Central Bedfordshire Council
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Annual director of public health report 2014

Mental Health and Wellbeing in Central Bedfordshire

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Foreword from the Director of Public Health

The annual Director of Public Health report is an independent document focused on the health of the people of Central Bedfordshire.

This year I am pleased to present my report on mental health and wellbeing. This is an area that is often overlooked whilst physical health is given prominence. Last year the important issues of premature mortality and the "big killers" of cancer, cardiovascular, lung and liver disease were highlighted in "Longer Lives" from Public Health England. The report showed higher rates of premature mortality in Central Bedfordshire compared with similar areas. Whilst the causes of premature mortality are physical health conditions, mental health and wellbeing is as equally important and the inter-relationship between physical and mental health is significant. People with long term conditions are more likely to have poor mental health and people with mental health illness die often earlier than those without mental illness.

We hope that this report increases awareness about the consequences of poor mental health and illustrates the widespread impact it can have on individuals, families, society and the economy. This report aims to summarise the current burden of disease in the population, highlight the evidence of what works, and provide an overview of some of the services that are available. There are areas that are working well but we also highlight areas that could be improved. By promoting good mental health and intervening early across the life course we can help prevent mental illness from developing and reduce its effects when it does. Effective action requires all stakeholders and partner organisations to work together.

The Joint Strategic Needs Assessment for Central Bedfordshire includes mental health and wellbeing chapters providing more depth into these areas. This is publically available on Council's website at www.centralbedfordshire.gov.uk/jsna

The recommendations made in the report are achievable, have evidence of effectiveness, will have the greatest impact on the population as a whole and that have been highlighted by those working in mental health services or affected by mental health disorders.

This report also provides an update since the last Public Health Report which focused on Health Inequalities. We will report on the progress made on these recommendations in the Annual Public Health report of 2015 to demonstrate where and how progress has been made.

My vision for the local area is one where mental health and wellbeing is addressed routinely and proactively in all stages of life; from pre-birth antenatal checks, in schools, workplaces, health and care environments, and in the later stages of life.

Muriel Scott

Director

Executive Summary

Call to Action

Mental health and wellbeing is important; good mental health and resilience are fundamental to our physical health, relationships, education, training, work and to achieving our potential. Poor mental health is also common; at least one in six people will experience a mental health problem in any one year[1] and mental health illness is the leading cause of long term absence from work[2]. It affects any age group; 10% of 15-16 year olds experience mental health illness. In 50% of people with a lifelong mental illness their symptoms started before the age of 14 and in 75% symptoms started before their mid-twenties[3]. Older people are at increased risk of depression due to factors such as retirement, social isolation, bereavement, physical illness or disability and social isolation[4].

By promoting good mental health and intervening early across the life course we can help prevent mental illness from developing and reduce its effects when it does.

[1] The Office for National Statistics Psychiatric Morbidity report, 2001
[2] Centre for Business Innovation. www.cbi.org.uk/media/.../cbi-pfizer_**absence**___workplace_health_2013.pdf
[3] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014
[4] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/O/older-people/ accessed on 16/4/2014

Children and Young People

National data[5] estimates the rates of mental health problems in males between the ages of 5-10 years is almost twice that of females (10.4% vs 5.9%) and the rate in females increases to narrow this gap by the ages of 11-15 years (12.8% for males and 9.65% for females). There are an estimated 1,100 males and 595 females aged 5-10 years with a mental health problem in Central Bedfordshire[6] and 1,260 males and 905 females aged 11-15.

In Central Bedfordshire it is imperative that we improve mental health and wellbeing for all children due to the long lasting negative impact of mental health illness. We believe that this requires action in three key areas; ensuring the best start in life; strengthening emotional resilience and wellbeing; and detecting and treating illness early.

Key recommendations to address mental health in children and young people:

1. Ensure excellent maternal mental health:
    a. Identify women early who have poor mental health through antenatal and postnatal maternal mood assessments
    b. Ensure that the ante and postnatal pathways for maternal mental health are followed and women have access to high quality and timely support for mental health illness

2. Help children to become more resilient:
    a. Health and early years practitioners should develop and agree pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services (NICE guideline PH40)
    b. Ensure practitioners have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing (NICE guideline PH20)
    c. Provide a curriculum that promotes positive behaviour and successful relationships and helps reduce disruptive behaviour and bullying (NICE guideline PH20 *Mental health and behavior in schools: Department for Education. June 2014*)

3. Increase the early identification of children who are at risk of poor mental health earlier and ensure that they have access to appropriate services

[5] National Statistics Online, Mental Health: Mental Disorder More Common In Boys, at www.statistics.gov.uk, (2004)
[6] Calculated from applying national prevalence to Central Bedfordshire population (Exeter database 2014)

Adults and Older People

The adult population of 20-64 year olds in Central Bedfordshire totalled 159,600 and those aged 65 and over numbered 44,600 (Exeter database 2013/14 Q2). Approximately 26,200 residents are predicted to have a common mental health disorder (anxiety, depression, obsessional compulsive disorder) and 11,700 to have two or more mental health disorders.

People with mental health disorder have poorer physical health and often are subject to discrimination and stigma. Males with mental illness die on average 16 years earlier and women with mental illnesses die 12 years earlier than those without mental illness.

Cardiovascular disease and cancer account for 75% of this reduction in life expectancy[7]. Despite mental health problems affecting one in four people at some point in their lives, people with mental health conditions are least likely out of all people with a long term condition or disability to be included in mainstream society[8].

The recommendations made below would reduce inequalities, have the potential for widespread impact and are achievable. The current inequality in physical health and resultant premature mortality needs to be addressed urgently and there are services in place that we could use more effectively. Promoting mental health and wellbeing in the workplace would impact a large number of people and could prevent illness and sickness absence. Stigma has negative impacts on the person in terms of mental wellbeing, increases social isolation, and reduces the likelihood that people will seek help early.

Key recommendations to address mental health in adults and older people:

1. Improve the physical health of those with mental health illness by ensuring good access to healthy lifestyle support
2. Support employers to participate in Workplace Health initiatives and to signpost to relevant resources
3. Increase understanding of mental health and wellbeing and reduce stigma of mental ill health

[7] The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ 2013; 346 doi: http://dx.doi.org/10.1136/bmj.f2539 (Published 21 May 2013)

[8] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/stigma-discrimination/ (Accessed 15/05/2014)

Call to Action

> Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community
>
> WHO

Good mental health and resilience are fundamental to our physical health, relationships, education, training, work and to achieving our potential.

If we achieve our aims for improving mental health and wellbeing in Central Bedfordshire:

1. **More people will have good mental health**
2. **More people with mental health problems will recover**
3. **More people with mental health problems will have good physical health**
4. **More people will have a positive experience of care and support**
5. **Fewer people will suffer avoidable harm**
6. **Fewer people will experience stigma and discrimination**

Mental Health illness affects many people across all ages and in 75% of people with a lifelong mental illness their symptoms started before their mid-twenties[9]. At least one in six people will experience a mental health problem in any one year[10]. Some people might have a single episode of mental illness and people of all ages are affected; 10% of 15-16 year olds experience mental health illness and mental health illness is the leading cause of long term absence from work[11]. Older people are at increased risk of depression due to factors such as retirement, social isolation, bereavement, physical illness or disability and social isolation[12].

Mental health illness results in a broad range of impacts[10].

Impacts of Mental disorder in **childhood and adolescence**:

7. Poorer health and lower levels of educational attainment
8. Higher risk of self-harm and suicide
9. Several-fold higher levels of health risk behaviour such as smoking, alcohol consumption and drug misuse
10. Higher rates of antisocial and offending behaviour and violence

[9] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014
[10] The Office for National Statistics Psychiatric Morbidity report, 2001
[11] Health at work – an independent review of sickness absence. Dame Carol Black and David Frost CBE. 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf (Accessed on 17/6/2014)
[12] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/O/older-people/ accessed on 16/4/2014

Impacts of Mental disorder during **adulthood**:

11. Higher unemployment
12. Higher rate of debt problems
13. Higher risk of homelessness
14. Higher smoking prevalence
15. Increased risk of physical health problems especially heart disease and cancer
16. Reduced life expectancy of 16 years for men and 12 years for women

The ultimate aim of work on mental health prevention is a community in which people take appropriate action to prevent mental health issues in themselves and in their families, but if they do develop an issue, they obtain timely professional help, receive and adhere to evidence-based treatments, feel supported by those in their immediate social network and hopefully recover sooner.

Improving the general public's mental health and wellbeing is one of the most important issues in Public Health.

Actions that can be taken to influence wellbeing include:

- **Connect** to those around you and build positive relationships with family, friends, colleagues and neighbours
- **Be active**. Find the activity that you enjoy, and make it a part of your life.
- **Keep learning**. Learning new skills can give you a sense of achievement and a new confidence.
- **Give to others**. Even the smallest act can count whether it's a smile, a thank you or a kind word. Larger acts, such as volunteering at your local community centre, can improve your mental wellbeing and help you build new social networks.
- **Take notice**. Be more aware of the present moment, including your feelings and thoughts, your body and the world around you. Some people call this awareness "mindfulness", and it can positively change the way you feel about life and how you approach challenges.

NHS Choices. Five Steps to Mental Wellbeing

For children, these activities have been found to be helpful[13]:

1. Seeing friends
2. Teaching yourself new things and
3. Noticing and enjoying your surroundings

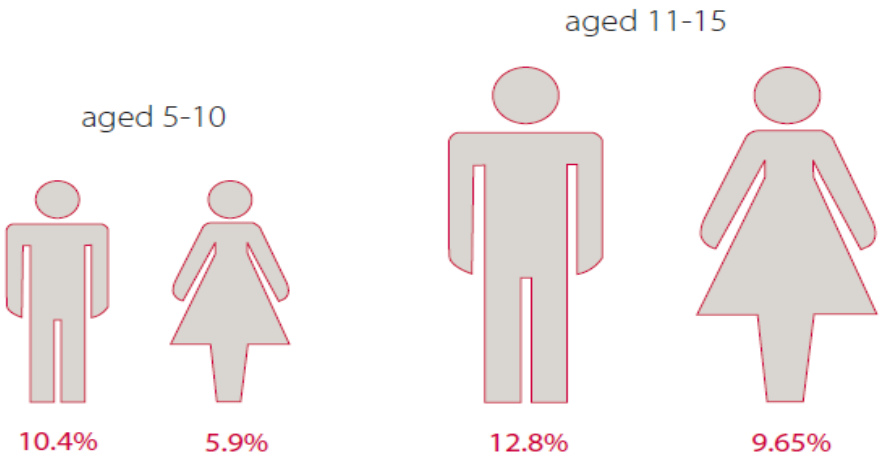
[13] The Good Childhood Report. The Children's Society. 2013.

1. Children and Young People

Of those with a lifetime mental health illness; 50% will experience their first symptoms before the age of 14 years and around 75% by their mid-twenties[14].

Figure 2 shows the difference in rate of mental health illness in different ages and gender groups. National data[15] estimate the rates of mental health problems in males between the ages of 5-10 years as being almost twice that of females (10.4% vs 5.9%) and the rate increases in females to narrow this gap by the ages of 11-15 years (12.8% for males and 9.65% for females). There are an estimated 1,100 males and 595 females aged 5-10 years; 1,260 males and 905 females aged 11-15 with a mental health problem in Central Bedfordshire.

Figure 2: National rates and local numbers of children and young people with mental health problems.



Est. No. of CYP affected in CBC	1,100	595	1,260	905

Source: Fundamental Facts. Mental Health Foundation 2007.

Mental Health disorders in children and young people are divided into the following categories: conduct disorders, emotional disorders (anxiety disorder including OCD and phobias, depressive disorders); hyperkinetic disorders (including Attention Deficit Hyperactivity Disorder); developmental disorders (Autistic Spectrum Disorder); eating disorders; substance misuse; psychotic disorders and self-harm.

Some mental health disorders are more frequent in males and others in females. Conduct disorders are more common in males than females and emotional disorders are more frequent in females.

The estimated prevalence for conduct disorders in Central Bedfordshire in 2012 was 910 in children aged 5-10 years and 805 children between 11-16 years.

[14] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

[15] National Statistics Online, Mental Health: Mental Disorder More Common In Boys, at www.statistics.gov.uk, (2004)

Boys account for approximately 65-70% of those affected[16]. In addition it is estimated there were 445 children (210 males) aged 5-10 years and 945 children (390 males) between 11-16 years with an emotional disorder. There is a marked difference in numbers of males and females with an emotional disorder between the ages of 16-19 years and an expected 545 males will have an emotional disorder whilst this number is 1,105 in females[14].

Please note the data available regarding numbers of children with mental health illness are provided nationally using prevalence obtained through research and applying this to the local population. It is therefore an estimate and not the number of patients identified locally with the specified condition.

Recommendation 1: Ensure excellent maternal mental health

Maternal mental disorders following childbirth are common and often serious. Pregnancy and childbirth are major life events, with potential consequences on maternal mental wellbeing. Women may develop mental illness for the first time during the perinatal period (covering the antenatal period through to 1 year post birth) or may experience an exacerbation of a pre-existing illness. The risk for severe mental illness (postnatal psychosis) is higher in women with pre-existing mental illness[17].

Local picture

Table 1: Rates of perinatal psychiatric disorder per thousand maternities

Rates of perinatal psychiatric disorder per thousand maternities		Estimate of number of women affected in Central Bedfordshire*
Postpartum psychosis 2/1000	2 in 1000	<10
Chronic serious mental illness 2/1000	2 in 1000	<10
Severe depressive illness 30/1000	30 in 1000	100
Mild-moderate depressive illness and anxiety states 100-150/1000	100-150 in 1000	330-500
Post traumatic stress disorder 30/1000	30 in 1000	100
Adjustment disorders and distress 150-300/1000	150-300 in 1000	330-500

Source: Guidance for commissioners of perinatal mental health services. JCPMH. http://www.jcpmh.info/wp-content/uploads/jcpmh-perinatal-guide.pdf. Accessed 16/06/2014

*Based on a birth rate of 3300 in Central Bedfordshire

Early years mental health promotion services are available in Central Bedfordshire as part of the 0-5 years Healthy Child Programme - led by the Health Visiting Service. This service is delivered at 3 levels - Universal, Universal Plus and Universal Partnership Plus, depending on need.

[16] Source: CHIMAT: CAMHS Needs Assessment. http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34 (Accessed 10/2/2014)

[17] Royal College of Psychiatrists. http://www.rcpsych.ac.uk/expertadvice/problems/postnatalmentalhealth/postpartumpsychosis.aspx. Accessed 16/6/2014

The Universal element is delivered to all women and includes a postnatal maternal mood assessment. Latest data on the maternal mood assessment completion is for Q1 2014/15 and is low at 29% of all mothers at 6-8 weeks post-natally being assessed. However, the number reported may be low as the previous indicator required this assessment to be done at 10 weeks and it may be that adjustment that has affected the result. This figure currently covers all of Bedfordshire but this indicator is expected to be reported by Local Authority in 2014/15.

Maternal health in general, including breastfeeding and smoking, has a longer term impact on child mental health and wellbeing. The breastfeeding rate in Central Bedfordshire at 6-8 weeks was 46.4% in 2012/13 which is slightly lower than the England average of 47.2% (ChiMat 2014 data). The percentage of mothers who are smoking at the time of delivery in Central Bedfordshire is slightly higher than the England average from national comparison data in 2012/13.

Improved early years mental health and wellbeing would be expected to impact upon the pre-school stage. Currently Central Bedfordshire has a lower "school readiness" of its children compared with the England average; 49.1% of children achieved a good level of development within Early Years Foundation Stage Profile in 2012/13 in Central Bedfordshire compared with 51.7% in England as an average (Public Health Outcomes Framework 2014).

What works

Good antenatal care, postnatal care and parental support improve parental mental and physical health and as a result, child mental health and wellbeing. Table 2 describes the interventions which are evidence-based and describes the positive impacts that have been demonstrated.

Table 2: Mental health and wellbeing outcomes for evidence-based interventions in early years

Life Stage	Intervention	Evidenced based outcome
Starting Well	1. Promotion of parental mental and physical health	Reduction in maternal smoking is associated with reduced infant behavioural problems and Attention Deficit Hyperactivity Disorder
	2. Increased breastfeeding	Increased breastfeeding is associated with higher intelligence score later in life, reduced obesity and reduced behavioural problems
	3. Support after birth such as home visiting	Improved maternal and child health
	4. Parenting support	Improved parental mental health Improved child emotional and behavioural adjustment Promotion of pro-social behaviours Reduced antisocial behaviour Reduced aggression and violence in children with conduct disorder

Source: Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

What we should be doing

We should continue to support women through pregnancy with effective antenatal support and through this promote a healthy lifestyle - such as not smoking, aiming for a healthy weight and increased physical activity. We should also continue to effectively support women to breastfeed their children.

We should strengthen the area of antenatal support, ensuring that all women's mental health and wellbeing is assessed at each of the key points during the antenatal period – i.e.:

- at booking/by 12 weeks (or at first contact if later (Midwife)
- at 16-28 weeks (Midwife)
- 28-32 weeks (Health Visitor)
- 32-36 weeks (Midwife)

Postnatal support should also be strengthened, ensuring that **all** women receive their postnatal maternal mood assessment with a Health Visitor at 6-8 weeks. We must increase the percentage of women receiving this assessment from 29% to the following stepped targets which have been locally agreed between commissioner and provider. These targets have been set to reflect planned increase in, and up-skilling of the health visitor workforce.

Targets for percentage of women receiving their postnatal maternal mood assessment:

- 75% by Q3 2014/15
- 95% by Q4 2014/15

So that all women have access to high quality and timely support for mental health illness, the agreed Bedfordshire Joint Care Pathways for Maternal Mental Health – antenatal and postnatal should be followed and reviewed and revised against the developing *0-5 Healthy Child Programme Integrated Commissioning & Delivery Toolkit* (NHS England, East Anglia Area Team), and updated NICE Guidance (to be published in December 2014).

Recommendation 2: Helping children become more resilient

Children need to build skills early in life to be able to increase their resilience to future life events. This will help to prevent behavioural problems (including drug and alcohol misuse) and mental illness. Resilience results in the ability to be autonomous, problem-solve and manage emotions.

Local picture

All children should receive social, emotional and developmental support from professionals outside specialist mental health services who should deliver this as part of their everyday work. These professionals include teachers, social workers, special educational needs workers, health visitors, school nurses and GPs. This level of intervention is known as "Tier 1" support. This level of support forms the base of mental health support for Children and Young people as seen in the tiered diagram in Figure 3.

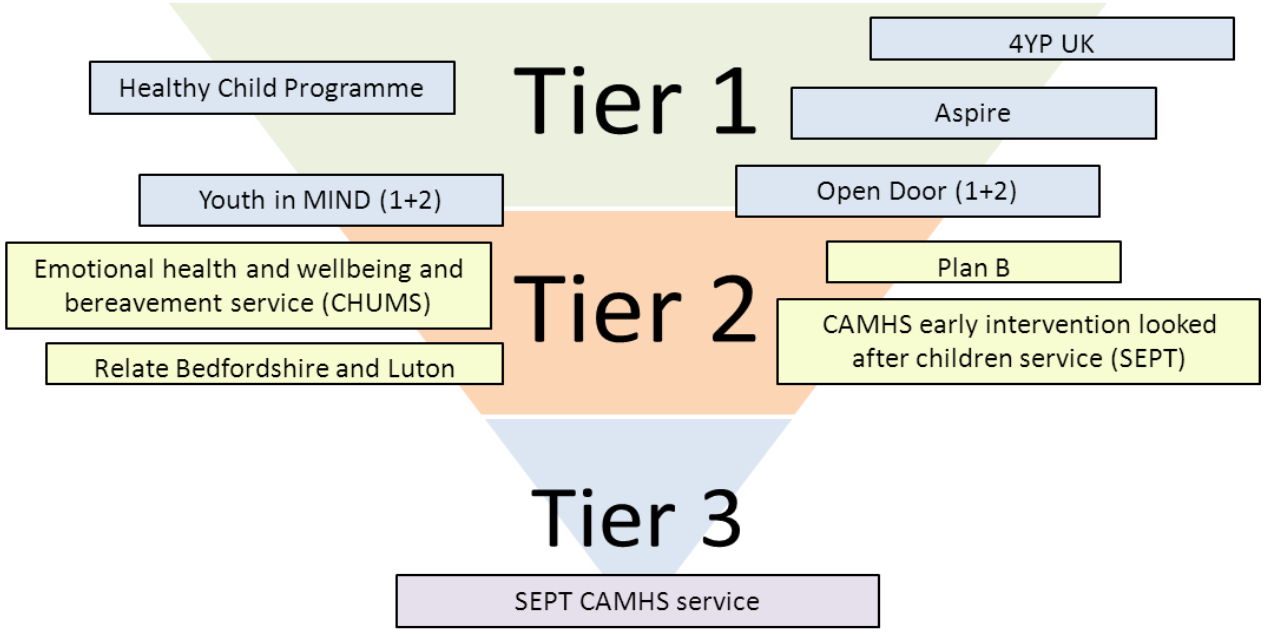


Figure 3: Tier 1-3 Children and Young People Mental Health Services

Features of Tier 1 support such as universal delivery through routine contacts made with children and young people make it difficult to assess. The 2013/14 Tier 1 and 2 review looked at the current provision and through discussions with stakeholders identified that some of these services could be strengthened. Increased support at early stages is important. It can prevent mental health illness from developing or reduce the severity of existing mental health illness by intervening early. This will both improve the mental wellbeing of the population through acting early and also reduce costs associated with the need to treat more severe mental health illness.

Poor mental health and wellbeing in children and young people can lead to negative outcomes such as poor educational attainment and an increased risk of unemployment.

This is likely to be a two-way association and poor mental health can lead to, and be a result of young people being Not in Education Employment or Training (NEET). In Central Bedfordshire there were 390 16-18 year olds who were NEET in 2012 which is 4.6% of this age group. This compares with a national average of 5.8% and whilst this is statistically significantly lower, we still need to provide support to this vulnerable group.

What works

There is a good evidence base for intervention during childhood and adolescence and in particular for school-based interventions as shown in Table 3.

Table 3: Mental health and wellbeing outcomes for evidence-based interventions in childhood

	Intervention	Evidence-based outcome
Developing Well	1. Pre-school and early education programmes as in the Healthy Child Programme	Improved cognitive skills, school readiness, academic achievement, prevention of emotional and conduct disorder
	2. School-based mental health promotion programmes and intervention strategies – promoting positive mental health for all and identifying and targeting those with problems	Improved wellbeing with resultant improvement in academic performance, social and emotional skills, classroom behaviour and reductions in anxiety and depression. Social and emotional learning (school based intervention) showed 10% reduction in classroom misbehaviour, 11% improvement in achievement tests, and 25% improvement in social and emotional skills

Source: Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

School based interventions have been evaluated and found to produce a net cost saving as shown in Table 4.

Table 4: Calculations of cost savings of interventions. Cost savings presented related to £1 investment

Intervention	Saving per £1 investment
School-based social and emotional learning programmes	£84
Pre-school educational programmes for 3-4 year olds in low-income families	£17
School-based interventions to reduce bullying	£14
School-based violence prevention programmes with net savings six and ten years after the programme began	£829 and £6,446 net savings six and ten years after the programme began

Source: Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

What we should be doing

It is clear that early years and school-based interventions are both effective and cost-effective. The National Institute for Health and Care Excellence (NICE) has produced guidelines for emotional and social wellbeing for early years and secondary schools (PH40 and PH 20 respectively). The recommendations are also informed by a review of Tier 1 and 2 child and adolescent services for mental health and wellbeing for Central Bedfordshire. Undertaken in 2014, the review compared current service provision against the available evidence and NICE guidelines.

Progress towards full implementation of the Healthy Child Programme (HCP) 0-5 years was identified as a gap in 2010 and is now being addressed through the 2011-2015 Health Visiting Implementation Plan. We should continue to act to increase health visitor workforce and full implementation of the HCP 0-5 years. Health and early years providers, should put systems in place to deliver integrated universal and targeted services that support vulnerable children's social and emotional wellbeing. This should include systems for sharing information and for multidisciplinary training and development. It was also recommended that health and early years, practitioners should develop and agree common pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services

The review also highlighted that Tier 1 and 2 services should be strengthened. Professionals working with children who are responsible for the delivery of Tier 1 services must primarily be aware of this responsibility and have the right skills to deliver this service. We therefore recommend that practitioners working with children and young people have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing. They should also provide an environment that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying.

Recommendation 3: Increase identification of children who are at risk of poor mental health earlier and ensure that they have access to appropriate services

Risk factors for mental ill health in children and young people can be grouped into child, parental and household risk factors. These include:

- substance misuse and maternal stress during pregnancy,
- poor parental mental health,
- parental unemployment,
- social deprivation,
- low birth weight,
- child abuse and
- being a looked after child.

Local Picture

Domestic Violence, Substance Misuse and Mental Health Illness are three influencing factors in a child's environment. They have been shown to have a potentially amplifying and negative effect. This has been termed the "Toxic Trio"[18]. Pressures on parents from factors within the Toxic Trio can adversely affect parenting capacity and extra support should be considered in these circumstances. It is estimated that 26% of babies in the UK have a parent who is affected by one of the "Toxic Trio"[19].

Between April 2013 – March 2014 there were 2698 incidents of domestic abuse in Central Bedfordshire, an 11% increase on the same time period the previous year. 41% of the domestic abuse incidents in Central Bedfordshire were noted to have a child present at the time of the abuse occurring, this is a 4% decrease on the same time period last year.

Data regarding the Toxic Trio risk factors are collected by the drug and alcohol misuse services in Central Bedfordshire. Table 5 shows the number of clients in contact with the drug and alcohol services in Central Bedfordshire living with children. The total number of clients seen living with children was 193 of whom 5 had all three of the Toxic Trio risk factors.

[18] All Babies Count. NSPCC. Available at: http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/all_babies_count_pdf_wdf85569.pdf Accessed on 10/02/2014

[19] The 1001 Critical Days, the importance of the conception to the age 2 period. A cross-party manifesto. Leadsom, A; Field, F; Burstow, P; Lucas, C. Available online at http://www.andrealeadsom.com/downloads/1001cdmanifesto.pdf (Accessed on 30th January 2014). Adapted from the NSPCC's all babies count campaign.

Table 5: Number of clients of drug and alcohol services living with children and Toxic Trio risk factors (snapshot May '14)

Toxic trio Risk factors		Central Bedfordshire
Substance Misuse	Substance Misuse only	140
Two out of three	Substance Misuse and Mental Health Illness	40
	Substance Misuse and Domestic Violence	8
All three	Substance Misuse, Mental Health Illness and Domestic Violence	5
All Clients with Children Total		193

Source: Drug and Alcohol Services provider data

Young offenders are a specific group of young people who are vulnerable to mental health illness and whilst the numbers of first time entrants have reduced annually within Central Bedfordshire, many of those entering the system have mental health needs. In 2013/14 17 of the 65 first time entrants were referred to the CAMHS worker seconded to the Youth Offending Service.

What works

NICE has produced guidance for early intervention for a range of mental health disorders. These have been summarised in Appendix 1. Importantly, both the model of interventions used (e.g. Cognitive Behavioural Therapy, medication, family therapy) and the way the clinician works in collaboration with a family or young person (the therapeutic or working alliance) can have a significant effect on clinical outcomes.

As well as the moral argument for early intervention, there is also a positive return on investment for interventions. Cost effectiveness data has shown that for a £1 intervention for psychosis there is a return of £18 and early interventions for parents of children with conduct disorder there is a return of £8[20].

What we should be doing

Tier 1 services should not only improve resilience and wellbeing but also identify children who need more targeted intervention. Once a mental health issue has been identified that has not been resolved by Tier 1 support there should be a referral made to Tier 2 services. Tier 2 is the first step of the 'specialist Child and Adolescent Mental Health Service'.

We should increase identification and early intervention through raising awareness of existing Tier 1 and 2 child mental health and wellbeing services locally as part of the development of a standard referral pathway. This would be helped by the creation of a directory of services (e.g. on a webpage) for child mental health and wellbeing which is kept up to date.

We recommend a longer time period for Tier 2 mental health services to be delivered to patients, echoing the recommendation made by the recent Tier 1 and 2 review.
Currently most local services offer 4-8 sessions and NICE recommends that 8-12 weeks treatment may be required for certain mental health illnesses such as depression to improve outcomes. This increased intervention at Tier 2 should be monitored to ensure that it improves outcomes and prevents some children and young people needing more intensive treatment.

[20] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on25/3/2014

Case Study

Why were mental health services approached for support?

Lucy's* mother contacted our service to request support for her daughter who appeared to be suffering from anxiety and panic attacks. The anxiety had impacted on Lucy's day to day activities and she had decided to drop out of college as she was struggling to attend lessons and concentrate on her work. She was therefore spending most of her day at home and had dis-engaged from seeing friends and going out with family. The reduction in activities and anxiety seemed to impact on her mood and she appeared to also be suffering symptoms of depression secondary to the anxiety.

What support and services were provided?

Lucy attended for an initial assessment within CHUMS Emotional Wellbeing Service **(**Tier 2 intervention service) where it was agreed to offer Lucy on-going psychological support based on Cognitive Behaviour Therapy (CBT). CHUMS deliver the CYP-IAPT service (Children and Young People's Improving Access to Psychological Therapies service) which enabled Lucy to access an evidence based long-term intervention of 16 sessions of support. Lucy attended weekly appointments which were targeted to support her work towards her goals of reducing the frequency of panic attacks, going back to school and seeing her friends more regularly. We utilised a CBT approach to enable her to develop strategies to understand panic attacks and to identify helpful coping strategies.

What was the outcome?

At the end of the intervention, Lucy was working weekends as a shop assistant and had started back at college full time. She had significantly reduced the frequency of panic attacks from two per day to not experiencing a panic attack for the last 3 weeks of intervention. She was now going out with friends more regularly and felt that her mood had improved owing to the increase in her daily activities.

What could have made the service even better?

Lucy was able to take benefit of accessing longer term support within a Tier 2 service, which supported her to work on her goals without necessitating a referral to specialist Tier 3 colleagues. Owing to the volume of referrals to our service Lucy had a waiting time between referral and assessment and again between assessment and intervention. It would have enhanced the level of care if this was a more timely process for Lucy and her family.

Case study from clinical psychologist at CHUMS

*Name has been changed to maintain confidentiality

Summary

Among teenagers, rates of depression and anxiety have increased by 70% in the past 25 years[21]

In Central Bedfordshire it is imperative that we improve mental health and wellbeing for all children due to the long lasting negative impact of mental health illness. We believe that this requires action on the following recommendations:-

- a good start in life,
- emotional resilience and wellbeing and
- detecting and treating illness early.

Key recommendations to address mental health in children and young people:

1. Ensure excellent maternal mental health
   a. Identify early women with poor mental health through antenatal and postnatal maternal mood assessments
   b. Ensure that the ante and postnatal pathways for maternal mental health are followed and women have access to high quality and timely support for mental health illness

2. Help children become more resilient
   a) Health and early years practitioners should develop and agree pathways and referral routes that define how practitioners will work together, as a multidisciplinary team, across different services (NICE guideline PH40)
   b) Ensure practitioners have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing (NICE guideline PH20)
   c) Provide a curriculum that promotes positive behaviour and successful relationships and helps reduce disruptive behaviour and bullying (NICE guideline PH20: Mental health and behavior in schools. Department for Education. 2014)

3. Increase the early identification of children who are at risk of poor mental health earlier and ensure that they have access to appropriate services

[21] Fundamental Facts. Key facts and Figures about Mental Health. 2007. Mental Health Foundation. http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental_facts_2007.pdf?view=Standard Accessed 16/06/2014

2. Adults and Older People

At any one time, approximately one in six of us experience a mental health problem and mental health problems are estimated to cost the English economy around £105 billion[22].

Mental illness in adults can be classified through common mental disorders (anxiety, depression, obsessional compulsive disorder), personality disorders, psychoses, eating disorders (including anorexia nervosa and bulimia) or disorders related to substance misuse (alcohol and drugs). The number of the population in Central Bedfordshire who are affected by mental health disorders are described in Table 6 with future projections to 2016 (based on the changing population)

Table 6: Five year projections of common mental disorders, personality disorder, psychotic disorders and two or more psychiatric disorders (all persons) in Central Bedfordshire

Mental Health - All People	2012	2013	2014	2015	2016
People aged 18-64 predicted to have a common mental disorder	25,782	25,948	26,232	26,503	26,735
People aged 18-64 predicted to have a borderline personality disorder	721	725	734	741	748
People aged 18-64 predicted to have an antisocial personality disorder	559	563	568	575	579
People aged 18-64 predicted to have psychotic disorder	641	645	652	659	664
People aged 18-64 predicted to have two or more psychiatric disorders	11,522	11,600	11,723	11,846	11,947

Source: www.PANSI.org.uk (Based on National Prevalence of 17.6% of 16-64 year olds; applied to 18-64 year olds)

Through estimations of the changes in population it is predicted that there will be an 11% rise in the prevalence of dementia cases in those aged 65 years and over between 2013 and 2016 in Central Bedfordshire. This is an increase in cases from 2,804 to 3,104 (POPPI data figures). The ratio of recorded to expected prevalence of dementia is used to detect unmet need. Latest comparison figures in the Community Mental Health Profiles 2013 show that this ratio in Central Bedfordshire in 2010/11 was lower than the England average. This means that the proportion of people with dementia who are formally diagnosed is lower than the England average. This means that there may be higher unmet need for dementia in Central Bedfordshire.

[22] No Health Without Mental Health Framework. Department of Health

Recommendation 1: Improve the physical health of those with mental health illness by ensuring good access to healthy lifestyle support

Males with mental illness die on average 16 years earlier and women with mental illness die 12 years earlier than those without mental illness. Cardiovascular disease and cancer account for 75% of this reduction in life expectancy[23]

An estimated 70% of new cases of depression in older people are related to poor physical health[24]

Mental ill health can lead to poor physical health and physical ill health can lead to poor mental health. We know that we can modify our lifestyles to have a large impact on our physical health. Whilst there can be direct reasons why people with mental health illness find it harder to adopt healthy lifestyles such as not smoking, having a healthy weight and taking regular exercise, there needs to be equal and fair access to healthy lifestyle support.

Local Picture

Local services are available to support people stop smoking, lose weight, reduce harmful drinking and to be more physically active. It is not possible to determine precisely what proportion of people accessing most services also have a mental health issue, however we do know that approximately 20% of those entering treatment for drug and alcohol misuse in Central Bedfordshire also have a diagnosed mental health issue.

Cancer screening programmes and the NHS Health Check Programme are important to detect disease early and improve physical health outcomes. Data that links mental health diagnosis with attendance at these programmes is not routinely collected but anecdotal evidence suggests that those with mental health illness are less likely to attend these programmes.

What works

Evidence based interventions that are currently offered locally to improve physical health are:

- providing healthy lifestyles support including stop smoking services and weight management
- cancer screening
- early detection of illness through the NHS health check programme and
- “Making Every Contact Count” (MECC) which takes opportunities during health care contacts with patients to detect risk, deliver brief advice and signpost to relevant services

[23] The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ 2013; 346 doi: http://dx.doi.org/10.1136/bmj.f2539 (Published 21 May 2013)

[24] The Fundamental Facts. Mental Health Foundation 2007.

What we should be doing

Services to promote physical health are in place locally but we need to ensure that those with mental health illness are able to access these services equally. We recommend that GPs should identify and contact patients with known mental health illness who smoke and offer them referral to Smoking Cessation Services. Health and care professionals should be aware of the higher prevalence of smoking in those with mental health illness and increase the use of MECC to identify smokers and direct them to appropriate services. Data should be recorded of those people with mental health illness who have accessed the available services for physical health promotion so that we can ensure that we are accessing this population and further activity should be taken if these numbers are low.

Recommendation 2: Support employers to participate in Workplace Health initiatives and to signpost to relevant resources

There is a strong relationship between employment and mental health. Work is generally good for physical and mental health and well-being and can be therapeutic for people with common health problems. Unemployment is associated with poorer physical and mental health and well-being. Stress and mental health disorders are one of the biggest causes of long-term absence and, according to a number of business surveys, are on the increase as a reason for absence. It is estimated that each year one in six workers in England and Wales is affected by anxiety, depression and unmanageable stress[25]. Mental health promotion can help to make the workplace environment a positive one[26].

The Sainsbury Centre for Mental Health estimates that mental health illness costs £8.4 billion due to absenteeism and £15.1 billion due to "presenteeism" to UK employers. "Presenteeism" is a term used to describe the loss in productivity caused by illness whilst the employee is still present in the workplace and not on sick leave. This is equivalent to a cost of £335 and £605 per average employee for absenteeism and presenteeism respectively.

Local Picture

It is important to note that there is a significant gap in the employment rate for those in contact with secondary mental health services and the overall employment rate. In Central Bedfordshire there is a difference of 61.7% (percentage point difference) in these two groups; the range in the local authorities in the East of England in 2012/13 was between 56.6-71.5%[27]. This is the difference in percentage of people employed who either have or do not have mental health illness. It is possible that providing a healthy workplace could help to reduce this gap.

The Acas training course for mental health and Mental Health First Aid awareness course is an example of a widely used intervention designed to increase understanding of mental health, increased ability to identify mental health illness and support those with illness.

A recent survey from Business in the Community (BITC) indicated that 82% of local businesses wanted to know more about mental wellbeing in the workplace.

[25] Health at work – an independent review of sickness absence. Dame Carol Black and David Frost CBE. 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf (Accessed on 17/6/2014)

[26] Centre for Business Innovation. Healthy Returns? Absence and workplace health survey 2011 www.cbi.org.uk/media/.../cbi-pfizer_**absence**___workplace_health_2013.pdf

[27] PHOF, www.phoutcomes.info accessed 24/4/2014

What works

There are several aspects and benefits of work-based mental health promotion. Work-based mental health promotion intervention leads to increased performance at work, reduced sickness rates and reduced anxiety and depression. The provision of work-based stress management reduces work-related stress/sickness absence. There is evidence to show that support during a period of unemployment leads to both increased likelihood of subsequent employment and reduced distress[25].

We know that there is a great financial impact on society as a result of mental ill health. The Department of Health has shown through cost calculations how small investments in public mental health services which focus on early intervention and prevention can result in cost savings. The impact of £1 investments in the various interventions below show that substantial cost savings can be made and, therefore in an age of austerity, should be prioritised.

For every £1 invested in public mental health interventions could save[28]:

- £10 – work-based mental health promotion (after 1 year)
- £5 – early diagnosis and treatment of depression at work

What we should be doing

Continue partnership working between the local authority, health services and voluntary and community organisations. The aim should be to support employers to provide a healthy workplace through providing health and wellbeing information and support to their staff and signposting to the relevant agencies.

In addition to training, Public Health offer mental health support to workplaces through staff health events, newsletters, Workplace Health brochure and the workplace health webpage on Central Bedfordshire Council's website.

[28] Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on 25/3/2014

Recommendation 3: Increase understanding of mental health and wellbeing and reduce stigma of mental ill health

Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives[29]

Despite mental health problems affecting one in four people at some point in their lives, people with mental health conditions are the least likely out of all people with a long term condition or disability to be included in mainstream society[29]. Part of this problem is due to the inaccurate view of people with mental health illness being in some way violent or dangerous. In fact, people with mental health illness are more likely to be victims of crime than the perpetrators[29].

A good way to tackle myths surrounding mental illness is through social contact; this, both reduces stigma and the negative cycle of social isolation[29].

Local Picture

Social isolation is not only a consequence but an important risk factor for mental ill health The Adult Social Care Survey has shown that in Central Bedfordshire only 43.5% of adults receiving social care report that they have as much social contact as they would like. This low percentage is also the national average showing that it is a widespread problem. The same survey question was asked of adults carers of whom 41.6%% reported that they had as much social contact as they would like. This group of people are at increased risk of mental health illness due to the increased pressures of caring for someone else.

What works

The majority of evidence-based mental health promotion interventions for adults and older people involve opportunities for social interaction as shown in Table 7.

[29] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/stigma-discrimination/ (Accessed 15/05/2014)

Table 7: Evidence based recommendations for mental health promotion in adults and older people

Life Stage	Activity	Evidenced based outcome
Living well	1. Neighbourhood enhancement and regeneration	"walkable" neighbourhood schemes increase rates of physical activity and provide more opportunity for social interaction. Increase perceived safety.
	2. Increased opportunity for physical activity including active leisure and transport	Reduction in depression, improved wellbeing in people with schizophrenia, better cognitive performance in children, better mental health outcomes in older people.
	Activity	Evidenced based outcome
	3. Spiritual awareness, practices and beliefs	Improved mental and physical health as well as improved quality of life and recovery from mental health illness.
	4. Increased social capital; arts, music, creativity, learning, volunteering	Improvement of social skills and reduction in health risk behaviour, improved recovery from mental ill health, meaningful occupation and participation. Individual and community empowerment.
	5. Access to safe, open, green spaces; community spaces and allotments	Improved mental health, reduced stress and aggression, improved social interaction, social inclusion and training.
Ageing Well	6. Interventions to reduce social isolation such as befriending	Improved mental wellbeing. Befriending reduces depression.
	7. Psychosocial interventions	Promote wellbeing and prevent depression.
	8. Volunteering opportunities	Improved wellbeing, self-reported health, and reduced depression.
	9. Learning programmes	Improve wellbeing.
	10. Addressing hearing loss	Improved quality of life.

Source: Joint Commissioning Panel for Mental Health, 'Guidance for commissioning public mental health services' http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf Accessed on 25/3/2014

What we should be doing

We make the recommendation of reducing stigma through decreased social isolation and increased understanding of mental health illness to the whole population of Central Bedfordshire, as well as the organisations responsible for health and wellbeing.

We encourage people to reach out to those around them with simple acts of befriending; especially to those that they know to be vulnerable to social isolation such as the elderly and the marginalised. A regular visit to an elderly person's home or a weekly telephone call can be simple but effective ways of providing that support.

There are several ways to increase social contact; one example is through the "Time to Change" campaign. This advocates sending an e-card to a friend with an invitation to a social activity which can be as simple as; spending time together; having a cup of tea; going for a bike ride or playing a video game. For more details on this campaign see http://www.time-to-change.org.uk/

An assessment of the Health Needs of people with Dementia will be carried out later in 2014 to inform the further development of preventative and supportive care for those affected by dementia and their carers.

Case Study

Why were mental health services approached for support?
This client had depression and anxiety and was struggling to cope. There were also issues with mounting debts and ex-employer.

What support and services were provided?
The client received intervention from; community mental health team, counselling at GP, psychological input and medication, psychiatrist, care co-ordinator and group help.
This client also self-referred for advocacy services and Christians Against Poverty (CAP)

What was the outcome?
A compromise agreement was reached with employer. Housing issues were resolved regarding rent and discretionary payment. Debts were cleared with CAP. Client is now in receipt of Disability Living Allowance (DLA) all with advocacy support. Client still has support of care coordinator and groups

What could have made the service even better?
Time to get to know client and listen to her.
More group sessions for longer time and support should be available outside of the group as issues have to wait for another week to be discussed.
The crisis team need to be more client focused rather than time focused.

This client would like to say:
Don't judge me!!
Case study from PoWher
POhWER is a charity and membership organisation. PoWher provides information, advice, support and advocacy to people who experience disability, vulnerability, distress and social exclusion.

Summary

Adults and Older People

The recommendations made here have been highlighted because they will reduce inequalities, have the potential for widespread impact and are achievable. The current inequality in physical health and resultant premature mortality needs to be addressed urgently and there are services in place that we could use more effectively. Promoting mental health and wellbeing in the workplace would impact on a large number of people and could prevent illness which would reduce sickness absence. Stigma both has negative impacts on the person in terms of mental wellbeing and reduces the likelihood that people will seek help early.

Key recommendations to address mental health in adults and older people:

1. Improve the physical health of those with mental health illness by ensuring good access to healthy lifestyle support
2. Support employers to participate in Workplace Health initiatives and to signpost to relevant resources
3. Increase understanding of mental health and wellbeing and reduce stigma of mental ill health

3. Progress against key recommendations in the 2013 DPH report on inequalities

The Director of Public Health's Annual Report on Health Inequalities in Central Bedfordshire (published in January 2013), set out a number of key recommendations for Central Bedfordshire Council, General Practices and Bedfordshire Clinical Commissioning Group (BCCG). Some of the recommendations related to strengthening 'business as usual' so this summary focuses on progress of new local or national initiatives commenced, or those further developed during 2012/13.

It was clear from the Director of Public Health's Report on Health Inequalities that progress can only be made by key organisations working together and considering what combined action they can take. This summary demonstrates that we have achieved progress in this area and we will continue to strengthen partnership working. (See Appendix 2).

There has been a reduction in the life expectancy gap between people living in the most and least deprived areas of Central Bedfordshire for both men and women (2010-12). The life expectancy gap is now 6.6 years for men (8.0 years in 2009-11) and 5.4 years for women (6.3 years in 2009-11).

The conditions in which people are born, grow, live, work and age can all lead to health inequalities. The 2010 Marmot Review, Fair Society, Healthy Lives[30], identified six key objectives to reduce inequalities in health:

1. giving every child the best start in life;
2. enabling all children, young people and adults to maximise their capabilities and have control over their lives;
3. creating fair employment and good work for all;
4. ensuring a healthy standard for all;
5. creating and developing sustainable places and communities;
6. strengthening the role and impact of ill-health prevention.

These objectives define the vision in Central Bedfordshire, outlined in the refreshed priorities of the Joint Health & Wellbeing Strategy:

- giving every child the best start in life;
- ensuring good mental health and wellbeing at every age;
- improving outcomes for frail older people;
- enabling people to stay healthy longer.

Central to the Marmot Review is the recognition that disadvantage starts before birth and accumulates throughout life. Thus, the first priority – giving every child the best start in life – remains of paramount important and focus in Central Bedfordshire[31].

[30]The Marmot Review 2010, Fair Society, Healthy Lives.URL:http://www.instituteofhealthequity.org / Content/FileManager/pdf/fairsocietyhealthylives.pdf

[31]Children and Young People's Plan June 2013 – March 2015.

Appendix 1

NICE Best Practice for mental health disorders in Children and Adolescents

Conduct Disorders		
NICE Parent-training/education programmes in the management of children with conduct disorders TA102 (2006)	Parenting programmes (for children under 12 years old). Evidence based and ideally lasting 8-12 sessions. Some evidence for individual interventions to help with coping skills and problems solving in adolescents.	Tier 1/2

Emotional Disorders		
NICE Depression in children and young people : identification and management in primary, community and secondary care CG28 (2005)	Mild depression can be treated at tier 1 or 2 with psychological interventions for 2-3 months (if not improved after 4 weeks of watchful waiting). Include individual non-directive supportive therapy, group CBT or guided self-help. Referral to specialist services is suggested if not improved. Psychological therapies are also appropriate therapy for anxiety problems.	Tier 1/2/3

Hyperkinetic Disorders		
NICE Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults CG72 (2008)	Watchful waiting up to 10 weeks or offering a referral to a parent-training/education programme considered if suspected ADHD is having an adverse impact on development or family life. For young people with moderate levels of impairment a group parent-training/education programme, either on its own or together with a group treatment programme, CBT and/or social skills training, for the child or young person.	Tier 2/3

Developmental Disorders		
NICE Autism in children and young people CG128 (2011)	Local pathway for recognition, referral and diagnostic assessment of possible autism. 'Autism team' to be set up. Single point of referral to autism team. Behavioural interventions to address a wide range of specific behaviours in children and young people, to reduce symptom frequency and severity, increase development of adaptive skills.	Tier 2/3

Eating Disorders		
NICE Eating disorders CG9 (2004)	People with suspected anorexia nervosa should be referred to specialist care immediately. Those with suspected bulimia can be managed with an evidence-based self-help programme. Adolescents can be appropriately managed with cognitive behavioural therapy but will normally need 16-20 sessions over 4-5 months	Tier 1/2/3

Self - Harm		
NICE Self Harm CG16 (2004)	Referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, it should not be determined solely on the basis of self-harming.	Tier 1/2/3

Appendix 2: Summary Against Key Recommendations (from 2013)

The report recommended:	Progress to date:	Next steps:
a) Give every child a good start in life by ensuring:		
• Early access to antenatal care;	SEPT Community Health Visiting Service is working in close partnership with Midwifery Services in both local hospitals to provide antenatal contact from The Health Visiting Service between 28 and 34 weeks for all pregnant women. This contact includes a discussion with both parents to discuss preparation for parenthood and to deliver key public health messages around smoking; feeding; maternal obesity; dug and alcohol issues; guidance on reducing the risk of Sudden Infant Death Syndrome (SIDS). The Health Visiting Service is currently able to contact approximately 60% of pregnant women. Health Visitors and Midwives have also piloted *'Bump, Birth and Baby Stuff'* Programmes in community based clinics in Children's Centres in Dunstable and Houghton Regis – with very effective outcomes. A Maternal Obesity Programme began in March 2014 to support obese pregnant women in the south of Central Bedfordshire who deliver at the Luton & Dunstable hospital. The programme is delivered in partnership by Slimming World and the Midwifery Service at Luton & Dunstable hospital. Pregnant women are able to access a 12-week programme to support them in their pregnancy and to signpost them to manage their weight post-natally.	Formal Information Sharing Agreements (ISAs) are due to be finalised imminently with both Bedford Hospital and The Luton & Dunstable Hospital to ensure that information regarding 100% pregnant women is shared between Midwifery and Health Visiting Services. Additional *'Bump, Birth and Baby Stuff'* Programmes will now be rolled out in all localities across Central Bedfordshire. The impact and outcomes from the programme will be monitored and reviewed to inform commissioning beyond 2014.
• Reducing smoking in pregnancy and the number of babies living with a smoker;	The Stop Smoking Service has piloted a new, Specialist Stop Smoking in Pregnancy Programme - targeted in areas of high prevalence: Houghton Regis, Dunstable and Leighton Buzzard. The conversion rate from attendance to	The Specialist Stop Smoking Programme will now be rolled out across all of Central Bedfordshire. Other work also includes the continuity of working closely with maternity teams and children's services to ensure brief interventions are being given

	quit has increased significantly in the pilot, with latest figures showing 90% of women quitting after 4 weeks. Figures also show an increase in women signing up to the long term Smoking in Pregnancy Programme. Links are also being made with Outreach Workers in Children's Community Centres to deliver support to stop smoking and referrals to the *'Smokefree Homes and Cars'* programme.	to pregnant smokers and young parents to increase access to the Stop Smoking Service and meet quitters targets.
• Increase in breastfeeding;	Midwives are actively encouraged to discuss/promote breastfeeding with all pregnant women as part of routine antenatal visits, and as part of the 28-34 weeks antenatal visit by Health Visitors. There is continued support for breastfeeding at birth by midwives and Health Visitors, with additional support from Health Visitors to promote beast feeding until the 6-8 week assessment: • 6-day phone call • New Baby Face-to-face Review by 14 days • 4-week phone call UNICEF Baby Friendly Accreditation achieved – which supports breastfeeding and parent/infant relationships. Implementing Baby Friendly standards is a proven way of increasing breastfeeding rates.	Midwifery and Health Visiting Service to maximise antenatal opportunities to promote, encourage and support breast feeding. The Midwifery Service to continue to actively promote "skin to skin" and breastfeeding initiation immediately after birth. Ensure that The Baby Friendly Action Plan is implemented, monitored and evaluated, with a particular emphasis on key actions to: • Increase the numbers of Breastfeeding Buddies and Baby Brasseries • Further develop *'Out and About Breastfeeding'* • Establish and expand the special support service for breastfeeding mothers by the Baby Friendly Team
• Reduction in childhood obesity.	Two Family Weight Management Intervention Programmes – *BeeZee Tots (2-4 years)* and *BeeZee Bodies (7-15 years)* have been commissioned locally to support children and their families in to embrace a healthier lifestyle. These programmes encourage boosting children's self confidence and equipping them with the information and skills to make positive lifestyle choices. Those children who are identified through The National Child Measurement Programme (NCMP) as having high levels of obesity are targeted specifically to engage with these programmes.	Further developments include developing more bespoke programmes within targeted areas for example a *BeeZee Bodies* programmes specifically for girls aged 9-15 to run alongside the current *BeeZee Bodies* programmes. There are also new initiatives and training planned to strengthen pathways for referrals from School Nurses and other health and education professionals into commissioned family weight management programmes and appropriate support services. Public Health will be working with schools within high obesity areas to strengthen their engagement with the School Food

	A local schools based programme to increase physical activity, self-esteem and positive eating choices - 'Making *the Most of Me'* – has also been piloted in Years R and Year 4 in targeted school communities.	Trust and to review and develop their Whole School Food and Physical Activity Policies and Practice to secure maximum positive outcomes. All Lower School communities will be able to access *'Making the Most of Me'* via a rolling programme of training across the academic year. Public Health will also be contributing to development planning which would assist with the improvement of use of green spaces, cycle ways, increasing activity as well as changing eating habits with healthier food outlets – e.g. to ensure that hot food take away establishments are restricted for planning permission within 500 metres near schools.
b) Improve the wider determinants of health such as:		
• Housing;	Worked with Private Sector Housing around improving the quality of peoples homes through the on the Warm Homes Healthy People scheme, for example to provide better heating, more efficient insulation etc., for the target vulnerable populations Awareness of the strategic links between housing and addressing inequalities ('*Designing in Health')* were fed into the draft Housing Development Strategy document to ensure that environments, services, facilities and opportunities are available to prevent inequalities in new developments as well presenting opportunities to reduce inequalities in existing neighbouring communities.	Develop WHHP outline through secondment post with a view to identifying sustainable, on going action plan and resource. To continue to identify and use opportunities to reduce/prevent inequalities linking with housing related to developments, e.g. to inform the Pharmaceutical Needs Assessment
• Employment;	The LSOA have identified the rates of employment and average wages as requiring further work to improve the skills of those of working age. Recommendation of a number of initiatives have been put in place to support those living in the areas of greater deprivation to access work - for example; a Work Club at	Next steps to increase access to skills and employment support, particularly in the south of the area will be to link with Job Centre arrangements also need to be resolved, which although are a combined service in Watling House for the top 10-15% most vulnerable clients, the remainder have to go to Luton for job support. This links with the issue of affordable transport and childcare as a major barrier to work and ensure

	Kingsland; the Library in Dunstable offers ICT access and support in addition to the innovation centre in Dunstable which offers support for those wishing to set up in business and train in sustainable construction skills. Working with Central Bedfordshire College includes delivering a bespoke course to develop skills in hospitality, and attendees are referred by Job Centre Plus, who upon completion offer guaranteed interviews. The College are extending this offer to both Tragus (one of the Centre Parcs franchises) and HoneyTop Foods who are recruiting another 100+ staff each over the next year. Another development linked with social housing and housing association tenants in targeting training and employment opportunities directly to this group led by tenant participation officers.	good ICT access to be able to apply on line and job search. Further development required for work with the Travel Choices Team to make sure people are confident in being able to get to work.
c) Secure high quality alcohol and drug prevention and treatment services for our most vulnerable residents.		
	The contract for drugs and alcohol has been re-procured and a new provider started in September 2012. This included an integrated service and increased emphasis on recovery (being drug or alcohol free) rather than reducing the harm associated with addiction. It has been noticed that the proportion of people successfully completing treatment and not representing within six months is gradually increasing, and the service provision within Central Bedfordshire has increased with the hub at Dunstable having been re-furbished and new satellite services being established. There is an increased provision of community based alcohol services which has also commenced and furthermore, the drug and alcohol prevention and treatment service is also being re-procured - with increased emphasis on prevention - targeted in the areas of higher deprivation.	Recommendations are to increase the numbers accessing and successfully completing treatment. Also to ensure that the services are working closely with social care and meeting the needs of vulnerable groups such as troubled families, looked after children, and people with mental health issues. There is a review currently in progress to identify required alcohol treatment and provision.

	There has also been a rise in numbers of front-line workers that have been trained to deliver interventions and brief advice for alcohol (IBA).	
d) Continue to deliver on public health targets which influence health inequalities such as:		
• Teenage pregnancy rates;	Targeted work continues with vulnerable groups with continuity of improvements to increase access to Contraceptive and Sexual Health (CASH) Services and high quality PSHE/SRE.	To implement a PHSE/SRE Partnership Network to support school communities in ensuring that all young people have access to high quality PHSE/SRE. There will also be the launch of a new, local website and marketing materials which are part of the Sexual Health Communications Strategy. Further work will explore how harmful drinking is linked with teenage pregnancy and how to help young people to build their resilience and coping strategies.
• Obesity;	Workplace Health Events provide opportunities for visual and verbal advice on healthy eating/obesity, including information to those with families. All GP Practices across Central Bedfordshire are now participating in a Weight Management Referral Scheme to ensure that the most vulnerable and most deprived communities are able to access a weight management programme. Weight Watchers and Slimming World have been commissioned to deliver the programme. Work is also being done with Physical Activity/Leisure Services, to ensure food within vending machines at all 6 leisure centres in Central Bedfordshire have a healthy option of at least 25%. Centres must also provide a Well Being Plan, working alongside the Submission Committee appointed the Contractor for 4 of the leisure centres.	Continued support for adults (16+) to access weight management referral and exercise schemes. To continue to monitor the uptake of the programme in the most deprived areas and to ensure that the programme is promoted through GP Practices and through other partners in Health, and in Social Care.

• NHS Health Checks;	Delivery of a Health Check Programme involving all GP practices as providers, supplemented by provision in a number of other community contexts.	To develop a new wave of campaigning for implementation links to a 'Systm One' Health Check template currently being produced for GP Practices to utilise. There is an emphasis on Practices looking at ways of targeting vulnerable communities in their areas. To also enhance promotion with local companies throughout Central Bedfordshire currently being consulted on the benefits of Health Checks.
e) Increase access to the Stop Smoking Service for the populations with the highest smoking prevalence and premature mortality rates by:		
• Additional support to GP practices serving these people and setting and monitoring challenging quitter targets.	Stop Smoking Service continue to review best effective methods of promoting access to the Service. These promotions are done through workplaces with smoke awareness stands, encouraging employers to offer group stop smoking support especially targeting workers in distribution warehouses. Other stop smoking promotions considered are car park tickets, working closely with pharmacies and evening clinics to improve awareness of local services. GP Practices are also involved in assisting with raising the target of quitters. Targets for 2013/14 were set using historical prevalence data and have been monitored quarterly.	Commissioning decisions are to ascertain methods to increase quitter target with suggestions including premium incentives for Practices who achieve targets and specific targets from MSOA areas. Practices who underachieve will receive a possible penalty to encourage them to take on a more proactive responsibility in reaching their quitter targets.
f) Produce tailored information on health inequalities for GP practices in the most deprived areas and make practice-specific recommendations for evidence-based action.		
	The Stop Smoking Service is currently encouraging GP Practices to send Stop Smoking information included with patients mail outs with a financial support in line with patient confidentiality regulations. Other support includes	The development of phase 2 of the Locality Profiles will include other indicators and drivers of inequalities of health and will have an additional focus on children.

	regular visits by L2 Advisers and general training has been redesigned to adapt to meet Practice needs. Data reports are provided for Practices to assist with achieving targets and any decision making resources delivered free. There are also Locality Profiles which have been developed for each of the 4 Localities within Central Bedfordshire and have identified areas where there is a variation in care, which has influenced the locality plans to drive reduction in variations of care. Contracts with community, mental health and acute providers for 2013/14 are all including targets for Making Every Contact Count, and this includes SEPT Community Service areas also including targets for smoking quitters. These are all currently monitored on a monthly basis.	
g) Make Every Contact Count (MECC) by ensuring that relevant frontline council staff have received MECC training.		
	MECC training is currently being promoted through CBC website and forums. Social Care, Health and Housing, Care Forum, Leisure Services and Voluntary and Community Sector have all requested training.	MECC training and Train the Trainer courses will be continually promoted to all council front-line staff. These will be delivered to a range of providers/staff who will often be accessing a number of vulnerable populations, for example Fire & Rescue staff who will be going into homes to do safety checks.