

Mental Health of Adults and Older People

Executive summary

In the UK one in four people will experience a mental health problem at some point in their lives, and one in six has a mental health problem at any one time. People with poor mental health are more likely to be unemployed, live in areas of deprivation, be homeless, have poor physical health and a lower life expectancy.

Population needs

In 2010/11 North Somerset had a higher level of GP diagnosed depression (16.5%) than England (11.7%). Prevalence increased by 10.8% over the last 4 years. Modelled data which takes into account the population characteristics indicates that North Somerset should have 7% fewer common mental health problems than the national average. The reason for this discrepancy is unclear.

Rates of serious mental health problems (0.8%) recorded in GP practices are similar to the England average (0.8%) and are higher in more deprived areas. The number of cases has risen by 14% in the last 5 years. An estimated 3,420 people in North Somerset have dementia although GP practices only record 1,415 patients with dementia. The GP recorded prevalence of dementia (0.7%) is higher than England (0.5%), in part reflecting the relatively elderly population.

Rates of suicide in North Somerset have been rising over the last 5 years and are now a third higher than the national average. Suicides are more common in men, and are closely linked to levels of deprivation. A high proportion of those dying from suicide had previous mental health problems, a history of self harm, alcohol and drugs misuse. Other risk factors include unemployment (40%); living alone (44%); contact with the Criminal Justice System (14%); financial difficulties (12%) and bereavement (14%).

Rates of self harm are similar to the England average and have risen over recent years. Rates are highest in females, young people and those from deprived areas. 4% of those admitted for deliberate self harm in recent years have subsequently died with 30% of those deaths due to suicide and 20% to alcohol. In 2011/12 North Somerset patients had 4,036 admissions to a general hospital with a mental health diagnosis. This represents 7.1% of all admissions and 23% of occupied bed days. The rate of mental health admissions has risen over recent years and is higher in deprived areas. Patients with a mental health diagnosis were more likely to be admitted as an emergency, stay longer in hospital, die in hospital and be discharged to a residential or care home.

North Somerset has many factors that are protective against poor mental health or reduce the risk of poor mental health. However some key risk factors indicate a similar or higher level of need than the national average, these being: similar levels of drugs and alcohol misuse; lower levels of physical activity; higher levels of youth offending; and a higher prevalence of long term physical conditions.

Results from the first national wellbeing survey showed North Somerset had marginally better levels of self reported wellbeing to England.

Current services

A wide range of mental health services are provided by a number of organisations including primary care, the local authority, the voluntary sector, and the specialist mental health provider Avon Wiltshire Partnership (AWP).

GP practices performs better than the national average on most clinical indicators for mental health in the QOF, however there is still significant variation in performance between practices. In 2011/12, North Somerset had a lower proportion of people with anxiety/depression entering Improving Access to Psychological Therapies (IAPT) services (7.3%) than the England average (8.7%). Recovery rates were also lower although this may be due more complex patients accessing the service. Unlike antidepressant prescribing, referral rates are only slightly associated with deprivation. Uptake is lower in the over 50's.

In 2010/11, 3807 adults in North Somerset accessed AWP specialist mental health services and 333 patients were admitted to hospital. Rates of contact with specialist services and in-year bed days were among the lowest in the country. Psychiatric liaison services are provided in all hospitals in Bristol and North Somerset but provision is variable. In 2011/12, 1209 people receiving services from North Somerset Council were recorded as having a category of mental health needs or dementia. Most were women and elderly. A number of voluntary organisations provide support for mental health needs. This includes support for housing, advocacy, psychological therapy, employment and substance misuse.

Consultation with the voluntary sector and service users has identified a number of gaps in service provision including support for young people aged 16-25; employment support; dual diagnosis; learning disabilities; carers; information about medication; provision of talking therapies to older people; and lack of regular contact and ongoing support for those with dementia.

Challenge for consideration by commissioners

A number of recommendations are detailed in this report, aimed at ensuring more people have good mental health; recover from mental ill health; have good physical health; have a positive experience of care and support; and fewer people suffer from avoidable harm, stigma and discrimination.

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Why is this important?

The World Health Organisation defines mental health as

*"a state of well-being in which every individual realizes 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"*¹.

It relates to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.²

In the UK one in four people will experience a mental health problem at some point in their lives, and one in six has a mental health problem at any one time³. In England one person dies every two hours as a result of suicide.⁴ Mental health problems have a significant impact and cost on individuals, carers and society. People with poor mental health are more likely to be unemployed, find it harder to stay in work, be living in areas of deprivation and are more likely to be homeless⁵. Poor mental health also has a significant impact on an individual's physical health, and those with poor mental health die an average 20 years earlier than the general population.

Poor mental health has a significant economic cost to both individuals, society, business and the economy. Estimates of the cost of poor mental health in England put costs at £49 billion.⁶ Nearly 13% of the NHS budget in England spent on mental health.

Policy

In 2011 a new national mental health strategy, 'No health without mental health', was published. The strategy has two aims: to improve the health and wellbeing of the population and keep people well; and improve outcomes for people with mental health problems through high quality services that are equally accessible to all. The strategy has six high level objectives:

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

This document fits within the context of other policy changes for the NHS, Public Health and Social Care as detailed in the NHS white paper 'Equity and Excellence. Liberating the NHS', the public health white paper 'Health Lives healthy people' and the social care paper 'A vision for adult social care – capable

communities and active citizens'. In 2009 a national dementia strategy was published, 'Living well with dementia: a National Dementia Strategy'.

In 2012 a new national suicide prevention strategy was published with two objectives: 'a reduction in the suicide rate in the general population in England' and 'better support to those bereaved or affected by suicide'.⁷ Six key priority areas were identified for action, these being:

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

Underpinning these policy documents are a range of outcomes frameworks for the NHS, Public Health and Adult Social Care which contain indicators for measuring success in terms of specific mental health outcomes and risk factors. The national strategy's 'No health without mental health' implementation plan contains a proposed list of outcomes specifically to measure progress against the six objectives⁸.

What are the needs of the population?

This is a summary of the main findings of the mental health needs assessment for North Somerset undertaken in 2012. The full report can be accessed on the JSNA website.

Anxiety and depression: The most common mental health problems are anxiety and depression. An estimated 25,072 people in North Somerset suffer from depression and/or anxiety. Over the last few years, North Somerset has had a consistently higher rate of GP diagnosed depression than the England average as recorded in the Quality and Outcome Framework (QOF). In 2011/12, the prevalence of GP diagnosed depression in North Somerset as part of the QOF was 16.5% and 11.7% in England.

Modelled data which takes into account the characteristics of the population indicate that North Somerset should have 7% fewer common mental health problems than the national average. GP diagnosed depression has increased by 10.8% over the last 4 years. Contrary to national research GP diagnosed depression rates locally do not correlate with levels of deprivation. The reasons for these differences are unclear and require further investigation.

The biggest economic impact of depression is on employment due to decreased productivity at work, increased sickness absence, labour turnover and accidents. Anxiety and depression is the single most important cause of workplace absenteeism and nationally cost £8 billion in incapacity benefit.

Personality disorder: Personality disorders are long standing mental health conditions that affect a person's ability to make and sustain relationships. Personality disorders are common affecting 4.4% of adults in Britain aged 16-74 although most are mild and do not require specialist intervention. However two types – antisocial and borderline personality disorder – have a high burden on individuals, statutory services, and society. Prevalence is high in psychiatric outpatients (30-40%), psychiatric inpatients (40-50%) and prisoners (50-78%).

Antisocial personality disorder is present in 0.3% of adults aged over 18 (approximately 450 people in North Somerset), and 0.4% of adults with borderline personality disorder (approximately 576 in North Somerset).

Psychoses: The most common types of psychoses are schizophrenia and affective psychosis such as bi-polar disorders. Risk factors include a family history of psychosis, black ethnic groups (men only), living alone, and being unemployed. Life expectancy for schizophrenia is 25 years shorter compared with the general population.

Diagnosed levels of serious mental health problems recorded as part of QOF in GP practices in North Somerset (0.8%) are similar to the national average (0.8%) and are higher in the more deprived practices. There has been a 14% increase in the last 5 years. The MINI (2000) index which estimates the prevalence of severe and enduring mental illness indicates that North Somerset has a similar level to England.

Dementia: An estimated 3,420 people in North Somerset have dementia, although GP practices record only 1,415 patients as part of the QOF. The QOF prevalence in North Somerset is 0.7%, higher than the England average 0.5%. Over the last 6 years there has been a 31% rise in dementia cases on the QOF register.

Between May 2011 and May 2012, 460 new cases were diagnosed by the Memory Service. This is considerably higher than the number of new cases diagnosed through QOF – an additional 40 cases between 2010/11 and 2011/12. As North Somerset has a relatively elderly population compared with the national average, it is likely that the prevalence of dementia will be higher than the England average. With more people surviving to old age, the number of people with dementia is expected to rise considerably doubling over the next 30 years nationally.

Autistic spectrum: Autistic spectrum conditions is the collective term for Autism, Aspergers, Atypical Autism and Pervasive Developmental Disorder. These are lifelong neuro-developmental disorders that affect how a person is able to learn and make sense of the world, process information and relate to others. Based on national data 1.1% of adults have autistic spectrum disorder, equating to 1,285 people aged 18-64 in North Somerset.

Suicide: Suicide rates in North Somerset have been rising over the last 5 years and are now a third higher than the national average. There were 76 suicides in the three years between 2008 and 2010. Suicides are more common in men (ratio 3:1, female: male) and are closely linked to deprivation with rates highest in Weston-super-Mare.

A high proportion of cases had previous mental health problems, including a history of self harm, alcohol and drugs misuse. Other risk factors included unemployment (40%); living alone (44%); contact with the Criminal Justice System (14%); financial difficulties (12%); and bereavement (14%). Compared to neighbouring PCTs, North Somerset had the lowest proportion of suicides who had previously been in contact with AWP (14%).

Self harm: In 2010/11 there were 398 self harm admissions in North Somerset. Rates of admissions for self harm in North Somerset were not significantly different to England but have been increasing over time. Rates were higher in females, young people with a second peak in those aged 35-44 and deprived

areas. 4% of those admitted for deliberate self harm in recent years have subsequently died with 30% of those deaths due to suicide and 20% to alcohol.

Two thirds of admissions were in Weston General Hospital, with those admitted to Weston General Hospital more likely to have a repeat attendance than those attending a Bristol hospital. 4% of those admitted for deliberate self harm in recent years have subsequently died, with 30% of these deaths due to suicide and 20% from alcohol.

Hospital admissions: The prevalence of mental illness in in-patient and emergency department patients is high. In 2011/12 there were 4,036 mental health admissions in North Somerset patients attending a general hospital. This represents 7.1% of all admissions and 23% of occupied bed days. 61% of these patients went to Weston General Hospital.

The mental health admission rate has risen over recent years and is higher in more deprived areas. Most admissions were for mood disorders (35%), self harm (29%), alcohol and dementia (20%). Patients with a mental health diagnosis were more likely to be admitted as an emergency, be readmitted, stay longer in hospital, die in hospital, and be discharged to a residential or care home compared with those without a mental health diagnosis.

Risks factors: North Somerset has many factors that protect or reduce the risk of poor mental health. However some key areas indicate a similar or higher level of need than the national average, these being: drugs; alcohol; physical activity; youth offending; and prevalence of long term conditions and learning disabilities.

Employment and unemployment: There is good evidence that being in work can be protective against poor mental health. There is also good evidence that poor quality work (repetitive, insecure, involving few social networks) increases mental problems. Unemployment rates have risen in North Somerset over the last 5 years. Nationally the economic downturn has been associated with a rise in suicides. Economic activity in adults with mental health problems is much lower than other health conditions. In North Somerset only 36% of people of working age with mental illness or a learning disability were employed in 2011/12, lower than for other health conditions.

Physical health: People with common mental health problems are more likely to have a poor diet, take less exercise, be heavy smokers and take have alcohol or substance misuse problems. Depression is more common in those with physical long term conditions. The interaction between poor physical and mental health increases the cost of health care by between 12-18%. A conservative estimate is that £1 in every £8 spent on treating a long term condition is related to poor mental health. North Somerset has a higher prevalence of most of the common long term conditions compared with England, including cardiovascular diseases, hypertension, cancer, and COPD.

Wellbeing & stigma: Results from the first national wellbeing survey in 2012 showed North Somerset had marginally better levels of self reported wellbeing to England. In the four measure of wellbeing contained in the survey, North Somerset performed slightly better than the England average in three measures - life satisfaction, worthwhile, happy yesterday - and slightly worse on one measure - anxious yesterday.

National data indicates improvements in understanding and tolerance of mental illness. However a significant minority of people have negative attitudes to a range of mental health issues. Men, those aged under 35's and over 55's, and unskilled / semi-skilled groups were the least tolerant.

Current services

A wide range of mental health services are provided by a number of organisations including primary care, the local authority, the voluntary sector, and the specialist mental health provider Avon Wiltshire Partnership (AWP).

Primary Care: North Somerset performs better than the national average on most clinical indicators for mental health in the Quality and Outcomes Framework (QOF) but there is still significant variation in performance between practices. Compared to the national average, North Somerset had higher rates of prescribing for hypnotics, anxiolytics, and dementia drugs. Prescribing for antidepressants and anti-psychotics has been rising over recent years. Antipsychotic prescribing in people with dementia (3%) was lower than the national average (4.5%). Prescribing rates for depression are strongly correlated with deprivation levels. The Primary Care Liaison Service started in April 2012 and is being evaluated.

IAPT: The Improving Access to Psychological Therapies programme (IAPT) is provided by PostiveStep in North Somerset. In 2011/12, North Somerset had a lower proportion of people with anxiety / depression entering treatment (7.3%) than the England average (8.7%). Recovery rates locally (38%) were also lower than England (46%) although this may be due a higher proportion of complex cases. Unlike antidepressant prescribing, referral rates are only slightly associated with deprivation. Uptake is lower than the estimated need in the over 50's.

Specialist mental health services: In 2010/11 3807 adults in North Somerset accessed AWP services and 333 patients were admitted to hospital. Rates of contact with mental health services and in-year bed days for North Somerset were among the lowest in the country. Compared to the national average, North Somerset had a much lower proportion of contacts provided by consultant

psychiatrists (8% locally; 14% England) and clinical psychologist (0.7% locally; 7% England).

Mental Health Care Clusters are grouping of service users based on their characteristics, and will form the basis of future payments to mental health services. A total of 21 different mental health clusters have been identified grouping patients with similar needs which can be grouped into three 'super clusters' –non-psychotic, psychosis, and organic.

In April – August 2012, most North Somerset patients were in the 'organic' super cluster. The breakdown of numbers of services users in each of the super clusters was 53% organic (clusters 18-21 – dementia or related illness); 27% non-psychotic (clusters 1-9); and 20% psychosis (clusters 10-17). At the time of writing there were no national comparisons for these clusters.

In line with the national trend in-patient admissions have been declining over time. Ethnic groups other than White British are overrepresented in the inpatient population (14% of the admitted compared to 8% in general population). The proportion of people on a care programme approach (43%) is much higher than the national average (21%). NHS North Somerset commissions approximately 60 residential, nursing or hospital placements for people with a mental ill health.

Psychiatric liaison services are provided in all hospitals in Bristol and North Somerset but provision is variable. 67% of people presenting at A&E do so at a time when there is no service and the service sees only a small proportion of in-patients with diagnosed mental health conditions.

Further work is required to ensure comprehensive care pathways are available for people on the autistic spectrum, Korsakoff's Syndrome, borderline personality disorder including transition from young people to adult services and people who have experienced sexual abuse.

Social Care: In 2011/12, there were 1209 people receiving services from North Somerset Council recorded as having a category of mental health needs or dementia. Most were women and elderly. This figure is likely to be an underestimate of the true extent of mental health and dementia among people receiving social care. Just under 32% of service users were eligible for a personal budget, compared with 43% of the service users as a whole. Of the people with eligible services, 56% received their services via a personal budget compared with 69.7% of the service users as a whole.

Voluntary sector: A number of voluntary organisations provide support for mental health needs. This includes housing, advocacy, psychological therapy, employment support, and substance misuse services.

Employment: The Carlton Centre provides support for people who are long term unemployed to progress towards work. North Somerset has one of the highest proportions of people on a care programme approach who are employed. This has risen from 10.7% in 2008/09 to 15.1% in 2010/11.

Housing: In 2011/12, 21% of people accepted as statutorily homeless had a mental health problem, the proportion rising from 12% in 2007/08. A higher proportion of people on a care programme approach (61%) were in settled accommodation than the England average (59%). In 2011/12, 80% of people on a care programme approach were in settled accommodation. There is a need to review the provision of supported accommodation provision for those with complex needs and “extra housing” provision.

Reablement: START is a short term assessment and reablement service provided to adults who are experiencing a reduction in their daily living skills. The service is designed to help people make the most of their abilities and remain as independent as possible. In 2011/12, 36 referrals (4%) to START were from the Mental Health Teams.

Better physical health: Several schemes are being run by statutory and voluntary organisations and services to improve the physical health of mental health patients including the Go4Life cheque book scheme, Health Walks, and AWP inpatient physical assessments.

Costs: North Somerset has one of lowest levels of NHS funding allocation and expenditure for mental health in the country. For adults aged 18-64, local authority spend for 2010/11 for mental health was slightly higher than other similar areas. In 2010/11 North Somerset spent £2,300,000 on drugs for mental health, mostly on antidepressants (39%), anti-psychotics (33%) and anti-dementia drugs (18%).

Community voice

Consultation with the voluntary sector and service users has identified a number of gaps in service provision including young people aged 16-25; employment support; dual diagnosis; learning disabilities; carers; information about medication; provision of talking therapies to older people; and lack of regular contact and ongoing support for those with dementia. The voluntary sector wanted clarity from statutory services about commissioning intentions for older people and mental health.

Consultation with AWP services users were positive although there is room for improvement in adults knowing who their care co-ordinator is and information about medication. Users of dementia services and their carers had high

satisfaction levels but lack support following discharge. The level of satisfaction with social care was also high.

What works

A wide range of evidence based resources are contained in the full report. These include recommendations from the

- NHS Confederation – Mental Health Network,
<http://www.nhsconfed.org/Networks/MentalHealth/Pages/home.asp>
- Kings Fund
<http://www.kingsfund.org.uk/>
- Centre for Mental Health
<http://www.centreformentalhealth.org.uk/>
- National Institute for Health and Clinical Excellence
<http://www.nice.org.uk/>

Challenges for consideration

The challenges for consideration are structured in relation to the government's mental health strategy 'No health without mental health'. The strategy contains the following objectives:

- A. More people will have good mental health
- B. More people with mental health problems will recover
- C. More people with mental health problems will have good physical health
- D. More people will have a positive experience of care and support
- E. Fewer people will suffer avoidable harm
- F. Fewer people will experience stigma and discrimination

There are also specific recommendations related to information.

A. More people will have good mental health

Primary care:

1. Increase the proportion of people with dementia receiving a clinical diagnosis.
2. Increase the proportion of people diagnosed with dementia entered onto the QOF register to reach at least 60% of expected prevalence by 2014.
3. Enhance the primary care elements of the North Somerset Dementia Pathway.
4. Improve equity of access to Improving Access to Psychological Therapies (IAPT) services, promoting access in older people and those from deprived areas and monitoring the impact of expanding access to those with long term conditions. Improve completion of data recording around ethnicity and employment.
5. Audit management of depression and anxiety in primary care including use of diagnostic tools, compliance with NICE guidelines, long term antidepressant prescribing, referrals and coding.
6. Review the quality of service provision of self-harm in primary care.
7. Understand and where possible reduce the variation between practices in QOF clinical outcomes related to mental health.
8. Continue to reduce the use of inappropriate hypnotics in primary care and antipsychotic medication in those with dementia.
9. Develop a co-ordinated and ongoing mental health programme of continuing professional development for GPs and other primary care staff, including addressing issues of cultural sensitivity.
10. Ensure carers of those with a diagnosed mental illness are included on the carers register.
11. Review the accessibility of primary care for those with mental ill health, including those with drug and alcohol problems.

12. Practices should make 'reasonable adjustments' to service provision for those with poor mental health.
13. Review primary care provision and referral patterns of people dying as a result of suicide and people with serious mental ill health who have died prematurely.
14. Raise awareness in primary care of voluntary and community sector provision, developing a care pathway to support access to services. A social prescribing model could be used to support this.

Secondary care

1. Understand the skill mix of local teams with regard to access to clinical psychologists and psychiatrists.
2. Implement the demand and capacity plan for the Memory Assessment Service.
3. Psychiatric liaison provision in acute trusts should be developed to better align with the needs of patients in A&E and on the wards.
4. Review the capacity around Tiers 2 and 3 of the IAPT services.
5. Ensure specialist services are accessible to people with mild learning disability and autism.
6. Evaluation of the primary care liaison service is due in 2013 and should be used to inform service developments including provision of those at high risk of suicide.
7. Work with primary care on cost effective pathway for use of antipsychotics.
8. Improve information provision to older people particularly concerning the use of medication and talking therapies.
9. Provide a holistic response to those who are stepping down from specialist mental health services, ensuring awareness of the range of services available to support health, social and emotional needs, including services in the Voluntary and Community Sector.

Social care

1. Ensure the mental health needs of people in reablement and enablement services are met. Consider a review of current service model to ensure we meet future demand on this service.

Voluntary sector

1. The statutory sector must be explicit in its commissioning intentions to support the voluntary and community sector to remain viable in the market in the context of mental health clusters.

Care homes

1. Work with people in care homes to ensure the workforce is skilled and has knowledge in the care of people with dementia and other mental health problems.

Multiagency

1. Review the service model and develop comprehensive care pathways for the following conditions: Korsakoff syndrome; autistic spectrum disorders (including Aspergers); confirmed borderline personality disorder; and people who have experienced abuse.
2. There is also a need to review service provision for those with multiple mental health problems who do not reach the threshold for treatment for any single condition.
3. Review service models to increase the proportion of people with mental health and learning disabilities treated within the area.
4. Implement any mental health recommendations resulting from Winterborne View.
5. Ensure the care workforce is skilled and knowledgeable in the care of people with dementia. Enhance the offer of a stepped model of education for staff in caring roles across North Somerset.
6. Involvement of service users and carers and community and voluntary sector in the commissioning, redesign and evaluation of services should remain a priority for statutory agencies.

B. More people with mental health problems will recover

Employment

1. Establish a co-ordinated approach across North Somerset to support people to stay in work and to increase the proportion of people in work.
2. Statutory sector organisations should take a lead in becoming a 'Mindful Employer'.
3. Support carers of those with poor mental health to maintain or gain employment where required.

Housing

1. Better understand the mental health needs of people who are homeless including accommodation needs.
2. Monitor the impact of the changes in housing benefit on those with poor mental health.
3. Ensure the commissioning and provision of effective services to support people with their dementia to continue to live in their homes for as long as possible.
4. To reduce the number of permanent placements into care homes, in line with national government policy of care home enablement.
5. Review the capacity of quality supported accommodation for service users with high complex needs and "Extra Housing" provision.

Self care

1. Increase capacity for self care and peer support for specific conditions.

C. More people with mental health problems will have good physical health

These recommendations originate from the Department of Health's Health Inequalities National Support Team's visit to North Somerset.

1. The North Somerset Mental health Strategy needs to be explicit with regard to the physical health needs of people with mental illness. It should be supported by a comprehensive workforce strategy, which needs to support service providers across all sectors to offer brief interventions and appropriate referrals e.g. to screening programmes - '**Making all contacts counts**' to ensure that people with mental health problems who do not access mental health services are supported.
2. Once a need is established either across diseases or within specific disease areas for both physical and mental health then health outcomes for such populations needs to be agreed, a performance framework developed to drive service improvement and prioritised within commissioning priorities. A mortality audit could help in this process.
3. Systematic pathways to address the physical health needs of people with mental health problems are needed between primary and secondary health services, mental health services and voluntary sector (particularly housing) to ensure appropriate support is provided and no bottlenecks occur.
4. Services needed to be sufficiently scaled to meet the needs of the population.
5. Clear pathways are required between mental health services and services addressing healthy lifestyle.

D. More people will have a positive experience of care and support

1. Monitor the impact of the new carers service on mental health support including older people. Review the use of assisted technology to support carers in their role.
2. Ensure that people with a diagnosed mental ill health including dementia and their carers are supported by high quality, integrated and personalized services following diagnosis.

E. Fewer people will suffer avoidable harm

1. All agencies should priorities the implementation of the recent suicide prevention action plan.

F. Fewer people will experience stigma and discrimination

1. To have communities in North Somerset who are mental health and dementia friendly. This can be achieved by a co-ordinated approach to mental health promotion across North Somerset aimed at increasing awareness of symptoms, promoting early access to services and reducing stigma and discrimination.

Information gaps

1. A more comprehensive identification of user and service provider views is required to identify gaps in service provision.
2. Work with AWP to ensure data is available to identify inequalities in access to services to support vulnerable groups.
3. Improve data recording in social care to more accurately capture those with poor mental health and dementia. Improve recording of GP practice.
4. Explore the use of data from primary care clinical systems to better understand population need, service use, and outcomes.

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