MENTAL HEALTH AND WELLBEING
A SERIES OF SPECIAL BRIEFINGS
FOR SHROPSHIRE COUNTY ELECTED MEMBERS
SUMMARY
OCTOBER 2014 - JUNE 2015
This report was written and edited by Paola Alessandri-Gray at Help2Change, with significant contributions from Aislinn Bergin, Michael Bevan, Richard Dunnill, Sarah Evans, Julie Howe, Jo Robins and Diane Steiner.

The views expressed during the sessions are those of the individual contributors and do not necessarily reflect Shropshire Council policy or opinions.
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Public Health has a crucial role to play in preventing mental illness and promoting mental wellbeing. The standard process to ensure that we provide the interventions that are relevant and appropriate for Shropshire’s residents is to carry out a mental health needs assessment, based on robust local data. Collecting such data is more difficult than one might imagine, especially if we are trying to gauge general mental wellbeing and levels of distress and unhappiness before they develop into fully diagnosable mental illnesses.

Mental ill health is still a relatively hidden problem. Due to the stigma still associated with it many people tend to conceal it, making it difficult to measure its real scale in the population and to deliver effective treatment. Research at national level is also an area of concern, as funding allocated to it is not proportional to the impact that the problem has on the Country’s burden of disease, but also because the complexity of mental health makes standard research protocols inadequate and problematic.

Mental health is undoubtedly a big area of concern if we want to work towards a healthier and more equal society. I welcome any initiative that aims at raising awareness of the issue and bring people together to find solutions.

Prof Rod Thomson
Director of Public Health, Shropshire

Given that one in four adults experience a mental health problem in any year, it is clearly important that care of our mental health and wellbeing receives ‘parity of esteem’ with care of our physical health. At present, patients experiencing mental health problems experience much worse physical health than the rest of the population, with the result that serious mental illness is associated with a three times higher mortality from chronic diseases such as cardiovascular disease, respiratory disease, diabetes and cancer. This is largely preventable. As well as addressing risk factors, such as smoking, poor diet and obesity, much can be done to promote positive mental health by addressing the social determinants of health, and improving equity of access to diagnosis and treatment. There is no better measure of our success as a civilised society than our ability to meet this challenge. This
report provides a valuable resource for engaging with this issue and I am grateful to all the contributors for sharing their experience and expertise.

Dr Kevin Lewis
Director of Help2Change

When we talk about mental health as Councillors we generally have an understanding of its importance. We know that without good and stable mental health we do not have the same capacity for dealing with the everyday ‘crap’ that life brings our way. I make no apologies for using that word, because problems, issues, difficulties do not fully describe that position we sometimes find ourselves in.

When we are ‘healthy and stable’ in our mental wellbeing, we can find a way of dealing with relationship, financial, employment and bereavement issues (to name a few!) But without the stability of good mental health the everyday problems become insurmountable.

As Councillors we have a platform to raise awareness and by doing so we put mental health on the same level as diabetes, cancer, MS or other physical health problems, and we can help to reduce the stigma often associated with mental ill-health.

As we talk more often and more freely about having someone within our family or extended family circle suffering from Alzheimer’s or dementia, so it should be absolutely the same for mental illness in general and for all age groups. Our next steps are to ask Councillors to become Mental Health Champions, to take the conversation and challenge out to their communities, to make talking about mental health as ‘normal’ as talking about cancer, diabetes, or a broken leg!

We look forward to hearing from you.

Karen Calder
Portfolio Holder for Health and Wellbeing, Shropshire Council
ACKNOWLEDGEMENTS

We are extremely grateful to all the speakers who have been so generous in giving their time, knowledge and experience in delivering the sessions:

Dianne Beaumont
Aislinn Bergin
Michael Bevan
Miranda De Barra
Richard Dunnill
Sarah Evans
Julie Howe
Naomi O’Hanlon
Kate O’Hara
Alison Owen
Lilian Owens
Patrick Pietroni
Jo Robins
Diane Steiner
James Woodridge

We are also grateful to Professor Patrick Pietroni, who has expertly chaired all the session.

Thank you to Julie Fildes who has been an invaluable support in communicating with the Elected Members and ensuring that things worked smoothly during the sessions.

Thank you to Paola Alessandri-Gray who has conceived and organised this series of briefings.
INTRODUCTION

Help2Change is pleased to present this summary of the series of special briefings organised for Elected Members in Shropshire on the theme of Mental Health and Wellbeing.

The briefings were conceived as a means to raise awareness of the importance and impact of mental health and wellbeing on the lives of individuals and whole communities. They were intended to help equip the Members with knowledge and insight into a variety of aspects of the area, so that they could be more informed and effective both in the work within their constituencies and as decision makers for Shropshire County.

According to the World Health Organisation, ‘mental health is defined 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.’

Local Authorities are uniquely placed to make decisions in many areas of public life that have influential bearings on the mental wellbeing of the population. Urban planning, housing, leisure and recreation facilities, green spaces, community development are only some of the areas where Councils can exert a powerful influence to improve the mental wellbeing of their citizens.

Extensive research into the negative social and economic repercussions of poor mental health leaves no doubt about the urgent need to prioritise the improvement of people’s mental wellbeing.

We hope this series of briefings and this report will prove the start of a fruitful stream of work aimed at putting positive mental health and wellbeing much higher on the agenda of Shropshire Council and all its partners.
We present here a small selection of intelligence data that is meant to give some general background information about Shropshire County as compared to national averages. Overall, the health of the population in Shropshire is good, and both male and female life expectancy is significantly higher than the national figures. Similarly, rates of all-age all-cause mortality for males and females are significantly lower than the national figures. Life expectancy has increased in the total population in the last decade, and all-age all-cause mortality has decreased. However, inequalities in health persist in Shropshire, and the increases in life expectancy and reductions in all-age all-cause mortality have not had equal impact across all sections of the population. The same pattern of inequality is true for mental health issues.

Anybody interested in a wider range of indicators should consult Public Health England’s Public Health Profiles at http://fingertips.phe.org.uk

Wider determinants of health

The wider determinants have been described as ‘the causes of the causes’. They are the social, economic and environmental conditions that influence the health of individuals and populations. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances.

4.1% of 16-18 year olds were not in education, employment or training in 2014 (England average 4.7%).

Young people aged 16-18 years old who are not in education, training or employment (NEETS) are more likely to have poor health and die an early death. They are also more likely to have a poor diet, smoke, drink alcohol and suffer from mental health problems.

There were 6.6 episodes of violent crime, rate per 1,000 population, in 2013-14 (England average 11.1).

Crime levels are associated with both illness and poverty, increasing the burden of ill health on those communities least able to cope. Violent crime can result directly in psychological distress and subsequent mental health problems.

2.7% of the population was living in the 20% most deprived areas in England in 2013 (England average 20.4%).

This indicator identifies areas with substantial levels of multiple deprivation, which helps to measure and identify health inequalities across England. Many studies have demonstrated the association between poor health and deprivation. For instance, all cause mortality, smoking prevalence and self-reported longstanding illness are all correlated with deprivation. Any increase in inequalities in deprivation is likely to result in widening inequalities in health.

There were 4.7 people in long-term unemployment per 1,000 working-age population, in 2014 (England average 7.1).
There is strong evidence to suggest that work is generally good for physical and mental health and wellbeing, taking into account the nature and quality of work and its social context. Long term worklessness is associated with poorer physical and mental health.

There were 1.5 statutory homeless households of all ages, rate per 1,000 households, in 2013-14 (England average 2.3). This indicator highlights a group that are amongst the most vulnerable in society. Homelessness is associated with severe poverty and is a social determinant of health.

Levels of Mental Health and Illness

At any one time, roughly one in six of us is experiencing a mental health problem. Mental health problems are also estimated to cost the economy £105 billion per year. It's important to monitor and investigate the levels of mental health in order to target and improve mental health services at a local level.

There were 432 hospital admissions as result of self-harm in 10-24 year olds, rate per 100,000 of 10-24 year olds, in 2013-14 (England average 412). Self-harm is an expression of personal distress. It can result from a wide range of psychiatric, psychological, social and physical problems and self-harm can be a risk for subsequent suicide.

6.0% of over 18s had a diagnosis of depression in 2012-13 (England average 5.8%) and 11% of people completing a GP patient survey in 2012-13 said they were moderately or extremely anxious and depressed (England average 12%). This indicator estimates the prevalence of depression from General Practice records. Depression is common and disabling. The estimated prevalence of major depression among 16-65 year olds in the UK is 21/1000 (males 17, females 25). Mixed anxiety and depression is prevalent in a further 10 per cent of adult patients attending general practices. It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after cardiovascular disease in terms of the world's disabling diseases. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs.

There are an estimated 5300 adults (18+) with dementia, of which approximately 3600 have received a formal diagnosis. This indicator estimates the prevalence of dementia from CCG data. Dementia is a syndrome characterised by catastrophic, progressive global deterioration in intellectual function and is a main cause of late life disability. The prevalence of dementia increases with age and is estimated to be approximately 20 per cent at 80 years of age. In a third of cases, dementia is associated with other psychiatric symptoms such as depressive disorder, adjustment disorder, generalised anxiety disorder and alcohol related problems.
4.1% people had a low satisfaction score in 2013-14 in a self-reported wellbeing questionnaire (England average 5.6%).

9.1% people had a low happiness score in 2013-14 in a self-reported wellbeing questionnaire (England average 9.7%).

17.9% people had a high anxiety score in 2013-14 in a self-reported wellbeing questionnaire (England average 20.0%).

An average ward population in Shropshire is around 4,750 people, of which around 3,848 would be over 18 years old. Therefore if the previous figures were applied to this population around 231 would have a diagnosis of depression and 423 stated that they would be moderately or extremely anxious. If the results from the national self-reported wellbeing questionnaire were applied to this population around 689 people would have a high anxiety score, 350 would have a low happiness score and 158 would have a low satisfaction score.

Suicide

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
<th>0-19</th>
<th>20-35</th>
<th>36-50</th>
<th>51-65</th>
<th>65+</th>
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<tbody>
<tr>
<td>2010</td>
<td>39</td>
<td>31</td>
<td>8</td>
<td>5</td>
<td>7</td>
<td>11</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>2011</td>
<td>45</td>
<td>34</td>
<td>9</td>
<td>5</td>
<td>10</td>
<td>13</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>2012</td>
<td>44</td>
<td>30</td>
<td>14</td>
<td>&lt;5</td>
<td>10</td>
<td>13</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>2013</td>
<td>33</td>
<td>28</td>
<td>5</td>
<td>&lt;5</td>
<td>6</td>
<td>17</td>
<td>&lt;5</td>
<td>6</td>
</tr>
<tr>
<td>2014</td>
<td>30</td>
<td>21</td>
<td>9</td>
<td>&lt;5</td>
<td>8</td>
<td>12</td>
<td>7</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

The above data has been supplied directly by Shropshire’s Coroners and is included here without comparison with the national context. For a report on the UK picture see Samaritans’ ‘Suicide Statistics Report 2015’ at http://www.samaritans.org/sites/default/files/kfinder/branches/branch-96/files/Suicide_statistics_report_2015.pdf

THE SESSIONS

The briefings consisted of 9 separate sessions, designed to cover a range of aspects in the field of public mental health, starting with an overall exploration of the main relevant concepts and including issues specific to different age groups as well as lived experience of mental health problems.

Before the first session, Professor Patrick Pietroni gave an introductory overview of the wider issues, titled ‘The challenges facing our current approach to mental illness and mental health in prevention, promotion and treatment’. Before all subsequent sessions he reminded participants of the main points of his presentation. A summary of his introduction is included in this report.

The following table gives a summary of the sessions

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>TITLE</th>
<th>SPEAKER</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.10.2014</td>
<td>3.30</td>
<td>‘Improving Mental Wellbeing and preventing mental Illness’</td>
<td>Diane Steiner</td>
<td>The session explored basic concepts relevant to public mental health and the difference and relative value of promoting wellbeing and addressing mental health.</td>
</tr>
<tr>
<td>27.10.2014</td>
<td>1.30</td>
<td>‘The Mental Health Challenge. Local councils championing mental health’</td>
<td>Michael Bevan</td>
<td>The speaker talked about the role that members can play in supporting the promotion of mental wellbeing and presented the resources available to help councillors to develop understanding and confidence to talk to constituents about how best they can support them.</td>
</tr>
<tr>
<td>17.11.2014</td>
<td>2.00</td>
<td>‘Apps for Mental health’</td>
<td>Aislinn Bergin</td>
<td>Aislinn Bergin, PhD researcher at the University of Chester run an interactive session on mobile phone apps and websites for mental health.</td>
</tr>
<tr>
<td>24.11.2014</td>
<td>2.00</td>
<td>‘Coventry Communities Feeling Good and Doing Well’</td>
<td>Kate O’Hara</td>
<td>This talk looked at the programmes put in place by Coventry to promote the wellbeing of its population.</td>
</tr>
<tr>
<td>14.5.2015</td>
<td>2.00</td>
<td>‘Mindfulness. What’s it all about?’</td>
<td>Julie Howe</td>
<td>A session that taught how to actually practice mindfulness and looked at the scientific research that demonstrates its effectiveness.</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Title</td>
<td>Presenters</td>
<td>Description</td>
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</tr>
<tr>
<td>26.5.2015</td>
<td>2.00-3.30</td>
<td>‘A local and national perspective of dementia’</td>
<td>Sarah Evans, Dianne Beaumont</td>
<td>A talk about the local dementia strategy and action plan, and a description of the practical work that goes on in the county to support sufferers and their carers.</td>
</tr>
<tr>
<td>8.6.2015</td>
<td>2.00-3.30</td>
<td>‘Children and young people’s emotional wellbeing and resilience’</td>
<td>Jo Robins, Naomi O’Hanlon</td>
<td>The speakers described the range of mental health services available in Shropshire for children and adolescents.</td>
</tr>
<tr>
<td>24.6.2015</td>
<td>2.00-3.30</td>
<td>‘Mental health Voluntary Sector organisations in Shropshire’</td>
<td>Richard Dunnill, Lilian Owen, Jan Perry</td>
<td>An address directly from some of the voluntary sector organisations about the vital work they do in Shropshire offering a wide range of mental health services.</td>
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‘The challenges facing our current approach to mental illness and mental health in prevention, promotion and treatment’

Professor Patrick Pietroni, Public Health Lead, Mental Health and Wellbeing, Shropshire

This is a very brief overview of some of the broad issues that are relevant to the field of mental health and wellbeing.

First I want to consider the factors that can affect people’s mental health. Unemployment, loss of function, marital breakdown, long term illness, isolation, bereavement, termination, loneliness, homelessness are just some examples of a group of conditions that produce distress, unhappiness and misery. They don’t necessarily have a medical label, but they undoubtedly come under the umbrella of mental health concerns and they are also the problems that will turn up most frequently in General Practice.

On the other hand there are a set of clinically diagnosed conditions such as schizophrenia, psychosis, bipolar disorder, depression, anxiety, which have been studied, measured and described and for which standard treatment and pathways are officially recommended
The problems listed in the first instance are the ones likely to be pre-cursors or to lead to diagnosable mental illness. This connection is not as clear and well defined as with causal factors in other medical conditions, for example in diabetes or cardiovascular disease, but it is well understood how they can be contributing influences to worse mental health conditions. The interaction between socio-economical and bio-medical factors adds considerably to the complexity of the field of mental health and wellbeing.

Enormity of the problem

In the UK mental health constitutes 22.8% of the burden of disease, compared with 15.9% for cancer or 16.2% for cardiovascular disease, yet it attracts only 11% of the total NHS budget. It has enormous financial implication for the country, costing about £110 billion a year and with 10 million sick days lost in 2013, and it is going to get worse with our aging population and the increase in dementia cases. Mental health has also some specific equality issues, with 40% of people on employment Support Allowance (ESA) reporting a mental health problem, and people with Severe Mental Illness (SMI) dying 15 to 20 years earlier than those with physical problems. All this is a huge problem for the country as a whole and also importantly for the individuals affected.

Parity of esteem

Parity of esteem and stigma are significant issues that need addressing. Not only the percentage of NHS budget for mental health does not match its impact on the health of the UK population, research investment is also very low, with only 5.5% of all funds dedicated to this field. Because of the considerable stigma that mental health sufferers encounter regularly, it is estimated that 87% of service users experience discrimination, and 70% of people with mental health problems conceal their illness, making it more difficult for them to receive treatment.

Employment is another area in which parity of esteem is lacking, with only 24% of people with a mental health problem in work as opposed to 65% of those with a physical health diagnosis. This is compounded by the fact that only 25% of those in need receive treatment for their mental health condition, making it more difficult for them to build the confidence, skills and resilience to be more successful in the job market.

Data and research methodology

It is generally very complicated to collect reliable and clear data relating to mental health. Quantitative measures, also referred to as metrics, only capture part of the picture, and qualitative measures such as narratives, patients’ stories, practice based evidence and so on, are often regarded as anecdotal ‘grey data’ that cannot be replicated and therefore has limited validity.

As far as research is concerned, it is not clear how we should study mental health issues, whether the traditional format of Random Controlled Trials (RCT) is appropriate and adequate or whether we should use a sociological approach that looks at the wider determinants of health such as family, education, housing, employment etc. Mental health disorders have multiple determinants and complex evolutions, and any research in this area requires long lead times that allow for the correspondent length of treatment if
we hope to obtain meaningful results. This constitutes a considerable drawback in a health culture where results are expected on shorter time scales.

The training deficit

There is a definite problem with how General Practitioners are equipped to deal with mental health issues they encounter among their patients. We know that 90% of all mental health problems are managed in primary care, and it is estimated that 60% of all problems taken to GPs have a mental health component. Yet only 40% of British GPs undertake six months training in psychiatry. Even this doesn’t necessarily give them the appropriate tools to better respond to the range of issues they are faced with in daily practice, as psychiatry studies the management of seriously ill patients with diagnoses such as psychosis, bipolar disorder, schizophrenia etc., yet we know that GPs mainly deal with problems that are broader and more generic. Our General Practitioners are the first port of call for large numbers of people presenting with mental health difficulties that cause them considerable distress and unhappiness, but that do not amount to a full blown diagnosis yet. We need our GPs to be equipped to deal effectively with these patients, but the current training leave a deficit in this important area of their work.

To view the video recording of this briefing follow the link
http://youtu.be/BhQsbnR1rDA

To view the Power Point presentation follow the link
http://www.healthyshropshire.co.uk/assets/mentalhealthwellbeing/patricksslides.pdf
Mental wellbeing can be seen as having two main components. It is partly how we subjectively experience emotions such as feeling happy, satisfied, optimistic, content, powerful, enthused etc. It also relates to how we function in our lives and our environment, whether we have a sense of purpose, confidence, autonomy, self-awareness and acceptance. Mental wellbeing, then, is more than simply the absence of mental illness. One definition is ‘feeling good and functioning well.’

The term ‘mental health,’ although in itself potentially neutral, is often taken to mean ‘mental illness’ and more often than not assumes a negative connotation in people’s minds. ‘Mental health’ is used here to encompass all mental states, including mental wellbeing and mental illness or distress.

The level of our mental wellbeing can be seen as a continuum from poor or languishing to good or flourishing. Mental wellbeing, however, is not necessarily the opposite of mental illness, and the two terms aren’t mutually exclusive. We all, whether having a diagnosed mental illness or not, may move along the mental wellbeing continuum. Mental illness may at times make flourishing more challenging. At the same time, it is possible for someone with no mental illness to languish and have a low level of mental wellbeing.

Preventing mental illness - why is it important?

Mental, emotional or psychological problems, many of which fall short of diagnosable mental illness, together account for more disability than physical health problems, but only around 24% of mental disorders are treated, compared to 65% of physical disorders. Estimates of how many people suffer from mental illness vary - from one in four people to one in two over the course of a lifetime.

Sickness absence due to mental ill health costs around £8 billion per year (70 million sick days) and lost productivity costs £15 billion. Replacing staff who leave their posts because of mental illness costs employers £2 billion. Mental health problems represent a large cost to the NHS - 11% of current spending - and 43% of those on long-term benefits due to health
Issues have a primary mental health problem. Mental illness costs England approximately £70-100 billion each year once its impact on work, crime and violence has been taken into account, which is equal to 4.5% of GDP.

There are also significant links between mental illness and physical health, which means that people with a serious mental illness may die on average 15 years earlier than those without a mental illness.

Last but not least, it is important to prevent mental illness because treatment doesn’t always work. In fact it has been estimated that if everyone with a mental disorder had optimal treatment, only 28% of the burden of mental illness would be averted. Mental illness also frequently strikes at a much earlier age than other long-term illnesses, and can have life-long impacts.

Improving mental wellbeing - why is it important?

There is not as much research into mental wellbeing as there is in other areas of health. Nevertheless there is a growing body of evidence that suggests that work to improve mental wellbeing can have positive outcomes.

There is emerging evidence that those with good mental wellbeing have greater resilience in the face of key stressors, higher educational attainment, better physical health, fewer days off work, use less health care and have lower risk taking behaviour.

Measuring and studying mental wellbeing, rather than concentrating exclusively on mental illness, can help to illuminate what keeps people mentally well and resilient. This in turn can help local authorities to be better equipped to implement effective programmes to promote mental wellbeing.

Interventions

There are a wide range of interventions that can be implemented in different settings and for different groups that can have a positive effect on the population’s mental wellbeing. Some examples are:

- Parenting programmes
- School based programmes
- Workplace programmes
- Links to lifestyle programmes (e.g. diet, exercise)
- Volunteering, arts, gardening, time banks, community choirs, social support
- Mindfulness, yoga
- Access to green spaces

While targeted services are sometimes needed, universal services are also important, for example offering good parenting advice to all new parents.

What can be done locally?

At a local level it’s useful to understand current levels of mental wellbeing, possibly using population surveys - in part to inform decisions on what should be done and also to assess whether activities are having an impact. This can be done systematically, for example by using a validated survey tool such as the Warwick-Edinburgh Mental Well-being Scale (WEMWBS).
Specific programmes to increase mental wellbeing, such as those listed above, can be implemented. It is also important to embed work to improve mental wellbeing and prevent mental illness throughout the work of the local authority and its partners.

Carrying out and acting on Mental Wellbeing Impact Assessments (MWIA) of a local authority’s major initiatives can help to reduce potential harm to mental wellbeing. Taking action to improve the mental health and wellbeing of employees is another way to reach a large part of the local population, as well as enhancing the work of the organisation.

Food for thought
- How could Shropshire Council and its partners improve the mental health and wellbeing of the county?
- Is mental health given emphasis equal to physical health?
- What work to improve mental health is already being done? What is done well? What needs to be done more? What gaps are there?
- How could the Council embed mental health and wellbeing into all of its business?

Acknowledgements: Professor Sarah Stewart-Brown, University of Warwick, and the Faculty of Public Health’s Better Mental Health for All website.

To view the video recording of this briefing follow the link
http://youtu.be/BhQsbnRIrDA
To view the Power Point presentation follow the link
http://www.healthyshropshire.co.uk/assets/mentalhealthwellbeing/dianesteinerems15-10-14.pdf
27.10.2014

‘The Mental Health Challenge. Local councils championing mental health’

Michael Bevan, Councillor, Dorset Council

Thirteen years ago I was a very troubled man in a very troubled space; my marriage was in tatters, I had acute financial problems and I was suffering at work, being bullied by a very senior, highly respected manager.

There seemed to be no relief, escape or help available and daily life was like travelling through a long, endless black tunnel. I persevered through life automatically.

Over a number of days I went from chemist to chemist buying up 30 paracetamols at a time and one morning on my way to work I snapped, stopped in an isolated rural lay-by and swallowed the bulk of the tablets.

In what was intended to be a final farewell I phoned my best friend to thank him for all his support and despite his pleas I stayed on the line to talk, I switched off and waited for the inevitable. Within the hour the police and ambulance services were on the scene followed by that friend. He knew the regular route I took to work.

I was later told that in another half hour I would have been dead.

The subsequent events are another story. I was both physically and mentally healed after a time, I rebuilt my life and regained confidence in work when the manager who had bullied me was dismissed.

Life was improving but the principal setback to my eventual recovery was the loss of my children. They left a note on my lounge table one night to say they were staying with friends and would see me the next day.

I have not seen or heard from them in nine years. I do not know where they are.

Seven years after my breakdown I was, very surprisingly, elected as a Dorset county councillor. My predecessor had held the seat for 28 years and I needed to focus on what mattered most which were the mental health issues of social care.

There existed in the council an elective vacuum where mental health was concerned: no member initiated debates on the subject and stigma, hostility and discrimination went unchallenged.

In July 2010 I put the case for an elected member champion for mental health before a very sympathetic, supportive council leader and this in turn was placed before cabinet and full council and the proposal adopted.

I subsequently found I was the first ever local authority member champion in both England and Wales. The concept was new and challenging but I was allowed scope to take initiatives in unchartered waters and since 2010 the following has taken place:
• We held Dorset’s first ever mental health conference in October 2011, attended by 140 delegates. The resolutions from that event are actively pursued to this day.
• We were the second county council in the country to sign up to the Time to Change mental health pledge.
• Instrumental in conjunction and co-operation with the Centre for Mental Health in forming the National Network of LA mental health champions. This meets annually and co-operates regularly seeking improvements in mental health education, care and funding. There are now over 45 mental health champions in Local Authorities.
• Secured the appointment of lead officers for mental health across all the directorates of the county council and we meet quarterly as a mental health action group to monitor progress of the local authority mental health action pledge.
• Actively liaise with voluntary organisations such as Rethink, Richmond Fellowship, Dorset CCG and the NHS mental health services.

The post of mental health champion should be held by someone with personal knowledge of mental health problems, accompanied by a dedication to the task of helping others. You should publicly be prepared to stand out and be identified with all attempts to fight discrimination at work, in housing and in the social mainstream of life.

WHAT IS THE MENTAL HEALTH CHALLENGE
Local authorities have a key role in implementing the mental health strategy and improving mental health in their communities. We want to support and encourage local authorities to take a proactive approach to this crucial issue. So we’ve set up the Challenge.

Ten actions
We are asking all upper tier local authorities to take up The Mental Health Challenge which sets out ten actions that will enable councils to promote mental health across all of their business.

1. Appoint an elected member as ‘mental health champion’ across the council
2. Identify a lead officer for mental health to link in with colleagues across the Council
3. Follow the implementation framework for the mental health strategy where it is relevant to the council’s work and local needs
4. Work to reduce inequalities in mental health in our community
5. Work with the NHS to integrate health and social care support
6. Promote wellbeing and initiate and support action on public mental health for example through our joint health and wellbeing strategy
7. Tackle discrimination on the grounds of mental health in our community
8. Encourage positive mental health in our schools, colleges and workplaces
9. Proactively engage and listen to people of all ages and backgrounds about what they need for better mental health
10. Sign up to the Time to Change pledge.
Support from national organisations

National mental health organisations will support local authorities that take on the challenge by:

- Providing resources (for example published evidence, expert opinion and briefings) to help councils to take local action in support of the strategy.
- Offering networking opportunities and peer support for mental health champions, including an annual meeting and through use of electronic media.
- Recognising and acknowledging publicly the councils that sign up to the challenge and the ‘champions’ they appoint.

Member ‘champions’ may be a cabinet member or health and wellbeing board member or they might be ‘backbench’ councillors. The role would be distinctive from the formal responsibility of the lead member for social care, though it is possible that the same individual could do both.

Enthusiasm and commitment are more important than formal position in becoming a member champion. What is crucial is that an elected member takes on this role in order to influence the full range of the authority’s activities and responsibilities.

The role of champion will be defined locally but key activities might include:

- Raising awareness of mental health issues in the development of council policies and strategies, and in public forums;
- Ensuring the overview and scrutiny committee have a view to mental health in their workplans;
- Leading discussions on mental health issues with NHS organisations in the local area;
- Speaking with schools, businesses and community groups about mental health;
- Linking with mental health service users and voluntary groups locally to understand their needs and concerns;
- Tackling myths and misperceptions about mental health in the local community.

To view the video recording of this briefing follow the link
http://youtu.be/XlvH4KHApNU

For more information on The Mental Health Challenge visit
http://www.mentalhealthchallenge.org.uk/
This morning I am here as a Time to Change champion, which means I speak out under the guise of someone who has lived experience of a mental illness, and the stigma and discrimination that I have experienced because of it.

Before I was diagnosed with bipolar disorder I felt insubstantial, as if I lived life like a half person with my head lost in the clouds. I struggled to reconcile a very demanding and highflying job as an agent managing actors with coping with everyday life. I would lose myself in escapism, and this tension led to my first breakdown. I was taken into hospital and immediately diagnosed with bipolar disorder.

Having a mental health label felt very restrictive, like being chained up. Because of my illness I lost my job, my flat, my boyfriend and many of my friends. I felt a failure and a second class citizen, and for a long time I attempted the fool’s errand of trying to understand what I had done wrong to find myself in such a situation.

Since my first breakdown in January 1998, I have been hospitalised 10 times, twice under section against my will. I have been held down by nurses, forcibly sedated, put in solitary confinement. When not in hospital I would feel enormous shame about my illness, and make up stories to cover up what had happened. I knew it was difficult for people to believe that somebody could be extremely successful professionally and high functioning, and yet be so profoundly unwell.

For 16 years I lived between illness and concealment, having to decide who I would trust and open up to, who I could confide in, because in so doing I would make myself incredibly vulnerable and I did not want to risk any more of the rejections I had experienced from friends and colleagues when I was first taken ill.

But at the beginning of 2014 I had what I would call a light bulb moment, and decided that I would not choose anymore: I would just tell everybody about my mental illness and see who would choose to trust me. So one morning I went on facebook and posted a message about my diagnosis. It felt a bit like I had run into Tesco, taken all my clothes off and said ‘There, what are you going to do about it?’. The response I had from my friends was incredibly supportive and I was buoyed up by a sense of renewed purpose. I felt finally rooted in reality again and I discovered Time to Change, whose campaign I now support and promote as one of their champions.
WHAT IS TIME TO CHANGE

Time to Change is a campaign to end the stigma and discrimination that people with mental health problems face in England. It’s run by the charities Mind and Rethink Mental Illness, with funding from the Department of Health, Comic Relief and the Big Lottery Fund. But at heart, Time to Change is a social movement made up of hundreds of thousands of individuals and organisations across England, who are all doing their bit to change the way the nation thinks and acts when it comes to mental health.

Since it began in 2007, more than two million people have improved attitudes, and more people than ever are able to be open about their mental health problems. Working with both adults and children and young people, Time to Change aims to empower people to challenge stigma and speak openly about their own mental health experiences, as well as changing the attitudes and behaviour of the public towards those of us with mental health problems.

The campaign tackles stigma and discrimination within the systems which have a big impact on people’s lives, focusing on the workplace and mental health professionals. This is the first project in England that aims to change behaviour, rather than just attitudes.

Improving public attitudes and intended behaviour

Time to Change commissions an annual survey which asks a representative sample of the English population questions about their knowledge, attitudes and intended behaviour towards people with mental health problems. In the most recent survey, conducted at the end of 2014, the sample size was 1736. The results from this survey showed that during 2014 there was a 6% improvement in attitudes between 2011 and 2014, against a 5% target. The survey also saw a record number of people saying they would be willing to live, work and continue a relationship with someone who has experience of a mental health problem.

Since Time to Change began in 2007, there has been an overall 8.3% improvement.

Changing behaviour and reducing discrimination

We measure levels of discrimination by asking 1,000 people who have a diagnosed mental illness and have recently been in contact with secondary mental health services, about the discrimination they face in 21 different areas of their lives. The areas of life we ask about range from family, friends and social life (which Time to Change is directly targeting) to areas affected by the wider policy context such as housing, benefits and the police.

In 2008 when our first survey was carried out, 91% of people reported discrimination in at least one area of life. Though this decreased by 3% between 2008 and 2011, it increased again to 91% between 2011 and 2012.

There was also a significant 11.5% decrease in the average levels of discrimination reported between 2008 and 2011. This was the first time internationally that there was evidence that it is possible to change behaviour towards people with mental health problems.

However, between 2011 and 2012 the data showed that discrimination increased among the survey sample. Some of the gains between 2008-2011 were lost and the overall decrease in average levels of discrimination since 2008 is now 5.5%.

The link between the campaign and improved attitudes and behaviour

According to evaluation of Time to Change by the Institute of Psychiatry, Psychology and Neurology, King’s College London, there is a clear and consistent link between awareness
of the Time to Change campaign and having more positive attitudes. People who had seen the campaign are more likely to have better knowledge, attitudes and behaviour towards people with mental health problems than those who have not.

**Starting conversations about mental health**

The public attitudes survey has shown a significant increase in the number of adults who now say they know someone with a mental health problem - from 58% in 2009 to 65% in 2014. This suggests greater levels of openness about mental health in the population as a whole and should in turn lead to further improved attitudes as ‘social contact’, or knowing someone who is open about having a mental health problem has a clear and positive impact on public attitudes and behaviour.

There’s still more to be done until no one has to face discrimination on the grounds of a mental health problem, and until talking about having a mental health problem becomes unremarkable and every day, so Time to Change aims for 2015-16 are to:

- Improve adult public attitudes towards people with mental health problems by 2%.
- Increase the number of people with lived experience of mental health problems who are empowered to take action to challenge stigma and discrimination.
- Ensure that people with mental health problems report reduced levels of discrimination in their work place, in mental health services, and in personal relationships.
- Secure changes to policy, practice and organisational culture in order to reduce stigma and discrimination in the longer term.

To view the video recording of this briefing follow the link

[http://youtu.be/lkB7RXVlaFo](http://youtu.be/lkB7RXVlaFo)

For more information on Time to Change visit

The NHS Five Year Forward View emphasised the role that technology can play in helping to alleviate some of the extra pressures being placed on public health. In the Chief Medical Officer’s public health report she wrote about a number of prominent digital resources that were playing a significant role in helping those with mental health issues. It is perhaps not surprising that technology, and now the digital world, is so often used alongside mental health services considering that many of you will be familiar with playing a game on your smartphone as a way to relax or distract. Equally you will recognise the complexity when that game leads to your phone being flung across the room.

In a room of 5 people only 1 won’t use the internet and only 2 won’t have a smartphone. The significance of so many of us using the internet is that a world of information becomes available. Smartphones are so ubiquitous because they are affordable, mobile and personal. How many people have access to your landline (if you even have one anymore) compared with your mobile?

We can communicate through so many different mediums, all with their own strengths and weaknesses. Waiting for a text message, unsure if the person received the one you sent, unsure if it was the right number - these can all be overcome with apps such as Whatsapp if you have a smartphone. ‘Instant’ messaging lets you view profiles and see who is online. Video calls are also now easier, clearer and used for everything from referrals to diagnosis.

The world of ‘apps’ can be confusing but in the health sphere there are databases popping up, such as NHS Health Apps Library or Mindapps, which bring together some of what is available. These can measure, assess, intervene, advise... Some offer static information and interventions whilst others will use the data you provide (whether through manual input or passive tracking) to personalise their service to your needs.

When we go online most of us will use a search engine but when you aren’t sure what you are looking for this can make things difficult. Often with mental health it can be a struggle to describe what you are feeling. Using a search engine also means that often the first few results are websites that have paid money to be there. There are some excellent resources out there, such as Mind.

Also on the Web is a confusing array of online services, many offering internet-based CBT. These may or may not be evidence-based, although there is research demonstrating the efficacy of certain interventions for mild to moderate depression and anxiety along with NICE approval of their use.
Many of us like to interact with others online and this has led to some fantastic social support being offered through online services. Consider Big White Wall where people are supported in an online space by trained counsellors, or PatientsLikeMe where people can use their experiences to help support and empower research.

The future is bright. Whilst not in common practice, yet the use of virtual reality to deliver, for instance, exposure therapy in PTSD has consistently demonstrated positive results. Augmented reality allows us to impose a virtual picture or video over a real life feed, such as through the screen of your smartphone. Virtually Free are using this to place virtual spiders onto the real life hands of people with spider phobia in a game app commercially available right now. And as AI becomes more advanced they can be used on websites to provide information, through automated ‘chatbots’.

Games are often vilified as a cause of mental health problems but they can also be a very powerful way to teach life skills, and in turn improve mental health. For instance in New Zealand a group have been working on a game called SPARX that teaches adolescents the skills they need. They can be used to motivate but also as a way to distract - consider people with anxiety who could benefit from a game shown to decrease those feelings.

Many of us are accustomed to the devices out there but as sensors, screens and batteries become smaller the possibility of using our jewelry, our glasses and even our clothes to run these capabilities or collect data becomes ever more a reality.

There are some advantages and disadvantages of digital mental health from a public health perspective. Many of these are the same as the use of digital tools in everyday life. Consider anonymity - it helps reduce perceived stigma and inhibitions, allowing disclosure and a sense of comfort but equally there are those who allow the reduced inhibitions to lead them to bully and torment. The World Health Organisation Mental Health Survey listed wanting to deal with problems themselves as the most common barrier for help-seeking in those with a diagnosable mental health condition. These resources are aiding in self-support and many are proving to be a gateway into getting the help people need but they might also be seen as the only option, and fail to support people as much as they need.

Taking into consideration the advantages and disadvantages of digital mental health, it is clear there are some areas that need to be addressed for progress to be made.

- Policies are needed for the safety, integration and payment systems.
- Digital resources could be leveraged to improve mental health promotion and prevention efforts.
- The skills of the workforce need to be developed.
- Resources need to be supported.
- Good practice must be encouraged.
To view the video recording of this briefing follow the link

http://youtu.be/mJ8Yt6meC4g

To view the Power Point presentation follow the links (please note 3 separate sections)

http://www.healthyshropshire.co.uk/assets/mentalhealthwellbeing/aislinnberginappsfor
mentalhealthsection1.pdf

http://www.healthyshropshire.co.uk/assets/mentalhealthwellbeing/aislinnberginappsfor
mentalhealthsection2.pdf

http://www.healthyshropshire.co.uk/assets/mentalhealthwellbeing/aislinnberginappsfor
mentalhealthsection3.pdf
‘Coventry Communities Feeling Good and Doing Well’
Kate O’Hara, Public Health Practitioner, Sandwell Council

Coventry Communities Feeling Good and Doing Well – Wellbeing Project started with a focus on wellbeing and understanding mental wellbeing. The project title covers the 2 aspects of wellbeing: the hedonic (subjective - feeling good, happiness, levels of life satisfaction) and eudemonic (psychological/social - personal growth, purpose in life, positive relationships).

To measure the wellbeing of Coventry’s population we have used the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) in our household survey. There are other measures that can be used, such as WHO 5, GHQ 12 or ONS 4, but WEMWBS has been chosen because of its focus exclusively on positive questions, and the fact that it is validated for use for 13+ year olds.

We have identified 10 ways to feeling good and doing well in Coventry. The first 5 come from research produced by the new economics foundation in 2008 as part of the Foresight report on Mental Capital and Wellbeing where they presented the evidence based actions that people can take in their daily lives to improve their wellbeing. They are the wellbeing equivalent of the 5 fruit and veg a day. They are:

- Connect
- Be active
- Take notice
- Keep learning
- Give

5 further ways have emerged from the Household Survey which included WEMWBS we have carried out in the past 3 or 4 years in Coventry, so are very specific to our population. They are:

- Have rewarding work
- Feel safe and good about where I live
- Feel good physically
- Eat and drink healthily
- Sleep well

We use these 10 ways as a tool to embed wellbeing and mental health in all the work we undertake, for example by using them as a way to strike a conversation between public-facing staff and potential clients/customers, or as a way for employers to self-assess against the standards of the Coventry and Warwickshire Workplace Wellbeing Charter.

More practically, we have set up a Wellbeing Fund Pilot, to support the work in the 2 pilot areas of Bell Green and Foleshill, where we were also trialing different asset based approaches to community work.
The Fund has been conceived so that small groups of community members could apply for up to £500 to turn their ideas into action and to help improve the wellbeing of their neighbours and local community. The main criterion to fulfil in their application is that their idea must meet at least 6 of the 10 ways to wellbeing, and must be supported by more than one applicant. During the pilot phase we supported 18 different successful bids, ranging from knitting groups to walking, computer skills, dance, history, poetry and photography.

An important part of how Coventry has supported the development of the community’s wellbeing has been by using and asset based working approach. This is in sharp contrast to how professionals have tended to look at our communities, primarily based on a deficit approach that focuses on the risks, problems, needs and deficiencies, concentrating on problem individuals, problem families, problem communities, problem areas. Following this kind of analysis, professionals design services to ‘fix’ the problems. As a result the community and individuals can feel disempowered or become ‘service dependent’. Some people become passive recipients of expensive services, while the professionals have not seen the people behind the needs or taken into account the assets and contributions they can offer. Asset based working helps to dispel the myth that communities are not interested in their own health and wellbeing.

To redress this imbalance we need to:

- start with people rather than data;
- build from people’s strengths, stories, assets and skills rather than seeing people only through the prism of needs;
- work in partnership on how to understand local issues and how to resolve them

Asset based working is fundamental to the wellbeing approach. It is about working with communities to genuinely support them to enhance their wellbeing, but not offloading onto them the onus of creating the type of services that should be provided by the statutory sector.

In this context the word ‘asset’ denotes something different from what is understood in the world of finance. To try and clarify the concept, the following list identifies some of the possible assets to be found in communities:

- Individuals: skills, knowledge, networks, time, interests and passions
- Associations: informal networks and ways that people come together
- Organisations: not just local services, but also other assets they control, parks, community centres faith buildings etc.
- Physical assets: green open space, unused land, buildings, streets, markets, transport
- Economic: economic activity is at the heart of rebuilding a community, what skills and talents are (not) being used in the local economy. How associations and local people can contribute
- Cultural: art and culture, talents for music and drama, opportunities for creative expression

Asset based working can help us to build the cultural shift that is needed and begin to create the conditions for true co-production. Colleagues in Community Development...
and the VCS sector have been driving these approaches for many years. The Marmot review ‘Fair Society, Healthy Lives’ considers that taking this approach fosters greater local confidence and self-esteem for people and communities, giving rise to greater control over their lives. This is not going to solve inequalities in itself and it is not an alternative to anti-poverty measures but it is identified as a missing focus in any work that tries to address inequalities.

In Coventry we have trialled 2 of the many asset based approaches in 2 disadvantaged areas of the city.

**In Foleshill - C2 Connecting Communities** - working with residents on their priorities for their neighbourhood, with the aim of setting up an equal decision making partnership between local residents, agencies and services. ‘Foleshill Moving Forward’, a mainly resident led group, was established and constituted through the C2 process, reaching step 4 of a 7 step approach.

**In Bell Green using the 10 ways** - engaging with residents in conversations about wellbeing. Finding out what is good about where they live and what they want to do to improve wellbeing working with their neighbours and community. Formal Asset mapping took place to uncover the community assets, the strengths that exist in people, groups and organisations to begin to join these up and build upon them.

In learning about the assets of our communities we can begin to see and understand the whole rich picture of areas in Coventry and where their assets are, which we can support and build on for creating truly co-produced local solutions and services.

Some people may object that asset based working is just good community development and some hold a degree of cynicism about it. Fundamentally asset based working is about professionals sharing power and getting out of organisational silos and boundaries that get in the way of people-centred outcomes and community building.

An assets approach:

- Values the capacity, skills, knowledge, connections and potential in individuals, families and communities
- It is a ‘salutogenic’ approach which highlights the factors that create and support resilience and well-being
- It requires a change in attitudes and values
- Requires professional staff to be willing to share power
- Never does for a family, an individual or a community what they can do better for themselves or with the support of others

To view the video recording of this briefing follow the link

https://youtu.be/o2pyvfQXRgU

To view the Power Point presentation follow the link

What is Mindfulness?

Mindfulness is a mind-body approach or way of being which can help people change the way they think about and respond to their experiences, especially stressful experiences.

Everyone already has the ability to be mindful - it is innate. Mindfulness practice is about choosing to cultivate and develop this ability.

Mindfulness is based on age old practices, mainly from Eastern spiritual traditions (but also globally), but is available as a secular practice for anyone. It does not conflict with any beliefs or tradition.

Mindfulness is simply about noticing / paying attention to:

- thoughts
- feelings
- bodily sensations
- in the here and now without criticism.

The actual skills might be simple, but because it is so different to how our minds normally behave, it takes a lot of practice.

What might be the benefits?

By paying more attention to our thoughts, feelings and bodily sensations, we can become more aware of their transient, changing nature. We can become more aware of our unhelpful habits of mind, speech and behaviour and feel better able to accept them with kindness and manage them. We can choose to respond in ways that benefit us and those around us rather than reacting without thought. It is not about accepting the unacceptable.

Research suggests that people who practice being more mindful are less likely to experience psychological distress, including depression and anxiety. They report feeling greater well-being and life satisfaction and are more likely to have a greater sense of inner peace. People also report sleeping better (Brown et al, 2007).

Practicing mindfulness will not remove challenging thoughts or emotions, but it can help you to understand and accept them and feel less overwhelmed by them. Mindful people tend to recover from bad moods more quickly.

Regular meditation can change and develop new connections in the brain in the regions that control and regulate emotions, thoughts and decision-making, attention and awareness. Experience moulds the brain!
**Who practices Mindfulness?**

All sorts of people: it does not require any special knowledge or abilities. Because Mindfulness is a secular practice many people cultivate it alongside their beliefs or interests. Mindfulness is about finding a better way to appreciate your existing life rather than needing to change what you do.

Since 2013, over 85 MPs and peers from across the political spectrum have completed a Mindfulness course or attended classes. Many of them meet for a practice session in Parliament each Tuesday. In 2014 an All Parties Parliamentary Group was set up to explore ways in which mindfulness might be introduced into public policy.

Tracey Crouch MP (Con) has said, “Mindfulness is not exactly a majority pursuit in parliament but it’s acknowledged that it’s not some weird kooky kind of fad.”

Chris Ruane MP (Lab) has said, “The name of the game is to live with mind and body in the same place at the same time, so you’ve got focus, attention, whatever’s in front of you is the thing you pay attention to.”

**Mindfulness and health care**

It is increasingly acknowledged that effective health care requires engaging patients in looking after their own well-being. We know through research findings that illness is influenced by stress, mental attitude, and behaviour choices.

If we are to lighten the load on overstretched health services, we need new approaches that can help people manage their well-being.

The focus in health care generally, and mental health care especially, is on strategies that can prevent illness occurring/re-occurring and promote health and well-being. Mindfulness is entirely in tune with this approach. Mindfulness training encourages people to be psychological ‘masters’ of their own mind and body states, however well or ill they are (Halliwell, 2010).

**Cost effectiveness**

There is a potential to find cost advantages in Mindfulness training over many existing treatments, especially clinical treatments for mental health problems. For example:

- interventions are delivered to groups rather than one-to-one, requiring less time per patient.
- unlike much medication, courses are time-limited: once the techniques have been taught, they can continue to be practised without further input

One study found Mindfulness Based Cognitive therapy (MBCT) was as cost-effective as maintenance antidepressant prescription over the 15-month period during and after delivery of the course, but that MBCT became more cost-effective over the final three months. (Kuyken et al, 2008).
References:


Halliwell, E (2010). The Mindfulness Report, Mental Health Foundation


Suggested reading and websites:


The Mindful Way through Depression: Freeing Yourself from Chronic Unhappiness by Williams, Teasdale, Segal and Kabat Zinn (published 2007 by Guilford Press).

www.franticworld.com

www.bemindfulonline.com

www.getselfhelp.co.uk/mindfulness

www.mindfulnet.org

To view the Power Point presentation follow the link

http://www.healthyshropshire.co.uk/assets/mentalhealthwellbeing/ems14-05-15mindfulness.pdf
Introduction

Shropshire Dementia Strategy and Action Plan 2014-16 was developed in partnership with the Local Authority, local health partners and local voluntary organisations. The purpose of the strategy and action plan is to develop services for people with dementia and deliver key outcomes that reflect improved quality and cost effectiveness of care and support services.

The objectives of the strategy

- To raise awareness and understanding of dementia within all communities
- To better identify those at risk of dementia
- To ensure early diagnosis and early intervention
- To ensure all people diagnosed with dementia and their carer’s have access to high quality care and support
- To ensure people are able to live well with dementia and reduce the risk of crisis
- To ensure high quality end of life care

What is dementia?

The term ‘dementia’ describes a set of symptoms that may include loss of memory, difficulties with planning, problem solving or communicating and sometimes changes in mood or behaviour.

Dementia is not a natural part of ageing. It occurs when the brain is affected by a disease. The most common types are Alzheimer’s disease and vascular dementia. Some people have a combination of these, known as mixed dementia. Dementia is a progressive condition, meaning that people with dementia and their family and carers have to cope with changing abilities over time. These changes include an increasing and fluctuating impairment in the person’s capacity to make decisions about life events and day to day situations (1). It is possible to live well with dementia and there is more to a person than dementia; each person is unique and will experience dementia in their own way.

Dementia is caused by diseases of the brain, the most common of which is Alzheimer’s:

- Alzheimer’s disease accounts for 62% of dementia diagnoses. The brain chemistry and structure changes causing brain cells to die.
- Vascular dementia accounts for 17% of cases and is caused by strokes or small vessel disease
- Mixed dementia accounts for 10% of cases and the diagnosis is both Alzheimer’s disease and vascular dementia
- Dementia with Lewy bodies accounts for 4% of cases and is caused by irregularities in brain cells leading to symptoms similar to Alzheimer’s disease and Parkinson’s disease.
- Frontotemporal dementia accounts for 2% of cases and affects the front aspect of the brain causing behaviour and personality changes.

In later stages of dementia a person will require increasingly more support to carry out day to day activities, however many people live well for many years after their diagnosis and are able to maintain independence especially if they have timely access to information, advice and are well supported in their communities (2).

The impact of dementia

Dementia now costs the UK economy £26.3 billion a year. To put that into context, that is enough to pay the energy bills for a year of every household in the UK (8).

As the symptoms of dementia progress, people need more support to help them to remain living in their own home and once symptoms of dementia become severe people may need/choose to live in a care home. Two-thirds of people with dementia live in the community (3). Of these, one-third live alone in their own homes (4). One-third of people with dementia live in care homes (3) and around 70% of care home residents in the UK have dementia or significant memory problems (5).

Unpaid carers spent 1.3 billion hours caring for people with dementia in 2013. That’s more than 150,000 years. However, much of the cost of dementia is paid by the state approximately £8.6bn (one third) (8).

People with dementia are frequent users of NHS services. At any one time, up to a quarter of hospital beds are occupied by people with dementia (6) and they tend to have longer stays than patients without dementia (1).

National context

The provision of high quality care and support for people with dementia and their carers is a top priority for the NHS. The Prime Minister’s Dementia challenge 2013 set out the first ever national target to improve diagnosis rates for 66.7% of the estimated 850,000 people with dementia to receive a diagnosis. This number is expected to double over the next thirty years.

850,000 people live with dementia in the UK which is expected to rise to 1,142,677 by 2025 which is more than the entire population of Birmingham, the UK’s second largest city and to 2,092,945 by 2051 which is more than the entire population of Liverpool, Manchester and Birmingham combined. 225,000 people develop dementia every year, that’s roughly one person every three minutes (8).
Dementia can affect anyone of any age, however it is estimated that one in six people over the age of 80 and one in fourteen people over the age of 65 has a form of dementia. Research shows that one in three people over the age of 65 will develop dementia before they die (7). 1 out of 20 people living with dementia are under the age of 65 (8).

**The cost to the person**

According to the Alzheimer’s Society, many people with dementia and their carer’s struggle to maintain a good quality of life and to live well with dementia, partly due to stigma and misconceptions, for example only 23% of people think that it is possible for people with dementia to live on their own (7). Depression, isolation and loneliness can be a significant problem for a person living with dementia, 40% of people with dementia feel lonely, 61% feel anxious or depressed and 34% say that they do not feel part of their community (8).

Family carer’s provide much of the support for people with dementia and they themselves can find it difficult to manage their own physical and mental health needs and are at greater risk of stress and depression (7). 43% of unpaid carers reported that they do not receive enough support (8).

**Local context**

Shropshire has unique health and social care challenges due to its rural nature and sparse population which is approximately 306,129 (49.5% are men and 50.5% are women). This population is getting older when compared to the national average, the number of people aged 65 years and over in Shropshire accounts for 20.6% of the total population. 98% of the population were classified as white, with 1% of the population classed as Asian or Asian British ethnic groups (9).

**Prevalence of dementia in Shropshire**

According to most recent figures for Shropshire from the Practice Level Dementia Prevalence Calculator 2014/15:

- The estimated number of people with dementia in Shropshire is 5325
- The number of patients on the dementia register in Shropshire are 3139
- In 2014/15 Shropshire achieved a dementia diagnosis rate of 58.95% (against a national target of 66.7%), in 2013/14 Shropshire achieved a diagnosis rate of 46%

**Benefits of a timely diagnosis**

- Enables access to specialist services
- Allows access to medication where appropriate
- Enables access to information and guidance to allow informed decision making
- Opportunity to make advanced decisions and plan for the future
- Opportunity to access carer’s assessment
Local services and activity

The Memory Service:

- Is a single point of referral for all cases of suspected dementia. The Memory Service is a multidisciplinary team that completes the assessment and diagnosis of dementia and also provides follow up reviews, information, advice, support and signposting to other services for the person diagnosed with dementia and their carer.
- The Home Treatment Team is part of the Memory Service and main function is to prevent unnecessary admission due to the experience of a severe, acute, relatively transient episode of mental ill health and facilitate early discharge from hospital.

The Alzheimer’s Society:

- Dementia Support Workers (DSW) provide practical and emotional support and information to support people with dementia and their carers to be as independent as possible on their journey with dementia. This support includes telephone support and home visits which includes finding the most appropriate solutions to their practical and emotional needs and liaising with other services across Shropshire.
- Peer Support Groups provide carers of people with dementia information and peer support and are facilitated monthly by the dementia support workers and trained volunteers in three locations in Shropshire; Church Stretton, Whitchurch and Shrewsbury.
- Dementia Cafes are aimed at carers, families and the person with dementia and provide a wider opportunity for both information and socialising. The cafes have a clear structure and offer low level support in a social environment. The dementia support workers facilitate monthly Dementia cafes supported by trained volunteers in two locations in Shropshire; Ludlow and Oswestry.
- Carer Information and Support Programme (CrISP) is a structured information programme for people who care for a person with dementia.

Other services and activities include:

- Books on Prescription - Dementia
- Assistive technology
- Advocacy
- Dementia awareness raising, including, local promotion and activity for Dementia Awareness Week
- Creating Dementia Friendly communities
- Dementia Friendly Churches
- Dementia Friends Champions and Dementia Friends
- Local Dementia Action Alliances
- Service User Involvement groups
- Volunteering
- Fundraising
- Campaigning
- Singing for the Brain
- Art Therapy
- Telephone information provision
- Information workers
- Age UK - Diamond Drop In’s
- Peer support and respite
- Dementia Roadmap
- Carers’ assessments
- Benefits advice
Service user feedback

- ‘Being able to talk to others with similar problems is so reassuring as well as practical advice offered’
- ‘It makes me think of different ways to cope and find it helpful’
- Meeting a DSW has increased my knowledge about dementia. I have learnt strategies to help mum stay at home’
- ‘Meeting others and learning more to improve life for us both’

To view the video recording of this briefing follow the link

https://youtu.be/VER9CKg--fQ

To view the Power Point presentation follow the link

http://www.healthyshropshire.co.uk/assets/mentalhealthwellbeing/ems26-05-15dementia.pdf
8.6.2015

‘Children and young people’s emotional wellbeing and resilience’

Jo Robins, Public Health Consultant, Shropshire Council
Naomi O’Hanlon, Targeted Mental Health Services (TAMHS) Coordinator, Public Health, Shropshire Council

Elected Members Briefing, Shropshire Council, June 2015

Summary of a presentation and discussion on the Shropshire School Based Programme TaMHS (Targeted Mental Health Services) that uses whole school approach to promote emotional health, well-being and resilience amongst children and young people.

The Local and National Context

• There is an overarching preventative model in place in Shropshire called the Healthy Child Programme (HCP) which is the government’s early intervention and prevention public health programme from conception to 19 years.
• Delivery includes all agencies working with children and young people
• The local authority is responsible for commissioning school nursing (from 2013)
• From 1st October 2015, all local authorities will be responsible for commissioning Health Visiting services.

Why is Children’s Emotional Health & Wellbeing Important?

Shropshire is committed to improving the emotional health and wellbeing of its 68,500 children and this has been recognised in many local strategic documents and partnerships and as importantly through our own local young people’s forums (through the MYS’s and Health Champions). Some key facts and figures:-

• There are 68,000 Children and Young People in Shropshire (0-19 years)
• At any one time 4,000 need ‘specialist’ treatment
• In a class, three pupils will have an emotional health need
• Looked after children and those with disabilities are more vulnerable
• Half of all those with lifetime mental health problems first symptoms arise by the age of fourteen
• Improving emotional health and wellbeing can result in improvements in attainment, attendance and reduce exclusions.
• Ofsted found a strong association between schools with a high grade for PSHE and those graded good for overall effectiveness
Identifying Risk and Developing Resilience

These include violence, lack of control, bereavement, abuse / neglect, divorce of parents, loneliness, parental mental illness, discrimination and institutional care in childhood. As the risks accumulate for young people more protective factors are needed to act as a counterbalance. When risk factors and stressful life events outweigh the protective factors, even the most resilient individual can develop problems. If a child has one risk factor their chance of developing an emotional health problem is 1-2%, three risk factors is 8% and with four or more it increases to 20%.

It is important to counterbalance this and develop resilience because it can help to protect against the development of some mental health problems and helps to maintain wellbeing in difficult circumstances. This is especially important amongst children and young people. Giving children and young people a good start in life will be beneficial immediately and also for their longer term health outcomes. Resilience can be achieved through schools with strong academic and non-academic opportunities, high morale in school with policies that address behaviour, attainment and bullying.

Why Deliver This Programme in Schools

The evidence informs us that the school is an ideal setting to develop children’s emotional health and wellbeing and also provides an opportunity to make improvements. It is seen as a valuable setting for promoting health and its longer term impacts are recognized by the Chief Medical Officer annual report of 2012.

Promotion of health by schools helps schools achieve their ‘core business’ of increasing educational attainment and enhancing later life chances. A refocusing of school health services is needed Chief Medical Officer (2012).

Locally our schools report increasing numbers of young people with problems around anxiety, anger, poor attachment, loss, poor self-esteem and confidence. This is mirrored in primary and secondary schools and the latter report seeing more and more self harming behaviour and poor levels of resilience.

Delivery of Think Good Feel Good in Primary and Secondary Schools across Shropshire

In Shropshire we are working hard to ensure our Think Good Feel Good programme is delivered through our primary and secondary schools. The core aim of the programme is to develop a whole school approach on emotional health and well-being through the delivery of an evidence based training programme, ongoing project support, development of resources and educational materials and by working closely with key professionals such as the local CaMHS service (Children, adolescent, mental health services), school nurses and other professionals. The programme was initially aimed at school age children 5-16 years as well as their families and the whole range of school based staff, however this has now expanded to over 16 year olds. The programme achieves the following:-
• Increases awareness of mental health/mental ill-health amongst staff
• Develops a common language that expresses thoughts and feelings
• Promotes and develop projects in schools that that build confidence, self-esteem and resilience
• Improves communication and consultation with specialist services such as CAMHS
• Delivers a training programme for school staff and partners that dispels myths and helps staff to put on school based projects.
• Develops school based resources for the curriculum and daily use in the schools

The programme is delivered through a project manager with a small core team and the success to date is due to the joint ownership and delivery of the training and interventions in collaboration and consultation with schools and partners. The programme supports, involves and builds on existing work of all local professionals who work in and around schools, including school nurses, the local authority health development team, specialist CaMHS service and those working on a prevention agenda for children and young people including the voluntary sector.

Measuring the Impact

There are different measurement tools in place within the programme The school and pupil related indicators include individual measures of anxiety, feelings, pupil perception and attitudes with others related to attainment, attendance and exclusion. The training programmes include measures on activity levels of schools and participant feedback with pre and post baseline to capture impact. From the training programme staff reported increased confidence in the early identification of need, understanding of specialist services, how and when to access local specialist services such as CAMHS and child protection. Direct qualitative feedback from the children has also been very promising and Ofsted have provided positive feedback following inspections. More detailed work is now underway around evaluation and impact.

Comparison of Prevention Versus Hospital Care

Recent work complete by the West Midlands Strategic Clinical Network has calculated that the annual cost per bed for a child referred as an inpatient to hospital bed treatment is £186,000. This programme costs far less than that.
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To view the video recording of this briefing follow the link
https://youtu.be/MA6jA_e6JbY
To view the Power Point presentation follow the link
http://www.healthyshropshire.co.uk/assets/mentalhealthwellbeing/tamhspresentation080615emb.pdf
To view the video on the TaMHS programme follow the link
https://www.youtube.com/watch?v=sABWYe0k6w&feature=youtu.be
24.6.2015

‘Mental Health Voluntary Sector Organisations in Shropshire’

Lilian Owens, Chair, Voluntary Sector Mental Health Forum of Shropshire and Telford & Wrekin

Richard Dunnill, Director, Shropshire Samaritans

Alison Owens, Director, The Green Oak Foundation

VOLUNTARY SECTOR MENTAL HEALTH FORUM

The Forum is not a ‘membership’ organisation. It is open to all organisations and groups interested in or associated with mental health. Users of services, carers of people with mental health difficulties, and public and private providers of services are welcome to attend. However, anyone joining should bear in mind the purpose of the forum, which places a clear focus on the involvement and interests of voluntary, community and not-for-profit sector organisations and groups. The Forum has formal representation to the Voluntary and Community Sector Assembly Board.

Purpose

The Forum exists to provide opportunities for people from community, voluntary, and not-for-profit independent organisations and groups, whose work involves mental health, to meet each other and to develop effective working relationships with public and private providers of services associated with mental health, as well as users of those services and their carers.

Activities

The Forum meets four times a year, supported by the South Staffordshire and Shropshire Healthcare NHS Foundation Trust who provide a room for meetings at the Redwood Centre, refreshments and a revolving secretariat.

The Forum holds a mailing list of more than 100 individuals and organisations, and on a regular basis circulates information regarding funding opportunities, events to attend, training opportunities and other relevant communications.

Is it worthwhile? Do we make a difference?

During the last six months areas we have influenced the following issues:

Housing Discharge from Redwoods - Recently arranged a ‘housing discharge’ meeting following on from concerns raised at the forum and Castle Lodge consultation meetings stating service users were arriving at homeless projects (particularly in Telford) without a
key worker, without any money, without a bed for the night. This is now being followed on by a recognition that there are problems discharging someone without money, bed or named worker.

Training/Raising awareness - Organised mental health training across both Shropshire and Telford & Wrekin for all face to face job centre staff


Future of Castle Lodge - Telford CCG and others are currently looking at options talking to agencies and hopefully will take ideas into consideration. There is an inherent problem with traffic to the site as it is a cul de sac at the end of a housing estate with no alternative access.

Why the forum is important
It is totally independent.
It campaigns on behalf of people with mental health needs, raise awareness of their needs and concerns both locally and nationally.
It is a source of information, advice and support for people who will often approach us rather than the statutory sector with their questions and concerns.
The sector brings in its own income and resources to provide support to people.
It inputs into local strategy and development of services, often bringing a different perspective to the thinking.
The forum can respond to issues of concern collectively thereby providing protection for the organisations that are commissioned.
The forum can also provide a source of support for new initiatives within other sectors.
The sector provides added social value when public sector organisations contract with us.
The Forum believes that working more closely together will help to overcome the barriers to developing appropriate and effective services by facilitating an understanding of mutual difficulties and differences, as well as common ground and purposes.

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SAMARITANS

Samaritans was founded in 1953 by Chad Varah, a vicar in the Church of England Diocese of London. It is a registered charity and a secular organisation, whose vision is that fewer people die by suicide. It does this by providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland.

Nearly 22,000 volunteers do everything to raise funding, to run the branches and to run the national charity supported by a very small number of paid staff (around 100).

Samaritans are not only for people who feel suicidal
To reduce suicide we must reach people earlier on in the crisis cycle, which means reaching out to and helping people who are distressed, or in despair but who would not consider themselves to be suicidal.

We do this by:
- Being available 24 hours a day, every day of the year, to provide emotional support
- Reaching out to high risk groups and communities.
- Working in partnership with other organisations, agencies and
- Working with government to help inform public policy and raise awareness

We are available to anyone who wants to contact us and we support people through:
- Listening - because exploring feelings alleviates distress and helps people to reach a better understanding of their situation and the options open to them.
- Confidentiality - because if people feel safe, they are more likely to be open about their feelings.
- People making their own decisions - wherever possible, because we believe that people have the right to find their own solution and telling people what to do takes responsibility away from them.
- Being non-judgemental, because we want people to be able to talk to us without fear of prejudice or rejection.
- Human contact, because giving people time, undivided attention and empathy meets a fundamental emotional need and reduces distress and despair.

HOW DO WE WORK IN SHROPSHIRE?
We are one of 201 Samaritans branches across the UK and Ireland. Each is a separate charity as well as part of the national organisation.

Our 74 Volunteers come from all parts of Shropshire. Initial training takes a year and we do ongoing training every year. Role specific training has to be undertaken by those volunteers helping to run our branch.
We each agree to do an average of a four hour shift every week of the year. This includes a late shift (ending at 0230 in the morning) in one month and an overnight shift (ending at 0500 in the morning) on alternate months.

We take around 1300 calls per month and this seems to be increasing month by month. Most are by phone but increasing numbers are using text and email and we still have face to face callers.

We also work in the community with people at high risk and in high risk locations. We work with other charities and with British Transport Police, Oakwood Prison, the hospitals, the Hospice, Mental Health Services, Schools & Colleges and West Mercia Police

WHAT ARE THE FACTS?
In the UK
- 4,727 suicides in 2013 (compared to 1,713 road traffic fatalities)
- Women’s numbers have been steady for some years
- Children and young people’s numbers have had a slight drop
- Men are at much highest risk (78%) and middle aged men are at particular risk
- Shropshire men are at higher than average risk
- Primary schools in Shropshire and beyond report increasing numbers of children self-harming

In Shropshire
- 39 suicides in 2010 - 8 women, 31 men
- 45 suicides in 2011 - 9 women, 34 men
- 44 suicides in 2012 - 14 women, 30 men
- 33 suicides in 2013 - 5 women, 28 men
- 30 suicides in 2014 - 9 women, 21 men

MOST COMMON FACTORS AFFECTING OUR CALLERS
Mental health; anxiety; depression; family; relationship; money; work; rape (for females).

ADDITIONAL FACTORS AFFECTING OUR MOST SERIOUS CALLERS
Alcohol; child abuse; domestic violence, abusive relationship.

WE DO NOT ASK YOU FOR MONEY AND RESOURCES
We simply ask that you include Shropshire Samaritans in relevant conversations so that, together, we can make sure our work is helping as many people as possible.

Thank you for the opportunity to share the work of volunteers from all across Shropshire with you, our elected members.
THE GREEN OAK FOUNDATION

The Green Oak Foundation was established in 2012 as a Community Interest Company to provide affordable counselling for the people of Shropshire. The founding Directors recognised the need to provide counselling which was truly affordable, timely and not limited in the number of sessions available to a client. Whilst acknowledging the excellent work done by the NHS it was also noted that the waiting lists for counselling were ever increasing and that patients should be given a third sector choice between NHS and Private counselling.

The Green Oak Foundation moved to new premises in September 2014 which has enabled us to accommodate more clients and has given us a facility for in house training.

The Green Oak Foundation CIC is a not for profit organisation and is based on a donation fee model. Clients are able to access counselling for a £20 donation per session and in the case of individuals or couples facing financial difficulties a lower donation is accepted. Clients can be seen within 7 to 10 days of their initial contact with us and in cases of crisis within 24/48 hours. There are no limits to the number of sessions available and we try wherever possible to book sessions that are convenient for the client. Green Oak operates from 9am to 9pm, Monday to Friday and Saturday from 9am to 2pm.

All our counselling team members are members of an appropriate body such as the BACP and are very experienced. They all work as volunteers, which is the reason why we are able to offer our sessions at rates lower than normal.

The Counselling Team can provide help with a full range of issues for individuals and couples such as depression, anxiety, stress, abuse, low self confidence and divorce to name but a few. Bereavement counselling is available for individuals, couples and family groups. We run a wellbeing group which has been very successful where individuals support one another within the group setting; this has been running since 2012. We see children from 5 years upwards. Our Family Support team has forged links with the pastoral care teams of several junior schools within Shropshire. We see young adults and more recently students returning from University for their summer break.
Clients are able to self refer or are referred to us by a number of organisations such as Shropshire MIND, Shropshire Carers Support Service, West Mercia Women's Aid, Enhance Shropshire, Cruse for non bereavement issues, Adoption Service and Aquarius. We are included on the Family Information Service website for Shropshire Council. We have recently formed a strategic partnership with Shrewsbury Samaritans.

We receive no grant funding and are reliant upon client donations and income from training and support of trainee counsellors for personal counselling and supervision. We are committed to providing this excellent and professional service for the Shropshire community and ask only that Shropshire support us by making full use of our service through client use, GP referrals, supporting us by fund raising or becoming a 'Friend' of the Green Oak Foundation.

Contact details
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CONCLUSIONS

There is widespread agreement that improving people’s mental health and wellbeing is a priority more important than ever.

In Shropshire two recent high level documents have identified mental health as a key area for focused work:

- The draft Health and Wellbeing Strategy lists mental health as one of three exemplar projects on which to concentrate efforts.
- The Health and Wellbeing Peer Challenge conducted by the Local Government Association in January 2015 contains a list of key recommendations, one of which is to ‘establish a strategic forum for mental health’.

Help2Change, in partnership with Public Health and Shropshire Council, want to work extensively in the county promoting increased awareness of mental health issues and reducing the stigma experienced by people living with mental health problems.

One of the ways to achieve this could be the establishment of a cross party group of Elected Members with a special interest in mental health. This could become an engine and a catalyst for the promotion and endorsement of appropriate messages, attitudes and initiatives in the whole of Shropshire.

We hope this document can provide a useful start for any future work in such a direction.