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East Sussex
County Council

Enabling people to manage and maintain their mental health and wellbeing

Foreword

The first of April 2013 saw the successful completion of the transfer of Public Health Services from the Primary Care Trusts to the County Council, and the Health and Wellbeing Board, established in shadow form in 2011, take on its full statutory powers and duties.

The Health and Wellbeing Board has developed its first Health and Wellbeing Strategy – *Healthy Lives, Healthy People, The East Sussex Health and Wellbeing Strategy 2013-2016* – which aims to protect and improve people's health and wellbeing and reduce inequalities. The Strategy sets out the seven key priorities for improvement over the next three years:

1. The best possible start for all babies and young children
2. Safe, resilient and secure parenting for all children and young people
3. Enabling people of all ages to live healthy lives and have healthy lifestyles
4. Preventing and reducing falls, accidents and injuries
5. Enabling people to manage and maintain their mental health and wellbeing
6. Supporting those with special educational needs, disabilities and long term conditions
7. High quality and choice of end of life care

These priorities are areas where the Board can make a real difference and the strategy sets out how this will be achieved through the commissioning of services, joint working and collective action.

The Annual Report of the Director of Public Health 2013/14 was produced to inform delivery of the Health and Wellbeing Strategy. Whilst the full Annual Report covers all seven priority areas, a series of booklets have also been produced which focus on each of the priority areas in turn. Each booklet reproduces what is contained in the Annual Report for that area.

This booklet presents the results for priority 5: Enabling people to manage and maintain their mental health and wellbeing.

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Chapter 1: Introduction

The Director of Public Health is required by statute to prepare and publish an annual report. This year's report provides the evidence to help commissioners identify the interventions that will deliver the priorities which have been agreed in the East Sussex Health and Wellbeing Board's Health and Wellbeing Strategy for 2013-2016 "Healthy Lives, Healthy People".

The report presents the results from a series of rapid evidence and literature reviews aligned to the seven priority areas identified in Healthy Lives, Healthy People and the recommendations will help service commissioners to ensure that they make the best investment of the resources they have available and to weigh the return on that investment against other competing priorities.

For each of the seven priority areas, sub-topics have been identified which are important for delivery. Recommendations from the evidence reviews have been included in the appendices, and the full evidence review reports are included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

To make the recommendations more easily accessible a series of booklets have been produced. Each booklet focuses on one of the priority areas in Healthy Lives, Healthy People, and reproduces what is contained in the full annual report for that area, including all the recommendations contained in the appropriate appendix.

Booklet 1:	The best possible start for all babies and young children
Booklet 2:	Safe, resilient and secure parenting for all children and young people
Booklet 3:	Enabling people of all ages to live healthy lives and have healthy lifestyles
Booklet 4:	Preventing and reducing falls, accidents and injuries
Booklet 5:	Enabling people to manage and maintain their mental health and wellbeing

Booklet 6: Supporting those with special educational needs, disabilities and long term conditions
Booklet 7: High quality and choice of end of life care

Commissioners can use the booklets to prioritise the key recommendations for implementation. Recommendations should be prioritised where they:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings
- may be viewed as potentially contentious or difficult to implement for other reasons.

The Health and Wellbeing Strategy Action Plan

Healthy Lives, Health People is supported by an action plan setting out high level actions, outcomes, indicators and targets including those aimed at 'narrowing the gap' between the best and worst performing areas in the county. Table 1.1 presents the targets and indicators for priority area 5: Enabling people to manage and maintain their mental health and wellbeing.

The Structure of this Booklet

This booklet outlines the approach taken to review the literature and evidence, identifies the sub-topics that are important for delivery, presents some of the key facts and figures for and then identifies evidence based recommendations for implementation.

The full evidence review report for this priority area is included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

Table 1.1 The Health and Wellbeing Strategy Action Plan: Priority Area 5 – Enabling people to manage and maintain their mental health and wellbeing

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES
Priority 5: Enabling people to manage and maintain their mental		
People of all ages to experience good mental health and wellbeing, and those with mental health conditions and their carers are able to manage their condition better and maintain their physical health.	• Develop the support pathway for children and young people with emerging mental health needs. • Enhance the mental health care pathway for adults, older people and their carers from prevention through to care planning and recovery with a more personalised approach within all care settings. • Align the mental health care pathway with care pathways for long term conditions and strengthen links with wider services.	• Earlier identification, diagnosis, support and treatment (all ages). • More people (all age using community based support. • More people with more severe mental health needs having a comprehensive car plan. • Fewer incidences of self harm and suicid • Improved physical health for people wit mental health suppo needs. • Better mental health outcomes and qualit of life for carers (all ages).

	STRATEGIC OUTCOME INDICATORS
l health and wellbeing	
, s) e e. h rt y	5.1 Improve the experience of NHS mental healthcare for people with mental health conditions. Indicator definition: Percentages of service users responding to survey questionnaires who report being 'satisfied' and/or 'very satisfied' with the mental healthcare services they received, (return rates required being 33%). Baselines: (2012/13) Q3 Hastings and Rother PCT % Satisfied 83%, % Very Satisfied 33%; East Sussex Downs and Weald PCT % Satisfied 84%, % Very Satisfied 39%. Targets by 2016: Satisfied 80%; Very Satisfied 50% (future data will be available at CCG level) 5.2 Report improved outcomes for people with mental health conditions arising from NHS mental healthcare. Indicator definition: TBC – using 'Health of the Nation Outcome Scores', reports are being developed that will enable periodic review of outcomes for all adults receiving NHS mental healthcare (working age adults and older peoples services). Although details will not be available until early 2013/14, with baselines available 3-6 months afterwards, the ability to report on improvements and clinical outcomes on a large scale, and over the next 2-3 years, makes this measure sufficiently important to merit inclusion in this action plan. Baselines: New measure from 2013/14. Targets by 2016: To be determined during 2013/14.

Chapter 2: Evidence based commissioning

2.1 The approach – identifying the evidence

Within each of the seven priority areas of the Health and Wellbeing Strategy several sub-topics were identified as important for delivery. These were reviewed for evidence to support health and social care interventions and services.

The reviews focused on systematic reviews and meta-analyses, but where there was a lack of evidence, randomised controlled trials were also included. Each review aimed to identify the most important and relevant message supported by the scientific literature. They deliver a summary of clear and concise evidence statements based on the 5-10 most recent and relevant systematic reviews or meta-analyses.

Table 2.1: Sub-topics for the overall literature review of priority area 5: Enabling people to manage and maintain their mental health and wellbeing

Priority area	Sub-topic
Enabling people to manage and maintain their mental health and wellbeing	a. Interventions to promote early identification, diagnosis, support and treatment of mental health conditions (all ages)
	b.Interventions to promote community based mental health services and support (all ages)
	c.Interventions to promote utilisation of comprehensive care plans for people with severe mental health needs (all ages)
	d.Interventions to reduce the incidents of self-harm and suicide (all ages)
	e. Interventions to improve the physical health of people with mental health conditions (all ages)
	f. Interventions to promote better mental health outcomes and quality of life for carers (all ages)

Evidence was classified based on the Scottish Intercollegiate Guidelines Network (SIGN) methodology. These reviews did not include a full systematic assessment of study quality, perceived levels of bias and probabilities of causal relationships were scored based on an assessment of each source's methodology. Scorings were indicative rather than definitive.

Table 2.2: Study Quality Classification

1++	High quality meta-analyses, systematic reviews of Randomised Controlled Trials, or RCTs with a very low risk of bias.
1+	Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.
1-	Meta-analyses, systematic reviews, or RCTs with a high risk of bias.
2++	High quality systematic reviews of case control or cohort or studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.
2+	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal.
3	Non-analytic studies, e.g. case reports, case series.
4	Expert opinion.

The recommendations for each topic were classified using a system based on the overall quality of the evidence. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest.

Table 2.3: Recommendation Strength Classification

A	At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results.
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+.
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++.
D	Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+.

2.2 Commissioning prioritisation

This booklet aims to provide commissioners and multi-agency partnerships with a checklist against which commissioning plans and strategies can be compared to ensure they are based on current best evidence.

The evidence review includes some interventions that are well established within local services. However, it is recommended that commissioners and multi-agency partnerships review the full list of recommendations against strategies.

A process of prioritisation and building recommendations into work plans is recommended using the following criteria to identify interventions which:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings; and
- may be viewed as potentially contentious or difficult to implement for other reasons.

Chapter 3: Enabling people to manage and maintain their mental health and wellbeing

Focus on	
3.1	Interventions to promote early identification, diagnosis, support and treatment of mental health conditions (all ages)
3.2	Interventions to promote community based mental health services and support (all ages)
3.3	Interventions to promote utilisation of comprehensive care plans for people with severe mental health needs (all ages)
3.4	Interventions to reduce the incidents of self-harm and suicide (all ages)
3.5	Interventions to improve the physical health of people with mental health conditions (all ages)
3.6	Interventions to promote better mental health outcomes and quality of life for carers (all ages)

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England average, November 2013.

		Public Health Outcome Indicator	Comparison to England
1.06	ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation	Worse
2.23		Self-reported well-being	
	i	people with a low satisfaction score	Worse
	ii	people with a low worthwhile score	Worse
	iii	people with a low happiness score	Better
	iv	people with a high anxiety score	Better
4.10		Suicide rate (provisional)	Significantly worse

3.1 Key facts and figures: early identification, diagnosis, support and treatment

Nearly a quarter (23%) of the total burden of disease in the UK is attributable to mental disorder. This compares to 16% for cardiovascular disease and 16% for cancer.

The annual cost of mental disorder in England is estimated at £105 billion. By comparison the total costs of obesity is £16 billion a year and £31 billion for cardiovascular disease

It has been estimated that one in six adults (16.7%) has a mental health problem at any given time. This would be equivalent to 70,500 persons in East Sussex.[1]

- 25% of older adults have depression requiring intervention.
- Dementia affects 20% of people aged over 80.

By 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million. However, this does not take account of the current economic climate which is likely to increase prevalence

Some mental disorders arise early in the life course:

- 40% of young people experience at least one mental disorder by age 16
- 50% of lifetime mental illness (except dementia) arises by age 14
- 75% of lifetime mental illness arises by the mid-20's

One in five (20%) children (aged 17 and below) experience mental health problems in any given year. This is equivalent to 20,900 children in East Sussex.[2,3]

Some groups have a higher risk of mental disorder and poor wellbeing (Table 3.1). It is important to target these groups with prevention and promote interventions to prevent further widening of the inequality they already experience.

Table 3.1: Risk factors for child and adolescent mental disorder

Group		Expected prevalence of mental disorders
Looked after children		45%
Children with special educational need requiring statutory assessment		44%
Children with learning disability		36%
Children absent from school more than 15 days in previous term		
	emotional disorder	17%
	conduct disorder	14%
	hyperkinetic disorder	11%
Children from households with no working parent		20%
Children from household reference person in routine occupational group		15%
Children of parents with no educational qualifications		17%
Children from weekly household income <£100		16%
Children living in less prosperous/mixed areas		15%
Children in stepfamilies		14%
Children from lone parent families		16%

Source: Joint Commissioning Panel for Mental Health – Guidance for commissioning mental health services

Parents of children with a mental health illness

- 51% of parents of a child with conduct disorder have an emotional disorder; 18% have a severe emotional disorder
- 48% of parents of children with emotional disorder have an emotional disorder

Mental disorder in childhood and adolescence is associated with:

- poorer health, poorer social skills and lower levels of educational attainment
- higher risk of self-harm and suicide
- higher levels of health risk behaviour including smoking, alcohol consumption and drug misuse
- higher rates of antisocial and offending behaviour and violence.

Mental disorder in childhood leads to poorer outcomes and inequalities in adulthood, such as:

- higher levels of unemployment and lower earnings
- higher risk of crime and violence
- higher risk of adult mental disorder

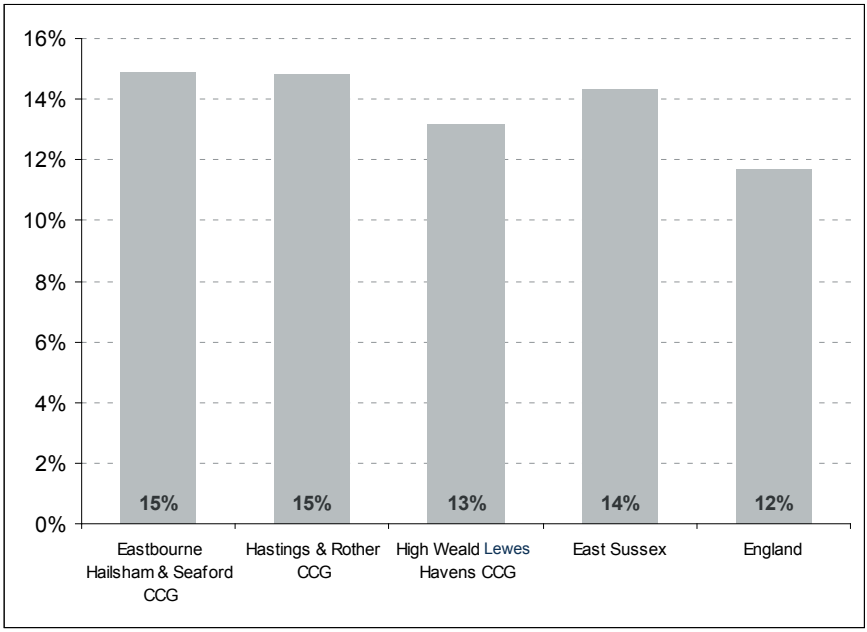
3.2 Key facts and figures: community based mental health services and support

Community mental health services support or treat people with mental health needs in the community, instead of a hospital setting. The goal of community mental health services often includes much more than simply providing outpatient psychiatric treatment.

Demand for community mental health services is high. A high percentage of patients registered with GPs in East Sussex have depression. Figure 3.1 shows incidence by CCG area. Overall 61,909 people in East Sussex are identified on GPs registers as having depression, although not all of these people will be in touch with community mental health services.

In England in 2010/11 3% of adults used hospital or community mental health services.

Figure 3.1 GP reported incidence of depression, Clinical Commissioning Groups, 2011/12



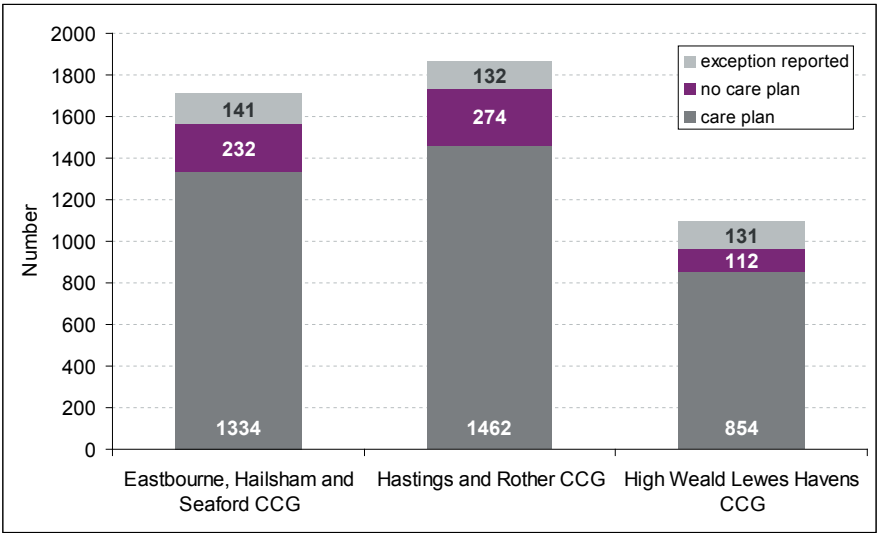
Source: Quality Outcomes Framework 2011/12, East Sussex JSNA scorecard 4.9 and Health & Social Care Information Centre
www.eastsussexjsna.org.uk/scorecards/2013nhsview
www.hscic.gov.uk/qof

3.3 Key facts and figures: comprehensive care plans for people with severe mental health needs

A high number of people in East Sussex require comprehensive care plans relating to severe mental health needs. There are 4,075 patients registered with GPs with mental health disorders, approximately 1% of General Practice lists, similar to England.

In High Weald Lewes Havens CCG 88% of patients on mental health registers have a comprehensive care plan, in Eastbourne, Hailsham and Seaford CCG it is 85% and in Hastings and Rother CCG it is 84%

Figure 3.2: GP reported number of patients on mental health registers by care plan status Clinical Commissioning Groups, 2011/12

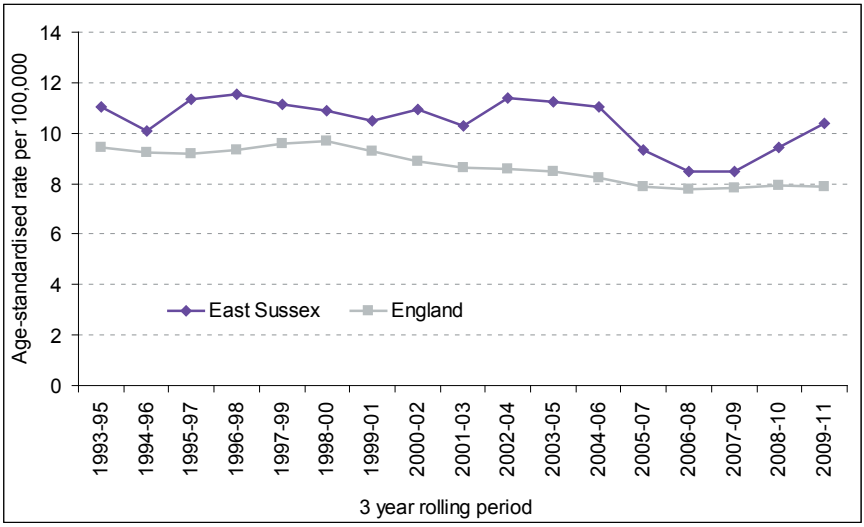


Source: Quality Outcomes Framework 2011/12
www.hscic.gov.uk/qof

3.4 Key facts and figures: self-harm and suicide

The suicide rate in East Sussex is significantly worse than the rate for England as a whole and has been so for many years. Since 2007/09 the rate has been increasing.

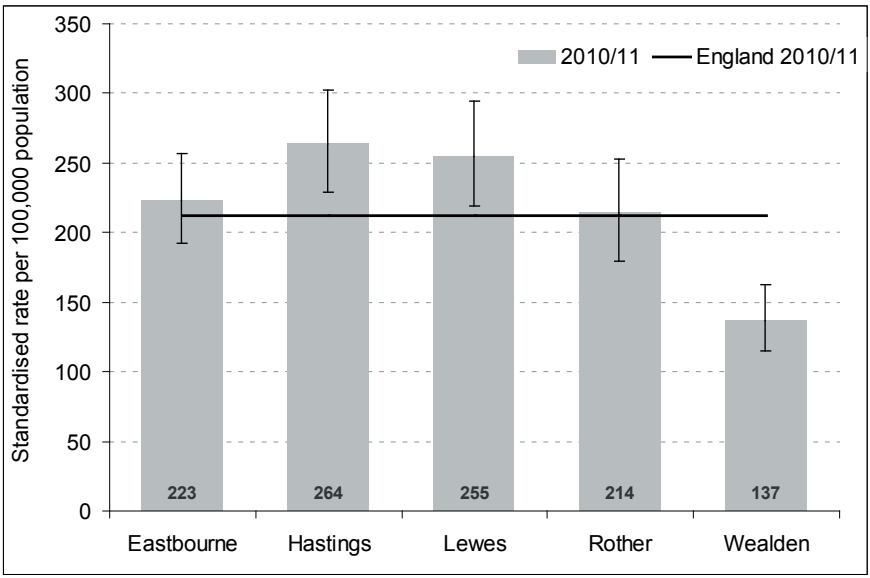
Figure 3.3: Mortality from suicide and injury undetermined



Source: Compendium of Population Health Indicators, Health & Social Care Information Centre www.indicators.ic.nhs.uk/webview/

Emergency hospital admissions for intentional self-harm are the same or higher than national rates in Eastbourne, Hastings, Lewes, Rother and across East Sussex as a whole. In Hastings and Lewes the rates are significantly worse than England.

Figure 3.4: Emergency hospital admissions due to self harm, rate per 100,000 with 95% confidence intervals, 2010/11



Source: Health profiles 2012, Public Health England
www.eastsussexjsna.org.uk/profiles/health.aspx

3.5 Key facts and figures: physical health of people with mental health conditions

Nearly half (46%) of people with mental health problems have other medical long-term conditions.

Overall, people with mental disorders are more likely to engage in unhealthy lifestyles and some drug treatments have side-effects such as weight gain. Hence these people are more prone to poor physical health as compared with the general population.[4]

Smoking is twice as common among people with mental disorders.[5]

Obese people have a 55% increased risk of developing depression and depressed persons have a 58% increased risk of becoming obese.[6]

Mental disorder during adulthood is associated with other health and social problems, such as:

- higher risk of homelessness;
- higher unemployment;
- increased suicide and self-harm level;
- increased health risk behaviours, including poor diet, and less exercise;
- higher prevalence of smoking, drug and alcohol misuse;
- increased risk of physical illness
    - depression is associated with an increased risk of coronary heart disease and diabetes;
- reduced life expectancy
    - depression is associated with a 50% increased mortality from all disease and reduced life expectancy of around 11 years in men and seven years for women;
    - schizophrenia is associated with increased mortality from all diseases and a reduced life expectancy of around 21 years for men and 16 years for women.

3.6 Key facts and figures: better mental health outcomes and quality of life for carers

A carer is a person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who cannot manage to live independently or whose health would deteriorate without help. This could be due to frailty, disability or a serious health condition, mental ill health or substance misuse. More than 60% of people will become a carer in their lifetime.

Being a carer comes at a physical and psychological cost:

- Up to 40% of carers experience psychological distress or depression.
- Carers have an increased rate of physical health problems e.g. providing high levels of care is associated with a 23% higher risk of stroke.
- Older carers who report 'strain' have a 63% higher likelihood of death in a year period than non carers or carers not reporting strain.
- Carers are at increased risk of mental disorder which affects their ability to care.

In a local survey of carers needs; all the respondents said that they had experienced some stress during the last 12 months as a result of their caring role and about half of them said that they were very stressed all of the time.

The 2011 Census identified 59,409 persons in East Sussex providing unpaid care, with a third of these providing care for 20 or more hours per week.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Chapter 4. Where gaps or weaknesses are identified, interventions for implementation should be prioritised using criteria outlined in Chapter 2.

References

1. NHS Information Centre (2009). Adult psychiatric morbidity in England, 2007: results of a household survey. London: NHS Information Centre.
2. National CAMHS Support Service (2012): Better Mental Health Outcomes for Children and Young People.
3. Green H., et al. (2005). Mental health of children and young people in Great Britain
   2004, London: Office for National Statistics.
4. Chris N., et al. (2012). Long Term Conditions and Mental Health: The Cost of Co-morbidities. The Kings Fund, Centre for Mental Health, London, UK.
5. Smoking and Mental Health: A Joint Report by the Royal College of Physicians and the Royal College of Psychiatrists, 2013. Luppino F.S., et al. (2010). Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Archives of General Psychiatry, 67(3):220-9.
6. World Federation for Mental Health. (2010). Mental Health and chronic physical illnesses: The need for continued and integrated care.

Chapter 4: Evidence based recommendations for priority area 5

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.
- East Sussex CCGs operate a 'Low Priorities Procedures' process whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an 'individual treatment panel'. It is important to recognise that the agreed processes should be followed for these interventions.
- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted in this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK

2.2 Recommendations for interventions to promote early identification, diagn

This evidence review recommends:

Intervention	
Identification and assessment	
Ensure:	
2.2.1	when assessing a person with a suspected common mental health disor
	• a diagnostic or problem identification tool or algorithm;
	• a validated measure relevant to the disorder or problem being asses
2.2.2	if identification questions indicate a possible common mental health dis reviews the person's mental state and associated functional, interperson
2.2.3	when working with people with significant language or communication di member or carer about the person's symptoms to identify a possible com
2.2.4	all staff carrying out assessment of suspected common mental health dis line with the service setting in which they work.
2.2.5	if the presentation and history of a common mental health disorder is of providing psycho-education and active monitoring before providing or ref
Treatment	
2.2.11	Promote the following evidence based interventions:
	• assertive community treatment for people with severe mental disord
	• crisis intervention for people with severe mental illnesses;
	• music therapy for schizophrenia or schizophrenia-like illnesses;
	• psycho-education for schizophrenia.
Ensure:	
2.2.6	when discussing treatment options with a person with a common mental are considered.
2.2.7	additional supportive information is provided when discussing treatmen

nosis, support and treatment of mental health conditions (all ages)

	Grade
der, staff consider using:	A
sed.	
order, a practitioner who is competent to perform a mental health assessment nal and social difficulties.	A
ifficulties staff consider using the Distress Thermometer and/or ask a family mon mental health disorder.	A
sorders are competent to perform an assessment of the presenting problem in	A
recent onset it is suggested that it may be mild and self-limiting and consider ferring for further assessment or treatment.	A
	B
ers;	
health disorder the wider factors that may impact on the treatment options	A
t options for people with a common mental health disorder.	A

Intervention	
2.2.8	staff take account of patient preference when choosing evidence-based t
2.2.9	staff follow the stepped-care approach, usually offering or referring for th
2.2.10	if a person with a common mental health disorder needs social, educatio groups, or support groups and other local and national resources, or bef support services
2.2.6	when discussing treatment options with a person with a common mental are considered.
Treatment - anxiety and depression symptoms	
2.2.12	Ensure that people with persistent sub-threshold depressive symptoms a
Promote:	
2.2.13	primary care depression screening and care management programs with involvement, to increase depression response and remission.
2.2.14	close monitoring of all adult patients who initiate antidepressant treatme improved safety.
Treatment - learning disability	
2.2.15	Ensure that for people with a common mental health disorder and a mild for the same interventions relevant to people with the same common me
Developing local care pathways	
Ensure:	
2.2.16	managers and commissioners collaborate to develop local care pathways disorders.
2.2.17	local care pathways are developed to promote implementation of key pri
2.2.18	that the development, management and evaluation of local care pathway secondary care clinicians, managers and commissioners.

	Grade
reatments.	A
e least intrusive, most effective intervention first.	A
onal or vocational support, staff consider: informing them about self-help riending or a rehabilitation programme or educational and employment	A
health disorder, the wider factors that may impact on the treatment options	A
are offered one or more low-intensity interventions.	A
staff assistance, such as case management or mental health specialist	B
ent, particularly those younger than 30 years, to ensure optimal treatment and	B
learning disability or mild cognitive impairment, are where possible, referred ntal health disorder.	A
s that promote access to services for people with common mental health	A
nciples of good care.	A
ys lies with a designated leadership team, which should include primary and	A

Intervention	
2.2.22	that the local care pathway has protocols for users with other professiona
	• sharing and communicating information with people with comm their care;
	• sharing and communicating information about the care of servic
	• communicating information between the services provided with
	• communicating information to services outside the pathway.
2.2.23	local care pathways have robust systems for outcome measurement in pl effectiveness. Ensure information is provided about mental health servic
Promote:	
2.2.19	local care pathways with a stepped-care model of service delivery.
2.2.20	pathways that offer prompt assessments and interventions that are appr people with common mental health disorders and keep to a minimum th
2.2.21	pathways that minimise the need for transition between different service pathway around the services.
Access and uptake of services	
2.2.24	Promote access to services and increase the uptake of interventions by:
	• ensuring systems are in place to provide for the overall coordination
	• designating a healthcare professional to oversee the whole period of
2.2.25	Ensure services for people with common mental health disorders are pro for the structure and distribution of services.
2.2.26	Provide all information about mental health services in a range of langua range of settings throughout the whole community.

	Grade
als (including GPs) including:	A
non mental health disorders, and where appropriate families and carers, about	
ce;	
in the pathway;	
ace, which should be used to inform all involved in a pathway about its es and interventions that constitute the local care pathway.	A
	A
opriately adapted to the cultural, gender, age and communication needs of e number of assessments needed to access interventions.	A
s or providers, allowing services to be built around the pathway not the	A
	A
and continuity of care of people with common mental health disorders.	
care (usually a GP in primary care settings).	
vided in a variety of settings and use an assessment of local needs as a basis	A
ges and formats (visual, verbal and aural) and ensure that it is available from a	A

Intervention	
Older adults with mental health conditions	
Promote:	
2.2.27	psychosocial interventions for older adults to improve quality of life and p
2.2.28	social activities interventions to improve positive mental health, life satis
2.2.29	interventions lasting more than three months over shorter interventions.
2.2.30	Consider meaningful social activities, tailored to the older individual's ab
High risk people with mental health conditions	
2.2.31	Ensure assessors of mental health disorders always ask people directly a
	• assess whether the person has adequate social support and is aware
	• arrange help appropriate to the level of risk;
	• advise the person to seek further help if the situation deteriorates;
	• ensure that if a person with a common mental health disorder, in par
	then take into account toxicity in overdose, if a drug is prescribed, an the amount of drug(s) available;
	• consider increasing the level of support, such as more frequent direc
	• consider referral to specialist mental health services.
2.2.39	Ensure, if a person with a common mental health disorder presents cons to emergency services or specialist mental health services.
Psychosis with mental health conditions	
Promote	
2.2.40	early intervention services over standard care for people with early psych
2.2.41	family interventions services for people with early psychosis.

	Grade
positive mental health	B
sfaction and quality of life and reduce depressive symptoms.	B
	B
bilities and preferences	B
bout suicidal ideation and intent. If there is a risk of self-harm or suicide:	A
e of sources of help;	
rticular depression, is assessed to be at risk of suicide	
nd potential interaction with other prescribed medication; if necessary, limit	
t or telephone contacts;	
iderable and immediate risk to themselves or others, they are referred urgently	A
osis.	B
	B

Intervention	
School interventions for people with mental health conditions	
2.2.42	Promote school based interventions with the following characteristics:
	• teaching skills focusing on positive mental health;
	• balancing universal and targeted approaches;
	• starting early with the youngest children and continuing with older or
	• operating for a lengthy period of time and embedding work within a r
2.2.43	Ensure school based interventions are completely and accurately implem

This evidence review does not recommend:

Intervention	
2.2.44	routine antidepressants for people with persistent sub threshold depressi
2.2.45	depression screening programs without substantial staff-assisted depress

2.3 Recommendations for interventions to promote community based men

This evidence review recommends:

Intervention	
Community treatment Interventions	
Promote	
2.3.1	community mental health team management over non-team standard ca
2.3.4	interventions to aid adults with serious mental illness in community inte
	• social skills training;
	• life skills and instrumental activities of daily living training;
	• neurocognitive training paired with skills training in the areas of wo
	• social participation, and instrumental activities of daily living;
	• client-centred interventions.

	Grade
	B
nes;	
multi-model/whole-school approach.	
ented.	B

	Grade
ive symptoms or mild depression,	A
sion care supports.	B

tal-health services and support (all ages)

	Grade
re.	B
gration and normative life roles, such as:	B
rk;	

Intervention	
2.3.2	For assertive community treatment, promote community treatment that u
Intensive case management interventions	
Promote intensive case management:	
2.3.5	interventions to improve outcomes for people with severe mental illnesse
2.3.7	for people with severe mental illnesses who are in the sub-group of thos
2.3.6	over standard care to reduce hospitalisation, increase retention in care a
Collaborative care interventions	
Promote collaborative care:	
2.3.8	for adult patients with depression and anxiety.
2.3.10	interventions providing a supportive network of professionals and peers
Crisis interventions	
Promote care based on crisis intervention:	
2.3.11	with or without an ongoing home care package to treat people with serio
2.3.12	based on crisis intervention principles over standard care.
Outreach interventions	
2.3.13	Promote multidisciplinary working within assertive outreach services.
2.3.14	Ensure practitioners within assertive outreach services receive sufficient
Low-income urban youth	
Promote:	
2.3.15	community-based mental health and behavioural interventions that focu
2.3.16	programs that focus on the youth plus one or more environmental target

	Grade
ıses a team approach with small case loads.	B
es.	A
e with a high level of hospitalisation (about 4 days/month in past 2 years).	A
nd Improve social functioning.	A
	A
for patients with depression, especially at the primary care level.	A
us mental illnesses.	B
	B
	B
training and managerial and clinical supervision.	B
s on the environment for low-income urban youth.	B
s or environmental targets alone.	B

This evidence review does not recommend:

Intervention	
2.3.17	compulsory community treatment.
2.3.18	youth only interventions in community-based mental health; and Behavioural programs for low-Income urban youth.

2.4 Recommendations for interventions to promote utilisation of comprehens

This evidence review recommends:

Intervention	
Collaborative care interventions	
2.4.1	Collaborative care system to include:
	• collaboration between a GP and at least one other healthcare pr
	• the use of a structured management protocol or guidelines;
	• scheduling regular follow-up appointments;
	• a system or mechanism to facilitate and enhance inter-professio
2.4.2	Collaborative chronic care models across a wide variety of care setting improve mental and physical outcomes for individuals with mental dis
Organisational structure and strategy interventions	
2.4.3	Ensure organisational structures and strategies, such as rewards syste healthcare professionals to gain the knowledge and skills required for
Patient self-care interventions	
Ensure:	
2.4.4	clear, comprehensible information and support for self care in adult m
2.4.5	needs-oriented continuity of care is provided for people with mental ill
2.4.6	personal continuity of care is provided to avoid fragmented therapeuti

	Grade
	B
	B

sive care plans for people with severe mental health needs (all ages)

	Grade
	A
ofessional;	
nal communication regarding the care plan.	
s to provide a robust clinical and policy framework for care integration and to order.	B
ems, are aligned to allow teams to function and training is provided to enable effective team working.	B
ental health is provided.	A
lness.	B
c relationships in complex mental health care provision.	B

Intervention	
Health Professional interventions	
2.4.7	Ensure health professionals review the needs of families and carers ar has not been offered previously.
2.4.8	Promote practice-based inter-professional collaboration (IPC) interven
Care and crisis plans	
Ensure service users:	
2.4.9	are fully involved and active in the design and delivery of care plans, a social care professionals and service users. A copy of the care plan sho
2.4.10	who may be at risk of crisis are offered a crisis plan. The crisis plan sh be respected and implemented, and incorporated into the care plan. T
	• possible early warning signs of a crisis and coping strategies;
	• support available to help prevent hospitalisation;
	• where the person would like to be admitted in the event of ho
	• the practical needs of the service user if they are admitted to
	• details of advance statements and advance decisions;
	• whether and the degree to which families or carers are involv
	• information about 24-hour access to services and named cont
	• named contacts.
2.4.11	routinely have access to their care plan and care record, including elec can document their views and preferences, and any differences of opin
2.4.12	help to develop any advance statements and advance decisions for the in primary and secondary care records.
2.4.13	are provided with effective and empathic packages of care and that th assist and encourage families.

	Grade
nd offer an assessment of their caring, physical and mental health needs if one	A
tions to improve healthcare processes and outcomes	B
nd that any documents created in collaboration are signed by the health and ould be provided for the service user and a review date should be agreed.	A
ould be developed by the service user and their care coordinator, which should The crisis plan should include:	A
spitalisation;	
hospital;	
ed;	
tacts;	
tronic versions. Care records should contain a section in which the service user nion with health and social care professionals.	A
eir care plans and that copies of the care plan are held by the service user and	A
ey offer informal means of communication as well as formal interventions to	B

Intervention	
Ensure:	
2.4.14	health professionals get adequate training to work with informal carer
2.4.15	families are included in treatment and decision-making.
2.4.16	Promote a covenant between mental health services and the people w family carers in respect of their relative, with a starting point being tha empathetically with carers.
Mental health services interventions	
Ensure:	
2.4.17	mental health service providers strive to involve family carers in the co services.
2.4.18	clear principles are published to guide information sharing between m and the needs of family carers.
2.4.19	Promote the implementation of discharge interventions in mental heal as well as symptomatic impairment.
Primary care interventions	
2.4.20	Promote the following interventions in primary care settings:
	• collaborative mental health care for case review meetings in prim
	• regular review of mutual patients by primary care staff and visiti
	• coordination of all care planning and management by occupatio
	• collaboration of primary care staff with accommodation staff .

	Grade
s and in particular with culturally diverse families.	B.
	B
ho depend on services, to clarify what professionals and others expect of t carers give ongoing support, and practitioners engage supportively and	B
nstruction and provision of services and make it easier to access these	B
ental health services and carers that take account of confidentiality, consent	B
lth care to reduce hospital stays and improve patient's adherence to aftercare	B
	B
mary care settings;	
ng psychiatrist;	
nal therapists;	

Intervention	
Community care interventions	
2.4.21	Use diverse media to communicate with community care service users service user's preference.
2.4.22	Ensure that care plans are developed jointly with community care serv
	• address social inclusion such as education, employment, volunt dependants;
	• provide support to help the service users realise the plan;
	• provide the service user with an up-to-date written copy of the ca
Depression	
Ensure:	
2.4.23	people with depression have the option to develop advanced decision primary and secondary care records along with copies given to the per
2.4.25	teams working with people with depression develop comprehensive m (and their family or carer with permission). The care plan should: ident professionals involved; develop a crisis plan that identifies potential t shared with the GP and the person with depression and other relevant
Promote:	
2.4.27	care management with the following features: patient education and s adherence; decision support for medication management; a patient re
2.4.28	collaborative care interventions for depression in older people.
Children and young people with depression	
Ensure:	
2.4.29	that children and young people with depression have the opportunity Department of Health's reference guide to consent for examination or

	Grade
, including letters, phone calls, emails or text messages according to the	A
ice user, and include activities that:	A
eering and other occupations such as leisure activities and caring for	
are plan, and agree a suitable time to review it.	
s and statements for their care plan and copies of the care plan are placed in son and to their family or carer, if the person agrees.	A
ultidisciplinary care plans in collaboration with the individual with depression tify clearly the roles and responsibilities of all health and social care riggers that could lead to a crisis and strategies to manage such triggers; be t people involved in the person's care.	A
elf-management; monitoring of depressive symptoms and treatment egistry and mental health supervision of care managers.	B
	B
to make informed decisions about their care and treatment following the treatment (2001).	A

Intervention	
2.4.30	unless specifically excluded by the child or young person, parent(s) or young person's care and treatment. The parent(s) and carer(s) should
2.4.31	information is provided to the patient and their parent(s) and carer(s)
2.4.32	healthcare professionals involved in the treatment of children or young relationship with both the patient and the family or carers.
2.4.33	healthcare professionals make all efforts necessary to engage the child enable meaningful and properly informed consent before treatment is
2.4.34	families and carers are informed of self-help groups and support group

Psychosis and substance misuse	
Ensure:	
2.4.35	written and verbal information is offered to families, carers or significa treatment of psychosis and substance misuse, including how they can appropriate language or, for those who cannot use written text, in an a
2.4.36	advance decisions and advance statements are honoured wherever po
2.4.37	healthcare professionals in primary care and secondary care mental he collaboratively with voluntary sector organisations.
2.4.38	protocols are developed between organisations for routine and crisis c
2.4.39	when healthcare professionals asses adults and young people with ps evidence from families, carers or significant others where this is possi substances. This should include changes in: the way the use of substa circumstances and treatment. Share the summary with the person and
2.4.41	adults and young people with psychosis and coexisting substance mis
2.4.42	That when people with psychosis and coexisting substance misuse are

	Grade
carer(s) have the opportunity to be involved in decisions about the child or also be provided with the information and support they need.	A
at an appropriate time and age-appropriate manor.	A
g people with depression take time to build a supportive and collaborative	A
d or young person and their parent(s) or carer(s) in treatment decisions to initiated.	A
os and are encouraged to participate in such programmes where appropriate.	A

nt others appropriate to their level of understanding about the nature and help to support the person. Written information should be available in the ccessible format (audio or video).	A
ssible.	A
ealth services, and in specialist substance misuse services, work	A
care.	A
ychosis and coexisting substance misuse, they seek corroborative ble and permission is given to review any changes in the person's use of nces affects the person over time, patterns of use, mental and physical state, d record it in their care plan.	A
use are offered evidence-based treatments for both conditions.	A
e discharged from an inpatient mental health service, that they have:	A

Intervention	
	• an identified care coordinator;
	• a care plan that includes a consideration of needs associated with
	• been informed of the risks of overdose if they start reusing substa inpatient stay.
2.4.40	when developing a care plan for an adult or young person with psycho between substance misuse, psychotic symptoms, emotional state, beh

Children and young people with psychosis	
Ensure:	
2.4.43	a care plan is developed with the parents or carers of younger children possible after the diagnosis of psychosis which includes activities pro
2.4.44	all children and young people with a first presentation of sustained ps mental health service, either CAMHS (up to 17 years) or an early interve psychiatrist with training in child and adolescent mental health.
2.4.45	that if a child or young person is at risk of crisis, a crisis plan is develo person and their parents or carers, and with their care coordinator.
2.4.46	that when a child or young person with a diagnosis of psychosis or sch primary healthcare professionals refer to the crisis section of the care the crisis plan.
2.4.47	daytime activities of children and young people with psychosis or schi occupational outcomes.
Schizophrenia comprehensive care plans	
Ensure:	
2.4.48 2.4.55	people with schizophrenia have a comprehensive bio-psychosocial ass provide an understanding of the presenting problems of the service us the development of a care plan that addresses a broad range of client
2.4.49	co-morbid conditions are identified, including substance misuse or ph

	Grade
both their psychosis and their substance misuse;	
nces, especially opioids that have been reduced or discontinued during the	
sis and coexisting substance misuse the complex and individual relationships naviour and the person's social context are considered.	A
, or jointly with the young person and their parents or carers, as soon as moting physical health and social inclusion.	A
ychotic symptoms (lasting 4 weeks or more) are urgently referred to a specialist ention in psychosis service (14 years or over), which includes a consultant	A
ped with the parents or carers of younger children, or jointly with the young	A
izophrenia presents with a suspected relapse and is still receiving treatment, plan and consider referral to the key clinician or care coordinator identified in	A
zophrenia are routinely recorded in their care plans, including educational and	A
sessment prior to the development of the care plan. The assessment should ser within the context of their life, both past and present, and should facilitate needs beyond symptom reduction.	A
ysical illness.	A

Intervention	
2.4.50	that following a full needs assessment, a comprehensive care plan is i diagnosis has been reached, it should be fully explained and discusse
2.4.51	effective communication of care plans: following a clear structure, writ contribution to the successful delivery of management strategies.
2.4.52	issues of consent are appropriately addressed throughout the care pat particularly the Mental Health Act (HMSO, 2007) and the Mental Capac
2.4.53	advanced decisions and statements are developed collaboratively with copies in the care plan in primary and secondary care. Give copies to t agrees.
2.4.54	that when a person with schizophrenia is planning on moving out of ar primary care providers, and sends them the current care plan.
2.4.56	a crisis plan is included in the care plan, based on a full risk assessme
2.4.57	all teams providing services for people with schizophrenia offer social, arrangements in their care plan.
2.4.58	staff routinely record the daytime activities of people with schizophren
Generalized anxiety disorder comprehensive care plans	
Ensure:	
2.4.59	persons with Generalized Anxiety Disorder (GAD) receive a specialist a
2.4.60	that a comprehensive care plan is developed in collaboration with the functional impairment and has a clear treatment plan.
Bipolar disorder comprehensive care plans	
Ensure:	
2.4.61	advance directives covering both mental and physical healthcare are d professionals. These directives should be documented in care plans, a coordinator and GP.

	Grade
mplemented whenever a schizophrenia diagnosis is suspected. Where a ed with the service user (and with the carer where appropriate).	A
ing in understandable language and preferably typed, provides a crucial	A
thway. Professionals must be fully aware of all appropriate legislation, city Act (HMSO, 2005).	A
n people with schizophrenia. Record decisions and statements and include he service user and their care coordinator, and their carer if the service user	A
rea, their current secondary care provider contacts the new secondary and	A
ent.	A
group and physical activities (including in inpatient settings) and record	A
ia in their care plans, including occupational outcomes.	A
ssessment of needs and risks	A
person with Generalized Anxiety Disorder that addresses needs, risks and	A
developed collaboratively by people with bipolar disorder and healthcare and copies given to the person with bipolar disorder, and to his or her care	A

Intervention	
2.4.62	primary care clinicians refer patients with suspected bipolar disorder f plan, where either of the following are present:
	• periods of overactive, disinherited behaviour lasting at least 4 d
	• three or more recurrent depressive episodes in the context of a l
2.4.63	primary care clinicians urgently refer patients with mania or severe de health services.
2.4.65	parents or carers of children with bipolar disorder are involved in deve psychological goals of treatment, and help treatment adherence.
2.4.64	Promote crisis resolution for people with bipolar disorder carried out b supporting early discharge from hospital.

2.5 Recommendations for interventions to improve the physical health of p

This evidence review recommends:

Intervention	
Health behaviour interventions	
Promote:	
2.5.1	health behaviour interventions to improve the physical health and ge
2.5.2	integration of health promotion interventions targeting physical activi
2.5.3	behavioural interventions in outpatients to effectively prevent and rec
2.5.4	the following to reduce antipsychotic-induced weight gain: adjunctive behavioural therapy and nutritional counselling.

	Grade
for a specialist mental health assessment and for the development of a care	A
ays with or without periods of depression;	
history of overactive, disinhibited behaviour.	
pression who are a danger to themselves or other people to specialist mental	A
loping care plans so that they can give informed consent, support the	A
by home treatment teams managing crises at home/in the community and/or	A

people with mental health conditions (all ages)

	Grade
neral health of individuals diagnosed with a serious mental illness.	B
ty and eating habits into the daily care of people with severe mental disorders.	B
duced antipsychotic-associated weight gain.	B
non-pharmacological interventions, either individual or group; cognitive-	B

Intervention	
Activity interventions	
2.5.5	Promote physical activity interventions for people with severe mental fitness, health-related behaviour and mental health.
Ensure:	
2.5.6	physical therapists take into account the emotional (negative symptor parameters) components of mental illness when offering physical acti
2.5.7	physical activity stimulus is adapted to the individual's physical fitnes
Treatment interventions	
Management of patients with mood disorders and co-morbid metabolic disorders: Promote:	
2.5.8	non-pharmacological weight-management interventions as a priority,
2.5.9	pharmacological approaches for excess weight are metformin and top
2.5.10	cognitive-behavioural therapy as well as topiramate, zonisamide, and eating disorder.
2.5.11	cognitive-behavioural interventions and anti-diabetic, antilipidemic, a including dysglycemia, dyslipidemia, and hypertension.
2.5.12	for patients with diabetes: diabetes education that incorporates diet motivation, and weight gain that may result from antipsychotics.
2.5.13	Ensure those individuals with major depressive disorder and bipolar d syndrome.
Mental health nurses	
2.5.14	Promote a change in the culture of mental health service provision to a of people with serious mental illness.

	Grade
disorders. This results in positive effects on: metabolic outcomes, physical	B
ms, self-esteem, self-efficacy, and stress) and physiological (cardio-metabolic vity interventions.	B
ss level and that any side effects of antipsychotic medications are considered.	B
particularly during the early stages of antipsychotic treatment.	B
iramate, with emerging evidence for liraglutide and modafinil.	B
in select cases selective serotonin reuptake inhibitors, for those with binge	B
and antihypertensive treatments. for those with co-morbid metabolic disorders,	B
and exercise components, as well as addressing challenges such as cognition,	B
disorder are routinely screened for risk factors that increase risk for metabolic	B
allow the role of the mental health nurse to include the physical health needs	B

Intervention	
Ensure mental health nurses:	
2.5.15	have a positive attitude to help make changes in their role and engag
2.5.16	have the right support and training to help improve the physical healt
Interventions for children and young people with psychosis and schizophrenia	
Ensure:	
2.5.17	primary care registers are developed and used to monitor the physica schizophrenia.
2.5.18	GPs and other primary healthcare professionals monitor the physical once a year.
2.5.19	children and young people with psychosis or schizophrenia who smok measurement are identified at the earliest opportunity and monitored
2.5.20	children and young people with psychosis or schizophrenia who have
2.5.21	healthcare professionals in secondary care make sure (as part of the or schizophrenia receive physical healthcare from primary care while effects of antipsychotic medication.
Preventive interventions	
2.5.22	Promote preventive approaches as they have the potential to be more

This evidence review does not recommend:

Intervention	
2.5.23	inpatient settings.

	Grade
e patients in change.	B
th needs of people with serious mental illness.	B
l and mental health of children and young people with psychosis or	A
health of children and young people with psychosis or schizophrenia at least	A
ke or who have high blood pressure, raised lipid levels or increased waist l for the emergence of cardiovascular disease and diabetes.	A
diabetes and/or cardiovascular disease are treated in primary care.	A
care programme approach) that children and young people with psychosis continuing to maintain responsibility for monitoring and managing any side	A
effective, acceptable, cost-efficient and beneficial.	B

	Grade
	B

2.6 Recommendations for interventions to reduce the incidents of self-har

This evidence review recommends:

Intervention	
Planning services to reduce the incidents of self-harm and suicide **Ensure:**	
2.6.1	joint planning of the configuration and delivery of integrated physical self-harm, including emergency departments, commissioners , local m
2.6.2	joint planning of the configuration and delivery of integrated physical and young people who self-harm, including emergency departments c local children's mental health services, local service users and carers
2.6.3	people who self-harm are involved in the commissioning, planning an
2.6.4	consider integration of mental health professionals into the emergenc for people who self-harm, and provide routine and regular training to
2.6.5	emergency department and local mental health services should jointl
2.6.25	mental health services, including community mental health teams an the longer-term treatment and management of self-harm. In children a adolescent mental health services (CAMHS)
Interventions to reduce the incidents of self-harm and suicide	
2.6.6	Promote effective suicide prevention interventions, including: training improving accessibility of care for at-risk people; and restricting acces
Respect, understanding and choice for people who have self-harmed	
Ensure:	
2.6.7	people who have self-harmed are treated with the same care, respect

m and suicide (all ages)

	Grade
and mental healthcare services within emergency departments for people who mental health services, local service users and carers.	A
and mental healthcare services within emergency departments for children catering for children and young people under 16 years of age, commissioners , s.	A
d evaluation of services.	A
cy department, to improve the psychosocial assessment and initial treatment non-mental-health professionals working in the emergency department.	A
y plan effective liaison psychiatric services available 24 hours a day.	A
d liaison psychiatry teams are responsible for the routine assessment and and young people this should be the responsibility of tier 2 and 3 child and	A
g general practitioners to recognise and treat depression and suicidality; s to means of suicide.	A
and privacy as any patient.	A

Intervention	
2.6.8	all staff undertaking care of those who self-harm have regular clinical and understood.
2.6.9	people who have self-harmed are offered the choice of male or female
2.6.11	Provide people who self-harm with full information about the differen
Consent and confidentiality	
2.6.12	Health and social care professionals who work with people who self-h the principles of the Mental Capacity Act (2005) and Mental Health Ac about when treatment and care can be given without consent.
2.6.13	Health and social care professionals who have contact with children a roles and uses of the Mental Capacity Act (2005), the Mental Health A in the context of children and young people who self-harm.
Risk assessments to reduce the incidents of self-harm and suicide	
Ensure:	
2.6.14 2.6.15	all people who have self-harmed are offered an assessment of needs, psychological and motivational factors specific to the act of self-harm, social needs assessment.
2.6.16	that when assessing the risk of repetition of self-harm or risk of suicid them.
2.6.17	social and health policy, and interventions relating to prevention of su prevalence) but also the potential effects of interventions relating to b
Treatment and care to reduce the incidents of self-harm and suicide	
2.6.18	Ensure people who have self-harmed are offered treatment for the ph psychosocial assessment or psychiatric treatment.

	Grade
supervision in which the emotional impact upon staff members is discussed	A
e staff for both assessment and treatment.	A
t treatment options available.	A
arm should be trained to: understand consent and confidentiality and apply t (1983; amended 1995 and 2007); assess mental capacity; and make decisions	A
nd young people who self-harm should be trained to understand the different ct (1983; amended 1995 and 2007) and the Children Act (1989; amended 2004)	A
which should be comprehensive and include evaluation of the social, , current suicidal intent and hopelessness, as well as a full mental health and	A
le, identify and agree with the person who self-harms the specific risks for	A
uicide, should focus not only on individual psychiatric factors (high risk, low roader socio economic factors (low risk, high prevalence).	B
ysical consequences of self-harm, regardless of their willingness to accept	A

Intervention	
2.6.19	Summarise the key areas of needs and risks identified in the assessm conjunction with the person who self-harms and their family, carers o the service user and share them with the GP.
2.6.20	Discuss, agree and document the aims of longer-term treatment in the
2.6.26	Ensure people who self-harm, and their families, carers and significar about the short-term management of self-harm.
2.6.27	Consider offering 3 to 12 sessions of a psychological intervention spec
Risk management plans	
Ensure:	
2.6.21	a risk management plan is a clearly identifiable part of the care plan.
2.6.22	the risk management plan is consistent with the long-term treatment
2.6.23	a person who self-harms is informed of the limits of confidentiality an professionals.
2.6.24	the risk management plan is updated regularly for people who continu associated factors for the service user, and evaluate the impact of trea
Harm reduction	
2.6.28	Strategies aimed at harm reduction reinforce existing coping strategie
2.6.29	Treat associated mental health conditions by providing psychological,
2.6.30	Ensure health professionals take into account the toxicity of the presc associated mental health conditions.
Referral, admission, and discharge to reduce the incidents of self-harm and suicide **Ensure:**	
2.6.31	that referral, treatment and discharge following self-harm is based on
2.6.32	referral for further treatment and help is based upon a comprehensive risk, and is not determined solely on the basis of having self-harmed.
2.6.33	the referral for further assessment and/or treatment is based upon a underlying problems or particular diagnosis rather than simply treatin

	Grade
nent and use them to develop a care plan and a risk management plan in r significant others if this is agreed with the person. Provide printed copies for	A
e care plan with the person who self-harms.	A
nt others where this is agreed with the person, have access to information	A
cifically structured for people who self-harm.	A
	A
strategy.	A
d that information in the care and risk plan may be shared with other	A
ue to be at risk of further self-harm. Monitor changes in risk and specific atment strategies over time.	A
es and develop new strategies as an alternative to self-harm.	A
pharmacological and psychosocial interventions as appropriate.	A
ribed drugs in overdose when prescribing drugs to people who self-harm for	A
the overall assessment of needs and risk.	A
e psychiatric, psychological and social assessment, including an assessment of	A
comprehensive psychosocial assessment, and aims to treat a person's ng self-harming behaviour.	A

Intervention	
Managing endings and supporting transitions to reduce the incidents of self-harm and s	
2.6.34	Anticipate that for people who self-harm, the ending of treatment, ser provoke strong feelings and increase the risk of self-harm.
2.6.35	Child and adolescent mental health services and adult health and soc negative effect of transferring young people from child and adolescent
Consent, mental capacity and mental ill health to reduce the incidents of self-harm and	
2.6.36	Ensure issues of consent, mental capacity and mental ill health in the addressed by all healthcare professionals involved in the care of this g
Staff interventions to reduce the incidents of self-harm and suicide	
2.6.37	All healthcare practitioners involved in the assessment and treatment a priority, the fact that the experience of care for people who self-harm
2.6.38	Promote high quality care from health and social care professionals w
Staff training and supervision interventions to reduce the incidents of self-harm and sui	
Promote:	
2.6.39	dedicated training to all staff that come into contact with people who and care they provide.
2.6.40	effective collaboration of all local health organisations as essential to
Ensure:	
2.6.42	ambulance staff are trained in the assessment and early management self-harm and the appropriate treatments, the likely effects if untreate and to children and young people.
2.6.43	children's and young people's triage nurses are trained in the assessm the assessment and early management of children and young people
2.6.44	staff who have emergency contact with children and young people wh in children of different ages and to understand how issues of mental c times to specialist advice about these issues.

	Grade
suicide	
vices or relationships, as well as transitions from one service to another, can	A
cial care professionals should work collaboratively to minimise any potential t mental health services to adult services.	A
suicide	
assessment and treatment of people who self-harm is understood and group.	A
t of people who self-harm should ensure that the care they offer addresses, as n is often unacceptable.	A
orking with people who self-harm.	A
icide	
self-harm to improve both their understanding of self-harm and the treatment	A
develop properly integrated services.	A
t of self-harm. Training should particularly address the different methods of ed, and issues of consent and mental capacity, as these apply both to adults,	A
ment and early management of mental health problems and, in particular, in who have self-harmed.	A
o have self-harmed should be adequately trained to assess mental capacity capacity and consent apply to this group. They should also have access at all	A

Intervention	
2.6.45	health and social care professionals who work with people who self-h treatment and management of self-harm, and educated about the stig
2.6.46	health and social care professionals who provide training about self-h ensure that the training specifically aims to improve the quality and e using service-user feedback as an outcome.
Primary care interventions to reduce the incidents of self-harm and suicide	
Promote:	
2.6.47	the important role primary care has in the assessment and treatment
2.6.52	cooperative working when people who self-harm are receiving treatme health and social care professionals should attend care programme a
Ensure:	
2.6.48	that when an individual presents in primary care following an episode risk, and the person's emotional and mental state, in an atmosphere
2.6.49	that if urgent referral to an emergency department is not considered n urgent referral to secondary mental health services.
2.6.50	that service users who are considered at risk of self-poisoning, health dangerous in overdose, and prescribe fewer tablets at any one time.
2.6.51	Ensure that primary healthcare professionals are aware that, if a pers they should consider referring them to community mental health servi to child and adolescent mental health services for assessment.

Ambulance service interventions to reduce the incidents of self-harm and suicide	
2.6.53	Support ambulance staff's important role in the assessment and early groups.

	Grade
arm, including children and young people, are trained in the assessment, gma, discrimination and the need to avoid judgemental attitudes.	A
harm, involve people who self-harm in the planning and delivery of training; xperience of care for people who self-harm; assess the effectiveness of training	A
of people who self-harm.	A
ent or care in primary care and secondary care. In these circumstances, primary pproach (CPA) meetings.	A
e of self-harm, healthcare professionals urgently establish the likely physical of respect and understanding.	A
ecessary, a risk and needs assessment is undertaken to assess the case for	A
care professionals prescribe, whenever possible, drugs which are least	A
on presents in primary care with a history of self-harm and a risk of repetition, ices for assessment. If they are under 18 years, should consider referring them	A
y treatment of self-harm through effective collaboration with other professional	A

Intervention	
Emergency department interventions to reduce the incidents of self-harm and suicide	
Ensure:	
2.6.54	emergency department staff have the knowledge and skills to assess encourage people who have self-harmed to stay for further psychosoc
2.6.56	people who have self-harmed and presented to services but wish to le diminished capacity and/or the presence of a significant mental illnes Appropriate measures should also be taken to prevent the individuals
2.6.54	emergency department staff have the knowledge and skills to assess encourage people who have self-harmed to stay for further psychosoc
Support and advice interventions	
2.6.57.	Promote support and advice for people who repeatedly self-harm.
2.6.58	Ensure service users who repeatedly self-poison, and their carers whe
2.6.59	Ensure people who repeatedly self-harm by self-inflicting superficial i minimisation techniques, alternative coping strategies and how best
Interventions for relatives or carers	
Ensure:	
2.6.60	people who self-harm are allowed, if they wish, to be accompanied by However, for the initial psychosocial assessment, the interview should
2.6.61	healthcare professionals provide emotional support and help if neces be experiencing high levels of distress and anxiety.
Children and young people (under 16 years)	
Ensure:	
2.6.62	children and young people under 16 years of age who have self-harme and doctors in a separate children's area of emergency departments.
2.6.63	children, young people and adults from black and minority ethnic grou harm based on clinical need and that services are culturally appropria

	Grade
risk and emotional, mental and physical state quickly, as well as skills to ial assessment.	A
eave before psychosocial assessment has been undertaken, and in whom ss is established, are referred for urgent mental health assessment. s leaving the service.	A
risk and emotional, mental and physical state quickly, as well as skills to ial assessment.	A
	A
ere appropriate, are offered advice about the risks of self- poisoning.	A
njuries receive advice regarding self-management of superficial injuries, harm to deal with scarring.	A
a family member, friend or advocate during assessment and treatment. d take place with the service user alone to maintain confidentiality.	A
sary to the relatives/carers of people who have self-harmed, as they may also	A
ed are triaged, assessed and treated by appropriately trained children's nurses	A
ups who self-harm have the same access to services as other people who self- ate.	A

Intervention	
2.6.64	that when language is a barrier to accessing or engaging with service preferred language and in an accessible format; psychological or oth interpreters.
2.6.65	all child and adolescent mental health services (CAMHS) professiona the child's or young person's needs should be assessed according to
2.6.66	there are correct procedures in place for when children or young peop
	• Use a multi-agency approach, including social care and educat
	• Consider using the common assessment framework.
	• If serious concerns are identified, develop a child protection pl
2.6.67	Review information available locally on websites and ensure it is evid
Older people (older than 65 years) interventions	
Ensure:	
2.6.68 2.6.71	all people older than 65 years of age who have self-harmed are asses people who self-harm. Assessment should follow the same principles to the potential presence of depression, cognitive impairment and ph situation.
2.6.69	acts of self-harm in people older than 65 years of age are regarded as
2.6.70	Given the high risks amongst older adults who have self-harmed, con assessment, and time given to monitor changes in mental state and l
2.6.72	Consider using telecommunications to reach vulnerable older adults, elderly suicide.
Interventions for people with learning disabilities to reduce the incidents of self-harm a	
2.6.73	Ensure people with a mild learning disability who self-harm have acc

	Grade
s for people who self-harm, they are provided with: information in their er interventions, where needed, in their preferred language; and independent	A
ls who work with children and young people who self-harm, consider whether local safeguarding procedures.	A
ple who self-harm are referred to CAMHS under local safeguarding procedures:	A
tion, to ensure that different perspectives on the child's life are considered.	
lan.	
lence based.	B
ssed by mental healthcare practitioners experienced in the assessment of older s as for younger adults who self-harm, but should also pay particular attention nysical ill health, and should include a full assessment of their social and home	A
s evidence of suicidal intent until proven otherwise.	A
nsideration should be given to admission for mental health risk and needs evels of risk.	A
and evaluate the effects of means restriction and physicians education on	B
and suicide	
ess to the same age-appropriate services as other people.	A

Intervention	
Community mental health services Interventions to reduce the incidents of self-harm an	
2.6.74	Offer an integrated and comprehensive psychosocial assessment of n a therapeutic relationship

This evidence review does not recommend:

Intervention	
2.7.75	risk categorization of individual psychiatric inpatients.
2.7.76	school-based programmes to prevent suicide among adolescents.
2.7.77	universal school education programmes to prevent youth suicide.

2.7 Recommendations for interventions to promote better mental health o

This evidence review recommends:

Intervention	
Commissioners	
2.7.2	Commissioners should ensure sufficient capacity to meet the distinc
Provider organisations	
Ensure:	
2.7.3	provider organisations nominate a lead to oversee the development and carers.
2.7.4	carers are offered a separate assessment and respond positively wh
2.7.6	organisation teams 'signpost' all family members and carers to loca sources of emotional and psychological support
2.7.8	organisation teams provide families and carers with a clear indicatio

	Grade
d suicide	
eeds and risks to understand and engage people who self-harm and to initiate	A

	Grade
	B
	B
	C

utcomes and quality of life for carers (all ages)

	Grade
ct needs of this group.	A
and implementation of services that specifically focus on the needs of families	A
en a carer asks for one.	A
l and national sources of information, advice and practical support, including	A
on of the personnel they might contact in relation to a range of needs.	A

Intervention	
Support interventions	
Ensure	
2.7.10	family members and carers are offered the opportunity for their nee patients. Cultural and ethnic preferences on family involvement sho
2.7.11	family members and carers are made aware of, and have easy acces own needs.
2.7.12	families and carers have access to professionals capable of providin
2.7.14	practitioners enquire about the concerns of caregivers and consider
2.7.16	the following factors are considered when providing support groups
2.7.10	family members and carers are offered the opportunity for their nee patients. Cultural and ethnic preferences on family involvement sho
2.7.15	Promote support groups for carers to improve carer's psychological
Involve carers in discussions about patient treatment	
2.7.18	Ensure that whenever possible and appropriate, family members an involved in discussions about treatment and care, in accordance wit
Multi-component interventions	
Promote:	
2.7.20	fully developed multi-component interventions that encompass a di
2.7.21	networked ICT interventions that are multifaceted with elements of
2.7.22	combined intervention programmes for people with dementia living
2.7.23	multi-component interventions for caregivers of people with dement

	Grade
ds for support and information to be assessed separately from those of uld be taken into account.	A
s to, sources of local information, advice and support designed to meet their	A
g confidential emotional support .	A
that they may benefit from additional support.	A
for carers: theoretical models, session length and session intensity.	B
ds for support and information to be assessed separately from those of uld be taken into account.	A
well-being, depression, burden and social outcomes.	B
d carers are invited to accompany patients during clinical encounters and are h the patient's wishes.	A
versity of services for carers.	B
networked peer support to moderately improve carer stress and depression	B
at home and their caregivers.	B
ia to reduce the risk of institutionalization.	B

Intervention	
Bereavement support interventions	
Ensure:	
2.7.25	family members and carers who are bereaved are, in the first instan
2.7.26	providers of specialist bereavement support work closely with other family members can access services when needed.
2.7.28	provider organisations are equipped to offer the first component of b components.
2.7.31	a leaflet is made available to families and carers around the time of involved in the provision of bereavement services, and include infor
2.7.32	specialist bereavement services are sufficiently resourced to enable social care professionals in relation to this aspect of care.
2.7.33	those who offer bereavement services that include volunteer suppor managing volunteers are in place.
2.7.27	Promote the development and implementation of a three-componen addressed through variety in service provision.
Interventions for health and social care professionals	
Ensure:	
2.7.34	health and social care professionals that provide day-to-day care to an ongoing basis.
2.7.35	a system is established to allow family members and carers to have
Interventions involving other families and carers	
2.7.38	Ensure that providers set up arrangements for families and carers to wished. These services are ideally provided in partnership with the v
Interventions for different ethnicities and cultures	
2.7.39	Ensure that the needs of family members from different ethnic popu considered.

	Grade
ce, encouraged to use existing support systems.	A
care providers (both statutory and voluntary) to make sure that carers and	A
bereavement support and have strategies in place to access the other	A
the bereavement. Ideally, this should be developed locally, agreed by those mation on anticipated feelings and how to access local and national services.	A
them to contribute to the preparation and ongoing support of health and	A
t workers, should ensure mechanisms for recruiting, training, supervising and	A
t model of bereavement support to ensure that people's individual needs are	A
patients also assess and address the needs of family members and carers on	A
regular opportunities to discuss particular concerns.	A
meet other families and carers who have experienced similar situations, if voluntary sector.	A
lations, including differences in language, religious practice and culture, are	A

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