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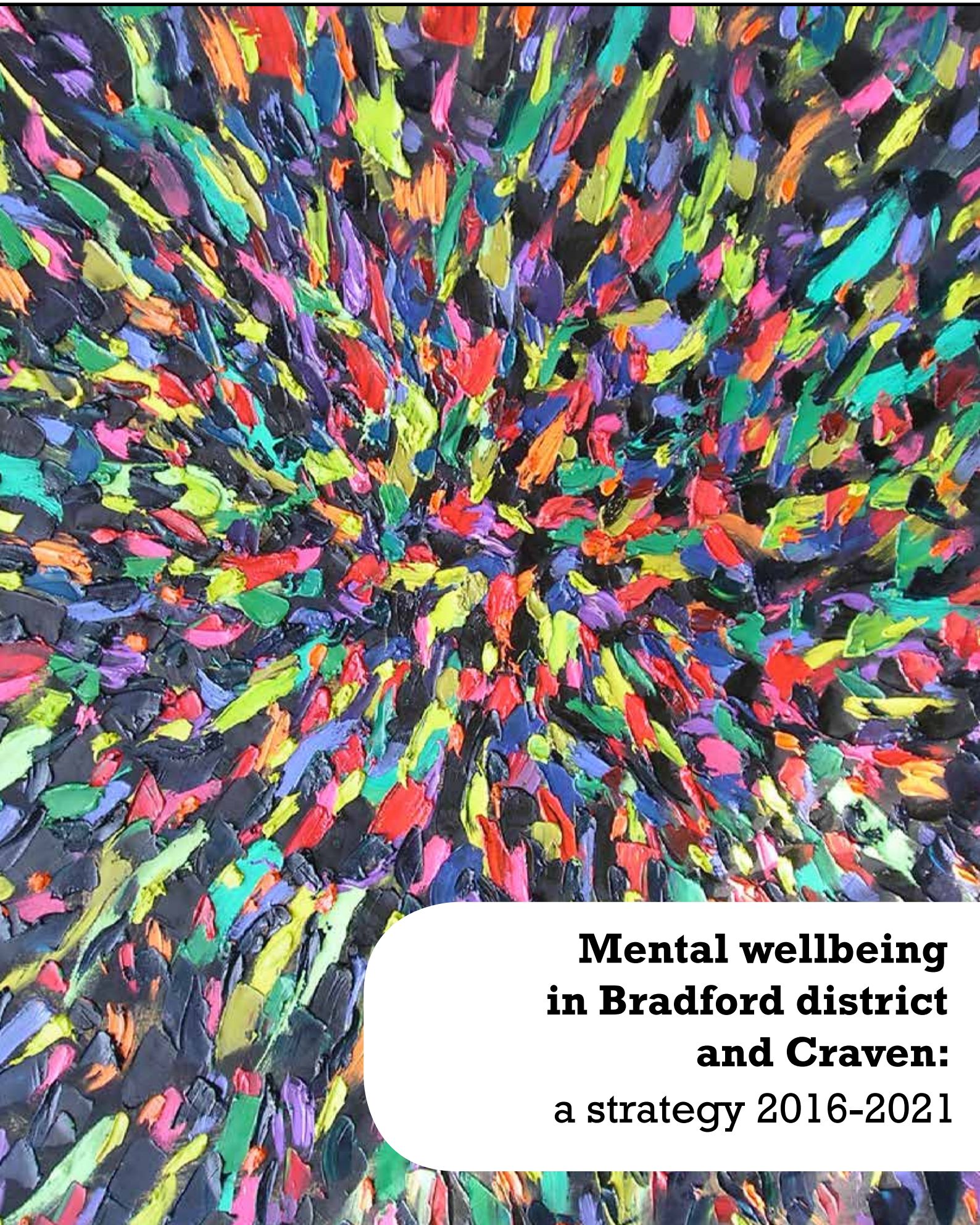

Mental wellbeing in Bradford district and Craven:

a strategy 2016-2021

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1. Introduction

We are delighted to endorse our new mental wellbeing strategy for Bradford district and Craven. This is the first time we have written such a comprehensive strategy, covering all age ranges, with a very clear focus on promoting mental wellbeing and tackling the things that we know can cause mental ill health. It sets out our vision and strategic priorities for the people of Bradford district and Craven over the next five years. It has been developed collaboratively with our stakeholders; most importantly with members of the public and those who have a lived experience of services and their carers.

Mental wellbeing is much more than simply not being mentally ill. It is about having positive self-esteem, good coping mechanisms and feeling empowered and in control. This is an important element of the ambition of our strategy. We want to actively promote mental wellbeing through addressing the broader determinants and providing early interventions.

We are rightly proud of the many notable examples of excellent quality mental health care that we are already offering in the district and we want to continue to build on these. This strategy will not only enable us to deliver the commitments and targets set out in the Five Year Forward View (5YFV) for mental health but also the things that local people have told us are important to them. Most importantly, it will enable us to take a radical approach to prevention and early intervention, based on the principles of the Care Act (2014).

This strategy is deliberately ambitious and we know that it will be a significant challenge to deliver our vision and priorities in the current financial climate. We recognise that the effective support of people experiencing mental health problems is set to become one of the greatest challenges we face. Without action on the increasing demand for mental health services, it will be very difficult to meet the growing demand for support to people experiencing mental ill health in the long term. Because of this we have agreed that we need to act decisively to focus our efforts on preventing mental ill health occurring and worsening.

Our aim for Bradford district and Craven is to create environments and communities that will keep people well across their lifetime, achieving and sustaining good mental health and wellbeing for all. We believe that we will be successful if we remain committed to working together with individuals, families, employers, educators, communities and the public, private and voluntary sectors to promote better mental health and to drive transformation.

Separate strategies exist, or are being developed, that are interdependent with this mental wellbeing strategy. These include dementia, autism, self-care, learning disabilities as well as broader issues such as housing. These and other strategies have been considered during the development of the mental wellbeing strategy to ensure all of our plans link up and complement one another.

The summary on page seven gives a flavour of our vision, outcomes and priorities. For those who want to explore the issues more closely, there are more detailed descriptions of the district, and what we know about the people who live here and their health and wellbeing. Following in-depth engagement with local people, we have also described what they have told us about their aspirations and what they think about services now. We have then used this to describe the three strategic priorities for the next five years:

- **Our wellbeing:** building resilience, promoting mental wellbeing and delivering early intervention.
- **Our mental and physical health:** developing and delivering care through the integration of mental and physical health and care.
- **Care when we need it:** ensuring that when people experience mental ill health they can access high quality, evidence-based care.

The final sections of the strategy describe the things that will help us to deliver these priorities and how we will make plans and monitor our progress.

We will use this strategy as the basis for developing detailed action plans for delivering the priorities set out within it. The Joint Mental Health Commissioning Board and the Health and Wellbeing Board will monitor these along with five measurable outcomes that will show us what impact the delivery of the plans has had on the mental health and wellbeing of the people of the district. We are proud to be able to set out such an ambitious strategy that seeks to tackle the determinants of poor mental health in such a comprehensive manner. We look forward to being able to demonstrate the impact of this in the future.

Councillor Susan Hinchcliffe, Leader - Bradford Council
Sam Keighley and Helen Speight, Co-chairs - Bradford District Assembly Health and Wellbeing Board
Dr Akram Khan, Clinical chair – NHS Bradford City Clinical Commissioning Group
Michael Luger, Chair - Airedale NHS Foundation Trust
Professor Bill McCarthy, Chair - Bradford Teaching Hospitals NHS Foundation Trust
Dr James Thomas, Clinical chair – NHS Airedale, Wharfedale and Craven Clinical Commissioning Group
Michael Smith, Chair - Bradford District Care NHS Foundation Trust
Emma Stafford, Chair - Bradford People's Board
Dr Andy Withers, Clinical chair - NHS Bradford Districts Clinical Commissioning Group

In brief

2. In brief

Background

About the area
There are 531,200 people living in the Bradford district with a further 55,600 in Craven.

We are a big economy with globally successful businesses, a skilled and enterprising workforce and a distinctive identity that reflects our young, diverse and growing population.

However, mental health issues will affect about 155,000 people in our locality at some time during a person's life, with approximately 6,200 people being in need of and in contact with specialist mental health services at any given time.

The risk of having a mental health disorder is affected by a combination of genetics (the physical characteristics each person is born with), personal circumstances and the environment a person lives in. Social issues such as the impact of poverty, living conditions, quality of relationships, work and other activities are also very relevant.

In Bradford, there are large numbers of people living in environments that pose a high-risk of mental illness: almost 120,000 people are thought to be income deprived, and just under 1 in 3 people were economically inactive in 2015/16.[1] Furthermore, in a recent survey of Bradford's housing, 18% of housing had class 1 hazards classifying them as non-decent.[2]

What is the strategy about?

Our ambition locally was to develop a strategy that took an all age, life-course approach with a strong focus on tackling the things that can cause mental health problems and intervening early.

This strategy is for everyone. First and foremost it is for people who use these services and their carers. It is also for people who buy services on behalf of the local population (the commissioners) and those who provide both mental health services and physical health. We have been aspirational in terms of the vision for change that is set out in the strategy, but are realistic that given the financial constraints placed on both health and social care at the current time, that these aspirations may take longer to achieve.

Developing the strategy

What have we done to develop the strategy? The development of this strategy was informed by engagement with many people: we talked to people with lived experience of services and other members of the public, including children, young people and their families. We also had involvement with schools, the local authority, local GPs, clinical colleagues from Bradford District Care NHS Foundation Trust, voluntary and community sector and specialised commissioning colleagues. We shared the views and experiences we had heard to date, sought views on gaps and identified areas that needed to be strengthened.

We know that the effective support of people experiencing mental health problems is set to become one of the greatest challenges of this decade. Without action on the increasing demand for services it will not be possible to meet the rising demand for support to people experiencing mental ill health in the long term. Because of this we have agreed that we need to act decisively to work to prevent mental ill health occurring and worsening. Mental health is greater than just the absence of mental illness. It includes the notions of positive self-esteem, coping mechanisms and the importance of empowerment and control. This is an important element of the ambition of our strategy, to tackle this issue and promote mental wellbeing through addressing the broader determinants.

We also know that when people have physical health problems are more likely to develop mental health problems and that when they do, this makes the outcomes of their physical ill health worse. People with a mental health problem have an increased chance of developing physical illness – eg increasing the risks of the person having conditions such as coronary heart disease, type 2 diabetes or respiratory disease. Because of this we are also targeting mental and physical health.

One in 10 children between the ages of five and 16 has a mental health problem and almost one in four adults experiences a mental health problem in their lifetime. For some, mental health problems are treated and never return. However, for others, mental health problems last for many years, especially if not treated properly. The district is seen as a leading economy for its work, particularly in the fields of crisis care, dementia diagnosis and the physical/mental health interface, and we will continue to develop services to ensure that they maintain or improve the access, quality and effectiveness of the services on offer. For this reason we have focused some of the strategy on making sure people can access good quality care when they need it.

Our vision and strategic priorities

Our vision

Hope • Empowerment • Support

Our strategic priorities

Our wellbeing	Our mental and physical health	Care when we need it
We will build resilience, promote mental wellbeing and deliver early intervention to enable our population to increase control over their mental health and wellbeing and improve their quality of life and mental health outcomes.	Mental health and wellbeing is of equal importance with physical health. We will develop and deliver care that meets these needs through the integration of mental and physical health and care.	When people experience mental ill health we will ensure they can access high quality, evidence based care that meets their needs in a timely manner, provides seamless transitions and care navigation.

We have five strategic outcomes that we can measure progress against so we know how well we are doing to deliver the three strategic priorities

These three strategic priorities are supported by 47 strategic commitments. We will use these to develop actions plans that set out what we are going to do to deliver our wellbeing, our mental and physical health and care when we need it

These are supported by a number of other general priorities that will help us make a difference – things like using technology better, giving people more control through personal budgets, developing the workforce and making sure we make good use of resources

How will we know we have achieved this?

Strategic outcomes

People in Bradford district and Craven will:

- be supported to recognise and value the importance of their mental wellbeing and take early action to maintain their mental health through improved prevention, awareness and understanding;
- enjoy environments at work, home and in other settings that promote good mental health and improved wellbeing;
- experience seamless care and have their physical and mental health needs met through services that are integrated and easily accessible;
- reach their maximum potential through services which are recovery focused, high quality and personalised and which promote independence;
- expect support to be commissioned and delivered in a way which leads to increases in efficiency and enables transformation of care through reinvestment.

Where do we want to be by 2021?

We want these statements to be true for everyone who lives in Bradford district and Craven

I have as much choice and control as possible in my life

I understand my health needs and what keeps me well, and I am encouraged and supported to do more of the activities that keep me well

In situations where I am not able to be in control, I am supported to maintain my rights and dignity and to make choices that support my recovery

I am treated with warmth and compassion and I feel respected and listened to. My concerns are taken seriously

I know how and when to access advice, support and treatment

I am not judged for how I feel or what I have done

I understand my condition and have the help I need to live my life to the best of my ability without my condition taking over my life

I have choice and opportunity to access different therapies, approaches and activities and I have support to get better without medication

My family or carer is actively supported and involved in my care

How will we get there?

- We will seek the views of people with a lived experience, families and carers and professionals to design and deliver services to support this strategy.
- We will base our commissioning decisions on the best evidence available and build on our partnerships with academic institutions to evaluate innovations delivered locally.
- We will use the "pathways and packages" approach to commission evidence-based care to meet people's needs.
- We will significantly expand the use of personal budgets to enable people to achieve greater choice and control over their own care and support.
- We will develop an integrated workforce plan to deliver the outcomes set out in this strategy.
- We will work with the voluntary and community sector (VCS) to help build their capacity to respond to the priorities set out in this strategy.
- We will work to support the move to a more integrated commissioning model at a place-based level, to remove barriers and deliver efficiencies.
- We will commit to protecting the current level of investment in real terms in mental health services, recognising the importance of effective mental health and wellbeing interventions in reducing the overall health and care bill.
- We will rigorously review the use of those protected resources to ensure their effective use.
- We will support opportunities to use technology to help deliver this strategy.

What happens next?

The money
Parity of esteem is the principle by which mental health must be given equal priority to physical health across the health and social care system. It was enshrined in law by the Health and Social Care Act 2012. Our plans to deliver this strategy include a commitment to protect the current level of investment in mental health services, recognising the importance of effective mental health and wellbeing interventions in reducing the overall health and care bill. The CCGs have also committed to make further investment in line with the growth money received over the next five years.

Action plans
We will use the 47 strategic commitments as the basis for developing detailed action plans for delivering the priorities set out in the strategy. These will be monitored by the Joint Mental Health Commissioning Board and the Health and Wellbeing Board.

Measuring progress
The strategy is supported by measurable outcomes that will show us what impact the delivery of the plans has had on the mental health and wellbeing of the people of the district. We also expect the more detailed action plans to be supported by more specific measures that tell us what impact they have had.

How does this link to other issues?

Addressing the wider determinants of poor mental health requires housing and regeneration policies to support the vision and priorities set out by the strategy.

This strategy is focused on mental health and wellbeing and there are a number of other areas that have a significant impact on people's mental health. As well as the broader issues like housing, environment and employment, things like drug and alcohol misuse, dementia, learning disabilities and autistic spectrum condition also play a significant part. Whilst they are mentioned in the strategy, we have not gone into detail. This is because there are separate strategies, either already agreed or in development, that tackle these issues.

Our vision

3. Our vision for mental health and wellbeing services in Bradford district and Craven

Our vision
Hope - Empowerment – Support

3.1 Strategic priorities

Our wellbeing	Our mental and physical health	Care when we need it
We will build resilience, promote mental wellbeing and deliver early intervention to enable our population to increase control over their mental health and wellbeing and improve their quality of life and mental health outcomes.	Mental health and wellbeing is of equal importance with physical health. We will develop and deliver care that meets these needs through the integration of mental and physical health and care.	When people experience mental ill health we will ensure they can access high quality, evidence-based care that meets their needs in a timely manner, provides seamless transitions and care navigation.

Strategic outcomes

People in Bradford district and Craven will:

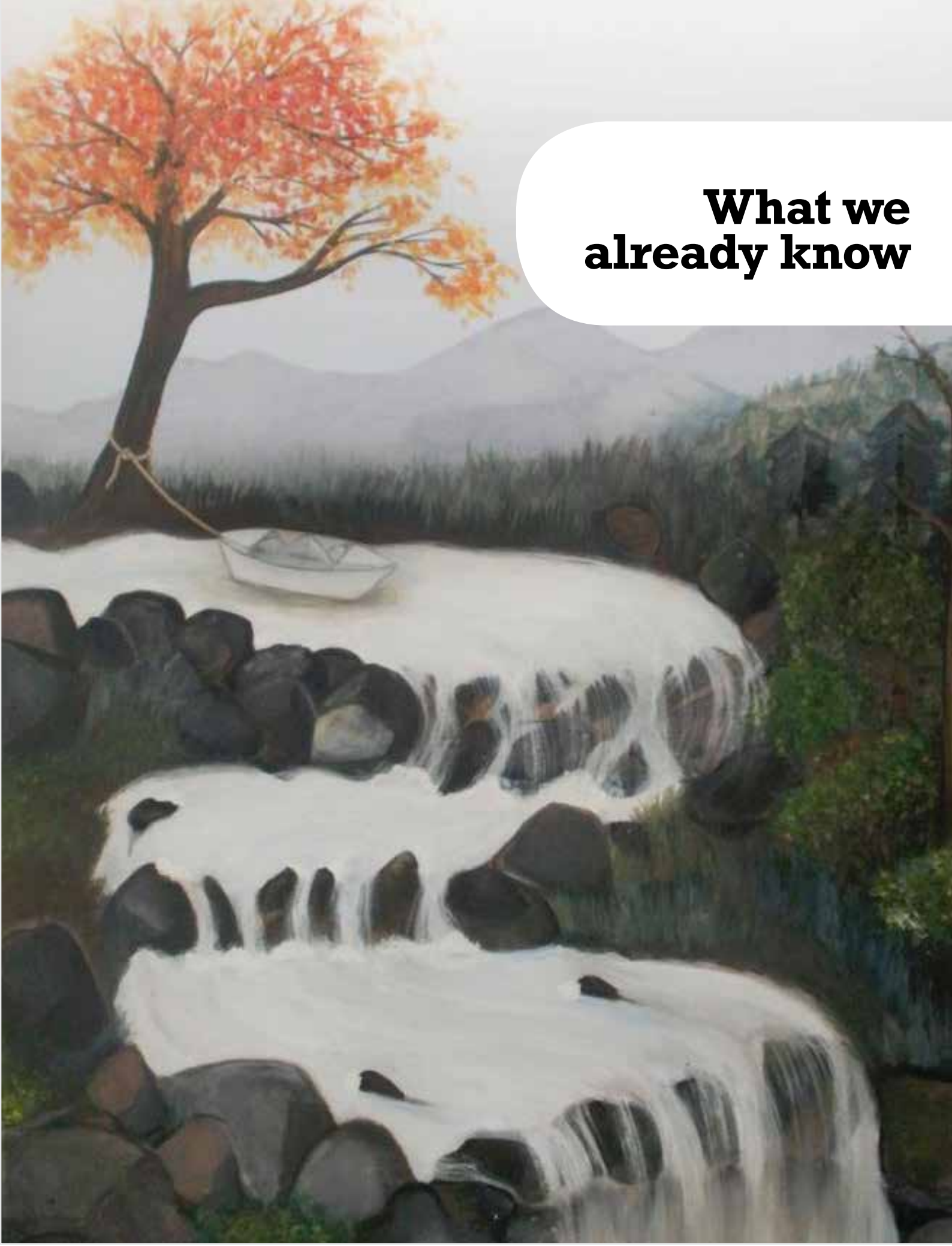
- be supported to recognise and value the importance of their mental wellbeing and take early action to maintain their mental health through improved prevention, awareness and understanding;
- enjoy environments at work, home and in other settings that promote good mental health and improved wellbeing;
- experience seamless care and have their physical and mental health needs met through services that are integrated and easily accessible;
- reach their maximum potential through services which are recovery focused, high quality and personalised and which promote independence;
- expect support to be commissioned and delivered in a way which leads to increases in efficiency and enables transformation of care through reinvestment.

The overarching vision of hope – empowerment – support is based on the aspirations of our stakeholders. It is supported by three strategic priorities: our wellbeing, our mental and physical health and care when we need it.

These three priorities are used to group our strategic commitments and they will be the starting point for three programmes to deliver our wellbeing, our mental and physical health and care when we need it respectively.

Each of these programmes will agree detailed action plans, with associated outcome metrics to measure progress of their delivery and the achievement of the five strategic outcomes listed in section 3.2.

What we already know



4. What we already know

4.1 Assets in Bradford district and Craven

Over half a million people live in Bradford district with a further 55,600 in Craven. We are a big economy with globally successful businesses, a skilled and enterprising workforce and a distinctive identity that reflects our young, diverse and growing population. Bradford has a rich cultural heritage. Bradford Council has committed to building on this by making Bradford a "leading cultural city" over the next decade, which celebrates diversity and connects communities.[3] Bradford District and Craven have 37 public parks, including a multi-million pound City Park, and much of the region is rural. Across the region there are 15 leisure centres and pools, 33 libraries, and multiple museums, art galleries and theatres, including Bradford Industrial Museum and the recently refurbished Cartwright Hall Art Gallery.[4,5] Bradford is UNESCO's first City of Film, and home of the National Media Museum. The village of Saltaire is a UNESCO World Heritage Site.[6] The University of Bradford ranks in the UK top 10 for some courses, and recently it has been voted the greenest university in the UK and eighth in the World.[7]

Within Bradford district there is a strong focus on community, and there is a solid history of work in the region to develop safer and stronger communities. A key part of this work is the Communities of Interest (COI) Partnerships. These groups are community-led, and are brought together to address specific issues faced by defined groups where there is an existing or emerging need. Another key partnership in community development is the Neighbourhood Engagement and Active Communities (NEAC) Group. This group works closely with a range of organisations to support and develop a strong, dynamic voluntary and community sector (VCS). Community safety delivery groups are also instrumental in safeguarding the most vulnerable people in Bradford and Airedale, and preventing crime, anti-social behaviour and re-offending. Bradford is a City of Sanctuary, building a culture of hospitality for people seeking refuge, with Bevan House, Refugee Action and Horton Housing, amongst others, providing specialist support to refugees in Bradford.

There are a number of community development projects in Bradford are commissioned by the City of Bradford Metropolitan District Council and the clinical commissioning groups. For example, *People Can* (http://peoplecanbradforddistrict.org.uk/) is a campaign developed by the VCS to support local people who want to help make a difference for Bradford. It has a clean, green and active approach, and encourages people who take part to be neighbourly, take community action, volunteer, or raise money. Sandale Community Development Trust is one example of a service aimed at making people feel good about where they live. The trust hosts events, such as "Buttershaw by the Sea" in 2016, and runs a local café. The Warm Homes, Healthy People Project, jointly funded by the NHS and Bradford Council, aims to support a range of community-based projects that target vulnerable people living in cold housing through a range of activities that encourage people to be more neighbourly.

Services delivered by Girlington Community Centre work in partnership with statutory and community organisations to deliver advice, signposting, peer support, volunteering, befriending and support services to people from marginalised, isolated and seldom heard communities. The Doula Project trains volunteers to support vulnerable, pregnant women with the aim of improving the physical and emotional wellbeing of both mother and baby.

Bradford district has a young population: our children and young people are our greatest asset. Bradford has the youngest, fastest growing population outside London and is set to be the youngest population in Europe by 2020. The Bradford Youth Service provides things to do, someone to talk to and places for young people to go, in addition to opportunities for young people to participate in a range of activities, celebrate their achievements and become actively involved in their communities.

Taken together, this work appears to be successful: in 2015 over 60% of people in Bradford district thought that their local communities were living together harmoniously: a positive feeling which appears to have increased over the past five years.[8]

4.2 Mental health needs in Bradford district and Craven

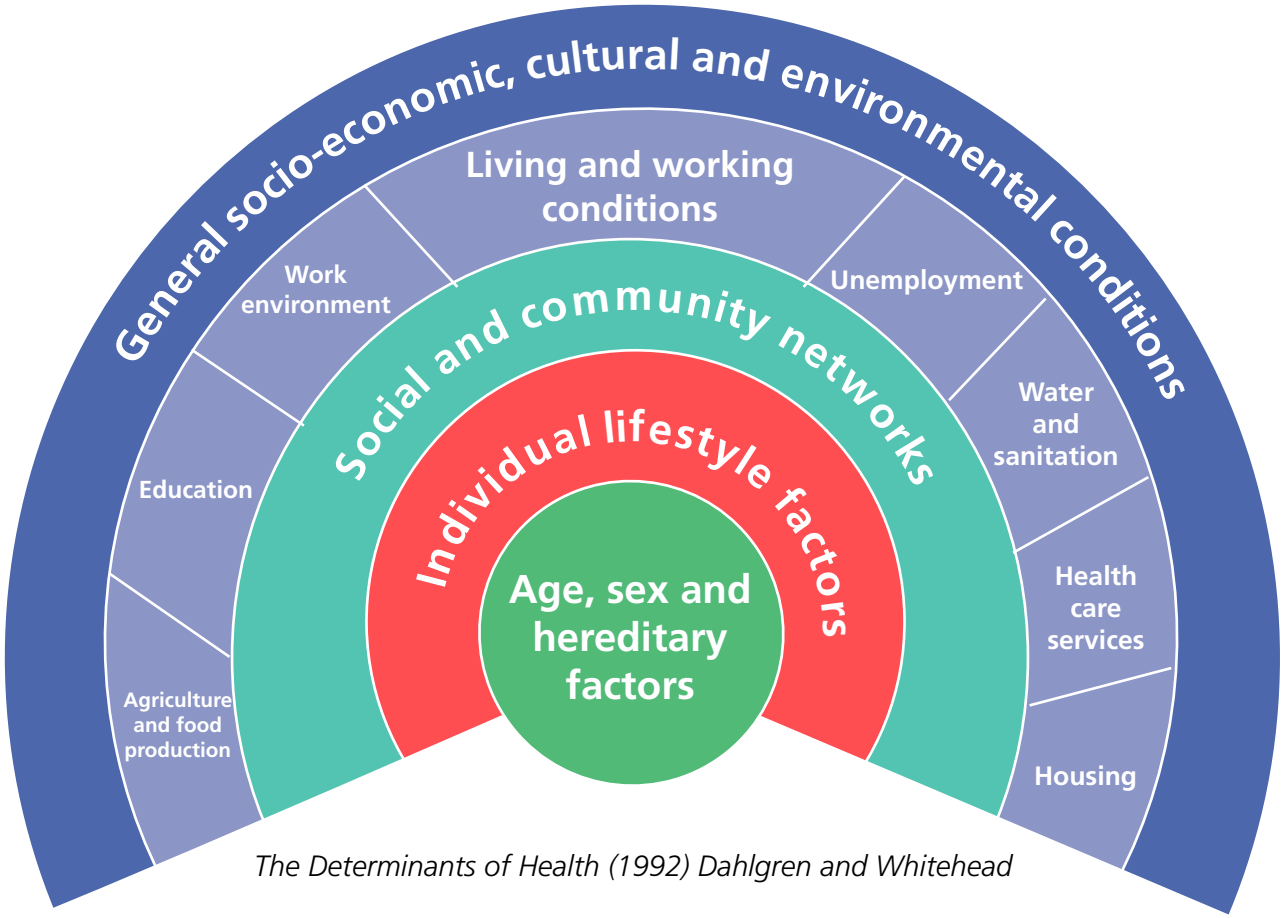
One in 10 children between the ages of five and 16 has a mental health problem and almost one in four adults experiences a mental health problem in their lifetime.[9] For some, mental health problems are treated and never return. However, for others, mental health problems last for many years, especially if not treated properly. Mental health is greater than just the absence of mental illness. It includes the notions of positive self-esteem, coping mechanisms and the importance of empowerment and control.

Mental health problems are the largest cause of ill health in the United Kingdom with a cost of up to £100 billion pounds to the economy as a whole. Up to three quarters of people with mental health problems receive no treatment.

There is a large range of mental health disorders, including common problems such as anxiety, depression, phobias and panic disorders, and less common, but severe, problems such as schizophrenia and bipolar affective disorder.

4.2.1 Wider determinants

The risk of having a mental health disorder is affected by a combination of genetics (the physical characteics each person is born with), personal circumstances and the environment a person lives in. Social issues such as levels of poverty, living conditions, quality of relationships, work and other activities are also very relevant.

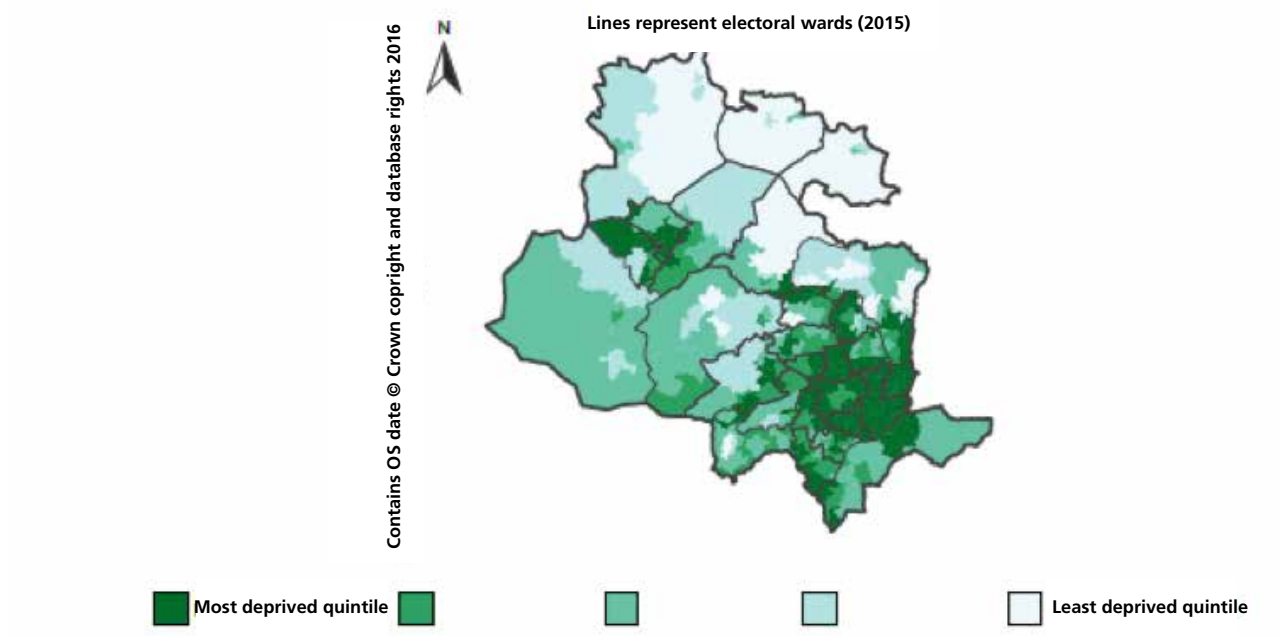


The Determinants of Health (1992) Dahlgren and Whitehead

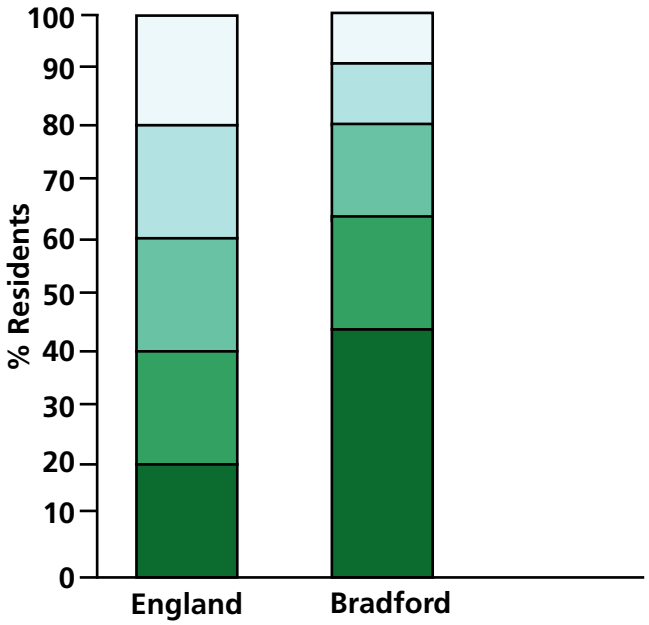
Environment

Living in a deprived community, poor housing conditions, inequalities in education, unemployment or poor working conditions, a poor built environment with lack of access to green spaces, and financial insecurity can all increase the risk of both physical and mental health problems.[10,11] Other factors, such as what a person believes about their health, and how much control they have, or feel they have, affects how people ask for help when they become ill.[12]

The map below shows differences in deprivation in the Bradford district based on national comparisons from 2015. The darkest coloured areas are some of the most deprived neighbourhoods in England.



The chart below shows the percentage of the population who live in areas at each level of deprivation. In Bradford 45.2% of people live in the 20% most deprived areas in England. This is more than double the percentage of people in England as a whole who live in the 20% most deprived areas (20.4%).[13]



In Bradford, there are large numbers of people living in environments that pose a high-risk of mental illness: almost 120,000 people are thought to be income deprived (the fourth largest figure in England), and more than one in three people of working age were out of work in 2011. Furthermore, in a recent survey of Bradford's housing, just over 40% of housing in the private sector was classed as "non-decent".

Poverty, poor nutrition, stress and certain infections before birth and in the first few years of life can have a big impact on future physical and mental wellbeing.[14,15] Bradford district and Craven has one of the biggest populations of children in the country, many living in environments that increase the risk of poor wellbeing; especially linked to poverty. The Bradford district is ranked the 32nd most deprived local authority district in the country out of 354. It also has one of the lowest proportions of working age residents in employment of any local authority in the Yorkshire and Humber region. Employment or similar constructive activities increase self-worth and can reduce mental health issues. Staying in work once a person has mental health issues is important to recovery.

Craven, by contrast, has a lower than average rate of children living in poverty compared with the rest of England and low unemployment rates for adults of working age, although there are pockets of deprivation within the area[16]. However, some of the population in Bradford district and much of Craven is living in rural or very sparsely-populated areas, which have a higher risk of suicide compared to the rest of England.[17]

Stigma and discrimination

Stigma is a big issue for those suffering from mental health problems. It can lead to social exclusion, with impacts on employment and relationships, so adding to the problems faced by people with mental illness. It can also be a barrier to asking for help.[18.19]

Discrimination as a result of race, disability, age, sexual identity, gender and faith can further disadvantage people with mental health problems and add to their distress. Bullying, violence, abuse and hate crimes can cause increased isolation for people with mental health problems.

Person

There are many risk factors related to the individual for developing mental illness. High-risk groups include Looked After Children, children who have experienced abuse,[20] carers,[21] people who identify as lesbian, gay, bisexual or transgender,[22] Black and minority ethnic individuals, those with a learning disability or physical disabilities, prisoners and people who are homeless.[23] The Bradford district has a higher than average proportion of people in some of these vulnerable groups. Men and women also have different risks for different conditions. While people at any stage of life may be affected by mental ill health, the likelihood of experiencing certain conditions changes with age.

Gender

Mental health risk factors that disproportionately affect women include gender-based violence and abuse, and socio-economic disadvantage. Women may experience low social status, insecure jobs and low income resulting in reduced control over the circumstances of their own lives, while also having responsibility for care of a family and household. More women than men are diagnosed with common mental health disorders such as depression and anxiety, and self-harm is more common among women than among men. Women have been found to have high rates of post-traumatic stress disorder following past experiences of sexual violence or abuse.

Men may be reluctant to seek help for mental distress, have high levels of isolation, high rates of drug and alcohol misuse, are at greater risk of homelessness, display more externalised and destructive behaviours, and are more likely than women to be involved with the criminal justice system. There is a continuing cultural expectation that they will act as protectors and providers for others. Men as well as women may experience violence and abuse. The rate of suicide among men far exceeds the rate among women.

Age

Children and young people have many of the same risk factors for mental illness as adults, with some notable additions. The recent National Confidential Inquiry into Suicide and Homicide by People with Mental Illness identified 10 common themes relating to suicide in people aged under 25 in England between January 2014 and April 2015.[24] These are:

- family factors such as mental illness
- abuse and neglect
- bereavement and experience of suicide
- bullying
- suicide-related internet use
- academic pressures, especially related to exams
- social isolation or withdrawal
- physical health conditions that may have social impact
- alcohol and illicit drugs
- mental ill health, self-harm and suicidal ideas.

Older people may also have particular risk factors for poor mental health, in particular: discrimination; reduced participation in meaningful activities; relationships; physical health and poverty.[25]

Sexual orientation

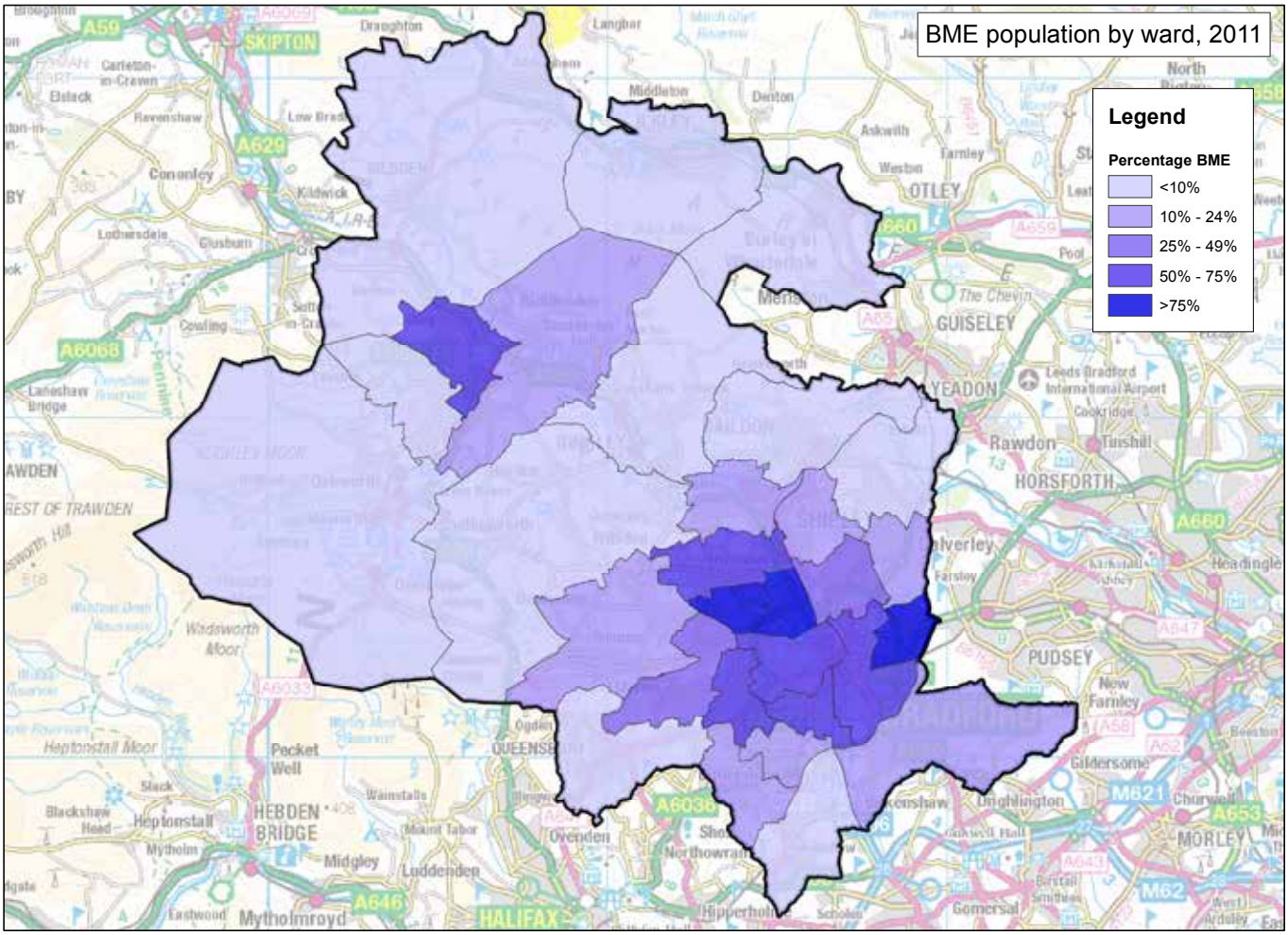
Gay men and lesbians report more psychological distress than heterosexuals despite similar levels of social support and physical health as heterosexual men and women. They are also more likely than other patients to report a negative experience of using health services and less likely to report that they have been treated with dignity and respect. Anxiety, depression, self-harm and suicidal feelings are more common among lesbian, gay and bisexual people, and rates of drug and alcohol misuse are also higher.

Gender re-assignment

People who identify as transgender experience high levels of mental illness. In one study, 88% of transgender people had either currently or previously had depression, 80% had stress, and 75% experience anxiety.[26]

Race

There is a rich mix of ethnic groups and cultures in the region, with approximately 75% of the population estimated to be white, and 20% from Asian backgrounds. However, this diversity is not uniform across the region, but is concentrated in particular areas.



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Public Health Analysis Team, Bradford

Bradford, as an industrial textile city, attracted a large community to work in the mills and factories and more recently has attracted migrant workers and provided homes for refugees fleeing conflict areas.

The ethnic and cultural diversity of Bradford district is an asset to the region. However, it also brings challenges, as being from a black and minority ethnic (BME) group is a risk factor for poor mental health. The effects of the migration process, resettlement and transition alongside racism, alienation, language barriers, cultural differences and limited understanding of accessing services experienced by people - and the impact this has on their mental health - cannot be underestimated. Mental wellbeing may be understood differently by different communities, and therefore approaches to improving mental wellbeing must be tailored to each group.

Religion and belief
Bradford has a rich diversity of faiths and spiritual beliefs. Faith and spiritual belief can play an important role in helping people maintain good mental health, build resilience and live with - or recover from - mental health problems. Faith and spiritual beliefs can influence the decisions people make about the treatment they receive or how they want to be supported.

It is important to understand the association between mental health and belief and recognise where positive aspects can be tapped into and negative issues acknowledged. Faith can be a reason for stress, discrimination and stigma.

Disability
People with disabilities use health and care services more often than people who do not have a disability. However, evidence suggests that they routinely struggle to access appropriate care and support; because of this many disabled people experience less favourable health outcomes.

Bradford has a higher proportion of adults and children with learning disabilities compared to England. An estimated 25-40% of people with learning disabilities also have mental health problems. People with learning disabilities are more vulnerable to more of the risk factors associated with mental ill health, such as adverse life events and lack of social support, and are much less likely than the general population to be able easily to access psychiatric services.

Carers
In the 2011 census, around 50,000 people in Bradford identified themselves as carers. Around 16,500 of these were aged 50-64 years and 8,500 were over 65 years of age. It is likely that there are many more than this, as many carers do not recognise themselves as carers. The number of carers in Bradford district and Craven is thought to be rising. Carers report high levels of psychological distress which can include anxiety, depression, and loss of confidence and self-esteem.

Mental health conditions account for 23% of all disease in England (compared to 16% for cancer and 16% for heart disease) but account for just 13% of NHS spending.

There is a complex relationship between physical and mental health and social care: poor physical health may contribute to mental health problems, and people with mental health problems are at greater risk of worse physical health and related social care needs. The presence of co-morbid mental and physical illness is known to worsen outcomes for patients and increase costs for health services.[27] In 2010-11, mental illness raised the cost of physical health care in the NHS by an estimated £10 billion.[28]

For people with long-term conditions, co-morbid mental health problems are a major determinant of overall costs, typically associated with a 45–75 per cent increase in service costs.

People with severe mental illness live, on average, 15-20 years less than the general population. Rates of diabetes, cardiovascular disease and respiratory disease are also higher than in the general population. This is due to a number of reasons, including lifestyle (such as smoking, diet, etc.), side effects of medications, and higher rates of alcohol and substance misuse.[29]

Almost half of all tobacco consumption and deaths due to smoking occur in people with mental disorders.

People with mental illness may also experience barriers accessing health services. These may include difficulties in seeking help, communicating problems, and physical problems being overlooked due to a focus on their mental health diagnosis.

Genetics
There is strong evidence that some mental health disorders run in families. In particular, schizophrenia, bipolar disorder and major depressive disorder have been linked to genetic causes.[30] However, having a family history of mental illness only increases a person's risk. Stressful life events and environmental factors play a major role in the development of mental health problems.

4.3 Epidemiology

4.3.1 Children

The early years are very important in mental wellbeing: half of all cases of mental illness begin by age 14 and three-quarters by the mid-twenties.[31,32]

Research suggests that early intervention in childhood could prevent between a quarter and a half of adult mental illness, with corresponding individual, economic and social benefits.

Table 1 shows the average ages at which different mental health problems start.

Ages of onset for mental disorders

Attention deficit hyperactivity disorder (ADHD)	7-9 years
Oppositional defiant disorder	7-15 years
Conduct disorder	9-14 years
Psychosis	Late teens – early 20s
Anxiety disorders	25-45 years
Mood disorders	25-45 years

Adapted from Kessler RC 2007

In Bradford district and Craven it is estimated that almost one in 10 children – around 8,477 children in total – between the ages of 5 and 16 have a mental health disorder.

This means that between two and three children in every primary school class and between three and four children in every secondary school class in Bradford district and Craven is likely to have a diagnosable mental health difficulty. For many this is persistent: surveys have shown that a quarter of children with a diagnosable mental health disorder still had the same disorder three years later.[33] On top of this, it is thought that a further five to 10% are likely to have less severe emotional or mental health difficulties at any one time. This means that there are an estimated 17,000 children with some level of emotional difficulty or mental health problem living in Bradford district and Craven. By 2025, this is expected to increase to around 23,600 children.

4.3.2 Working age adults

Mental wellbeing

People in Bradford have generally reported lower levels of wellbeing than people in England as a whole, with around 10% of people in Bradford having a low happiness score, and 26% having high anxiety.

People who report having higher wellbeing have less illness, recover more quickly and for longer, and generally have better physical and mental health. An improvement in wellbeing is a key part of the Care Act 2014.

While most of the differences between Bradford and the rest of the country were small and could be explained by chance variation in the numbers, the difference in anxiety score was too large to be explained by chance.

Mild, moderate and severe non-psychotic disorders
In 2013/14, 5,520 people were diagnosed with depression across the three CCGs in Bradford district and Craven. This amounted to around 1% of all people living here, which is higher than the rate for England as a whole.

Around 20% of working age people in Bradford have experienced depression or anxiety at some point in their lives. Some of these people will have recovered, whilst others may still experience signs and symptoms of depression or anxiety. Females in Bradford, like in the rest of the country, are more likely to have anxiety and depression than males. People aged 15-24 are the least likely to be recorded as having ever experienced depression or anxiety, whilst those aged 50-59 are most likely.

Non-psychotic chaotic and challenging disorders
The adult psychiatric morbidity survey estimates that, in any single year, as many as 0.3% of adults may experience anti-social personality disorder, with men being more likely than women to have the condition. Similarly, around 0.4% of adults have borderline personality disorder in any one year: this is slightly higher in women than men.

Locally, around 25 people each month are referred into services for treatment of a chaotic and challenging non-psychotic disorder. The average age of presentation with this type of illness is 37 years old, and 62% of the 344 people under the care of mental health services locally were female. People with personality disorders often have very chaotic lifestyles and despite having poor engagement with services will often then present in an emergency.

Psychosis
Around one in every 227 people in Bradford has a psychotic illness. Each year, just over 5% of people with psychosis or bipolar disorder experience an acute psychotic episode. The majority of people with a new diagnosis of a psychotic illness are young, aged 24 and under at the time of first presentation.

4.3.3 Older adults
Older people can have all the mental health problems faced by younger adults in addition to specific challenges resulting from older age. A national survey of older people (National Centre for Social Research and Department of Epidemiology and Public Health at the Royal Free and University College Medical School 2007) found that 22% of men and 28% of women over the age of 65 years scored highly on test indicating possible depression. The risk of a high score increased with advancing age, with 40% of men and 43% of women aged 85 and over having a high score. Deprivation, poor physical health, and lack of social support all increased the risk of possible depression. Depression is not always easy to diagnose in elderly people, as the symptoms can be confused with those of other health conditions, including dementia.[34]

Depression and dementia are closely linked: about half of older adults with a new onset of depression also have some level of dementia, and 20-60% of those with dementia are thought to have depression.[35] It is known that depression in older people often goes undiagnosed and untreated; one study for example, finding that 60% of older people with depression were not receiving any treatment for this.[36]

4.3.4 Specific challenges in Bradford district and Craven
Bradford has the third largest child population in the UK. As discussed above, there are risk factors which increase the likelihood of poor wellbeing and mental health, in particular the high numbers of children living in poverty.

The overall child population increased by 10.5% between 2002 and 2012, and is expected to grow by a further 5.5% by 2025. The 10-14 age group is expected to grow by 10.2% in the next 10 years. This population growth is likely to be bigger in the most deprived areas of the city. [37] Over the next 25 years, it is expected that the numbers of older people in the Bradford District will increase substantially, but at a slower rate than in England as a whole. Craven has an older population, with a higher proportion of people aged over 65 than in England as a whole.[38]

The proportion of children achieving a "good level of development" before they start school in Bradford increased from 55% in 2014 to 62% in 2015. However, this is still below the national average of 66%.[39] In Craven the high proportion of people living in rural areas alongside the comparatively older population pose specific challenges which must be considered.[40]

Locally, there are also issues related to new migration, asylum seekers and refugees. There are small groups of asylum seekers and refugees who come to the district who have very high levels of need, including mental health needs. Refugees are about 10 times more likely than the age-matched general population to have post-traumatic stress disorder (PTSD): 9% of refugees in general and 11% of children and adolescents have PTSD.[41] Refugee and asylum-seeking women have specific healthcare needs. Asylum-seekers arrive in the district under the dispersal policy, with a higher proportion being housed in Bradford than elsewhere across the district. There are currently two resettlement programmes for refugees in place: the Home Office oversees the Gateway Programme and there is also a Syrian Resettlement Programme (formally the VPRS), which is a joint unit between Home Office, Department for International Development and Department for Communities and Local Government.

For both schemes the NHS receives additional funding for the first year of care. There is a flat fee for primary care as well as a reimbursement of the actual secondary care costs. However, meeting these needs can represent a workforce challenge for provider services and rising to this challenge needs to be reflected in the wider workforce strategy. The joint working between the BDCFT Homeless and New Arrivals Health Team and Bevan Healthcare CIC is recognised as an excellent example of an integrated physical and mental health team, delivering services closely with GPs and voluntary sector partners.

4.3.5 The financial crisis and mental health

The financial crisis has had health implications across Europe. Research has shown an increase in suicides over the past two decades, and a decrease in road traffic deaths, as well as an unexpected increase in outbreaks of infectious disease.[42] In Portugal, another country highly affected by the financial crisis, between 2004 and 2012 significant increases in the rate of depression were seen in men aged 55–64 years, women aged 45–54 years, and those older than 75 years. Between 2011 and 2013, there was a large increase in children and adolescents attending psychiatric outpatient appointments.

4.4 What people tell us

The development of the strategy has being informed by working together with a number of key stakeholders including, most importantly, the involvement of service users, people, children, young people and their families. The engagement has also included involvement from schools, the local authority, health commissioners and providers, voluntary and community sector and specialised commissioning colleagues. Engagement on the strategy commenced in April 2016. An engagement plan supporting this work was developed. The purpose of the engagement was to share the views and experiences we have heard to date, seek views on gaps and identify areas that needed to be strengthened.

Engagement consisted of:

1. Reviewing existing data held by the CCGs

Each CCG has an ongoing mechanism of engagement which informs commissioning and service development. Data was collated and analysed to form part of the engagement process and was shared with people and stakeholders. The information considered as part of this exercise included:

- ongoing 'Grass Roots' insight[43]
- consultations and engagement (eg inpatient hospital provision), specific reviews and projects (eg IAPT, Future in Mind, day services review, outcomes commissioning framework, project reports)
- Bradford District Care NHS Foundation Trust involvement structures with patient groups (eg involvement groups). BDCFT is the main provider of mental health services in the Bradford district and Craven.
- monitoring information from commissioned contracts through the VCS (protected groups, non-user views, eg MIND, Cellar Trust, Sharing Voices, Horton Housing, Relate, Bradford counselling, Girlington Centre etc).

2. Communications campaign to support engagement

Planned media communications were developed and shared to engage and involve people in the development of the strategy. We invited people to feedback and share their views through a range of options:

- through our Grass Roots insight feedback system
- offer to host meetings, events or interviews and feedback to us
- invitation to attend their forum, meetings, events or interviews
- feedback via our website
- a survey was designed which groups could adapt and use to feedback comments and suggestions
- share their experiences on social media
- a series of press releases and articles were published to promote the work and encourage participation.

3. Engagement activities

These consisted of:

- conducting face-to-face interviews during 'discovery visits and invitations' to voluntary and community sector organisations, Lynfield Mount Hospital, community groups and events
- attending the VCS health and wellbeing forum on two occasions and initiating discussion to start a specific mental health forum which will support implementation of the strategy. Organisations were encouraged to feedback to us directly. To date we have heard back from 31 organisations including organisations working with seldom-heard groups such as homeless, young people, carers, BME groups, substance misuse, young mothers, domestic abuse, refugees, LGBT and women's groups
- carrying out focus groups and individual interviews between June and August 2016 and attending a series of community held events to share information about the strategy and gain further views
- in total, we carried out 39 interviews, attended 21 groups and nine events.

4.5 How mental health services are organised in Bradford district and Craven now

Support to people with mental health needs is available through many different services, provided by a broad range of organisations.

Often people think of mental health services as those that are provided by mental health trusts and social services. However, for many people their most frequent contacts are with primary care, the voluntary and community sector and a broad range of other public services, including other council services such as housing or leisure services, the police and the Department for Work and Pensions. Many people experiencing mental distress or ill health will also be in contact with services around their physical health needs, often without their mental health needs being formally recognised.

A number of the existing services for people with mental health problems are recognised to be good practice examples and/or cutting edge in their approach to delivering good quality care and we should rightly be proud of these achievements. Here are four examples.

In partnership with Local Authority and emergency services, we undertook a whole system review of our crisis mental health services to meet the ambitions of the national Crisis Care Concordat. As a result, we introduced an integrated acute care pathway for adult mental health offering a single point of access for all referrals, including self-referral. This urgent mental health response is acknowledged nationally as a good practice blueprint for others to learn from and is cited within the NHSE implementation guidance for the Five Year Forward View for Mental Health. It has resulted in no people from Bradford district and Craven being placed in beds outside of the district, already meeting one of the targets that have recently been set for the Five Year Forward View for Mental Health.

As part of the work to develop the acute mental health pathways locally we have also developed two new services with local VCS partners. The Sanctuary at MIND in Bradford provides an alternative to in-patient admission and the Haven at the Cellar Trust an alternative to A&E attendance for people with a mental health presentation. They have established a model based on a strong partnership between VCS and statutory services. Working with VCS enables a creative approach to workforce development and gives opportunities to experts by experience, as well as ensuring the clinical and social needs are met with expert advice and support when needed.

The physical health check template for use with people with severe and enduring mental health problems was developed in Bradford. It is now available nationally due to its success and backing at national level by the previous national clinical director for mental health, NHS Improving Quality, Health Education England and Academic Health Science Network.

The local primary care wellbeing service has been recognised as a key good practice example by the King's Fund as a way of effectively addressing the mental health needs of people with medically unexplained symptoms. The service supports people with high levels of physical health service use and possible mental health needs through a primary care-based multi-disciplinary team. Its interventions have reduced both iatrogenic harm and the overall costs of care.

Rather than try to describe or list all of the services that are available, we have set out below the key mental health services that are currently commissioned or directly provided by local authority and/or NHS organisations. From our review of services and stakeholder engagement we have also identified a number of service gaps and areas for improvement. These are shown by dotted lines in the diagram.

<table>
<tr><th>Our wellbeing</th><th>Our mental and physical health</th><th>Care when we need it</th></tr>
<tr><td rowspan="4">Social care for children: education, Early Years, looked after children, children with disabilities, Youth Justice</td><td rowspan="3">Public health: identify healthcare needs
assess effectiveness of interventions
public awareness campaigns</td><td>Local specialised services: assessment of autism, ADHD</td></tr>
<tr><td>Care Act assessments and personal budgets
Nursing and residential home care</td></tr>
<tr><td>Dementia diagnosis
Care and support for people with dementia and their carers</td></tr>
<tr><td>Psychological therapies for mild to moderate depression and anxiety</td></tr>
<tr><td rowspan="4">Social care for adults: daytime activities, supported employment, supported housing</td><td rowspan="3">Physical health of people with severe mental illness, Primary Care Wellbeing Service,
Healthcare psychology</td><td>Community-based care for severe mental health needs including CMHT, early intervention in psychosis, children and young people's mental health services</td></tr>
<tr><td>Urgent and acute mental health care
Public health: treatment for substance and alcohol misuse</td></tr>
<tr><td>Specialist inpatient services including Rehabilitation</td></tr>
<tr><td rowspan="2">Homeless and New Arrivals Team</td><td>Specialist services commissioned by NHS England:
Secure and forensic services, Tier 4 mental health services for children and young people, Tier 4 services for personality disorders, gender identity, services for those with serious perinatal problems, eating disorders, services for the deaf</td></tr>
<tr><td>Social care: approved mental health professionals, Mental Health Act duties, best interest assessors</td></tr>
<tr><td rowspan="4">More peer-led models, intergenerational work and resilience building</td><td rowspan="4">Psychological help for people with physical health problems</td><td>Eating disorders services for adults</td></tr>
<tr><td>Autistic spectrum conditions (adults and children
ADHD – assessment and treatment (adults and children)</td></tr>
<tr><td>Improved perinatal mental health services</td></tr>
<tr><td>The future model for community mental health services
Community pathway for people with personality disorder</td></tr>
</table>

As indicated opposite, however, there are many other services that play a vital role – particularly in the voluntary sector, whose services are often essential elements of the packages of care provided to those experiencing mental ill health. Voluntary organisations provide a range of essential services including:

- advocacy
- carers' support
- befriending
- employment support services
- bereavement counselling
- talking therapies
- self-help groups
- meaningful daytime activity
- vocational and educational services
- supported housing
- services to reach minority groups and communities
- preventative and wellbeing services.

We know that some voluntary sector groups have already closed or are vulnerable in terms of uncertainty about long-term funding and that users of their services, in particular, are concerned about how they remain sustainable. Many VCS groups already fill gaps created by pressures in the statutory services and we need to ensure that their contribution to the overall network of support services can be sustained.

We also know that VCS organisations funded for mental wellbeing contracts subsidise their contracts with non-recurrent funds, fundraising, income from social enterprise activity and their reserves and we need to understand better the potential impacts of this. To enable this we will work with them to help build their capacity to respond to the priorities set out in this strategy.

4.6 Finance

The table below sets out a summary of current spend on mental health services in the Bradford district and Craven.

New services can be established and existing services expanded only if there is evidence that they provide good value for public money as well as high quality care and good outcomes for service users.
Financial constraints affecting any part of the health and social care system may have an impact on people's mental health. Changes to areas such as social care and housing may result in additional mental health care needs; if so, we will need to respond to them.

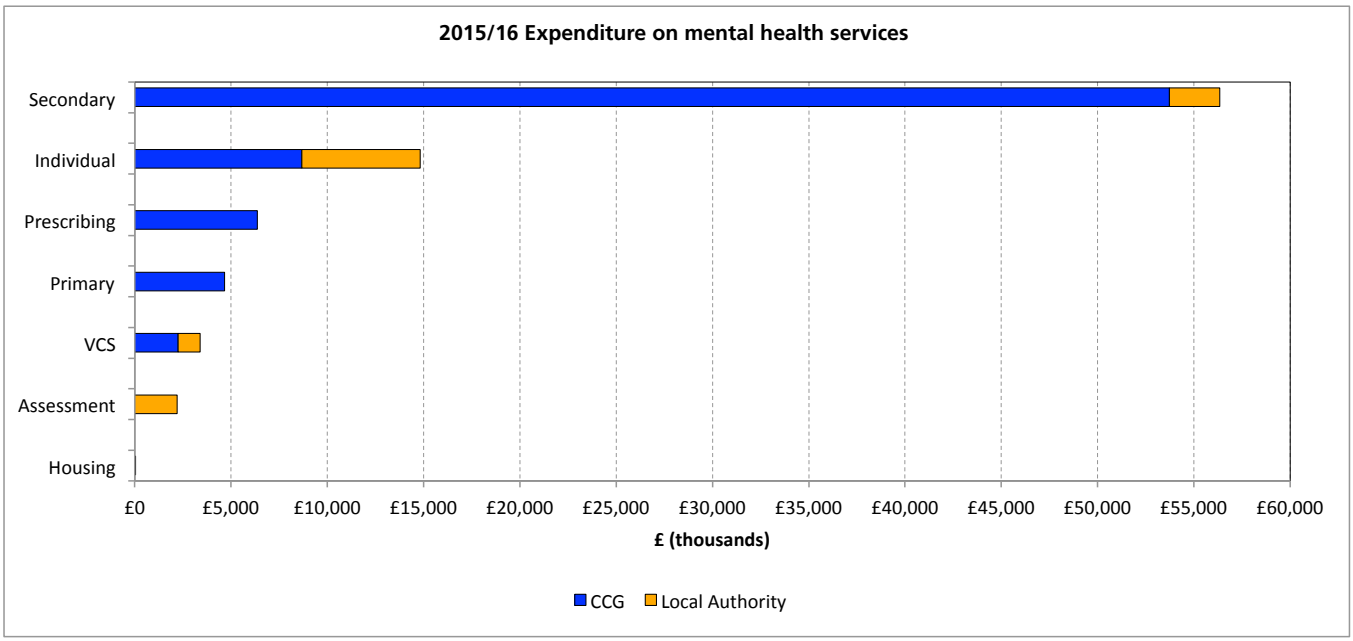
2015/16 Expenditure on mental health services

	CCG **	Local Authority ***	Total
Total 2015/16	**£75,681,062**	**£12,153,561**	**£87,834,623**

** Airedale, Wharfedale & Craven CCG, Bradford City CCG and Bradford Districts CCG

*** Bradford Metropolitan District Council

Not included:
1. Primary care services: approximately 25% of GP consultations are mental health-related
2. North Yorkshire County Council contributions (currently not available)
3. Specialist and tertiary mental health care commissioned by NHS England on behalf of CCGs
4. Mental health prevention undertaken by teachers, social workers, school nurses, health visitors



4.7 National guidance

4.7.1 The Five Year Forward View for Mental Health

Published in February 2016, the Five Year Forward View for Mental Health is the report from the independent Mental Health Taskforce to the NHS in England focused on the experience of people with mental health problems. It initiated a process of transformation to achieve the recognition of equal importance between mental and physical health for people of all ages. The implementation plan published in July 2016 set out five common principles that local areas should adopt as they plan to deliver this Five Year Forward View:

- co-production with people with lived experience of services, their families and carers
- working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing
- identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery
- responding to the needs of all individuals including those from BME communities and lesbian, gay, bisexual and transgender (LGBT) people
- designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives
- underpinning the commitments through outcome-focused, intelligent and data-driven commissioning.

These are the principles that we adopted in developing this mental health strategy for Bradford district and Craven; they inform the options we considered, the vision we describe and the ways we will work with people and organisations to turn this strategy into a real system that will improve mental health and emotional wellbeing for everyone in the district.

4.7.2 Safeguarding children and adults

As well as abuse and neglect being recognised as one of the antecedents of mental ill health, children and adults who have mental health needs are at particular risk of abuse. Consequently, many clients disclose both current and historical experiences of abuse. This highlights the need for all services to contribute to the prevention of abuse, as well as ensuring effective recognition and responses to safeguarding concerns, which must include access to long term recovery work for survivors.

Working Together to Safeguarding Children (2015) and The Care Act (2014) set out the legal frameworks for safeguarding children and adults, with clear requirements on all agencies to work collaboratively at both operational and strategic levels. This means that prevention, recognising and responding to abuse, whether current or historical, must be considered in all aspects of mental health commissioning and service delivery.

4.7.3 The Care Act 2014

The Care Act 2014 builds on legal reforms, replaces numerous laws and provides a coherent approach to the provision of adult social care in England. It affects the local authority and all of its partners, especially the NHS, VCS and police.

Part one of the Act (and its statutory guidance) consolidates and modernises the framework of care and support law; it sets out new duties for local authorities and all its partners, and new rights for service users and carers.

The Care Act is designed to achieve:

- clearer, fairer, care and support
- wellbeing – physical, mental and emotional – of both the person needing care and their carer
- prevention and delay of the need for care and support
- people in control of their care.

The Care Act 2014 provides health and social care with a new emphasis on wellbeing. Underpinning the Act is the new statutory principle of individual wellbeing which should be the driving force behind any care and support.

Local authorities (and their partners in health, housing, VCS, welfare and employment services) must now take steps to support prevention, to reduce or delay the need for care and support for all local people.

The Act includes a statutory requirement for local authorities to collaborate, co-operate and integrate with other public authorities.

Information and advocacy should be available to all.

All areas should have safeguarding as a priority.

Everyone has the right to request an assessment leading to a care plan and services via individual budgets or direct payments when possible.

This mental health strategy is based upon the integration of the Care Act 2014 with the Five Year Forward View plan to ensure that mental health services are providing the full range of support required in an integrated way.

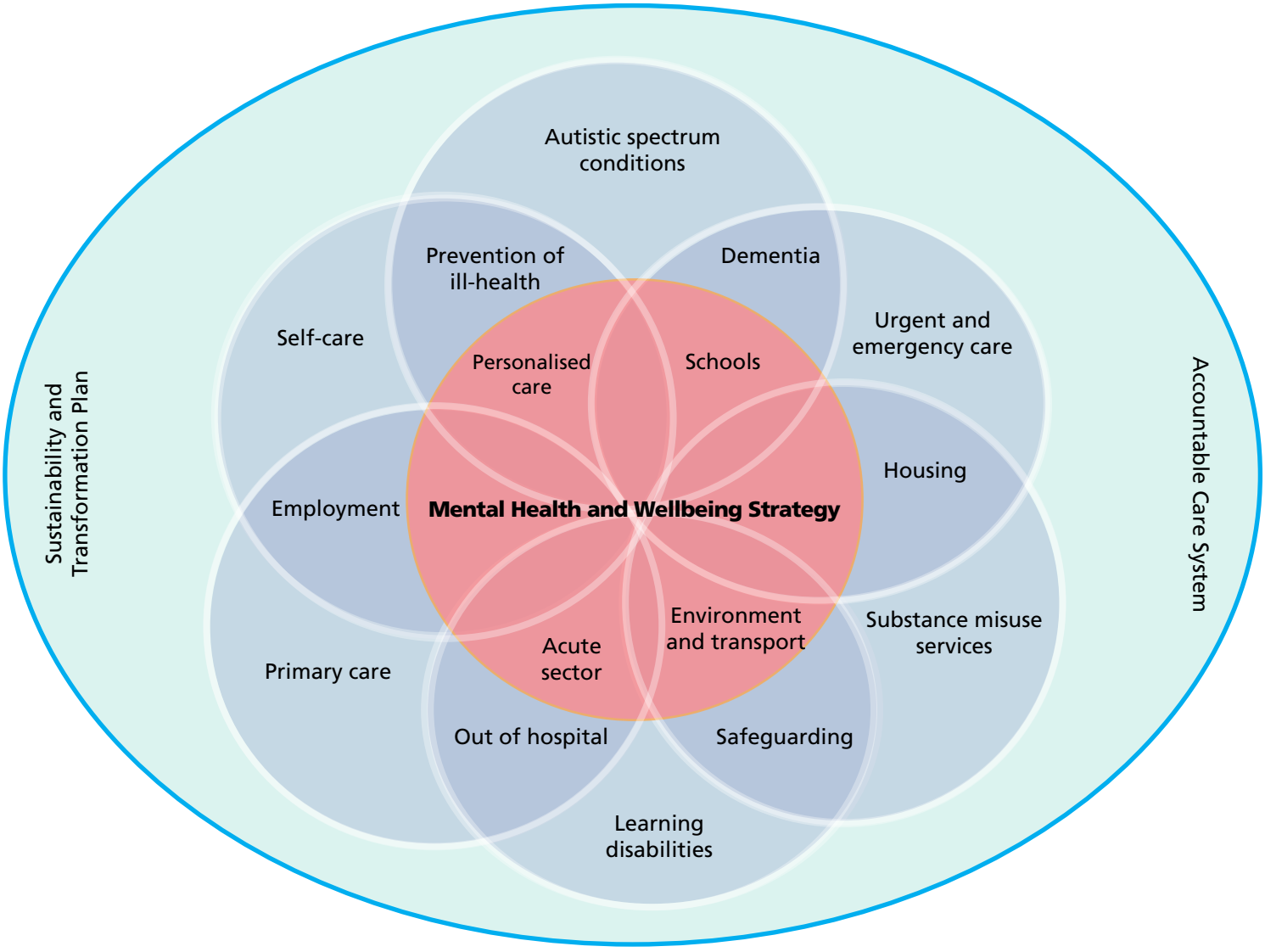
4.7.4 Children and young people

Future in Mind was published in March 2015 by the government's Children and Young People's Task Force.[44] It provides an opportunity to develop services collaboratively and challenges localities to establish a locality transformation plan against the following five key themes:

- promoting resilience, prevention and early intervention
- improving access to effective support – a system without tiers
- care of the most vulnerable
- transparency and accountability
- developing the workforce.

4.8 Relationships with other strategies and developments

Mental health and wellbeing services are part a broad network of systems that affect the way we live, how we take care of ourselves and our families, and our access to support from professionals. The diagram below shows how this strategy for mental health and wellbeing is related to other areas, some of which are complete while others still require development.



The future

5. The future of mental health services in Bradford district and Craven

Where do we want to be?

We will work to ensure that when this strategy is fully implemented in 2021, these statements will be true for everyone who lives in Bradford district and Craven:

I have as much choice and control as possible in my life

I understand my health needs and what keeps me well, and I am encouraged and supported to do more of the activities that keep me well

In situations where I am not able to be in control, I am supported to maintain my rights and dignity and to make choices that support my recovery

I am treated with warmth and compassion and I feel respected and listened to. My concerns are taken seriously

I know how and when to access advice, support and treatment

I am not judged for how I feel or what I have done

I understand my condition and have the help I need to live my life to the best of my ability without my condition taking over my life

I have choice and opportunity to access different therapies, approaches and activities and I have support to get better without medication

My family or carer is actively supported and involved in my care

5.1 Our wellbeing

Strategic, system-wide action is required to identify and take opportunities to improve the mental health of our population, at all stages of life.

We need to ensure that in the future, health and care is viewed as a universal asset to be strengthened and protected. In thinking about mental health in this way, managing mental ill health is still an important factor but is no longer the primary focus. It will require commissioning that is expanded beyond the current focus on services that are specific to mental ill-health to community, social relationships and place-based solutions, as laid out in the Care Act.

However, we recognise that we will need to balance this shift of focus, ensuring that high-quality services are available and accessible to those who need them, but at the same time intervening early to reduce the need for more specialised services and to give people and communities, the resources to protect and manage their own mental health.

The effective support of people experiencing mental health problems is set to become one of the greatest public health challenges of this decade. Without action on the increasing demand for public services, it will not be possible to absorb the rising costs of providing care and support for those experiencing mental ill health in the long-term. This creates an economic imperative for working to prevent mental ill health arising and worsening. We need to act decisively.[45]

We can only do this by working with communities to understand the influences on their mental wellbeing and, where possible, build on their existing strengths, resources and resilience. This can be advanced through a 'whole community approach', which provides a framework to consider all of the factors that influence mental health and allows mental health to be reviewed across a wide range of local policies, services, systems and data that impact the mental health and wellbeing of communities.[46]

The complexity and size of this task can make the prioritisation of local preventative actions challenging, but the initial step is to map existing prevention-focused services onto the local data to understand the gaps and priorities for the locality. The Mental Health Foundation's sample mapping tool is reproduced in Appendix 2. This would allow a 'universally proportionate' approach[47] to be adopted where mental health can be protected overall, but also ensure that people at higher risk of mental health problems are given an appropriate level of priority. Such an approach paves the way to tackle prevention and wellbeing at three levels:

1. primary prevention through improvements to the social, emotional and physical environment for everyone
2. secondary prevention targeted support for high-risk groups and at known trigger points in people's lives
3. tertiary prevention targeted at people are already experiencing distress or have a known mental health problem to prevent problems getting worse.

The Five Year Forward View (5YFV) for Mental Health provides an important context for this approach. A key aspect is the development of a national prevention concordat programme to support all health and wellbeing boards (along with CCGs) to put in place joint strategic needs assessment and mental ill health prevention plans by no later than 2017. The Care Act also supports this approach, especially the emphasis on wellbeing, prevention and choice.

The Five Year Forward View for Mental Health[48] identifies the following areas for action:

1. support for new mothers and babies
2. mental health promotion within schools and workplaces
3. being able to self-manage mental health
4. ensuring good overall physical and mental health and wellbeing
5. getting help early to stop mental health problems from escalating.

The publication of this strategy provides significant opportunities for the district to take action to improve and protect the public's health.

The mental health and prevention report from the Mental Health Foundation provides a comprehensive set of evidence-based examples to inform local action.[49] The following priorities are informed by this work in the context of local needs as well as the policy drivers. A number of the recommended areas for action are covered by priorities in other local strategies and plans as well as in specific sections later in this document.

The Care Act 2014 outlines the following areas for action:

1. wellbeing to be at the heart of our strategy
2. prevention to be at the heart of our strategy
3. control and individual budgets to be at the heart of our strategy
4. advocacy to be fully available
5. safeguarding to be core to all services
6. for all services to be linked to our self-care strategy.

5.1.1 Developing mentally healthy communities and places

It is well known that stressful life events place people at higher risk of mental health problems. These stressors include abuse, homelessness, financial insecurity, bereavement and unemployment, to name only a few. The concept of resilience can explain the extent to which people are protected from the damaging effects of stressful life events. Resilience can be at a community or individual level (World Health Organisation Europe 2009).[50] Prevention of mental illness should combine both universal approaches to strengthen the resilience and mental health awareness of communities and individuals, and targeted approaches. Targeted work would involve identifying those people at higher risk of mental Illness due to their environment or individual risk factors, or specific life events, and giving them additional support.

W1 *We will design and deliver a comprehensive mental health improvement programme that will target increased awareness, capacity for self-management and the need for early intervention and self-care.*

As described in chapter four, the environment in which people live and the circumstances in which they are living have a big impact on their wellbeing and risk of developing a mental health disorder. Improvement of wellbeing and prevention of mental illness, therefore, can only be achieved through the co-ordinated efforts of local policy and decision-makers. Organisations that are crucial in supporting positive wellbeing include, but are not limited to, those with impacts on community, housing, education, employment, food, the built environment, green space, transport, and the criminal justice system. Every decision made by an organisation or department with an impact on such areas must, therefore, aim to improve the wellbeing of the population.

W2 *We will ensure that mental health improvement is a central outcome of all community investment and regeneration.*

5.1.2 Reducing stigma and discrimination

Public Health England has signed up to Time to Change, an anti-stigma campaign run by the leading mental health charities Mind and Rethink Mental Illness.[51] According to the English parliament website, public awareness campaigns have been the principal means of tackling negative attitudes and dispelling misconceptions about mental health.[52] The largest campaign has been Time to Change, which includes a media advisory service. Locally we are committed to reducing the stigma and discrimination experienced by people with lived experience of mental health. We are expanding our use of digital technology, especially social media and web, to raise awareness amongst our wider population around the stigma and discrimination faced by those experiencing mental health issues.

W3 *We will develop and deliver evidence-based stigma and discrimination reduction programmes that focus on sustained behavioural change.*

W4 *We will promote mutual support opportunities and encourage the spread of mental health champions in organisations and business.*

5.1.3 Social care, social work and mental health

Social care and the social model of mental health support and recovery has a major role in the provision of mental health services. Social care provides most of the housing support for vulnerable people and a range of longer-term care and support through residential, nursing or specialist placements, often jointly with the NHS. Section 117 of the Mental Health Act means that social care services have a responsibility to people in hospitals, prisons and secure care and increased responsibilities when they leave. Social care supports people as they get older, if they are vulnerable or lose capacity. Many mental health problems develop from social issues and prevention and recovery is dependent on social care and health providers working hand in hand in line with the Care Act 2014. The social care focus on assessment, personalisation and recovery, supports people to make positive, self-directed change.

The all party parliamentary group on social work (September 2016) recognised the vital role mental health social work in supporting people with mental health problems:

Social workers fulfil a vital role in protecting people's rights when they are in crisis or where a situation has deteriorated – particularly through their work in safeguarding, as approved mental health professionals (AMHPs) and best interests assessors (BIAs). Social workers are also trained to take a strengths-based approach to prevent and reduce deterioration – to work holistically and collaboratively with them, their family and social networks. They focus on empowerment and a solution-focused approach. They focus on protecting human rights and promoting social justice for individuals, families and communities. These are often the things that people using services say are most important to their recovery.[53]

The social care model of mental health recognises the social antecedents and determinants of mental distress throughout life that this strategy seeks to address.[54] This includes poverty, self-care, quality of housing, work, relationships, trauma, loss and abuse. It also means supporting recovery and change through focusing on the person as a whole – their fundamental human potential and the opportunities they could access to bring about change.

W5 *We will continue to support a strong social care and social work role within mental health services, integrated with health and VCS service provision.*

5.1.4 Integrated approaches to health and social care

Mental health services in Bradford district and Craven have a substantial track record of providing integrated health and social care services as well as a strong reputation for joint working with the VCS. We are committed to the continued development of this approach through joint working and developing joint services and strategies, including an expansion of the scope of integration through the development of accountable care systems to include the integration of physical, social and mental health pathways. In addition to existing commitments we will also prioritise the following.

W6 *We will adopt wellbeing models and pathways that integrate physical and mental health, in which social care is a core part of our strategy and we will support social function, spirituality, self-management and peer support through the Care Act 2014.*

5.1.5 Developing mentally healthy homes

Housing is a basic need for everyone and developing mentally healthy homes is an important element of the recommendations from the Mental Health Foundation report on developing prevention strategies. In keeping with the universally proportionate approach, as well as developing mentally healthy homes as a universal principle, we must also have a clear focus on the needs of those with an existing mental health problem, as good quality housing is a key part of the prevention and recovery process. To this end, a range of appropriate housing options is essential to facilitate effective discharge from hospital. In our locality we have a history of good quality supported housing for people with mental health care needs.

People with a mental health problem are less likely to require urgent and hospital-based care if they live in good stable housing, especially where specialised social and health support is provided and particularly if that support can be flexible and reflect the level of need. Furthermore, where people have had to be admitted to hospital, lengths of stay can be kept to a minimum and the risk of re-admission reduced when they can be moved into supported accommodation designed for their needs.

Ensuring that we have sufficient supported accommodation to support people is essential to the realisation of caring for people in the least restrictive environment and avoiding hospital admission. Effective support at home provides the opportunity to realise cost reductions in the provision of more specialist inpatient care, residential or nursing care and service users have better outcomes and more independence in their own home. This is in line with an enablement and recovery model of care.[55,56]

Commissioners have already implemented a new supported living framework that has clarified the standards, pricing structure and support expectations for supported accommodation for all providers in our locality. This commissioning strategy supports the use of this framework to develop supported accommodation provision.

As in many other areas across the country the NHS, local authority and housing providers are committed to working in partnership to develop jointly commissioned supported housing provision.

In addition we will support the following evidence-based interventions for delivering mentally healthy homes in Bradford district and Craven.

W7 *We will ensure local housing and regeneration policy and planning creates public and private housing which provides a safe, stable environment that promotes community cohesion and mental wellbeing.*

W8 *We will develop a range of social and supported housing options for people with mental health care needs.*

5.1.6 Developing mentally healthy workplaces

The 'whole system approach' to improving mental health, clearly identifies the workplace as an important setting to educate and raise awareness, encourage positive health behaviours and self-care, and protect the mental health of individuals. There is also a good opportunity for early detection and prevention of deterioration which can lead to long periods of sickness absence, and worklessness in the longer-term. This is incredibly important as the longer a person is off sick, the more difficult it becomes for them to return to work and the less likely it is that they will return to work at all.

'Good work' has a positive impact on both physical and mental health. It is clearly linked to social identify and status, building resilience, self-esteem and self-efficacy, and is a setting for social contacts and support. It is also a means of 'structuring and occupying time; activity and involvement; and a sense of personal achievement. That as many as 90% of workless people who use mental health services wish to work suggests that people with mental health problems are aware of the benefits of employment.

The key, though, is 'good work' and there are clear factors in the workplace which are protective and beneficial for health. Conversely, poor work conditions can have a detrimental effect on the mental health of individuals. Seventy-seven per cent of more than 3,000 people who responded to a national employee wellbeing survey said they had experienced symptoms of poor mental health; 62% of these attributed their symptoms to work or said that work was a contributing factor.[57] In addition, mental ill health leads to many employees leaving employment and is the most common reason for claiming health-related unemployment benefits. Despite this, employer awareness of mental health issues at work in the UK is poor and discrimination still rife.

Making the case

The moral, economic and legal case for enhancing mental health in the workplace is abundantly clear for individuals, organisations and the wider economy. Research by the Centre Forum Commission led by former Health Minister Paul Burstow found that mental health problems cost UK employers £26 billion each year, through lost working days, staff turnover and lower productivity, averaging £1,035 per employee.[58] From a legal perspective, management of health and safety at work regulations 1999 also require employers to assess and to act to control the risk of stress-related ill health arising at work.

Conversely, research shows that investment in health and wellbeing programmes, increases employee satisfaction, leads to higher organisational profile and reputation, higher productivity, reduced sickness absence and reduced staff turn-over.[59] Evidence from the Sunday Times' "best companies to work for in the UK" has shown that companies with higher levels of employee engagement – as measured by employee wellbeing, line management and team working – have 13% lower staff turn-over, less than half the sickness absence of the UK average and, on the stock market, have consistently out-performed the FTSE 100.[60]

Outside the workplace there are clearly numerous social and economic benefits to individuals, families and communities. Families without a working member are more likely to suffer from persistent low income and poverty. There is also evidence of a correlation between lower parental income and poor health in children.[61]

Aspirations for the future

Our vision is that workplaces across Bradford district and Craven become renowned for tackling stigma, promoting positive mental health and wellbeing for all, creating the conditions needed for 'good work' and delivering supportive, reasonable adjustments for those individuals who need additional help to stay well and retain their work. This strategy recommends that all of its signatories set an example in encouraging organisations from all sectors to proactively champion mentally healthy and inclusive work places. This will include a proactive approach to recruiting individuals with mental health problems.

We also want to take a system-wide, proactive and person-centred approach to supporting people into work after a period of mental ill health, or with long-term mental health conditions – recognising that one size does not fit all and there is a spectrum of need across our district. One of the key deliverables of the 5YFV for Mental Health is doubling the reach of employment support individual placement and support (IPS). BDCFT is a centre of excellence for IPS through its Making Work, Work scheme, which saw 86 services users going into paid employment during an 18-month timescale. These people will have reduced or no need for services from community mental health teams (CMHTs). Evidence suggests IPS participants are twice as likely to gain employment (55% versus 28%) compared with traditional vocational alternatives.[62] We will explore how this evidence-based approach can be embedded and sustained.

This strategy will support and develop people at every stage of their recovery to become ready for work and then to access employment. We will also concentrate on supporting people having difficulty in work due to their mental health, to retain their employment, thus avoiding the risk of long-term worklessness.

Outside the workplace there are clearly numerous social and economic benefits to individuals, families and communities. Families without a working member are more likely to suffer from persistent low income and poverty. There is also evidence of a correlation between lower parental income and poor health in children.[63]

W9 *As the largest local employers, we will lead the way in establishing a district-wide network of organisations that are passionate about, and committed to, mentally healthy workplaces with all health and local authority services achieving a mental health charter mark. We will proactively share best practice and facilitate small to medium enterprises to engage through accessible training and tools.*

W10 *We will support people to develop the skills and confidence needed to be work ready, engage with employers to enhance accessible job opportunities, and provide support to both individuals and employers to help more people with mental health problems to retain their employment.*

In Great Britain as a whole 73.7% of people aged 16-64 were in employment during the period April 2015 – March 2016 compared with only 66.4% of people in Bradford.[64]

5.1.7 Suicide prevention

The suicide rate is rising in Bradford in line with national trends, but consistently above them. A rate of 12.1 deaths by suicide per 100,000 people was recorded from 2012-2014, compared to a national rate of 10.1 per 100,000 nationally. This means between 40 and 50 people a year are taking their own lives in the district (although numbers vary considerably each year). There have been a small number of suicides in young people aged 15-19 in the district over the last decade, similar to rates seen nationally, and Public Health, the Bradford Safeguarding Children Board Child (BSCB) death overview panel and the Future in Mind Strategy Group work together to monitor these trends.

Partners in the district – including the hospital and mental health trust, commissioners, local authority, MIND, Samaritans, WY Police and WY Fire and Rescue - meet regularly as part of a suicide prevention group. During 2015/16 this group updated the comprehensive audit of deaths by suicide in Bradford from 2013 and reviewed the national and international evidence for effective prevention. This is now leading to the formulation of an action plan, based on the national prevention strategy, which will be completed in early 2017. Partners are also involved in work at a West Yorkshire level around suicide prevention within the urgent and emergency care vanguard.

The key areas we will focus on are:

- prevention through targeted approaches to improve mental wellbeing in specific groups
- reducing the risk of suicide in high-risk groups (adults and children)
- providing better information and support to people bereaved of affected by suicide
- reducing access to the means of suicide
- support in the media in delivering sensitive approaches to suicide and suicidal behaviour
- support research, data collection and monitoring to inform local actions.

W11 *We will support the development and implementation of the local suicide prevention strategy.*

5.2 Our mental and physical health and care

5.2.1 Primary care

In April 2016, NHS England (NHSE) in partnership with The Royal College of General Practitioners (RCGP) and Health Education England (HEE) published the General Practice Forward View.[65] This document is a 'Forward View' for primary medical care services, also known as 'general practice'. It highlights the key challenges which face primary medical care currently and the changes and developments which NHSE, RCGP and HEE identify as being high priority in ensuring a high quality and sustainable primary medical care service is in place in the future.

The General Practice Forward View (GPFV) focuses on five main areas: investment; workforce; workload; practice infrastructure; and care re-design.

Against each area the GPFV outlines what NHSE expects in order to support delivery of the Forward View. One of the main areas of interest relating to mental health is that over the next five years there will be investment in an extra 3,000 mental health therapists to work in primary care by 2020, to support localities to expand the improving access to psychological therapies (IAPT) programme.

To deliver the GP Forward View we will develop local plans to stabilise general practice delivery now, to be resilient and sustainable in the future and to prepare for new ways of delivering care as part of accountable care systems (ACS). General practice is the cornerstone of care and the key foundation of the whole health and social care system. It is unlikely that the future model of general practice will look like the service that is here today. Over the next five to 10 years the service needs to transform, adopting new ways of working and new ways of delivering care as part of an ACS. The ACS will require all providers to work together to deliver defined outcomes which meet individuals' physical, psychological and social care needs. To do this we will learn from what we have done well and, we will be at the forefront of testing new models of care and accountable care. We will innovate and share learning acquired through involvement in national programmes such as 'Pioneer' and 'Accelerate' and look to national and international examples of best practice. We will establish a culture which facilitates curiosity, to enable new ideas to be tested and tried. We will change cultures and mind-sets so individuals become active participants in their own health and wellbeing and have ready access to information and support to self-care and self-manage conditions. Prevention is key and we will work with stakeholders and individuals with the aim of preventing and avoiding early onset of mental and physical health conditions.

Contemporary western medicine is based on a tradition of treating mental health separately from physical health – a tendency to assume that diseases occur independently of the social context. When mental health is treated as separate from physical

health and social determinants, the healthcare experience is often stigmatised and the care process is fragmented. Depression, the most common mental health condition seen in general practice, often occurs with, and compromises, care of other chronic illnesses; yet stigma and secrecy often cause depression to go undetected, undiagnosed, or under-treated.[66,67] We will ensure that the outcomes defined as part of an ACS take account of individuals' physical, psychological and care needs and mental health is equally as important as physical health.

The GP Forward View has six priority themes for general practice, all of which will improve the care and treatment of people with mental health problems and the development of a local response to the GPFV will have mental health at its core. The six themes are:

- improving access to primary medical care services (in and out-of-hours)
- improving the quality of primary medical care services
- developing the primary medical care workforce
- promoting self-care and prevention
- collaborative working
- estates, finance and contracting, better premises and well-resourced practices can provide better care for patients with mental health problems.

In response to these we will:

H1 *We will improve the knowledge and awareness of mental health within the primary care workforce to enable a more holistic approach to patient management.*

H2 *We will develop a model of integrated physical and mental health services whereby people can have their care needs met at the same location as part of an agreed pathway of care.*

5.2.2 Mental and physical health

The presence of co-morbid mental and physical illness is known to worsen outcomes for patients and increase costs for health services.[68] Overall, the research shows that co-morbid mental health problems are a major determinant of overall costs, typically associated with a 45-75% increase in service costs for long-term physical health conditions. In 2010-11, mental illness raised the cost of physical health care in the NHS by an estimated £10 billion.[69]

One of the two main groups in which management of co-morbidity is particularly challenging is patients with medically unexplained symptoms (MUS) and somatisation. MUS cause considerable distress, disability and poor outcomes for patients.[70] Primary care is the patient's first and continuing point of access but GPs may lack time, specialist knowledge and strategies to manage them. Repeated investigation of the causes of symptoms can lead to unnecessary, costly and sometimes damaging tests and treatments.[71] The patient-health professional relationship suffers as there is no resolution, which is frustrating for the patient and the GP. It has been estimated that around 20% of all primary care consultations are for MUS and the annual healthcare costs in the UK exceed £3.1 billion, with total costs to the UK economy estimated at over £18 billion.[72,73] The Bradford and Airedale primary care wellbeing service has been recognised as a key good practice example by the King's Fund as a way of addressing this issue.[74] The service supports people with high levels of physical health service use and possible mental health needs through a primary care based multi-disciplinary team. Its interventions have reduced both iatrogenic harm as well as reduced overall costs of care.

Co-morbid physical and psychological conditions – usually described as long-term conditions (LTCs) – also result in poorer health outcomes and reduced quality of life.[75] Multi-morbidity is particularly associated with mental illness, which delays recovery from both mental and physical symptoms.[76] Co-morbidities have a further interaction with deprivation which makes a significant contribution to generating and maintaining health inequalities.[77] The total cost to the NHS each year of poorly managing these conditions is estimated at between £8-13 billion, the costs to the UK economy as a whole being estimated to exceed £100 billion.[78] As part of the Five Year Forward View for Mental Health, NHS England has set out plans for the expansion of IAPT for people with LTCs. This is supported in 2017/18 through non-recurrent funding to establish IAPT LTC services, with a clear set of expectations that sustainable funding will be generated through savings within physical health care.

In secondary care, 50% of outpatients fulfil criteria for MUS with a wide range of disorders.[79] At 12 months these percentages across different specialities are: gynaecology (66%), neurology (62%), gastroenterology (58%), cardiology (53%), rheumatology (45%), general medicine (40.5%).[80]

These two key clinical problems overlap since people with MUS often have a physical disorder which forms the basis of their complaints but which cannot explain all their symptoms, and people with poor adjustment to one or more LTC will often present with an undue focus on the symptoms or treatment of their physical disorder.

There are currently a range of services provided across the spectrum of need, but they are not currently co-ordinated, consistent or equitable in meeting needs.

In designing a future model, we need to consider the evidence base to inform the prioritisation of areas for action and the skills that are required to meet those needs, whilst acknowledging that existing examples of good practice are limited and that local services are already viewed as best practice exemplars. This, for example, could build on the learning from the Airedale complex care model where 70% of referrals experience depression with the next most common presenting problems being chronic pain followed by anxiety.

This is an existing priority area for the district and further to consultation and discussion the following areas have been highlighted for action.

W12 *We will provide support to people with mental health problems and complex physical needs to navigate services to maximise wellbeing and independence.*

H3 *We will develop the role of VCS and community groups to provide access to early intervention support which improves personal resilience.*

H4 *We will develop an integrated approach to the identification of mental ill health in secondary care pathways, to improve the outcomes of physical health treatment.*

H5 *We will further develop the targeted approach to patients with medically unexplained symptoms (MUS) in primary care to improve patient outcomes and efficiency.*

5.2.3 Psychological therapies

Psychological therapies have a significant role to play in improving the mental health of our local population. Our vision is increased access to psychological therapy, engaging people earlier to prevent deterioration in their mental health; reducing the social and economic impact for individuals, their family and community.[81]

Since its introduction in 2008, the national improving access to psychological therapies (IAPT) programme has successfully increased the accessibility of talking therapies for common mental health disorders (anxiety and depression). Across the district services aim to engage 15% of those estimated to be suffering from anxiety and depression at any given time, around 75,000 people.

We are already transforming our local psychological therapy services into a multi-provider network that offers choice, flexibility and easy access. Historically over 90% of referrals for psychological therapy services are via GP, which can lead to delays in engagement.

Increasing access to psychological therapy is a key objective for mental health services nationally and locally, aiming to increasing from around 12,000 to 19,500 treatments per year across the district by 2020/21.[82]

Delivering new LTC IAPT services is expected to deliver substantial savings, with services quickly becoming self-sustaining. These savings are based on evidence of physical health improvements for people with long-term conditions when co-morbid mental health problems are treated in an integrated way.[83] Reduced healthcare utilisation in, for example, A&E attendances, short stay admissions and prescribing costs will release funds to enable continued investment in these new services.[84,85] The conditions for which there will be the greatest reduction in cost are those for which depression or anxiety co-morbidity leads to a 50-100% increase in physical healthcare costs. The strongest evidence is in diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular disease and – for some people – chronic pain and medically unexplained symptoms. It is expected that over the longer-term, fewer complications will result in reduced demand across the pathway.

W13 *We will extend the recovery college service model through a multi-provider network to offer online evening and weekend psychological interventions.*

W14 *By 2020/21, 90% of people who access psychological therapies will engage through direct self-referral.*

H6 *We will increase access to IAPT from 15% – 25% prevalence providing an additional 7,500 treatments per year, 5,000 of whom will have long-term conditions.*

H7 *We will ensure that services provide a balanced range of effective therapies as well as pharmacological interventions that are culturally appropriate and effective.*

5.2.4 Care pathways for victims of sexual assault and domestic violence

Only 20% of victims of sexual assault will go to a sexual assault referral centre and the rest present elsewhere (eg A&E, GP and mental health services). Many of the clients in mental health services disclose a history of abuse. Even where victims of abuse make an initial attendance at a specialist resource, many victims will require longer-term on-going support. However, victims of child sexual abuse will take an average six years to report and will often present as adults rather than children. There is a need to ensure partners and the public are fully aware of the services available to provide longer-term support and intervention

W15 *We will ensure that local services/pathways are skilled to recognise and meet the longer-term needs of people who experience sexual assault or domestic violence.*

5.2.5 Physical health care of people with severe mental illness

People with severe mental illness (SMI) die on average 15-20 years before the general population. This is mainly due to cardiovascular problems eg heart attacks, or cancer as a result of smoking and obesity, which can be related to the medication given. The cost of smoking in SMI people was £2.46 billion in 2009/10.

In Bradford district and Craven we have developed an electronic template to make doing annual physical health checks in SMI patients much easier. It provides a structured process to ensure clinical staff undertake all the necessary checks (eg blood pressure, weight, smoking status etc.). This has resulted in the district featuring in the top 10 in the country for performing physical health checks in SMI patients, allowing doctors to pick up early warning signs of problems such as heart disease. The process is shared with inpatient and community mental health services in BDCFT although more work needs to be done in children's mental health services and early intervention in psychosis to ensure the checks are undertaken routinely. BDCFT services are smoke-free, which should lead to a reduction in smoking.

The physical healthcheck template developed in Bradford is now available nationally due to its success and backing at national level by the previous national clinical director for mental health, NHSIQ, Health Education England and Academic Health Science Network.

Not looking after SMI patients' physical health is known to result in an increase in accident and emergency attendances and unplanned admissions. This is significant since 81% of emergency admissions for SMI patients are for physical health problems.[86,87,88]

H8 *We will reduce premature mortality associated with physical ill health in people with severe mental illness to below the Yorkshire and Humber average by 2020.*

5.3 Mental health care when we need it

5.3.1 Children and young people

Future in Mind: the children and young people's mental health transformation plan for Bradford district and Craven sets the local vision for children's mental health and wellbeing.[89] Children and young people will have access to a comprehensive range of psychological interventions to meet the needs of a diverse young population. Services will be accessible, informed and flexible to meet the needs of children and young people in a variety of settings. This involves partners across statutory, voluntary and community services that have a shared goal supporting and safeguarding the mental health and emotional wellbeing of children and young people across the district. Access to psychological interventional help should be at the earliest opportunity for all young people to reduce risk of escalation and eventual need for specialist intervention.

To achieve this, we will improve access to, and the quality of, services and outcomes for children up to the age of 18 years. This covers acute and urgent care, community services, child and adolescent mental health services (CAMHS), health promotion and ill health prevention. Further to this work, Future in Mind was published in March 2015 by the government's Children and Young People's Task Force. It challenged localities to establish a locality transformation plan against the following five key themes:

- promoting resilience, prevention and early intervention
- improving access to effective support – a system without tiers
- care of the most vulnerable
- transparency and accountability
- developing the workforce.

Further guidance for the transformation plans was published in August 2015 with additional recommendations for eating disorder services and crisis intervention. A locality transformation plan (LTP) has been developed via a multi-agency group and the participation of children and young people. [90] This is a five year plan in order to build responsive and sustainable services in order to ultimately improve the mental health and wellbeing of CYP in Bradford and Craven.

The LTP has resulted in local commissioners being able to access funding relative to their population size which amounted to £1.1m recurrently for five years in Bradford and Craven. This has been agreed to support the priorities within the Future in Mind guidance and commitments in the LTP locally. This investment has also afforded the opportunity for commissioners and providers to review the existing pattern of investment and re-align towards meeting the needs of priority groups.

The incidence of mental health and emotional wellbeing problems is more prevalent in looked after and adopted children and they are more likely to be involved with youth offending, substance misuse and child sexual exploitation.

Locally, young people as well as other stakeholders have told us that the transition to adult services isn't always as good as it could be. The experience of transition is often affected by the individual's needs, but it is acknowledged that some young people need additional supports until they are older. Many services adopt a more flexible approach to meeting needs up to the age of 25 and the local plans for Journey to Excellence include the development of an integrated service for young people aged 14-25 with complex health and/or disabilities. Young people will benefit from this approach being the norm across mental health care and we will embed this aspiration into other service development plans.

W16 *We will develop a network to deliver mental health and emotional support in each school to promote mental wellbeing amongst young people.*

W17 *We will improve the awareness and understanding of mental health for all people working with children and young people*

C1 *We will establish mental health expertise within the entry point to children's services to enable access to early help/mental health services.*

C2 *We will develop a community-based service for young people with eating disorders to support care delivery at home in order to reduce hospital admissions.*

C3 *We will extend access to crisis care through the First Response Service (FRS) by appointing CYPMH specialists within the team.*

C4 *We will develop a dedicated looked after and adopted children therapy team to deliver support, consultations and supervision to those teams working with these vulnerable groups.*

5.3.2 Perinatal mental health

Perinatal mental illness is a significant complication of pregnancy and the postpartum period. These disorders include depression, anxiety disorders, and postpartum psychosis. Perinatal mental illnesses cost the NHS around £1.2 billion for each annual cohort of births. In comparison, it would cost only an extra £280 million a year to bring the whole pathway of perinatal mental health care up to the level and standards recommended in national guidance.[91] This is a case for investment that cannot be ignored. Perinatal mental ill health is associated with 23% of maternal death, 1 in 7 of which are suicides. BDCFT has used existing resources to improve perinatal, including parent-infant, mental health care.

Taken together, perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth.

Within the 5YFV for mental health there is a target for NHSE specialist commissioning to increase access to specialist perinatal mental health support in the community or in-patient mother and baby units by 2020/21. This will require collaborative working across the STP footprint but also requires local services to be able to respond to the needs of women during this period. Mental health teams need to be alert to and aware of perinatal mental health issues, including the specific characteristics of severe perinatal mental illness such as post-partum psychosis and locally there is a referral pathway, via a single point of access, for perinatal illness.

C5 *We will work with partners to develop a West Yorkshire specialist perinatal mental health team that interfaces with local evidence-based pathways.*

5.3.3 Early intervention in psychosis

The Bradford and Craven early intervention in psychosis services are integrated health and social care services that have historically responded to the needs of people from 14 to 35 years of age and provides evidence-based care for people who are experiencing the first symptoms of psychosis. Psychosis has far-reaching implications for the individual and their family; without support and adequate care, psychosis can place a heavy burden on carers, family and society at large. The onset of psychosis is most frequently between the ages of 14 and 35, therefore often during a critical period in a person's development.

In the past it has taken up to two years after the first signs of illness for an individual to begin to receive help and treatment, but early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal harm.

Nationally, one in 10 people with psychosis commits suicide – two thirds of these deaths occur within the first five years of illness.

Intervening early in the course of the disease can prevent initial problems and improve long-term outcomes. Some people experience things that could be 'warning signs' that people are vulnerable to the development of psychosis. These early experiences are called 'prodromal' symptoms. Psychological and social interventions can be provided to reduce the risk of transition to psychosis

The 5YFV for Mental Health requires, by 2020/21, at least 60% of people with a first episode of psychosis to start treatment with a NICE-recommended package of care with a specialist early intervention in psychosis service within two weeks of referral. It also requires services to extend the service to include people aged 14-65 years.

C6 *We will improve access for people experiencing a first episode of psychosis to a NICE approved care package within two weeks of referral from 50% to 60% by 2020/21.*

W18 *We will develop an evidence-based pathway for people at risk of psychosis to reduce the risk of transition to psychosis.*

5.3.4 Community mental health services

Community mental health teams

Community mental health teams currently provide services to those experiencing a range of mental health problems that require expert and often collaborative approaches from a multi-disciplinary team of professionals integrated across health and social care. This model has been in operation for several decades and incorporates multiple clinical pathways and medical, nursing, social, and psychological approaches. Often community mental health teams have been providing a long-term and open-ended supportive approach to individuals.

As services have developed specific evidence-based delivery in areas of speciality such as early intervention in psychosis and IAPT, the model and client groups served by CMHTs have shifted. As a result, the current model of CMHT requires a comprehensive review so that they complement these developments and look to provide a recovery and prevention oriented approach within clear clinical pathways that are outcome based. Stakeholders also want to explore the options for better integration with primary care and other community services.

CMHTs have also been the key focus for the integration of health and social care in mental health services. Social work, community psychiatric nursing, occupational therapy and a range of support specialisms all have a crucial role in mental health services and improving mental health outcomes for citizens. Mental health nursing has formed the core of the CMHT workforce since their inception. The role of nursing within CMHTs has expanded over many years, including the development of specialist nurse practitioners, nurse prescribing and the delivery of a broad range of therapeutic interventions. It has also been influenced by the integration with social care. Social workers bring a distinctive social and rights-based perspective to mental health services. The social care focus on assessment, personalisation and recovery supports people to make positive, self-directed change. Social workers also manage some of the most challenging and complex risks for individuals and society, and take decisions with and on behalf of people within complicated legal frameworks, balancing and protecting the human rights and best interests of different parties. This includes, but is not limited to, their vital role as the core of the approved mental health professional (AMHP) workforce and as best interest assessors.

The social care model of mental health recognises the social antecedents and determinants of mental distress throughout life that this strategy seeks to address.[92] This includes poverty, self-care, quality of housing, work, relationships, trauma, loss and abuse. It also means supporting recovery and change through focussing on the person as a whole – their fundamental human potential and the opportunities they could access to bring about change.

There are a number of key principles and aims that will be incorporated in the review of community mental health services:

- **Integration:** this will include the continued integration between mental health, physical health, primary care and social care;
- **Recovery:** ensuring that services work towards supporting people to be as well and independent as is personally possible;
- **Prevention of crisis:** community mental health services should put into place support systems that reduce mental health crisis;
- **Clinical pathways:** in line with the 5YFV, care will be provided based on evidence-based pathways to ensure the delivery of a co-ordinated recovery based packages of care providing expert knowledge, facilitation and treatment with a multi-professional approach;
- **Primary care:** community mental health services will enhance partnership working with primary care;
- **Partnership with VCS organisations:** community mental health services will strengthen and further develop collaboration and partnership with voluntary and third sector organisations.

C7 *We will complete a review of the current model of CMHT and re-design services to meet future needs, ensuring that the needs of people with personality disorder and dual diagnosis, or within criminal justice services are incorporated into future pathways*

Personality disorders

As noted previously, around 25 people each month are referred into services for treatment of these disorders and their frequently chaotic lifestyles and poor engagement with services means that people often then present in an emergency. Currently, evidence-based services are provided by the BDCFT Helios Centre services. However, it is recognised that within the generic community mental health services there is a lack of a cohesive evidence-based response to meet the needs of this group. This can result in inappropriate inpatient admissions, risk of eviction and rooflessness and frequent A&E attendances. The development of a clear pathway of care needs to be a key element of the review of community mental health services.

C8 *We will design and implement a clear pathway of care to meet the needs of people with a personality disorder in the community.*

Adult eating disorders

The review that informed this strategy has highlighted significant gaps in the current local provision to adults with an eating disorder. These include the care and support of young people transitioning from CAMHS into adult services, support for people who require hospital care for physical complications, community services and the interface with more specialist regional services commissioned by NHSE. The development of a clear evidence-based pathway that provides seamless transition as well as a skilled response from community mental health services for adults locally needs to be developed.

C9 *We will design and implement a clear pathway of care to meet the needs of adults with eating disorders.*

5.4 Urgent and emergency mental healthcare

In 2015/2016 we undertook a review of our crisis care pathway, achieving better access to urgent care. We worked with partners including the local authority, health, VCS and emergency services to create a whole-system approach.

'When I need urgent help to avert a crisis I, and people close to me, know who to contact at any time, 24 hours a day, seven days a week. People take me seriously and trust my judgement when I say I am close to crisis, and I get fast access to people who can help me get better.'

A single point of access was created making self-referral available by telephone 24 hours a day, seven days a week for those in need of urgent mental healthcare. Roles within the service include tele-coaches (psychological therapists) who are able to assess and support via telephone, nurses and social workers who are able to make in situ assessments and advanced nurse practitioners (ANP) who are able to prescribe and divert away from out-of-hours and emergency services. Police and emergency services have also been given access to a timely response for people they have identified as being in crisis.

Alternative spaces for people in crisis were created in partnership with voluntary services including The Haven, which is open seven days a week, as an alternative to A&E attendance and The Sanctuary, which is available for those needing support during the evening.

New roles were introduced in the inpatient setting including ANPs to support with nurse-led discharges; this process supports stepping down to the care of the intensive home treatment team. A housing social worker post was created to support with delays in identifying suitable accommodation which were preventing people from being discharged home in a timely way.

The intensive home treatment team undertook a review of their model and pathways to enhance their home support as an effective alternative to hospital admission.

This urgent mental health response is acknowledged nationally as a good practice blueprint for others to learn from and has resulted in no-one from the area being placed out of district because there were no acute mental health beds available locally.

We will continue to provide 24 hours a day, seven days a week single point of access and crisis and out of hours care for all people requiring a mental health service. Services will continue to support and encourage a least restrictive practice model ensuring recovery is the focus and providing people with capacity the opportunity to be the lead in their care through the options offered. Mental Health Act assessments are always a last resort and pathways will continue to be developed and demonstrate that each practitioner works through the least restrictive options for the service users.

We will continue to work with and further develop services with the police. We currently provide expert mental health support for calls made to emergency services, in an attempt to identify speedily if the person is in, or requires, mental health services and respond or signpost appropriately.

The Sanctuary and the Haven have established a model which is based on a strong partnership between VCS and statutory services. Working with VCS enables a creative approach to workforce development and gives opportunities to experts by experience, as well as ensuring the clinical and social needs are met with the expert advice and support when needed.

We will continue to offer an A&E liaison service within the A&E departments of our acute hospitals and develop tools that support the acute hospitals teams to assess and signpost service users to the most appropriate care pathway.

We will continue to develop the Haven as an alternative service to attendance at A&E with the aim of increasing community resilience, reducing the number of individuals attending A&E in mental distress and provide a community-based, non-clinical setting that provides a welcoming environment for people.

These approaches will continue to ensure that required admissions to mental health wards are delivered locally with no out-of-area placements.

C10 *We will use stakeholder feedback to deliver continuous improvement in the operation of First Response.*

C11 *We will ensure our local acute providers have all-age mental health liaison teams in place and by 2020/21 will meet the "Core 24" standards.*

5.5 The rehabilitation of people with serious and enduring mental health problems

Despite the success of local services in ensuring that the level of disability experienced by people with severe and enduring mental health problems is minimised, and that their care and treatment is delivered in the least restrictive environment, at any given time there is a small cohort of people (currently 23) who require intensive treatment in inpatient settings to enable them to live independently in the future. BDCFT provides a

12-bed inpatient facility at Lynfield Mount Hospital but others have needs that require placement in more specialised facilities. These specialised placements tend to be expensive and every opportunity is taken to keep the use of such facilities to a minimum and ensure that resources are used effectively. Case managers ensure that the safety and quality of placements meet required standards. Reducing the use of such placements can place pressures on social care (eg supported housing) and community support services and it is important that we work across the system to ensure that the specialised needs of this small group are met in the least restrictive environment as locally as possible. To facilitate this we will ensure that the resources available are reviewed to explore how they are used in a collaborative way that encourages a partnership approach to the delivery of care.

5.6 Older people's mental health

There are many different views on when older age begins. Some people are (as a result of their life experiences) more likely to develop the first signs of older age such as physical decline earlier than others, whilst others reaching state pension age do not consider themselves as 'old'.

Supporting people to age well involves reducing social and emotional isolation, preventing depression and/or ensuring early case identification and access to treatment, providing integrated support to meeting mental and physical health needs, supporting carers and improving the lives of people with dementia.

Loneliness and isolation are linked to poor physical and mental health in older age.[93]

Depression affects one in five older people living in the community and two in five living in a care home.[94] Depression has been linked to dementia and it is estimated that up to 40% of people with dementia may have a co-morbid depression.[95] Depression can compound isolation and speed up cognitive decline. Depression in later life can often go undiagnosed despite the exposure to risk factors and losses including bereavement, retirement, and loneliness and deteriorating physical health.[96] The most vulnerable older people are those who live with physical health problems associated with ageing. Many older people live with one or more long-term conditions and make up the majority of patients in acute hospitals. A stay in hospital for a physical health problem can leave people feeling lonely with little opportunity for social contact.

There is an existing district-wide strategy for dementia.[97] and mental health services make an important contribution through the diagnosis of dementia in memory assessment and treatment services (MATS) and guiding people and their carers into local post diagnostic support pathways. Mental health services also provide advice and support on the longer-term management of people with dementia to care homes and physical healthcare settings. As part of our on-going support to the delivery of the dementia strategy we will ensure that the MATS and post-diagnostic support pathways are fit for purpose and provide sufficient capacity to meet future need.

Although treatment for depression is as effective for older patients as for younger adults, the condition is often under-recognised and under-treated: locally 13.97% of people are over 65, but the percentage of people over 65 being referred to IAPT services is currently only 5.26% locally (6.36% nationally)

W19 *We will provide improved detection and access to evidence-based treatment of depression for older people.*

W20 *We will tackle loneliness, fear and isolation through supporting the further development of schemes that improve mental health in later life through supporting emotional and social connections.*

H9 *We will empower older people and their carers by improved involvement in personalised care planning to reduce admissions and ensure improved partnership between intermediate care and mental health.*

W21 *We will ensure that carers are identified, their needs are assessed and a plan agreed to support their personal wellbeing and role as a carer.*

C12 *We will ensure improved access to addiction services for older people.*

C13 *In view of the critical role of carers, we will actively seek their feedback and contribution to the future design of services.*

5.7 Carers

Carers are the first line of prevention. Their support often stops problems from escalating to the point where more intensive packages of support become necessary. But carers need to be properly identified and supported. The carers' strategy for the district needs to be reviewed.[98]

This coincides with the Department of Health (DH) undertaking a consultation in order to develop a new national carers' strategy, to provide updated guidance on improving support for carers. This will help to guide and inform local developments and in recognition of the vital role played by carers we will ensure that the needs and views of carers who support people with a mental health problem is supported by the local carers' strategy.

The Carers' Resource is the local, specialist carers' centre for the Bradford district and Craven and they offer a broad range of support to carers including advice, information, practical support and opportunities to access groups. BDCFT's carers' hub provides education and support and is committed to the triangle of care: a therapeutic alliance between service user, staff and carer that promotes safety, supports recovery and sustains wellbeing.[99]

5.8 Protected characteristics

The Equality Act 2010 provides scope for positive action and strengthens protection against discrimination, based on nine protected characteristics. These are: age, disability, gender, race, religion and belief, sexual orientation, marriage and civil partnership, maternity and pregnancy and gender reassignment. The potential impacts of protected characteristics on the likelihood of experiencing mental ill-health and on access to effective treatment are detailed in section four. Everyone in Britain is protected by the Equality Act.

Inequalities that arise as a result of protected characteristics are compounded by the stigma and discrimination surrounding mental ill health. One of the cornerstones of tackling inequalities in service provision is delivering a truly personalised approach that identifies the specific needs of each individual and their family and carers, maximises their control over the support they receive and ensures that they are not disadvantaged by discrimination.

Throughout this document we have specifically set out our commitment to improving wellbeing and developing services. Through our engagement work, we have identified areas of work to focus on, develop and improve. Our work with local

community groups and organisations is vital to ensuring we have the engagement and dialogue to develop responsive services.

5.9 Other areas of care

5.9.1 Mental health and autism

Mental illness can be more common for people with autism than the general population. In particular, anxiety is very common with around 40% having symptoms of at least one anxiety disorder at any time, compared with up to 15% in the general population. Many people on the autism spectrum may have difficulty describing the symptoms they experience. Understandably, this can lead to sadness or depression – one reason why a mixture of anxiety and depression is common. [100]

It may be especially hard for depressed people with autism to seek help because they might find change daunting and anxiety-provoking, feel worried that they will be blamed, or feel unsure about how to describe their symptoms. Anxiety and depression can also make people more generally introverted, withdrawn and isolated.

The Autism Act 2009 did two key things: it put duty on the government to produce a strategy for adults with autism, together with statutory guidance for local councils and local health bodies on implementing the strategy.[101] The most recent strategy – Think Autism[102] – was published in April 2014 and statutory guidance that tells local authorities, NHS bodies and NHS foundation trusts what actions should be taken to meet the needs of adults with autism living in their area was published in March 2015.[103] The local authority and NHS locally are committed to updating the local autism strategy in line with this.

The strategy is clear that there should be a 'pathway' for adults to diagnosis and care, and support in place in every local area. It provides detail of how health and social care should collaborate in the delivery of this.

If local services identified and supported just four per cent of adults with high functioning autism and Asperger syndrome, the outlay would become cost neutral over time. If they did the same for just eight per cent, it could save the Government £67 million per year.

Although an initial cost with identification will be placed on the NHS – estimated to be around £28 million for an 8% identification rate – the saving for local authorities would potentially be around £105 million.

Locally, in 2014, we commissioned the Bradford and Airedale neuro-developmental service to do this, but the service requires review to ensure that it can provide the required care and treatment to those who need it. Children's autism services are commissioned via different pathways and are not covered within this strategy.

C14 *We will recommission the local diagnostic pathway for autism for adults to improve access, quality and outcomes.*

C15 *We will contribute to the development and implementation of autism strategies for both children and adults in Bradford district and Craven.*

5.9.2 Criminal justice and liaison diversion

People who are being discharged from prison or forensic psychiatric care with ongoing mental health issues have very specialist needs to ensure a successful transition to community services. In addition people who find themselves in police custody due to their mental health issues or are found to have mental health problems by officers need to be diverted into support services.

We commission a local liaison and diversion scheme, based in the police cells, that works alongside our police hub and first response and 24 hour approved mental health professional service. These services divert vulnerable people from police custody if this is inappropriate. The delivery model ensures that there is a social care element to this diversion and that all staff entering the police cells have an integrated approach.

The local authorities and NHS commissioners will continue to work with all local criminal justice settings (prisons, YOIs, forensic mental health hospitals) to improve the discharge of prisoners with mental health issues, learning disabilities and autism. This is compliant with duties and the principle of equivalence under the Care Act 2014, and recognises the high prevalence of mental health problems and the risks to mental health posed by being in custody.

C16 *We will develop housing, education, employment and social care and support systems for people leaving prison, forensic care or other forms of custody.*

5.9.3 Armed forces veterans

NHS and LA partners are committed to supporting the local armed forces community, having signed an Armed Forces Community Covenant Pledge (Bradford) on 30 January 2012.[104]

Local NHS mental health providers apply the duties of the armed forces covenant to our local armed forces community, in particular veterans as defined within the covenant.[105]

Mental health assessments undertaken by GPs and specialist mental health assessments by BDCFT identify record and prioritise veterans where it relates to a condition which results from their service in the armed forces, subject to clinical need.

BDCFT has established links with the regional Veterans' Outreach Service (VOS) to ensure that staff have access to training and agreed clinical pathways are in place.[106] BDCFT also works closely with the local branch of the Soldiers, Sailors, Airmen and Families Association (SSAFA)[107], which has agreed referral routes into specialist mental health, including eye movement desensitization and reprocessing (EMDR) therapy for those suffering from post-traumatic stress disorder (PTSD).[108]

C17 *We commit to the identification and prioritisation of access to services by armed forces veterans in line with the Bradford Community Covenant Pledge.*

5.9.4 Dual diagnosis

Drug, alcohol and mental health services all report that the level of complexity of co-morbidities such as physical and mental health, poverty and reduced social capital show a marked and continuing rise. People with a dual diagnosis have needs that cross organisational boundaries and will include drug, alcohol and community mental health services as well as physical health and the existing dual diagnosis services. However, people often find it difficult to access more than one service at a time. Often, the chaotic behaviours displayed by people with a dual diagnosis are not accommodated by mental health and physical care services and people are discharged back to the sole care of alcohol and substance misuse services. It is generally perceived that there is poor communication and that this lead to confusion and co-ordination of care between the existing services. The result is poor overall quality of care to the vulnerable individuals who require these pathways of care who are then likely to disengage.

Other agreed priorities within the strategy provide potential solutions to many of the issues identified by local stakeholders. This includes opportunities to develop electronic solutions to provide shared access to care records, as well as ensure that the future model for the delivery of community mental health teams has elements that enable the development of co-located practitioners that can deliver joint packages of care that meet needs more efficiently. Commissioners for mental health, substance misuse and alcohol need to work collaboratively to deliver this.

C18 *We will ensure the needs of people with dual diagnosis are embedded within agreed multi-agency pathways of care.*

How we will get there

6. How we will get there

The following section outlines enabling structures, processes and systems.

6.1 Co-design

Mental health services contribute to the wellbeing of the people of Bradford district and Craven. We believe that services that have been co-designed with the help of people with lived experience of services and their families or carers, will be more likely to encourage people to seek help early, improve peoples' experience of care and improve their outcomes. We will make our decisions about the future design of services after seeking the views of service users of all ages, carers, and health and social care professionals. We will work together to design and deliver person-centred care, underpinned by the evidence, which helps and supports people to lead fuller, happier lives.

P1 *We will seek the views of people with a lived experience, families and carers and professionals to design and deliver services to support this strategy.*

6.2 The evidence base

Research and its evidence translated into practice are vital in transforming services to improve patient outcomes and thereby addressing challenges faced by health and social care. Our ambition is to routinely consult the evidence and design-in evaluation. Pursuing the use of evidence and evaluation will improve how we measure the impact for patients and will enable us to learn from what works well, and what does not. Locally, we are committed to providing the best care to achieve the best outcome and therefore we will ensure that opportunities to base our commissioning decisions, service design and delivery models on the best available evidence are taken.

The average time it takes to translate a research discovery into clinical practice is widely recognised as more often than not being too slow. So, as well as a commitment to being a research active health and social care economy, we commit to accelerating the quicker adoption of the best available research evidence, best clinical practice, new technology and innovation.

We also aim to build strong partnerships with other agencies working in the research field to better articulate our research evidence needs, thereby ensuring better alignment of effort. Research evidence tells us that patients have improved outcomes from participating in research and clinicians expand their skill base and motivation. Both are powerful reasons for individuals and organisations to get involved with research. The Academic Health Science Networks have been created with the role of helping to produce significant improvements in the health of the population by reducing service variability and improving patient experience in the health care system. We will ensure that local commissioners are linked to these developments. We will also seek to build on our partnerships with academic institutions, working in partnership to evaluate innovations delivered locally.

P2 *We will base our commissioning decisions, service design and delivery models on the best evidence available and build on our partnerships with academic institutions to evaluate innovations delivered locally.*

6.3 The voluntary and community sector (VCS)

The broader contribution to the mental wellbeing of the population

The VCS often works with our most marginalised and vulnerable community members and operates at a level which is embedded in local neighbourhoods and communities. Bradford district and Craven has over 2,000 VCS autonomous organisations. Many of these organisations or groups are not funded to deliver specific mental health interventions but most, if not all, will impact on the mental wellbeing of individuals and communities, including working in a preventative manner to stop mild mental health

issues from deteriorating through tackling social isolation, as well as addressing wider social issues such as welfare and housing advice, and substance misuse. Most receive funding from different sources including from grants, foundations and trusts, some have contracts or service level agreements from statutory bodies; but many are small community groups that operate on a purely voluntary basis.

Few of these are strategically linked to the interventions offered by projects funded by local commissioners. There is no step up or step down pathway and therefore referral pathways occur by chance through VCS networks. So, although we know that such organisations are delivering valuable work in the heart of the communities they serve, it is not possible to realise the true potential of such work for Bradford district and Craven.

We also know that VCS organisations funded for mental wellbeing contracts are subsidising their statutory contracts with non-recurrent funds, fundraising, income from social enterprise activity and their reserves and we need to better understand the potential impacts of this. Similarly, many have issues with service capacity being out-stripped by demand.

P6 *We will work with the VCS sector to help build their capacity to respond to the priorities set out in this strategy.*

6.4 Personalisation and asset-based care planning

Mental health service users can use individual social care budgets and personal health budgets to achieve greater choice and control over their own care and support. In Bradford district and Craven we want to see a major expansion of the use of these personal budgets. To achieve this we will create an integrated system that identifies how health and social care personal budgets can be used as part of an integrated care plan created across services and jointly with service users. These care plans will be asset-based and strengths-based with the principle of positive risk assessment at its core. This will require the integration and modernisation of the current care planning systems we use to deliver the Care Act 2014 and the mental health care programme approach system.

P3 *We will significantly expand the use of personal budgets to enable people to achieve greater choice and control over their own are and support.*

6.5 West Yorkshire vanguard

NHS England has assigned West Yorkshire as an urgent and emergency care (UEC) vanguard site. Vanguard sites are expected develop new care models that act as future blueprints for the rest of the NHS and enable the delivery of the Five Year Forward Review. The aim of the West Yorkshire UEC vanguard is to develop a shared outcomes model for mental health services across West Yorkshire that aligns the work of the urgent care network and the West Yorkshire STP.

The vanguard is being delivered through collaborative working between leadership groups and 'task and finish' groups which have representatives from the three mental health providers (BDCFT, Leeds & York Partnership NHS Foundation Trust and South West Yorkshire Partnership Foundation Trust), the Healthy Future Collaborative Forum's 11 CCGs, West Yorkshire Police, West Yorkshire Fire and Rescue Service, Yorkshire Ambulance Service and six local authorities.

It is focusing on five outcomes to support future development of shared standards and expectations for mental health care across West Yorkshire: elimination of out of area placements, reduction of unnecessary mental health A&E attendance, reduction of Section 136 place of safety episodes, avoidance of unnecessary emergency responses and reduction of suicides.

6.6 Pathways and packages

The pathways and packages approach was initially launched across Yorkshire and the North-East as a way of ensuring that people with similar groups of need had their health and social care needs met using packages of care that were based on the best evidence and could thus be used to promote consistent, high quality services across economies and providers. The use of these evidence-based pathways became a nationally mandated approach to commissioning and providing services in 2014/15. Local commissioners and BDCFT are recognised as a leading economy in developing this approach, providing support to NHS Improvement nationally to help other providers and commissioners implement this approach.

The recent publication of the guidance - Implementing the Five Year Forward View for Mental Health - has provided additional direction on the use of pathways and packages and reinforces the requirement to move towards accountable payment approaches linked to quality and outcomes in 2017/18.[109] It re-states the expectation that the pathways and packages approach is used for adult and older people's mental health services as previously set out by NHS England and NHS Improvement. We are committed to using this approach as the central mechanism for the commissioning and contracting of core mental health services.

> **P4** *We will use the "pathways and packages" approach to commission evidence-based care to meet people's needs.*

6.7 Workforce development

There is a district-wide workforce strategy called the Integrated Workforce Programme (IWP). It has been co-created and co-designed by partners within and across the health and care system. The IWP brings together the challenges, key priorities, good practice and potential workforce solutions from a wide range of health and care, voluntary and education partners. This provides an overarching, system-wide strategy that has been shaped, tested and refined over time.

The IWP is an overarching and enabling programme which aims to work collaboratively to identify and work towards developing a system-wide integrated health and social care workforce that is fit for the future. At its heart is the principle of putting service users and their carers at the centre of everything we do; creating and developing a workforce that works in a system-wide way to deliver seamless and integrated care.

The IWP recognises that individual and tailored workforce plans will need to be developed and implemented for each of the delivery programmes/ patient pathways. The mental health workforce plan will ensure that recruitment reflects the diversity of local populations. Staff will be equipped with knowledge and understanding to promote wellbeing, empowerment and recovery.

The vision of the IWP is:
"The best people, providing seamless care, the Bradford district and Craven way"

The delivery of this mental wellbeing strategy will present many workforce challenges, some of which will be addressed by the IWP. However, there are already significant risks such as national shortages of qualified staff (particularly nursing and medical staff), the over-reliance on these groups and the challenges that such shortages and an ageing workforce present. The current organisation of the workforce in professional silos does not support the ambition of this strategy to provide holistic integrated care and there will need to be a radical review of skill-mix, new ways of working supported by technology and new roles and/or reshaping of existing roles in order to move forwards with our vision.

It is recognised that, once implementation plans have been agreed, partners will need a specific programme of workforce development to deliver the outcomes set out in this strategy. This will include working closely with Health Education England and local education providers to ensure that their programmes will deliver the workforce needed to deliver this strategy.

P5 *We will develop a mental health workforce plan to deliver the outcomes set out in this strategy.*

6.8 Partnership commissioning arrangements

Investment in the promotion of mental wellbeing, prevention of mental disorder and early treatment of mental disorder results in significant economic savings even in the short-term. Due to the broad impact of mental disorder and wellbeing, these savings occur in health, social care, criminal justice and other public sectors.

As we move to more integrated commissioning at the West Yorkshire level, we will also move to a place-based level for Bradford district and Craven. Integrated commissioning can offer greater effectiveness, efficiency and accelerate transformation and innovation. The benefits and impact of this have been demonstrated, especially in the last three years, and we continue to take shared commissioning decisions. Commissioning efficiently will reduce costs that can be re-invested into population health and patient and client care.

This lifespan of this five-year strategy runs through likely changes in the health and care commissioning landscape. We are committed to the principle that our strategic ambition will stand regardless of the future footprint of commissioning organisations – be that at local or regional levels. The forum that has driven the development of this strategy will, in future, become the programme board for the implementation of the Bradford district and Craven Mental Health and Wellbeing Five Year Plan leading the further integration of strategic commissioning.

P7 *We will work to support the move to a more integrated commissioning model at a place-based level, to remove barriers and deliver efficiencies.*

P8 *The Joint Mental Health Commissioning Board will become the programme board for the implementation of this strategy, informing the future integration of services.*

6.9 Our Investment in mental health

At a purely conceptual level, a solid case can be made for investing in mental health, whether on the grounds of enhancing individual and population health and wellbeing, reducing social inequalities, protecting human rights, or improving economic efficiency. Mental health and wellbeing are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. They directly underpin the core human and social values of independence of thought and action, happiness, friendship and solidarity. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies. "Investing in mental health" relates both to the promotion and protection of mental health and to the prevention and treatment of mental illness or disorders.

P9 *We will commit to protecting the current level of investment in real terms in mental health services, recognising the importance of effective mental health and wellbeing interventions in reducing the overall health and care bill.*

The magnitude of the current and projected burden of mental disorders might be considered a sufficient reason alone for investment, but only if that investment can be channelled towards effective and affordable solutions. A number of interventions are self-financing over time, even from the narrow perspective of the NHS alone. However, the scope for 'quick wins', in the sense of very short payback periods for the NHS, is relatively limited. Many interventions have a broad range of payoffs, both within the public sector and more widely; such as through better educational performance, improved employment/earnings and reduced crime.

In some cases the payoffs are spread over many years. Most obviously this is the case for programmes dealing with childhood mental health problems, which in the absence of intervention have a strong tendency to persist throughout childhood and adolescence into adult life. However, the overall scale of economic payoffs from these interventions is generally such that their costs are fully recovered within a relatively short period of time. From a societal perspective, the pay-off for certain interventions – including early intervention for psychosis, suicide prevention, and learning programmes for conduct disorder – exceeds a ratio of 10 (ie for every £1 spent, there is more than £10 of benefit). Many interventions are very low cost and a small shift in the balance of expenditure from treatment to prevention/promotion should generate efficiency gains.[110]

P10 *We will rigorously review the use of those protected resources to ensure their effective use.*

Disturbances to a person's mental wellbeing can adversely compromise this capacity and the choices made, leading not only to diminished functioning at the individual level but also to broader welfare losses for the household and society. The onset or presence of a mental disorder also increases the risk of disability and premature mortality from other diseases due to neglect of the person's physical health. In terms of the impact on the economy, mental disorders are associated with high rates of unemployment and also under-performance while at work.

As part of our overall strategy which incorporates mental health, the CCGs have made a commitment to maintain current funding levels in mental health and make further investment in line with the growth received over the coming years and to work along our providers to develop new ways of working to improve services moving forward. Bradford Council is committed to ensuring the mental health needs of our residents are properly cared for and will continue to provide the services that are needed under the guidance of the Care Act 2014.

P11 *We will articulate the case for additional investment through the appropriate QIPP and business planning processes.*

6.10 Technology

The local digital roadmap for Bradford district and Craven, currently awaiting review by NHS England, sets out the vision for developments in the use of technology and data as a way to improve access to care, make services safer, transform services to reduce variability and ensure services are value for money. The journey to a local electronic health record that all services can access and use is at the heart of the plan and we have already made considerable progress via our integrated digital care record programme and optimisation of SystmOne.

We have been recognised nationally as a result of the enhanced health in care homes vanguard, providing a single point of access to all aspects of specialist health and care advice through technology and an extended use of telemedicine.

We are also using risk stratification to identify high-risk and/or complex individuals early so that we can put in place co-ordinated care that is personalised to reduce avoidable admissions, high cost interventions and help people remain independent and in their home for longer. This work requires us to do more to recognise and treat the mental wellbeing issues that also exist within this group of patients and which add to the costs and difficulty in giving these patients the right treatment.

Our local authorities continue to be key partners in the development of new models of care and the collective drive to close the gap between health and social care continues with particular strides being made in the areas of safeguarding.

Our local digital roadmap will continue to develop alongside the sustainability and transformation plan to take account of developments in accountable care system thinking and will remain integral to how the ACS will form and prioritise in 2016/17 and 2017/18.

We are currently using and continuing to expand our use of digital technology, including social media and web, to help raise awareness of crisis services and to facilitate self-care. This includes links to national and localised resources which are accessible all of the time. We appreciate how social media and website resources can be used to support individuals and professionals in the management of care and are continuing to develop this offering in line with our local digital roadmap.

From a mental health perspective we will work with the Digital Bradford programme to deliver progress in the following areas:

P12 *We will support the development of integrated records, which will facilitate the delivery of this strategy.*

P13 *We will support the use of collaboration tools which will improve the quality and efficiency of the management of crisis.*

P14 *We will support the implementation of digital applications to facilitate self-care and therapeutic interventions.*

6.11 How will we know we have made a difference?

Across health and social care there are already a great number of measures that are routinely reported and performance managed. Many of these are process measures, although some are measures of outcome. Fewer still are measures of health and care outcomes, where changes can be directly attributed to interventions and treatments provided to people.

Over 400 metrics from public health, social care and the NHS were considered in seeking to measure the outcomes from the implementation of this strategy. Overleaf are listed the key measures for the programme as a whole.

6.12 Mental wellbeing in Bradford district and Craven: metrics

1. The people of Bradford district and Craven will be supported to recognise and value the importance of their mental wellbeing and take early action to maintain their mental health through improved prevention, awareness and understanding
1.a Self-reported wellbeing
1.b Suicide rate **(NHSOF 1.5iii)
2. Enjoy environments at work, home and in other settings which promote good mental health and improved wellbeing
2.a Social isolation † (ASCOF 1.18)
2.a.i Percentage of adult social care users who have as much social contact as they would like
2.a.ii Percentage of adult carers who have as much social contact as they would like
2.b Employment
2.b.i Employment rates for district
2.b.ii Employment of people with long-term conditions (ASCOF)
2.b.iii Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**)
2.c Housing
2.c.i Proportion of adults in contact with secondary mental health services living independently with or without support
2.c.ii Households in temporary accommodation (ASCOF 1.15ii)
2.c.iii Fuel poverty (ASCOF 1.17)
2.d Index of multiple deprivation: proportion of lower layer super output areas (LSOAs) in most deprived 10% nationally
3. Experience seamless care and have their physical and mental health needs met through services that are integrated and easily accessible
3.a People with long-term condition (LTC) feeling supported to manage their condition(s) (IAF) (CCGOF)
3.b Improving outcomes from planned treatments: total health gain as assessed by patients for elective procedures (i Physical health-related procedures; ii Psychological therapies; iii Recovery in quality of life for patients with mental illness)
3.c Enhancing quality of life for people with mental illness: health-related quality of life for people with mental illness (ASCOF 1A** & PHOF 1.6**)
3.di People with SMI receiving a full annual health check
3.dii Excess under 75 mortality rate in adults with serious mental illness (PHOF)
4. Reach their maximum potential through services which are recovery focused, high quality and personalised and which promote independence
4.a Proportion of people who use services who have control over their daily lives (ASCOF)
4.b Improving access to psychological therapies (IAPT) - recovery rate
4.c People with first episode of psychosis starting treatment with a NICE-recommended package of care within two weeks of referral
4.d Percentage of CYP with a diagnosable mental health condition receive treatment from an NHS funded community mental health service
4.e Percentage of people with common mental health problems accessing psychological therapies
4.f Enhancing quality of life for carers: health-related quality of life for carers (ASCOF 1D**)
4.g Proportion of community mental health service users feeling that overall they had a good experience (NHS Community Mental Health Survey)
5. Expect support to be commissioned and delivered in a way that leads to increases in efficiency and enables transformation of care through reinvestment.
5.a Spend and outcome tool (SPOT) (www.yhpho.org.uk/default.aspx?RID=49488)

Appendices

Appendix 1: Strategic priorities, strategic outcomes, strategic commitments and enabling priorities

Our strategic priorities		
Our wellbeing	**Our mental and physical health**	**Care when we need it**
We will build resilience, promote mental wellbeing and deliver early intervention to enable our population to increase control over their mental health and wellbeing and improve their quality of life and mental health outcomes.	Mental health and wellbeing is of equal importance with physical health. We will develop and deliver care that meets these needs through the integration of mental and physical health and care.	When people experience mental ill health we will ensure they can access high quality, evidence based care that meets their needs in a timely manner, provides seamless transitions and care navigation.

Strategic outcomes

People in Bradford district and Craven will:

- be supported to recognise and value the importance of their mental wellbeing and take early action to maintain their mental health through improved prevention, awareness and understanding;
- enjoy environments at work, home and in other settings that promote good mental health and improved wellbeing;
- experience seamless care and have their physical and mental health needs met through services that are integrated and easily accessible;
- reach their maximum potential through services which are recovery focused, high quality and personalised and which promote independence;
- expect support to be commissioned and delivered in a way which leads to increases in efficiency and enables transformation of care through reinvestment.

Strategic commitments

Our wellbeing	Our mental and physical health	Care when we need it
W1 We will design and deliver a comprehensive mental health improvement programme that will target increased awareness, capacity for self-management and the need for early intervention and self-care.	**H1** We will improve the knowledge and awareness of mental health within the primary care workforce to enable a more holistic approach to patient management.	**C1** We will establish mental health expertise within the entry point to children's services to enable access to early help/mental health services.
W2 We will ensure that mental health improvement is a central outcome of all community investment and regeneration.	**H2** We will develop a model of integrated physical and mental health services whereby people can have their care needs met at the same location as part of an agreed pathway of care.	**C2** We will develop a community-based service for young people with eating disorders to support care delivery at home in order to reduce hospital admissions.
W3 We will develop and deliver evidence-based stigma and discrimination reduction programmes that focus on sustained behavioural change.	**H3** We will develop the role of VCS and community groups to provide access to early intervention support which improves personal resilience.	**C3** We will extend access to crisis care through the First Response Service (FRS) by appointing children and young people's mental health specialists within the team.
W4 We will promote mutual support opportunities and encourage the spread of mental health champions in organisations and business.	**H4** We will develop an integrated approach to the identification of mental ill health in secondary care pathways, to improve the outcomes of physical health treatment.	**C4** We will develop a dedicated looked after and adopted children therapy team to deliver support, consultations and supervision to those teams working with these vulnerable groups.
W5 We will continue to support a strong social care and social work role within mental health services, integrated with health and VCS service provision.	**H5** We will further develop the targeted approach to patients with medically unexplained symptoms (MUS) in primary care to improve patient outcomes and efficiency.	**C5** We will work with partners to develop a West Yorkshire specialist perinatal mental health team that interfaces with local evidence-based pathways.
W6 We will adopt wellbeing models and pathways that integrate physical and mental health, in which social care is a core part of our strategy and we will support social function, spirituality, self-management and peer support through the Care Act 2014.	**H6** We will increase access to IAPT from 15% - 25% prevalence providing an additional 7,500 treatments per year, 5,000 of whom will have long-term conditions.	**C6** We will improve access for people experiencing a first episode of psychosis to a NICE approved care package within two weeks of referral from 50% to 60% by 2020/21.
W7 We will ensure local housing and regeneration policy and planning creates public and private housing that provides a safe, stable environment that promotes community cohesion and mental wellbeing.	**H7** We will ensure that services provide a balanced range of effective therapies as well as pharmacological interventions that are culturally appropriate and effective.	**C7** We will complete a review of the current model of CMHT and redesign services to meet future needs, ensuring that the needs of people with personality disorder and dual diagnosis, or within criminal justice services are incorporated into future pathways

Our wellbeing	Our mental and physical health	Care when we need it
W8 We will develop a range of social and supported housing options for people with mental health care needs.	**H8** We will reduce premature mortality associated with physical ill health in people with severe mental illness to below the Yorkshire and Humber average by 2020.	**C8** We will design and implement a clear pathway of care to meet the needs of people with a personality disorder in the community.
W9 As the largest local employers, we will lead the way in establishing a district-wide network of organisations that are passionate about, and committed to, mentally healthy workplaces with all health and local authority services achieving a mental health charter mark. We will proactively share best practice and facilitate small to medium enterprises to engage through accessible training and tools.	**H9** We will empower older people and their carers by improved involvement in personalised care planning to reduce admissions and ensure improved partnership between intermediate care and mental health.	**C9** We will design and implement a clear pathway of care to meet the needs of adults with eating disorders.
W10 We will support people to develop the skills and confidence needed to be work ready, engage with employers to enhance accessible job opportunities, and provide support to both individuals and employers to help more people with mental health problems to retain their employment.		**C10** We will use stakeholder feedback to deliver continuous improvement in the operation of First Response.
W11 We will support the development and implementation of the local suicide prevention strategy.		**C11** We will ensure our local acute providers have all-age mental health liaison teams in place and by 2020/21 will meet the "core 24" standards.
W12 We will provide support to people with mental health problems and complex physical needs to navigate services to maximise wellbeing and independence.		**C12** We will ensure improved access for older people to addiction services.
W13 We will extend the recovery college service model through a multi-provider network to offer online evening and weekend psychological interventions.		**C13** In view of the critical role of carers, we will actively seek their feedback and contribution to the future design of services.

Our wellbeing		Care when we need it
W14 By 2020/21, 90% of people who access psychological therapies will engage through direct self-referral.		**C14** We will recommission the local diagnostic pathway for autism for adults to improve access, quality and outcomes.
W15 We will ensure that local services/pathways are skilled to recognise and meet the longer-term needs of people who experience sexual assault or domestic violence.		**C15** We will contribute to the development and implementation of autism strategies for both children and adults in Bradford district and Craven.
W16 We will develop a network to deliver mental health and emotional support in each school to promote mental wellbeing amongst young people.		**C16** We will develop housing, education, employment and social care and support systems for people leaving prison, forensic care or other forms of custody.
W17 We will improve the awareness and understanding of mental health for all people working with children and young people.		**C17** We commit to the identification and prioritisation of access to services by armed forces veterans in line with the Bradford Community Covenant Pledge.
W18 We will develop an evidence-based pathway for people at risk of psychosis to reduce the risk of transition to psychosis.		**C18** We will ensure the needs of people with dual diagnosis are embedded within agreed multi-agency pathways of care.
W19 We will provide improved detection and access to evidence-based treatment of depression for older people.		
W20 We will tackle loneliness, fear and isolation through supporting the further development of schemes that improve mental health in later life through supporting emotional and social connections.		
W21 We will ensure that carers are identified, their needs are assessed and a plan agreed to support their personal wellbeing and role as a carer.		

Enabling priorities

P1	We will seek the views of people with a lived experience, families and carers and professionals to design and deliver services to support this strategy.
P2	We will base our commissioning decisions, service design and delivery models on the best evidence available and build on our partnerships with academic institutions to evaluate innovations delivered locally.
P3	We will significantly expand the use of personal budgets to enable people to achieve greater choice and control over their own care and support.
P4	We will use the "pathways and packages" approach to commission evidence-based care to meet people's needs.
P5	We will develop a mental health workforce plan to deliver the outcomes set out in this strategy.
P6	We will work with the VCS to help build their capacity to respond to the priorities set out in this strategy.
P7	We will work to support the move to a more integrated commissioning model at a place-based level, to remove barriers and deliver efficiencies.
P8	The Joint Mental Health Commissioning Board will become the programme board for the implementation of this strategy, informing the future integration of services.
P9	We will commit to protecting the current level of investment in real terms in mental health services, recognising the importance of effective mental health and wellbeing interventions in reducing the overall health and care bill.
P10	We will rigorously review the use of those protected resources to ensure their effective use.
P11	We will articulate the case for additional investment through the appropriate QIPP and business planning processes.
P12	We will support the development of integrated records, which will facilitate the delivery of this strategy.
P13	We will support the use of collaboration tools which will improve the quality and efficiency of the management of crisis.
P14	We will support the implementation of digital applications to facilitate self-care and therapeutic interventions.

Appendix 2: Mental Health Foundation whole community prevention framework

	Individual	Family	Community – structural	Systems
Early years and family formation	Perinatal pathways of support for mothers General mental health support Assessment for risk and early intervention Specialist support	Support for attachment	Peer support groups for young mums (or young fathers)	**Maternal health** **Health visiting** **Primary care**
Children and adolescents	Self-management approaches (including digital) Psychological interventions	Parenting programmes Family therapy	Whole school approaches Bullying programmes Behaviour interventions	**Education** **Further education** **Primary care**
Adults	Workplace support – line management interventions Psychological interventions – cognitive behavioural therapy (CBT), solution-focused	Parenting support Carers' support	Stigma and discrimination programmes Mentally healthy workplace approaches Trauma-informed services	**Workplace** **Housing** **NHS - general**
Later life	Self-management for long-term conditions Pre-retirement preparation	Family-based dementia support Socially connected care homes	Volunteering opportunities Peer mentoring/ befriending Psychologically-informed physical health settings	**Primary care** **Home help** **NHS – general** **Care home sector**

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7. Glossary

Accountable care system
An accountable care system is a group of healthcare providers working together to take responsibility for quality and cost of care for a defined population within an agreed budget.

Advocacy
Advocacy means getting support from another person to help you express your views and wishes, and to help make sure your voice is heard.

BDCFT
Bradford District Care NHS Foundation Trust – a provider of mental health, learning disabilities and community health services across Bradford, Airedale and Craven.

Commissioning
Commissioning is the process through which the health and social care needs of the local population are identified and the services purchased and reviewed to meet those needs.

Co-morbid
A person has co-morbid illness when they have more than one illness at the same time.

Dual diagnosis
Dual diagnosis is the term used to describe the condition of people with both mental illness and problematic drug and/or alcohol use.

Epidemiology
Epidemiology is the study of how often illnesses occur in different groups of people and why.

Iatrogenic
Iatrogenic harm is harm caused by medical examination or treatment.

Looked after children
Children who are in the care of the local authority.

Non-psychotic
Non-psychotic disorders include depressive disorders and anxiety disorders like phobias, panic attacks, and obsessive-compulsive disorder (OCD).

Parity of esteem
Valuing mental health equally with physical health.

Perinatal mental health
Mental health during pregnancy and in the year after birth. Perinatal mental health issues include problems that arise at this time and those that were present before the pregnancy.

Primary care
Day-to-day healthcare for first contacts and ongoing care including GPs, nurse practitioners and pharmacists.

Psychosis
Psychosis is a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality.

QIPP
QIPP stands for quality, innovation, productivity and prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be re-invested into the NHS.

Resilience
Emotional resilience is the ability to adapt and bounce back when something difficult happens in your life.

Stakeholder
The stakeholders in this strategy are everyone with an interest or concern in mental wellbeing in Bradford district and Craven including members of the public, people who use services, carers and people who work in health and social care.

Sustainability and Transformation Plan
A local plan produced by every health and care system in England to show how services will evolve and become sustainable during the period 2016 – 2021 to provide better health, better patient care and improved NHS efficiency.

Transgender
Transgender is a term used to describe people who feel that their gender is different from the gender the doctor marked on their birth certificate.

Voluntary and community sector
The voluntary and community sector or voluntary sector consists of organisations that are not-for-profit and non-governmental. This sector is also called the third sector, in contrast to the public sector and the private sector.

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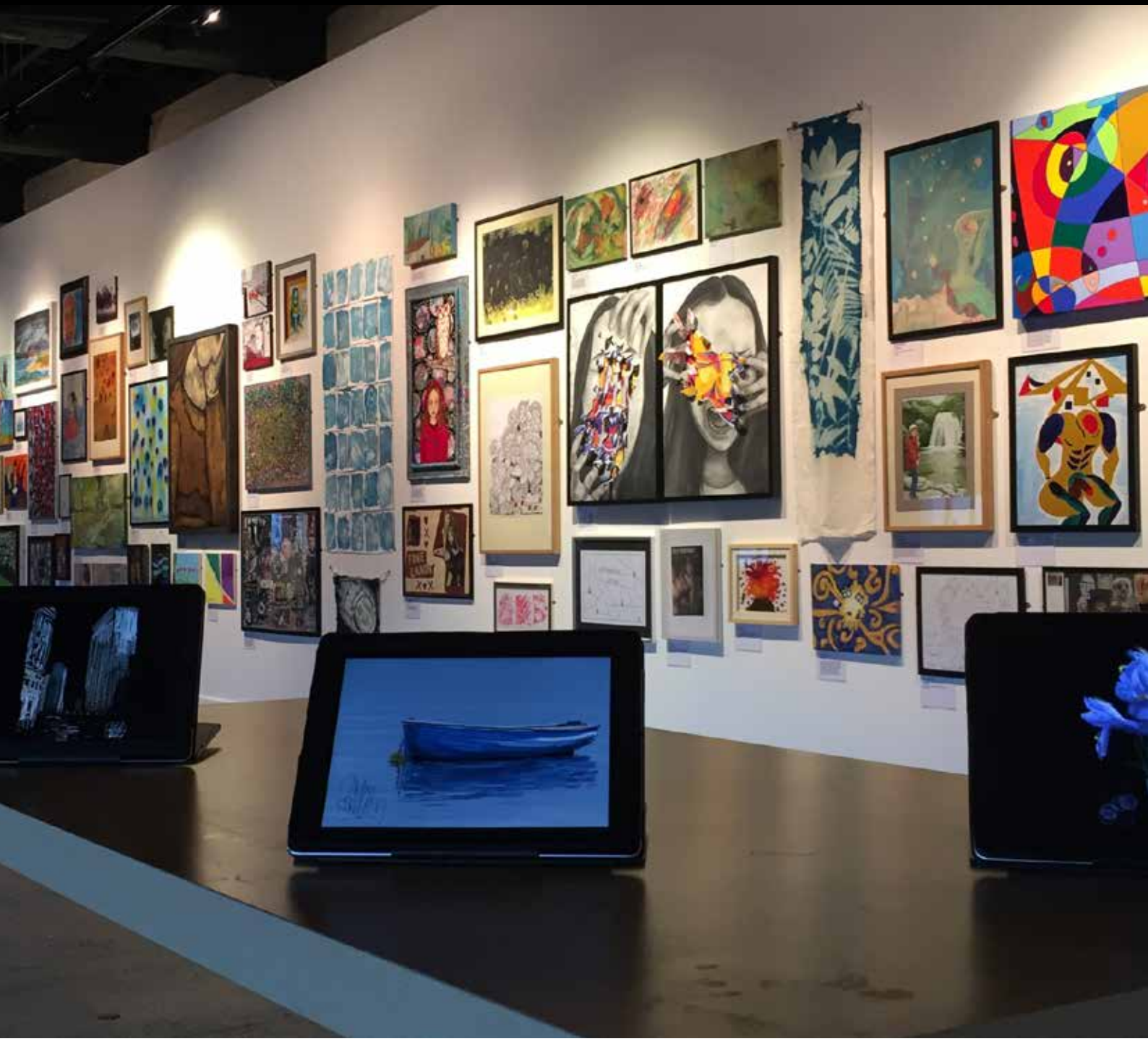
1in4 art exhibition

In a bid to tackle the stigma surrounding mental health illness, Bradford District Care NHS Foundation Trust held a major art exhibition between 6 and 10 October 2016 to coincide with World Mental Health Day. The 1in4 art exhibition, which was named to reflect the high proportion of people who experience mental ill health, was held at Salts Mill, Saltaire, well-known for its association with David Hockney. The exhibition showcased innovative and thought-provoking artwork created by people who have experience of mental health issues - and promoted the benefit of art in supporting good mental health.



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