County Durham
Public Mental Health Strategy

2013 - 2017

Contents

Foreword

The Public Mental Health Strategy for County Durham was developed by the Public Mental Health Strategy Development Group consisting of key partners, service users and carers. It is based on comprehensive identification of needs and identifying evidence based practice to promote good mental health.

Public mental health encompasses both mental health improvement and suicide prevention, recognising that mental health improvement is a vital tool in the prevention of suicide. This strategy outlines the implications for public mental health in light of the recent mental health strategy, *No Health Without Mental Health*[1] and *Preventing Suicide in England, A Cross Government Strategy to Save Lives*[2]. Taking a life course approach, it recognises that the foundations for lifelong wellbeing are being laid down before birth. It aims to prevent mental ill health, intervene early when it occurs and improve the quality of life for people with mental health problems and their families. It is for people of all ages – children and young people, working age adults as well as older people.

Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work, and to achieving our potential. Good mental health is the foundation for well-being and the effective functioning of individuals and communities. It impacts on how individuals think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential. Communities with greater social capital can be shown to have higher level of good mental health. Through promoting good mental health and early intervention we can help to prevent mental illness from developing and mitigate its effects.

The strategy aims to build a healthier, more productive and fairer society which builds resilience, promotes mental health and wellbeing and challenges health inequalities.

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Public Mental Health Strategy: Vision and Objectives

The vision: *Individuals, families and communities within County Durham to be supported to achieve their optimum mental wellbeing.*

Key Objectives

Promoting Mental Health
- Objective 1: Improve mental health and wellbeing of individuals through engagement, information, activities, access to services and education.

Prevention of Mental Ill-Health
- Objective 2: Prevention of mental illness and dementia through targeted interventions for groups at high risk

- Objective 3: Reduce the suicide and self-harm rate for County Durham

- Objective 4: Improve physical health of people with poor mental health through integration of mental health into existing programmes and targeted approach to those experiencing mental ill-health

- Objective 5: Reduce stigma and discrimination towards people who experience mental health problems by raising awareness amongst the general public, workplaces and other settings.

- Objective 6: Prevent violence and abuse through interventions which promote mental health and target interventions for those in high risk groups.

Early Identification of those at risk of Mental Ill-Health
- Objective 7: Improve early detection and intervention for mental ill-health across lifespan

- Objective 8: Promote mental health and prevent mental ill-health through targeted intervention for individuals with mild symptoms.

- Objective 9: Increase early recognition of mental ill-health through improved detection by screening and training the workforce.

Recovery from Mental Ill-Health
- Objective 10: Improve recovery through early provision of a range of interventions including supported employment, housing support and debt advice.

Introduction

This strategy adopts the *Mental Illness and Mental Health: The Two Continua Model Across the Lifespan[3]* (figure 1) This model moves past the concept that mental health is the absence of mental illness and believes that mental health can be enhanced regardless of a diagnosis of mental illness. Delivering mental health improvement programmes to those with mental illness requires moving beyond a simplistic categorisation of people as either mentally healthy or mentally ill. In many cases, symptoms of acute mental illness are episodic in nature and surrounded by periods of recovery or wellness. A person can experience mental well-being in spite of a diagnosis of mental illness or, conversely, be free of a diagnosed mental illness but still be experiencing poor mental health.

Figure 1 demonstrates a model with four possible options which individuals may experience.
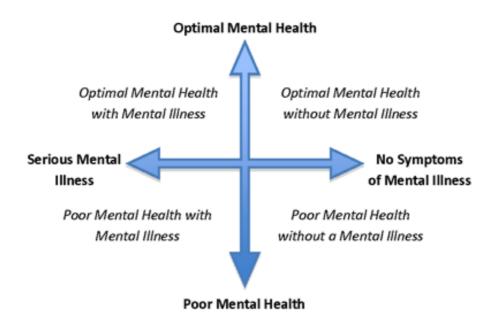
Optimal Mental Health

Optimal Mental Health with Mental Illness   *Optimal Mental Health without Mental Illness*

Serious Mental Illness   **No Symptoms of Mental Illness**

Poor Mental Health with Mental Illness   *Poor Mental Health without a Mental Illness*

Poor Mental Health

Figure 1: The Mental Health/Illness Continuum

This strategy aims to promote mental wellbeing and prevent the development of mental health issues. It will do this through increasing the resilience of the population in County Durham and reducing risk factors associated with poor mental health. There is a need to promote mental health and emotional well-being at individual and community level; improve the mental health and wellbeing of children and young people, and to reach out to the groups at greatest risk of poor mental health.

The strategy adopts core beliefs to ensure effective delivery including joined-up working between community and voluntary, statutory and business sectors; commitment to engagement and consultation with local community, service users and carers; commitment to achieving and sharing evidence based practice; population and targeted approach to delivering strategy.

DEFINITIONS

The terms 'mental illness' and 'mental wellbeing' are used in this document with the following definitions. This approach follows Joint Commissioning Panel for Mental Health report on Commissioning Public Mental Health Services:

Mental Health and Wellbeing refers to a combination of feeling good and functioning effectively. The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence and affection. The concept of functioning effectively (in a psychological sense) involves the development of one's life, having a sense of purpose such as working towards valued goals, and experiencing positive relationships

Mental Illness and Mental Ill-Health refers to depression and anxiety (which may also be referred to as 'common mental disorder') as well as schizophrenia and bipolar disorder (which may also sometimes be referred to as severe mental illness)

Mental Health Early Intervention refers to secondary prevention which involves the early identification of mental ill health and early intervention to treat and prevent progression.
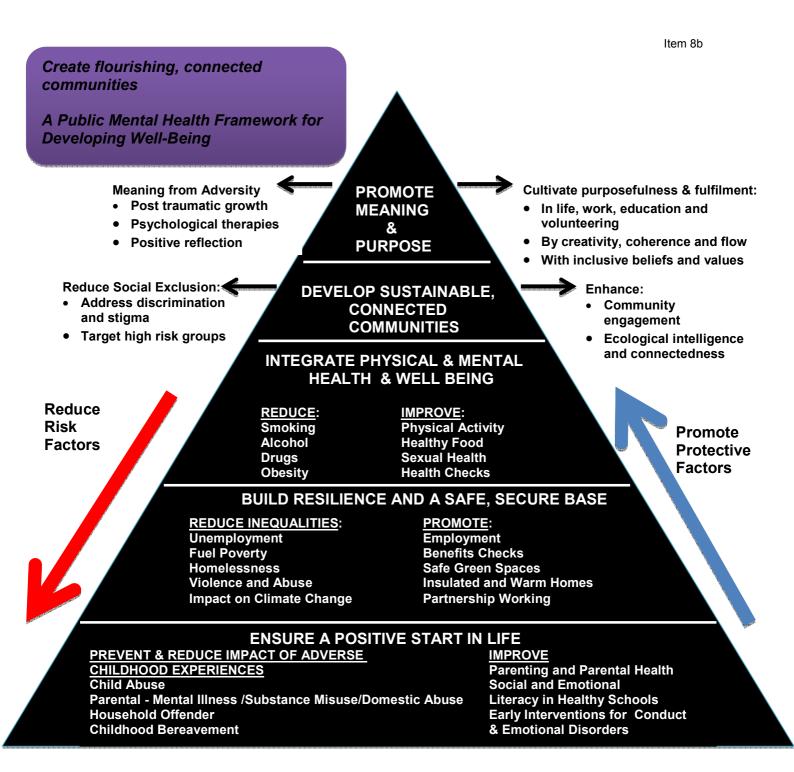
WHAT IS PUBLIC MENTAL HEALTH?

Public Mental Health is the emotional and spiritual resilience which enables us to enjoy life and survive pain, suffering and disappointment. It is a positive sense of wellbeing and an underlying belief in our and others' dignity and worth[4].

Public mental health:

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

Public mental health is fundamental to public health and health improvement. As the title of the Government mental health strategy declares, there is "no health without mental health. Good mental health provides the bedrock for good physical health and for a range of other important life skills, capacities and capabilities[5]. Figure 2 identifies the factors that influence mental health and offers a framework for the developing wellbeing.

Create flourishing, connected communities

A Public Mental Health Framework for Developing Well-Being

Meaning from Adversity
- **Post traumatic growth**
- **Psychological therapies**
- **Positive reflection**

PROMOTE MEANING & PURPOSE

Cultivate purposefulness & fulfilment:
- **In life, work, education and volunteering**
- **By creativity, coherence and flow**
- **With inclusive beliefs and values**

Reduce Social Exclusion:
- **Address discrimination and stigma**
- **Target high risk groups**

DEVELOP SUSTAINABLE, CONNECTED COMMUNITIES

Enhance:
- **Community engagement**
- **Ecological intelligence and connectedness**

INTEGRATE PHYSICAL & MENTAL HEALTH & WELL BEING

Reduce Risk Factors

REDUCE:
Smoking
Alcohol
Drugs
Obesity

IMPROVE:
Physical Activity
Healthy Food
Sexual Health
Health Checks

Promote Protective Factors

BUILD RESILIENCE AND A SAFE, SECURE BASE

REDUCE INEQUALITIES:
Unemployment
Fuel Poverty
Homelessness
Violence and Abuse
Impact on Climate Change

PROMOTE:
Employment
Benefits Checks
Safe Green Spaces
Insulated and Warm Homes
Partnership Working

ENSURE A POSITIVE START IN LIFE

PREVENT & REDUCE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES
Child Abuse
Parental - Mental Illness /Substance Misuse/Domestic Abuse
Household Offender
Childhood Bereavement

IMPROVE
Parenting and Parental Health
Social and Emotional
Literacy in Healthy Schools
Early Interventions for Conduct
& Emotional Disorders

Nurse J [6]

Figure 2: A Public Mental Health Framework for Developing Well-being

Risk and protective factors for positive mental health

Whilst protective factors (Appendix 1) are associated with positive mental health outcomes, generally, they can be summarised as:

- Psycho-social, life and coping skills of individuals, for example increasing a sense of self-esteem and autonomy.
- Social support as a buffer against adverse life events, for example self-help groups, someone to talk to.
- Access to resources and services which protect mental well-being, for example increasing benefit uptake and increasing opportunities for physical, creative and learning activities.

Risk factors increase the likelihood of experiencing poorer mental health and are associated with poorer outcomes for people with mental health problems. Generally, the risk factors can be summarised as:

- The incidence or the impact of negative life events and experiences for individuals, for example, abuse, relationship breakdown, long term illness or disability
- Social isolation and exclusion
- The impact of deprivation and structural inequalities in health

Through acknowledging a wider range of issues which impact on mental health, preventative action can be delivered more effectively.

Risk and protective factors for suicide and suicidal behaviour

Protective factors

Coping skills
A number of coping skills require an understanding of self as an individual capable of shaping motives, behaviour and future possibilities and appear to be protective against suicidal behaviour, including self-control and self-efficacy, social skills and positive future thinking.

Reasons for living
High levels of reasons for living, future orientation and optimism protect against suicide attempt among those with depression.

Physical activity and health
An attitude towards sport as a healthy activity and participation in sporting activity is protective against suicidal behaviour among adolescents.

Family connectedness
Good relationships with parents mitigate against suicide risk, especially in adolescents and including those who have been sexually abused. Positive family relationships also provide a protective effect for adolescents including those with learning disabilities and behavioural conditions.

Marriage is a protective factor against suicide. There is also evidence that marriage has a protective buffering effect against socio-economic inequalities related to suicide, particularly for men. Married men were less likely than non-married men to have problems with drugs, sex, gambling and having used or currently using psychiatric medicine.

Supportive schools
Supportive school environments, including access to healthcare professionals, are important protective factors among adolescents including those who have experienced sexual abuse, those with learning disabilities, behavioural conditions and those who identify as lesbian, gay, bisexual or transgendered.

Social support
Social support in general is protective against suicide among a range of population groups, including women who have experienced domestic abuse.

Religious participation
There is a wide range of evidence to suggest that religious participation may be a protective factor against suicidal behaviour.

Employment
Employment, especially full-time, has a protective effect against suicide [7].

Risk factors

Mental illness

Across all age groups, several diagnoses of mental illness, and a history of psychiatric treatment in general have been established as risk factors for completed suicide. The risk of suicide for some mental health diagnosis may be increased by additional risk factors, such as a history of suicide attempts, other psychiatric diagnoses, drug or alcohol misuse, anxiety, recent bereavement, severity of symptoms and hopelessness.

Substance misuse

Substance misuse increases the risk of suicide attempt and death by suicide. The risk associated for mixed intravenous drug use is greater than that for alcohol misuse. The risk of suicide from alcohol misuse is greater among women than among men. Substance misuse in this country remains a significant factor in poor health outcomes, criminality and worklessness and continues to have far reaching effects upon individuals, families and society as a whole.

Attempted suicide

Those who self-harm have a much greater risk of dying by suicide compared with those who do not engage in this behaviour.

Suicide and older people

People over the age of 65 are more successful than any other age group at taking their own lives. Evidence from a growing body of research shows that suicide in older people is reasonably well understood; it results from complex social, psychological, biological and spiritual processes; depression, underlying physical ill health and frailty and social isolation are important markers.

Personality traits

There may be increased suicide risk associated with particular individuals or personality factors. Suicide risk is higher in a range of personality traits including hopelessness, neuroticism, extroversion, impulsivity, aggression, anger, irritability, hostility, anxiety, attention deficit hyperactivity disorder (ADHD) and eating disorders such as anorexia nervosa and bulimia; and low problem solving skills for example inability to identify and solve singular problems.

Unemployment

Unemployment is linked to increased risk of suicide. Occupational social class and suicide and deliberate self-harm are inversely linked: the lower the social class, the higher the risk of suicidal behaviour.

Poverty

Poverty and deprivation are linked to suicide risk. Areas with greater levels of socio-economic disadvantage have higher suicide rates.

The Economic Cost of Mental Illness

Nationally mental health problems effect one in four of us at some time in our lives. As well as being a major cause of distress for individuals and their families, there is a cost to society in terms of lost productivity and avoidable costs for the criminal justice system as well as the costs of care and support. Although the cost of mental ill health is forecast to double over the next 20 years, some of the cost could be reduced by greater focus on whole-population mental health improvement and prevention, alongside early diagnosis.

The financial costs of the adverse effects of mental health illness on people's quality of life are estimated at £41.8 billion per year in England*[8]*

Mental ill health is the single largest cause of disability in the UK, contributing up to 23% of the total burden of disease in the UK and 13.8% of NHS expenditure[1].

The economic costs of mental illness in England on the wider economy in terms of welfare benefits and lost productivity at work amount to £77 billion a year.[8]

11% of adult health care costs in the UK are attributable to physical symptoms caused or exacerbated by mental health problems[9].

Labour Force Survey data suggest that 11.4 million working days were lost on Britain 2008/09 due to work related stress, depression and anxiety. Average annual cost of lost employment attributable to an employee with depression is £7,230 and £6,850 for anxiety.

An estimated one million carers in the UK have given up work or reduced working hours to care, over two thirds of those who had given up work to care were more than £10,000 a year worse off as a result. 4 in 10 carers were in debt as a result of caring and the stress of money worries had affected the health of 1 in 2 of UK carers[10].

In England 4,400 people took their own lives in 2009. Suicide has a devastating impact on society and economic costs are also high, estimated at £1.7 million for each life lost for those of working age[11].

Nationally, only 24% of those with a mental health problem work, compared to 75% of the general population. In the North East this falls to around 16%[12].

The Cost Benefit of Public Mental Health

Public mental health interventions reduce the impact of mental illness and poor mental health and produce a broad range of benefits associated with improved wellbeing

Improving mental health impacts on wide range of domains which results in considerable cost savings.[13]

Evidence-based parenting support for families and at-risk children prevents mental health problems in later life and results in better outcomes in health, education, employment, education and relationships[14].

Interventions in families with children at higher risk of conduct disorder would cost £210 million but save £5.2 billion[15].

It is estimated that improved mental health support in the workplace could save UK businesses up to £8 billion a year[16].

Return to work after a period of sick leave for mental health reasons results in reduced welfare claims and reduced use of health and social services, including mental health[17].

Investment in improving access to talking therapies across England through the delivery of employment support, alongside treatment for common mental health problems such as depression and anxiety, can help people to stay in work or return to work[18].

Costs of mental health services can be reduced by half when people with severe mental health problems are supported into mainstream employment[19].

People with severe and long-term mental health problems who are given intensive support to return to the workplace report fewer and shorter subsequent hospital stays than people receiving usual mental health services[20].

The type of savings which can be made from public mental health interventions are highlighted by a recent Department of Health report. This found that for every £1 invested, the net savings were[21]:

• £84 saved – school-based social and emotional learning programmes

• £44 saved – suicide prevention through GP training

• £18 saved – early intervention for psychosis

• £14 saved – school-based interventions to reduce bullying

• £12 saved – screening and brief interventions in primary care for alcohol misuse

• £10 saved – work-based mental health promotion (after 1 year)

• £10 saved – early intervention for pre-psychosis

• £8 saved – early interventions for parents of children with conduct disorder

• £5 saved – early diagnosis and treatment of depression at work

• £4 saved – debt advice services.

National Policy Drivers

No Health without Mental Health[1]: the cross-Government mental health strategy for people of all ages takes a life course approach to improving mental health outcomes for people of all ages with a strong focus on early and effective intervention. The national mental health strategy sets out a clear and compelling vision for improving the mental health and wellbeing of England through six objectives which emphasise the importance of the wider influences on mental health including housing, education, criminal justice system, physical health and employment. Six objectives are:

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

In 2012 the Department of Health published the implementation framework which provides guidance on action at a local level and is designed to influence the full range of organisations whose work has an impact on people's mental health and wellbeing.

Preventing Suicide in England: A cross government outcomes strategy to save lives[22] focusses on six main areas for action:

- Reduce the risk of suicide in key high risk groups
- Tailor approached to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

In December 2010 the government launched its new drug strategy, **Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug-free life.**[23]

A major change to government policy, the 2010 Strategy set out a fundamentally different approach to preventing drug use in our communities, and in supporting recovery from drug and alcohol dependence. The strategy has recovery at its heart and:
- puts more responsibility on individuals to seek help and overcome dependency

- places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing
- aims to reduce demand
- takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad
- puts power and accountability in the hands of local communities to tackle drugs and the harms they cause

Drug addiction goes hand in hand with poor health, homelessness, family breakdown, and offending. Addicts use drugs compulsively, damaging themselves and those around them. Drug addiction is a complex condition, however, it is treatable.

Starting well

No Health without Mental Health[1] emphasises the crucial importance of early intervention in emerging emotional and mental health problems for children and young people. The social and biological influences on a child's health and brain development start even before conception and continue through pregnancy and the early years of life. Parental mental health is an important factor in determining the child's mental health. Better parental mental health is associated with better outcomes for the child, including better relationships, improved learning and academic achievement, and improved physical health.

Children and Young Peoples Outcomes Strategy[24] mental health thematic report describes the outcome indicators to support delivery of each of the six objectives from No Health without Mental Health[1] and identifies key areas including:

More children and young people will have good mental health

- Fewer children and young people will develop mental health problems by starting well, developing well, learning well, working and living well.

More children and young people with mental health problems will recover

- More children and young people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they needs for living and working, improved chances in education, better employment rates and a suitable and stable place to live as they reach adulthood.

More children and young people with mental health problems will have good physical health and more children and young people with physical ill-health will have better mental health

- There will be improvements in the mental health and wellbeing of children and young people with serious physical illness and long-term conditions.

More children and young people will have a positive experience of care and support

- Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give children and young people and their families the greatest choice and control over their own lives and a positive experience of care.
- Fewer children and young people will suffer avoidable harm
- Children and young people and their families should have confidence that care is safe and of the highest quality.
- Fewer children and young people and families will experience stigma and discrimination
- Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to children and young people with mental health problems will decrease.

Developing Well

As part of the national strategy the Government has committed to take forward detailed plans to extend the Improving Access to Psychological Therapies (IAPT) programme to children and young people. This service transformation for children and young people's mental health care will embed best evidence based practice, training staff in validated techniques, enhanced supervision and service leadership and monitoring of individual patient outcomes.

Living Well

Healthy lives, healthy people: our strategy for public health in England[25] sets out a range of local approaches to improve physical and mental health and acknowledges that the community and environment in which we live can also strongly influence both population and individual mental health and wellbeing.

Approaches of particular importance include:

- reducing isolation, support during times of difficulty, and increasing social networks and opportunities for community engagement;
- providing easy access to continued learning;
- improving support for informal carers;
- warm homes initiatives;

- promotion of physical activity and physical health.

The refreshed carers strategy**, Recognised, Valued And Supported: Next steps for the Carers Strategy**[26], sets out the actions that the Government will take over the next four years to ensure the best possible outcomes for carers and those they support. These include:

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset, both in designing local care provision and in planning individual care packages;
- Enabling those with caring responsibilities to fulfil their educational and employment potential;
- Personalised support, both for carers and for those they support, enabling them to have a family and community life; and
- Supporting carers so that they remain mentally and physically well.
- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset, both in designing local care provision and in planning individual care packages;

Working Well

Being in work has important psychological and economic benefits. People who become unemployed are at increased risk of developing mental health problems. The longer a person is out of work, the harder it is for them to return to the job market. Early intervention can help to prevent deterioration of mental health and support job-seeking.

The **Health and Safety Executive Stress Management Standards**[27] set out what employers can do to limit work-related stress and create a culture in which the risks of stress are reduced. Some employers find it hard to understand the difficulties faced by people experiencing mental health problems. They may need advice in order to support employees to remain in or return to work.

The link between employment and mental health is proven. Research shows that generally people enjoy better mental health when they are at work. Satisfying work can therefore play a vital role in improving everyone's well-being and mental health (**Working our way to better health**,[28]). By creating healthy workplaces and raising awareness of mental health issues, employers can reduce both sickness absence due to mental health problems and the costs associated with low productivity

The Government is committed to the health and welfare of people serving in the armed forces, both during and after their time in service. **The Military Covenant**[29] is the basis for government policy aimed at improving the support

available for the armed forces community. The covenant is a pledge made by the government to ensure that the armed forces are not disadvantaged as a result of their service. Mental health services have a key role to play in fulfilling this Covenant.

When individuals leave the armed forces, their healthcare needs become the responsibility of the NHS. For the great majority, that works well. However, for some veterans extra provision is needed because of their reluctance to seek help or because of difficulties navigating civilian health.

The Government has committed further resources in order to work with our strategic partners in ensuring the best treatment possible for veterans with mental health problems.

Ageing Well

As life expectancy increases, healthy life expectancy also needs to increase. By 2033, the number of people in the UK aged 75 and over is projected to increase from 4.8 million in 2008 to million. For those aged 85 and over, the projected increase is from 1.3 million in 2008 to 3.3 million in 2033.89

Depression is the most common mental health problem in older people and is associated with social isolation, long term physical health problems or caring roles, and living in residential care. Dementia affects 5% of people aged over 65 and 20% of those aged over 80.

National policy integrates mental health from the start, and takes into account how physical and mental health is interconnected.

Rapid improvement in dementia care, through local delivery of quality outcomes and local accountability for achieving them is the approach set out in **Living well with dementia: a National Dementia Strategy**[30] and associated compendiums.

Promoting Equality and Reducing Inequality

The **Government Equalities Office states that the Equality Act**[31] is intended to provide a new cross-cutting legislative framework to protect the rights of individuals and advance equality of opportunity for all; to update, simplify and strengthen the previous legislation; and to deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

Better mental health, mental wellbeing and better services must be better for all – whatever people's age, race, religion or belief, sex, sexual orientation, disability, marital or civil partnership status, pregnancy or maternity, or gender

reassignment status. These areas constitute the 'protected characteristics' or groups as set out in the Equality Act[31].

No Health Without Mental Health[1] sets out the Government's commitment to promoting equality and reducing inequalities in mental health in relation to the protected characteristics.

Public Health England will have a role in taking forward initiatives that can help tackle stigma and discrimination. People with mental health problems have worse life chances than other people. Part of this is a direct effect of the condition but a large part is due to stigma, ignorance, discrimination and fear surrounding mental health.

Local Policy Drivers

Public Mental Health strategy links to the following local strategies and plans:

- County Durham Joint Health and Wellbeing Strategy[32]
- County Durham Alcohol Harm Reduction Strategy[33]
- County Durham Domestic Abuse Strategy[34]
- County Durham and Darlington Dual Diagnosis Strategy[35]
- County Durham Children, Young People and Families Plan[36]
- County Durham Sexual Violence Strategy[37]

County Durham Joint Health and Wellbeing Strategy

The Health and Social Care Act[38] places clear duties on local authorities and Clinical Commissioning Groups to prepare a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy which will influence commissioning strategies for health and social care, to be discharged through the Health and Wellbeing Board. The County Durham Joint Health and Wellbeing Strategy is a document that aims to inform and influence decisions about health and social care services in County Durham so that they are focused on the needs of the people who use them and tackle the factors that affect health and wellbeing.

The County Durham Joint Health and Wellbeing Strategy[32] strategic objective 4 aims to improve mental health and wellbeing of the population through:

- Develop and implement programmes to increase resilience and wellbeing through practical support on healthy lifestyles.
- Work together to find ways that will support ex-military personnel who have poor mental or physical health.
- Ensure that people using mental health services who are in employment have a care plan that reflects the additional support needed to help them retain this employment.
- Develop and implement a multi-agency Public Mental Health Strategy including Suicide Prevention for County Durham.
- Continue to improve access to psychological therapies.
- Develop a more integrated response for people with both mental and physical health problems, in particular supporting people with common mental health problems (such as depression or anxiety).

Mental Health Profile - National

Mental illness has a range of significant impacts with 20% of the total burden of disease in the UK attributable to mental illness (including suicide), compared with 17% for cardiovascular diseases and 16% for cancer. This burden is due to the fact that mental illness is not uncommon

- At least one in four people will experience a mental health problem at some point in their life.

- One in ten children aged between 5-16 years has a mental health problem, and many continue to have mental health problems into adulthood.

- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.

- Almost half of all adults will experience at least one episode of depression during their lifetime.

- One in ten new mothers experiences postnatal depression. Over a third (34%) of people with mental health problems rate their quality of life as poor, compared with 3% of those without mental illness.

- 25% of older adults have depression requiring intervention

- Dementia affects 20% of people aged over 80

Levels of mental illness are projected to increase. By 2026, the number of people in England who experience a mental illness is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million[39]. However, this does not take account of the current economic climate which may increase prevalence.

Age and Mental Health

There is high incidence of mental health problems in older people in the UK. For every 10,000 people aged 65 or over, there are:

     2500 people with a diagnosable mental illness
     1350 people with depression (1135 receiving no treatment)
     500 people with dementia (333 not diagnosed)
     650 people with other mental illness[40]

Approximately 700,000 people in the UK have dementia, and this is predicted to rise to over one million people by 2025 [41]

Women and Mental Health

Recorded rates of anxiety and depression are between one and a half and two times higher in women than in men.

Rates of self-harm are two to three times higher in women than in men.

Men and Mental Health

One in eight men has a common mental health problem.

Men have measurably lower access to the social support of friends, relatives and community and are less likely than women to seek help for emotional health problems.

Three quarters of suicides are male.

Lesbian, Gay, Bisexual, Transgender and Mental Health

Gay men and lesbians report more psychological distress than heterosexuals, despite similar levels of social support and physical health as heterosexual men and women[42]

Anxiety, depression, self-harm and suicidal feelings are more common among lesbian, gay and bisexual people than among heterosexual people.
There is a strong association between homophobic bullying and mental ill health, including low self-esteem, fear, stress and self-harm[43]

Learning Disabilities, Behavioural Conditions and Mental Health

An estimated 25-40% of people with learning disabilities also have mental health problems[44] Mental health problems such as depression tend to be under-diagnosed in people with learning disabilities. Many symptoms of mental illness are wrongly regarded as challenging behaviour and so do not receive appropriate treatment[45].

Prevalence of anxiety and depression in people with learning disabilities is the same as for the general population, yet for children and young people with a learning disability, the prevalence rate of a diagnosable mental illness is 36%, compared with 8% of those who do not have a learning disability[46].

Physical Health and Mental Health

Life expectancy is on average 10 years lower for people with mental health problems due to poor physical health.

Physical illness increases the risks of poor mental health:

- there is a higher risk of depressive illness for a wide range of physical illnesses including hypertension, asthma, arthritis and rheumatism, back pain, diabetes, heart disease and chronic bronchitis[47]
- there is a 20% increase of depression or anxiety within one year of diagnosis of cancer or first hospitalisation with a heart attack[48].

Children and Young People and Mental Health

Children and young people with emotional disorders are almost five times more likely to report self-harm or suicide attempts; four and half times more likely to rate themselves or be rated by their parents as having 'fair/bad health', and over four times more likely to have long periods of time off school.

Comorbidity of disorders is common – children and young people frequently have both emotional and behavioural conditions and mental illness and physical health problems[4950].

Mental health and employment

At any one time, one in three people of working age in the UK is likely to be experiencing some kind of mental distress or mental health problem. One in six adults of working age in the UK experiences some symptom of mental distress (sleeplessness, irritability, worry) that does not meet the criteria for a diagnosis of mental ill health but can affect their ability to work

Mental health and offenders

Prisoners have been shown to have significantly higher rates of mental health problems than the general public. For example, 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or substance misuse problems.

Housing is a key issue for prisoners and ex-offenders. A third of prisoners are homeless on entering prison, while a further third lose their accommodation because of their imprisonment.

Veterans and Mental Health

A number of UK studies have found links between active service and mental health problems in armed service personnel involved in recent conflicts. A very recent study[51] of 10,000 serving personnel (83% regulars; 27% reservists) found lower than expected levels of PTSD. Mental ill-health and alcohol misuse were the most frequently reported mental illnesses among UK armed forces personnel.

In particular, levels of alcohol misuse overall were substantially higher than in the general population.

Stigma and discrimination in mental health

Nearly 9 out of 10 people with mental health problems have been affected by stigma and discrimination and more than two thirds reported that they have stopped doing things they wanted to do because of stigma.

Public attitudes to mental ill health are gradually improving, with less fear and more acceptance of people with mental health problems.

However, according to the annual national surveys of attitudes to mental illness in England:

- 36% of people think someone with a mental health problem is prone to violence (up from 29% in 2003)
- 48% believe that someone with a mental health problem cannot be held responsible for their own actions (up from 45% in 2009)
- 59% agree that people with mental illness are far less of a danger than most people suppose

Direct social contact with people with mental health problems is the most effective way to challenge stigma and change public attitudes[52].

Carers and Mental Health

Carers provide unpaid care by looking after an ill, frail or disabled family member, friend or partner.
There are now 2.2 million people in UK alone caring for more than 20 hours per week and 1.4 million caring for more than 50 hours per week.
The number of carers is likely to increase in the future as proportion of older people in population increases and peoples life expectancy increases, coupled with the direction of community care policy a 40% rise in the number of carers could be needed by 2037 – an extra 2.6 million carers, meaning the carer population in the UK will reach 9 million.

Mental Health Profile for County Durham

Current information in relation to mental wellbeing is poor. Assessing need in relation to mental health and wellbeing is complex and there are a number of ways in which this challenging problem may be tackled. It is essential to consider sources of information which tell us who and where in our communities are receiving support for mental health issues alongside the range of wider determinants which impact on mental health wellbeing and cause individuals to be more vulnerable to poor mental health.

It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Many of the acknowledged risk factors for mental illness are linked to deprivation. Measures of deprivation can help to identify geographical areas where the need for mental health services is likely to be greatest. County Durham has some of the most deprived areas in the country.

The North East Public Health Observatory published a Community Mental Health Profile for County Durham[53] which is designed to give an overview of mental health risks, prevalence and services at a local level.

Those at higher risk of suffering from poor mental health include:
- More deprived populations
- Those with poor educational attainment
- The unemployed
- Older people
- Those with long term conditions e.g. coronary heart disease
- People with learning disabilities

Mental Health and Deprivation

Nearly 30 % of the residents of County Durham live in the most deprived areas of England, while 10 % of residents live in some of the least deprived areas in England. Deprived areas have substantial levels of multiple deprivation, which helps to measure and identify health inequalities across England. Many studies have demonstrated the association between poor health and deprivation, for example all-cause mortality, smoking prevalence and self-reported longstanding illness are all correlated with deprivation. Any increase in inequalities in deprivation is likely to result in widening inequalities in health.

Mental Health and Housing

The causes of homelessness are complex. For some people homelessness may result from relationship breakdown, from leaving institutional care or because of financial difficulties. County Durham statutory homeless households rate per 1,000 households across all ages for 2010/11 is 1.76 which is significantly better

than England with a rate of 2.03. This indicator highlights a group that are amongst the most vulnerable in society.

Mental Health and Long Term Illness

Poor quality of life through physical illness is known to be closely related to mental health problems. People with mental health problems are twice as likely as the general population to experience a long term illness or disability. The percentage of the population aged over 65 with a limiting long term illness within County Durham (2001) was 23.5% compared to a national average of 16.9% of population.

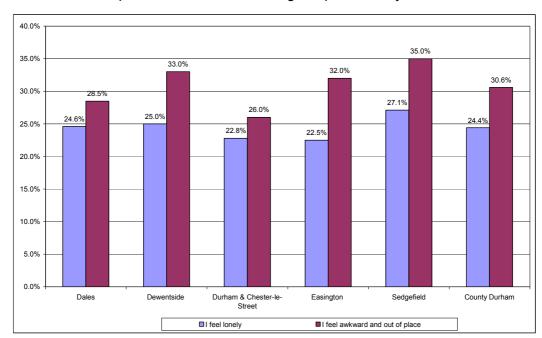**Mental Health and Wellbeing of Children and Young People**

Young people aged 16-18 years old who are not in education, training or employment (NEETS) are more likely to have poor health and die an early death. They are also more likely to have a poor diet, smoke, drink alcohol and suffer from mental health problems. County Durham is significantly worse than the England average with a rate of 7.5 per 1000 population compared to 6.2 nationally.

County Durham Children's Trust used the following definition when researching children and young people relationships (2008). Good relationships are when '*children state that they have one or more good friends, and state that they are able to talk about worries, talk to their parents and friends but not another adult*'.

- 56.3% of respondents in County Durham reported good relationships in 2009 compared to 60.3% in 2008.

- Derwentside experiences the highest rate of children and young people that report they have good relationships, 65.4%. Compared to the lowest in Easington, 54.4%

Percentage of children and young people that report they feel lonely, awkward and out of place (Figure 1)

- 24.4% of respondents felt lonely and 30.6% awkward and out of place.

- Sedgefield reported the highest proportion of children and young people feeling lonely 27% and awkward and out of place 35%. This was followed closely by Derwentside with 25% who felt lonely and 33% who felt awkward and out of place.
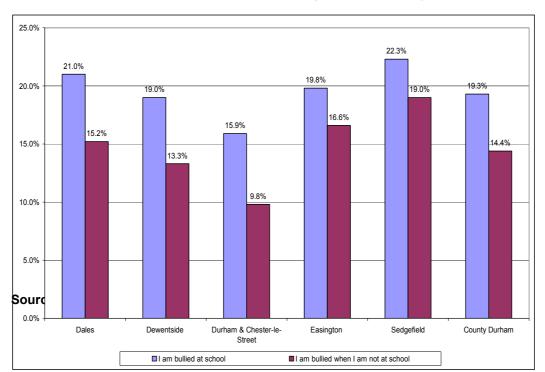
Figure 1: Percentage of children and young people that report they feel: lonely; awkward and out of place – Children and Young People's Survey.

Source: County Durham Children's Trust Children and young people's survey.[54]

Percentage of children and young people that report they are bullied at school and bullied when not at school (Figure 2)

- All areas reported the majority of bullying occurred in school environment
- Sedgefield reported highest levels of bullying both in and out of school

Figure 2: Percentage of children and young people that report they are bullied at school and bullied when not at school – Children and Young People's Survey.
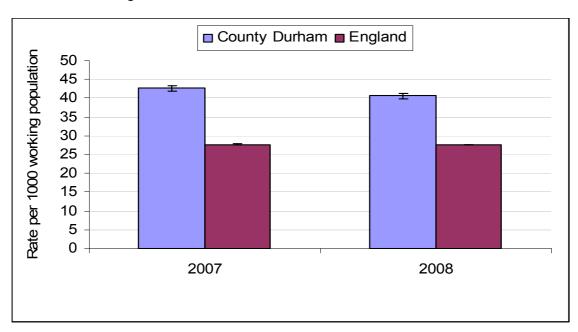

Hospital admissions caused by unintentional and deliberate injuries in under 18 year olds during 2009/10 are significantly higher than the national average at a rate of 123 per 1000 population. The hospital admissions indicator for under 18s is one of the key health improvement outcome measures. It aims to help people to live healthy lifestyles, make healthy choices and reduce health inequalities.

Mental Health and Employment

Long term worklessness is associated with poorer physical and mental health. County Durham rate per 1,000 population working age adults who are unemployed, (2010/11) is higher than England with a rate of 62.2 compared to England rate of 59.4.

Mental Health and Welfare Support

Rates of incapacity claimants (per 1,000 working age population) in County Durham were significantly higher than England in 2007 and 2008 (Figure 3)

Figure 3: Claimants of incapacity benefit with mental or behavioural problems per 1,000 working age population, with 95% confidence intervals, County Durham and England, 2007 and 2008.

National Clinical Health Outcomes Database (NCHOD).[55]

Mental Health and Alcohol

Alcohol misuse leads to a range of public health problems and the long term effects of excessive alcohol consumption are a major cause of avoidable hospital admissions. Alcohol affects all of society, from the burden on the NHS in terms of hospital admission and treatment in primary care, the economic burden due to loss of employment and reduced capacity to work, through to other negative effects of alcohol on the social and behavioural welfare of communities. Rate per 1,000 population (2010/11) for hospital admissions for alcohol attributable conditions, County Durham is higher than England average at rate of 30.2 and England rate of 22.1.

County Durham local suicide audit has identified that over half of all suicides have over the legal drink drive limit of alcohol in their system at time of death.

People with Learning Disabilities and Behavioral Conditions

People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities. Percentage of adults aged 18 years and over with learning disabilities (2011/12) within County Durham is 0.57% which is higher than the England average of 0.45%.

The incidence of children with mild to severe learning disabilities is expected to rise by 1% year on year for the next 15 years due to a number of factors and 40% of these children have a diagnosable mental health problem. Across County Durham there are approximately 1000 children and young people with a learning disability and of these 390 will have mental ill-health, rising to 450 over the next 5 years.
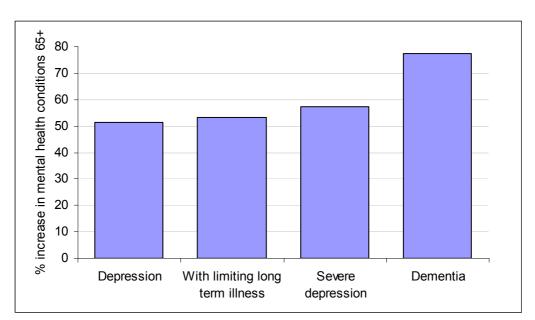
A growth in the size of the population aged 65 years and over is expected which will increase the numbers of adults with a learning disability. As adults with a learning disability grow older, their carers will also grow older and will therefore be more likely to need services themselves. There is evidence that adults with a learning disability are more likely to be affected by dementia than people without a learning disability.

Diagnosed Mental Illness

Dementia is a syndrome characterised by catastrophic, progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20 % at 80 years of age. In a third of cases, dementia is associated with other psychiatric symptoms such as depressive illness, generalised anxiety and alcohol related problems.

POPPI (2011)[56] predicts (figure 4) that in County Durham the number of people predicted to have:

- depression will rise from 7,986 to 11,869 (48.6%).

- limiting long term illness will rise from 52,734 to 79,188 (50.2%).

- severe depression will rise from 2,512 to 3,870 (54.1%).

- dementia will rise from 6,153 to 10,951 (78%)

Figure 4: Percentage increase in people aged 65+ predicted to have a mental health diagnosis, projected to 2030, County Durham

Source: Projecting Older People Population Information Systems (POPPI)[57]

Within County Durham the percentage of adults (18+) with depression during 2011/12 is almost 15% which is significantly worse than England average of 11.5%[58]. Depression is the most common mental health problem in older people. Some 25% of older people in the community have symptoms of depression that may require intervention. Older people with physical ill health, those living in residential care and socially isolated older people are at higher risk. Yet these problems often go unnoticed and untreated. Studies show that only 1 out of 6 older people with depression discuss their symptoms with their GP and less than half of these receive adequate treatment.

As well as the impact on quality of life, untreated depression in older people can increase the need for other services – including residential care.

By 2029 it is projected that 28.9% of the population in County Durham will be over the (current) pensionable age. An ageing population in County Durham will present several challenges for both health and social care. An increasingly older population will see rising prevalence of mental health conditions, dementia, increased levels of disability and long term conditions and will significantly increase the number of people needing to provide care to family members or friends.

Carers

Labour Market Profile for County Durham[59] estimate 6,060 carers in receipt of carers allowance within County Durham. However based on 2001 census data there are 57,225 carers living in the County Durham, of those:

- 14,000 are providing 50 hours or more of care a week
- 1000 carers from black and minority ethnic groups
- 6000 carers who are also full time workers

In light of an aging population the number of carers is expected to increase as is the scale of support needed across County Durham.

Suicide

Reliable, timely and accurate suicide statistics are essential to inform an effective Public Mental Health Strategy for County Durham. To facilitate this, a systematic suicide audit programme has been in place locally since 2002.

Demographically, 81% of those who took their own life between 2005 and 2012 were male, with a peak age of 40-49. 62.% were divorced and 32.% lived alone. Hanging was identified as the most common method used. A significant number of suicides were found to have diagnosed mental health problems (58.9%). Furthermore, 30% were recorded as alcohol dependent, 13% were recorded as users of illicit drugs, and 39.2% had a history of self-harm.

Triggers for suicide are complex and may be a combination of factors. Through the County Durham Suicide Audit some key factors were identified; 26% experienced a relationship or family breakdown; 17% recently bereaved and 12% were in financial difficulty..

Self Harm

Self-harm is an expression of personal distress. It can result from a wide range of psychiatric, psychological, social and physical problems and self-harm can be a risk factor for subsequent suicide. Self-harm occurs in all sections of the population but is more common among those who are socio-economically disadvantaged or those who are single or divorced, live alone, are single parents or have a severe lack of social support.   County Durham has a significantly higher self-harm directly standardised rate than England with 343 hospital admissions during 2010/11 compared to England average of 207.

Priority Groups

- **Children and Young People**
- **People with Learning Disabilities and Behavioral Conditions**
- **Those at high risk of Suicide and Self Harm**
- **People who are unemployed**
- **People who are Homeless**
- **People with co-morbidity of drug and alcohol misuse**
- **Carers**
- **Veterans**
- **people over 65 years**

Public Mental Health National Evidence of Effective Interventions

There is good quality evidence for the benefits of promoting mental health and the cost effectiveness of public mental health interventions which can:

- promote wellbeing and resilience with resulting improvements in physical health, life expectancy, educational outcomes, economic productivity, social functioning, and healthier lifestyles
- prevent mental illness, health risk behaviours and associated physical illness, inequalities, discrimination and stigma, violence and abuse, and prevent suicide
- deliver improved outcomes for people with mental illness as a result of early intervention approaches.

An economic analysis of Public Mental Health identified the following 'best buy' interventions [60]:

- Supporting parents and early years: parenting skills training, pre-school education, home learning environment
- Supporting lifelong learning: health promoting schools and continuing education
- Improving working lives: employment and healthy workplaces
- Positive steps for mental health: diet, exercise, sensible drinking and social support systems
- Supporting communities: environmental improvements

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

Many of the interventions for parents and children are included in the Healthy Child Programme (HCP) which is a framework of good practice in evidence based interventions to promote the health and wellbeing of both children and parents[5].

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

Developing well

- pre-school and early education programmes (improved school readiness, academic achievement, positive effect on family outcomes)
- school-based mental health improvement programmes (reduced levels of mental illness, improved academic performance, social and emotional skills).
- childhood conduct and prevention of emotional disorder through reduced maternal smoking during pregnancy, parenting programmes, school and pre-school programmes (e.g. Family Nurse Partnership)
- maternal depression prevention through post-partum psychosocial support, home visitation, health visitor training and peer support

Living well

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

Working well

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

Ageing well

- psychosocial interventions
- socialisation and prevention loss
- interventions for 'living well'
- depression prevention in older people through targeted interventions for groups at high risk
- dementia prevention via access to physical activities, social engagement, cognitive exercise and antihypertensive treatment.

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

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

Prevention of inequality:

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

Prevention of stigma and discrimination:

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

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

Prevention of violence and abuse

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

Strategic framework performance measures

The performance management framework aligns to the priorities identified within No Health Without Mental Health[1]. The Public Mental Health Strategy group is accountable to the County Durham Mental Health Partnership Board (appendix 4). Progress on delivery of the strategic objectives and action plan will be reported on a six monthly basis to the Children and Families Trust and to the Health and Wellbeing Board.

The Public Mental Health Strategy Group considers a quarterly performance report which contains a range of indicators (Appendix 1). The Public Mental Health Strategy Group maintains an action plan appropriate to the issues raised from the performance report. Any key issues are escalated to the County Durham Mental Health Partnership Board.

Summary of Action Plan 2012-2017

Promoting Mental Health

Ensure commissioners and partners utilise the Mental Wellbeing Impact Assessment Tool which will enable organisations and communities to engage with and improve mental health and well-being and to assess and improve a policy, programme, service or project to ensure it has a maximum equitable impact on people's mental well-being.

Develop interventions which aim to improve mental health and wellbeing of children and young people through:

- foster supportive relationships within families and other social networks
- promote 'peer counselling' interventions which build on the coping strategies identified by young people (e.g. physical activities, creative activities, engaging in pleasant activities)
- promote the importance of effective parenting
- promote the role of schools and colleges in delivering a 'whole school' approach to supporting all pupils' wellbeing and resilience
- address bullying both within school and community environment
- ensure children's workforce are aware of how mental health relates to their work

Through the delivery of local workplace health programme, employers will promote healthy workplaces for all, and tackle the causes of mental ill health at work.

Examine how interventions for older people can be extended to address social isolation, increase social interaction and promote greater, safer independent lives.

Ensure services promote equality and are accessible and acceptable to all. Public bodies meet their obligations under Equality Act[31] in relation to mental health and ensure quality of access and outcomes for groups with particular mental health needs, which may include the most vulnerable in society.

Local public health campaigns target people with mental health problems to tackle smoking, obesity and co-morbidities.

More individuals and organisations join the Time to Change and Mindful Employer campaigns[61]

Organisations challenge poor reporting and ensure consistent reporting of mental health issues in the media.

Develop capability and capacity within the wider workforce to deliver services which support and promote public mental health.

Prevention of Mental Ill-Health

Multi-year (interventions with young people that extend over many years of their lives), strategies to address high-risk behaviour in school including prevention, intervention and post vention (bereavement support after suicide) need to be developed and evaluated systematically.

Encourage collaboration in the delivery of effective public mental health approaches which recognise that illness, health and wellbeing are influenced by a broad range of social, cultural, economic, psychological, and environmental factors at every stage of the life course.

Expand local provision of social prescribing options to include arts of prescription, leisure on prescription, learning on prescription, computerised CBT, books on prescription, and exercise on prescription.

Support carers in their caring role enabling them to have a life of their own and to stay mentally and physically well

Promote the delivery of the outcomes in the National Dementia Strategy[62]
Improve opportunities for people experiencing mental health issues or who may need extra support to access and retain employment, a place in education or training and other meaningful activity in the community.

Employment support organisations to use effective approaches to help people with mental health problems to find and keep work.

Increase provision of general bereavement support services and bespoke individual and group post-vention support

Provide access to local relationship support services

Ensure health and social care services consider the impact of domestic violence on mental health and wellbeing and provide support appropriately

Provide an integrated welfare rights and money/debt advice service targeted at people within County Durham experiencing mental health issues.

Improve access to lifestyle advice including stop smoking and weight management services within community venues for people with poor mental health.

Co-ordinate services to increase the physical health of people with poor mental health through the promotion of healthy lifestyles and reducing health risk behaviours.

Promote the delivery of physical health checks to improve the physical health of people with poor mental health.

<u>Early Identification of those at risk of Mental Ill-Health</u>

Through additional education and training, public services will recognise people, of all ages at risk of mental health problems and take appropriate timely action; recognise the wider determinants of mental health and wellbeing including how these differ for specific groups and address them accordingly.

Frontline workers, across the full range of services, are trained to understand mental health, principles of recovery and suicide prevention.

Develop a dual diagnosis strategy for people with dual mental health/learning disability and substance misuse issues.

Ensure early recognition of mental illness through improved detection by screening and health professional education programmes as well as improved mental health literacy among the population to facilitate prompt help seeking.

<u>Recovery from Mental Ill-Health</u>

Services work together to support people with mental health problems to maintain, or return to, employment.

Provide specialist employment support service for individuals' with mental illness, accessing primary care services, who are receiving sickness benefits or who are at risk of losing their employment as a result of mental health difficulties.

Provide specialist employment support for those with severe mental illness, utilising the evidence based model of Individual Placement and Support

Improve access for individuals into support and recovery through early provision of activities such as supported employment, housing support, and debt advice.

Appendix 1 Protective Factors for Positive Mental Health

Individual	Community	Workplace	Societal/Structural
Feeling safe	Stable and supportive environment	Feeling safe, not bullied or harassed	Socio-economic conditions: income, financial security
Self-determination	Participation and influence: local democracy	Decision-making latitude	Participation and influence
Resilience and problem solving skills	Cultural life		Tolerance and trust Absence of discrimination
Feeling in control	Opportunities for lifelong learning	Job control	Respect for diversity
Confiding relationships	Social capital: networks, supports and resources	Reasonable adjustment	
Access to social networks	Tolerance and trust	Social support - vertical and horizontal	
Financial security	Amenities and services	Effort reward balance	Economic stability Absence of marked social and economic inequalities
Meaningful activity and roles	Hopefulness	Opportunities for development and learning	
Creativity	Opportunity for arts and creative activities		
Spirituality	Access to faith groups	Respect for diversity	Tolerance and respect for diversity

(Equal Minds, 2005)[63]

Appendix 2 Key Performance Indicators

Indicator	Latest Performance	2013/14 Target
Emotional Wellbeing		
Emotional and behavioural health of looked after children	15.9% (2012/13)	Tracker
Percentage of children and young people who report that they make friends easily - Primary	91.4% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they make friends easily - Secondary	92.9% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they are happy - Primary	97.7% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they are happy - Secondary	96.1% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they feel awkward and out of place - Primary	31.4% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they feel awkward and out of place - Secondary	37.4% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they feel lonely – Primary	26.1% (2011/12 Ac Yr)	Tracker
Percentage of children and young people who report that they feel lonely – Secondary	22.6% (2011/12 Ac Yr)	Tracker
Percentage of children in Reception with height and weight recorded who have excess weight	23.6% (2011/12 Ac Yr)	Tracker
Percentage of children in year 6 with height and weight recorded who have excess weight	38.4% (2011/12 Ac Yr)	Tracker
Self-reported wellbeing - people with a low satisfaction score	26.1% (2011/12)	Tracker
Self-reported wellbeing - people with a low worthwhile score	21.6% (2011/12)	Tracker
Self-reported wellbeing - people with a low happiness score	34.7% (2011/12)	Tracker
Self-reported wellbeing - people with a high anxiety score	43.3% (2011/12)	Tracker
Maintaining Independence		
Percentage of adults receiving secondary mental health services known to be in settled accommodation	89% (2012/13)	85%
Proportion of adults with learning disabilities who live in their own home or with their family	86% (2012/13)	
Trust and Safety		
Repeat incidents of domestic violence (referrals to MARAC)	12.6% (2012/13)	Less than 25%
Dealing with concerns of Anti Social Behaviour and crime issues by the local council and police	59% (Jan-Dec 2012)	Tracker

Indicator	Latest Performance	2013/14 Target
Perceptions of ASB	44.5% (April 2013)	Tracker
Number of hate incidents	222 (2012/13	Tracker
Percentage of children and young people reporting that they are bullied when they are at school – Primary	16.6% (2011/12 Ac Yr)	Not set
Percentage of children and young people reporting that they are bullied when they are at school – Secondary	14.6% (2011/12 Ac Yr)	Not set
Percentage of children and young people reporting that they are bullied when they are not at school – Primary	16.3% (2011/12 Ac Yr)	Not set
Percentage of children and young people reporting that they are bullied when they are not at school – Secondary	5.7% (2011/12 Ac Yr)	Not set
Substance Misuse		
Alcohol harm related hospital admission rates	2,483 (2011/12)	Tracker
Percentage of successful completions of those in drug treatment – opiates	8% (2012/13)	11%
Percentage of successful completions of those in drug treatment - non-opiates	33% (2012/13)	48%
Percentage of young people who drink alcohol	33.9% (2011/12 Ac Yr)	Not set
Percentage of young people who take drugs	3% (2011/12 Ac Yr)	Not set
Learning & Development		
Achievement of 5 or more A*-C grades at GCSE or equivalent including English and Maths	62.5% (2011/12 Ac Yr)	63.0% (2012/13 Ac Yr)
Percentage of pupils on Level 3 programmes in community secondary schools achieving 2 A levels at Grade A*-E or equivalent	99.1% (2011/12 Ac Yr)	98.1% (2012/13 Ac Yr)
16 to 18 year olds who are not in education, employment or training (NEET)	10.4% (2012/13)	Tracker
Care leavers in education, employment or training	82% (2012/13)	75%
Healthy Lifestyle		
Percentage of young people reached through youth work	23.6% (2012/13)	17%
Children and young people's participation in out-of-school sport - Primary	89.4% (2011/12)	Not set
Children and young people's participation in out-of-school sport - Secondary	78.4% (2011/12)	Not set
Percentage of children and young people who have taken part in an activity outside of school in the last 4 weeks - Primary	74.5% (2011/12 Ac Yr)	Not set
Percentage of children and young people who have taken	58.5%	Not set

Indicator	Latest Performance	2013/14 Target
part in an activity outside of school in the last 4 weeks - Secondary	(2011/12 Ac Yr)	
Prevalence of Chlamydia in under 20 year olds (per 100,000)	1,752 (2012)	
Under 75 all cause mortality rate per 100,000 population	302 (2010)	296.8 (2011)
Hospital admissions as a result of self-harm per 100,000 population	354.6 (2010/11)	Tracker
Economic Security		
Children in poverty	23.0% (2010)	Tracker
Proportion of adults with learning disabilities in paid employment	3.6% (2012/13)	
Proportion of adults in contact with secondary mental health services in paid employment	11% (2012/13)	9%
Gap between the employment rate for those with a long term health conditions and the overall employment rate	8.2% (2012)	Tracker
Access to Services		
Number of new referrals to Child and Adolescent Mental Health Services (CAMHS)		10% increase from previous year
Patient experience of community mental health services	88 (2012)	87
The percentage of service users reporting that the help and support they receive has made their quality of life better	94.9% (2012/13)	92%
Carer-reported quality of life	8.7 (2012/13)	
Suicides		
Suicide Rate per 100,000 population	11.4 (2009-11)	Tracker

Appendix 3 *Organisations* involved in the County Durham Public Mental Health Strategy and Implementation Group

BCTV
Breathing Space
British Legion
Canvas – Service user and carer group
CDDFT
Chester-Le-Street Mind
County Durham Carers
Countywide mental health service user and carer forum
Cruse North East
DDES CCG
DISC
Durham Coroners Office
Durham County Council
Durham Police
Durham University
East Durham Trust
Healthworks Easington
Home Group
If U Care Share
Ingeus
Jobcentre Plus
Living Mindfully

Mental Health Care
Mental Health Matters
Mental Health North East
Middlesbrough Mind
Mindful Employer North East
NECCS
New College Durham
NHS
North Durham CCG
PCP
Probation Services
Relate North East
RT Projects
Samaritans
SD Training Ltd
Shaw Trust
Success North East
Support and Recovery, DCC
Teesdale CAB
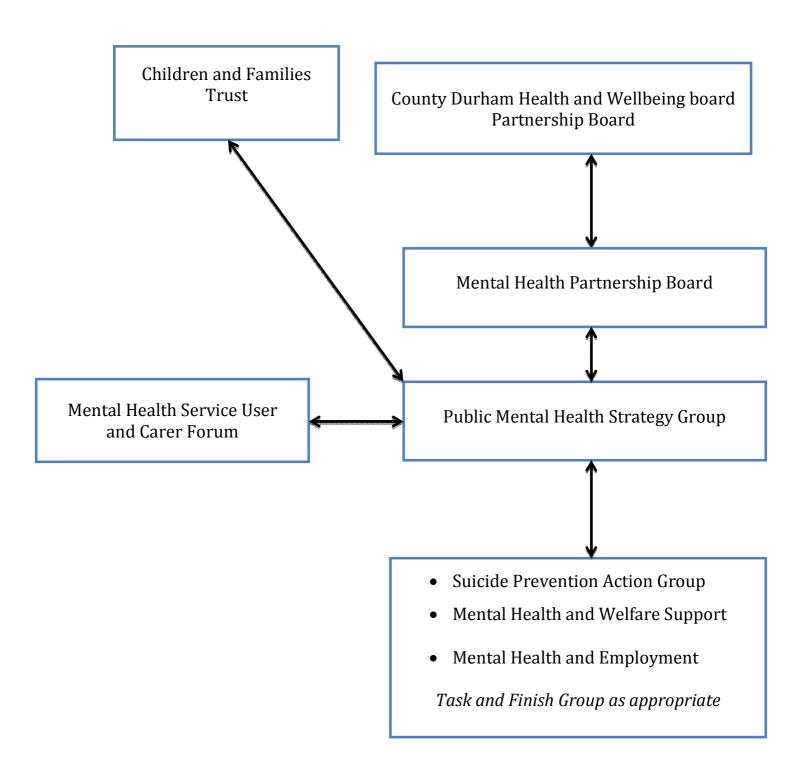TEWV
Waddington Street Centre
Welfare Rights

Appendix 4 County Durham Public Mental Health Strategy Group Structure

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┌─────────────────────────┐        ┌──────────────────────────────────┐
│  Children and Families  │        │ County Durham Health and         │
│         Trust           │        │ Wellbeing board                  │
│                         │        │ Partnership Board                │
└─────────────────────────┘        └──────────────────────────────────┘
             ↖                                      ↕
               ↘                      ┌──────────────────────────────────┐
                 ↘                    │  Mental Health Partnership Board │
                   ↘                  └──────────────────────────────────┘
                     ↘                                ↕
┌─────────────────────────┐        ┌──────────────────────────────────┐
│ Mental Health Service   │ ←───→  │ Public Mental Health Strategy    │
│ User and Carer Forum    │        │ Group                            │
└─────────────────────────┘        └──────────────────────────────────┘
                                                     ↕
                                    ┌──────────────────────────────────┐
                                    │  • Suicide Prevention Action     │
                                    │       Group                      │
                                    │  • Mental Health and Welfare     │
                                    │       Support                    │
                                    │  • Mental Health and Employment  │
                                    │                                  │
                                    │  *Task and Finish Group as       │
                                    │   appropriate*                   │
                                    └──────────────────────────────────┘
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