

# NIMHE MENTAL HEALTH PROMOTION *update*

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## EDITORIAL

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*Mental Health Promotion Consultant*

**Welcome to the April edition of Mental Health Promotion Update which has as its theme 'Commissioning for mental well being/ practice based commissioning'.**

The opening article by Jude Stansfield, Kate O'Hara and Trish Crowson looks at world class commissioning for improved mental health and well-being, and this is developed further in the article by Steve Feast. Launched in December 2007, World Class Commissioning aims to deliver a more strategic and long-term approach to commissioning services, with a focus on delivering improved health outcomes, and ultimately delivering better health and well-being for all. The eleven organisational competencies for World Class Commissioning can each be related to improving mental health and well-being, and the roles of local mental health promotion/ public mental health specialists are key in achieving this. Shifting the focus from diagnosis and treatment to prevention and well-being cannot come too soon, as evidenced by the article by Lynne Friedli on the economic case for mental health promotion. As the main healthcare commissioners, PCTs will lead the work to turn the world class commissioning vision into a reality, and to apply it in a way that ensures the needs and priorities of the local population are met. This will be achieved through building close relationships with key local partners, including patients, the public, local authorities, clinicians and providers. Alan Cohen explains the challenge for general practice and practice based commissioning by examining firstly, what the individual practice can do – both for individual patients, and to influence the commissioning decisions of the PCT; and secondly, if the general practice is part of a practice based commissioning (PBC) cluster, what can be done for their specific population. A huge part of commissioning is market development and the independent sector becoming 'commissioning-ready' – and what this entails. An article from the Mental Health Foundation looks at how the voluntary and community sector can become 'commissioning-ready'.

Mental Health Promotion Update will continue in 2008/9. If you would like to contribute to future editions, please email John Scott at [john.scott@dh.gsi.gov.uk](mailto:john.scott@dh.gsi.gov.uk), or Mary Tidyman at [marytidy@hotmail.com](mailto:marytidy@hotmail.com)

## PUBLICATIONS & RESOURCES

### Mental Health at Work: Developing the Business Case

Every organisation in Britain is affected by mental distress and ill health in the workforce. At any one time, one worker in six will be experiencing depression, anxiety or problems relating to stress. The total cost to employers is estimated at nearly £26 billion each year. That is equivalent to £1,035 for every employee in the UK workforce. Simple steps to improve the management of mental health in the workplace should enable employers to save 30 per cent or more of these costs – at least £8 billion a year.

The Sainsbury Centre for Mental Health have published a new policy paper on the costs to business related to mental health problems amongst the workforce addressing the issues of productivity, absenteeism and presenteeism, staff turnover as well as the financial aspects. It looks at how mental ill health in the workforce affects employers and details the costs of ignoring mental distress at work.

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### In this issue . . .

- Mental health promotion: the economic case for investment
- World Class Commissioning for improved mental health and well-being
- Fit for the future? Commissioning-ready services from the voluntary & community sector

## PUBLICATIONS & RESOURCES

### Living with long term physical health conditions in Manchester – An information booklet on emotional wellbeing

The demands and burden of living with physical illness can place an individual under immense psychological stress. It is well established that people living with long term physical health conditions, many of whom are older, are more vulnerable to poor mental health compared to the general population. (Creed and Dickens 2007).

Mental health is everybody's business and as such everyone has a role to play in detecting and managing mental health concerns. Co-morbidity where it exists has significant cost implications to the individual, their family and the health and social care economy. (Layard 2004) Improved identification and "management of depression (for those with long term conditions) can deliver some significant health and service improvements and reduce demand for a range of specialist and acute services". (Lyons et al 2006)

Although the importance of addressing the emotional and psychological needs of this group is increasingly acknowledged, their mental health needs are still often overlooked, unrecognised or under treated in the presence of physical illness. People often still report feeling unsupported and isolated particularly at diagnosis. So how could they be enabled to make sense of what was going on for them emotionally, enable them to help themselves or find the treatment and support they need?

#### Development of resource – aims and objectives

The aim of producing the emotional wellbeing booklet was to increase recognition and early identification of emotional needs/mental health problems and in addition to support management and encourage timely treatment of mental health problems. The government has highlighted the need for staff to be able to identify and manage psychological need (DoH 2001).

The content of the booklet reflects specific areas that require action:

- The link between physical and mental health – to raise awareness of the negative impact that physical illness can have on an individual's psychological wellbeing and often subsequently then on their physical health
- Prevention and increasing resilience by highlighting factors that can promote and strengthen our mental wellbeing
- Improving recognition of depression and anxiety by including sections on how to identify symptoms of depression and anxiety
- Encouraging self management by providing self help / coping strategies to implement if experiencing emotional difficulties
- Provision of information about local support options, services and treatments available for people with

depression and anxiety

- Reassurance that emotional distress is often a normal adjustment to illness and not a sign that they are going "mad"
- Dispelling the myth among public and professionals that depression is a natural part of ageing and a consequence of living with illness
- De-stigmatising mental health and encouraging people to talk – since many older people do not discuss emotional issues with their GP. (Godfrey and Denby 2006).

#### Who is the booklet for and how will it be used?

The booklet was developed for adults with any long-term physical health condition both newly diagnosed or those who may have been living with illness for many years. The booklet may also be a useful practical resource for carers, families and staff who work with people living with health conditions.

It is hoped the booklet will be made available to any person diagnosed with a long term condition. Improving the information provided to people with long term conditions enables them to manage their own condition. (See government initiative [www.informationprescription.info/](http://www.informationprescription.info/) )

Since 2006 the QoF indicators for depression within general practice have included screening for depression in patients with diabetes and Coronary Heart Disease. This may be a useful resource to aid them in this process and help identify patients with other conditions that are deemed "at risk". Initial feedback from general practice and other agencies has been positive.

The booklet is available for distribution across Manchester with the goal to reach as many people living with long term conditions as possible. This will include community settings: libraries, GP practices, Manchester PCT staff services, condition management teams, social care, Voluntary agencies, and also Inpatient / outpatient hospital settings.

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 w: [www.manchesterpct.nhs.uk](http://www.manchesterpct.nhs.uk) or  
[www.manchesterpublichealthdevelopment.org/impdhs/mental-health/mental-health-resources.html#emotionalhealth](http://www.manchesterpublichealthdevelopment.org/impdhs/mental-health/mental-health-resources.html#emotionalhealth)

#### References:

Creed, F & Dickens, C (2007) 'Depression in the medically ill' in *Depression and Physical Illness* ed A.Stepto  
 DoH (2001) *The NHS Cancer Plan*  
 Godfrey, M & Denby, T (2006) *Depression and older people. The Policy Press*  
 Layard, (2004) *Mental Health: Britain's Biggest Social Problem.*  
 Lyons, C Nixon, D & Coren, A (2006) *Long – Term Conditions and Depression Considerations for Best practice in practice based commissioning. CSIP, NIMHE*

## Managing stress and violence at work – A training Programme for Mental Health Services

Mental health workers endure considerable stress in the course of carrying out their work. Managing Stress and Violence at Work is a comprehensive training programme designed to enable staff to successfully manage and reduce the affects of occupational stress and violence in the workplace.

Work-related stress has been consistently identified as one of the major workplace concerns to employees and can ultimately challenge the healthiness and performance of an organisation. The training provided by this resource will empower staff to deal with and reduce workplace stress and violence. It can also be delivered to teams of staff who work together and this approach can be used within organisations to build support and to implement medium-term and long-term strategies to prevent violence and minimise occupational stress.

### Aims:

- To improve the quality of working life for mental health workers
- Materials in the resource can be adapted by a trainer to suit the particular needs of individual teams.

### The four training formats provided are:

- A full, four-day format, the first two days concentrating on stress management and the second two on risk and violence
- A two-day 'short' format, offering 'edited highlights' of the four-day format and covering elements of occupational stress management and the management of violence
- A two-day format with a focus on violence in the workplace

- A one-day format concentrating on risk assessment.

The materials are intended to be delivered by a trainer with a good practical knowledge of clinical work in the mental health sector.

Format: ringbound training manual with a CD-rom containing supporting OHPs, handouts and video clips.

Price: £195

ISBN: 978 1 84196 211 5

Publication date: Winter 2007

### Contact:

*PavilionOnline@pavpub.com*

## Mental health promotion: the economic case for investment Lynne Friedli and Michael Parsonage

Published by the Northern Ireland Association for Mental Health 2007. See the article by Lynne Friedli later in this issue.

Available from: [www.niamh.co.uk/info.php?content=inforpublications&submenu=Publications](http://www.niamh.co.uk/info.php?content=inforpublications&submenu=Publications)



## INITIATIVES

## Choosing Health Group, Cheshire & Wirral

Cheshire & Wirral Partnership NHS Foundation Trust (CWP) is a Mental Health trust providing community and in-patient services to people with mental health problems, drug and alcohol issues and people with learning disabilities.

### Aims of the Choosing Health Group

The Choosing Health Group is a trust-wide group charged with the task of overseeing the introduction of a public health agenda into the daily workings of CWP.

We aim to do this via:

- partnership working with PCTs, acute trusts and other stakeholders in order to make an impact on reducing health inequalities for service users
  - striving to be an employer who promotes positive physical health and mental well-being for service users and employees
- educating people within the organisation to understand their contribution to the public health agenda and ensure the promotion of positive physical health and mental well-being is embedded in the organisation's philosophy and service delivery.

### What have we done so far?

In addition to work around smoke-free environments, smoking cessation and improving working lives, the Trust has also invested in the following:

- developed & rolled out a trust-wide public health strategy
- baseline mapping exercise to identify any public health initiatives or health promotion work across the Trust (service user or staff related)
- established a working party looking at how we improve physical health care for people accessing our services (from identification of unmet health need, pathways for transfer between CWP inpatients & acute care through to training issues for staff in inpatient areas)
  - introduced a continuing health care peer review forum in Wirral to support clinicians with the CHC process
  - established learning disability / mental health champions on some of the key strategic groups within PCTs (e.g. NHS Lifestyles and Weight Management Operational Group Wirral; Obesity Strategy Group Central & Eastern Cheshire PCT)
    - joint work with Wirral PCT looking at developing a healthy foods framework to be implemented across CWP
    - established a public health work plan mapped against strategic goals & national performance indicators
  - ongoing review of pertinent NICE Guidance with a view to making recommendations on what's required to implement the guidance across the organisation (e.g. NICE Obesity Guidance)
    - worked with service user groups to ensure representation at some of the key PCT strategic planning consultation events (e.g. Central & Eastern Cheshire Disability Equality Duty Consultation & Older Peoples

Consultation)

- begun to identify 1 or 2 key public health campaigns we could contribute to within the Trust (last year rolled out the national 'Know Your Numbers Campaign' on BP; this year looking at contributing to a local 'Small Change Big Difference Campaign' in March)
- public health 'Essence of Care' benchmark in progress across the Trust
  - begun evidence-based collation around national poor health / unmet health needs of people with mental health problems or learning disabilities & presented findings internally.

### Conclusion

The above describes work in progress and we see this as a long term commitment. Early wins include an increased profile of Public Health issues within Trust services. The work has provided a focal point of expertise for people within the Trust to help people develop their ideas. Also, there has been an increased profile with local partner commissioning and provider organisations of the importance of considering mental health, drug and alcohol issues and people with learning disabilities in mainstream public health planning.

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## Welcome to your Library (WTYL) in Hillingdon Project

In 2006 the London Borough of Hillingdon was chosen to be part of the second phase of this London Library Development Agency (LLDA) project. The project is a partnership of Hillingdon Library Service, Healthy Hillingdon and Hillingdon HOPE.

### What have we done?

- Activities are for all communities but Refugees and Asylum Seekers (R&AS) have been specifically encouraged to attend, using a community worker employed by the project to identify and network with R&AS. Activities at different libraries targeting refugee and asylum seeker communities have included:
- A family-based learning model developed between a local school and the library. A Tamil community coffee morning became established and meets monthly at the library, and members are now involved in wider cultural events
  - In a library on a dual site with a secondary school, a project was set up involving young people and parents looking at living in Harlington, and a major art exhibition was created. Celebrations at two libraries attracted over 650 attendees
  - A library in partnership with the young peoples' activity group network at YMCA made a successful bid for

citizenship sessions and homework support sessions, and these are now developing into regular use of the library for conversation sessions.

### Outcomes

A partnership group has been set up between Healthy Hillingdon, Hillingdon HOPE and Hillingdon Library Services, and there is a greater understanding of the potential for partnership working to improve the service and community engagement activities. There has been recognition of this model as a workable methodology for community engagement.

WTYL outreach engagement has been cited as a model of best practice by Cultural Services Comprehensive Performance Assessment Inspection. Staff development is evidenced by increased confidence and changed work practices in community engagement. There has been an increased use of libraries by specific targeted communities.

The HOPE project included WTYL as a core project to address broader health needs of refugees and asylum seekers and funded the project support worker. The community action learning model has been applied to other HOPE projects.

Working links have been developed to access library services for Tamil parents and children, Afghani mothers and toddlers, Yeading Junior School, unaccompanied minors through YMCA Refugee Support worker. 15 visits to libraries were arranged with community groups from Albania, Somalia, Sri Lanka, Afghanistan, Iraq, India and Pakistan. There has been interest from the Tamil community to volunteer in library services. Conversation classes have been held with a diverse range of ethnic individuals to learn about citizenship and informal English language. There is a reported impact on learning in Yeading Junior school working with Yeading library, and greater involvement by parents in the library and school.

WTYL has been promoted with a range of stakeholders. A multi-agency task group was created to plan for 2007 refugee week activities. There is a clearer knowledge of contacts and networks for support for service and community needs and provision.

### Lessons learned

- Adopting a clear localised service plan that set 'stretching objectives' for active engagement of specific

communities did result in those communities becoming more involved in libraries, health services and schools that were engaged in the programme. Find out who your community is and use this intelligence to influence your plans for service development and commissioning and communication experiences

- Build good practice into strategic aims and objectives
  - Focus on organisational learning. The partnership approach model is an effective way to develop services for targeted groups
  - Partnership working helps address health inequalities through using principles of health literacy across services i.e. Primary Care, Public Health, Mental Health
  - Need to engage at the highest levels at the start of projects like this and get some 'buy in' which can then be built on
  - Actively planning cultural activities to bring diverse communities together was valued by communities and stakeholder services
  - The role of the library as neutral space that is committed to open access to information was seen to be important in enabling communities to come together
  - Engaging with communities because they are people also appeared to be valued by participants (as opposed to participants being a target due to being perceived as a minority or having a health need)
  - The specialist skills of the Library Outreach team in being confident to engage with people and enable the development of cognitive skills and 'bridging social capital' was an important factor in both planning with stakeholders and engaging with communities
  - The physical quality and location of library services in communities are clearly essential elements in the provision of library services, and the skills of staff in enabling access for all appears to significantly determine library use
  - Planning joint work with libraries and extended school partners resulted in a considerable and positive shift in target communities' attitude towards libraries and school
  - There is a growing body of long term studies of public health evidence that suggest a clear link between the development and maintenance of cognitive learning and life expectancy
  - Evidence from communities that have participated in the programme suggests that they feel more confident to access services, including libraries, and have a stronger sense of belonging to the wider community. Promoting community engagement in the use of libraries may have value in terms of promoting health literacy and may represent a valuable area of joint working – for example with initiatives that also aim to develop community cohesion and work to develop economic development.

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## INITIATIVES

## Health Improvement Podcasts – Halton & St Helens

Halton & St Helens Primary Care Trust have developed a new scheme – 'Health Improvement Podcasts' or HIPs as they are being affectionately called. HIPs are short audio programmes, downloadable to your computer or MP3 music player featuring health education, interviews with health professionals, patients and people from the local community, as well as interesting news features and topical discussions. This unique scheme is part of a drive to utilise new technologies to communicate health information and information on services to people locally.

The scheme has been developed to create a means of communicating developments in local health initiatives. Podcasts are increasingly being used to access a wide range of information easily and effectively. More local people can be reached with health information, many of who may have found it difficult for one reason or another to access information in other formats in the past.

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## Work to increase the awareness of the mental health needs of lesbian, gay and bisexual (LGB) people

A systematic review of studies on mental disorders, suicide and deliberate self harm in lesbian, gay and bisexual people was published recently and has produced some startling findings that should lead to improvements in mental health services for LGB people, and should help support efforts to meet government targets of reducing suicide rates in England by 20% by 2010.

The study, carried out by the National Institute for Mental Health in England (NIMHE), appears to support previous

research findings that lesbian, gay and bisexual people do appear to be at greater risk than heterosexual people of mental disorders and suicidal behaviour.

For example, it supports the findings of work carried out in 2003 by the mental health charity MIND, which concluded that gay men, lesbians and bisexuals report more psychological distress than heterosexuals.

This latest study by NIMHE confirmed the following:

- There is at least twice the risk of suicide attempts in lesbian, gay and bisexual people compared to heterosexuals
- This risk is increased to four times in gay and bisexual men
- Depression, anxiety, alcohol and substance misuse were at least 1.5 times more prevalent in LGB people
- Lesbian and bisexual women were particularly at risk of suicidal ideation (thinking about suicide) and substance dependence, while lifetime risk for suicide attempt was especially high in gay and bisexual men.

The level of mental health distress in the LGB community is attributed in large part to the social hostility, stigma and discrimination that people from these groups still experience despite the progress that has been made in recent times.

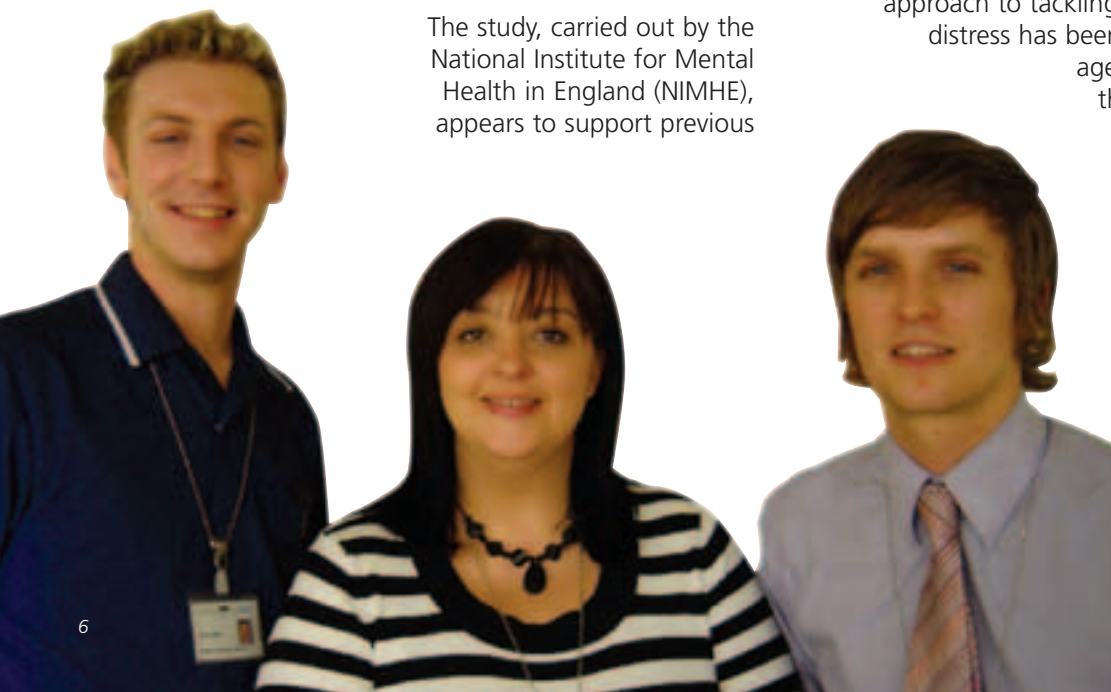
This is supported by a Department of Health publication – 'Reducing health inequalities for lesbian, gay, bisexual and trans people – briefings for health and social care staff' published in 2007, which states that 'discrimination has a negative impact on the health of LGBT people in terms of lifestyles, mental health and other risks'.

This latest NIMHE report suggests that there is an urgent need for mental health services to develop LGB-sensitive services and a need to promote greater awareness of LGB issues through diversity training for staff.

Tackling the root causes of mental distress among the LGB community will be an effective way of addressing the 'inequality' in mental health that is experienced by LGB people when compared with heterosexual people.

In Halton & St Helens, a community 'stakeholder' approach to tackling the root causes of mental health distress has been adopted; and work with partner agencies helps support investment in the protective factors that enhance positive mental health among diverse groups.

*Left to Right: Andrew Perkins, Alcohol Liaison Nurse and 'Mental Health Champion' with Jen Brown & Mark Swift, Health Improvement Team – Halton & St Helens Primary Care NHS Trust.*



Their newly implemented Mental Health Promotion Strategy identifies community 'champions' who are raising awareness of issues like LGB mental health, mobilising community support, building capacity and identifying resources to tackle the root causes of distress. In order to get serious about tackling mental distress in the LGB community, they recognise the need to listen to, and work with LGB people in order to understand the root causes of their distress and how these might be overcome.

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Halton & St Helens Community Mental Health Directory  
[www.mhdirectory.net](http://www.mhdirectory.net)

**References:**

*Department of Health (2007) Reducing health inequalities for lesbian, gay, bisexual and trans people – briefings for health and social care staff*

*National Institute for Mental Health in England, (2008) Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people: a systematic review.*

*Mind (2003) Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales.*

## If you only knew... Campaign in Suffolk

A Suffolk-wide campaign 'If only you knew...' to address stigma against people with mental health or substance misuse problems, or who use learning disability services, was launched in late February 2008, and encourages people to imagine what it's like to be at the receiving end of stigma, and to think twice before reaching unfair conclusions. The Trust wanted to launch the campaign following feedback from its public consultation into NHS Foundation Trust status. Throughout the consultation, people said that if the Trust wanted to fulfill its Foundation Trust pledge of 'Helping people make the most of their lives', then tackling stigma was a top priority.

The first few months of the campaign will include a series of adverts in local newspapers and on local radio, a poster/postcard campaign, service users working with school groups to talk about what their lives are really like

and a planned event with Northgate High School drama students at the end of April.

A website – [www.ifyouknew.co.uk](http://www.ifyouknew.co.uk) will accompany the campaign, with personal experiences of service users, information about what family and friends can do to help, the facts about mental ill health and information for carers.

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## The NHS North West Commission on Mental Health Services – A review of mental health services in the North West

The NHS (NW) Commission on Mental Health Services was set up by the Strategic Health Authority in advance of the 'Our NHS, Our Future' review. The aim of the commission is to look at mental health services across the region and identify what needs to happen for those services to improve. There will also be consideration of the mental health and well being agenda. A significant strand of the review will be to consider the commissioning process. The commission will take a flexible, local, user-centred approach listening carefully to those who use and work in mental health services.

The Commission was launched at two events in September 2007, in Manchester and in Preston. An invitation was extended to service users and carers from across the North West. The aims of the events was to tell people about how the commission members were planning to carry out the review and give an early opportunity for people to shape this work. The commission was also keen to hear what people thought were the key issues for the review to look at, and gather comments about the ways and means of doing this.

A reference group of about 40 people has been set up to help support the work of the commission, and to test out early thinking and shape work as the commission progresses. Users and Carers at the launch events were given an opportunity to nominate themselves and others to join the group; other members have been drawn from different regions across the North West and nationally, and from statutory and 3rd sector organisations.

The starting point is to listen first, analyse carefully and finally be prepared to find new ways of improving mental health services for the better. There are lots of views to be heard but none is more important than those of the people who use services or their carers.

### Engaging Health and Social Care Communities

Care Service Improvement Partnership (CSIP) have now held seven Open Space events across the North West. Invitations were extended to all stakeholders with adverts in local newspapers and local radio to attract as wide an audience as possible.

### Engaging Local Communities

The University of Central Lancashire (UCLAN) advertised across the North West for community groups who wanted to take part in the review. The groups they targeted were those whose voices are often not heard in large consultations and include younger people, older people, people from black and minority ethnic groups, gay and lesbian groups, detained people offenders. UCLAN have extensive experience of carrying out this type of work and have established networks they can draw on as well as a very experienced staff team.

### Commission Engagement

The Commission members have also been out on their travels meeting with groups of service users, carers, staff from statutory and 3rd sector organisations, community support services, emergency services, acute care, prison etc. etc. So far the commission members have met with about 60-70 groups or individuals with many more dates in the diary. Some people have written in to share with us their experiences of using mental health services – some are good, some not so good.

### Information and Intelligence

A group of representatives from the Health Authority, CSIP, library services and PCTs are meeting regularly to review what is already known about mental health services. Initially we are identifying what information is already collected and where we can find it. We have also asked organisations to make us aware of local pieces of work that may be useful to the commission. As our work progresses we will draw on this information to test out what we are hearing at our listening events.

Between May – July 2008, preliminary findings will be shared through structured small events to test them with a wide range of interested parties. In August, the draft report will be finalised and presented to the Strategic Health Authority. It will form the basis for a framework for changes to health and social care from 2008 to 2012.

### Have your say

If you would like to have an opportunity to say what you think, you can invite the commission to come and meet with you and your group, or send your thoughts in writing.

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## WEBSITES

### Shaping Our Lives National User Network website

Shaping Our Lives Network is a unique resource for service user controlled organisations to share knowledge, good practice and information with each other. Each organisation will have access to a notice board where events, questions, campaigns and conferences are posted. Over 220 groups have joined to view over 170 news and events listings.

Shaping Our Lives Network would like to invite non service user organisations to join their network as Associate members or friends. This will allow non service user organisations to use the notice board to advertise events, consultations and publications that will be of interest to service user organisations. What is unique with this network is that each individual service user organisation will have complete control over how much information they will let Associate members (non service user controlled organisations) have access to. This will be an opportunity to keep in touch with other service controlled groups and keep up to date with the latest news of interest to service user groups.

The website is at an early stage but Shaping Our Lives is confident it will grow and become increasingly important to service users, their organisation and for others who want to consult with service users.

**Contact:**

Shaping Our Lives Network  
t: 08452 410383 w: [www.solnetwork.org.uk](http://www.solnetwork.org.uk)

referral scheme say they would use one if it were available. 1 in 6 GPs (16%) have noticed an increase in the number of people asking whether exercise would be a suitable treatment for their depression.

However, exercise on prescription is still not widely available – with less than half of GPs (49%) able to access an exercise therapy referral scheme for people with depression.

The Mental Health Foundation is now working to expose the barriers that prevent exercise therapy from being offered universally. The research programme, partly funded by the Department of Health, involves the charity working with six sites across England that run exercise referral schemes (in Bedfordshire, Cambridgeshire, London, Northamptonshire, Redcar and Cleveland, and the Wirral).

The research findings will be published in early 2009, in addition to a toolkit that will include practical advice on setting up and delivering an exercise referral scheme, as well as training packages for referrers in primary care and industry staff involved in exercise therapy delivery.

Two information booklets about exercise and depression are available from the Mental Health Foundation – ‘How exercise can help beat depression’ for patients and ‘Exercise referral and the treatment of mild or moderate depression’ for GPs and healthcare practitioners.

**Contact:**

Download the booklets from  
[www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)  
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## RESEARCH

### Research by the Mental Health Foundation into GPs prescribing exercise for depression

The last three years have seen a significant rise in the number of GPs prescribing exercise to people with mild to moderate depression, according to new research from the Mental Health Foundation, carried out by GfK Marketing Services UK, and involving a sample size of 200 GPs. The charity says that 22% of GPs now prescribe exercise therapy as one of their three most common treatments for depression compared with only 5% three years ago.

The new figures also show a change in GPs' beliefs about exercise therapy. Almost two-thirds of GPs (61%) now believe a supervised programme of exercise to be 'very effective' or 'quite effective' in treating mild to moderate depression, in comparison to 41% three years ago. And two thirds of GPs (66%) who currently do not have access to an exercise



# World Class Commissioning for improved mental health and well-being

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## Introduction

World Class commissioning offers many opportunities to improve the mental health and well-being of communities. It is seen as one of the most important mechanisms for achieving the NHS vision of delivering a health and care system that is fair, personalised, effective, and safe; having a direct impact on population



health and significantly reducing inequalities between the areas with the worst health and the population as a whole. All of which are significant in terms of addressing the inequalities associated with mental ill-health as well as improving the mental health of the general population.

It is acknowledged that “World class commissioners will need to have a good understanding of what really matters to patients, public and staff.” (DH 2008) The Our Health Our Care Our Say White Paper consultation with the public showed mental well-being was of public concern: it was the second highest priority signifying the public's wish for action to help maintain mental and emotional well-being just as much as physical health and fitness.

The aim is that world class commissioning will be “pivotal in shifting the focus of care from diagnosis and treatment to prevention and well-being.” (DH 2008) This can not come too soon, as you will see in the following article by Lynne Friedli on the economic case for Mental Health Promotion. This indicates that even with optimal treatment services

in place, only 40% of the burden of mental illness is averted – so we can't rely on treatment alone, preventative services also need to be commissioned.

It is important, therefore, that mental health promotion and public mental health specialists capitalise on World Class Commissioning, joint commissioning and Practice Based Commissioning flexibilities to accelerate mental health improvement, particularly in the light of ever reducing spend on Mental Health Promotion, as evidenced in the Financial Mapping exercises as part of the National Service Framework annual assessments. Such specialists and practitioners play a fundamental part in the local commissioning system.

This article describes the World Class Commissioning eleven organisational competencies and how they relate to improving mental health and well-being.

## 1) World class commissioners are recognised as the local leader of the NHS

Mental health promotion is driven by the NHS through Standard One of the National Service Framework for Mental Health. This is contestable given the determinants of good mental health fall well outside NHS delivery. However, as stated in the competencies, leading the NHS locally is not seen as an isolated activity and will only be achieved through partnership, seeking to stimulate discussion on NHS and wider community health matters. Local Area Agreements (LAAs) and Joint Strategic Needs Assessment (JSNA) will provide further opportunities for partnership working to deliver improvements in mental health and well-being. Having a clear vision and strategic direction for mental well-being are essential to strong leadership.

**Role of local MHP/ PMH specialist:** Provide leadership for mental health improvement and build capabilities of colleagues and stakeholders.

## 2) World class commissioners work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities

As many of the determinants of mental health lie outside the health care system, partnerships are essential to jointly commission action to improve mental health and well-being and tackle mental health inequalities. Both of these will lead to better outcomes in general mortality, morbidity and health inequalities.

The impact of mental health and mental illness on general health and disease is by no means universally acknowledged across the health care system. A recent survey found that depression is more disabling when compared with chronic physical diseases such as angina, arthritis, asthma and diabetes (Moussavi et al, World Health Surveys 2007) and being in poor mental well-being and depressed is the second highest risk factor for coronary heart disease. (Keyes 2007) Equally, good mental health is a protective factor for many physical illnesses and leads to better outcomes in physical health, health care usage, educational achievement, employability and earnings, crime reduction, community cohesion. (Keyes 2007)

Reductions in health inequalities will only be achieved through addressing mental health inequalities. Improving the physical health outcomes for people with mental health problems is central to this. We know that someone with schizophrenia can expect to live 10 years less than the general population, (SEU 2004) and that the largest group of people

claiming incapacity benefit are those with mental health problems.

**Role of local MHP/ PMH specialist:**

Engage key partners in the Mental Health Promotion Strategy; integrate mental health promotion across other health & social care programmes e.g. improving mental health and well-being of people with physical illness and long-term conditions; ensure the needs of people with mental health problems are addressed within Tackling Health Inequalities strategies and programmes.

**3) World class commissioners proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health**

Engagement in decision-making processes in itself is good for mental well-being. Having opportunities for expressing views and being heard, influencing decisions and local democracy as well as having the knowledge to access services are all determinants of mental health.

Engagement in all aspects of health and provision of services will therefore improve mental health. Consideration will also be needed, however, to engage people with mental health problems. Many face stigma and discrimination from health services and their engagement in the improvement of all services, not just mental health services, is important. Appropriate methodology needs to be considered and shared understandings about mental health developed.

Engagement should be supported by mental health and well-being information material specific to local (mental) health needs and aspirations. These should encompass both those with mental health problems (which may be more easily defined and more accessible); and the mental health needs of the majority who may only be in contact with low level mental health services through Primary Care, or not in touch with health services at all. These could, for example, be defined and accessed through workplaces.

Local Involvement Networks (LINKS) will be important drivers and informants on what is commissioned or decommissioned but must represent the range of mental health needs and issues, both those of service users and the community as a whole.

**Role of local MHP/ PMH specialist:**

Advise on and facilitate opportunities for meaningful engagement; support inclusion of people with mental health problems into engagement processes.

**4) World class commissioners lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design, and resource utilisation**

There are a number of areas for collaboration with Primary Care and Secondary Care mental health clinicians, in particular in improving physical health care for mental health service users. Examples include improving employment and housing opportunities for mental health service users and complying with the smoke free legislation and commissioning stop smoking support including staff training and pharmacological support.

In addition, the importance of collaboration for the development and delivery of high-class primary care mental health services and take-up of models to increase access to psychological therapies would be a good example. Implementing the Ten High Impact Changes for Mental Health Services (NIMHE 2006) and CSIP's forthcoming High Impact Changes for Health & Social Care would also require continuous clinical engagement.

**Role of local MHP/ PMH specialist:**

Facilitate clinical engagement and support service improvement in mental health promotion and in services attaining Health Care Commission public health core standards.

**5) World class commissioners manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements**

Mental health needs assessment should be assured as part of Joint Strategic Needs Assessment (JSNA). The Core data set presented in the recent JSNA guidance is limited in relation to mental health. Use of new and emerging tools such as the Warwick Edinburgh Mental Well-being Scale (Tennant et al 2007) and Mental Well-being Impact Assessment (Coggins et al 2007) could help to redress the balance. Information on mental illness prevalence, service usage and outcomes as well as mental well-being status and determinants of mental well-being needs to be strengthened.

Finally as we become more sophisticated in our relationships with communities and assessing their health needs, we should be advised to expand our focus on 'needs'. This currently offers a deficit model and creates dependencies on services and often a purely negative picture of communities. We need to broaden our view to one where we look to assess community assets, leading to more solution-focussed interventions, with communities themselves becoming providers and an assessment of health outcomes and capacities (Community Capacity Assessment). (Kretzmann & McKnight 1993)

**Role of local MHP/ PMH specialist:**

Provide advice and expertise to designing and conducting JSNA that incorporates mental health; facilitate community needs assessment exercises.

**6) World class commissioners prioritise investment according to local needs, service requirements and the values of the NHS**

Direct commissioning of Mental Health Promotion is low. The 2005/06 national survey of investment in mental health reported it was 0.08% of the total mental health spend. (Mental Health Strategies, 2007) This reinforces that a shift in investment is needed, from downstream treatment and care to upstream prevention and promotion.

The DH guidance 'Making it Possible' (NIMHE 2005) identifies nine priorities where there is a strong case for action and against which local mental health promotion strategies are reviewed.

Effective local strategies will have identified local need and system requirements, together with the evidence base, to agree local priorities. Such strategies should form part of local commissioning strategies, by clearly identifying the priorities for investment to improve mental well-being. The local mental health promotion strategic lead will be an invaluable resource to the commissioning system in realising this competence.

**Role of local MHP/ PMH specialist:** Develop, implement and monitor robust mental health promotion strategies, based on need and stakeholder ownership, that identify priorities for investment.

**7) World class commissioners effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes**

Stimulating the market to deliver mental health improvement interventions is a key priority. As many sectors are engaged in this activity it is important to develop a coherent picture of provision and priorities for market development, including:

- Encouraging and strengthening the local 'market' to become providers of a wider range of accessible, community-based, non-medical mental health and well-being interventions
- Building knowledge and capabilities in public mental health, needs assessment and evaluation of mental health
- Developing the third sector market, which are often best placed to provide low level mental well-being support and services and community interventions.

**Role of local MHP/ PMH specialist:** Build capacity and capability of providers of mental health improvement interventions; build knowledge and capability of third sector providers in evaluating service mental health outcomes.

**8) World class commissioners promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration**

The possible menu of flexibilities provided in the Practice-based Commissioning clarification on health funding is stated as not being exhaustive. Of the areas outlined, most, if not all, can contribute to improving mental health and well-being, for example by supporting healthy lifestyles, developing social and practical support for isolated older people, support to parents, debt advice, purchase of respite care etc. However within this list, mental health is narrowly defined as developing multi-disciplinary mental health resources in community settings delivered through mental health professionals. This signifies a potential continued emphasis on treatment rather than on prevention and promotion.

Other mental health and well being interventions to add, therefore, could include social prescribing, benefiting both mental and physical well-being; and supporting early interventions through stepped care and recovery and well-being outcomes for those with existing mental illness and other disabilities and long-term conditions. Social prescribing interventions include books, exercise, arts and learning on prescription as well as signposting to advice and support and providing information prescriptions for increased self management and self care.

**Role of local MHP/ PMH specialist:** Keep up-to-date with emerging good practice nationally and internationally; explore, develop and evaluate innovative and creative practice.

**10) World class commissioners effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcome**

In a growing system of outcomes-focussed commissioning it is important to clarify the mental health & well-

being outcomes needed to improve population mental health, including those within mental health services. Incorporating such outcomes with specific indicators within contracts will lead to measurable improvements. This would strengthen the alignment to Local Area Agreements.

**Role of local MHP/ PMH specialist:** Agree local mental health and well-being outcomes and indicators and methods for measurement

**11) World class commissioners make sound financial investments to ensure sustainable development and value for money**

Continued investment in mental health services without investment in prevention and promotion is unsustainable. Mental health promotion is cost-effective and is vital to avert the growing burden of mental illness. (Friedli & Parsonage 2007)

Recent cost-benefit analysis provides a provisional list of "best buys" for mental health improvement (Friedli & Parsonage 2007) which are parenting skills and pre-school education, Health Promoting Schools, employment/ workplace and lifestyle (diet, exercise, alcohol).

**Role of local MHP/ PMH specialist:** Develop sustainable practice and partnerships; keep abreast of emerging evidence based practice; build links with researchers and economists to identify, support and influence cost effective solutions.

**Summary**

In conclusion, Public Mental Health and Mental Health Promotion specialists and practitioners have an essential role to play in supporting World Class Commissioning. This includes providing knowledge and expertise in evidence-based practice and effective interventions, facilitating public and clinical engagement, designing and conducting appropriate methodologies for needs assessment, ensuring strategies identify priorities for investment, providing leadership for well-being and supporting the system-

wide shift to a focus on improving well-being across the population. Commissioning is not an isolated task of one person but requires the skills and expertise demonstrated by mental health promotion practitioners over many years.

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## Mental health promotion: the economic case for investment

Dr Lynne Friedli, Mental Health Promotion Specialist



Developing the economic case for mental health promotion is a challenging undertaking, raising a number of complex methodological problems. These are addressed in a new report, published by the Northern Ireland Association for Mental Health and launched at Stormont late last year (see below).

The report uses economic analysis to develop the case for greater investment in mental health promotion, defined as the prevention of mental illness and the promotion of positive mental health. Improving mental health, i.e. promoting the circumstances, skills and attributes associated with positive mental health is a worthwhile goal in itself: most people place a high value on a sense of emotional and social well-being. In addition, positive mental health:

- contributes to preventing mental illness
- leads to better outcomes, for example in physical health, health behaviours, educational performance, employability and earnings, crime reduction.

Making the case for promoting positive mental health involves demonstrating that these outcomes are not just the result of the absence of mental illness, but are due, wholly or in some degree, to aspects of positive mental health. This includes identifying the benefits of promoting positive mental health for people with a diagnosis: for example confidence, self esteem, hopefulness and social integration are now known to influence both clinical and quality of life outcomes for people with mental health problems.

Building on this general rationale, any specific intervention to improve mental health needs to be justified in the first instance on the basis of evidence of its effectiveness: does it work? In other words, how much does the intervention improve mental health and well-being, along with other relevant outcomes such as physical health? Economic analysis adds the further test of value for money: not only 'does it work?' but 'is it worth it?' Economic evaluation can broadly be defined as a systematic attempt to identify, measure and compare all the costs and all the benefits of alternative interventions, including a baseline option of not intervening. The economic case for mental health promotion is not just or even mainly about achieving narrowly defined economic or financial benefits such as reducing future NHS costs or increasing GDP. Such benefits should certainly be included but are usually of relatively minor importance. It is emphatically not part of the economic approach that the direct improvements in mental health and well-being which form the fundamental rationale for promotion should be ignored or excluded simply because they are not conventionally valued, marketed or counted in national income.

Although there are many gaps in the data, the economic benefits of improving positive mental health may be extensive. For example, subjective well-being increases life expectancy by 7.5 years, provides a similar degree of protection from coronary heart disease to giving up smoking, improves recovery and health outcomes from a range of chronic diseases (e.g. diabetes) and in young people, significantly influences alcohol, tobacco and cannabis use. Positive affect<sup>1</sup>

also predicts pro-social behaviour e.g. participation, civic engagement and volunteering. While the best outcomes are generally associated with the absence of mental illness, the presence of positive mental health brings additional benefits, including for people with mental health problems.

The scale of the economic benefits of preventing mental illness is considerable:

- Mental health problems have very high rates of prevalence; they are often of long duration, and have adverse effects on many areas of people's lives, including educational performance, employment, income, personal relationships and social participation
- No other health condition matches mental ill-health in the combined extent of prevalence, persistence and breadth of impact
- Mental health problems often begin early in life and cause disability when those affected would normally be at their most productive (unlike most physical illnesses)

The scope for securing benefits by means of treatment, rather than prevention, is very limited. Even with optimal treatment reaching everyone who needs it, three fifths of the social and economic costs of mental illness would not be averted.

The overall cost of mental health problems in the UK amounted to over £110 billion in 2006/07. The cost of mental illness is also very large relative to other health conditions, accounting for more disability adjusted life years (DALY) lost:

<b>Mental illness (including suicide)</b>	<b>20.0%</b>
Cardiovascular disease	17.2%
Cancer	15.5%

Relative to its importance as a health problem, spending on mental health is disproportionately low. Shown as a percentage of public expenditure on all health and social care, the figures are:

England – 11.8%

Scotland – 11.1%

Northern Ireland – 9.3%

Figures for England suggest that spending on mental health promotion is less than 1% of all NHS and local authority expenditure on mental health and may be less than 1% of all public spending on health promotion activity overall.

The benefits of promoting positive mental health are less clearly established in quantitative/financial terms than the benefits of preventing mental illness. Nevertheless they are likely to be substantial, partly because of the very large numbers of potential gainers. In Scotland, only 14% of adults have good or "flourishing" mental health, implying that over 85% of the population could benefit. Broadly the report found that promoting positive mental health is associated with improvements as follows:

- reduced prevalence of mental health problems
- physical health (morbidity/mortality)
- health behaviours
- employability, productivity, earnings
- educational achievement

- crime / violence reduction
- pro-social behaviour/social integration/relationships
- quality of life.

One example of a common mental health problem for which there is robust evidence of effective interventions is conduct disorder. According to new estimates presented in the report:

- Preventing conduct disorders in those children who are most disturbed would save around £150,000 per case in lifetime costs
- Promoting positive mental health in those children with moderate mental health would yield benefits over the lifetime of around £75,000 per case.

These calculations are based on 700,000 children born in the UK each year, with an estimated 5% with conduct disorders (35,000), 45% with some conduct problems (315,000) and 50% with no disorder:

- the total value of the benefits of prevention in a one-year cohort of children in the UK is £5.25 billion (35,000 x £150,000)
- the corresponding figure for promoting positive mental health is £23.625 billion (315,000 x £75,000).

In comparison, the costs of intervention are very low, ranging from £1350 to £6000 per child for parenting programmes. Substantial investment in these programmes is therefore justified even if their effectiveness is limited, given the size of potential benefits relative to costs. A range of evidence indicates that success rates at the level required can be achieved in real life settings.

For this reason, the report recommends investment in support for parents as the top priority in the provisional list of 'best buys' in promoting mental health, as follows:

#### Priorities for investment

- Supporting parents and early years: parenting skills training/pre-school education
- Supporting children and young people: health promoting schools and continuing education
- Improving working lives: employment/workplace
- Positive steps for mental health: lifestyle (diet, exercise, sensible drinking and social support)
- Supporting communities: environmental improvements

Although the evidence is incomplete in some cases, these areas of intervention appear to offer the most favourable balance of effectiveness, scale of potential benefit and likely cost of implementation. They demonstrate that all sectors have a role to play in improving mental health and the need for interventions that involve individuals and communities, but also those that address structural barriers to mental health and well-being.

#### Conclusion

Although there is now a much greater policy focus on positive mental health and well-being, there is still a great deal to do. There is a need for more consistent definition

and measurement of mental health, to untangle the many different influences on mental well-being and to improve data on both the effectiveness and cost-effectiveness of interventions. New measures validated for use in the UK, for example the Warwick and Edinburgh Mental Well-being Scale (WEMWBS), will be of considerable value in providing a more complete picture of the mental health of the population. Nevertheless, even on the basis of existing data, the evidence summarised in the report (see below) demonstrates a very strong case for greater investment, not only in the prevention of mental illness but also in the promotion of positive mental health. This needs to be taken into account during the commissioning process.

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**Copies of the report Mental health promotion: the economic case for investment** by Lynne Friedli and Michael Parsonage are available from [www.niamh.co.uk/info.php?content=infopublications&submenu=Publications](http://www.niamh.co.uk/info.php?content=infopublications&submenu=Publications)

*1 A tendency to be cheerful, energetic and to experience positive moods; sometimes referred to as a positive disposition.*

## World Class Commissioning

Dr Steve Feast, Senior Advisor Health and Wellbeing, Department of Health



**World Class Commissioning, launched at the end of last year, encapsulated the vision and competencies**

(see box 1 below) that NHS commissioners, in conjunction with their public service partners, are required to turn from competence in to capability. PCTs must be seen and be trusted as the NHS local leader, capable of accurately assessing the needs of local people and in partnership with them, transforming their health outcomes.

### Vision & competencies

- 1) Locally lead the NHS
- 2) Work with community partners
- 3) Engage with public and patients
- 4) Collaborate with clinicians
- 5) Manage knowledge and assess needs
- 6) Prioritise investment
- 7) Stimulate the market
- 8) Promote improvement and innovation
- 9) Secure procurement skills
- 10) Manage the local health system
- 11) Make sound financial investments

Commissioning can no longer be the task of a beleaguered commissioning manager, supported by a team more concerned with cost and volume, protecting the bottom line. It must become the task of the whole organisation. World-class performance happens when the whole organisation takes on the commissioning role, with quality and outcomes centre stage, underpinned by a locally secured and understood compelling vision that all stakeholders understand.

Commissioning has of course been happening for years. Mental health commissioners have been at the forefront of the growing tribe of experts, recognised and respected for their ability to commission services that match to people's needs. Critically mental health commissioning is already secured through local partnerships operated across health and local authorities. It is made more complex by the additional dimension of the legal and criminal justice elements associated with mental illness. This existing expertise must be respected and built upon, in turn helping others to develop the competence and capability to invest public funds to greatest effect.

Mental health commissioners have faced considerable challenges. Recent service development has focused on establishing and building up assertive outreach and rapid response teams targeted especially at those with greatest needs. Primary care has in turn

responded by investing in more local practice based services. The National Institute for Health and Clinical Excellence (NICE) guidelines clarify the need for those with mild to moderate depression to have access to therapy services, not just medicines. Achieving these changes is not just a question of resources; frequently the skills required are also in short supply, challenging commissioners to work with local workforce and education colleagues to develop the skills required.

The physical health and an excess of lifestyle risks associated with tobacco, alcohol and obesity experienced by those with mental illness remains a significant threat to their future wellbeing. These are the wider challenges that World Class Commissioning has been established to meet. If it fails to improve the health of those least able to help themselves, fails to give voice to those least able to advocate for themselves and fails to help people co-produce their own health outcomes, it will not have done what it says on the tin.

We know what the risk factors are that can lead to poor mental health. We also know what can be done to improve both individual and community resilience in order to avoid mental health problems in the first place. The needs of carers are often as important as the needs of those they care for. World-class commissioning is about understanding the needs of all those at risk of ill health as well as securing first class services for those with

established illness.

**Commissioners need to invest in strategies that:**

- Enhance control
- Increase resilience and build community assets
- Facilitate participation
- Promote inclusion.

Work has an important role for improving health – it can assist the recovery process and being unemployed has strong negative impacts on an individual's health and increases inequalities. In particular, prolonged inactivity affects mental health by worsening an existing condition or leading to the development of secondary mental health problems, such as depression, stress and anxiety.

Over the last few years Lord Layard, one of the country's leading economists, has written extensively about the negative impact of poor mental health. This includes 'The Depression Report' and 'Mental Health: Britain's Biggest Social Problem?' As well as the impact on the individual, he estimated the cost to society as substantial. Lost output is around 2% of GDP and the cost to the Exchequer is similar.

Dame Carol Black is currently leading a major review of the health of the working age population which will begin to help commissioners understand how best to invest in the health and work agenda. However, at 26% the employment rates for all people with mental health conditions is amongst the worst of any group, but for those with

more severe and enduring mental health problems it is half again, at around 13%. For those with schizophrenia the employment is as low as 4%. Despite the facts, most people with mental health problems, including severe conditions, say they want a job.

The associated economic and social costs to society and the individual of these unfulfilled aspirations are high. Case studies show that adults with severe mental health problems are often in contact with up to ten different agencies, with each person costing statutory services tens of thousands of pounds every year. At the same time, their continued poor employment outcomes increases social exclusion and causes harm to themselves, their families and their communities. World-class commissioners need to turn aspirations in to realities. They need to build services around the needs of individuals, simplifying pathways to health and wellbeing.

Directors of Public Health, jointly appointed across PCTs and local government, join up the needs assessment process. The new duty of Joint Strategic Needs Assessment comes in to force from April and underpins the local Commissioning Strategy. Mental health commissioners will have to use increasing amounts of community level and personalised information, analysing and aggregating trends, patterns and needs in order to prioritise and respond to maximal need within available resources. Investment decisions need to be shared with local people, engaging them in future assessment and planning processes.

It is unlikely that all the skills required to achieve World Class Commissioning performance already fully exist in any one organisation. PCTs, local authorities and wider public service partners need to work together to maximise each organisations contribution to commissioning the best outcomes for people. Already many mental health commissioners are collaborating with local academic institutions, analysing data and tracking change. Local authority legal and contracting expertise may have much to offer PCTs. Critically, where expertise cannot be secured through local public service partnerships, it needs to be secured from elsewhere, typically from the private sector via the Framework for External Supply for Commissioners (FESC). Commissioners will acquire skills by learning, sharing or procuring the expertise and input required.

World Class Commissioning raises the bar and challenges all commissioners, in mental health and wider, to develop investment portfolios that both protect those with severe and enduring mental illness and promote everyone's right to a healthy disease-free life. The winners will be patients and the public. As commissioning has moved in to centre stage, the skills required to execute its aims will be at a premium. Mental health commissioners are well placed to become some of the first to achieve its aspirations.

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## A Primary Care Perspective on Commissioning for Mental Health and Wellbeing

Alan Cohen, FRCGP, Primary Care Lead, CSIP



### Introduction

In December 2007, the Department of Health launched a vision for World Class Commissioning. This vision was summarised in the following way:

World class Commissioning will deliver better health and well-being for all

- People will live healthier and longer lives
- Health inequalities will be dramatically reduced
- It will deliver better care for all
- Services will be evidence-based and of the best quality
- People will have choice and control over the services that they use, so they become more personalised
- It will deliver better value for all

- Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources
- PCTs will work with others to optimise effective care.

The challenge for those delivering mental health promotion is translating this vision into something that will deliver improved mental health for those who are most vulnerable and at risk.

The challenge for general practice and practice based commissioning is even greater as there is a need to address two specific questions: firstly, what can the individual practice do – both for individual patients, and to influence the commissioning decisions of the PCT? Secondly, if the general practice is part of a practice based commissioning (PBC) cluster, what can be done for their specific population?

### **The Role of the Individual General Practitioner and their Practice**

Undertaking mental health promotion in general practice is difficult to describe accurately, as most of the examples that exist describe a population-based intervention. The best summary of the role of the primary care team to deliver both mental health promotion and mental illness prevention is described in a chapter written by Dr Hilary Guite in a forthcoming book from the Royal College of General Practitioners called “Delivering Mental Health in Primary Care – an evidence based approach” (publication date May 2008).

### **Dr Guite describes different ways that the practice can intervene effectively to deliver improved mental health promotion:**

- In pregnancy and child birth, providing antenatal care is effective in reducing complications of pregnancy, including long term mental health problems
- Reducing the risks associated with teenage pregnancies through early and appropriate counselling as well as linking to other statutory agencies such as health visitors, social workers etc, will improve the mental health and physical health of the teenage mother
- Identifying, through the use of screening tools such as the Edinburgh Post Natal Depression questionnaire, new mothers who may suffer from post natal depression, and offering them evidenced-based interventions, including referral to the Improving Access to Psychological Therapies programme
- Early referral of “at risk” parents to parenting programmes like Sure Start have been shown to reduce mental illness, and to have longer term benefits to the child
- Helping individuals understand the relationships that exist between long term conditions such as diabetes or ischaemic heart disease, and mental health conditions such as depression. The Quality and Outcome Framework incentivises the identification of people who are co-morbid for depression and diabetes or ischaemic heart disease
- For older people, especially those who are in some form of nursing home or institution, ensuring that relationships are encouraged, and resources and agencies offered to older people, so that supportive relationships with others can be developed. Isolation in older age groups is a particular problem, and working with other agencies so that the

individual can develop contacts is valuable. As a practical example, suggesting an isolated older person attends the local community centre can be enormously useful

- Improving the physical health of those with a severe and enduring mental illness such as schizophrenia and bi-polar disorder is also incentivised in the GP contract. Using the current evidence on the association between these long-term mental health conditions and a number of physical health disorders, significant improvements can be made which result in improved health outcomes for this vulnerable group.

### **Practice Based Commissioning (PBC)**

There are currently difficulties around PBC for mental health promotion in the same way that a PCT might commission such a service.

Firstly, the allocation of a budget to a PBC cluster is usually just for the commissioning of acute services, such as hip replacements or dermatology services. Few PBC clusters have a budget for mental health illness services let alone a mental health promotion service.

Secondly, even if there were a specified budget, many of the current examples of effective interventions require joint working between health organisations such as PCTs and local authorities or the voluntary sector. Most PBC clusters have not yet addressed this aspect of the wider commissioning implications of joint working.

Thus, it is likely to be some years away before a provider of mental health promotion services might be able to expect to be commissioned by a PBC cluster. However there are aspects of care where PBC can be very effective, and where a psychological element could be included within their commissioning plans.

The association between various long-term physical health conditions such as diabetes, stroke and ischaemic heart disease, and depression or anxiety are well recognised. Further, there is significant evidence that providing a psychological intervention for people reduces health care consumption, and improves outcomes. The Improving Access to Psychological Therapies (IAPT) programme has a sub-group dedicated to this large group of people – which is both summarising the evidence, and encouraging the IAPT sites to develop innovative ways of delivering care for these people. Since IAPT is a commissioner-led service, it is the type of service that PBC is particularly likely and effective to commission.

An associated group of people who benefit from psychological therapies, whose care could be provided by the IAPT, PBC commissioned service, are those people with medically unexplained symptoms (MUS). This group represents up to 20% of primary care attendances, and over 50% of medical out-patient attendances. Influencing this group will clearly have a significant impact on both the welfare of this difficult-to-manage group, and on appropriate health care consumption. Further details of both groups can be found at [www.mhchoice.csip.org.uk](http://www.mhchoice.csip.org.uk)

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# Fit for the future? Commissioning-ready services from the voluntary & community sector

Louise Lingwood, Head of Service Improvement and Workforce Development, Mental Health Foundation/Foundation for Learning Disabilities



## From mental illness to mental well-being, recovery and social inclusion

In recent years we have seen a gradual shift from the mental illness model in public mental health services towards one of promoting recovery and well-being. Increasingly, there is a better understanding of the impact of social exclusion on mental health and the need to challenge stigma and discrimination, combined with an emerging interest in recovery practice. Commissioners are starting to recognise that in order to genuinely promote social inclusion many existing services, both statutory and voluntary, require radical redesign.

The Voluntary and Community Sector (VCS) have a crucial role to play in fast tracking service transformation. The VCS are values and mission driven. Frequently founded by people with direct experience of the issues they are seeking to address, they can often inspire higher levels of trust and credibility than can the statutory sector because of their independence and base in the local community. The current Government is keen to promote public sector service provision by the voluntary and community sector and there are good reasons for doing so. The VCS has the potential for greater innovation in service redesign. They can deliver services that are more personalised and demonstrate the ability to positively engage with the wider community. The VCS are also widely regarded as more successful in reaching marginalised and disadvantaged groups and can offer the means by which local communities can influence commissioning decisions and service delivery.

## Commissioning-ready services

Stand and Deliver, a 2007 survey by the Charity Commission highlighted the predominance of regionally-based charities in delivering public services.

The survey revealed that while many smaller charities were keen to engage in greater public service delivery, they faced barriers such as lack of capacity or competition from larger charities. Northamptonshire VCS is a typical example. The Mental Health Foundation has been working with local mental health voluntary sector providers to support the development of local solutions. Currently half way into the project, Fit for the Future is a three-year DH funded workforce development project. The Foundation already has links with Northants with a well-being initiative called Up and Running, a primary care exercise referral programme. With Fit for the Future we have been keen to explore the sector's capacity to contribute to service transformation by supporting the development of services better able to promote social inclusion and recovery outcomes. To support the strategic needs of the local VCS, Northamptonshire County Council has divided the local voluntary sector into thematic partnerships. Our early discussions with thematic leads and local voluntary sector champions for change unearthed a realistic understanding of the need for more joined up working and the potential for negotiating collectively, not just as individual organisations. We wanted to foster this enthusiasm and negotiated the development of an action learning set comprising thematic partnership leaders. The set is facilitated by the Foundation and aims to explore ways to strengthen partnership working across the sector, offering space to plan, design and develop services that can be defined as 'commissioning ready'. The Report of the Third Sector Commissioning Task Force emphasised the importance of involving the VCS organisations in service design so that barriers can be identified and opportunities developed that appeal to the sector's strengths. Participants of the action learning set

therefore aim to involve commissioners in the learning set at a later stage to forge creative collaboration on service planning.

## Capabilities for inclusive practice

Developing a workforce that has the capabilities to deliver the kind of outcomes service users require is vital in demonstrating a commissioning-ready service. The skills and capabilities of VCS staff are often under valued by statutory services. In partnership with NSIP (National Social Inclusion Programme), the Foundation has developed a pilot training programme based on the Capabilities for Inclusive Practice guidance published last year that builds on the Ten Essential Shared Capabilities. Importantly, the guidance recognises that socially inclusive practitioners can only be effective within services or organisations that also promote inclusive working.

Northamptonshire VSC staff have been enthusiastic and knowledgeable programme participants. We wanted participants to have the opportunity to apply learning from the programme back in their workplaces so the training has been delivered in six sessions over a nine-month period. Commissioning issues have been consistently raised at the sessions and we have worked with participants to help them consider how they can more effectively communicate the unique selling points of their organisation as well as demonstrate effective governance arrangements. The Voluntary Sector Workforce Strategy for the East Midlands, Tomorrows People, highlighted the difficulty that small to medium organisations have in finding time for training due to the limited numbers of staff. This problem has been experienced in our own pilot programme. One way we hope to address this is by developing local trainers from our current programme participants to provide in house

training to colleagues. Northampton Mind, for example, has delivered the session on recovery to their staff team.

### Bidding for statutory grants and tenders

The sector typically lacks a wide range of infrastructure skills and resources, (in relation to finance, human resources and IT) which can create significant barriers to exponential growth. For example, the Audit Commission has highlighted the need to submit high quality, fully costed bids that address commissioners' service objectives, but many smaller VSC organisations lack the necessary expertise. In Northamptonshire the VCS are facing an increase in competitive tendering for services

currently provided by the local voluntary sector. In response to this a consultant with expertise in preparing for successful bids has been brought in by Fit for the Future to help skill up the mental health providers.

As part of our training programme we have worked with participants in developing 'organisational CVs' that demonstrate their ability to deliver service user defined outcomes. We have based this on the belief that commissioners should ensure that tenders and other opportunities are promoted by the outcomes and impact to be achieved rather than the service provided, and thus promote innovation and enhance existing service provision. Fit for the Future is

supporting local voluntary sector organisations develop the kind of services that service users should be able to expect. In return they should anticipate a more creative and courageous model of commissioning that moves away from traditional practice, that supports positive risk taking, effective outcomes and services that promote social inclusion, recovery and wellbeing.

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## Improving Access to Psychological Therapies: Stoke Healthy Minds Network

Tom Howell, IAPT Project Manager, CSIP West Midlands



### Background

In May 2007, Stoke-on-Trent PCT was selected from over 80 other PCTs to become one of eleven Pathfinder sites as part of the national Improving Access to Psychological Therapies (IAPT)

programme. The IAPT programme, which is led by Care Services Improvement Partnership and Department of Health, was established to help build the case for the expansion of evidence based psychological therapies and to support the implementation of NICE guidelines for the treatment of depression and anxiety.

Stoke-on-Trent PCT was awarded Pathfinder status because of its innovative plans to commission a new 'Healthy Minds Network' to help meet the needs of the local population. Following an exacting tendering process, Stoke-on-Trent PCT recently announced that Rethink and The University of York had been selected to provide the core IAPT service. Stoke-On-Trent's Healthy Minds Network will be fully operational from June 2008.

### Services/ interventions to be provided

The Healthy Minds Network will deliver the full range of psychological/talking therapies and psychosocial interventions to people experiencing mild or moderate common mental health problems across the whole PCT locality. Referrals into the service will come initially from primary care with the service working closely with GPs.

The service is designed around a stepped model of care in which people are provided with the least intensive form of treatment that is appropriate to their need. A person referred into the service may in the first instance be offered supported self-help through Books on Prescription or a computerised CBT package. Other forms of social prescribing, such as exercise on prescription, will be used and people will also be given advice, information and support around developing a healthy lifestyle. At the same time, the person may also be signposted to additional community-based services for assistance with other issues that are having an impact on their mental health and well-being, such as housing, employment and debt.

Where further support is required, people may then be offered short term psychological interventions such as CBT and then referred on to a more intensive therapeutic intervention if necessary. However, a key principle of the model is to ensure that the services delivered provide people with tools that help them develop strategies and techniques to manage and maintain their own mental health and well-being in the future. To help embed some of these principles within the system more widely, a programme of advice and training for primary care staff on mental health promotion and the availability of community and voluntary sector services is also planned.

As part of the development of the service, a mental well-being impact assessment (MWIA) was undertaken. The MWIA tool was used to help make an assessment of the new service and

its likely impact on mental well-being. This supports the planning process by identifying how positive impacts can be maximised and negative impacts mitigated. The process produces recommendations and indicators to track progress.

### Providers working together

Rethink and the University of York have been commissioned to provide what might be termed the 'core' Healthy Minds Network services – that is the range of supported self-help and therapy. These services will be delivered by a team of therapists specifically trained to deliver either lower or higher intensity interventions. The HMN core service will be made up of 3 teams each working directly with GP practices in Practice-based Commissioning (PbC) clusters. It will also include Community Development Workers / Peer Educators working with BME communities. However, what particularly impressed the national Pathfinder selection panel was the intention to develop a wider network of community and voluntary sector providers who would be able to offer the broader social support outlined above. Stoke-on-Trent has a strong and active community and voluntary sector, and commissioners took the view that rather than 'reinvent' or indeed 're-commission the wheel' the expertise to deliver this kind of support was already in existence.

### A special focus on older people within Stoke-on-Trent

As a Pathfinder site Stoke-on-Trent PCT was asked, in addition to developing the service for the whole population, to take a particular focus upon a group within the population that have specific access issues around talking therapies. Stoke-On-Trent's chosen focus is around older people and people with long term or medically unexplained symptoms. Prior to the Healthy Minds Network there has been little or no provision of talking therapies to older people in Stoke-on-Trent. Despite the common misconception that older people become depressed 'because they are old' in fact depression is not a 'normal' part of growing old. Depression in older adults is typically of mild or moderate severity and is eminently treatable.

However, in many cases services are closed to referrals for people over 65. Where services are open to older people they often report a lack of referrals for this group. It is well recognised that mental distress can be masked by physical symptoms such as back pain for which there appears to be no physical cause. The Healthy Minds Network will be looking at ways to use psychological therapies to improve the health of such patients.

The decision to develop a special focus on older people is driven by the belief that supporting the mental well-being of older people, like other groups in the population, helps them to remain socially engaged, to contribute and to feel included and helps to keep them living independently and out of institutional care. It is also seen as vital that the mental well-being of older people no longer able to live independently is supported and promoted to improve their quality of life. As such the HMN is aiming to improve access for older people by raising the profile with GPs for early identification / diagnosis of common mental health disorders like anxiety, depression and phobias in older people and by helping to redefine outcomes as people move beyond traditional working age.

### Looking forward

In October 2007 Alan Johnson announced funding to implement full talking therapy services across the country by 2015. Funding was announced for the first 3 years of this period with at least 50% of all PCTs running a service by 2011. Implementation is being led by NHS West Midlands and CSIP West Midlands with 2 PCTs being funded to establish services in 2008/09.

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## MODEL OF GOOD PRACTICE

# SMILE Projects (Severe Mental Illness Learning & Evaluation) Innovative promotion of physical health for people with SMI

**Setting:** Community

**Level of Action:** Individual, community, organisational

**Target Group:** Practitioners working with clients with severe and enduring mental illness, who wish to develop an innovative way of working to promote their physical health.

**Aims**

- To commission, develop and evaluate a minimum of 10 innovative projects to promote the physical health of clients with schizophrenia and bi-polar disorder
- To undertake a mapping exercise to identify work in progress across the south east, and share this

information via a web page

- To develop a network to share good practice and support individuals who are moving forward the SMI/physical health agenda.

#### Background

Severe mental illness has been recognised as one of the most

complex long term conditions and people with mental health problems are some of the most excluded and marginalised people in our society. It is widely known that if you suffer from Schizophrenia or bi-polar illness, compared to someone who does not have a serious mental illness:

- On average, your life expectancy is reduced by 10 years
- You are twice as likely to die from coronary heart disease and diabetes
- You are four times more likely to die from respiratory disease
- You are likely to have a higher incidence of ischaemic heart disease, stroke, hypertension and epilepsy
- If you develop cancer, you will have a 50% lower chance of survival.

Despite this, people with mental health problems have been much less likely to be offered blood pressure, cholesterol, urine or weight checks, or be offered opportunistic advice on smoking cessation, alcohol, exercise or diet.

### Programme

The Centre for Public Innovation (CPI) has been working in the field of public sector innovation for a number of years, and has successfully promoted innovation and innovation grant funding amongst a number of statutory providers. CSIP invited CPI to work with them, bringing their ideas and experience to see what could be done around the issue of the physical health and wellbeing among clients with severe and enduring mental illness. CSIP provided a grant-pot to seed-fund practitioners in the field with an idea about working with this client group in a new and interesting way; CPI were responsible for training the innovators. A call for ideas was put out by CSIP over the summer of 2007. Individuals were asked to submit ideas that they wanted to take forward and these submissions were in turn sifted by CPI to choose the best. The criteria for selection were:

- Feasibility – whether the idea was realistic
- Sustainability – whether it was likely the idea could be sustained beyond

the immediate timeframe of the SMILE programme

- Within budget – we were looking for ideas that cost in the region of £1,500
- Innovator led – whether the idea was to be carried out by a named innovator rather than an organisation
- Outcome focussed – whether the proposed project had a clear vision for clients.

In total 61 submissions were received, of which 28 were taken forward.

The projects were selected according to priority target groups and addressed underlying risk factors and promoted protective factors within a number of settings and groups e.g. Prisons, BME, Women, Primary care, Secondary care, voluntary sector. There was an effort to ensure the projects selected embraced the principles of equality and diversity. CPI provided a one-day innovation event for the selected innovators, dealing with a number of issues including what is innovation, what are outcomes, how to plan a project. The innovators then presented their idea to an investment panel who determined the level of investment they wished to make in each project.

The projects were offered three learning sets for participants, facilitated by CSIP, to build the knowledge and skills of individuals involved. They were given 5 months to try out their idea and determine how successful it was. CSIP staff took on the role of mentoring the innovators over the lifespan of the programme.

### Dissemination

A report will be published jointly by CPI and Government Office for the South East.

A network to share good practice and support individuals who are moving forward the SMI/physical health agenda is being developed and will be launched in partnership with the centre for professional development in mental health as part of their SMI/physical health conference in October 2008. To join the network, contact [julie.sharp@csip.org.uk](mailto:julie.sharp@csip.org.uk). A wellbeing conference will showcase

the outcomes and learning.

### Outcomes

An evaluation was led by CPI, drawing together comparative qualitative and quantitative data to demonstrate the impact and effectiveness of the projects on their target population and the learning outcomes for the participants.

The whole project is strongly focused on outcomes. The project as a whole is working towards a number of outcomes:

- Minimum 10 innovative projects testing solutions to challenges around SMI and physical health needs, across the region worth up to 3.5k
- Minimum of 50 clients with SMI will see some improvements in their physical health through engaging with innovation projects
- Minimum of 20 clients with SMI will report a sustained improvement in health through engaging with innovation projects
- Approximately a minimum of 20 participants (2 from each project) will have undergone the SMILE development programme via learning sets
- Publication of a short report on; the models used by individual projects, key learning outcomes from the innovations tested by projects, key learning outcomes from the personal journey taken by participants
- Projects will be showcased at a regional wellbeing conference in April 2008
- Development of web page following mapping exercise
- Launch of SMI/physical health network.

Each innovation project is also working to achieve a number of service specific outcomes (see Opportunity Dances in the Models of Good Practice section). Innovators were asked to develop their own outcomes for their projects with clear guidance that these outcomes should report on behavioural, health and wellbeing changes among their clients. Outcomes for three projects described in more detail below are provided.

As the programme draws to an end, innovators are being asked to submit self-evaluation forms which will form the basis of the assessment of the impact of the programme. The results are to be presented at an event for those in the South East region (see Big A Fayre in the News and Events section) in April 2008.

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The Centre for Public Innovation works to improve people's health and to reduce crime by providing consultancy and training services to organisations tackling social disadvantage. CPI is an independent, community interest company.

## MODEL OF GOOD PRACTICE

### Opportunity Dances

**Setting:** A medium secure forensic setting

**Level of Action:** Individual, community

**Target Group:** A group of 11 female mentally disordered offenders living in a medium secure forensic setting, who are resistant to any form of exercise.

#### Aims

- To offer a non-traditional form of exercise to help improve their physical health in a fun and innovative way
- To provide weekly dance taster sessions over a period of three to four months, offering varied and culturally diverse forms of non-contact dance, such as belly dancing, salsa, Indian dancing, Irish dancing, tap, line dancing.

#### Programme

SMILE is a new programme being run by the Care Services Improvement Partnership (CSIP) and the Centre for Public Innovation (CPI) (See previous Model of Good Practice). The programme aims to stimulate new ideas and encourage new ways of working with clients with severe mental illness. The three issues that are being tackled through this programme are:

- Improving the physical health of people with severe mental illness
- Improving the general wellbeing of people with severe mental illness
- Helping people with severe mental illness to stop smoking.

Opportunity Dances was one of eleven projects that was successful at gaining funding from SMILE.

The target group had low activity levels and was resistant to traditional forms of exercise. 9 out of 11 had a body mass index of 30 or more; a high prevalence of diabetes; increased smoking levels; decreased opportunities to participate in varied forms of exercise in the community due to the nature of the unit – with limited balance between self care, leisure and productivity activities; low mood levels; poor body image (low self esteem, prevalence of self harm); and low control over routine and lifestyle e.g. food provided by hospital.

Dance is well known to burn calories, lift mood, improve fitness levels and promote general well-being. It is also envisaged that the women will benefit from the social aspect of dance and be united through a common experience, but above all have time out from the daily regime of the ward to have fun.

It was hoped that women would be inspired to take part, following the "have a go" culture established with the ward staff. The women would then be encouraged to pursue any new found interests via local dance centres, adult education and other community centres.

#### Outcomes

Five targets were agreed and the results are shown here:

##### Target 1:

**3 patients will show increased motivation to engage in further activities and lifestyle changes e.g. reduced smoking as part of their routine.**

There are some changes in lifestyle for 2 patients; however it is not certain

whether this is solely due to the dance sessions. One patient who has attended nearly all 13 sessions so far has now reduced her daily cigarette intake, attends a healthy living group and has a goal to go on a short walk every day. Another has shown increased attendance in activities on the ward, engaging in the therapeutic programme at least once a day, especially sporting activities. This patient has also recently bought a dance mat and play station so she can use this as a form of exercise instead of the treadmill on the unit.

Other patients showed some changes in lifestyle e.g. increased engagement in other activities on offer; however this has not been consistent.

##### Target 2:

**3 patients will report they feel brighter in mood and happier with themselves and ward dynamics.**

All 8 patients who attended a dance session filled in a "rate your dance" questionnaire rating mood after each dance session in November and December. All patients rated their mood higher or the same using a 10 point scale. Patients also made comments on the questionnaires and verbally to facilitators including: it "increased my self esteem", gave them a "buzz", was "stimulating" and "very fun" and it "got rid of the cobwebs!" In addition one comment included that the session had made them feel "great."

No direct reference was made by patients about ward dynamics.

##### Target 3:

**3 patients will show a decreased**

### weight over the months of completing the dance sessions.

Although patients' weight may have decreased, this cannot be used as a true measure of success of the group as there are several other contributing factors for their weight changes. However, the group may have encouraged patients to change their diet and more investigation around this target needs to be undertaken. Observation also showed that exercise tolerance also increased as the groups continued and participants who engaged on a regular basis required less frequent breaks.

#### Target 4:

##### 3 patients will have developed a leisure interest they will pursue in the community.

Three patients have shown an interest in pursuing certain forms of dance in the community and have spoken to the dance teachers about their interests and also the facilitator about how they can go about following this up. One patient wrote:

"I would like to do this dancing again – maybe when I leave the unit."

Patients have shown an interest in videoing a session to send to the Koestler awards, which is an arts awards charity for people in prisons or secure hospitals.

#### Target 5:

##### 3 patients will report a higher satisfaction with the current

### therapeutic programme on offer.

5 patients in a focus review group reported they felt the dance sessions had contributed positively to the ward programme, expressing it was "exciting," "challenging" and an "opportunity to get out of the ward environment." A written comment from a patient described a session as "intense fun." Another patient wrote "I've got to go back to the ward and I can't practice there ... But I would like to come back next week."

#### Other wellbeing issues

- Patients reported that they enjoyed learning about other cultures through experiencing multicultural dances
- Although patients did not report specific dietary changes, after the original 7 sessions, healthy snack foods were on offer to the patients. They all expressed how much they enjoyed them and some would consider them as options instead of crisps/chocolate in the future
- Observation of patients from staff noted at least 3 patients on different occasions engaged in more activities on the day of some of the dance sessions. Also some were more inclined to use the activity hall for different groups
- Patients were able to cope with an audience and seemed to benefit from positive feedback from their peers and staff in increasing their self esteem. Their level of perseverance showed an ability to believe in their own ability. All patients enjoyed

looking at photos of their performance, asking for copies of them, showing an increased sense of self esteem. Patients have also asked for a viewing of a video recording of them doing a dance session

- Increased communication between patients and also between patients and staff during the sessions. This has allowed patients to support each other and for certain patients that currently have little engagement in the programme to participate in something they enjoy. There has been an increase in staff morale at times in uniting the ward when sessions were run on the ward environment.

#### Recommendations for the future

- Investigate ways to assess fitness levels
- Review which is the most appropriate environment for optimum engagement
- Increase links with accessible dance services in the community
- Consider appropriateness of movement therapy
- Investigate whether sessions could be continued outside therapeutic time with other staff members (consistent with meaningful day approach)
- Consider frequency of sessions

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## MODEL OF GOOD PRACTICE

# Third Sector database development

**Setting:** Third Sector Health and Social Care provider organisations

**Level of Action:** Community, Organisational

**Target Group:** Pilot centred on Mental Health, but potential application will be generic across all health and social care Third Sector organisations.

#### Aims

- To support Third Sector organisations to demonstrate and describe their value, cost effectiveness and outcomes for well being
- The management information provided by the database will support organisations in their decisions regarding funding, finances, service costs, governance and project delivery/workload.

#### Background

This project evolved from a conference focused on rural suicide. A recurring theme of the day was that smaller sector organisations who felt they were often best placed to offer support and services that contributed to suicide prevention found it difficult to 'break in to' being commissioned by the statutory sector for two reasons:

- Smaller organisations did not have

the capacity to develop the necessary systems to capture the information that commissioners wanted and to demonstrate their softer outcomes

- Commissioners needed to know that public money was invested in to efficient organisations with safe and robust operational and organisational governance.

#### Programme

The project has been jointly developed within CSIP with a project team including specialists from suicide prevention, mental health promotion, Third Sector, commissioning and public health (Government Office West Midlands) – along with the organisations that are currently piloting the resource. (We would like to give a big thank you to Worcestershire lifestyles, the Rural Emotional Support Team or REST and the Project group).

The resource is currently still being piloted and will be available electronically from the CSIP West Midlands web site after 1st April 2008. It will be freely downloadable and is being designed for easy access and usability.

There will be an updated version developed later in 2008 when organisations use and feedback on the tool, and we also hope to add the Warwickshire /Edinburgh Wellbeing Scale as another outcome measure.

#### Proven Outcomes

Because CSIP West Midlands had a limited timescale to develop this tool given its priority, they piloted the tool with three small organisations who had successfully expressed an interest. We were keen to get a working model available as soon as possible which could be further developed once organisations had used the tool and provided feedback. We also wanted to know it was a practical tool even for very small community-based organisations.

#### Initial feedback is positive:

*“The project group is now – thanks to the support from CSIP – using the database with confidence and starting to use queries, which help us when writing our regular reports to the PCT, with funding applications and to report to our steering group. The installation of a sophisticated database seemed like a very daunting task to us as a creative business, but CSIP helped make the implementation easy and smooth.”*  
[www.theprojectgroup.co.uk/](http://www.theprojectgroup.co.uk/)

#### Another pilot site REST (rural emotional support team) said:

*“The database developed by CSIP for the use of the third sector has enabled us to use a more effective process to monitor the interventions and contacts with all our clients. It focuses our team on the need to record specific information required by commissioners and other funding*

*agencies. We have found it extremely useful as a tool that highlights referral pathways, outcomes of our interventions, geographical needs/unmet needs and providing a process that pulls all client information together. Overall, a valuable tool that provides the third sector with a process that is easy to use in a language that is understood by the statutory agencies.”*  
[www.rest-staffordshire.org.uk/](http://www.rest-staffordshire.org.uk/)

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Specific link to partially developed future site [www.westmidlands.csip.org.uk/mental-health/mental-health-awareness-training-table/third-sector/activity-and-outcomes-database.html](http://www.westmidlands.csip.org.uk/mental-health/mental-health-awareness-training-table/third-sector/activity-and-outcomes-database.html)

## MODEL OF GOOD PRACTICE

### Wish-You-Well

**Setting:** HMP Drake Hall; an all female, semi-open prison in Staffordshire

**Level of Action:** Individual and organisational

**Target Group:** Female offenders

#### Aims

- To produce an easy to read and practical resource, the mental health promotion prompt card, to address many of the issues faced by

women offenders (see below).

#### Programme

Compared with the general population, women offenders are more likely to suffer from the following:

- Drug and alcohol misuse problems
- Up to 80% have a diagnosable mental health problem
- High rates of self-harm
- Up to 50% have experienced domestic abuse
- Parenting problems.

A prompt card has been developed to help tackle these problems. This is a practical mental health promotion resource developed to meet the specific needs of women at HMP/YOI Drake Hall. The Wish U Well prompt card provides an invaluable practical resource, which can help staff and peer supporters see prisoners' problems in a different light, one which is built around their mental health. By using it, offenders will grow more confident in meeting the challenges of their working

day and more able to deal with mental health issues for prisoners.

The card can be used when an offender explains a concern, for example, weight loss, imminent release or anxiety, to define the underlying causes of the problem and to refer them to the appropriate place. This could be employment services, healthy living classes or the adult learning centre. There is no need to be an expert in mental health to use this resource; much of it is common sense.

#### Proven Outcomes

A group of female offenders attended a workshop where they were asked to outline their views.

One offender said: *"I wanted to keep healthier, keep fit and I was told to go to see a health trainer"*

This offender is now near to the completion of a course allowing her to become a health trainer herself, allowing a self-perpetuating cycle.

Another offender who is also now on her way to becoming a health trainer is also a listener and says the prompt card enables her to send people to the right place, be that for employment, mental health or physical health.

*"This information wasn't available before, if you provide the information the women will read it"*

*"Even if they don't access the suggested service straight away, they*

*keep the knowledge and can use it when they're ready"*

One of the offenders has also started up a smoking cessation project off the back of this and is currently looking at concrete employment opportunities upon her release.

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## NEW AND EVENTS

# Depression Awareness Week

**When:** 16th-22nd April 2008

**Where:** Across England

Depression Awareness Week has been organised by the Depression Alliance for the last 12 years and has grown into one of the most successful initiatives in the busy awareness campaign calendar. As the UK's leading charity for people affected by depression, Depression Alliance is an invaluable and often first point of contact for many. They provide vital information and support services to those in need as well as continuing to challenge the stigma and dispel the many myths that surround the whole issue of depression.

Depression Awareness Week is an excellent opportunity to raise the profile of depression, and help raise money to develop and

improve the range of services offered by the Depression Alliance. Whether you are interested in organising an art exhibition, treasure hunt, dress up/down day, pogo race, dance-a-thon, sponsored walk, swim or swear box, please get in touch, all new ideas are welcome.

#### Contact

To discuss the many ways you could contribute towards making this Depression Awareness Week the most successful ever, contact:

e: [support@depressionalliance.org](mailto:support@depressionalliance.org)

## NEW AND EVENTS

# Well Being Centre Launches in Northamptonshire

**When and Where:** Tues 22nd April 08; Wellingborough and Daventry Libraries. Wed 23rd April 08; Kettering Library. Thurs 24th April 08; Northampton (Abington Street) and Weston Favell libraries. Fri 25th April 08; Corby Library

All start at 10am and finish at 4pm, and refreshments are available.

Based within libraries, Well Being Centres will provide a wealth of public information on health and well being, such as books, CDs and DVDs on various health topics. Visitors can also borrow from a range of books in the "Read Yourself Well" scheme. These are books recommended by health professionals to support local people making healthy lifestyle changes.

The launches will also provide the opportunity to meet one of the newly appointed Trainee Health Trainers in Northamptonshire. When qualified, our Health Trainers will provide a personal service helping people to improve their health and well being. They will

be specifically trained to give local people health information and individual support with lifestyle changes such as healthy eating, managing stress and increasing physical activity.

The first six launches are in the following libraries; Corby, Daventry, Kettering, Northampton (Abington Street), Wellingborough and Weston Favell.

Many local clubs, groups and organisations are getting involved in the well being launches, providing fun displays and activities ranging from: Indian head massage, food tasting, dance lessons, and gardening to blood pressure checks and self defence.

#### Contact

For more information contact: **Lisa Boland**, Health Improvement Co-ordinator – Inequalities, Public Health, Northamptonshire Teaching PCT

t: 01604 615144 e: [Lisa.Boland@northants.nhs.uk](mailto:Lisa.Boland@northants.nhs.uk)

NEW AND EVENTS

## THE BIG A-FAYRE

**When:** 23 April 2008 10.00-16.30

**Where:** H. G. Wells Conference & Events Centre, Woking

Open to those working in the South East region.

Interested in wellbeing and innovation? Explore with us different ways of working, experience innovation illustrations, shop for new ideas at the Bazaar, chill with yoga, music, massage and dance, get involved in the arts, feed your appetite with Mood and Food, contribute to the 'Wellbeing Wall'.

**Contact**

For more information and booking your place please contact:

**Mel Andrews**, SEDC, Regus House, 3000 Cathedral Hill, Guildford GU2 7YB

e: [mel.andrews@csip.org.uk](mailto:mel.andrews@csip.org.uk) t: 01483 246470

f: 01483 245113

**Production Team:**

Poppy Jaman; Malcolm Barrett; Julie Sharp; Mel Andrews

NEW AND EVENTS

## The Manchester Women's Conference

**When:** 8th-9th May 2008: 8th May, The Physical Health of Women with Mental Illness. 9th May, Workshops – Developing and Implementing Healthier services for Women in your Area

**Where:** Hulme Hall, Oxford Place, Victoria Park, Manchester M14 5RR

Research suggests that people with mental illness have high rates of physical illness, much of which goes undetected. People suffering mental illness are twice as likely to die as the general population and calls for health professionals to be more aware of the physical health needs of this vulnerable group, and for better medical screening and treatment, have not led to a reduction in this risk. Women with mental illness may be even more at risk than men. All women need ongoing care and assessment of their reproductive and sexual health. Added to this, the range of poor lifestyle (lack of exercise, poor diet, smoking, substance misuse) experienced by the mentally ill, as well as pregnancy and childbirth provide further physical health risk for women with mental illness making them a particularly vulnerable population.

The conference and workshop days will generate discussion of how and why women in mental health services are at risk of poor health

and what the service responses to this should be. Service planners and providers from health and social care, service users, carers, and advocacy groups will be present. The emphasis will be on finding imaginative solutions which are acceptable and useful to patients.

This Conference aims to develop priorities for action which will improve the physical health of mentally ill women. Progress will depend on a multidisciplinary approach from policy and health commissioners, and both mental health and primary care staff being aware of the potential responses to the problem.

Day 1 only – £160 per delegate

Day 2 only – £160 per delegate

Attendance on both days – £260

**Contact**

**Carol Rayegan**, Centre for Women's Mental Health Research, Williamson Building, University of Manchester, Manchester M13 9PL.

t: 0161 275 0714 f: 0161 275 0716

e: [Carol.Rayegan@manchester.ac.uk](mailto:Carol.Rayegan@manchester.ac.uk)

NEW AND EVENTS

## Improving the Odds: Sustaining Employment

**When:** Thursday 22 May 2008

**Where:** Exeter racecourse, Kennford, Exeter EX6 7XS

This event is organised by SEMPnet, a network of people interested or involved with mental health vocational rehabilitation.

The aim of this event is to enable participants to feel more supported and informed in their work with people whose mental health affects their ability to find or sustain employment.

There will be a mixture of presentations and workshops.

Workshops include:

- Job retention – the role of the vocational advisor and employer

- Sustaining employment for new and existing employees
- Employee Assistance programmes
- Leaving the NHS – the reality of setting up a social firm
- Steps to social enterprise – exploring how to set up a social enterprise business
- Star Social Firms: Employment for everyone

**Cost:** £75 or £20 for mental health service users

**Contact**

**Christine Wardle** t: 01392 208836

**Lynn Aggett** t: 01392 208833

## NEW AND EVENTS

# Ecotherapy and the green agenda for mental health Why health professionals need to get on board

**When:** Monday 2 June 2008

**Where:** ORT House Conference, London NW1

This conference follows Mind's May 2007 campaign Ecotherapy: The green agenda for mental health, and the agenda-setting research by the University of Essex that contributed to the campaign. It will bring together service providers, service users, leading academics, policy-makers, opinion-formers and others. This event will provide a unique forum for examining the evidence on the mental health benefits of 'ecotherapy' and 'green exercise' – getting outdoors and getting active in a green environment as a way of boosting mental well-being. It will look at practical ways to take the green agenda work forward, both nationally and locally, and how to learn lessons from best practice around the country.

- Inform healthcare professionals about the potential benefits of green exercise, as well as voluntary sector specialists, substance misuse workers and people working with offenders
- Encourage healthcare practitioners to see green interventions as a mainstream treatment or therapeutic option for people experiencing mental health problems
- Promote good practice in green exercise/ecotherapy and provide an opportunity for policy specialists to engage with service users and service providers
- Debate the best way forward for the green agenda for mental health
- Identify and address opportunities, risks and barriers to progress

### Key themes

- Ecotherapy and green exercise for public health
- Nature-based approaches for mental health services
- The role of green care approaches for those working with the most marginalised and those with complex needs
- Costs and benefits of green approaches
- Green projects, including social and therapeutic horticulture and offender and nature programmes

### Who should attend?

Health professionals, including GPs, psychologists and psychiatrists; relevant specialists from primary care trusts and local authorities; providers of voluntary sector services to mental health service users; relevant specialists working in the criminal justice system, such as probation officers; local and national health and social policy specialists; mental health service users; land management, wildlife and conservation professionals.

Standard rate: £250 + VAT (central government / private sector organisation)

Cost: £216 + VAT (public sector / educational / charitable / NHS / voluntary organisation)

£165 + VAT (unwaged / student / small voluntary sector organisations)

### Contact

**Pavilion** t: 0870 890 1080 e: [info@pavpub.com](mailto:info@pavpub.com)

## NEW AND EVENTS

# Health, Wellbeing and Happiness: from Local Action to Global Change

**When:** 29 June 2008-01 July 2008 , 9.00am-5.30pm

**Where:** University of Teeside, Middlesbrough TS1 3BA

In the 18th century, philosopher Jeremy Bentham argued that one of the main aims of a government should be to bring as much happiness to as many people as possible. But what is happiness? In the last 50 years people in Western countries have become much richer, work less, have longer holidays, travel more, live longer and are healthier, yet, they are not happier.

Yet some studies of less affluent Asian, African or South-American countries suggest that people who live in less secure environments, who are less wealthy and have poorer health are reported to be more happy than Westerners claim to be.

Titled "Health, Wellbeing and Happiness: from Local Action to Global Change" this conference will bring together leading social scientists and humanities scholars from around the world to present and evaluate contributions to the rapidly growing academic field of health, wellbeing and happiness studies.

### Key questions

What is happiness? How do we measure happiness? What could

be done to increase the amount of happiness in the world? Can we construct meaningful statistical indicators of happiness and life satisfaction?

Measures of happiness and policy: Can subjective well-being indicators help shape policy? And what does satisfaction with different domains of life imply for policy-making?

What makes us happy? What do we know about the factors determining happiness and what don't we know? How can government have an impact?

Confirmed keynote speakers include Professor Frank Furedi, University of Kent; Professor Michael Murray, Keele University; Dr Dimitris Ballas, University of Sheffield; Dr Daniel Nettle, University of Newcastle; Dr Iain Wilkinson, University of Kent.

Cost: Full conference including meals and accommodation: £160; daily rate £100

### Contact

**Catherine Iles** t: 01642 384656 e: [c.iles@tees.ac.uk](mailto:c.iles@tees.ac.uk)

## USEFUL WEBSITES

Age Concern England – [www.ageconcern.org.uk](http://www.ageconcern.org.uk)  
Care Services Improvement Partnership (CSIP) – [www.csip.org.uk](http://www.csip.org.uk)  
Clifford Beers Foundation – [www.cliffordbeersfoundation.co.uk](http://www.cliffordbeersfoundation.co.uk)  
Department for Children, Schools and Families – [www.dfes.gov.uk](http://www.dfes.gov.uk)  
Department of Health – [www.dh.gov.uk](http://www.dh.gov.uk)  
Depression Alliance – [www.depressionalliance.org](http://www.depressionalliance.org)  
Disability Rights Commission – [www.drc-gb.org](http://www.drc-gb.org)  
Every Child Matters – [www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)  
Faculty of Public Health – [www.fph.org.uk](http://www.fph.org.uk)  
Health First – [www.healthfirst.nhs.uk](http://www.healthfirst.nhs.uk)  
The Kings Fund – [www.kingsfund.org.uk](http://www.kingsfund.org.uk)  
Local Government Association – [www.lga.gov.uk](http://www.lga.gov.uk)  
Manic Depression Fellowship – [www.mdf.org.uk](http://www.mdf.org.uk)  
Mental Health Care (IOP, SLAM and Rethink) – [www.mentalhealthcare.org.uk](http://www.mentalhealthcare.org.uk)  
Mental Health Foundation – [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)  
Mental Health in Later Life (MHF) – [www.mhilli.org](http://www.mhilli.org)  
Mental Health Media – [www.mhmedia.com](http://www.mhmedia.com)  
Mind – [www.mind.org.uk](http://www.mind.org.uk)  
MINDFUL EMPLOYER – [www.mindfulemployer.net](http://www.mindfulemployer.net)  
National Social Inclusion Programme – [www.socialinclusion.org.uk](http://www.socialinclusion.org.uk)  
New Economics Foundation – [www.neweconomics.org](http://www.neweconomics.org)  
NIMHE – [www.nimhe.csip.org.uk](http://www.nimhe.csip.org.uk)  
NIMHE Knowledge Community – <http://kc.nimhe.org.uk>  
Rethink – [www.rethink.org](http://www.rethink.org)  
Royal College of Nursing – [www.rcn.org.uk](http://www.rcn.org.uk)  
Royal College of Psychiatrists – [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)  
Sainsbury Centre for Mental Health – [www.scmh.org.uk](http://www.scmh.org.uk)  
Samaritans – [www.samaritans.org.uk](http://www.samaritans.org.uk)  
Sane – [www.sane.org.uk](http://www.sane.org.uk)  
Shift – [www.shift.org.uk](http://www.shift.org.uk)  
Social Care Institute for Excellence – [www.scie.org.uk](http://www.scie.org.uk)  
Together – [www.together-uk.org](http://www.together-uk.org)  
UK Public Health Association – [www.ukpha.org.uk](http://www.ukpha.org.uk)

## Mental Health Promotion Update

This newsletter is produced to reinforce the aims of the White Paper Choosing Health by providing NIMHE nationally and regionally with a vehicle to support local work and to ensure that mental health promotion remains on local agendas.

It provides information, articles and opinions for the mental health promotion community and those tasked with effectively implementing Standard One of the National Service Framework. Each issue also includes details of models of good practice, information on upcoming events and conferences and further contacts for organisations supporting the promotion of public mental health.

The next issue will look at mental health promotion activity which supports the national suicide prevention strategy for England. If you are interested in including something in this or future editions of Mental Health Promotion Update please contact John Scott on email: [john.scott@dh.gsi.gov.uk](mailto:john.scott@dh.gsi.gov.uk) or Mary Tidyman on email: [marytidy@hotmail.com](mailto:marytidy@hotmail.com)

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For further copies of this document, please contact your local development centre or the mental health promotion team at:

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