care services (1.12% of the 65 and over population) (**table 21**), with the greatest proportion again occurring for Barrow-in-Furness (2.19%). Over 44% of clients in this age group were registered as having dementia. A larger proportion received residential and nursing care than in the under 65 age group.

Table 21: 2008/09 Clients with mental health problems (over 65 years old) receiving social care services (Source: RAP Return)

Locality	Clients receiving social care services	% of population (65 years and over)	Number with dementia	Community services in own home	Residential Care	Nursing Care
Allerdale	129	0.69%	68	77	63	14
Barrow-in-Furness	282	2.19%	146	167	134	73
Carlisle	205	1.06%	49	142	81	37
Copeland	253	1.99%	141	164	120	34
Eden	84	0.79%	35	63	18	15
South Lakeland	141	0.59%	46	94	50	33
Cumbria	**1,094**	**1.12%**	**485**	**707**	**466**	**206**

- Cumbria's **Supporting People Programme** delivers high quality and strategically planned housing-related services which complement existing care services for vulnerable people.

- There appears to be under-provision of supported housing in Copeland, Allerdale and South Lakeland and over-provision in Eden and Carlisle (**Table 22**).

Table 22: 2009/10 Supporting People Programme: number of available units of support for mental health client group (Source: Cumbria Supporting People Services, 2009)

	Service Type			Mid-2008 Population Estimate (16+ years)(%)
	Accommodation Based	Floating Support	All Services	
	Number	Number	Number (%)	
Allerdale	29		29 (12%)	78,120 (19%)
Allerdale / Copeland		8	8 (3%)	-
Barrow	37		37 (15%)	58,520(14%)
Carlisle	56	20	76 (31%)	85,780 (21%)
Copeland	23		23 (9%)	57,880 (14%)
Eden	38	4	42 (17%)	43,280 (11%)
South Lakeland	28	3	31 (13%)	87,560 (21%)
All	**211**	**35**	**246 (100%)**	**411,020** (100%)

- 58 Cumbrian residents with mental health problems are supported in Residential Homes or Nursing Homes. Some of these homes are within the county boundary and others are further afield. A coordinated programme to provide more care nearer home is currently under way to reduce the number of occasions that people need to enter residential or nursing care.

- Personalisation is being introduced to mental health services in 2010, in line with the rest of the Council's social care services where significant progress has already been made.

- Cumbria is also a pilot site for individual placement support and for commissioning for social outcomes for mental health service users.

6.8 Third sector provision

- Of the estimated 5,000 third sector organisations in Cumbria, about 30 specifically provide a range of services to people recovering from mental health problems, funded either through contracts with the statutory sector or through grants.

- Of Cumbria's 2,056 registered charities, a high proportion (60%) are very small charities (annual income <£10,000) compared to the national average (46%). Allerdale and Eden having particularly high proportions of very small charities (65% and 64% respectively). This may suggest a strong sense of social responsibility and dedication to the county's community life.

- Cumbria also has a lower proportion of medium and large charities than nationally (medium: Cumbria 7%, England 9.3%; large: Cumbria 3%, England 4.4%).

- The geographic spread of charities does not match population distribution: only 5% of the county's registered charities are in Barrow and 32% in South Lakeland.

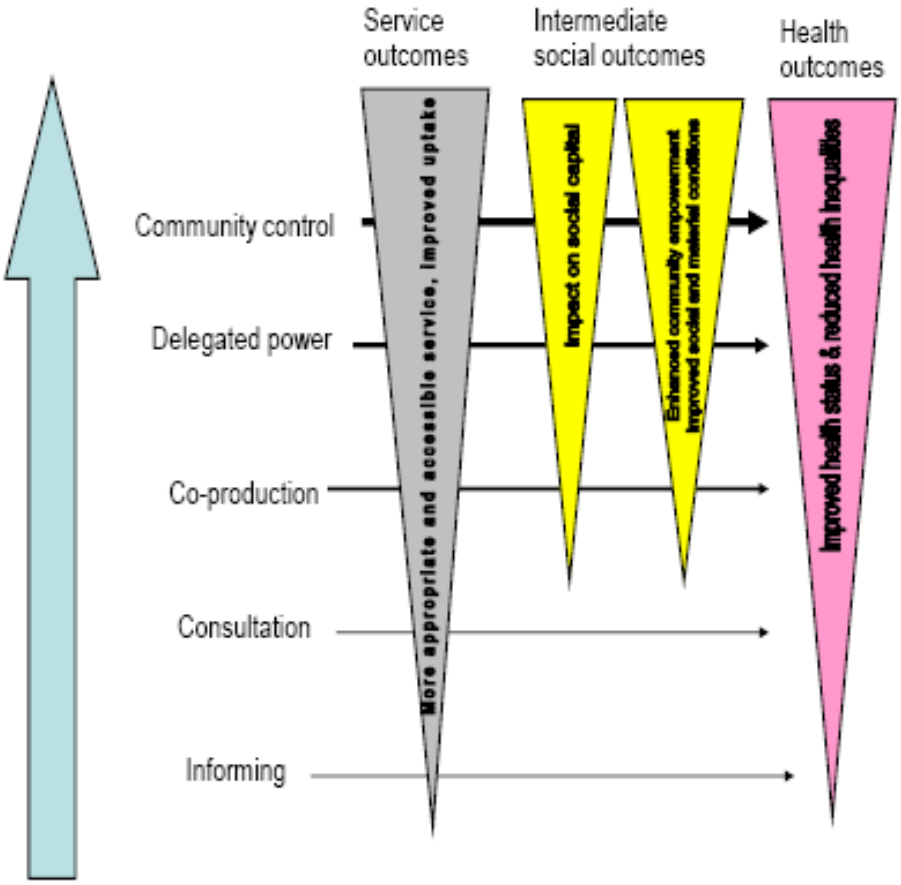
- In an informal consultation in 2010, members of Cumbria's Mental Health Provider Forum reported that statutory sector funding levels are relatively low, that services with little or no statutory funding may struggle to sustain services over the long term, and that a coherent commissioning structure for third sector provision is lacking.

- Statutory-funded third sector provision includes supported accommodation; supported employment; domiciliary support; and day opportunities.

7 Public engagement and user involvement

Engagement is not only a right, it also improves the quality of services, builds skills and cohesion in communities and can, when communities are empowered, enhance health and reduce health inequalities. The more control people have over important aspects of their lives, including services which support them in leading the lives they choose to lead, the better is their health (Popay et al, 2010).

Figure 15: Theoretical model linking community empowerment to health outcomes (Popay 2010)



Ascertainment of the views of the public, service users and carers and other stakeholders on mental health assets, needs and gaps in services for the purposes of this needs assessment was undertaken in 2009-10 through established mechanisms for public engagement. These are Cumbria Mental Heath Group (CMHG), which is commissioned by NHS Cumbria; Cumbria Partnership NHS Foundation Trust's Charter Monitoring Group, which monitors the Trust's performance against standards laid out in its Charter of Rights and whose members include service users, carers, staff and colleagues from voluntary and other organisations; and NHS Cumbria and Cumbria Count Council's jointly commissioned Targeted Community Engagement Programme and its community development worker team.

The main constituency of these groups are people with severe and enduring mental health problems and their carers. CMHG locality meetings usually attract up to 50 people at a meeting; the CPFT Trust claims an active membership of about 3,000; and the community development team has a remit for 'hard to reach' populations. The voice of the many Cumbrians with common mental health problems is less prominent in these groups and

therefore may be under-represented in this needs assessment. Cumbria's forthcoming Mental Health Strategy presents an opportunity to develop a more systematic approach to public engagement for Mental Health, embedded across the commissioning cycle.

The evidence collated provides invaluable insights into people's experiences of mental health and mental health services, and views as to how to improve mental health. What is more, the experience of engagement in itself appears to be valued by users and carers.

Key issues raised during consultation in 2009 include:

Need for a directory of statutory and voluntary services, to enable:

- Better knowledge and hence access to and uptake of services including 'social prescribing' services, either through professional referral or self referral.
- Identification of gaps and inequities in existing services.

The directory would complement and be linked to other important strands of the mental health strategy, including: social prescribing; assets based approaches; self management; personalised care; pathways development; communications and training.

A user suggested that if this directory were web-based, there would be potential to develop it as an interactive resource that could include blogs and forums. Some concerns were raised about hosting, updating, expense, and duplication.

Training of professionals and 'gatekeepers', public education and communication

- CMHG participants highlighted the isolation arising from public perceptions of mental health problems – primarily lack of understanding, not knowing what to say and fear of 'contagion' of mental health problems.
- Professionals – whether health or other sectors – did not always seem to understand 'what its like to be in my shoes'.
- Saying 'how are you'? would make a difference.
- The suicide prevention reference group has been looking into training and awareness raising, communications and social marketing. Suicide audit work has highlighted the role of alcohol as 'self medication', risk factor and trigger for suicide.

Specialist services and staff are overstretched; services are not sufficiently user focused.

Access to support in time of crisis: 24 hour access to professional care; scope for volunteer involvement?

Open access to high quality recovery focused support, both 'service based' (e.g. Croftlands, MIND, community gym) and 'community based' (scope to develop community buddying schemes, whether face to face, telephone based, or virtual).

Support for people bereaved through suicide should include both access to appropriate professional support and development of peer support groups (e.g. SOBS).

Management of transitions from young people's to adult services and from adult to older adult services.

Specific issues of hard to reach communities: report on health of gypsies and travellers highlights high levels of stress and mental illness and lack of appropriate services, in particular, culturally appropriate talking therapies; Outreach Cumbria raises issues of inequality in access to services, and high levels of eating disorders, self harm and suicide in lesbian gay and bisexual people.

8 What would high quality services and interventions look like?

In this section we outline this evidence regarding both:

- Improvement of the mental health and well-being of the population.
- Improvement of the quality and accessibility of services for people with poor mental health.

There is an extensive evidence base for the effectiveness of interventions to improve mental health and wellbeing. Main sources include:

- Foresight Mental Capital and Wellbeing Project (2008) - www.foresight.gov.uk
- The National Mental Health Development Unit, NMHDU - www.nmhdu.org.uk
- The Centre for Mental Health – www.centreformentalhealth.org.uk
- Royal College of Psychiatrists, in particular its policy section, and the College Centre for Quality Improvement - www.rcpsych.ac.uk
- Relevant NICE guidance - www.nice.org.uk
- New Horizons (DH, 2009) - www.dh.gov.uk/newhorizons

8.1 Services and interventions to improve population mental health and well-being

8.1.1 Addressing the structural determinants of well-being at a whole population level

Well-being across societies is influenced by the distribution of power, resources, capabilities and rights. Poverty, discrimination, employment, education, housing, welfare and public service provision all influence well-being.

Interventions that reduce poverty, reduce income inequalities, create employment opportunities and enhance workplace conditions are likely to result in increased levels of well being, for example:

- Redistributive taxation policies, policies to reduce child poverty, fuel poverty, etc.
- Debt advice and support.
- Improved pay, working conditions, job security and job control.
- Keeping staff in work if they develop a mental health problem or personal crisis, including early referral to workplace based support and counselling.
- Evidence based services to improve employment outcomes of people with mental ill health.
- Targeted mental health support for people affected by unemployment.

- Changes in public attitudes and perceptions of well-being and mental health, including anti-discrimination and anti-stigma activity.

- Responsible media reporting of mental health and illness and suicide.

8.1.2 Flourishing, connected, safe and sustainable communities

Well-being is linked to people's sense of belonging to cohesive and inclusive communities and having a valued social role. A healthy built environment is conducive to well-being. Good relationships with neighbours, friends and family and being able to influence decisions about what happens in the local area are important. Measures that can improve well-being include:

- Increasing opportunities for social contact through planning, environmental quality improvements and transport policies, e.g.:
  - Create green spaces for leisure and safe play.
  - Develop community transport schemes.
  - Ensure that public spaces such as shopping malls do not exclude specific groups, for example teenagers.

- Increase access to and participation in community artistic, cultural and sporting activities.

- Enable democratic involvement and participation.

- Action to improve community and personal safety and perceptions of safety.

- Anti-bullying strategies in schools and workplaces.

Mental well-being impact assessment is a way to evaluate the potential impact on population mental health of policies, services, programmes and projects (Cooke and Stansfield, 2009).

8.1.3 Resilient individuals and families

There is evidence to support interventions to promote resilience and emotional well-being across the lifecourse - from minus nine months to grave. Effective interventions not only increase people's awareness of what constitutes well-being but also equip them with the skills and support they need.

Delivery of social prescribing, usually via primary care, is a mechanism for linking patients with non-medical resources in the community. These can strengthen wellbeing by increasing skills, increasing sources of social support, and increasing access to resources and services that protect wellbeing. They include: opportunities for arts and creativity, physical activity, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems.

There is increasing acknowledgement in policy and practice of lay people's capabilities and assets and ways in which these can be mobilised to enhance individual and collective well-being, e.g. through face to face and virtual peer support networks.

The New Economics Foundation's evidence on actions that people could take themselves to improve their well-being estimates that life expectancy could be extended by 7.5 years by building the following actions - or '***five ways to wellbeing'*** - into daily life.

Connect… with the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

Be active… Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take notice… Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters.

Keep learning… Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Give… Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

8.2 Services and interventions to improve the quality of services for people with poor mental health

8.2.1 Models of delivery of mental health services

There is no single model of what 'ideal' services should look like and what care they should deliver. Research studies and systematic evidence reviews are generally designed for clinical decision making and tend to focus on effectiveness and cost effectiveness of treatments for specific conditions and priority groups. However, the aims of policy makers and commissioners tend to be wider and more complex. Guidance as to 'what works' also needs to encompass the types/models of service delivery that optimise outcomes across the range of dimensions of quality, and according to level and complexity of people's need, their age and their legal status.

The recent report ***Looking ahead: future development of UK mental health services: recommendations from the Royal College of Psychiatrists' enquiry*** (RCP, 2010) goes some way to making recommendations for service redesign.

The leadership given by ***New Horizons*** to the transformation of mental health service delivery will be superseded by the new government's mental health policy. It is likely however that key themes identified in ***New Horizons*** will be reflected in future policy. These are:

- prevention and public mental health.
- early intervention.
- tackling stigma.
- strengthening transitions from child and adolescent services to adult services.
- engagement and personalised care.
- innovation.

New Horizons acknowledges the need for an ongoing programme of service improvement, with the aim that mental health services:

- Deliver evidence-based approaches as set out by NICE.
- Involve service users and carers in decisions about their care and offer real choices.
- Integrate physical and mental health.
- Are recovery-focused.

Other important principles set out in New Horizons include:

- Equity, rights and inclusion.
- Reaching our full potential.
- Being in control of our lives.
- Valuing relationships.

Future mental health policy is likely to emphasise the role of primary care in the delivery as well as the commissioning of mental health services. The case for a delivery model where ***mental health is integrated into primary care*** has been made by the WHO on the grounds that the burden of mental disorders is great; mental and physical health problems are interwoven; and primary care for mental health can enhance access, promote respect of human rights, improve health outcomes and reduce costs (WHO and WONCA, 2008).

Primary care is both an access point to specialist services and a doorway to the community. Most common mental disorders are managed in primary care, which is also ideally placed to meet the psychological needs of people with long term physical health conditions. Primary care also plays a major role in managing people with more severe disorders, and in particular supporting their physical healthcare and recovery. Primary care also constitutes a

'hub' where family-oriented approaches to mental healthcare, with services looking after families rather than individuals, can be developed.

There is huge potential to develop linkages between primary care and the community along the lines of social prescribing and assets based development. This in turn will support people in shaping their own communities and leading healthier and more fulfilling lives.

In England, the important role of primary care in the identification and management of mental health disorders has been incentivised through the Quality and Outcomes Framework and is recognised in ***New Horizons***: 'Physical and mental health are intimately linked: the same risk factors affect both; mental ill health can present with both mental and physical symptoms; physical ill health often has an impact on mental health, and vice versa. Effective health services provide care that addresses both physical and psychological needs' (DH, 2009, p.52). The integration of mental health into community oriented primary care is clearly also in line with NHS Cumbria's ***Closer to Home*** strategy.

Integration of mental health into primary care is however in its early days and while it presents potential in the Cumbria context, its implementation requires close evaluation. As stated in ***Looking ahead*** (2010:10) 'Although the integration of psychiatry into primary care is a potentially fruitful and extremely welcome development – given the robust evidence base from countries such as the USA – a thorough evaluation of this kind of practice is indicated in the UK'.

Evidence based collaborative care and stepped care models to improve the quality of primary mental healthcare are described in the needs assessment.

Given current financial constraints, future service developments need to make the case that they will lead to savings elsewhere in the health system and beyond. A list of the ten interventions most likely to be the most cost effective in reducing the burden of mental illness has been compiled (Newbigging & Stansfield, 2009). These are:

- Universal routine enquiry and targeted treatment for *women at risk of depression* with home visiting therapist for post natal depression, as part of a package of measures to improve peri-natal mental health.
- Universal assessment of potential parenting problems and targeted *early intervention programmes for common parenting problems*, including school-based learning.
- Early interventions with individual home based programmes for conduct disorders.
- Whole school approaches to build the emotional resilience of children and young people.
- Interventions, delivered through '*social prescribing'*, to increase opportunities for participation, personal development and problem-solving
- Integrate physical and mental well-being through universal access to lifestyle programmes to reduce smoking alcohol use, substance use, and obesity. This means that key groups may need to be specifically targeted, for example people with a mental illness or learning disability, older people and pregnant women.
- Improve working lives by early intervention to reduce risks of unemployment through primary care and Job centres and support NHS, LA and Third Sector organisations offering locally based interventions to improve healthy working lives and support occupational health schemes.
- Implementation of initiatives to prevent, identify and respond to emotional, physical and/or sexual abuse.
- Ensuring access to psychological therapies, including CBT, for people with long term conditions, disabilities and carers.
- Early intervention and targeted approaches for high risk groups, including suicide reduction programmes.

8.2.2 Evidence based approaches for specific conditions

The extensive NICE guidance for mental health includes:

Completed guidelines

- Antenatal and postnatal mental health
- Antenatal care
- Antisocial personality disorder
- Anxiety
- Attention deficit hyperactivity disorder (ADHD)
- Bipolar disorder
- Borderline personality disorder (BPD)
- Dementia
- Depression (replaced by CG90)
- Depression in adults (update)
- Depression in children and young people
- Depression with a chronic physical health problem
- Drug misuse: opioid detoxification
- Drug misuse: psychosocial interventions
- Eating disorders
- Medicines adherence
- Obsessive compulsive disorder (OCD) and body dismorphic disorder (BDD)
- Post-traumatic stress disorder (PTSD)
- Schizophrenia (replaced by CG82)
- Schizophrenia (update)
- Self-harm
- Violence
- When to suspect child maltreatment

Guidelines in development

- Alcohol dependence and harmful alcohol use
- Alcohol use disorders - clinical management
- Anxiety (partial update)
- Autism spectrum disorders in children and young people
- Autistic spectrum disorders in adults
- Common mental health disorders
- Delirium
- Nocturnal enuresis in children (bedwetting)
- Pregnancy and complex social factors
- Psychosis with substance misuse
- Self-harm (longer term management)

Completed interventional procedures

- Transcranial magnetic stimulation for severe depression
- Vagus nerve stimulation for treatment-resistant depression

Completed public health guidance

- Behaviour change
- Mental wellbeing and older people
- School-based interventions on alcohol
- Social and emotional wellbeing in primary education
- Social and emotional wellbeing in secondary education

Public health guidance in development

- Alcohol-use disorders: preventing harmful drinking
- Preventing domestic violence
- Social and emotional wellbeing - vulnerable children at home
- Social and emotional wellbeing: early education and day care

Completed appraisals

- Alzheimer's disease - donepezil, galantamine, rivastigmine (review) and memantine
- Attention deficit hyperactivity disorder (ADHD) - methylphenidate, atomoxetine and dexamfetamine (review)
- Conduct disorder in children - parent-training/education programmes
- Depression and anxiety - computerised cognitive behavioural therapy (CCBT)
- Drug misuse - methadone and buprenorphine
- Drug misuse - naltrexone
- Electroconvulsive therapy (ECT)
- Insomnia - newer hypnotic drugs
- Schizophrenia - atypical antipsychotics (replaced by CG82)
- Structural neuroimaging in first-episode psychosis

Appraisals in development

- Alzheimer's disease - donepezil, galantamine, rivastigmine and memantine (review)
- Bipolar disorder (children) - aripiprazole
- Dementia (non-Alzheimer) - new pharmaceutical treatments (suspended)
- Schizophrenia - aripiprazole

9 Recommendations

9.1 Improving population health and wellbeing

Policy and action to improve mental health and well-being can have wide positive social and economic impacts and therefore supports delivery of many other strategies across organisations. It should therefore be jointly owned by a wide range of agencies, embedded in Cumbria's Strategic Partnerships and visible across all the themes of Cumbria's Local Area Agreement.

There has, to date, been underinvestment in public mental health, wellbeing promotion and prevention of mental health problems in Cumbria. Investment in prevention and early intervention can help deliver efficiencies by reducing demand for mental health and other public services. There is a strong case for rebalancing the mental health investment profile towards prevention.

In order to address inequalities in mental health, interventions that promote well-being and prevent mental ill-health should be distributed equitably across the gradient of health need. Based on the principle of progressive (or proportionate) universalism, there should be a mix of universal interventions available to all and targeted approaches to meet the needs of people who are at higher risk of experiencing poor mental health, in particular people experiencing deprivation.

Well-being interventions must acknowledge and build on Cumbrians' inherent capabilities, assets and resources. They should both increase people's awareness of what constitutes well-being and equip people with the additional skills and support they need. We should try to better understand why some people seem to adapt to adversity and achieve better outcomes than expected given their life circumstances, and to learn from these examples of resilience.

9.1.1 Addressing the structural determinants of mental health and wellbeing

Many of the modifiable risk and protective factors for mental health and well-being are linked to the socio-economic characteristics of local communities. Interventions that focus only on individuals' health problems, to the exclusion of the broader landscape of, employment, housing, education and social networks, will be unlikely to produce the desired outcomes for users, their families and communities.

We recommend mainstreaming action across sectors to improve well-being, including:

- All agencies aligned through the Cumbria Strategic Partnership and Health and Wellbeing Board demonstrate strong local leadership to mainstream mental health and wellbeing within public policy, commissioning, programmes and projects, whether in the areas of housing, planning, the environment, the workplace, education, learning and leisure, or efforts to reduce inequalities.
- Investment to mitigate the risk factors for poor mental health and to enhance protective factors.
- Systematic use of mental health impact assessment to maximise the positive impacts on well-being of public policy and programmes. This includes economic, planning and environmental policy and programmes.
- Act to reduce inequalities in mental health outcomes, recognising the close link between inequalities in health and wealth.

- Monitor closely the impact of economic factors on mental health and suicide.
- Ensure that advice on debt management, benefits, how to cope with redundancy, and relationships is available in the community, and that people who need this advice and support are signposted towards it, including through primary care.
- Improve workplace conditions and support employers to keep people with mental health problems in work.
- Tackle unemployment and provide targeted mental health support to people affected by unemployment.
- Ensure the right kinds of support are available to people with mental health problems to return to work, e.g. through encouraging wider use of the individual placement support model.
- Improve housing conditions and reduce homelessness.
- Prevent violence and crime and reduce fear of crime.
- Encourage 'investment to save' in diversion schemes for people with mental health problems who come in contact with the criminal justice system; consider investment in supporting families and easing transitions into and out of prison and enabling people with a history of offending to get and keep a job.
- Change public attitudes and perceptions of well-being and mental health, including anti-discrimination and anti-stigma programmes and initiatives.
- Change public attitudes and perceptions of alcohol use, including its role in depression, violence and criminal behaviour, and suicide.

9.1.2 Flourishing, connected, safe and sustainable communities and fostering resilience in individuals and families

There is evidence that a range of interventions to promote resilience and emotional well-being across the life-course - from conception to grave - are both effective and cost effective. There are clear economic benefits of improved well-being in terms of improved physical health, educational attainment, employment, and reduced crime, as well as a reduction in the burden of mental illness.

Measures to enable a positive start are key to mental health throughout life. Good relationships with neighbours, friends and family enhance well-being. People's sense of belonging to cohesive and inclusive communities, having a valued social role, and being able to influence decisions about what happens in their local area contribute to well-being.

We recommend prioritising action across the life-course to:

- Ensure a positive start in life through: promotion of parental mental and physical health; support for good parenting; development of social and emotional skills through whole schools interventions; early intervention in childhood mental disorders; prevent emotional, physical & sexual abuse.
- Raise public and professional knowledge and awareness of the 'five ways to wellbeing' (connect; be active; take notice; keep learning; give).
- Increase numbers of Cumbrians with basic 'Mental Health First Aid' knowledge and skills.
- Develop a directory of local statutory, third sector, and peer-led services and activities that enhance well-being by strengthening psychosocial skills, increasing social interaction/cohesion and/or providing advice and support within each locality.
- Increase engagement in services and activities that enhance well-being through 'social prescribing', signposting and self referral (e.g. through inclusion of evidence-based wellbeing services and activities in service specifications, integrated care pathways, and direct payment protocols).

- Address gaps in well-being services and activities, including through development of assets-based approaches to increase well-being (e.g. peer support networks).

9.2 Improving outcomes for people with mental health problems

9.2.1 Whole systems reform for mental health

The current challenges facing our economy, the NHS and other services present us with unique opportunities to redesign the whole delivery system for mental health and illness with a view to improving outcomes.

We recommend that:

- A social model of mental health is adopted, which takes account of the social, material and biographical context of mental illness.
- Aligned commissioning arrangements for mental health services between health and social care are further developed and implemented.
- A smooth transition to new NHS commissioning arrangements led by GP consortia is assured.
- The market is stimulated to develop the role and contribution of the third sector and community based support for people with mental health problems.
- Clinicians are enabled to lead on redesigning service models and integrated care pathways with support from managers and involvement of social care, the third sector, service users and carers.
- There is continued investment in prevention and early intervention, particularly with children and young people.
- A full range of evidence based, person-centred, safe, integrated, services is available and accessible to all, with plurality and flexibility of provision.
- People with mental health problems have greater autonomy and freedom to choose the support that best meets their health social and material needs through the flexible offer of evidence based services and personalisation.
- Ensure high quality governance and safeguarding procedures are in place, and that the findings of serious untoward incident (SUI) reviews are implemented and monitored and that the learning is widely shared.
- The quality of service provision is continually improved as measured by agreed outcome measures, including measures of patient experience and patient reported outcome measures (PROMS).
- High quality intelligence systems are in place to support strategic and operational decision making, linked to the JSNA process.
- Communication between agencies is accurate, timely and relevant.
- Guidelines are developed for transition between services and placements, e.g. acute admissions to residential / nursing care, transitions from out of area placements back to local services.
- Information about all services and interventions to improve mental health is available for all categories of users (from strategic leaders to the general public) including information about outcomes.
- Assets based approaches are built into future needs assessments/the JSNA, strategy development and wider action to improve mental health.
- Ensure the workforce for mental health – from the general public to the specialist workforce - is developed to deliver the Mental Health Strategy.
- Ensure that people with mental health problems are always treated with respect and dignity and that their needs are fully met.
- Monitor staff satisfaction and user/carer perceptions of staff attitudes and well-being.

9.2.2 Primary care and the closer to home agenda

Cumbria's general practitioners are leading the transformation of healthcare provision across the county and its districts, in line with proposals set out in the NHS White Paper to devolve responsibility for the bulk of the NHS budget in England to general practitioner based consortia. Public satisfaction with GPs is high. However, the needs assessment identified some variations in mental health care delivery, and in perceptions of levels of expertise and understanding of mental health issues between health professionals, in primary care.

GPs are the first point of contact for most people experiencing health problems and are uniquely placed to understand and address their physical and mental health needs holistically and to collaboratively manage their care. Their role in the management of common mental disorders and in making linkages between physical and mental health is especially important.

With regards to primary care, we recommend that commissioners:

- Explore the potential to develop a model of mental healthcare in Cumbria that is integrated into primary care, and is oriented towards the community and its assets.
- Ensure the implementation of evidence based interventions to reduce modifiable risk factors that impact on both physical and mental health, including smoking, alcohol and drug misuse, obesity, nutrition and physical activity.
- Ensure the identification and management of mental health problems is integrated into care pathways for people with cardiovascular disease, cancer, chronic conditions and pain.
- Ensure that people with medically unexplained symptoms (MUS) are appropriately managed.
- Increase GP capability to identify early, assess and holistically manage mental health problems, especially in more deprived areas of Cumbria, through training and the development and implementation of evidence based models of care based on collaborative/ stepped care (to include social prescribing).
- Ensure all GP trainees are trained in mental health and GPs undertake ongoing mental health training as part of their CPD.
- Monitor patterns of diagnosis, activity and management of mental health disorders in primary care across Cumbria, including through QOF, prescribing and specialist referral data.
- Ensure the physical health of people with mental health problems is monitored and that appropriate healthy living interventions are offered.
- Continually improve access to psychological therapies, and monitor equity of referral and uptake by deprivation, ethnicity, gender and age.
- Continually improve management of medicines and address variations in GP prescribing of antidepressants, benzodiazepines and antipsychotics, including in older patients.

9.2.3 Specialist secondary, tertiary and secure services

Cumbria Partnership NHS Foundation Trust (CPFT) is the main provider of specialist mental health services for children and young people, adults and older adults, drug and alcohol services and services for people with learning disabilities in Cumbria. Some specialist services are provided by other NHS Trusts and third sector providers.

With regards to specialist mental health services, we recommend that commissioners:

- Seek clarification concerning the reasons why NHS overall expenditure on mental health in Cumbria appears higher and direct expenditure appears lower than in 'comparator' health economies.
- Reduce expenditure on unnecessary out of area treatments and reinvest a proportion of savings to address identified gaps in local service provision.
- Closely monitor the quality, relevance, accuracy and completeness of data in accordance with contractual arrangements, implementation of mental health payment by results and iterative needs assessments.
- Further develop and standardise outcome measures, in particular HoNoS, PBR, client reported outcomes and recovery focused outcomes.
- Ensure there is an optimal, needs driven, balance between specialist, community, and primary care based mental health teams and that an explicit whole systems model is adopted across services.
- Ensure individuals' needs are identified early through high quality clinical assessments and that patients are 'clustered' according to need into appropriate services.
- Review and further develop integrated care pathways for service users across MHPBR clusters in consultation with all stakeholders including social care, the third sector, service users and carers.
- Care pathways to be developed for forensic services, drug and alcohol misuse to include dual diagnosis, detox and rehabilitation, eating disorders, and maternal and infant mental health.
- Align services, workforce and other resources with these pathways.
- Ensure that service offer is adjusted to meet the additional needs of people at increased risk of mental health problems, including people experiencing deprivation, people in contact with the criminal justice system, veterans, people with learning disabilities, ethnic minorities including gypsies and travellers, gay, lesbian and bisexual people.
- Ensure that service offer is age and gender appropriate.
- Ensure that transitions between children's and young people's and adult mental health services is optimised and develop a protocol for the management of transition from children's to adult services.
- Ensure that people over the age of 65 have equitable access to the full range of services to meet their needs.
- Ensure that the needs of carers and families are fully met and that the potential benefits of family-oriented approaches to mental healthcare are across taken into account in child and adolescent and adult mental health services.

9.2.4 Acute service provision

Nearly 8,000 Cumbrians are admitted to North Cumbria University Hospitals and University Hospitals of Morecambe Bay for mental health and behavioural problems each year.

With regards to acute hospital services, we recommend that commissioners:

- Examine more closely data concerning activity and outcomes of acute hospital services related to mental health problems.
- Clarify reasons for wide variations in admission rates by GP practice and by locality.
- Review integrated pathways for the management of self harm in young people and adults.

- Review integrated pathways for the management of alcohol specific conditions and for people with a dual diagnosis.
- Review care pathways for the management of organic conditions within acute services.
- Ensure that mental health liaison services are accessible equitably across Cumbria, in particular to meet the needs of people presenting in A&E, older people with organic mental health disorders and people with medically unexplained symptoms.
- Ensure that the physical environment is designed and/or adapted to the needs of people with mental health problems.

9.2.5 Social care and the third sector

With regards to social care, we recommend that commissioners:

- Reduce expenditure on residential care and support people to achieve independence and recovery by shifting resources from residential provision towards care in the community.
- Facilitate timely and safe step-down housing through collaborative working across NHS, social services and the voluntary sector.
- Ensure that a full range of supported housing is provided equitably across Cumbria.

With regards to the third sector, we recommend that commissioners:

- Develop a database that is accessible to all concerning third sector mental health provision, including but not limited to services commissioned by statutory agencies.
- Appraise the scope for expanding voluntary sector provision, in particular of rehabilitation and recovery focused services.
- Ensure barriers to commissioning services from third sector providers are identified and addressed.
- Ensure contracting arrangements are in place to assure the quality of third sector services and to monitor their outcomes.
- Map and avoid gaps and duplication in third sector offer.

9.3 Achieving value for money: efficiencies and the QIPP agenda

To best use all available resources, we recommend that commissioners:

- Undertake a review of the mental health commissioning function in relation to the move towards GP consortia based/locality commissioning.
- Undertake detailed comparative analyses of service costs linked to activity and outcomes, by service area and by locality.
- Use all available tools, including MHPBR and programme budgeting and marginal analysis by locality, service, activity and outcomes, to better inform financial planning and business case development.
- Increase - where possible and in an evidence based way - the proportion of total expenditure on mental health that is directed towards public mental health and wellbeing, prevention and early intervention, and rehabilitation and recovery.
- Review contracting arrangements, develop outcome based systems aligned with HoNoS and the recovery star, the national mental health contract and mental health payment by results .

- Disinvest in ineffective services and extend services to people with unmet needs and/or provide evidence based services to improve outcomes of people receiving inappropriate services.
- Foster and share innovation.
- Ensure that where evidence of effectiveness is incomplete, a research and development process to contribute to the evidence base is clearly specified, in order to better prioritise investment.
- Make research a priority for investment – we need to understand the effectiveness of some types of interventions.

Priorities for finding efficiencies include:

- Operational efficiencies – these will typically involve merging back-office functions. This will need careful planning to ensure changes bring about efficiencies and patient benefits, rather than unintended consequences.
- Care pathway efficiencies – service redesign is key. Clinical leaders and managers need to be prepared to take this work forward together.
- Staffing efficiencies – staff are the greatest resource of the NHS. However, staff also account for the vast majority of costs in the NHS. It is therefore inevitable that workforce efficiencies will be made.
- Wider system efficiencies – new offers to primary care, addressing physical healthcare costs through mental health intervention, psychological therapies and joined-up working may lead to savings.
- Allocative efficiencies – we need to acknowledge where disinvestment is needed, consider where we might bring patients back into local services and provide greater support for commissioners.

9.4 Public Engagement for mental health

Public engagement is vital to empower people to make choices about the lives they want to lead and to inform the further development of mental health services in Cumbria.

Building on the momentum for public engagement across Cumbria and its localities, we recommend:

- A shift towards greater empowerment of people with mental health problems, e.g. through training, changes to professional attitudes and cultures, organisational changes, assets based community development and opportunities for volunteering, development of social enterprises and access to employment.
- Develop a more systematic approach to listening to experience so that experience is heard and acted on and there is a better ‘fit’ between user/carer stories and models of care.
- Develop measures/evaluation criteria for engagement outcomes.
- Focus for public engagement on mental health and wellbeing, capabilities, resilience and recovery.

References

Acheson, D. (1998) *Independent Inquiry into Inequalities in Health*. HMSO.

Adult psychiatric morbidity in England, 2007: Results of a household survey, The Health and Social Care Information Centre, Social Care Statistics

Aked, J., Michaelson, J., and Steuer, N. (2010) *Good Foundations: towards a low carbon, high well-being built environment*. New Economics Foundation [Internet] Available from: <http://www.neweconomics.org/publications/good-foundations> [Accessed: 4 April 2010]

AOMRC (2009) *No Health without Mental Health. The Alert Summary Report.* [Internet] Available from: <http://www.aomrc.org.uk/aomrc/admin/reports/docs/NMMH_EMAIL.pdf> [Accessed: 18 January 2010]

Aspinall, P. (2009) *Estimating the size and composition of the lesbian, gay, and bisexual population in Britain. Equality and Human Rights Commission*. Manchester.

Audit Commission (1999) *Listen Up! Effective Community Consultation*. Audit Commission. London.

Bartley, M., Sacker, A., and Clarke, P. (2004) *Employment status, employment conditions, and limiting illness: prospective evidence from the British household panel survey 1991 – 2001,* Journal of Epidemiology and Community Health, Vol 58, pp 501 - 506

Birmingham, L. (2004) *Mental Disorder and Prison*, Psychiatric Bulletin, Volume 28, pp. 393 – 397

Bower, P. and Gilbody, S. (2005a) *Managing common mental health disorders in primary care: conceptual models and evidence base.* British Medical Journal 330:839-842.

Bower, P. and Gilbody, S. (2005b) *Stepped care in psychological therapies: access, effectiveness and efficiency: Narrative literature review.* Br J Psychiatry 186:11-17.

Brodie, E. et al (2009) *Understanding participation: A literature review*. Involve.

Brown, P., Hunt, L., and Condie, J. (2008) *Cumbria Gypsy and Traveller Accommodation Needs Assessment*, University of Salford

Brugha T, McManus S, Meltzer H, Smith J, Scott FJ, Purdon S, Harris J and Bankart J (2009) *Autism Spectrum Disorders in adults living in households throughout England.* [Internet] Available from: <http://www.ic.nhs.uk/webfiles/publications/mental%20health/mental%20health%20surveys/APMS_Autism_report_standard_20_OCT_09.pdf> [Accessed: 21 January 2010]

Burchardt, T., Le Grand, J., and Piachaud, C. (1999). Social exclusion in Britain 1991-1995. *Social Policy and Administration. 33/3*: 227-44.

Care Quality Commission (2010) *Position statement and action plan for mental health 2010-2015* [Internet] Available from: <http://www.cqc.org.uk/_db/_documents/20100315_Mental_health_5_year_action_plan_FINAL.pdf > [Accessed: 4 April 2010]

CSIP/NIMHE (2007) *New Ways of Working for Everyone: A best practice implementation guide* [Internet] Available from: <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079106.pdf > [Accessed: 4 April 2010]

Care Services Improvement Partnership (2008) *Social Prescribing for Mental Health - a Guide to commissioning and delivery.* [Internet] Available from: <http://www.nmhdu.org.uk/silo/files/social-prescribing-for-mental-health-.pdf> [Accessed: 25 March 2010]

Centre for Mental Health (2010) *The economic and social costs of mental health problems in 2009/10, Centre for Mental Health* [Internet] Available from: <http://centreformentalhealth.org.uk> [Accessed 4 October 2010]

Centre for Policy on Ageing (2009) *Ageism and age discrimination in mental health care in the United Kingdom. A review from the literature*. Available from: <http://www.cpa.org.uk/information/reviews/CPA-ageism_and_age_discrimination_in_mental_health_care-report.pdf> [Accessed 4 April 2010]

Clark, C., Candy, B. and Stansfield, S. (2006) *A systematic review on the effect of the built and physical environment on mental health* [Internet] Available from: <http://www.apho.org.uk/resource/item.aspx?RID=67532> [Accessed: 29 October 2009]

Communities Scotland (no date) *National Standards for Community Engagement*. Scottish Executive. Edinburgh.

Cooke, A. and Stansfield, J. (2009) *Improving mental well-being through impact assessment. A summary of the development and application of an improving mental well-being impact assessment tool.* NMHDU

Cumbria County Council (2009) *Supporting People Programme*. [Internet] Available from: <http://www.cumbria.gov.uk/supportingpeople/default.asp> [Accessed: 27 November 2009]

Cumbria County Council (2009b) *Cumbria Local Area Agreement 2008 – 2011* [Internet] Available from: <http://www.cumbriastrategicpartnership.org.uk> [Accessed 01 December 2009]

Cumbria CVS (2009) *Cumbria Third Sector Census*.

Department for children, schools and families (2009) *NEET data* [Internet] Available from: <http://www.dcsf.gov.uk/14-19/index.cfm?go=site.home&sid=42&pid=343&lid=337&ctype=Text&ptype=Single> [Accessed 11 January 2010]

Department for Communities and Local Government (2006) *Strong and prosperous Communities. The Local Government White Paper.* TSO. Norwich.

Department of Environment (1995) *Involving Communities in Urban and Rural Regeneration: a guide for practitioners*. Department of the Environment. Ruislip.

Department of Health (2006) *Our health, our care, our say: a new direction for community services*. TSO. Norwich.

Department of Health (2009) *Recognising complexity: commissioning guidance for personality disorder services* [Internet] Available from:

<http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101789.pdf > [Accessed 4 April 2010]

Department of Health Mental Health Division (2009) *New Horizons: A Shared Vision for Mental Health.* [Internet] Available from: <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf> [Accessed 25 May 2010]

Department of Health (2010) *Confident Communities, Brighter Futures. A framework for developing well-being* [Internet] Available from: <http://newhorizons.dh.gov.uk/assets/Reports/20100325-A-framework-for-developing-well-being.pdf> [Accessed 4 April 2010]

Dewa, L., Deacon, L., Spalding, J., Carlin, H., Giles, S., Stansfield, J., Perkins, C. and Bellis, M. (2010) *Cumbria Mental Wellbeing Survey 2009*. North West Public Health Observatory, Liverpool.

Dewe, P. and Kompier, M. (2008) *Wellbeing and work: Future challenges*.

Dixon, M., Reed, H., Rogers, B. and Stone, L. (2003) *CrimeShare. The unequal impact of crime.* Institute for Public Policy Research, London.

Dual Recovery Anonymous (2009) [Internet] Available from: <http://draonline.org/dual_diagnosis.html> [Accessed: 28 October 2009]

Emerson E, and Hatton C. (2007) *Mental health of children and adolescents with intellectual disabilities in Britain*. British Journal of Psychiatry 191: 493-499.

Foresight Mental Capital and Wellbeing Project (2008) *Final Project Report*. Government Office for Science, London.

Foy, R. et al. (2010) *Meta-analysis: effect of interactive communication between collaborating primary care physicians and specialists*. Ann Intern Med 152: 247-58.

Glover, G. (2008) *Estimating the prevalence of common mental health problems in PCTs in England.* Mental Health Observatory. North East Public Health Observatory.

Goodchild, C. (2009) *Living well with dementia – the National Dementia Strategy Joint commissioning framework for dementia.* Department of Health. London.

Gurin, G., Veroff J., and Field, S. (1960) *Americans view their mental health*. Basic Books. New York.

Health and Safety Executive (2007) *Managing the causes of work-related stress. A step-by-step approach using the Management Standards*. HSE, London.

Health and Safety Executive (2009) *Stress-related and psychological disorders.* [Internet] Available from: <http://www.hse.gov.uk/statistics/causdis/stress/country.htm> [Accessed: 18 November 2009]

Health, Work and Wellbeing Programme (2009) *Working our way to better mental health: a framework for action*. [Internet] Available from: <http://www.workingforhealth.gov.uk/documents/Working-our-way-to-better-mental-health-tagged.pdf> [Accessed: 25 March 2010]

Hean, S., Cowley, S., Forbes, A. and Griffiths, P. (2004) *Theoretical development and social capital measurement.* In Morgan A and Swann C. *Social capital for health: issues of definition, measurement and links to health*. London: Health Development Agency

HM Government (2007) *Putting People First.* [Internet] Available from: <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081119.pdf> [Accessed: 25 March 2010]

HM Treasury and DCLG (2010) *Total place: a whole area approach to public services*. London: HM Treasury [Internet] Available from: <http://www.hm-treasury.gov.uk/d/total_place_report.pdf > [Accessed: 2 October 2010]

The Information Centre for health and social care (2009) *Social Care and Mental Health Indicators from the National Indicator Set – further analysis 2008-09* [Internet] Available from: <http://www.ic.nhs.uk/webfiles/publications/Social%20Care/socialcarepubs300909/Social_Care_and_Mental_Health_Indicators_2008_09.pdf> [Accessed: 01 February 2010]

The Information Centre for health and social care (2009b) *Social Care and Mental Health Indicators from the National Indicator Set – further analysis, provisional, 2008-09* [Internet] Available from: < http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/social-care-and-mental-health-indicators-from-the-national-indicator-set--further-analysis-provisional-england-2008-09> [Accessed: 01 February 2010]

Involve (2005) *People & Participation: How to put citizens at the heart of decision-making*. Involve. London.

Jahoda, M. (1958) *Current concepts of positive mental health.* Basic Books. New York.

Jenkins, R., Meltzer, H., Jones, P.B., Bebbington, P., Farrell, M., Crepaz-Keay, D. and Knapp, M. (2008) *Foresight Mental Capital and Wellbeing Project, Mental health: Future challenges,* The Government Office for Science, London

Johnson, R. et al (2006) *Housing and Community Care*, Mental Health Today*,* November, pp. 25 – 28

Jorm, A.F., Korten, A.E., Jacomb, P.A., et al (1997) *Mental health literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment*, Medical Journal of Australia. 166: 182-86

Jorm, AF, Barney, L, Christensen H, et al. (2006) *Research on mental health literacy: what we know and what we still need to know*. Australian and New Zealand Journal of Psychiatry*.* 40: 3-5

Kawachi I, Kennedy BP, Lochner K and Prothrow-Smith D. (1997). *Social capital, income inequality and mortality*. American Journal of Public Health. 87:1491-8

Keyes C (2002) *The mental health continuum: from languishing to flourishing in life*. Journal of health and social research 43: 207-222

Kilroy, A., Garner, C., Parkinson, C., Kagan, C. and Senior, P. (2008) *Invest to Save: Arts in Health Evaluation*. Arts for Health at Manchester Metropolitan University, Manchester.

Knapp, M., and Prince, M. (2007) *Dementia UK* [Internet] Available from: <http://www.psige.org/psige-pdfs/Dementia_UK_Summary.pdf> [Accessed: 10 Aug 2009]

Lamb, S., Hansen, Z., Lall, R., Castelnuovo, E., Withers, E., Nichols, V., Potter, R. and Underwood, M. (2010) *Group cognitive behavioural treatment for low-back pain in primary care: a randomised controlled trial and cost-effectiveness analysis*. Lancet. 375: 916-923.

London Health Observatory (2009) *Crime*. [Internet] Available from: <http://www.lho.org.uk/LHO_Topics/Health_Topics/Determinants_of_Health/Crime.aspx> [Accessed: 24 November 2009]

The Marmot Review (2010) *Fair society, healthy lives. Strategic review of health inequalities in England post-2010*. [Internet] Available from: <http://www.ucl.ac.uk/gheg/marmotreview/FairSocietyHealthyLivesExecSummary> [Accessed: 24 March 2010]

Marshall, M. and Rathbone, J. (2006) *Early Intervention for psychosis. Cochrane Database of Systematic Reviews.* Issue 4. Art. No.: CD004718. DOI: 10.1002/14651858.CD004718.pub2 [Internet] Available from: <http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004718/sect0.html> [Accessed: 24 March 2010]

McCrone, P., Dhanasiri, S., Patel, A., Knapp, M. and Lawton-Smith, S. (2008) *Paying the Price. The cost of mental health care in England to 2026*. King's Fund. London.

McCrone, P. and Knapp, M. (2007) *Economic evaluation of early intervention services*. British Journal of Psychiatry 191:s19-s22.

McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (2009) *Adult psychiatric morbidity in England, 2007. Results of a household survey*. The NHS Information Centre for Health and Social Care. Leeds.

Muntaner C. (2004) *Commentary: social capital, social class and the slow progress of psychosocial epidemiology*. International Journal of Epidemiology. 33:674-80

MIND (2007) *Housing and Mental Health* [Internet] Available from: <http://www.mind.org.uk/help/social_factors/housing_and_mental_health> [Accessed: 14 August 2008]

MIND (2008) *Mental Health Act 1983: An outline guide*. [Internet] Available from: <http://www.mind.org.uk/help/rights_and_legislation/mental_health_act_1983_an_outline_guide> [Accessed: 07 January 2010]

Mental Health Commissioning Team (2009) *Mental Health services in Cumbria: Our response to the consultation process on further improvements. Progress Report – July 2009.* NHS Cumbria.

Mental Health Division (2009) *New Horizons: A Shared Vision for Mental Health. Department of Health*. London.

Mental Health Foundation (2009) *Volunteering during the economic crisis can protect people's mental health* [Internet] Available from: <http://www.mhf.org.uk/information/news/?entryid17=67090> [Accessed: 30 October 2009]

Mental Health Strategies (2010) *LIT Results of Financial Mapping 2009/10 for Cumbria*. Department of Health.

Ministry of Justice (2009) *Lord Bradley report on people with mental health problems or learning disabilities in the Criminal justice system: a government response*. [Internet] Available from: <http://www.justice.gov.uk/publications/docs/bradley-mental-health-cjs-gov-response-grid.pdf> [Accessed: 4 April 2010]

Muijen, M. (2009) *Access to Healthcare. Prevention of depression and suicide – making it happen*. Budapest.

National Collaborating Centre for Mental Health (2003) *Depression – Core Interventions in the Management of Depression in Primary and Secondary Care (National Clinical Practice Guideline – Draft for Consultation)*. National Institute for Clinical Excellence, London.

National Institute for Mental Health in England (2007) *Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people: a systematic review*. Care Services Improvement Partnership.

NHMDU (2010) *Pathways to personalisation*. [Internet] Available from: <http://www.nmhdu.org.uk/silo/files/paths-to-personalisation.pdf> [Accessed: 25 March 2010]

NHS (2004) *Risk and protective factors for mental health* [Internet] Available from: <http://www.library.nhs.uk/SpecialistLibrarySearch/Download.aspx?resID=105868> [Accessed: 30 October 2009]

NHS Choices (2009) *Bipolar Disorder* [Internet] Available from: <http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Introduction.aspx> [Accessed: 18 January 2010]

NHS Confederation Mental Health Network (2009) *Fact sheet: Key facts and trends in mental health* [Internet] Available from: <http://www.nhsconfed.org/Publications/Documents/MHN_factsheet_August_2009_FINAL_2.pdf> [Accessed: 04 April 2010].

NHS Cumbria (2008) *Moving care closer to home: integrating health and social care for adults in Cumbria.*

NHS Cumbria (2010) *Epidemiological Review of Suicide in Cumbria*.

NHS Cumbria (2009) *Electro-convulsive therapy for patients detained in hospital: Patient information leaflet*. [Internet] Available from: <http://www.cumbriapartnership.nhs.uk/Services/MentalHealthAct/Information.aspx> [Accessed: 04 November 2009].

NHS Health Scotland (2009) *Mental Health Improvement. Background and Policy Content.* [Internet] Available from: <http://www.healthscotland.com/mental-health-background.aspx > [Accessed: 4 November 2009]

NHS Information Centre, Mental Health and Community Care Team (2009) *Mental Health Bulletin Third report from Mental Health Minimum Dataset annual returns, 2004-2009* [Internet] Available from: <http://www.ic.nhs.uk/webfiles/publications/mental%20health/NHS%20specialist%20mental%20health%20services/MHMDS09/MH_Bulletin_2004_2009.pdf> [Accessed: 04 April 2010].

NHS North West (2008) *A Better Future in Mind. Mental Health Services in the North West.* Report of the NHS North West Commission on Mental Health Services.

New Economics Foundation (1998) *Participation Works! 21 techniques of community participation for the 21st century*. New Economics Foundation.

NICE (2003) *Guidance on the use of electroconvulsive therapy. Technology Appraisal 59.* [Internet] Available from: <http//www.nice.org.uk> [Accessed: 04 November 2009].

NICE (2009a) *Public Health Guidance 22: Promoting mental wellbeing through productive healthy working conditions* [Internet] Available from: <http://guidance.nice.org.uk/PH22/QuickRefGuide/pdf/English> [Accessed: 25 March 2010].

NICE (2009b) Stepped Care Models. [Internet] Available from: <http://www.nice.org.uk/usingguidance/commissioningguides/cognitivebehaviouraltherapyservice/steppedcaremodels.jsp> [Accessed: 25 March 2010].

NICE (2009c) *Depression: Treatment and management of depression in adults, including adults with a chronic physical health problem.* [Internet] Available from: <http://www.nice.org.uk/nicemedia/pdf/CG%2090%20QRG%20LR%20FINAL.pdf> [Accessed: 25 March 2010].

Office for National Statistics (1997) *Psychiatric morbidity among prisoners: Summary report*, Government Statistical Service.

Office for National Statistics (2002) *Mental health of carers* [Internet] Available from:<http://www.statistics.gov.uk/downloads/theme_health/Mental_Health_of_Carers_June02.pdf> [Accessed: 14 August 2009]

Office of the Deputy Prime Minister (2004a) *Empowering communities, improving housing: Involving black and minority ethnic tenants and communities*. ODPM. London.

Office of the Deputy Prime Minister (2004b) *Evaluation of Local Strategic Partnerships – Community Engagement: a briefing note for LSPs by LSP.* ODPM. London.

Office of the Deputy Prime Minister (2004c) *Evaluation of Local Strategic Partnerships – Governance: a briefing note for LSPs by LSPs*. ODPM. London.

Office of the Deputy Prime Minister (2005) *National Framework for Tenant Participation Compacts*. ODPM. London.

Office of the Deputy Prime Minister (2006) *Promoting Effective Citizenship and Community Empowerment: a guide for local authorities on enhancing capacity for public participation*. ODPM. London.

Osborn, D.P.J (2001) The poor physical health of people with mental illness, *British Medical Journal,* Volume 175, No. 5, pp. 329 – 332

Pearson, M. and Burn, L. (2008) *Infant and Maternal Mental Health Services Across the North West: Mapping Provision*. Report Prepared for the North West Regional Network for Infant and Maternal Mental Health.

Pickett K.E. and Wilkinson R.G. (2007) *Child wellbeing and income inequality in rich countries: ecological cross sectional study.* British Medical Journal 335:1080.

Platt, S., Boyle, B., and Crombie, I. (2007) *The epidemiology of suicide in Scotland 1989-2004: an examination of temporal trends and risk factors at national and local levels*. The Scottish Government, available: http://www.scotland.gov.uk/Publications/2007/03/01145422/1

Popay J, Attree P, Hornby D, Milton B, Whitehead M, French B, Kowarzik U, Simpson N, Povall S (2007) *Community engagement in initiatives addressing the wider social determinants of health: a rapid review of evidence on impact, experience and process.* Lancaster University. Lancaster.

Putnam R (1993) Making democracy work. Civic traditions in modern Italy. New Jersey: Princeton University Press

Rehkopf, D.H., and Buka, S.L. (2006) The association between suicide and the socio-economic characteristics of geographic areas: a systematic review. *Psychological medicine*, 36: 145-57

Rethink (2004) *Dual diagnosis toolkit: Mental health and substance misuse, a practical guide for professionals and practitioners* [Internet] Available from:< http://www.rethink.org/dualdiagnosis/> [Accessed: 28 October 2009]

Riper H. and Smit, F. (2009*) Internet and media as tools to tackle depression and suicide.* Presentation to European Commission conference on Prevention of depression and suicide: making it happen, Budapest, December 2009. Available from: <http://ec.europa.eu/health/mental_health/docs/ev_20091210_co33_en.pdf> [Accessed 20 April 2010]

Royal College of Psychiatrists (2008) *Mental health and work* [Internet] Available from: http://www.workingforhealth.gov.uk/documents/mental-health-and-work.pdf [Accessed: 25 March 2010]

Royal College of Psychiatrists (2009) *Bipolar Disorder – Manic Depression* [Internet] Available from: <http://www.rcpsych.ac.uk/mentalhealthinfo/problems/bipolardisorder/bipolardisorder.aspx> [Accessed: 18 January 2010]

Royal College of Psychiatrists (2009b) *Root and Branch General and Community Faculty E-newsletter Edition Two* [Internet] Available from: <http://www.rcpsych.ac.uk/college/faculties/generalandcommunity/newsletters/e-newsletters/e-newsletterjune2009.aspx> [Accessed: 21 January 2010]

Royal College of Psychiatrists (2009c) *Benzodiazepines* [Internet] Available from: <http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/benzodiazepines.aspx> [Accessed: 02 February 2010]

Royal College of Psychiatrists (2009d) *Age discrimination in mental health services: making equality a reality.* [Internet] Available from: <http://www.rcpsych.ac.uk/pdf/PS2_2009_for%20website1.pdf> [Accessed: 25 March 2010]

Royal College of Psychiatrists Social Inclusion Scoping Group (2009) *Position Statement Mental Health and Social Inclusion: Making Psychiatry and Mental Health Services Fit for the 21st Century*. [Internet] Available from: <http://www.rcpsych.ac.uk/pdf/social%20inclusion%20position1%20statement.pdf> [Accessed: 25 March 2010]

Royal College of Psychiatrists Mental Health Network, NHS Confederation & London School of Economics and Political Science (2009) *Mental health and the economic downturn*. *National priorities and NHS solutions.* [Internet] Available from: <http://www.rcpsych.ac.uk/pdf/OP%2070%20%20economic%20downturn%20(website).pdf> [Accessed: 25 March 2010]

Save the Children (2005) *DIY guide to Improving your Community: getting children and young people involved*. Save the Children Scotland. Edinburgh.

Seymour, L. and Grove, B. (2005) *Workplace interventions for people with common mental health problems*. Sainsbury Centre for Mental Health. [Internet] Available from: <http://www.scmh.org.uk/employment/supported_employment.aspx> [Accessed: 25 March 2010]

Shiers, D., Smith, J. and McCrone, P. (2006) *Briefing about the economic impact of Early Intervention Services.* [Internet] Available from: <http://www.mentalhealthnurse.co.uk> [Accessed: 14 May 2010]

Shift (2009) *What's the story? Responsible media reporting of mental health and suicide* [Internet] Available from: <http://www.shift.org.uk/mediahandbook/whatsthestory/index.html> [Accessed: 25 March 2010]

Skinner S. and Wilson, M. (2002) *Assessing Community Strengths: a practical handbook for planning capacity building*. Community Development Foundation. London.

Social Care Institute for Excellence (2009) SCIE research briefing 20: The implementation of individual budget schemes in adult social care. [Internet] Available from: <http://www.scie.org.uk/publications/briefings/briefing20/index.asp> [Accessed: 25 March 2010]

Social Exclusion Unit (2004) *Mental Health and Social Exclusion*, Office of the Deputy Prime Minister, London

Sustain (2009) *Food and Mental Health* [Internet] Available from: <http://www.sustainweb.org/foodandmentalhealth/> [Accessed: 30 October 2009]

Thomas, C., Benzeval, M., Stansfeld, S.A. (2005) Employment transitions and mental health: an analysis from the British household panel survey, Journal of Epidemiology and Community Health, Vol. 59, pp. 243 – 249

Thornicroft and Tansella (2003) *Synthesis report on community based mental health.* [Internet] Available from: <http://www.euro.who.int/document/E82976.pdf> [Accessed: 25 March 2010]

Twiselton, I. and Huntington, F. (2009) *Health Needs Assessment: Cumbria Gypsy Travellers*. NHS Cumbria.

University College London (2007) *Individuals with high fear of crime twice as likely to suffer from depression.* [Internet] Available from: <http://www.ucl.ac.uk/news/news-articles/0709/09072801> [Accessed: 24 November 2009]

Van Steenbergen-Weijenburg, K. et al. (2010) *Cost-effectiveness of collaborative care for the treatment of major depressive disorder in primary care. A systematic review.* BMC Health Services Research, 10:19.

Weich, S., Twigg, L., and Lewis, G., (2006) Rural/non-rural differences in rates of common mental disorders in Britain: Prospective multilevel cohort study *British Journal of Psychiatry*, Volume 188, pp. 51-57

Whitelaw, S., Swift, J., Goodwin, A. and Clark, D. (2008) *Physical Activity and Mental Health: the role of physical activity in promoting mental wellbeing and preventing mental health problems. An Evidence Briefing.* NHS Health Scotland, Edinburgh.

Wilkinson R. (1996) *Unhealthy Societies: the afflictions of Inequality*. London: Routledge.

Wilkinson, R. (2005) *The Impact of Inequality: How to Make Sick Societies Healthier.*

Wilson, G., Vitousek, K. and Loeb, K. (2000) *Stepped care treatment for eating disorders*. Journal of Consulting and Clinical Psychology, 68, 564 -572.

Windle, G., Hughes, D., Linck, P., Russell, I., Morgan, R., Woods, R., Burholt, V., Tudor Edwards, R., Reeves, C. and Yeo, S. (2008) *Public health interventions to promote mental well-being in people aged 85 and over: systematic review of effectiveness and cost-effectiveness.* [Internet] Available from: <http://www.nice.org.uk/nicemedia/pdf/MentalWellbeingOlderPeopleEffectivenessCostEffectivenessReview.pdf> [Accessed 20 April 2010]

Women's Aid (2005) *Domestic Violence and Mental Health* [Internet] Available from: <http://www.womensaid.org.uk/domestic-violence-articles.asp?section=00010001002200040001&itemid=940&itemTitle=Domestic+violence+and+mental+health> [Accessed: 26 October 2009]

World Health Organisation (2005) *Alcohol and mental health* [Internet] Available from: <http://www.euro.who.int/document/MNH/ebrief12.pdf> [Accessed: 12 August 2009]

World Health Organisation and Wonca (2008) *Integrating mental health into primary care: a global perspective.* [Internet] Available from: <http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf> [Accessed: 25 March 2010]

Authors

- Jane Mathieson
- Emma Finlinson
- Ben Barr

Acknowledgements

Acknowledgements are also due to the following people for their valuable contribution in the compilation of this Mental Health Joint Strategic Needs Assessment: Elaine Church; Martin Ewin; James Fraser; David Le Mare; Rachel Brown; Helen Willey; Carolynne Foulkes; Marsali Caig; Grant Little; Beren Aldridge; Jim Bradley and members of the Cumbria Mental Health Group; Zoe Cowgill; and Grace Hurford.