

Sheffield Mental Health Partnership Board
for Sheffield First for Health and Wellbeing

**Sheffield Strategy
for
Mental Health
and Well-Being**

2009

Sheffield Strategy for Mental Health and Well-Being 2009

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1. Mental health – everybody’s business

All of us have mental health needs and most of us will have mental health problems of some sort in our lives. These problems have a range of causes and need to be tackled by all of us. At home, at work, mental health is everybody’s business.

Health and social care agencies have an important role in promoting mental health and well-being, including making sure treatment and support is available when required. This Strategy is about how the health and social care agencies in Sheffield will work to do that over the next 5 years.

Sheffield needs to promote and improve mental health across the life span of all its citizens. The Strategy focuses mainly on the mental health of adults, including older adults, but aims to improve mental health services for people of all ages.

2. What the strategy does

The Strategy first identifies the sources that it has drawn on – other city-wide plans, previous planning for mental health services, local and national guidance and evidence of what works. It goes on to look at what we know about mental health and illness in Sheffield, progress on services and what people have said they want to see for the future. It draws out from all of these things a vision of what services should be like and states some fundamental aims. It then describes the model of services for the future (how services will need to fit together) and how they will need to change. It ends by summarising the main priorities for change over the next 5 years. The Glossary on page 22 explains abbreviations and terms used.

3. Not a blank sheet of paper!

We have not started with a blank sheet in developing the Strategy. The Strategy draws on the following:

- **City-wide planning**

The Strategy has been developed within the overall framework of planning to improve health and well-being for Sheffield. We have built on the basis of the Sheffield First for Health and Well-Being Plan and NHS Sheffield’s *“Achieving Balanced Health”* strategy. We have also tried to take account of the many other city-wide plans that help to set the context for looking at mental health. This includes existing plans to meet the mental health needs of children and older people, in particular the *“Sheffield Strategy for Older People with Functional Mental Illness”*.

- **Previous work on planning mental health services for adults**

The *“Strategy for Adult Mental Health”*, agreed in 2003, set new directions for services, particularly around the development of specialist teams to respond to the needs of people with severe mental illness, giving greater emphasis to talking treatments and aiming to provide services in line with a “stepped care model” (this is the idea that services should be arranged so that people can access support

appropriate for their level of need). The “Whole Systems Review” of services carried out between 2003 and 2005 looked at how people access services and move between them, known as “care pathways”, and informed the design of the new services. A great deal of change has taken place and this helps to provide the basis for looking at further improvements.

● **National and regional guidance**

The Strategy is informed by a range of national guidance, including:

- the “*Mental Health National Service Framework*” (Department of Health 1999), which has driven developments in mental health services for the last ten years;
- “*Choosing Health*” (DH 2004), the Public Health White Paper, with its emphasis on wider social action to promote mental health;
- “*Our Health, Our Care, Our Say*” (DH 2006), which sets out a vision for good quality social care based on prevention, choice and self-determination; and
- “*Putting People First*” (DH 2008), outlining the direction of social care for the next 10 years, with an emphasis on universal services, early intervention and services provided through a “self directed support” approach.

The Strategy has also been influenced by the “*Report of the Mental Health Clinical Pathway Group*”, published by the Yorkshire and Humber NHS (2008) as a contribution to the review of the NHS by Lord Darzi. This highlights the need to identify both urgent and non-urgent ways of getting support for mental health problems.

● **Evidence of what works**

Service change and development needs to be informed by evidence of what works. We have therefore used National Institute for Health and Clinical Excellence guidelines on specific mental health conditions, the experience we have in Sheffield of implementing change and what people have been told has been effective as further building blocks of our Strategy.

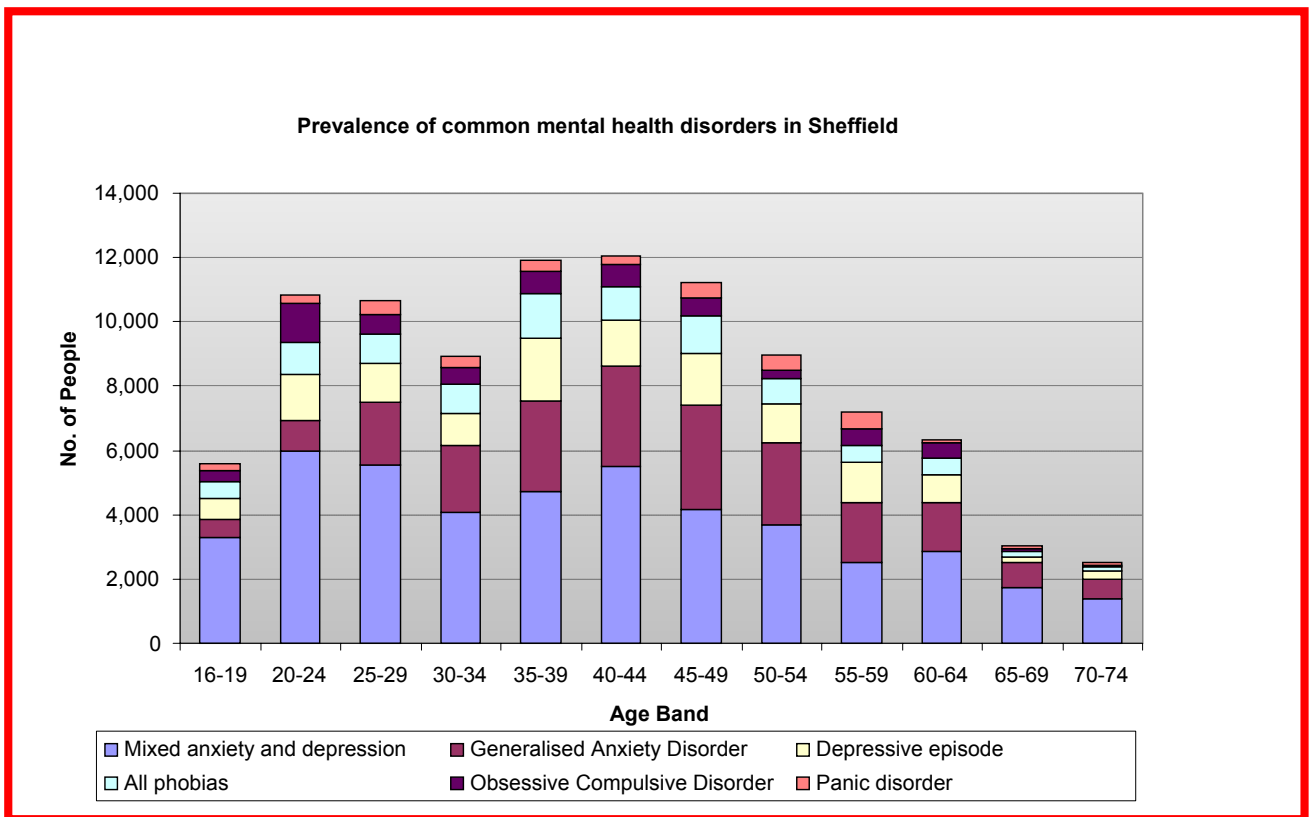
4. What we know about mental health and illness in Sheffield

The Strategy needs to be based on what we know about mental health and mental illness in Sheffield. The following is a summary of key points:

- ⇒ Based on national prevalence, we would expect one in six of the population as a whole, approximately 100,000 people, to have a mental health problem.
- ⇒ National data (Figure 1) shows the prevalence of common mental health problems amongst adults aged 16-74 years is 164 per 1000 adults - this equates to an estimated 84,500 adults aged 16 to 74 years in Sheffield in 2007¹.

¹ Calculated using the National Psychiatric Morbidity Survey 2001 applied to the 2007 Sheffield resident population and adjusted for deprivation

Figure 1: Estimated prevalence of common mental health problems in Sheffield



⇒ Anxiety and depression are the most common problems. For example, approximately 45,000 adults suffer mixed anxiety and depression, 22,000 generalised anxiety disorder and 13,000 a depressive disorder. There are about 16,000 adults with a personality disorder in Sheffield².

⇒ Mental health problems are equally common in men and women, but the types of problems differ. Women are one-and-a-half times more likely to be affected by anxiety and depression, while men suffer more from substance abuse (one in eight men is dependent on alcohol) and anti-social personality disorders. Men are also more prone to suicide: 75% of suicides are men, mostly young men.³

⇒ National data suggest that rates of depression decline in older age groups. Local work in Sheffield⁴, however, suggests that depression increases by age-group, with the highest rates (including borderline depression) in the 85-94 age-band (32.5%) and the lowest in the 18-24 age-band (6.5%).

⇒ Local work also shows higher rates of depression in the non-White ethnic group as a whole compared to the White ethnic group – 11% compared to 7% for symptoms suggestive of definite depression.

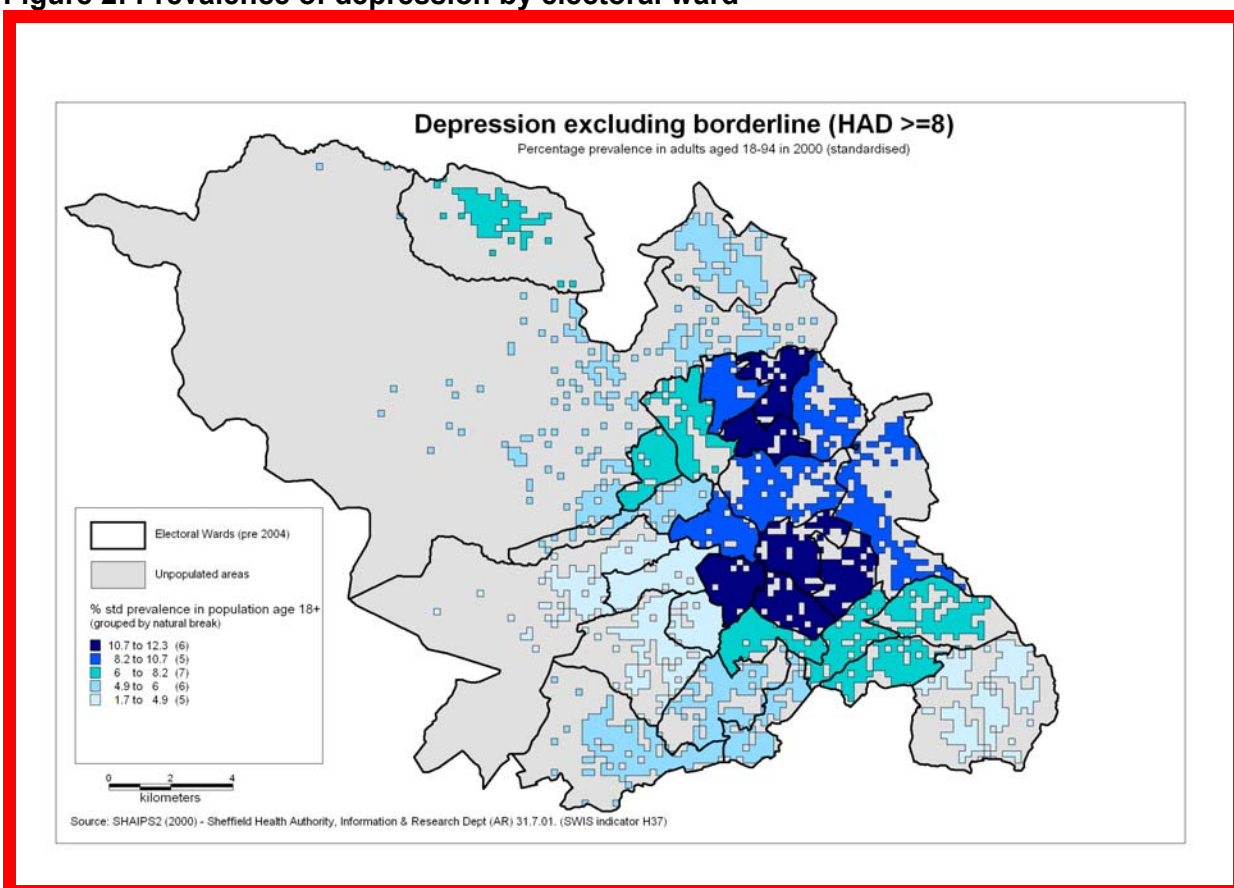
² Estimates from Mental Illness in Sheffield. A Population Needs Assessment. January 2007

³ Source: NHS Choice website

⁴ Source: Sheffield a picture of health. Report of the second Sheffield Health and Illness Prevalence Survey (SHAIPS2) Volume 2: Analysis and Commentary

- ⇒ If prevalence rates stay the same, numbers of people with common mental health problems are expected to rise by 2,000 by 2012 and by another 1,000 by 2018⁵. However, the latest national research⁶ indicates that there is an increasing prevalence of common mental health problems amongst women aged 16 to 64.
- ⇒ Looking across the city, there are large variations in rates of common mental health problems. There are high concentrations of adults with depression (both including and excluding borderline depression) in the centre, north and north-east of the city, as shown by the map below (Figure 2).

Figure 2: Prevalence of depression by electoral ward



- ⇒ Rates of treatment of mental health problems vary by type of symptoms and national research⁷ indicates that only one-third of people with neurotic symptoms assessed as needing treatment actually receive it. Treatment is more likely to be in the form of medication than talk-based therapy.
- ⇒ In terms of severe and enduring mental health problems, it is estimated that there are 1,800 adults with psychosis in Sheffield⁸. Sheffield has nearly 3,700 people with severe and long-term mental health problems requiring regular follow-up registered with Sheffield general practices, comprising 0.7% of registered patients⁹.

⁵ Estimates based on National Psychiatric Morbidity Survey using in the IAPT Workforce Capacity Tool and applied to the Population Health Register using 2004 ONS population projections

⁶ Adult Psychiatric Morbidity in England, 2007: results of a household survey, The NHS Information Centre. January 2009

⁷ Adult Psychiatric Morbidity in England, 2007: results of a household survey, The NHS Information Centre. January 2009

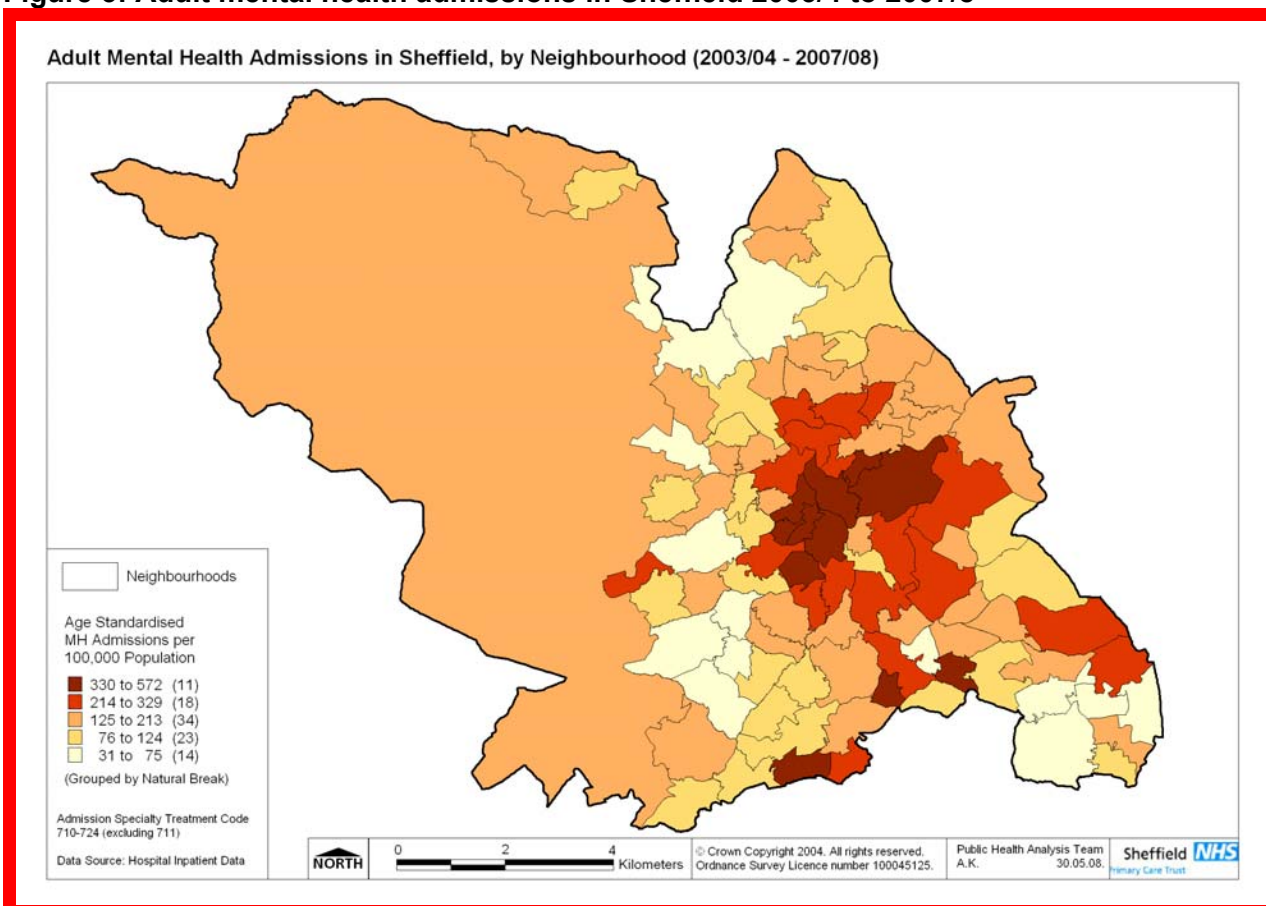
⁸ Estimate from Mental Illness in Sheffield. A Population Needs Assessment. January 2007

⁹ Based on Quality and Outcomes Framework data Feb 2007 – shows unadjusted rate

We know that the number of people on the Care Programme Approach is around 1,400.

- ⇒ The Mental Health Needs Index indicates that Sheffield has a higher (15% higher) than predicted admission rate for severe mental health problems than England as a whole. Between 2003/4 and 2007/8, adult mental health admissions were 163 per 100,000 population, equating to approximately 980 admissions per year on average.
- ⇒ There are large variations in rates of admission across the city, with higher rates in central, north-east and south-east areas (as shown in Figure 3 below).

Figure 3: Adult mental health admissions in Sheffield 2003/4 to 2007/8



- ⇒ Deaths from suicide and undetermined injury in Sheffield are lower than for both England and Yorkshire & Humber (7.03, 8.25 and 8.61 deaths per 100,000 respectively in 2004-06)¹⁰. Between 2004 and 2006, on average 38 people per year committed suicide¹¹. Suicide rates are declining both locally and nationally. Based on changes in suicide rates over time, the Sheffield rate is projected to fall to 5.7 per 100,000 population by 2010¹².

¹⁰ Source: National Centre for Health Outcomes Development, data for 2004-6

¹¹ Figures based on that date of registration of a death among people resident in Sheffield. Source: Compendium of clinical and health indicators, National Centre for Health Outcomes Development. The actual number of deaths varies year on year.

¹² Age standardized rate per 100,000 population from suicide and injury of undetermined intent. Based on trends 1997-9 to 2004-6

- ⇒ It is estimated that there are 25,000 carers providing support for someone with a mental health problem in the city¹³.
- ⇒ Mental health impacts on physical health. For example, people with schizophrenia are expected to live 10 years less than people on average. Tobacco smoking-related diseases are twice as high amongst people with severe mental health problems. People with mental health problems are three times more likely to be dependent on alcohol and are at higher risk of cardiovascular disease¹⁴.
- ⇒ Mental ill health may also be a consequence of serious physical illness and disability. For example, people with heart disease are more likely to suffer from depression. Local data¹⁵ on people over 50 suggest that approximately a quarter of those with angina also have depression and over 40% of people who have had a stroke also have depression.
- ⇒ National information shows that inequalities may be more severe for certain ethnic groups. For example, African Caribbean and Black African communities are less likely to be referred to mental health services by a GP. They are also more likely to be given medication, and at higher doses, and are less likely to be offered psychotherapy, counselling and other non-medical interventions. However, people from some black and minority ethnic communities are twice as likely to be admitted to in-patient mental health services and up to five times more likely to be compulsorily admitted under the Mental Health Act.
- ⇒ Mental health problems can be both a cause and a consequence of social exclusion. There are well known links between poor mental health and levels of deprivation, unemployment, inequality and social isolation. Areas of Sheffield with higher levels of deprivation are likely to have more people with mental ill health. The Sheffield Health and Illness Prevalence Survey confirmed a close relationship between levels of depression and deprivation across the city. Recent national work¹⁶ has shown that there are also associations between poor mental health and other aspects of poverty such as debt and fuel poverty.
- ⇒ Links between unemployment and mental ill health show up in higher rates of admission of unemployed people to psychiatric hospitals at a local and national level.
- ⇒ People with mental health problems are more than twice as likely to lose their job as people without such problems – with the Yorkshire and Humber region below the national average for the percentage of adults aged 16 to 59 years who have a mental health problem and are in employment (21.8% and 24.7% respectively, data for 2003). The Labour Force Survey for Sheffield suggests that only 14% of people with mental health problems are in work compared to 68% for the general population (2006).

¹³ National estimate based on information in Caring About Carers: A National Strategy for Carers, H.M. Government 1999. The broad estimate includes carers looking after patients with common and enduring or severe mental health problems and those in touch and not in touch with statutory or voluntary sector services.

¹⁴ Source: Sheffield Joint Strategic Needs Assessment

¹⁵ Source: Coy, J., SHAIIPS Prevalence of comorbidity using the SHAIIPS 2 Dataset (draft) 2008, NHS Sheffield.

¹⁶ Adult Psychiatric Morbidity in England, 2007: results of a household survey, The NHS Information Centre. January 2009

- ⇒ Nationally, rates of depression are twice as high amongst people receiving benefits as amongst those not receiving benefits. Rates are higher in Yorkshire and Humber than England (276.8 and 262.6 per 100,000 respectively in 2004/5).
- ⇒ An estimated 40% of Incapacity Benefit claimants suffer from a mental illness, with a further 10% of claimants having a mental illness as a secondary problem. For the Sheffield population, this equates to 10,200 claimants (source: Department of Work and Pensions benefits administration data 2007).
- ⇒ Other broad factors affect vulnerability to mental health problems. Homelessness, refugee status, discrimination, having a physical disability all increase the risk, as do family factors (e.g. partner violence), drug and alcohol problems and lack of social support from others. It is known that there is a strong association between offending and mental health problems. We know that:
 - In national research¹⁷, 44% of community mental health team patients reported problem use of drugs and/ or were assessed to have used alcohol at hazardous or harmful levels in the previous year. A quarter of patients reported hazardous or harmful alcohol use in the previous year. Nearly a third reported problem drug use in the past year.
 - The Sheffield Health and Illness Prevalence Survey indicated that 13% of people felt that they experienced a severe lack of social support, and rates were higher in more deprived areas of the city and in non-White ethnic groups.
 - The rate of partner violence in Sheffield is 3.44 per 1000 households¹⁸.
 - More than half the offenders in prison experience common mental health problems such as depression and anxiety, very often linked to issues such as a history of family poverty, family breakdown and substance misuse¹⁹.
 - Two-thirds of women prisoners show symptoms of disorders such as depression, anxiety and phobias²⁰.
- ⇒ The sense of trust and security people feel in their neighbourhood and the physical environment they live in also affects vulnerability to mental health problems. Local data²¹ show that levels of satisfaction with the local area as a place to live are high at 77.0%. However, only 8.5% of people feel very/ fairly safe alone at home at night; only 38.8% feel very/ fairly safe when walking out alone at night; and only 49.1% of residents have access to green space (e.g. a park).

¹⁷ Source: T.WEAVER, P.MADDEN, V.CHARLES, G.STIMSON, A.RENTON, P.TYRER*, T.BARNNES, C.BENCH, H.MIDDLETON, N.WRIGHT, S.PATERSON, W.SHANAHAN, N.SEIVEWRIGHT and C.FORD on behalf of the Comorbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) study team. British Journal of Psychiatry, 2003, 183, 304-313.

¹⁸ Partner violence is violence against a person where the offender is identified as a partner or ex-partner of the victim, and the incident takes place at a residential address. Data for April 07 - Jan 08.

¹⁹ Source: Offenders, Positive Practice Guidance, January 2009, IAPT website

²⁰ Source: Together Women Project factsheet

²¹ Source 2007 Neighbourhood Survey, Sheffield City Council

5. Progress on improving services

Since the last “*Strategy for Sheffield Adult Mental Health*” in 2003 there have been significant improvements in services.

There has been additional funding to develop the Sheffield Assertive Outreach Service for people who find it difficult to keep in regular contact with services; the Early Intervention Service for young people with a psychosis; and the Crisis Resolution and Home Treatment Service.

The number of counsellors and other mental health workers in primary care has increased.

There has been an increase in support for carers, a greater emphasis on prevention and mental health promotion and more attention to the needs of black and minority ethnic communities.

Effort has gone into improving the way the system works, with progress towards developing mental health services in primary care, focusing on treatments recommended by NICE.

Voluntary and community groups have increased their vital contribution, increasing the provision of services that are non-discriminating, focused on particular communities and able to work with people who do not wish to use statutory services.

However, we know that services could and should be radically better. In February, 2008, we held a stakeholder day on future services – “*Your Mental Health in 2015*”. People identified the following as the main areas for improvement:

- More work to promote better mental health for the population as a whole.
- Challenging any lack of respect and individuality in how people are treated in mental health services.
- Better consideration of people’s lives in the round and much more emphasis on planning for recovery.
- More attention to the links between mental and physical health.
- Tackling the marginalisation of people who have both mental health and other disabilities.
- Much better access for people with depression and anxiety to get help.
- Making it easier for people to get the services they need when and where they need them. This means better access to services at all levels and between teams.
- Increased alternatives to hospital admission and continued improvement in the environment in hospital in-patient wards to promote recovery.

- Developing more training, support and information to help service users and carers know how to look after their own mental health.
- Making sure people of different ages receive the same standards of services.
- Ensuring smooth transition from children's to adult services.

6. What people have said they want in the future

At the stakeholder day, people also discussed specific ideas for service improvement. These were some of the main suggestions:

- Promote a “Five a Day” message for public mental health – have fun, exercise, do something for someone else, eat well and get enough sleep.
- Improve access for people who currently don't get treatment.
- Ensure that GPs and primary care services are working together with secondary care services to provide treatment and support.
- Join up what we have got. Make what's there work and create services that meet the needs of the population – not just add more of the same.
- Promote recovery – focus on people's strengths and what they can do. Use the idea of recovery plans.
- Provide mental healthcare from the cradle to the grave, dependent on your needs not your age.
- People should be able to design their own individual packages of support – with someone to help advise and access the support needed - a “care navigator”.
- Increase support for people to work, get involved in social activities and interest groups.
- Respect people who use services and people who are carers.
- Services for black and minority ethnic communities should be part of the mainstream. It is the business of all services to make sure they are accessible and can respond appropriately to the communities of Sheffield.
- Get on and do what people have been asking for.

7. Vision and aims of the strategy

The fundamental aims of the Strategy are to:

- ❖ Promote mental well-being
- ❖ Prevent mental ill health
- ❖ Promote recovery from mental ill health
- ❖ Reduce mental health inequalities

It is our vision to achieve these things for the people of Sheffield by:

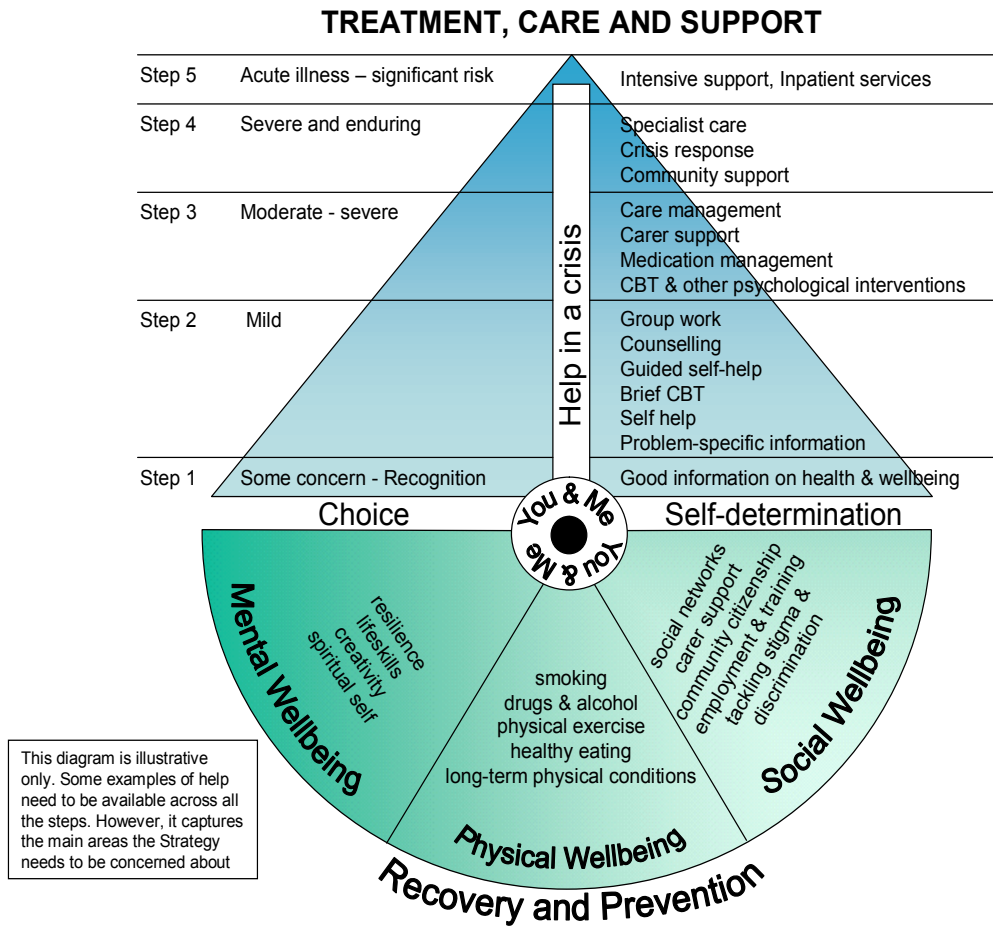
- ⇒ Making help available at an early stage in places that are easy to access.
- ⇒ Providing services that people want to use, support them to have a better life and keep them included in the life of their families and friends, their community and opportunities for work and leisure.
- ⇒ Helping to make Sheffield a place that supports and improves the health of all its people.

8. Future model of services

Figure 4 below illustrates the proposed model of services for the future. This aims to prevent and reduce mental ill health and support people to lead full lives within the community. It is intended to be a model of excellence for the future.

The model shows a person-centred service that addresses not just mental health symptoms but also the other factors that affect our mental well-being. It is built on principles of self-determination and choice. At the same time, mental health treatment, care and support services are provided through a stepped care approach that emphasises early intervention and support for people to tackle their mental ill health. Services are provided on the basis of what is most effective for people whatever their age, rather than on preconceived notions of what is appropriate for particular age groups. Services are developed in partnership with service users and carers.

Figure 4: Service model



Choice and self-determination

When we have mental health problems, we have the right to make informed choices about our use of services. We need sound advice, guidance and support to maintain control of our lives, and, in partnership with services, to achieve our objectives. Depending on our mental health, our ability to make informed choices will vary from time to time. We will want to be in control of different things - this may vary from wanting to choose the time and place for using a service, to deciding which service to use from a list of options, to having a budget to purchase services and deciding how to use it. Choice also implies that services will need to be available equally to all sections of the population. Finding ways to make sure people have real choice is therefore a challenge to everyone involved in mental health services.

Some of the implications of this are that:

- The development of care plans will need to be led by people who use services.
- Good information about treatments and services will need to be available to all. This will need to be in a range of languages and formats, and make use of the latest technologies.
- Ways of enabling people to control the resources tied up in their care will need to be found.
- People may choose different forms of support from traditional health and social care services.
- Advance directives and similar ways of allowing people to remain in control when they are ill will need to be routinely used.
- Advocacy services will need to be readily available to support people to develop their care plans.
- Health and social care agencies will need to explore how best to support people to design their own individual packages of support – with someone to help advise and access the support needed (care navigation).
- People from black and minority ethnic and other minority communities must be supported to use services and get a culturally appropriate response.
- The needs of priority groups such as offenders will have to be better addressed.
- Services will need to respond better to the needs of people with dual diagnosis, ie mental health problems together with conditions such as learning disabilities, physical disabilities, long-term neurological conditions and substance misuse problems.
- The distribution of services geographically across Sheffield will need to correspond much more closely to varying levels of need.

The whole person approach

Services in the future will be centred around the needs of the whole person. They should support the individual to be part of the community they live in and promote social and physical well-being as well as tackling mental health problems. The overall aim should be to help people manage the issues they feel are important to their quality of life.

This will mean that:

- Health and social care agencies will need to build partnerships with organisations across the city to improve the quality of life of people with mental health problems and all Sheffield citizens.
- Commissioning of mental health services will need to be based on delivering improvements in people's quality of life.
- Mental health care plans will need to address physical and social well-being as well as mental health. They will need to include help to access life-skills training where appropriate and on-going learning where people want it. They will need to promote healthy eating and physical exercise. As part of promoting social well-being, they will need to support people to develop social networks, have good accommodation and a job or other activities, and manage issues related to poverty, including benefits and debt.
- Services must adopt a "recovery" focus rather than focussing on illness. People will be supported to re-build a meaningful life.
- Services will need to see individuals in a social context and have a structured approach to involving and supporting carers, family members and others who are important in their lives.
- People with mental health problems must receive a high standard of physical healthcare and people with acute or chronic physical illness must have their mental health needs prioritised.
- Specialist services will need to be delivered, so far as possible, in community settings and integrated with other services to reduce stigma.

Stepped Care

Services will be developed on the basis of stepped care. The model on page 13 shows how services will be provided at five levels, with less intensive help, for example good information, being offered to the population as a whole, short-term interventions like guided self-help and brief CBT being offered to those with mild or moderate problems and more intensive interventions like longer-term CBT and case management being reserved for people with the most serious problems. The model shows the sorts of choices that will be available at the different levels. It is illustrative only: some types of support, for instance help in managing medicines, will need to be available across all levels.

Stepped care is based on offering people quick access to the level of support that they need to prevent problems becoming more serious. People are screened to determine the level of support that matches their needs and move straight to services at the appropriate level. For most people this means accessing services directly at their GP surgery or in other community settings. However, there are arrangements for people to

move quickly to specialist services where that is what they need. It is also part of the role of specialist services to provide advice, consultancy and joint working to support the quality of assessment and treatment in primary care.

The implications are that:

- There will need to be a greater emphasis on and investment in promotion of good mental health for Sheffield as a whole. Policies and action that promote public mental health will need to be given more weight than in the past. These will need to encourage healthy lifestyles, deliver a healthy environment and promote mutual social support. Inequalities must be reduced and discrimination opposed.
- The direct access services in primary care and the community will need to identify people with mental health problems and ensure that their mental and physical health is regularly monitored. They will need to include much better availability of a range of effective psychological therapies than in the past. They will also need to provide on-going support for people who have more serious mental health problems, for example recurrent depression, who may not need specialist services.
- There will need to be local specialist services working closely with primary care practices. These will offer treatment, care and support for people with severe and complex problems associated with psychosis or other mental health conditions. This will include longer-term support where required, but with a strong emphasis on recovery and helping people to participate in community living.
- Local mental health services will be complemented by high-quality specialist services for people whose conditions require expertise in that area, for example people with severe eating disorders, maternal mental health problems, personality disorders, Asperger syndrome and mentally disordered offenders. These services, because of their relatively small size, will operate across the city or perhaps even regionally.
- All specialised services will need to develop their role in providing consultancy and support to direct access services in primary care and the community.
- Services will need to be commissioned from community and voluntary sector (third sector) organisations to provide an alternative route into services to promote access for black and minority ethnic and other groups that experience particular difficulty in accessing services.

Services based on effectiveness not age

Sheffield needs to ensure all adults, including younger people and older people with functional mental health problems, can access the most effective mental health services for their needs. Services should be able to respond to particular needs associated with age, but should offer the same high standard of care to everyone.

The main implications of this are that:

- The local mental health services that people use to access services must be all-age.
- Older people with functional mental health problems must have equal access to specialist services.
- A plan will need to be developed for effective mental health services for young people who currently come within the adult mental health services but whose needs are not well met by these services.

Partnership with service users and carers in the planning and development of mental health services

People who use services and their carers should be joint partners in the planning and development of mental health services, as well as leading their own individual care.

This will mean that:

- Commissioners and service providers will need to reach out to gather people's views in a systematic way.
- Service users and carers will need to be involved in all groups planning mental health services.
- They will need to be involved in such numbers and in such ways that they are comfortable and can contribute confidently.
- Information must be shared in sufficient detail and at an early enough stage to enable service users and carers to have a real influence over decisions.
- Service users and carers who are involved in the planning of services will need to receive training and support for this role.

9. How will people access services?

People will need to be much clearer about how they can access and move through services in the future. This can be described in terms of the "care pathways" for getting support in urgent and non-urgent situations. The care pathways proposed for Sheffield are set out below.

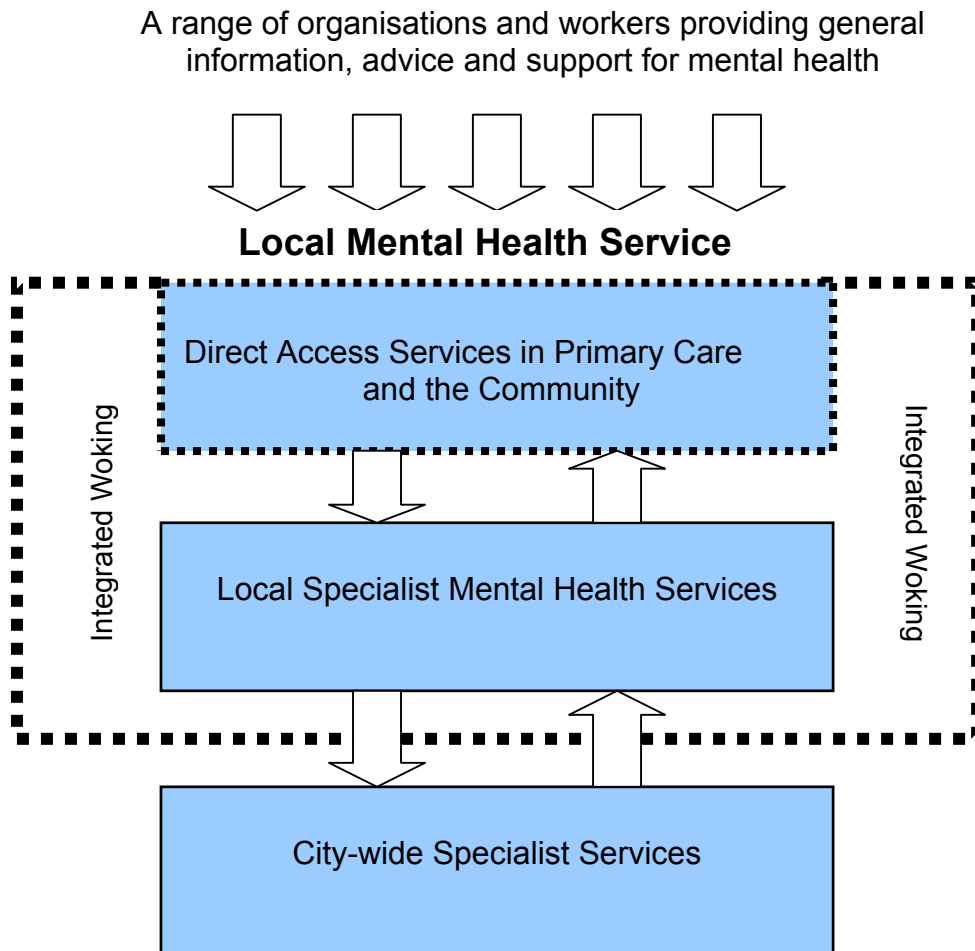
Non-urgent pathway

- A range of organisations and workers will provide general advice and support, including information about how to access help with mental health problems, for

instance health visitors, practice nurses, A & E, social care offices and occupational health services.

- There will be an integrated local mental health service, provided in and for the general practices in an area of the city, with resources matching the needs of the population of the area.
- Most people will access help with mental health problems at primary care practices or other direct access locations in the community, for example possibly local health centres, advice centres and employment offices. These direct access services will include:
 - arrangements to see a mental health worker direct for people who do not want to see their GP first;
 - rapid access to a variety of evidence-based psychological therapies, ie not just CBT, including for chronic physical health problems and “unexplained” medical conditions;
 - educational workshops and groupwork;
 - on-going case management for people who need it;
 - availability of advocacy support;
 - identification and support for carers;
 - sign-posting to other sources of support.
- Some people with more complex problems will need referral on to local specialist services. This will be based on clear protocols. Local specialist services will include:
 - minimum waits;
 - managing referrals of both younger and older adults;
 - care planning and management, including via CPA , with referral on as appropriate to specialist mental health services for older people and children and young people;
 - linking people in to self-directed support;
 - integrated health and social care;
 - early intervention and assertive outreach services;
 - community recovery service;
 - carer support;
 - independent advocacy;
 - extended hours working;
 - consultancy and support to direct access services.
- Relatively small numbers of people will need referral to city-wide specialist services for particular conditions requiring expertise in managing those conditions. Referral will be via the local mental health services, which will also usually continue to provide care co-ordination. City-wide specialist services will act in a supportive capacity, offering intensive support and gate-keeping to more specialist provision where necessary, but with the aim at all times of promoting recovery.

Figure 5: Non-urgent pathway

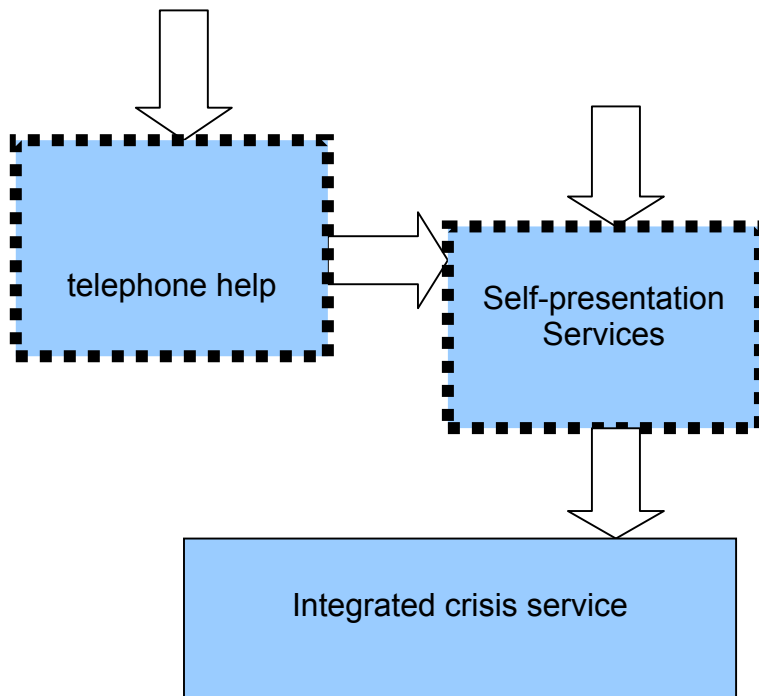


Urgent pathway

- People in urgent need, or others on their behalf, will contact 24-hour accessible general helplines like NHS Direct or a specific mental health crisis line, or will present directly at GP and GP on-call services, local mental health services, A & E, the police, etc. They will receive an urgent response or advice and support sufficient to keep them safe if services cannot respond immediately.
- Small numbers of people will need intensive crisis support and will be referred on to an integrated crisis service. This will offer a range of interventions to suit need, including:
 - home treatment;
 - other alternatives to in-patient admission;
 - gate-keeping of all in-patient admissions;
 - high quality in-patient care where necessary, including needs-based wards, an emphasis on therapy, good availability of activities, sensitivity to different cultural needs, in modern buildings;

- promotion of early discharge;
- good access to supported accommodation.

Figure 5: Urgent pathway



10. Major Priorities for the Next 5 Years

The following summarises the priorities suggested as a focus for the implementation of the service model over the next 5 years:

Priority	How this will be taken forward
❖ that makes sure choice and self-determination is at the heart of mental health services.	Develop individual support and recovery planning done with the advice and assistance of services. This will include the development of self-directed support across health and social care.
❖ of the city and across all communities have equal access to mental health services.	Improve access to mental health care and support for black and minority ethnic communities and other communities of interest with the greatest disadvantage. Review the distribution of services in relation to need.

❖ Work with partners to improve access to employment, training and other aspects of living a quality life.	Develop vocational rehabilitation that supports people with their aspirations to gain experience through volunteering, training and employment. Promote employment opportunities including tackling discrimination in the workplace.
❖ outcomes that address “quality of life” as the basis for future commissioning and service provision.	Develop quality of life outcome measures by drawing on work carried out in Sheffield and elsewhere and the individual support and recovery planning process, and build these into service specifications and monitoring arrangements.
❖ the physical health of people with mental health problems and address the mental health needs of people with physical illness.	Promote physical well-being. Further develop health screening for people with mental illness. Improve the recognition and management of mental health problems amongst staff in generic services. Address the psychological health needs of people with long-term conditions and medically unexplained symptoms.
❖ care approach, including access for most people to local mental health services working closely with primary care.	Review the operation of services in line with stepped care, and build this into service specifications. Improve access to mental health advice, treatment and support by building capacity at primary care and community level, including access to psychological therapies.
❖ programmes that promote mental health across all parts of the community.	Tackle stigma and discrimination and improve awareness of mental health problems and how they can be identified early and appropriate support obtained. Work to make Sheffield a mental health promoting place to live and work.
❖ framework, make sure there are high quality specialist mental health services for people who need them.	Ensure the provision of specialist services as appropriate to meet the needs of people with severe and complex mental health problems. Develop staff skills and knowledge in line with best practice and NICE guidance, and make sure services are provided with respect.
❖ pathways”, making sure there are clear routes for people to access services and move between them.	Develop care pathways that can provide choice and support individual support and recovery planning, including needs-based crisis and in-patient services. Build these into service specifications.

❖ Work with partners to improve availability of housing and accommodation with support.	Develop initiatives both short-stay and longer-term that help avoid the need for hospital admissions and reduce their length of stay where this is appropriate.
❖ mental health services with service users and carers	Involve service users and carers in the development of service specifications and service procurement and promote self-help initiatives.
❖ diagnosis can access high quality mental health services.	Review services for people with all types of dual diagnosis to make sure that they are of an equal standard to other mental health services.
❖ health services for younger and older people.	Support the development of plans for age appropriate services for younger people with mental health problems. Use service specifications to ensure that older people have equal access to high standard services.

Glossary of abbreviations and terms

Adults	All people over of 16 and over
Functional mental illness	Disorders of mood and thinking that are not related to dementia
Stepped care model	A model of mental health services whereby services are delivered at five “steps” according to people’s level of need
Care pathway	How people access and move between services
Self-directed support	An approach encouraging people to plan and manage their own services
DH	Department of Health
IAPT	Improving Access to Psychological Therapies
ONS	Office of National Statistics
CPA	Care Programme Approach - system of multi-disciplinary care planning and monitoring for people with severe mental illness
NICE	National Institute for Health and Clinical Excellence
GP	General Practitioner
CBT	Cognitive behavioural therapy
Primary care	GP and related services that can be accessed directly
Secondary care	Services that are accessed by referral from primary care
Care navigator	Someone to help advise and access the support needed
A & E	The Accident and Emergency Department