Mental Health and Wellbeing Assets and Needs Assessment for Coventry and Rugby

1. Introduction

This document is based on the full draft technical document 'Mental Health and Well-being Assets and Needs Assessment for Coventry and Rugby'. This will contribute to the revised Joint Strategic Needs Assessment in 2015.

2. Background

There is 'no health without mental health' and yet we know that at least one in four British adults will experience some kind of mental health problem in any one year. Mental health and many common mental disorders are influenced by a wide range of social, economic and environmental factors. Mental health problems are increasing and they place an enormous strain on individuals, families and local communities. As a consequence national policy now demands that mental health be treated on a par with physical health.

Good mental wellbeing plays an important role in the promotion of both physical and mental health.

This review looks at the factors that underpin mental well-being and mental health for the adult populations of Coventry and Rugby (although there was limited information available for the Rugby population). It reflects both the needs of the population and some of the local assets available to underpin good mental health. Whilst the focus is on adult mental health it is recognised that many of the influential factors operate from conception (or before) and accumulate through childhood and adolescence.

The work was commissioned by the Coventry and Rugby CCG and by Coventry City Council's People Directorate in recognition of their need to jointly review the services and support currently available to those who suffer with poor mental health.

2. Aims and Objectives

This review aims to describe the population needs and community assets available in relation to mental well-being and mental ill-health. The main components of the review are:

1. An epidemiological analysis of:
    a. The wider determinants of mental health and wellbeing;
    b. Vulnerable groups and risk factors for mental illness;

c. Indicators of mental wellbeing and mapping of community assets and local initiatives to promote mental wellbeing;

d. The prevalence of common and severe mental health disorders;

2. A description of mental health services currently commissioned by Coventry City Council and Coventry & Rugby CCG, and recent activity and funding for those services;

3. Consultation with stakeholders, including service users, carers, providers and commissioners; seeking their views on needs, assets and mental health services.

4. Discussion with health and social care clinicians, commissioners and users (experts by experience) to consolidate findings and formulate recommendations

3. Wider Determinants of Mental Health and Wellbeing

There are many factors that influence an individual's mental health and wellbeing. These factors operate at many levels and include; personal (e.g. genetic factors, diet, exercise, relationships, how a person may perceive events), social and community (e.g. family structure, friends, isolation, area of deprivation) and larger societal and environmental conditions (e.g. education, social connectedness, health care provision, unemployment levels, equality).

Figures 1a and 1b summarise the most recent available indicators relating to the wider determinants of mental health and wellbeing. Overall, factors that are associated with an increased risk of poor mental health and wellbeing are higher in Coventry than the national average, reflecting higher levels of socioeconomic deprivation in the city. However in Rugby, which is a more affluent town, most risk factors (where this information is available) are below the national average. However both areas have higher levels of fuel poverty (Coventry 16.3%, Rugby 12.4%) compared to the England average of 10.4%.

Key to Figures 1a and 1b

Figure 1a: Summary of most recent indicators relating to the wider determinants of mental health and wellbeing in Coventry.

	Indicator	Period	Local Number	Local Value	Eng Avg	Eng low	England Range	Eng high
1	Overall IMD score	2011	n/a	**28.4**	21.5	5.4		43.4
2	% of population living in the 20% most deprived wards	2012	104,044	**32.2**	20.4	0.0		83.8
3	% of children in poverty (all dependent children under 20)	2011	18,650	**25.4**	20.1	2.9		46.1
4	% of children in poverty (under 16)	2011	16,385	**25.9**	20.6	2.8		43.6
5	Long-term unemployment: % of working age adults	Jun 2014	2,015	**1.0**	0.7	0.0		2.4
6	16-18 year olds not in education employment or training (NEETs)	2013	840	**7.4**	5.3	1.8		9.8
7	Adults with low education: % of adults with no qualifications or level 1 qualifications	2011	94,581	**37.2**	35.8	11.0		49.8
8	Statutory homelessness: Homeless acceptances (crude rate per 1,000)	2013/14	550	**4.2**	2.3	0.1		12.5
9	Statutory homelessness: % of households in temporary accommodation	2013/14	35	**0.3**	2.6	0.0		29.7
10	Fuel poverty: % of households	2012	20,515	**16.3**	10.4	2.4		21.3
11	Overcrowding: % of households	2011	7,246	**5.6**	4.8	1.3		25.4
12	Rented accommodation: % of households	2011	48,417	**37.7**	34.5	18.2		72.7
13	Complaints about noise: Rate per 1,000 resident population	2012/13	6,962	**21.5**	7.5	2.5		149.1
14	% of population exposed to road, rail and air transport noise of 65dB(A) or more, during daytime	2011	7,200	**2.3**	5.2	0.0		28.5
15	% of population exposed to road, rail and air transport noise of 55 dB(A) or more during night-time	2011	14,190	**4.5**	8.0	0.0		42.4
16	Population turnover (internal migration): Rate per 1,000 resident population	2012	33,800	**104.6**	85.0	45.6		236.8
17	Migrant GP registrations: Rate per 1,000 resident population	2012	8,260	**25.6**	9.6	0.7		56.0
18	English language skills: % of people who cannot speak English/ speak it well	2011	9,242	**3.0**	1.1	0.1		8.7

Sources: Public Health Outcomes Framework; Mental Health Intelligence Network

Figure 1b: Summary of most recent indicators relating to the wider determinants of mental health and wellbeing in Rugby.

	Indicator	Period	Local Number	Local Value	Eng Avg	Eng low	England Range	Eng high
1	IMD score: Quality of indoor living area	2010	n/a	**11.4**	21.7	3.1		99.0
2	% of children in poverty (all dependent children under 20)	2011	2,835	**13.1**	20.1	2.9		46.1
3	% of children in poverty (under 16)	2011	2,545	**13.7**	20.6	2.8		43.6
4	Adults with low education: % of adults with no qualifications or level 1 qualifications	2011	26,485	**32.8**	35.8	11.0		49.8
5	Statutory homelessness: Homeless acceptances (crude rate per 1,000)	2013/14	106	**2.5**	2.3	0.0		12.5
6	Statutory homelessness: % of households in temporary accommodation	2013/14	26	**0.6**	2.6	0.0		29.7
7	Fuel poverty: % of households	2012	5,076	**12.4**	10.4	2.4		21.3
8	Overcrowding: % of households	2011	1,019	**2.4**	4.8	1.2		25.4
9	Rented accommodation: % of households	2011	11,896	**28.4**	34.5	16.1		72.7
10	Complaints about noise: Rate per 1,000 resident population	2012/13	528	**5.2**	7.5	0.6		149
11	English language skills: % of people who cannot speak English/ speak it well	2011	1,367	**1.4**	1.1	0.1		8.7

Sources: Public Health Outcomes Framework; Mental Health Intelligence Network

Socioeconomic deprivation

Deprivation or poverty can be both a determinant and a consequence of poor mental health. There is a marked social gradient in the prevalence of psychiatric disorders, with the lowest socioeconomic classes experiencing the highest rates of illness.[1] Area analyses of poverty and mental health have found higher levels of hospital admissions, outpatient use for mental health services and suicide in poorer areas.[2,3]

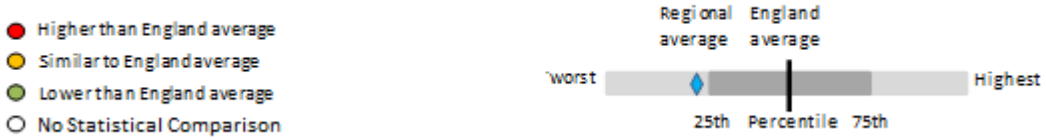
4. Vulnerable Groups and Risk Factors for Mental Illness

Within the population there are a number of groups that have an increased risk of developing mental illness. It is important to emphasise that this does not necessarily represent a direct causal link; risk factors may be correlates of mental illness rather than causes, and the relationship may be mediated by other related factors.

Figures 2a and 2b summarise the most recent available indicators relating to vulnerable groups and risk factors for mental illness. The Coventry picture is more varied than that for the wider determinants of health. While several family-related risk factors are more prevalent (e.g. rates of looked after children and care leavers), and there are also higher rates of violent crime, Coventry appears to do better than the national average on the employment of people in contact with secondary mental health services and rates of domestic abuse. Rugby generally has lower rates of risk factors than the national average, but it is worth noting that far fewer indicators were available.

Key to Figures 2a and 2b

Figure 2a: Summary of most recent indicators relating to vulnerable groups and risk factors for mental illness in Coventry.



	Indicator	Period	Local Number	Local Value	Eng Avg	Eng low	England Range	Eng high
1	Prevalence of physical disability: Estimated % of population aged 16-64	2011	56,247	**10.1**	11.1	8.3		12.6
2	Long-term health problems or disability: % who say day-to-day activities are limited by health or disability	2012	21,297	**17.6**	17.6	11.2		25.6
3	Adults with a learning disability who live in stable and appropriate accommodation - %	2012/13	590	**73.6**	73.5	32.6		96.6
4	Adults in contact with secondary mental health services who live in stable and appropriate accommodation - %	2012/13	1,040	**71.1**	58.5	5.5		94.1
5	Gap in employment rate between those with a long-term health condition and overall employment rate (percentage points)	2012	n/a	**1.8**	7.1	-5.3		21.7
6	Gap in the employment rate between those with a learning disability and the overall employment rate (percentage points)	2013/14	n/a	**59.4**	65.1	46.7		79.1
7	Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (percentage points)	2012/13	n/a	**53.1**	62.3	53.1		75.1
8	Unpaid carers: % of population who provide substantial unpaid care	2011	7,938	**2.5**	2.4	0.9		4.0
9	Lone parent households - %	2011	12,396	**9.6**	7.1	2.1		14.4
10	Looked after children: Rate per 10,000 <18 population	2013/14	630	**86.1**	60.3	0.0		153.3
11	Children leaving care: Rate per 10,000 <18 population	2013/14	330	**45.1**	26.4	0.0		71
12	Higher risk drinking: % of people 16+ drinking at increasing or higher risk levels	2008 - 09	n/a	**20.5**	22.3	15.7		25
13	People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	196	**45.1**	46.8	19.7		69.8
14	Domestic abuse incidents recorded by the police (crude rate per 1,000)	2012/13	n/a	**13.3**	18.8	5.6		30.2
15	Violent crime (including sexual violence): Hospital admissions for violence (DSR per 100,000)	2010/11 - 12/13	972	**90.8**	57.6	9.3		168
16	Violent crime (including sexual violence): Violence offences (crude rate per 1,000)	2013/14	4,074	**12.6**	11.1	4.6		80
17	Violent crime (including sexual violence): Sexual offences (crude rate per 1,000)	2013/14	348	**1.1**	1.0	0.4		6.6
18	Re-offending levels - % of offenders who re-offend	2011	963	**27.9**	26.9	14.4		36.3
19	Re-offending levels - average number of re-offences per offender	2011	2,927	**0.8**	0.8	0.3		1.3

Sources: Public Health Outcomes Framework; Mental Health Intelligence Network

Figure 2b: Summary of most recent indicators relating to vulnerable groups and risk factors for mental illness in Rugby.

	Indicator	Period	Local Number	Local Value	Eng Avg	Eng low	England Range	Eng high
1	Long-term health problems or disability: % who say day-to-day activities are limited by health or disability	2011	16,114	**16.1**	17.6	11.2		26.0
2	Gap in employment rate between those with a long-term health condition and overall employment rate (percentage points)	2012	n/a	**16.8**	7.1	-10.5		24.0
3	Unpaid carers: % of population who provide substantial unpaid care	2012/13	2,062	**2.1**	2.4	0.9		4.1
4	Lone parent households - %	2012/13	2,675	**6.4**	7.1	2.1		14.4
5	Higher risk drinking: % of people 16+ drinking at increasing or higher risk levels	2012	n/a	**23.3**	22.3	15.7		25.1
6	Violent crime (including sexual violence): Hospital admissions for violence (DSR per 100,000)	2013/14	128	**43.3**	57.6	9.3		167.8
7	Violent crime (including sexual violence): Violence offences (crude rate per 1,000)	2012/13	742	**7.4**	11.1	2.8		79.9
8	Violent crime (including sexual violence): Sexual offences (crude rate per 1,000)	2011	92	**0.9**	1.0	0.3		6.6
9	Re-offending levels - % of offenders who re-offend	2011	188	**22.5**	26.9	14.4		36.3
10	Re-offending levels - average number of re-offences per offender	2013/14	476	**0.6**	0.8	0.3		1.3

Sources: Public Health Outcomes Framework; Mental Health Intelligence Network

5. Mental Wellbeing and Community Assets

Indicators of Mental Wellbeing in Coventry

As stated above a wide range of factors can influence MWB and there are a number of ways in which it is measured. The Integrated Household Survey currently includes four questions on subjective individual wellbeing, covering life satisfaction, happiness, feeling worthwhile and anxiety. Appendix 1 includes a summary of the responses for Coventry, the West Midlands and England for the years 2011/12 and 2012/13, with Coventry showing a trend in a positive direction for all four indicators.

The Coventry Household Survey includes measurement of well-being using the WEMWBs tool. Over the last 4 years the following WEMWBS measurements have been obtained.

CHS valid sample Year	n	mean, 95%ci
2010	3370	51.2 (50.9, 51.5)
2011	2707	51.8 (51.6, 52.2)
2012	2111	54.1 (53.7, 54.4)
2013	2208	51.1

The rise in the 2012 mean score may be explained by a problem with the way the WEMWBs questions were presented within the 2012 survey (similar to a primacy effect producing a possible bias in responses). The national average WEMWBs score in the Health Survey for England (2013) was 51.5 and thus similar to the Coventry value. The continued investigation of wellbeing is providing more insight into what is important for wellbeing in Coventry and for different groups.

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The 10 Ways to Wellbeing

Mental wellbeing can be affected by many external factors as well as those the individual can control or change. The Wellbeing Project in Coventry identified '10 Ways to Wellbeing' based on the two themes of feeling good (i.e. happiness and life satisfaction) and functioning well.[4] These expand on the New Economics Foundation's Five Ways to Wellbeing[5] by suggesting ways that individuals can improve their wellbeing. The Ways to Wellbeing 6 to 10 were derived from evidence of what's important for local MWB as reflected in the Household Survey.

The 10 Ways to Wellbeing are as follows:

1. Connect with family, friends, colleagues and neighbours
2. Be active
3. Take notice - be aware of the world around you and what you are feeling
4. Keep learning
5. Give. Try something new.
6. Have rewarding work
7. Feel safe and good about where I live
8. Feel good physically
9. Eat and drink healthily
10. Sleep well

Support within communities and from public services, for example measures to improve community safety, improve workplace wellbeing and ensure equitable access to good quality housing and services, can help enable people to achieve these aims.

Community assets

Coventry's Asset Based Working Strategy for 2015-16 sets out ways to improve health and quality of life for local citizens, while making the city globally connected

and attractive to businesses and investors. It recognises the limitations of public services that encourage dependency, and promotes a working culture that supports and enables people to find solutions to their problems. Examples of current initiatives to improve wellbeing and promote asset based working include the following:

- Community Wellbeing Project,
- The Workplace Wellbeing Charter
- Coventry on The Move
- Coventry Time Union
- Making Every Contact Count (MECC) and the 10 Ways to Wellbeing

6. Mental Illness and Mental Health Services

Common Mental Health Disorders

Common mental health disorders include depression, anxiety, phobias, obsessive-compulsive disorder (OCD), eating disorders and post-traumatic stress disorder (PTSD). People can have these conditions at various severities and may need input from self-help, primary care, psychological therapies or secondary care in severe cases.

Figure 3 shows the most recent indicators relating to mental ill-health epidemiology in Coventry. Estimates for the conditions shown are broadly similar to or below the England average, with the exception of mixed anxiety and depressive disorders that have a slightly higher local prevalence.

Based on 2012 estimates, approximately 67,028 people in Coventry aged 16-74 have a common mental health disorder.

Personality disorder

People with personality disorders are at increased risk for many psychiatric disorders, particularly mood disorders.

The 2007 Adult Psychiatric Morbidity Survey estimated the prevalence of borderline personality disorder to be 0.3% in males and 0.6% in females aged 18-64. The prevalence of antisocial personality disorder was estimated to be 0.6% in males and 0.1% in females. Based on these figures, 940 adults in Coventry in 2014 were estimated to have borderline personality disorder, and 746 were estimated to have antisocial personality disorder

Figure 3 shows that rates of severe mental illness and related indicators are broadly similar to or lower than the national average, with the exception of emergency admissions for self-harm, for which the local rate is significantly higher.

Key to Figure 3

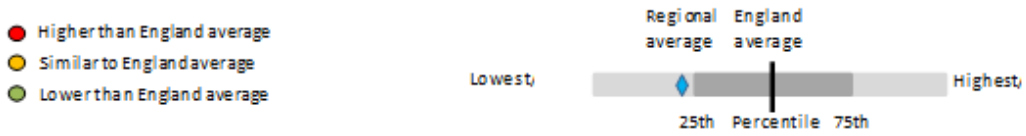


Figure 3: Summary of most recent indicators relating to common and severe mental disorders in Coventry.

	Indicator	Period	Local Number	Local Value	Eng Avg	Eng low	England Range	Eng high
1	Prevalence of mixed anxiety and depressive disorder: Estimated % of population aged 16-74	2012	24,541	**10.4**	8.9	5.3		14.7
2	Prevalence of generalised anxiety disorder: Estimated % of population aged 16-74	2012	9,448	**4.0**	4.5	2.8		7.8
3	Prevalence of depressive episode: Estimated % of population aged 16-74	2012	4,677	**2.0**	2.5	1.1		4.1
4	Prevalence of all phobias: Estimated % of population aged 16-74	2012	4,080	**1.7**	1.8	1.0		3.6
5	Prevalence of obsessive compulsive disorder: Estimated % of population aged 16-74	2012	2,479	**1.0**	1.1	0.5		2.4
6	Prevalence of panic disorder: Estimated % of population aged 16-74	2012	424	**0.2**	0.7	0.1		1.2
7	Prevalence of eating disorders: Estimated % of population aged 16+	2012	14,820	**6.3**	6.7	5.7		7.9
8	Prevalence of post traumatic stress disorder (PTSD): Estimated % of population aged 16+	2012	6,559	**2.8**	3.0	2.5		3.2
9	Depression and anxiety among social care users - %	2012/13	–	**48.8**	53.4	23.2		64.7
10	New cases of psychosis: Estimated incidence per 100,000 aged 16-64	2011	63	**30.2**	24.2	15.6		71.9
11	Schizophrenia emergency admissions: Rate per 100,000 population	2009/10 - 11/12	–	**56.0**	57.0	5.0		233
12	Emergency hospital admissions for intentional self-harm: Directly age-sex standardised rate per 100,000	2012/13	1,029	**298**	188	50.4		596
13	Emergency admissions for neuroses: Indirectly age and sex standardised rate per 100,000 population	2011/12	–	**16.7**	16.8	0.0		57.7
14	Admissions for depression: Directly standardised rate per 100,000 aged 15+	2009/10 - 11/12	–	**30.1**	32.1	4.7		84.8
15	Premature (<75) mortality in adults with serious mental illness: Rate per 100,000 population	2012/13	134	**1,137**	1,319	496		2,294
16	Excess under 75 mortality in adults with serious mental illness: Standardised mortality ratio	2012/13	134	**346**	347	139		564
17	Suicide: Age-standardised mortality rate per 100,000 population	2011-13	90	**10.0**	8.8	0.0		22.1

Severe mental illness

Severe mental illness is generally used to refer to conditions that include psychotic symptoms, namely bipolar disorder, schizophrenia and other non-organic psychotic conditions. More detail of these conditions is provided in Appendix 2.

A systematic review in 2008 estimated that the incidence of schizophrenia in England was 15.2 per 100,000 person-years.[6] The incidence of all psychoses was estimated to be 31.7 per 100,000 person-years.

The 2007 Adult Psychiatric Morbidity Survey estimated the prevalence of psychotic disorders in adults aged 18 to 64 to be 0.3% of males and 0.5% of females. Based on these figures, it is estimated that in 2014 there were 516 people aged 18 to 64 with psychotic disorders in Coventry.

Self-harm and suicide

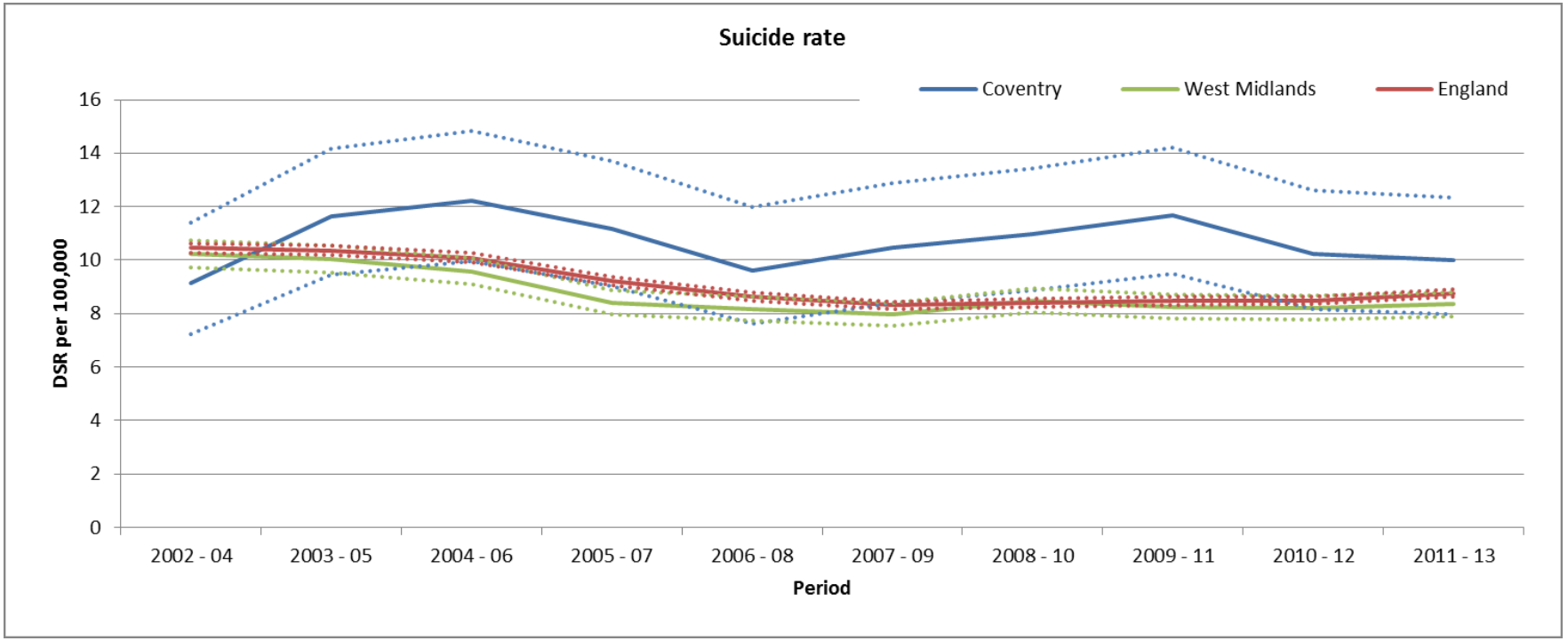
The incidence of self-harm in the UK, particularly among young people, has risen over the last 20 years, and is said to be among the highest in Europe.[7]

Figure 4 shows trends in suicide rates in Coventry, the West Midlands and England, directly standardised by age. In 2011-13 the DSR of suicide in Coventry was 10.0 deaths per 100,000 population, which was higher than both the regional and national estimates (8.3 and 8.8 deaths per 100,000 respectively); however, the differences were not statistically significant.

Table 1 shows numbers of suicides in Coventry and Rugby from 2008-10 to 2011-13. Numbers of suicides have remained broadly similar in Coventry and Rugby throughout this period; however, there has been an increase among Coventry males and a decrease among Coventry females.

Whilst the numbers are relatively small the impact is massive on family, friends, communities and the economy.

Figure 4: Directly standardised rate (DSR) of suicide per 100,000 population in Coventry, West Midlands & England, all ages, 2002-04 to 2011-13.[a] *Dotted lines denote 95% confidence intervals around each estimate.*



[a] Rugby is not shown as DSRs could not be calculated from 2005-07 onwards, due to small numbers.

Table 1: Numbers of suicides in Coventry and Rugby stratified by sex, all ages, 2008-10 to 2011-13.

	Coventry		Rugby	
Period	**Male**	**Female**	**Male**	**Female**
2008-10	62	36	16	*<6*
2009-11	69	34	19	*<6*
2010-12	70	19	20	*<6*
2011-13	75	15	19	*<6*

Mental Health Indicators at CRCCG Level

Appendix 3 includes a comparison of indicators at the CRCCG level, comparing measures to a socio-economically similar group (ONS cluster) of CCGs. Some of the key points to note are:

In terms of the treatment indicators:

- The range of spend per 100,000 population for the ONS cluster is £23,508 to £40,907. CRCCG ranks 7th highest of the 25 CCGs at £34,336 (no cluster average available). This is despite the fact that both the indicators "number of bed days per 100,000 population" and "people in contact with mental health srvices per 100,000 population" are both below the cluster average for CRCCG.
- % of secondary care spend on mental health ranges 7.1% to 15.5% with CRCCG ranking 6th highest at 14.1%
- Hospital admissions for unintentional injuries 0 to 24 per 10,000 population range from 76.3 to 160.9 with CRCCG ranking 7th highest at 149.9
- Detentions under the Mental Health Act are unremarkable at 17.9 compared to an ONS average of 18.9 per 100,000

In terms of the levels of mental illness:

- Comparison shows nothing particularly remarkable with a tendency for CRCCG to report lower levels of illness than the cluster average

In terms of outcomes:

- For emergency admissions for self-harm values range from 137.4 to 354.9 and CRCCG ranks 2nd highest in the group at 283.4 per 100,000 population (no cluster average available) but England average 15 given as 191.

7. Primary care

i. Snapshot of General Practice activity in Coventry

For many people with mental health problems, their GP will be their first point of contact and therefore the first step in the care pathway. In order to try to capture the volume of MH activity a 'snapshot' of activity over a two-month period was provided by a practice in Coventry. In October and November 2014, approximately 7-8% of consultations related to mental health, including new or first presentations and review appointments (Table 2). During this period overall there were also 27 IAPT referrals and 26 psychiatric referrals. The ratio of female to male patients presenting with mental health problems over the two-month period was 1.44:1. The average age (weighted by numbers presenting in each month) was 43.1 years.

If this represents typical activity over a two-month period, this practice would expect to record approximately 2,754 consultations relating to mental health over the course of a year, and to make approximately 318 referrals to IAPT or psychiatric services.

'Low mood' was the diagnosis accounting for the most mental health-related consultations in each month, followed by diagnoses describing depression and anxiety states. It is likely that this is an underestimate of mental health presentations.

Table 2: Mental health-related consultations at a General Practice in Coventry, October & November 2014.

				Episode (N, %)				Referrals	
Month	Total consultation N	N consulting for mental health	% of consultations that were mental health	New	First	Review	None	IAPT	Psychiatric
Oct-14	3,223	251	7.8	24	72	121	34	0	13
Nov-14	3,059	208	6.9	19	55	119	15	27	13

ii. Quality & Outcomes Framework (QOF)

The Quality and Outcomes Framework[b] requires registers to be maintained in General Practice of patients diagnosed with depression or severe mental illness, and sets out requirements for follow-up care of these patients. This includes indicators relating to physical health needs for patients with severe mental illness.

Tables 3a and 3b show how Coventry & Rugby CCG compares to England overall for prevalence, achievement and exception reporting indicators for the Depression and Mental Health clinical areas. The prevalence of Depression recorded in Coventry and Rugby practices was slightly higher than the national average in 2012/13, and slightly lower in 2013/14. The percentage of QOF points achieved decreased over this period both locally and nationally, whereas the rate of exception recording increased considerably.

Table 3a: QOF prevalence, achievement and exception rate indicators for Depression (18+) - Coventry & Rugby CCG and all CCGs in England, 2012/13-2013/14.

Year	Prevalence (%)		Achievement (%)		Exception rate (%)	
	CRCCG	England	CRCCG	England	CRCCG	England
2012/13	6.04	5.89	90.22	89.68	4.43	5.25
2013/14	6.34	6.59	84.96	87.23	19.79	20.69

Table 3b: QOF prevalence, achievement and exception rate indicators for Mental Health - Coventry & Rugby CCG and all CCGs in England, 2012/13-2013/14.

	Prevalence (%)		Achievement (%)		Exception rate (%)	
	CRCCG	England	CRCCG	England	CRCCG	England
2012/13	0.86	0.83	94.60	94.57	13.41	15.54
2013/14	0.86	0.85	89.52	90.98	7.95	11.63

[b] Quality & Outcomes Framework – Health & Social Care Information Centre: http://www.hscic.gov.uk/qof

iii. Prescribing for mental health

Hypnotics and antidepressants are among the key prescribing areas listed by NICE, with national targets to reduce prescribing.[8] Risks associated with long-term use of hypnotic drugs include falls, accidents, cognitive impairment, dependence and withdrawal symptoms. Among Coventry practices, there has been a notable improvement over the last year in hypnotic prescribing rates, as well other therapeutic areas.[9] NICE recommends a stepwise approach to managing common mental health disorders such as depression or anxiety, with the least intrusive, most effective intervention offered first. Non-drug interventions should therefore be the preferred option for many patients, with medication reserved for more severe or persistent illness.[8]

Table 4 shows total items, costs, and prescribing rates measured as Average Daily Quantity (ADQ) by Specific Therapeutic group Age-sex Related Prescribing Units (STAR-PU) for a number of drugs prescribed for mental health conditions.

Prescribing rates within Coventry & Rugby CCG are lower than the national average for antidepressants, and higher for drugs acting on benzodiazepine receptors. The rates for the CRCCG compared to the ONS cluster group are shown in appendix 6 and indicate that antidepressant prescribing is lower in CRCCG than the cluster average.

Table 4: Summary of drugs prescribed for mental health conditions for the financial period 2013/14 – Coventry & Rugby CCG.

	Antidepressants	Anxiolytics	Hypnotics	Benzodiazepine receptors	Mania	Antipsychotics	Anti-psychotic Depot
Total items	384,797	45,458	82,602	-	10,445	71,302	2,305
Total cost	£1,664,319	£104,934	£510,436	-	£72,976	£1,179,558	£178,685
Difference in items from 2012/13	+27,454	-2,076	-5,388	-	+78	+1,141	+53
Difference in cost from 2012/13	+£343,060	-£16,632	+133,516	-	+2,472	-221,082	+£27,016
ADQ/STAR PU	7.76	0.52	1.41	11.75	-	0.69	101.10

- CCG average							
ADQ/STAR PU - England average	8.91	0.56	1.18	10.59	-	0.61	61.76

iv. Social prescribing and self-help

Social prescribing is a means of linking patients with non-medical sources of support within the community, and may include artistic and creative activities, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with other areas of life such as housing, employment or finances.[10] Self-help therapy may be recommended by the GP in the first instance for common mental health disorders, particularly conditions such as mild to moderate depression or anxiety. This can be in the form of self-help books, or online counselling or cognitive behavioural therapy (CBT). Current national and local initiatives are described in Appendix 4.

8. Emergency admissions for Self Harm

A number of individuals with mental health problems will present in Accident & Emergency (A&E) departments due to being in a state of crisis.

Data from Hospital Episode Statistics indicate that in 2012/13 the rate of hospital stays for deliberate self-harm in Coventry was 298.0 per 100,000 population, which was significantly higher than the national rate of 199.8 per 100,000[c].

Table 5 shows numbers of A&E attendances and admissions to University Hospital Coventry & Warwickshire (UHCW) where deliberate self-harm was identified, with associated costs.

Table 5: Numbers of A&E attendances and emergency admissions for deliberate self-harm - University Hospital Coventry & Warwickshire NHS Trust, 2013/14-2014/5.[d]

Numbers of attendances & admissions	Apr to Mar 2013 2014		Apr to Nov 2014 2015		Forecast Out turn 2014 2015	
	Activity	*Finance £*	*Activity*	*Finance £*	*Activity*	*Finance £*
A & E Attendances with Patient Group Identified as Deliberate Self Harm	274	27,824	170	18,563	255	27,845
A & E Attendances with Patient Group Identified as Deliberate Self Harm that were recorded as being Admitted	164	17,083	96	11,087	144	16,631
Emergency Admissions with intentional Self Harm recorded in ICD10 Coding	577	338,241	397	220,892	596	331,338

[c] Source: Public Health Outcomes Framework

[d] There is disparity between the admission figures from A&E and the emergency admissions figures per the Inpatient dataset, due to issues around coding.

9. CCG and Council Commissioned Services

Coventry & Rugby CCG and Coventry City Council commission a number of mental health services in the local area. The following sections describe activity and costs for mental health services commissioned by the CCG or the Council.

CCG Commissioned Services

The provider of specialist Mental Health Services is Coventry and Warwickshire Partnership Trust (CWPT) and the services are commissioned by the CCG. A number of the services provided by CWPT are described in Appendix 5.

Mental health outpatients

First attendances to mental health outpatients units are shown in Tables 6a and 6b, stratified by age and sex.[e] First attendances decreased overall over the three-year period in both Coventry and Rugby; Table 7 shows the number of outpatient attendances at out of city (non-CWPT) providers.

Table 6a: Mental health outpatients first attendances – Coventry, 2012/13-2014/15.

		2012/13		2013/14		2014/15 FOT	
Age Group	**Sex**	**N**	**%**	**N**	**%**	**N**	**%**
18-24	Female	260	8.6	198	7.2	175	6.5
	Male	194	6.4	180	6.5	125	4.7
18-24 Total		**454**	**15.0**	**378**	**13.7**	**300**	**11.2**
25-64	Female	942	31.1	786	28.6	885	33.2
	Male	815	26.9	836	30.4	979	36.7
25-64 Total		**1,757**	**58.0**	**1,622**	**58.9**	**1,864**	**69.8**
65+	Female	509	16.8	456	16.6	301	11.3
	Male	307	10.1	297	10.8	204	7.6
65+ Total		**816**	**27.0**	**753**	**27.4**	**505**	**18.9**
Total		**3,027**	**100**	**2,753**	**100**	**2,669**	**100**

Table 6b: Mental health outpatients first attendances – Rugby, 2012/13-2014/15.

[e] Speciality codes 710 to 730 (mental health excluding LD) were extracted and then anything with a primary diagnosis of F7 (Mental Retardation) and F00 to F03 (Dementia) were excluded; however, most of the diagnosis codes were null. The dataset is based on patients who attended Outpatients between April 2012 and Dec 2014 and were seen. Locations are determined from GP practice, not patient postcode.

Age Group	Sex	2012/13 N	2012/13 %	2013/14 N	2013/14 %	2014/15 FOT N	2014/15 FOT %
18-24	Female	36	4.0	34	4.1	29	5.1
	Male	38	4.2	27	3.3	13	2.3
18-24 Total		**74**	**8.2**	**61**	**7.4**	**43**	**7.4**
25-64	Female	183	20.2	177	21.5	99	17.0
	Male	164	18.1	126	15.3	99	17.0
25-64 Total		**347**	**38.3**	**303**	**36.7**	**197**	**34.0**
65+	Female	296	32.6	249	30.2	204	35.2
	Male	190	20.9	212	25.7	136	23.4
65+ Total		**486**	**53.6**	**461**	**55.9**	**340**	**58.6**
Total		**907**	**100**	**825**	**100**	**580**	**100**

Table 7: Number of out-of-city outpatient attendances – Coventry & Rugby, 2012/13-2014/15.

	2012/13	2013/14	2014/15 FOT
Coventry	434	308	279
Rugby	48	46	56
Total	**482**	**354**	**335**

Mental Health Admissions

Tables 8a and 8b summarise patient demographics for mental-health related admissions to any provider Trust for the Coventry and Rugby populations from 2012/13 onwards.[f] Data for 2014/15 are the forecast out-turn (FOT) based on figures for the first three quarters. Numbers of patients admitted have generally decreased over the last three years in both areas. Among Coventry adults aged 18-64, men were more likely to be admitted than women over the two most recent periods, whereas among over-65s more women were admitted. Among Rugby adults aged 25-64, more men were admitted in the most recent period, reversing the trend of previous periods.

Table 8a: Emergency mental health admissions stratified by age and sex – Coventry, 2012/13-2014/14.

[f] Speciality codes 700 to 730 (mental health including LD) were extracted and then anything with a primary diagnosis of F7 (Mental Retardation) and F00 to F03 (Dementia) were excluded. The dataset is based on patients with an episode end date in the period April 2011-Dec 2014. In each year, counts are based on patients admitted from admission date criteria (e.g. 2013/14 is based on admission dates between 1/4/13 and 31/3/14). Because we are only able to count admissions of patients who have been discharged, this may result in an underestimate of patients admitted, particularly in the most recent period. Locations are determined from GP practice, not patient postcode. The counts shown are all of spells.

Age	Sex	2012/13		2013/14		2014/15 FOT	
		N	%	N	%	N	%
18-24		**64**	**10.9**	**67**	**12.1**	**56**	**12.1**
	Female	29	4.9	25	4.5	23	4.9
	Male	35	6.0	42	7.6	33	7.2
25-64		**417**	**70.9**	**391**	**70.8**	**368**	**79.8**
	Female	211	35.9	169	30.6	141	30.7
	Male	206	35.0	222	40.2	227	49.2
65+		**107**	**18.2**	**94**	**17.0**	**37**	**8.1**
	Female	57	9.7	57	10.3	21	4.6
	Male	50	8.5	37	6.7	16	3.5
	Total	**588**	**100**	**552**	**100**	**461**	**100**

Table 8b: Emergency mental health admissions stratified by age and sex – Rugby, 2012/13-2014/14.

Age	Sex	2012/13		2013/14		2014/15 FOT	
		N	%	N	%	N	%
18-24		**14**	**14.9**	**7**	**8.5**	**8**	**11.6**
	Female	–	–	–	–	–	–
	Male	–	–	–	–	–	–
25-64		**59**	**62.8**	**54**	**65.9**	**45**	**65.7**
	Female	28	29.8	31	37.8	19	27.1
	Male	31	33.0	23	28.0	27	38.6
65+		**21**	**22.3**	**21**	**25.6**	**16**	**23.2**
	Female	11	11.7	11	13.4	–	–
	Male	10	10.6	10	12.2	–	–
	Total	**94**	**100**	**82**	**100**	**69**	**100**

Community and daycare services

Table 9 shows numbers of Coventry and Rugby individuals seen in a range of community services for the financial year 2013/14.[g] The majority of attendances overall were to Adults and Older Adults Community Mental Health Teams, and Crisis Resolution. Numbers of attendances to outpatient and daycare services are shown in Tables 9 and 10. Numbers <6 have been suppressed.

Table 9: Numbers of patients seen in community mental health services, stratified by age – Coventry & Rugby, 2013/14.

Service	Coventry				Rugby			
	18-24	25-64	65+	Total	18-24	25-64	65+	Total
ADULTS Assertive Outreach	*<6*	106	*<6*	**115**	7	50	6	**63**
ADULTS Community MH Teams	1,570	7,048	856	**9,474**	314	1,712	178	**2,204**
ADULTS Crisis Resolution	317	1,374	123	**1,814**	91	403	52	**546**
ADULTS Early Intervention	130	133	0	**263**	29	27	*<6*	–
ADULTS Injection Clinic	28	315	78	**421**	*<6*	20	*<6*	–
Older Adults Community MH Teams	7	119	2,284	**2,410**	0	18	434	**452**

[g] Excludes CAMHS Community Teams, Children's LD, LD Community Team, and Older Adults Early Onset Dementia.

Table 10: Numbers of patients seen in daycare mental health services, stratified by age – Coventry & Rugby, 2013/14.

Service	Coventry				Rugby			
	18-24	25-64	65+	Total	18-24	25-64	65+	Total
Community		161		**161**		313		**313**
Day Care (A)	146	2,861	125	**3,132**	119	440	*<6*	–
Day Care (O)		67	1,292	**1,359**				
Totals	**146**	**3,089**	**1,417**	**4,652**	**119**	**753**	***<6***	–

Criminal Justice Liaison & Diversion Scheme and Street Triage

Coventry's Criminal Justice Liaison & Diversion scheme started in 2013, with the aim to improve health and wellbeing in offenders aged 10 and above and prevent re-offending.

The Mental Health Street Triage scheme began in December 2014, and deals with emergency calls requiring police response involving an element of mental health need. The service is provided between 5pm and 2am each day.

Table 11 shows that an average of 100 individuals per month were identified by Criminal Justice agencies as benefitting from assessment, with approximately 16% refusing to be seen. Over 1,000 contacts were offered during the period including June 2014 and July to December 2014, with approximately 15% not attending. All non-attendances were followed up with the individual or the services working with the individual.

Table 11: Assessment and engagement activity for Coventry Criminal Justice Liaison & Diversion scheme, 2014/14.

Period	Assessments		Engagement	
	Referrals	***Refused (N, %)***	***Contacts offered***	***Did not attend (N, %)***
Q1 2014/15: June only	64	10 (16)	178	27 (15)
Q2 2014/15	364	-	419	61 (12)
Q3 2014/15	275	44 (16)	589	93 (16)
Total	**703**	**-**	**1,186**	**181 (15)**
Estimated total 2014/15[h]	***1,205***	**-**	***2,033***	***310***

[h] FOT based on 7 months' data – June 2014, Q2 & Q3 2014/15.

CWPT Service Quality

The Care Quality Commission (CQC) is responsible for undertaking inspections of health services to inform judgements about their quality. Appendix 6 provides a summary of the key findings and action taken as a consequence of inspections led CWPT undertaken in January and July 2014, together with CCG and other external assessments reflecting the quality of CWPT services.

Other Services commissioned by Coventry & Rugby CCG and jointly commissioned services

Table 12 summarises mental health services commissioned by Coventry & Rugby CCG (including 3rd sector services jointly commissioned with the Council), with numbers of people supported and sums invested.

Table 12: Activity and investment for mental health services commissioned by Coventry & Rugby CCG/CRCCG & Coventry City Council (continued on next page).[i] Excluding CWPT

Service	Description	Provider	Commissioner	Investment	Number supported 2013/14	Number supported 2014/15
Bipolar UK	Coventry Peer Support Group - supporting individuals and families affected by bipolar		CCG	£1,000 (59%)	169	120
Arty-Folks	Therapeutic art provision, community involvement programme and asset building programme		CCG	£2,000 (6%)	120	N/A
Sahil Project	Asian community social inclusion project which works with people with mental health needs, through signposting to a range of services across the city, both local and city wide.		CCG Coventry CC	£68,224 (34%) £40,736	642	N/A
Coventry AIMHS	City wide user development and involvement service supporting adults and where appropriate young people in transition with mental health issues.		CCG	£69,848 (83%)	845	1,037
ASD support	Provides a variety of social and informal educational opportunities which encourage the young people to develop their confidence, self-esteem, social skills and understanding of their emotional health	C&W MIND	CCG	£17,063 (94%)		
SHARE (stress & anxiety management)	12 week stress and anxiety management programme for people needing support	C&W MIND	CCG	£37,306 (95%)		
Befriending service	Offers individuals a befriender with whom they can build a one to one focussed relationship, provides social support in the community for people who feel lonely and isolated	C&W MIND	CCG	£60,301 (100%)	55	N/A
Coopers Lodge day service	This project is designed to support those recovering from mental illness. It provides 'a range of centre and community based activities for people with enduring mental health support needs which are preventative, responsive to	C&W MIND	CCG Coventry CC	£47,843 (51%) £46,302	36 89(CCG)	173 (9 months to date)

[i] The Pod is also jointly commissioned, but has been included in Table 28 as it is provided by Coventry CC.

	need, within an anti-discriminatory and anti-oppressive environment'					
Drop in	Wellington Gardens drop in, signposting/info hub and outreach	C&W MIND	CCG Coventry CC	£77,152 (64%) £42,740	355 299(CCG)	378 (9 months to date)
Independent Advocacy Alliance	Statutory, hospital and community mental health advocacy service		CCG	£75,450 (15%)	180 Statutory 156 Hospital 204 Community	
GP counselling	Relationship/family/specialist counselling provided at various GP practices across Coventry by Relate counsellors	Relate	CCG	£36,626	143 Clients	
MH core funding	Used to fund/subsidise counselling for people who are on low income/benefits.	Relate	CCG	£16,186	769 Relationship Counselling 159 Sex Therapy Counselling	N/A
The Lighthouse	Professional counselling service to men and women of any age or race irrespective of ethnicity, gender, sexual orientation or personal beliefs, and covering wide a range of issues using a number of different counselling modalities.		CCG	£14,880 (16%)	432	385
Helpline	Independent charity managed and operated entirely by unpaid volunteers, who provide free confidential emotional support 24/7 (mainly via telephone) to anyone who is upset, troubled or feeling suicidal.	Coventry Samaritans	CCG Coventry CC	£4,398 (7%) £2,307	2,340 – CCG Telephone Calls 1,578 – CCC Telephone Calls CCG email requests – 91 SMS requests – 129 Personal callers - 61	2,808 - CCG 1,626 (provider estimate) – CCC CCG email requests – 109 SMS requests – 155 Personal Callers – 73

Mental Health Advocacy

This service provides support to users of specialist mental health services. Table 13 shows numbers of cases dealt with by the Independent Advocacy service in 2009/10 and 2013/14.

Table 13: Issues dealt with by the Independent Advocacy service: Comparison of 2009/10 and 2013/14.

Type of support	Number of cases			
	2009/10	2013/14	Spells ratio	Statistically significant (p-value)
Benefit support/appeals	36	78	2.17	Yes (<0.01)
Housing support (inc. housing benefit appeals)	28	48	1.71	Yes (<0.05)
Finance (inc. debt)	16	72	4.50	Yes (<0.01)
Legal issues (inc. family)	16	48	3.00	Yes (<0.01)
Care	30	36	1.20	No (>0.05)
Ward rounds	46	51	1.11	No (>0.05)
MH Act managers and tribunals	19	17	0.89	No (>0.05)

Services Commissioned by Coventry City Council

Table 14 summarises mental health services commissioned and/or provided by Coventry City Council, with numbers of people supported and amounts invested.

Community Services accommodation for Mental Health clients is summarised in Table 15.

Table 14: Activity and investment for mental health services provided or commissioned by Coventry City Council.

Service	Description	Provider	Investment	Number of people supported 2013/14	Number of people supported 2014/15
The Pod	Referral based service for clients with severe and enduring mental illness	Coventry CC		267	248
Clifton House Floating Support	Short-term assisted living and step down flats	Axholme services	£70,000	26	26
Floating and accommodation support services		C&W MIND	£690,000		
Tamarind	Mental health resource centre for BME groups. These include basic needs services such as friendship and information, access and referrals to a range of health, social care and support services and activities to reduce social isolation, develop skills and physical health and increase opportunities for people from ethnic minority groups		£101,264	272	297
Coventry Employment and Training Service (CETS)	Employment Support Workers who work across Coventry to provide advice for people with mental health problems on possible career opportunities, and create development plans to help individuals move towards their employment goals. Home support works with vulnerable people who are recovering from mental health issues but are living in their own home	Rethink	£85,495	195	163 (Q3 14/15)
The Employment Support Service (TESS)	Provides Individual Placement Support (IPS) to FACS eligible clients, referred by specialised mental health services	CCC	£160,000	N of referrals: 42 N supported into employment: 24 N supported into placements: 17	N of referrals: 47 N supported into employment: 26 N supported into placements: 24
Home support service		Rethink	£156,007		
Anjuman	Supports vulnerable adults to achieve independent living	Housing related support	£60,000		

Table 15: Community Services accommodation and costs, 2013/14 & 2014/15.

Type of Accommodation	Provider	Commissioner	Cost	Number of beds (CCC funded)	Investment 2013/14	Investment 2014/15
Residential	Aspect House	CCC- Circa	£900/week	12 bed (3 CCC funded)	Similar costs to 14/15	Circa £84k
Residential	Meadow House	CCC- Circa	£650/week	9 bed (3 CCC funded)	Similar costs to 14/15	Circa £96k
Residential	Holyhead	CCC- Circa	£650/week	30 bed (11 CCC funded)	Similar costs to 14/15	Circa £373k
Residential	Minster Lodge	CCC- Circa	£650/week	27 bed (15 CCC funded)	Similar costs to 14/15	Circa £477k
Residential	Out of city			Circa 51 people funded with a mental health need	Similar costs to 14/15	30 Adults OOC circa £1.8m 21 Older People OOC circa £989k
Housing with care	20 schemes (10 internal provided and 10 external Providers)	Circa	£200/week	Circa 19 people placed in city with a mental health need	Similar costs to 14/15	Circa £200k
Supported Living	Clifton House	Coventry City Council	£532/week	10 people (10 funded)	Same as 14/15	Gross exp £347k

10. Social care

Coventry City Council provides 'in house' services that support people with mental health problems. Further detail about these services is included in Appendix 7.

The numbers and demographics of mental health clients receiving assessments and packages of care through Social Care are shown in Tables 14a and 14b
The majority of clients access just one type of service/support - a minority have more complex needs.

Table 14a: Users of adult social care mental health services by sex - Coventry, 2011/12 to 2013/14.

	Sex: N (%)		
Period	Male	Female	**All**
2011/12	787 (47.9)	856 (52.1)	1,643 (100.0)
2012/13	669 (47.5)	739 (52.5)	1,408 (100.0)
2013/14	829 (44.0)	1,055 (56.0)	1,884 (100.0)

Table 14b: Users of adult social care mental health services by age group - Coventry, 2011/12 to 2013/14.

	Age group: N (%)			
Period	18-24	25-64	65+	**All**
2011/12	127 (7.7)	1,110 (67.7)	406 (24.7)	1,643 (100.0)
2012/13	54 (3.8)	933 (66.3)	421 (29.9)	1,408 (100.0)
2013/14	178 (9.4)	1,117 (59.3)	589 (31.3)	1,884 (100.0)

11. Overall Investment in Adult Mental Health by Commissioners

The overall level of investment by the Council and by the CRCCG in Adult Mental Health Services is as follows:

	CRCCG Total for Rugby	CRCCG Total for Coventry	CRCCG Total	CCC	Coventry Total
2011/12				5,843,717	N/A
2012/13				6,179,053	N/A
2013/14	7,729,658	38,672,921	46,402,579	6,153,725	44,826,646
2014/15	7,661,528	38,891,545	46,553,073	5,837,744	44,729,289

More details of the expenditure is shown in Appendix 8, but it can be seen that overall funding levels have been fairly stable.

12. Detentions Under the Mental Health Act

Use of the Mental Health Act 1983 allows someone to be admitted, detained and treated in hospital against their wishes if they have a mental disorder and are putting themselves or someone else at risk of harm. More detail of the more commonly used sections of the MHA is provided in Appendix 9.

Table 15 shows numbers of detentions under the Mental Health Act between 2008/09 and 2013/14 as recorded by CWPT. Over the period of 2008/09 to 2013/14 there has been an 84% increase in admissions as a consequence of use of the MHA and an 80% increase in total detentions under the act.

Table 15: Summary of CWPT detentions under the Mental Health Act (includes all ages & all commissioners).

Section	Year					
	2008/09	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Section 2	306	297	351	277	303	382
Section 2 (LD)	10	<6	14	12	17	12
Section 3	113	78	90	66	75	92
Section 3 (LD)	*<6*	7	*<6*	*<6*	*<6*	*<6*
Section 4	12	10	7	*<6*	*<6*	0
Section 136	N/A	N/A	N/A	289	277	323
Other Sections	*<6*	*<6*	*<6*	*<6*	*<6*	*<10*
Other Sections (LD)	0	*<6*	*<6*	*<6*	6	*<10*
Total Admissions	**447**	**403**	**466**	**659**	**687**	**824**
CTOs	44	61	46	59	71	59
CTO Recall	7	55	17	71	34	53
Revocations						
Discharges from CTO	0	18	21	28	33	31
Total Detentions (Admissions and CTOs)	**491**	**464**	**512**	**718**	**758**	**883**

13. Care in Crisis

The Crisis Care Concordat was published in February 2014 and is underpinned by 'Closing the Gap: priorities for essential change in Mental Health' which outlines a programme to deliver essential services for people who experience Mental Health Crisis and come into contact with emergency and acute services.

A local action plan has been developed based on an assessment of needs, outlining improvements required in relation to the following:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well / prevention

14. Mental Health Needs of People with LTCs and Physical Health Needs of People With Mental Illness

Long-term conditions and mental health

The two-way relationship between physical and mental health is well known. It is estimated that at least 30% of people with a long-term physical health condition (LTC) have a comorbid mental health problem.[11] Mental health problems can interact with and exacerbate physical illness, and hinder their treatment.[12] 12-18% of all NHS expenditure on LTC is linked to poor mental health and wellbeing, which equates to £8-13 billion in England each year; the lower estimate (£8 billion) equates to around £1 in every £8 spent on LTC.[13,14] Furthermore, the increased costs tend to be due to increased physical care costs rather than expenditure on mental health treatment, indicating that the costs of comorbidity are greater than the combined individual costs of physical and mental health conditions.[12]

In mid-2013, 330,000 people were estimated to be resident in Coventry, which is approximately 0.61% of the England population. Based on the figures above, this means there are approximately 99,000 (30%) with LTC – 29,700 (30%) of which have comorbid

mental problems. Taking the lower estimate of £8 billion spent in England each year on LTC and comorbid mental health problems, the cost of comorbid LTC and mental health problems in Coventry is estimated at least £6,100,000 per year

National Commissioning for Quality & Innovation (CQUIN) 2014/15: Improving Physical Healthcare to reduce premature mortality in people with severe mental illness

The average life expectancy of people with serious mental illness is 20 years less than that of their peers. This excess premature mortality is largely a consequence of cardiovascular disease, with increased likelihood of a poor diet, obesity, lack of exercise and smoking as contributory risk factors. Over recent years there have been increasing efforts both in primary care and in specialised mental health services to improve the physical health of those with mental illness.

The Quality and Outcomes Framework (QoF) provides an important lever for ensuring that the physical health care needs of those with Severe Mental Illness are met in Primary Care. Appendix 10 provides a summary of the achievement of Coventry and Rugby practices. For all of the indicators over half of GP practices are achieving the standard to obtain the maximum QoF points. However there is a large variation across the city and many practices appear to have a low proportion of patients receiving the specified intervention.

15. Stakeholder Engagement

This review incorporated a significant degree of stakeholder engagement. The views of service users and carers, health and social care commissioners, providers of mental health services, voluntary and community groups and wider public services were obtained using a range of different methods as described below.

Service users and carers

Service user and carer survey

A survey was conducted In February 2015 to obtain feedback on mental health services in Coventry from both service users and carers (see Appendix 11). Figure 34 summarises responses relating to specific characteristics of the service: safety, efficiency, responsiveness, how caring the service is, how well led it is, and whether people are aware of how to make complaints. The majority responded positively to all the questions, but a sizeable minority responded negatively or stated that they did not know.

Table 16: Themes from user and carer responses relating to characteristics of mental health services in Coventry: qualitative (continued on next page).

Theme	Sub-themes	What works well	What could be improved
Support	Professional support and resources	• Giving people as much time as they need; slowing down processes if necessary • Providing more intensive support as required • Advocating for the rights of service users • Providing safe spaces to meet	• Long periods without contact or support • Lack of knowledge among some staff regarding illnesses •
	Personalised support	• One-to-one sessions • Giving more 'tailored' options and opportunities that take into account the person's situation	• 'One size fits all' approach to therapy, e.g. CBT
	Peer support and social connectedness		• Creating social opportunities via services • Social events organised by members
Care pathways and access	Availability and accessibility of care	• Being able to phone for help 24 hours a day if needed •	• Long waiting times • Convoluted and confusing referral processes • Services that are available at a cost to the individual are not affordable to all
	Continuity of care		• Having to see different professionals from one session to the next makes it difficult to establish rapport and a full understanding of the person and their needs • Follow-up contact or feedback sometimes not fulfilled, leading to anxiety and worry for the service user • Too many changes in the system seen as detrimental to continuity and patient care
	Joined-up working	• Linking to other services, e.g. TESS,	

		Independent Advocacy	
	Termination of care		• Sudden withdrawal of care provision without explanation, leading to feelings of abandonment • Terminating one type of care without a suitable alternative
Empowerment	Putting people first	• Focusing on the person and not their illness • User-led services and discussions • Involving service users in creating their own care plans • 'Nothing happens without you'	• Too much emphasis on form-filling and targets, e.g. the Recovery Star
	Building confidence and resilience	• Making people aware of their potential and confident in their own ability to make positive changes • Providing a safe space to do this	• Not feeling 'safe' due to lack of consistency and continuity of care
	Practical skills	• Teaching new skills and enhancing existing ones through involvement in project work • Providing support with other areas of life, e.g. housing	
	Supporting independence	• Focusing on recovery and wellbeing • Encouraging people to think about the future and take positive risks • Enabling people to take control	
Interpersonal interactions	Compassion	• Friendly staff • Everyday actions that demonstrate genuine caring • Showing care towards family members	• Some respondents felt that there was a lack of care and compassion from staff, and that communication could be improved
	Respect	• Non-judgmental attitudes of staff • Protecting and making service users aware of their rights	• Lack of communication in decisions about care, e.g. termination • Service users' wishes not being respected in care decisions
	Equality	• No power imbalance between staff and service users • Staff being honest with service users	
	Empathy	• Services led and staffed by people with lived experience of mental health issues	• 'Formal' communication style • Lack of understanding among some healthcare

		• Staff who listen	professionals relating to the individual's experience of their condition, and also the impact on carers and family members

Service user focus groups

A focus group was held in February 2015 with service users and carers with the support of the commissioned provider of user support (AIMHS) and the Mental Health Advocacy provider. Through structured discussion participants considered the services currently available to them.

In general service users and carers valued services that:

- Provide peer support and a sense of belonging
- Connect service users to mainstream opportunities in the community
- Provide opportunities for education & involvement, that help users build confidence and feel valued

In commenting on factors that need to be improved, the group identified a range of factors including the need for:

- More information in mainstream settings e.g. Libraries, local newspapers and GP surgeries etc.
- GPs to be more aware of community resources/support that is available
- Earlier intervention and support helping people maintain their independence in particular in relation to welfare benefits and advice
- More self-help provision and less medicalisation where possible

In relation to preventing crises a number of points were noted including the following:

- There is a gap in support for those who may be experiencing what they feel is a crisis, but without imminent danger of suicide or self-harm.
- Prevention of crisis is helped through group support, sharing issues and problems.
- Doing voluntary work helps – having a purpose – helping people socialise.

The key points raised through discussion at the focus group are included in Appendix 12.

An additional focus group was held with the Recovery Forum. The Recovery Forum are a group of former and current service users who are recovering from addiction, many of whom also have received support from Mental Health services.

The group expressed the view that valuing community, promoting relationships and enabling people to find purpose was key to promoting well-being and they identified the 5 ways/10 ways to wellbeing as positive measures to be adopted by front-line services. They also recommended that public services should give continued recognition to the benefits of Assets Based Working.

With respect to services the group felt that more services need to be 24/7, 365 days and there needs to be more integration between services – and more generally an integration of services into the communities they serve (more ‘outreach’).

There was a general feeling that there are too many cracks between services and the group recommended that commissioners should seek evidence from providers that they are connected to each other and connected to communities. A summary of the key discussion points is included in Appendix 13.

Voluntary and community groups

A workshop was held in December 2014 which was attended by 22 voluntary and community groups with an interest in Mental Well-being and/or Mental Health services. In groups the participants discussed factors that promote or inhibit mental well-being, before considering the strengths and weaknesses of local Mental Health services.

In terms of improvement it was noted that well-being would be better supported if services took a more holistic approach to individuals and their circumstances.

The group also noted that there needs to be a mechanism for communication between third sector, health and social care and suggested the need for a partnership forum between integrated agencies, council, CCG, and MH service providers.

The group were of the view that the third sector is well placed to support prevention so individuals don't reach secondary care services and noted advantages in terms of reduced stigma for the use of such services.

A summary of the key discussion points is included in Appendix 14

Wider stakeholders: health, social care and wellbeing services

In February 2015 a group of wider partner agencies met to consider the factors that support mental well-being and where there is scope for improvement, alongside considerations of current mental health services.

With respect to mental well-being positive factors that were identified included social prescribing opportunities, healthy walks and a range of community activities. Things where improvement is required were identified as the need for increased choice for individuals and better and more diverse roots into volunteering, for example.

A range of views were expressed in terms of potential areas for improvement including better links required between some client groups and professional social worker support (for example troubled families) and a need for more advocacy support for Mental Health Service Users. A full summary of the main points raised during the workshop is included in Appendix 15.

16. Conclusions and Recommendations

It is recognised that the commissioning of services needs to be taken forward in the context of significant budget constraints and an emerging policy environment whereby parity of esteem for mental health clients is paramount.

The overall commissioning budget for adult mental health needs to be considered in the context of how the total spend on mental health across the life course can be deployed to best support improved outcomes. 50% of all mental illnesses start before 14 years of age yet nationally only 6% of the mental health budget is devoted to CAMHS services. As such commissioners need to consider the most appropriate balance between investment in children and adult services. It is also important to note the strong evidence base for interventions and support in the early years in supporting good mental well-being throughout life.

Further to this, adult provision needs to respond to agreed changes in CAMHS (for example the introduction of ‘flexible transition’ from children’s to adult services (between the age of 18 to 25) and explore options, for example, to develop family focussed ‘multi systemic therapy’ services (a proposed CAMHS 3.5 development)

There is a need to consider the extent to which services currently commissioned reflect the diversity of Coventry’s population and the more recently arrived communities.

There is an emerging consensus that from a client/patient’s first presentation the overall model of care and support should be integrated with primary, social, specialist and 3rd sector provision working collaboratively, each with the potential for appropriate intervention across the entire pathway. The introduction of ‘Centres of

Wellness' based in primary care and other community settings needs to be considered, possibly as part of the 'New Models of Care' envisaged for the NHS.

In general Mental Health Services need to be well-being and recovery focussed, promoting control and striving to achieve user defined outcomes by actively linking clients to mainstream support that empower them to be well (rather than the risk of supporting individuals to be 'content' with their mental health diagnosis). This can be achieved in part by enhancing links to existing individual, family and community assets.

There is a substantial body of evidence published by NICE to inform Mental Health service delivery. In addition to this evidence has been published on the cost-effectiveness of measures to prevent mental illness and to promote recovery from severe mental illness. A brief summary is included in Appendix 16.

In the context of the above and other factors, the recommendations which have been developed through consultation with a wide range of stakeholders, including an expert reference group, are set out below. These need to be considered by commissioners and in particular commissioners need to consider how the recommendations might be reflected in a Coventry (or Coventry and Warwickshire wide) Mental Health strategy.

Provisional Recommendations Include:

1. <u>Improved Population Mental Well Being</u>

1.1 Consider the need for a Mental Wellbeing or Public Mental Health Strategy or action plan to reflect needs across the life course drawing together recommendations from this review; the CAMHs redesign process and the dementia strategy.

1.2 Consider development of a multiagency suicide prevention strategy building on existing work including:

- CWPT review of unexpected deaths

1.3 Support further roll-out of MECC/10 ways to Well-being to all NHS, public and voluntary sector organisations (linking to emerging NHS plans to maximise prevention, as signalled in 5 year forward review)

1.4 Consider introduction of 'social prescribing' linking general practice to Asset Based Working opportunities – including the Community Development Service, Acting Early Programme, VAC Directory – building on the evidence (e.g. Rotherham) and the Rugby Pilot.

1.3 Continue to roll-out and support of Workplace Wellbeing Charter.

1.4 Consider introduction of the ‘Mindful Employer’ Programme to employers as an adjunct or alternative to the WWB Charter.

1.5 Consider specific programmes to promote workplace wellbeing and/or to provide workplace screening for depression and anxiety.

1.6 Extend COTM to benefit ‘at risk’ groups – such as young people’s groups.

1.7 Actively promote MWB through existing programmes, such as:

- Age Friendly City (reducing social isolation)
- Implementation of the Care Act
- Development of the carer’s strategy

1.8 Improve access and engagement of population groups in accessing parks and green space (Eco therapy)

1.9 In light of the recently commissioned review of WEMWBS and alternative measures of MWB, support development of the local evidence base for interventions.

1.10 Consider the need for local programme to tackle the stigma and discrimination associated with Mental Illness – linking into existing 3rd sector providers, MHFA training and actively promoting the ‘Time to Change’ campaign.

1.11 Consider the opportunity for prevention of mental illness through targeted provision of debt advice.

1.12 Explore opportunities to improve Mental Well-being and support to Mental Health service users through closer working with housing providers and considering continued measures to reduce fuel poverty.

1.13 Enhance behaviour change support – helping to identify psychological issues that underpin unhealthy behaviours.

1.14 Improve the ability of all Council policy and programme developments to enhance MWB through the introduction of a process to embed health impact assessment screening.

1.15 Consider the evidence base for the provision of mindfulness training for key population and professional groups.

2. <u>Prevention/delay in Mental Health problems</u>

2.1 Provide more personalised prevention/early intervention – including early access to support and benefits, housing, employment support; particularly welfare advice.

2.2 Secondary/specialist MH services to actively consider the family impact of parental mental illness, especially the impact on children and review the evidence for programmes demonstrated to be effective.

2.3 Increase access to social support (including community support and access to the advice of Social Workers) to individuals and families affected by:

- Domestic Violence (and other violence)
- Troubled families
- Alcohol/substance misuse
- Homeless

Building on the impact of newly introduced services such as street triage and liaison and diversion services and linking to future opportunities e.g. the proposed 'housing first' pilot.

2.4 Explore opportunities to build links between the commissioning and provision of drug & alcohol services and MH services.

2.5 Consider ways of meeting the psychological needs of all groups 'at risk' of and suffering from anxiety, depression, phobias etc. (currently excluded from or under-represented in IAPT services), to include:

- Those suffering from LTCs (including cancer)
- Refugees and asylum seekers
- LGBT groups
- Younger and older people
- Substance and alcohol misuse

Consider the introduction of collaborative care for depression in Type II diabetes and the case for introducing e-learning/self-management support for those with cancer (eg 'HOPE' Hoping to Overcome Problems Effectively).

2.6 Consider the evidence base for the use of technology in supporting population groups to maintain and improve their mental health.

2.7 Secure equitable access to culturally appropriate services for all population groups (reflecting City's ethnic profile)

2.8 Consider appropriate provision of early support for those with eating disorders.

2.9 Consider the scope to improve joint working between MH services and the City's universities in meeting the needs of students.

2.10 In relation to Crisis services, there needs to be:

- Better links between statutory and non-statutory and primary care service provision
- Improved integration of health and social services for older adults.
- A strengthened role for GPs in the management of crisis.
- A recovery approach to crisis.

3. Increased Rate of Recovery from Poor Mental Health

3.1 Review the scope to increase recovery from mental illness based on evidence of effectiveness/cost-effectiveness (eg. Knapp et al. 2014). This includes the provision of employment support for those with mental disorders – building on existing local evidence based provision (IPS model).

3.2 Review and enhance the management of physical health problems of those with mental health problems, building on the CWPT CQUIN and QoF related provision.

3.3 Consider the introduction of a 'Recovery College' as part of specialist provision linked to wider educational and employment opportunities in line with emerging national evidence.

3.4 Urgent and emergency access to crisis care needs to be reviewed as follows:

- Review capacity and remit of CRHT (in and out of hours) and scope potential increased involvement of the 3rd sector.
- Review the possibility for recurrent funding for street triage.
- Review capacity of Place of Safety in light of potential alternative pathways after S136 and potential need for a mental health urgent care centre.

4. Improved Treatment, Recovery and Inclusion

4.1 Commission recovery focussed services that promote co-production and client well-being – focussing on the achievement of user defined outcomes (utilising 'experts by experience' as appropriate) Discouraging providers from

'holding on' to mental health clients whilst acknowledging the support required.

4.2 Maximise opportunities for early detection and early intervention in psychosis.

4.3 Promote the referral of clients to safeguarding assessments and appropriate referral of carers for carers' assessments (link to Coventry City Council's Carers Strategy and NHSEs commitment to carers)

4.4 Support CWPT in responding appropriately to CQC and other external assessment findings and recommendations.

4.5 Strengthen the relationship with specialised services to understand the needs and opportunities to better support forensic clients returning to the city (recognising that treatment of such clients moves from a rehabilitation model to a personalisation model).

4.6 Promote care plans developed with users and carers and family that are based on a holistic assessment of needs incorporating social, spiritual and other personal needs.

4.7 Quality of treatment and care when in crisis:

- Consider development of 'web portal' to assist people to navigate the current system of care and support.

4.8 Improve the physical health of those receiving Mental Health services through promoting evidence based healthy lifestyle support (Public Health lead)

5. <u>Training</u>

5.1 Consider training all front-line staff (universal services) in Mental Health FA.

5.2 Consider undertaking a training needs analysis of GPs and other primary care staff in regards to their knowledge, confidence and skills in managing common mental health problems.

5.3 Consider commissioning RCGP approved suicide prevention training for GPs (and other staff as appropriate).

5.4 Review organisation/staff training needs in light of the recently published Public Mental Health Workforce guidance.

5.5 Consider offering training around 'care act awareness' for all frontline health and social care staff.

6. Governance

6.1 Consider introducing a partnership forum or board to engage commissioners (CCG, Social Care and Public Health) including social workers and GPs, with providers and service user representatives.

6.2 Consider implementation of integrated information system capturing assessment of needs, delivery of care and outcomes (e.g. using total mobile)

6.3 Further support the role of the Local Authority Mental Health champion.

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