Item No 6

Cabinet

22 November 2012

Adult Mental Health Needs Assessment

Recommendation

The Cabinet is asked to approve the 2012 Adult Health Mental Health Needs Assessment

1.0 Key issues

1.1 The Adult Mental Health Needs Assessment pulls together an overview of mental health, and in the light of the Department of Health document, 'No Health without Mental Health', February 2011, analyses and examines current and future mental health and well-being needs of Warwickshire's population.

1.2 The document will support commissioners in a greater understanding of local provision and highlight areas where further analysis will be required as they seek to ensure the needs of their local population are supported.

2.0 Proposal

2.1 The Adult Mental Health Needs Assessment was undertaken in 2011/12 by NHS Warwickshire and Warwickshire County Council. The emerging themes of the document have been used to shape current commissioning intentions during this period for both Clinical Commissioning Groups (CCGs) and WCC.

2.2 The document represents work over a 12 month period with each chapter subjected to challenge through the consultation phase.

2.3 The issues raised will need to be continually reviewed in the light of progress and change, and will be key questions for commissioners moving forward.

2.4 Members are asked to approve the Adult Mental Health Needs Assessment and to incorporate the challenging recommendations within the document to support commissioners shape the development of services.

3.0 Timescales associated with the decision/Next steps

3.1 The publication of the Adult Mental Health Needs Assessment, once approved, will be available as hard copy, electronic link, and on a chapter by chapter basis for easier reading, on the JSNA website.

Background Papers

None

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Warwickshire JSNA

Adult Mental Health Needs Assessment 2012

NHS Warwickshire

Warwickshire County Council

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Executive Summary

Introduction

The National Mental Health Strategy 'No Health without Mental Health'[1] published by the Department of Health February 2011 outlines the overarching goal to mainstream mental health, and establish parity of esteem between services for people with mental and physical health problems. The vision to achieve this is broken down across six shared high-level mental health objectives. These are a comprehensive set of shared priorities and objectives that cover better mental wellbeing, better mental health care and support and better physical health for individuals with mental health problems.

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

'Service Users felt that stigmatisation was a key issue for them and had an impact on their daily lives. Stigmatisation had adverse effects when people were looking for work or for those already in work. It was argued that generally people with mental health problems were treated very differently from people with physical health problems'.

Mental illness affects not only the individual with the condition, but also family, friends and the wider society. Poor mental health impacts on the ability of an individual to work and to contribute to society. Where mental illness exists, many costs fall on health and social care and on families to provide informal and unpaid care. The Marmot Review[2] in 2010 highlighted that unemployment can trigger distress, anxiety or depression.

Joint Strategic Needs Assessment (JSNA)

The assessment also forms part of the Joint Strategic Needs Assessment, the purpose of which is to analyse and examine the current and future health and well-being needs of the local population, to inform and guide the commissioning of health, well-being and social care services.

What isn't included in this HNA?

The majority of under-18 services have been excluded from this document. The children's and adolescent mental health services (CAMHS) needs assessment will be available in early 2012. However, to ensure there was an understanding of the transition arrangement of adolescents into adult services, 1:1s were held with this in mind.

[1] Department of Health. 2010, Healthy Lives, Healthy People: Our Strategy for Public health in England.

[2] Marmot Review Team. 2010, Fair Society, Healthy Lives.

Learning disability services, although connected with mental health services, have not been included in this HNA. There were a number of 1:1s that highlighted the interactions between the two services and some of the challenges facing learning disabilities, and it is recommended that a learning disability HNA be carried out within the next 12 months.

What are the big issues?

Each chapter provides its own recommendations. However, there were a number of common themes arising from the consultation that are repeated throughout the chapters. It is recommended that a steering group is set up, including providers, commissioners and service users to take forward the following recommendations:

Geographic Variation of Service Delivery

With few exceptions, services and their teams are described in terms of their geographical set up. In the majority of cases this is in terms of North Locality and South Locality, with Rugby part of one or other.

A number of 1:1s highlighted that there are differences between a variety of locality teams – waiting lists, active use of personal budgets, staffing levels, length of stay with a particular team etc. It is noted that Service Providers did highlight some evidence of action and movement to offer consistent services across both Warwickshire and Coventry.

Consideration needs to be given to the developments already made by service providers to improve the consistency across the county. There were some concerns raised that with the Clinical Commissioning Groups (CCGs) being locality based, that they may inadvertently reverse the improvements in consistent service delivery.

There are also services that continue to be offered in single localities, due mainly to historical funding. An example would be Admiral Nurses for dementia patients. They are commissioned to deliver their service to the north of the county. Any referrals out of their defined area are only able to be offered signposting advice.

Data Collection and Analysis

Throughout the chapters, improved and more relevant data would enable a better insight and understanding of the challenges faced by mental health service users in Warwickshire. As we move to 'Payment by Results' and 'Care Cluster' methodology, it is recommended that commissioners and providers alike, fully collect, utilise and understand what the data tells us about the presenting needs of mental health patients.

A sustainable approach to accessing and analysing primary care data would be useful for commissioners to gain a more realistic picture of the prevalence of mental health conditions in Warwickshire.

Transition between Levels of Care

There was an acknowledgement that thresholds for services are helpful in identifying if a client is suitable for referral to a particular service. However, there was concern that thresholds are being used to keep people out of services, without an alternate, more appropriate suggestion being offered.

For example, while there was positive feedback for the Improving Access to Psychological Therapies (IAPT) service, and for most in primary care this was seen as a clear and robust referral pathway, there were a number of cases identified where the patient was more complex than the thresholds for IAPT, but not (yet) meeting secondary care mental health thresholds.

These same concerns were raised when discussing secondary and tertiary care, the learning disability and mental health interface, and the relationships between health care and local authority concerning older people and the physical disabilities.

There were suggestions from many people involved in the consultation, that the patient's need should be the priority, and that teams should be aware of the thresholds above and below their level of care and ensure they offer positive signposting when declining a referral.

Single Point of Entry

The majority of interviewees identified a preference for a single point of entry to services. Where services have identified a single point of entry, it is often a single point of entry for each specific locality team, not county-wide.

Whilst not appropriate for every team, consideration should be given to providing this service. This would ensure that a referrer should be able to refer into mental health services and know that the most appropriate care professional will accept the referral.

Key Findings

- During the last two year period, 10% of all individual mental health outpatients accounted for over 40% of mental health outpatient attendances. Similarly, a quarter of all individual inpatients accounted for over half of all inpatient spells.
- There is a variation of outcome of Mental Health Act assessments between the north and south of the county.
- There are estimated to be nearly 7,000 people in the county living with dementia. This ranges from over 1,800 people in Stratford-on-Avon to around 700 in North Warwickshire.
- 89% of the inpatient admissions for organic mental health disorders (most commonly, dementia) came from the south of the county.
- By 2014, more than 9,500 people aged 65 and over are projected to have depression in Warwickshire.
- In 2009, there were 39 suicides in Warwickshire. The rate of suicide in the county fell between 2007 and 2009. The rate is comparable to both the England rate and West Midlands Region rate.
- Regular physical activity is associated with improved mental health and wellbeing. Across each borough and district, 'measured miles' and 'green gyms' are established or planned for the near future.
- Since Books on Prescription was launched in 2010, over 11,000 resources have been loaned to support people with common mental health problems.
- For 2010/11, Improving Access to Psychological Therapies (IAPT) services had over 7,000 referrals.

- Nearly 50% of people who complete IAPT treatment are moving to recovery.

What do we need to do?

- Commissioners need to identify a process to review progress on the findings from this Needs Assessment. It is commissioners who need to prioritise implementation and follow up of changes made.
- We need to understand why diagnosis is not recorded for the majority of individuals in the Mental Health Minimum Dataset (MHMDS) and why minority ethnic groups are underrepresented within the MHMDS compared with the population as a whole. We need to share the MHMDS information with GPs and Clinical Commissioning Groups to better understand and identify variation and develop more consistent pathways.
- Improved and continued analysis of service users to identify where access to the different mental health services is lower within vulnerable groups.
- Further investigation should be undertaken to identify the reasons why variation in community services demand exists at a District/Borough level.
- To explore the potential for service user peer support project.
- South Warwickshire commissioners should examine the dementia services in the North of the county that are not currently available to their residents, and to identify the potential benefits to patients.
- In 2011, approximately 150 Warwickshire residents may have early onset dementia. An updated care pathway is suggested to ensure age and clincially appropriate services are identified for this group of patients.
- Monitor the Key Performance Indicators of the new Addaction and Cranstoun services to ensure services are meeting the needs of the local population. The main KPI that applies to dual diagnosis is for 'Improved well-being at the 1st care plan review in each period'.
- Supporting People to work towards having housing support services that better reflect the geographical distribution of needs.
- Continue to prioritise housing as a key cross cutting issue within Warwickshire's Joint Strategic Needs Assessment (JSNA) and incorporate the use of data from each of the District and Borough Councils.
- There is a need to ensure there is a review of the variation of outcome of a MHA assessment that has been identified between the north and the south of the county.
- To assist commissioners, a more extensive analysis of bed utilisation for older people inpatients and residential facilities across the county is recommended. As part of this, an assessment of the impact of CAITT model of working on spells/individual should occur.
- The number of older people using substance misuse services should be monitored, and commissioners may wish to ensure that services are meeting the needs of this 'new' group of service user.
- To review pathways for Personality Disorder, including the Warwickshire DBT service, across Arden Cluster to ensure clarity and consistency of access to services.
- Further analysis of A&E attendance data should be undertaken by the Public Health Intelligence team (PHIT) in the next 12 months to provide improved guidance and understanding to providers and commissioners.

- Analysis of people with long term conditions accessing IAPT should be undertaken. This will enable an understanding of the patients that are accessing the service, to allow the service to adapt to the needs of the population.
- Further analysis of the users and outcomes of employment services for people with mental health conditions should be undertaken by commissioners. This will help to ensure that the objective of reablement can be achieved.

Other useful links:

Department of Health's Mental Health Strategy 'No Health Without Mental Health'

Fair Society Healthy Lives (the Marmot Review)

Joint Director of Public Health Report 2010: Best Health for Older People in Warwickshire p30/31

Living Well with Dementia in Warwickshire

Royal College of Psychiatrists' Report Physical Health in Mental Health

Who needs to know?

- Warwickshire County Council
- NHS Warwickshire
- Coventry and Warwickshire NHS Partnership Trust
- Acute Trusts
- Warwickshire GPs and Clinical Commissioning Groups
- Third sector organisations supporting mental health and wellbeing

Topic Area - What is a Joint Strategic Needs Assessment?

The Joint Strategic Needs Assessment (JSNA) is a process undertaken in partnership across Health and Social Care. The JSNA provides a framework to examine all the factors that impact on the health and wellbeing of the Warwickshire population including: employment, education, housing and environmental factors. This information enables us to prioritise resources and commission services that will improve outcomes for Warwickshire's community.

JSNA is the process by which the current and future health and well being needs of Warwickshire's population are identified. The JSNA is designed to provide an understanding of the need for health and social care in the short term (three to five years) and the longer term (five to ten years).

The JSNA aims to establish a shared, evidence based consensus on the key local priorities across health and social care and will be used to develop Warwickshire's Health and Well-Being Strategy.

Health Needs Assessment - Need, Demand and Supply

A Health Needs Assessment (HNA)'s objectives are to identify, quantify and qualify the levels of need, demand and supply that exist for the population under review.

Assessment of needs should take into account the needs of the individual and the wider population, over a period of time. These needs should be continually reviewed as needs of the population change over time.

Different groups – professionals, service providers, and the public will have different views on the needs of the population:

- Needs may be reported only if services are known to be available to meet them
- People may choose not to express their needs for a variety of personal reasons
- Low expectations of needs being met will be a barrier to reporting need
- Social circumstances and traditions may affect what is tolerated in smaller cultural groups

Demand is usually easier to measure – reviewing the number of referrals, attendances etc. However, this relies on the data being recorded accurately and the relevant information being collected. It is also important to note, that it is also only measuring demand on services that are available. The most appropriate service may not be available in a particular area, and so the next most appropriate service is accessed. This may lead to a belief that there is demand for a particular service, which is not truly the case.

Supply information is identified by talking to service providers, users of the service and referrers. Service Providers are able to describe the services and teams that are available and outline the personnel numbers and qualifications that deliver the service. Users often provide a spotlight on where services are perceived to be of a quality (good or bad) that is worth reporting. Referrers are able to describe the services that they know about, and the level of service that referrers and patients receive from service providers.

Topic Area - Legislation

It is imperative for health and social care to comply with Mental Health Legislation. With the Mental Capacity Act 2005[3] and the Mental Health Act 2007[4], there are formal responsibilities placed on Primary Care Trusts and Local Social Services Authorities.

The 'Needs' discussed within this chapter, will therefore not only reflect the needs of individuals, but also the needs to comply with legislation.

[3] Mental Capacity Act 2005

[4] Mental Health Act 2007

Introduction

The Mental Health Act 1983 explained

The main purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to make sure that people with mental health issues get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

Part 2 of the Act sets out the civil procedures under which people can be detained in hospital for assessment or treatment of their mental health. Detention under these procedures normally requires a formal application by either an Approved Mental Health Professional (AMHP) or the patient's nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies.

In certain circumstances, people who have been detained in hospital for treatment can be discharged onto a Community Treatment Order. This means they are free to leave hospital and continue their treatment in the community, subject to the possibility of being recalled to hospital if necessary. This is also known as Supervised Community Treatment (SCT).

Part 2 also sets out the procedures for making an application for someone to be received into guardianship under the Act.

Part 3 of the Act concerns the criminal justice system. It provides powers for Crown or Magistrates' Courts to remand an accused person to hospital either for treatment or a report on their mental disorder. It also provides powers for a Court to make a hospital order, on the basis of two medical recommendations, for the detention in hospital of a person convicted of an offence who requires treatment and care. The Court may also make a guardianship order. A restriction order may be imposed at the same time as a hospital order to place restrictions on the movement and discharge of a patient for the protection of the public; all movement is then subject to the agreement of the Secretary of State for Justice.

Most patients who are detained in hospital under the Act can be given treatment for their mental health without their consent.

Most patients who are detained have the right to apply to a Tribunal for their discharge. The Tribunal is an independent, judicial body. Part 5 of the Act sets out when patients, and sometimes their nearest relatives can apply. Most detained patients can also ask the managers of the relevant hospital to discharge them. Patients' responsible clinicians must also keep the appropriateness of continued compulsory measures under review

There is also a responsibility to review this decision periodically. There is also a requirement for Primary Care Trusts and Local Authorities to collaborate and ensure there are systems in place to justify any deprivation of liberty that occurs when the Mental Capacity Act is used.

Summary of Deprivation of Liberty

There are some circumstances in which depriving a person, who lacks capacity to consent to the arrangements made for their care or treatment, of their liberty is necessary to protect them from harm, and is in their best interests. Deprivation of liberty can be authorised by supervisory bodies (primary care trusts (PCTs), local authorities as an example. To obtain authorisation to deprive someone of their liberty, managing authorities have to apply for an authorization.

Once an application has been received, the supervisory body must then follow the assessment processes before it can authorise deprivation of liberty. It should be borne in mind that a deprivation of liberty authorisation does not, in itself, give authority to treat someone.

Mental Health Act 1983 as amended by Mental Health 2007

In 2007 amendments were made to the Mental Health Act. The following are the main changes to the 1983 Act made by the 2007 Act:

Definition of mental disorder: it changes the way the 1983 Act defines mental disorder, so that a single definition applies throughout the Act, and abolishes references to categories of disorder.

Criteria for detention: it introduces a new appropriate medical treatment test which applies to all the longer-term powers of detention. As a result, it is not be possible for patients to be compulsorily detained, or their detention continued, unless appropriate medical treatment and all other circumstances of the case is available to that patient. These criteria abolished the treatability test.

Professional roles: it is broadening the group of practitioners who can take on the functions currently performed by the approved social worker (ASW) and responsible medical officer (RMO).nearest relative: it gives to patients the right to make an application to the county court to displace their nearest relative and enables county courts to displace a nearest relative who it thinks is not suitable to act as such: the provisions for determining the nearest relative are amended to include civil partners amongst the list of relatives.

Supervised Community Treatment (SCT): it introduces SCT for patients following a period of detention in hospital. SCT will allow certain patients with a mental disorder to be discharged from detention subject to the possibility of recall to hospital if necessary. This is particularly intended to help avoid situations in which some patients leave hospital and do not continue with their treatment, with the result that their health deteriorates and they require detention again – this is sometimes referred to as the revolving door.

Electro-convulsive therapy: it introduces new safeguards for patients

Tribunal: it reduces the periods after which hospital managers must refer certain patients' cases to the Tribunal if they do not apply themselves. It introduces an order-making power to make further reductions in due course.

Independent mental health advocacy: it places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.

Age-appropriate services: it will requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs). This is on course to be implemented in April 2010.

Section 117 Aftercare

Section 117 states that aftercare services must be provided to patients who have been detained in hospital:

- for treatment under section 3
- under a hospital order pursuant to section 37 (with or without a restriction order)
- following transfer from prison under section 47 or 48.

However, section 117 does not apply to:

- patients detained in hospital for assessment under section 2
- patients detained in an emergency under section 4
- patients detained while already in hospital under section 5(2)
- patients who were not detained under any section (informal or voluntary patients)
- patients under guardianship or discharged from guardianship.

Aftercare should be planned with the patient, their family and carers, as well as professionals, looking at both health and social care needs. The type of aftercare required will depend on the circumstances of the individual and health. Social services are entitled to take their resources into account when assessing needs.

National Perspective

The number of detentions under the Mental Health Act in England rose to 49,717 in 2009/10 compared to 47,725 in 2008/9. This 3.5% rise is the largest rise over the past three years [5] .

[5] Mental Health Network NHS confederation. 2011, Key Facts and Trends in Mental Health

MHA Assessments in Warwickshire

The data collected following assessments under the MHA for Warwickshire:

Outcome	North Warwickshire Jan – Aug 2010		North Warwickshire Jan - Aug 2011		South Warwickshire Jan – Aug 2010		South Warwickshire Jan – Aug 2011		Warwickshire Jan – Aug 2010		Warwickshire Jan –Aug 2011	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Remain in Police Custody	0		1		0		2		0		3	
Other Outcome	18	4	19	7	3		1		21	3	20	5
No Further Action	36	8	14	5	9	4	8	5	45	7	22	5
Crisis Accommodation	0		0		1		0		1		0	
Crisis Treatment	27	6	12	5	5	2	9	5	32	5	21	5
Admission to General Hospital	0		0		1		0		1		0	
No Admission	86	20	48	18	35	14	29	18	121	18	77	18
Informal Admission	45	10	39	15	34	14	19	12	79	12	58	13
Remains Informal	3		1		0		3		3		4	
Section 4	0		0		2		0		2		0	
Section 3	61	14	40	15	69	28	37	22	130	19	77	18
Section 2	128	30	68	26	81	32	52	32	209	31	120	28
Mental Capacity Act	2		0		0		0		2		0	
Community Treatment Order	20	5	22	8	10	4	5	3	30	4	27	6
Section 7 Guardianship	7	2	2		0		0		7		2	
	433		266		250		165		683		431	

Source: Coventry and Warwickshire Partnership Trust

% calculated only where more than 5 cases in each locality, and therefore will not add to 100

Two full years' data has not been provided for interpretation and so analysis has been undertaken on the same 8 months (Jan – Aug) in both 2010 and 2011.

- For the January-August data, in 2010 there were 298 referrals in the north of the county and 172 assessments in the south of the county. This fell in both localities in 2011 – In the north there have been 266 referrals and in the south 165 referrals – an approximate 9% drop across the county. This may be due to a number of reasons:
  - A change in the interpretation of the new legislation
  - A change in the process of undertaking the assessment
  - Patients being identified sooner by other health care professionals and teams, treatment starting earlier thereby reducing the number of reactive MHA assessments
- The four most common outcomes from the MHA assessment are the same across the county regardless of locality:
  - No admission (18% across the county)
  - Informal admission (13% for the county)
  - Section 3 (18% across the county)
  - Section 2 (28% across the county)

Across the two localities there are differences in outcomes. In the North, the use of Section 3 was the outcome in assessments in 14% and 15% of cases in 2010 and 2011 respectively. However, in the South this figure is higher at 22% and 19% of cases in the same time periods. The narrowing of the difference in 2011 is noted.

The reasons for the difference in the use of Section 3 may be similar to those listed previously – a difference in interpretation and processes or differences in the identification of patients. There may be a difference in 'risk threshold' that different teams and assessors have across the county.

From the 1:1s phase of the HNA, perceptions of mental health staff suggest that there variations in requests for assessments do exist – that in the North other opportunities for supporting patients are able to be found – only 44% and 41% of assessments in 2010 and 2011 resulted in either a Section 2 or Section 3. In the South 0f the county, 60% and 55% of assessments result in the same Section arrangements. The reasons less opportunities for alternative outcomes may be appropriate is that the patient is in a deeper crisis in the south when they are referred and a Section arrangement is the most appropriate solution.

With regard to staffing numbers, there are also differences in the number of AMHPs contributing to the MHA rota by district. In the North Warwickshire and Rugby team the number of AMHPs is 10.43 WTE (as at July 2011). In South Warwickshire there are 5 AMHPS in Stratford and 9 AMHPs in Warwick, forming a team of 14 WTE.

For 2011, this suggests that there are 25.5 assessments per AMHP in the North team, compared with 11.8 assessments per AMHP in the South.

This is obviously a crude comparison, as AMHPs are involved with more service delivery than just MHA assessments, but does indicate that both teams may not be working to identical systems, processes or populations. It is understood that a review of numbers on rotas is being undertaken to reduce these differences.

With regard to the 'Least Restrictive Principle', a number of concerns were raised by health care professionals. The AMHP, the responsible clinician and a GP should be involved in the assessment. Whereas in the past, the patient would probably be assessed

by their registered GP, this no longer happens and is most likely to be a GP on a rota for a wide geographical area.

This is felt, sometimes, to put additional pressure on the AMHP, as those who do not know the patient (clinician and GP) may be more risk averse, than the local team who may have previously had contact with the patient. Additionally, the rota GP is unlikely to be able to commit primary care colleagues to support the mental health services in keeping the patient in the community.

GPs involved in the 1:1s felt that local GPs could and would be involved but the logistics of timing the assessment versus the needs of the surgery are difficult to manage.

Independent Advocacy

In Warwickshire, the statutory responsibility for delivering independent mental health advocacy is provided by Independent Advocacy. The advocacy service provides support at meetings such as tribunals, appeals, assessments and ward rounds. They are also able to support with more practical issues such as housing and benefit enquiries.

Their caseload for one quarter in 2010/11 for Warwickshire AND Coventry shows :

- 203 clients were seen as part of the legal entitlement following a section
- 227 clients requested assistance during a hospital admission
- 323 clients requested advocacy support while they were in the community

As a snapshot, in the last quarter of 2010/11, 42 statutory referrals were made to Independent Advocacy for Warwickshire residents only:

	Male	**Female**	**Total**
Total	24	18	42
White	11	17	28
Asian British	2	1	3
Chinese/other	1		1
Not recorded			10
Total			42
18-25	7	6	13
26-40	9	8	17
41-64	8	4	12
Total			42

Source: Independent Advocacy, 2011

This data tells us that 42 people accessed Independent Advocacy in January-March 2011. However, for the same time period, a higher number, 166, were by AMHPs for a MHA assessment. Of the 166 MHA assessments, 76 were placed under either a Section 2, 3 or 4.

Whilst there may be a time delay in requiring or requesting Independent Advocacy, there is a gap between those who have a statutory right to advocacy and those accessing it. This may be explained by a number of reasons:

- Data is new referrals not new clients (for both MHA data and Advocacy data) – it may be that clients may already have received the advocacy support they require in a previous admission
- Clients may not believe they require advocacy or understand the role of Independent Advocacy
- Clients may ask at a later date in the Sectioning process to speak to Independent Advocacy

Case Study *– The client was referred by the ward and had been admitted to hospital under a section 2 of the Act. The client was visited and the detention explained etc under the statutory obligation. The client was too unwell to fully understand the sectioning, the role of the IMHA or indeed the value of any other help they could access.*

The patient was seen after approximately 2 weeks of admission and was considerably more responsive. The patient declined the right to appeal against their section but was obviously more concerned about their personal debt and how this was affecting (and would affect in the future after discharge) their life and their general mental health well-being.

The client was moved to a section 3 of the Act and the advocate arranged for CAB debtline to visit the ward to assist the client with the priority and non-priority debts. The client was supported through this first interview and then the debt issue was taken on by the CAB service.

Learning Difficulties and Mental Health – The challenge facing Health and Social Care

During the consultative process, the responsibility for members of the community who are vulnerable either from a learning difficulty (as opposed to a learning disability), and a mental health condition was raised by various interviewees.

"Whether an individual has an IQ of 70 or 80 shouldn't be the discussion point, they are still a vulnerable person and adding in a mental health condition makes them even more complex to manage, but secondary care has thresholds that the patient doesn't meet for either the learning difficulty or the mental health condition"

Although this HNA is for mental health, there were concerns raised about the services believed to be available or more often, not available for this client group.

The overall impression was that if there was not a clear diagnosis of need either from a learning disability or mental health issue, then no service was responsible for these vulnerable adults.

Usually in the HNA, there has been a reflection on the data available to identify gaps in service, areas of good practice or for improvement, but it has not been easy to achieve for this group.

One set of data surrounds the numbers of individuals with a learning disability who are receiving services as part of Section 117.

In this data there are 64 individuals with learning disability under section 117. As already mentioned, services provided under Section 117 need to continue as long as the service is needed for their mental health condition. However, there is often uncertainty as to whether a service is provided for their mental health or their learning difficulty. This may lead to disputes as to whether the care is funded by health or social care or removed if it is to support their learning difficulty.

Recommendations

- There is a need to ensure there is a reduction in the variation of outcome of a MHA that may occur purely on a geographical basis. This review should be completed within 6 months of the HNA and provide information to commissioners regarding:
    - Clear countywide pathways for referring earlier to mental health teams
    - Clear countywide pathways for ensuring the least restrictive principle is undertaken
    - Evidence, if any, should primary care professionals be using MHA, CMHTs and AMHPs differently that impacts on the frequency and outcomes of MHA assessments
    - Publication and easy access to the pathways and guidance produced for primary and secondary care professionals
- The lead Clinical Commissioning Group for Mental Health should consider what improvements can be made to the involvement of the patient's GP in the Mental Health Act assessment
- To identify additional services/promotional opportunities to support people under section. It may be possible for a piece of work to be undertaken by Independent Advocacy +/- Making Spaces to speak to users to give confidence to the PCT and LA that all those people under section who are eligible for Advocacy services are referred to Independent Advocacy, if desired.
- A guideline/policy document is agreed within the next 12 months between health and social care services that acknowledges the issues of learning difficulty/mental health clients. This should support:
    - Primary care in understanding who will provide higher expertise for these vulnerable people depending on need
    - How to identify more simply who is responsible for the funding of care, and working on Section 117 care protocols
    - Secondary care services informing LA and PCT at the earliest opportunity of a patient that will require Section 117 aftercare.

Topic Area – The Economy and Mental Health

Underlying social, economic and environmental factors that can affect a person's well-being include: employment status, education, health and the local community. It is also known that during periods of high unemployment and recession that mental health problems increase.

As growth forecasts continue to be cut, the economy remains a strong focus both nationally and locally as uncertainty into the economic recovery continues. Recent months have seen reductions in the numbers claiming unemployment benefits in Warwickshire, although numbers remain much higher than before the recession began.

Despite this relative improvement, recovery is likely to be slow, reflected in falls in earnings and income, higher inflation levels and restrained customer demand. In the coming months it will be important to understand and monitor any impact of these economic trends on the mental health and wellbeing of the Warwickshire population.

Introduction

Work is widely recognised as having a positive impact on mental health, while unemployment has a negative effect and often leads to deterioration in mental well-being[6].

The importance of employment in ensuring mental wellbeing is by now widely recognised. People with mental health difficulties often suffer stigma and discrimination in the workplace, and those who are unemployed, in an unsatisfactory job, or at risk of unemployment, experience much poorer mental health than those in stable employment.

For many people, the reality of the recession and economic downturn has been a complex relationship of falling property prices, rising costs and in some cases, increasing personal debt. For some, this will be accompanied by unemployment, fear of job loss, reduced incomes, and changed retirement plans. For those with lower income, which is more common amongst older people, disabled people or families with young children, the effect of the any economic downturn is likely to be more direct. As people on lower incomes are forced to economise, they may find that they have less to spend on food, heating and transport. If people were already living in a poorly heated home, had poor diet, mental health problems or were socially isolated, any downturn in the economy will only make the issues more acute, with poorer mental health a likely consequence.

National Perspective

The Economic and Social Cost of Mental Illness

In 2002/03, The Sainsbury Centre for Mental Health[7] estimated the annual cost of mental health problems in England to be £77.4 billion. More than half of the total is accounted for by the cost of impaired quality of life. If this is removed, the estimated cost of mental health problems in England and Scotland is £39.5 billion. About 35% of this sum is accounted for by the costs of health and social care and 65% by lost economic activity.

The estimated national annual cost of absenteeism due to mental ill health is £8.4 billion. The Centre has also estimated that impaired work efficiency ('presenteeism') due to mental ill health costs £15.1 billion. This means that as much as 60% of the employment related costs of mental illness are due to presenteeism. This could be because people with mental health problems lack obvious outward signs and are reluctant to have to 'prove' they are ill because of the resulting stigma.

Using the same methodology, a straightforward updating of the 2003 £77.4 billion estimate suggests that the aggregate cost of mental health problems in England increased to £105.2 billion in 2009/10. This includes £21.3 billion in health and social care costs, £30.3 billion in lost economic output and £53.6 billion in human suffering. The aggregate cost of mental health problems increased by 36% between 2002/03 and 2009/10 with a particularly large increase in the costs of health and social care (+70%).

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[6]Fair Society and Healthy Lives' (The Marmot review)-Strategic Review of Health Inequalities in England post-2010

[7]The Sainsbury Centre for Mental Health. 2003, 'The Economic and Social Costs of Mental Illness'

How does mental wellbeing affect the broader economy?

People who experience mental ill health remain one of the most disadvantaged groups in the job market. The Department of Work and Pensions highlighted that;

- Only 20% of people with severe mental health problems are employed compared to 65% of people with physical disabilities, and 75% for the whole adult population.
- In the case of people with more common conditions such as depression, only about half are employed.
- 90% of people with mental health problems want to work compared to 52% of disabled people generally[8] .

The result is that there are more mentally ill people on incapacity benefits than the total number of unemployed people on benefit, and 70 million days are lost each year because of mental health problems. The combined costs of sickness absence, non-employment, effects on unpaid work and output losses to the UK is £26 billion a year, which is equivalent to £1,035 for every employee in the UK workforce (Sainsbury Centre 2007).

What causes mental health problems?

Work-related stress is not itself a mental health problem, but can cause mental illness or make it worse. Research suggests it is responsible for 40% of absences from work and can reduce performance by up to 70%.

Stress is a very individual thing – what causes overwhelming pressure for one person, another may find easy to handle. It is also notoriously difficult to predict. But even so, like many of the causes listed below, it is not entirely outside an employer's control.

All potential sources of stress, like someone simply being in the wrong job for their skills, abilities and expectations, not being clear about the scope or responsibilities of their role, or feeling torn by conflicting demands, are made worse by lack of managerial or supervisory support.

People with mental health problems may be attracted to working in areas like health and social care because they expect their condition to be more readily accepted, even though these types of job are likely to be particularly stressful.

It should be emphasised that anyone can suffer mental health problems and it should not be assumed that senior or more experienced staff are immune. Managers may face particular pressures, and feel isolated and anxious, not least because of their position of responsibility.

What's happening in Warwickshire?

The analysis for Warwickshire concentrates on unemployment and worklessness. However, it is important to recognise that, obviously not all benefit claimants will have mental health

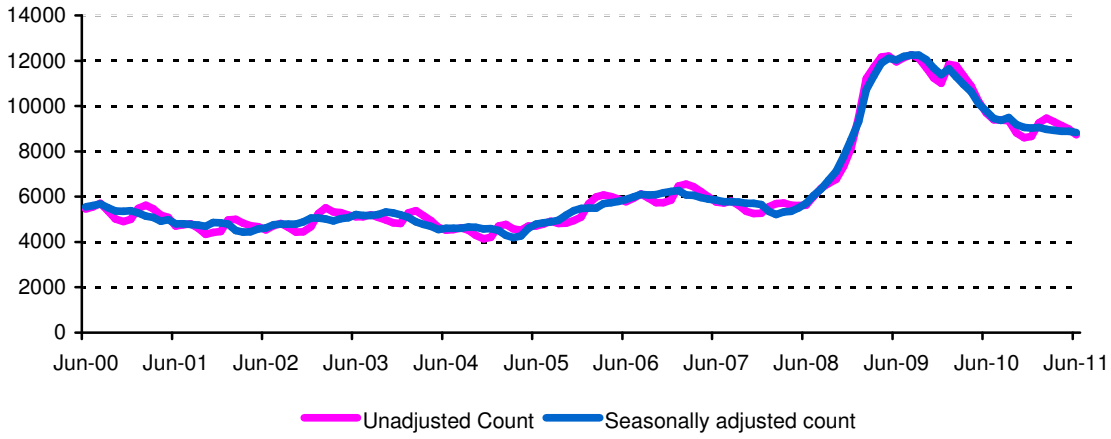
[8] The Centre for Economic Performance's Mental Health Policy Group. 2006,

issues and that those in work can still be susceptible to mental ill-health. There is no robust data for this to be accurately analysed in Warwickshire.

Job-Seekers' Allowance (JSA) Claimant Count

Between 2000 and 2005, the JSA claimant count in Warwickshire fluctuated between 4,000 and 6,000, with levels slightly rising between 2006 and 2008. However, the claimant count began to increase rapidly in the final months of 2008 as a result of the recession and resulting economic downturn. At its peak, in August 2009, there were 12,267 JSA claimants in Warwickshire. The rate of increase in the County's claimant count in the year up to August 2009 was faster than that experienced regionally or nationally. This is likely to be a consequence of the particular structure of the Warwickshire economy; its relatively low share of employment in the public sector means the workforce is more susceptible than others to fluctuating market conditions, and there are relatively high proportions employed in the most vulnerable sectors such as manufacturing, construction and financial services. However, the claimant count had been falling until December 2010 and increased again between January and April 2011. June 2011 saw levels return to those experienced at the end of 2010.

Warwickshire Claimant Count, June 2000 – June 2011



Source: National Statistics (www.nomisweb.co.uk) © Crown Copyright, 2011 and Warwickshire County Council

In November 2010, there were 8,609 JSA claimants living in Warwickshire, the lowest number since December 2008. The claimant count rate (number of JSA claimants expressed as a proportion of the resident working age population of an area) for Warwickshire was 2.5%, much lower than the UK rate of 3.4% and the West Midlands rate of 4.4%.

At borough/district level, the proportion of residents claiming JSA benefits ranges from a low 1.4% in Stratford-on-Avon District to 4.0% in Nuneaton and Bedworth Borough. Only Nuneaton and Bedworth Borough has a claimant count proportion higher than the average for England and Wales (3.6%). Every borough and district, as well as Warwickshire, the West

Midlands and England and Wales, have seen a reduction in the claimant count proportion since June 2010.[9]

The year-on-year figures vary across the sub-region and the County, but all of Warwickshire's boroughs and districts have lower claimant rates than the same time last year (June 2010). Again, there is some variation within the County; Stratford District has seen a 17.4% fall in JSA claimants over the last year whereas Warwick District has seen a 6.4% reduction over the same period. There have been year-on-year improvements in each of the district and boroughs compared to increases seen in both the West Midlands (+1.2%) and England and Wales (+3.1%). This suggests that employment in Warwickshire may be recovering at a faster rate.

Change in the Claimant Count, June 2010 - June 2011

	June 2010		June 2011		Year-on-year % change
	Number	Rate (%)	Number	Rate (%)	
North Warwickshire	1,146	2.9	997	2.5	- 13.0%
Nuneaton and Bedworth	3,341	4.3	3,086	4.0	- 7.6%
Rugby	1,869	3.2	1,671	2.9	- 10.6%
Stratford-on-Avon	1,236	1.7	1,021	1.4	- 17.4%
Warwick	2,096	2.3	1,961	2.1	- 6.4%
Warwickshire	9,688	2.8	8,736	2.6	- 9.8%
West Midlands	158,104	4.6	160,046	4.6	+ 1.2%
South East	134,135	2.5	132,561	2.5	- 1.2%
England & Wales	1,255,308	3.5	1,293,816	3.6	+ 3.1%

Source: Claimant count, National Statistics (www.nomisweb.co.uk) © Crown Copyright 2011

Note: Rates are calculated using the resident working-age population (16-64 for males; 16-59 for females) as denominators and are consistent with those published by the Office for National Statistics

The downward trend is mirrored in those aged 18-24 claiming JSA. In June 2011 there were 2,390 claimants aged 18 to 24 in Warwickshire, this represents a fall of 155 claimants from June 2010.

[9] The latest data (June 2011) is compared to June 2010 here to avoid seasonal variations in figures.

Claimant Count by Gender, June 2011

	Male		Female		Persons	
	Number	Rate (%)	Number	Rate (%)	Number	Rate (%)
North Warwickshire	655	3.3	342	1.7	997	2.5
Nuneaton and Bedworth	2,087	5.3	999	2.6	3,086	4.0
Rugby	1,122	3.8	549	1.9	1,671	2.9
Stratford-on-Avon	663	1.8	358	1.0	1,021	1.4
Warwick	1,336	2.8	625	1.4	1,961	2.1
Warwickshire	5,863	3.4	2,873	1.7	8,736	2.6
West Midlands	109,583	6.3	50,463	2.9	160,046	4.6
South East	88,391	3.3	44,170	1.6	132,561	2.5
England & Wales	867,824	4.9	425,992	2.4	1,293,816	3.6

Source: Claimant count, National Statistics (www.nomisweb.co.uk) © Crown Copyright 2011

Note: Rates are calculated using the resident working-age population (16-64 for males; 16-59 for females) as denominators and are consistent with those published by the Office for National Statistics

The JSA claimant rate among women is typically less than half that of the rate among men. The age group which makes up the largest proportion of claimants is the 18 to 24 year age group; with 27.4% of claimants from this group. It is important to recognise these demographic patterns in terms of the types of people who may have a greater likelihood to suffer future mental health problems.

The proportion of claimants receiving JSA for between six and twelve months has remained similar since June 2010. However, a much smaller proportion of those on benefits in June 2011 have been claiming for over twelve months. In June 2010, there were 1,595 people in Warwickshire who had been claiming JSA benefit for more than twelve months, this has reduced to 955 in June 2011. However, these particular cohorts need to be monitored closely as they are more likely to experience deterioration in their mental wellbeing.

Claimant Count by Duration, June 2011

	Up to 6 months		Over 6, up to 12 months		Over 12 months		Total
	Number	%	Number	%	Number	%	Number
North Warwickshire	715	71.9	175	17.6	105	10.6	995
Nuneaton and Bedworth	2,090	67.7	660	21.4	335	10.9	3,085
Rugby	1,160	69.5	310	18.6	200	12.0	1,670
Stratford-on-Avon	740	72.5	160	15.7	120	11.8	1,020
Warwick	1,395	71.4	360	18.4	200	10.2	1,955
Warwickshire	6,100	69.9	1,670	19.1	955	10.9	8,730
West Midlands	98,285	61.5	35,520	22.2	26,035	16.3	159,845
South East	89,110	67.4	25,305	19.1	17,790	13.5	132,210
England & Wales	841,170	65.2	267,680	20.7	181,895	14.1	1,290,745

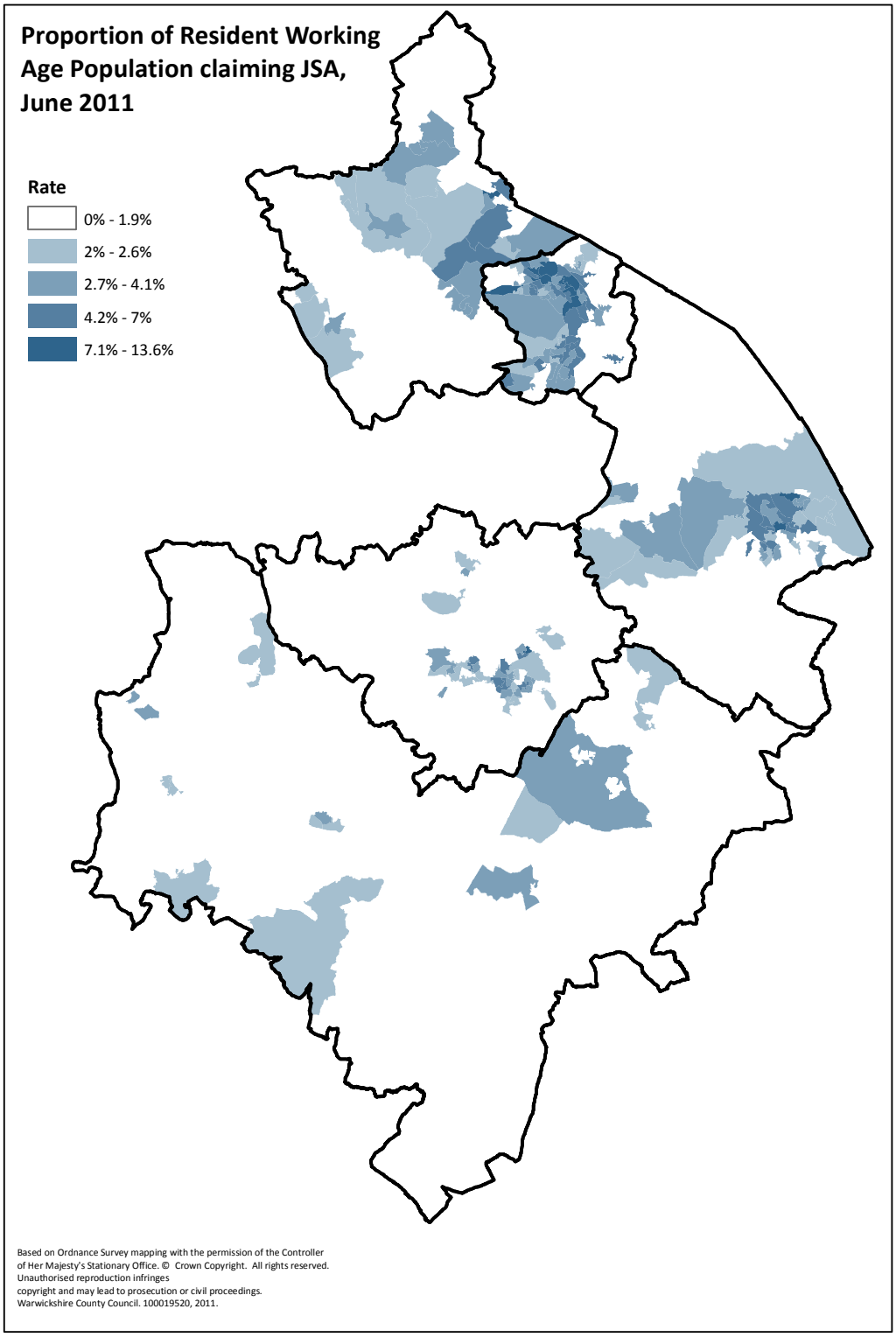
Source: Claimant count, National Statistics (www.nomisweb.co.uk) © Crown Copyright 2011Note: Data is rounded to nearest five because of disclosure controls. Figures may not sum to previous totals due to rounding

Unemployment claimant counts are available for geographic units called lower layer Super Output Areas (SOAs). Lower layer SOAs are typically smaller than electoral wards and contain around 1,000-2,000 people. There are 333 lower layer SOAs in Warwickshire. Examining the unemployment claimant count at this level allows for the identification of pockets of unemployment that may otherwise be hidden in ward level statistics. This may also highlight those geographic areas with the types of people with greater likelihood to suffer future mental health problems as a result of being out-of-work.

Whilst Nuneaton and Bedworth Borough has the greatest number of localised small areas with high levels of claimants, pockets also exist in Warwick District, Rugby Borough and North Warwickshire Borough. In June 2011, the highest claimant rates in Warwickshire were in Abbey Town Centre (13.6%), Bar Pool North and Crescents (10.6%) and Camp Hill Village Centre (10.5%). All of which are in Nuneaton and Bedworth Borough.

Of the 10% highest claimant rates in Warwickshire at an SOA level, 23 are in Nuneaton and Bedworth Borough; six in Rugby Borough, three in Warwick District and one in North Warwickshire Borough.

Proportion of Resident Working Age Population claiming JSA, June 2011



Source: Claimant count, National Statistics (www.nomisweb.co.uk) © Crown Copyright 2011

Worklessness

Worklessness is a less familiar term than unemployment which is used to describe all those of working age who are not employed. There is no official definition for worklessness, but in practice, the term is most often used to describe people of working age who are not employed and are claiming a benefit. This indicator examines the number of people claiming benefits where lack of work is the primary factor in determining eligibility; these benefits include Jobseekers' Allowance, Employment and Support Allowance, Incapacity Benefit, and Income Support.

The proportion of working-age people claiming workless benefits provides an indication of the health and economic activity levels of residents and, consequently, the impact this has on residents' quality of life. This dataset is based on administrative counts provided by the Department for Work and Pensions and is therefore more accurate than survey-based estimates at county and borough or district level. The use of the broader worklessness definition may help to better ascertain the potential population which may have a greater likelihood to experience mental health and wellbeing issues linked to economic circumstance and unemployment.

For the first time since 2007, the proportion of residents claiming workless benefits in Warwickshire has decreased since the previous year, from 9.5% in 2009, to 8.7% in 2010. Although the rate has also decreased in England and Wales, Warwickshire continues to have a significantly lower proportion compared to the national rate of 12.0%.

At a borough and district level, there has been an improvement in worklessness since 2009 across all five districts and boroughs, with the most significant decrease in the proportion of residents claiming workless benefits in North Warwickshire Borough, which has reduced by 1.4 percentage points. Claimant rates are particularly low in Stratford-on-Avon District, where only 7.1% of the working-age population claim workless benefits. However, Nuneaton and Bedworth Borough has a workless claimant rate that exceeds the national average, where 12.6% of working-age residents claim at least one workless benefit.

In Warwickshire, worklessness has been decreasing steadily since February 2010. In November 2010, 29,870 working-age people were in receipt of at least one workless benefit, 2,780 less than for the same period in 2009. The decrease is predominantly due to a reduction in claims for Jobseekers' Allowance (JSA), where numbers have dropped by 2,360 over a one year period. Employment and Support Allowance (ESA) and Incapacity Benefit claimants comprise the largest proportion of claimants on out of work benefits, which can be shown by disaggregating the worklessness total into the following four benefit groups:

•Jobseekers (claiming of Jobseekers' Allowance):	8,410
•Incapacity Benefits and ESA (claimants of Incapacity Benefit):	16,130
•Lone Parents (claimants on Income Support with a child under 16 and no partner):	3,940
•Other claiming income-related benefit (Income Support claimants not included in one of the three groups above):	1,390

Looking at the five year period from 2005 to 2010, the number of working age Warwickshire residents claiming workless benefits has increased by 3,030 claimants, or 11.3%. This increase occurred primarily because of the sharp increase in new claimants between 2008 and 2009, particularly those claiming Jobseekers' Allowance as a result of the economic downturn. However, the gap between the five-year period from 2005 to 2010 appears to be smaller than between 2004-2009, where there was an increase of 6,150 claimants.

All Warwickshire's boroughs and districts experienced an increase in the number and proportion of claimants between 2005 and 2010, although there was large variation among the areas. Rugby Borough and Nuneaton and Bedworth Borough saw the largest increase in total numbers claiming worklessness benefits, with an additional 910 claimants in both boroughs. However, the percentage increase in Rugby was largest at 20.6%, whilst in Nuneaton and Bedworth it was just 10.2%. Conversely, in North Warwickshire there were only 60 more claimants in 2010 compared to 2005, which is a 1.7% increase.

Change over five year period in number of workless claimants, by district, 2005-2010

	November 2005		November 2010		Change	
	Number	Rate (%)	Number	Rate (%)	Number	(%)
North Warwickshire	3,500	8.7%	3,560	8.9%	60	1.7%
Nuneaton and Bedworth	8,920	11.5%	9,830	12.6%	910	10.2%
Rugby	4,420	7.7%	5,330	9.1%	910	20.6%
Stratford-on-Avon	4,140	5.8%	4,570	6.3%	430	10.4%
Warwick	5,860	6.5%	6,590	7.1%	730	12.5%
Warwickshire	26,840	8.0%	29,870	8.7%	3030	11.3%

Source: Department for Work and Pensions (www.dwp.gov.uk), © Crown Copyright 2010. Figures may not sum due to rounding

In Warwickshire, in February 2011, just over 1,500 people were claiming Employment & Support Allowance for mental or behavioural disorders.

Services in Warwickshire

Re.Work is part of the Coventry and Warwickshire Partnership Trust's mental health rehabilitation service. It offers a wood workshop and craft centre based in Rugby with the aim to work alongside mental health service users to help them develop the skills needed to get back into work or education.

People who attend might require support to develop in many different areas. They may need a little support building up their confidence, or some help with getting back into a routine. Sometimes people just need to work on their time keeping skills. By attending

groups at the workshop, people gain access to a social network and a supportive environment where they can build up their self esteem and social skills.

Of the 14 people discharged over a 12 month period between 2009 and 2010, the outcomes were:

Re.Work Outcomes 2009/10

Reason for leaving Re.Work	Number of Clients
Volunteering opportunity	5
No longer attends	5
Employment	3
Education	1

Source: Re.Work

Warwickshire Employment Service offers an employment and education service for people with severe and/or enduring mental health illness. Referrals are accepted directly from care co-ordinators and Occupational Therapists. One to one support is given on an ongoing basis to help people achieve their goals and ambitions along side a vocational profile action recovery plan.

As a snapshot, during the period April 1st to June 30th 2011, 33 people were referred to Warwickshire's Employment Service, of which over 50% were aged 36-50 years old and 15% were from Black and Minority Ethnic Groups. 24 of the 33 clients were from the South Warwickshire Districts of Warwick and Stratford-on-Avon.

Recommendations

- Commissioners should monitor any impact of these economic trends on the mental health and wellbeing of the Warwickshire population.

- Further analysis of the users and outcomes of employment services for people with mental health conditions should be undertaken by commissioners. This will help to ensure that the objective of reablement can be achieved.

Topic Area – Mental Health and Social Care

The People Group brings together the former directorates of, 'Adult, Health and Community Services', and 'Children, Young People and Families'. Its Aims and Vision are: -

- To support people, especially the most vulnerable and disadvantaged, to access throughout their lives every opportunity to enjoy, achieve and live independently.

- The People Group will provide social care, learning, and achievement and health related services for all ages.

The People Group has direct responsibility for a number of services.

Warwickshire County Council offer 'preventative services' designed to reduce the number of clients that reach crisis point and in extreme circumstances to prevent long term residential or hospital admission. These services include Day Opportunities, Home Care, Reablement, Telecare, Occupational Therapy equipment and Respite Breaks. However some clients require more specialist services such as Residential and Nursing Care.

Introduction

The National Mental Health Strategy 'No Health without Mental Health'[10] published by the Department of Health February 2011 outlines the overarching goal to mainstream mental health, and establish parity of esteem between services for people with mental and physical health problems.

The vision to achieve this is broken down across six shared high-level mental health objectives. These are a comprehensive set of shared priorities and objectives that cover better mental wellbeing, better mental health care and support and better physical health for individuals with mental health problems.

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

This is underpinned by 'The Vision for Adult Social Care: Capable Communities and Active Citizens'[11] published by the Department of Health November 2010, it outlines the Government's vision for Personalisation. This vision focuses on the Government's commitment to:

- Break down barriers between health and social care funding to incentivise preventative action
- Extend the greater rollout of personal budgets to give people and their carers more control and purchasing power
- Use direct payments to carers and better community-based provision to improve access to respite care.

In line with Personalisation, there is an emphasis on choice and control for service users and their carers, with consideration of both national and local policy, evolving changes in society, financial pressures and social and demographic challenges.

[10] Department of Health. 2011, No health without mental health. A cross-government mental health outcomes strategy for people of all ages.

[11] Department of Health. 2010, A vision for adult social care: Capable communities and active citizens.

National Perspective

The National Mental Health Strategy 'No Health without Mental Health' and its objectives are underpinned by 'The Vision for Adult Social Care: Capable Communities and Active Citizens' published by the Department of Health November 2010.

The paper highlights the importance of communities and the changing role and relationship they will need with the state; shifting the power from central to local, state to citizen and from provider to people who use services. The paper discusses three values (freedom, fairness and responsibility) which are built on seven principles; overall providing a platform for reform and improvement for the social care system.

The Localism Bill[12] devolves greater power to councils and neighbourhoods whilst giving local communities more control over housing and planning decisions. It outlines a lasting shift in power away from central government and towards local people, including:

- New freedoms and flexibilities for local government
- New rights and powers for communities and individuals
- Reform to make the planning system more democratic and more effective
- Reform to ensure that decisions about housing are taken locally.

The Quality, Innovation, Productivity and Prevention Programme is a large scale transformation programme being undertaken by the NHS to improve the quality of care alongside efficiency savings of up to £20 billion by 2014-15. The programme is focussed on ensuring that each pound spent is done to ensure maximum quality and benefit to the client.

Think Local, Act Personal[13] is a sector wide commitment to moving forward with personalisation and community based support which details an 'efficient, effective and integrated service delivery alongside partnership working to support individuals, their families, carers and the wider community.' Superseding Putting People First[14] this document provides a framework for action, detailing how councils, their partners and social care providers need to work together to develop a personalised, community based care and support system which focuses on prevention.

Modernising Commissioning[15] underpins other national policy and this document sets out the government's vision for modernisation of commissioning, focussing on two main factors for change; the power shift and the overall aim of increasing quality and efficiency.

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[12] Localism Bill 2011

[13] Think Local Act Personal. A sector-wide commitment to moving forward with personalisation and community based support. 2011

[14] Putting People First. 2007

[15] Modernising Commissioning: Increasing the role of charities, social enterprises, mutuals and cooperatives in public service delivery. 2010

The Adult Social Care Outcomes Framework[16] applies to the year 2011/2012 and forms an important part of the Government's commitment to rebalancing the relationship with local government, and with a focus on what matters most to people. The expected outcomes are:

- Enhancing Quality of Life for People with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

NB This is not an exhaustive list.

[16] The Adult Social Care Outcomes Framework – Handbook of Definitions 2011

What's happening in Warwickshire?

The National Health Service Act[17] made it possible for Health and Local Authority partners to work together delivering services more effectively. The Act enables Health and Local Authorities to pool funds for designated services, lead commissioning by agreement that one commissioning service is the responsible organisation and through integrated provision such as joining staff, resources, management structures etc.

Under Section 75 of the National Health Service Act (2006) the Coventry and Warwickshire Partnership Trust is responsible for the co-ordination of a number of activities/treatment for individuals for whom Warwickshire County Council have ultimate responsibility; these activities/treatment are delivered through the section 75 agreement which involves the establishment of a joint and integrated Community Mental Health Team. The integrated teams are listed below.

(Please visit the links for more information)

Assertive Outreach - Coventry and Warwickshire Partnership Trust have four Assertive Outreach Teams making up one service. The teams deliver a high quality of care for individuals who have experienced a psychosis and who have previously not engaged with traditional mental health services. The teams use a psycho-social model, which includes direct support with benefits, housing, social inclusion and other psychosocial and bio-psychosocial interventions. The team objective is to provide an alternative to traditional care, which is tailored to individual needs and promotes recovery.

http://www.covwarkpt.nhs.uk/ourservices/mentalhealth/pages/assertiveoutreachservices.aspx

Community Mental Health - Community Mental Health Teams (CMHTs) provide services to adults aged 18-65 living in their area. Many of these people have time-limited disorders and are referred back to their GP when their condition has improved.

Statistics relating to the roles within the Community Mental Health Teams is detailed below in the client demographics (referred to as the Partnership Trust).

http://www.covwarkpt.nhs.uk/OurServices/MentalHealth/Pages/CommunityMentalHealthTeams.aspx

Crisis/Home Treatment - Crisis Teams accept referrals from service users, carers, police, social services, GPs, or other mental health teams when someone between the ages of 16 and 65 is experiencing a crisis with their mental health. They provide multidisciplinary assessment and, if appropriate, offer home treatment as an alternative to hospital admission.

[17] The National Health Service Act 2006

http://www.covwarkpt.nhs.uk/OurServices/MentalHealth/Pages/CrisisInterventionandHomeTreatment.aspx

Community Rehabilitation - The philosophy of rehabilitation and recovery is to empower and support individuals to recognise their potential despite experiencing severe mental health issues. The different services have assorted resources and cater for clients on varying stages of their recovery. We follow a recovery ethos that promotes social inclusion and works in partnership with users and carers.

http://www.covwarkpt.nhs.uk/OurServices/MentalHealth/Pages/RehabilitationServices.aspx

Early Intervention - The Early Intervention Service (EIS) offers assessment, treatment and support to young people who are experiencing a suspected first episode psychosis.

http://www.covwarkpt.nhs.uk/OurServices/MentalHealth/Pages/EarlyIntervention.aspx

The People Group has direct responsibility for a number of other services. The services offered to clients with mental health concerns can differ greatly dependent on the level of need. Warwickshire County Council offer 'preventative services' designed to reduce the number of clients that reach crisis point and in extreme circumstances to prevent long term residential or hospital admission. These services include Day Opportunities, Home Care, Reablement, Telecare, Occupational Therapy equipment and Respite Breaks. However some clients require more specialist services such as Residential and Nursing Care.

The information illustrated below is a breakdown of clients for both the Integrated Community Mental Health Teams (to which this applies) and Adult Social Care (People Group).

Categories of Age – Clients 2010-2011

Integrated Community Mental Heath Teams

Age Group	North Warwickshire		Nuneaton and Bedworth		Rugby		Stratford		Warwick		Out of county		All clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
18-24	40	8%	102	12%	46	10%	55	8%	100	10%	22	10%	365	10%
25-34	61	13%	149	17%	71	15%	87	12%	160	16%	31	14%	559	15%
35-44	93	19%	168	20%	76	16%	104	14%	204	21%	37	17%	682	18%
45-54	80	16%	131	15%	89	19%	110	15%	187	19%	36	17%	633	17%
55-64	53	11%	84	10%	48	10%	73	10%	122	12%	22	10%	402	11%
65-74	36	7%	49	6%	47	10%	80	11%	82	8%	34	16%	328	9%
75-84	46	9%	94	11%	44	9%	123	17%	76	8%	19	9%	402	11%
85+	78	16%	78	9%	52	11%	87	12%	64	6%	15	7%	374	10%
Totals	**487**	**100%**	**855**	**100%**	**473**	**100%**	**719**	**100%**	**995**	**100%**	**216**	**100%**	**3745**	**100%**

Adult Social Care

Age Group	North Warwickshire		Nuneaton and Bedworth		Rugby		Stratford		Warwick		Out of county		All clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
18-24	0	0%	2	2%	2	3%	0	0%	1	1%	0	0%	5	1%
25-34	1	2%	4	4%	0	0%	3	4%	1	1%	3	6%	12	3%
35-44	6	13%	8	8%	3	5%	3	4%	8	7%	3	6%	31	7%
45-54	4	9%	7	7%	6	10%	12	16%	25	22%	7	13%	61	14%
55-64	3	7%	21	21%	5	8%	8	11%	17	15%	8	15%	62	14%
65-74	10	22%	24	24%	14	22%	13	17%	17	15%	10	19%	88	20%
75-84	8	18%	20	20%	25	40%	18	24%	21	19%	15	28%	107	24%
85+	13	29%	12	12%	8	13%	19	25%	23	20%	8	15%	83	18%
Totals	**45**	**100%**	**98**	**100%**	**63**	**100%**	**76**	**100%**	**113**	**100%**	**54**	**100%**	**449**	**100%**

The data illustrates that the clients accessing activities/treatment through the Integrated Community Mental Health Teams is dispersed across all age ranges however the highest proportion of clients accessing services offered directly by Warwickshire County Council are aged 45 and over. Seventy one per cent of clients accessing either activities or treatment through the Integrated Community Mental Health teams are of working age whilst the figures for Adult Social Care show only thirty nine per cent. This suggests that the older age categories are more likely to access the service offered by Adult Social Care.

Below this information is reflected by gender of clients (2010-2011).

Integrated Community Mental Heath Teams

Gender	North Warwickshire		Nuneaton and Bedworth		Rugby		Stratford		Warwick		Out of county		All clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
M	327	67%	465	54%	266	56%	400	56%	553	56%	102	47%	2113	56%
F	160	33%	390	46%	207	44%	319	44%	442	44%	114	53%	1632	44%
Totals	**487**	**100%**	**855**	**100%**	**473**	**100%**	**719**	**100%**	**995**	**100%**	**216**	**100%**	**3745**	**100%**

Adult Social Care

Gender	North Warwickshire		Nuneaton and Bedworth		Rugby		Stratford		Warwick		Out of county		All clients	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
M	26	58%	63	64%	42	67%	43	57%	71	63%	28	52%	273	61%
F	19	42%	35	36%	21	33%	33	43%	42	37%	26	48%	176	39%
Totals	**45**	**100%**	**98**	**100%**	**63**	**100%**	**76**	**100%**	**113**	**100%**	**54**	**100%**	**449**	**100%**

The gender split illustrated above is slightly higher than the England general population split of 51% female and 49% male.

Ethnicity Statistics - 2010-2011.

Integrated Community Mental Heath Teams

Ethnicity	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
White British	457	786	403	640	825	196	3307
African		2	3		4		9
Caribbean	1	3	7		6	1	18
Chinese			1	1	6		8
Indian		19	6	3	40	1	69
Other		3	6	2	6	0	17
Other Asian	1	5	2	1	10	1	20
Other Black		1	3		1		5
Other Mixed			3		3	1	7
Other White	6	7	9	19	29	5	75
Pakistani		3	4			1	8
White & Asian	1		1		2		4
White & Blck African			1		1		2
White & Blck Carib		2	6	2	5	2	17
White Irish		2	3	3	8	3	19
Not Recorded	19	22	7	45	38	5	136
Not Stated	2		8	3	11		24
Totals	**487**	**855**	**473**	**719**	**995**	**216**	**3745**
Totals (Recorded)	**466**	**833**	**458**	**671**	**946**	**211**	**3585**

Adult Social Care

Ethnicity	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
White British	41	90	53	74	96	46	400
African					1		1
Caribbean		1	3		1	1	6
Chinese				1			1
Indian		1	2		6	1	10
Other							
Other Asian					2		2
Other Black							
Other Mixed							
Other White	1	1	2	1	1	4	10
Pakistani							
White & Asian							
White & Blck African							
White & Blck Carib			1				1
White Irish					2		2
Not Recorded	3	3	1		1	1	9
Not Stated		2	1		3	1	7
Totals	**45**	**98**	**63**	**76**	**113**	**54**	**449**
Totals (Recorded)	**42**	**93**	**61**	**76**	**109**	**52**	**433**

The tables above illustrate that the largest client group accessing both the Integrated Community Mental Health Teams and Adult Social Care are White British.

Research and statistics nationally indicate that there is a higher than average percentage of people from minority communities that are diagnosed with Mental Health needs yet this is not reflected in the numbers of people accessing services. This highlights that more work needs to be done to raise awareness of services available to all communities across Warwickshire.

The referral figures outlined above can be broken down to illustrate the type of referral; this is shown below for the Adult Social Care figures.

New Assessments (Adult Social Care – Older People Mental Health)

New Assessments can be defined as:

- A completely new client being assessed for the first time OR
- If a client returns to services after a break in provision. No services, activities/treatment is being delivered at the point of the new assessment.

Reassessments (Adult Social Care – Older People Mental Health)

Reassessments can be defined as:

- A client undergoing an assessment, where they are already receiving a current service or being monitored without a current service OR
- The client's needs or circumstances have changed prompting a reassessment.

Reviews and Monitoring (Adult Social Care – Older People Mental Health)

Reviews can be defined as:

- A pre-arranged annual visit with the client to review services/package in place. The Local Authority has a statutory requirement to ensure all clients are reviewed annually regardless of whether the client's circumstances have changed.

Monitoring can be defined as:

- A lighter review of services that can occur at any time. An example would be calling a client after a new service has been in place for six months. A high proportion of these consist of a telephone call.

Assessments, Reassessments and Reviews – 2009/10

Number of Assessments completed Year to Date by type

Team Responsible for Assessment	New Assessments	Reassessments	Full Reviews	Monitoring
Older People Mental Health Total	**84**	**239**	**413**	**488**
North Warwickshire - Older People Mental Health	17	38	102	104
Nuneaton & Bedworth - Older People Mental Health	33	73	118	158
Rugby - Older People Mental Health	27	50	41	73
Stratford - Older People Mental Health	1	43	107	106
Warwick - Older People Mental Health	6	35	45	47

New Assessments by Outcome

Team Responsible for Assessment	New Assessments Leading to Service	New Assessments not leading to new service	Client refused new services
Older People Mental Health Total	**56**	**13**	**15**
North Warwickshire - Older People Mental Health	12	1	4
Nuneaton & Bedworth - Older People Mental Health	20	7	6
Rugby - Older People Mental Health	19	4	4
Stratford - Older People Mental Health	1	0	0
Warwick - Older People Mental Health	4	1	1

Assessments, Reassessments and Reviews - 2010/11

Number of Assessments completed Year to Date by type

Team Responsible for Assessment	New Assessments	Reassessments	Full Reviews	Monitoring
Older People Mental Health Total	**104**	**238**	**367**	**494**
North Warwickshire - Older People Mental Health	18	42	85	111
Nuneaton & Bedworth - Older People Mental Health	40	71	129	158
Rugby - Older People Mental Health	30	67	60	101
Stratford - Older People Mental Health	5	24	80	70
Warwick - Older People Mental Health	11	34	13	54

New Assessments by Outcome

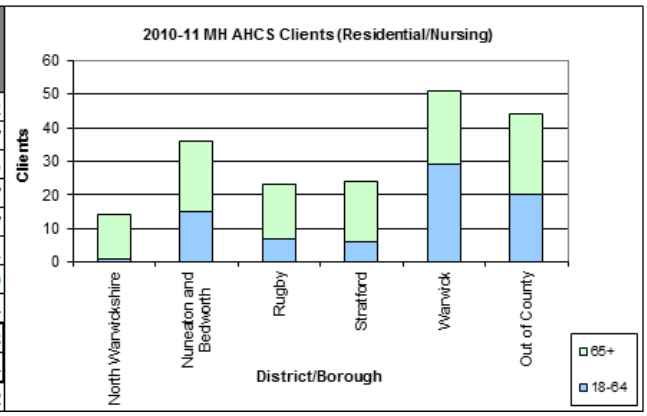
Team Responsible for Assessment	New Assessments Leading to Service	New Assessments not leading to new service	Client refused new services
Older People Mental Health Total	**72**	**22**	**10**
North Warwickshire - Older People Mental Health	14	2	2
Nuneaton & Bedworth - Older People Mental Health	30	7	3
Rugby - Older People Mental Health	19	7	4
Stratford - Older People Mental Health	4	1	0
Warwick - Older People Mental Health	5	5	1

The data for both new assessments and reassessments for both time periods are relatively consistent. The number of new assessments not leading to a new service has however increased; this could be a reflection of a change within Warwickshire's eligibility criteria (Fair Access to Care).

Residential/Nursing Care

2010-11

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24		1	1				2
25-34		1	1	1	1	3	7
35-44	1	4	4		4	2	15
45-54		3	1	3	13	7	27
55-64		6		2	11	8	27
65-74	2	8	2	3	8	8	31
75-84	4	6	10	6	4	9	39
85+	7	7	4	9	10	7	44
18-64	1	15	7	6	29	20	78
65+	13	21	16	18	22	24	114
Totals	**14**	**36**	**23**	**24**	**51**	**44**	**192**



The table and graph illustrate that for the period 2010/2011 one hundred and ninety two individuals were in either a residential or nursing placement. If this data is compared to the data from 2009/2010 it is evident that there has been an increase of 4.9%.

Both sets of data show that the Warwick area has the highest number of clients for both time periods.

In 2009/2010 22% of the clients are recorded as 'Out of County,' rising to 23% in 2010/2011. This data could suggest that there are not sufficient specialist places within Warwickshire to meet the need or that alternative services are unavailable to support individuals to remain as independent as possible.

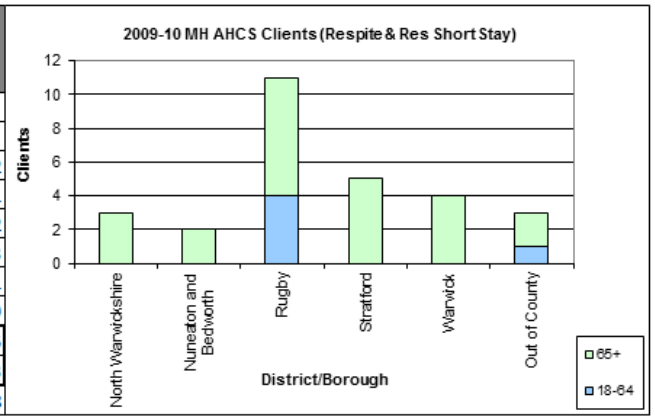
Respite/Residential Short Stay

As illustrated in the data below the number of clients receiving either respite or residential short stay services packages has declined from 28 in 2009/2010 to 25 in 2010/2011, with Rugby area issuing the highest.

This decline could be due to a shift in delivery with a number of clients arranging their own respite breaks through Personal Budgets (Direct Payments). In 2010/2011 there were 172 payments made to carers for this service.

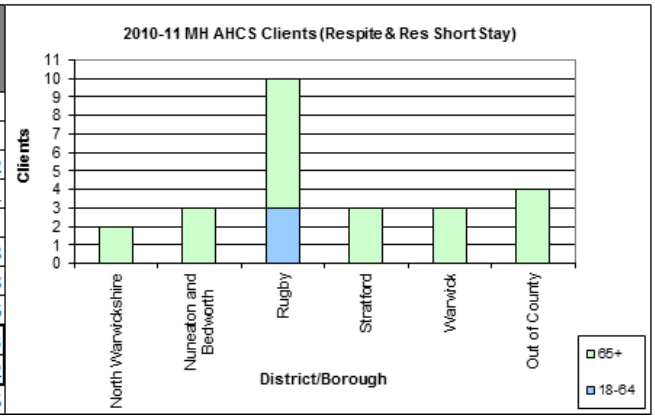
2009-10

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24							
25-34							
35-44			2				2
45-54			1				1
55-64			1			1	2
65-74		1	1	1			3
75-84		1	5	1	2	2	11
85+	3		1	3	2		9
18-64			4			1	5
65+	3	2	7	5	4	2	23
Totals	**3**	**2**	**11**	**5**	**4**	**3**	**28**



2010-11

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24							
25-34							
35-44			2				2
45-54			1				1
55-64							
65-74	1	1	5			1	8
75-84	1	1	2	1	1	2	8
85+		1		2	2	1	6
18-64			3				3
65+	2	3	7	3	3	4	22
Totals	**2**	**3**	**10**	**3**	**3**	**4**	**25**

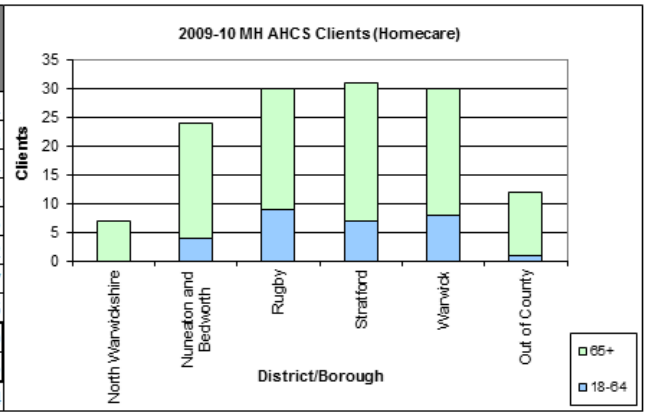


Homecare

Homecare packages have declined from 134 in 2009/2010 to 126 in 2010/2011. Both sets of data highlight that the majority of clients are aged sixty five and over, with the number of clients aged between sixteen and sixty four remaining the same. This correlates with the data of clients accessing either a residential or nursing placement which increased by 4.9% in 2010/2011.

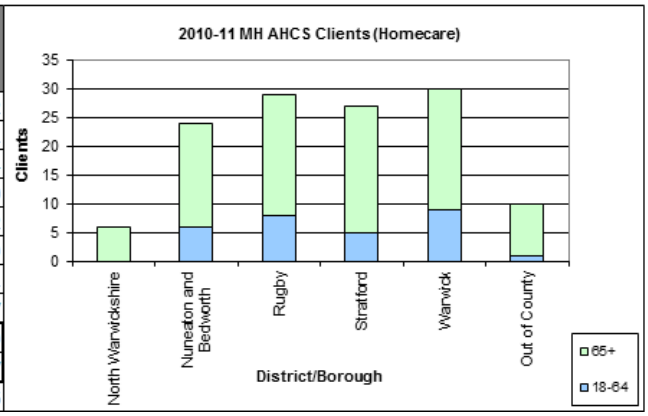
2009-10

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24		1					1
25-34				1	1	1	3
35-44			1				1
45-54			4	3	4		11
55-64		3	4	3	3		13
65-74	2	8	7	8	5	2	32
75-84	2	6	12	9	12	6	47
85+	3	6	2	7	5	3	26
18-64		4	9	7	8	1	29
65+	7	20	21	24	22	11	105
Totals	**7**	**24**	**30**	**31**	**30**	**12**	**134**



2010-11

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24		1			1		2
25-34				1			1
35-44			1		2	1	4
45-54			3	2	5		10
55-64		5	4	2	1		12
65-74	3	6	5	8	6	1	29
75-84	1	8	12	7	8	5	41
85+	2	4	4	7	7	3	27
18-64		6	8	5	9	1	29
65+	6	18	21	22	21	9	97
Totals	**6**	**24**	**29**	**27**	**30**	**10**	**126**

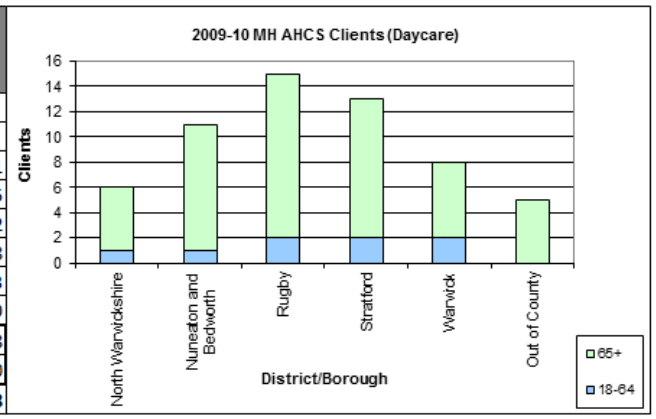


Day-care

The number of clients in receipt of a traditional day-care package has declined by 13.8% from 2009/2010 and 2010/2011. This is as a consequence of Warwickshire moving away from traditional day care to day opportunities, encouraging individuals to consider alternative ways of meetings their outcomes to traditional services. In the first half of the year for 2011/2012 the figure has only reached 34 which would indicate a further decline.

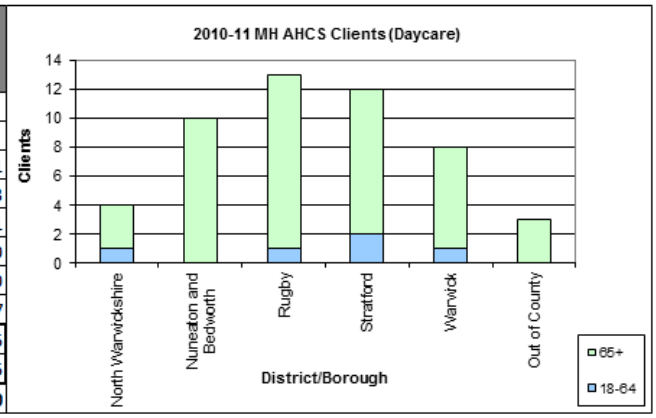
2009-10

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24							
25-34							
35-44			1				1
45-54	1		1	1	2		5
55-64		1		1			2
65-74	1	2	3	1		1	8
75-84		6	9	4	2	2	23
85+	4	2	1	6	4	2	19
18-64	1	1	2	2	2		8
65+	5	10	13	11	6	5	50
Totals	**6**	**11**	**15**	**13**	**8**	**5**	**58**



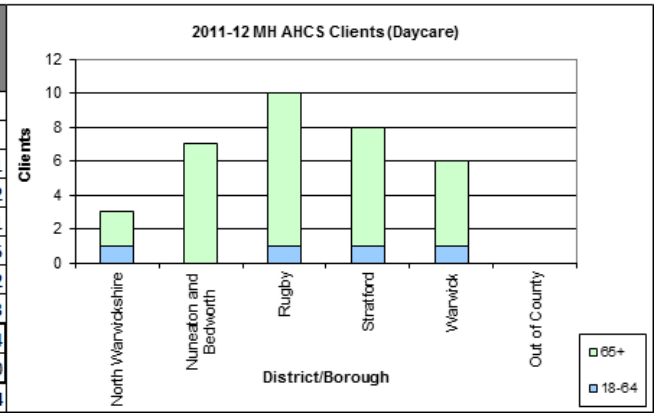
2010-11

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24							
25-34							
35-44			1				1
45-54	1			1	1		3
55-64				1			1
65-74	2	2	4	1			9
75-84		4	7	4	2	2	19
85+	1	4	1	5	5	1	17
18-64	1		1	2	1		5
65+	3	10	12	10	7	3	45
Totals	**4**	**10**	**13**	**12**	**8**	**3**	**50**



2011-12

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24							
25-34							
35-44			1				1
45-54	1				1		2
55-64				1			1
65-74	1	2	2				5
75-84		4	5	2	1		12
85+	1	1	2	5	4		13
18-64	1		1	1	1		4
65+	2	7	9	7	5		30
Totals	**3**	**7**	**10**	**8**	**6**		**34**



Rugby and Stratford have remained the areas with the highest referrals to this type of service. With the majority of clients aged sixty five and over.

Assistive Technology

Assistive technology is defined by the Audit Commission as 'any item, piece of equipment, product or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties.' It can help individuals maintain independence, increase safety and confidence and support carers alongside traditional healthcare, social care and housing initiatives.

The number of clients accessing equipment has remained quite low with 28 in 2009/2010 and 24 in 2010/2011. This could be due to lack of awareness within Social Care and Support Teams or needs of clients not suitable for this service.

Telecare is a key element of both national and local strategies and cuts across health, social care and housing. The national vision in Lifetime Homes, Lifetime Neighbourhoods and the local vision for the transformation of housing support services in Warwickshire both see Telecare and assistive technology as an integral part in the range of housing options as part of a wider and more joined up approach to meeting housing need in order to support people to live independently.

Numbers of Telecare are low however this is a relatively new service with uptake gradually increasing across all client groups. In 2009/2010 there were 9 clients accessing this service rising to 13 in 2010/2011.

Nottingham Rehab Supplies (NRS) have been awarded the contract for delivery and installation for equipment and have begun work in one district (Nuneaton and Bedworth). A wider catalogue of equipment is now available under NRS with many of these pieces of equipment suitable for people with Mental Health needs. It is expected that the numbers accessing assistive technology will increase significantly as a result of this

Personal Budgets

Personal budgets are an indicative amount of money that can combine several funding sources that can be used by an individual to purchase services, from the public, private or voluntary sector. One way of receiving this is by taking a direct payment. This is a cash amount paid to the individual so they can acquire their own services rather than the council sourcing them on their behalf.

There are two types of direct payments these are known as one offs and on-going.

One-off Direct Payments are paid to clients as a lump sum, usually for the purpose of meeting an individual short-term need but is also often used to meet long-term needs (i.e. the purchase of a home computer to enhance social inclusion).

In 2010/2011 Warwickshire made 376 one-off direct payments (breakdown below). These were issued to clients and their carers. The breakdown illustrates that the primary use for carers was to access respite services and for clients leisure and relaxation activities.

These services accounted for £77,118 for carers and £44,727 for clients and supports the move away from traditional day care to a more universal offer within local communities.

Direct Payment Type	Payments for Carers	Payments for Clients
Accommodation	1	0
Education	6	12
Financial Pressures	1	0
Home Improvement	5	10
Leisure / Relaxation Activities	25	73
Leisure / Relaxation Equipment	6	32
Respite	172	2
Transport / Travel	17	11
Treatments	3	0
Total	**236**	**140**

On-going Direct payments differ in that a regular monthly payment is made for a long-term need - examples include paying for a regular cleaner/home help, and on-going subscriptions for internet access.

In 2009/2010 there were 99 individuals in receipt of an on-going direct payment falling slightly to 74 in 2010/2011. The analysis below shows that the majority were used to access either a 1:1 service with an agency or through recruitment of a personal assistant.

The majority of clients for both time periods fell within the age category 18-64 which could indicate a shift from Local Authority provision to individual choice and control of services.

Direct Payment Type	Payments for Clients
1:1 Agency	20
Cleaning	2
Day Care	1
Home Care	1
Leisure / Relaxation Activities	10
Leisure / Relaxation Equipment	4
Personal Assistant	22
Transport / Travel	3
Total	**63**

2009-10

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24	1	1	1		2		5
25-34	3	3		7	8		21
35-44	5	2	1	7	8	1	24
45-54	3	9	3	2	9	2	28
55-64	2	6		2	2		12
65-74		1				1	2
75-84			2		1		3
85+	1			1	2		4
18-64	14	21	5	18	29	3	90
65+	1	1	2	1	3	1	9
Totals	**15**	**22**	**7**	**19**	**32**	**4**	**99**

2010-11

Age Group	North Warwickshire	Nuneaton and Bedworth	Rugby	Stratford	Warwick	Out of county	All clients
18-24	1	1			2		4
25-34	1	5		2	1		9
35-44	6	7	1	3	2		19
45-54	2	5	2	3	7	1	20
55-64	2	5		2	3		12
65-74		1	1			1	3
75-84		1	2				3
85+				1	2	1	4
18-64	12	23	3	10	15	1	64
65+		2	3	1	2	2	10
Totals	**12**	**25**	**6**	**11**	**17**	**3**	**74**

Dementia

Warwickshire undertook a market analysis prior to the development of the Dementia Strategy 'Living Well with Dementia' (2011-2014)[18] to assist in building a picture of existing local services as well as a wider picture of the market and an assessment of current gaps in services availability.

Raising Awareness and Understanding

Wellbeing Exchanges are currently provided to meet the needs of general mental health adults and older adults with functional conditions but none for Organic (Dementia). These are jointly funded through the Local Authority and NHS Warwickshire. There at seven bases across the County (5 x Mental Health Services and 2 x Local Authority) at a value of £60,000 per service.

Services report that they have provided signposting to both Age Concern and Alzheimer's society services and some drop in services for functional mental health do attract working age /early onset dementia users who do not want to access older age services.

Early Diagnosis and Support

General Practice

Practices in Warwickshire currently record some 2000 patients with a diagnosis of Dementia against the national prevalence and research indicators.

GP Consortia	Recorded Incidence	Expected Prevalence	Percentage	Difference
Warwick	522	1492	35%	970
Leamington	420	1440	29%	1020
Rugby	219	580	38%	361
North Warwickshire	726	2218	33%	1492
Stratford	207	414	50%	207
Nuneaton	286	1073	27%	787

There are currently around 7,200 people with dementia living in Warwickshire which suggests registration is not representative of need. This is a key issue for individuals as Quality Outcome Framework registers require individuals to be registered and for their care to be reviewed every 15 months. For those individuals diagnosed early this ensures speedy

[18] Warwickshire County Council. Joint Commissioning Dementia Strategy, Living Well with Dementia. 2011

referral to Memory Assessment Services (MAS) and pharmaceutical and therapeutic interventions that will help them live active lives for longer. NHS Warwickshire has asked 15 low recording GP practices to specifically improve their Dementia QOF registration over the next year.

Memory Assessment Clinics

NHS Warwickshire currently commission Memory Assessment Services (MAS) through Coventry and Warwickshire Partnership Trust. There are currently three memory assessment clinics, each with their own consultants, in; Rugby, North Warwickshire and South Warwickshire.

Warwickshire County Council currently spends approximately £90,000 on commissioned information services. Primarily commissioned through the Alzheimer's society, the service provides information and advice to people with dementia and their carers.

Part of this expenditure is used to develop a dementia specific website that links several other sites including; NHS Choices, Guideposts, Alzheimer's, and Sterling University. The site development is part of the dementia demonstrator site bid award and is supported by a range of organisations including; the Phoenix group, a post diagnostic support group in the North of the County. Adult Health and Community Services as part of the dementia demonstrator site work have commissioned the Phoenix group to research the type, format, source, accessibility and usefulness of advice and information available to newly diagnosed dementia users and carers.

In addition to the service provided by the Alzheimer's Society a number of other providers supply information and advice for both users of services and their carers/families. All of the material used by these providers is currently accessible through the WCC Dementia website. This is to ensure ease of access and a central gateway to services for both professionals and the public.

Advocacy

Warwickshire currently commissions its Advocacy services jointly with NHS Warwickshire from a single voluntary sector provider.

In July 2010 NHS Warwickshire commissioned Independent Advocacy, the joint provider, to produce a report and recommendations in respect of the needs of people with dementia. The report indicated that some 197 contacts were made by service users for support ranging from; benefit advice, housing related support legal issues, debt, finances, and appeals. Recommendations have been made to NHS Warwickshire in respect of converting part of the current service to a Dementia specific resource. There is also further work to scope future advocacy services for social care underway to ensure better commissioning of this form of support.

Dementia Advisor

Warwickshire was successful in securing 1 of 22 national Dementia Advisor Demonstrator sites in the North of the County. A Dementia advisor has been appointed. The service currently is linking with the Admiral Nurse Service in the North of the County to ensure that

carers are also fully supported and issues such as Advance Directives are discussed. Admiral Nurses provide support to carers of people with dementia. The purpose of this role is to provide information and support to newly diagnosed patients and to signpost the journey ahead and the services and support that will be available to people with dementia and their carers. Intervention at this stage when people are first diagnosed is seen as key to enabling people with dementia and their carers to come to terms with the disease and enable them to cope better throughout their journey with dementia. A key benefit of this role is the relationship with the memory assessment service and links to people at the point of diagnosis.

Peer Support & Dementia Cafés

Peer support is key to living well with dementia. Peer support services have developed to give people with dementia an understanding of how other people with dementia perceive and cope with their own illness and the problems they may encounter every day.

The dementia cafes are designed to complement formal care and information services and are part of a wider range of psychosocial treatment, care and support, which is critical for an illness with limited medical treatment options.

Current Spend on Low-level dementia services

Service	Location	Annual contract value	Funding Source	Evaluation
Alzheimer's Society Advice and Information	Rugby, South, North	£42,000	AHCS (inc one-off grants)	Low-level services review
Alzheimer's Society Café	South, Warwick	£10,777	AHCS (one-off grant)	Low-Level services review
Peer Support/ Phoenix	North/ N+B	£10,000	CWPT	Under review
Joes Cafe	North/ N+B	£2,000	CWPT	-
Dementia website	Countywide	£2,000	Dementia Demonstrator (DoH)	On-going review as part of Demonstrator site
Dementia Advisors Project	North	£103,750	Dementia Demonstrator Site (DoH)	Full review being carried out by consultancy
Gross Spend		£159,750		

Domiciliary Care

Specialist domiciliary care for people with dementia is a necessary component of support to enable people with dementia to be supported to live in their own homes. Not all people with dementia necessarily require specialist dementia domiciliary care as their needs follow a continuum and many people's needs are appropriately met through standard domiciliary care where staff are appropriately trained in dementia awareness.

There are currently three models of domiciliary care that caters for people with dementia. These include:

- A countywide generic model of maintenance through a block contract with providers, valued at £304,333 per week with call off
- A specialist dementia spot purchase contract provided by Guideposts valued at £8988 per week, this covers 35 people per week totalling 432.32hrs.
- An in house specialist model operating in the North of the County and Stratford only, the value of this contract is £400,000 working with some 17 clients in total in 2009/10 clients with dementia.

Non-Specialist domiciliary care

In addition to the specialist dementia domiciliary care provided a number of people living with dementia have a predominant need of personal care that can be met with non-specialist domiciliary care. In November 2010 119 people identified with Dementia were receiving non-specialist domiciliary care totalling 1000 hours per week (8.4 hours per person per week on average).

Voluntary sector day services

Warwickshire County Council also commissions the voluntary sector to provide day services:

Organisation Name	District	Value of Contract	Users/ wk	Cost per unit	Contract Type
Alzheimer's Society	Stratford/Warwick	£115,351	61	36.3	Block
Age UK	North	£122,361	60	35	Block
Rugby Mind	Rugby	£52,275(+25K PCT)	75	20.6	Block
TOTALS		289,987	317		

Independent day care

As at 2009/10 and through block and/or spot arrangements the following day care was provided specifically for people with dementia:

Name	Area	Annual Value	Sessions per wk	Spot or Block contract
Gildawood Court	Nuneaton & Bedworth	60,921	30	Block (voids)
Pinnacle Care	Rugby	137,473	105	Block (voids)
Bentley House	North W	37,606	13	Spot
Chasewood Lodge	Nuneaton & Bedworth	8,271	3	Spot
Total Spend		244,721	151	

Day care block contracts with independent providers are currently underused with a large number of voids. It is vital that this is addressed given the financial pressures

Carers Services

Warwickshire's strategic intentions with regard to services to support carers embody the core principles of the "Vision for Adult Social Care: Capable Communities & Active Citizens" for services to be more personalised, more preventive, more outcome focused.

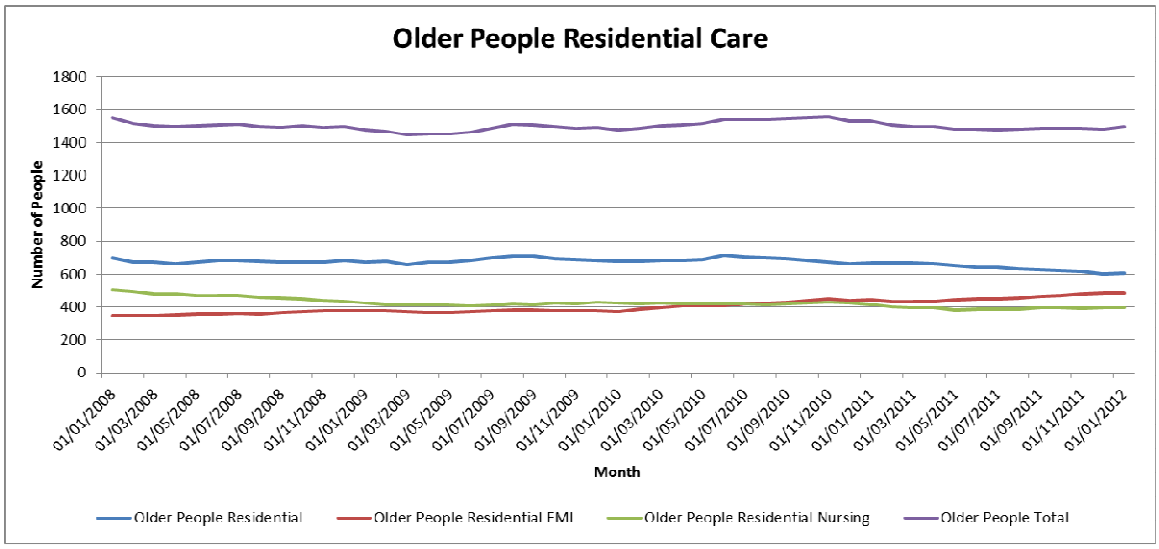
Currently, generic information, advice and support services are being provided by Guideposts Trust in the north of the county and the Carers Support service in the south. These services offer support to carers of people with dementia. Rethink also provides a countywide information and support service targeting carers of people with mental ill health.

Residential Care

National research provides evidence that:

- A quarter of all hospital beds are occupied by patients with dementia, half of unplanned admissions for patients over the age of 80 years will suffer from dementia.
- People with dementia have a delayed discharge from hospital and almost one third of people admitted from their own home are subsequently admitted to residential or nursing homes.
- Dementia patients have increased risk of falls, incontinence, institutionalisation and mortality.
- Longer hospital stays for dementia patients result in an increased risk of admission to care, worse health and use of antipsychotics.
- 20% of Re-admissions are for people with dementia
- One weeks reduction in hospital stays for Dementia sufferers with TIA, UTI or hip replacement surgery is estimated to save over £80 million per annum.

The split between ordinary (or 'higher dependency') residential care and specialist dementia care has shifted considerably over the last few years. A recent independent survey highlighted that in the proportion of dementia care in the residential care market had risen from 9% to 52% over the last 10 years. The graph below shows that the number of older people in standard residential care has been falling in the past 18 months but this has been matched by an increase in the numbers of older people in residential EMI.


Older People Residential Care
Number of People
1800
1600
1400
1200
1000
800
600
400
200
0
01/01/2008
01/03/2008
01/05/2008
01/07/2008
01/09/2008
01/11/2008
01/01/2009
01/03/2009
01/05/2009
01/07/2009
01/09/2009
01/11/2009
01/01/2010
01/03/2010
01/05/2010
01/07/2010
01/09/2010
01/11/2010
01/01/2011
01/03/2011
01/05/2011
01/07/2011
01/09/2011
01/11/2011
01/01/2012
Month
Older People Residential
Older People Residential EMI
Older People Residential Nursing
Older People Total

Topic Area – Housing and Mental Health

Good housing is often a major positive contributory factor in good mental health. On the other hand, poor housing can be a major cause of mental illness or one of the factors that affects recovery.

Introduction

One of the best ways to stay mentally healthy is to minimise stressful situations. If people are satisfied with their housing they will have a base from which to plan out their lives. Feeling secure, comfortable and being able to socialise at home supports wellbeing[19].

Good housing is often a major positive contributory factor in good mental health. On the other hand, bad housing can be a major cause of mental illness or one of the factors that affects recovery.

Often poor housing or homelessness is linked in with other forms of social exclusion, such as poverty. For some people, housing issues are inextricably linked with complex and chaotic life experiences. Mental health problems, drug and alcohol dependencies and institutional experiences are linked with difficulties in achieving good housing[20] .

The Marmot Review[21] (2010) refers to a Shelter study from 2006 that suggested that children in bad housing are more likely to have mental health problems, reflecting the direct impact of housing and the associated material deprivation.

The Department of Health[22] in 2010 identified that health, social care and their voluntary sector partners should jointly focus on more 'upstream' interventions, so that more individuals can be supported into less chaotic lifestyles or supported to prevent the fall into homelessness etc.

National Perspective

There are a number of issues associated with housing and mental health:

- Good housing is often a major positive contributory factor in good mental health
- Mental health problems are linked with difficulties in achieving good housing

The links between poor mental health and inadequate housing or homelessness are complex. It is often difficult to work out which comes first and how they inter-relate with each other. However, it is recognised that:

- People with mental health problems are under-represented within owner occupied accommodation which is seen as the most socially valued and secure housing in contemporary society.

[19] Housing Mental Health: Yorkshire and Humberside: http://housingmentalhealth.co.uk/starting-out

[20] Joseph Rowntree Foundation. 2011, Tackling Homelessness and Exclusion: Understanding complex lives

[21] The Marmot Review. 2010, Fair Society Healthy Lives

[22] Department of Health. 2010, High Quality of Care for All

- Compared with the general population those with mental health problems are twice as likely to be unhappy with their housing and four times as likely to say that poor housing contributes to their health problems.
- Mental ill health is one of the most citied reasons behind tenancy breakdown.
- Housing problems are often cited as one of the factors lying behind an individual's admission to in-patient psychiatric care.

The Government's (2011)[23] 'Vision to end rough sleeping: No Second Night Out nationwide' commits to preventing homelessness, and the document recognises that simply providing homes to the most vulnerable does not fully support the individual and that the complex underlying needs of people needs to be addressed.

The Supporting People programme began on 1 April 2003, bringing together seven housing-related funding streams from across central government. It is now administered via top-tier authorities who have complete discretion over where to direct their funds to best meet local needs.

Nationally, Supporting People services help around one million people at any one time, including approximately 37,300 people with mental health problems.

What's happening in Warwickshire?

Warwickshire's housing needs for its current and future populations have been identified as a priority for the JSNA. District and Borough Councils will be central to this piece of work as will the third sector. For example, with a growing and ageing population and the associated increase in people with dementia, this will need to be taken into account to meet the future needs of the population. The focus of this chapter has been the provision of Supporting People housing related support services which are the responsibility of Warwickshire County Council.

The principal purpose of Supporting People is to support service users to achieve and / or maintain the ability to live independently and in so doing to assist in reducing homelessness, hospitalisation and institutionalisation.

There are some housing related support services that provide support exclusively for people experiencing mental illness. However many people experiencing mental illness will access other housing related support services aimed at other categories of need, for example, people who are homeless.

[23] HM Government. 2011, Vision to End Rough sleeping: No Second Night Out

Floating Support Services and Accommodation Based Supported Housing

The two main models of housing related support in Warwickshire are floating support services and accommodation based supported housing. The emphasis in both cases is to support the individual to achieve true independence.

Floating Support involves the provision of housing related support in the service user's own home. Therefore if the service user moves home within the same area as that catered for by their floating support service, then the support can follow them to their new home.

'If not enough emphasis is placed on 'moving on', individuals can become quite dependent on support, which doesn't fit well with the idea of short term services .

Accommodation based services provide support for people as part of a support and accommodation package.

The range of support provided in both accommodation based and floating support can include:

- Help in setting up and maintaining a home;
- Developing domestic and / or life skills;
- Developing social skills and/or behaviour management
- Advice, advocacy and liaison with outside organisations
- Help in managing finances and benefit claims
- Emotional support, counselling and advice
- Help in gaining access to other services
- Help in establishing personal safety and security
- Supervision and monitoring of health and well-being
- Peer support and befriending
- Help in maintaining the safety and security of the dwelling

'Support to move on and access more suitable long term accommodation, and support to access employment are important to establish self reliance. .

Current Supporting People Services

Following a Strategic Review of service provision a new set of services for people experiencing mental illness were commissioned in the county. These commenced operation in June 2011. New service users must be aged 16 or over and have a diagnosis of mental illness and must also be eligible to receive a secondary care service for mental illness. People experiencing mental illness who do not fit the above criteria may however be eligible to access other housing related support services not dealing exclusively with this client group.

Floating Support

The new floating support service provides support to between 115 and 125 people throughout the county at any given time. To ensure that the service reflects relative geographical needs around the county, the service is required to aim to provide support to individuals in different areas as shown in the table below.

Target geographical distribution of service users supported by new floating support service.

Local Authority Area	Target Distribution (%)
North Warwickshire	9%
Nuneaton and Bedworth	19%
Rugby	15%
Stratford	26%
Warwick	31%
TOTAL	**79**

Source: Warwickshire County Council - Supporting People

The above distribution is based on the area of residence of people aged 16 and over who received a secondary care service for mental illness at any time from April 2008 to March 2009.

These percentages will not be achieved immediately as the new service inherited all service users receiving support from the previous support providers when those providers' contracts ended. The geographical distribution of service users at that point did not reflect the above percentage distribution.

Accommodation based Support

The distribution of accommodation based support is as follows:

Distribution of Accommodation based Support as at 14.7.2011

Local Authority Area	Number of Units of Accommodation	Percentage
North Warwickshire	-	-
Nuneaton and Bedworth	17	21.5%
Rugby	6	7.6%
Stratford	21	25.6%
Warwick	35	44.3%
TOTAL	**79**	

Source: Warwickshire County Council - Supporting People

There is some variation in the current geographic distribution of accommodation based support when compared with the target distribution of service users.

Age of New Service Users Commencing Support at Specialist Housing Related Support Services, April 2009-March 2011

Age Group	North Warwickshire		Nuneaton & Bedworth		Rugby		Stratford-on-Avon		Warwick		Other		Warwickshire	
	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11
16-20	0	0	0	0	0	0	4	2	0	0	-	0	**4**	**2**
21-25	0	0	2	0	0	1	7	4	4	4	-	0	**13**	**9**
26-30	0	0	2	0	0	0	5	9	9	2	-	0	**16**	**11**
31-35	0	1	2	4	2	3	4	5	4	5	-	0	**12**	**18**
36-40	0	1	1	2	1	5	8	5	7	5	-	0	**17**	**18**
41-45	1	0	0	0	5	3	5	11	5	4	-	0	**16**	**18**
46-50	0	0	1	0	0	2	3	7	4	6	-	3	**8**	**18**
51-55	0	0	1	2	1	0	4	4	3	5	-	0	**9**	**11**
56-60	0	0	1	2	0	3	4	1	2	0	-	0	**7**	**6**
61-65	0	0	1	0	0	2	1	5	3	0	-	0	**5**	**7**
66+	0	0	1	0	0	0	0	2	2	0	-	0	**3**	**2**
Not known	0	0	0	0	0	0	0	1	0	0	-	0	**0**	**1**
Total	**1**	**2**	**12**	**10**	**9**	**19**	**45**	**56**	**43**	**31**	-	**3**	**110**	**121**

Source: Warwickshire County Council, Supporting People New Client Data

Ethnicity of New Service Users Commencing Support at Specialist Housing Related Support Services, April 2009-March 2011

Ethnic Group	North Warwickshire		Nuneaton & Bedworth		Rugby		Stratford-on-Avon		Warwick		Other		Warwickshire	
	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11
Asian/Asian British: Pakistani	0	0	1	0	0	0	0	0	1	1	-	0	**2**	**1**
Asian/Asian British: Indian	0	0	0	0	1	0	0	1	0	2	-	0	**1**	**3**
Asian/Asian British: Other	0	0	0	0	0	0	0	0	0	0	-	0	**0**	**0**
Black/Black British: Caribbean	0	0	0	0	0	1	0	0	0	0	-	0	**0**	**1**
Black/Black British: Other	0	0	0	0	0	0	0	1	0	1	-	0	**0**	**2**
Gypsy/Romany/Irish Traveller	0	0	0	0	0	0	0	0	0	0	-	0	**0**	**0**
Mixed: White & Black African	0	0	0	0	0	0	0	0	1	0	-	0	**1**	**0**
Mixed: White & Black Caribbean	0	0	0	0	2	0	0	1	1	0	-	0	**3**	**1**
Refused	0	0	0	0	0	0	0	1	0	1	-	0	**0**	**2**
White: British	1	2	11	10	6	18	45	51	39	26	-	3	**102**	**110**
White: Irish	0	0	0	0	0	0	0	1	1	0	-	0	**1**	**1**
White: Other	0	0	0	0	0	0	0	0	0	0	-	0	**0**	**0**
Total	**1**	**2**	**12**	**10**	**9**	**19**	**45**	**56**	**43**	**31**	**-**	**3**	**110**	**121**

Source: Warwickshire County Council, Supporting People New Client Data

Approximately 93% of new service users in 2009/10 and 91% in 2010/10 were White British. This compares with just over 88% of the total population according to the Office for National Statistics (ONS) mid-2009 population estimates by broad ethnic group. This means that Black and Minority Ethnic Groups (BME) are slightly underrepresented in the new service users profile when compared to the population as a whole. Commissioners need to assure themselves that this is a true reflection of the need of the population and that there is not unmet need in the BME communities.

It is important to note for the data above that:

- The data collected from service providers has not always been complete.
- The numbers of service users per district will be a reflection of where services were available at the time, i.e. Supply affecting demand. The distribution of service provision at the time did not exactly reflect the geographical distribution of needs and hence the figures should not be used to compare needs in the different parts of the county.
- Supporting People are now working towards having services that better reflect the geographical distribution of needs.
- Some services were 'short term' with up to 2 years of support being provided for each service user whereas others provided support for longer. Obviously a 'short term' service will tend to have more new service users than 'long term' services. Now all services are short term with an emphasis on recovery and empowering people to live truly independent lives when they cease to receive support.
- The contracts for many of the services that existed at the time required the services to support people aged 18 or over and imposed an upper age limit. This will obviously have affected the age profiles. Now all services are contracted to admit people of any age from 16 upwards, subject to certain specified eligibility criteria.
- Until June 2011 some services were only required to assist, for example, people with 'mental health problems' and therefore it is difficult to assess the level of mental health need of each individual.

The specifications for the new services we have commissioned state that the minimum requirement is that people eligible for the service will be aged 16 or over and will have a diagnosis of mental illness and will be eligible to receive a secondary care service for mental illness.

Summary of Service Users – Non Specialist Housing Related Support Services

Age of New Service Users Experiencing Mental Illness at Non Specialist Housing Related Support Services, April 2009- March 2011.

Age Group	North Warwickshire		Nuneaton & Bedworth		Rugby		Stratford-on-Avon		Warwick		Other		Warwickshire	
	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11
16-20	0	2	10	5	1	5	5	4	4	14	2	3	**22**	**33**
21-25	1	0	12	6	3	2	5	4	3	11	0	3	**24**	**26**
26-30	1	0	3	6	1	0	5	1	1	7	0	1	**11**	**15**
31-35	2	1	3	4	3	3	0	10	7	6	3	0	**18**	**24**
36-40	1	0	9	6	3	3	7	7	3	2	0	0	**23**	**18**
41-45	0	1	3	4	2	4	4	2	12	6	2	1	**23**	**18**
46-50	0	1	3	1	2	6	4	3	3	6	0	0	**12**	**17**
51-55	0	0	6	5	0	1	1	3	1	5	1	0	**9**	**14**
56-60	1	1	0	3	1	1	1	0	1	2	0	0	**4**	**7**
61-65	0	0	1	1	1	0	0	1	1	0	0	0	**3**	**2**
66+	0	0	0	0	0	0	1	0	0	2	0	0	**1**	**2**
Not known	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
Total	**6**	**6**	**50**	**41**	**17**	**25**	**34**	**35**	**36**	**61**	**8**	**8**	**151**	**176**

Source: Warwickshire County Council, Supporting People- New Client Data

The general age profile of new service users in non-specialist services across Warwickshire is younger than that for specialist services. For example, 34% of service users in non-specialist areas were aged between 16 and 25 compared with only 9% in specialist areas.

Ethnicity of New service Users Experiencing Mental Illness at Non Specialist Housing Related Support Services, April 2009 – March 2010

Ethnic Group	North Warwickshire		Nuneaton & Bedworth		Rugby		Stratford-on-Avon		Warwick		Other		Warwickshire	
	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11
Asian/Asian British: Pakistani	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Asian/Asian British: Indian	0	0	0	1	0	0	0	0	0	1	0	0	**0**	**2**
Asian/Asian British: Other	0	0	2	0	0	0	0	0	0	0	0	0	**2**	**0**
Black/Black British: Caribbean	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Black/Black British: Other	0	0	0	0	2	0	0	1	0	0	0	0	**2**	**1**
Gypsy/Romany/Irish Traveller	1	0	0	2	1	0	1	1	0	1	0	0	**3**	**4**
Mixed: White & Black African	0	0	0	0	0	0	0	0	0	1	0	0	**0**	**1**
Mixed: White & Black Caribbean	0	0	1	1	0	0	0	0	2	6	0	0	**3**	**7**
Refused	0	0	0	1	0	0	0	0	0	0	0	0	**0**	**1**
White: British	5	5	0	35	13	24	30	33	33	50	8	8	**89**	**155**
White: Irish	0	0	1	1	1	1	2	0	0	1	0	0	**4**	**3**
White: Other	0	1	1	0	0	0	1	0	1	1	0	0	**3**	**2**
Total	**6**	**6**	**45**	**41**	**17**	**25**	**34**	**35**	**36**	**61**	**8**	**8**	**146**	**176**

Source: Warwickshire County Council - Supporting People- New Client Data

The above figures relate to new service users commencing support in Supporting People services targeted at other categories of need. The New Client data has been interrogated to find any indication of possible mental illness.

Once again, it is important to note that:

- The identification of someone suffering mental illness may often be based upon a conversation between the new service user and their Support Worker and accuracy cannot be guaranteed.

- It is not possible to identify if those accounted for represent all new service users experiencing mental illness or just a proportion of them.
- The numbers of service users per district will be a reflection of where services were available at the time which will not necessarily reflect the distribution of mental health needs, i.e. supply affecting demand.
- Not all services admit people aged under-18 and some will have an upper age limit.

There are indications of a number of other possible gaps in service provision as follows:

- people suffering from the early stages of dementia.
- people with a dual diagnosis or complex needs.
- people with eating disorders
- people with Personality Disorders
- Emergency supported accommodation

In addition, people on the autistic spectrum, including Aspergers Syndrome, do not exactly fit into the criteria for accessing services for people experiencing mental illness or services for people with a learning disability though they may access services for other client groups such as people who are homeless.

Recommendations

- More work to establish the level of unmet housing support needs in the vulnerable groups identified as not accessing housing services, and the new ways of supporting people in accessing long term housing solutions.

- Supporting People to work towards having services that better reflect the geographical distribution of needs.

- Consideration should be given to undertaking an audit of the homeless population, to better identify their health and social care needs.

- An audit of individuals known to have mental health problems that do not access floating support, to understand how well the service is promoted.

- Stronger working links are needed between hospital discharge teams, housing services and providers to establish appropriate care, support and accommodation on discharge.

- Continue to prioritise housing as a key cross cutting issue within Warwickshire's Joint Strategic Needs Assessment (JSNA) and incorporate the use of data from each of the District and Borough Councils.

Topic Area - Common Mental Health Disorders and Services Available in Primary Care

Common mental health disorders, such as depression, generalised anxiety disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population at any one time.

There is an association between mental health issues and a higher prevalence of lifestyle risk taking behaviours, such as smoking, alcohol or drugs misuse, risky sexual behaviours and obesity.

Our most deprived communities have the poorest rates of mental well-being.

All of these common mental health conditions can be associated with long-term disability. However, many individuals do not seek treatment and common mental health conditions often go unrecognised (NICE, 2011)[24].

[24] National Institute of Clinical Excellence. 2011, National Clinical Guideline Number 123 Common Mental Health Disorders: Identification and Pathways to Care

Introduction

In 2011, the cross-government mental health strategy[25] was published. The Government acknowledged the need to give equal weight to both physical and mental health.

The Strategy highlighted that mental health is core to our quality of life. Mental distress affects not only the individual with the condition, but also family, friends and wider society. Poor mental health impacts on the ability of an individual to work and to contribute to society. Where mental illness exists, many costs fall on health and social care, and on families to provide informal and unpaid care.

Positive mental well-being is known to reduce population mortality. Populations with good mental well-being and psychological resilience have improved overall health, recover more rapidly, are admitted to hospital less frequently and have higher levels of employment and productivity[26].

Underlying social, economic and environmental factors that can affect a person's well-being include employment status, education, health and the local community. With such a wide variety of issues impacting on well-being, it is an area where all sectors of the community can contribute to its improvement.

"People experiencing difficulties in the early stages should be given basic information about their mental health problems, medication and side effects. The information should be clear, simple and jargon-free. Any information given should be in small chunks and provided over a period of time'.

For common mental health disorders it is estimated that:

- at least one in four people will experience a mental health problem at some point in their life
- one in six adults has a mental health problem at any one time
- almost half of all adults will experience at least one episode of depression during their lifetime
- Up to 90% of people with a mental health problem will be treated entirely in primary care

National Perspective

The National Mental Health Strategy 'No Health without Mental Health'[27] published by the Department of Health February 2011 outlines the overarching goal to mainstream mental

[25] HM Government. 2011, No Health without Mental Health: A Cross Governmental Health Outcomes Strategy for People of all Ages

[26] World Health Organisation. 2009, Improving Health Systems for mental health

[27] HM Government. 2011, No Health without Mental Health: A Cross Governmental Health Outcomes Strategy for People of all Age

health, and establish parity of esteem between services for people with mental and physical health problems. The vision to achieve this is broken down across six shared high-level mental health objectives. These are a comprehensive set of shared priorities and objectives that cover better mental wellbeing, better mental health care and support and better physical health for individuals with mental health problems.

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

Across Great Britain, the reported prevalence of anxiety and depression has increased from 1993 and 2000, with a slight reduction seen in the 2007 survey:

Mental Health Disorder	1993	2000	2007
Mixed anxiety and depression	7.8%	9.2%	9.0%
Generalised anxiety disorder	4.6%	4.7%	4.4%
Depressive episode	2.3%	2.8%	2.3%

Source: ONS: Psychiatric morbidity among adults living in private households in Great Britain (2007)

This may be due to a number of factors including improved diagnosis, reduced stigma, and increased awareness by the general population.

Nearly a third of GP appointments involve mental health problems, yet at least 25% of people with symptoms such as depression or anxiety do not report it to a GP.

There is a growing recognition that intervening early with psychological therapy, helps people experiencing these common mental health disorders to recover their mental well-being. In October 2007, a new national initiative called IAPT – Improving Access to Psychological Therapies – was announced with the aim of improving counselling and psychological support in primary care. The aims of IAPT include quick access to services when they are needed, the provision of differing levels of treatment to meet individual needs as required; along with the provision of an evidence based alternative or addition to medication.

What is happening in Warwickshire?

The Warwickshire County Council People Group Mission Statement is:

'To support people, especially the most vulnerable and disadvantaged, to access throughout their lives, every opportunity, to enjoy, achieve and live independently.'

This mission statement is achieved by ensuring that the population of Warwickshire have:

- Accessible and responsive services
- Help where it is most needed – early intervention, safeguarding, maximising independence and reablement
- Supporting communities to help themselves.

Warwickshire has used the North East Public Health Observatory's (NEPHO)[28] 2008 data to plan for Improved Access to Psychological Therapy (IAPT) services. The data is an estimation of the numbers likely to be diagnosed with each condition at any point in time, and to assist in interpretation, comparative PCTs are also included:

Common Mental Health Conditions - Rates per 1,000 population aged 16-74 years

PCT	Any neurotic disorder	All Phobias	Depressive Episode	Generalised Anxiety Disorder	Mixed Anxiety Depression	Obsessive Compulsive Disorder	Panic Disorder
Warwickshire	121.4	12.2	14.5	30.3	72.5	7.3	1.3
Worcestershire	122.4	12.3	14.7	30.8	72.9	7.4	1.3
South Staffordshire	119.2	12.0	14.2	29.9	71.0	7.2	1.3
Leicestershire County and Rutland	124.3	12.2	20.4	34.5	64.6	6.8	4.2

Source: http://www.nepho.org.uk/mho

In 2008, when this analysis was undertaken, it was found that Warwickshire sat in the lowest ten PCTs for rates/1000 population. The PCTs that were found to have the highest rates are in inner city areas – Manchester, Liverpool, and Knowsley for example.

Converting these rates into estimated number of cases showed:

[28] North East Public Health Observatory. http://www.nepho.org.uk/mho

Common Mental Health Conditions – Number of Estimated Cases

PCT	Any neurotic disorder	All Phobias	Depressive Episode	Generalised Anxiety Disorder	Mixed Anxiety Depression	Obsessive Compulsive Disorder	Panic Disorder
Warwickshire	46,138	4,634	5,506	11,533	27,552	2,786	490
Worcestershire	49,190	4,933	5,891	12,378	29,286	2,962	526
South Staffordshire	52,916	5,330	6,324	13,273	31,516	3,197	564
Leicestershire County and Rutland	60,912	5,981	9,983	16,901	31,658	3,349	2,082

Source: http://www.nepho.org.uk/mho

The data is also available by district/borough:

Common Mental Health Conditions – Number of Estimated Cases

PCT	Any neurotic disorder	All Phobias	Depressive Episode	Generalised Anxiety Disorder	Mixed Anxiety Depression	Obsessive Compulsive Disorder	Panic Disorder
Warwickshire	46,138	4,634	5,506	11,533	27,552	2,786	490
North Warwickshire	526	528	633	1,332	3,123	317	56
Nuneaton and Bedworth	12,394	1,248	1479	3,087	7,409	750	131
Rugby	7,364	742	879	1,855	4,395	442	78
Stratford on Avon	9,058	898	1,089	2,322	5,367	540	97
Warwick	12,066	1,219	1,427	2,937	7,259	737	129

Source: http://www.nepho.org.uk/mho

Therefore, with estimated need as above, it should be expected that Nuneaton and Bedworth and Warwick district should have the highest number of people accessing services that are suitable for common mental health conditions: Books on Prescription (BOP), IAPT, and Wellbeing Services, but data further in the chapter will show variations to this.

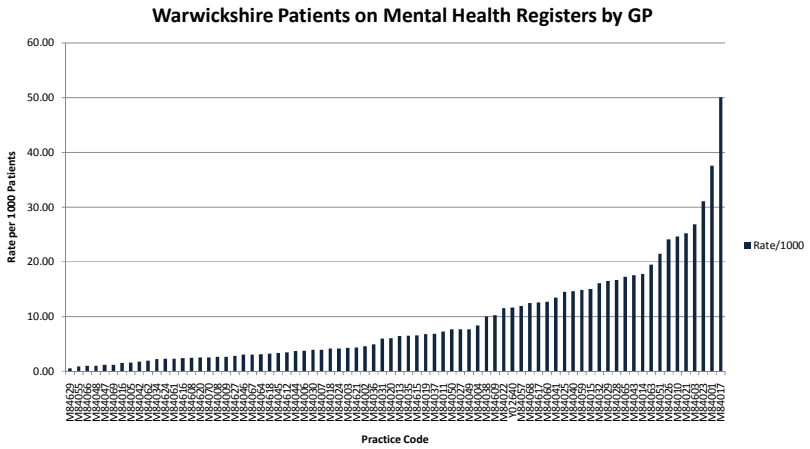
The data and information that follows within this chapter is helpful in providing general information about who is currently accessing services. However, it is acknowledged that there is further work to be undertaken to understand whether the services offered in

Warwickshire are suitable for all communities that need them or do we have some gaps. Vulnerable groups that may not be accessing primary care services include:

- Minority ethnic communities,
- Men (who have the highest rates of suicide)
- Travellers
- Homeless
- Maternal mental health
- Offenders
- Older people in residential or care homes or hospital with depression
- War Veterans
- Unemployed
- People with learning disabilities

GP Services

There are a number of tools available to estimate the demand that mental ill-health places on general practice. GP Quality and Outcomes Framework (QOF) Registers, onward referrals to mental health services and prescribing data. However, all of these have limitations, and affect the robustness of the conclusions from reviewing the data.



Source: The NHS Information Centre for Health and Social Care: Quality Outcomes Framework

It can be seen from the data that there is wide variation between practices on the rate/1000 patients that are on the Mental Health Register – from 0.52/1000 patients to 50.9/1000 patients.

There are a number of reasons for this, and it is not simply that there is more mental ill-health in one practice than another:

- differences in recording
- different cultural groups attend GPs for different levels of mental health need

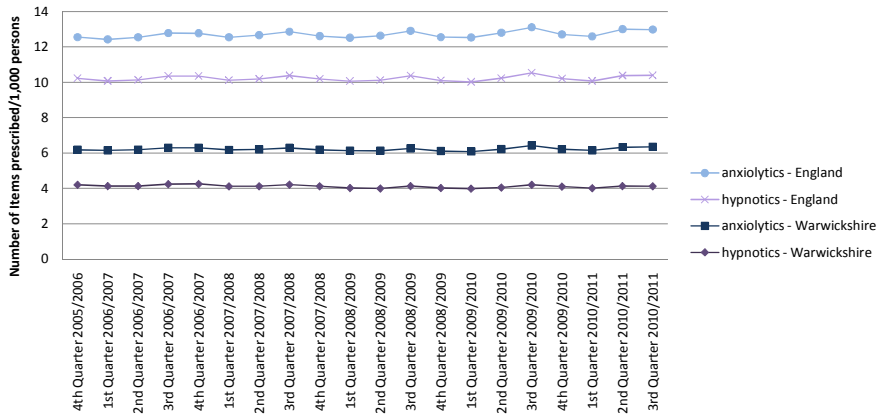
- different socio-economic areas – as seen earlier – inner city areas have more estimated need

Prescribing

The use of medication and prescribing is also (crudely) available to identify differences between practices across the country and allow monitoring of prescribing practice:

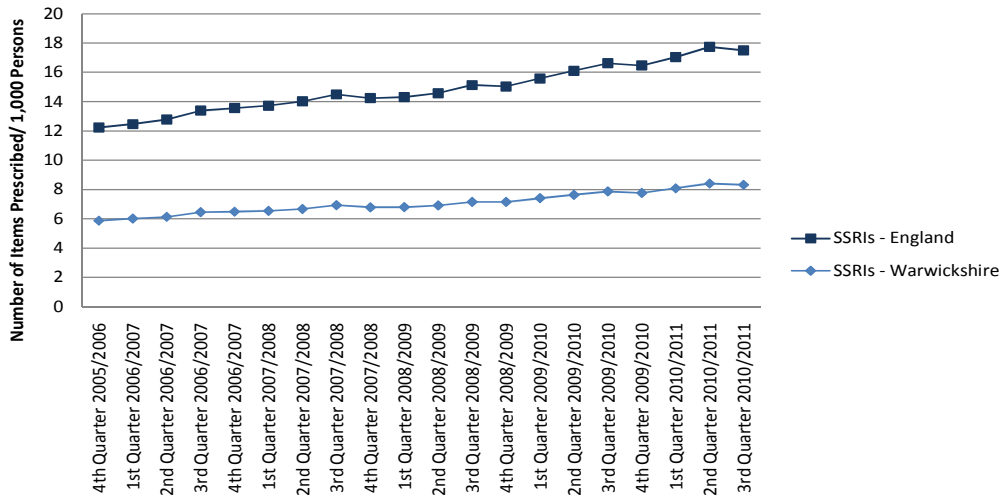
Hypnotics and Anxiolytics (Used to treat insomnia, anxiety and stress)

Trend in Prescribing of Hypnotic and Anxiolytics, 2005/6-2010/11



Source: ePACT, NHS Warwickshire

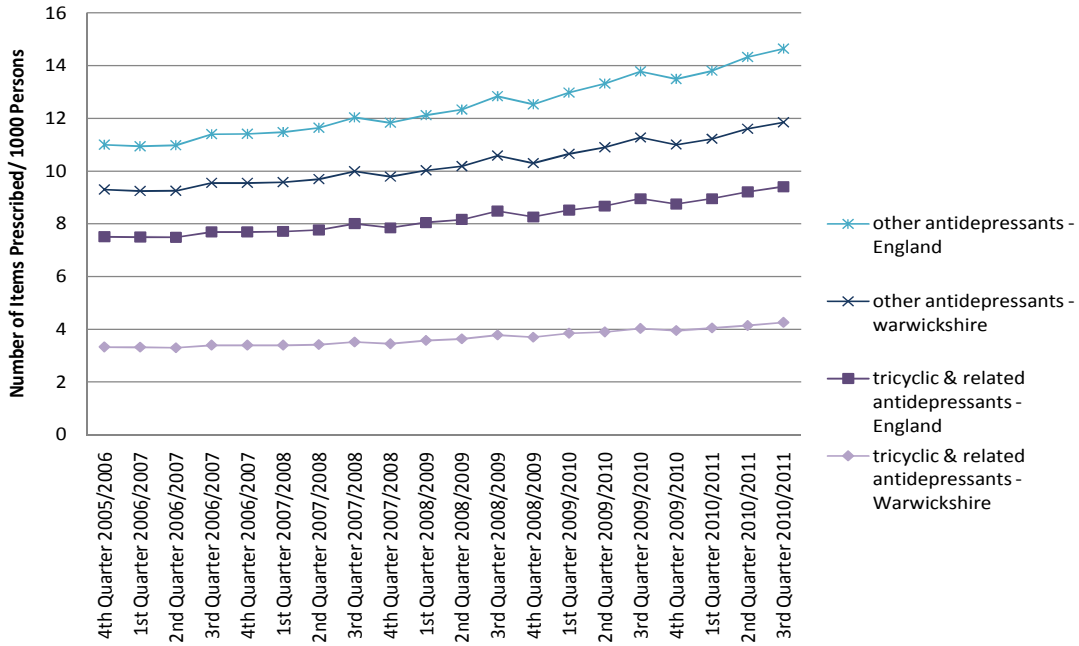
Selective Serotonin Re-uptake Inhibitors (SSRIs) (Used to treat depression), 2005/6-2010/11



Source: ePACT, NHS Warwickshire

Tricyclic & related antidepressants and other antidepressants (Used to treat depression)

Trend in Prescribing Tricyclic and Related Antidepressant Drugs and Other Antidepressant Drugs, 2005/6- 2010/11



Source: ePACT, NHS Warwickshire

The caution with dealing with ASTROPU data is that it:

- only gives the count of the number of prescriptions made

- not possible to know how many prescriptions were actually collected and used by patients

In all cases, the available data on per capita basis suggests that prescribing of drugs to treat common mental health conditions is lower in Warwickshire than for England.

Community Based Services

It is acknowledged that people with low level mental health needs present not only to GPs, but also to a variety of front-line workers, be they other health related primary care staff, public sector staff working in Council and local authority services, and/ or to a variety of voluntary sector and community based organisations. These agencies therefore play a vital role in the identification and onward signposting of people to appropriate services.

Services for People with Common Mental Health Needs

Once a person has been identified as requiring additional support for their mental health, there are a number of services available within Warwickshire to support individuals, aid recovery and build resilience. These services have all been established since 2009, and are therefore new additions to the mental health services portfolio for Warwickshire. They have brought the potential for increased support and evidence based treatment for common mental health issues, based on a stepped care model for mental health. This model aims to ensure that a person can access the least intrusive form of treatment to achieve a positive outcome for their ongoing mental well-being. Plans are in place to ensure that the full benefits of these newer services are realised as the services mature over the next period.

The Service Users from Making Space feedback that:

"Support provided in the early stages should be from other service users. A staged approach would be helpful. This could include one to one support in Stage 1 from service users who were dedicated volunteers, possibly based in GP surgeries. Stage 2 could involve group support in drop-in centres run by service users. Stage 3 would then involve more engagement from medical professionals"

Books on Prescription

Books on Prescription (BOP) was launched in 2010 and is provided by Warwickshire County Council Libraries and Information Service. It was developed in partnership with public health at NHS Warwickshire, as part of strategic plans to improve the support for people with common mental health problems. The local IAPT Service, and Well-being Services provided by specialist community and voluntary sector organisations have also been integral in the design and delivery of the new BOP Service.

"Books on Prescription is a very useful resource to complement talking therapies and the use of antidepressant medication. Having peer reviewed self-help books in local libraries is an asset to the general community, and the books can be used by patients working with the IAPT practitioners"

BOP provides access to self-help books (and audio CDs), for anyone to borrow at Warwickshire libraries covering a whole range of issues including: low mood, anxiety, stress, anger management, sleep issues, bereavement and self-esteem. The resources can also be prescribed by GPs and other health care professionals, and are in line with recommended national NICE guidelines as a first step for the treatments of mile to moderate symptoms of low mood and anxiety. Copies of the BOP resources are on display in 17 libraries across Warwickshire for people to browse and borrow, although the books can be requested from any of the libraries, mobile libraries or Home Library Service. People accessing the scheme using a prescription from a healthcare worker have certain benefits attached to their use of the scheme: if they are not members of the library their prescription form acts as identification so that they can be issued with a library card immediately, and there are no fines for late returns.

"The Black Dog should be mandatory reading for every school / college / university male student, and a few staff too. As a Man, I really did my best to hide my depression until it was all too late and I had a breakdown. The black Dog books have been at my side, and now my own black Dog is a mere Puppy"

BOP Loans January 2010 to Sept 2011

Quarterly loans	Jan-Mar 2010	Apr – Jun 2010	Jul-Sep 2010	Oct – Dec 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sep 2011	Total
North Warwickshire								
Atherstone	47	67	55	48	49	73	138	**477**
Baddesley	1			3				**4**
Coleshill	17	34	34	66	68	80	111	**410**
Dordon	9	19	10	16	15	14	10	**93**
Kingsbury				7	9	6	19	**41**
Polesworth	1	4	7	6	34	46	51	**149**
Water Orton					1	2	7	**10**
Nuneaton & Bedworth								
Nuneaton	81	111	186	136	237	293	267	**1,311**
Bedworth	3	28	53	50	67	59	182	**442**
Bulkington		5	5	4	28	26	10	**78**
Camp Hill	12	31	7	0	16	7	14	**87**
Hartshill			1	2		1		**4**
Keresley					1	1	2	**4**
Stockingford		2	1		4	8	7	**22**
Rugby								
Rugby	74	108	268	337	430	345	356	**1,918**
Dunchurch			1	7	5	7	4	**24**
Wolston			1					**1**
Stratford-on-Avon								
Stratford	23	44	96	73	142	204	137	**719**
Alcester	63	65	82	59	59	78	75	**481**
Bidford	2		3	2			2	**9**

Harbury					5	2	2	**9**
Henley				4	4	2	3	**13**
Studley	5	6	5	8	35	18	29	**106**
Shipston	22	33	50	40	49	64	60	**318**
Southam	4	5		16	89	59	102	**275**
Wellesbourne	1	1		3	12	15	6	**38**
Warwick								
Leamington	120	138	110	327	358	410	446	**1,909**
Kenilworth	7	1	7	19	52	103	140	**329**
Lillington	30	47	74	46	71	64	45	**377**
Warwick	68	114	147	190	280	245	359	**1,403**
Whitnash		2	2	5	9	17	8	**43**
Mobiles / Home Library Service								
Mobiles		2	1	12	7	2	5	**29**
Total	**590**	**867**	**1,206**	**1,486**	**2,136**	**2,251**	**2,597**	**11,133**
Shaded = 17 libraries with BOP on display; **Unshaded = libraries where the books needed to be obtained on request as no collection.**								

The table above identifies that over 11,000 resources have been loaned since the scheme was introduced with good access across the County. The vast majority of resources borrowed were by self- referral and access to the libraries.

The scheme was launched to GPs and some other health care workers for them to prescribe the books from September 2010 onwards. By September 2011 a total of 419 prescriptions had been issued as outlined below:

Healthcare worker BOP Prescriptions

BOP Prescriber	Number – From Launch to September 2011
GP	236
IAPT Practitioner	147
Occupational Therapist	18
Community Mental Health Team	4
Wellbeing Centre	5
Health Visitor	1
Occupational Health	4
Other	4

Compared to the levels of self-selection, the prescribing rates are much lower. However, there could be a number of reasons for this:

- Anecdotal evidence from Library staff suggests that healthcare workers may be signposting people to the libraries to browse and borrow from the collection themselves, rather than formally "prescribing" a particular resource;
- Anecdotal evidence also suggests that people may be choosing not to present their "prescription" but self-selecting the resource(s) themselves when they get to the library;
- Scheme leads recognise that more needs to done to fully engage GPs and other healthcare workers in the benefits of the Scheme, and to utilise it appropriately as a first level intervention for people with common mental health needs, and as part of well-being plans for people recovering from more complex needs.
- Local Well-being Services each have a complete set of the books on display for people to browse through and this may be limiting their prescriptions as people use the resources in the Centres.

It is also important to acknowledge that compared to prescribing rates from another local authority the prescribing rates were in-line with, if not exceeding their initial trajectories.

Wellbeing Resource Services

Within Warwickshire, there is Wellbeing Resource Service in each borough and district provided by specialist mental health community and voluntary sector organisations including: Mind, Rethink and Friendship. Each service has also identified whether there is a requirement for outreach into the more rural areas of the district and adapted their availability accordingly.

These Well-being services are commissioned as a network of support across the County by both NHS Warwickshire and Warwickshire County Council. Each service provides a drop-in centre for the public to receive information and support related to mental health and wellbeing. People who use the service can self-refer, and do not need to have had contact with primary care or more specialist mental health services. These Well-being Services have undergone significant transformation from traditional models of day centres to a more early intervention / preventative model, and a development group exists to support this transformation process.

The support that each Wellbeing Service offers include:

- Information and signposting to other appropriate services (e.g. housing, Citizens Advice, leisure services, volunteering, education and training opportunities)
- One to one support to assist in recovery or re-enablement
- Guided self help
- Books on Prescription
- Computerised Cognitive Behaviour Therapy

Additional wellbeing sessions are delivered, depending on need or demand from service users including relaxation, benefits advice, exercise and creative activities. Each service also provides a café to encourage group and peer support. The services are also aiming to offer more outreach work within local community settings to promote awareness of how to look after your mental well-being, and how and when to recognise when you may need some additional support with mental health needs. Examples of this work include: Coventry and Warwickshire MIND displayed their Information Bus outside Rugby Library and Friendship attended the health markets in Nuneaton & Bedworth.

Providers of Health and Wellbeing Services and Resource Cafes

District/Borough	Provider
North Warwickshire	Friendship
Nuneaton and Bedworth	Friendship
Rugby	Coventry and Warwickshire Mind
Warwick	Rethink
Stratford	Springfield Mind

Well-being Services Use April 2011 - June 2011

Locality	Total Number of Service Users	Number of New Users	Total Number of Service Visits
North Warwickshire: Outreach Service	16	2	236
Nuneaton & Bedworth Centres	54	19	1,070 – 679 Nuneaton 391 Bedworth
Rugby	67	42	375
Warwick		21	219
Stratford		14	984

Well-being Services Use; July 2011 to Sept 2011

Locality	Total Number of Service Users	Number of New Users	Total Number of Service Visits
North Warwickshire: Outreach Service	18	1	257
Nuneaton & Bedworth Centres	29	62	1,179 779 Nuneaton 400 Bedworth
Rugby	40	13	301
Warwick		4	332
Stratford		21	1,086

Service providers have provided data for the first 6 months of 2011/12 including age, gender and ethnicity profiles. The data collection tool has yet to be standardised and therefore it is not possible to provide the data in table form, but early analysis shows:

- Over 65 yrs population are under-utilising these services and with the high prevalence rates of depression in this group they are a key target group for promoting the services to or outreaching into the communities direct.
- Ethnicity data – limited demand in the north of the county in the period is reported. Rugby recording does show greater variation and access by multiple ethnic groups.

- There are differences between the gender of service users at the different centres. In North Warwickshire and Stratford more females attend the centres. In Leamington, this is completely reversed and there is a much higher proportion of males that attend the service, and more males also attended Bedworth too. In Rugby, there is a more equal split between male and female attendees at that Centre.

The data from BOP and Wellbeing Services suggests that the vast majority of people do SEEK advice and support without contact with primary or secondary care services. This again, fits with the feedback from the User and Carer Engagement Group that people when they become aware of mental health concerns have a preference for support from non health care Professionals.

Case Study on Wellbeing Centre Service User K

K attended day services about 6 years ago after his son was knocked over and died in a road traffic accident and K went into serious depression.

K was a fairly quiet person at first but seemed to come out of his shell when he was drawing and painting in fact he was extremely good at art and craft in general and appeared to like helping others develop their skills in art.

The art group had an exhibition and which went extremely well selling over £1200 over the weekend with K selling quite a few of his drawings and paintings and with the money going to the social enterprise group fund.

K had now gained confidence and wanted to be a volunteer in the resource café and completed an NVQ level 2 and all other in house training such as food hygiene, manual handling and fire training etc.

Now with his confidence high K took his volunteering very seriously and wore trouser and shirts instead of his usual shell suit tops and t-shirts. K in my opinion was a changed man with a positive outlook and life and wanted to help others as he knew how mental illness affects your life.

K was now discussing with staff about returning to work and went to the job centre to find more information with regard to his benefits and such. K applied and got a post as a support worker in a residential home for people with learning difficulties in Bedworth which he enjoyed but due to shift patterns it caused personal problems at home.

However, during the consultation exercise it was revealed that amongst primary care and secondary care, that there was limited knowledge about the new role of the Health and Wellbeing Services and Resource Cafes, and that this needs to be addressed.

Each locality has one, and the one to one's highlighted the tiny number of users that attend the cafes that have been referred by health care professionals for additional support.

At the User and Carer Engagement Group, it was clear from discussions and the surveys that had been carried out with Making Space, that when users attended the GP to discuss a mental health issue, that they did not necessarily want a secondary care referral, but they did want to talk to someone who did not need to be a health care professional. Service users have also highlighted that they would like the opportunity to talk to others who have experienced similar issues to themselves, rather than to a professional and the development of a Peer Support Volunteer Scheme is one that is currently being explored.

Improving Access to Psychological Therapies Service (IAPT)

The Improving Access to Psychological Therapies (IAPT) national programme is designed to support the NHS in delivering:

- Evidence-based psychological therapies, as approved by the National Institute for Health and Clinical Excellence (NICE), for people with depression and anxiety disorders
- Access to services and treatments by people experiencing depression and anxiety disorders from all communities within the local population
- Increased health and well-being, with at least 50 per cent of those completing treatment moving to recovery and most experiencing a meaningful improvement in their condition
- Patient choice and high levels of satisfaction from people using services and their carers
- Timely access, with people waiting no longer than locally agreed waiting times standards
- Improved employment, benefit, and social inclusion status including help for people to retain employment, return to work, improve their vocational situation, and participate in the activities of daily living.

IAPT performance is monitored regionally and nationally via agreed Key Performance Indicators that all services must report on, and two of these are now contained in the NHS Operating Framework (Proportion of people entering treatment against the level of need in the general population, and the proportion of people entering treatment against the level of referral). The service model and quality standards are set nationally and the scope of IAPT is set to continue to expand over the next four years.

The IAPT Service in Warwickshire is delivered jointly by Coventry and Warwickshire Partnership Trust and Coventry and Warwickshire MIND, and is funded by NHS Warwickshire. Clients are supported to develop their skills to self-manage their condition, and to enhance their psychological resilience. The service provides assessment and access to two levels of intervention. Lower intensity treatments include: computer based Cognitive Behavioural Therapy, stress control courses, low mood groups, telephone and face to face

therapy. Higher Intensity Workers provide access to more intensive therapy, including up to 20 sessions of Cognitive Behavioural Therapy.

The data for 2010/11 for IAPT shows:

Key Performance Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
The number of people who have been referred for psychological therapies	1,701	1,787	1,658	1,867	7,013
The number of active referrals who have waited more than 28 days from referral to assessment	864		1,563	1,308	
The number of people who have entered psychological therapies	1,012	960	1,026	980	3,978
The number of people who are moving to 'recovery'	179	265	247	282	973
The number of people moving off sick pay and benefits	35	63	65	54	217

The data for 2011 /2012 for IAPT shows:

Key Performance Indicator	Quarter 1	Quarter 2	Total
The number of people who have been referred for psychological therapies	2,036	1,953	3,989
The number of active referrals who have waited more than 28 days from referral to assessment	1,479	678	2,157
The number of people who have entered psychological therapies	1,061	1076	2,137
The number of people who are moving to 'recovery'	288	313	601
Recovery Rate	48.2	48.8	
The number of people moving off sick pay and benefits	41	80	121

'IAPT has brought some people into the service that wouldn't have come to other mental health services'.

Throughout the one to ones, there has generally been positive feedback:

'I was initially sceptical, but now impressed by the culture of IAPT as they are focused on the health needs of the individual".

This suggests that now health care professionals have confidence in the service, they are more readily referring to the service. However, the tendency to refer to a third party, such as IAPT services, may not always be necessary. It may be appropriate for health care professionals including GPs, to consider watchful waiting and the BOP service prior to referral to IAPT.

During 2011/2012, The IAPT Service will continue to prioritise increasing access to its provision by people from particularly vulnerable groups who have traditionally had low access to such services. In Warwickshire the following four groups have been particularly highlighted for focused interventions:

- People with long term physical conditions who have associated anxiety and / or depression;
- Older people building on the successful peer support project with Age Concern Warwickshire in North Warwickshire;
- Young adults aged 18-25 who are particularly at risk in the current economic climate;
- Carers of people with mental health and physical health needs.

Brief Interventions: Up-skilling Frontline workers for Early Identification and Signposting

As noted previously, frontline workers across all sectors often identify people experiencing mental distress. The public health department are developing a model of Brief Advice and Intervention to up-skill frontline workers to signpost and refer people to appropriate services. Mental Health needs will be included in this work which is under development.

Recommendations

- A central system to ensure signposting to the earliest and most appropriate service for the individual, and increased cross-referrals between lower level services to step people up and down as appropriate.

- To review the number of low level IAPT referrals that could have been referred to BOP / Well-being Services initially.

- To explore potential for service user peer support project.

- Further analysis of service users to identify where access to services is lower within vulnerable groups.

- To pilot on line early intervention service as means to reach people who are known to not access existing services.

- To review the mental well-being strategy and agree priorities for meeting the needs of particularly vulnerable groups.

- To improve the quality of some of the service data so that we get a more robust picture of service gaps.

Topic Area - Physical Health and Mental Health

Within this chapter, there are two aspects to this topic.

Firstly, it is known that patients with long term health conditions are more likely to have mental health conditions, too. There is a need to provide patients with chronic diseases with supportive mechanisms and resources to enable them to build resilience to reduce mental health problems.

Secondly, that people with known mental health problems are more likely to experience major illness, develop them younger and to have lower life expectancy compared to the general population[29].

The promotion of both physical and mental health to the whole population is therefore a priority for Warwickshire.

[29] Disability Rights Commission 2006, Disability Briefing March 2006

Introduction

The Royal College of Psychiatrists[30] highlight that people with mental disorders have a higher risk of poor physical health and premature mortality than the general population. The Health Inequalities National Support Team [31] also report that that poor mental health is associated with increased health-risk behaviours (including alcohol and tobacco consumption).
The quality of life for an individual with a long term condition will often be dependent on how empowered are to manage the challenges of their condition. Better mental health and less depression are identified as benefits of self management.

National Perspective

Mental Health Impacts on Physical Health

The Royal College of Psychiatrists[32] highlight that people with mental disorders have a higher risk of poor physical health and premature mortality than the general population. The Health Inequalities National Support Team [33] also report that that poor mental health is associated with increased health-risk behaviours (including alcohol and tobacco consumption).
Mental illness further exacerbates inequality and is associated with increased mortality and illness, as well as poorer economic, social and health outcomes:

- Life expectancy for people with schizophrenia is an average of 25 years shorter compared with the general population, with more deaths being due to treatable cardiovascular, respiratory and infectious diseases.
- A diagnosis of depression in those over 65 years of age increased mortality by 70%
- Increased psychological distress is associated with an 11% increased risk of stroke
- Depressed patients were three times more likely to be non-compliant with treatment
- High rates of physical co-morbidity have been found in long-stay psychiatric patients.
- People with serious mental illness are less likely to exercise

Guidance to GP suggests that GPs should set up specific clinics for people with mental disorders. The Royal College of Psychiatrists' guidance highlights the need for regular and appropriate physical health checks for patients with psychiatric disorders. It highlights that physical healthcare includes dentistry, chiropody, physiotherapy and other allied health care professionals such as dietitians and speech and language therapists.
The National Institute for Health and Clinical Excellence[34] highlights that their guidance on

[30] The Royal College of Psychiatrists. 2009, Physical Health in Mental Health. Final Report of a Scoping Group

[31] Health Inequalities National Support Team. 2011, Improving the Physical Health and Wellbeing of People with Mental Health Problems: Reducing the Gaps in Premature Mortality and Healthy Life Expectancy

[32] The Royal College of Psychiatrists. 2009, Physical Health in Mental Health. Final Report of a Scoping Group

[33] Health Inequalities National Support Team. 2011, Improving the Physical Health and Wellbeing of People with Mental Health Problems: Reducing the Gaps in Premature Mortality and Healthy Life Expectancy

[34] National Institute for Health and Clinical Excellence. 2009, Depression in Adults with a Chronic Physical Health Problem

physical health applies to users of mental health services too. This includes ensuring that opportunities are provided for:

- Health promotion – supporting patients to attend screening programmes – breast, cervical, colorectal screening should occur
- Mental Health Care Coordinators should liaise with patients' GPs every year to confirm that an annual physical health assessment has been conducted.
- CPA reviews should include a review of physical health needs and an agreed care plan to address identified needs
- Community patients should have access to appropriate community groups that support and encourage good physical health e.g. walking groups, weigh management and healthy living groups

Smoking and Mental Health

According to the most recent adult psychiatry morbidity survey[35] whilst the smoking rate is 21% of the general population, it increases to 32% for those with a depressive or anxiety disorder, 40% for those with probable psychosis, 46% for those will alcohol dependence and 57% for those attempting suicide in the last year. Even higher rates of smoking occur within psychiatric inpatient settings, where up to 70% are smokers.

Smoking is responsible for the largest proportion of the excess mortality of people with mental disorder. Smokers with mental health issues often require combination and more intensive pharmacological and non-pharmacological interventions.

Physical Health Impacts on Mental Health

The Royal College of General Practitioners [36] identifies that there are currently 15.4 million people in England with a long term condition (a long term condition – one that cannot be currently cured, but can be managed with the use of medication and/or other therapies). Due to the ageing population, it is estimated that the number of people with at least one long term condition will rise by 3 million to 18 million.

People with long term conditions account for 70% of the total health and social care spend in England, more than 50% of all general practice appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days[37].

Welch et al (2009)[38] summarise multiple studies and show that depressed patients had significantly higher costs than non-depressed patients across 11 chronic conditions.

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[35] The NHS information Centre for Health and Social Care. 2007, Adult Psychiatric Morbidity in England: Results of a household survey

[36] Royal College of General Practitioners. 2011, Care Planning: Improving the Lives of People with Long Term Conditions

[37] Department of Health. 2011, No Health Without Mental Health

[38] Welch et al 2009

The Health Inequalities National Support Team[39] summarised the evidence around physical illness and mental health:

- People with diabetes have 2-3 times increased risk of depression, people with COPD also have increased rates of depression and anxiety
- Up to 70% of all new cases of depression in older adults are caused by poor physical health
- Physical illness and two or more adverse life events increases risk of mental illness by six times compared to without physical illness
- There is a 20% rate of new onset of depression or anxiety in the year after diagnosis of cancer and first hospitalisation with a heart attack

The importance of holistic care is even more important due to the increasing numbers of people with multiple long term conditions, including mental health illnesses.

Green Spaces

The Marmot Review[40] refers to evidence that well designed green and open spaces can benefit communities – increasing social contact and social integration, particularly in underprivileged neighbourhoods. People are more likely to be physically active if they live in neighbourhoods with many destinations and where they have a number of reasons for walking including walking to work, for recreation and for other tasks. Prevalence rates for diseases such as diabetes, cancer and depression are lower where there is more green space, and mental health may be particularly affected by the amount local green space.

What is happening in Warwickshire?

Accident & Emergency (A&E) Attendances – Physical Health and Mental Health

There is little robust data available that allows an analysis of the numbers of people diagnosed with both physical and mental health conditions. To attempt to understand the common issues, it has been possible to review the A&E admissions for Warwickshire residents in a two year period.

The following analysis includes all admissions to Acute Care Providers, where the patient has a recorded diagnosis that falls within the ICD10 category starting with 'F', this being Mental and Behavioural Disorders. The data covers the two year period between April 2009 and March 2011.

During the period, 2009/2010-2010/2011, there were a total of 21,850 A&E admissions by 13,320 individual Warwickshire residents where a mental health diagnosis was recorded as a supplementary diagnosis.

[39] Health Inequalities National Support Team. 2011, Improving the Physical Health and Wellbeing of People with Mental Health Problems: Reducing the Gaps in Premature Mortality and Healthy Life Expectancy

[40] The Marmot Review. 2010, Fair Society Healthy Lives

Total Number of A&E Admissions with a recorded Mental Health Diagnosis by Year of Admittance, 2009/10 – 2010/11

	2009/10	2010/11	Total Spells	Percentage Change 2009/10 to 2010/11 (%)
Total Admissions	6,215	15,635	21,850	151.6

Source: Evolve, NHS Warwickshire Intelligence

Total Number of Individuals Admitted to A&E with a recorded Mental Health Diagnosis by Year of Admittance, 2009/10 – 2010/11

	2009/10	2010/11	Total Spells	Percentage Change 2009/10 to 2010/11 (%)
Total Individuals	3,989	9,331	13,320	133.9

Source: Evolve, NHS Warwickshire Intelligence

Between 2009/10 and 2010/11, total A&E admissions with a recorded mental health diagnosis and the total number of unique individuals attending A&E both increased at a similar rate, more than doubling between 2009/10 and 2010/11. This increase may be explained by the development of the 'payment by results' process which may have contributed to the more detailed diagnosis of associated mental health conditions.

58% of individuals admitted to A&E with a recorded mental health diagnosis were female and 42% were males. Between 2009/10 and 2010/11, the number of male and female admissions increased by similar proportions.

Total Number of Individuals Admitted to A&E with a recorded Mental Health Diagnosis by Gender and Year of Admittance, 2009/10 – 2010/11

	Year of Admission		Total	Percentage Change 2009/10 to 2010/11 (%)
Gender	2009/10	2010/11		
Female	2,352	5,391	7,743	129.2
Male	1,637	3,940	5,577	140.7
Total	**3,989**	**9,331**	**13,320**	**133.9**

Source: Evolve, NHS Warwickshire Intelligence

There is little variation at District and Borough level in terms of the crude rate per 1,000 population for individuals attending A&E with a recorded mental health diagnosis. Using total individuals for the two year period, crude rates were highest in Warwick District and lowest in North Warwickshire Borough. This is the same pattern as that exhibited in the inpatient and outpatient data.

Total Number of Individuals Admitted to A&E with a recorded Mental Health Diagnosis by District/Borough of Residence, 2009/10 – 2010/11

	Year of Admission		Total	Percentage Change 2009/10 to 2010/11 (%)	Crude Rate per 1,000 Resident Population
	2009/10	2010/11			
North Warwickshire Borough	351	455	806	29.6	13.0
Nuneaton & Bedworth Borough	737	1,076	1,813	46.0	14.8
Rugby Borough	609	712	1,321	16.9	14.0
Stratford-on-Avon District	696	1,029	1,725	47.8	14.5
Warwick District	883	1,203	2,086	36.2	15.0
Warwickshire	3,276	4,475	7,751	36.6	14.5
Null*	713	4,856	5,569	581.1	-
Total	**3,989**	**9,331**	**13,320**	133.9	**-**

Source: Evolve, NHS Warwickshire Intelligence

Further work can be done to analyse the data by mental health condition or by physical health condition. This has not been fully undertaken within this needs assessment due to the significant numbers of 'null' values and unspecified conditions that exist in the current dataset. However, early analysis highlights:

- 81 diabetes patients were seen in A&E with a recorded underlying mental health condition
- 97 Chronic Obstructive Pulmonary Disease (COPD) patients were seen in A&E with a recorded underlying mental health condition
- 660 patients with orthopaedic fractures were seen in A&E with a recorded underlying mental health condition
- 320 patients with cancer were seen in A&E with a recorded underlying mental health condition,

With the most common underlying mental health conditions recorded by A&E being:

- Depression
- Dementia
- Anxiety

Mental Health and Physical Wellbeing

Regular physical activity is associated with improved mental health and wellbeing and lower rates of depression and anxiety across all age groups.

NICE concluded that the evidence supports physical activity as an effective treatment for sub-threshold depressive symptoms and mild to moderate depression. NICE also found that group physical activity has particular benefits for mental health.

Warwickshire and Physical Activity

For Warwickshire, the Quality of Life Indicators identify that just over a quarter of respondents reported achieving the recommended levels of exercise. There is some variation between boroughs and districts with the lowest levels being reported in Nuneaton and Bedworth at 25.3% and highest in Stratford-on-Avon with 29.2%.

Proportion of respondents who exercise five times per week by borough and district:

District/Borough	Proportion doing five x thirty minutes of exercise per week
North Warwickshire	26.1%
Nuneaton & Bedworth	25.3%
Rugby	26.2%
Stratford-on-Avon	29.2%
Warwick	26.0%
Warwickshire	26.5%

Source: Warwickshire Observatory: Warwickshire County Council

Under 25s achieve the highest levels of exercise with a third achieving recommended levels of exercise per week.

Proportion of respondents who exercise five times per week by age:

	Proportion doing five x thirty minutes of exercise per week
Under 25	33.0%
25-34	24.6%
35-44	23.7%
45-54	26.8%
55-64	31.2%
65+	26.7%

Source: Warwickshire Observatory: Warwickshire County Council

Green Therapy

Mind [41] highlights that outdoor activities are a natural, free and accessible treatment that boosts mental wellbeing – either horticultural and allotment programmes or simple walks in the park. In Warwickshire, 'Measured Miles' have been developed across the county:

- Within Nuneaton and Bedworth, 4 way-marked measured miles routes have been commissioned with the aim to train volunteer walk leaders to run 4-5 led walks per week for each locality:
    - Riversley Park
    - Middlemarch
    - George Eliot Hospital
    - Bedworth Miners Park
- North Warwickshire has a measured mile in place in Hurley
- Warwick District have two measured miles:
    - Victoria Park, Leamington
    - St Nicholas Park, Warwick
- Stratford-on-Avon is planning a measured mile around the recreation ground in Stratford
- Rugby have plans to develop a measured mile in Caldecott Park

Additionally, Green Gyms are also being planned:

- Stratford-on-Avon – have two green gyms in the district and are planning one more
- Nuneaton and Bedworth are planning to have three green gyms in the borough.

The joint benefits of physical health and mental health can be seen in the following case study:

A client started with the Brunswick Gets Physical programme October 2010, who had low self esteem and highly significant confidence issues. The client attended numerous classes with one to one emotional support provided to prompt further development in confidence. He/she has implemented in group activities well and taken a huge step in participating in a gym on a solo basis. Other positive changes noted are the clients drop of excessive weight , their blood sugar is in a healthy & manageable level (previously at double figures and now stabilised at 6.4) and has became instrumental to the promotion of physical activity to other members in our community.

[41] Mind. 2007, Ecotherapy: The green agenda for mental health'

Warwickshire and Talking Therapies

The IAPT services are detailed separately in this needs assessment. However, a development of the service in 2011/12 is to increase access to the service for people with long term conditions.

Recommendations

- Further analysis of A&E attendance data should be undertaken by the Public Health Intelligence team (PHIT) in the next 12 months to provide improved guidance and understanding to providers and commissioners.

- Commissioners should liaise with the Public Health Information Team to gain an understanding of the current physical conditions that patients present with at A&E and the associated mental health conditions.

- All mental health service patients should have their smoking status routinely recorded. Staff who provide mental health services should conduct a brief intervention (Every Contact Counts) and refer to stop smoking services.

- A number of staff who care for mental health in-patients should be trained to provide intensive stop smoking support for clients.

- Promotion of measured miles and green gyms to the public, primary care professionals, hospital staff and voluntary sector organizations to ensure those with either physical health or mental health issues are supported in optimizing their physical activity**.**

- A review of the measured miles and their users should be undertaken to understand which groups of the community are using them and more importantly if there are particular population groups that are not accessing the facilities**.**

- Analysis of the uptake of the 2011/12 figures for long term conditions accessing IAPT should be undertaken. This will enable an understanding of the patients that are accessing the service, those not accessing, as well as reviewing the age and locality that individuals with long term conditions are from to allow the service to adapt to the needs of the population.

Topic Area - Secondary Care Mental Health Services Data Analysis

For the analysis of secondary care mental health services, there are a number of datasets that have been analysed

1. Mental Health Minimum Data Set
2. Coventry and Warwickshire Partnership Trust Contract Inpatient Datasets
3. Coventry and Warwickshire Partnership Trust Contract Community Datasets

No one dataset provides the full picture, and due to changing definitions as well as missing data, there can be minor discrepancies when comparing the different dataset numbers. Therefore, careful judgement has been undertaken to ensure that the most appropriate dataset is used for each analysis of demand on secondary care mental health services.

Following the general analysis of the datasets, priority areas are analysed as separate chapters of the mental health needs assessment.

Mental Health Minimum Data Set

Introduction

The Mental Health Minimum Data Set (MHMDS) is the only dataset that covers specialist mental health services provided in the community, as well hospital and outpatient care. It covers services for adults of working age and people over the age of 65. The MHMDS has been compulsory for NHS providers since April 2003 and some information was published for 2003-2004 and 2004-2005.

The MHMDS is derived from routine records of patient care - details of admissions, attendances and appointments recorded in provider organisation's patient administration systems

The data covered in this report spans the period April 2010 to March 2011

MHMDS facilitates the collection of person focused clinical data and the sharing of such data to underpin the delivery of mental health care. It is structured around the clinical process and includes an outcome assessment (HoNOS). It records the key role played by partner agencies, particularly social services.

The MHMDS describes Mental Health Care Spells. These comprise all interventions made for a patient by a specialist mental health care team from initial referral to final discharge. For some individuals the spell will comprise a short outpatient episode; for others it may extend over many years and include hospital, community, outpatient and day care episodes.

Information is collected relating to various stages in the patients journey including activity such as inpatients, outpatients, community care, and NHS day care episodes; mental health reviews and assessments including Care Programme Approach (CPA) and Health of Nation Outcome Scales (HoNOS); contacts with mental health professionals such as care coordinator, psychiatric nurses and consultants and also any diagnosis and treatments.

The main reason for the inclusion of this analysis is that it contains useful information on diagnoses of mental health conditions. It should be noted due to differences in the way data is recorded; total numbers will not be the same as those used elsewhere in the needs assessment. We also only have one year's worth of data so the following analysis is purely a snapshot of the most up to date information.

Analysis

During the period, 2009/2010, there were a total of 30,360 mental health care spells by Warwickshire residents recorded on the MHMDS. This includes individuals with multiple attendances. For comparison, there were 12,408 unique individuals who attended during the same time period. This indicates that on average, each individual had 2.4 attendances during the one-year period.

Of the 12,408 total individuals in Warwickshire who had a mental health care spell during 2010/11, 59% did not have their most recent diagnosis recorded within the MHMDS. Where the information was recorded, the most common diagnoses were mood disorders which

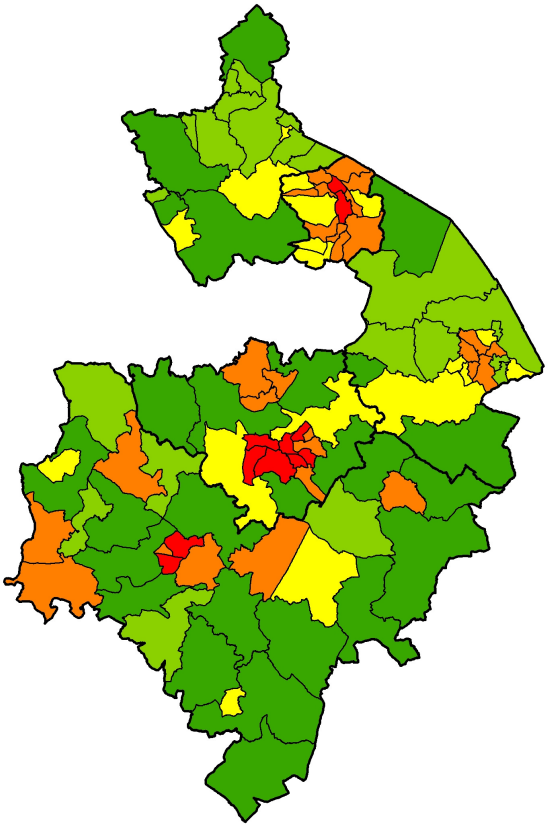
includes depressive episodes and bipolar affective disorder. These were closely followed by organic mental disorders which includes dementia. These diagnoses combined comprise over 50% of the total recorded.

Total Individuals with a Mental Health Care Spell by Most Recent Broad Diagnosis (ICD-10 Blocks), 2010/11

Most Recent Diagnosis Recorded	Total Individuals
No diagnosis recorded	7,330
Mood (affective) disorders (e.g. depression, bipolar affective disorder)	1,435
Organic, including symptomatic, mental disorders (e.g. dementia)	1,241
Neurotic, stress-related & somatoform disorders (e.g. anxiety disorders)	844
Schizophrenia, Schizotypal & delusional disorders	692
Mental & behavioural disorders due to psychoactive substance use (e.g. alcohol)	358
Disorders of adult personality & behaviour (e.g. personality disorders)	163
Factors influencing health status & contact with health services	124
Behavioural syndromes associated with physiological disturbances & physical factors (e.g. eating disorders)	79
Symptoms & signs involving cognition, perception, emotional state & behaviour	45
Other	32
Unspecified mental disorder	26
Behavioural & emotional disorders with onset usually occurring in childhood and adolescence	22
Disorders of psychological development	17
Total	**12,408**

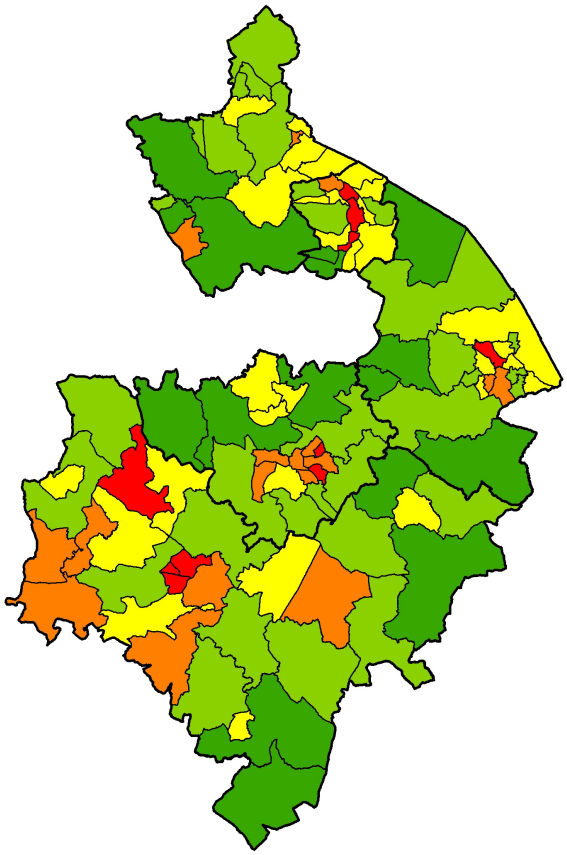
Source: Mental Health Minimum Dataset, 2010/11

Total Individuals with a Mental Health Care Spell by Ward, 2010/11



In terms of absolute numbers, the wards within the urban areas of Leamington Spa, Warwick, Stratford-upon-Avon and Nuneaton had the highest numbers of individuals with a mental health care spell during 2010/11. Willes and Brunswick wards, both located in Leamington Spa had the highest numbers with 308 and 302 individuals respectively.

Total Individuals with a Mental Health Care Spell by Ward, Rate per 1,000 15+ Population, 2010/11



When rates per 1,000 15+ population are considered, the general pattern is similar to that for total individuals. However, rates were highest in Stratford Avenue & New Town, Crown ward in Leamington Spa, Wem Brook in Nuneaton and Stratford Guild & Hathaway. Interestingly, the more rural Henley ward also featured as having a relatively high rate.

Source: Mental Health Minimum Dataset, 2010/11

Total Individuals with a Mental Health Care Spell by Ethnicity, 2010/11

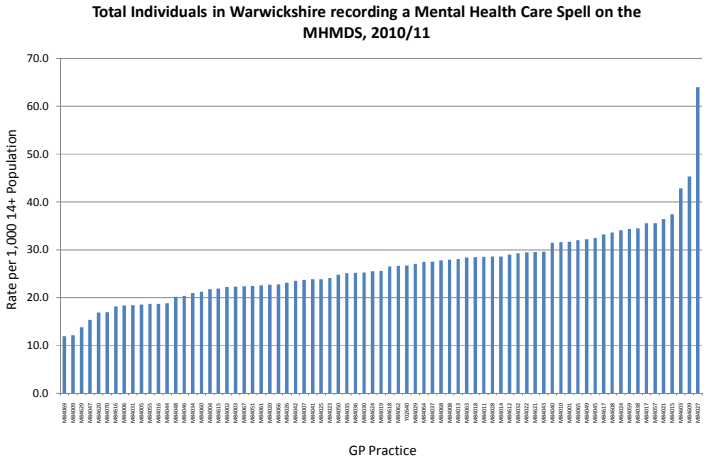
Ethnic Group	Total Individuals	% of Total (excluding those not stated)	% of the Total Population (ONS Population Estimates by Ethnic Group Mid-2009)
White - British	9,616	93.0%	88.3%
White - Irish	66	0.6%	1.2%
Any Other White Background	243	2.4%	2.7%
Mixed - White & Black Caribbean	22	0.2%	0.5%
Mixed - White & Black African	4	0.0%	0.1%
Mixed - White & Asian	12	0.1%	0.4%
Mixed - Any Other Mixed Background	18	0.2%	0.3%
Asian - Indian	172	1.7%	2.9%
Asian - Pakistani	19	0.2%	0.8%
Asian - Bangladeshi	0	0.0%	0.2%
Any other Asian Background	52	0.5%	0.4%
Black - Caribbean	37	0.4%	0.5%
Black - African	20	0.2%	0.5%
Any other Black Background	7	0.1%	0.1%
Chinese	8	0.1%	0.5%
Any other ethnic group	41	0.4%	0.5%
Not stated	2,071	-	-
Total	**12,408**		

Source: Mental Health Minimum Dataset, 2010/11

When the data is broken down by ethnicity, there is a large proportion of the data (17%) where the information has not been recorded or where an individual has chosen not to state their ethnic group. However, when those records have been excluded and the proportion of individuals with a mental health care spell by ethnic group is compared with the breakdown

across the total population, those groups other than the White-British category tend to be underrepresented within the data.

The graph below shows the crude rate per 1,000 aged 14+ GP registered population for patients recording a mental health care spell for each of the 76 GP Practices in Warwickshire during 2010/11. Although the majority of practices experience similar rates around the 20-30 per 1,000 14+ population mark, there are a few prominent outliers both with high and low rates. More work needs to be undertaken to fully understand these discrepancies.



Source: Mental Health Minimum Dataset, 2010/11

Recommendations

- We need to understand why diagnosis is not recorded for the majority of individuals in the Mental Health Minimum Dataset.

- We need to better understand why minority ethnic groups are underrepresented within the MHMDS compared with the population as a whole.

- We need to share the MHMDS information with GPs and Clinical Commissioning Groups to better understand and identify the causes of this variation as a means of developing more consistent pathways.

Mental Health Inpatient Data Analysis

Introduction

The following is an analysis of two complete years (2009/2010-2010/2011) worth of Mental Health inpatient data extracted from the Coventry and Warwickshire Partnership Trust Contract Datasets. An inpatient is defined as a patient who is admitted with the expectation that they will remain in hospital for at least one night. If the patient does not stay overnight after all, they are still classed as an inpatient.

Analysis

A quarter of all individual inpatients accounted for over half of all spells

During the period, 2009/2010-2010/2011, there were a total of 2,645 inpatient spells. This includes individuals who will have been admitted multiple times. For comparison, there were 1,733 unique individuals who were admitted during the same time period. 25.7% of this total (445 patients) were admitted more than once during the two year period but they accounted for 51.3% of the total inpatient spells (1,357 spells).

Total Number of Inpatient Spells by Year of Admittance, 2009/10 – 2010/11

Year of Admittance	2009/10	2010/11	Grand Total	Percentage Change 2009/10 to 2010/11 (%)
Total Spells	1,403	1,242	2,645	-13.0

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Total Individual Inpatient Admissions by Year, 2009/10 – 2010/11

Year of Admittance	2009/10	2010/11	Grand Total	Percentage Change 2009/10 to 2010/11 (%)
Total Individual Admissions	1,035	698	1,733	-48.3

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Between 2009/10 and 2010/11, while both the total number of inpatient spells and total individual inpatient admissions decreased, the rate of decrease was much sharper for

individual inpatient admissions with a fall of nearly 50% between the 2 years. This was also reflected in the District and Borough data although the pattern was not uniform. The decrease in Individual Inpatient Admissions between 2009/10 and 2010/11 varied from 27% in Stratford-on-Avon to 100% in North Warwickshire. However, it should be borne in mind that these changes only reflect a short one year trend. More work is required to fully understand why there were such dramatic falls in inpatient admissions over this time period and there is a need for improved data collection for future monitoring.

It is worth noting that Mental Health services have been redesigned over the last 18 months and the number of inpatient beds was reduced in early 2010/11, by closing a unit based in Rugby. The net result of this was a reduction of 15 beds. This helps to explain the large reduction in admissions, particularly in the North of the County. The rationale behind these changes went alongside the continued implementation of the crisis resolution services, whose remit is to act as a 'gate keeper' to inpatient admissions, as well as managing crises in the community and preventing unnecessary admissions. The Assertive Outreach service should have already been managing the 'repeat' service users, so this group of patients historically would have been admitted on a regular basis. However, they have been set up for a number of years now.

One of the outcomes of this change was to obviously reduce admissions, however, anecdotally, feedback from the Partnership Trust indicated that there were the same number of admissions, but they were for shorter time periods, as there was a change in attitudes towards risk management, as services were in place to better manage this.

There is also some variation at District and Borough level in terms of the crude rate per 1,000 population for individual inpatient admissions. Using total admissions for 2009/10 and 2010/11, crude rates were highest in Warwick District and lowest in North Warwickshire Borough. Warwick District also experienced the largest proportion of individual inpatient admissions with 29% of the County total.

Total Individual Inpatient Admissions by District/Borough of Residence, 2009/10 – 2010/11

	Year of Admittance		Total	Percentage Change 2009/10 to 2010/11 (%)	Crude Rate per 1,000 Resident Population
	2009/10	2010/11			
North Warwickshire Borough	104	52	156	-100.0	2.5
Nuneaton & Bedworth Borough	224	134	358	-67.2	2.9
Rugby Borough	175	120	295	-45.8	3.1
Stratford-on-Avon District	186	146	332	-27.4	2.8
Warwick District	275	183	458	-50.3	3.3
Warwickshire	964	635	1,599	-51.8	3.0
Null*	71	63	134	-12.7	-
Total	**1,035**	**698**	**1,733**	**-48.3**	**-**

**No address data provided.*

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

54% of the total individual inpatient admissions were for males, with 46% for females. Between 2009/10 and 2010/11, the number of female admissions fell by a larger percentage than the number of male admissions.

Total Individual Inpatient Admissions by Gender

Gender	Year of Admittance		Total	Percentage Change 2009/10 to 2010/11 (%)
	2009/10	2010/11		
Female	486	314	800	-54.8
Male	549	384	933	-43.0
Total	**1,035**	**698**	**1,733**	**-48.3**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

There is widespread variation in the total individual inpatient admissions by Clinical Commissioning Group (CCG) primarily due to the large differences in the numbers of patients which they serve. Admissions were highest for South Warwickshire CCG and lowest for Nuneaton and Bedworth CCG. However, South Warwickshire CCG has a GP registered population of approximately 270,000 compared with only 40,000 for Nuneaton & Bedworth CCG. When crude rates per 1,000 GP registered population for individual inpatient admissions are considered, there is actually very little variation between the CCGs.

Total Individual Inpatient Admissions by Clinical Commissioning Group

Clinical Commissioning Group	Year of Admittance		Total	Percentage Change 2009/10 to 2010/11 (%)	Crude Rate per 1,000 GP Registered Population
	2009/10	2010/11			
North Warwickshire	279	172	451	-62.2	3.2
Nuneaton and Bedworth	80	38	118	-110.5	3.0
Rugby	185	124	309	-49.2	3.1
South Warwickshire	484	355	839	-36.3	3.1
NULL	7	7	14	0.0	-
Total	**1,035**	**696**	**1,731**	**-48.3**	**-**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

The table below details the individual mental health inpatient admissions by service area. The largest number and proportion of admissions between 2009/10 and 2010/11 were for the adult's service area. 45% of all admissions were accounted for by this particular service area. As expected, there were large falls in the number of admissions across each of the different service areas during the two years.

Total Individual Inpatient Admissions by Service Area

Service Area	Year of Admittance		Total	Percentage Change 2009/10 to 2010/11 (%)
	2009/10	2010/11		
Adults	446	342	788	-30.4
Learning Disabilities	18	7	25	-157.1
Older People	322	188	510	-71.3
Substance Misuse	249	161	410	-54.7
Total	**1,035**	**698**	**1,733**	**-48.3**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

In terms of service description, acute services received the highest number of individual inpatient admissions over the period 2009/10 to 2010/11, accounting for nearly 40% of all individual inpatient admissions over the 2 year time period. Other areas experiencing high numbers of mental health inpatient admissions included mixed services, organic services and those for alcohol. These four areas accounted for over 80% of all admissions.

Total Individual Inpatient Admissions by Service Description

Service Description	Year of Admittance		Total	Percentage Change 2009/10 to 2010/11 (%)
	2009/10	2010/11		
Acute	373	304	677	-22.7
Alcohol Admissions	190	113	303	-68.1
Drug Admissions	44	40	84	-10.0
Eating Disorders Admissions	15	8	23	-87.5
Functional	64	29	93	-120.7
Learning Disability Inpatients (Old)	11	5	16	-120.0
Learning Disability Inpatients (Other)	4	2	6	-100.0
Learning Disability Inpatients (Respite)	3	-	3	-
Mix	154	94	248	-63.8
Organic	104	65	169	-60.0
Psychiatric Intensive Care Unit (PICU)	67	32	99	-109.4
Rehabilitation	6	6	12	0.0
Total	**1,035**	**698**	**1,733**	**-48.3**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

At a District and Borough level, there is considerable variation in terms of the number of individual inpatient admissions for each of the more detailed service descriptions. Some of this variation can most likely be explained by the physical location of where some specialist inpatient services are provided across the County.

Warwick District has the highest total inpatient admissions and the highest (or joint highest) numbers of admissions across six of the 12 services across the County.

Total Individual Inpatient Admissions by Service Description & District/Borough of Residence

Service Description	North Warwickshire Borough	Nuneaton & Bedworth Borough	Rugby Borough	Stratford-on-Avon District	Warwick District	Null*	Total
Acute	70	146	126	102	179	54	677
Alcohol Admissions	18	74	52	57	90	12	303
Drug Admissions	5	14	18	19	25	3	84
Eating Disorders Admissions		2	4	9	8		23
Functional		1	6	37	44	5	93
Learning Disability Inpatients (Old)		1	2	4	5	4	16
Learning Disability Inpatients (Other)			5			1	6
Learning Disability Inpatients (Respite)			2		1		3
Mix	51	80	61	7	11	38	248
Organic	4	5	9	78	63	10	169
Psychiatric Intensive Care Unit (PICU)	8	31	9	16	28	7	99
Rehabilitation		4	1	3	4		12
Total	**156**	**358**	**295**	**332**	**458**	**134**	**1,733**

**No address data provided.*

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Over half of all individual inpatient admissions were for patients aged between 25 and 54. Only 6% were for those aged up to 24. More than one in five were aged 75 or over.

Higher numbers of younger patients tended to be admitted for alcohol, drugs, eating disorders and to psychiatric intensive care compared than older patients. In contrast, higher numbers of older patients were admitted for functional, mixed and organic services (which is not surprising as these cater for conditions such as dementia).

Total Individual Inpatient Admissions by Service Description & Age

Age Group	Service Description												
	Acute	Alcohol Admissions	Drug Admissions	Eating Disorders Admissions	Functional	Learning Disability Inpatients (Old)	Learning Disability Inpatients (Other)	Learning Disability Inpatients (Respite)	Mix	Organic	Psychiatric Intensive Care Unit (PICU)	Rehabilitation	Total
Up to 24	67	7	6	8	0	2	6	3	1	0	12	2	114
25-34	136	65	36	6	0	2	0	0	1	0	24	2	272
35-44	161	100	31	4	0	4	0	0	3	0	24	2	329
45-54	169	74	9	3	0	6	0	0	0	0	24	4	289
55-64	113	43	1	1	0	2	0	0	10	2	10	1	183
65-74	27	11	1	1	38	0	0	0	73	27	5	1	184
75-84	2	3	0	0	33	0	0	0	86	87	0	0	211
85+	1	0	0	0	22	0	0	0	74	53	0	0	150
All Ages	**677**	**303**	**84**	**23**	**93**	**16**	**6**	**3**	**248**	**169**	**99**	**12**	**1,733**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Recommendations

- More work is required to fully understand why there were such dramatic falls in inpatient admissions and there is a need for improved data collection for future monitoring.

- We need to share inpatient data and information with GPs and Clinical Commissioning Groups to better understand and identify the causes of this variation as a means of developing more consistent pathways.

- With the introduction of Payment by Results, commissioners and providers should ensure that data collection is relevant so that care pathways can be better identified.

Mental Health Community Services Data Analysis

Introduction

The following is an analysis of two complete years (2009/2010-2010/2011) worth of Mental Health Community Services data extracted from the Coventry and Warwickshire Partnership Trust Contract Datasets. This essentially includes all non-inpatient activity for adults and older people. Outpatient activity is a subset of this data is explicitly analysed in a subsequent section. An outpatient is defined as someone who attends a hospital or clinic for treatment but does not use an overnight hospital bed for recovery purposes.

For the purposes of this analysis, we have chosen to omit data on learning disabilities and substance misuse as this information is more accurately and comprehensively captured elsewhere. As an indicator of milder mental health needs, we have also provided some brief analysis on number of patients who have accessed mental health day care services at the end of this chapter.

Analysis

During the period, 2009/2010-2010/2011, there were a total of 373,394 mental health community services attendances by Warwickshire residents. This includes individuals with multiple attendances. For comparison, there were 24,375 unique individuals who attended an adult and older people community service during the same time period. This indicates that on average, each individual had 15 attendances during the two-year period.

A fifth of all individuals accounted for nearly 85% of all mental health community services attendances

There were 5,295 individuals who recorded more than ten attendances during the two year period. Excluding the null values for where there was no NHS number recorded, these patients (21.7% of the total unique individual service users) accounted for 84.7% of the total attendances.

Total Number of Community Service Attendances by Year of Admittance, 2009/10 – 2010/11

	2009/10	2010/11	Total	Percentage Change 2009/10 to 2010/11 (%)
Total Attendances	159,759	213,635	373,394	33.7%

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Total Individual Users of Community Services by Year, 2009/10 – 2010/11

	2009/10	2010/11	Total	Percentage Change 2009/10 to 2010/11 (%)
Total Individuals	10,395	13,980	24,375	34.5%

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Between 2009/10 and 2010/11, total community services attendances and numbers of unique individuals both increased at a very similar rate.

There is some minor variation at District and Borough level in terms of the crude rate per 1,000 population for individual users of community services. Using total individuals for the two year period, crude rates were highest in Warwick District and lowest in North Warwickshire Borough. This is the same pattern as that exhibited in the inpatient data.

Total Individual Users of Community Services by District/Borough of Residence, 2009/10 – 2010/11

	Year of Attendance		Total	Percentage Change 2009/10 to 2010/11 (%)	Crude Rate per 1,000 Resident Population
	2009/10	2010/11			
North Warwickshire Borough	947	1194	2,141	26.1%	34.6
Nuneaton & Bedworth Borough	2,141	2542	4,683	18.7%	38.3
Rugby Borough	1,592	1847	3,439	16.0%	36.5
Stratford-on-Avon District	2,201	2627	4,828	19.4%	40.6
Warwick District	2,713	2991	5,704	10.2%	41.1
Warwickshire	**9,594**	**11,201**	**20,795**	16.8%	38.8
Null*	663	2596	3,259	291.6%	-
Total	**10,257**	**13,797**	**24,054**	34.5%	**-**

**No address data provided.*

Due to the way in which the data has been analysed, total numbers of individual users differs slightly from those in the initial table.

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

In 37% of all individual cases, gender was not recorded in the data. However, where gender was recorded, 58% of community service users were female and 42% were males. Between 2009/10 and 2010/11, the number of male and female admissions increased by similar proportions. However, the number of cases where gender was not recorded more than doubled.

Total Individual Users of Community Services by Gender

Gender	Year of Attendance		Total	Percentage Change 2009/10 to 2010/11 (%)
	2009/10	2010/11		
Female	4,311	4,550	8,861	5.5%
Male	3,089	3,319	6,408	7.4%
Not Known	2,857	5,928	8,785	107.5%
Total	**10,257**	**13,797**	**24,054**	**34.5%**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

During the period 2009/10-2010/11, the average number of attendances per individual was highest in Warwick District at over 19 spells. In contrast, in North Warwickshire, the average was 13 spells per individual.

Average Number of Attendances per Individual by District/Borough of Residence, 2009/10-2010/11

	Total Individuals	Total Attendances	Average Attendances per Individual
North Warwickshire Borough	2,141	27,133	12.7
Nuneaton & Bedworth Borough	4,683	74,266	15.9
Rugby Borough	3,439	52,281	15.2
Stratford-on-Avon District	4,828	84,087	17.4
Warwick District	5,704	109,295	19.2
Warwickshire	**20,795**	**373,394**	**18.0**
Null*	3,259	26,332	8.1
Total	**24,054**	**448,734**	**18.7**

**No address data provided.*

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

There is widespread variation in the total individual users of mental health community services by Clinical Commissioning Group (CCG) primarily due to the large differences in the numbers of patients which they serve. Numbers of individual service users were by far highest for South Warwickshire CCG and lowest for Nuneaton and Bedworth CCG. However, South Warwickshire CCG has a GP registered population approximately 7 times as large as that for Nuneaton & Bedworth CCG. When crude rates per 1,000 GP registered population for individual service users are considered, they are actually very similar across the CCGs.

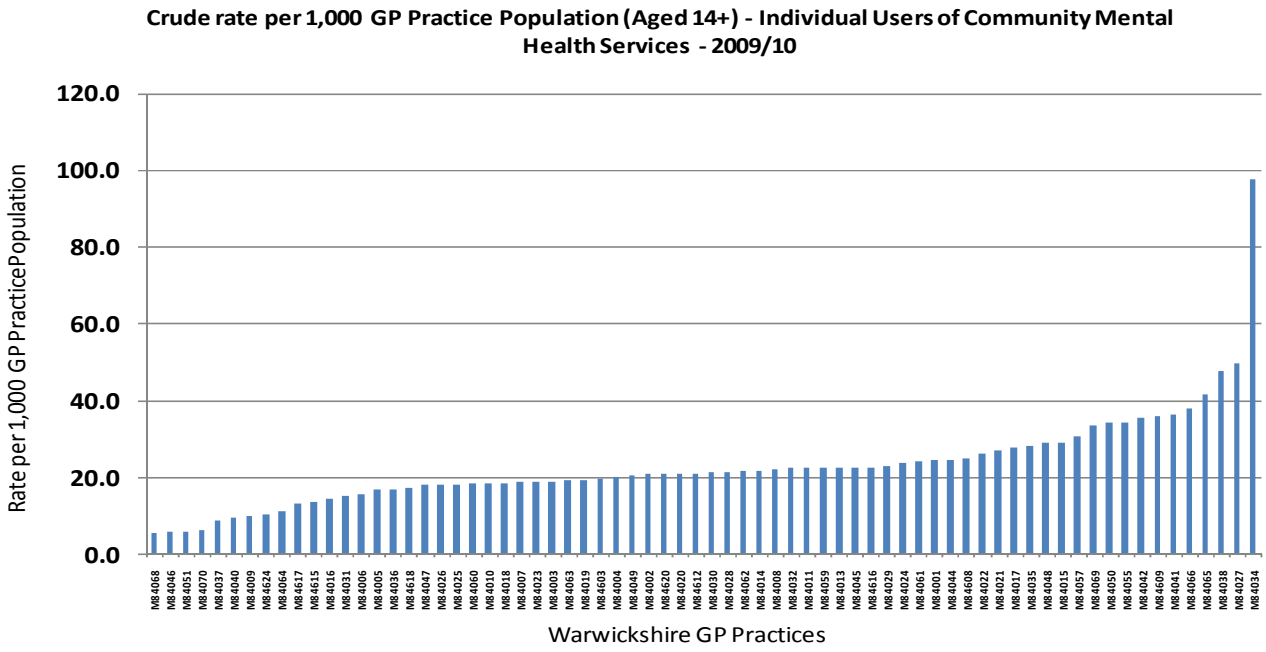
Total Individual Users of Community Services by Clinical Commissioning Group

Clinical Commissioning Group	Year of Attendance		Total	Percentage Change 2009/10 to 2010/11 (%)	Crude Rate per 1,000 GP Registered Population (Aged 14+)
	2009/10	2010/11			
North Warwickshire	2,500	3,104	5,604	24.2%	40.1
Nuneaton & Bedworth	671	768	1,439	14.5%	37.9
Rugby	1,630	1,850	3,480	13.5%	36.0
South Warwickshire	4,697	5,784	10,481	23.1%	39.9
Other	9	5	14	-44.4%	-
Null*	750	2,286	3,036	204.8%	-
Total	**10,257**	**13,797**	**24,054**	**34.5%**	**-**

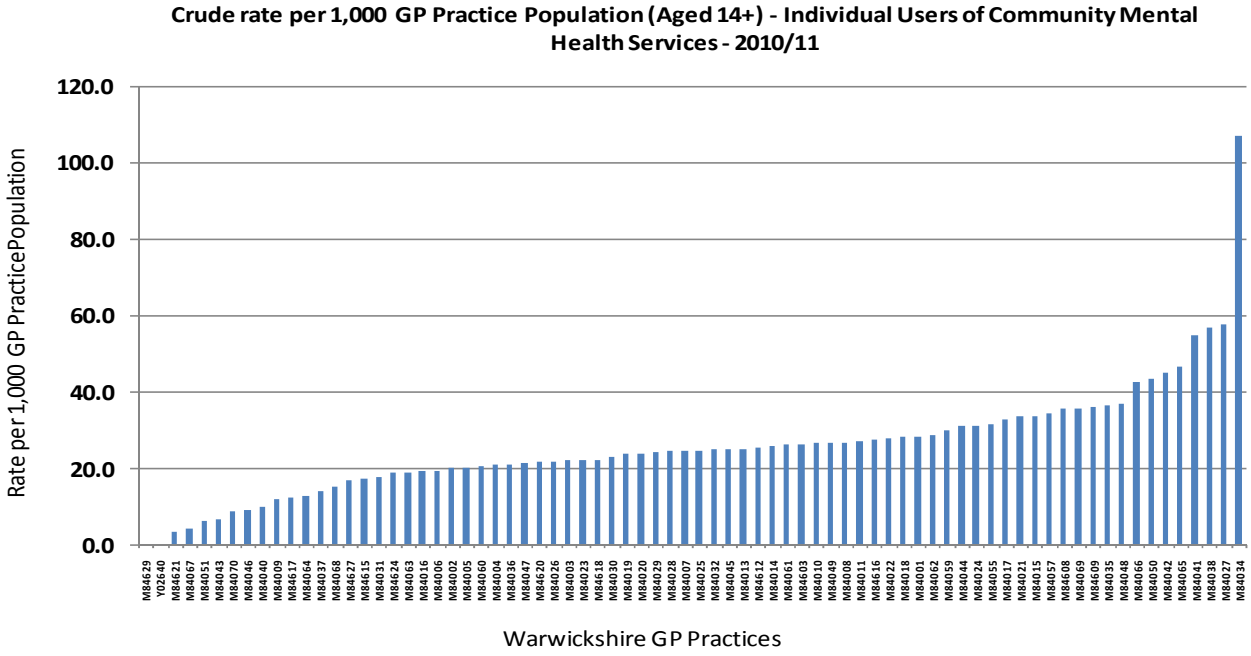
**No address data provided.*

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

The graphs below show the crude rates per 1,000 GP registered population for individual community mental health service users for each of the 76 GP Practices in Warwickshire for each of the last two years. Crude rates have generally fallen between 2009/10 and 2010/11 across the GP practices. Although the majority of practices experience similar rates, there are a few outliers both with high and low rates. More work needs to be undertaken to fully understand these discrepancies.



Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence



Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

The table below details individual users of community mental health services by PAM service description. The largest number of individual users for both 2009/10 and 2010/11 were for the Adults Community Mental Health Teams. A third of all individuals were accounted for by this particular service area. As expected, there were increases in the number of individual service users across the majority of the different service areas during the two years. However, the Improving Access to Psychological Therapies (IAPT) service experienced a particularly dramatic increase following its transition from development to full roll-out. The

number of individuals using IAPT increased by 2,775 or nearly 1,500% albeit from a low starting point in 2009/10 when the service first began.

In terms of some of the services which have experienced large increases or falls in service users, it is important to understand whether there are real differences in services delivered or whether there is a coding issue. There is a need to review and ensure consistent coding practice across services.

Total Individual Users of Community Services by PAM Service Description

Service Description	Year of Attendance		Total	Percentage Change 2009/10 to 2010/11 (%)
	2009/10	2010/11		
Adults Assertive Outreach	188	210	398	11.7%
Adults Community Mental Health Teams	4,053	3,891	7,944	-4.0%
Adults Crisis Resolution	778	1,034	1,812	32.9%
Adults Early Intervention	89	98	187	10.1%
Adults Follow Up Outpatients Mental Health	1,287	1,199	2,486	-6.8%
Adults New Outpatient Mental Health	343	4	347	-98.8%
Adults New Outpatients Psychotherapy	1	346	347	34500.0%
Adults Outpatients Other	5	21	26	320.0%
Improving Access to Psychological Therapies (IAPT)	190	2,965	3,155	1460.5%
Older Adults Community Mental Health Teams	2,290	2,629	4,919	14.8%
Older Adults Early Onset Dementia	2	10	12	400.0%
Older Adults Follow Up Outpatients	802	1,151	1,953	43.5%
Older Adults New Outpatients	229	239	468	4.4%
Total	**10,257**	**13,797**	**24,054**	**34.5%**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Further related analysis, data and narrative is available in the following chapters:

- Dual diagnosis
- Psychosis
- Physical Health and Mental Health
- Older People

Mental Health Outpatient Data Analysis

Introduction

The following is an analysis of two complete years (2009/2010-2010/2011) worth of Mental Health outpatient data extracted from the Coventry and Warwickshire Partnership Trust Contract Datasets. An outpatient is defined as someone who attends a hospital or clinic for treatment but does not use an overnight hospital bed for recovery purposes.

Analysis

During the period, 2009/2010-2010/2011, there were a total of 48,495 mental health outpatient attendances. These figures include individuals with multiple attendances. For comparison, there were 13,446 unique individuals who attended an outpatient appointment during the 2 year period. This indicates that on average, each individual had 3.6 outpatient attendances during the two-year period.

10% of all individual outpatients accounted for over 40% of all outpatient attendances

There were 1,394 individuals who recorded more than ten outpatient attendances during the two year period. Excluding the null values for where there was no NHS number recorded, these patients (10.4% of the total unique individual outpatients) accounted for 43.3% of the total outpatient attendances.

Total Number of Outpatient Attendances by Year of Admittance, 2009/10 – 2010/11

	2009/10	2010/11	Total	Percentage Change 2009/10 to 2010/11 (%)
Total Attendances	18,544	29,951	48,495	61.5%

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Total Individual Outpatients by Year, 2009/10 – 2010/11

	2009/10	2010/11	Total	Percentage Change 2009/10 to 2010/11 (%)
Total Individual Admissions	6,159	7,287	13,446	18.3%

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Between 2009/10 and 2010/11, total outpatient attendances increased at a faster rate than the total number of individuals.

Mental Health Day Care Services (Adults & Older People) Data Analysis

As an indicator of milder mental health needs, we have also looked at the number of patients who have accessed mental health day care services.

During the period, 2009/2010-2010/2011, there were a total of 28,891 mental health day care spells by Warwickshire residents. This includes individuals who accessed services multiple times. For comparison, there were 2,189 unique individual users during the same time period.

Total Number of Day Care Spells by Year of Admittance, 2009/10 – 2010/11

	2009/10	2010/11	Total	Percentage Change 2009/10 to 2010/11 (%)
Total Day Care Spells	15,225	13,666	28,891	-10.2%

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Total Individual Day Care Users by Year, 2009/10 – 2010/11

	2009/10	2010/11	Total	Percentage Change 2009/10 to 2010/11 (%)
Total Day Care Users	1,027	1,162	2,189	13.1%

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Recommendations

- For community data, we need to understand why gender is not always recorded and why numbers of 'not known' codings have increased at such a dramatic rate.

- Further investigation should be undertaken to identify the reasons why variation in community services demand exists at a District/Borough level. Is it to do with caseload mix, demand capacity or different ways of working?

- Community Mental Health data needs to be shared with GPs and Clinical Commissioning Groups to support the identification of the causes of variation and to develop more consistent pathways.

- We need to fully analyse the impact of the IAPT service and review next year's data to understand if it is actually reducing demand for Coventry & Warwickshire Partnership Trust services of if it is simply delaying people going into secondary services. It is recommended that further work is undertaken to find out how many and what proportion of IAPT service users eventually require secondary care.

- We need to better understand the way in which data is coded to a particular community mental health service to more accurately ascertain whether there is a significant, 'real' change in demand or provision.

Topic Area - Mental Health and Older People

Many older people in the UK are healthy, happy and contribute to society. However, although the UK population is living longer and is in better health than ever, there is increasing evidence that the proportion of older people who are lonely, depressed or less satisfied with their lives is increasing.

Three areas that impact most on the mental wellbeing of the older population are:

- Social exclusion and isolation
- Life events – retirement and bereavement
- Poverty and deprivation

Note: There are separate chapters for Dementia and Social Care.

Introduction

Many older people in the UK are healthy, happy and contribute to society. However, although the UK population is living longer and is in better health than ever, there is increasing evidence that the proportion of older people who are lonely, depressed or less satisfied with their lives is increasing.

The older population who are from lower socio-economic classes are increasingly affected by lower income and poor housing and environments. For those older people living alone, social isolation impacts on their mental health and wellbeing. Older carers are also at risk of reduced wellbeing due to their caring commitments and social isolation.

The data on mental health issues in older people is limited by the known fact that many mental health problems in older people are undiagnosed and untreated. This may be due to insensitive screening tools, insufficient proactive screening in primary care or lack of awareness of services and support available to the older population.

The mental health and wellbeing in older people was highlighted as a key health and social care priority when in 2008 the National Institute for Health and Clinical Excellence (NICE)[42], developed guidance for those with a role in promoting older people's wellbeing.

By promoting mental health and wellbeing in later life, the whole of society will benefit by maintaining older people's social and economic contributions, minimise the costs of care and improve quality of care.

National Perspective

By 2020, it is expected that one in five people will be aged 65 and over. This poses challenges for health and social care services in providing appropriate services for this age group.

Similarly, the number of people aged 75 and over and 85 and over will also increase over time. For example, the over 85s are estimated to increase from 1.2 million in 2006 to nearly 3million in 2031.

However, whilst people will be living longer, not all the years lived will be in good health. Chronic diseases and long term conditions will affect this age group, and there is increasing evidence (as seen in the physical health/mental health chapter), that living with these conditions increases the probability of depression and other mental health problems.

The Social Care Institute for Excellence (SCIE)[43] reports on Department of Health data that suggests:

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[42] *NICE.2008, Guidance for Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care*

[43] Social Care Institute for Excellence. 2006, Adults Services: SCIE Guide 03 – Assessing the Mental health Needs of Older People

40% of older people seeing their GP

50% of older people in general hospitals

60% of care home residents have a mental health issue. The impact of these figures are important to consider as older people with mental health problems are more likely to end up in institutional care, recover less well from physical problems and illness and are more vulnerable to abuse.

Depression

Depression in older people, as with the general population, is the most common mental health problem[44] . Lee (2006)[45] estimates that up to a quarter of older people have their quality of life affected by depression. However, experiencing isolation, loneliness or loss will also cause many more to experience psychological or emotional distress.

Nationally, there are estimated to be over 2.4 million older people with depression impairing their quality of life. Once again though, it is expected that this is an under-estimation due to the low levels of those with depression actually discussing their ill health with their GP – for older people it is suggested that less than a third discuss their depression symptoms with their GP[46].

Allen (2008)[47] suggests that commissioners of older people services should expect to see an increase in the numbers of older people with poor emotional wellbeing for several reasons:

- The increase in the numbers of older people, as well as in the 'older' old population
- An increase in the number of older people caring for relatives and at higher risk of depression
- Mental health problems may be more prevalent over the life course

A 2004 Help the Aged Report[48] is reflected on in the SCIE report – which suggests that suicide is a significant risk for older people who are depressed. Older men aged 75 and over have the highest incidence of suicide.

[44] National Institute of Mental Health England. 2005.

[45] Lee. M. 2006, Promoting Mental health and Well-being in Later Life: First Report from the UK Inquiry into Mental Health and Well-Being in Later Life London: Mental Health Foundation and Age Concern.

[46] Chew-Graham. C and Burroughs. H. 2004, Depression in the Elderly

[47] Allen. J. 2008, Older People and Wellbeing: Institute for Public Policy Research

[48] Age Concern. 2004, Depression…..It's More Common Than you Think

Social Exclusion and Mental Health

Allen's review of Office of National Statistics Data shows that for pensioners (men over 65 and women over 60), between 1996 and 2005, their average income rose faster than younger people's. The proportion of pensioners in the bottom fifth of income distribution in 2004/5 had fallen to 25%.

However, more recent figures show a worsening trend for relative pensioner poverty and between 2005 and 2007, there was an increase of 300,000 pensioners living in relative poverty.

Poverty has a clear relationship with poor emotional wellbeing, as does inequality. Within the over 65 age group itself, the gains in income have not been evenly distributed[49] :

- Older pensioners have less income than younger pensioners
- Female pensioners have lower incomes than men, on average.
- Minority ethnic groups are less likely to receive occupational or private pensions. They are also less likely to receive the state retirement pension.

Pickett and Wilkinson (2007)[50] have identified that stress associated with living in an unequal society are associated with poverty - including making ends meet and social exclusion - and these are no different in older people.

Social and community participation, and a close, confiding relationship improve mental wellbeing and can also reduce the impact of depression. Within the UK however, estimates suggest that one million older people are socially isolated, and this number is projected to rise to 2.2 million over the next fifteen years.

Dunnell (2008)[51] identifies that a quarter of men over 75 years live alone. For women over 75 years this increases so that nearly a third are living alone.

Older People as Carers

People aged 50 and over, are more likely to be providing informal care than any other age group. It has been reported that those individuals who provide more than 20 hours of care per week have increasing symptoms of depression. With an increasing older population, the impact on carers' wellbeing will also continue to rise.

[49] Office for National Statistics. 2006b, The Pensioners Income Series 2004/5:

[50] Picket. K and Wilkinson. R .2007, Child Wellbeing and Income Inequality in Rich Societies: Ecological Cross Sectional Study

[51] Dunell. K. 2008, Diversity and Differing Experiences in the UK: National Statistician's Annual Article on Society London

Older People and Substance Misuse

In 2011, the Royal College of Psychiatrists produced a report[52] from its Older Persons' Substance Misuse Working Group. During the 1:1s this topic was also raised as an increasing concern for service providers within Warwickshire.

From Office of National Statistics data (2009), the number of deaths in the UK linked to alcohol more than doubled between 1992 and 2008, with the highest death rates found in men aged 55-74. Among women, those aged 55-74 had the highest alcohol-related deaths.

Deaths related to drug poisoning among people aged over 40 years have also increased since 2004. Within the report, it is also suggested that these figures may be an under representation due to variations as to whether drug or alcohol's contribution to a death are actually recorded on the death certificate.

Morbidity is also affected by substance misuse. The SCIE report identifies that:

- alcohol consumption has been identified as one of the three most common reasons for falls in older people
- alcohol can react adversely with prescribed medication
- excessive drinking puts older people at risk of coronary heart disease, stroke and quality of life for older people
- heavy drinking can lead to self-neglect, poor nutrition, poor hydration and hypothermia

Mental Wellbeing and Older People

The 2008 NICE guidance identified priorities including:

- Recommending that professionals who provide support and care services for older people in the community or residential settings should apply the principles and methods of occupations therapy. This includes regular group or individual sessions to encourage older people to identify and carry out daily routines and activities to maintain or improve wellbeing
- Increase older people's knowledge and awareness of where to get reliable information on healthcare, nutrition, personal care, staying active, benefits, home and community safety and transport schemes
- Tailored exercise and physical activity programmes in the community focusing on moderate intensity exercise and strength and resistance training
- Encouraging older people how to exercise safely on a daily basis
- Offer a range of walking schemes to suit different abilities
- Promote regular participation and information on the benefits of walking

[52] Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists. 2011, College Report CR165: Our Invisible Addicts

What is happening in Warwickshire?

Older People Population Estimates in Warwickshire

Population Mid-2010 Estimates	Older People Numbers	Older People Percentage of the Total Population
North Warwickshire	11,300	18.3%
Nuneaton and Bedworth	20,900	17.1%
Rugby	16,800	17.8%
Stratford-on-Avon	25,700	21.6%
Warwick	23,400	16.9%
Warwickshire	98,000	18.3%

Source: Office of National Statistics 2011

Figures may not add due to rounding and all figures are rounded to the nearest 100

The population of Warwickshire is projected to reach at total of 634,900 – an increase of 101,700 or 19.1% on the 2008 ONS mid-year estimate. This increase over the 25 year period is higher than the projected regional and national population growth rates of 14% and 18% respectively.

Across Warwickshire as a whole, the highest rates of projected population growth are in the groups aged 65 and over. The rate of growth increases with age, with the oldest age group (those aged over 85 and over) projected to almost treble in size from 12,000 to 35,000 by 2033. This trend is reflected across all the districts and boroughs.

'We know the number of older people are growing, we need to get the planning of services right now, so that we can mobilise and offer the right care in the right setting in the right location.

Depression

The POPPI (Projecting Older People Population Information) website provides date on those aged 65+years that are predicted to have depression:

Depression in People Aged 65 and Over in Warwickshire

Mental Health Problem	2012	2013	2014
Males aged 65-69 predicted to have depression	951	980	986
Males aged 70-74 predicted to have depression	787	821	869
Males aged 75-79 predicted to have depression	525	549	566
Males aged 80-84 predicted to have depression	611	631	640
Males aged 85 and over predicted to have depression	240	255	270
Females aged 65-69 predicted to have depression	1,864	1,918	1,940
Females aged 70-74 predicted to have depression	1,178	1,235	1,302
Females aged 75-79 predicted to have depression	1,102	1,145	1,177
Females aged 80-84 predicted to have depression	754	764	773
Females aged 85 and over predicted to have depression	999	1,021	1,043
Total People aged 65 and over to have depression	**9,011**	**9,319**	**9,557**

Source: POPPI

Severe Depression in People Aged 65 and Over in Warwickshire

Mental Health Problems	2012	2013	2014
People aged 65-69 predicted to have severe depression	835	863	870
People aged 70-74 predicted to have severe depression	381	398	419
People aged 75-79 predicted to have severe depression	672	700	721
People aged 80-84 predicted to have severe depression	435	441	447
People aged 85 and over predicted to have severe depression	534	550	573
Total People aged 65 and over to have severe depression	**2,857**	**2,952**	**3,031**

Source: POPPI

The datasets from the Coventry and Warwickshire Partnership NHS Trust have allowed the following analysis:

Outpatient Services

Total Individual Users of Community Services by PAM Service Description

Service Description	Year of Attendance		Total	Percentage Change 2009/10 to 2010/11 (%)
	2009/10	2010/11		
Older Adults Community Mental Health Teams	2,290	2,629	4,919	14.8%
Older Adults Follow Up Outpatients	802	1,151	1,953	43.5%
Older Adults New Outpatients	229	239	468	4.4%
Total	**3,321**	**4,029**	**7,340**	**21.3%**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

There has been an increase in the total individual users of community services in all categories of older people services.

Total Spells of Community Services by PAM Service Description

Service Description	Year of Attendance		Total	Percentage Change 2009/10 to 2010/11 (%)
	2009/10	2010/11		
Older Adults Community Mental Health Teams	25,636	26,172	51,808	2.1%
Older Adults Follow Up Outpatients	2,937	6,095	9,032	207.5%
Older Adults New Outpatients	957	1,656	2,613	57.8%
Total	**29,539**	**33,942**	**63,481**	**14.9%**

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

The number of spells has increased by 14.9% within the Older Adults Outpatient Services. In 2009/10 there was an average of 8.9 outpatients spells per individual, but in 2010/11, and this has reduced slightly to 8.4 outpatient spells per individual.

Inpatient Services

A review of the inpatient data was undertaken which excluded:

- Under 55s
- Organic category (i.e. Dementia)

Which would then allow an understanding of the general older adults admissions. It was found that over the two years 2009/10 and 2010/11 there were 637 individuals admitted to Coventry and Warwickshire Partnership NHS Trust inpatient beds.

These 637 individuals represent 36% of the total inpatient admissions to the Partnership Trust.

With regard to substance misuse within older people, when reviewing the 55+year old admissions, it was seen that there 63 inpatient admissions to the Partnership Trust with substance misuse identified. This equates to 15% of the total recorded substance misuse inpatient admissions.

As of July 2011, there are 101 inpatient beds across Coventry and Warwickshire for inpatient care. There are 25 beds for functional mental illness in South Warwickshire and 12 beds for functional mental illness serving North Warwickshire and Rugby.

From the one to one consultations, it was suggested that there are insufficient residential and nursing home beds in the South of the county which leads to delayed discharge. A delayed discharge for mental health patients can make recovery more problematical.

Rugby and Community Assessment and Intensive Treatment Team

To support older people at home, the development of a Crisis Intervention and Home Treatment Team (CAITT) has been piloted and developed in Rugby, as a new way of working.

Predominantly the team assesses and support patients during the diagnosis of dementia, and aims to do this within the patient's home. The service is not starting to provide crisis and assertive outreach in older people

The service follows a model of care where there is a beginning, a middle and an end to the treatment to enable the patients to be discharged from the service, generally after 5-6 weeks of input.

'The CAITT model in Rugby would be a good service redesign across the county'.

With only two year's reviewed for outpatients, it is difficult to draw firm conclusions, but the new way of working by CAITT may be contributing to the reduction in the number of outpatient spells per older person.

Older People's Mental Health (OPMH) Teams

There are 5 multidisciplinary CPMH Teams within Warwickshire:

- Manor Court for Nuneaton, Bedworth and North Warwickshire
- The Oaks, St Michaels Hospital, Warwick
- Loxley Unit, Stratford upon Avon
- The Railings, Rugby
- CAITT Team, Rugby

The teams provide health and social care to older people with mental health needs and their carers and whose needs are complex and fall within the scope of the service. The Team provides assessments and interventions to:

- People over the age of 65 with mental health problems
- Service users previously known to working age CMHT who have now graduated into older adults psychiatry due to their presenting needs
- People under the age of 65 who have a diagnosis of early onset dementia

As discussed in the Legislation chapter, there are Approved Mental Health Practitioners (AMHPs) who carry out the assessments under the Mental Health Act. Within these numbers, there are 5 social workers from within OPMH teams and during 2010/11 undertook a total of 51 new assessments leading to service delivery.

In the 1:1s, it was raised that while working as a multidisciplinary team and attempting to share skills and caseload, this is made difficult by health and social care using different recording systems and

'one recording system across health and social care would be ideal'.

Perhaps one of the biggest issues raised during the consultation regarded workforce planning. Whilst the number of older people is growing, the workforce to support them in health and social care isn't. Older People's Mental Health is not being chosen by care professionals. Additionally, older people with mental health problems are also requiring nursing staff to support their physical health too.

This is being prioritised in a number of ways:

- A review into recruitment into retention
- Recruiting RGN nurses with mental health nursing skills to help support the physical and mental health needs of inpatients
- Reviewing case-mix – nursing staff may not be the only professionals that can provide the support and skills on the wards – allied health professionals may be a solution
- Assistive technology

Voluntary Sector

The voluntary sector provides a wide range of services for older people – to assist with physical needs as well as mental health and well-being. Other chapters raise the need for a central source of information to be identified to ensure the maximum awareness and access for all Warwickshire's older people.

Warwickshire Strategy

In 2008, Warwickshire's 'Older People Mental Health and Wellbeing - A Strategy for Warwickshire 2008-2011' was published, highlighting the importance that the local authority and NHS had for this issue.

The strategy's vision 'is of an inclusive society where the needs of older people with all types of mental health problems and the needs of their carers are understood, taken seriously, given their fair share of attention and resources and are met in a way that enables them to lead meaningful and productive lives'.

Warwickshire County Council's Citizen Panel identified the top three priorities for older people as:

- To support more people to live at home by providing more low level social care
- The provision of increased support to carers to help them continue their caring role
- The development of a greater range of alternatives to care homes where personal care is available 24 hours a day.

The Warwickshire Strategy identifies that there is a commitment to support people in settings of their own choosing, enable access to community resources including housing,

education, work and friendship – that they think is critical to their own recovery. The vast majority of people have real prospects of recovery if they are supported by appropriate services.

Recommendations

- To assist commissioners, a more extensive analysis of bed utilisation for older people inpatients and residential facilities across the County is suggested.

- An assessment of the impact of CAITT model of working on spells/individual should be made available to commissioners.

- The number of older people using substance misuse services should be monitored, and commissioners may wish to ensure that services are meeting the needs of this 'new' group of service user.

- A central source of information should be developed to maximise the awareness of voluntary and public sector services available to older people.

- A review of workforce planning for older people's mental health should be supported by commissioners, care providers, educational providers and the voluntary sector.

Topic Area - Dementia

Dementia is one of the most severe and challenging disorders we face (Banerjee, 2009)[53]. With the numbers of people with the disease increasing as the older population increases, the costs to health, social care and volunteers will dramatically rise.

There is evidence that investing in a more personalised approach and earlier care for people with dementia, will enable people to remain independent and engaged in their communities for longer.

It has been recognised that much of the resources invested in dementia services are focused on those in the later stages of the condition and that the provision of better quality dementia care represented an opportunity for releasing significant investment (National Audit Office, 2007)[54].

Note: There are separate chapters for Mental Health and Older People, and Social Care.

[53] Banerjee S. 2009, The Use of Antipsychotic Medication for People with Dementia: Time for Action

[54] National Audit Office. 2007, Improving Services and Support for People with Dementia

Introduction

NICE (2006)[55] has described dementia as 'a disorder that affects how the brain works. Symptoms of dementia vary from person to person, but can include:

- Loss of memory
- Difficulty thinking through and understanding
- Problems with language (reading and writing)
- Confusion and agitation
- Hallucinations and delusions
- Difficulty controlling movements of the body

There are many different types of dementia with the most common being:

- Alzheimer's disease
- Vascular dementia
- Dementia with Lewy bodies
- Frontotemporal dementia

National Perspective

A number of key documents have been produced that highlight the need to raise the profile and priority of dementia in the planning of both health and social care services -- NICE (2006)[3] , Alzheimer's Society (2007)[56], Banerjee Report (2009)[1] , Department of Health (2009)[57], The King's Fund (2008)[58] and the National Audit Office (2007)[2] .

The Alzheimer's Society 2007[4] Dementia UK report has been reviewed in 2010 and it is reported that there are now 750,000 people in the UK with dementia. Projections suggest that this will rise to 940,000 by 2021 and over 1.7 million by 2051 [59].

The national costs of dementia have been estimated by the Kings Fund[6] in 2008 as £15 billion, and £20 billion in 2010 by the Alzheimer's Society. These figures are expected to rise with the increase in prevalence of dementia.

[55] NICE. 2006, Dementia: The National Institute for Health and clinical Excellence and Scoal Care Institute for Excellence Guideline on supporting people with dementiaand their carers

[56]Alzheimer's Society. 2007, Dementia UK : A report to the Azheimer's Society in the prevalnce and economic cost of dementia in the UK

[57] Department of Health. 2009, Living Well with Dementia: A national dementia strategy

[58] The King's Fund. 2008, Paying the price: the cost of mental health care in England to 2026

[59] Alzhemer's Society. 2010, Dmentia UK: Update

What is happening in Warwickshire?

As a priority area for Warwickshire County Council and the Primary Care Trust, a 'Living Well with Dementia in Warwickshire' Joint Strategy is already being progressed. The strategy identifies that it anticipates a gradual transformation of services, and a collaboration by all agencies to work to improve the experiences and outcomes of people with dementia and their families.

The main data source for dementia numbers is from the Alzheimers Society Report[4]. The data suggests that for 2011, estimated dementia numbers in Warwickshire are:

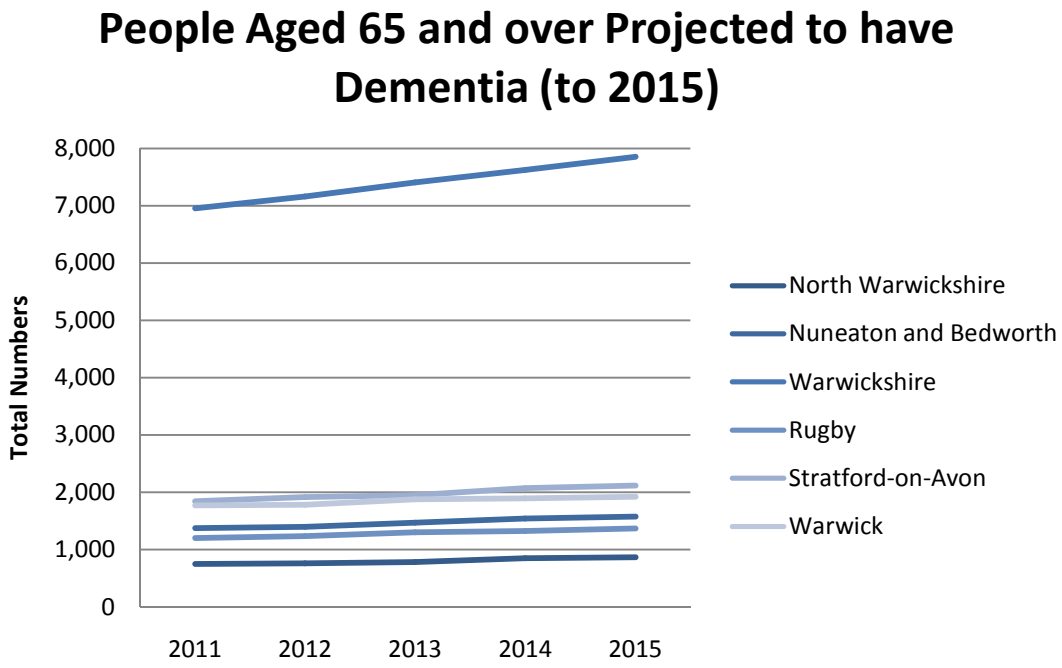
Estimated numbers of people with dementia in Warwickshire

	Males aged 65-79 years	Males over 80 years	Females aged 65-79 years	Females over 80 years	Total Numbers for District
North Warwickshire	123	149	131	345	748
Nuneaton and Bedworth	221	278	243	632	1374
Rugby	177	252	179	592	1199
Stratford on Avon	269	381	288	902	1839
Warwick	231	415	268	853	1766
Warwickshire	1018	1519	1109	3311	6956

Source: London School of Economics and the Institute of Psychiatry at King's College, London for the Alzheimer's Society, 2007.

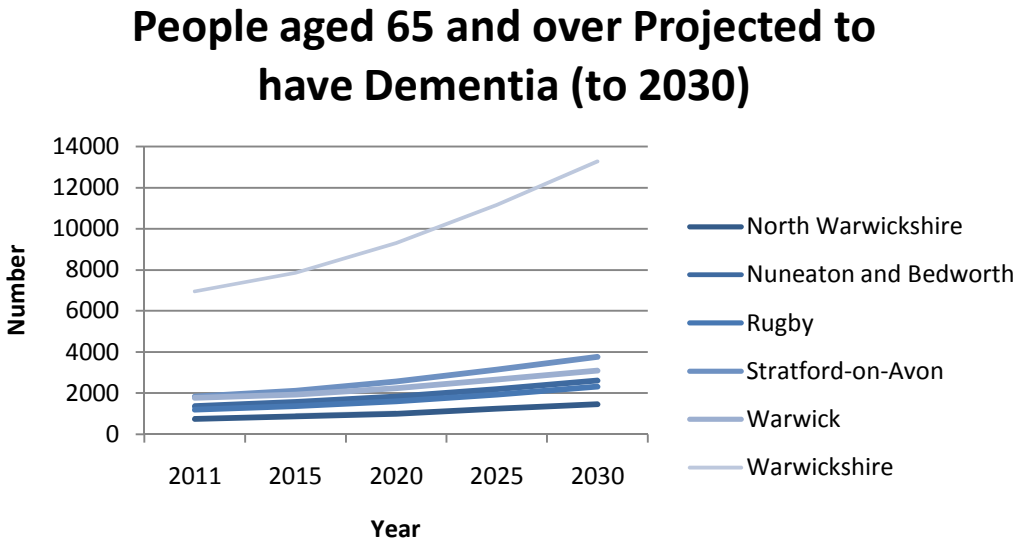
The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia.

Using the same assumptions, additional projections have been made for future years.



Source: POPPI

In 2015, it is projected that for these age groups there will be 7853 people with dementia in Warwickshire and in 2020, this figure rises to 9304 people with dementia in Warwickshire. The 2020 figures indicates a 33% rise in prevalence of people with dementia.



Source: POPPI

From the data, it can be seen that Warwick and Stratford-on-Avon districts have the highest number of people with dementia aged 65 years and over. For all districts and age categories, there are higher numbers of cases of people with dementia.

Inpatient data shows that over the 2009/10 and 2010/11 two year period, there were 202 inpatient admissions Coventry and Warwickshire Partnership NHS Trust with 'Organic Disorders' and it has not been possible to identify dementia explicitly. The average age of the 202 individuals is 80.5 years

Total Inpatients admitted with Organic Mental Health Disorders by District and Borough

	North Warwickshire	Nuneaton & Bedworth	Rugby	Stratford-on-Avon	Warwick	NULL	Total
Total Inpatients admitted with Organic Mental Health Disorders	4	6	10	100	65	17	202

Source: Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

As can be seen from the data, 89% of the inpatient admissions for organic mental health disorders came from the south of the county (Stratford-on-Avon and Warwick Districts). Whilst this may be expected due to the higher prevalence in the South, it is known that additional services such as the Admiral Nurses are available in the North, CAITT services in Rugby and Age UK Peer Support programmes in North Warwickshire, and it is not clear what impact these services are having on reducing admissions.

Early Onset Dementia

Whilst the majority of dementia occurs in the age groups above, early onset dementia cases occur in those people aged under 65 years. Using the same data source, it is suggested that in 2011 the following numbers of people with early onset dementia were predicted in Warwickshire.

Estimates of People with Early Onset Dementia in Warwickshire

	Males under 64 years predicted to have early onset dementia	Females under 64 years predicted to have early onset dementia
North Warwickshire	11	8
Nuneaton and Bedworth	20	14
Rugby	15	10
Stratford-on-Avon	22	15
Warwick	21	14
Warwickshire	89	60

Source: Dementia UK

The data suggests that within Warwickshire there is predicted to be approximately 150 people with early onset dementia. Of note, for each district, it is projected that more males will have early onset dementia. This may have a larger impact on the family unit – with men being more likely to be in work than women (75% versus 65%)[60].

However, the dataset information shows limited recording of early onset dementia users:

Total Individual Users of Community Services by PAM Service Description

Service Description	Year of Attendance		Total
	2009/10	2010/11	
Older Adults Early Onset Dementia	2	10	12

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Total Individual Spells of Community Services by PAM Service Description

Service Description	Year of Attendance		Total
	2009/10	2010/11	
Older Adults Early Onset Dementia	9	19	28

It is unclear at this stage whether the very small numbers recorded in the dataset are due to:

[60] Poverty.org.uk

- Numbers referred to the Partnership Trust being actually this low, or are Early Onset Dementia patients recorded in a number of other services
- A lack of identification of Early Onset Dementia by individuals, carers and primary care resulting in no referrals to the Partnership Trust
- A perception that there are no services available for Early Onset Dementia patients and so no referrals made

There were concerns raised during the consultation phase of the Needs Assessment regarding the services available for Early Onset Dementia. The clinical care is able to be met by the Older People's clinicians and practitioners, but there are issues regarding the suitability of younger dementia patients being treated on care of the elderly wards which for some was seen as 'inappropriate'.

Services in Warwickshire

Throughout the 1:1 consultations, it was apparent that many services are being delivered on a locality basis, and a perception that not all services were available to all people with dementia in Warwickshire.

Concerns were raised in the 1:1s that rural areas may not be as well resourced with support, and domiciliary care may be limited due to travelling costs. With the introduction of personalised budgets, one organisation admitted that:

"There are limitations to service provision in a rural village, and we would have to decline the patient if financially non-viable"

CAITT

As described in the Older People chapter, the Coventry and Warwickshire Partnership Trust has developed a new way of working, initially in Rugby, to assist and enable older people (including those with dementia) to remain living in their normal environment.

The following list is not exhaustive of all the voluntary sector activities in the community, but were the ones that were most frequently recalled by other health and social care staff, and highlights the geographical variation that exists in dementia services in Warwickshire.

Admiral Nurses (Dementia UK)

The Admiral Nurses provide a service in Nuneaton and Bedworth. Admiral Nurses are specialist mental health nurses specialising in dementia. Admiral Nurses work with family carers and people with dementia, in the community and other settings. When the Admiral Nurses are contacted about a family in other parts of the county, they assist with signposting to other services, in particular the Admiral Nursing DIRECT national telephone helpline, provided by experienced Admiral Nurses and supported by the charity Dementia UK. It offers practical advice and emotional support to people affected by dementia.

Guideposts

Guideposts Trust exists to provide direct services in the community for people with or recovering from mental health issues, for people with Alzheimer's and other forms of dementia and is based in Rugby.

Guideposts Information Service

Having been in Rugby for 3 years, now provide Warwickshire wide service including a website, helpline and drop in service designed for families and informal carers of dementia patients.

Guideposts Help at Home

Part of Guideposts, this service provides domiciliary service for dementia patients for patients in Rugby, Leamington, Warwick and Kenilworth. Keeping patients out of hospital is important as capacity can be lost if admitted due to disorientation, and lack of control of the facilities.

Carer Support Service – Guideposts have provided a carer support service in North Warwickshire and now providing support for all carers (dementia and non dementia patients) for the whole of Warwickshire.

Alzheimer's Society Cafes
These provides information, emotional support, social support, informal consultations, encourages peer support and the opportunity to meet with professionals in a social setting. They are held in Rugby, Leamington, Warwick, Shipston and Atherstone.

Alzheimer's Society Community Support Stratford District
This service is for people who are in the early stages of dementia and want to and are able to continue with their usual social activities. A Leisure and wellbeing worker visits the home and provides encouragement and companionship to the person with dementia.

Alzheimer's Society Leamington Spa
The Carer Information and Support Programme provides support and up to date, relevant and evidence based information in a group environment.

The initial contact with the patient or family living with dementia was seen as important by many, but the most difficult to achieve at the earliest opportunity. There appears to be a number of reasons why a delay in seeking help occurs:

- A delay by the patient or carer seeing the GP regarding memory loss symptoms
- A reluctance by carers to individually seek help
- Lack of awareness in primary care of support services available locally

Recommendations

- South Warwickshire commissioners should examine the dementia services in the North of the county that are not currently available to their residents, and to identify the potential benefits to patients.

- The Needs Assessment is able to provide data (approx 149 patients in 2011) of the Warwickshire population that may have early onset dementia. An updated care pathway is suggested to ensure age and clinically appropriate services are identified for this group of patients.

- To identify a method of communicating local services regularly to GPs and primary care staff to ensure up to date and current information is able to be provided to dementia patients and their carers at the earliest opportunity.

- Commissioners should monitor the impact of personalised budgets and to have confidence that geographical isolation is not also reducing the services available and offered to service users.

Topic Area - Dual Diagnosis

Dual Diagnosis is a challenging problem for both mental health and substance misuse services. People with mental health problems, who also suffer from substance misuse are at an increased risk of suicide, as well as experience financial and housing problems and are less likely to engage with treatment interventions.[61]

[61] Dual Diagnosis - Good Practice Guidance, Dept of Health (2002);

Introduction

Dual Diagnosis is a challenging problem for both mental health and substance misuse services. People with mental health problems, who also suffer from substance misuse are at an increased risk of suicide, as well as experience financial and housing problems and are less likely to engage with treatment interventions.[62]

The National Institute for Health and Clinical Excellence (NICE) in its March 2011 clinical guidance refers to dual diagnosis as, "people with psychosis who use drugs and/or drink in a way that is harmful."[63]

In NHS Warwickshire, the following local definition has recently been agreed upon:
Dual diagnosis is "the co-existence of mental illness with substance misuse which has an adverse effect on an individual's biological, psychological and social well-being."[64]

National Perspective

A new National Drugs Strategy (NDS)[65] was launched by the Government in December 2010, "Reducing demand, restricting supply, building recovery: supporting people to live a drug free life". It has three main themes: Reducing demand for drugs, Restricting Supply of drugs, and building recovery in communities. The Strategy presents a new approach to drug treatment by placing the focus on recovery and outcomes rather than on harm reduction and maintenance. For the first time, the Strategy also covers severe alcohol dependency and advocates an integrated approach to treatment provision.

Alcohol is considered harmful when it leads to physical or mental health problems such as alcohol related injury, inflammation of the liver or pancreas, or depression. Alcohol can also exacerbate pre-existing mental health problems, relationship problems, problems at work, college or school, or violence.

There are obvious difficulties in estimating the numbers living with a dual diagnosis - NICE reports that in the UK, it is thought that the number of people with a potential dual diagnosis is high and possibly rising with community mental health teams typically reporting that 8-15% of their clients have dual diagnosis problems although higher rates may be found in inner cities.[66] However the findings from the 2010 British Crime Survey suggest that about half of patients in drug and alcohol services have a mental health problem, most commonly depression or personality disorder.[67]

The National Treatment Agency (NTA) for substance misuse reports figures for 2009/2010 which were published on 07th October 2010, show there are approx. 320,000 problem drug users in England who are dependent on heroin or crack cocaine, out of which 206,889 adults

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[62] Department of Health. 2002, Dual Diagnosis - Good Practice Guidance,

[63] National Institute of Health and Clinical Excellence. 2011, Clinical Guidance 120

[64] Rethink and Turning Point, 2004, Dual Diagnosis Good Practice Handbook

[65] Home Office. 2010, Reducing Demand, Restricting supply, Building Recovery: Supporting People to Live a Drug-Free Life

[66] Department of Health. 2002, Dual Diagnosis - Good Practice Guidance

[67] Royal College of Psychiatrists. 2002, Dual Diagnosis Information Manual. Extensive information for practioners working in the field

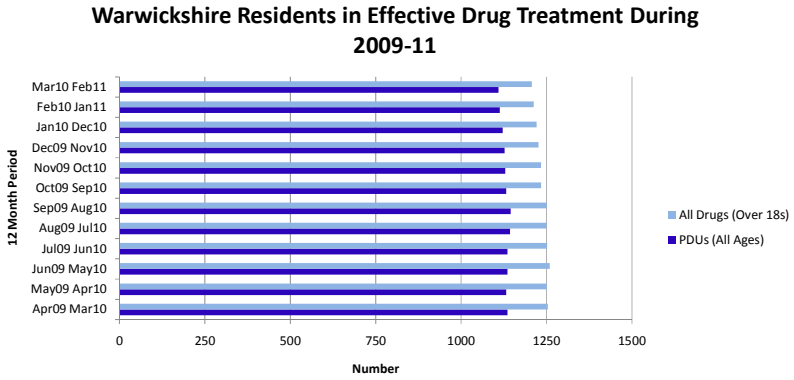
are in contact with treatment services out of which 23,680 adults successfully completed treatment free of dependency.

Early drug and alcohol use is related to a host of educational, health or social problems. A third of the adult treatment (drug or alcohol) population have parental responsibility for a child[68].

What's Happening in Warwickshire

The National Drug Treatment Monitoring System (NDTMS) records information about people receiving treatment for drug misuse in England (i.e. structured community-based services, or residential and inpatient services). Drug treatment data is collected in order to help determine if local drug treatment systems meet the aims and aspirations set out for them by service users, local communities and government.

The data in the table below has been taken from the NDMTS shows 1,127 Problem Drug Users in effective treatment in Warwickshire in 2010/2011 which represent 0.2% of the Warwickshire population (based on mid-2009 population estimates).



Source: National Drug Treatment Monitoring System (NDTMS)
A "PDU" (Problem Drug User) is defined as a client presenting with opiates and / or crack cocaine as their main, second or third drug recorded at any episode during their latest treatment journey.

Episodes where alcohol is cited as the primary substance are excluded from all drug reporting so is not included in PDU figures irrespective of having opiates and/or crack cocaine as their second/third drug.

There were 1,109 PDUs in effective treatment in Warwickshire from Mar 2010 till Feb 2011. The majority of drug users in treatment are male, heroin users aged 20 – 35. Crack is used as a secondary drug by a quarter of heroin users. Cannabis, heroin and cocaine are the main presenting drugs of Tier 2 service users.

[68] National Treatment Agency Media Release (2009) Moves to provide greater protection to children living with drug addicts

Clients "In effective treatment" are all individuals in contact with Tier 3 or 4 services, during the period in question, who are recorded as having begun a drug treatment intervention and who fulfil either of the following criteria:

- They were retained in treatment for 12 or more weeks from their triage date
- They were subject to a planned discharge following a planned exit from their treatment within 12 weeks of their triage date.

In 2009/10, current treatment providers received 1,440 referrals and provided tier 3 treatments for 931 alcohol users in Warwickshire. Tier 4 (specialist inpatient treatment) services at Woodleigh Beeches were accessed by 118 alcohol service users and 46 drug service users that year. 11 drug and alcohol service users commenced a residential rehabilitation placement.[69]

Woodleigh Beeches Activity April 2010- March 2011

Woodleigh Beeches Alcohol Activity	Inpatient Admissions	Outpatient Attendances New	Outpatient Attendances Follow-up
Apr-10	18	10	57
May-10	10	17	59
Jun-10	13	28	77
Jul-10	15	10	36
Aug-10	20	12	57
Sep-10	15	15	55
Oct-10	22	13	64
Nov-10	10	4	35
Dec-10	8	13	42
Jan-11	13	17	41
Feb-11	6	10	66
Mar-11	19	10	61
Total	**169**	**159**	**650**

Source: Warwickshire Substance Misuse Service – Drug and Alcohol Action Team (WDAAT) - Warwickshire County Council 2010-2011

[69] Specification for Lot 2: Adult Community Tier 2 / 3 and Criminal Justice Substance Misuse Services and Adult Tier 4 Inpatient Substance Misuse Services for Coventry and Warwickshire, 2011

In 2010/2011, the Inpatient services at Woodleigh Beeches reported a total of 169 admissions for alcohol related activity with 159 new outpatient attendances and 650 outpatient follow-ups representing a total of 978 tier 3 treatments for alcohol users in Warwickshire which is a 5% increase from the year before.

The data presented in the table below has been provided by the Warwickshire Drug and Alcohol Action Team and shows the distribution of substance misuse service users in different parts of Warwickshire as per contact with the local teams.

Warwickshire Substance Misuse Service Users in Warwickshire, Numbers

2010-2011	Q1	Q2	Q3	Q4
No of clients in treatment on last day of qtr via Tier 3 and Tier 4 Services	929 (30/06/2010)	927 (30/09/2010)	882 (31/12/2010)	844 (31/03/2011)
Criminal Justice Drugs Team	56	49	0	0
Leamington CDT	224	228	245	220
Nuneaton CDT	292	292	295	287
Rugby	173	173	185	178
Stratford CDT	159	165	156	158
Co-morbidity Team	4	4	1	1
Woodleigh Beeches In-Patients	2	3	0	0
Rapid Prescribing	19	13	0	0
No of PDUs in treatment on last day of qtr	903 =97.02%	905 =97.21%	868=98.41%	832=98.58%
Criminal Justice Drugs Team	50	43	0	0
Leamington CDT	221	226	242	220
Nuneaton CDT	289	289	292	285
Rugby CDT	166	167	178	172
Stratford CDT	155	160	155	154
Co-morbidity Team	1	1	1	0
Woodleigh Beeches In-Patients	2	3	0	0
Rapid Prescribing	19	13	0	0
No of clients in treatment YTD	1059	1180	1296	1437
New Episodes in Quarter	121	116	141	59

Source: Warwickshire Substance Misuse Service – Drug and Alcohol Action Team (WDAAT) - Warwickshire County Council 2010-2011

National Drug Treatment Monitoring System in its annual report showed that the ratio of Male to Female patients is approx 3:1 with considerable differences in the age breakdown across West Midlands.

NDTMS: Clients gender & age-group for West Midlands: 2009/10

	Gender	18 - 24	25 - 29	30 - 34	35 - 39	40+	Totals
West Midlands	Female	1,214	1,576	1,173	802	944	5,709
	Male	2,405	4,157	4,220	3,090	3,388	17,260
National Total	Female	9,002	11,989	11,827	9,562	13,158	55,538
	Male	18,069	28,496	33,137	30,157	41,492	151,351

Source: http://www.nta.nhs.uk/uploads/ndtmsannualreport2009-10finalversion.pdf

The above NDTMS report also provides an ethnic distribution of users of the service, which showed that majority of the patients accessing the service in West Midlands were White accounting for 83% of all service users (according to mid-2009 population estimates 92.2% residents in Warwickshire are white), followed by 7% Asians (according to mid-2009 population estimates 4.26% residents in Warwickshire are Asians), and other mixed race users.

Substance Misuse Services in Warwickshire

As part of the new contract, substance misuse services starting 1st Dec 2011 (inclusive of Dual Diagnosis services) are expected to cost approx. £15.3 million across Coventry and Warwickshire for the first two year, of which £3.8 million per year will be for Warwickshire.

The Dual Diagnosis Service in Warwickshire aims to provide an integrated response to people with serious mental health problems and problematic substance misuse (dual diagnosis) to ensure that they receive appropriate diagnosis, treatment and care for their often complex needs.

The objectives of the service are to[70]:

- Engage service users who fall within the local definition of dual diagnosis, and work jointly with users in screening and assessing their needs, according to the various levels of presenting need and risk.
- Maintain the achievement of personal harm reducing goals through treatment and support, and adopt an integrated care pathway approach to ensure that the system of treatment and care is coordinated and seamless.
- Facilitate positive change and promote stabilisation, thereby improving health and social functioning and reducing drug related harm to the individual and the community.
- Promote collaborative multi-agency working to provide a comprehensive care package for the identified client group.

[70] Warwickshire Drug and Alcohol Action Team - Specification for Lot 2: Adult Community Tier 2 / 3 and Criminal Justice Substance Misuse Services and Adult Tier 4 Inpatient Substance Misuse Services for Coventry and Warwickshire, 2011

- Provide a targeted and comprehensive care package to support the provision of community-based treatments and re-integration of adults, in the community, with co-morbid needs.
- Provide a range of evidence-based, social and psychological interventions taking into account user choice and service compatibility.
- Enable access to a range of services which are able to address the needs of the client group thereby preventing relapse, promoting recovery and improving the quality of life for the individuals and their carers.

Who is Eligible in Warwickshire to receive Dual Diagnosis Service?

Service users must be resident within Warwickshire and not be solely dependent on prescribed, or over the counter medicines.

Who takes priority[71]?

The following groups have priority in having access to the service:

- BME Communities (Black and Minority Ethnic)
- Crack users
- Homeless
- Refugees and asylum seekers
- Parents

Patients whose needs fall outside dual diagnosis or whose needs are better met by another support service or treatment tier are excluded.

[71] Warwickshire Drug and Alcohol Action Team (WDAAT)

Recommendations

- Monitor the KPIs of the new Addaction and Cranstoun services to ensure services are meeting the needs of the local population. The main KPI that applies to dual diagnosis is for 'Improved well-being at the 1st care plan review in each period'.

- Establish, review and enhance local pathways as the new contract develops.

- To use the Quality in Alcohol and Drug Services (QuADS) audit to inform commissioners.

Topic Area – Personality Disorder

Some personalities develop traits that make it difficult for people to live with themselves or others. Unlike personality changes that result from an injury to the brain or a traumatic event, these characteristics will have been noticeable from childhood or early teens and may influence the ability to:

- make or keep relationships
- get on with people at work
- get on with friends and family
- keep out of trouble
- control feelings or behaviour

Many people with personality disorder are able to negotiate the tasks of daily living without too much distress or difficulty, but there are others who, because of the severity of their condition, suffer a great deal of distress, and can place a heavy burden on family, friends and those who provide care for them.

Personality Disorder has been included in this Health Needs Assessment as within mental health nationally there are concerns that clinicians and practitioners are reluctant to work with people with personality disorder because they believe that they have neither the skills, training or resources to provide an adequate service, and because many believe there is nothing that mental health services can offer.

There is a requirement to understand the needs of those with Personality Disorder, the pathways of care available to them, and to identify who is responsible for the coordination of care for those individuals requiring clinical support.

Introduction

The Royal College of Psychiatrists outlines three categories which the different types of personality disorder fall into:

- Cluster A: 'Suspicious'
- Cluster B: 'Emotional and impulsive'
- Cluster C: 'Anxious'

The World Health Organisation lists ten "conditions and behaviour patterns of clinical significance"[72] which are classed as Personality Disorders.

Personality disorders usually appear in late childhood or adolescence and tend to manifest into adulthood, thus making appropriate diagnosis possible after the age of 16 or 17. The condition must not be attributable to gross brain damage or disease or to another psychiatric disorder and according to the World Health Organisation must meet several criteria. These include:

- Disharmonious attitudes relating to areas of functioning such as impulse control, and ways of perceiving and thinking
- A longitudinal pattern of abnormal behaviour appearing in childhood and manifesting into adulthood
- The behaviour pattern is pervasive and maladaptive to a broad range of personal and social situations
- The disorder is usually associated with significant problems in occupational and social performance
- The disorder leads to considerable personal distress but this may only become apparent late in its course

National Perspective

According to the Royal College of Psychiatrists[73], about 40-70% of people on a psychiatric ward will have a personality disorder.

Data from the Office for National Statistics[74] estimates that there is a 4.4% prevalence of personality disorders in the age 16-74 population in England, Wales and Scotland. The highest prevalence (5.8%) is seen in the 55-74 year age group.

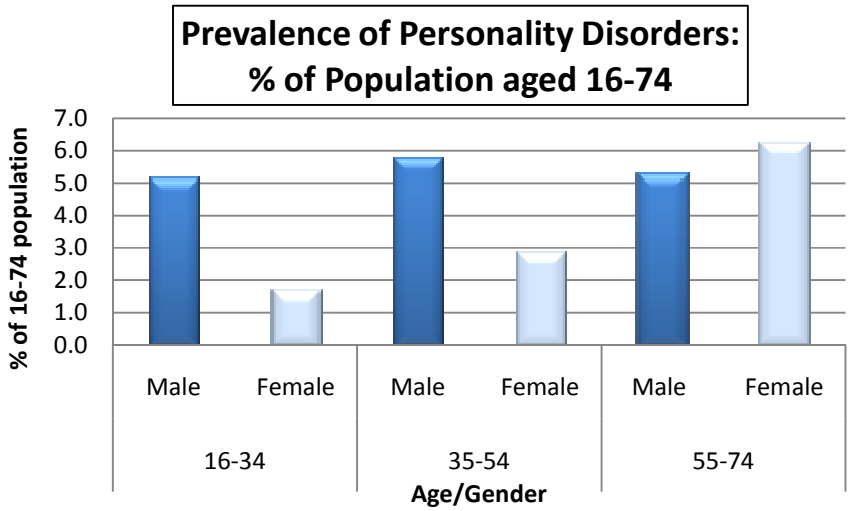
There is a gender disparity in the prevalence of personality disorders (see figure 1), with prevalence in men estimated at 5.4% and prevalence in women at 3.4%. For men the highest prevalence of personality disorders is in the 35-54 year age group (5.8%), although there is relatively little variation across the age bands. There is more variation across the age bands

[72] World Health Organisation, http://apps.who.int/classifications/apps/icd/icd10online/

[73] Royal College of Psychiatrists, http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/personalitydisorders/pd.aspx

[74] Office for National Statistics, http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/MentalHealthPrevalence.aspx

for women, with the prevalence ranging from 1.7% in ages 16-34 to 2.9% in ages 35-54, peaking at 6.3% in ages 55-74.



Source: Office of National Statistics

Obsessive-compulsive is the most common personality disorder, with a national prevalence across the ages and genders of 1.9%. Dependent and Schizotypal types were the least prevalent, each with a rate of 0.1%.

What is happening in Warwickshire?

If Warwickshire was in line with the ONS estimates for personality disorders, the 4.4% prevalence would equate to approximately 17,300 cases of personality disorder. Assuming the ONS figures are relative to Warwickshire, approximately 10,600 men and approximately 6,700 women are estimated to have a personality disorder.

From the Warwickshire Intelligence Evolve Database, it has been possible to review the caseload of Personality Disorder. As with all the chapters in this mental health needs assessment, it is important to note that any analysis from databases relies on accurate coding and for a diagnosis to be included for every patient. In the case of Personality Disorder, it is known that not all patients are coded to the specific ICD-1-0 codes, namely F60 and F61.

Evolve shows that since 2005 to June 2011, there have been 281 inpatient admissions for specific personality disorders in Warwickshire. 94% of these admissions were non elective and 20% were emergency readmissions.

The majority of these were for emotionally unstable type (75%), with dependent type as the second most common (4%), followed by dissocial type and paranoid type (3% each). A large proportion of admittances were for unspecified personality disorders (14%).

79% of all admissions since 2005 have been females, with the 40-44 year old age group the most common age of admission. In males, the highest prevalence of admissions occurs in the 35-39 year age group.

Clients living in Nuneaton and Bedworth Borough accounted for the highest proportion of admissions (28%), followed by Rugby Borough and Warwick District Residents (22% each). North Warwickshire Borough and Stratford-on-Avon District account for the lowest proportion of admissions (14% each).

Warwickshire Dialectical Behaviour Therapy (DBT) Service is for people open to secondary mental health services in Warwickshire with a primary diagnosis of personality disorder or who:

- experience emotions as being unpredictable and/or out of control a lot of the time.
- engaged in self harming acts, suicidal thoughts and suicide attempts
- periods of despair, depression, anxiety, anger and a sense of being empty
- difficulties with all relationships
- feelings and behaviour that make their life and those around you feel unbearable?
- feel like their are living in torment most of the time

DBT is an intensive therapy programme that requires strong commitment from both the recipients and the providers of the service. The service provide individual and group therapy which lasts for a minimum of one year and focuses on two main areas; stopping dangerous behaviours, e.g., self-harming acts, suicidal thoughts and in some cases suicide attempts and developing the skills to cope more effectively with the difficulties in life.

"I've been finished DBT one-to-one for 6 months now. I'm enjoying life to the full…I've not been in hospital for over 2 years and I never self harm, have any (suicidal) thoughts and today still use all of the valuable experience I gained from this excellent service".

However, there is feedback from the 1:1s, by both referrers and commissioners that the care pathways for patients suspected of Personality Disorder is neither clear nor consistent. It was suggested during the consultation that a clear treatment package is required, with transparency so that the client and the professionals they are in contact with are clear about the support being offered, from whatever service is deemed most appropriate. Additional comments from the 1:1s are outlined below:

"Coventry has the 'Olive Tree' for patients with Personality Disorder, but Warwickshire doesn't have such a service. It means that community mental health teams are managing risky patients without much support.

"It can be difficult to know how to handle Personality Disorder (and self harm patients). Its not therapeutically beneficial for inpatient stay, but its hard to deal with as an outpatient if not safe

Recommendation

- To review pathways for Personality Disorder, including the Warwickshire DBT service, across Arden Cluster to ensure clarity and consistency of access to services.

Topic Area – Psychosis

Psychosis is a word used to describe symptoms or experiences that happen together. Each person will have different symptoms, but the common feature is that they are not experiencing reality like most people (Partnerships in Care).

Psychosis is a debilitating illness that has implications for the individual, their relatives and friends. It can affect education and employment, relationships, physical and mental wellbeing.

Introduction

The National Institute for Health and Clinical Excellence (NICE)[75] uses the term psychosis to 'describe a group of severe mental health disorders characterised by the presence of delusions and hallucinations that disrupt a person's perception, thoughts, emotions and behaviour. The main forms of psychosis are schizophrenia, bipolar disorder or other affective psychosis'.

Some people have a single episode and make a full recovery, for others, it is a longer process. A person with psychosis may:

- Hear, smell, feel or see things that others do not (hallucinations)
- Have strange thoughts or beliefs making the person fell they are being controlled, harassed or persecuted (delusions)
- Have muddled or blocked thinking (thought disorder)
- At times be unusually withdrawn or excited
- Not realise that there is anything wrong with themselves (lack of insight)

There is no specific single test for psychosis as the symptoms are common to a number of disorders. The diagnosis is made by talking to the person and their close contacts to get an understanding of the person's history and background.

The Care Quality Commission[76] reports that the mean onset of psychotic symptoms is 22, with the vast majority of first episodes occurring between the ages of 14 and 35.

Early treatment is crucial because the first years of psychosis carry the highest risk of serious, physical and social harm. One in ten people with psychosis commit suicide with two thirds of these deaths occurring within the first five years of illness. Rethink (2009)[77], reports on the research that has found there is a link between a long period of untreated psychosis and a poorer outcome and it is thought that the first 3 years of psychosis is a critical period where long-term symptoms may emerge and repeated relapses may occur.

NICE (2011)[78], report that approximately 40% of people with psychosis misuse substances at some point in their lives. This figure is at least double that of the general population. It is also known that patients with psychosis who misuse substances are at higher risk of relapse and hospitalisation.

If treatment is given early in the course of the illness and services are in place ensure long-term compliance to treatment, the prospect for recovery is improved.

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75 National Institute for Health and Clinical Excellence. 2011, Psychosis with coexisting substance misuse. Clinical Guideline 120

76 Care Quality Commission: http://www.cqc.org.uk/

77 Rethink. 2011. Factsheet: Early Intervention

78 National Institute for Clinical Excellence. 2011, Psychosis with Coexisting Substance Misuse: Assessment and Management in Young People

National Perspective

The 2007 Adult Psychiatric Morbidity Survey[79] provides estimates of prevalence of mental illness in the population and identified that for psychotic disorders:

	% Population	% Males	% Females
Psychotic Disorder	0.4	0.3	0.5

Source: Adult Psychiatric Morbidity Survey 2007

The Care Quality Commission suggests that a fully operation Early Intervention Service typically serves 450 people for a population of 1 million, with 150 new cases per year.

'No Health without Mental Health' consolidates the government's approach to mental health. Key priorities in the strategy include early intervention across all age groups supporting people who experience mental ill health to recover meaningful lives.

There is an increasing body of evidence that shows this approach leads to a better course of illness, fewer symptoms at eight years onwards and a halving of their suicide rate[80].

The long term impact of Early Intervention is dependent on what happens to readmission rates after discharge from the Early Intervention team.

What's happening in Warwickshire?

If Warwickshire was in line with the 2007 Adult Psychiatric Morbidity Survey estimates for psychotic disorder, the 0.4% prevalence would equate to approximately 2,140 cases. Assuming the 2007 figures are relative to Warwickshire, approximately 790 men and approximately 1,350 women are estimated to have a psychotic disorder.

Psychiatric Intensive Care Unit

As stated in the secondary care mental health care data, identifying the diagnosis of in-patients within the services is difficult. Psychiatric Intensive Care Unit (PICU) utilisation has been reviewed, but it is acknowledged that not all PICU patients will be admitted with psychosis.

[79] The NHS Information Centre for Health and Social Care. 2007, Adult Psychiatric Morbidity in England: Results of a Household Survey

[80] NHS Confederation Mental Health Network, 2011, Early Intervention in Psychosis Services

Total Individual Inpatient Admissions to Psychiatric Intensive Care Unit:

Service Description	Year of Admittance		Total	Percentage Change 2009/10 to 2010/11 (%)
	2009/10	**2010/11**		
Psychiatric Intensive Care Unit (PICU)	67	32	99	-109.4

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

From the Mental Health Minimum Data Set (MHMDS), slightly different numbers of PICU patients are recorded for the same time period. However, by examining their recorded 114 cases, it can be seen that there is a significant difference between genders. 31 female admissions occurred compared to 83 male admissions over the two year period, a 1:3 ratio.

Looking at the same 114 cases from the MHMDS, it was seen that only 51 individuals were under the age of 35 (the upper age for the Early Intervention Service). The average age of the total cases was actually 38.4 years, with the oldest being 66 years.

A benefit of the Early Intervention Service may be that it reduces the number of admissions for the under 35s, but that older cases may not receive the same level of support. This benefit of Early Intervention should be continually monitored.

Early Intervention in Warwickshire

"The aim is to get in early and to prevent vicious circle of inpatient and relapse"

Within the Community Mental Health Services dataset, the numbers of individuals seen by the Early Intervention Team was:

Total Individual Users of Early Intervention Service:

Service Description	**Year of Attendance**		**Total**	**Percentage Change 2009/10 to 2010/11 (%)**
	2009/10	2010/11		
Adults Early Intervention	89	98	187	10.1%

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

Total Individual Spells of Early Intervention Service Access:

Service Description	**Year of Attendance**		**Total**	**Percentage Change 2009/10 to 2010/11 (%)**
	2009/10	2010/11		
Adults Early Intervention	7424	9342	16,766	25.8%

Source: Coventry and Warwickshire Partnership Trust Contract Datasets via NHS Intelligence

There were an average of 83.4 spells per individual user in 2009/10, and this increased to an average of 95.3 spells per individual user in 2010/11. The additional support provided by Early Intervention services may be one of the reasons why there was a reduced number of individuals admitted to PICU.

Services in Warwickshire

Two Early Intervention Teams cover Warwickshire – one in the South and one in the North (including Rugby). The teams have an overarching Operational Policy and the criteria for referral to Early Intervention are:

- 14-35 years old
- First episode of psychosis of at least a duration of 7 days and have experienced psychotic symptoms (delusions, hallucinations, thought disorder) or exhibited bizarre behaviours.

"Give tools at a young age to manage own mental health".

The support offered is usually for a period of 3 years and provides the following:

- A reduction in the time that young people with psychosis remain undiagnosed and untreated
- Address issues of access to education and training, with the aim of improving social inclusion
- Engagement with service users and their families/carers with interventions to promote recovery
- Ensure care is transferred seamlessly and effectively at the end of the period of intervention

During the 1:1s there was concern that whilst efforts were made to transfer care seamlessly to other community mental health teams, the transfer could often be problematic. One of the issues raised was the change in the level of support received from the Early Intervention team by clients aged in their 30s who are transferred to Community Mental Health teams. This can be difficult for clients to understand.

"There can be an issue that the patient will end up with CMHT without the same support as they used to have with Early Intervention."

Recommendations

- To monitor the number of Early Intervention Services patients that are admitted as an inpatient more accurately.

- To explore the relationship between Early Intervention and PICU to understand the potential cost benefits.

Topic Area - Suicide

Suicide is a devastating event. The consequences of which are felt by family, friends and the community. It is estimated that for every person who commits suicide up to 26 other people will be affected and six of these will experience intense grief reactions. Some of these will themselves be at risk of suicide.

In Warwickshire in 2009 there were 39 suicides (source: ONS Public Health Mortality Files) of whom 13 were known prior to their deaths by mental health services.

86% of people who commit suicide have had contact with a primary care physician in 12 months prior to death and 66% had contact in their last month

Introduction

Suicide is a devastating event. The consequences of which are felt by family, friends and the community.

A number of national initiatives have been developed to reduce suicide rates. Guidance for the improvement of inpatient mental health care has led to a decrease in the numbers of inpatient suicides by 30%, recommendations for improving media coverage of suicides and legislation on the content of websites promoting suicide hope to bring about a reduction in suicide, especially in adolescents and young adults. Recent reforms to the Coroners service are designed to make the process easier for those bereaved by suicide and aid information sharing so that lessons can be learnt. National campaigns such as Age Concern's 'Down, but not out' and Reach out and C.A.L.M aim to promote mental health and well being, reduce stigma and improve management of vulnerable or high risk groups.

The recent government white paper 'No Health Without Mental Health'[81] sets out a new approach to mental health in Britain. Key themes include: preventing as well as treating mental health problems, focusing on promotion of mental health and wellbeing, tackling stigma of mental health illness, early intervention, personalized care, multi agency commissioning, innovation, value for money and strengthening transition between children, adolescent services and adult services.

Suicide prevention is one of the seven standards for improving mental health care in the Department of Health National Service Framework for Mental Health (1999)[82]. The national strategy is clear that suicide prevention is not the sole responsibility of any one sector, or of health services alone and advocates a broad strategic approach that both targets high risk groups in addition to interventions that improve the well being of the general population and facilitate access to specialist services. This requires co-ordination and collaboration between all public services, the voluntary and private sectors, academic institutions and the concerned individual.

National Perspective

A National Confidential Inquiry [83] found that 26% of suicides, in England, during 1997-2008 were identified as patient suicide, i.e. the person had been in contact with mental health services in the 12 months prior to death. 13% of suicides were inpatients at the time of death. The most common methods of suicide by patients were hanging, self-poisoning (overdose) and jumping/multiple injuries (mainly jumping from a height or being struck by a train).

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[81] HM Government (2011) No Health Without Mental Health: Across Governmental Mental Health Outcomes Strategy for People of all Ages.

[82] Department of Health (1999) National Service Framework for Mental Health. London.

[83] Suicide and Homicide by People with Mental Illness (2011)

Suicide rates across England are falling and are currently at their lowest rate on record, however over 5,000 people still commit suicide in the UK every year (ICD-10 codes X60-X84 classified as intentional self-harm). On average, a person dies every two hours as a result of suicide accounting for 1% of all deaths in England. It is the leading cause of death in men under 35 and is the main cause of premature death in people with mental illness.

The causes of suicide are complex and multi-factorial. People at higher risk of suicide include young men, those with a mental health illness, those living in poverty, the unemployed, those who misuse drugs and alcohol, those that self- harm, Indian, East African and South Asian women, Irish immigrants and those in contact with the justice system. Life events such as divorce, bereavement and financial problems can be a trigger for those that are vulnerable.

Suicide in the context of serious physical illness has become an increasingly important focus of public attention in recent years as growing numbers of UK citizens with chronic or terminal conditions travel to Dignitas in Switzerland to receive assistance with suicide. Bazalgette et al, 2011[4] conclude from their survey of PCTs that approximately 10% of suicides, that take place in England, are by a person who is chronically or terminally ill. However, the same survey also suggests that coroners choose not to include relevant health information and thus the number of assisted suicide cases is likely to be higher than records indicate.

A study by the Royal College of Psychiatry[84] found that people bereaved by suicide are between 80% and 300% more likely to commit suicide themselves than the general population.

The Samaritans recognise the public health scale of damage caused by suicides and are committed to taking the lead to reduce numbers. In 2010, Samaritans dialogue contacts, in England, accounted for over 2.7 million contacts, 85.2% of whom made contact via telephone. Over 500,000 callers (20.3% of dialogue contacts) expressed suicidal feelings at the time of the call. This equates to one such call every 57 seconds during 2010.

In the case of email contacts to The Samaritans, in 2010, the proportion expressing suicidal feelings was significantly higher at 42.9% (80,000 emails) at the time of sending and higher still where contact was made via text message 52.2% (87,000 texts).

SANE is a leading mental health charity that recognises the need to improve quality of life in order to reduce suicides. Their staff provide confidential emotional support for anyone affected by mental illness.

In 1999, the Government produced the White Paper 'Saving Lives: Our Healthier Nation'[85]. It set a target of reducing suicide by 20% by 2010. The National Suicide Prevention Strategy

[84] Bazalgette L, Bradley W and Ousbey J. 2011. The Truth About Suicide. Demos, London

[85] Department of Health ,1999, Saving Lives: Our Healthier Nation. London, Stationery Office.

(NSPS)[86] was developed in 2002 to deliver this target and aimed to reduce suicide from a baseline of 9.2 deaths per 100,000 population in 1995/97 to 7.3 by 2010.

Self-Harm

Self-harm (often referred to as deliberate self-harm) is intentional self poisoning or injury, irrespective of the apparent purpose of the act.

Levels of self-harm are one indicator of the mental health and well being of young people in our society in general. Self-harm represents one of the most common reasons for hospital presentation of adolescents.

A past history of self-harm is a key risk factor for future self-harm or suicide. Around 40% of suicides have a history of self-harm and at least 1% of people who self-harm take their own lives within a year. Rates of self-harm have been increasing since the mid 1980s. In contrast to suicide, rates are highest in young girls and women - the highest incidence is in 15-19 year olds. In men the highest rates are in 20-29 year olds. The rates are much lower amongst those aged over 50 years. Though the calls are not evidence of actual self-harm incidents, the number of children speaking to ChildLine[87] counsellors about self-harming has grown steadily over recent years. In 2005, more than 5,200 children told ChildLine that they were self-harming and around half of them said they had been cutting themselves. This is a 3% increase on the previous year. Girls were 16 times more likely than boys to call about self-harm.

Many patients who attempt suicide will re-attempt, particularly shortly after discharge from a psychiatric hospital. 50% of those who commit suicide have made at least one previous attempt.

What is happening in Warwickshire?

In Warwickshire, the rate for 1995/97 was 6.33 suicides per 100,000 which was below the average for the West Midlands. The Warwickshire rate fell in the 2007-2009 period to 5.76 per 100,000 – exactly the same rate as for England and almost identical to the West Midlands rate of 5.75 suicides per 100,000 (Source: NCHOD).

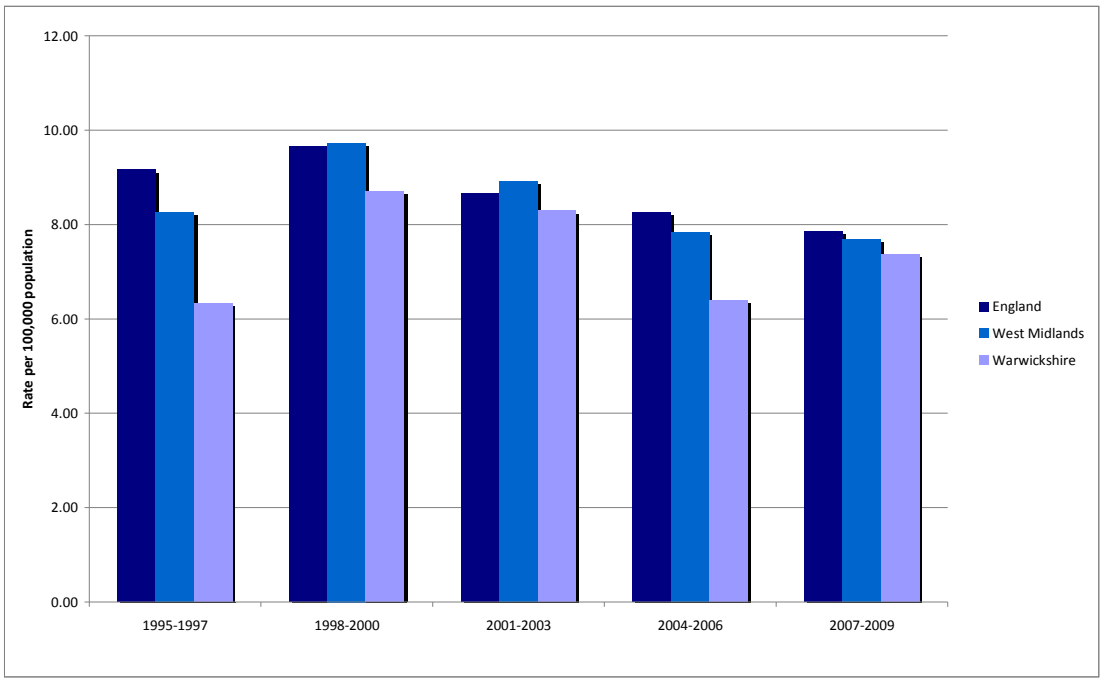
Between 2009/10 and 2010/11, there were 979 Warwickshire individuals who attended A&E with a recorded mental health diagnosis who were also coded with poisoning as the primary reason for their attendance. This equates to 7% of all those individuals with a mental and physical condition who attended A&E. We are unable to ascertain the proportion of

[86] Department of Health ,2002, National Suicide Prevention Strategy for England. London.

[87] ChildLine Annual Review 2005 at www.childline.org.uk

poisonings which were intentional or unintentional. This may be a useful piece of work to be undertaken in the future.

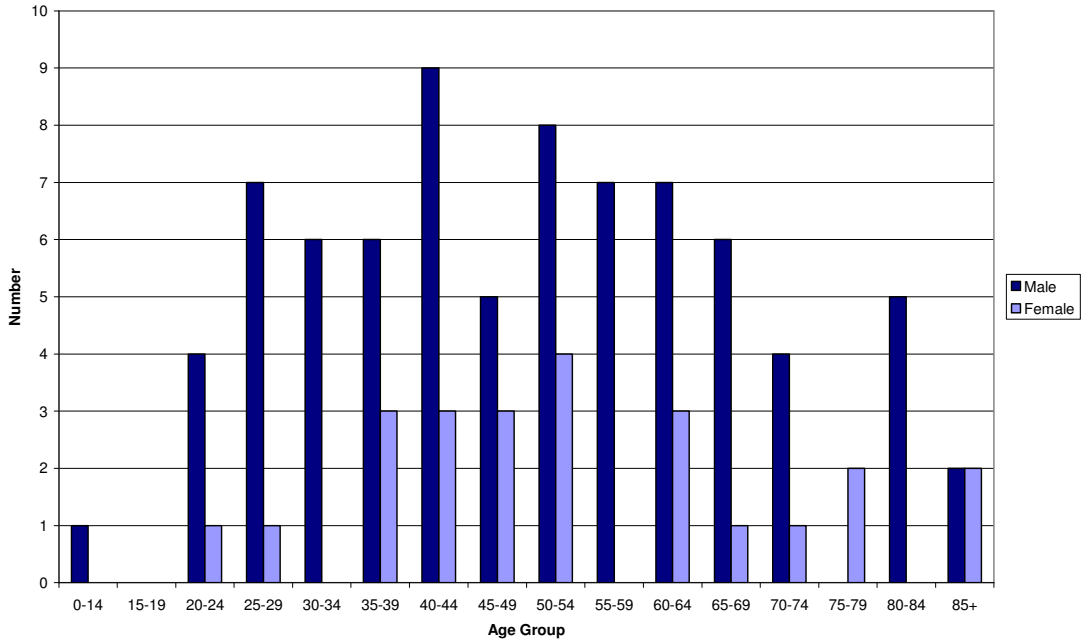
Directly standardised rate of suicides for all persons. 3 year pooled data from 1995-2009



Source: NCHOD

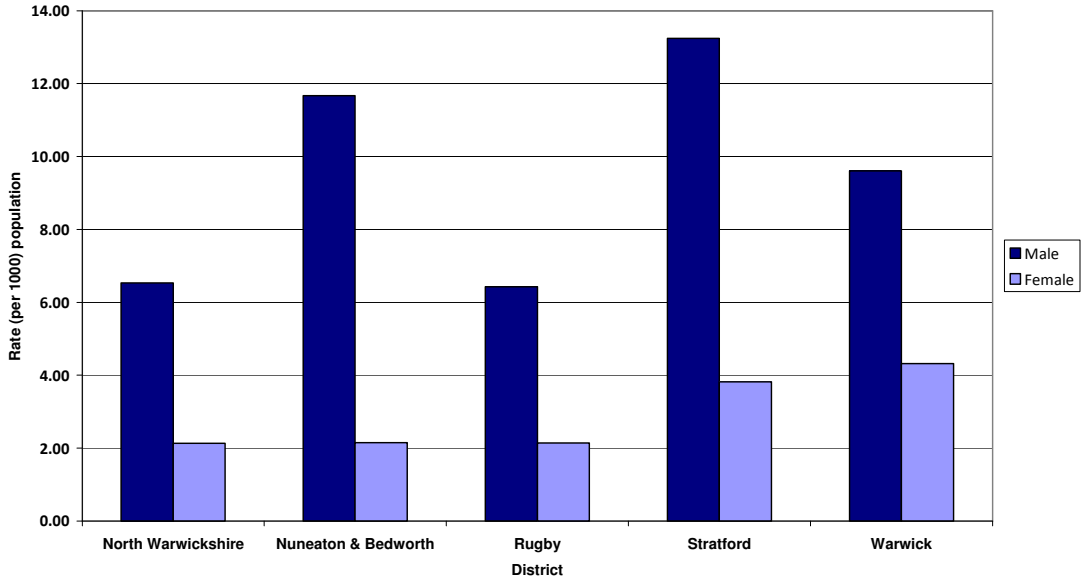
Analysis of suicides that occurred in Warwickshire between 2007/9 (Source: ONS Public Health Mortality Files) found that 76% were males (of whom 51% were under 50 years of age). 10% of all the suicides were in those aged over 80. 63% died by strangulation/hanging and 21% by poisoning/overdose.

Warwickshire suicides by age group and sex 2007-2009



Source: ONS Public Health Mortality Files

Warwickshire Suicides Rate Per 1,000 Population



Source: ONS Public Health Mortality Files

The Warwickshire NHS Suicide Prevention Strategy[88] takes a broad strategic approach to the prevention of suicide and is designed to encompass a multidisciplinary approach to the prevention of suicide and links in closely with Warwickshire's Mental Health and Well Being strategy.

The goals and objectives of this strategy are in line with those of the National Suicide Prevention Strategy[89].

Goals	Objective
1. Reduce suicides in high risk groups	1: Reduce the number of suicides by people who are currently or have recently been in contact with Mental Health Services 2: Reduce the number of suicides in the year following self –harm 3: Reduce the number of suicides by young men
2. Promote the mental health and wellbeing of the wider population	1: Promote the mental health of socially excluded and deprived groups 2: Promote mental health among people from black and ethnic minority groups 3: Promote the mental health of people who misuse drugs and/or alcohol. 4: Promote the mental health of victims and survivors of abuse 5: Promote mental health in those who are victims of child sexual abuse and domestic violence 6: Promote mental health among children and young people (ages under 18 years) 7: Promote mental health among women during and after pregnancy 8: Promote mental health among older people
3: Reduce the availability and lethality of suicide methods	1: Identify local hotspots 2: Continue to audit methods to ensure interventions are tailored appropriately.
4: Improve the reporting of suicidal	

[88] NHS Warwickshire suicide prevention Strategy 2009-12

[89] Department of Health, 2002, National Suicide Prevention Strategy for England. London.

behaviour in the media	
5: Promote research into suicide and suicide prevention	
6: To improve monitoring of progress towards the Saving Lives: Our Healthier Nation targets for reducing suicide.	

Services in Warwickshire

Safeline is a Warwickshire based charity who provide individual counselling to relieve suffering amongst people experiencing the after effects of the trauma of rape and sexual abuse. During 2009-10 the charity received 9,400 attempted calls to their helpline of which 1,164 were answered. Over 3,100 counselling sessions were provided to a total of 193 clients across Warwickshire and Coventry.

Mental Health Matters is a telephone helpline in Coventry and Warwickshire available to anyone experiencing mental distress can call for help at any time of day, 365 days a year from the confidential service. The service is provided by national charity Mental Health Matters, managed by Coventry and Warwickshire Partnership NHS Trust.

Recommendations from the West Midlands Regional Development Centre

A report produced in 2009 by the West Midlands Regional Development Centre set out a number of recommendations for local approaches to suicide prevention and mental health well being across the West Midlands.

The recommendations were:

- The formation of sub-regional suicide prevention groups. These groups would; work collaboratively on suicide audit, work on identifying and eliminating hotspots, and work across boundaries with media, public transport operators and mental health trusts.

- Mental health commissioners work with public health to improve intelligence regarding the mental health needs of the local population.

- Localities should consider the changing economic situation of the mental health and wellbeing of the local population in order to target services effectively.

- Localities should use number of years of life lost (Y'LL) and disability adjusted life years (DALYs) for mental health and suicide locally to inform policies.

- Suicide prevention plans should not purely focus on those who take their own life, but should provide support for those who are affected by someone who takes their life. This could be done through work place mental health and community based mental well being programs.

- Localities can commission WMPHO to provide data support (such as rates and analysis) to mental health commissioners across the region. WMPHO could also provide further support regarding suicide audit, Y'LLs, DALY's and hot spot analysis.

- Review commissioners access to PCT suicide data and if this is variable consider developing regional network for analysis of suicide data.

- Consider systems of coding DSH (coding is different in A&E) and look at possibility of auditing this locally.

- Target groups for training should include those working with children and young people in distress (CAMHS), staff who come into contact with young people who self harm, front line staff working with older people with depression and dementia, and primary care staff dealing with people with depression. Support should also be offered to those in professions known to be at high risk of suicide and support for those who come in to contact with victims of suicide such as the police and transport officials.