AGENDA MANAGEMENT SHEET

Name of Committee	**Health Overview And Scrutiny Committee**	
Date of Committee	**27th July 2005**	
Report Title	**Report of the Mental Health Panel on Mental Health Provision in Warwickshire**	
Summary	The report reviews Mental Health Provision in Warwickshire.	
For further information please contact:	Alwin McGibbon Health Scrutiny Officer Tel: 01926 412075 alwinmcgibbon@warwickshire.gov.uk	Carole Pattison Corporate Review Team Manager (Acting) Tel 01926 736319 carolepattison@warwickshire.gov.uk
Would the recommended decision be contrary to the Budget and Policy Framework?	No.	
Background papers	Appendices 1-7of the report of the Mental Health Panel on Mental Health Provision in Warwickshire	

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	....
Local Member(s)	☐	
Other Elected Members	☐	....
Cabinet Member	☒	Cllr Bob Stevens, Colin Hayfield
Chief Executive	☒	David Carter
Legal	☒	Jane Pollard
Finance	☐	....
Other Chief Officers	☒	Marion Davis, John Deegan
District Councils	☐	....
Health Authority	☐	....
Police	☐	....

Other Bodies/Individuals	☐	....

FINAL DECISION NO

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	☒	
To Council	☐	....
To Cabinet	☐	....
To an O & S Committee	☐	....
To an Area Committee	☐	....
Further Consultation	☐	....

Agenda No

Health Overview And Scrutiny Committee - 27th July 2005.

Report of the Mental Health Panel on Mental Health Provision in Warwickshire

Report of the County Solicitor and Assistant

Recommendation

1. That the committee considers the final report of the 'Mental Health Panel'

2. That the committee considers the recommendations as set out in section 15 of the report

1. Background

1.1 At its meeting on 23rd July 2003, the Health Overview and Scrutiny Committee agreed its Health Scrutiny Programme of work for the period 2003-2005. This followed extensive consultation with the statutory and voluntary sector to identify initial issues to be scrutinised. The programme included the scrutiny of 'Mental Health Provision'. The terms of Reference for the scrutiny exercise were agreed (Appendix 1) and are included in the background papers. Part the way through the review a revised scope was agreed (Appendix 2) again included in the background papers.

1.2 The Committee nominated the following County Council Members to the scrutiny exercise panel: Cllr Jerry Roodhouse (Chair) Cllr Sidney Tooth and Cllr Helen McCarthy. North Warwickshire Borough Council Member Cllr Richard Meredith and Stratford District Council Member Cllr Jane Harrison. Officer support provided by Alwin McGibbon (Health Scrutiny Officer) and Phil Maull (Committee Services).

1.3 The first panel meeting was held on 13th October 2004 and the majority of the review was carried out between November 2004 and April 2005.

2. Recommendations

2.1. The Committee is asked to consider the report and its recommendations.

DAVID CARTER
County Solicitor and Assistant
Chief Executive

Shire Hall
Warwick

23 June 2005

Report of Mental Health Panel
On Mental Health Provision in Warwickshire

Part 1

Contents

1. **Introduction**
2. **Aims and Objectives**
3. **Key Facts & Figures Great Britain & World Health Organisation**
4. **Mental Health Provision in Warwickshire**
5. **Scope**
6. **Mental Health Event**
7. **Stratford Springfield Mind Visit**
8. **Bedworth Resource Café' Visit (FCH)**
9. **Employment Strategy for Mental Health**
10. **Supporting People**
11. **Benefits and Money – Warwickshire Welfare Rights**
12. **Deprivation**
13. **Mini Scores for Warwickshire**
14. **Conclusion**
15. **Recommendations**

Part 2 – Available on request (Background Papers)

Appendices

Appendix 1 **Terms of Reference**
Appendix 2 **Revised Scope**
Appendix 3 **Mental Health Event**
Appendix 4 **Review of Adult Mental Health Services for Black & Minority Ethnic (BME) Populations in North Warwickshire, Nuneaton, Bedworth and Rugby – January 2005**
Appendix 5 **Employment Strategy for Mental Health**
Appendix 6 **MINI scores for Warwickshire**
Appendix 7 **Comprehensive LIT Themed Review: Black & Minority Ethnic Services, South Warwickshire PCT.**

Glossary of Terms

BME – Black & Minority Ethnic

CAB – Citizens Advice Bureaux

CBT – Cognitive Behaviour Therapy

CMHT – Community Mental Health Teams

Commissioning – process by which health needs of population are defined, priorities determined & appropriate services are purchased & evaluated.

Counselling – talking therapies

CPA – Care Programme Approach

Crisis Intervention/Home Treatment Team - Team of MH professionals to bring about resolution to problems & prevent emergency admissions

DALYs - Disability Adjusted Life Years

DBT - Dialectical Behaviour Therapy

DICE – Diversity in Community Education & Employment

FCH – Housing & Care Across the Midlands

FESP – Family Education and Support Service

LIT – Local Implementation Team

MH – Mental Health

NSF – National Service Framework

OCD – Obsessive Compulsive Disorders

PALS – Patient Liaison Service

PCT – Primary Care Trust

PICU – Psychiatric Intensive Care Unit

WSMS – Warwickshire Substance Misuse Service

Acknowledgements

The Health Overview and Scrutiny Committee would like to thank the following people for their help and support while conducting this review:

Mary McGorry – Acting Service Manager for Mental Health
Kate Phipps – Director for Mental Health and Disabilities
Shaun Clee – Director of Operation South Warwickshire PCT
Kate Morrison & staff - Stratford Springfield Mind
Anne Bond & staff - 'New Horizon' Resource Café Bedworth
Rosie James – Supporting People
Simon Veasey – WCC, Social Services
Mike Fawcett & Julie Poultney- Rethink
Silpa Jethwa- Rugby Borough Council (Housing)
Lynn Webster- Warwickshire Welfare Rights
Jan Turnbull – Specialist Care Worker (South)

A special thank you to Karen Holtzhausen – Springfield Mind for bravely giving a presentation on her personal experiences as a user of Mental Health Services

Finally all those who provided advice and/or attended the Mental Health Event - 'Walk, Talk, Work, Relax, Connect, Making the Links for Mental Health

1. Introduction

1.1 The Health and Social Care Act 2001 gave English Local Authorities with Social Services responsibilities a new power. From January 2003 Local Authority Overview and Scrutiny Committees have been required to review and scrutinise the operation of health services in their area and make reports and recommendations to NHS bodies relating to these investigations. This scrutiny does not only look at services provided by the NHS, but considers the services provided by Warwickshire County Council and the Borough and Districts, which could impact on the health of their citizens.

1.2 Warwickshire's Strategic Plan for 2002-2005 and the County Council's Best Value Performance Plan 2003-2004 both identify 'improving health and well being of Warwickshire citizens' as a key priority. This new responsibility reinforces existing plans, actions and targets set out in these documents.

1.3 At its meeting on 23rd July 2003, the Health Overview and Scrutiny Committee agreed its Health Scrutiny Programme of work for the period 2003-2005. This followed extensive consultation with the statutory and voluntary sector to identify initial issues to be scrutinised. The programme included the scrutiny of 'Mental Health Provision'. The terms of Reference for the scrutiny exercise were agreed and are attached **(Appendix 1)**. Part the way through the review a revised scope was agreed **(Appendix 2)**

1.4 The Committee nominated the following County Council Members to the scrutiny exercise panel:
Cllr Jerry Roodhouse (Chair) Cllr Sidney Tooth and Cllr Helen McCarthy.
Borough and District Members:
Cllr Richard Meredith (North Warwickshire) and Cllr Jane Harrison (Stratford District)
Officer support provided by:
Alwin McGibbon (Health Scrutiny Officer)
Phil Maull (Committee Services)

2. Aims and Objectives

2.1 The aim of this scrutiny exercise was to assess the link between mental illness and health inequalities. It involved scrutinising the mental health provision in Warwickshire that is jointly provided by the Primary Care Trusts and Social Services. Also it will look how effective are the links made between statutory and voluntary agencies that provide support to those affected by mental health problems.

2.2 A successful outcome from this review would be that there is

- A better understanding of how mental health is linked with health inequalities
- The relationship between mental illness and health provision
- An understanding of what the health services does to meet the needs of those affected.
- To ensure that the health service provides a flexible, appropriate, clinically effective and accessible service in response to the needs of those affected.

2.3 It takes into account equity of access to services in line with the social inclusion agenda. Also that it will help Members and officers have a better understanding of the implications of being mentally ill in Warwickshire

2.4 In order to achieve the aim set out in paragraph 1, this scrutiny will explore the following:

- The patient journey – the care packages that could be offered for someone with mental health needs
- Mental health provision for adults (16 - 65) in Warwickshire
- Whether there are significant differences in the number of patients with health needs from an ethnic minority background as opposed to white
- The extent/number of patients with mental health needs in Warwickshire
- Whether there is an equity of access and service provision across the county
- The waiting times for mental health provision across the county
- To find out the numbers of specialist staff (NHS and Local Authority) in Warwickshire and whether they are sufficient to ensure those with mental health needs are seen in time
- To see if people with mental health needs are given adequate help to access to other specific health service/social services provision, such as smoking cessation, support in the community, etc.
- What support is offered in the transition from school to work or college
- What support is offered to obtain work or remain in work for those with mental health needs

2.5 It will also explore how the NHS and Social Services link with the agencies and organisations set out below and vice versa, but not reviewing the services they offer:

- Benefits Agency
- Housing – District/Boroughs/Housing Associations
- CAB, Trading Standards
- Education
- Job Centre Plus
- Work Step

- Voluntary Mental Health Support Groups
- Supporting People

This review will not be looking at mental health provision for children or adults over the age of 65 years.

The ODPM report from the Social Exclusion Unit is keen to promote social inclusion and sets out a new model for partnership working across sectors led jointly by the PCT's, local authorities, Patient & Public Involvement Forums and Jobcentre Plus. Other key local partners would be users and carers, voluntary, community and private sector service providers (including ethnic minority groups), local employers, Learning and Skills Councils.

A key lever for implementation at a local level is the Department of Health's (DH) health and social care planning framework and targets for 2005 – 2008 which states:

> **"Unemployment and social isolation are important risk factors for deteriorating mental health and suicide. Information on how to help people with mental health problems gain and retain work, and improve community engagement, is set out in the report on mental health by the Government's Social Exclusion Unit."**

3.1 Key Facts and Figures – GB, Social Exclusion Unit, ODPM[1]

1. People with mental health problems are more likely to be victims than perpetrators of violence.
2. Severe mental health problems such as schizophrenia are rare affecting one in 200 adults each year.
3. Depression and anxiety affect up to one in six of the population at any one time.
4. Mental health problems are estimated to cost Britain more than 77 billion a year, prescriptions cost around £540 million a year.
5. Only 24 % of adults with mental health problems are in work, this is the lowest employment rate for any of the main groups of disabled people.
6. Fewer than four in ten employers say they would employ someone with a mental health problem.
7. People with severe mental health problems are three times more likely to be divorced than those without
8. They are also are three times more likely to be in debt as those without.

[1] Mental Health Key Facts and Figures, Social Exclusion Unit, Office of the Deputy Prime Minister - Website accessed 2005

3.2 Key Facts and Figures - World Health Organisation[2]

1. About 450 million people suffer from mental health disorders
2. One person in four will develop one or more mental or behavioural disorders in their lifetime
3. Mental and behavioural disorders are present at any point in time in about 10% of the adult population worldwide
4. Mental and neurological disorders account for 13% of the total Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries in the world.
5. Five of the ten leading causes of disability worldwide are psychiatric conditions, including depression, alcohol use, schizophrenia and compulsive disorder
6. By the year 2020 it has been projected that neuropsychiatric conditions will account for 15% of disability worldwide, with unipolar depression alone accounting for 5.7% of DALYs
7. The economic impact of mental disorders is wide-ranging, long lasting and expensive. For example the USA total annual total costs have been reported as reaching 147 billion US dollars. This is more than the costs attributed to cancer, respiratory disease or AIDS
8. Although costs in low-income countries do not reach this level because of low availability and coverage of mental health services, there are indirect costs arising from lost productivity
9. Mental disorders represent not only an immense psychological, social and economic burden, but also increase the risk of physical illness.
10. Finally the impact of stigma and discrimination or lost opportunity costs to individuals and families are hard to measure costs of poor mental health.

4.1 Mental Health Provision in Warwickshire

4.1.1 The first point of contact for people who are suffering from mental health problems most often is their GP. More time can be arranged for the appointment and depending on what is required the GP may arrange to see the person with mental health concerns about once a week to talk through problems, prescribe medication in the short term, refer them for specialist treatment or counselling, psychotherapy or complementary therapy. In North Warwickshire the PCT runs dedicated mental health counselling services in all GP practices and plans to improve this in North Warwickshire and in Rugby.

4.1.2 In addition to this help can be obtained from NHS Direct, or a telephone helpline such as the Samaritans or Saneline. Warwickshire also has two specialist mental health helplines. Rethink – North Warwickshire Mental Health Helpline and Solace – South Warwickshire Mental Health Helpline. They can be a useful point of call for those experiencing mental health problems, their carers or information and advice.

4.1.3 Resource Cafes in Warwickshire also provide information and advice on mental health issues, volunteering employment, accommodation and benefits.

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[2] Summary Report - Prevention of Mental Disorders: Effective Interventions and Policy Options, World Health Organisation 2004

These cafes are not day services but can provide a platform for groups of individuals to meet together and organise self- help support, social and recreational activities. There are Resource Cafes in Nuneaton, Atherstone, Bedworth, Leamington Spa and Stratford.

4.1.4 The Crisis Intervention /Home Treatment Teams provides 24 hours support for those people who might otherwise be admitted to a psychiatric hospital. They offer intensive support, including where necessary daily visits. The teams are based in Nuneaton, Rugby, Leamington Spa and Stratford upon Avon. They are multi-disciplinary with social workers, nurses, occupational therapists, support workers and medical staff.

4.1.5 If a patient goes into hospital North and South Warwickshire PCTs ensure that their care is reviewed regularly throughout their stay in hospital and their relatives and carers can be involved if they wish. Review meetings help to monitor progress and support leave as part of planned discharge. A discharge planning meeting is arranged before people leave hospital. When people go back home on-going the specialist community team that best meets their needs will provide care and support.

4.1.6 There are four hospital sites that provide mental health care in Warwickshire:

4.2 Avenue Clinic, Nuneaton (North Warwickshire PCT)

4.2.1 The Avenue Clinic in Nuneaton has four wings and admission is determined by the geographical location of the person with mental health needs. All rooms are single and ensuite. It serves people that live in Nuneaton & Bedworth and North Warwickshire. One wing offers a higher level of support and supervision (Psychiatric Intensive Care). There is a dedicated women's only lounge in one of the wings as well as specialist day support. The unit is currently undergoing refurbishment as part of the national Kings Fund Healing Environment programme, this will improve both the intensive care facilities and the dedicated services for women. There is a separate acute unit on the same site with 17 beds (Stanley & Pembleton) for people over 65. Highfield House is situated in Attleborough (Nuneaton) and has 6 beds for people in North Warwickshire and Rugby who need longer admission for rehabilitation.

4.3 Linden Unit, Rugby (North Warwickshire PCT)

4.3.1 The Linden Unit is on the Hospital of St Cross site has 18 acute beds for adults in Rugby. All rooms are single and ensuite. It has a dedicated women's only area and day support. There is a separate 20 bed ward for people over 65.

4.3.2 The Linden Unit and Avenue Clinic work closely together and with the crisis and home treatment teams in their areas. They have been successful in reducing the need for people to go "Out of Area" for acute care.

4.4 St Michaels Hospital, Warwick (South Warwickshire PCT)

4.4.1 St Michaels Hospital has six wards with a total of 77 beds, which serve people that live in Warwick or Stratford District. There are 40 adult acute (5 for psychiatric intensive care), 20 mental health older people and 17 for rehabilitation. There are specific wards that can look after clients (alternative term rather than patient for those with mental health needs) that require psychiatric intensive care, functional older persons care, those that have challenging behaviour or require rehabilitation. One of the wards has a women's area, which includes a lounge, smoking room, female only single rooms and a children's visiting room. In addition to the hospital accommodation there are also two-day services operated by qualified staff.

4.5 The Care Programme Approach (CPA)

4.5.1 The aim of the 'Care Programme Approach' is to involve the client as well as providing support. The client has a care co-ordinator, which could be a nurse, social worker, psychiatrist or psychologist.

4.5.2 The client should receive a copy of their care plan and a leaflet explaining what services to expect when they first receive care.

4.5.3 The CPA system is intended to ensure that all clients receive the following:

- A comprehensive assessment of their health and social care needs following which the client will be allocated to a CPA level.
- Screening for employment, education and training
- A plan of care produced by professional staff to meet assessed needs in consultation with the client and where appropriate their relatives or carers.
- An allocation of a care coordinator and for some clients an associate key worker
- Regular monitoring
- Periodic review of progress
- Carers also have the right to have their own needs assessed.
- Clients can write an 'Advance Directives' to communicate to others their wishes if they become unwell.

4.5.4 A system of 'direct payments' is available for anyone who is eligible for a service from their local authority. This gives more independence and choice on how people access services. They are provided with funds to directly buy the services they want. Although 'direct payments' are good in principle it can cause concern for those with mental health problems. The accounting procedures require the client to keep financial records and maintain a separate bank account. For some clients this would be too onerous a task and can complicate recovery, so take up of 'direct payments' is not as high as it could be. However, support is available for those who do choose to use the 'direct payments' system.

4.6. Community Based Mental Health Provision

4.6.1 In addition to the hospitals there are a number of community based mental health and other related teams that will provide support to either prevent an admission or support the client after discharge from hospital.

4.6.2 Crisis Intervention/Home Treatment Teams offer intervention and support 24 hours a day, 7 days a week. These teams provide a real choice when people are acutely unwell as the care that is needed can be provided at home. An in-patient admission will be used when people need continuous support and/or because their illness is serious or complex and can only be treated in hospital.

4.6.3 Assertive Outreach Team is an active form of working with individuals who have severe and enduring mental illness for whom a traditional 9-5 service is too inflexible to meet their needs or who have found it difficult to benefit from services organised on this basis. The Assertive Outreach Team have smaller caseloads, this means they can provide intensive and personalised support and are able to see their clients frequently, including evenings and weekends.

4.6.4 Community Mental Health Teams (CMHT) are multidisciplinary team providing mental health assessment, care co-ordination and on-going support to individuals who have a wide range of mental health needs. They typically operate 9-5, Monday to Friday. In South Warwickshire they work in close liaison with GPs. In North Warwickshire this liaison is further supported by dedicated counselling services run by the PCT.

4.6.5 Early Intervention Service exist in the North and the South of the county and offer assessment, treatment and support to young people aged 14 to 35 years who are in the first three years of an episode of psychosis and provide planning for the subsequent care of clients following their discharge.

4.6.6 Recovery and Rehabilitation Services provide dedicated support to help people to re-establish the ordinary pattern of their lives. They provide dedicated support over many years, helping people to develop their own expertise in managing their illness and supporting families and carers. There are specialist in-patient admission beds for people in North Warwickshire and Rugby at Highfield House and for people in South Warwickshire at St Michaels Hospital. Both Primary Care Trusts also purchase longer term in-patient rehabilitation from highly specialist hospitals like St Andrews Hospital in Northampton.

4.6.7 Both North Warwickshire PCT and South Warwickshire PCT provide a wide range of psychological and psychotherapeutic services. This includes specific therapies like Cognitive Behavioural Therapy (CBT) and Dialetical Behavioural Therapy (DBT) as well as personalised psychological treatment programmes. CBT and DBT addresses the specific thoughts, feelings, behaviour and attitudes of people with mental health concerns.

4.6.8 Warwickshire Substance Misuse Services (WSMS) is the lead provider for Substance Misuse Treatment Services for both drug and alcohol treatment in Warwickshire. The service provides a range of treatment services options

and is managed by South Warwickshire Primary Care Trust as a countywide service.

4.6.9 Community Alcohol Service (partly commissioned by Social Services to provide some tiers of intervention in alcohol & drugs) aims to reduce the risk and harm associated with substance misuse where alcohol is the primary presenting problem. They offer free and confidential service to clients and their families or friends. There are three offices in Rugby, Nuneaton and Leamington Spa.

4.6.10 Voluntary and Community Organisations play a varied and valuable role on providing support services. Many are registered charities or community groups and are non-profit organisation contracted by either Social Services or the NHS to provide services. In Warwickshire many of the day, employment, community support and resource cafes are provided by organisations such as MIND, Rethink, Guideposts Trust, Netherfield and FCH Housing and Care. Rethink provide specialised mental health employment service to help individuals to get back into volunteering, employment, education or training.

4.6.11 The private and independent sector are involved in the provision of nursing and residential care accommodation.

4.6.12 Also there are community development workers based in the north and south of the county and graduate primary care workers.

4.7 Service Users Organisations

4.7.1 Warwickshire has two Service User Involvement Projects one in the North of the county based in Atherstone and one in the South based in St Michaels Hospital, Warwick.

4.7.2 Users can also contact the Advocacy Service and P.A.L.S. (The Patient Liaison Service) that are provided by both Primary Care Trusts.

4.8 Services for Carers

4.8.1 The Buddies service is available across the county and can provide support to enable the primary carer a short break.

4.8.2 A Carers Empowerment Worker is available and they work across the county. Their key role is to ensure that carers are fully involved in policy and service development, planning and evaluation of mental health services.

4.8.3 Carers can take advantage of a Family Education and Support Programme (FESP). The FESP is an education programme and assists carers in managing their change in role and the transition to becoming a carer.

4.8.4 There are also self-help support groups for carers located at the Old Bank in Warwick, Springfield Mind in Stratford, and in Nuneaton, Bedworth and Rugby.

4.8.5 Carer support workers are placed with Mental Health Teams and offer need assessments for carers.

4.8.6 GP are also required to assess the health of carers under the GP Contract arrangements.

4.8.7 There is a Carers Charter provided by the Local Implementation Team (LIT)

4.8.8 There will be a carers' event 'Partners in Care' in May 2005. This is opportunity for carers and consultants to get together to discuss services for carers.

5. Scope

5.1 In order to achieve the aim set out in paragraph 1, this scrutiny so far has explored the following:

a) The patient journey – the care packages that could be offered for someone with mental health needs
b) Mental health provision for adults (16 - 65) in Warwickshire
c) Whether there are significant differences in the number of patients with health needs from an ethnic minority background as opposed to white
d) Whether there is an equity of access and service provision across the county
e) To see if people with mental health needs are given adequate help to access to other specific health service/social services provision, such as smoking cessation, support in the community, etc.
f) What support is offered in the transition from school to work or college or from working age to retirement
g) What support is offered to obtain work or remain in work for those with mental health needs
h) The links with agencies and organisations set, but not reviewing the services they offer.

5.2 Areas still to be explored from the 1st phase of the review are:

a) The extent/number of patients with mental health needs in Warwickshire
b) The waiting times for mental health provision across the county
c) To find out the numbers of specialist staff (NHS and Local Authority) in Warwickshire and whether they are sufficient to ensure those with mental health needs are being seen in time. These will be taken forward to the second phase of the mental health review.

5.3 In addition, the 2nd phase will now include:

- The possible implications of the new Mental Health Act on existing mental health provision
- The transitional arrangements from children to adult services and adult to older peoples services

5.4 To achieve the scope's objectives the panel have sought advice from Mary McGorry, Acting Service Manager for Mental Health, St Michaels Hospital,

Shaun Clee, Director of Operations, South Warwickshire Primary Care Trust and Kate Phipps, Director for Mental Health and Disability, North Warwickshire Primary Care Trust.

5.5 Initial desktop research, talking with interested parties such as the Primary Care Trusts and Social Services formed the basis of the review. An event was Held in Rugby, 'Walk, Talk, Work, Relax, Connect, Making the Links for Mental Health'. The panel also visited 'Springfield Mind' in Stratford and a 'Resource Café' in Bedworth.

6.1 Mental Health Event

6.1 A mental health event 'Walk, Talk, Work, Relax, Connect Making the Links for Mental Health' was held at Benn Hall, Rugby on 2nd February 2005. Ninety delegates attended on the day and there were representatives from statutory and voluntary organisations as well as service users and carers.

6.2 The day started with four presentations in the morning followed by five workshops in the afternoon **(See Appendix 3)**. There were displays from various agencies that attended with an opportunity for delegates to network during lunch. The aim of the event was to establish whether effective links were being made between agencies and to see what was working well and not so well. The day finished with three top priorities to be taken forward from each workshop that would help improve mental health provision in Warwickshire.

6.2 Priorities from the Workshops

6.2.1 There were five workshops each with a set of questions relating to the links being made between agencies. The aim was to identify three key priorities to be taken forward, which would improve the links being made between agencies. The questions were:

1. What links are being made?
2. What links are working well?
3. What links are not working as well as they could be or not at all?
4. What needs to alter to improve these links?

6.3 Three Key Priorities

6.3.1 Workshop 1, Mental Health Provision (Signposting Services)

1. Work at service users pace. Care co-ordinators having time to plan and the need to begin early to map out support networks

2. Information sharing and confidentiality between organisations and services

3. Place alcohol outreach into MH Resource Cafes – actions are already being taken to implement this.

6.3.2 Workshop 2, Links with Housing

Recognise that this should involve service users. Their three key priorities were:

1. A set of protocols that everyone should sign up to across the county. This would require communicating with each other.

2. Agencies must talk to each other and monitor and evaluate on a regular basis

3. Start a Mental Health Forum. One person from each agency to sign up to the forum and attend.

6.3.3 Workshop 3, Links with Benefits and Money

1. Benefits should be assessed by sympathetic and appropriately qualified staff. This should be done in accessible and 'friendly' venues. (**NB** It has been raised since that there can be legal implications if Social Services employees provide advice, especially if it is not totally up to date. To overcome this Warwickshire Welfare Rights currently provide help for professionals).

2. Need for a transitional benefit and stronger support into and out of work

3. Better partnership support between support agencies

6.3.4 Workshop 4, Links to Support in the Workplace and Getting Back to Work

1. Resource café's available for clients in employment – both day and evening.
   - Psychologists to go in to assess the employment environment. (**NB** It has been since raised that psychologists cannot assess an employee's environment).

2. Helpline for employees/employers to get advice while in employment
   - There is no directory of where to go
   - Clients feeling pressurised to get back to employment

3. Rethink opportunities course – possibly tailor the course to education
   - JCP Pathways course

An action from this workshop is that Warwickshire County Council, as part of disability awareness, are going to invited employees to a Mental Health Awareness Day.

6.3.5 Workshop 5, Linking with Carers

1. More information and sharing + easy access to it e.g. carers info centre. Helping carers to recognise they are carers and to look after themselves.

2. Training for carers to be part of service development and also link with service user forums.

3. More shared sustainable funding between statutory and voluntary organisations. More empowerment workers to be involved in looking at training to consultants. Respite services for carers. More funding for over 65s carer's services.

7. Stratford Springfield Mind Visit

7.1 Springfield Mind is a registered charity based in Stratford upon Avon affiliated with MIND. Their members are people living in the community experiencing mental/emotional distress. Their purpose is to enable each user achieve their full potential:

- By providing highest quality of care based on individual needs,
- By enabling users to integrate and access all community services and amenities,
- Supporting and empowering mentally distressed people by promoting inclusion and challenging discrimination,
- Networking closely with all agencies and individuals working and campaigning in developing quality services for emotionally distressed individuals. It is open 7 day a week for those aged 18 – 65 years.

7.2 The visit with the manager revealed that it is the Government's intention that support for those with mental health needs will be moving into the community rather than being based in day care centres. People with mental health needs will be given more one to one support in the home as well as being able to visit Resource Cafes based in the community. It is hoped that this will go some way to reducing the stigma of mental health as well as providing support. There are three Resource Cafes based in the Stratford area: Picture House, Stratford; The Pavilion Alcester Opportunities, Alcester and The White Bear Hotel, Shipston on Stour.

7.3 The manager raised concerns about how the change is being managed, the rules can be difficult to administer, funding requires accountability, which creates more paperwork and generally the contract is only for two years, but people with mental health needs may require it for longer.

7.4 There were concerns that clients that have been accessing services for many years will find it more difficult to integrate into the community and will probably need the existing levels of support already being offered. This age group were often made to feel their life was over and there was not the expectation to work again.

7.5 Further enquires revealed that people in services when they reach the age of 65 should continue to receive adult mental health provision, but when those needs change they fall within the remit of older people mental health services. Each transfer is negotiated by a case-by-case basis. For Social Services adult mental health, the commissioning budget is for working age adults. The budget for older people mental health currently rests with older people services. Social Services have gone some way to lessen the impact of

transition by funding existing clients so that they can continue to receive support through agencies such as Springfield Mind and Age Concern.

7.6 However, new clients over 65 years are not able to access this transition arrangement. There is a short-term arrangement to provide support specifically for older mental health clients in Alcester, but it was recognised that this is not necessarily convenient if living in Warwick, Leamington or Kenilworth. It was thought that a longer-term arrangement would be of benefit not only in Alcester, but elsewhere in the county

7.7 Also older people mental health teams are also not set at the same level of integration as adult mental health and the carers services are currently less well developed. It is thought that the older people's services offered may not always be appropriate to individual needs and are less developed in providing mental health support. Also the client may not feel they are ready to join in activities generally associated in being older.

7.8 The visit highlighted that there seems to be a lack of clarity of approach to the transition arrangements from adult mental health to older mental health services. There have been several discussions with Social Services and the PCT to gain an understanding of what are the arrangements when a person reaches 65 years. Each person gives a slightly different perspective on when the transition occurs which must make it very difficult for users and carers. The transition from one service to another due to age is also recognised as being problematic at the other end of the spectrum for younger mental health service users.

7.9 The biggest barriers facing Springfield Mind were money, time, personnel and breaking down prejudice within the community. There were concerns raised about the number of beds available at St Michaels Hospital (St Michaels Hospital have said that they are not aware of any shortage of available beds for emergency admissions). Springfield Mind did highlight occasions when the crisis team would not visit clients, who were clearly showing signs of distress. This did result in an emergency situation, which could have been avoided. The visit also highlighted that there are long waiting lists for psychotherapy - from 1 year to 18 months.

8. Bedworth Resource Café Visit (FCH)

8.1 Resource Cafes were set up as part of the 'Road to Recovery Model' and they have been in operation for about a year. The panel visited the 'New Horizon', Resource Café, Leicester Road, Bedworth. There are two others based in the north of the county 'Clarence House', Queens Road, Nuneaton and 'New Haven', Coleshill Road, Atherstone. They work with service users to develop self interest groups, which have moved into the community. Their aim is:

- To develop confidence,
- To join community and college groups,
- To engage in volunteering
- To provide information within a wide range of opportunities

8.2 On average there are approx 110 clients at any one time and they made 1340 attendances throughout the year (**NB** clients may make more than one visit throughout the week). The members of the New Horizon Resource Café in 2004-05 were predominantly male (71%) and the café has a high white/British membership. The suggestion was made that the low representation from BME groups is due to the stigma they attach to mental illness and the tendency for them to use their own day services. Both North Warwickshire and South Warwickshire PCT have recently reviewed their services for Black and Ethic Minority (BME) populations **(See Appendices 4 and 7)**. This was as a result of the Bennett Inquiry Report, which made a number of recommendations to ensure that the mental health needs of the BME population are being met.

8.3 The building that houses the Resource Café is adequate for day services, but it is limited by size for café purposes. Funding is available for heating, building costs but there is nothing available for computers, which are sorely needed to enable members to receive training for employment. They recognise that it takes a lot of valuable staff time to put together a bid for funding and it is not always successful and would appreciate some assistance.

8.4 The main barriers they face is not having enough money for social activities such as holidays and leisure activities. They also face difficulties in recruiting due to under-funding. The funding that was available from charities is not forthcoming. There are also problems with being able to transport members to any activities, because the people carrier is not large enough.

8.5 The manager expressed the need for more housing. 'Supporting People' provide 24 hour housing in various locations in Nuneaton and Bedworth, but this is only available for the tenant (those on housing benefit), this does cause problems for others. There is no housing available in North Warwickshire.

8.6 Another concern raised by the manager was the level of illness presenting itself to the Resource Café was greater than expected. They thought it was partly due to high level of paperwork required for referral. Because the Resource Café does not require the same amount of paperwork it is easier for other agencies to refer clients to them.

8.7 Also as in Springfield Mind a concern was raised that the 'Crisis Team' backup does not appear to be working. Clients that are very ill end up being admitted to hospital, which could have been prevented with the right support. In North Warwickshire the level of funding had not been sufficient for 24 hour coverage. However, with increased funding, for the current year, it is hoped that this will resolve these issues.

8.8 The manager also commented that there are sometimes assumptions made that mental health problems are the cause of other health symptoms and physical problems can be ignored. There was a serious case where a headache was attributed to mental health problems when in fact it was a tumour.

8.8 FCH (Housing & Care Across the Midlands) regularly conduct a user satisfaction survey and hold workshops at the Resources Cafes in the North of the County. The client's responses are used to improve the services provided by the Resource Cafes and highlight any gaps in provision.

9. Employment Strategy for Mental Health

9.1 The presentation from Rethink at the mental health event informed the delegates that mental health problems cost the country over £77 billion a year. Early intervention would significantly reduce these costs, because once a person reaches crisis point it is much more difficult to restore their employment and social status. Being able to continue in employment, education or training is very important for people suffering from mental illness, because it becomes much more difficult for them to return after a break of six months or more.

9.2 Additional information given at the event was that:

- Only 12% of people diagnosed with a mental health problem have a job,
- Only one in ten companies have a mental heath policy
- Stress has taken over from musculoskeletal problems as number one cause of sickness absence
- By 2020 the World Health Organisation predict that depression will the second leading cause of disability
- 2210 individuals in Warwickshire with mental health needs have been classed as economically inactive

9.3 The Government's the aim is to reduce social exclusion amongst adults with mental health problems through supported employment. The three key areas identified are:

- Exemplar Employer – reducing employment discrimination and increasing access to key posts within the mental health services (positive discrimination) for those experiencing mental health problems.
- Access to open employment and mainstream opportunities – enabling those employed to sustain employment as part of the care process and supporting the capacity of mainstream employment services.
- Specialist employment and sheltered opportunities in the social economy – work opportunities provided by health services for those with severe and enduring mental health problems and legally debarred from working in the community setting.

9.4 Employment opportunities can be provided via:

- Social Enterprise – businesses created for the purpose of promoting the economic and social integration of people disadvantaged in the labour market.
- Supported employment – via a consultant ascertaining is it the right type of job, working environment, conditions, etc. Also offering on the job training and support to help the individual until settled into work.

- Sheltered work opportunities – for those who need high levels of supervision and support at work.

9.5 Rethink Employment and Information Service offers information, advice and guidance to those recovering from a mental illness.

In the last three years the North of the county have had:
- Over 300 from the local Community Mental Health Teams
- Over 35 people into work (above the national average)
- 130 people into voluntary work
- Work opportunities course
- Over 100 people into some type of education
- Matrix Quality Standard Award

9.6 DICE (Diversity in Community Education and Employment) covers the south of the county. This is a specialist service where referrals are assessed and work is carried out with the service users by Occupational Therapists. DICE work very closely with local education providers and the Disability Employment Advisors.

9.7 An Employment Strategy for Mental Health was produced in January 2005 (See appendix 5).

10. Supporting People

10.1 The Supporting People Team provide housing related support to enable vulnerable people to live in the community (does not include personal care). They also help with teaching of life skills such as cooking or applying for benefits. They work in partnership with District and Borough Councils, Warwickshire County Council and Probation Services.

10.2 Housing related support is given for those who are 16 years and over with mental health problems, learning disabilities, drug and alcohol misuse, ex offenders, travellers and others. They provide 268 services to approximately 8,500 people. There are 223 units of accommodation (packages of care) for people with mental health needs

10.3 Their grant for 2004/05 is £10.7 million, but in 2005/06 this will reduce by 5% to £10.2 million. The Audit Commission Inspection recommends that there should be greater access to resources for mental health.

10.4 'Supporting People' will be reviewing all services by 2006. The aim is to have a more flexible approach and improve services for users and carers.

10.5 'Supporting People' are developing a five-year strategy to identify need for each client group. This strategy will be countywide and to be agreed by all partners in April 2005.

10.6 The strategy has already identified that an increase in housing provision would enable people with mental health problems to move away from acute

provision. This accommodation needs to be self-contained units with a communal area with a facility to provide support when required. They acknowledge that people with severe mental health issues will be harder to place **(See appendix 3)**.

11. Benefits and Money – Warwickshire Welfare Rights

11.1 A representative from Warwickshire Welfare Rights explained the pitfalls for someone with mental health needs in trying to claim benefits. The nature of the illness meant that they could be claiming benefits, which they could potentially lose if they took up voluntary work in excess of a certain number hours. Voluntary work is considered essential in helping people with mental health problems get back into the community.

11.2 Welfare Rights highlighted that claiming benefits is quite a complicated process. Proving that you are not fit for work, completing forms and identifying the types of benefits you can claim is an onerous task even when well. The complexities of the illness requiring support one week, maybe feeling well enough to work another, but possibly requiring support again in a short space of time doesn't fit well with claiming benefits. Also the current move to provide access only via the telephone may only exacerbate problems for those requiring one to one support to complete the forms to claim benefit. **(See Appendix 3)**

12. Deprivation

12.1 There has been some discussion on whether there is evidence to support that people living in a deprived area are more likely to develop mental health problems. Initial discussions with front line staff indicated that there was little evidence to support this argument in Warwickshire. They consider that people with mental health concerns tend to come from a variety of backgrounds. However, professionals from North Warwickshire PCT do not wholly agree with this and consider that people from more deprived areas are more likely to suffer from mental health problems. There is also evidence[3] that without proper support people with mental health concerns are more likely to lose their job and possibly their home and as a consequence could end up living in a more deprived area.

12.2 North and South Warwickshire PCTs commissioned Dr Greg Wells (public health lead for mental health across Warwickshire based in South Warwickshire PCT) to review the epidemiology of mental health across Warwickshire in 2004. Using the MINI indices (section 13) showed that there was a higher rate of mental illness from deprived communities in Warwickshire. Further analysis using discharge data for south Warwickshire also showed that there was a higher rate of admission into hospital from deprived communities. These results combined indicate that there is a good level of equity of access to in-patient care for people living in South Warwickshire.

[3] 'Out of the Picture' - Citizens Advice Bureaux 2004

13. Mini Scores for Warwickshire

13.1 Further work has been conducted to help planners, purchasers and providers of mental health care distribute facilities and resources within Warwickshire.

13.2 Thornicroft (1998) identified a number of variables below which can be used to predict the occurrence of mental illness. These are:

- marital status (single/divorce/widowed),
- male gender,
- permanent illness,
- accommodation type (non-enclosed accommodation or hostels)
- and mobility (use of own car)

For example male gender combined with marital status (single/divorced/widowed) is considered more likely to lead to a greater incidence of mental illness for men, than female gender combined with marital status above.

13.3 There are separate mini scores, for the population aged 16 – 59 years for four categories of mental illness: all types of mental illness; schizophrenia; affective disorder type illness and other mental illness (includes OCD (Obsessive Compulsive Disorder) and those as result of drug misuse & misdemeanour).

13.4 MINI works on the principle that England has a national average of 1. Local scores are expressed as a percentage either above or below the national average.

13.5 The work has identified that:

- Nuneaton and Bedworth has the greatest concentration of expected number of admissions for all types mental illness. It is three times greater than the median.
- Leamington Spa is the only other town where admissions are three times greater than the median
- Generally urban/built up areas of the county have a greater expected number of admissions.
- The lowest concentrations of admissions are in rural areas. However, when incidence occurs in rural areas social exclusion would be greater.

(**See appendix 6 for full report)**.

13.6 The PCTs and Social Services have reported that the variation in the number of people receiving treatment across the County matches the concentration and incidence of mental illness. They consider that this supports the view that there is equitable access to mental health services. However, North Warwickshire PCT and Rugby PCT intend to conduct further work in light of the MINI results and especially since they have been granted “Spearhead” status to specifically address health inequality issues in North Warwickshire.

14. Conclusions

14.1 The review has identified that there are a multitude of care packages for those with mental health needs but concerns have been raised on whether the agencies that provide care and support are always linking with each other. For example Stratford Mind and Bedworth Resource Café requested support from the 'Crisis Teams', which was not forthcoming, resulting in clients being admitted to hospital in an emergency and the 'Mental Health Event' showed that the necessary links were not always being made. Also the following incident, which a panel member needed to resolve, whilst conducting this review, indicates that the necessary links are not always being made. A family were having problems in finding appropriate housing for a family member who was experiencing mental health problems. This person was homeless and sleeping rough. They contacted what they thought would be the appropriate organisations, such as the housing association, their local council, but to no avail. In desperation the family then contacted a member of the panel who referred them to an appropriate service provider. This not only resolved the housing concern but also linked them with other mental health service providers. The panel consider that the initial contact and the links between service providers is very important. This ensures that those with mental health needs and their carers can easily access services to help them remain/gain employment, obtain education/training, access benefits and appropriate housing. . Social Services produce a publication called Café Chat, once a quarter with a list of contacts, which is regularly updated. This could be made available to community leaders. **(See Recommendations 15.1 and 15.2).**

14.2 Mental Health provision in Warwickshire is very complex and it must be difficult for service users and carers to be able to know what is readily available or where to go to seek help. It appears to be very reliant on the GP making a referral and agencies providing information in a consistent manner. Transitional arrangements highlight the differences in the information given which can be very confusing. The transition from children to adult services and from working age to retirement does cause problems for the client. Although the review has concentrated on those likely to be in employment, some work needs to be done to ensure that clients receive a seamless service regardless of age. **(See recommendation 15.3).**

14.3 It is important for mental health services to make the links with mainstream activities through:

- Social Inclusion Agenda
- Training at all levels
- Sustainability of funding
- Housing
- Recreational activities Warwickshire Art Action Zone

The panel want to ensure that there is consistency and equity of access to these services. **(See recommendation 15.4)**

14.4 The review has identified that those from the BME population do not appear to attend day services and the explanation given is that it is partly due to the stigma they attach to mental illness. Recommendations from the 'Bennett

Inquiry' report, has instigated the review of mental health provision for the BME population. The panel want this good work to carry on and that the BME population continue to have their mental health needs assessed. Hopefully, in time, this will encourage a greater take-up of services from the BME population. **(See recommendation 15.5).**

14.5 Services such as Springfield Mind and the Resource Cafes are providing the means for those wanting to access other health service/social services provision. Springfield Mind is intending to use the Smoking Cessation Services to help their clients to stop smoking if they so wish. These venues provide an ideal opportunity for services to come to the client to provide treatment and support. Also there are cases where physical health concerns have been attributed to mental health problems. **(See recommendation 15.6)**

14.6 The review has identified that there is considerable support being offered to those with mental health problems to remain in work or access employment. However, there is evidence to indicate that there is still stigmatism attached to mental health and more work with employers and employees could help reduce stigmatism in the workplace. **(See recommendation 15.7)**

14.7 The mental health event identified that there are still some problems with the links being made between the statutory and voluntary organisations. Several delegates at the event thought that an annual event where they could get together to network and discuss any concerns would be very helpful. **(See recommendation 15.8)**

14.8 There are still areas in the scope that were not covered by the review. The information required involves the numbers of patients, waiting times and staffing levels. **(See recommendation 15.9)**

14.9 A number of key priorities came out of the workshops at the mental health event. **(See recommendations 15.10 and 15.11)**

14.10 The review identified that the commissioning of services for 3 years causes problems for agencies such as Springfield Mind. **(See Recommendation 15.12)**

15. Recommendations

15.1 Recommend that information on existing mental health resources available via 'Supporting People' and Durham Mapping (Durham University Website) be used to highlight what provision is available in Warwickshire. This information could be used alongside other health and well-being data in Warwickshire's 'Quality of Life Report', which is published annually by the Research Team in PTES. This information, if updated annually, would form part of the County Council's monitoring of health related issues. However, this will require a commitment from the PCTs and Social Services, as joint providers, with 'Supporting People' to contribute to this process.

15.2 Recommend that a handbook or a CD-ROM about service provision for those with mental health needs be made readily available for community leaders (County, Borough and District Councillors, Vicars, etc.). Café Chat (Social Services publication) has a page devoted to contact information for mental health provision. Suggest that Social Services could be the lead body to take this forward.

15.3 Recommend that the PCTs and Social Services review how information is provided to users and carers to reduce confusion in how the transitional arrangements are implemented and they ensure there is consistency in the information given. (To be reviewed in 2nd phase)

15.4 Recommend that mental health providers link in with the community plans with the aim to improve mental health provision in the county.

15.5 Recommended that both PCTs (North and South Warwickshire) with a responsibility with mental health provision continue with the mental health needs assessment of the BME population to encourage a better take-up of mental health services by the BME population.

15.6 Recommend that the PCTs help promote healthy living activities to users and carers because there is a danger that other health concerns tend to be attributed to mental health problems. PCTs should be actively engaging in providing services such as smoking cessation or sexual health to users and carers. Also regular health checks should be encouraged such as blood pressure, blood sugar or cholesterol levels.

15.7 Recommend that Warwickshire County Council and the Borough and District Councils hold a 'Mental Health Awareness Raising Day' to help employers and employees understand what it is like to suffer form mental health problems. Human Resources or Personnel Departments to take the lead.

15.8 Recommend that an annual event is held with all mental health service providers, service users and carers. Supporting People are willing to take the lead, but they would need to discuss arrangements, funding and the way forward with other mental health service providers.

15.9 Recommend that the review continues to a 2nd phase of the review, which will include the areas not covered by the review and look more thoroughly at issues such as the transition arrangements such as children to adult and adult to older people services and the possible implications of the new Mental Health Act on provision (see paragraphs 4.2 & 4.3 in report).

15.10 The event highlighted that there are a number of providers in Warwickshire that support those with mental health needs such as housing, benefits, support in the workplace. Recommend that these providers evaluate their services to identify gaps in provision and where appropriate implement the key priorities raised at the event specified in section 5.

15.11 Recommend that benefits should be assessed by sympathetic and appropriately qualified staff and should be at accessible but inviting venues. Staff to be made aware of the difficulties in completing complex forms. Also having to travel long distances to uninviting venues can be daunting and expensive for those with mental health problems. The panel recognise there is a move towards providing information via 'one stop shops', however they want to ensure that staff have adequate training to help those with mental health needs.

15.12 Commissioning services for the voluntary sector on the basis of a contract for 3 years is too short. Recommend that a move to commissioning services for five years for smaller charities would help reduce staff time and costs. Initial discussions with the PCTs indicate that they would be happy to commission services for a longer period.

Background Papers

Report of Mental Health Panel (1st Phase)2005

Health Overview and Scrutiny Committee
27th July 2005

Agenda No

AGENDA MANAGEMENT SHEET

Name of Committee	**Health Overview and Scrutiny Committee**
Date of Committee	**27th July, 2004**
Report Title	**Terms of Reference for Mental Health Panel**
Summary	The following report provides suggested terms of reference for the scrutiny exercise of Mental Health Services. It includes a suggested reporting timetable culminating in a final report to this committee April/May? 2005. This committee is now asked to agree panel members for this scrutiny exercise, scope, methodology and resources.
For further information please contact:	Andrew Lawrence Head of Community Support Tel: 01926 412819 andrewlawrence@warwickshire.gov.uk Alwin McGibbon Health Scrutiny Officer Corporate Review Team Tel: 01926 746823 alwinmcgibbon@warwickshire.gov.uk
Would the recommended decision be contrary to the Budget and Policy Framework?	No.
Background papers	None

CONSULTATION ALREADY UNDERTAKEN:- Details to be specified

Other Committees	☐	....
Local Member(s)	☐	
Other Elected Members	☐	
Cabinet Member	☐	....
Chief Executive	☒	David Carter...
Legal	☒	Jane Pollard..
Finance	☐	....

Other Chief Officers	[X]	Marion Davis...
District Councils	[ ]	....
Health Authority	[ ]	....
Police	[ ]	....
Other Bodies/Individuals	[ ]	....

FINAL DECISION NO

SUGGESTED NEXT STEPS: Details to be specified

Further consideration by this Committee	[X]	....
To Council	[ ]	....
To Cabinet	[ ]	....
To an O & S Committee	[ ]	....
To an Area Committee	[ ]	....
Further Consultation	[ ]	....

Agenda No

Health Overview and Scrutiny Committee - 27th July, 2004.

Terms of Reference for Mental Health Service

Report of the County Solicitor and Assistant Chief Executive

Recommendation

That the committee agrees the terms of reference for the scrutiny of mental health with specific reference to:

- Panel Members
- Scope
- Methodology
- and Resources

1. Introduction

1.1 Concern has been raised about the level of health service provision in the county for those who have mental health problems. It has been suggested that by undertaking a scrutiny exercise on 'Mental Health Services' these concerns can be examined in greater detail.

1.2 The terms of reference in Appendix 1 suggests how these concerns can be considered.

1.3 The terms of reference include background information, which will help to inform members of the number of people that are likely to have mental health problems and the difficulties they may face trying to access health services. It will also explain how the illness may affect their ability to work and unless they are adequately supported may result in them being socially excluded.

2. Recommendation

2.1 That the committee agrees the terms of reference for the scrutiny of 'Mental Health Services' with specific reference to:

- Panel Members
- Scope
- Methodology
- and Resources

DAVID CARTER
County Solicitor and Assistant
Chief Executive

Shire Hall
Warwick

6th July 2004

Appendix 1

Terms of Reference for the Scrutiny on Mental Health Service

1. Aims and Objectives

The aim of this scrutiny exercise is to assess the link between mental illness and health inequalities. This will involve scrutinising the NHS services that provide assistance to those that are affected by mental health problems. This scrutiny may also involve the Boroughs and Districts Councils, relevant departments within the County Council and outside agencies, which may have an interest in mental illness and health.

A successful outcome from this review would be that there is

- A better understanding of how mental health is linked with health inequalities
- The relationship between mental illness and health provision
- An understanding of what the health services does to meet the needs of those affected.
- To ensure that the health service provides a flexible, appropriate, clinically effective and accessible service in response to the needs of those affected.

It takes into account equity of access to services in line with the social inclusion agenda. Also that it will help Members and officers have a better understanding of the implications of being mentally ill in Warwickshire

2. Background

The office of National Statistics estimates that one in six people suffer from a mental health problem at any one time, roughly over 7 million people between the ages of 16 and 74. The Sainsbury Centre recently estimated the economic and social costs of mental illness for England to be around £77 billion. The most recent Welsh Health Survey indicated that 9.4 per cent of adults suffered from depression and 7.3 per cent had suffered from anxiety.

The CAB report 'Out of the Picture' highlights that people with mental health problems often experience discrimination and are not adequately supported. This creates difficulties and reinforces their isolation the illness creates. The report considers the widespread discriminatory behaviour and failures to understand the difficulties people with mental health problems face makes raising awareness about mental illness a central issue.

The CAB considers that all those that come into contact directly or indirectly with people with mental health problems need to be better equipped to identify and help them whether they be in the public, private or independent sectors. Institutions need to review their procedures to avoid discriminatory outcomes. In addition there is a need to break down the barriers of discrimination by raising awareness about mental health issues among the general population.

Mental Health Facts

- Mental Health service users have the lowest employment rate of all disabled groups. Only 18 per cent are employed. Therefore most are dependent on benefit income

- They are some of the poorest people in the UK

- Poverty is linked to poor health, but people with mental health problems are trapped in poverty for longer periods than most.

- Persistent low income reduces their ability to participate in activities and services, which might help to reduce their isolation.

- Benefit system makes no allowance for people with mental health problems. The illness at times reduces the capacity to function normally and this can affect a claimant's ability to complete the forms necessary for benefit.

- Those with mental health problems are vulnerable to high pressure selling and can enter into agreements, which they may not be able to afford.

- The Royal College of Psychiatrists has reported that 40 per cent of people who present to their GP with mental health problems feel stigmatised and discriminated against by their GPs.

- 90 per cent of mental health problems are dealt with in primary care. These people may be in particular need of more support. GPs are unlikely to be in a position to refer these people for the effective support in the early stages of their illness that the government would like them to have.

- Some people find their Community Psychiatric Nurse and social workers difficult or impossible to reach. When professionals move away to other jobs the client's files are often closed, which means they then have to go back to their GP for a new referral.

- People who are referred on to the mental health services for specialist help from a psychiatrist and /or a Community Psychiatric Nurse (CPN) and the Community Mental Health Team are in a minority. Such referrals tend to be made when people's conditions deteriorate or become critical.

- Ethnicity also affects access to services, there are notable differences in the experience of mental health services. Rates for compulsory admission are higher for black and minority ethnic groups. This may be associated with more frequent involvement of the criminal justice system in their referrals. They are more likely to be considered as requiring a greater degree of control and security and therefore more likely to be admitted to secure environments.

- Mental health remains one the government's three clinical priorities, along with cancer and coronary heart disease.

3. Scope

In order to achieve the aim set out in paragraph 1, this scrutiny will explore the following:

- Mental health provision for adults (under 65) in Warwickshire
- Whether there are significant differences in the number of patients with health needs from an ethnic minority background as opposed to white
- The extent/number of patients with mental health needs in Warwickshire
- Whether there is an equity of access and service provision across the county
- The waiting times for mental health provision across the county
- To find out the numbers of specialist staff (NHS and Local Authority) in Warwickshire and whether they are sufficient to ensure those with mental health needs are seen in time
- To see if people with mental health needs are given adequate help to access to other specific health service provision, such as smoking cessation, etc.
- What support is offered to help those with mental health concerns remain in work or gain work
- What support is offered to help them claim benefits
- What support is offered to help those with mental health needs cope with any debt problems they may have incurred
- What support could be given to prevent those with mental health concerns being victims of pressure sales
- How much support is offered to carers of patients with mental health needs
- Whether homelessness an issue for this client group

4. Panel

Cllrs Jerry Roodhouse, Helen McCarthy, Sid Tooth Jane Harrison and Richard Meredith,

5. Methodology

Desktop Research and Event

6. Resources

Alwin McGibbon (Health Scrutiny Officer) and Phil Maull (Committee Services)

7. Timetable

Activity	*Timescale*
Draft Terms of Reference presented to Health and Scrutiny Committee	27th July 2004
Finalise Terms of Reference presented to Health Overview and Scrutiny Committee and agree Panel membership, Methodology and Resources	13th October 2004
First Meeting of Panel	13th October 2004
Carry out scrutiny	August 2004 – March 2005
Report to full committee	July 2005

Appendix 2

Revised Scope for Mental Health Review 15/12/04

In order to achieve the aim set out in paragraph 1, this scrutiny will explore the following:

- The patient journey – the care packages that could be offered for someone with mental health needs
- Mental health provision for adults (16 - 65) in Warwickshire
- Whether there are significant differences in the number of patients with health needs from an ethnic minority background as opposed to white
- The extent/number of patients with mental health needs in Warwickshire
- Whether there is an equity of access and service provision across the county
- The waiting times for mental health provision across the county
- To find out the numbers of specialist staff (NHS and Local Authority) in Warwickshire and whether they are sufficient to ensure those with mental health needs are seen in time
- To see if people with mental health needs are given adequate help to access to other specific health service/social services provision, such as smoking cessation, support in the community, etc.
- What support is offered in the transition from school to work or college
- What support is offered to obtain work or remain in work for those with mental health needs

It will also explore how the NHS and Social Services link with other agencies/organisations and vice versa, but not reviewing the services they offer:

- Benefits Agency
- Housing – District/Boroughs/Housing Associations
- CAB, Trading Standards
- Education
- Job Centre Plus
- Work Step
- Voluntary Mental Health Support Groups
- Supporting People

This review will not be looking at mental health provision for children or adults over the age of 65 years.

Appendix 3

Mental Health Event 2nd February 2005
Walk, Talk, Work, Relax, Connect – Making the Links for Mental Health

A mental health event 'Walk, Talk, Work, Relax, Connect Making the Links for Mental Health' was held at Benn Hall, Rugby on 2nd February 2005. Ninety delegates attended on the day there were representatives from statutory and voluntary organisations as well as service users and carers.

The day started with four presentations in the morning followed by five workshops in the afternoon. There were displays from various agencies that attended and an opportunity for delegates to network during lunch. The aim of the event was to establish whether the effective links were being made between agencies and to see what was working well and not so well. The day finished with three top priorities to be taken forward from each workshop which would hopefully improve mental health provision for the residents of Warwickshire.

Introduction to Mental Health - Springfield Mind

The first presentation was from Springfield Mind, Stratford. They highlighted that mental health services was going through change and there will be a more holistic approach taken. The intention is for mental health provision to be within the community via one to one in the home and light-touch support provided by Resource Cafes. These cafes provide information on issues such as housing and employment. Also they promote opportunities for users to be involved in volunteering. They stressed the importance of partnership working in providing effective mental health services for users.

This was followed by a presentation from a service user from Springfield Mind who explained what it was like to suffer from mental health problems and how support and understanding from everyone was very important to aid recovery. The service user also displayed 4 art panels at the event, which conveyed the stages of the illness and how they felt. The artwork and presentation was very well received by all those attended.

Five Year Strategy - Supporting People

They provide housing related support to enable vulnerable people to live in the community, but they do not provide personal care. However they do help with the teaching of life skills such as cooking or applying for benefits. They work in partnership with District and Borough Councils, Warwickshire County Council and Probation Services.

Housing related support is given for those who are 16 years and over. They support those with mental health problems, learning disabilities, young people, drug and alcohol misuse, ex offenders, travellers and others that require housing support. They provide 268 services to approximately 8,500 people.

There are 223 units of accommodation for people with mental health needs

They have a grant of £10.7 million for 2004/05, but in 2005/06 this will reduce by 5% to £10.2 million.

Supporting People will be reviewing all services by 2006. The aim is to have a more flexible approach and improve services for users and carers.

Supporting People are in the process of developing a five year strategy to identify need for each client group. The strategy is countywide and to be agreed by all partners by April 2005. The strategy has identified that an increase in housing provision would enable people with mental health problems to move away from acute provision. This accommodation needs to be self-contained units for single people with a communal area, but there should be a facility to provide support when required. They acknowledged that people with severe mental health issues could be difficult to place.

Benefits and Money – Warwickshire Welfare Rights

A representative from Warwickshire Welfare Rights explained the pitfalls for someone with mental health needs in trying to claim benefits. The nature of the illness meant that they could be claiming benefits, which they could potentially lose if they took up voluntary work in excess of a certain number hours. This remedial work is considered essential in helping people with mental health problems get back into the community.

The presentation highlighted that claiming benefits is quite a complicated process. Proving that you are not fit for work, completing forms and identifying the types of benefits you can claim is an onerous task even when well. The complexities of the illness requiring support one week, maybe feeling well enough to work another but possibly requiring support again in a short space of time doesn't fit well with claiming benefits. They identified that those with mental health needs may also require one to one assistance in completing the forms for benefits, but the move for more contact via telephone may only exacerbate problems for those who need support.

Employment Need – Rethink Warwickshire

The presentation informed the delegates that mental health problems cost the country over £77 billion a year. Early intervention would significantly reduce these costs because once a person reaches crisis point it is much more difficult to restore their employment and social status. They went on further to explain that:

- Only 12% of people diagnosed with a mental health problem have a job,
- Only one in ten companies have a mental heath policy
- Stress has taken over from musculoskeletal problems as number one cause of sickness absence
- By 2020 the World Health Organisation predict that depression will the second leading cause of disability
- 2210 individuals in Warwickshire with mental health needs have been classed as economically inactive

The barriers to work for people with mental health problems are low confidence; low expectations amongst staff; employer attitude; difficulties moving from benefits back to work and lack of support to help people retain jobs.
They provided information on how the Government's the aim is to reduce social exclusion amongst adults with mental health problems through supported employment.

The three key areas identified are:

- Exemplar Employer – reducing employment discrimination and increasing access to posts within the mental health services for those experiencing mental health problems.
- Access to open employment and mainstream opportunities – enabling those employed to sustain employment as part of the care process and supporting the capacity of mainstream employment services.
- Specialist employment and sheltered opportunities in the social economy – work opportunities provided by health services for those with severe and enduring mental health problems and legally debarred from working in the community setting.

The types of working environments that provide supported employment are through:

- Social Enterprise – businesses created for the purpose of promoting the economic and social integration of people disadvantaged in the labour market.
- Supported employment – via a consultant ascertaining is it the right type of job, working environment, conditions, etc. Also offering on the job training and support to help the individual until settled into work.
- Sheltered work opportunities – for those who need high levels of supervision and support at work.

The aim of Rethink Employment and Information Service is to offer information, advice and guidance to those recovering from a mental illness.

In the North of the county they have had in the last three years:

- Over 300 from the local Community Mental Health Teams
- Over 35 people into work (above the national average)
- 130 people into voluntary work
- Work opportunities course
- Over 100 people into some type of education
- Matrix Quality Standard Award

The South of the county is covered by DICE (Diversity in Community Education and Employment). This is a specialist service where referrals are assessed and work is carried out with the service users by Occupational Therapists. DICE work very closely with local education providers and the Disability Employment Advisors.

WORKSHOP 1

Case Study 1 – Tom

Tom is a 57-year-old man with a long history of mental health difficulties. Tom has recently moved into a second floor flat after a stay of over 18 months in a psychiatric hospital. He has a daughter Denise who lives with her family three miles away across the other side of town.

Tom lacks confidence and is asking to move back to the hospital already after claiming that he has been verbally and physically abused by neighbours, there does seem some substance to these allegations as council workmen have been called out three times in the last two weeks to repair some broken windows.

Other some sympathetic neighbours have told Tom to ignore the threats because "the same happens to all new residents2 and often stops within a couple of weeks "as the get used to you".

As Tom's Community Psychiatric Nurse what links would you need to make to resolve the issues?

- Day services/ resource café 'buddies'
- CPN – supporting people worker
- Care co-ordinator
- Daughter
    - Does Tom want her involved in his care plan?
    - More contact?
    - Carer's needs, info on mental illness
- STR/ Support worker
- Council housing department
    - Supported housing
    - Move nearer to daughter
- Neighbours
- Advocacy/ Counselling
    - Involving Tom – he should decide on his care
- Occupational therapist
- Psychiatrist
- Crisis intervention
- Income/ benefits
- GP
    - Are his physical health needs being met?

Case Study 2 – Steve

Steve is a 23-year-old man who has been under the care of Consultant Psychiatrist Dr. S. G. Eriksson for the last six months following a GP referral. Steve has smoked Cannabis recreationally for around five years and claims that the drug helps him relax and deal better with stress. Steve is also a fairly accomplished guitarist.

As well as coping with his own problems, Steve is the primary and only carer for his elderly mother Jill who is disabled with a physical illness.

Steve has told you that he really wants to go to college to train to be a plumber; he has attempted this previously but left due to bullying by other students.

What links would you need to make as Steve's Social Worker to enable him to achieve his goal?

- Direct for individual support e.g. Rethink Floating Support, MIND
- DICE college support services
- Social worker maintain links with psychiatrist and all agencies
- Counselling
- 'Buddies' help for carers and carers support service
- Home learning (or Learn-Direct)
- Access to drug advice service
- Social Services to assess mothers needs

Case Study 3 – Anne

Anne is a 42-year-old woman living in Nuneaton. Anne is a single parent of two children, one aged 13 years, the other 2 years. Anne has been picked up by security guards in a local shopping centre in the middle of the day in a confused state and the guards suspect she may be drunk or under the influence of drugs.

As a police officer responding to the call you will need to determine, amongst other things, whether the confusion is caused by drink, drugs or some form of mental health problem.

What course of action and links might you need to consider to ensure that Anne and her family receive the appropriate support?

- Ask Anne
- What risk is imminent?
- Reassure Anne
- Check ID – is she known to police or who is next of kin to clarify
- Assessment at A&E – if no physical problem A&E would liaise with GP
- Screen for drugs and alcohol
- If she's intoxicated check out support networks
- On diagnosis –

    - MH – link worker – assessment
    - Alcohol – CAS
    - Drugs – CDT
    - Children, Family/ or identified link – liaise with school – whether they have concerns (check children are safe)
- Starting to work
- Police to A&E – unsure?
- A&E – to MH worker – Crisis team plan in place involvement
- A&E – to school – unsure?
- A&E – to CAS – needs improving some links
- A&E to CDT – no
- MH – CAS improving
- However could be improved with MH links availability of service within resource as a duty
- Police – CAS improving
- Clear protocols on responsibility of care

Outcomes from Workshop 1 – 3 Key Priorities

- Work at service users pace. Care co-ordinators having time to plan – begin early to map out support networks

- Information sharing and confidentiality between organisations and services

- Place alcohol outreach into MH Resource Cafes

WORKSHOP 2

Question 1. What links are being made with Housing?

1. Protocols -
   Housing – Nuneaton/ Bedworth
   Housing – Rugby
   Variations within districts
   Availability of social housing
   Problem with mental health/ protocols
   Supporting people – not just SP but other agencies
   Need – difficulties at local district levels – ownership
   Effective use of protocols

2. Working with mental health worker plus rent deposit scheme
   Mental health acc. officer
   North/ south

3. Sign-up
   Directors of housing, health need to be signed up
   Knowledge and understanding

4. Reviewing need for client

5. Preventative

6. Networking

7. Regular meetings with mental health workers/ housing to flag up T's with MHP

8. Protocol with benefits agency (NBBC)

9. Community alcohol/ mental health training for housing staff

10. Information on notices

11. Directory of staff's roles and responsibilities

12. Appropriate accommodation

13. Mixed tenure use – use of sheltered acc for over 50s
    What about – 50

14. Moving away from "them" and "us"

15. Using other L's to help!

Promote good practice – Nuneaton

Early notification of hospital discharges

Question 2. What works well?

1. Pathways
   Fair and equal access to housing and health

Question 3. What is not working so well?

3. Lack of communications
   Regular meetings

4. Directory
   CMHT
   Protocol – why not
   Officers – engaging
   Talking to each other
   Service users – shops/ facilities

Question 4. What needs to improve to alter these links?

Our attitude between each other
Service users

Outcomes from Workshop 2 - 3 Key Priorities

Involvement of service users

1. Protocol – cross county
   Protocol – signed up – need to communicate with each other

2. Agency must talk to each other – monitor and evaluate on a regular basis

3. Mental Health Forum – for 1 individual from each agency to go to.

WORKSHOP 3

A Snakes & Ladders type game was played which helped show the benefits and pitfalls of claiming benefit support.

Types of Benefits

Contributory
Incapacity Benefit (IB)
Job Seekers Allowance (JSA)
Retirement Pension (RP)

Disability
Disability Living Allowance (DLA)
Attendance Allowance (AA)

Means-Tested
Income Support (IS)
Tax Credits (TC)
Job Seekers Allowance (JSA)
Health Benefits (HB)
Council Tax Benefit (CTB)

1. Disability benefits should be assessed by 'qualified' staff

2. Interviews/ medicals in 'friendly' environments

3. Transitional benefits and support

4. Better partnership between helping agencies

Workshop 3 - 3 Key Priorities

1. Benefits should be assessed by more appropriately qualified staff and this should be done in 'friendly' venues

2. Need for a transitional benefit and stronger support into and out of work

3. Better partnership support between support agencies

WORKSHOP 4

www.rethink.org

www.employers-forum.co.uk

www.mhmedia.com (reasonable adjustments)

www.scmh.org.uk – MH benefits in the workplace
Returning back to work with a MH illness

Education – Phil Scatte
Nottingham Trent University 0115 848 2536
Students with MH illness or those who are vulnerable

Benefits

- Permitted work
- Good for IB, DLA
- Not being declared
- Unsure of voluntary expenses/ hourly pay
- Write to Jobcentre Plus
- Unsure of what's allowed or not
- Problems being pushed through Jobcentre
- Clients struggling with reviews from Job Centre
- Lobby 'powers that be' more
- Everything is black and white, no grey areas
- Coventry & Warwickshire workshops for people working with MH clients

Reception by employers

- How employees deal with interviewing clients/ SU
- Training for interviewing people
- Discrimination for declaring MH on application forms
- Education employers – supporting employer/ee
- Discrimination or not depends on employer/ employee
- Warwickshire COMPACT – using MH services to go into employers and supply IAG
- Incentives for employers to recruit – MH illness
- Well written (advertise journals for universities, HR, personnel, trade unions, management – MH awareness
- Possible money through universities
- Good practice employers award scheme
- Liaising with employers
- Joint Investment Plan – promoting to employers recruiting people with disabilities
- Education/ contracts – not down feeding information to ground floor staff
- Why can't people supply placements (what does it cost?)
- Voluntary services tapping into funding streams from JCP
- Assisting employers with Reasonable Adjustments – work step
- Discrimination according to level of CPA

Workshop 4 - 3 Key Priorities

- Resource café's available for clients in employment – both day and evening.
    - Psychologists to go in to assess the employment environment.
- Helpline for employees/employers to get advice while in employment
    - There is no directory of where to go
    - Clients feeling pressurised to get back to employment
- Rethink opps course – possibly tailor the course to education
    - JCP Pathways course

WORKSHOP 5

Carers Workshop

Questions:

1. What links are being made?

2. What works well?

3. What is not working well?

- Links with other organisations which result in duplication
- Need more partnership working
- Carers not recognising they are carers
- Shortage of funds – leads to lack of co-operation due to competition of money

4. What needs to alter to improve links?
   - Internet
   - Carer forums
   - Counselling
   - Carers empowerment worker
   - Generic and specific carer support BFT carer training grant
   - MIND resources café
   - Age concern counselling to users and carers day staff. STAR workers befriending. Away to home 55+
   - Groups work well – therapeutic
   - Listening and personal contact
   - Registering with GPs
   - Assertive outreach, early intervention, support workers, up to date information and advice better than it was
   - CMHT
   - Carers in partnerships
   - Rethink

Workshop 5 - 3 Key Priorities

1. More information and sharing + easy access to it e.g. carers info centre. Helping carers to recognise they are carers and to look after themselves.

2. Training for carers to be part of service development and also link with service user forums.

3. More shared sustainable funding between statutory and voluntary organisations. More empowerment workers to be involved in looking at training to consultants. Respite services for carers. More funding for over 65s carer's services.

Feedback from the Mental Health Event

- 64% found the location very good or good and 36% thought it was only satisfactory. Some delegates thought the parking charges were excessive.
- 73% thought the venue was very good or good and 27% thought it was only satisfactory. This was lower than normal due to the air conditioning unit being inadvertently left on which made it uncomfortably cold and the hearing loop not working.
- 64% thought the food was very good or good. Some delegates did seem disappointed that there was no pudding.
- 91% thought the presentations were very good or good with 9% thinking that they were satisfactory. Presentation 1 was the most enjoyed by delegates.
- 100% of delegates thought the workshops were very good or good

Delegates were given the opportunity to make additional comments, which they may have not been able to raise in the workshops.

Here are a selection below:

‘ There is a need to have further events like this. Have a clear ownership, feedback & action plan distributed to all present (and those not present but equally stakeholders)’

‘Provision of mental health services for those with eating disorders, particularly for sufferers of bulimia nervosa – support needed for the family unit as well. I am not aware that this matter came up at the conference.’

‘If funding for incapacity benefit is to be reduced more funding will be needed to support people back into employment.’

‘Some difficulty in referring mentally ill cases through mental health resource centre – so far as existing tenants are concerned. Keeping in touch with appropriate person at Mental Health Resource Centre difficult due to continuous restructures at Social Services & Mental Health Resource Centre.‘

‘Difficulty in getting agencies/GPs to attend case conferences.’

Appendix 4A

REVIEW OF ADULT MENTAL HEALTH SERVICES FOR BLACK AND MINORITY ETHNIC (BME) POPULATIONS IN NORTH WARKS, NUNEATON, BEDWORTH AND RUGBY – JANUARY 2005

Background Information

- PCT: North Warks
- Local Implementation Team: North Warks and Rugby
- LIT population approximately 268,000
- Total percentage of BME population approximately 4% of the population class themselves in categories other than white
- Ethnic breakdown of the LIT/PCT population the largest minority ethnic group is Indian with significant numbers from Pakistani and Bangladeshi backgrounds. In cultural and religious terms the main populations are Muslim and Sikh. In Rugby there is also an Afro Caribbean background community.
- Ethnic breakdown of the LIT: All white British
- This report has been prepared in response to a request from the StHA of all mental health service providers to provide more information about services for BME populations. It is based on the themed review materials prepared by the Birmingham and Black Country StHA and should be read in conjunction with this documentation which is attached in Appendix 1. (Numbering cross-references with the BBC document)

1. Strategic Context

1 Strategy for BME Mental Health Communities:
There is a BME Steering Group reporting to the LIT that is developing this local plan. In addition there is a draft countywide BME mental health strategy. The local strategy will be presented to the LIT for approval in March.

2 Prioritisation of key challenges:
An action plan will be prepared once the strategy has been approved by the LIT.

2. Service User and Carer Involvement

3 BME User and Carers on LIT:
There are BME users and carers engaged in LIT BME sub group but not on the LIT itself.

4 Engagement of BME service users and carers in LIT process:

This is achieved via the BME sub group and by the Trust support and investment in the wider User Involvement Project and Carer Involvement Projects for North Warks and Rugby. Both of these organisations are required to foster and support close links with BME populations.

5 BME consultation processes:
This is achieved via the BME LIT sub group. This group also includes specialist mental health workers who have lead responsibility for BME services who have a responsibility to consult with local populations. This group also includes representation from the Trust's race equality team who have a similar duty, albeit not focussed solely on mental health.

6 BME User/Carer Participation in User and Career Groups:
The local user involvement project (UIP) does have BME members who are also members of the local BME sub group of the LIT.

3. Planning and Care Processes

7 Local Strategic Partnership:
The local strategic partnership, though important, does not have a central role in the development of mental health services across Warwickshire.

8 Women's Issues:
These will be addressed within the BME strategy when this is agreed and is already reflected within the Women's Mental Health Strategy, which the LIT has recently approved.

9 Advocacy:
This is provided by local independent organisation (Advocacy Alliance) whose service contract requires them to provide culturally sensitive advocacy services. This is monitored via the contract review process.

10 Information about advocacy:
Advocacy information is widely disseminated across the whole of the service in all public areas in community mental health teams, inpatient units, day units etc.

There are not any specific BME advocacy services but BME service users and carers are able to access advocacy services.

These services are jointly funded by the Trust and the Local Authority.

4. Accountability and Clinical Governance

11 Clinical Governance Infrastructure:
The lead clinical body within the organisation for mental health services (the Clinical Division) reviews services for BME populations both directly and via its Clinical Governance sub group.

The Trust Board receives regular reports from its Mental Health Act sub committees and this includes information regarding the Act and BME populations. However a more detailed report will be prepared as soon as the LIT has agreed its action plan (see above).

12 Executive Director responsible for BME Race Equality issues in mental health:
The Director of Mental Health and Disabilities has lead responsibility in this area in liaison with other senior managers and the Trust Race Equality Department.

13 Race Equality Scheme:
For details please see the draft Race Equality Scheme attached in Appendix 2.

14 Trust Board clarity about local needs:
The Trust Board does have clarity about local needs. The PCT's public health department makes a significant contribution to this understanding. In addition the development of the BME Mental Health Strategy will strengthen and increase the sensitivity of this understanding.

15 Audits:
It will be noted from the attached Race Equality Scheme and the attached response to the Bennett Enquiry, that a number of audits of staff, service use and service user profiles have either taken place or are planned.

16 Ethnic Monitoring:
When service users are registered ethnicity in a mandatory field scrutiny of these records initiates 98-99% compliance. In the past these high levels of recording have not been achieved. Consequently the Trust now have an opportunity to use the current comprehensive dates much more widely. Specifically it will inform the work done by the LIT, its BME subgroup and associated action plans.

17 David Bennett Enquiry: See action plan (Appendix 3) and David Bennett Audit response (Appendix 4)

18 Complaints:
All of the formal complaints received by the Trust regarding adult mental health services in 2003/4 were from people who

identified themselves as white British or who declined to give their ethnicity.

The Trust has a well developed complaint scrutiny procedure whereby key themes and learning points go forward to Clinical Governance bodies, the Trust Board, the PEC and relevant clinical and operational groups.

19 Harassment Policy:
The Trust is committed to equal opportunities and this is reflected in all of its clinical operational and Human Resource policies.

The main way that service users would be made aware of these matters would be via the complaints policy. Investigations into harassment around race, culture and ethnicity would not necessarily require involvement of BME community as part of the investigating group. However the investigating group would have to have within it the levels of competency, knowledge and sensitivity that are necessary to investigate these matters.

The Trust does not have a specific policy regarding patient on patient prejudice and racism and this will be addressed via the Race Equality scheme however the Trust does have a well developed policy on staff racism and bullying.

20 Mental Health Act Status:
Percentage of Detained Patients from BME population is 7.4% out of a total of 67 patients for the period 1.04.03 to 31.03.04. This represents 5 patients of which 3 were Section 2 and 2 were Section 3.

Data regarding leave and length of stay for BME populations is not currently routinely recorded.

5. Commissioning

21 LIT assessment of service needs:
This will be achieved via the LIT BME working party and development of a subsequent action plan

22 Community Development workers:
The Trust has one community development worker in post and a further post will be established shortly.

23 Investment :
The Trust does not contract with BME voluntary sector providers. It is acknowledged that more emphasis needs to be placed on the needs of local BME population in the development of voluntary sector service priorities. The Local Authority has

service contracts with a range of community providers for BME populations in general (other than BME populations with mental health difficulties). With the support of the joint Commissioner, it is proposed that more work will be done over the coming period to ensure that these services appropriately prioritise the needs of BME populations with mental health problems.

24 Translation and Interpreting Services:
The Trust currently accesses interpreters employed within its Race Equality Department. In addition funds are made available to access regional and nationally available Interpreting Services such as Language Line.

6. Partnership – Voluntary/Social Inclusion

25 Please note comments under 23 (above)

26 Active Links with the voluntary sector (see section 23 (above)):
As referred to above there is a BME sub group of the LIT whose primary responsibility at this stage is to develop a BME Mental Health strategy and action plan for the LIT area. The Terms of Reference of this group will be reviewed beyond this once this strategy has been received and approved by the LIT.

27 Innovative BME Service Developments:
The Trust acknowledges that at the moment we are at an early stage of development and although the Trust has a strong commitment to Equal Opportunities and well established Race Equality Department, there is a need for further innovation and development which it is hoped will emerge from the development of the BME/Mental Health strategy.

7. Training and Education

All mental health staff are required to attend Race/Cultural Awareness training sessions. These training sessions have recently been reviewed and a new programme launched for 2005/6.

The appendices detailed in the report are available on request.

Appendix 5

Employment Strategy for Mental Health

January 2005

Introduction

'Employment is an area where disabled people feel discrimination keenly. Opportunities for employment have a major impact on people's lives in terms of self-fulfillment, income and interactions in society.' SSI, "Making it Work", Inspection of Welfare to work for Disabled People.

Large numbers of adults with mental health problems want to work and their employment promotes improved health. However, they face many barriers to securing and sustaining jobs.

Due to stigma and discrimination, both realised and perceived, fewer than four in ten employers would consider employing someone with a history of mental health problems, compared with more than six in ten for candidates with a physical disability. Three quarters of employers would not consider employing someone with schizophrenia; even though schizophrenia can be controlled with medication and would not require physical adaptations to the work environment (Social Exclusion Report, ODPM, Chapter 3).

One third of people with mental health problems report having been dismissed or forced to resign from their job because of their previous psychiatric history and more than two thirds had been put off applying for jobs for fear of unfair treatment. There is anecdotal evidence of some employment contracts including, within their definition of gross misconduct, which can trigger instant dismissal, clauses such as 'if you become of unsound mind or a patient under the Mental Health Act 1983' (Social Exclusion Report, ODPM, Chapter 3, on www.socialexclusionunit.gov.uk)

Policy Context:

The last three years have seen the development of a radical agenda of change for all services, ie

- Health and Social Services
- Education
- Housing
- Employment agencies
- Environment
- Non-Government agencies/voluntary sector

This document will address key policies and drivers in respect of employment and in particular how these harness, engage, compliment and contribute to the Employment Strategy for people with Mental Ill Health within Warwickshire.

Government :

Delivering Employment services to adults with Mental Ill Health is not just about harnessing Health and SSD drivers but the policy drivers for partner agencies some of which are listed below:-

- **Modernising Mental Health Services** (White Paper) sets out the government's aspirations to provide **safe, more sound, and supportive mental health services for adults of working age.** Its overall aim is to build public confidence in mental health services by ensuring that existing services are strengthened and new services developed for people with mental health difficulties, particularly those who are difficult to engage. Part of that portfolio of services must be the ability of individuals to leave service through the route of **Recovery** and **Social Inclusion**.

- **Modernising Social Services;** (White Paper) identifies key deliverables which engages SSD with partners in delivering more robust services that support the individual throughout their route through service back into community or employment and ensure they retain or quickly regain good mental health.

- **Partnerships in Action;** promotes a partnership and whole systems approach when planning services to meet the needs of vulnerable people. **Section 31 of the Health Act 1999,** can act as a vehicle to enable those changes to be converted to action through Joint Commissioning, pooling of budgets and lead providers of service.

- **Best Value** a process required of Local Authorities to examine and review services to ensure they offer effectiveness and value for money.

- **The New Deal for Disabled people (NDDP),** part of a programme of initiatives of the Government aimed at helping sick and disabled people move into and remain in work.

- **Green Paper-Towards Full Employment** added to the above legislation by enabling adults with disabilities to challenge and engage with both employers and employment agencies in respect of assistance in seeking and keeping paid employment.

- **National Service Framework for Mental Health** addresses the needs of people with mental ill health, however it is important to recognise that within the framework of the NSF that individuals will or may need help to tackle discrimination.

- **Learning to Success white Paper,** addressing issues of participation and achievement by young people, equality through access to learning, engagement of employers in improving skills for employability and improvement in effectiveness and efficiency.

- **Joint Investment Plans (JIP's);** the requirement of local authorities to develop crucial partnerships to assist people disadvantaged within the job market to get back to work through the development of specialist support. These include social enterprises and social firms, direct payment schemes, and the recognition, through assessments, of what barriers may exist between social care and employment, that need specialist services and support to ensure equality of access.

Legislation requires organisations to make reasonable adjustments to accommodate the needs of disabled employees. **The Disability Discrimination Act 1996** placing a duty on employers to take steps to prevent disabled persons, including those with mental impairment, from being placed at a disadvantage.

The **National Service Framework for Mental Health** lists seven standards that set targets for mental health care of adults aged up to 65. These span five areas: health promotion and prevention, primary care and access to specialist services, needs of those with severe and enduring mental illness, carers needs, and suicide reduction.

- *Human Rights Act*

Allows individuals to challenge a public authority if it feels they have breached or are likely to breach a Convention right or freedom affecting them. The Act will apply to Local Authorities, the NHS and persons they contract services and private or independent bodies when they provide public services. It will be unlawful for Public authorities to act in a way that is incompatible with the Convention

A key policy driver has been the "**Action on Mental Health – A Guide to Promoting Social Inclusion",** ODPM, October 2004.

This is an overarching document which draws together and embeds key principles of social inclusion and anti-discrimination to include :

- Stigma and Discrimination
- Employment
- The roles of MH Professionals
- Community Participation
- Welfare benefits
- Housing
- Education
- Ethnicity
- Families and Carers
- Criminal Justice
- Financial Services

Key Partners in Delivery:

Linked to the above legislative drivers for Health and Social care are the policy drivers for key partner agencies who specialise in the support and delivery of employment and training for adults with disabilities or suffering disadvantage. An example of this is the Learning Skills Council through the Governments White Paper Learning to Succeed**, the key tasks being to which are widening participation, social inclusion and neighbourhood renewal and regeneration**

Data:

For the purpose of informing this strategy we have collated data collected within provider agencies and matched this with local and county data.

Assessment of Employment Need for Warwickshire Adult (16-64) Population

Table 1:

PCT area	Popul n	MH Pop	Emp figures	Emp MH figures	CPA	Vol sector	Emp
NW Male						177*	91
Female							68
R Male	331,79 3*	5503*	117,24*	1,013*		51*	7
Female							3
SW Male					279*	372*	40
Female							18

Notes:

Available statistics based on 2001 census made available the above figures. It must be noted that these were unavailable for this document by gender.

- **We would also add** that 2210 individuals in Warwickshire with mental health needs have been classed as 'economically inactive' and as such are a hidden population some of which may be contained within the voluntary and supported employment arena.
- **Of those actively seeking employment statistics would indicate that these are predominantly 26-50 yrs of age.**
- **Nuneaton and Bedworth have the highest level of multiple depravation in Warwickshire. It is rated as the 111th of 354 local authorities (where 1 is the most deprived)**

Existing Services:

A mapping exercise is attached that identifies resources and services provided across the county.

Table 2:

PCT area	Screening	Assessment and Training	Social Enterprise
NW PCT	Employment Development officer RETHINK	Kaleidoscope N/B and H College	Rethink Kopy Shop (N/B)

Rugby PCT	EDO Rethink OT's	Kaleidoscope Warwickshire college	Enterprise Workshop
SW PCT	Diversity In Community Education and Employment (DICE) pilot 6/2003	Rushmore Mid Warwickshire MIND Allotment Warwickshire College	Loft (Stratford) Rushmore

Unmet need:

Table 2 shows the processes which are in place to support individuals through the system. Unmet need is defined by need which is flagged. When systems are better developed to collect and correlate data that includes people's aspirations, the issue of unmet need will be better addressed.

What we do know within current employment support operating within the North and South of the county is that:-

- **The EDO posts within Kaleidoscope are, and have been at, maximum capacity for several months. The post in the North currently has a waiting list of some 65 adults. A forthcoming review is identifying the cause of this problem, which is currently thought to be inappropriate referral to the Service, rather than Service performance. Kaleidoscope in the South, operating within the remit of DICE, is developing co-working and partnership working with DICE, and advice and signposting in the resource cafes.**

Gaps in Provision:

Warwickshire is a diverse County, with three Primary Care Trusts and 5 District Councils. Users state there are inequitable levels of service provision across the county due to historic and different patterns of service delivery and organisational structures.

During the last three years, attention has been necessarily focussed on trying to create a more equitable distribution of good quality, secondary Mental Health resources across the county under the first implementation of the National Service Framework. The next three years has been heralded by the Social Inclusion report, as discussed above.

Stakeholder views :
Warwickshire has for some two years actively sought the views and opinions of key stakeholders in its delivery of employment and training within Mental Health.

As a result of views obtained both Health and Social services have been developing rehabilitation and in house employment support schemes, through

direct provision and commissioning. These include some more progressive projects which have led to social enterprises. In the main services have developed following research into the needs of individuals or groups in respect of their employment and training needs.

Consultation in 2000 with service users within Day services revealed that users wishing to leave services to seek paid employment lack the right kind of support, training and opportunity, following their period of incapacity.

For some this was an inability by agencies to understand an individual's training or retraining needs in respect of their mental health. Other users experienced fear of discrimination by their employers or colleagues, should their mental ill health reoccur. Others simply feared leaving the safety of services and possibly losing friends, social contacts and activities. This led to a fear of being lonely or unable to cope alone. Perceived problems in obtaining financial support for the transition compound these concerns.

The 'Work On' Partnership was formed to look at combating stigma and increasing social inclusion. The Partnership was key in producing a Warwickshire Mental Health Employment Strategy so that each Local Implementation Team for Mental Health could develop Action Plans to meet Government policies and local agendas, around good practice and employment.

To meet this changing agenda Warwickshire Mental Health services have embarked on service reviews in both the statutory and voluntary sectors, leading to outcome-related service level agreements, which incorporate outcomes for social inclusion, including employment.

Day Services
As part of partnership delivery with voluntary sector colleagues, Resource Cafes will be providing support and linkages to financial, benefits, housing and other advice for users who are becoming workforce participants, as well as for users who need social contact.

The therapeutic contracts will provide users with skills to access generic social resources, including those related to employment.

Schematic Diagram of Employment Delivery Model: (Appendix 1)
A model *(Appendix 1)* was drafted by the 'Work On' partnership as part of this Strategy, This will now need amendment to include fundamental changes in the operation of Kaleidoscope; one of the key employment partners, which is moving from centre-based support to offer inreach services to day services and resource cafes. This will need to take account of the service in the South, via DICE, and will require involvement in amendments from that service.

The five stages of Employment support:

<u>Identification of Individual Employment / Occupational need (Step 1)</u>

Service users should be encouraged, under Care Program Approach, to identify their needs with their care co-ordinator. The core values of the CPA process are person-centred assessment, recovery ethos, care planning, co-ordination and regular review. The Needs Assessment should address financial, housing, social and employment areas. A Care Plan should then emerge which sets out how these needs will be addressed. In the area of employment the first priority is to ensure that existing employment is retained, through advocacy and mediation with the user's current employer, led by the user wherever possible.

Specialist Assessment and Therapeutic Support (Steps 2 and 3)

Where there is a need for employment, learning opportunities or training identified by the care co-ordinator, an assessment of work readiness (or vocational assessment) should be done by an occupational therapist, or other suitably experienced employment worker, involving other appropriate agencies. This assessment should be inclusive of other needs for instance education and learning, as well as the individual's values and aspirations for their long-term future – whether these be related to employment, paid or unpaid, education or learning.

Such a vocational assessment is not done by the care co-ordinator, but the experienced workers nominated above, and includes :

- Aspirations
- Skills audit
- Vocational profiling
- Performance Functioning

The Employment Support Plan identifies ;

- Detailed needs summary
- User-led goal planning
- Who will meet the needs
- How the needs will be met
- How they will be reviewed.

Work Based Skills and Opportunity Program, including Placements (Step 4)

Support in becoming 'work ready' through :

i) Therapeutic Day Services– life-skill enhancement
ii) Voluntary Work – low-risk work hardening
iii) College – development of basic/key skills, foundation courses
iv) Voluntary sector training provision – first level , confidence building entry level qualifications
v) Prevocational programmes
vi) Work preparation schemes, through Job Centre Plus

Supported Employment (Step 5):

Support for those who are Work Ready for Supported Employment, or who require Supported Education

i) Careers Service
ii) Employment Development Officers – Rethink
iii) DICE in South Warwickshire
iv) Disability Employment Advisors/Job brokers
v) Job Centre Plus/gateway
vi) Employment Training
vii) Community/Further Education
viii) Training Agencies
ix) Resource Cafes – to include Welfare Rights (WWRAS) and CAB 'clinics'

Projects include :

i) *Social Enterprises* - Separately constituted organisations, but workers are productive although not seen as employees from the view of employment rights. Core funded but generating some income.

ii) *Social Firms* - A separate business, which manages its own finances. It may gain financial support from grants, but workers receive economic wage.

Open Employment (Step 6)

For the duration of the service user's contact with Warwickshire Employment Support Network, and mainstream Education, the user will be supported through the process by working alongside specialist employment workers, Employment Development Officers, and others, in order to ensure full co-ordination and linking in with the CPA process.

In order to promote individual service users' recovery, and facilitate discharge from mental health services, ongoing support to service users leaving service will be available through that district's Resource Café.

Consultation and Dissemination

A systemic approach to consultation has being integral to each stage of the employment model.

1. ***Strategic consultation*; seeking the views and visions of key stakeholders in developing the model and the service.**
2. ***User consultation*; this service has been designed with users at the centre. Users were represented on the 'Work On' Partnership, have been integral to a stakeholders consultation process and have commented on the model at County User group.**
3. ***Community consultation*; Information has been taken out to service users and local population through the provider agency, Rethink.**

4. ***Consult and Disseminate at relevant Conferences seminars workshops and network and partnership events.* These included:-**

- **Supporting People Conference**
- **Alcohol and Drugs County Conference**
- **Time for Action**
- **It's Your Shout**

Authors:

The 'Work On ' Partnership included representatives from the following groups:

- Health (3 PCT's) and Social services
- County Council
- Job centre Plus
- Further Education
- Voluntary and Community sector
- Service Users
- Social Inclusion
- Learning Skills Council
- Private sector

Each LIT will be considering how the Social Inclusion Agenda as a whole will be progressed, including the valuable contributions made by the Work On Partnership.

Appendix 6

MINI scores for Warwickshire

1. INTRODUCTION

The 'MINI' was devised as a numerical tool to help planners, purchasers and providers of mental health care to distribute facilities and resources within any particular NHS Trust.

Thornicroft (1998) identified a number of sympathetic variables that could be used to predict the occurrence of mental illness, based on a study of the North East Thames district in London. The variables used are:

- Marital status: single/divorced/widowed
- Male gender
- Permanent 'illness'
- Accommodation type: living in non-enclosed accommodation or hostels
- Mobility: use of own car

There are separate MINI scores, for the population aged 16-59 years, for four categories:

- All types of mental illness
- Schizophrenia type illnesses
- Affective disorder type illness
- 'Other' mental illnesses (which includes OCD and illness as a result of drug misuse and misdemeanour).

MINI works on the principle that England has a national average score rating of 1. Local scores are expressed as a percentage either above or below the national average, for example:

- Willes ward, Warwick = 1.21 for all types of mental illness, which is equivalent to 21% more cases than the national average
- Napton Priors ward, Stratford = 0.27 for all types of mental illness, which is equivalent to 73% less than the national average

Manchester City Council have used MINI scores for the Greater Manchester NHS Trust and concluded that whilst it is not totally precise, it is a viable tool which allows more accurate allocation of resources around the Trust, (www.manchester.gov.uk/health/jhu/intelligence/mini.htm).

2. METHODOLOGY

2.1 Ward Scores

We downloaded Warwickshire MINI scores from the Centre for Public Mental Health page on the University of Durham's website, (www.dur.ac.uk). The Warwickshire MINI scores are based on the 1991 census ward boundaries.

The database also includes 1998 population, expected admissions rates and expected admissions numbers.

We have re-calculated admission numbers and admission rates using 2004 populations from the FHS register. This assumes that the MINI scores are as appropriate now as in 1998.

2.2 GP Scores

We used a cross-tabulation of ward against practice populations to calculate the 'proxy practice admission rates'. This assumes that the proportions of each ward registered with a practice are reasonably typical of the ward as a whole. This then allows expected admission numbers to be calculated.

3. RESULTS

The following tables and maps have been produced, each with a short commentary regarding the relevance of what information is shown. The full spreadsheets of data are included in the appendix.

Map 1: Population distribution of Warwickshire for 2004 by electoral ward.

Map 2 & Table one: Expected admissions for all types mental illness in Warwickshire for 2004, by electoral ward.

Map 3 & Table two: Expected admissions for Schizophrenia type illnesses in Warwickshire for 2004, by electoral ward.

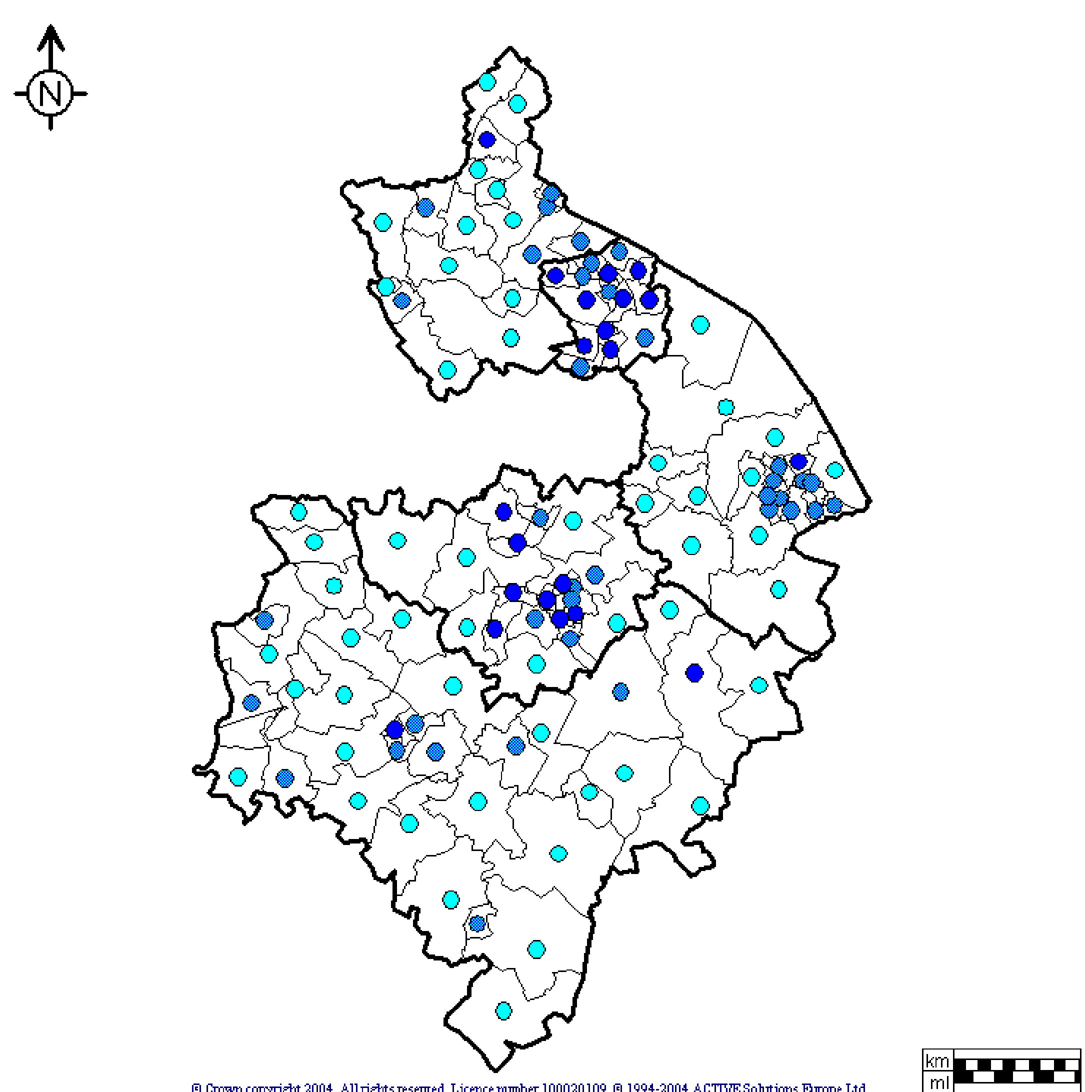
Map 4 & Table three: Expected admissions for Affective Disorder type illnesses in Warwickshire for 2004, by electoral ward.

Map 5 & Table four: Expected admissions for all 'Other' types of mental illnesses in Warwickshire for 2004, by electoral ward.

Appendix A: Full spreadsheet of expected numbers of admissions and MINI scores by District/Borough Council and ward.

Appendix B: Full spreadsheet of expected numbers of admissions and MINI scores by PCT and General Practice.

Map one: Population distribution of Warwickshire for 2004 by electoral ward.
Scaled by Colour

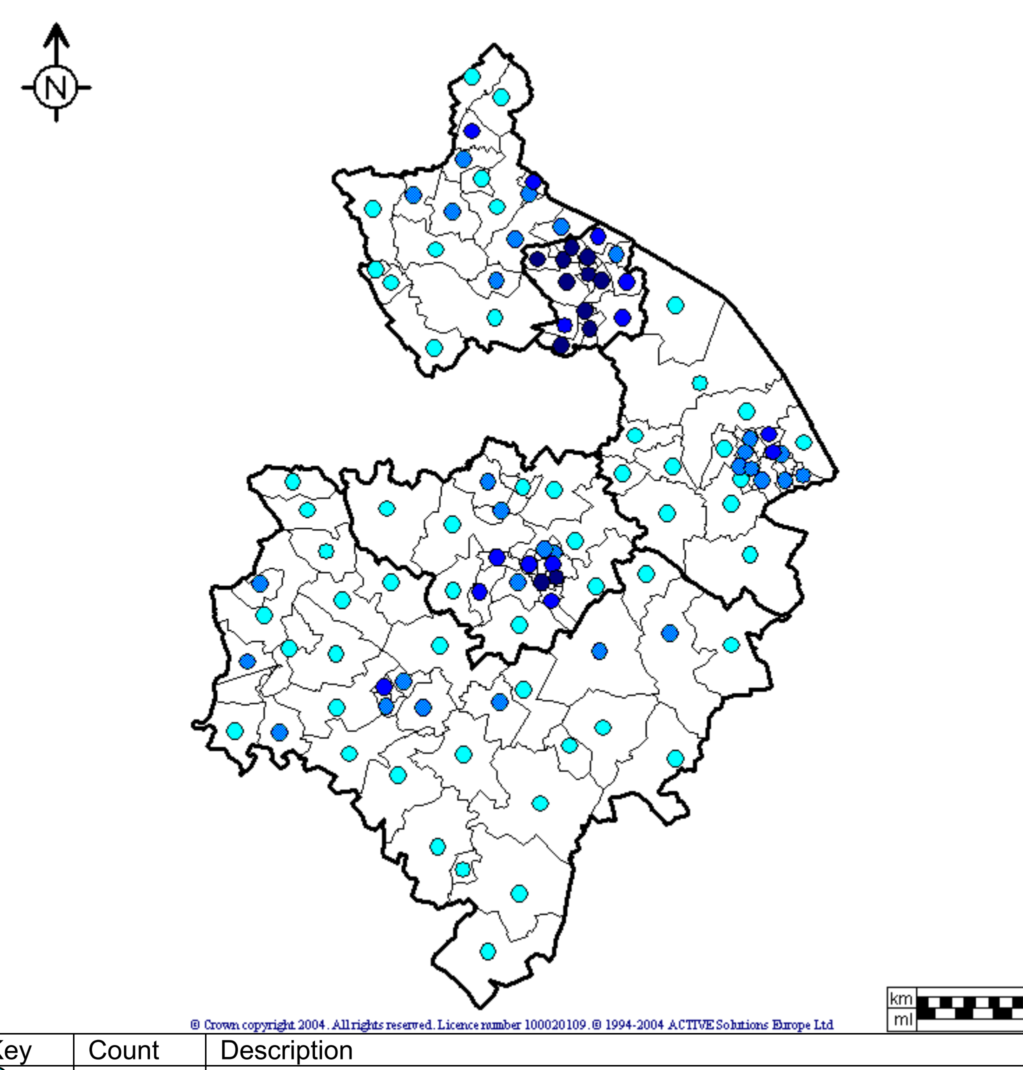


Key	Count	Description
	53	0 to 2199 (less than median)
	37	2200 to 4399 (median to less than twice median)
	21	4400 to 6599 (twice median and over)
	111	Total

Areas of the county that are shaded light blue are areas of low population, mainly small to medium sized rural communities. Mid blue shading indicates more built up settlements, mainly small towns or large villages. Dark blue shading indicates more densely populated communities, mainly in larger towns.

Almost half of the wards in Warwickshire have a population of 2199 or below. Approximately one fifth of the electoral wards have populations of 4400 – 6599.

Map two: Expected admissions for all types mental illness in Warwickshire for 2004, by electoral ward.
Scaled by colour.



Key	Count	Description
	55	0.00 to 5.95 (less than median)
	30	5.96 to 11.91 (median to less than twice median)
	14	11.92 to 17.87 (twice to less than three times median
	12	17.88 to 34.99 (three times median and over)
	111	Total

Nuneaton and Bedworth B.C. has the greatest concentration of expected number of admissions of mental illness with twelve wards featuring in the ‘three or more times the median’ category.

Urban/built up areas of the county have a greater expected number of admissions.

The lowest concentrations of expected number of admissions are in rural areas.

Table 1. MINI scores and expected numbers of admissions for all mental illness for five highest ranking wards in Warwickshire Local Authorities (1991 census boundaries)

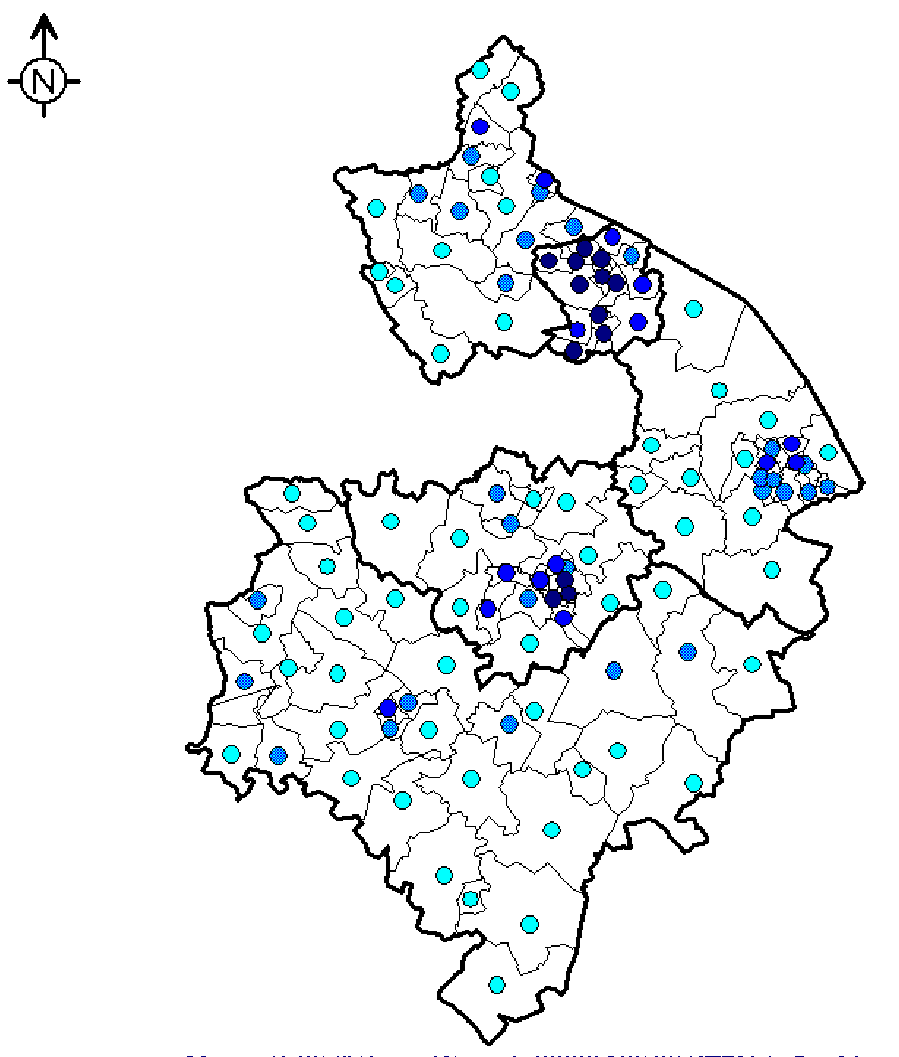
A: Expected numbers of admissions per year

Rank	**1**	**2**	**3**	**4**	**5**	
N. Warks	Polesworth	Atherstone N.	Mancetter	Kingsbury	Dordon	All wards
Numbers	14.7	12.7	9.9	9.0	8.6	118.9
Nun. & Bed.	Mount Pleasant	Abbey	Arbury	Camp Hill	Attleborough	All Wards
Nos	30.0	29.2	23.7	22.9	22.8	288.7
Rugby	Brownsover	Benn	New Bilton	Overslade	Newbold	All Wards
Nos	13.9	11.9	11.4	10.5	9.6	109.5
Stratford	Stratford Mkt. Hall	Southam	Alcester	Studley	Harbury	All Wards
Nos	15.3	11.0	10.2	9.8	7.9	86.1
Warwick	Willes	Brunswick	Clarendon	Warwick W.	Warwick N.	All Wards
Nos	23.9	20.8	16.3	14.8	14.6	171.6

B: MINI scores

Rank	**1**	**2**	**3**	**4**	**5**	
N. Warks	Dordon	Atherstone N	Arley	Atherstone S	Mancetter	
Score	1.33	1.29	1.18	1.1	1.08	
Nun. & Bed.	Abbey (NB)	Camp Hill	Chilvers Coton	Stockingford	Mount Pleasant	
Score	1.83	1.68	1.57	1.56	1.43	
Rugby	Benn	New Bilton	Newbold	Overslade	Hillmorton	
Score	1.25	1.16	1.04	0.91	0.8	
Stratford	Stratford Mkt Hall	Alcester	Bidford	Studley	Stratford New Town	
Score	0.85	0.84	0.77	0.76	0.73	
Warwick	Willes	Clarendon	Brunswick	Crown	Whitnash	
Score	1.21	1.14	1.13	0.91	0.89	

Map three: Expected admissions for Schizophrenia type illnesses in Warwickshire for 2004, by electoral ward.
Scaled by colour.



Key	Count	Description
	55	0.00 to 1.38 (less than median)
	28	1.39 to 2.77 (median to less than twice median)
	15	2.78 to 4.16 (twice to less than three times median)
	13	4.17 to 7.99 (three times median and over)
	111	Total

Nuneaton and Bedworth has eleven wards that feature in the 'three times or more above median' category. Royal Leamington Spa has three wards that fall into the 'three times or more above median' category Rugby has eleven wards that fall into the above median and above twice median categories. The higher expected numbers are found in the urban/built-up areas.

Table 2. MINI scores and expected numbers of admissions for schizophrenia for five highest ranking wards in Warwickshire Local Authorities (1991 census boundaries)

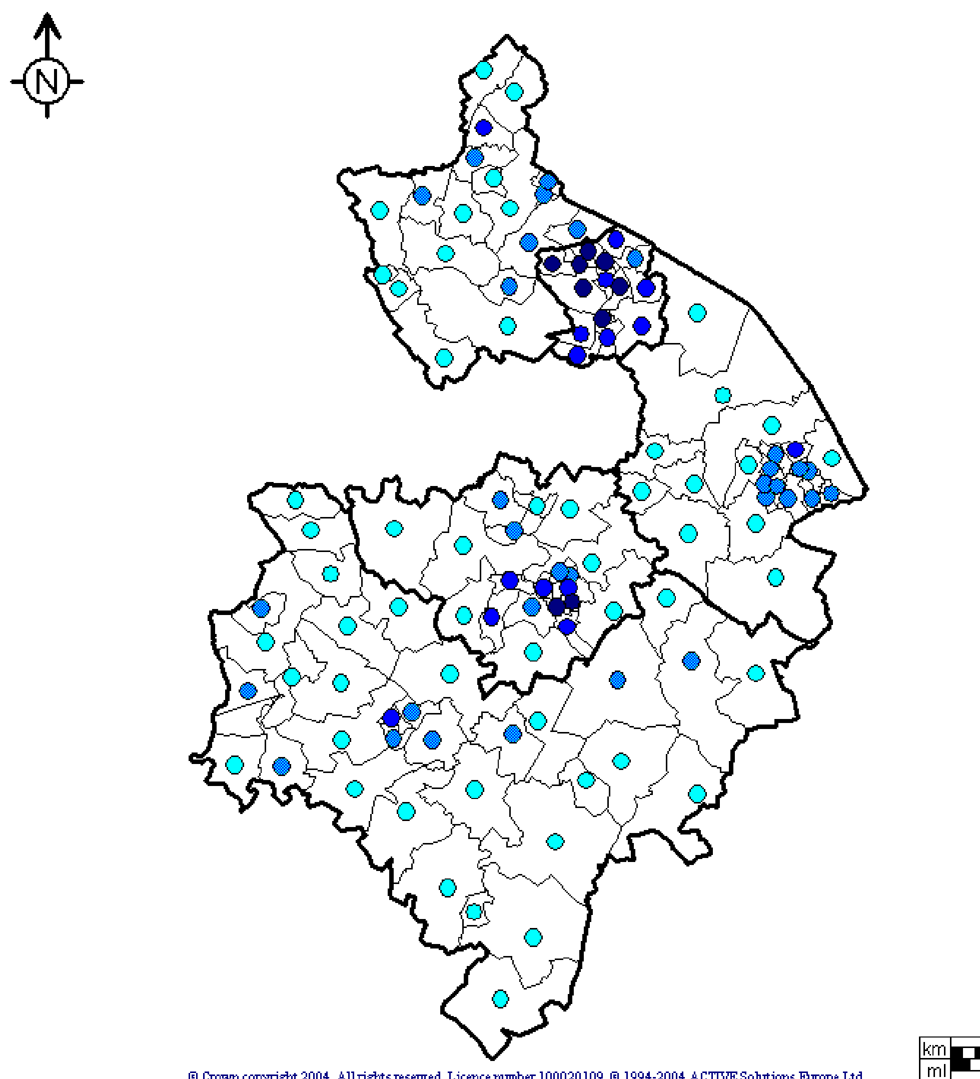
A: Expected numbers of admissions per year

Rank	**1**	**2**	**3**	**4**	**5**	**Total:**
N. Warks	Polesworth	Atherstone N.	Mancetter	Kingsbury	Dordon	All wards
Nos	3.5	3.0	2.3	2.1	2.0	27.1
Nun. & Bed.	Mount Pleasant	Abbey (NB)	Arbury	Attleborough	Camp Hill	All Wards
Nos	7.4	7.2	5.7	5.6	5.6	70.1
Rugby	Brownsover	Benn	New Bilton	Overslade	Newbold	All Wards
Nos	3.5	3.1	2.9	2.7	2.4	26.8
Stratford	Stratford Mkt. Hall	Southam	Alcester	Studley	Harbury	All Wards
Nos	3.5	2.5	2.3	2.2	1.8	19.0
Warwick	Willes	Brunswick	Clarendon	Warwick W.	Warwick N.	All Wards
Nos	6.3	5.5	4.2	3.8	3.8	34.0

B: MINI scores

Rank	**1**	**2**	**3**	**4**	**5**	
N. Warks	Dordon	Atherstone N	Arley	Mancetter	Atherstone S	
Score	1.11	1.1	0.97	0.92	0.91	
Nun. & Bed	Abbey (NB)	Camp Hill	Chilvers Coton	Stockingford	Mount Pleasant	
Score	1.63	1.49	1.38	1.37	1.26	
Rugby	Benn	New Bilton	Newbold	Overslade	Hillmorton	
Score	1.17	1.07	0.96	0.83	0.71	
Stratford	Stratford Mkt Hall	Alcester	Bidford	Studley	Stratford N. T.	
Score	0.71	0.68	0.62	0.62	0.58	
Warwick	Willes	Brunswick	Clarendon	Crown	Whitnash	
Score	1.15	1.08	1.06	0.84	0.81	

Map four: Expected admissions for Affective Disorder type illnesses in Warwickshire for 2004, by electoral ward.
Scaled by colour.



Key	Count	Description
(light cyan circle)	55	0.00 to 2.28 (less than median)
(light blue circle)	32	2.29 to 4.57 (median to less than twice median)
(blue circle)	15	4.58 to 6.86 (twice to less than three times median)
(dark blue circle)	9	6.87 to 9.99 (three times median and over)
	111	Total

Nuneaton and Bedworth has seven wards that feature in the 'three times and above median category, Leamington has two. Rugby features a cluster of ten wards with median and above expected numbers. The higher expected numbers are found in the urban/built-up areas.

Table 3. MINI scores and expected numbers of admissions for affective disorders for five highest ranking wards in Warwickshire Local Authorities (1991 census boundaries)

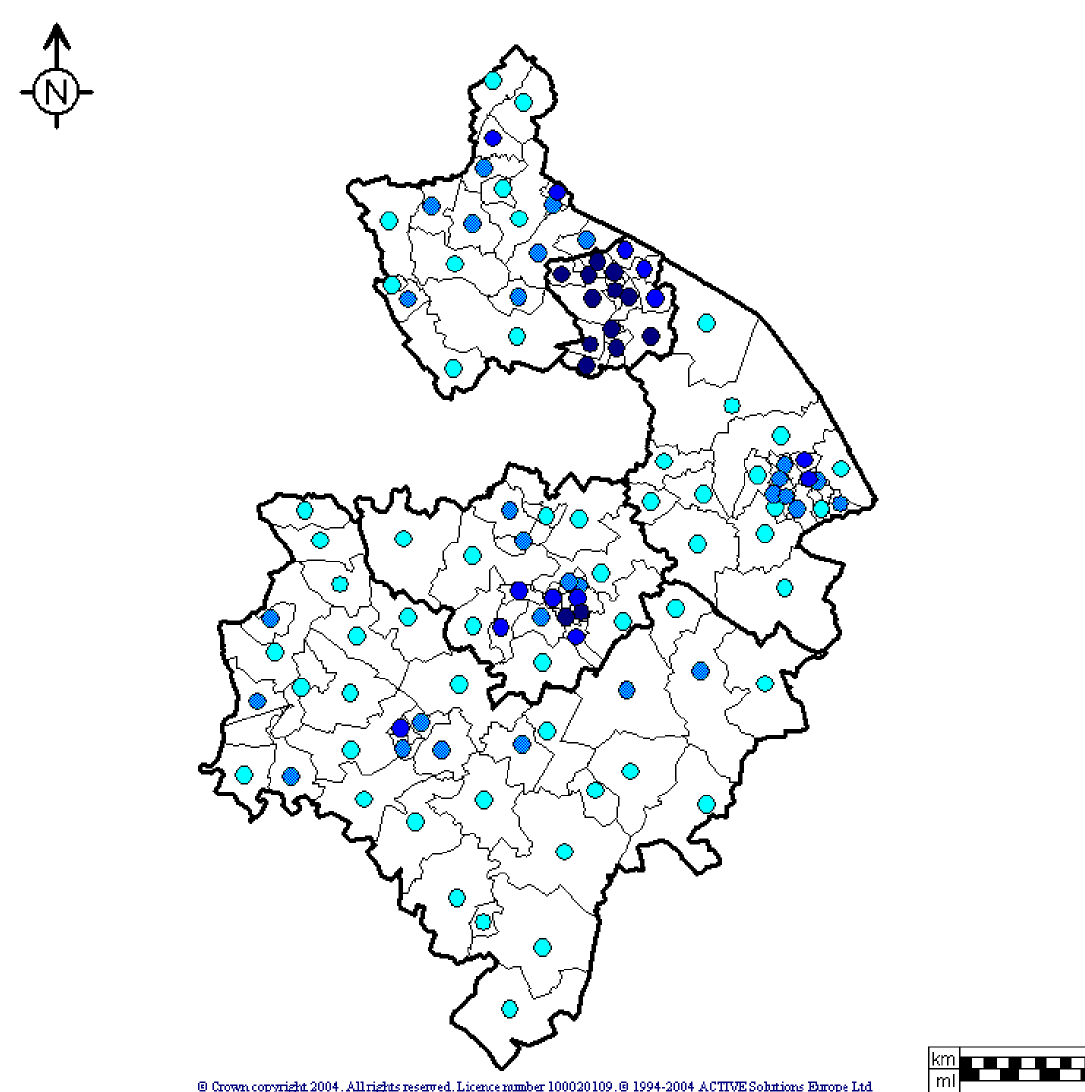
A: Expected numbers of admissions per year

Rank	**1**	**2**	**3**	**4**	**5**	**Total:**
N. Warks	Polesworth	Atherstone N.	Mancetter	Kingsbury	Dordon	All wards
Score	5.0	4.2	3.3	3.2	2.9	41.6
Nuneat. & Bedw.	Mount Pleasant	Abbey (NB)	Arbury	Galley Common	Camp Hill	All Wards
Score	9.4	8.7	7.9	7.0	6.9	91.3
Rugby	Brownsover	Benn	New Bilton	Overslade	Eastlands	All Wards
Score	5.3	4.2	4.1	3.9	3.5	42.1
Stratford	Stratford Mkt. Hall	Southam	Alcester	Studley	Harbury	All Wards
Score	5.6	4.2	3.8	3.7	3.0	33.0
Warwick	Willes	Brunswick	Clarendon	Warwick W.	Warwick N.	All Wards
Score	8.5	7.3	6.0	5.5	5.5	65.7

B: MINI scores

Rank	**1**	**2**	**3**	**4**	**5**	
N. Warks	Dordon	Atherstone N	Arley	Atherstone S	Mancetter	
Score	1.31	1.25	1.16	1.13	1.05	
Nun. & Bed.	Abbey (NB)	Camp Hill	Chilvers Coton	Stockingford	Mount Pleasant	
Score	1.6	1.49	1.42	1.41	1.32	
Rugby	Benn	New Bilton	Newbold	Overslade	Hillmorton	
Score	1.29	1.22	1.1	0.99	0.9	
Stratford	Stratford Mkt Hall	Alcester	Bidford	Studley	Shipston	
Score	0.91	0.91	0.83	0.83	0.82	
Warwick	Willes	Clarendon	Brunswick	Whitnash	Crown	
Score	1.27	1.23	1.16	0.99	0.97	

Map five: Expected admissions for all ‘Other’ types of mental illnesses in Warwickshire for 2004, by electoral ward.
Scaled by colour.



Key	Count	Description
	55	0.00 to 2.30 (less than median)
	29	2.31 to 4.61 (median to less than twice median)
	13	4.62 to 6.92 (twice to less than three times median)
	14	6.93 to 13.99 (three times median and over)
	111	Total

Nuneaton and Bedworth has the highest number of ‘three times median and over category’ in the county (12 occurrences).
Rugby has a fewer wards with above median numbers than for the other categories - schizophrenia and affective disorders.

Leamington Spa also features again with high-expected numbers, (two wards in the highest category, and also five wards with expected numbers above the median.).

Table 4. MINI scores and expected numbers of admissions for other mental illnesses for five highest ranking wards in Warwickshire Local Authorities (1991 census boundaries)

A: Expected numbers of admissions per year

Rank	**1**	**2**	**3**	**4**	**5**	**Total:**
N. Warks	Polesworth	Atherstone N.	Mancetter	Kingsbury	Dordon	All wards
Numbers	3.5	3.0	2.3	2.1	2.0	27.1
Nun. & Bed.	Mount Pleasant	Abbey (NB)	Arbury	Attleborough	Camp Hill	All Wards
Numbers	7.4	7.2	5.7	5.6	5.6	70.1
Rugby	Brownsover	Benn	New Bilton	Overslade	Newbold	All Wards
Numbers	3.5	3.1	2.9	2.7	2.4	26.8
Stratford	Stratford Mkt. Hall	Southam	Alcester	Studley	Harbury	All Wards
Numbers	3.5	2.5	2.3	2.2	1.8	19.0
Warwick	Willes	Brunswick	Clarendon	Warwick W.	Warwick N.	All Wards
Numbers	6.3	5.5	4.2	3.8	3.8	34.0

B: MINI scores

Rank	**1**	**2**	**3**	**4**	**5**	
N. Warks	Dordon	Atherstone N	Arley	Mancetter	Atherstone S	
Score	1.52	1.47	1.35	1.24	1.22	
Nun. & Bed.	Abbey (NB)	Camp Hill	Chilvers Coton	Stockingford	Attleborough	
Score	2.18	2	1.85	1.83	1.69	
Rugby	Benn	New Bilton	Newbold	Overslade	Hillmorton	
Score	1.29	1.17	1.05	0.9	0.78	
Stratford	Stratford Mkt Hall	Alcester	Bidford	Studley	Stratford N. T.	
Score	0.9	0.88	0.82	0.79	0.76	
Warwick	Willes	Brunswick	Clarendon	Crown	Whitnash	
Score	1.2	1.14	1.12	0.91	0.86	

4) CONCLUSION/SUMMARY

1. The locations of Warwickshire that are predicted to have the highest rates of mental illness admissions are Nuneaton and Bedworth (as a Borough Council), Leamington Spa, (as a town location) and Rugby (wards surrounding the town centre).

2. Nuneaton and Bedworth has the greatest concentration of wards that have high (at least three times the median value) expected numbers of admissions for all types of mental illness in the county.

3. Leamington Spa is the only other town/area that features expected numbers of admissions that are three times or greater than the median.

4. Rural localities have much lower rates of all types of mental illness than the urban/built up areas.

5. MINI scores are a useful indicator of the occurrence of mental illness, but the size of the population in a ward is the best predictor of the number of expected cases.

Rebecca Halliwell
Greg Wells
17 September 2004

Appendix 7

COMPREHENSIVE LIT THEMED REVIEW
Black and Minority Ethnic Services

- Name of the Primary Care Trust and/or Mental health Trust South Warks PCT
- Name of Local Implementation Team (LIT) South Warks
- LIT Population 237,383
- Total percentage of BME Population 5.7% (non white)
- What is the Ethnic breakdown of the LIT/PCT Population 2.6% Asian, under 1% of all others
- What is the Ethnic breakdown of the LIT? Currently 100% white

	1. STRATEGIC CONTEXT	
1.	Is there a separate or integral strategy for BME mental health communities that links to the organisations corporate objectives? If not what plans are there to develop local plans and what forum exists to discuss local needs?	• Warwickshire BME Strategy (draft) • Business Implementation Plan • Local Delivery Plan • SSD & PCT Race Equality Scheme
2.	*What analysis has been undertaken of need of local BME communities, with prioritisation of key challenges [say<4] to reflect identified and unmet need, patient experience and outcomes? *How has this translated to a shared stakeholder plan with clear responsibility for Board level championship, implementation and monitoring?	• Census identifies diverse makeup of Warwickshire, however under representation of BME communities in psychiatric services. • Local research currently underway to identify barriers to access (South Asian Community)

		• Consultation day held in January 2005 with Asian women to voice their needs/develop responses to these needs • BME Service development group → reporting to LIT for endorsement of development plan. • CDW role:
	2. SERVICE USER AND CARER INVOLVEMENT	
3.	Are there any BME users and carers on the LIT, how do they feedback to their constituent groups and how do they get selected? What other arrangements are there for the LIT engage with BME communities?	• Representation in Service Development group → LIT • CDW role
4.	How does the LIT engage and fund BME service users and carers? What support mechanisms do you have for BME users and carers? Do you have training and development processes to ensure effective involvement?	• Engagement via CDW & Service Development Group • Specialist carer worker/Care Co-ordinator • User forum training/Carer training – CDW
5.	*What structures and processes are in place to ensure that Black & Minority Ethnic services users and carers are represented, consulted and engaged in all aspects of planning, commissioning, delivering and evaluating services?	• Service development group • Asian Women's group • Future CDW role
6.	Do local service user and carer groups have BME representatives on them? How is the process of dissemination/feedback into the community ensured?	• Service user & carers currently not attending. To be developed by CDW

	3. PLANNING AND CARE PROCESSES	
7.	How are BME issues addressed within the Local Strategic Partnership (LSP) process?	• CDW to attend forthcoming meetings as a representative of Service Development Group
8.	**Women's Issues** How are specific BME issues relating to women addressed? How is the LIT meeting the needs of BME women in light of the implementation guidance "Into the Mainstream" document on improving mental health services for women?	• Women's Service Development Group – Women only area in psychiatric unit. • Link with Acute Care forum -suicide prevention sub group • Asian women's day service
9.	**Advocacy** *What information, choice and access do Black and Minority Ethnic Health service users have to culturally sensitive advocacy services, and how are these monitored and fed into governance procedures?	• LA contract with Advocacy Alliance is generic – not specific to BME • Worker from BME has left so no BME worker, consider proactive approach to recruitment from BME community • Use interpreters
10.	What information about advocacy is given to BME service users/carers when they come into contact with mental health services? Are there any specific BME Advocacy services? Are BME service users/carers able to access advocacy services? What types of advocacy services are currently available? And how are they being funded, supported and monitored?	• Information re advocacy services in the locality is generic • Interpreters used for NESB • LA contract is generic and monitored through SSD Commissioning unit

	4. ACCOUNTABILITY AND CLINICAL GOVERNANCE	
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11.	How do you ensure issues in relation to a differential impact on BME Communities e.g. detention rates, percentage of BME service users are prescribed medication above the recommended dosage are embedded into clinical governance infrastructure? What and how often are reports in part or separate made to the Trust/PCT board in relation to BME services and what has been the action by the Board in the last 2 years? What is the effectiveness of this process to the overall decision-making and commissioning process?	• CDW member of Clinical Governance group • Regular information on detention rates monitored against ethnic origin by MHAAC, which is a NED chaired sub group of PCT Board • Service Development Group report to LIT • Need identified & CDW appointed
12.	Is there an Executive Director responsible for BME/Race Equality issues for Mental Health?	• Director of Operations supported by the Director of Public Health (Director with responsibility for Equality)
13.	Do you have a Race Equality Scheme, action plan and how is it being implemented and monitored? Please attach the plan and any monitoring reports	• PCT & SSD Race Equality Schemes in place and under review in accordance with National timetable.
14.	Is the Trust Board clear about local needs related to its overall corporate	• Development Plans from

	objectives and core activities	Service Development Group feedback to Trust Board via the MH LIT. • Equalities committee to oversee each chapter of the LDP to ensure BME issues addressed.
15.	Have any audits relating to specific BME issues been undertaken in the last 3 years and briefly describe/ attach the results and any actions taken.	**Public Health audit of South Warks population percentages** LDP with public consultation includes BME service developments
16.	What percentage of ethnic monitoring is collected? What issues need to be addressed to improve this and how is the information used e.g. to inform commissioning. Can you give any examples where commissioning approaches have changed as a result of this information?	• 100% Ethnicity recorded • See PWC action plan. • Translated in to development of specific BME Mental Health Strategy in order to address gaps in provision of services
17.	*David Bennett Inquiry* Please complete Audit attached What impact has there been on the implementation of the David Bennett Inquiry Do you have a local action plan? Please enclose your local action plan	(Copy attached) • Equality & Diversity Training – mandatory for all staff – scheduled for April 2005

18.	**Complaints** What percentage of your complaints are from BME staff/service users/carers? How are complaints used to improve services?	• Ethnicity of complainants recorded however data not specific to mental health. Overall % of complaints from BME service users / carers is ****** • System to be developed to capture ethnicity with HR and Complaints dept.
19.	**Harassment Policy** How are service users and carers made aware of the policy? Is the policy permanently displayed in a prominent place? Are members of the BME community part of the investigating group where there is harassment around race, culture or ethnicity? How is this policy monitored to ensure effectiveness of outcome around race, culture and ethnicity? Does your policy cover patient on patient prejudice and racism, as well as patient and staff racism?	**No current harassment policy. PCT has sought input from NIMHE to develop one** SSD has one generic to Warks County Council MH to work with key partner agencies to draft policy Agreement reached with County Council to monitor incidents of racial abuse.
20.	**Mental Health Act Status**	• SWPCT completed the “Count me census” at

	What percentage of your detained patients is from BME communities? How is this broken down by part 2,3,4 of the 1983 Act How long are BME service users detained before they are granted leave away from the hospital? What is the length of stay in hospital for detained BME service users?	the end of March 2005. This identified information relating to 120 in patients. Of these the number of individuals from BME communities was 7, of which 2 were white Irish, 2 were white other and 1 was Afro-Caribbean and 2 were Asian. None from BME communities were detained either on admission or at date of census. • Length of stay in the last 12 months has reduced overall and there is no discernable difference between duration of stay for BME service users.
	5. COMMISSIONING	
21.	Does your needs assessment adequately address the needs of BME communities? How does the LIT identify service needs and what actions have been taken to address any service gaps?	• MH services to review the data from "Mapping Health Information for West Midlands PCT's -

		Ethnicity" • Annual report from CDW
22.	What outline plans are there to develop and recruit Community Development Workers? (CDWs)	• CDW's appointed and in post
23.	**Investment** In which area of service delivery does the Trust contract with the BME voluntary sector provider to provide services. Please provide data. Are there any future plans to support BME voluntary sector providers to tender for areas of service delivery where they are known to provide better outcomes for BME service users and carers?	• Joint working with Elderly Asian day service to develop women's group/day service provision for users of mental health services.
24.	**Translation and Interpreting Services** What services currently exists and what are the gaps and processes being developed to improve communication and translating services?	• Review of Policy. Access to interpreting service. Out of hours contact being developed via outside agency. • Information leaflets etc. & appnt letters in 'other' languages being developed
	6. PARTNERSHIP – VOLUNTARY/SOCIAL INCLUSION	
25.	What cross agency work exists between health, social services, BME Organisations, churches and voluntary and community groups?	• Single line managed teams – CDW • Links to be developed with 'outside' organisations and community groups • Health promotion – local Sikh Temple (April 2005) • Collaborative working with

		MIND re BME Mental Health
26.	Are there active links with the voluntary sector and what support /collaboration is there? Does the LIT have a BME sub-group/ network or steering group? What are their terms of reference? Please enclose. What is its current work programme? Please explain how this process of involvement feeds into the wider agenda of the LIT? How could you develop an effective partnership with the voluntary sector to stimulate strategic engagement, support and sustainable funding to improve access, outcome and experience	• Links with Elderly Asian day service & MIND - Representation in Service Development group • BME Service Development Group • Monthly development plan/action plan, written feedback after each meeting • Collaborative working with Race Equality Officers (SSD) • Remit of Service Development Group
27.	Please briefly describe any innovative BME service developments to meet NSF or local proprieties that have been developed by either voluntary or statutory services?	• CDW role • Asian women's group • MIND Support Workers • Access to culturally appropriate psychological therapies i.e. counselling
	7. TRAINING AND EDUCATION	
28.	Reference to section 4 – Training in the David Bennett Audit Framework; in particular: areas around mandatory training on cultural competency, awareness and sensitivity, including tackling overt and covert racism and institutional racism (Recommendation 2 from the Report). How are you addressing the training needs to enable your organisation delivering a culturally competent service? Please enclose your plans	• Equality & Diversity training – April 2005 • Training on cultural competency being devised at present • Further training needs to be identified and provided by CDW

COMPREHENSIVE LIT THEMED REVIEW
Black and Minority Ethnic Services

- Name of the Primary Care Trust and/or Mental health Trust South Warks PCT
- Name of Local Implementation Team (LIT) South Warks
- LIT Population 237,383
- Total percentage of BME Population 5.7% (non white)
- What is the Ethnic breakdown of the LIT/PCT Population 2.6% Asian, under 1% of all others
- What is the Ethnic breakdown of the LIT? Currently 100% white

	2. STRATEGIC CONTEXT	
25.	Is there a separate or integral strategy for BME mental health communities that links to the organisations corporate objectives? If not what plans are there to develop local plans and what forum exists to discuss local needs?	• Warwickshire BME Strategy (draft) • Business Implementation Plan • Local Delivery Plan • SSD & PCT Race Equality Scheme
26.	*What analysis has been undertaken of need of local BME communities, with prioritisation of key challenges [say<4] to reflect identified and unmet need, patient experience and outcomes? *How has this translated to a shared stakeholder plan with clear responsibility for Board level championship, implementation and monitoring?	• Census identifies diverse makeup of Warwickshire, however under representation of BME communities in psychiatric services. • Local research currently underway to identify barriers to access (South Asian Community)

		• Consultation day held in January 2005 with Asian women to voice their needs/develop responses to these needs • BME Service development group → reporting to LIT for endorsement of development plan. • CDW role:
	2. SERVICE USER AND CARER INVOLVEMENT	
27.	Are there any BME users and carers on the LIT, how do they feedback to their constituent groups and how do they get selected? What other arrangements are there for the LIT engage with BME communities?	• Representation in Service Development group → LIT • CDW role
28.	How does the LIT engage and fund BME service users and carers? What support mechanisms do you have for BME users and carers? Do you have training and development processes to ensure effective involvement?	• Engagement via CDW & Service Development Group • Specialist carer worker/Care Co-ordinator • User forum training/Carer training – CDW
29.	*What structures and processes are in place to ensure that Black & Minority Ethnic services users and carers are represented, consulted and engaged in all aspects of planning, commissioning, delivering and evaluating services?	• Service development group • Asian Women's group • Future CDW role
30.	Do local service user and carer groups have BME representatives on them? How is the process of dissemination/feedback into the community ensured?	• Service user & carers currently not attending. To be developed by CDW

	3. PLANNING AND CARE PROCESSES	
31.	How are BME issues addressed within the Local Strategic Partnership (LSP) process?	• CDW to attend forthcoming meetings as a representative of Service Development Group
32.	**Women's Issues** How are specific BME issues relating to women addressed? How is the LIT meeting the needs of BME women in light of the implementation guidance "Into the Mainstream" document on improving mental health services for women?	• Women's Service Development Group – Women only area in psychiatric unit. • Link with Acute Care forum -suicide prevention sub group • Asian women's day service
33.	**Advocacy** *What information, choice and access do Black and Minority Ethnic Health service users have to culturally sensitive advocacy services, and how are these monitored and fed into governance procedures?	• LA contract with Advocacy Alliance is generic – not specific to BME • Worker from BME has left so no BME worker, consider proactive approach to recruitment from BME community • Use interpreters
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