Merton

Adult Mental Health Needs Assessment

2013-14

Public Health Merton

London Borough of Merton

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Contents

List of tables

List of figures

Executive Summary

Background

The Merton Adult Mental Health Needs Assessment was commissioned by the Merton Health and Well Being Board (MHWBB) as part of the wider Merton Mental Health Review, to analyse current and future mental health needs to inform commissioning of health, well-being and social care services within Merton.

Aims, objectives and methodology

The MMHNA (Merton Mental Health Needs Assessment) aims to:

- describe the size and nature of adult mental health conditions
- describe the nature and extent of health inequalities in both the distribution of mental health illnesses in the population, and in uptake of and access to services
- identify evidence-based interventions and best practice to tackle mental health issues
- describe current health and social care provision and how this compares with best practise interventions
- identify gaps in service provision and make recommendations about how to address them, particularly in relation to reducing health inequalities and inequity.

The MMHNA includes an in-depth data analysis, consultations with services users, carers and service providers, and a review of the literature.

The picture of adult mental health in Merton

Overall Merton does well on many measures of mental health. Merton CCG has lower spend and better outcomes for mental health overall. While the per capita spend on mental health in Merton is much lower than for other CCGs in our ONS cluster (Hounslow, Harrow, Ealing, Redbridge and Barnet) and England, the outcomes overall are good- suggesting that the investments are good value for money.

While Merton is a relatively young borough, the proportion of older people is going to increase. By 2017 there is forecast to be an increase of 2,900 people (11%) in the over 65 age group with an increase of around 1,500 in the over 90 age group[1]. Modelled prevalence indicates that the numbers of people with Common Mental Health Disorders (CMDs) and Severe Mental Illnesses (SMIs) will increase in the next five years, and so will the number of dementia cases. This will place constant and increasing demands on mental health services and underscores the importance of prevention work in mental health.

[1] Merton Joint Strategic Needs Assessment, 2013-14

Key points

Overall:

- Data suggests that there is under-diagnosis and/or under-recording of depression and dementia in primary care in Merton
- Where Merton is doing particularly well:
  - Recording the diagnosis of a mental health condition
  - Assigning patients to a mental health cluster
  - Having significantly lower A&E attendances for patients with psychiatric disorders
  - Having significantly lower number of bed days,
  - Having a significantly higher rate of carers of mental health clients receiving assessments
- Where Merton not doing so well:
  - Providing newly diagnosed depression patients with severity assessment at the outset of their treatment
  - Having a significantly lower rate than England average of recovery for IAPT treatment (percentage of people completing IAPT who have moved to recovery)
- Merton has a significantly higher than national average percentage of mental health service users that are in-patient in a psychiatric hospital and a significantly lower rate than England average, of people on Care Programme Approach (CPA)
- Merton also has a significantly lower rate of mental health clients receiving community, residential or nursing home care and a significantly lower rate of people in contact with specialist mental health services
- The number of people with mental health conditions is expected to increase in Merton over time for all conditions (Common Mental Disorders, Borderline Personality Disorder, Antisocial Personality Disorder, Psychotic Disorder, and Two or more psychiatric disorder)
- Merton CCG has the lowest reported prevalence of mental health disorders among SW London and statistically similar CCGs
- There are considerable variations in the prevalence of mental health conditions by GP practices and also comparing practices in East and West Merton
- Proportion of adults in contact with secondary mental health services living independently, with or without support is below the London average and the lowest among SW London boroughs. It is second lowest among statistical neighbours

For Common Mental Health Disorders (CMDs):

- Public Health England estimates that Merton has one of the highest percentages of 16-74 years olds estimated to have a common mental health disorder
- Merton has significantly lower than national averages for adults with depression known to GPs, new cases of depression; and lower than national average long term mental health problems, and depression and anxiety among GP survey respondents
- The rate of initial assessment of depression in Merton was significantly lower than the England average while the percentage of adults with a new diagnosis of depression with a follow-up assessment after 4-12 weeks was significantly higher
- Merton performs significantly lower than average at case finding for depression and has a significantly lower than average percentage of people with long term conditions visiting GP who felt that they have had enough support from local services in the last 6 months

For Severe Mental Illness (SMI):

- Merton has a significantly lower than average number of people with SMI known to GPs
- The rate of contact with services, and day care attendances are significantly lower than average
- Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital
- Schizophrenia emergency admission rate was significantly higher in Merton than the national average although the data quality had some concerns
- For the percentage of people in contact with mental health services with a crisis plan in place was significantly less in Merton compared with the England average
- Merton rates were significantly lower than the England averages for social care mental health clients receiving services during the year, mental health clients in residential or nursing care, mental health clients receiving home care during the year, and mental health clients receiving day care or day services
- 2012-13 QOF data suggests that there is room for improvement and considerable variance between GP practices overall and between practices in East and West Merton in terms of proxies for caring for the physical health of patients with schizophrenia

For dementia:

- The NHS dementia calculator gives the current diagnosis rate as 47% (2013/14) and a dementia gap of 1,057 cases for 2014/15
- In 2012-13, there were 870 Merton residents on the dementia register out of a total registered population of 217,803. This gives an overall GP recorded prevalence of 0.4% for Merton CCG. The England prevalence is 0.57%
- There is considerable variance between practices and East and West Merton for the observed to expected prevalence ratio

For mental health inequalities in Merton:

- Black ethnicities were over-represented in the in-patient population and Asians under-represented in both the in-patient and Community Mental Health Services (CMHS) populations. This could be indicative of the underlying risks of mental illnesses in different ethnicities- especially in the case of black ethnicities and/or more repeat admissions in this group, but in the case of Asians this very likely indicates an inequity in access, perhaps due to cultural taboos or other reasons
- A majority of in-patients and CMHS patients belonged to the most deprived areas of Merton and most patients came from East Merton
- The majority of patients from West Merton belonged to the least deprived areas
- In terms of referral rates to CMHS, white, black and other ethnicities have comparable referrals rates while the rate in Asians is statistically significantly much lower. For in-patients, Black ethnicities have the highest admission rates in Merton and this is statistically significantly different from admission rates for other ethnicities. Asians have the lowest rate and this too is statistically significantly different from admission rates in white and black ethnicities
- Apart from organic disorders where the least deprived patients have the highest proportion of cases, for all other the major diagnostic groups the more deprived patients have the higher proportion of cases, indicating a positive correlation between mental illnesses and deprivation

- In all the major primary diagnostic groups there are a higher proportion of patients from East Merton compared with West Merton

For patients in Merton:

- The three top causes for in-patient admission were schizophrenia, followed by psychoactive substances and then mood affective disorders
- The three top causes for CMHS referrals were mood affective disorders, followed by psychoactive substances and then schizophrenia
- Psychoactive substances were the second most common cause for both in-patient admissions and CMH patients in adults overall from 2008-13, as well as the second most common cause for admissions in working age adults. Additionally this category was the most common cause for referrals to CMH in working age adults. In both in-patient admissions and CMHS referrals for substance misuse, a significant majority were due alcohol

Qualitative data: Focus Groups and Semi-structured interviews

Qualitative work was undertaken to ascertain the experiences and views of adult mental health services users, carers and providers in Merton. The study took place between August and October 2013. In all 31 informants participated in the study.

For the most part, service users were critical of mental health services in the borough. This is by no means unusual and is typical of much of the user experience documented in the mental health literature.

Concerns raised in the study included the continuing attitudes towards mental illness, experience of care and cuts in services. Other issues included the closure of drop-in/day centres, perceived powerlessness to influence care and services dominated by a medical approach to treatment. Carers highlighted their lack of involvement in the decision making process. BAME service users and carers reported particular challenges which highlight the importance of developing cultural competence within mainstream services along with more targeted provision specifically. This is a priority for further investigation.

Key themes emerging from the experience of service users and carers included:

- relationships with health professionals and the need for more involvement and empowerment
- communication, including listening, talking and understanding
- cultural competence of the service
- comparisons with services in neighbouring boroughs, especially Sutton and Wandsworth, which are seen as providing better care and a wider range of services

What are the gaps in Merton?

1. **Equity issue: Under-representation of Asians and over-representation of black minority ethnic groups**
   Analysis of the data clearly indicates which groups are the most vulnerable in Merton and which groups needs to be therefore targeted more effectively. Black ethnicities are over-represented (in-patients) and Asians significantly under-represented (both in-patients and Community Mental Health Services-CMHS) in our mental health services. In the case of Asian communities this under-representation suggests inequity in access and cultural taboos and stigma associated with mental illness. In Black ethnicities the over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community. More targeted work is required with these communities and there is a need to develop services that are more accessible to BME groups- especially Asians.

2. **Services that address the dual diagnosis of substance misuse and mental ill-health and hidden harms**
   Psychoactive substances are the most common cause for community mental health referrals and the second most common cause for in-patient admissions in working age adults in Merton. The overwhelming majority of these were for alcohol related problems. The issue of dual diagnosis is a significant one for Merton - with so many admissions and referrals due to psychoactive substances, increased focus is required on prevention and early detection in addition to treatment. The 'hidden harms' aspects of this are likely to be considerable, i.e. the impact on children living with parent(s) with dual diagnosis. There could be potential safe-guarding risks, crime-related issues and a wider reputational risk to both London Borough of Merton and the NHS. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

3. **Personality disorders (PD)**
   Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

4. **Primary care variation by practice, variable quality outcomes and under-diagnosis**
   Findings suggest that in primary care there is considerable variation by practice, variable quality of outcomes and under-diagnosis. The 2012-13 QOF data for both depression and dementia suggest that at primary care level, there is under-diagnosis of both in Merton, and that there is considerable variation between GP practices especially when comparing the GPs in East Merton (where the data indicates even more under-diagnosis) with those in West Merton.

   While the latest HSCIC data on further assessment of depression severity is reported for 2011-12 and is for Sutton and Merton PCT, it suggests that we have the lowest

percentage of patients undergoing further assessment of depression in SW London, lower than some statistical neighbours and lower than England. 2012-13 QOF data suggests considerable variation by GP practices in Merton, and that in East Merton especially for MH 17 - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, and MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months- there are more practices which have low percentages compared to GP practices elsewhere in Merton.

NHS Dementia Prevalence Calculator indicates that the current detection rate of dementia in Merton is 47% (CQUIN data Q3 2013-14) which is better than many of our geographical and statistical neighbours but still means that there are estimated to be 1,057 undiagnosed dementia cases in Merton in 2014-15. There is an on-going refresh of the Merton dementia strategy to deal effectively with this.

5. Primary Care management of the physical health of Merton residents with schizophrenia

Findings suggest that more work is required to ensure the physical health of Merton residents with schizophrenia is better managed at primary care level. While emergency hospital admissions for schizophrenia in Merton are among the lowest in London and lower than all our SW London and statistical neighbours, the 2014 NEPHO SMI profile for Merton indicates that Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital and that Merton has a significantly higher than average (England) percentage of mental health service users who were inpatients in a psychiatric hospital. Local data indicates that admissions and referrals for schizophrenia are also increasing. This could be reflecting an increase in the prevalence of psychosis in Merton. HSCIC data indicates that in Merton the follow-up of non-attendance at annual review among patients with psychoses is among the lowest in SW London (especially considering that Kingston and Richmond PCTs achieved 100%), lower than Ealing and Harrow PCTs among statistical neighbours, and lower than England. For 2012-13 QOF indicators MH 16 (The percentage of patients aged from 25 to 64 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years) and MH19 (The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months) the GP practices in Merton do not perform very well and there is considerable variation between practices and by East-West Merton.

6. Referrals to community mental health services

In terms of referrals to community mental health services in Merton, 44% were from GPs & the next largest sources of referrals were internal (16%) and then Accident & Emergency services (12%). While it is encouraging that GP referrals were the highest, this could be improved further. Furthermore it appears that GPs in East Merton are making fewer referrals than West Merton GPs. There were fewer referrals from the Merton Local Authority (including Adult Social Care, Education & other departments) combined (2.6%) than Merton residents who self-referred (2.9%) . This perhaps indicates that more training and awareness raising is required for front-line staff (in all sectors

including Metropolitan Police) on detecting the signs of mental ill health, local services and pathways, and how and where to refer someone to. The DH policy "No Health Without Mental Health" states that frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health[2].

7. IAPT services

In terms of IAPT services, Merton has the lowest proportion of cases that moved to recovery in SW London and compared with the London average. From August 2012-August 2013, the recovery rate for Merton was 35.7% against a local target of 43% and a national target of 50%. This has been the case for some years as the NEPHO 2014 community MH profile indicates that in 2012/13 the IAPT recovery rate at 37.9% was significantly worse than England (45.9%). The percentage of referrals waiting less than 28 days for IAPT services are significantly lower than average but in contrast for waiting times greater than 90 days Merton has significantly higher than average percentages. This could mean that more referrals are waiting over 90 days than they are less than 28 days. Merton CCG is undertaking a specific project to look at the IAPT service and how it can be made more effective.

8. Smoking and mental health

Smoking and mental health have very strong and significant links. SWLStG MH NHS Trust has had a CQUIN on smoking since 2010-11 and this ends in March 2014. Data provided by the Trust suggests that an effective smoking cessation service had been established although it was unclear from the data what the disaggregated figures for Merton were. This service is meant to be mainstreamed into SWLStG MHT but there is a risk to the service till it is assured that this has indeed happened.

9. Gaps expressed by service users in consultations

Although the consultations in the qualitative study identified a variety of both positive and negative experiences of mental health services in Merton, the views expressed by service users and carers were for the most part critical. Service users' main concerns in this study were around continuing attitudes to mental illness, experience of care, and cuts in services. Their most prominently expressed issues with Merton's mental health provision were the loss of drop-in/day centres, perceived powerlessness in influencing their care and services that where dominated by a medical approach to treatment.

10. Gaps expressed by carers in consultations

The most important issues for carers were their poor involvement in decisions about the care, properly informed sessions, providing support in the areas of training in managing specific situations. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

11. Cultural competence of services

BME service users and carers reported particular challenges in different areas, exposing the importance of developing cultural competence within the mainstream services along

[2] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

with targeted provision specifically tailored to their unique needs. The data stated earlier, which shows that black ethnicities were over-represented and Asians significantly under-represented, back this expressed need. Furthermore this is specifically emphasized in the DH policy, "No Health without Mental Health"[3] and the implementation framework[4] which state that services should actively promote equality and must be accessible, acceptable, and culturally appropriate to all the communities. Public Bodies must meet their obligations under the Equality Act 2010.

Service providers offered insights into the main strategies they employed to deliver more user-responsive services. These were:

a. Adopting a more open and candid approach with users informed by the policy recommendations of the Francis report.
b. Established feedback and stepped complaints procedures
c. Developing different ways of working, and
d. Fostering partnership working.

Staff training and education underpinned all four approaches.

Health and social care recommendations

1. Promoting Mental Health and Wellbeing

1.1. **Promoting public mental health**

There is growing emphasis to promote mental wellbeing of the whole population, as well as an on-going commitment to reducing health inequalities in health (there are separate recommendations on health inequalities included in recommendation 4).

a. It is recommended that steps are taken to promote positive mental health and wellbeing and prevent mental ill-health, taking a life-course approach.

b. This encompasses taking a whole community approach to recovery, addressing factors that influence mental wellbeing for everyone, whether or not they have a diagnosis; and creating environments and cultures that support wellbeing from schools and colleges, to work places and on the streets.

1.2. **Smoking cessation and healthy lifestyles**

a. As of 31st March 2014, the CQUIN on smoking cessation services for SWLStG MHT will cease to exist. It must be ensured that the Trust embeds this service in line with NICE public health guidance PH48 and that an on-site stop smoking services continues to be provided.

[3] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf

b. Smoking cessation support to Merton residents with mental ill-health must also be provided by community-based and primary care service and mental health should be mainstreamed within general smoking prevention and cessation programmes in the borough.

c. It is recommended that all patients on GP Practice's SMI register who smoke should be routinely referred to LiveWell for smoking cessation advice.

d. It must be ensured that people with diagnosed mental illnesses, especially psychosis or schizophrenia and those taking antipsychotics are offered a combined healthy eating and physical activity programme by their mental healthcare provider[5].

e. The percentage of adults participating in recommended levels of physical activity is lower in Merton than the London and England averages and this percentage must be increased as the link between physical activity and mental health and wellbeing is well established.

1.3. **Promoting mental wellbeing early in life**

a. The most important opportunities for prevention of mental illness and promotion of mental health wellbeing lie in childhood, many of them in the context of the family. *The most important modifiable risk factor for mental health problems in childhood, and thus in adult life in general, is parenting*[6].

b. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating). Parental mental illness and parental lifestyle behaviours such as smoking, and drug and alcohol misuse are important risk factors for childhood mental health problems[7].

c. Schools offer another important opportunity for promotion and prevention. School, school ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health[8]. Mental health promotion programmes that can modify these factors, and also mitigate mental health problems initiated from within the family, must be provided in schools in Merton.

1.4. **Enabling more people with mental ill-health to remain in or move into work**

People with mental ill health frequently experience high levels of unemployment. Conversely people who are not in employment are more susceptible to mental ill health. For people with mental ill health who are unable to attend mainstream education, training or work, London Borough of Merton should ensure that commissioned services

[5] NICE Clinical Guideline CG 178: Psychosis and schizophrenia in adults: treatment and management, Feb 2014 http://www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf

[6] http://www.fph.org.uk/parenting

[7] Göpfert M, Webster J, Seema MV, (eds). Parental psychiatric disorder: distressed parents and their families. Cambridge, CUP 2004

[8] Weare K. Promoting mental, emotional, and social health: a whole school approach. Psychology Press, 2000

are effective in providing alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.

1.5. **Providing good quality housing**

a. There is an extensive body of academic, policy-related and community based literature that describes the powerful nature of housing as a social determinant of population health. The relationship that exists between poor housing (or a lack of housing) and poor mental and physical health is well-documented[9][10]. The spectrum of accommodation in Merton, from high to low dependency and independent accommodation for people with mental health need should be reviewed, in order to establish the current needs, to enable forward planning for the future provision of housing and support options for people with mental health needs.

b. LBM should consider how Merton can benefit from the Department of Health recently allocating up to £43 million from the Care and Support Specialised Housing (CASSH) Fund[11] to support the construction of a small number of housing projects for people with mental health problems or learning disabilities. These projects will be designed in close conjunction with mental health and learning disability policy experts and representatives of relevant charities. Their ambition is to receive bids from potential developers by 2015 and seeing some homes available by 2017.

1.6. **Workplace wellbeing**

a. All employers in Merton (including in LBM and MCCG) should be sensitive to the potential mental health issues underlying sickness absence. They should ensure adequate occupational health provision, and through employee assistance programmes, employees are supported to prevent the build-up of unmanageable stress, and healthy workplaces are actively promoted. Evidence states that workplace screening for depression and anxiety disorders is cost-effective, with the benefits gained through the reduction in levels of absenteeism, and improved productivity through reduction in presenteeism.

b. Public Health Merton is currently developing a Merton workforce strategy based on absence research that is looking at the reasons behind the sickness absence rates in the London Borough of Merton (Council). Work related stress comes up in the findings as an important reason. It is recommended that the findings of this report are taken into account while considering measures to create a healthy workplace.

[9] Jacobs DE, Wilson J, Dixon SL, Smith J, Evens A. *The Relationship of Housing and Population Health: A 30-Year Retrospective Analysis Environmental Health Perspectives*. 2009;117(4):597–604

[10] Canadian Institute for Health Information. *Improving the Health of Canadians: Mental Health and Homelessness*. Ottawa: Canadian Institute for Health Information; 2007.

[11] Closing the gap: priorities for essential change in mental health, February 2014; Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

2. Parental and child mental health

The following generic recommendations are sourced from national policy documents[12] [13] and it is suggested that the Merton Local Safeguarding Children's Board (LSCB) partners should assure themselves and the LSCB that these are embedded in local practice.

2.1 **The Local Safeguarding Children's Board (LSCB) should assure that**:

Structures are in place for joint training and joint supervision to ensure that all children's and adult services practitioners working with families affected by mental health difficulties and/or drug and alcohol problems have a thorough understanding of the impact of these difficulties on children and the opportunity to reflect together on their joint responsibilities in tackling concerns.

2.2 **Adult mental health services should:**

a. increase awareness of the role of adult mental health professionals in safeguarding the children of adult service users.

b. orient early identification and assessment to ensure children and young people living with parental mental illness, learning disability, substance misuse and domestic violence, are not left in dangerous and abusive situations. Early identification depends on ensuring children and young people have opportunities to discuss their experiences with a trusted adult

c. review recording systems to ensure that information about children is set out clearly and in sufficient detail to establish children's needs and risks, to identify young carers and to assess whether there is a need for early support

d. collate data and report to the LSCB on the numbers of children affected by adult mental health difficulties

e. ensure that managers are aware of all cases in which adults with mental health difficulties have children, or where there are children in the household, and that all these cases have appropriate and recorded oversight.

2.3 **Commissioners of adult mental health services should:**

a. ensure that the role of adult mental health services in safeguarding and protecting children is set out comprehensively and explicitly in all relevant tender documents and in contracts

b. have systems in place to monitor the extent to which adult mental health services meet their responsibilities to safeguard and protect children

[12] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems; Ofsted March 2013, Ref no. 130066.

[13] Cleaver H, Unell I and Aldgate J; Children's Needs- Parenting Capacity, Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence; 2nd Edition, TSO (The Stationery Office); Norwich, 2011.

c. Ensure stable funding for voluntary and community based programmes is required to provide the necessary long-term support to ensure children living with families with complex needs are safe

2.4 **Adult mental health services and drug and alcohol services should**:

a. ensure that practitioners consistently challenge decisions by children's social care to take no further action if in their judgement action is warranted, using escalation processes where necessary

b. review recording systems to ensure that children and young people who are undertaking inappropriate caring responsibilities for parents or siblings are identified, and that their needs are explicitly considered and referred for support when necessary

c. ensure that adult assessments consider the need for early support for parents, carers and children and that action is taken to put this in place.

2.5 **Local authorities (Adult and Child Social Services), mental health services and drug and alcohol services should:**

Ensure that staff liaise with each other and agree a joint plan of action when parents or carers do not attend appointments with adult services.

2.6 **Local authorities (Adult and Child Social Services) and mental health services should**:

a. improve the quality of assessments of the impact of mental health difficulties on children, ensuring that children's social workers and adult mental health practitioners work together to assess and agree effective action plans

b. review arrangements for discharging patients from hospitals to ensure that discharge meetings involve children's social workers where appropriate; that the needs of the children are considered and that discharge plans set out clearly when/if parents or carers will be ready to resume the care of their children.

3. Tackling Dementia in Merton

3.1. **Supporting the Dementia Hub**

With the launch of the Dementia Hub in Merton[14] it must be ensured that relevant services are aware of this centre and how patients with dementia can be referred to it. This is particularly applicable to GP practices as GPs have a pivotal role to play in the early detection and referral of residents of Merton with dementia.

3.2. **Dementia awareness and training**

Dementia awareness and training sessions with relevant services, especially in primary care must be organised in a rolling programme that is repeated at regular intervals.

14 http://www.alzheimers.org.uk/site/custom_scripts/branch.php?branch=true&branchCode=13596&areaBC=EALO

3.3. **Dementia strategy refresh**

The current five year dementia strategy (for Sutton and Merton) which is due to end in 2015, must be refreshed to reflect the current organisational changes in health and social care, and the dementia strategy implementation plan must be updated.

3.4. **Preventing dementia**

Awareness must be raised of evidence-based measures to prevent dementia (the six pillars of a brain-healthy lifestyle: regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life[15]) to relevant services, professionals and lay public in Merton. Community-based projects or pilots to prevent dementia and promote dementia awareness should be considered.

4. Improving services for people with a dual diagnosis of substance misuse and mental ill-health

4.1. **Early identification of dual diagnosis and prevention work**

Developing &/or strengthening services should be considered, to ensure that dual diagnosis of substance misuse and mental ill health is identified early and that there are clear eligibility criteria, referral and care pathways, and robust outcome measures for dual diagnosis

4.2. **Joint service provision and pathways for dual diagnosis**

a. Joint commissioning of mental health and drug or alcohol services needs to become the norm in the areas of general health, mental health, substance misuse (including alcohol), social care, education, community safety, crime (including domestic violence) and safeguarding in both children and adults, linking promotion and prevention much more closely with treatment and care for substance use and mental health.

b. To ensure 4.2a above, all contracts with providers need to stipulate effective joint working and clear pathways, to meet the needs of people with co-existing mental health needs and substance misuse problems.

4.3. **"Hidden harms" of substance misuse**

LBM is planning a needs assessment on Hidden Harm in Merton. It is recommended that appropriate services are jointly developed; to tackle hidden harm and support this needs assessment, considering its recommendations in the development of this work. A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

4.4. **Personality disorders (PD)- with and without dual diagnosis**

Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better

[15] http://www.helpguide.org/elder/alzheimers_prevention_slowing_down_treatment.htm

access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

5. Addressing Health inequalities and inequity

5.1. **Black and Minority Ethnic groups**

The findings from this report indicate that black communities are over-represented in in-patient services (but not in CMHS) and Asians are significantly under-represented in both in-patient and community mental health services. A range of early intervention and support services should be considered that are culturally sensitive to Merton's BME groups that promote mental health wellbeing and reduce stigma. The services should be targeted and outcome specific.

5.2. **Local care pathways**

It should be ensured that local care pathways promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system and ex-service personnel.

5.3. **Services for older people**

a. It has been estimated that at any given time in a typical 500-bed district general hospital, 220 beds are occupied by older people with mental health problems: 102 with dementia and 96 with depression[16]. Services and pathways should be developed to address the specific needs of older adults in Merton and these services should be appropriate for this age group, helping to reduce the demand on acute beds by increasing care for the frail and elderly in community settings, providing a holistic assessment in the community, and ensuring that both mental and physical health are addressed..

b. Rather than the current generic system in Merton, a specialist liaison psychiatry service for older people based in acute hospitals could be developed. Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates[17].

c. Development in this area should be linked with the on-going integration work in Merton under the Better Care Fund.

[16] Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H, Seymour J (2009). The Need to Tackle Age Discrimination in Mental Health: A compendium of evidence. London: Faculty of Old Age Psychiatry, Royal College of Psychiatrists. Available at: www.rcpsych.ac.uk/pdf/Royal%20College%20of%20Psychiatrists%20%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf

[17] Naylor C, Bell A (2010); Mental Health And The Productivity Challenge, Improving quality and value for money; The King's Fund and Centre for Mental Health.

6. Improving engagement with and support for service users and carers

6.1. **Education and Training of front-line staff**

It must be ensured that frontline workers, across the full range of services, are trained to understand better about mental health, the principles of recovery and are able to tackle any stigma related to mental health. Furthermore training must be provided on the services that exist in Merton, the care pathways and how to refer a person to the appropriate mental health services.

6.2. **Education and Training of healthcare professionals in primary care**

Healthcare professionals in primary care including GPs need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health. Consultations with service users revealed that primary care professionals were perceived by some to have an inadequate understanding of mental illness, and service users reporting a negative experience on the whole.

6.3. **Carer needs**

Consultations with carers revealed that pro-active information-sharing and guidance, their involvement in decisions about the care provided, properly informed sessions and providing support/training in managing specific conditions were the most important issues for them. Feedback from the carers indicated that these arrangements and provisions were not as good as they needed to be. It needs to be ensured that these provisions are improved for carers. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

6.4. **Enabling access to services for Merton residents with mental health conditions**

Service users and carers in our consultations felt that not having the Freedom Pass severely limited their ability to get around and could contribute to a worsening of their problems. Many mental health service users are not in employment or on low incomes and they struggle with the cost of transport. It is recommended that the London Borough of Merton takes steps to enable Merton residents with mental ill-health to access services that are so vital for their wellbeing, bearing in mind that the Freedom Pass is no longer available.

7. Primary care and IAPT services

7.1. **Variation in quality and under-diagnosis in Primary Care**

Variations in quality and under-diagnosis need to be understood in greater depth (i.e. how much is due to differences in coding and how much is actual) and minimised in primary care, particularly in GP practices in East Merton. In the consultations in this needs assessment both service users and carers expressed the view that health services continue to give less attention to mental illnesses than to physical illnesses and primary care professionals had an inadequate understanding of mental illness. Health professionals in primary care (including GPs) need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health.

7.2. **Physical health of Merton residents with mental ill-health**

The physical health of Merton residents with mental health conditions needs to be monitored regularly. NICE guidance CG 178 recommends that GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The physical health of patients with schizophrenia in particular needs to be better managed in Primary Care.

7.3. **Transfer of care from secondary to primary care**

The transition between secondary care and primary care in relation to all mental illnesses but specially schizophrenia must be well managed.

7.4. **Primary Care integration**

There must be more integration of mental health related services in primary care between health, social care, housing, employment, legal services and community services. This includes greater integration between physical and mental health, and the early identification of illness and comorbidity, reduced stigma, and social inclusion.

7.5. **Psychological therapies**

There are a number of issues around the current IAPT service that are being addressed by the Merton CCG. These include consistently low recovery rates against local and national targets, and the profile of cases being seen tending to belong to the more severe spectrum of mental disorders. Merton CCG is undertaking a specific programme of work that is reviewing the IAPT service and considering how to make it more effective.

8. Improving rehabilitation and stepped down provision

8.1. There is a need to undertake a more detailed piece of work to understand the current step-down provision from acute services when patients are well enough to be discharged from an acute bed but not well enough to live independently at home. This work will help to consider alternative options and to design a provision that is fit for purpose, mindful of the principle of “Right Care at the Right Place” and commissioning services closer to home and in the least restrictive environment.

8.2. Co-ordinated working with LB Merton will be required to understand the demand and capacity for step-down placements for social care needs, including housing.

9. Areas where more research required

While this report covers a wide expanse of issues pertinent to adult mental health in Merton, there are some areas that are not covered and need more work. These areas are learning disabilities, the interface between children and adult mental health services (especially the transition) and in general there is need for a CAMHS health needs assessment.

Beyond the MMHNA: Next steps

The MMHNA will be reported to the MHWBB in September 2014, and form part of the evidence base for commissioning future mental health services for Merton residents.

A workshop was held with service users, carers, voluntary sector and community organisations, and statutory organisations including key providers, commissioners and mental health professionals in Merton. Hosted by the LBM and MCCG and facilitated by Merton Healthwatch, this workshop obtained views and facilitated discussion about the MMHNA findings. Feedback from participants (see supplementary report) will also support the future commissioning of mental health services in the Borough.

It is planned to have regular workshops with users and carers regarding mental health services to ensure commissioners hear live messages, and progress on commissioning and service delivery is shared.

Introduction

Mental illness is generally applied to conditions on a spectrum ranging from those almost entirely managed in Primary Care to conditions that are almost exclusively managed by specialists. The link between mental health problems and social exclusion is intricate and well documented. Mental ill-health can be both the cause and the consequence of social exclusion leading to a vicious cycle of homelessness, unemployment, and worsening physical and mental health.

One in four people in the UK will experience a mental health problem in the course of a year. The cost of mental health problems to the economy in England have recently been estimated at £105 billion each year and treatment costs are expected to double in the next 20 years (NEPHO). In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder (including self-inflicted injury), compared with 16.2% for cardiovascular disease and 15.9% for cancer, as measured by Disability Adjusted Life Years (DALYs)[18]. Depression alone accounts for 7% of the disease burden, more than any other health condition. It is predicted that by 2030, neuropsychiatric conditions will account for the greatest overall increase in DALYs[19].

The Department of Health launched the strategy 'No Health Without Mental Health' (DH 2011) which takes a cross government approach, including promoting mental wellbeing, reducing stigma and a focus on improving outcomes for people with mental illness.

Health inequalities in mental health

Research shows that different ethnic groups have very different experiences of mental distress and recovery. They may have higher rates of incidence than other groups, different routes into and out of treatment services, and different outcomes afterwards.

There is evidence that much of the variation amongst ethnicities can be attributed to associated factors, such as income, employment, lifestyle and physical health. Other factors associated with ethnicity include discrimination, experiences of migration and traumatic events. Culturally determined beliefs about age and gender roles, the meaning of health and wellbeing and levels of stigma associated with mental ill health and treatment services are influential[20].

However, different rates of mental ill health remain for some groups even after taking many of these factors into account. For example, White populations have the highest rates for suicidal thoughts, self-harm and alcohol dependence[21]; and rates of schizophrenia are

[18] World Health Organization (2008) Global Burden of Disease Report. WHO http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html

[19] World Health Organization (2004) Projections of Mortality and Global Burden of Disease 2004–2030. WHO

[20] Choosing Health: Supporting the physical health needs of people with severe mental illness – commissioning framework, Department of Health, August 2006.

[21] McManus S, Meltzer H, Brugha T, et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics. http://discover.ukdataservice.ac.uk/catalogue?sn=6379

higher among Black Caribbean and Black Africans compared with the White British population and after adjustment for socioeconomic status and age[22].

Another way in which ethnicity impacts mental ill health is through the different ways in which groups of people tend to access and experience services. In general, people from black and minority ethnic groups are more likely to enter the mental health services at a time of crisis or breakdown. They are more likely to be referred via the courts or the police rather than by a GP, and more likely to receive medication rather than talking therapies such as psychotherapy. Afro-Caribbean people in particular are more likely to be detained in hospital under the Mental Health Act and more likely to experience poor outcomes from treatment[23].

Similar to the differences in disorder between ethnicities, there is some evidence that mental ill health can vary based on gender and sexuality. For instance, eating disorders are more common among women throughout life and there is a higher probability of PTSD (Post Traumatic Stress Disorder) in all female age groups excluding 16– 24 years[24]. Analysis of a large UK-wide sample of adults found that people who identify as non-heterosexual have higher rates of unhappiness, anxiety and depression. They are also more likely to suffer from obsessive–compulsive disorder, phobic disorder, psychosis and acts of self-harm[25]. Research has found that the rate of suicide attempts is twice as high in non-heterosexual individuals and particularly high for non-heterosexual men[26]. Use of alcohol, drugs and cigarettes are also higher among some gay, lesbian and bisexual groups[27].

The reasons for the differences in mental ill health by ethnicity, gender, sexuality, and wider determinants are complex, poorly understood and confounded by many factors- such as the impact of social stigma and discrimination.

The key inequalities experienced by people with mental health problems are:

- Low levels of employment: less than 25% of people with mental ill-health work though many would like to do so. Of those with severe and enduring mental illness, 58% are capable of employment. During long-term unemployment, mental health can deteriorate thus further reducing the chance of gaining work
- Social exclusion might arise through stigma, discrimination and difficulties in maintaining social and family networks
- Barriers to accessing health services: the Social Exclusion Report (2004) indicated that 44% of people with mental ill health were dissatisfied with their GP because their physical health problems/symptoms were dismissed as a mental health issue

[22] Kirkbride JB, Barker D, Cowden F, et al (2008) Psychoses, ethnicity and socioeconomic status. Br J Psychiatry 193:18–24. http://www.ncbi.nlm.nih.gov/pubmed/18700213
[23] Mental Health Foundation. http://www.mentalhealth.org.uk/help-information/mental-health-a-z/B/BMEcommunities/
[24] Health & Social Care Information Centre. Adult Psychiatric Morbidity Survey - 2007. http://discover.ukdataservice.ac.uk/catalogue?sn=6379
[25] Chakraborty, A. et al. Mental health of the non-heterosexual population of England. British Journal of Psychiatry, Vol.198, February 2011, pp. 143-48. http://bjp.rcpsych.org/content/198/2/143.abstract?ijkey=9a44090b64de0d1e6b721de2c486615518710560&keytype2=tf_ipsecsha
[26] King, M. et al. A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. BMC Psychiatry, Vol. 18, August 2008, 8:70.
[27] Chakraborty, A. et al. Mental health of the non-heterosexual population of England. British Journal of Psychiatry, Vol.198, February 2011, pp. 143-48.

- Poorer physical health and increased mortality from some diseases. This may result from misdiagnosis of physical ailments; reluctance or inability to access health services; and unhealthier lifestyles, for example poor diet, less exercise and higher levels of smoking

The last two bullet points above point to key inequalities in physical health for people with serious mental health problems are:

- On average, a person with schizophrenia is at risk of dying on average twenty years prematurely[28] [29].
- Studies which examine prevalence of smoking within individual mental disorders have found a prevalence of 40% to 50% in people with depressive and anxiety disorders and 70% in people with schizophrenia[30]. The 2010 Health Survey for England found that smoking prevalence amongst people with a long standing mental health disorder was 37%[31] compared to 20% in the general population[32].
- Approximately 30% of people misusing drugs have mental health problems. In one study, half of alcohol dependant adults said they had a mental health problem[33].
- People with Severe Mental Illnesses have twice the risk of diabetes compared with the general population[34], 2-3 times the risk of hypertension and 3 times the risk of dying from coronary heart disease[35].

The inequalities described above are present and often more severe amongst people in Black, Asian and Minority Ethnic (BAME) groups with mental health problems. Additional inequalities include[36]:

- Increased risk of hospital admission and coercive care under the provisions of the Mental Health Act 1983
- Greater difficulty accessing mental health assessment and treatment
- Higher levels of dissatisfaction with mental health services
- Greater likelihood of considering their diagnosis inappropriate
- Greater likelihood of having medical problems misattributed to mental health

A recent report by Rethink "Lethal Discrimination", published in September 2013[37] found that:

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[28] Brown S, Kim M, Mitchell C and Inskip H., 2010. Twenty-five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry 196 pp 116–121.

[29] Parks J, Svendsen D, Singer P et al., 2006. Morbidity and Mortality in People with Serious Mental Illness. 13th technical report. Alexandria, Virginia: National Association of State Mental Health Program Directors.

[30] Olivier D, Lubman DI, Fraser R. Tobacco smoking within psychiatric inpatient settings: biopsychosocial perspective. Aust & NZ J Psych 2007; 41: 572-580

[31] The NHS Information Centre. Health Survey for England 2010. Published Dec 2011.

[32] McManus S, Meltzer H & Campion J. Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey 2007. National Centre for Social Research, Dec. 2010

[33] Mental Health and Social Exclusion: Social Exclusion Unit Report, June 2004. Office of the Deputy Prime Minister, London.

[34] Royal College of Psychiatrists, 2013 'Whole person care: from rhetoric to reality. Achieving parity between mental and physical health', Occasional paper OP88.

[35] Osborn, DPJ., 2007 Physical activity, dietary habits and coronary heart disease risk factor knowledge amongst people with severe mental illness: a cross sectional comparative study in primary care. Social Psychiatry Psychiatric Epidemiology pp 787-93.

[36] Mental health crisis care: commissioning excellence for black and minority ethnic groups: A briefing for clinical commissioning groups, March 2013; Mind UK. http://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf

[37] Rethink, 2013. http://www.rethink.org/get-involved/campaigns/lethal-discrimination

- More than 40% of all tobacco is smoked by people with mental illness, but they are less likely to be given support to quit.
- Fewer than 30% of people with schizophrenia are being given a basic annual physical health check.
- People gain an average of 13lbs in the first two months of taking antipsychotic medication and this continues over the first year. Despite this, in some areas 70% of people in this group are not having their weight monitored.
- Many health professionals are failing to take people with mental illness seriously when they raise concerns about their physical health.

Cost of mental ill health in London

The Greater London Authority published a paper early this year, 'London Mental Health: The invisible costs of mental health'[38]. The paper attempts to analyse the wider economic and social impacts of mental ill health and quantify in economic terms impacts including those that are beyond the usual measures of economic output (Gross value Added- or GVA) and include amongst other things, the "non-market" impacts such as quality of life from mental ill health. The wider impacts of mental ill health result in around **£26 billion** each year in total economic and social costs to London.

In adults in London, a simple comparison of the QALY (Quality Adjusted Life Years[39]) index values between those with at least moderate anxiety or depression and those without shows that the former group have QALY index values around 0.29 lower. Some of this difference can be attributed to a higher incidence of other health problems in those with depression or anxiety. The London figures suggest that individuals with anxiety or depression have around 1.3 other health problems (out of a maximum of 4), compared to just 0.4 among those without- giving an indication of co-morbidities being higher in those with anxiety or depression. When the QALY loss is adjusted for these co-morbidities, the estimated loss of QALYs due to depression and anxiety is 0.13 rather than 0.29. In other words an adult in perfect health will enjoy a QALY of 1 for each year s/he spends in that state. In comparison a person with depression or anxiety (and no other illness) will experience a QALY of 0.87 for each year s/he spends in that state.

The human component (that is the intrinsic enjoyment of life) of a QALY has been valued at around £42,000 per QALY in current prices. Therefore, the human costs resulting from the average QALY loss of 0.13 are valued at around £5,000 per year. Given that an estimated 1.1m adults (15.9% of those aged 16 and over) in London have a common mental disorder, the overall scale of quality of life losses due to poor mental health is therefore substantial at around **£5.75bn** for the estimated 138,000 QALYs lost each year in London.

[38] London Mental Health: The invisible costs of mental ill health; Greater London Authority, January 2014 http://www.london.gov.uk/sites/default/files/Mental%20health%20report.pdf

[39] This is a measure of the quality of life a person experiences. It is a validated measure based on respondents in the 2011 Health Survey of England rating five components of health related quality of life (mobility, self-care, usual activities, pain/ discomfort, anxiety/ depression) on a three point scale (No Problems (1), Moderate Problems (2), Extreme Problems (3))- resulting in a QUALY score for different health states. For example, a person with no problems on any of the dimensions would have an index value of 1 (referred to as one 'quality adjusted life year' or QALY- a year of life in perfect health), but if they were to develop moderate anxiety or depression their index value would fall to around 0.85, suggesting the health related quality of life they experience had declined by around 15%.

Impact of worklessness due to CMDs (Common Mental health Disorders)
Increased level of worklessness has costs at the individual level, as being out of work is associated with lower income and therefore reduced consumption and quality of life. There are also costs at the societal level, as fewer people working means that there is less output produced in the economy. Based on 22% of 5.6 million working age adults in London experiencing some form of anxiety or depression, this produces an estimate of lost output related to poor mental health in London of around **£3.5bn**. Alternative ways of measuring this show the lost output due to CMDs varies from **£5.49bn to £7.55bn** in London each year.

Increased sickness absence
More than a third of sickness absence days are due to stress, anxiety and depression, making these conditions more common causes than musculoskeletal disorders or infectious diseases. The estimated lost output from mental ill health related sickness absence ranges from **£0.92 to £1.08bn** per year in London.

Reduced productivity
Reduced productivity due to individuals attending work despite ill health is often referred to as presenteeism. Reports looking at the cost of mental ill health, such as the Sainsbury Centre for Mental Health (2007), have often assumed that 1.5 times as many working days are lost due to presenteeism as are lost due to mental ill health related absences. Value of the lost output for London each year for this is estimated around **£1.62bn to £1.89bn**.

Lost output due to premature death
In London in 2011 there were 583 suicides of individuals aged 15 or over[40]. Department for Transport (DfT) research[41] suggests that the lost output resulting from a suicide is worth around £0.58m on average. This means that the total cost of suicides in London in 2011 was around **£0.34bn** in terms of lost output alone. Additionally the total estimated annual cost of lost time due to transportation delays resulting from suicide attempts is around **£16.5m**.

Value of informal care
One of the more significant external economic costs of mental ill health in London comes through informal care provision. The 2009/10 GfK[42] NOP Survey of Carers in Households[43] reports that around 10% of adults in London, approximately 670,000 people are carers. The survey also reports that, for the whole of England, mental health problems are the reason for the care in around 13% of instances. Assuming this pattern broadly holds for London, there are an estimated 88,000 people providing informal care to others due to a mental health issue.

The same survey reports that carers spend an average of 32 hours each week providing care. This equates to around 1,700 hours per carer per year. If valued using the median care assistant wage in London, this represents care worth almost £14,000 per carer and an

[40] ONS. Suicides in the UK, 2011. – http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-288089
[41] Department for Transport, 2011. The Accidents Sub-Objective. – http://www.dft.gov.uk/webtag/documents/archive/1208/unit3.4.1.pdf
[42] GfK NOP is the name of the private company that did this survey.
[43] HSCIC, 2010. Survey of Carers in Households. – http://www.esds.ac.uk/doc/6768/mrdoc/pdf/6768_survey_of_carers_in_households_2009_10_england.pdf

estimated **£1.21bn** for the overall cohort of individuals providing informal care for people suffering with mental health problems.

Crime related
The economic costs of crime, lost outputs due to crime, property damage, theft and anticipatory spending related to crime related to mental ill health amounts to approximately **£1bn** a year in London.

Additionally the real resource cost to society from mental ill health (the actual public expenditure on mental ill health) ranges from **£6bn to £7bn**.

Economic and social costs: totals
The total economic and social costs of mental ill health in London are clearly substantial at an estimated £25bn to £27bn annually. **This equates to approximately £2,990 to £3,210 per person in London per year** and is equivalent to around 8.9 to 9.5% of London's GVA[44]. (This includes the cost of mental ill health in children and young people).

Co-morbidities in mental illness- physical ill health and mental ill health
Comorbidity is the presence of two or more conditions in a person at the same time. This could also mean more than one mental illness. The Institute of Public Care (PANSI) estimates that just under a quarter of adults (23.0%) meet the criteria for at least one psychiatric condition. Of those with at least one condition: 68.7% meet the criteria for only one condition, 19.1% meet the criteria for two conditions and 12.2% meet the criteria for three or more conditions. This means that in London, as many as 484,800 adults may have more than one mental health condition[45].

People experiencing a physical health condition are also more likely to suffer mental ill health. Thirty per cent of the population have one or more chronic or long-term physical conditions, such as diabetes, arthritis or HIV/AIDS. The presence of a long-term physical health condition increases the risk of mental ill health by two to three times over that of the general population. The reverse is also true. Mental ill health may often increase the risk of physical illness. People struggling with mental disorder may engage in riskier behaviours or may be less able to care for themselves as a result of their illness. The result is that people with mental health conditions are two to four times more likely to die prematurely, mainly from physical causes like cardiovascular disease[46].

[44] It should be noted that the comparison with GVA is not strictly accurate as it is not a like for like comparison. As set out in the text, the estimate of the total economic and social costs of mental ill health to London incorporate some 'nonmarket' aspects which are not included in the calculation of GVA. In this instance, framing the economic and social costs as a proportion of London's GVA acts simply to provide some idea of the scale of costs.
[45] London Mental Health: The invisible costs of mental ill health; Greater London Authority, January 2014 http://www.london.gov.uk/sites/default/files/Mental%20health%20report.pdf
[46] 'Long-term conditions and mental health: The cost of co-morbidities.' The King's Fund and Centre for Mental Health 2012 – http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-healthcost-comorbidities-naylor-feb12.pdf

The landmark 1980 study by Richard Hall et al[47] found that 46% of the psychiatric patients had physical ailments causing or exacerbating their mental symptoms.

A significant proportion of people with a range of physical health needs also have co-existing mental health needs or their mental state is made worse by their physical condition[48].

Examples of this are:

- A serious physical illness can affect every area of life, such as relationships, work, spiritual beliefs and how people socialise.
- This can result in increased levels of anxiety and depression
- Some drug treatments, such as steroids, affect the way the brain works and so cause anxiety and depression directly.
- Some physical illnesses, such as an under-active thyroid, affect the way the brain works. They cause anxiety and depression directly.
- Recent research[49] has shown that a history of celiac disease makes the risk of developing schizophrenia 3.2 times higher.
- Cancer – 33% patients depressed and these patients remain in hospital 40% longer and have 35% greater costs. Meta-analysis of PCTs revealed sustained beneficial gain from short focused CBT in terms of mental health, functional adjustment (return to work), and physical symptoms. Also evidence of increased survival rates and increased coping and quality of life-years.

One particular type of co-morbidity is the abuse of alcohol and drugs. Similar to physical illness, substance misuse and mental ill health have a two-way relationship. The presence of mental ill health increases the likelihood of substance misuse via self-medication and increased risk taking. Conversely, substance misuse can result in a host of behavioural and cognitive issues, such as depression or psychosis, that are characteristic of mental ill health. It is well documented that misuse of alcohol and drugs is higher among those with mental disorder, as are rates of smoking. For example, rates of drug dependence amongst people with social phobia are six times as high as those of the general population. People with obsessive compulsive disorder have a fourfold increase in the risk of developing alcohol dependence, and generalised anxiety disorder is associated with a 9% increase in the risk of being a smoker[50].

Smoking and mental health

A systematic review and meta-analysis of 26 observational longitudinal studies published in the British Medical Journal recently[51], investigated change in mental health after smoking cessation compared with continuing to smoke. Follow-up mental health scores were measured between seven weeks and nine years after baseline. The study found that anxiety, depression, mixed anxiety and depression, and stress significantly decreased

[47] Physical illness manifesting as psychiatric disease: II. Analysis of a state hospital inpatient population. Hall, Richard C; et al, Archives of General Psychiatry, Vol 37(9), Sep 1980, 989-995.
[48] Royal College of Psychiatrists Physical Illness and Mental Health
[49] Coeliac disease and schizophrenia: population based case control study with linkage of Danish national registers; Eaton,W. Mortensen, P.B., Agerbo, E. Byrne, M., Mors, O., Ewald, H. (2004) British Medical Journal 328 438-439.
[50] Adult Psychiatric Morbidity Survey, 2007. http://discover.ukdataservice.ac.uk/catalogue?sn=6379
[51] Taylor G, McNeill A, Girling A, et al.; Change in mental health after smoking cessation: systematic review and meta-analysis; BMJ 2014; 348:g1151 (Published 13 February 2014).

between baseline and follow-up in quitters compared with continuing smokers. Both psychological quality of life and positive affect significantly increased between baseline and follow-up in quitters compared with continuing smokers. The study concluded that smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders.

Common Mental health Disorders (CMDs) and Severe Mental Illnesses (SMIs)

In the UK, Mental Health conditions are clinically classified using ICD-10 - the WHO (World Health Organisation) International Classification of Disease. This is used in the clinical diagnosis of mental illnesses. Mental health conditions can also be broadly divided into common mental health disorders (CMDs) and Severe Mental Illnesses (SMIs). Common mental health disorders, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population at any one time. Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability. For example, depression is estimated to be the second greatest contributor to disability-adjusted life years throughout the developed world. It is also associated with high levels of morbidity and mortality, and is the most common disorder contributing to suicide[52]. There is no universal definition of severe mental illness. However, the term usually refers to illnesses where psychosis occurs. Psychosis describes the loss of reality a person experiences so that they stop seeing and responding appropriately to the world they are used to. Schizophrenia and bipolar disorder are the two main forms of severe mental illness. However, this does not mean that other conditions are not regarded as serious - there are others such as schizo-affective disorder, severe clinical depression and personality disorders.

Locally there is limited definitive data on prevalence and incidence of mental health conditions. A review of adult mental health services was started in August 2013 in order to shape the adult mental health services in Merton. The first stage of the review is this health needs assessment of adult mental health in Merton (MMHNA).

Aims and objectives of the health needs assessment

The MMHNA (Merton Mental Health Needs Assessment) is an epidemiological, corporate and comparative one that aims to:

- Describe the size and nature of adult mental health illnesses and conditions, and provide a comprehensive picture of adult mental health in Merton, based on the analysis of all available and relevant data, and consultations with key stakeholders, providers and users
- Describe the nature and extent of health inequalities in the

[52] Common mental health disorders, Identification and pathways to care; NICE clinical guideline 123; Issued: May 2011

  - distribution of mental health illnesses and conditions in the population of Merton, identifying local risk groups and risk factors, profiling such risk factors and describing how they relate to mental health
  - the uptake of services and any variations of uptake (by geography, ethnicity etc.) and explore any equity issues (access)
- Identify evidence-based interventions and best practise in tackling issues related to mental health, including public mental health
- Describe the current health and social care services available in Merton that impact on adult mental health and how these match up against best practise and interventions identified
- Identify the gaps in provisions for health and social care in Merton in relation to adult mental health and make recommendations as to how these could be addressed, particularly around reducing health inequalities and inequity

Methodology

The traditional model of epidemiological, corporate and comparative healthcare needs assessment has been developed by Stevens and Rafferty[53]. Epidemiological need looks at the severity and size of the health problem. Corporate need looks at the perceptions of the service providers and comparative need looks at the different service providers and users managing the health issue[54]. This health needs assessment includes all three approaches.

Epidemiological: primarily entailing the analysis of all available and relevant data. This may include auditing the primary and secondary health care and social care data from the past few years relating to adult mental health in order to establish any historical patterns and identifiable risk factors.

Corporate: through qualitative work in the form of focus groups and semi-structured interviews with mental health services users, carers and service providers.

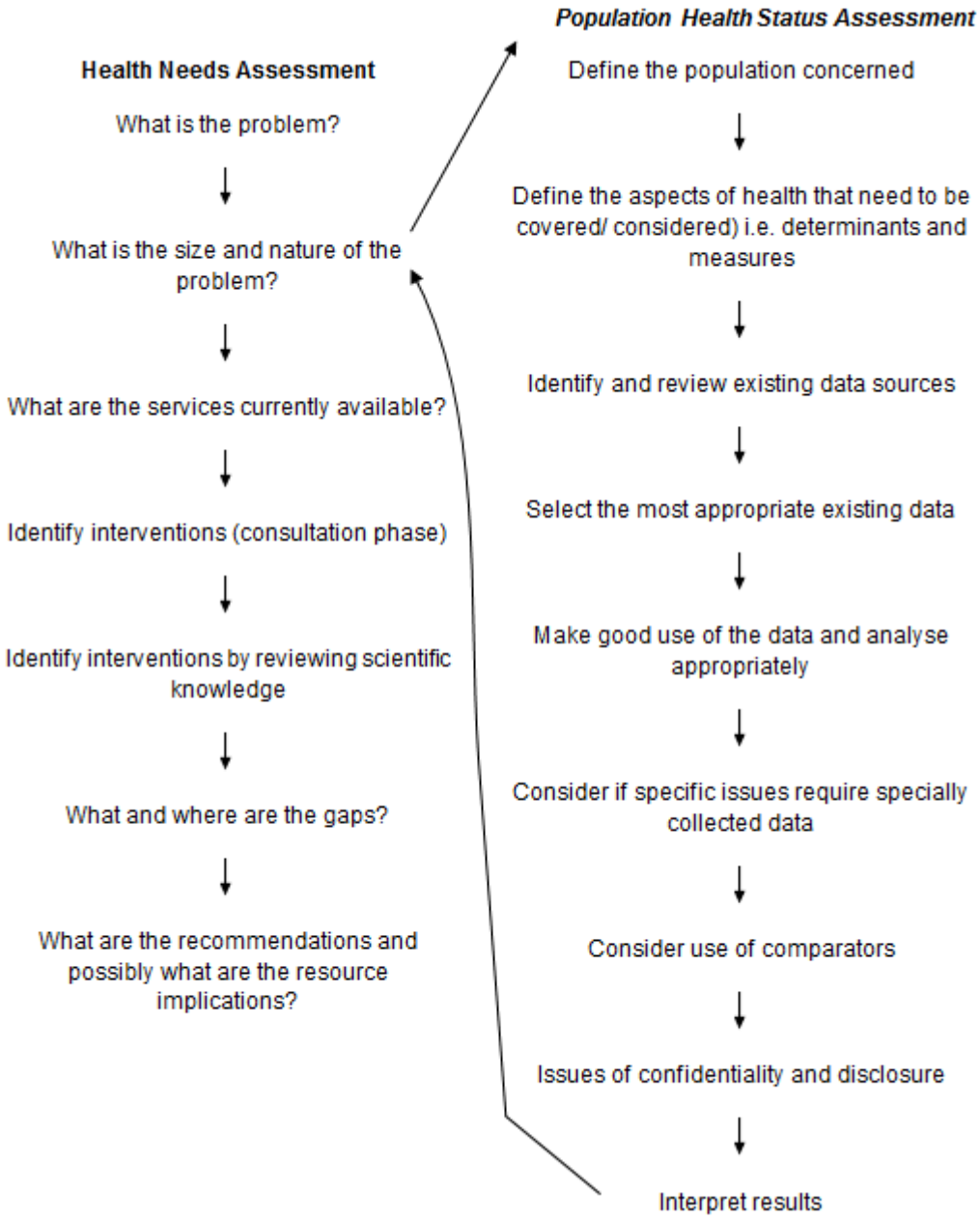
Comparative: through mapping the services in Merton and assessing how well the mental health needs of the adult population in Merton are met by this and identifying the gaps.

The steps proceeding with this health needs assessment are described in the figure below.

[53] Stevens A. Rafferty J. Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews, Vol. 1. Oxford: Radcliffe Medical Press

[54] Hooper J, Longworth P. Health needs assessment workbook. Health Development Agency. January 2002

Figure 1: Methodology of the MMHNA



Epidemiological analysis methodology

This was done through the collation and analysis of all available and relevant national, regional and local data.

Routinely collected data

Routinely collected national data were obtained from HSCIC (Health and Social Care Information Centre), POPPI (Projecting Older People Population Information), PANSI (Projecting Adult Needs and Services Information), NEPHO (North East Public Health Observatory), NHS Dementia Calculator and ONS (Office for National Statistics).

Ad-hoc data

Ad-hoc local data sets were obtained from the main local NHS Mental Health provider- South West London and St. Georges NHS Mental Health Trust (SWLStG MHT). This comprised of five years of inpatient data for admissions or discharges between 01/04/2008 and 31/03/2013. Community mental health services (CMH/ CMHS) data sets (referrals and contacts) include any Merton residents either referred or discharged from all non-inpatient services between 01/04/2008 and 31/03/2013. Referral source has been included such as those from a GP or via A&E Departments. A summary of IAPT (Improved Access to Psychological Services) performance were also obtained for the period between 01/08/2012 and 31/08/2013 to match a number of KPIs usually submitted to the Information Centre. The in-patient and community data were analysed separately. An analysis strategy was developed in consultation with the Mental Health Review's Task and Finish Group. The first stage was a descriptive analysis of the datasets, followed in the second stage by univariate analysis of specific risk factors and some bivariate/ multivariate analysis. The data were cleaned and further defined to create datasets that were analysed using a statistical software package, STATA SE13.

The primary and secondary diagnoses are by ICD-10 codes (see appendix) where "F-codes" are the ICD-10 codes directly related to mental health conditions (i.e. schizophrenia, neurotic disorders etc.). Additionally there are admissions and referrals primary diagnoses data coded with non-F ICD codes (i.e. other letters of the alphabet)- these include certain infections (including parasitic), neoplasms (cancers), blood disorders, endocrinal or metabolic conditions, neurological conditions, injuries, poisonings and conditions primarily affecting other parts of the body can also manifest with mental health symptoms. The overall analysis includes these non-F-codes as well, although the numbers are small.

Limitations of the data

Mental health conditions are a complex area and the data are often patchy and based on estimates and projections rather than actual numbers. This is in part due to the complexity of the service provision for mental health and also because of confidentiality and data sharing arrangements. We have attempted to bring together multiple sources of data, with valuable local data helping to create a more comprehensive picture for Merton adult mental health.

Limitations of the analysis

Some assumptions and caveats were made in order to calculate crude measures in this report:

- It was assumed that the de-duplicated records in both the datasets reflected the underlying numbers of patients with mental health conditions in a given year.
- It was assumed that in the case of the duplicate records, the patient was seen for the same primary diagnosis each time.
- It was assumed that the same patient would not be admitted as an in-patient and be seen by CMHS in the same year. This was necessary in order to calculate the diagnosed case prevalence even though it could well be the case, which means that the calculated prevalence is likely to double count some patients and therefore over-estimate the diagnosed case prevalence.
- Almost 50% of the CMHS data had no primary diagnosis, and therefore the distribution of known primary diagnosis codes was applied to the missing data to get an expected

number for the missing primary diagnoses- this assumed that the missing diagnoses would have the same distribution as the known cases.

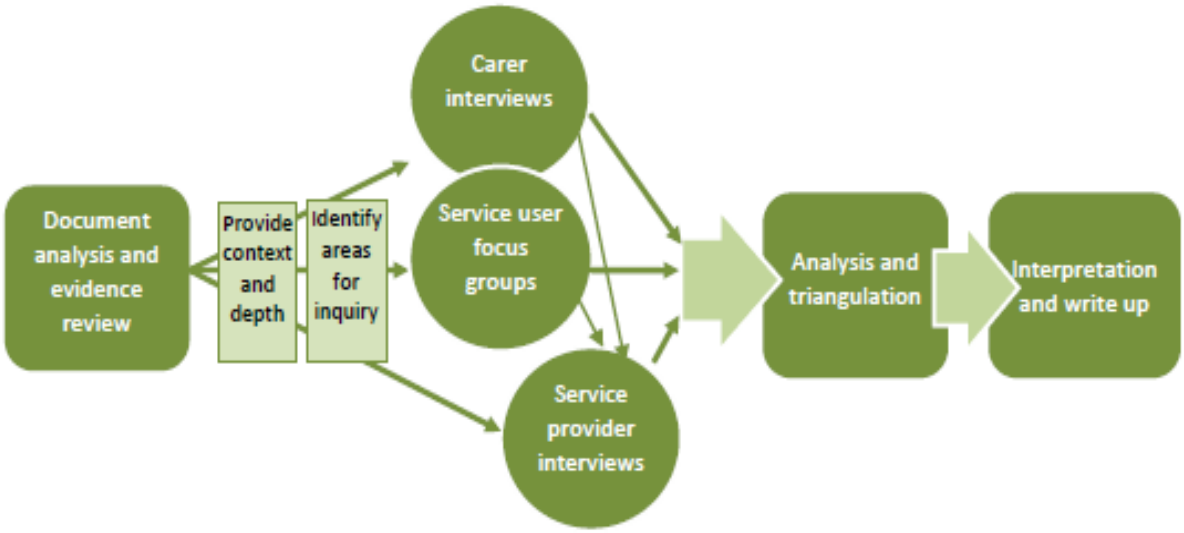
Qualitative work methodology

Qualitative work was undertaken to ascertain the experiences and views of adult mental health services users, carers and providers in Merton.

The specific objectives were to:
a. ascertain the mental health need of the adult and elderly population in the borough
b. identify gaps in service provision; and
c. make recommendations for the provision of effective and efficient services.

The study took place between August and October 2013 and drew on qualitative methods of inquiry - in-depth, semi-structured one-to-one interviews and focus group discussions complemented by document analysis and a targeted review of the mental health literature. The approach was informed by the exploratory nature of the study objectives. In all, 31 informants participated in the study.

Figure 2: Qualitative study design



Participants

Information was obtained from three stakeholder groups:
a. Adult mental health service users resident in Merton
b. Carers of service users
c. Mental health service providers (statutory and voluntary sector).

Informants were selected using a non-probability, purposive approach. A maximum variation strategy was taken to achieve as diverse a range as possible of people within the groups with information relevant to the study objectives.[55] An initial group of informants were

[55] Ritchie J, Lewis J, Elam G (2003). Designing and selecting samples. In: Ritchie J and Lewis J (eds.). Qualitative research practice: a guide for social science students and researchers. Sage: London.

identified by Merton Public Health team, and additional ones by snowballing.[56] Access to service users and carers was facilitated by Healthwatch Merton and two service user groups: Focus-4-1 and Rethink.

Composition of service users and carers

In all there were 16 services users and 6 carers that participated in the consultation. Due to small numbers, the gender and ethnicity breakdowns are expressed for the two groups combined and as percentages. Not all participants gave us their ages. The mean age of service users was 42 years (50% did not give their age) and the mean age of carers was 63 years.

Figure 3: Gender breakdown of service users and carers

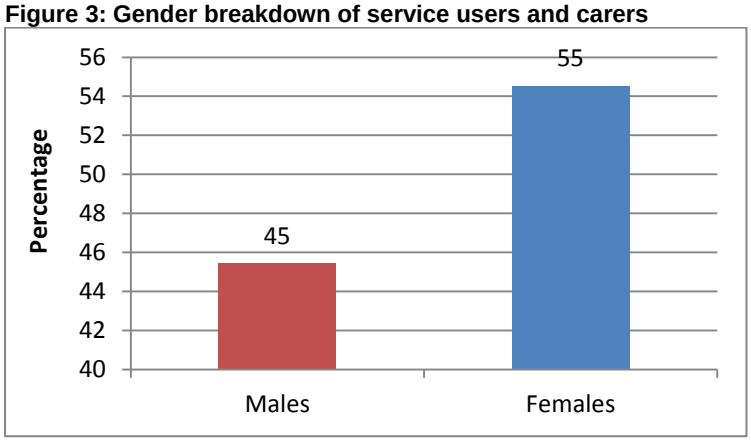
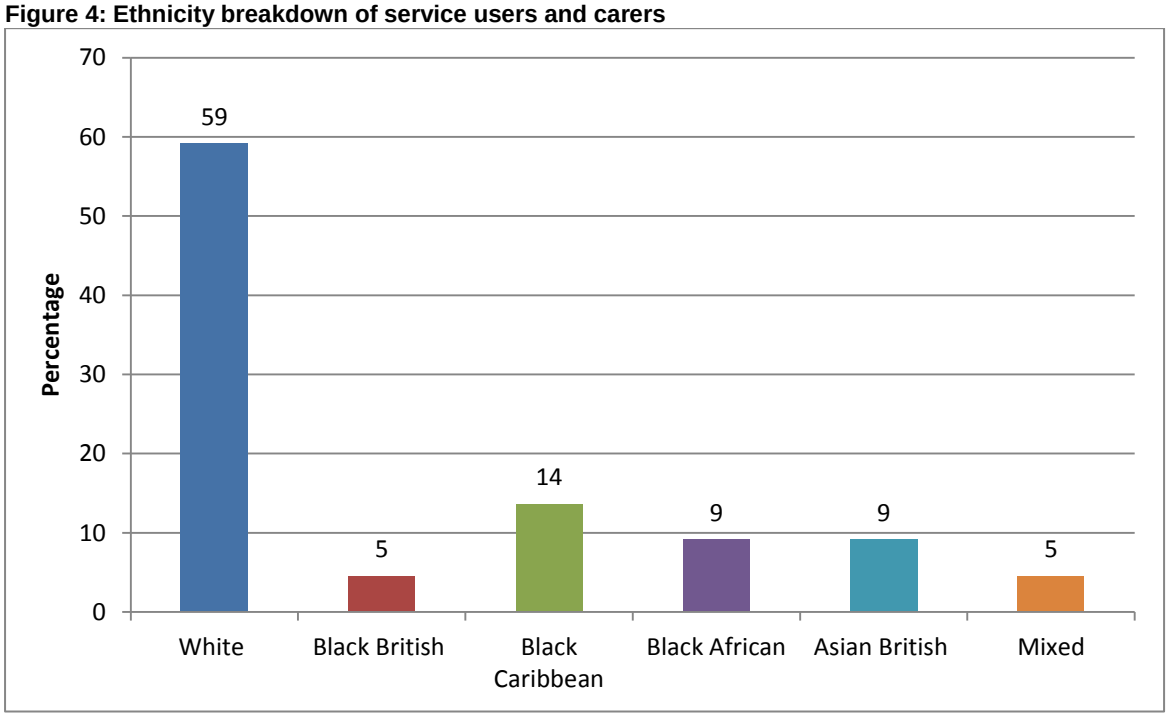


Figure 4: Ethnicity breakdown of service users and carers



55% of service users and carers were females and 45% males. Majority of the service users and carers were white and the next biggest group were black minorities.

[56] Hansen EC (2006). Successful qualitative health research: a practical introduction. Open University Press: Berkshire.

Focus-4-1 is based in Mitcham (east Merton) and promotes services for Black and Asian Minority Ethnic (BAME) groups, while Rethink is located in Wimbledon (west Merton) and serves a largely White population. There are substantial social and health inequalities between some of the most deprived communities in the east of the borough compared to the communities in the west[57] and the two groups were purposively chosen to ensure that these differences were represented in the study.

Interview schedules

Separate interview schedules for each stakeholder group were developed in collaboration with the Merton Public Health team. The topics for discussion were guided by a targeted review of the mental health literature (see Appendix for details). In particular, the service users schedule drew on the key dimensions of patient-centred care identified in NICE guidance.[58] The discussion topics for carers were informed by a Bristol Mind study on effective involvement in mental health services.[59]

Data collection

Thirty one informants were interviewed. Their distribution is shown in Table 1 below (see Appendix for further details). The focus groups lasted about 90 minutes and were supported by a carer (Focus-4-1) and mental health worker (Rethink). The interviews lasted about 40 minutes and were conducted face-to-face (except for two done by phone). Participants received an information sheet about the study and gave written or verbal consent before being interviewed. Brief socio-demographic information (age, gender and ethnicity) was obtained from the service users and carers to give perspective to their comments. All interviews were audio recorded and additional hand written notes taken by the interviewer.

Table 1: Distribution of informants

Stakeholder group	Number	Data collection method
Focus-4-1 service users	8	Focus group
Rethink service users	9	Focus group
Carers	6	Interview
Statutory services	6*	Interview
Voluntary sector providers	2**	Interview

* Two providers contacted did not respond.

** Four providers contacted did not respond or cancelled appointments.

[57] Merton Joint Strategic Needs Assessment 2013. http://www.mertonjsna.org.uk/causes-of-poor-health/mental-health.aspx

[58] National Collaborating Centre for Mental Health (2012). Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. National Institute for Health & Clinical Excellence National Clinical Guidance Number 136. The British Psychological Society and The Royal College of Psychiatrists.

[59] Davies R, Shocolinsky-Dwyer R, Mowat J, Evans J, Heslop P, Onyett S, Soteriou T (2008). Effective involvement in mental health services: assertive outreach and the voluntary sector. Bristol Mind.

Data analysis

After familiarisation with the data through review, reading and listening, thematic analysis was undertaken informed by Ritchie and Spencer's guidelines for framework analysis – an approach that is particularly suited to investigations with clearly specified questions, a limited time frame, and a pre-designed sample.[60] In addition, framework analysis provides insights quickly enough for public authorities to be able to use them in their decision-making.[61]

The discussion areas were grouped into overarching themes and informants' responses identified, examined and coded within the relevant theme. For the purposes of the analysis and given the limited timeframe, coding focused mainly on information relevant to the pre-identified themes. Comparisons were made within and across the data looking for patterns and relationships that could help organize the information more meaningfully. Exemplar quotes that best illustrated the aggregate information within each theme were extracted for anonymised reporting.

The data was first analysed within each stakeholder group and then triangulated across groups. Triangulation aimed to corroborate and strengthen the credibility of findings from one source[62], otherwise to challenge it and gain a more granular understanding of the evidence.[63]

Limitations of the study

Some limitations of the study are acknowledged. First, despite the strategy to maximise the diversity of the sample, non-response to requests for interviews by voluntary sector providers (which in fairness was mostly because of the tight timelines of the project and it's timing over summer) meant that views from the sector were relatively under-represented, especially carers. The total sample size of this study is 31- and further subdivided into users, carers and providers. Therefore the transferability of the findings needs to be treated with a degree of caution, although the objective of a qualitative study is to add more depth and understanding to the underlying issues- which this study achieved. Due to limited resources, a pragmatic approach was taken to analysis of the data. Only one researcher carried out the coding and interpretation. Not all responses were fully reported to avoid disclosing the identity of informants. However, a great deal of care was taken in developing the final analysis from the initial descriptive codes.

Literature review methodology

A review of the literature was undertaken to address the following areas:

- Best practice, national guidelines and policies in adult mental health
- Economic appraisals and cost-effectiveness evaluations of interventions to prevent mental ill health

[60] Ritchie J, Spencer L (1994). Qualitative data analysis for applied policy research. In: A.Bryman and R. G. Burgess [eds.] Analyzing qualitative data, pp.173-194. London: Routledge.

[61] Srivastava A, Thomson SB (2009). Framework analysis: a qualitative methodology for applied policy research. JOAAG, 4(2): 72-79.

[62] Creswell JW, Plano Clark VL (2007). **Designing and conducting mixed methods research.** Thousand Oaks, CA: Sage Publications.

[63] Gorard S, Taylor C (2004). Combining research methods in educational and social research. Berkshire; Open University Press.

Given the volume of literature on mental health and the relatively broad scope of the review, a systematic review was not attempted- a pragmatic approach was taken to this aspect of the health needs assessment.

A search of the bibliographic databases was undertaken to uncover existing evidence in relation to the effectiveness and possibly the cost-effectiveness of prevention related interventions. The research questions were broken down into concepts. Based on these concepts a search strategy was created and the bibliographic databases EMBASE, PUBMED, OVID, and CINAHL were searched. Additional searches on Google were undertaken. NICE guidelines were obtained from the NICE website. It was not possible to undertake any further searches on other data bases or manual searches.

Inclusion and Exclusion Criteria

The main inclusion criterion was the date of publication (2008 onwards), adult's mental health, England/ UK. Additionally articles in 'English language', 'systematic reviews or literature reviews or meta-analysis or randomised controlled trials' were eligible for inclusion. Any relevant NICE or other guidelines were eligible for inclusion too.

The results are reported in two areas in this report-

- The section on the literature review
- The section on policies, strategies, NICE Guidance & best practice

The picture of adult mental health in Merton

What does mental health in Merton look like overall?

Key Points

- *Overall Merton is a borough with lower spend and better mental health outcomes, compared with other statistically comparable CCGs*
- *Overall levels of mental health and illness, treatment, outcomes in Merton are generally either similar to the England average or better*
- *Data suggests that there is under-diagnosis and under-recording of depression and dementia in primary care in Merton*
- *Where Merton is doing particularly well:*
  - *Recording the diagnosis of a mental health condition*
  - *Assigning patients to a mental health cluster*
  - *Having significantly lower A&E attendances for patients with psychiatric disorders*
  - *Having significantly lower number of bed days,*
  - *Having a significantly higher rate of carers of mental health clients receiving assessments*
- *Where Merton not doing so well:*
  - *Providing newly diagnosed depression patients with severity assessment at the outset of their treatment*
  - *Having a significantly lower rate than England average of recovery for IAPT treatment (percentage of people completing IAPT who have moved to recovery)*
- *Merton has a significantly higher than national average percentage of mental health service users that are in-patient in a psychiatric hospital and a significantly lower rate than the England average, of people on a Care Programme Approach (CPA)*
- *Merton also has a significantly lower rate of mental health clients receiving community, residential or nursing home care and a significantly lower rate of people in contact with specialist mental health services*
- *The number of people with mental health conditions is expected to increase in Merton over time for all conditions (Common Mental Disorders, Borderline Personality Disorder, Antisocial Personality Disorder, Psychotic Disorder, and Two or more psychiatric disorder)*
- *Merton CCG has the lowest reported prevalence of mental health disorders among SW London and statistically similar CCGs*
- *There are considerable variations in the prevalence of mental health conditions by GP practices and also comparing practices in East and West Merton*
- *Proportion of adults in contact with secondary mental health services living independently, with or without support is below the London average and the lowest among SW London boroughs. It is second lowest among statistical neighbours*

Overall Merton does well on many measures of mental health. Merton CCG has lower spend and better outcomes for mental health overall. While the per capita spend on mental health in Merton is much lower than for other CCGs in our ONS cluster (Hounslow, Harrow, Ealing, Redbridge and Barnet) and England, the outcomes overall are good- suggesting that the investments are good value for money.

The Merton Community Mental Health Profile (NEPHO June 2014) (Figure 5)[64] provides an overview of levels of mental health and illness, treatment, outcomes. More detailed profiles on Common Mental Health Disorders (CMDs)[65] and Severe Mental Illness (SMIs)[66] have also recently been released (June 2014) broken down by risk and related factors, prevalence, services, quality and outcomes, and finance (see later). These profiles provide useful comparative information to supplement local data. However, it is important to note that they do not reflect geographical (other than in some indicators by GP practice), gender or ethnic variations across Merton.

Merton Community Mental Health Profile

The Community Mental Health Profile indicates that the overall levels of mental health and illness, treatment, outcomes in Merton are generally either similar to the England average or better. However there are a number of indicators where Merton is significantly and unfavourably different from England. All the indicators have to be interpreted in local context, as an indicator where Merton appears to be faring better than England could be partly explained by factors like under diagnosis or under-recording.

Levels of mental health and illness

These are based on 2012/13 QOF data and GP practice survey. For depression prevalence and incidence in adults, Merton has significantly lower figures than England, as it does for GP survey recorded depression and anxiety prevalence, prevalence of mental health problem (all ages) and percentage reporting a long-term mental health problem. While these indicate that depression and anxiety in Merton may be lower than many other places, a more detailed look at mood affective disorders further on in this report shows that the recorded prevalence is lower than expected, indicating under-diagnosis and under-recording in general practice.

Treatment

In this group of indicators for most part Merton is performing similar to or better than England. Where Merton is doing particularly well is in recording the diagnosis of a mental health condition, assigning patients to a mental health cluster, having significantly lower A&E attendances for patients with psychiatric disorders, significantly lower number of bed days, and a significantly higher rate of carers of mental health clients receiving assessments. However where Merton does not do very well is providing newly diagnosed depression patients with severity assessment at the outset of their treatment, where Merton has a significantly lower percentage than the England average. Merton also has a significantly higher than national average percentage of mental health service users that are in-patient in a psychiatric hospital.

Merton also has a significantly lower rate of mental health clients receiving community, residential or nursing home care in 2012/13, and a significantly lower rate of people in

[64] http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data#gid/8000053/pat/44/ati/19/page/9/par/E40000003/are/E38000105

[65] http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#gid/8000041/pat/6/ati/102/page/9/par/E12000007/are/E09000024

[66] http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data#gid/8000027/pat/6/ati/102/page/9/par/E12000007/are/E09000024

contact with specialist mental health services in 2013/14 (although the latter is a snap-shot of quarter 1). The interpretations of these figures are context specific. Merton has lower numbers of people with mental health problems recorded (QOF) than England, therefore it follows that there will lower rates of contact with specialist mental health services. A low number of people in contact with mental health services may indicate low prevalence, but may also reflect poor recognition and diagnosis of mental health conditions and availability of services, access issues, and higher thresholds for referrals. Similarly with rates of community, residential or nursing care, lower rates could be related to the significantly higher percentages of mental health service users in in-patient care.

Outcomes

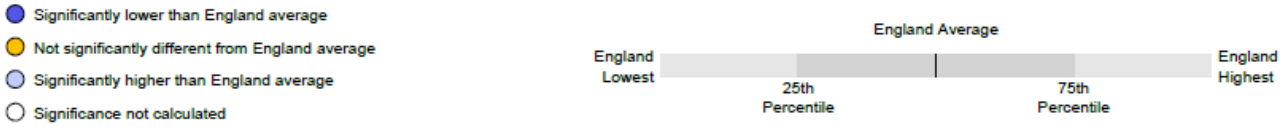
In terms of outcomes, Merton's suicide rate for 2010-12 is similar to the England average and the rate of emergency admissions for self-harm significantly lower than the England average (in fact less than half). Merton has a significantly lower rate than England average, of people on Care Programme Approach (CPA) although this is snap-shot of 2013/14 Q1. Although this rate is lower than average, of those adults on CPA, a significantly higher percentage are in settled accommodation than the national average. In Merton, the rate of recovery for IAPT treatment (percentage of people completing IAPT who have moved to recovery) is significantly lower.

The relatively low funding of mental health services in Merton creates the necessity for a tightly managed system which enables people to be treated in community wherever possible, and in inpatient care wherever required. Merton mental health services thus manage demand for inpatient services to operate with a lower than average bed occupancy for its population. This reflects a well performing Home Treatment Team, and good interfaces with community and inpatient services to support discharge planning.

A similar prioritisation process underpins the primary/secondary care interface, where Adult Mental Health and GPs actively manage the care pathway to ensure that people receive their treatment/support at the right level through regular practice based meetings. This results in a prioritised system where people do not remain under a CPA level of care longer than they require and therefore relatively few Merton residents, benchmarked against other CCGs, are under CPA at any one time. However, those that are on CPA at any one time will have complex needs, and a higher than average proportion of these will require admission. This high proportion relates to the low denominator of people on CPA, given that the absolute numbers of people requiring admission is low.

Figure 5: Merton Community Mental Health Profile: wider determinants, risk factors and levels of illness

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A dark blue circle means that this area is significantly lower than England for that indicator; a pale blue circle means that this area is significantly higher than the England average for that indicator.



Domain		Indicator	Period	Local value	Eng. value	Eng. lowest	Eng. highest
Levels of mental health and illness	1	Depression: QOF prevalence (18+)	2012/13	4.7	5.8	2.9	11.5
	2	Depression: QOF incidence (18+)	2012/13	0.9	1.0	0.5	1.9
	3	Depression and anxiety prevalence (GP survey)	2012/13	9.2	12.0	8.1	19.5
	4	Mental health problem: QOF prevalence (all ages)	2012/13	0.78	0.84	0.48	1.46
	5	% reporting a long-term mental health problem	2012/13	3.6	4.5	2.5	8.2
Treatment	6	Patients with a diagnosis recorded	2013/14 Q1	51.7	17.8	1.1	63.2
	7	Patients assigned to a mental health cluster	2013/14 Q1	88.0	69.0	1.9	94.8
	8	Patients with a comprehensive care plan	2012/13	88.6	87.3	79.9	95.0
	9	Patients with severity of depression assessed	2012/13	88.2	90.6	77.4	97.8
	10	Antidepressant prescribing (ADQs/STAR-PU)	2012/13	3.8	6.0	2.7	9.0
	11	People with a mental illness in residential or nursing care per 100,000 population	2012/13	14.9	32.7	0.0	124.3
	12	Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2013/14 Q3	3.4	2.4	0.7	12.3
	13	Detentions under the Mental Health Act per 100,000 population	2013/14 Q1	17.1	15.5	0.0	44.5
	14	Attendances at A&E for a psychiatric disorder per 100,000 population	2012/13	180.0	243.5	3.0	925.5
	15	Number of bed days per 100,000 population.	2013/14 Q1	2270	4686	685	11073
	16	People in contact with mental health services per 100,000 population	2013/14 Q1	1139	2176	116	5442
	17	Carers of mental health clients receiving of assessments	2012/13	168.0	68.5	0.0	343.4
	18	Spend (£s) on mental health in specialist services: rate per 100,000 population	2012/13	16425	26756	14296	49755
	19	% secondary care funding spent on mental health	2011/12	10.4	12.1	7.1	19.1
Outcomes	20	People on Care Programme Approach per 100,000 population	2013/14 Q1	482	531	17	1895
	21	% CPA adults in settled accommodation	2013/14 Q1	78.9	61.0	5.0	94.6
	22	% CPA adults in employment	2013/14 Q1	9.1	7.0	0.0	22.7
	23	Emergency admissions for self harm per 100,000 population	2012/13	88.7	191.0	49.8	595.6
	24	Suicide rate	2010 - 12	8.2	8.5	4.8	19.6
	25	Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population	2012/13	93.4	116.0	68.6	201.7
	26	Rate of recovery for IAPT treatment	2012/13	37.9	45.9	22.6	80.3

Indicator Notes
1 % adults (18+) with a record of unresolved depression recorded since 2006 (2012/13) 2 % adults (18+) with a new diagnosis of depression recorded in 2012/13 3 % respondents to the GP survey who reported moderate or extreme anxiety or depression, 2012/13 4 % adults with a serious mental illness (schizophrenia, bipolar disorder or other psychoses, or on lithium therapy), 2012/13 5 % people in people the GP practice survey reporting a long-term mental health problem, 2012/13 6 % patients in contact with mental health services with a diagnosis recorded, Q1 2013/14 7 % patients in contact with mental health services assigned to a cluster, Q1 2013/14 8 % patients with a serious mental illness who have a comprehensive care plan recorded, 2012/13 9 % new depression cases with a severity assessment at outset of treatment), 2012/13 10 Average dailly doses of antidepressants prescribed per patient (STAR-PU), 2012/13 11 Mental health clients aged 18-64 receiving community, residential or nursing home care in 2012/13 per 100,000 population 12 Standardised admissions of all people in contact with specialist mental health services/ 100,000 population 2012/13 13 Detentions under the mental health act\100,000 population, Q1 2013/14 14 Attendances at A&E for a psychiatric disorder, 2012/13 15 In-year bed days for mental health\1,000 population, 2012/13 16 17 People in contact with specialist mental health services\100,000 population, 2013/14 Q1 17 Carers of mental health clients aged 18-64 who were assessed during 2012/13 per 100,000 population 18 Spend on all publicly funded mental health services for adults aged 16-64, rate per 100,000 adults, 2010/11 19 Spend for specialist mental health services as a % of all secondary care services, 2011/12 20 People on CPA per 100,000 population 2013/14 Q1 21 % people with mental illness on CPA, aged 18-69, in settled accommodation, 2013/14 Q1 22 % people with mental illness on CPA, aged 18-69, in employment, 2013/14 Q1 23 Directly standardised rate for emergency hospital admissions for self harm, 2012/13 24 to Directly standardised mortality rate for suicide and undetermined injury, 2010-2012 25 Admissions for unintentional or deliberate injuries in <24s, 2012/13 26 % people completing IAPT who have moved to recovery, 2012/13

Source: NEPHO 2014 http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data

Spend and Outcome data for Merton

Programme budgeting is a well-established technique for assessing investment in programmes of care rather than services. All PCTs in England have submitted an annual programme budgeting return since 2003/4. The tool and factsheets use this Programme Budgeting data and overall indicators of health outcome by programme (where available) to present PCTs and CCGs with an analysis of the impact of their expenditure. This allows easy identification of those areas which require priority attention, where relative potential shifts in investment opportunities will optimise local health gains and increase quality. In all there are 23 programme budget areas, of which mental health is one. At CCG level the latest data is for 2011-12.

Overall Merton CCG compares favourably in terms of the spend and outcome data for the Mental Health (MH) programme – see figure 6 below where the red arrow denotes that programme. While this is a considered one of the big spend areas in the health budgets of all CCGs (along with circulatory disease and cancer), the MH programme in MCCG is an area of low spend and better outcomes, the best possible combination.

The SPOT (spend and outcomes) tool[67] enables more detailed analysis of the mental health programme budget for MCCG in comparison with other CCGs, and ONS clusters. The mental health (MH) programme is further categorised into six areas of spend:

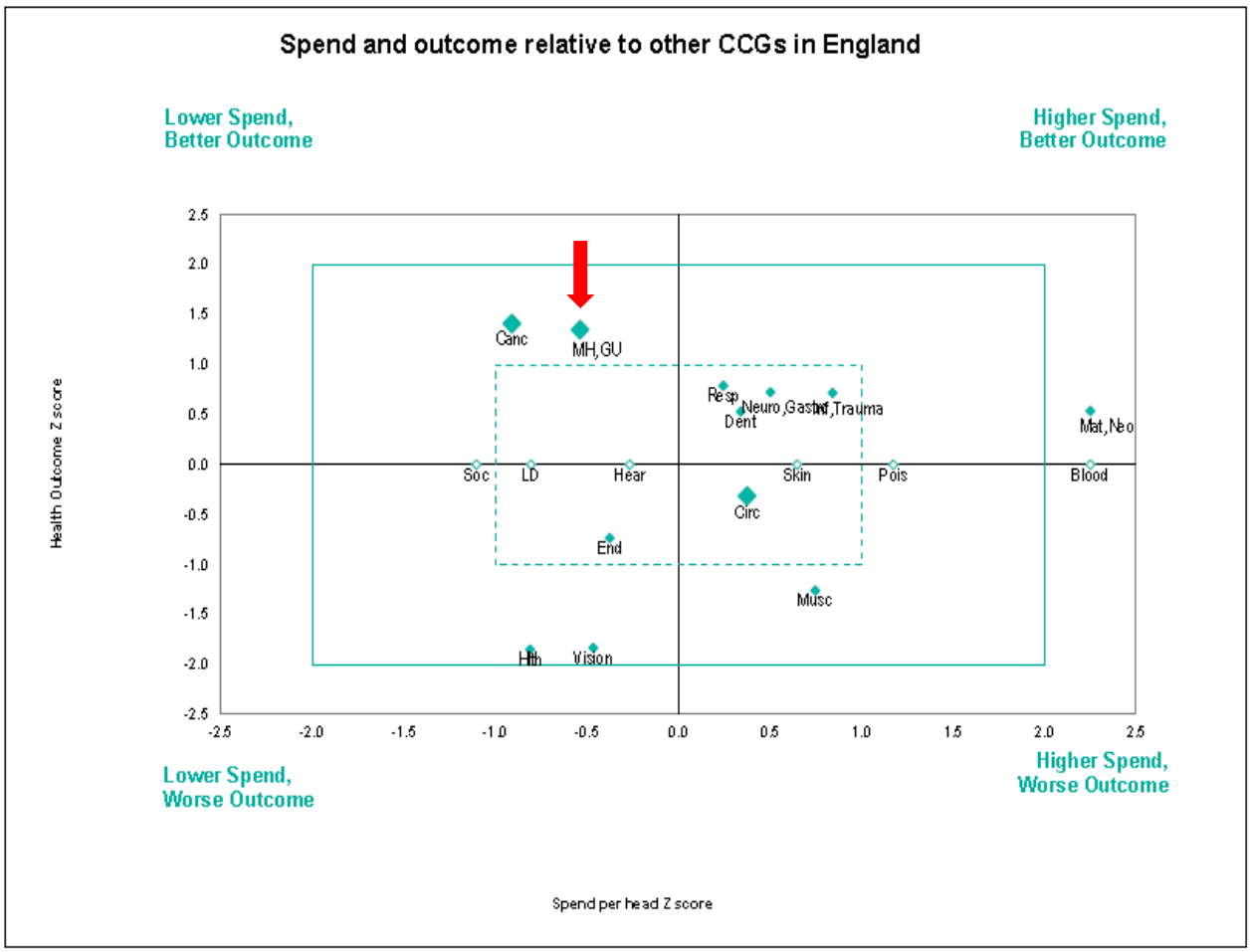
- Mental Health Disorders
- Organic Mental Disorders
- Psychotic Disorders
- Other Mental Health Disorders
- Substance Misuse
- Child and Adolescent Mental Health Disorders

For each of these areas of spend, the figures 7-12 depict the spend and outcomes of Merton CCG relative to other CCGs. Merton CCG is the largest light green dot (with red arrow) in each of these figures. Each dot represents a CCG. CCGs in the same ONS Cluster and/or SHA are highlighted.

For Mental Health Disorders - MCCG has lower spend and better outcomes
Organic Mental Disorders - MCCG has lower spend and better outcomes
Psychotic Disorders - MCCG has lower spend and better outcomes
Other Mental Health Disorders - MCCG has higher spend and better outcomes
Substance Misuse - MCCG has a much lower spend and better outcomes
Child and Adolescent Mental Health Disorders- MCCG has a much lower spend and better outcomes

[67] http://www.yhpho.org.uk/default.aspx?RID=49488

Figure 6: Merton CCG spend and outcomes for all programmes, 2011-12



◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

Interpreting the chart:
Spend: By population, Population: Unified Weighted
Each dot represents a programme budget category. The three largest spending programmes nationally (Mental Health, Circulatory Diseases and Cancer) are represented by larger dots.
The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. This means that for some programmes no outcome data is available.
The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.

A programme lying outside the solid +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome.

Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.

Z score:
A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further.

Figure 7: Mental Health Disorders, 2011-12

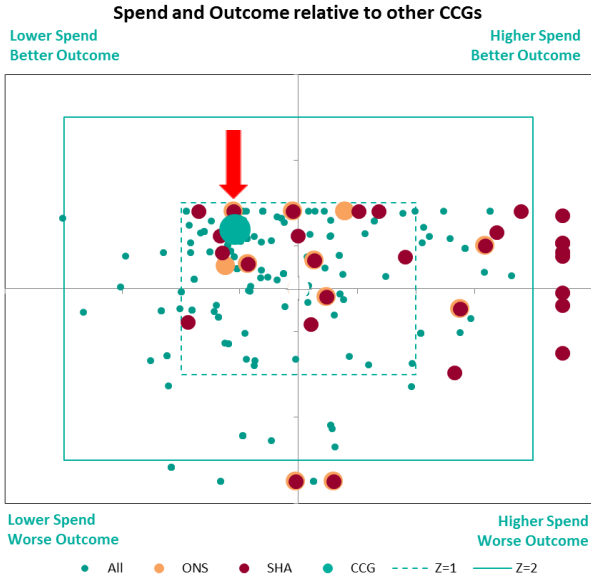


Figure 8: Organic Mental Disorders, 2011-12

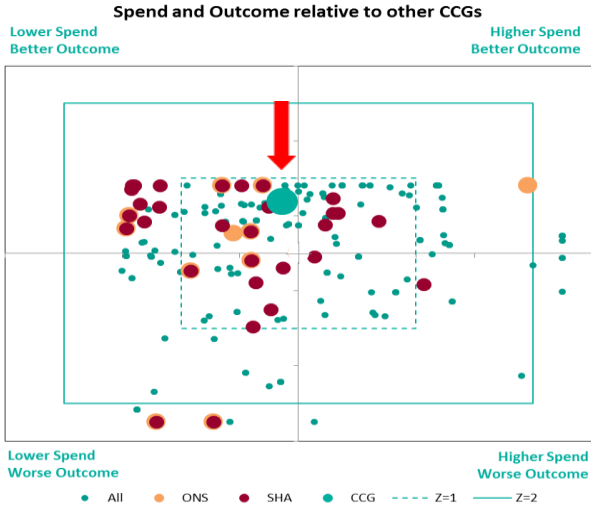


Figure 9: Psychotic Disorders, 2011-12

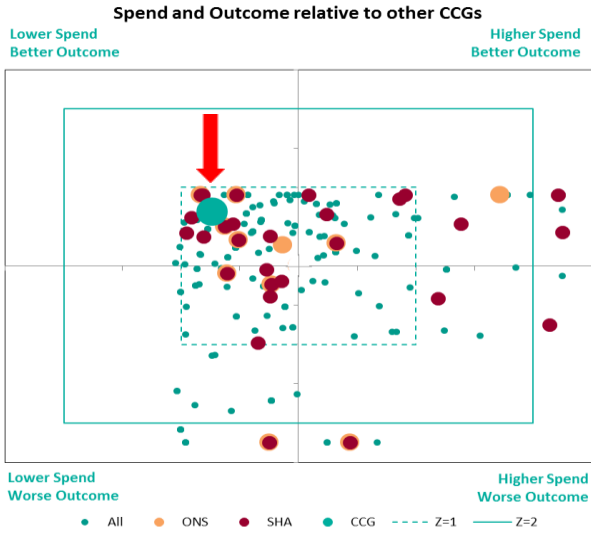


Figure 10: Other MH Disorders, 2011-12

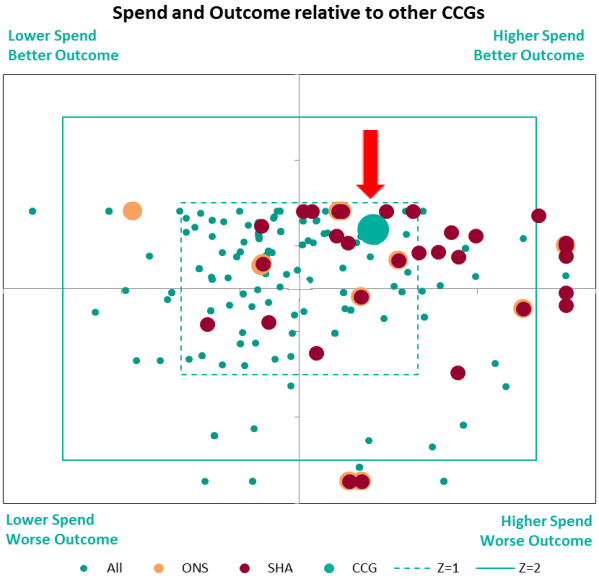


Figure 11: Substance Misuse, 2011-12

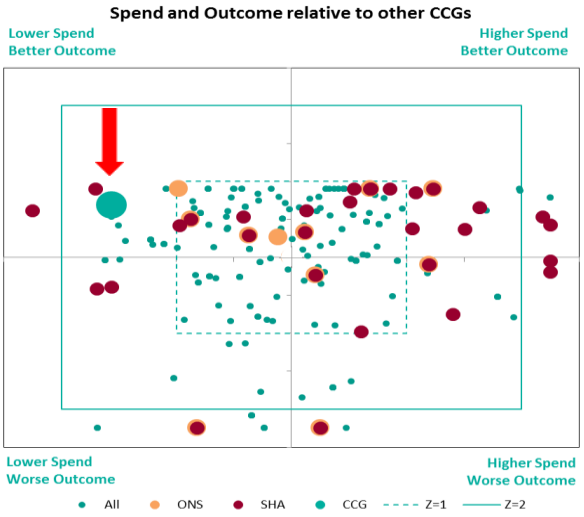
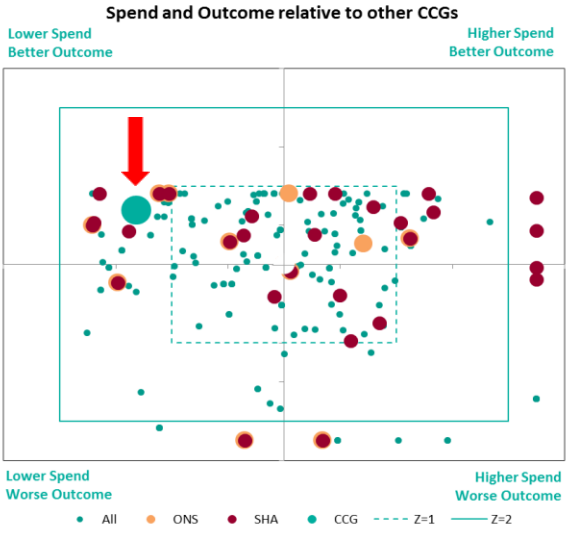


Figure 12: Child and Adolescent Mental Health Disorders, 2011-12



Spend per capita on mental health

As noted on the section before this, Merton CCG has lower spend and better outcomes for mental health, suggesting good value for money and returns on investments. The per capita spend is much lower than the comparator ONS cluster and England.

Table 2: Merton CCG per capita spend on mental health, compared with ONS cluster and England

Merton CCG			ONS Cluster 2011-12	England 2011-12
2009-10	2010-11	2011-12		
£183	£188	£185	£219	£212

Source: Spend and Outcomes Factsheets, NHS England, Public Health England, Right Care

Spend on mental health

Merton CCG

Table 2 above depicts the spend per capita. Despite plans in the Local Joint Mental Health Strategy (2010 - 2015) to create a shift in mental health spend from secondary care to primary care; NHS Merton still invests very little at the primary care end of the mental health care spectrum (see table 3).

Table 3: Merton CCG spend on mental health, 2012-13

MH Services	Merton (£000)	%Total spend
Primary Care	1,200	5.9%
Secondary Care	19,000	94.1%
Total (£000)	**£20,200**	

London Borough of Merton

Merton Council finances the social care elements of Merton's adult mental health services. These include adult placements, day care, direct payments to Merton residents with mental health conditions, home care, nursing and residential care. When the financial data for the periods from 2008-09 to 2012-13 are examined, the total gross spend has been decreasing year on year, but when the income[68] (which is falling year on year) is deducted from these gross amounts, we find a drop from 2009-12 but then the spend increases again slightly in 2012/13 (see table 4).

Table 4: London Borough of Merton Gross Mental Health Placements Spend, 2008-13

	Financial Years				
	2008/09	2009/10	2010/11	2011/12	2012/13
	£	£	£	£	£
Adult Placement	595,140	625,605	541,394	513,795	504,127
Day Care*	526,207	562,323	473,291	357,905	383,508
Direct Payment	74,356	164,118	116,871	99,106	105,804
Home care	81,385	129,615	132,025	142,915	188,731
Nursing	218,682	220,696	153,913	73,554	69,054
Residential	1,038,782	1,112,575	952,358	980,256	709,543
Other	61,037	57,133	29,832	29,257	23,763
Total Gross	**2,595,589**	**2,872,065**	**2,399,684**	**2,196,788**	**1,984,530**
Less Income		**-716,445**	**-742,751**	**-597,964**	**-361,205**
Total Net		**2,155,620**	**1,656,933**	**1,598,824**	**1,623,325**

* Includes day care contracts

[68] Income: these are contributions from customers if they have been assessed to pay. In earlier years(2009/10 and 2010/11) this also included government grants.

What is the size of mental ill health in Merton?

The prevalence of mental health conditions is calculated in various ways. The Adult psychiatric morbidity household survey in England, 2007[69] helped to generate national estimates of prevalence for various mental health conditions. The survey uses statistically robust methods to sample households and assesses psychiatric disorders where possible to actual diagnostic criteria. These are applied to local populations to estimate the expected numbers in that local population, of individuals having these mental health conditions. When the national prevalence is applied to the Merton population, the numbers are likely to under-estimate the true prevalence, as the national prevalence is not adjusted for ethnicity and certain ethnic groups are known to have higher prevalence of certain mental illnesses. Nevertheless this is a very useful metric and is the best available estimate. For depression and dementia, QOF (Quality and Outcomes Framework) data are able to provide an accurate record of the number of actual diagnoses of depression and dementia made by GP practices and this can be compared with the expected numbers.

Mental health conditions in working age (18-64 year old) in Merton

The table below shows the modelled number of people with mental health conditions in Merton, London and England for two periods- 2012 and 2018. The number of people with mental health conditions increases in time at all administrative levels and for all conditions.

Table 5: Expected Prevalence of Mental Health Conditions in working age adults (18-64) in Merton, London and England in 2012 and 2018

Working age adults (18-64)	2012			2018		
	Merton	London	England	Merton	London	England
Common Mental Disorder	22,182	894,822	5,336,014	24,996	964,009	5,481,450
Borderline Personality Disorder	620	25,019	149,207	698	26,924	153,215
Antisocial Personality Disorder	480	19,400	115,574	547	21,091	119,118
Psychotic Disorder	551	22,233	132,586	621	23,946	136,183
Two or more Psychiatric Disorders	9,910	399,958	2,384,591	11,193	432,647	2,451,198

Source: Projecting Adult Needs and Service Information (PANSI) web site 08.10.2013
Based on the Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009.

The table below indicates the national prevalence for common mental disorders and for two or more psychiatric disorders. These are applied to the Merton ONS mid-year population estimates for each of the years from 2012-2020.

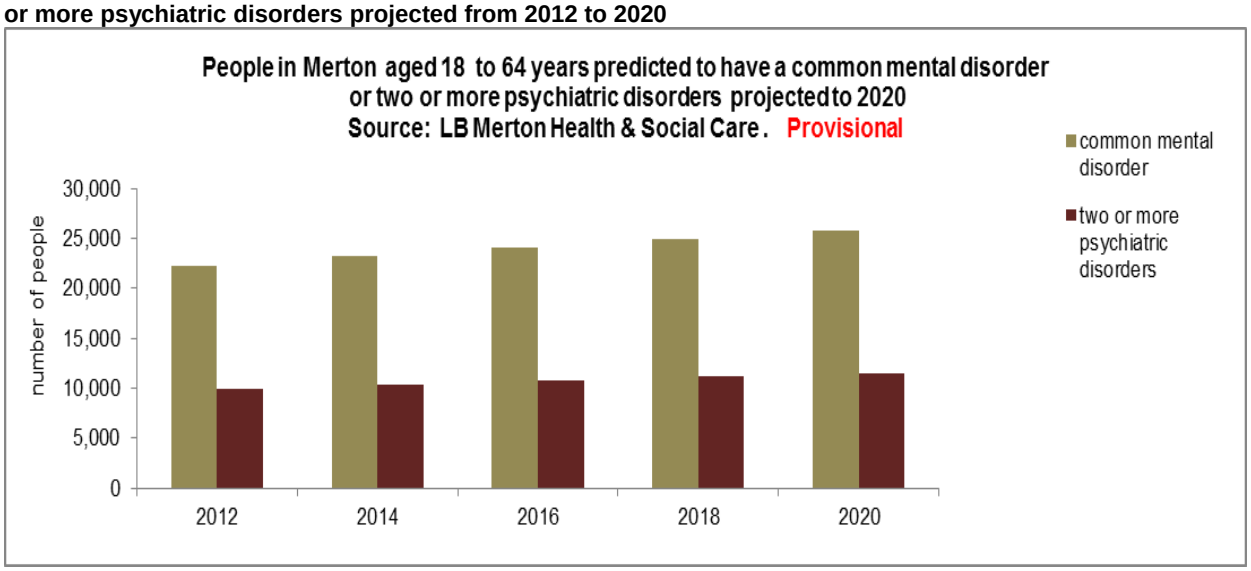
Table 6: Estimated prevalence in working age men and women in England

Prevalence	% males	% females
Common mental disorder	12.5	19.7
Two or more psychiatric disorders	6.9	7.5

[69] http://www.hscic.gov.uk/pubs/psychiatricmorbidity07

Figure 13 below shows the estimated number of 18-64 year olds in Merton predicted to have a common mental disorder or two or more psychiatric disorders from 2012 to 2020 (provisional). It shows that the number of working age adults in Merton with a common mental health disorder will increase progressively from 2012 to 2020. The number of working age Merton adults with two or more psychiatric disorders will also increase over this period but more gradually.

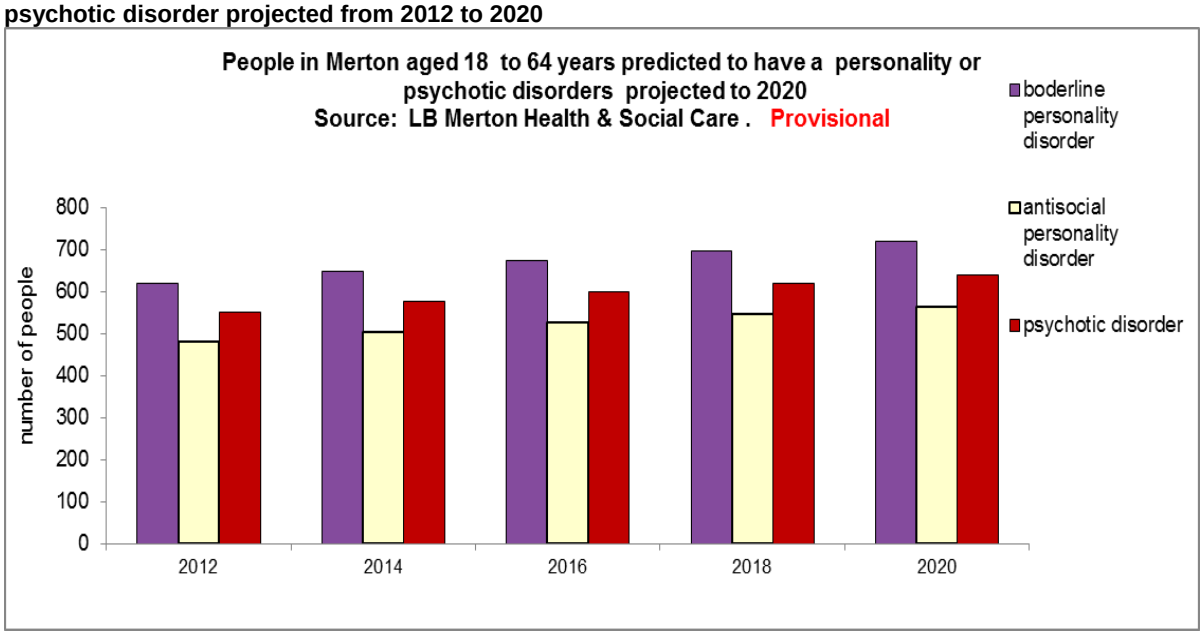
Figure 13: Estimated numbers of people in Merton predicted* to have a common mental disorder or two or more psychiatric disorders projected from 2012 to 2020



**The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2020.*

Figure 14 shows the estimated numbers of working age adults in Merton predicted to have personality and psychotic disorders from 2012 to 2020. The table depicts the national prevalence for these conditions in men and women. Borderline personality disorder and psychotic disorders are predicted to rise during this eight year period.

Figure 14: Estimated numbers of working age people in Merton predicted* to have a personality or psychotic disorder projected from 2012 to 2020



*The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2020.

Table 7: Estimated prevalence in working age men and women in England

Prevalence	% males	% females
Borderline personality disorder	0.3	0.6
Antisocial personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5

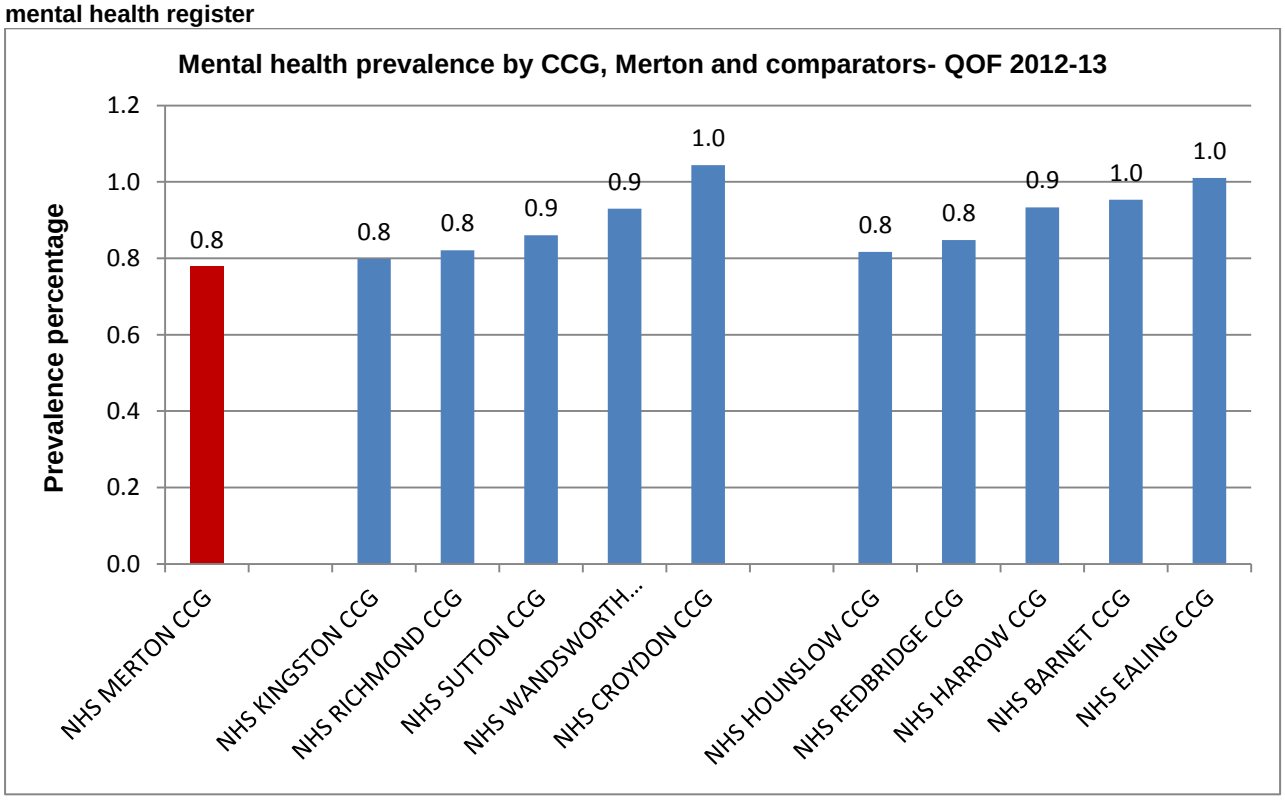
Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) rewards GP practices financially for the provision of quality care and helps to standardise improvements in the delivery of clinical care. Practice participation in QOF is voluntary but most practices on General Medical Services (GMS) contracts, as well as many on Personal Medical Services (PMS) contracts, take part in QOF. It was introduced as part of the new GMS contract in 2004.

In terms of mental health reported prevalence by CCG - the percentage of registered patients on the mental health register, in 2012-13 Merton CCG had the lowest prevalence among SW London CCGs as well as statistically similar CCGs (figure 15).

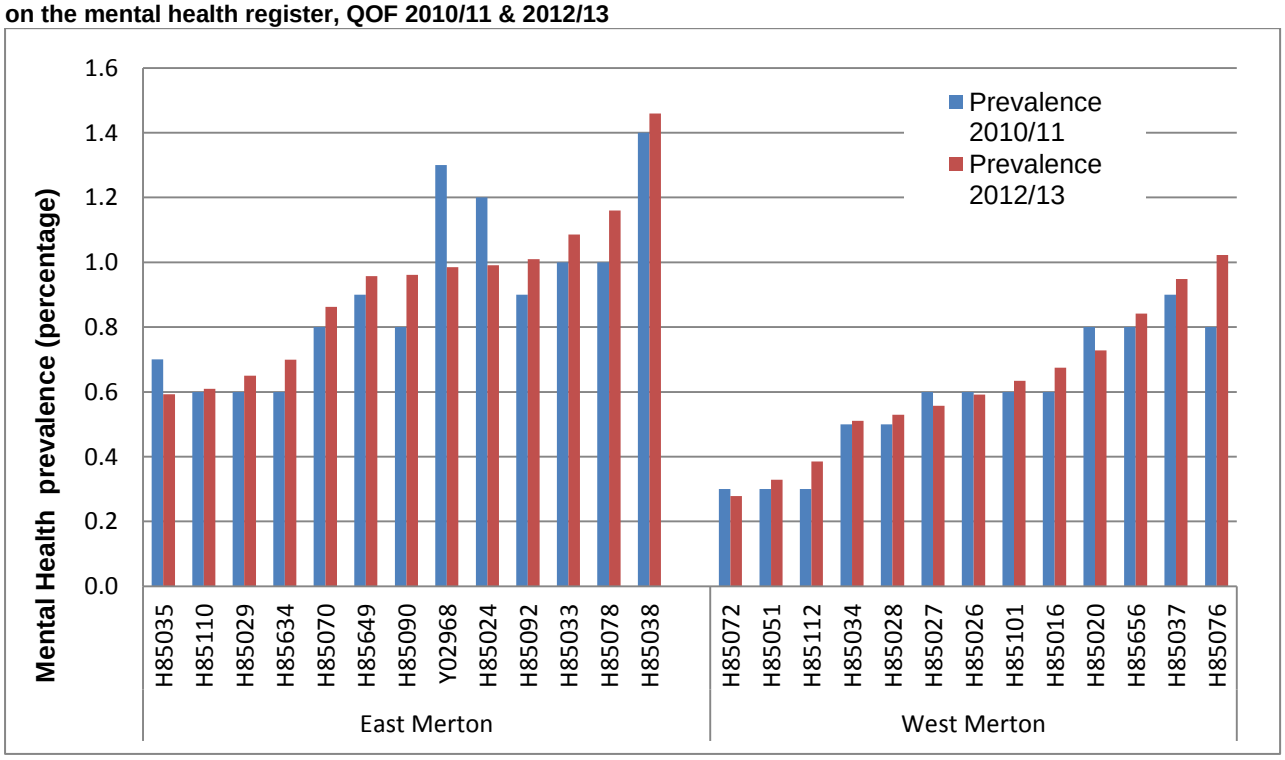
Figure 16 depicts the mental health reported prevalence by practices in East and West Merton, and also comparing data from 2010/11 with 2012/13. Most practices in East Merton had higher prevalence than practices in West Merton, across both periods. Only two practices in East Merton have seen a sharp drop in prevalence, and most practices have had increases from 2010/11 to 2012/13.

Figure 15: Mental health reported prevalence by CCG - the percentage of registered patients on the mental health register



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 16: Mental health reported prevalence by practice in Merton - the percentage of registered patients on the mental health register, QOF 2010/11 & 2012/13

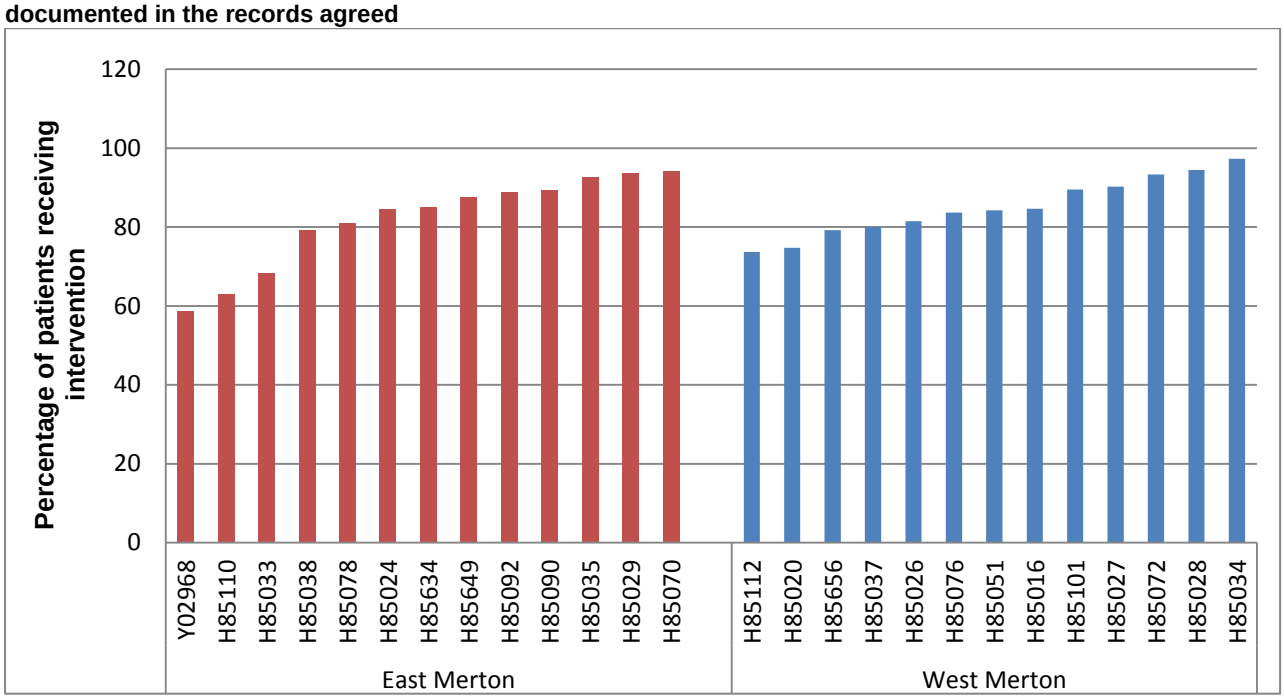


Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

QOF indicator MH 10 relates to "the percentage of patients on the register who have a comprehensive care plan documented in the records agreed"- Practices across both areas

of Merton have a very similar profile with most practices in the 70-90% range. Three practices in East Merton have low rates in the region of 60%.

Figure 17: MH 10-The percentage of patients on the register who have a comprehensive care plan documented in the records agreed



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

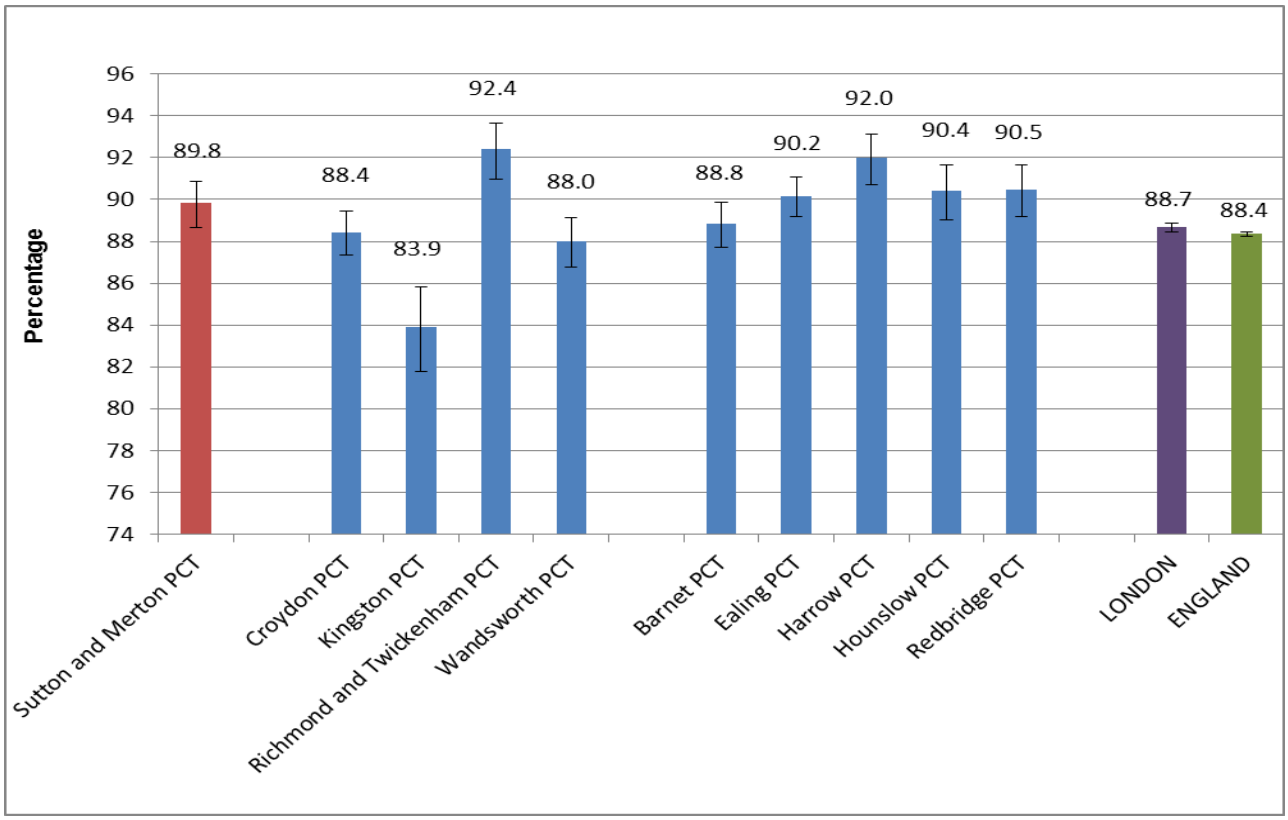
Health & social care outcomes related to mental health

The Health and Social Care Information Centre is the national database for all data relating to health and social care. Some of the indicators in it relate to mental health. The latest data is mostly for 2011-12 but in some cases for 2010-11. Also for Merton the data is in some cases reported as Sutton & Merton PCT (SMPCT) rather than as Merton CCG. However the comparative values give a reasonable idea of where Merton stands in relation to England, London, statistical and neighbouring boroughs. While the relevant HSCIC outcomes are reported in this document under the mental health conditions to which they apply, these are proxy indicators for the quality of care provided especially in the community, and help to benchmark Merton against national, regional and local comparators.

Comprehensive care plan for patients on mental health register

Patients on the mental health register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a comprehensive plan for care. This consultation may include the views of their relatives or carers where appropriate. For the patients who have a Severe Mental Illness and are seen in a primary care setting, it is important that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record. In 2011-12 SMPCT had the second highest percentage in SW London, higher than England and marginally higher than London. It was second lowest compared with statistical neighbours (figure 18 below).

Figure 18: Comprehensive care plan for patients on mental health register, 2011-12, all ages (%), with 95% confidence intervals*



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
** 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

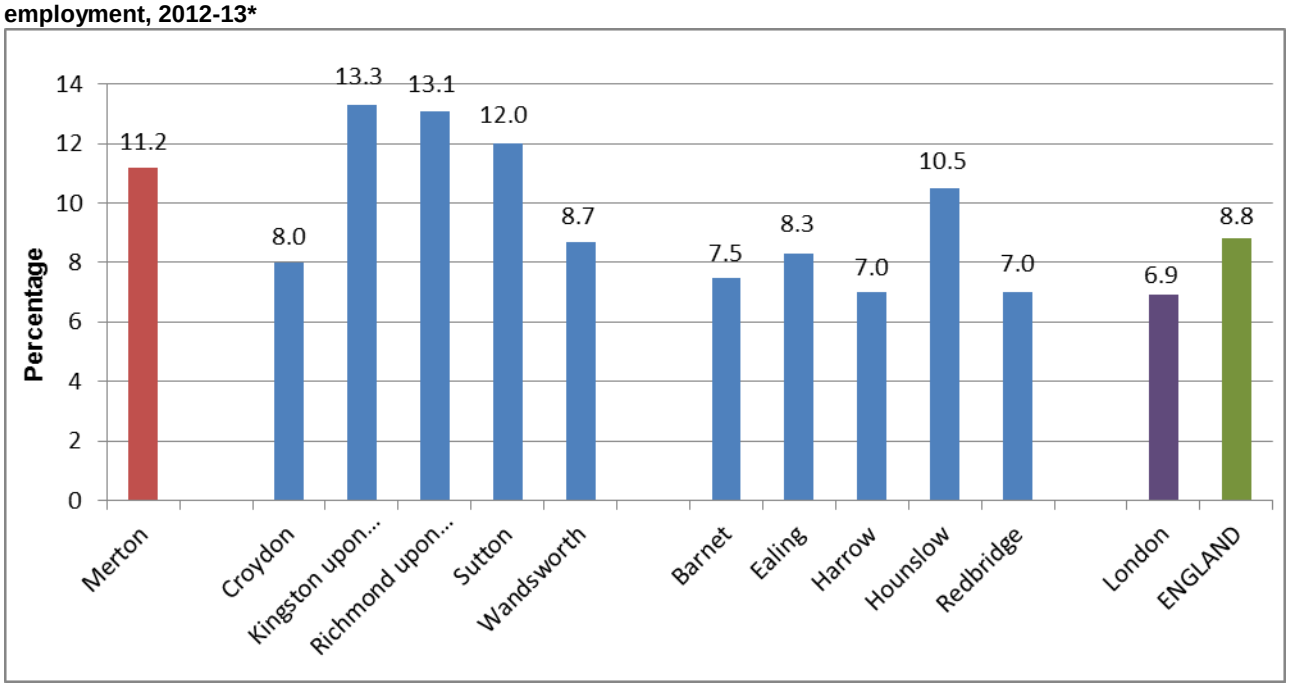
ASCOF 1F: Proportion of adults in contact with secondary mental health services in paid employment

This indicator measures working age adults who are receiving secondary mental health services and who are on the Care Programme Approach recorded as being employed, as a percentage of working-age adults who are receiving secondary mental health services and who were on the Care Programme Approach (aged 18 to 69). Merton is above England and London on this indicator, third lowest among SW London boroughs and higher than all statistical neighbours (figure 19).

ASCOF 1H: Proportion of adults in contact with secondary mental health services living independently, with or without support

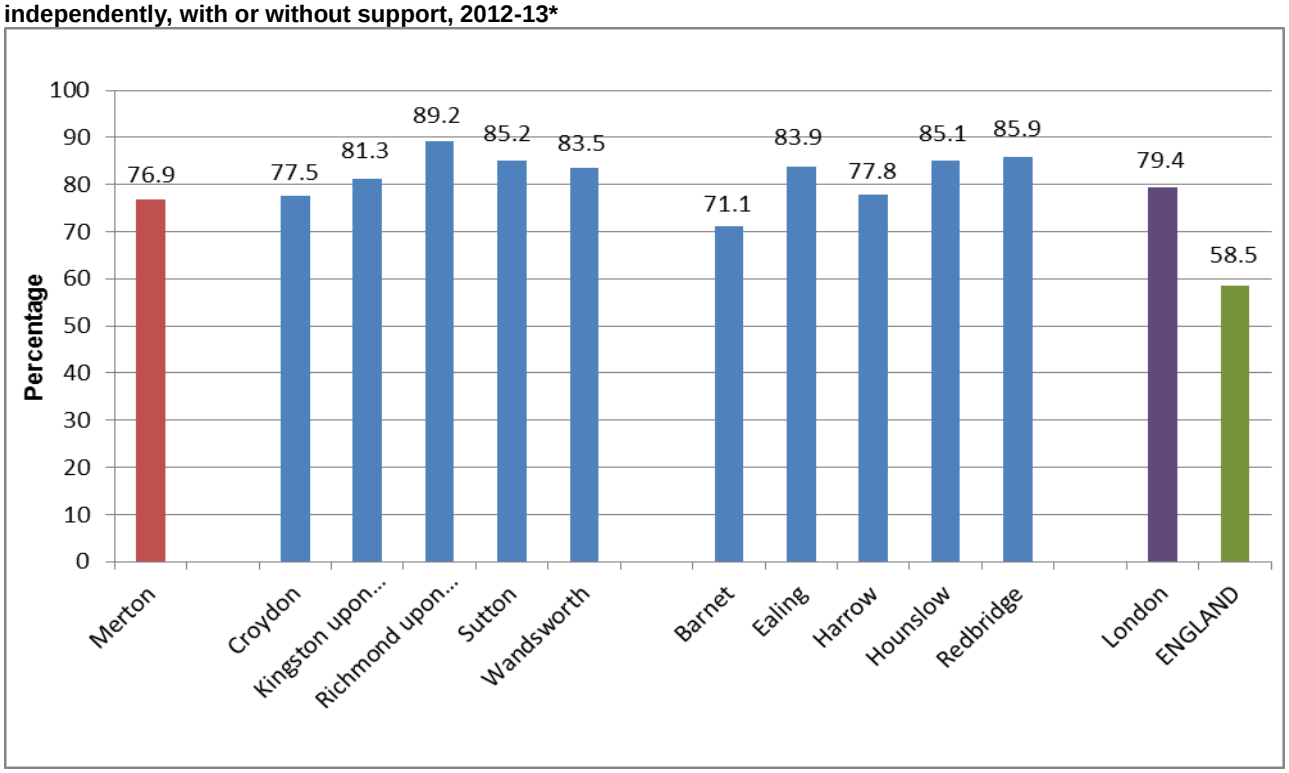
This indicator measures adults who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support, as a percentage of adults who are receiving secondary mental health services and who are on the Care Programme Approach (aged 18 to 69). While Merton is above the England average, it is below the London average and the lowest among SW London boroughs. It is second lowest among statistical neighbours (figure 20 below).

Figure 19: ASCOF 1F: Proportion of adults in contact with secondary mental health services in paid employment, 2012-13*



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
**ASCOF data does not include confidence intervals.*

Figure 20: ASCOF 1H: Proportion of adults in contact with secondary mental health services living independently, with or without support, 2012-13*



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
**ASCOF data does not include confidence intervals.*

Common Mental Health Disorders (CMDs)

Key Points

- *Public Health England estimates that Merton has one of the highest percentages of 16-74 years olds estimated to have a common mental health disorder*
- *Merton has significantly lower than national averages for adults with depression known to GPs and new cases of depression; and lower than national average long term mental health problems, and depression and anxiety among GP survey respondents*
- *The overall GP recorded depression prevalence is 4.7% for Merton CCG. the England prevalence is 5.8%*
- *In terms of the ratio of observed to expected depression prevalence, Merton has an overall ratio of 0.8 which suggests a level of under-diagnosis and there is considerable variance in diagnosis levels in Merton GP practices and between East and West Merton*
- *The rate of initial assessment of depression in Merton was significantly lower than the England average while the percentage of adults with a new diagnosis of depression with a follow-up assessment after 4-12 weeks was significantly higher*
- *Merton performs significantly lower than average at case finding for depression and has a significantly lower than average percentage of people with long term conditions visiting GP who felt that they have had enough support from local services in the last 6 months*
- *the IAPT (Improved Access to Psychological Therapies) referral rate (18+ yrs of age) in Merton was significantly higher than the national average as was the referral rate specifically for depression*
- *For mixed anxiety and depression the IAPT referral rate was significantly lower than average*
- *IAPT use by BME groups in Merton was significantly higher than the national average as was access to IAPT services expressed as a percentage of those estimated to have anxiety and depression*
- *The rate of beginning IAPT treatment was significantly higher than the national average while the rate of completion of treatment was significantly lower- suggesting low recovery rates, which indeed is the case in Merton*
- *For IAPT services in Merton, the percentage of referrals waiting less than 28 days are significantly lower than average but in contrast, for waiting times greater than 90 days Merton has significantly higher than average percentages*

CMDs include different types of depression and anxiety. They cause appreciable emotional distress and interfere with daily function, but do not usually affect insight or cognition. According to the Adult Psychiatric Morbidity Survey (APMS) 2007[70]:

- More than half of those with a CMD presented with mixed anxiety and depressive disorder (9.0%).
- Women were more likely than men to have a CMD (19.7% and 12.5% respectively), and rates were significantly higher for women across all categories of CMD, with the exception of panic disorder and obsessive compulsive disorder.

[70] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

- Overall, the proportion of people aged 16-64 meeting the criteria for at least one CMD increased between 1993 and 2000, but did not change between 2000 and 2007 (15.5% in 1993, 17.5% in 2000, 17.6% in 2007). The largest increase in rate of CMD between 1993 and 2007 was observed in women aged 45-64, among whom the rate rose by about a fifth.
- Rates of CMD varied by age: those aged 75 and over were the least likely to have a CMD (6.3%of men, 12.2% of women). In women, the rate peaked among 45-54 year olds, with a quarter (25.1%) of this group meeting the criteria for at least one CMD. Among men the rate was highest in 25-54 year olds (14.6%of 25-34 year olds, 15.0%of 35-44 year olds, 14.5% of 45-54 year olds).
- A quarter (24%) of people with a CMD were receiving treatment for an emotional or mental problem, mostly in the form of medication. The level and nature of treatment varied by type of CMD: over half (57%) the adults with a phobia were in receipt of treatment, but only 15%of those with mixed anxiety and depressive disorder. Half (48%) the people with two or more CMDs were receiving treatment for a mental or emotional problem.

Common Mental Health Disorders Profile for Merton (figure 21)

Risk and related factors

Social, economic and environmental conditions influence the mental and physical health of individuals and communities such as deprivation, employment, crime, and alcohol and drug misuse. In Merton indicators are generally significantly better than England; however Public Health England has identified household overcrowding, percentage of households living in rented accommodation, percentage of people who cannot speak English/ speak it well, population turnover (internal migration), and migrant GP registrations as areas with significantly higher than national average values for Merton.

Prevalence

Public Health England estimates that Merton has one of the highest percentages of 16-74 year olds estimated to have a common mental health disorder (31%). The statistical significance of this metric has not been calculated and the figure is likely to be revised as it is not accurate[71]. As mentioned earlier, Merton has significantly lower than national averages for adults with depression known to GPs, new cases of depression; and lower than national average long term mental health problems, and depression and anxiety among GP survey respondents. This might indicate a low prevalence in Merton but could also indicate under-diagnosis and under-recording.

Services

As a snapshot (Q3, 2013/14), the IAPT referral rate (18+ yrs of age) in Merton was significantly higher than the national average as was the referral rate specifically for depression. For mixed anxiety and depression the IAPT referral rate was significantly lower than average. IAPT use by BME groups in Merton was significantly higher than the national average as was access to IAPT services expressed as a percentage of those estimated to have anxiety and depression. The rate of beginning IAPT treatment was significantly higher

[71] NHS Merton Clinical Commissioning Group has corresponded with Public Health England on this figure, and it has been established that there was an error in the way it was calculated.

than the national average while the rate of completion of treatment was significantly lower- suggesting low recovery rates, which indeed is the case in Merton.

Quality and Outcomes

As mentioned earlier in this report, the rate of initial assessment of depression in Merton was significantly lower than average, expressed as the percentage of adults with a new diagnosis of depression with an assessment of severity at treatment outset, while the percentage of adults with a new diagnosis of depression with a follow-up assessment after 4-12 weeks was significantly higher. This suggests that Merton GP practices are better at follow-up assessment of depression after 4-12 weeks than they are in the initial assessment of depression. Merton performs significantly lower than average at case finding for depression, the metric for which is the percentage of patients on diabetes and/or CHD register for whom case finding for depression has been undertaken during the preceding 15 months. This suggests that the mental health of patients with physical health problems is not adequately addressed in primary care. This is further corroborated by the finding that Merton has a significantly lower than average percentage of people with long term conditions visiting GP who felt that they have had enough support from local services in the last 6 months.

For IAPT services in Merton, the percentage of referrals waiting less than 28 days are significantly lower than average but in contrast, for waiting times greater than 90 days Merton has significantly higher than average percentages. This means that more referrals are waiting over 90 days than they are less than 28 days. As mentioned earlier, IAPT recovery rate in Merton is significantly lower than national average. The DNA (Did Not Attend) rate is also significantly lower than average.

In terms of social care based on 2012/13 figures[72], Merton has a significantly lower than national average percentage of service users who are extremely or very satisfied with their care and support. The percentage of services users who say that services have made them feel safe and secure is also significantly lower than average. Public Health England has expressed some concerns with the quality of the data.

Finance

In general Merton has a lower spend on mental health compared with the national average. Where Merton's spend is considerably higher than average is the percentage spend on "other" mental health. It is also higher for secondary care spend on "other" mental health and the spend on IAPT services.

[72] http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#gid/8000043/pat/6/ati/102/page/1/par/E12000007/are/E09000024

Figure 21 : Merton Common Mental Health Disorders Profile (CMDs)

Risk and related factors

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Socioeconomic deprivation: overall IMD score	2012	15.0	21.5	5.8		47.4
Older people living in income deprived households: % of people over 60	2012	17.2	18.1	7.4		56.2
People with CHD and/or diabetes: % patients on the GP register	2012/13	5.8	7.3	4.3		10.4

Prevalence

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
People estimated to have any common mental health disorder: Estimated % of population aged 16-74	2013/14	31.04 ^	15.85	4.84		31.04
Adults with depression known to GPs: Patients with depression as % of all patients on the GP register	2012/13	4.7	5.8	2.9		11.5
New cases of depression: Adults with a new diagnosis of depression as % of all patients on the GP register	2012/13	0.9	1.0	0.5		1.9
Long term mental health problems among GP survey respondents: % people completing GP patient survey who report long-term mental health problem	2013/14	3.7	4.6	2.6		8.8
Depression and anxiety among GP survey respondents: % of people completing GP patient survey reporting they feel moderately or extremely anxious or depressed	2013/14	9.4	12.1	7.2		19.4

Services

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Adults with depression known to GPs: Patients with depression as % of all patients on the GP register	2012/13	4.7	5.8	2.9		11.5
New cases of depression: Adults with a new diagnosis of depression as % of all patients on the GP register	2012/13	0.9	1.0	0.5		1.9
Antidepressant prescribing: Average daily quantities (ADQs) per STAR-PU	2012/13	3.8	6.0	2.7		9.0
Use of '1st choice' antidepressants: % of prescription items that were '1st choice' generic SSRIs	2012/13	67.6	63.4	53.4		74.2
Hypnotics prescribing: Average daily quantities (ADQs) per STAR-PU	2012/13	3.30	4.18	1.90		7.98
IAPT referrals: Rate (quarterly) per 100,000 population aged 18+	2013/14 Q3	1052	624	3		1719
IAPT referrals for depression: Rate (quarterly) per 100,000 population aged 18+	2013/14 Q3	92.5	73.1	0.0		738.2
IAPT referrals for mixed anxiety and depression: Rate (quarterly) per 100,000 population aged 18+	2013/14 Q3	16.5	75.1	0.0		684.5
IAPT use by BME groups: % of referrals (in quarter) which are for people of black and minority ethnic groups	2013/14 Q3	41.5	16.1	0.9		75.1
Access to IAPT services: People entering IAPT (in month) as % of those estimated to have anxiety/depression	Dec 2013	14.6	9.5	0.0		50.4
Entering IAPT treatment: Rate (quarterly) beginning IAPT treatment per 100,000 population aged 18+	2013/14 Q3	697	416	0		1020
Completion of IAPT treatment: Rate (quarterly) completing treatment per 100,000 population aged 18+	2013/14 Q3	174	223	17		605
IAPT diagnosis coding completeness: % (in quarter) of IAPT referrals with a provisional diagnosis code	2013/14 Q3	21.0	43.2	0.5		100

Quality and Outcomes

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Assessment of depression: % of adults with a new diagnosis of depression with assessment of severity at treatment outset	2012/13	75.1	79.8	62.3		94.4
Follow-up assessment of depression: % of adults with a new diagnosis of depression with follow-up assessment after 4-12 weeks	2012/13	61.6	56.0	44.4		71.3
Case finding for depression: % of patients on diabetes and/or CHD register for whom case finding for depression has been undertaken during the preceding 15 months	2012/13	84.5	85.9	80.2		91.7
Exception rate for depression: % of patients on depression register excluded from quality indicators	2012/13	5.4	5.3	3.1		9.7
Support for people with LTCs: % of people with long term conditions visiting GP who feel they have had enough support from local services in last 6 months	2012/13	57.0	64.0	54.3		71.0
Waiting < 28 days for IAPT: % of referrals (in month) waiting	Dec 2013	23.9	61.9	5.7		98.4
Waiting > 90 days for IAPT: % of referrals (in month) waiting > 90 days for first treatment	Dec 2013	35.2	11.2	0.8		73.3
IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving to recovery"	Dec 2013	42.3	43.7	19.8		96.3
IAPT reliable recovery: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement"	2013/14 Q3	48.7	61.3	29.5		74.0
IAPT DNAs: % of IAPT appointments (in quarter) where patient did not attend and gave no advance warning	2013/14 Q3	6.6	12.0	2.2		29.6
Paired data completeness: % of referrals (in quarter) with paired PHQ9 and ADSM scores	2013/14 Q3	100	96.9	65.8		100

Finance

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Specialist mental health services spend: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	16425	26756	14296		49755
% spend on specialist mental health services: % of all secondary care service spend categorised as mental health (mapped from PCT)	2012/13	8.8	11.9	8.1		19.1
Spend on other mental health services: rate (£000s) per 100,000 population aged 18+ (mapped from PCT)	2012/13	13687	13772	3903		30893
% spend on other mental health: % of all mental health spend categorised as other mental health (mapped from PCT)	2012/13	83.3	51.5	13.1		87.7
Primary care prescribing spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	483	857	268		1419
Secondary Care spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	10832	6762	103		27077
Community care spend on other mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	0	2739	0		15718
Spend on Psychological Therapy Services (IAPT): rate (£000s) per 100,000 aged 16 - 64 (mapped from PCT)	2010/11	648	487	1		1621
Spend on Psychological Therapy Services (Non IAPT): rate (£000s) per 100,000 aged 16 - 64 (mapped from PCT)	2010/11	252	534	11		1809
Cost of GP prescribing for antidepressant drugs: Net Ingredient Cost (quarterly) per STAR-PU	2013/14 Q3	150.8	287.4	119.0		548.5
Cost of GP prescribing for hypnotics and anxiolytics: Net Ingredient Cost (quarterly) per STAR-PU	2013/14 Q3	435	586	225		1196

Indicators included in spine-charts are drawn from a range of sources, are based on differing populations and are presented for a number of time periods. Detail relating to each indicator is included within the tool under 'definitions'.

http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

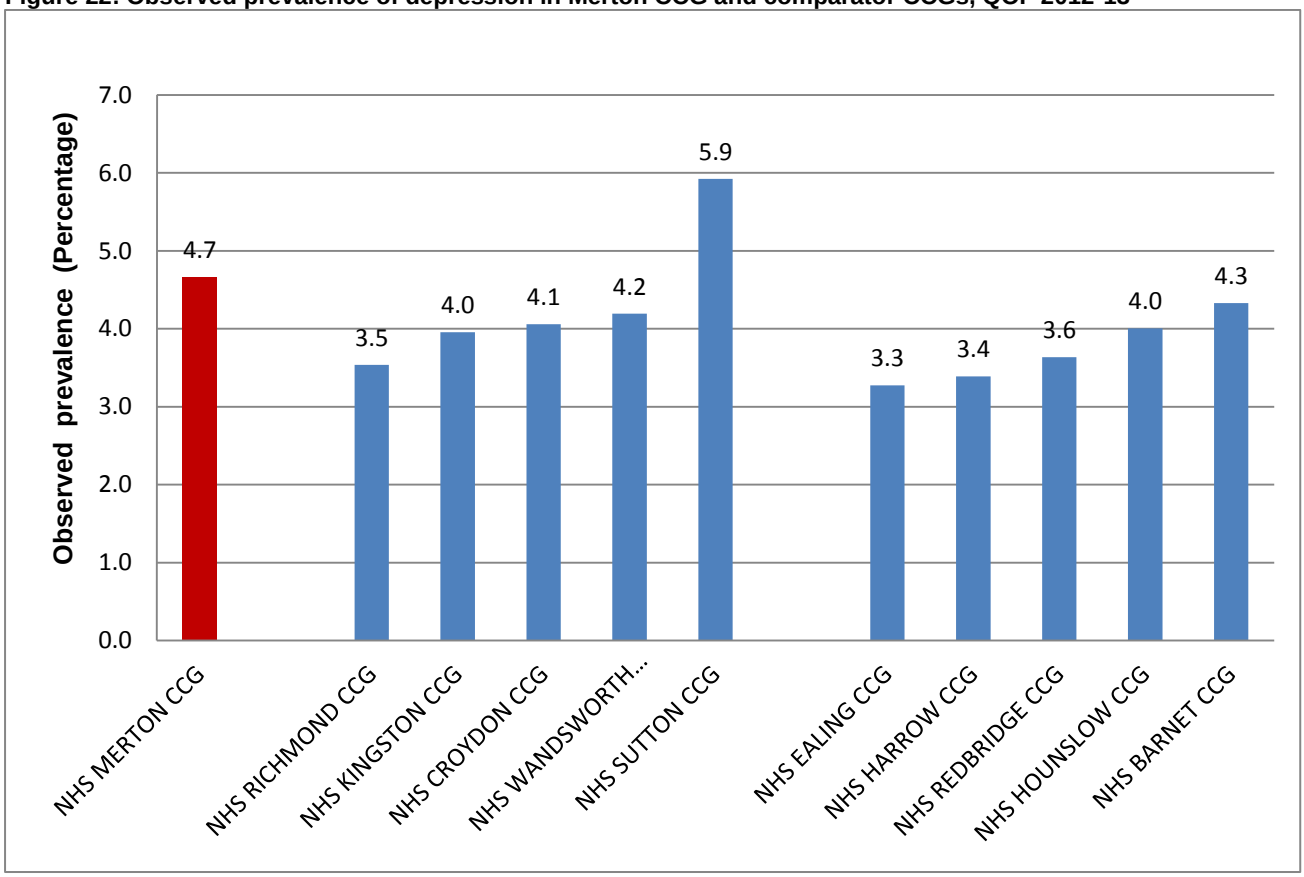
Source: NEPHO 2014 http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data

Mood affective disorders including depression

Analysis of depression in Merton from QOF 2012-13 data

In 2012-13, there were 7,997 Merton residents on the depression register (18+ years of age) out of a total registered 18+ years of age population of 171,358. This gives an overall GP recorded prevalence of 4.7% for Merton CCG. The England prevalence is 5.8%. Figure 22 compares the observed prevalence in Merton CCG with comparator CCGs. Among geographically neighbouring CCGs Merton has the second highest recorded prevalence, second only to Sutton, and has a higher prevalence than all statistically comparable CCGs.

Figure 22: Observed prevalence of depression in Merton CCG and comparator CCGs, QOF 2012-13* ¥

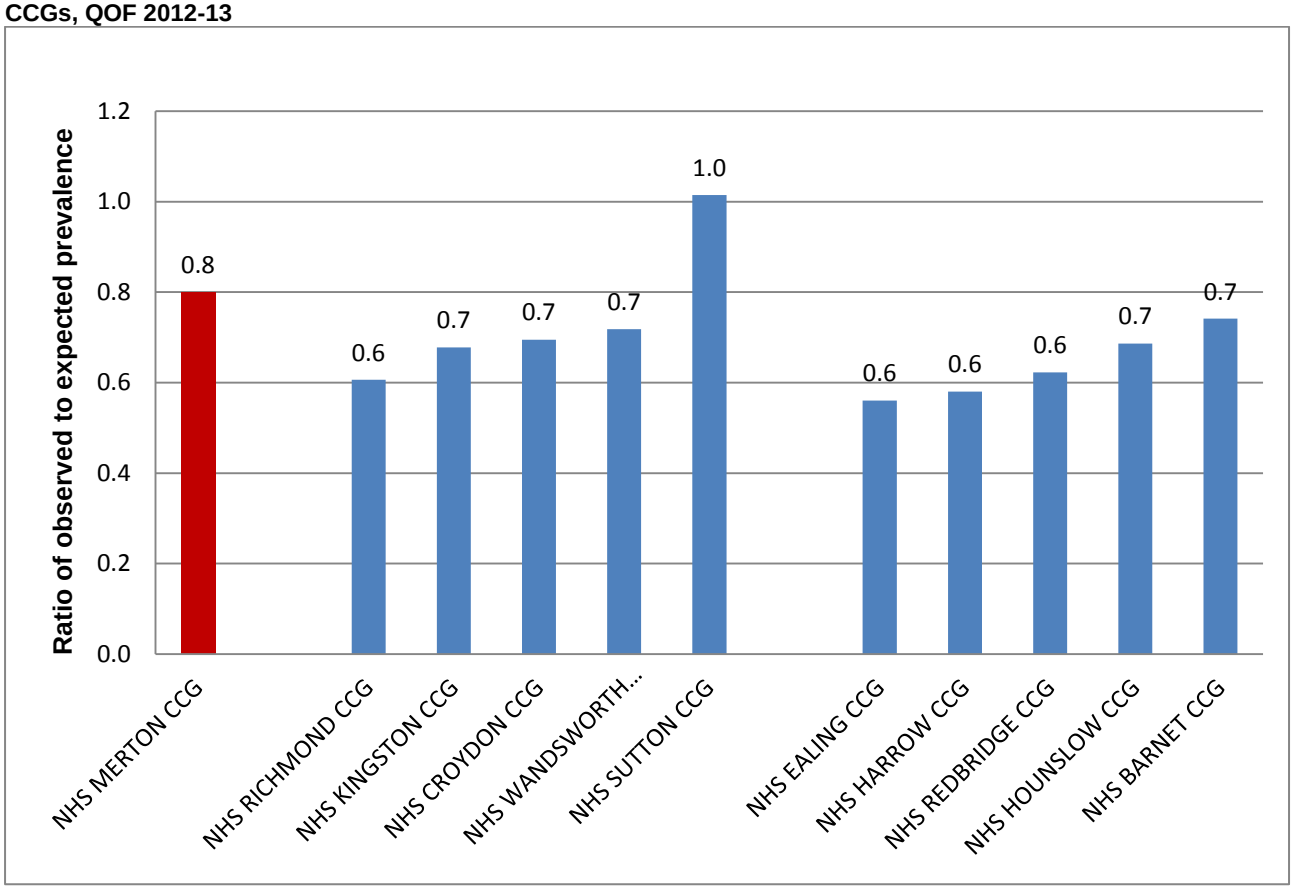


*Prevalence percentages are rounded off to the nearest tenth. ¥ England prevalence is 5.8%.

By applying the national QOF recorded age-specific (18+ years of age) prevalence for depression to individual GP practice populations in the 18+ years of age group, the expected number of cases for Merton overall and by GP practice can be ascertained. Dividing the observed by the expected numbers gives a ratio that is indicative of the level of over- or under-diagnosis. A value of 1 indicates that the level of diagnosis is roughly in line with what is expected. A value less than 1 indicates that there are less cases being diagnosed than expected. A value higher than 1 indicates that more cases are being diagnosed than predicted, which can suggest over-diagnosis. A simple rule of thumb is that the closer the metric is to 1, the more suggestive this is of effective diagnosis in primary care. Figure 23 below depicts the ratio of observed to expected prevalence for Merton CCG and comparator CCGs. Merton has an overall ratio of 0.8 which suggests a level of under-diagnosis, but

when compared with other geographical and neighbouring CCGs, only Sutton CCG has a better ratio (1.0)

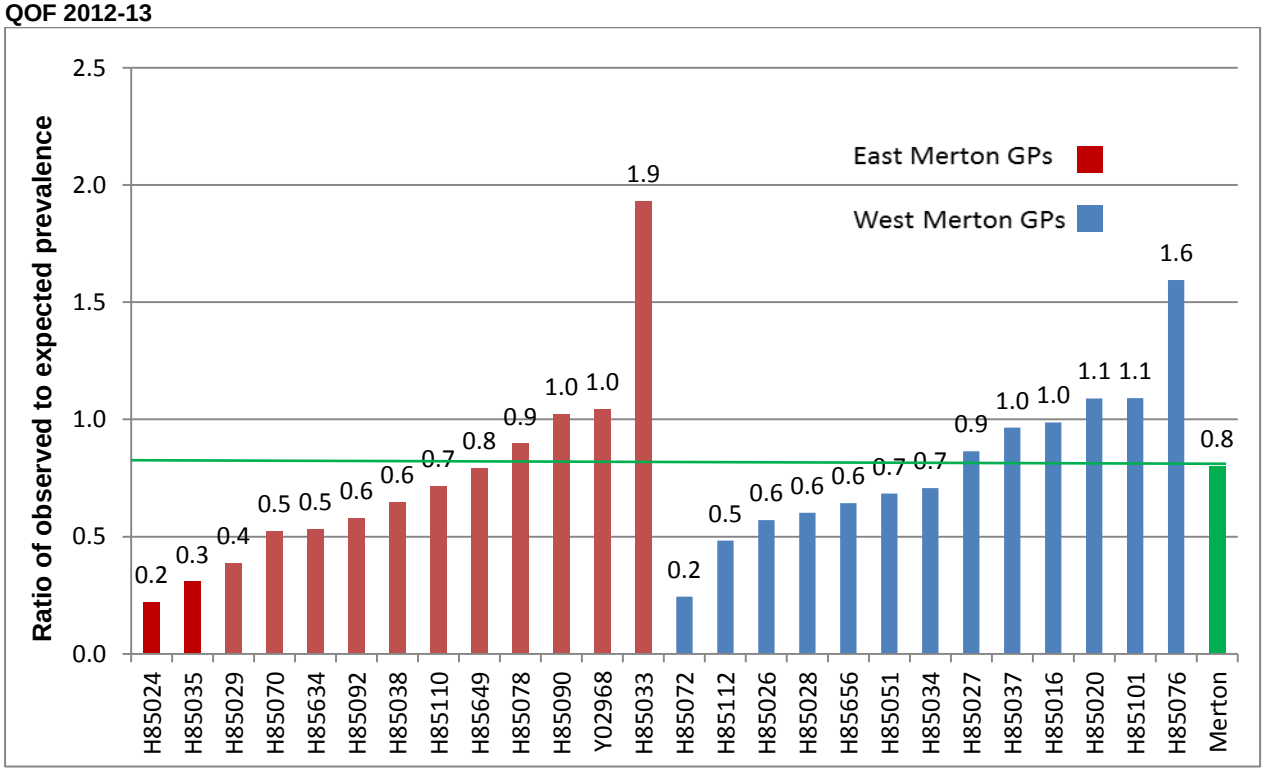
Figure 23: Ratio of Observed to expected prevalence of depression in Merton CCG and comparator CCGs, QOF 2012-13



Plotting the observed to expected prevalence ratios for individual practices in Merton and grouping them into east & west Merton practices illustrates the considerable variance in diagnosis levels between different practices. It is now well established that there are major health inequalities in the borough between east and west Merton[73]. Figure 24 further illustrates this point in relation to the diagnosis of depression. While in both east and west Merton there are considerable differences between practices in the levels of diagnosis, more practices in the east are below that optimal value (i.e. 1.0) than in the west. Furthermore a lot more practices in the east are below the Merton average of 0.8 (the green line) than in the west. This suggests that there are many more undiagnosed cases of depression in 18+ years of age adults in east Merton than in west Merton although there is under-diagnosis in both areas.

[73] Merton JSNA 2012-13, and 2013-14

Figure 24: Ratio of Observed to expected prevalence of depression in Merton GP practices, 18+ years, QOF 2012-13



Depression and severe depression in older people (65+ years) in Merton

The table 8 shows the modelled numbers of older people with depression in Merton, London and England for two periods- 2012 and 2018. Once again the numbers increase in time at all administrative levels and for all conditions. The table 9 indicates the estimated national prevalence of depression in men and women by age groups. This is used to estimate the local numbers.

Table 8: Expected Prevalence of depression and severe depression in older people (65+) in Merton, London and England in 2012 and 2018

Older People (65+)	2012			2018		
	Merton	London	England	Merton	London	England
Depression	2,085	80,909	781,879	2,310	88,718	881,279
Severe Depression	656	25,679	248,600	736	28,099	278,826

Source: Projecting Older People Information System (POPPI) web site 08.10.2013

Table 9: Estimated prevalence of depression in men and women in England

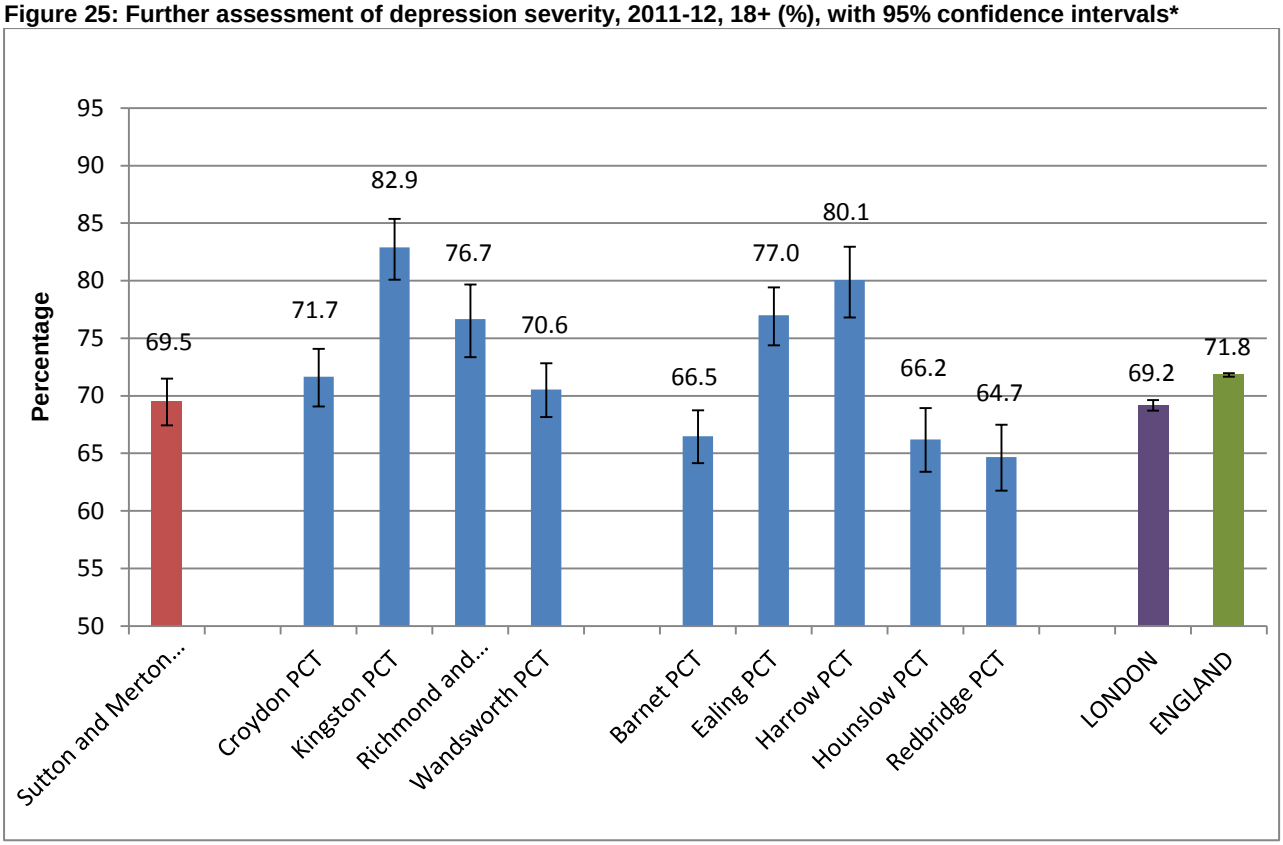
Rates for men and women diagnosed with depression:		
Age range	% Males	% Females
65-69	5.8	10.9
70-74	6.9	9.5
75-79	5.9	10.7
80-84	9.7	9.2
85+	5.1	11.1

McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787–1795.
Prevalence rates have been applied to ONS population projections of 65+ populations to give estimated numbers predicted to have depression

Further assessment of depression severity

Further assessment of depression severity is important to help ensure high standards of primary health care and treatment delivered to NHS patients diagnosed with depression. The rationale for such follow-up measurement is derived from the recognition that depression is often a chronic disease, yet treatment is often episodic and short-lived. If treatment with antidepressants is initiated, then patients should be being followed up regularly for several months. Early cessation of treatment is associated with a greater risk of relapse. In 2011-12 S&M PCT had the lowest percentage of patients undergoing further assessment of depression in SW London, lower than England and only marginally higher than London. Compared with statistical neighbours it was third highest after Harrow and Ealing PCTs.

Figure 25: Further assessment of depression severity, 2011-12, 18+ (%), with 95% confidence intervals*



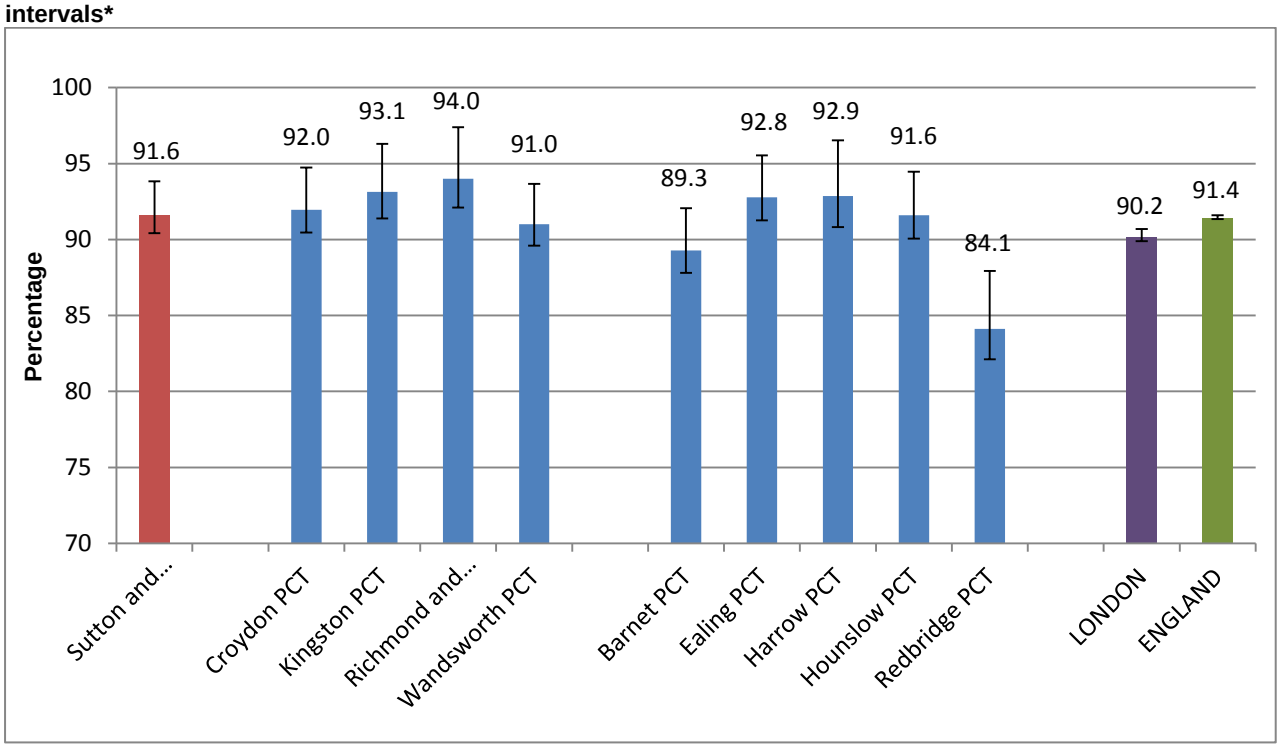
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
** 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

Depression severity assessment at outset of treatment

Depression severity assessment at outset of treatment is essential to decide on appropriate interventions and improve the quality of care. A measure of severity at the outset of

treatment enables a discussion with the patient about relevant treatment interventions and options, guided by the stepped care model of depression. Recent research has shown that patients value the use of severity measures and that doctors' treatment and referral rates are related to the scores on the measures[74]. In 2011-12 S&M PCT had the second lowest percentage in SW London, and it was marginally higher than England and higher than London, and comparable with other SW London PCTs although it was second lowest above Wandsworth. It was third highest with Hounslow, among statistical neighbours.

Figure 26: Depression severity assessment at outset of treatment, 2011-12, 18+ (%), with 95% confidence intervals*



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/
** 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

Of the nine quality indicators for mental health in the QOF, MH17 & MH18 relate to the treatment of depressive illnesses. The results in 2012-13 for these indicators are presented by practice grouped into East and West Merton:

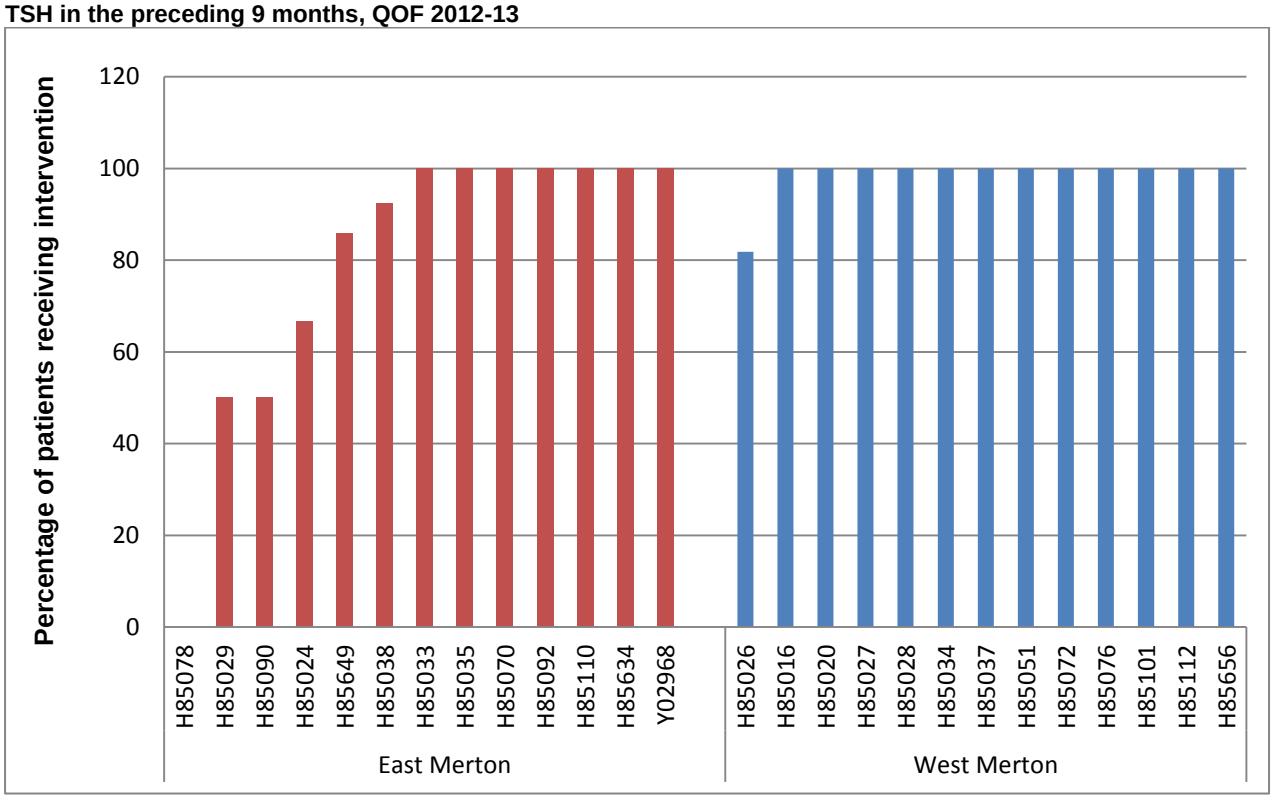
MH 17 - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months- Almost all practices in West Merton and half of East Merton practices achieve 100%. The other half of practices in East Merton has relatively low percentages considering that so many achieved 100%, with one practice not reporting.

MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months- Again more practices in West Merton

[74] HSCIC Meta data on indicator;
https://indicators.ic.nhs.uk/download/NCHOD/Specification/Spec_31Q_669PC_12_V1.pdf

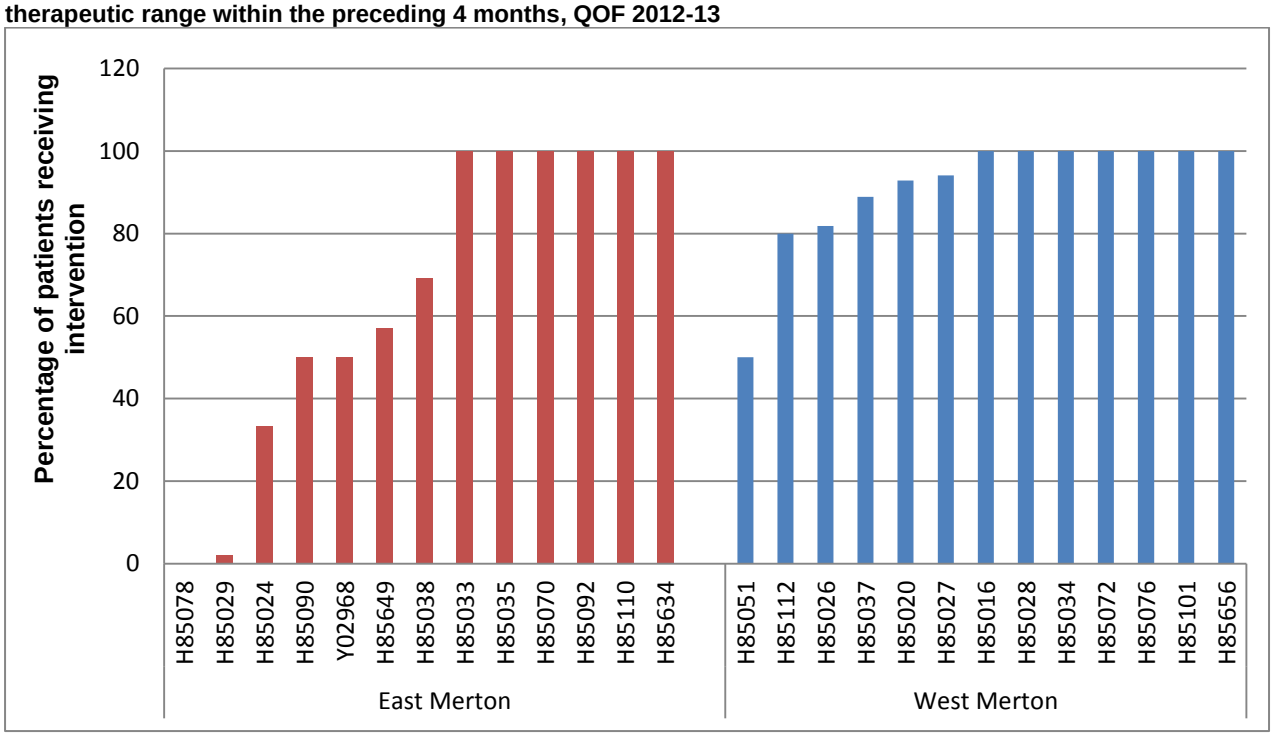
achieved 100% than in East Merton and there is a clear split in the East between the half of practices achieving 100% and a much lower percentage (mostly less than 60%) in the other half.

Figure 27: MH 17 - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, QOF 2012-13



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 28: MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months, QOF 2012-13



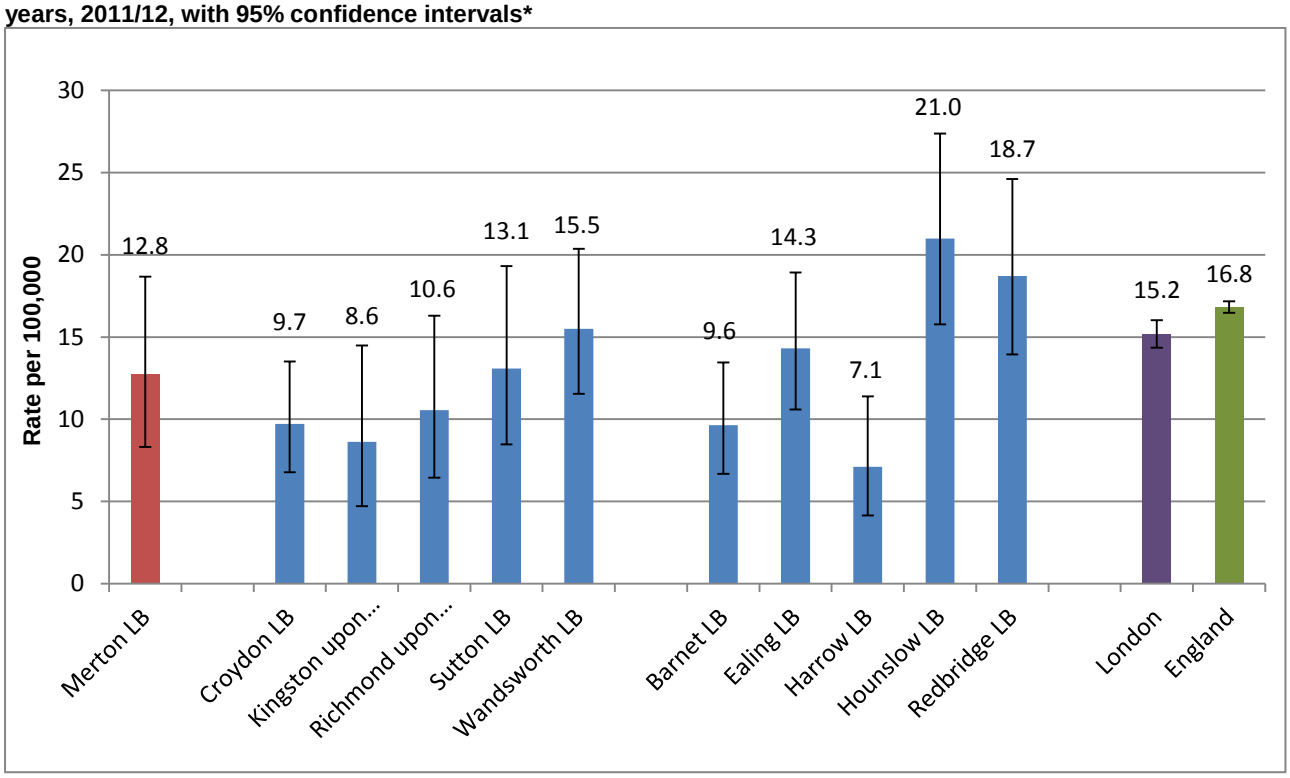
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Neurotic, anxiety and stress disorders

Emergency hospital admissions for neurosis

For emergency hospital admissions for neurosis, Merton rates are lower than England and London, and lower than Sutton and Wandsworth among geographical neighbours, and lower than Hounslow, Redbridge and Ealing among statistical ones. None of these differences are however statistically significant.

Figure 29: Emergency hospital admission rate (indirectly standardised) for neurosis, people aged 15-74 years, 2011/12, with 95% confidence intervals*



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

** 95% confidence intervals (CI) indicate the precision with which the rates are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the rates are compared, if the CI intervals do not overlap this represents a statistically significant difference*

Severe Mental Illness (SMI)

Key Points

- *Merton has a significantly lower than average number of people with SMI known to GPs. Merton also has a lower ratio than the England average of the QOF registered prevalence as a ratio of estimated prevalence. These point to relative under-diagnosis or under-recording of SMI in Merton compared with national the average*
- *For new cases of psychosis served by the Early Intervention teams, Merton rates are significantly higher than the national average, as they are for the rate of people being treated by the Early Intervention teams*
- *The rate of contact with services, and day care attendances are significantly lower than average*
- *Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital and significantly lower rates of mental health hospital admissions and discharges*
- *Admissions under the Mental Health Act in Merton were significantly higher than the national average- in fact more than double. Detentions on admission to hospital were also significantly higher than the national average*
- *Schizophrenia emergency admission rate was significantly higher in Merton than the national average although there were some concerns about data quality*
- *Merton rates were significantly lower than the England averages for social care mental health clients receiving services during the year, mental health clients in residential or nursing care, mental health clients receiving home care during the year, and mental health clients receiving day care or day services*
- *Merton rates were significantly higher than the England averages for mental health clients with new social care assessments during the year, and carers (of an adult with mental health conditions) assessed during the year*
- *The percentage of people in contact with mental health services with a crisis plan in place was significantly less in Merton compared with the England average*
- *Merton had significantly higher rate of delayed discharge than the England average- in fact more than 3.5 times*
- *For follow-up of non-attendance at annual review among patients with psychoses, in 2010-11 Sutton & Merton Primary Care Trust had the second lowest percentage in SW London, and it was lower than England and marginally higher than London*
- *2012-13 QOF data suggests that there is room for improvement, and considerable variance between GP practices overall and between practices in East and West Merton in terms of proxies for caring for the physical health of patients with schizophrenia*

Merton Severe Mental Illness Profile for Merton (figure 30)

Risk and related factors

Merton has a significantly lower than national average percentage of people with learning disabilities on a GP register- which means that a significantly lower percentage of people with learning disabilities are known to GPs in Merton than the England average.

Prevalence

Merton has a significantly lower than average number of people with SMI known to GPs, expressed as a percentage on the GP register. Merton also has a lower ratio than the England average of the QOF registered prevalence as a ratio of estimated prevalence. These metrics point to relative under-diagnosis or under-recording of SMI in Merton compared with national the average.

Services

In terms of new cases of psychosis served by the Early Intervention teams, Merton rates are significantly higher than the national average, as they are for the rate of people being treated by the Early Intervention teams. In Merton the rate of contact with services, and day care attendances are significantly lower than average. Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital but significantly lower rates of mental health hospital admissions and discharges. Admissions under the Mental Health Act in Merton were significantly higher than the national average- in fact more than double. Detentions on admission to hospital in Merton were also significantly higher. A&E attendances for a psychiatric disorder were significantly lower than the national average. However the schizophrenia emergency admission rate was significantly higher in Merton than the national average although there were some concerns about data quality.

For social care related metrics Public Health indicates that there were some concerns on data quality for all the metrics. Having said that, in 2012/13 Merton rates were significantly lower than the England averages for social care mental health clients receiving services during the year, mental health clients in residential or nursing care, mental health clients receiving home care during the year, and mental health clients receiving day care or day services. Merton rates were significantly higher than the England averages for mental health clients with new social care assessments during the year, and carers (of an adult with mental health conditions) assessed during the year.

Quality and outcomes

On most indicators Merton had comparable or better figures compared with England averages. However the percentage of people in contact with mental health services with a crisis plan in place was significantly less in Merton compared with the England average. Having said that, Merton had a low rate of emergency readmissions over the same period (local Trust data- if there were less people with a crisis plan in place, then emergency readmissions would be higher), which suggests that this could be a recording problem. For days of delayed discharge as a rate per 1000 bed days, Merton had significantly higher rate of delayed discharge than the England average- in fact more than 3.5 times. This could reflect a lack of accommodation available for patients due to be discharged.

In terms of social care in 2012/13, the percentage of social care mental health clients receiving direct payments in Merton was significantly higher than the national average (more than 6 times), as was the percentage of social care mental health clients receiving direct payments or having a personal budget (almost 3 times). In Merton 100% of carers received services or advice or information, as a percentage of mental health clients receiving community services- this was significantly higher than England average (approx. 5 times).

Finance

In terms of spend in Merton related to SMI, on all the metrics Merton spent less than the England average.

Figure 30: Merton Severe Mental Illness (SMI) Profile

Risk and related factors

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Socioeconomic deprivation: overall IMD score	2012	15.0	21.5	5.8		47.4
Number of people with learning disabilities known to GPs: % on register	2012/13	0.3	0.5	0.2		0.9

Prevalence

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Psychotic disorder: Estimated % of people aged 16+	2012	0.42 ^	0.40	0.18		0.77
Number of people with SMI known to GPs: % on register	2012/13	0.78	0.84	0.48		1.46
Comparison of QoF and estimated prevalence: QoF register prevalence as a ratio of estimated prevalence	2012	1.86	2.02	1.32		3.76

Services

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Number of people with SMI known to GPs: % on register	2012/13	0.78	0.84	0.48		1.46
Comparison of QoF and estimated prevalence: QoF register prevalence as a ratio of estimated prevalence	2012	1.86	2.02	1.32		3.76
GP prescribing of drugs for psychoses and related disoders: Items (quarterly) per 1,000 population	2013/14 Q3	34.2	44.5	21.3		95.4
People in contact with services: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	1097	2256	396		5247
People on Care Programme Approach: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	449	523	54		1728
Service users on CPA: % people in contact with MH servives who are on care programme approach (end of quarter snapshot)	2013/14 Q3	40.9	23.2	1.3		84.0
Use of mental health services by BME groups: % of people in contact with mental health services who are in black and minority ethnic groups	2012/13	25.9	8.6	0.3		55.2
New cases of psychosis served by Early Intervention teams: Rate (annual) per 100,000 population	2013/14	37.4	24.9	0.0		134.1
Rate of people being treated by Early Intervention teams: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	60.2	37.4	0.0		144.6
Rate of people receiving assertive outreach services: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	- *	26.6	0.0		104.3
Contacts and daycare attendances: Rate (quarterly) per 100,000 population	2013/14 Q3	7963	10597	290		33069
Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital (end of quarter snapshot)	2013/14 Q3	3.4	2.4	0.7		12.3
Mental health admissions to hospital: Rate (quarterly) per 100,000 population	2013/14 Q3	47.5	70.2	28.5		207.5
Mental health discharges from hospital: Rate (quarterly) per 100,000 population	2013/14 Q3	44.4	70.5	19.8		170.2
Attendances at A&E for a psychiatric disorder: Rate per 100,000 population	2012/13	180.0	243.5	3.0		925.5
People subject to Mental Health Act: Rate per 100,000 population (end of quarter snapshot)	2013/14 Q3	34.2	37.5	6.2		110.2

Quality and outcomes

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Patients with SMI who have comprehensive care plan: % with plan (patients receiving intervention)	2012/13	83.0	81.3	72.2		93.0
Patients on lithium therapy with record of serum creatinine and TSH: % with record in the preceding 9 months (patients receiving intervention)	2012/13	94.2	92.3	81.5		98.8
Patients on lithium therapy with levels in therapeutic range: % within preceding 4 months (patients receiving intervention)	2012/13	84.9	79.8	56.0		93.5
Exceptions from SMI checks: % of adults on SMI register exempt from checks	2012/13	14.8	15.5	10.1		23.7
Patients with SMI with alcohol consumption check: % with record in preceding 15 months (patients receiving intervention)	2012/13	82.2	82.0	71.8		89.2
Patients with SMI with BMI check: % with record in preceding 15 months (patients receiving intervention)	2012/13	81.3	81.1	73.1		87.4
Patients with SMI with blood pressure check: % with record in preceding 15 months (patients receiving intervention)	2012/13	86.0	84.9	77.3		90.8
Female patients with SMI who had cervical screening test: % tested in preceding 5 years (patients receiving intervention)	2012/13	71.7	72.5	61.1		82.6
Patients with SMI with cholesterol check: % with record in preceding 15 months (patients receiving intervention)	2012/13	40.8	42.4	32.2		49.8
Patients with SMI with blood glucose or HbA1c check: % with record in preceding 15 months (patients receiving intervention)	2012/13	64.7	66.3	55.9		74.4
Smokers on GP registers offered cessation advice or referral: % in previous 15 months	2011/12	93.3	92.9	89.2		96.5
Gate kept admissions: % (quarterly) admissions to acute wards that were gate kept by the CRHT teams	2013/14 Q4	100	98.3	82.6		100
Service users with crisis plans: % of people in contact with mental health services with a crisis plan in place (end of quarter snapshot)	2013/14 Q3	3.1	10.2	0.0		44.9
CPA review: % of people on CPA for more than 12 months who have had a review (end of quarter snapshot)	2013/14 Q3	91.3	83.6	23.3		99.4

Finance

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
Specialist mental health services spend: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	16425	26756	14296		49755
% spend on specialist mental health services: % of all secondary care service spend categorised as mental health (mapped from PCT)	2012/13	8.8	11.9	8.1		19.1
Primary care prescribing spend on mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	1231	2021	746		3933
Cost of GP prescribing for psychoses and related disoders: Net Ingredient Cost (£) per 1,000 population (quarterly)	2013/14 Q3	578	667	294		1476
Secondary Care spend on mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	11533	12518	440		34267
Community care spend on mental health: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	0	5094	0		19965
Spend on psychosis services: rate (£000s) per 100,000 population aged 18+ (mapped from PCT)	2012/13	462	4789	458		15576
% spend on psychosis: % of all mental health spend categorised as psychosis (mapped from PCT)	2012/13	2.8	17.9	1.7		48.5
Primary care prescribing spend on psychosis: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	417	541	159		1388
Secondary Care spend on psychosis: rate (£000s) per 100,000 aged 18+ (mapped from PCT)	2012/13	32	3051	0		13513

Indicators included in spine-charts are drawn from a range of sources, are based on differing populations and are presented for a number of time periods. Detail relating to each indicator is included within the tool under 'definitions'.

Source: NEPHO 2014 http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data

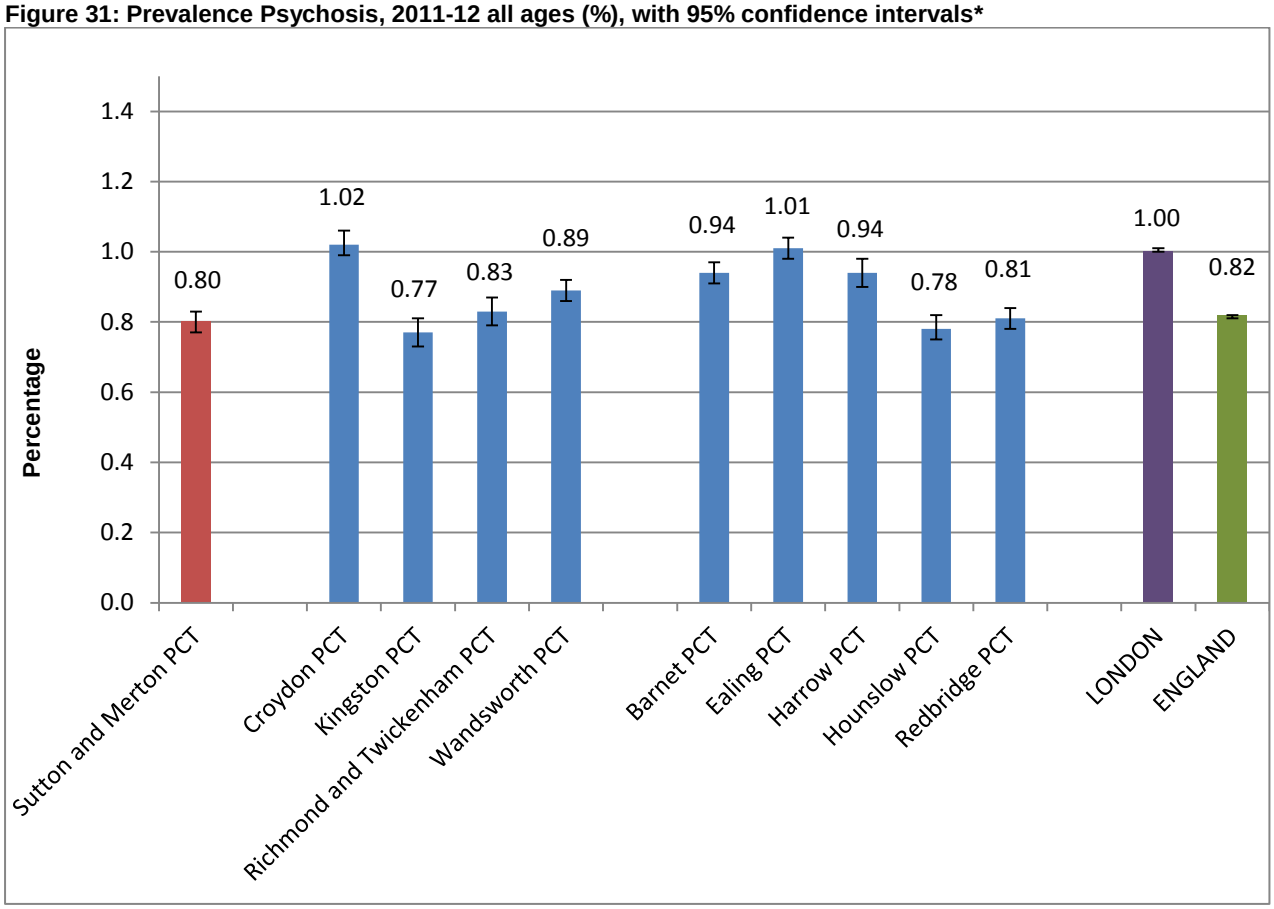
Psychosis

Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder. According to the Adult Psychiatric Morbidity Survey (APMS) 2007[75] the overall prevalence of psychotic disorder was found to be 0.4% (0.3% of men, 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively). The age standardised prevalence of psychotic disorder was significantly higher among black men (3.1%) than men from other ethnic groups (0.2%of white men, no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women.

Prevalence of psychosis in 2011-12

HSCIC data on prevalence of psychosis for 2011-12 indicates that Sutton and Merton PCT had among the lowest prevalences in SW London, with only Kingston and Hounslow PCTs being lower. It had a lower prevalence than England and London.

Figure 31: Prevalence Psychosis, 2011-12 all ages (%), with 95% confidence intervals*



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

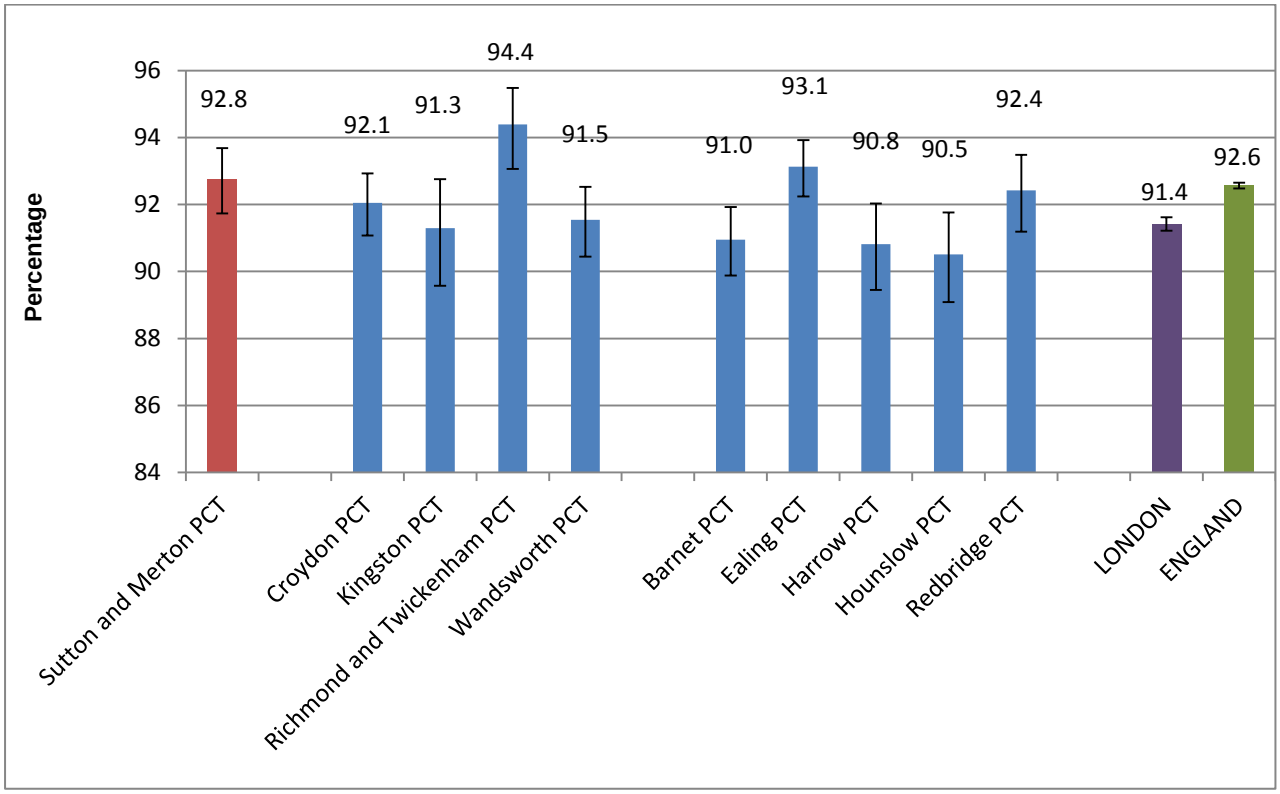
** 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

[75] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

Health reviews and treatment checks on patients with psychoses

Health reviews and treatment checks for psychoses are intended to reduce the levels of risk to health for patients with psychoses and ensure high standards of primary care and treatment delivered to them. In many cases, the bulk of care for patients with long-term mental health problems will be provided by specialist services, however, there are some aspects of management such as physical health which often lie within the general practitioner's responsibility. Patients with serious mental health problems are at considerably increased risk of physical ill-health than the general population. It is therefore good practice for a member of the general practice team to review each patient's physical health on an annual basis. In 2010-11 S&M PCT had a high percentage of patients with psychoses undergoing health reviews and treatment checks, comparable with London and England and second highest among PCTs in SW London after Richmond & Twickenham; and also second highest compared with statistical neighbours.

Figure 32: Health review and treatment checks on patients with psychoses, 2010-11, all ages % with 95% confidence intervals*



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

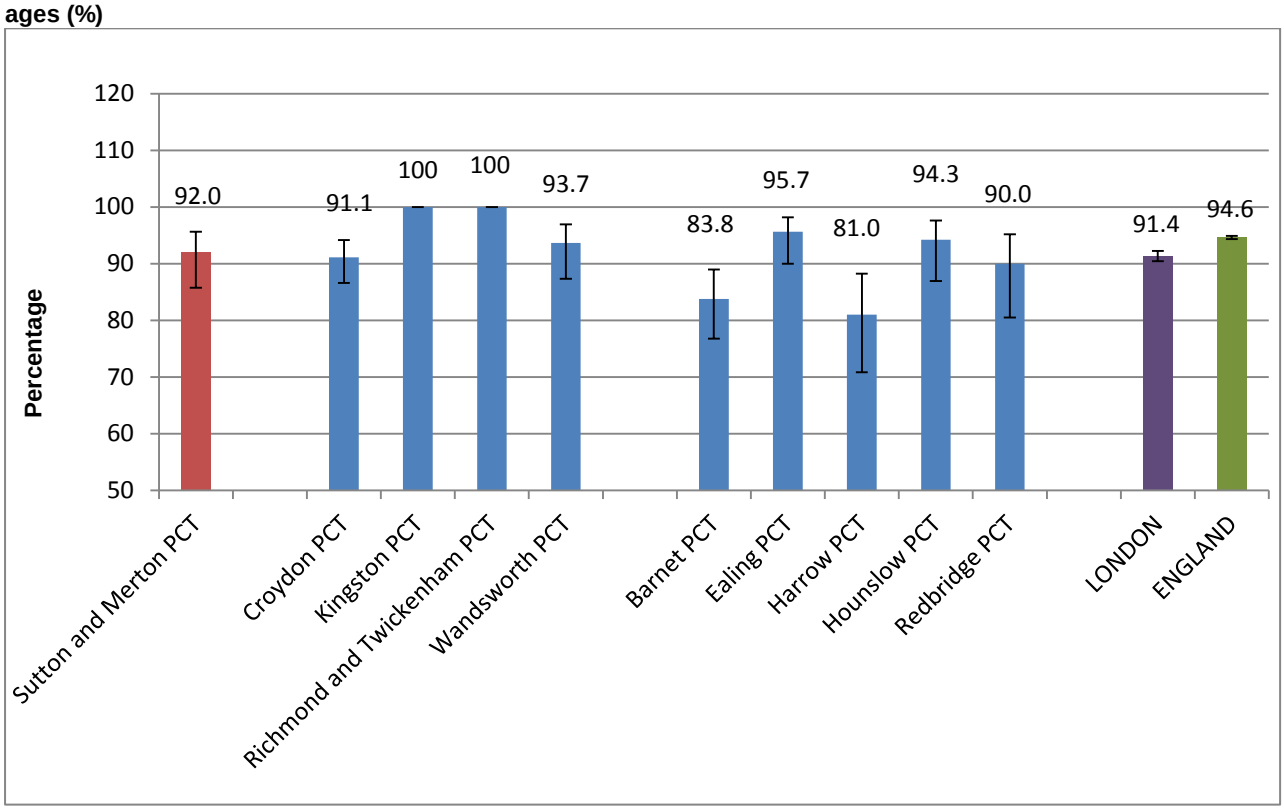
** 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

Follow-up of non-attendance at annual review among patients with psychoses

Poor compliance with medication among patients with psychoses may lead to relapse, hospitalisation and poorer outcomes. There is also evidence to suggest that non-attendance at appointments may be interpreted by some practices as part of a patient having a Severe Mental Illness, rather than recognising that not turning up for an appointment may be a sign of relapse. Follow-up of non-attendance at annual review among patients with psychoses

requires proactive intervention from the practice to contact the patients and enquire about their health status. In 2010-11 S&M PCT had the second lowest percentage in SW London, and it was lower than England and marginally higher than London. S&M PCT had the third highest percentage compared with statistical neighbours.

Figure 33: Follow-up of non-attendance at annual review among patients with psychoses, 2010-11, all ages (%)



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

** 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

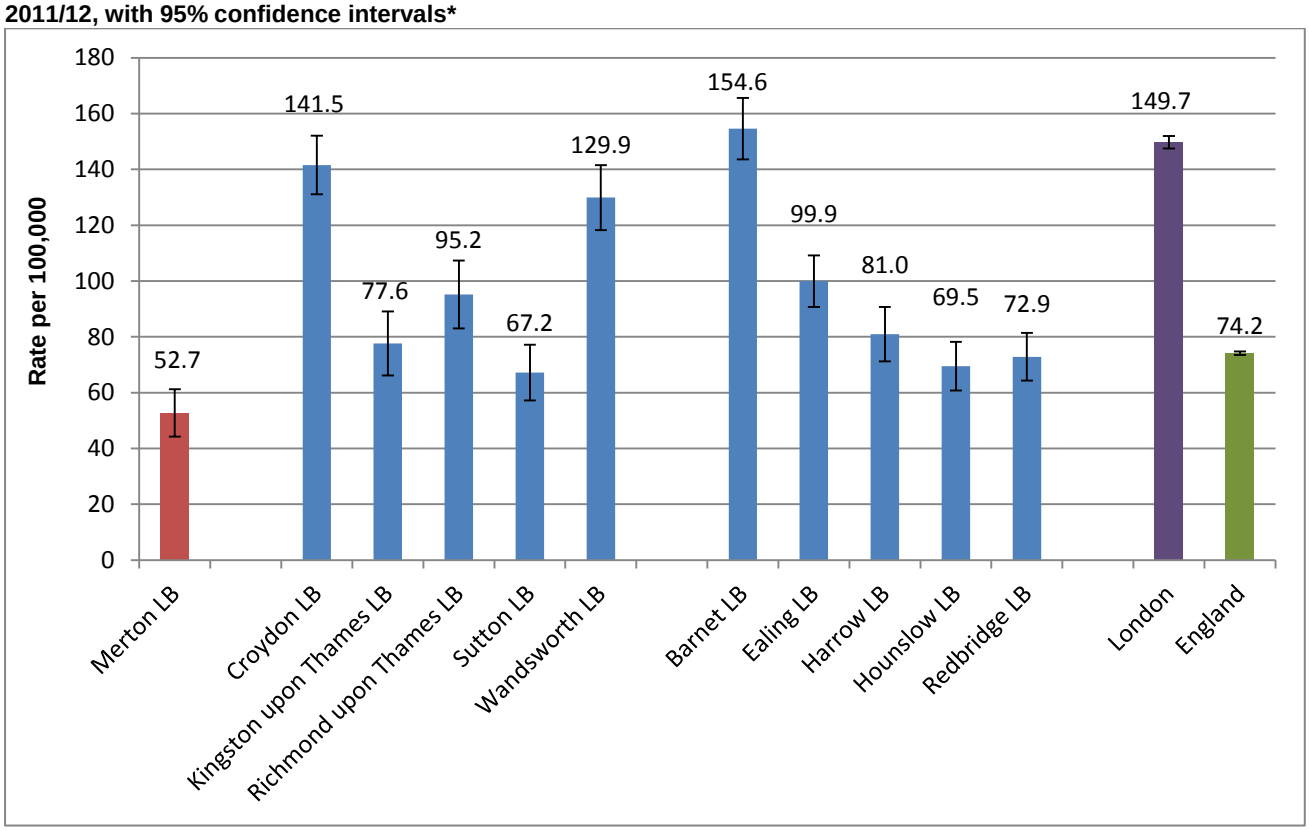
Schizophrenia, schizotypal and delusional disorders

Age standardised hospital episode rate (DSR per 100,000) for schizophrenia

This indicator is a useful measure of inequality - people from a black and minority ethnic group are more likely to be diagnosed with schizophrenia, be detained and treated compulsory under the Mental Health Act (1983) and be over-prescribed psychotropic medication[76]. A higher rate could be indicative of less effective community based care-this is a proxy measure for the quality of community care. Merton has a lower rate than England, London, statistical and geographical neighbours- and the differences are statistically significant.

[76] Evidence cited in King's Fund (2003) Ethnic diversity and mental health in London: Recent developments in London King's Fund: London.

Figure 34: Age standardised hospital episode rate (DSR) for schizophrenia, people aged 15-74 years, 2011/12, with 95% confidence intervals*



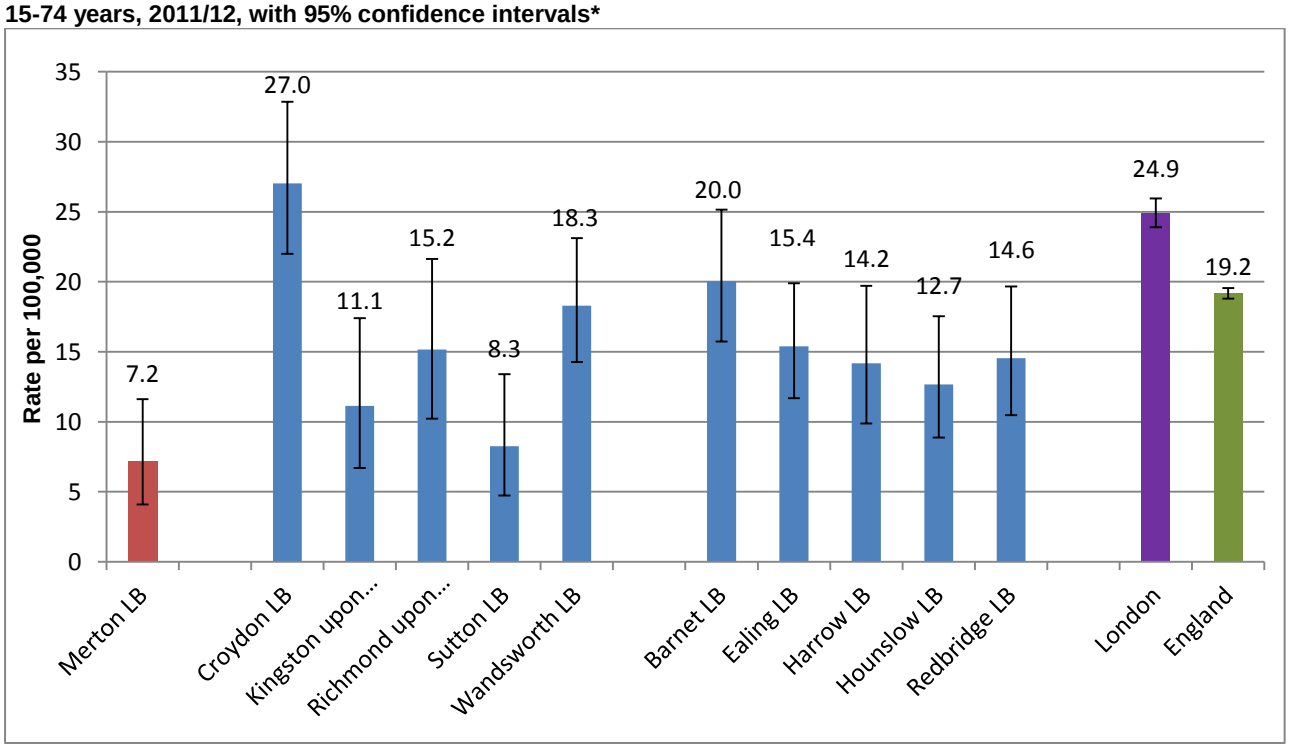
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

** 95% confidence intervals (CI) indicate the precision with which the rates are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the rates are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

Emergency hospital admissions for schizophrenia

These are other proxy measures for the quality of community care. For emergency hospital admissions for schizophrenia, Merton does well compared with all other geographical and statistical comparators as it has the lowest levels and suggests that more of the potentially avoidable admissions are most likely being avoided and seen effectively in the community. The differences with England, London and some geographical and statistical comparators are statistically significant.

Figure 35: Emergency hospital admission rate (indirectly standardised) for schizophrenia, people aged 15-74 years, 2011/12, with 95% confidence intervals*



Of the nine quality indicators for mental health in the QOF, MH11, MH12, MH13, MH16, MH19 & MH20 relate to the schizophrenia, bipolar affective disorders and other psychoses. These are also proxy indicators for the quality of primary care. The results in 2012-13 for these indicators are presented by practice grouped into East and West Merton (graphs after description):

MH 11 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months- Most practices in both East & West Merton achieve the 80% mark, but three East Merton practices have relatively low percentages and also some have 90+%.

MH 12 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months- For this again the profiles in East and West Merton are similar, with more practices in East Merton achieving higher percentages.

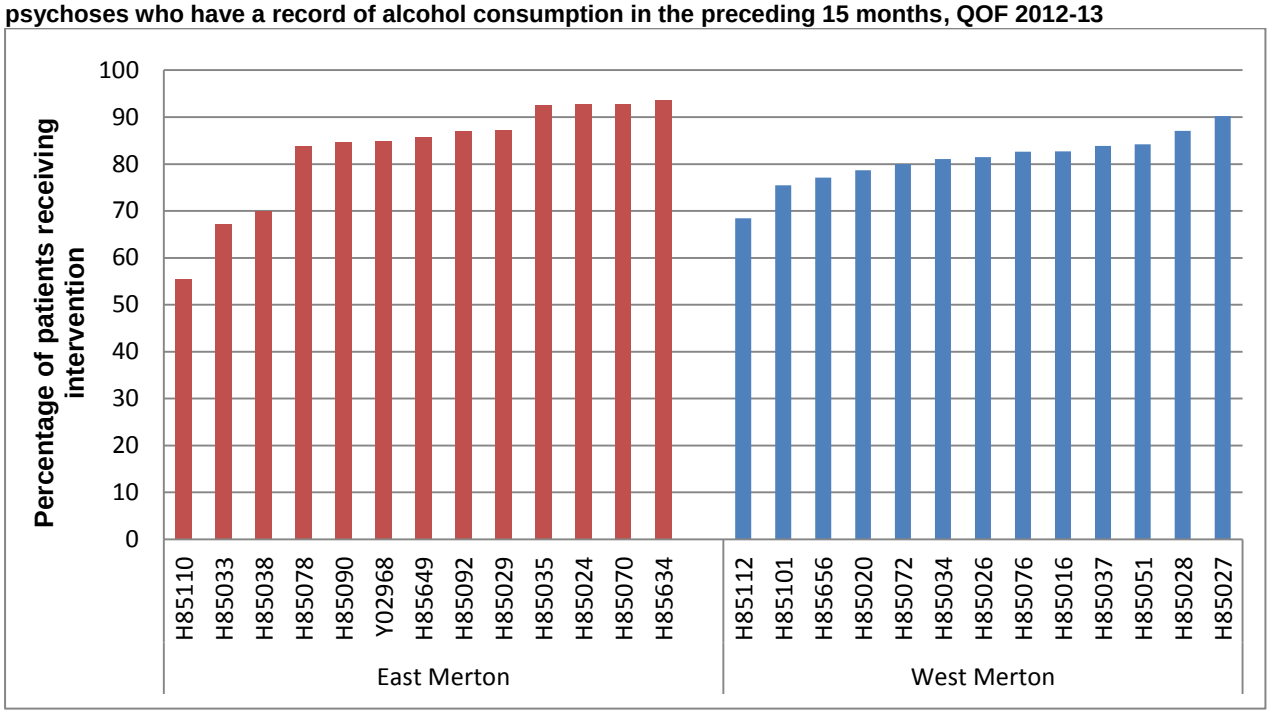
MH 13 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months- in this measure virtually all practices across Merton achieve high numbers, with more practices in East Merton achieving percentages close to 90%.

MH 16 - The percentage of patients (aged from 25 to 64) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years- this is low for all practices in Merton, with the comparatively lower percentages in West Merton reflecting the older age profile in that part of Merton.

MH 19 - The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months- This is low all across Merton with very few practices achieving more than 50%.

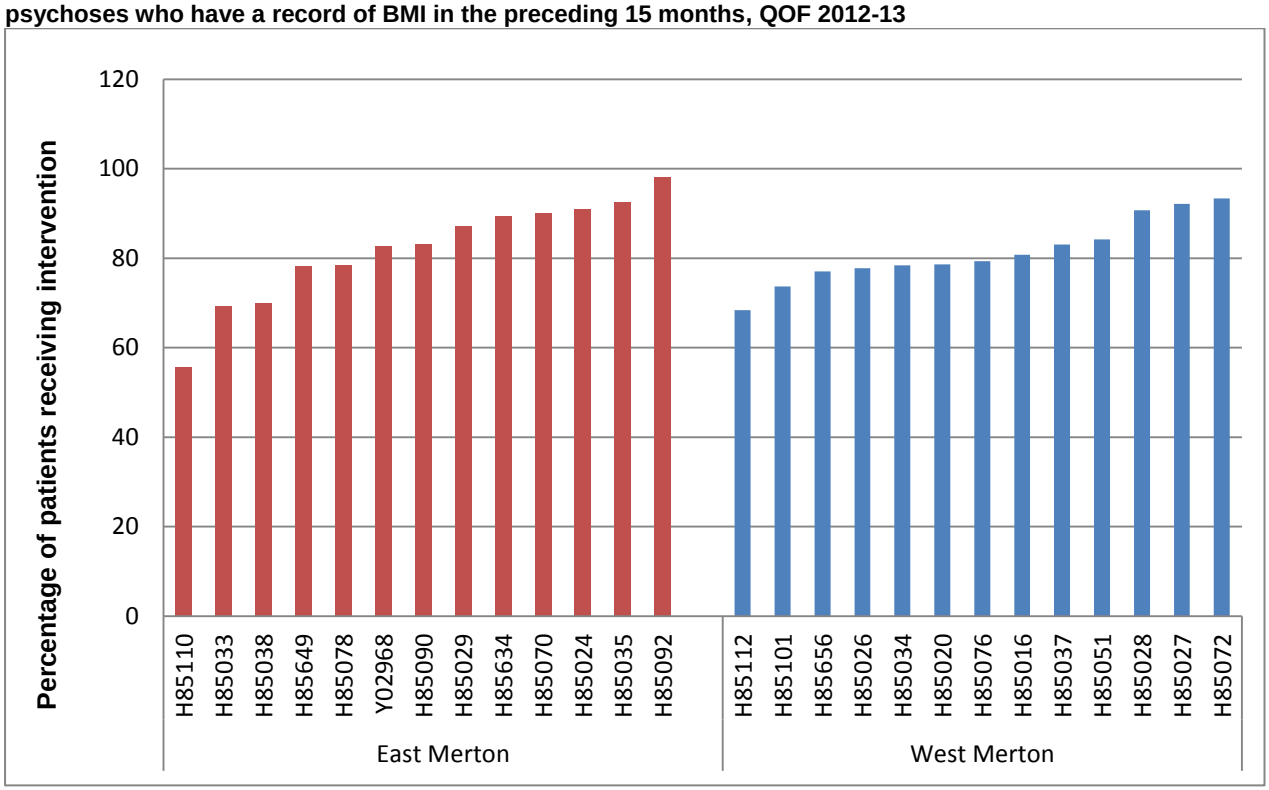
MH 20 - The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months- most practices in Merton were less than 75% on this measure, with many more in East Merton achieving less than 70%.

Figure 36: MH 11- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months, QOF 2012-13



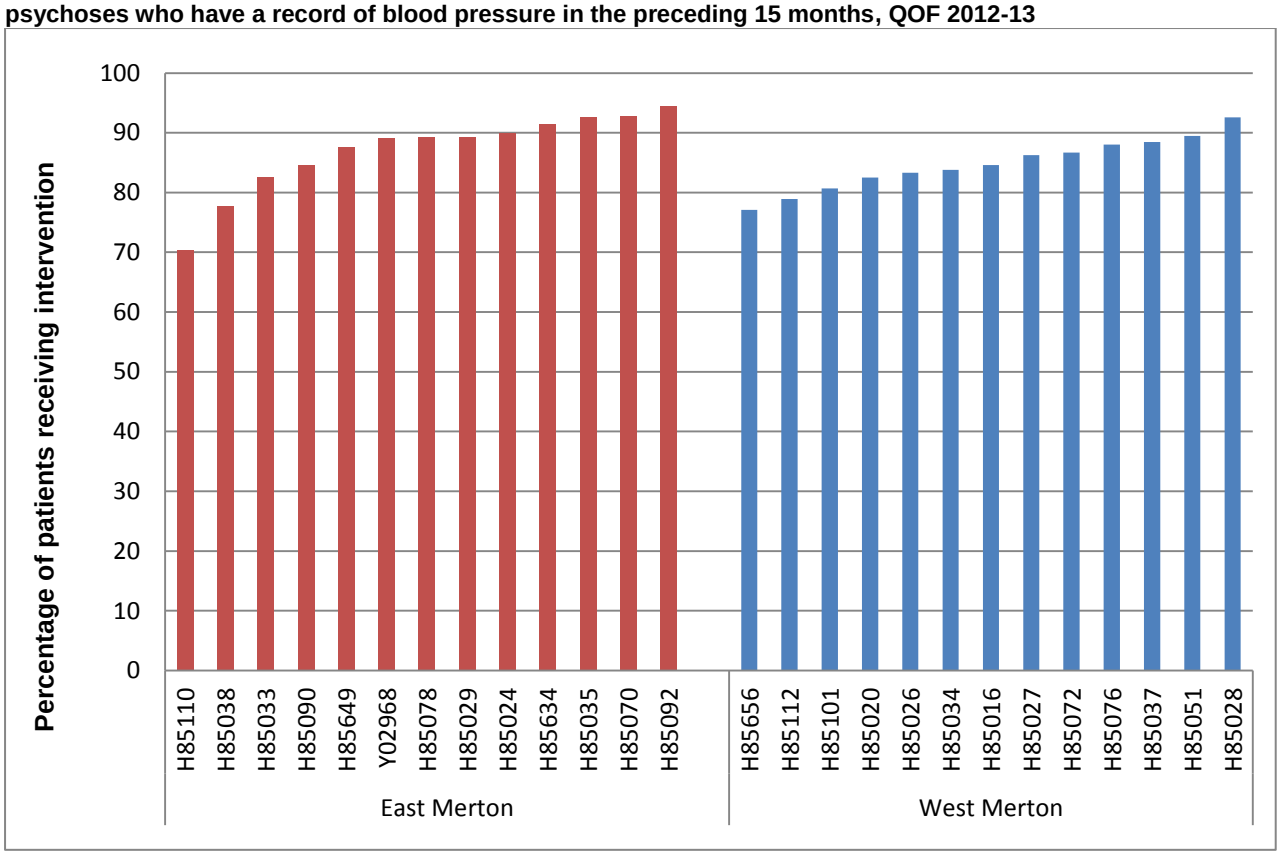
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 37: MH 12 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months, QOF 2012-13



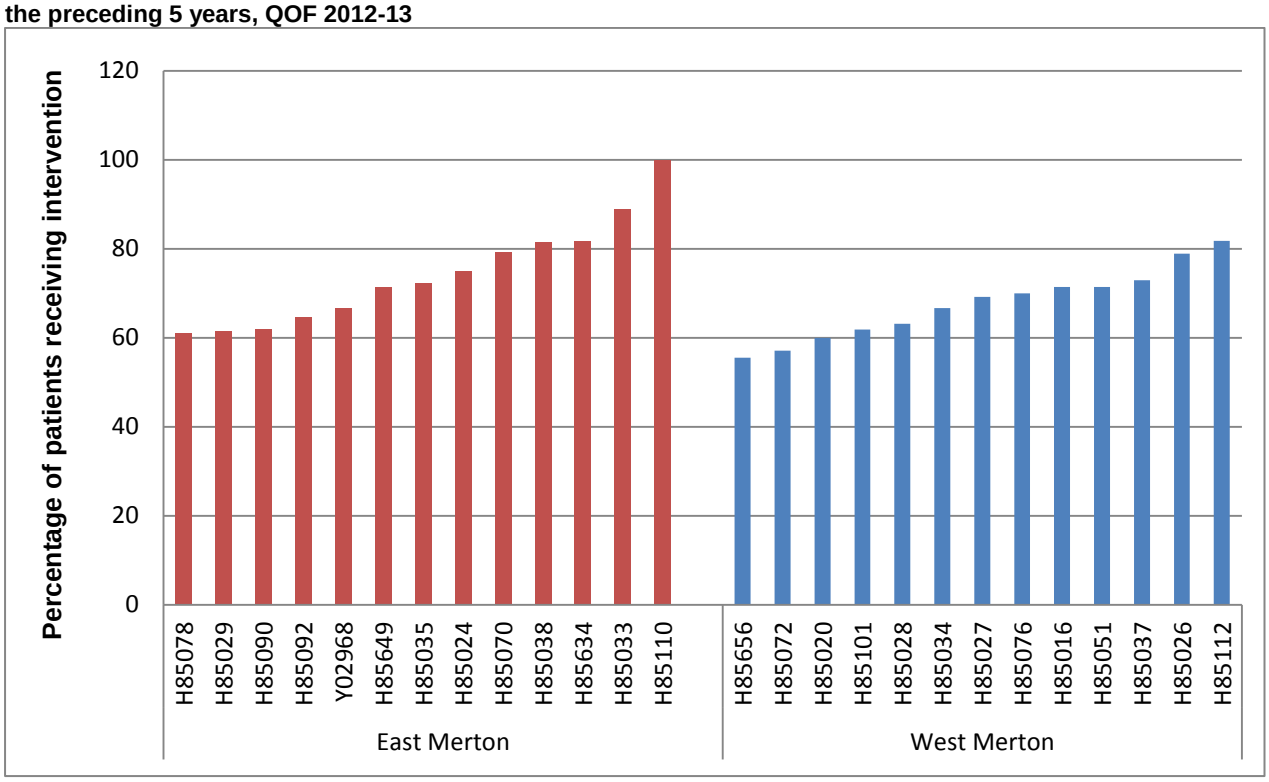
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 38: MH 13 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months, QOF 2012-13



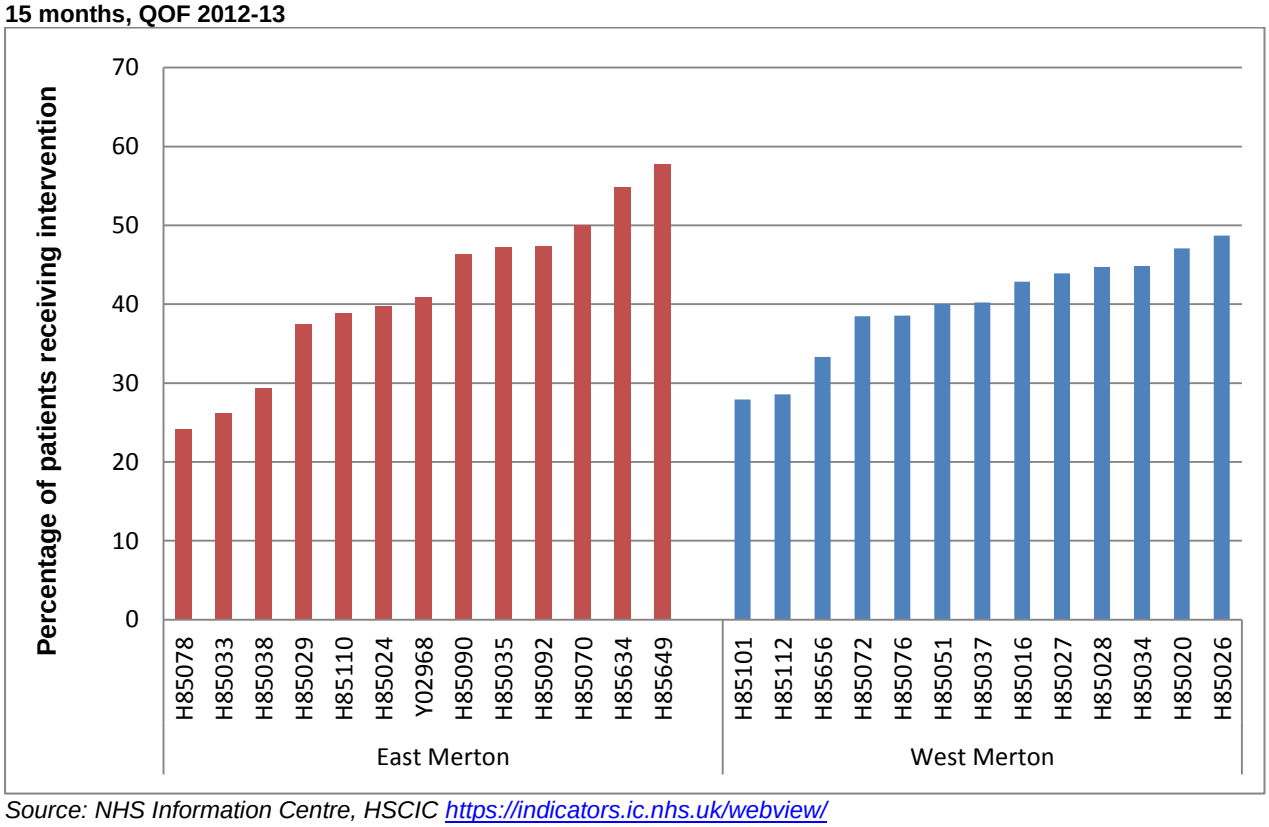
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 39: MH 16 - The percentage of patients (aged from 25 to 64) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years, QOF 2012-13



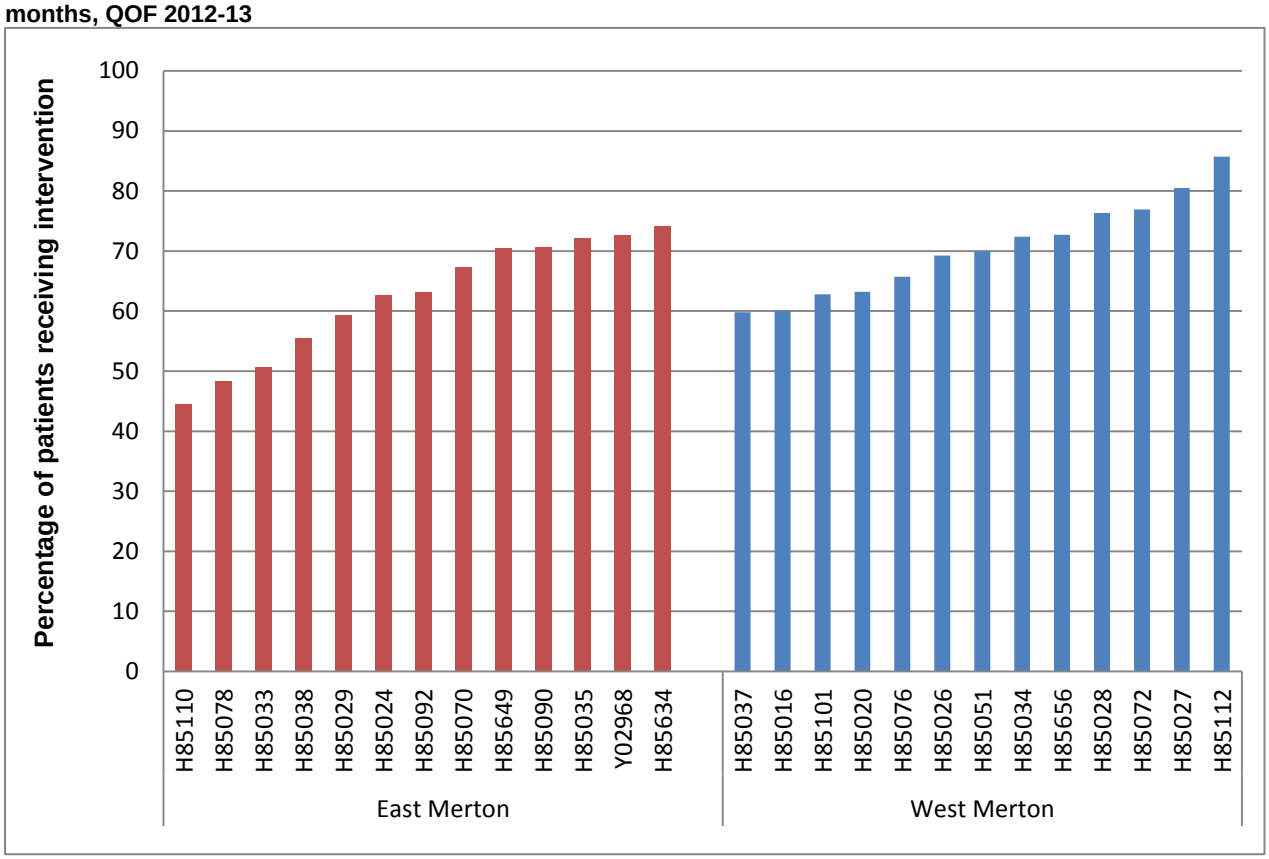
Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 40: MH 19 - The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months, QOF 2012-13



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Figure 41: MH 20 - The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 15 months, QOF 2012-13



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

Psychoactive substances

Psychoactive substances are the most common cause for CMH referrals and the second most common cause for in-patient admissions in working age adults in Merton. The overwhelming majority of these were for alcohol related problems. The next most common psychoactive substance was multiple drug use.

Personality disorders

Personality disorders are longstanding, ingrained distortions of personality interfering with the ability to make and sustain relationships. *Antisocial personality disorder (ASPD)* and *borderline personality disorder (BPD)* are two types with particular public and mental health policy relevance.

ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed. ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women)[77].

BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining

[77] Adult Psychiatric Morbidity Survey (APMS) 2007

relationships, and self-harm and suicidal behaviour is common. The overall prevalence of BPD was similar to that of ASPD, at 0.4% of adults aged 16 or over (0.3% of men, 0.6% of women)[78].

Organic disorders including dementia

Key Points

- *In Merton it is estimated that 7.2% of women and 5.3% of men aged over 65 have dementia (2007), by 2021 this is predicted to reduce to 6.7% for women and increase to 5.6% for men*
- *The NHS dementia calculator gives the current diagnosis rate as 47% (2013/14) and a dementia gap of 1,057 cases for 2014/15*
- *In 2012-13, there were 870 Merton residents on the dementia register out of a total registered population of 217,803. This gives an overall GP recorded prevalence of 0.4% for Merton CCG. The England prevalence is 0.57%*
- *The ratio of observed to expected prevalence of dementia is 0.7 for Merton, suggesting a level of under-diagnosis*
- *There is considerable variance between practices and East and West Merton for the observed to expected prevalence ratio*

Dementia in Merton

By far the biggest issue for mental health services for people over the age of 65 is dementia. Dementia has a significant impact on individuals and their families, presents major challenges for health and social services and remains a misunderstood and stigmatised disease. It is a syndrome, a term for a group of diseases and conditions that are characterised by the decline and eventual loss of cognitive functions such as memory, thinking and reasoning and by changes in personality and mood.

Old age is the largest risk factor for dementia and prevalence doubles every five years after the age of 65. Some 68% of all people with dementia are aged over 80 and most will also have co-morbid conditions and illnesses that result in physical impairment.

Alzheimer's disease (AD) accounts for 62% of all dementias, with vascular dementia and mixed dementia accounting for 27%. Dementia is a leading cause of disability and death in people aged over 65. A progressive disease, it is usually terminal some five to eight years after diagnosis. Women with dementia outnumber men by two to one.

In the UK people from Black, Asian and Minority Ethnic groups (BAME) make up just 1.7% of the total population affected by dementia. This group is expected to increase by 15% over the next decade. The younger age profile is reflected in the larger proportion of people from BAME groups with early onset dementia, 6.1% compared to 2.2% for the UK[79].

[78] Adult Psychiatric Morbidity Survey (APMS) 2007
[79] Dementia UK – The full report, Alzheimer's Society 2007

It is estimated that 63.5% of people with dementia live in the community, of whom two thirds are supported by carers and one third live alone. Approximately 36.5% live in care homes. The majority of residents in care homes for older people have a dementia.

In Merton it is estimated that 7.2% of women and 5.3% of men aged over 65 have dementia (2007), by 2021 this is predicted to reduce to 6.7% for women and increase to 5.6% for men. It is estimated that the rate of diagnosis in Merton is only 39% (Alzheimer's Society 2013), and this is consistent with the low levels of recorded dementia in GP practices across Merton. The NHS dementia calculator gives the current diagnosis rate as 47% (2013/14) and a dementia gap of 1,057 cases for 2014/15.

Table 10 below shows the number of cases and estimated prevalence of dementia in 2012/13, broken down by estimates in community settings and in residential care. The table

Table 10: Dementia numbers and forecasts using adjusted national dementia prevalence, Merton compared with statistical and geographical neighbours

Dementia numbers & forecasts by local authority using adjusted national dementia prevalence	Merton	Croydon	Kingston upon Thames	Richmond upon Thames	Sutton	Wandsworth	Barnet	Ealing	Harrow	Hounslow	Redbridge
Total number of people with dementia in 2012/13 (estimated)	**1927**	3841	1898	2075	2146	2277	4364	2976	2559	2069	2602
People with dementia living in the **community** in 2012/13 (estimated)	**1228**	1970	1169	1311	1370	1354	2525	1918	1723	1497	1788
People with dementia living in **residential care** in 2012/13 (estimated)	**699**	1871	729	764	776	923	1839	1058	836	572	814
Dementia register -The number of people diagnosed under Quality & Outcomes Framework (QoF), 2012/13	**870**	1662	731	989	838	1031	2293	1479	870	978	1121
Diagnosis rate -The percentage of the estimated prevalence that have been diagnosed, 2012/13	**45.16**	43.27	38.52	47.67	39.05	45.28	52.54	49.7	33.99	47.28	43.07
Dementia gap - the undiagnosed cases in 2014/15	**1057**	2179	1167	1086	1308	1246	2071	1497	1689	1091	1481
Dementia diagnosis rate (adjusted)- The percentage of the estimated prevalence that have been diagnosed, 2013/14, (source: CQUIN CCG data)	**47**	44	39.3	49	40.2	45.6	52.6	49.5	33.1	46.9	43.1
Source: NHS Dementia Prevalence calculator, version 3, 03/07/2014, The adjusted national dementia prevalence uses General practice patient list numbers											

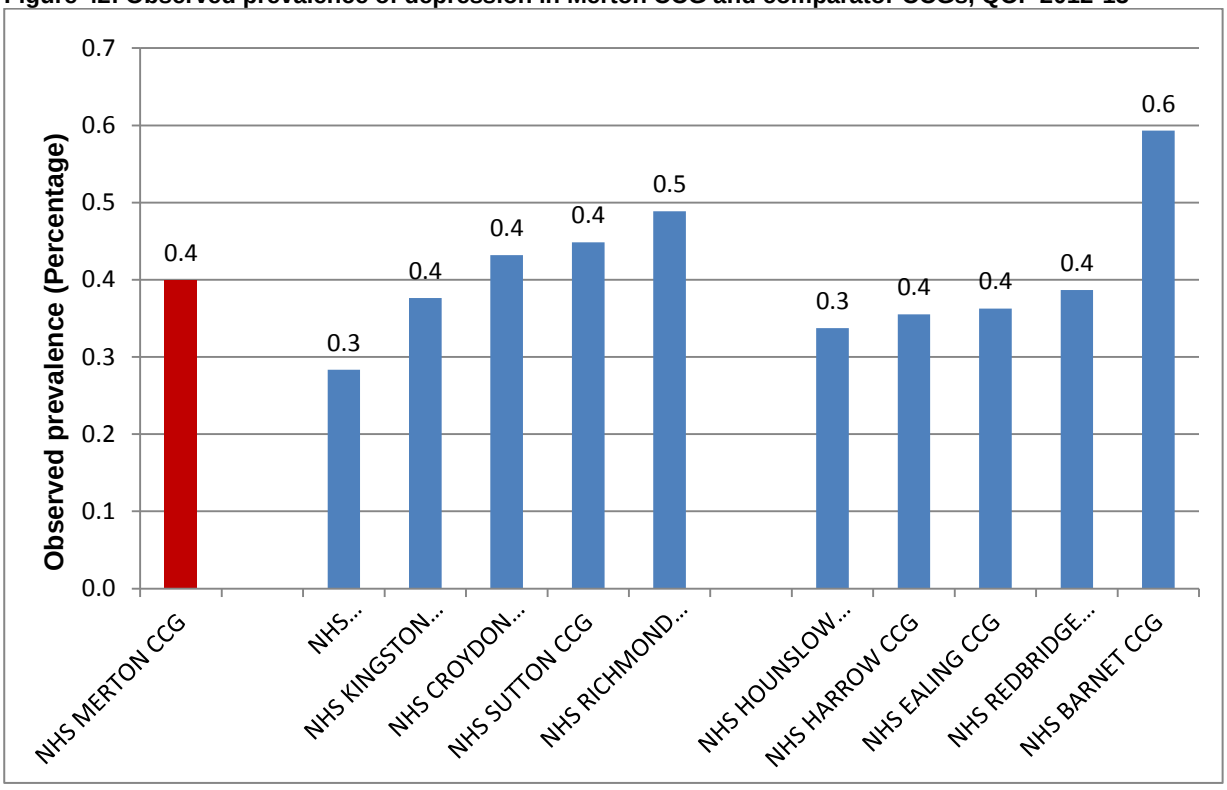
also shows the actual numbers diagnosed in the corresponding period according to QOF records. These two numbers enable the calculation of a *diagnosis rate* which is a percentage derived by dividing the numbers diagnosed by the estimated prevalence in 2012/13. In Merton this is 45.2% for 2012/13 which implies that each year approximately 55% of cases of dementia in the borough go undiagnosed. The table also gives a current estimate of the diagnosis rate for 2013/14 as 47%. The diagnosis rate allows the estimation of the number of *undiagnosed* cases which is called the **dementia gap**. The table shows that in Merton it is estimated that there will be 1,057 undiagnosed cases in 2014-15. This is the lower than all other geographical neighbours and all statistical neighbours.

Dementia prevalence is difficult to model, estimate and capture. The national standard for prevalence figures in use is from the Dementia UK report of 2007. However these figures are not considered sensitive enough for small populations at general practice level resulting in practice level prevalence being skewed. In order to overcome this, the calculator applies the 2007 prevalence to general practice registered populations by age and gender to estimate local prevalence.

Analysis of dementia in Merton from QOF 2012-13 data

In 2012-13, there were 870 Merton residents on the dementia register out of a total registered population of 217,803. This gives an overall GP recorded prevalence of 0.4% for Merton CCG. The England prevalence is 0.57%. Figure 42 compares the observed prevalence in Merton CCG with comparator CCGs. Among geographically neighbouring CCGs Merton has a lower recorded prevalence than the CCGs of Richmond, Sutton and Croydon, but higher than Kingston and Wandsworth. Merton CCG and has a higher prevalence than all statistically comparable CCGs except Barnet.

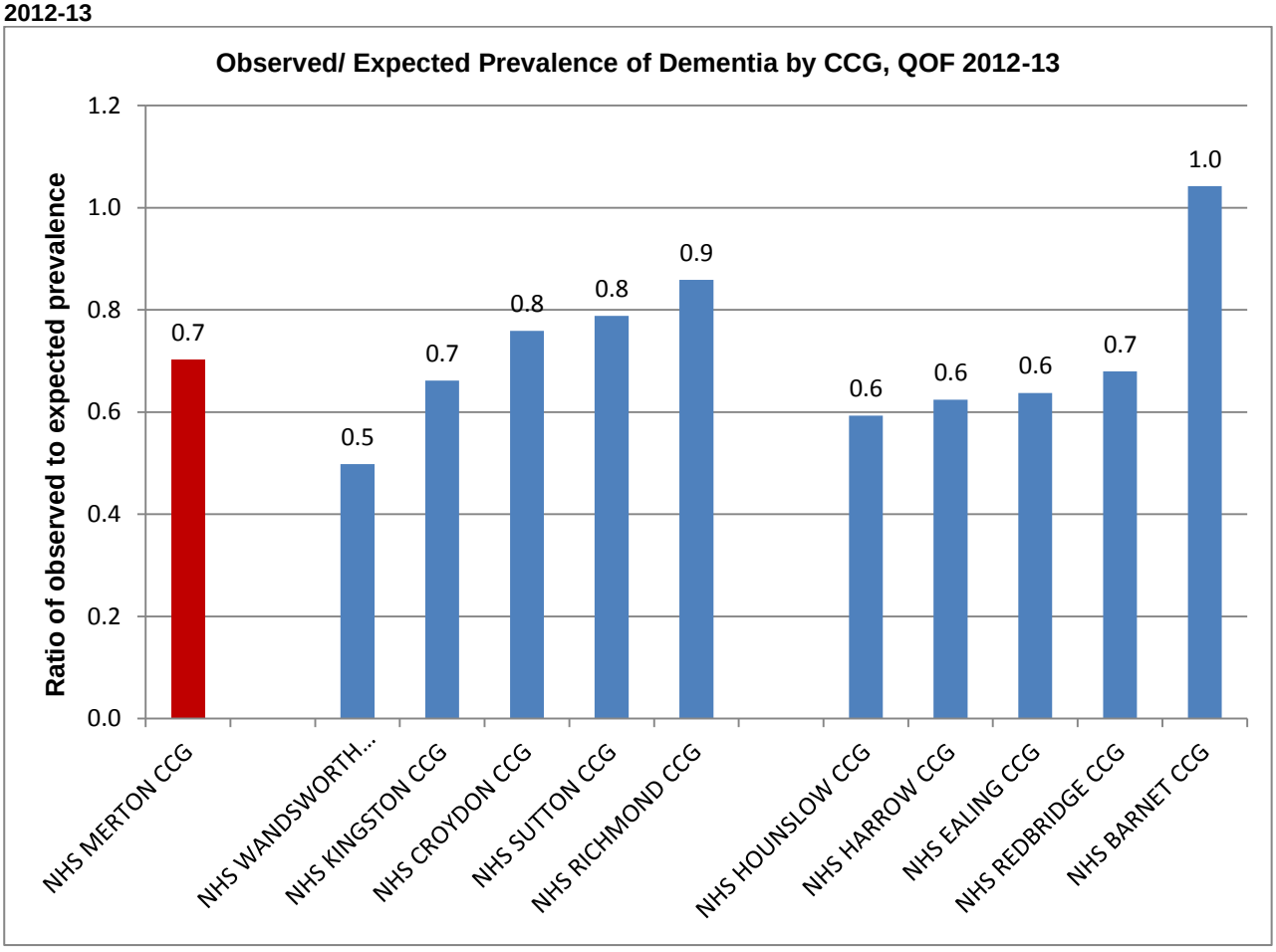
Figure 42: Observed prevalence of depression in Merton CCG and comparator CCGs, QOF 2012-13* ¥



*Prevalence percentages are rounded off to the nearest tenth. ¥ England prevalence is 0.57%.

By applying the national QOF recorded prevalence for depression to individual GP practice populations, the expected number of cases for Merton overall and by GP practice can be ascertained. Dividing the observed by the expected numbers gives a ratio that is indicative of the level of over- or under-diagnosis. A value of 1 indicates that the level of diagnosis is roughly in line with what is expected. A value less than 1 indicates that there are less cases being diagnosed than expected. A value higher than 1 indicates that more cases are being diagnosed than predicted, which can suggest over-diagnosis. Figure 43 below depicts the ratio of observed to expected prevalence for Merton CCG and comparator CCGs. Merton has an overall ratio of 0.7 which suggests a level of under-diagnosis. When compared with other geographical and neighbouring CCGs, Merton has a higher level of diagnosis than Kingston and Wandsworth, but is lower than Richmond, Sutton and Croydon CCGs. Among statistically similar CCGs, Merton is on par with Redbridge and only Barnet CCG is higher.

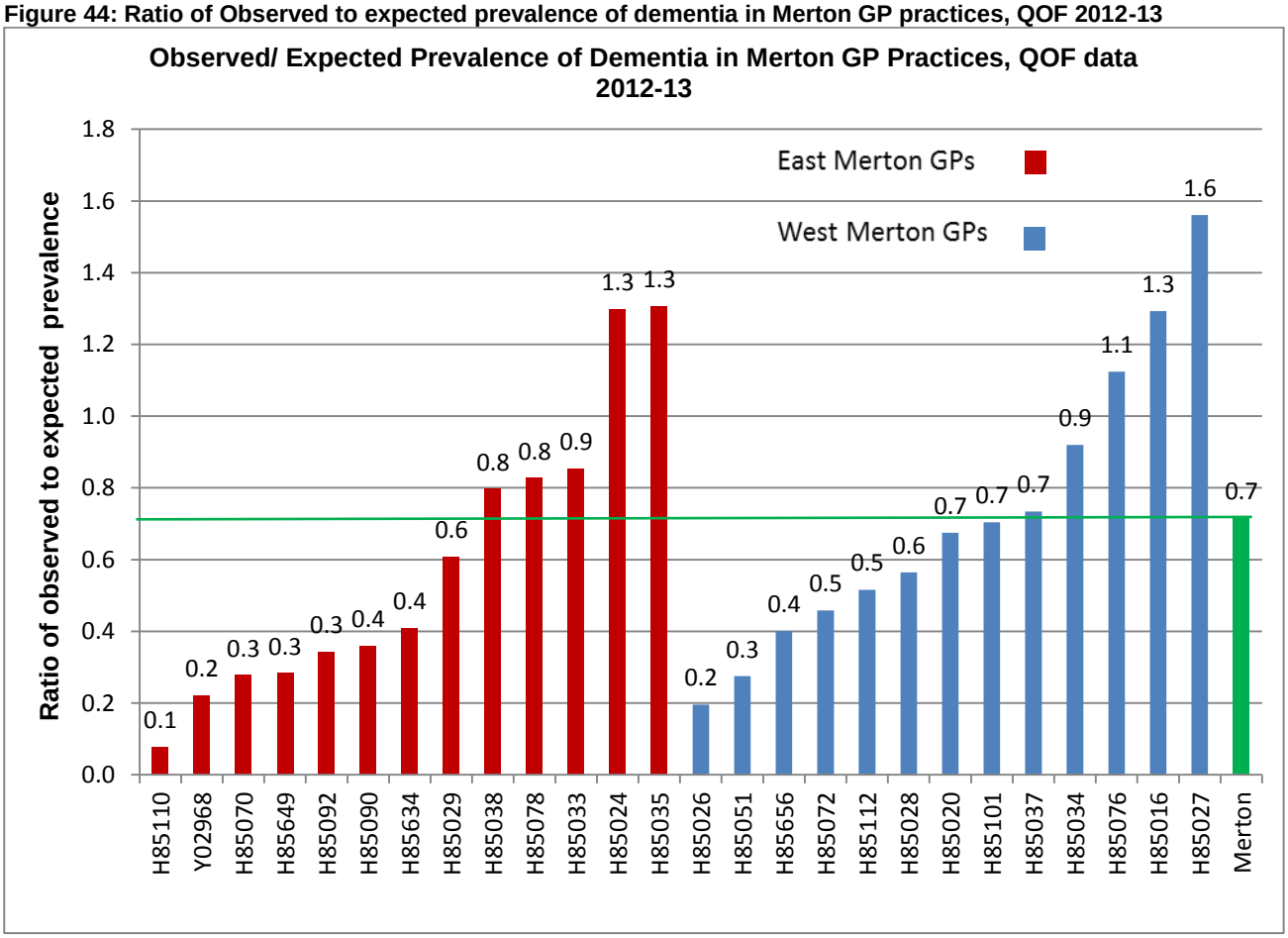
Figure 43: Ratio of Observed to expected prevalence of dementia in Merton CCG and comparator CCGs, QOF 2012-13



Plotting the observed to expected prevalence ratios for individual practices in Merton and grouping them into east & west Merton practices illustrates the considerable variance in diagnosis levels between different practices (figure 44). The figure further illustrates this point in relation to the diagnosis of depression. The optimal level of diagnosis would be the ratio value of 1. While in both east and west Merton there are considerable differences between practices in the levels of diagnosis, more practices in the east are below that optimal value (i.e. 1.0) than in the west. Furthermore the practices in the east which are below the Merton average of 0.7 (the green line)

have much lower levels of diagnosis than in the west. For those practices above the Merton average, the practices in the west are on the whole diagnosing more cases than the east. This suggests that there are many more undiagnosed cases of dementia in east Merton than in west Merton although there is under-diagnosis in both areas.

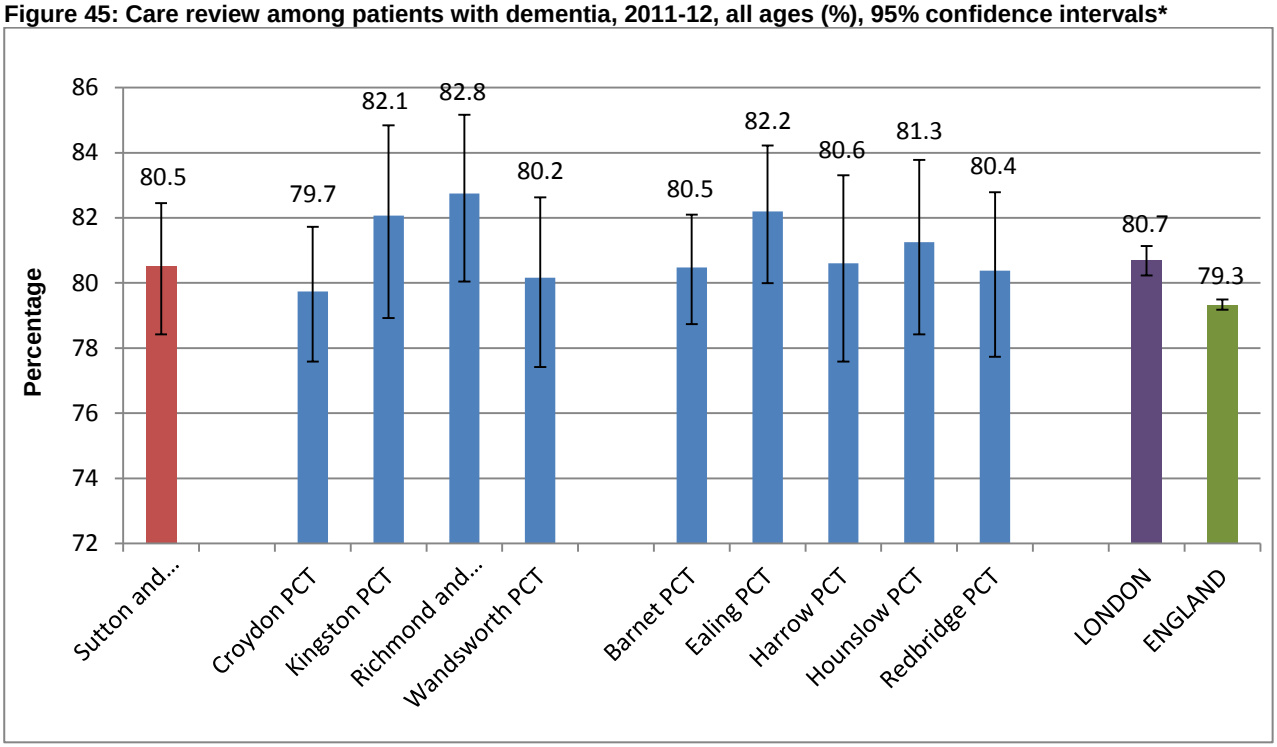
Figure 44: Ratio of Observed to expected prevalence of dementia in Merton GP practices, QOF 2012-13



Care review among patients with dementia

The face to face dementia review should focus on support needs of the patients and their carers. As the illness progresses, and more agencies are involved, the review should additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure that potentially complex needs are addressed. Communication and referral issues highlighted in the review need to be followed up as part of the review process. While none of the values across SW London, England or London for this indicator in figure 45 are statistically significantly different from each other, nevertheless for 2011-12, S&M PCT had a percentage marginally higher than England, similar to London and lower than Richmond & Twickenham, and Kingston PCTs in SW London. It was comparable and not significantly different from statistical neighbours.

Figure 45: Care review among patients with dementia, 2011-12, all ages (%), 95% confidence intervals*



Source: NHS Information Centre, HSCIC https://indicators.ic.nhs.uk/webview/

** 95% confidence intervals (CI) indicate the precision with which the percentages are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for the smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the percentages are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

Who are the patients in Merton and where are the health inequalities?

Key Points

- *A majority of the in-patients and community mental health services (CMHS) referrals were working age adults in Merton*
- *A majority of the admissions were in male adults. It is the opposite for CMHS, where there were more female referrals than male referrals*
- *Black ethnicities were over-represented in the in-patient population and Asians under-represented in both the in-patient and CMHS populations. In the case of Asian communities this under-representation could be due to inequity in access, and the cultural taboos and stigma associated with mental illness. In Black ethnicities the over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community.*
- *A majority of in-patients and CMHS patients belonged to the most deprived areas of Merton and most patients came from East Merton*
- *The majority of patients from West Merton belonged to the least deprived areas*

Age of patients

Figure 46 below depicts the age ranges of in-patients in South West London and St. George's Mental Health NHS Trust (SWLStG MHT) between 2008-13. A majority of the in-patients were working age adults (16-64 years of age). Among the patients referred to Community Mental Health Services (CMHS) between 2008-13, again a majority were working age adults with the most referrals received in patients in the 30-39 year age group. There are no referrals from the 40-49 age group (figure 47).

Figure 46: SWLStG MHT in-patients by age range in Merton (percentage), 2008-13

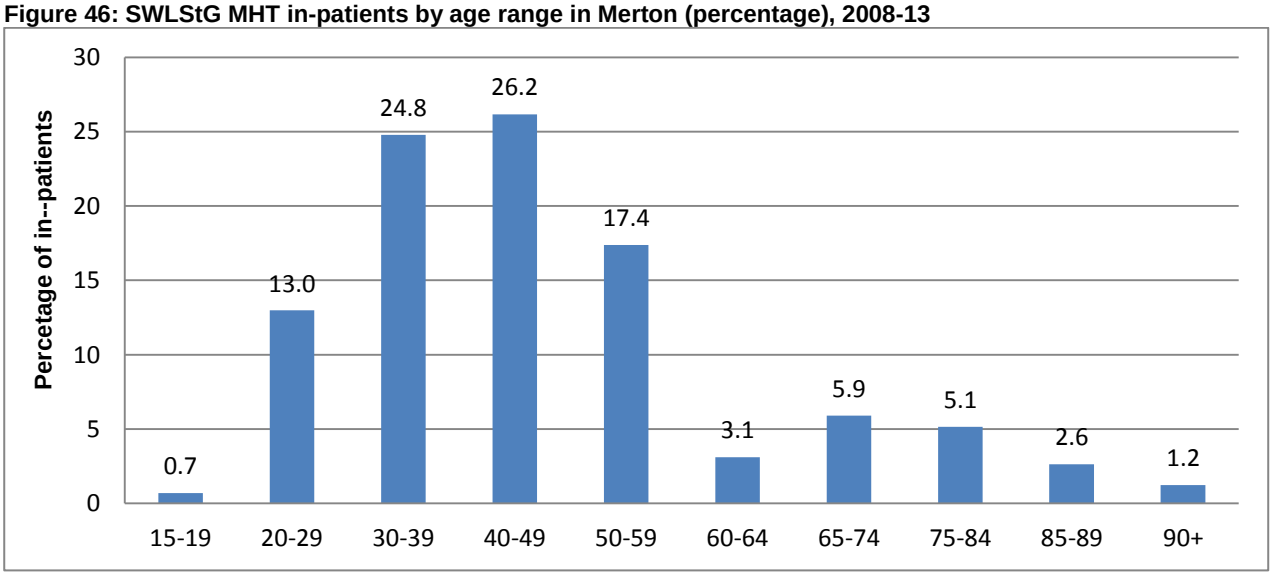
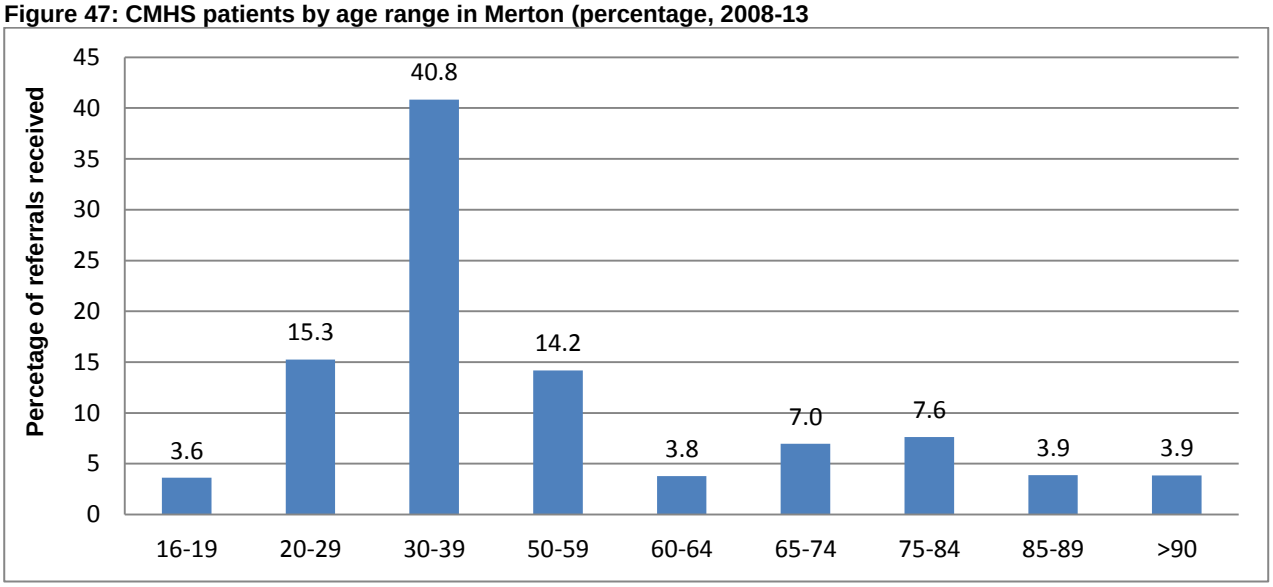


Figure 47: CMHS patients by age range in Merton (percentage, 2008-13



Gender of patients

Figure 48 below depicts the in-patients gender distribution. A majority of the admissions were in male adults. Interestingly it is the opposite in the case of referrals received for CMHS, where there are more female referrals than male referrals (figure 49).

Figure 48: Merton in-patients by gender in Merton, 2008-13

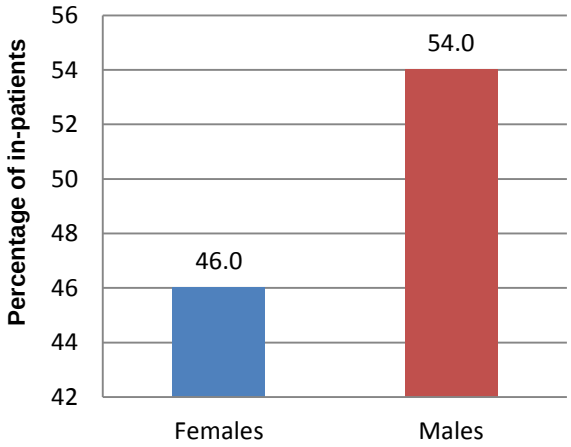
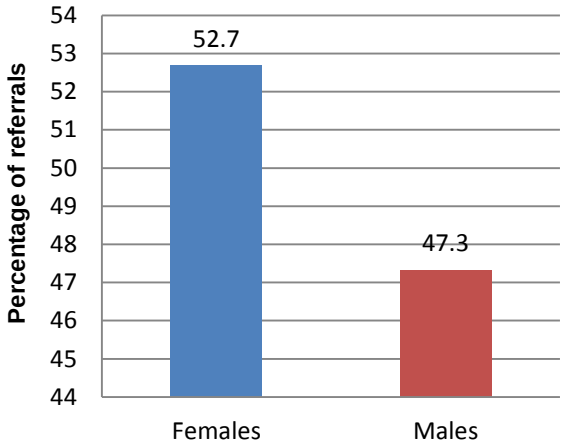


Figure 49: CMHS patients by gender in Merton, 2008-13



Among in-patients there are 56% working age males and 44% working age females. In older age adults 42% are males and 58% are females. This is partly explained by the higher life-expectancy in females and also reflects perhaps the differing distribution of mental health conditions between males and females[80]. In CMHS patients, for working age adults there are almost the same proportion of males and females, while in older adults there are a much higher proportion of females than males.

[80] http://www.who.int/mental_health/prevention/genderwomen/en/

Figure 50: Merton in-patients by gender in working group and older adults (percentage), 2008-13

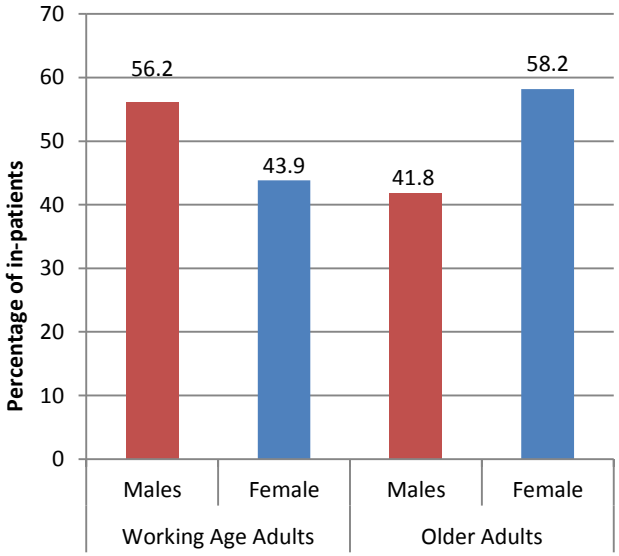
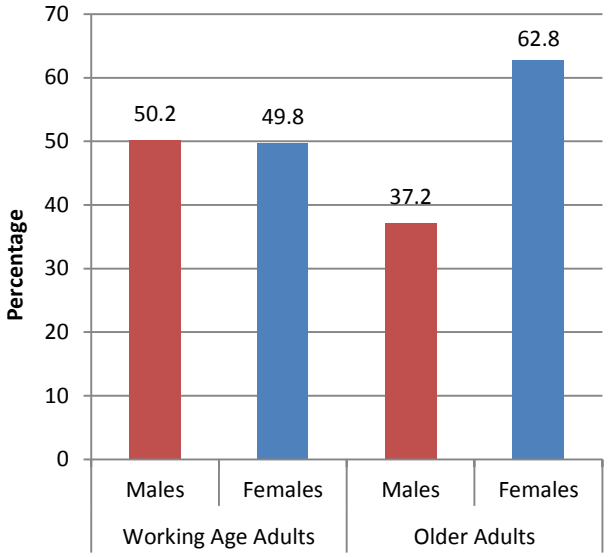


Figure 51: Merton CMHS patients by gender in working group and older adults (percentage), 2008-13



Ethnicity

Of the SWLStG MHT in-patients over 2008-13, a majority of admissions (67%) were in the white ethnicity group, followed by black (16%), Asian (11%), other ethnicities including mixed (5%) and 1% were not known. Of the CMHS referrals received over 2008-13, a majority of referrals (67%) were in the white ethnicity group, followed by equal proportions of black (10%), Asian (10%), other ethnicities including mixed (6%) and 7% were not known.

Figure 52: SWLStG in-patient occupancy by ethnicity for all causes in Merton, 2008-13

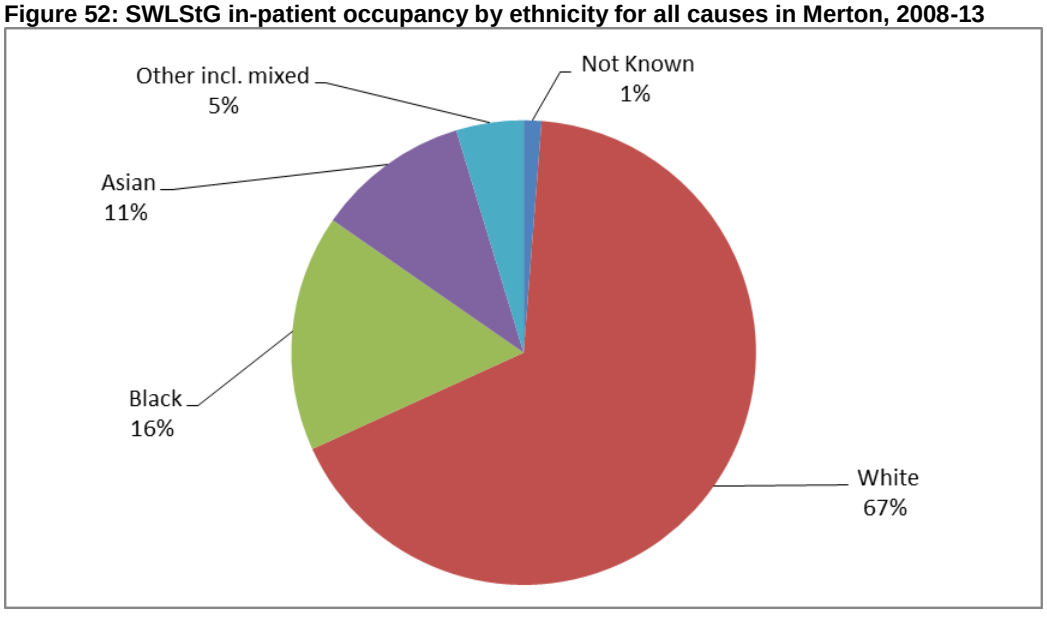
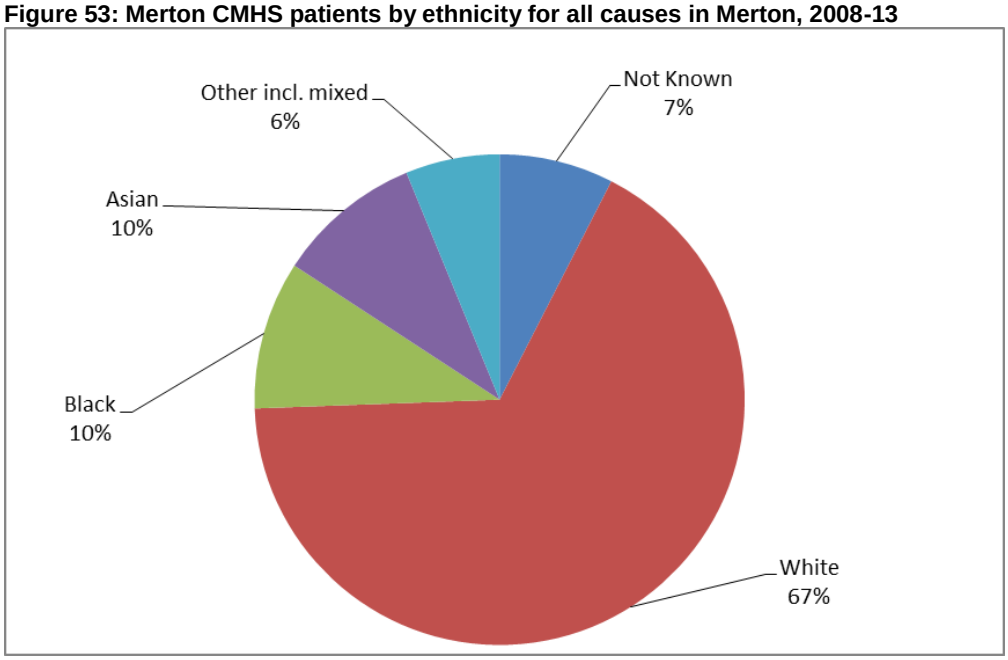
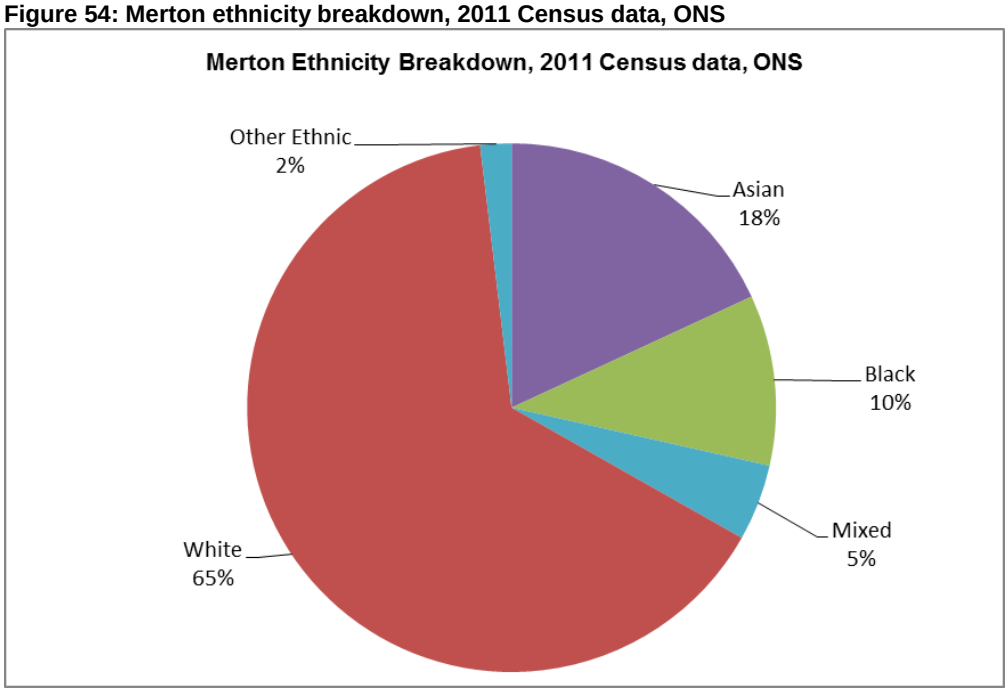


Figure 53: Merton CMHS patients by ethnicity for all causes in Merton, 2008-13



The ethnicity distribution for in-patients and CMHS patients corresponds quite closely to the underlying ethnicity distribution for the white ethnicity group in Merton (Figure 54). However while the underlying black population in Merton is 10%, the in-patient population had 16% blacks (the CMHS black proportion is same as the underlying black population proportion). While there are 18% Asians in the general population the in-patient population had 11% Asians and the CMHS only 10%. In other words blacks were over-represented in the in-patient population and Asians under-represented in both the in-patient and CMHS populations. In the case of Asian communities this under-representation suggests inequity in access and cultural taboos and stigma associated with mental illness. In Black ethnicities the in-patient over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community.

Figure 54: Merton ethnicity breakdown, 2011 Census data, ONS



A more detailed breakdown is shown in table 11 below.

Table 11: Breakdown of Merton in-patient & CMHS ethnicities for SWLStG MHT, 2008-13

Ethnicity Group	SWLStG in-patients Percentage	CMHS referrals Percentage
Not Known	1.2	8.4
White British	55.6	54.9
White Irish	3.0	1.8
White Other	8.4	9.2
Black African	7.2	3.9
Black Caribbean	6.6	4.1
Black British	0.4	0.3
Black Other	2.2	1.6
Indian	3.1	2.2
Pakistani	0.9	1.6
Bangladeshi	1.0	0.7
Sri Lankan	1.4	0.8
Other Asian	3.9	3.6
Mixed White & Black African	0.3	0.4
Mixed White & Black Caribbean	1.4	1.2
Mixed White and Asian	0.3	0.4
Mixed Other	0.8	1.1
other Ethnicity	1.4	3.1
Chinese	0.5	0.3
Asian or Asian British	0.3	0.2
Mixed Asian	-	0.2

Examining the ethnicity groups of in-patients and CMHS patients by East and West Merton reveals differences in terms of the percentages in each ethnicity group admitted from each area. From the East there are fewer whites, more blacks and Asians, and roughly the same number of other ethnicities. This is in line with the diversity in east Merton but comparing the patient distributions of ethnicities with the distribution in the overall population, by East and West Merton, in in-patients there is over-representation of white and black ethnicities from the East and an under-representation of Asian ethnic groups. In CMHS populations there is under-representation of both black and Asians compared with the general population, although this is more pronounced for Asians. For West Merton the representations of whites are in line with the underlying population

while blacks are over-represented and Asians are under-represented. While part of the over-representation can be explained by underlying differences in the patterns of mental illness by ethnicity and also by repeat admissions, this analysis further re-enforces a point made earlier that the under-representation of Asians is very likely to be an equity issue and furthermore, the over-representation of blacks could be because of increased admissions due to cases being diagnosed later (see figures 55, 56 and 57).

Figure 55: Merton in-patients (percentage) by ethnicity in East and West Merton, 2008-13

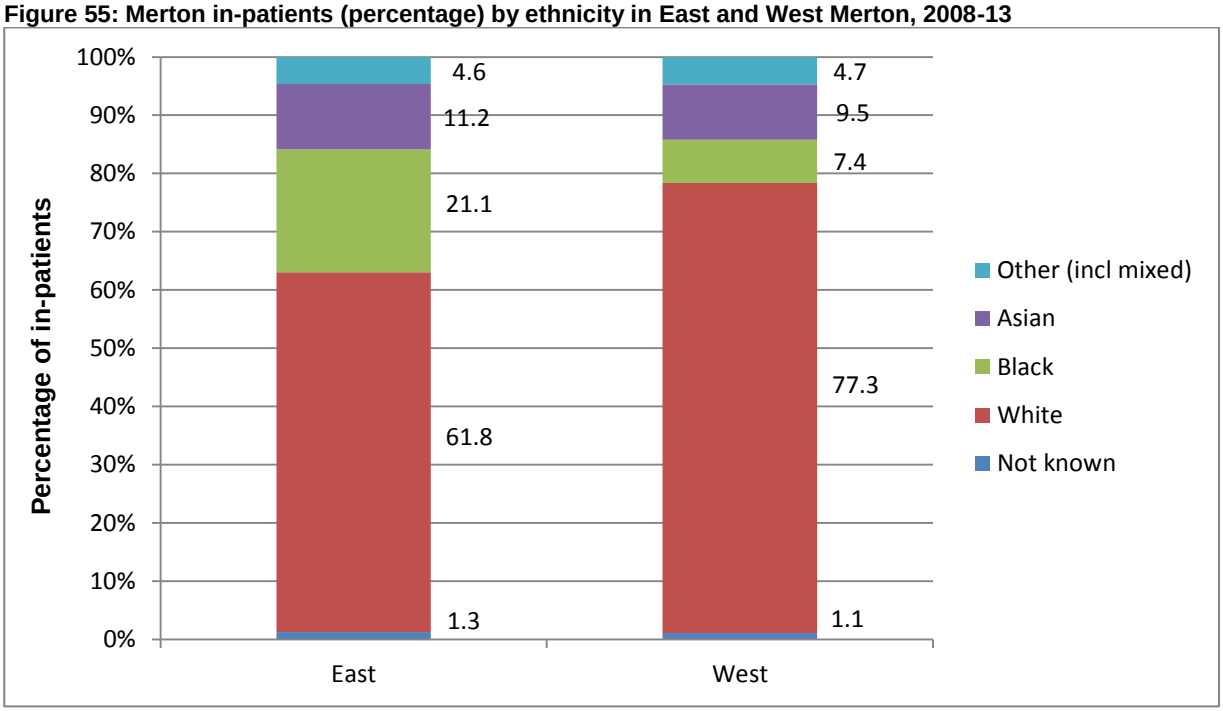


Figure 56: Merton CMHS patients (percentage) by ethnicity in East and West Merton, 2008-13

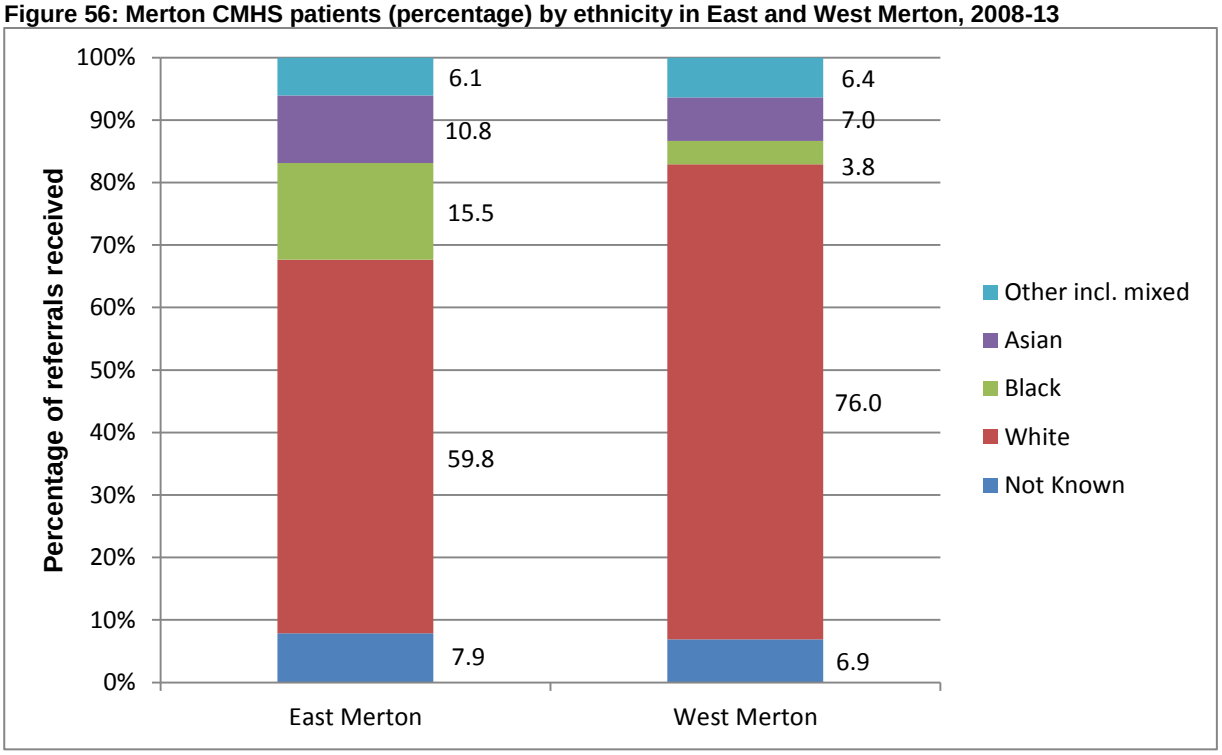
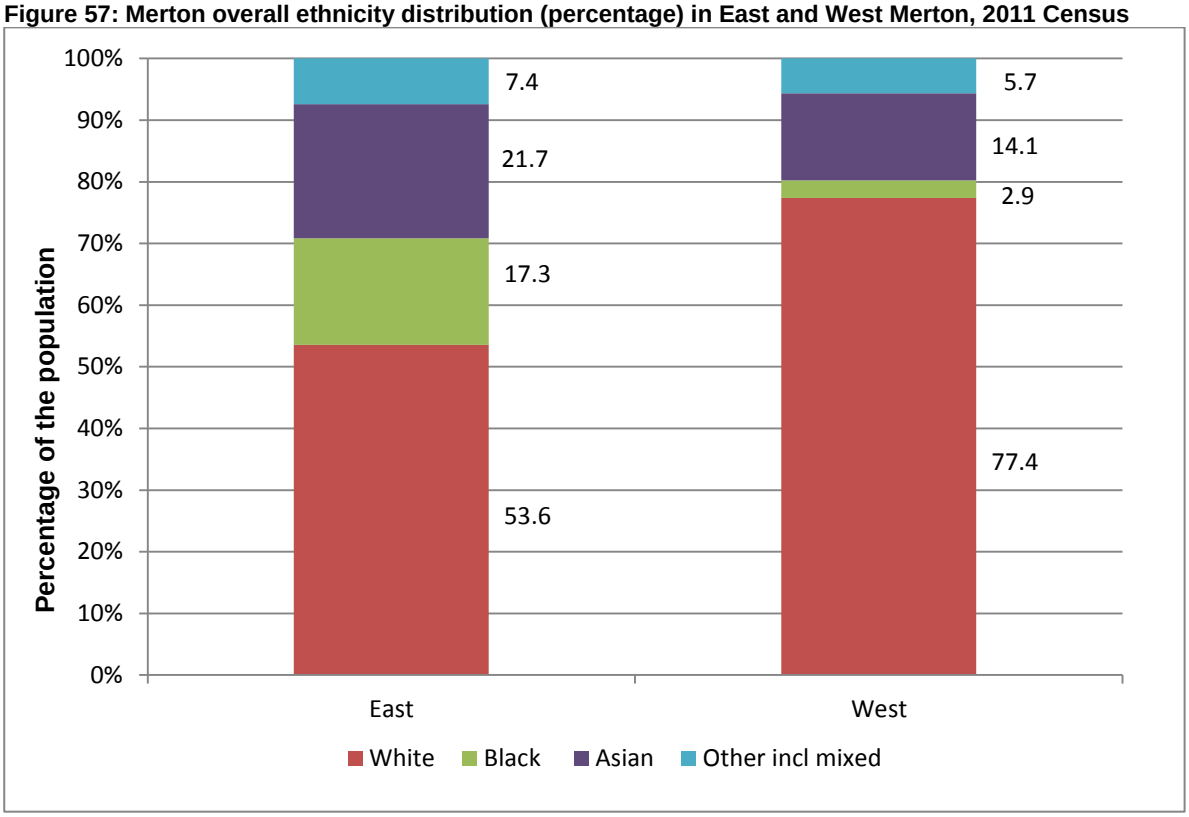


Figure 57: Merton overall ethnicity distribution (percentage) in East and West Merton, 2011 Census



Admissions by deprivation quintile

When the in-patient occupancies were broken down by IMD (Index of Multiple Deprivation) quintile where IMD 1 is the least deprived and IMD 5 is the most deprived, a majority of the in-patients belonged to IMD 4 (37%) followed by IMD 3 (26%), IMD 1 (16%), IMD 2 (15%) & IMD 5 (3%). Similarly for CMHS patients, most referrals were from the second most deprived quintile (IMD4-31%) and then IMD 3 (26%), IMD 1 (22%) IMD 2 (15%) and IMD 5 (3%). The low numbers in IMD 5 are perhaps because Merton is in general a wealthy borough and there not many people in IMD 5 as such but more in IMD 4 in terms of deprivation (figure 58, 59).

As mentioned earlier the health inequalities between East and West Merton are well established, and also that East Merton is much more deprived than the West[81]. Examining the data by patient's place of residence reveals that 64% of the in-patient population was from East Merton, 33% from West Merton and 3% not attributable. It was more evenly split for CMHS, with 42% from East Merton, 37% from West and 21% not attributable (figures 60 and 61).

[81] Merton Joint Strategic Needs Assessment 2013-14

Figure 58: In-patients in Merton by IMD deprivation quintiles, 2008-13 (1= least deprived)

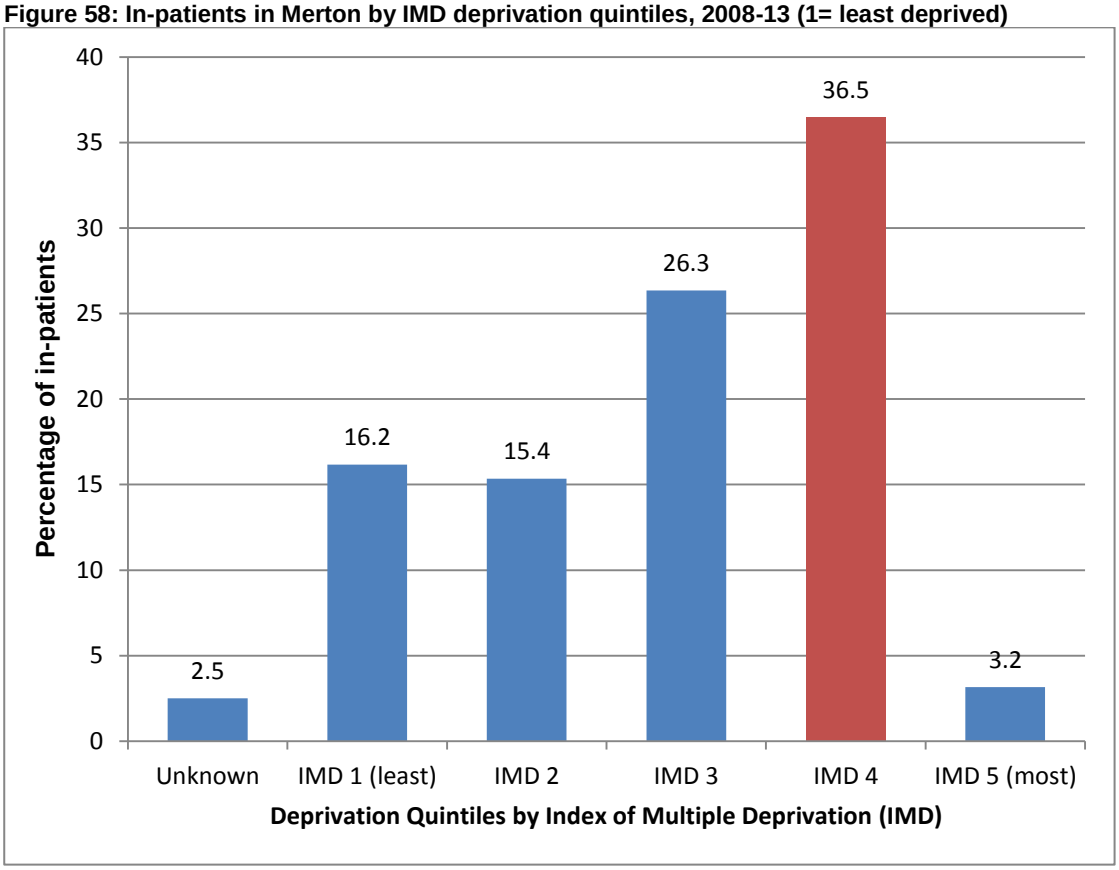


Figure 59: CMHS patients in Merton by IMD deprivation quintiles, 2008-13 (1- least deprived)

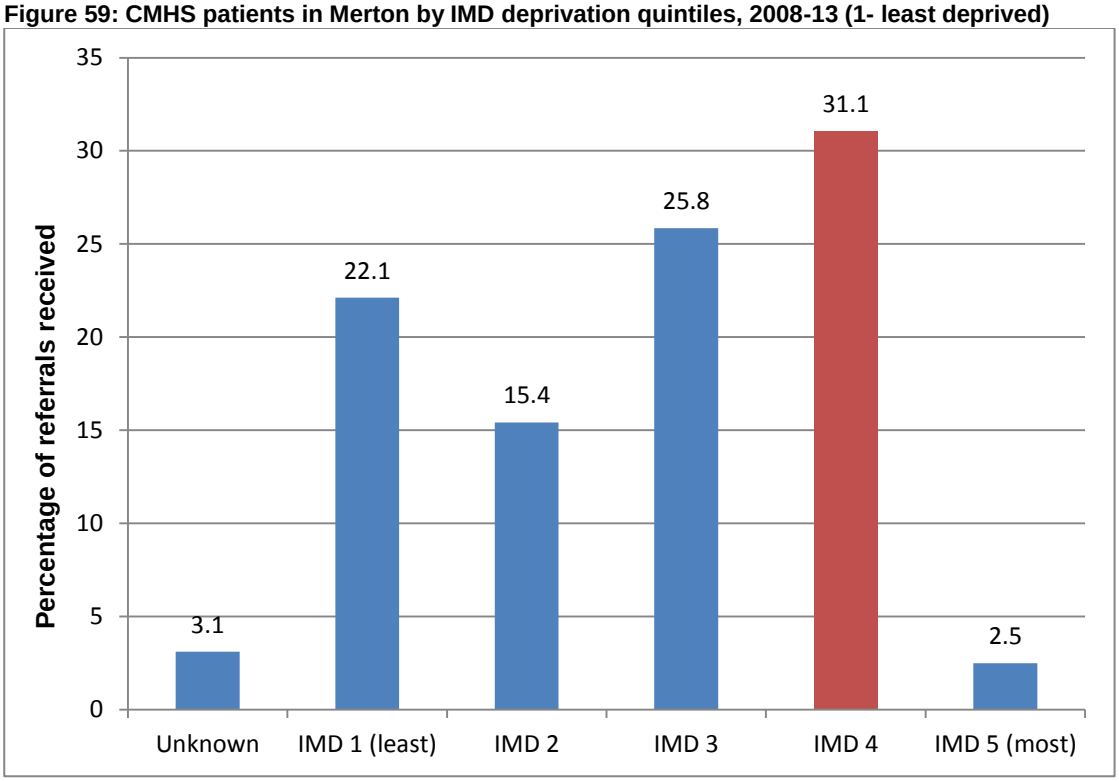


Figure 60: In-patients from East and West Merton, 2008-13

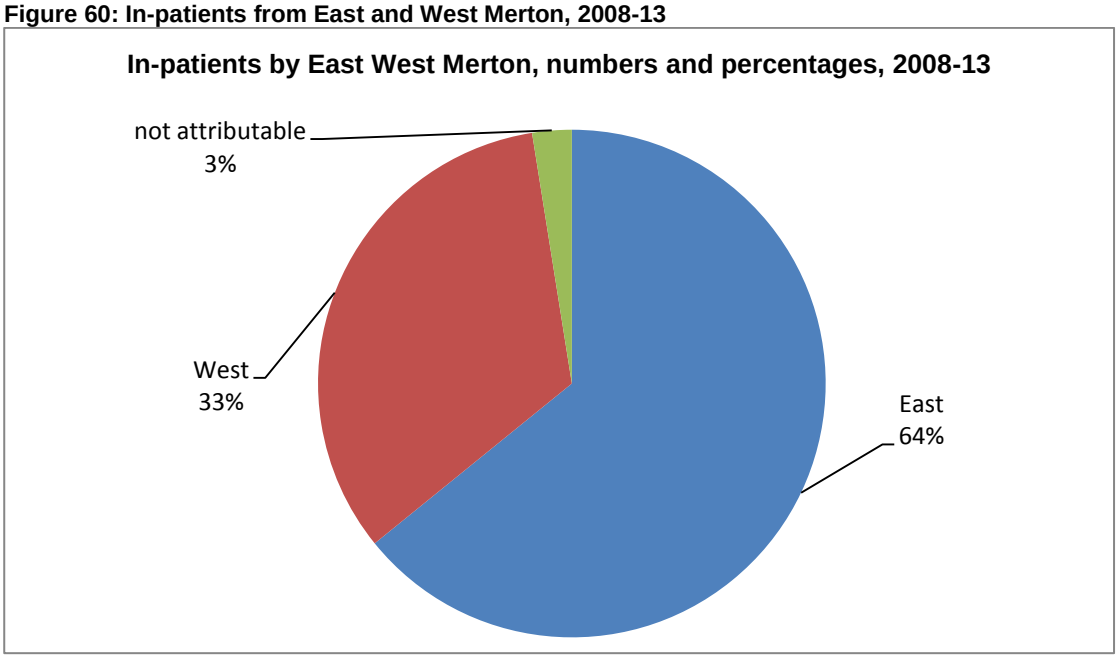
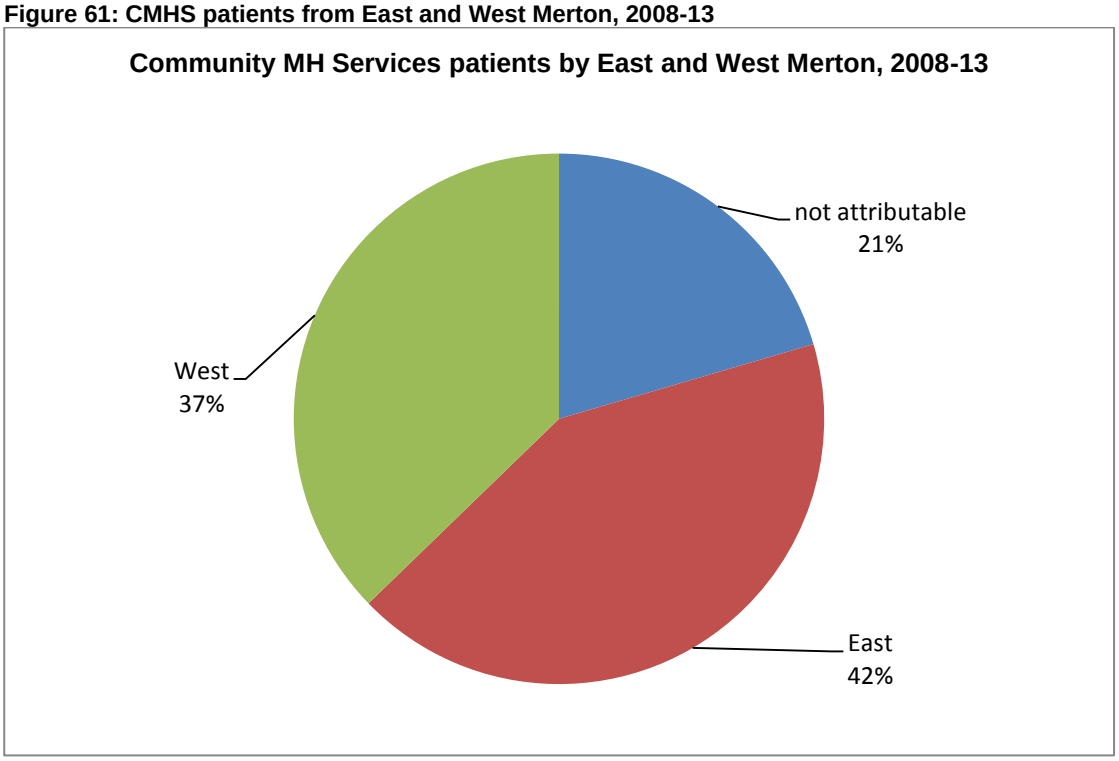


Figure 61: CMHS patients from East and West Merton, 2008-13



When the deprivation quintiles are examined separately for East and West Merton, there is a sharp contrast in the proportion of patients belonging to each deprivation quintile, to the extent that they are almost a mirror image of each other. Whereas in East Merton the highest proportion of patients belongs to IMD quintile 4 (second-most deprived) and progressively less patients belong to the less deprived quintiles and the least proportion of patients belong to the least deprived quintile. In the case of West Merton, it is the exact opposite, with the most patients belonging to the least deprived quintile and the least number of patients belonging to the highest deprivation quintiles. This is observed for both in-patients and CMHS patients.

Figure 62: Percentage of in-patients by deprivation quintile (1= least deprived) in East and West Merton, 2008-13

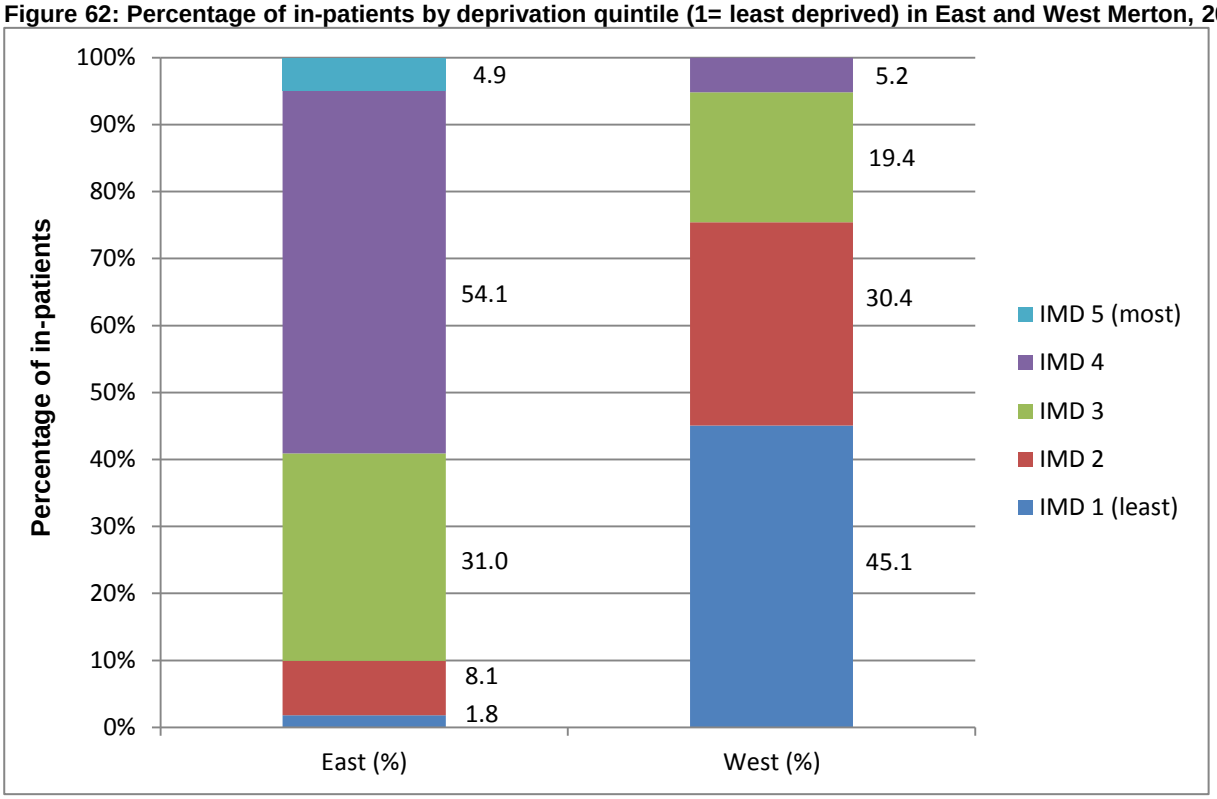
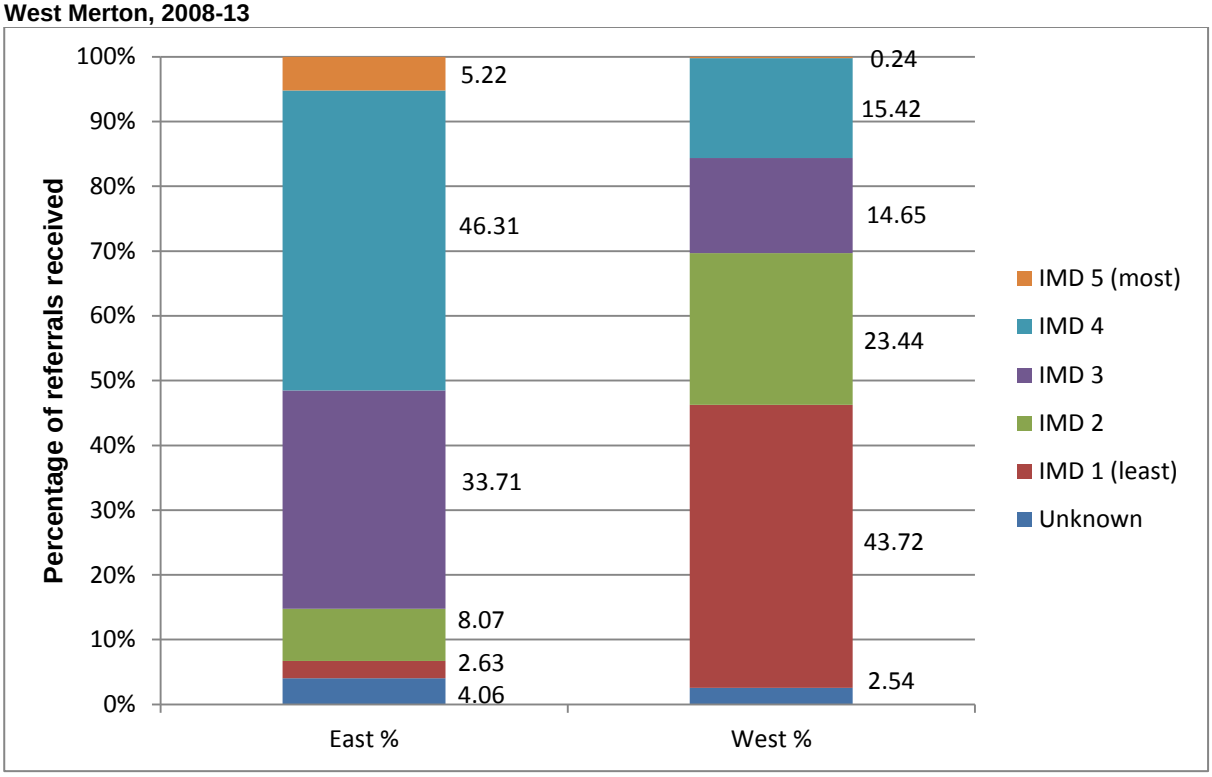


Figure 63: Percentage of Community MH Services patients by deprivation quintile (1= least deprived) in East and West Merton, 2008-13



What are the overall trends and main causes of admissions and referrals in Merton?

Key Points

- *The in-patient admissions show a decreasing trend from 2008-13. Overall there was a drop in the mean length of stay for in-patients in Merton from 2008-13*
- *In terms of referral rates to CMHS, white, black and other ethnicities have comparable referrals rates while the rate in Asians is statistically significantly much lower. For in-patients, Black ethnicities have the highest admission rates in Merton and this is statistically significantly higher than the admission rates for other ethnicities. Asians have the lowest rate and this too is statistically significantly different from admission rates in white and black ethnicities*
- *The three top causes for in-patient admission were schizophrenia, followed by psychoactive substances and then mood affective disorders*
- *The three top causes for CMHS referrals were mood affective disorders, followed by psychoactive substances and then schizophrenia*
- *In working age adults the most common cause of admission was schizophrenia while in older adults it was mood affective disorders. The next most common in working age adults was psychoactive substances while in older adults it was schizophrenia*
- *For CMHS, in working age adults the most common diagnosis is psychoactive substances, while in older adults it is organic disorders. The next most common in working age adults is mood affective disorders while in older adults it is affective disorders*
- *Psychoactive substances were the second most common cause for both in-patient admissions and CMH patients in adults overall from 2008-13, as well as the second most common cause for admissions in working age adults. Additionally this category was the most common cause for referrals to CMH in working age adults. In both in-patient admissions and CMHS referrals for substance misuse, a significant majority were due alcohol*
- *For Merton in-patients, black ethnicities were admitted in the highest proportion after white ethnicities for schizophrenia, mood disorders and organic disorders. Asians were represented in higher proportions than black ethnicities among patients with neurotic, anxiety and stress disorders, and psychoactive substances. White ethnicities had a particularly high proportion of admissions for psychoactive substances, organic disorders and personality disorders*
- *For Merton CMHS patients, after white ethnicities the next highest ethnic proportion is of black ethnicities in schizophrenia and adult personality disorders. Asians are represented in higher proportions than black ethnicities in patients with neurotic, anxiety and stress disorders, organic disorders and by small margins in psychoactive and mood disorders*
- *Apart from organic disorders where the least deprived patients have the highest proportion of cases, for all other major diagnostic groups the more deprived patients have the higher proportion of cases, indicating a positive correlation between mental illnesses and deprivation*
- *In all the major primary diagnostic groups there are a higher proportion of patients from East Merton compared with West Merton*
- *Majority of referrals to CMHS were from GPs. The percentage of referrals from the Local Authority was very low.*

Overall admission and referral trends

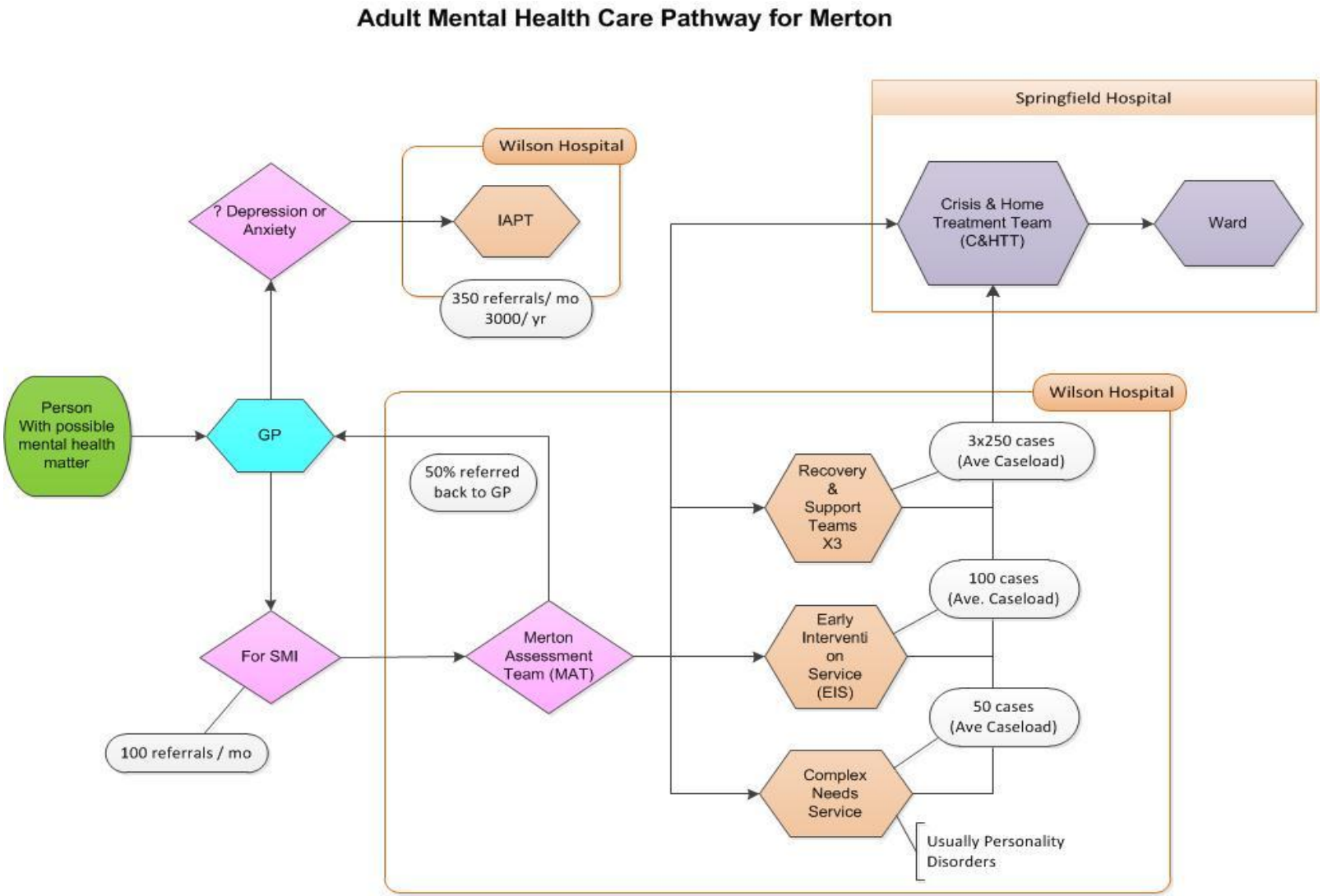
While the mental health services in Merton will be described at length in a subsequent section of this document, it would be useful to consider the way the SWLStG MHT services are organised in Merton (see figure 64 below). The first point of contact for a person with mental health concerns is their GP. For anxiety and depression related problems the GP may refer the person to Merton's IAPT services. For SMI (Severe Mental Illness) the person may be referred to the Merton Assessment Team (MAT) which triages cases and determines which service is most appropriate for the person (community mental health services- Recovery & Support Team, Early Intervention Service or Complex Needs Service; or the Crisis & Home Treatment team) and can lead to a hospital admission.

In total there were 1,024 in-patient admissions over the period 2008-2013 in the SWLStG MHT Springfield University Hospital. The total number of adult patients referred to CMHS for all causes in the period 2008-13 was 29,441. As with in-patients, these include many patients that were seen on more than one occasion.

Table 12: Summary of SWLStG MHT in-patients and CMHS referrals in Merton for period 2008-13

Metric	Number of patients
Overall number of patients that were admitted during the period 2008-13, due to any cause	1,024
Overall number of referrals to CMHS in adults during the period 2008-13, due to any cause	29,441

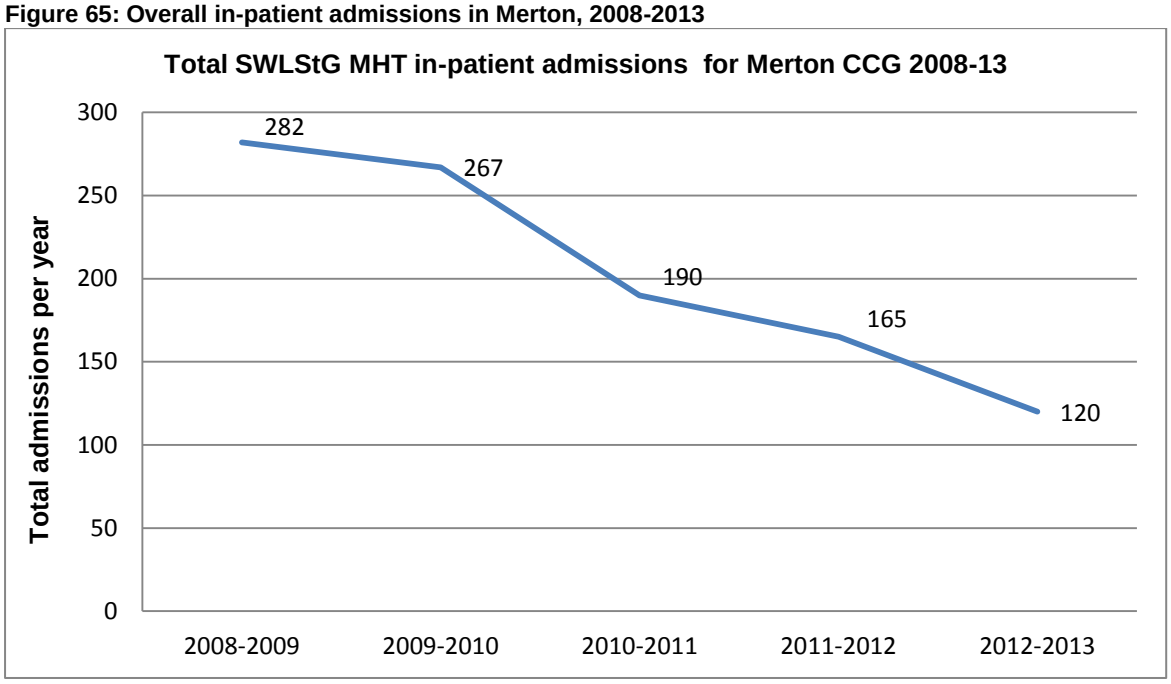
Figure 64: Care pathway of adult mental health services in Merton



Admission and referral trends

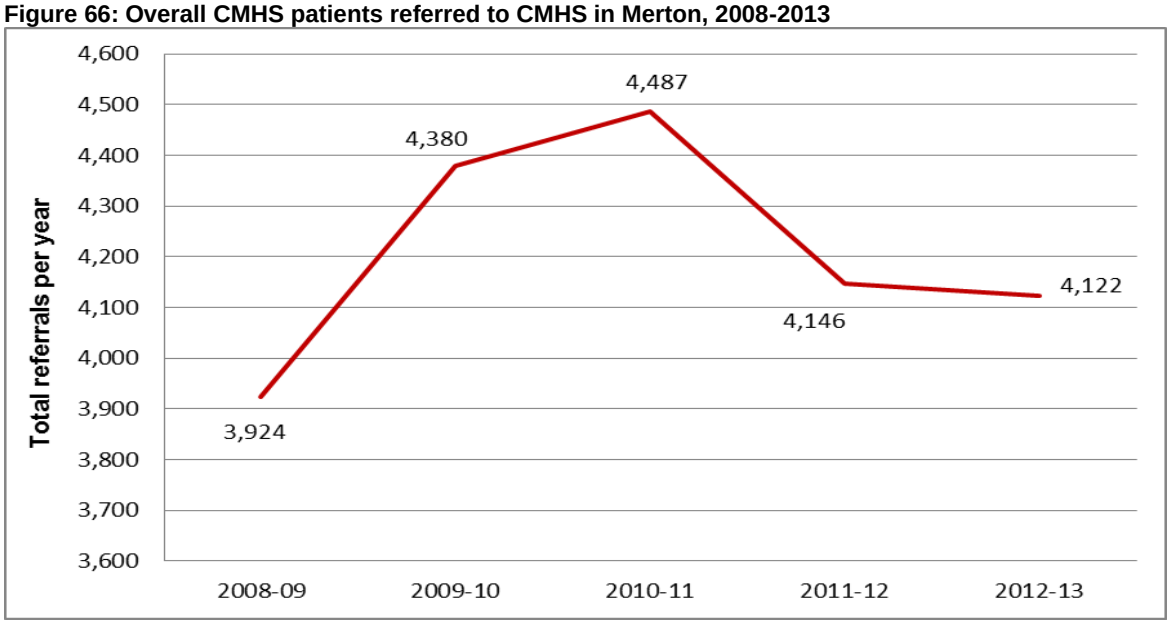
The in-patient admissions trend overall over 2008-13 shows a decreasing trend from 2008-09 to 2012-13. The decrease is more pronounced during the period 2009-2011, and then a relatively more gradual decrease occurs over the 2011-2013. The reductions probably reflect the changes in the way mental health services were provided and the increasingly effective triaging done by the Merton Assessment Team, so that more cases are seen in the community and fewer more serious cases were admitted to hospital.

Figure 65: Overall in-patient admissions in Merton, 2008-2013



The trends for CMHS patients overall over 2008-13 show sharp increases from 2008-09 to 2009-10, then a more gradual increase over the next financial year (2010-11), after which the number of referrals drop significantly over 2011-12 and then more gradually over 2012-13 (figure 66).

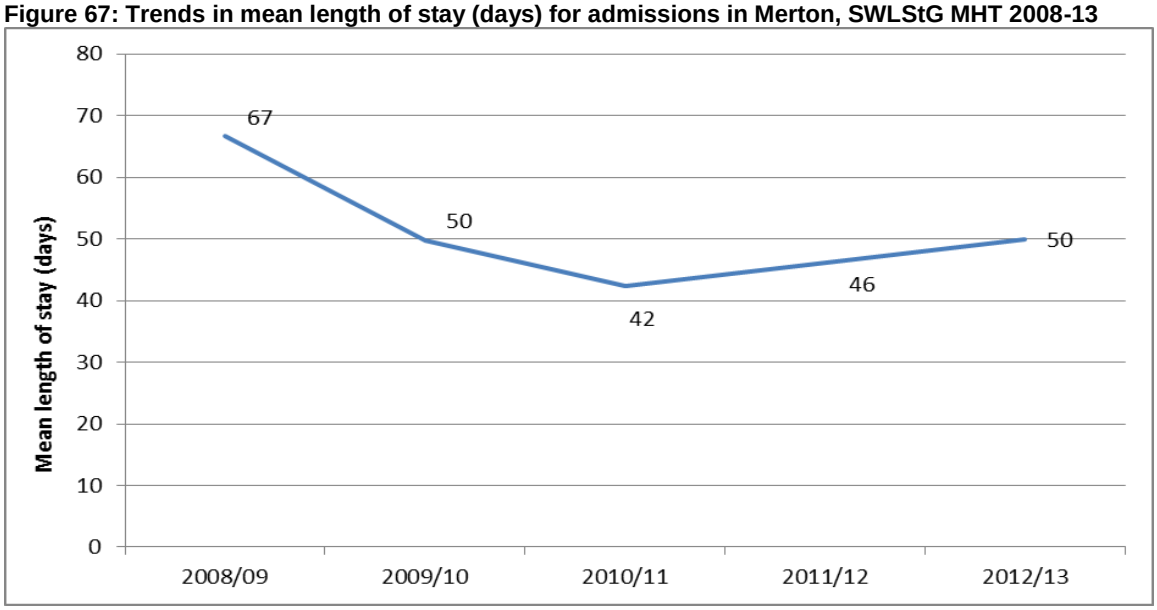
Figure 66: Overall CMHS patients referred to CMHS in Merton, 2008-2013



Mean length of stay for in-patients

The figure below shows the mean length of stay in days for admissions in that particular year. It shows that there was a drop in mean length of stay from 2008/09 to 2010/11 after which the mean length of stay has increased slightly year on year.

Figure 67: Trends in mean length of stay (days) for admissions in Merton, SWLStG MHT 2008-13



Over 2010-13, while there has been a reduction in the number of admissions there has been an increase in the mean length of stay. One interpretation of this is that while fewer admissions are taking place and more people are being seen in the community mental health services, the cases that are being admitted have a greater severity of symptoms due to which their length of stay in hospital is increasing.

Admission and referral rates by ethnicity and age group

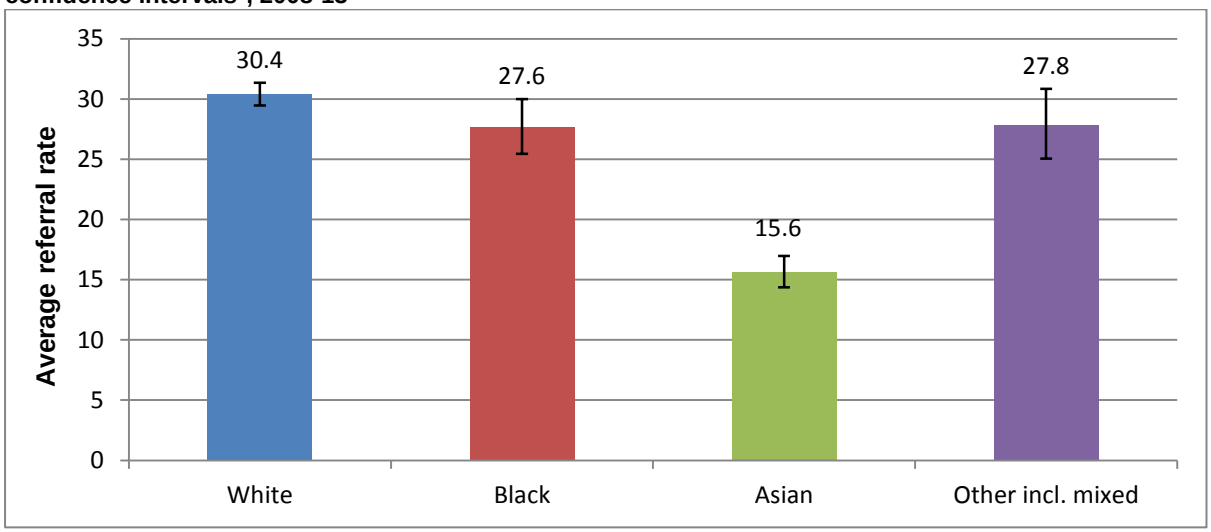
A crude rate was developed for both in-patient admissions and CMHS referrals by ethnicity and also by age group. This was done by calculating the average number of admissions and referrals over 2008-13 and then dividing these by the ONS 2011 Census Merton population break-down by ethnicity (for rates by ethnic groups) and the average age-specific ONS population projections for Merton from 2008 to 2012 (for the age-specific rates). All the rates are expressed per 1000 population in that group- for example, a referral rate of X for say the 20-29 year age group means that there were X referrals per year for every thousand 20-29 year olds in Merton.

Referral and admission rates by ethnicity

While in absolute terms it appears that a large number of admissions/ referrals were from the white population, this is also explained by the fact that there are many more white people in Merton. By creating admission and referrals rates, this brings greater clarity and perspective.

Figure 68 shows the referral rates for CMHS in Merton by ethnicity, with 95% confidence intervals. White, black and other ethnicities have comparable referrals rates while the rate in Asians is statistically significantly much lower.

Figure 68: Merton CMHS average referral rates (per 1000 population) per year by ethnicity with 95% confidence intervals[$], 2008-13*

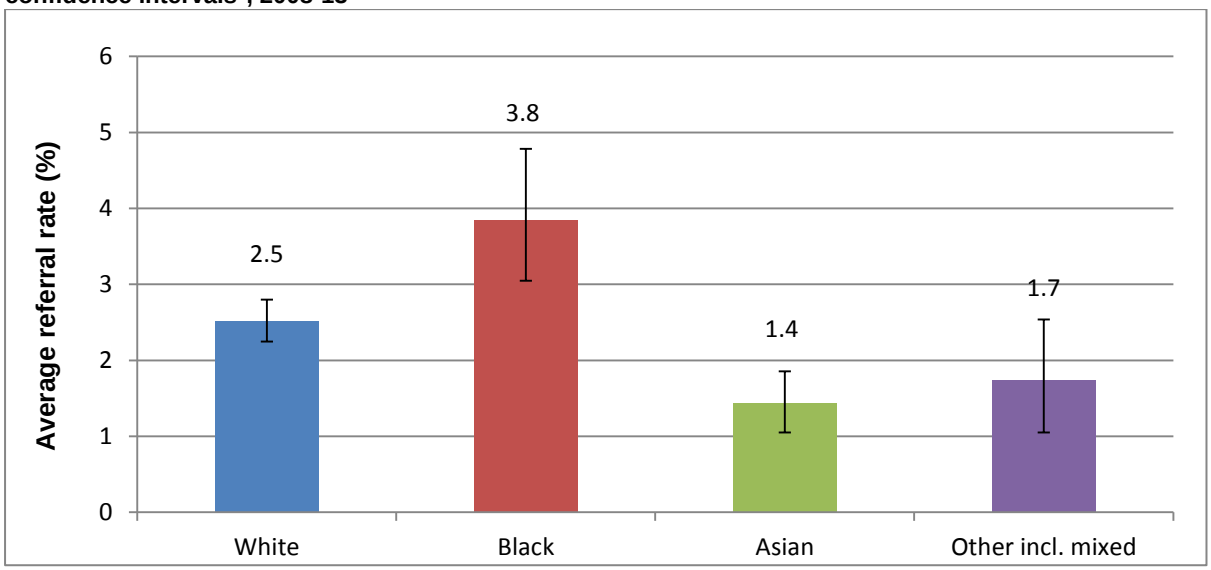


[$] *95% confidence intervals (CI) indicate the precision with which the rates are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the rates are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

**Rates were calculated from average numbers of referrals for 2008-13 and ONS 2011 ethnicity populations for Merton.*

Figure 69 shows the admission rates for SWLStG MHT in-patients in Merton by ethnicity, with 95% confidence intervals. Black ethnicities have the highest admission rates in Merton and this is statistically significantly different from admission rates for other ethnicities. Asians have the lowest rate and this too is statistically significantly different from admission rates in whites and blacks, but not other including mixed.

Figure 69: Merton in-patient average admission rates (per 1000 population) per year by ethnicity with 95% confidence intervals[$], 2008-13*



[$] *95% confidence intervals (CI) indicate the precision with which the rates are calculated. They also indicate the range of values in which there is a 95% likelihood that the true value for the patient population lies - the narrower the range, the more precise the calculation. The intervals are the widest for smaller sample sizes. These are shown by the vertical lines at the top of the bar graphs. When the rates are compared, if the CI intervals do not overlap this represents a statistically significant difference.*

Cause of admission

The cause of admission for in-patients that occupied a bed at any point during the period 2008-13 is depicted in the figure 70. Overall, the majority of in-patients were admitted with a primary diagnosis of schizophrenia, followed by psychoactive substances > mood affective disorders>Personality & behavioural disorders> neurotic, anxiety and related disorders> Organic disorders (which includes dementia)> others.

Figure 70: Merton in-patients by primary diagnosis, 2008-13

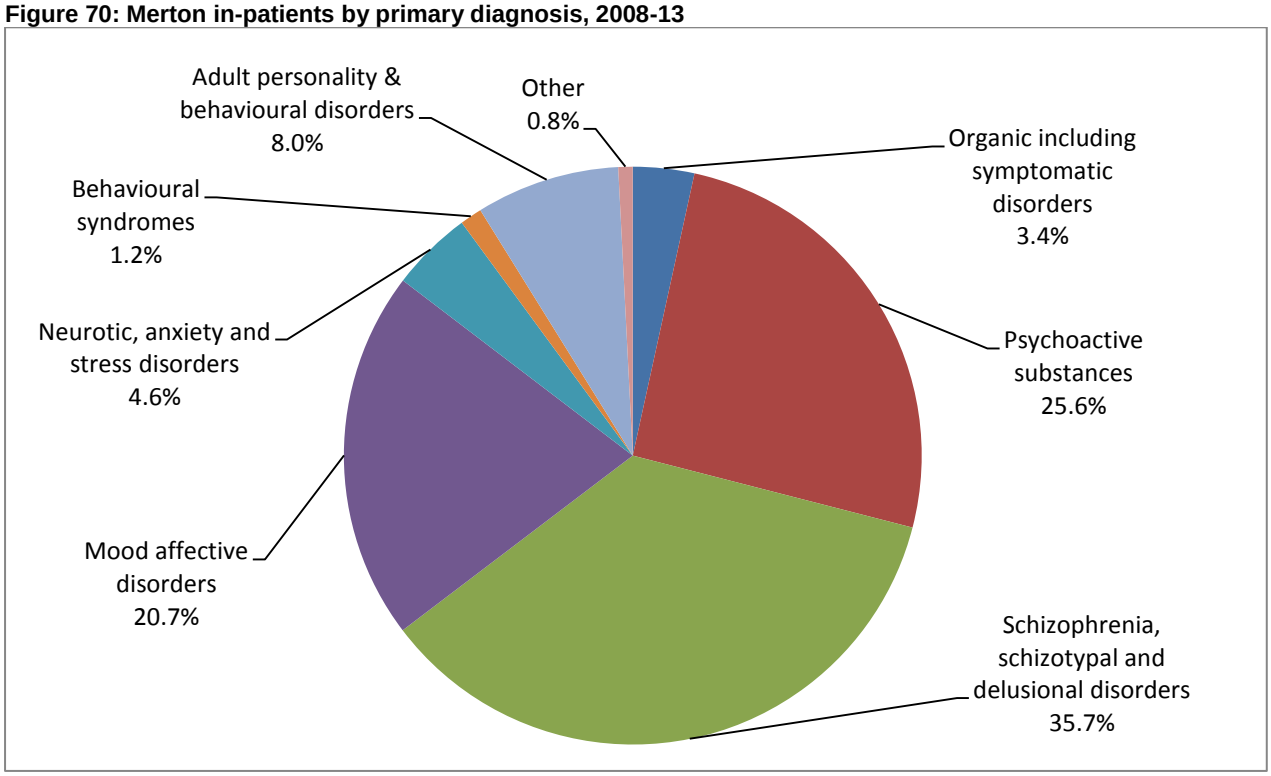
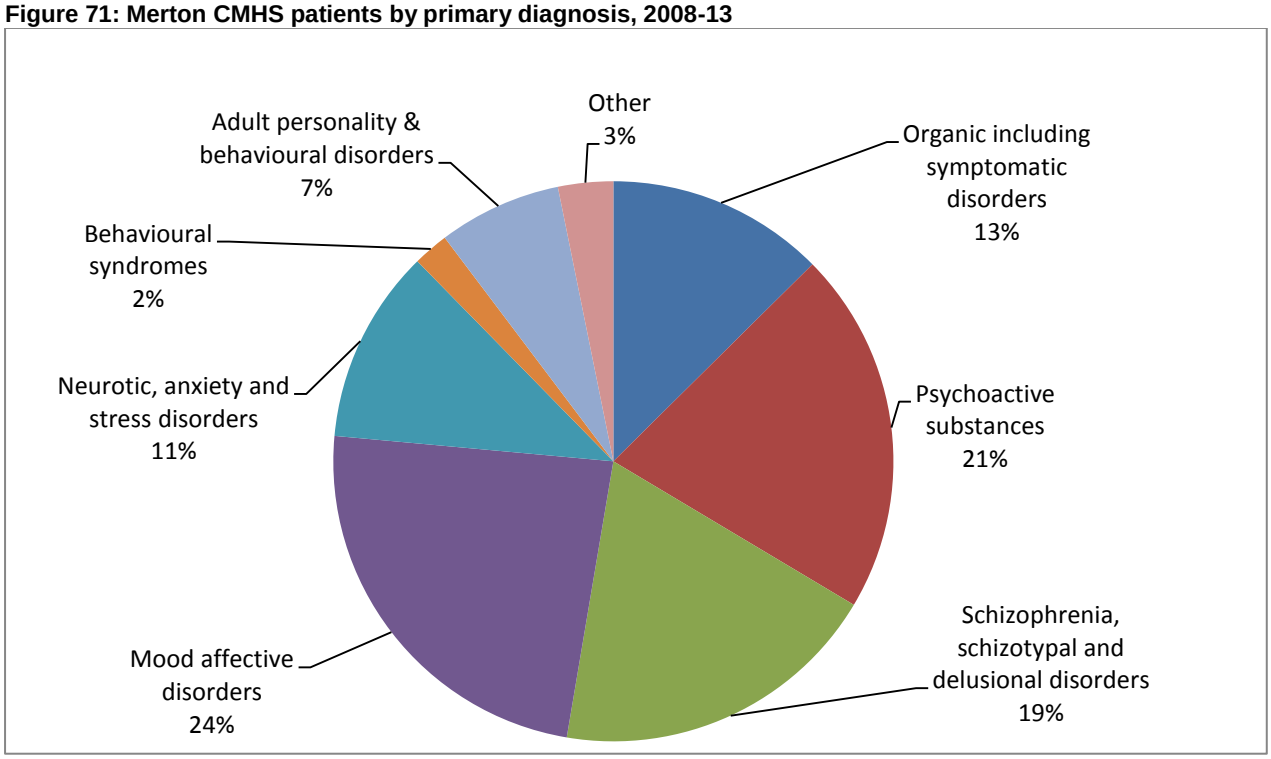


Figure 71: Merton CMHS patients by primary diagnosis, 2008-13



The picture is somewhat different for CMHS patients (figure 71) where the order of primary diagnosis from most common to least is:
Mood affective disorders> psychoactive substances > schizophrenia> Organic disorders (which includes dementia)> neurotic, anxiety and related disorders> Personality & behavioural disorders> others

Cause of admission by working age and older adults

There are interesting differences when the primary diagnosis for in-patients is analysed separately for working age (16-64 yrs. of age) and older (65+ yrs. of age) adults. In working age adults the most common cause of admission is schizophrenia (37.9%) while in older adults it is mood affective disorders (42.1%). The next most common in working age adults is psychoactive substances (28.9%) while in older adults it is schizophrenia (23%). The third most common in working age adults is mood disorders (17%) while in older adults it is organic disorders including dementia (21.2%)- organic disorder only form (as expected) a small fraction of the admissions in working age adults. Neurotic disorders share roughly the same proportion of admissions in both age groups (4.5%, 5.0%). But while personality disorders are a significant proportion of working age adult admissions (9.2%) there are none in older age adults.

Figure 72: Merton in-patients by primary diagnosis in working age adults, 2008-13

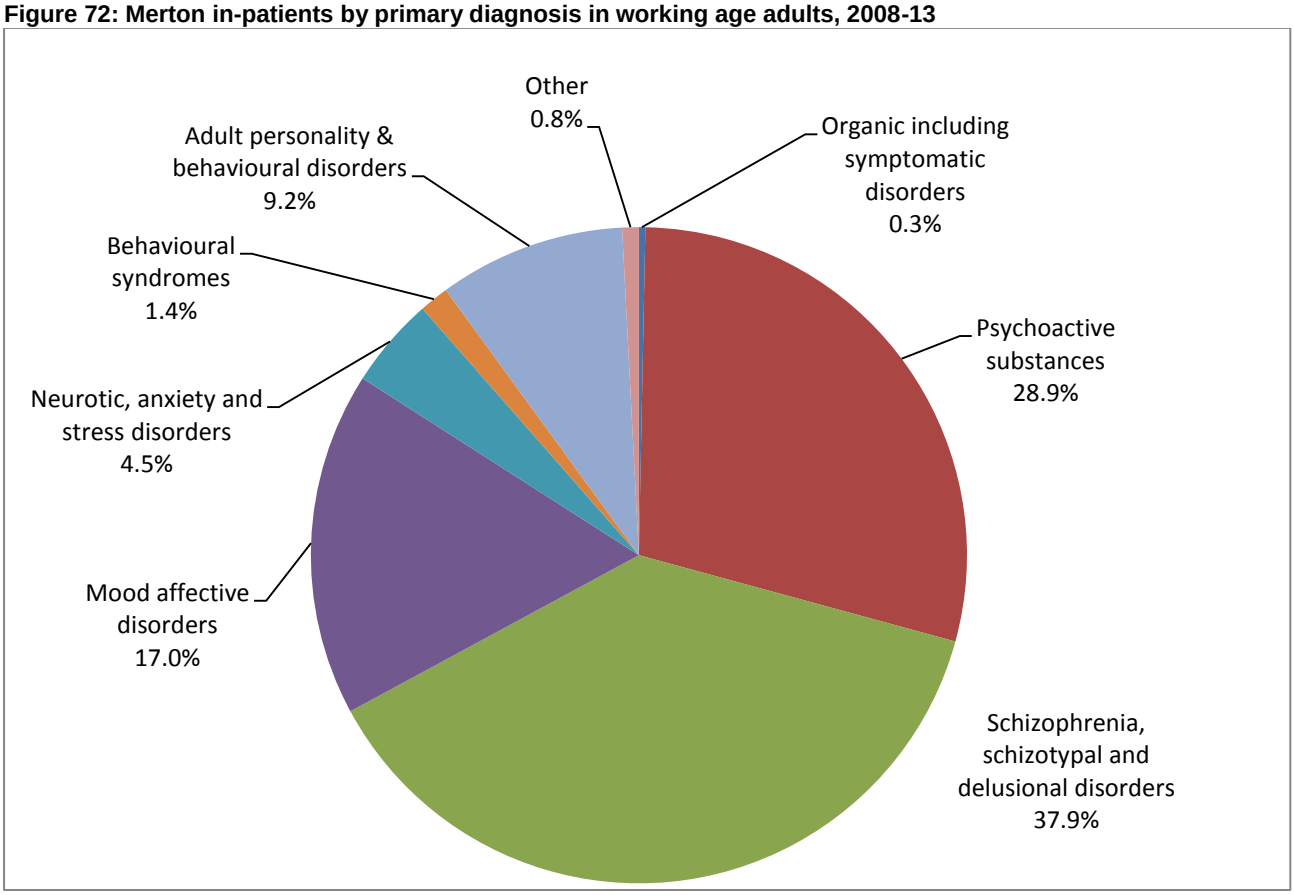
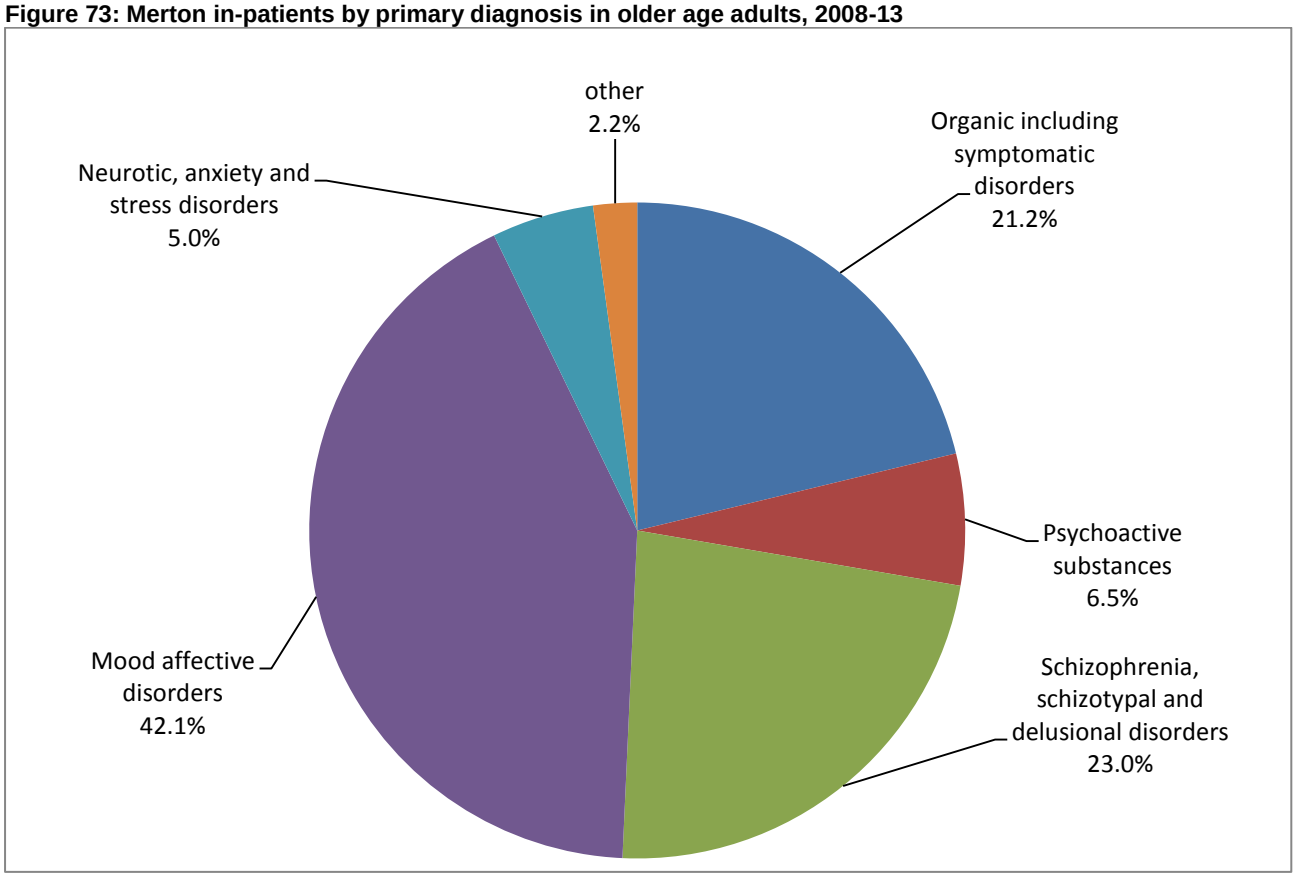


Figure 73: Merton in-patients by primary diagnosis in older age adults, 2008-13



There are interesting differences when the primary diagnosis for CMHS patients is analysed separately for working age (16-64 yrs. of age) and older (65+ yrs. of age) adults. In working age adults the most common diagnosis is psychoactive substances (25.8%) while in older adults it is organic disorders (53.3%). The next most common in working age adults is mood affective disorders (24.2%) while in older adults it is affective disorders (22.3%). The third most common in working age adults is schizophrenia (21.7%) while in older adults it is schizophrenia (9.9%). Next most common in working age and older adults is neurotic, anxiety and stress disorders (12.1%, 8.1%) Adult personality disorders still form a significant part of the conditions for working age adults, but for older adults it is less so, and psychoactive substances only form a small proportion of conditions affecting older adults relative to working age. Organic disorders only form (as expected) a small fraction of the admissions in working age adults.

Figure 74: Merton CMHS patients by primary diagnosis in working age adults, 2008-13

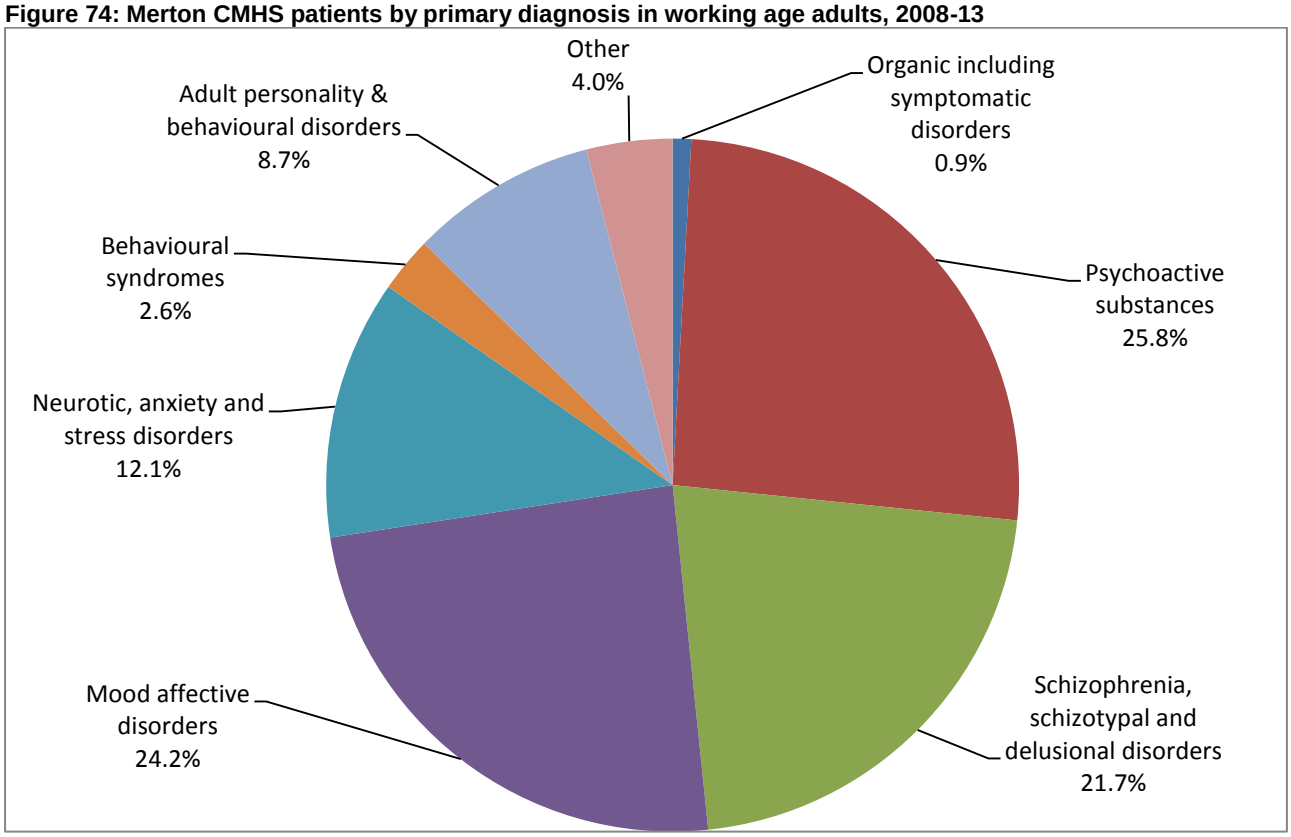
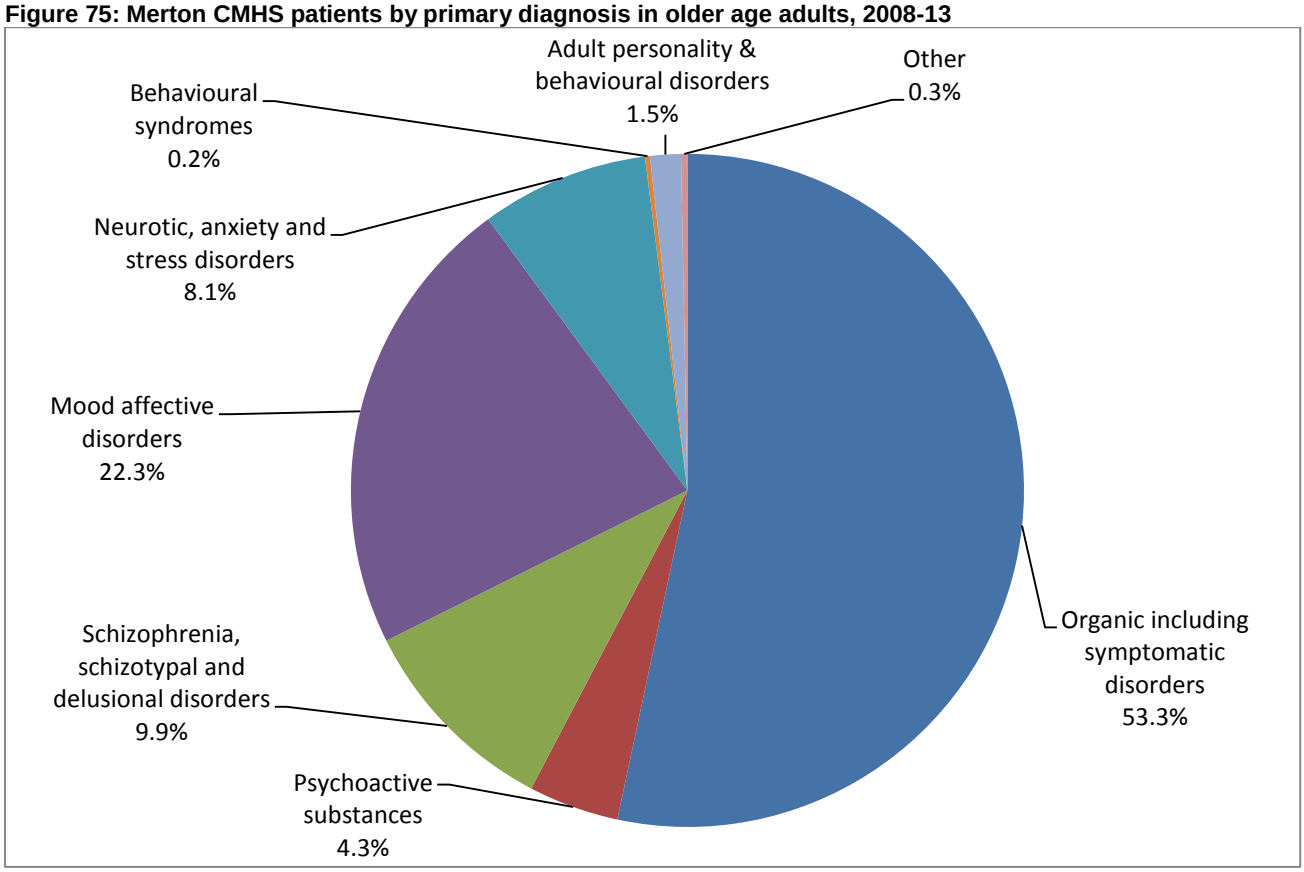


Figure 75: Merton CMHS patients by primary diagnosis in older age adults, 2008-13

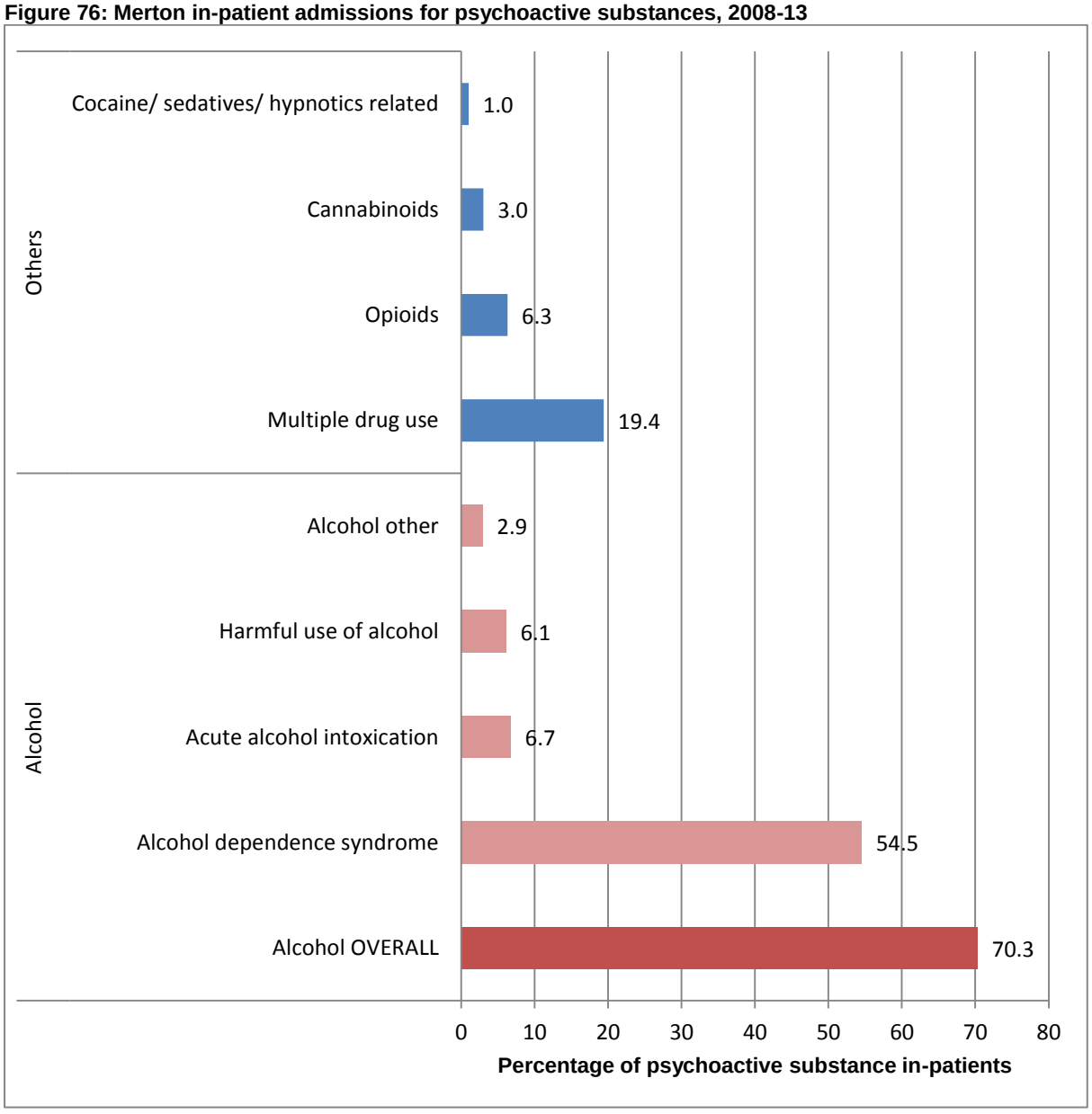


Subset analysis: Psychoactive substances

Psychoactive substances were the second most common cause for both in-patient admissions and CMH patients in adults overall from 2008-13, as well as the second most common cause for admissions in working age adults. Additionally this category was the most common cause for referrals to CMH in working age adults. However psychoactive substances cover a wide range of substances from alcohol to cocaine to cannabis. Therefore this subset was further analysed to drill down into the different types of substances that Merton residents were seen by the mental health services for.

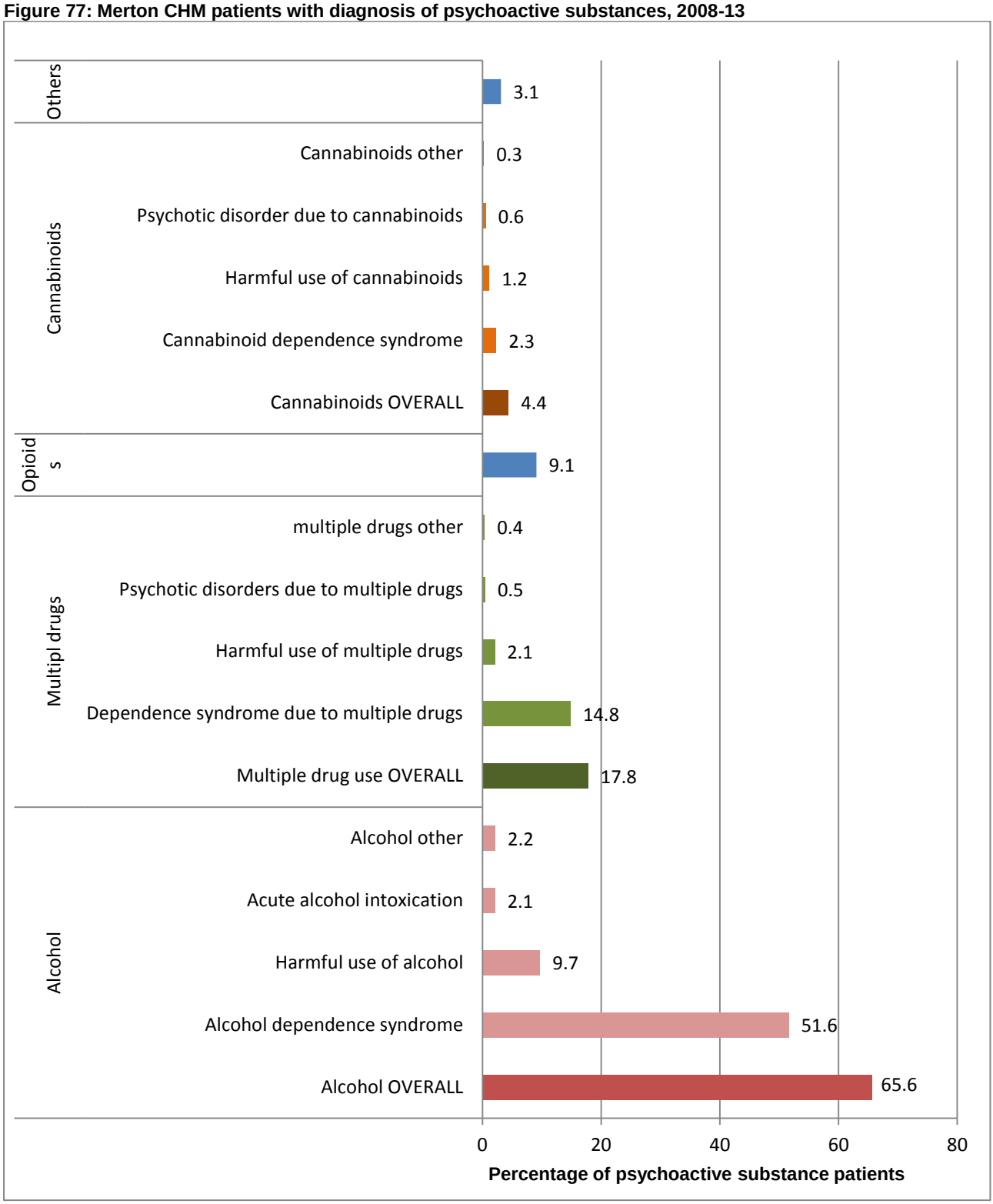
Figure 76 below shows the breakdown of psychoactive substance in-patient admissions and reveals that 70% of such admissions were due to alcohol, out of which the majority were due to alcohol dependence syndrome. Multiple drug use was the second most common reason for admission in this group.

Figure 76: Merton in-patient admissions for psychoactive substances, 2008-13



A similar picture is revealed for CMH patients with diagnosis of psychoactive substances, where a majority were due to alcohol (66%) and again alcohol dependence was the most common reason in the alcohol group. 18% patients in the psychoactive substances group had a diagnosis of multiple drug use of which majority were due to dependence syndromes. Opioid dependence was the next biggest group (9%).

Figure 77: Merton CHM patients with diagnosis of psychoactive substances, 2008-13



Cause of admission by gender

When primary diagnosis is examined separately for in-patients by gender, the order of primary diagnosis is as follows:

Males- schizophrenia 40.7%> psychoactive substances 32.2%> mood affective disorders 16%> Personality & behavioural disorders 4.1%> neurotic, anxiety and related disorders 3.2%> Organic disorders (which includes dementia) 3%

Females- schizophrenia 29.7%> mood affective disorders 26.2%> psychoactive substances 17.8%> Personality & behavioural disorders 12.7%> neurotic, anxiety and related disorders 6.2%> Organic disorders (which includes dementia) 4%

Figure 78: Merton in-patient primary diagnosis by gender- males, 2008-13

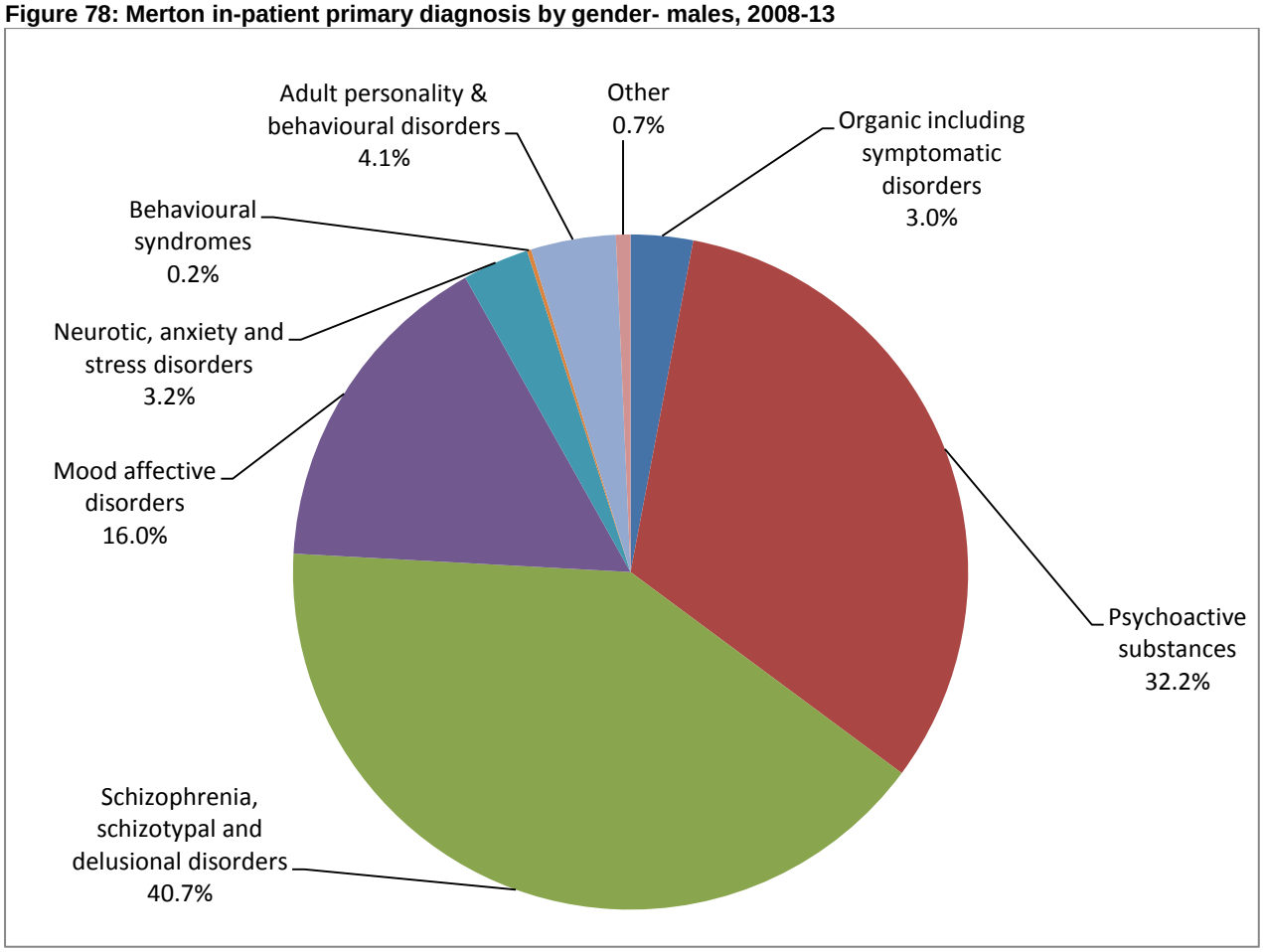
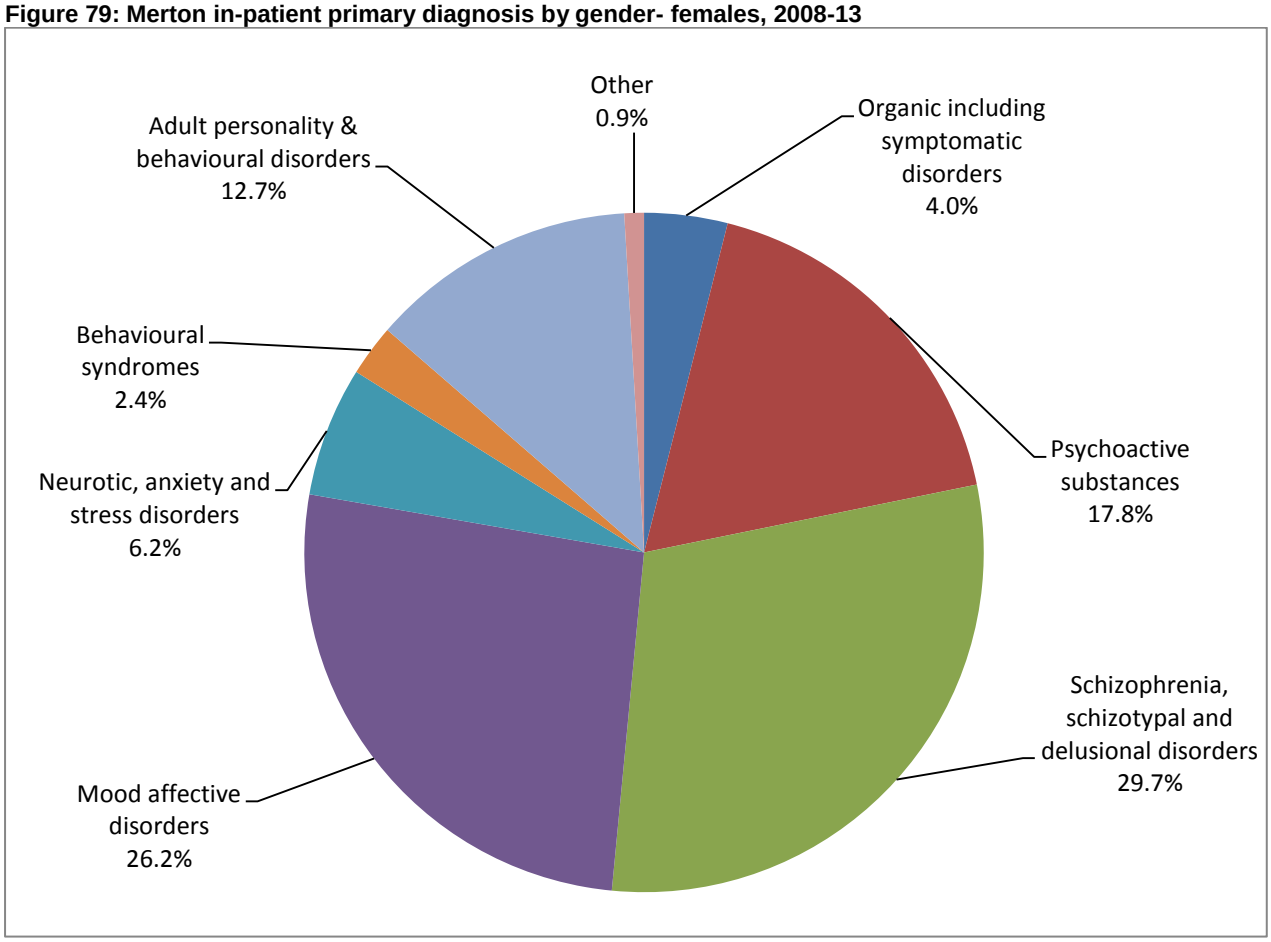


Figure 79: Merton in-patient primary diagnosis by gender- females, 2008-13



When primary diagnosis is examined separately for CMHS patients by gender, the order of primary diagnosis is as follows:

Males- psychoactive substances 28.9%> schizophrenia 23.8%> mood affective disorders 19%> Organic disorders (which includes dementia) 9.8%> neurotic, anxiety and related disorders 9.7%> Personality & behavioural disorders 4.2%>

Females- mood affective disorders 28%> Organic disorders (which includes dementia) 15.1%> schizophrenia 14.9%> psychoactive substances 13.9%> neurotic, anxiety and related disorders 12.6%> Personality & behavioural disorders 9.8%

Figure 80: Merton CMHS patients by primary diagnosis- males, 2008-13

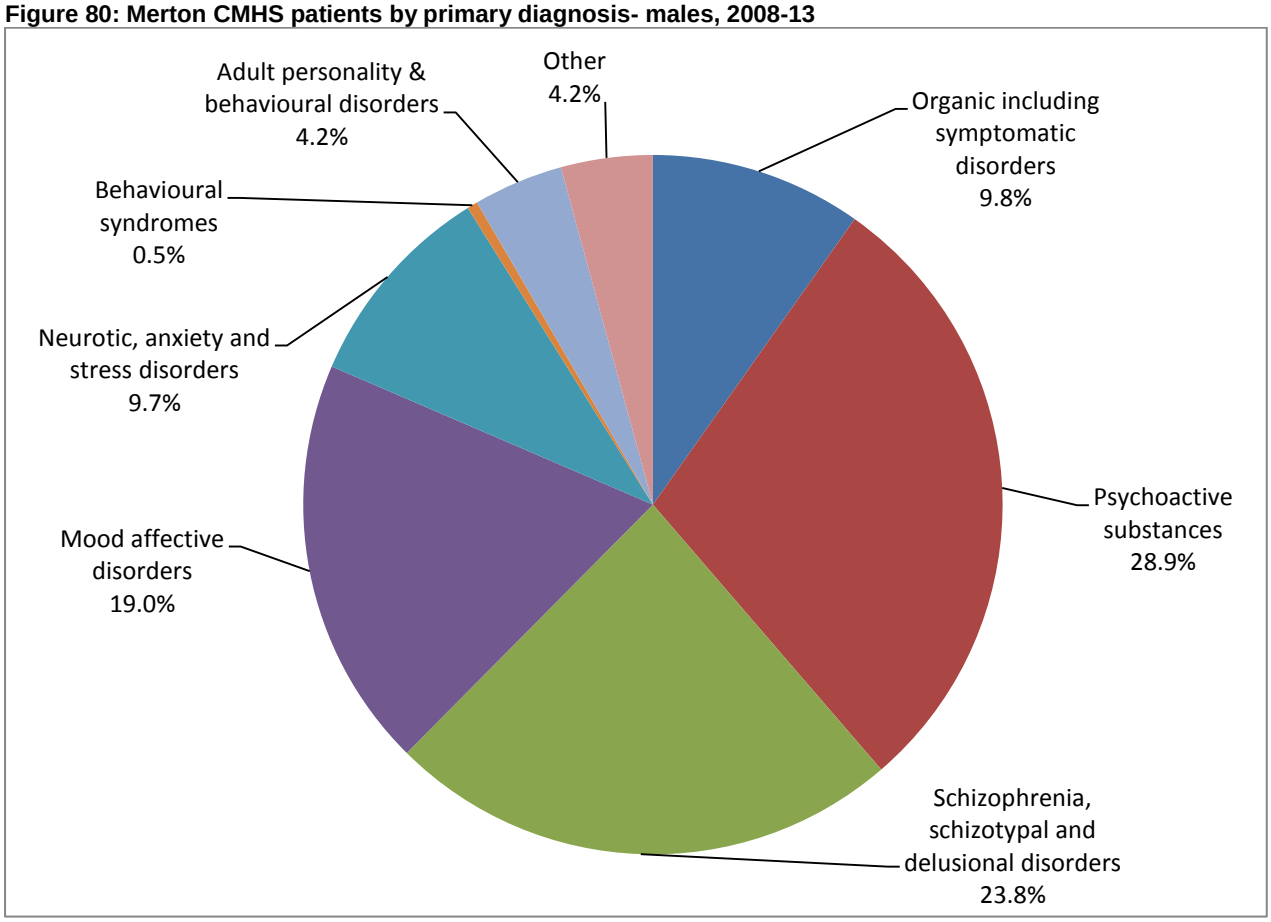
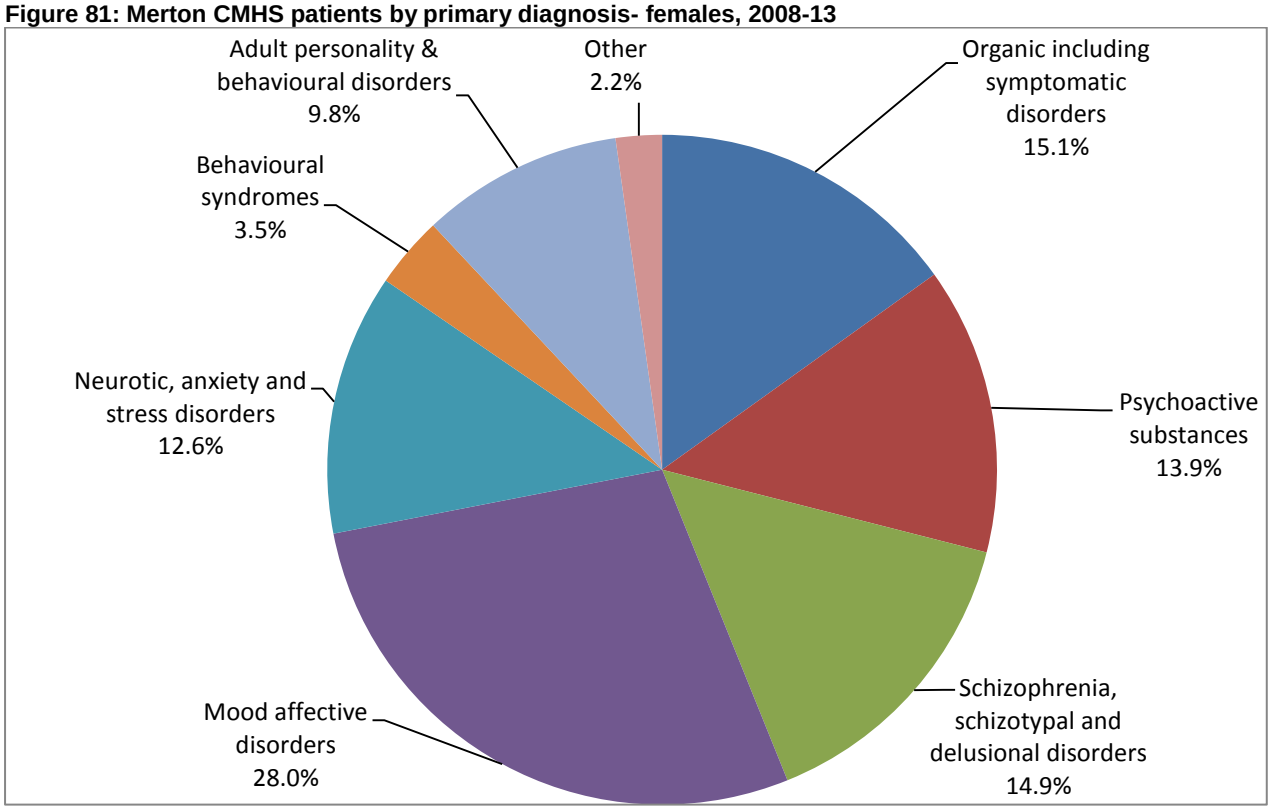


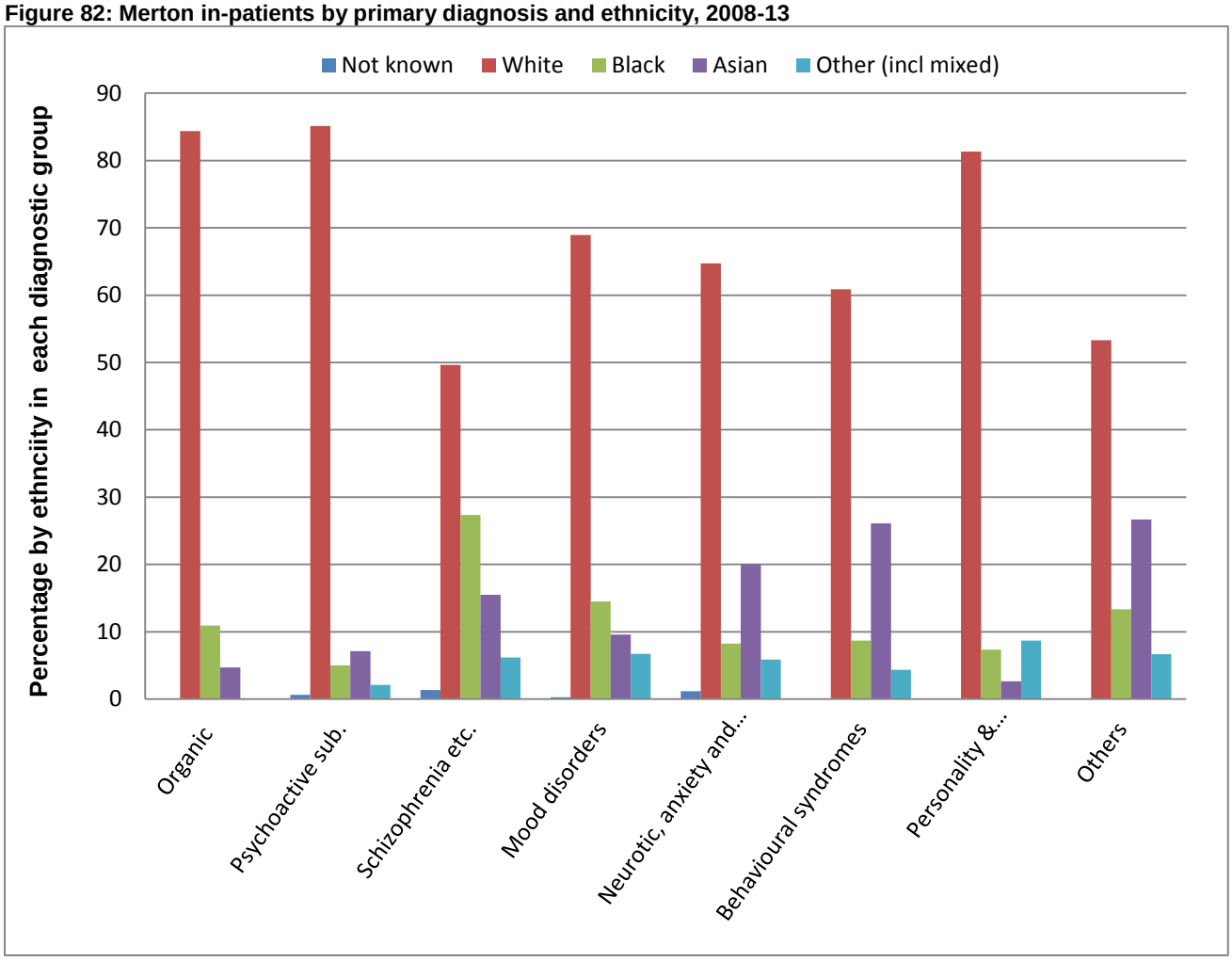
Figure 81: Merton CMHS patients by primary diagnosis- females, 2008-13



Cause of admission by ethnicity

When the data is analysed for primary diagnosis by ethnicity some interesting patterns emerge specifically for minority ethnic groups.

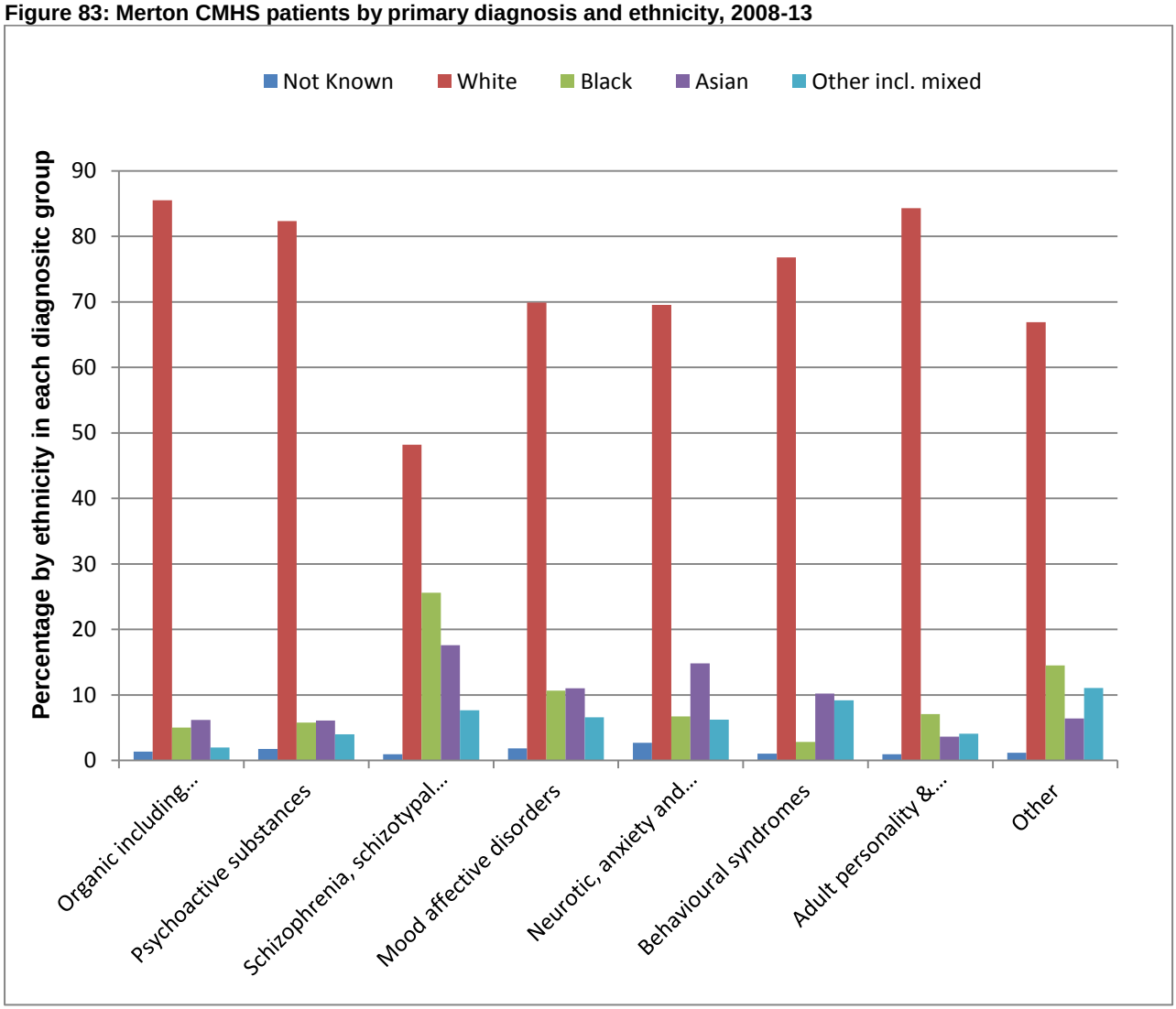
Figure 82: Merton in-patients by primary diagnosis and ethnicity, 2008-13



Overall, the diagnostic groups with the most in-patients are schizophrenia, psychoactive substances, mood disorders, personality and behavioural disorders, neurotic disorders and organic disorders. Within these groups, the black ethnicities are in the highest proportion after whites in schizophrenia, mood disorders and organic disorders. Asians are represented in higher proportions than blacks among patients with neurotic, anxiety and stress disorders, and psychoactive substances. Whites are in the highest proportion in all in-patients, but the contrast is particularly stark in psychoactive substances. Whites also have a very high representation in organic disorders and personality disorders.

Overall, the diagnostic groups with the most patients in CMHS are mood disorders, psychoactive substances, schizophrenia, organic disorders, neurotic disorders and personality and behavioural disorders. Within these groups after whites, the next highest ethnic proportion is of black ethnicities in schizophrenia and adult personality disorders. Asians are represented in higher proportions than blacks in patients with neurotic, anxiety and stress disorders, organic disorders and by small margins in psychoactive and mood disorders.

Figure 83: Merton CMHS patients by primary diagnosis and ethnicity, 2008-13



Cause of admission by deprivation quintile

As observed earlier, the highest admissions and CMHS referrals were from the IMD 4 quintile which is the second most deprived quintile in Merton. Figure 84 & 85 break down the in-patient admissions and CMHS referrals by IMD quintiles in each primary diagnosis category. For schizophrenia and psychoactive substances a similar pattern emerges- whereby as one goes from the least to the most deprived quintiles (with the exception of IMD 5) the percentage of in-patients progressively increase. Apart from organic disorders where the least deprived quintile has the highest proportion of cases, for all other the major diagnostic groups the more deprived quintiles have the higher proportion of cases. So as expected there appears to be a positive correlation between mental illnesses and deprivation. Organic disorders include dementia, and this affects older people much more than working age adults. The older populations in Merton tend to be in the wealthier western parts of Merton. Therefore it is unsurprising that the highest proportion of in-patients is from the least deprived IMD quintile in this diagnostic group. However IMD 3 & 4 combined has a higher proportion.

Figure 84: Merton in-patients by deprivation in each primary diagnosis group, 2008-13

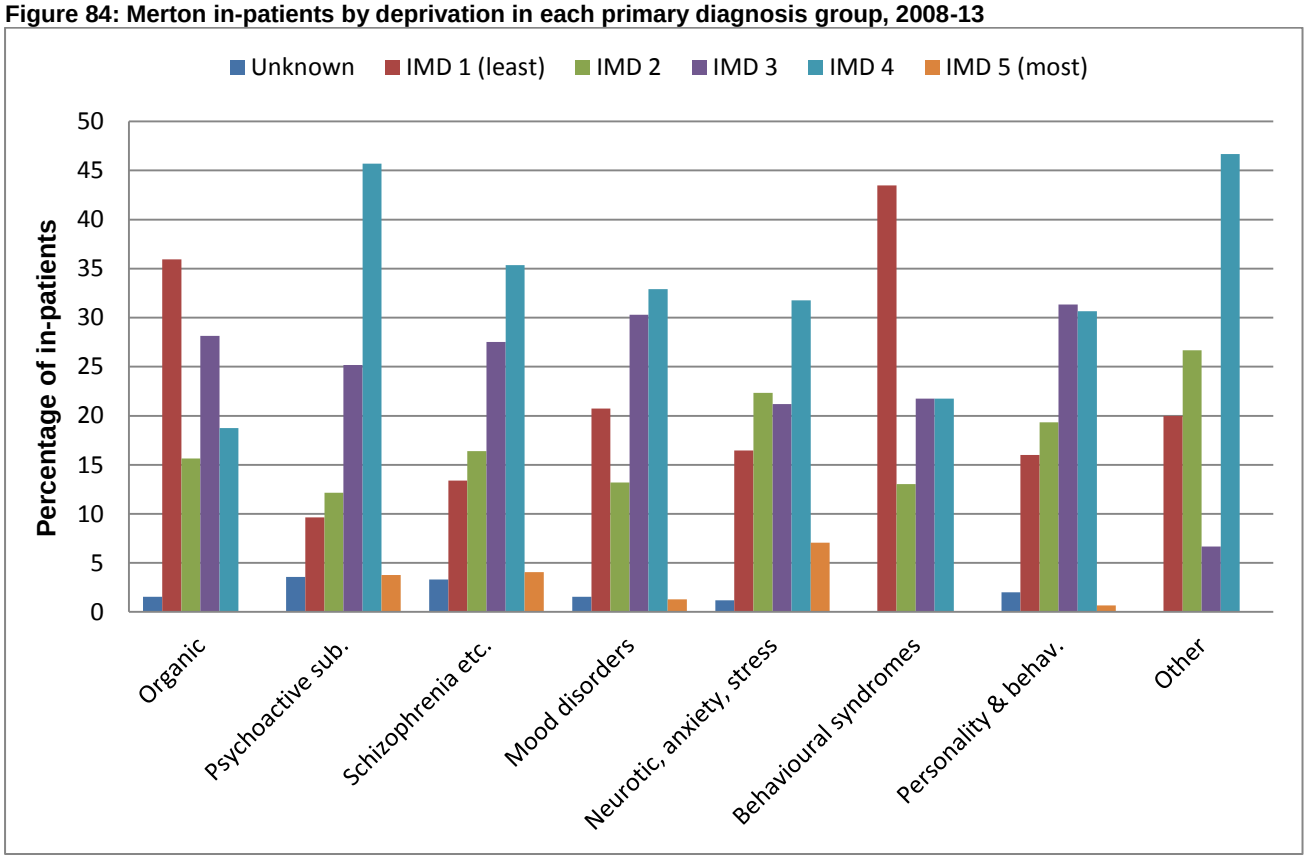
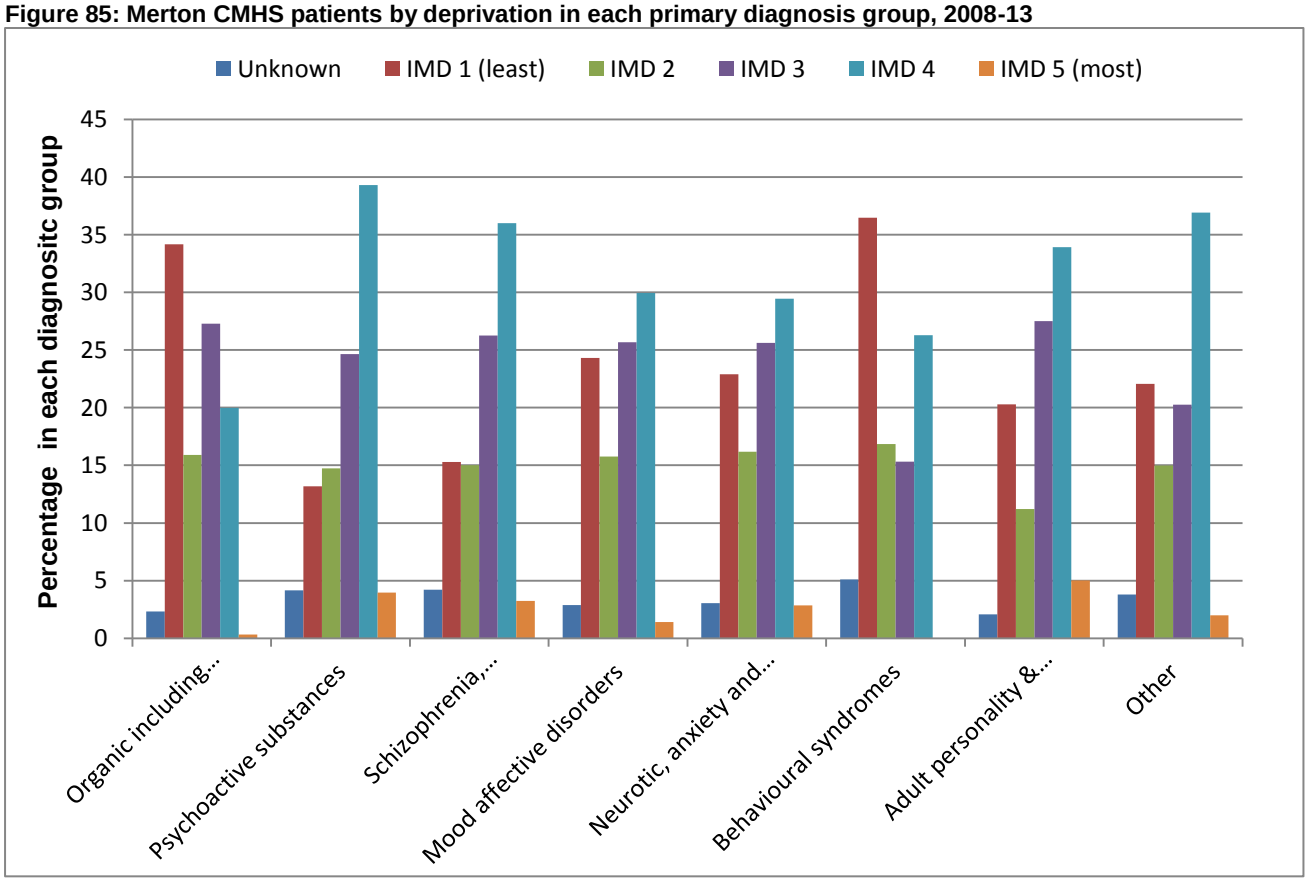


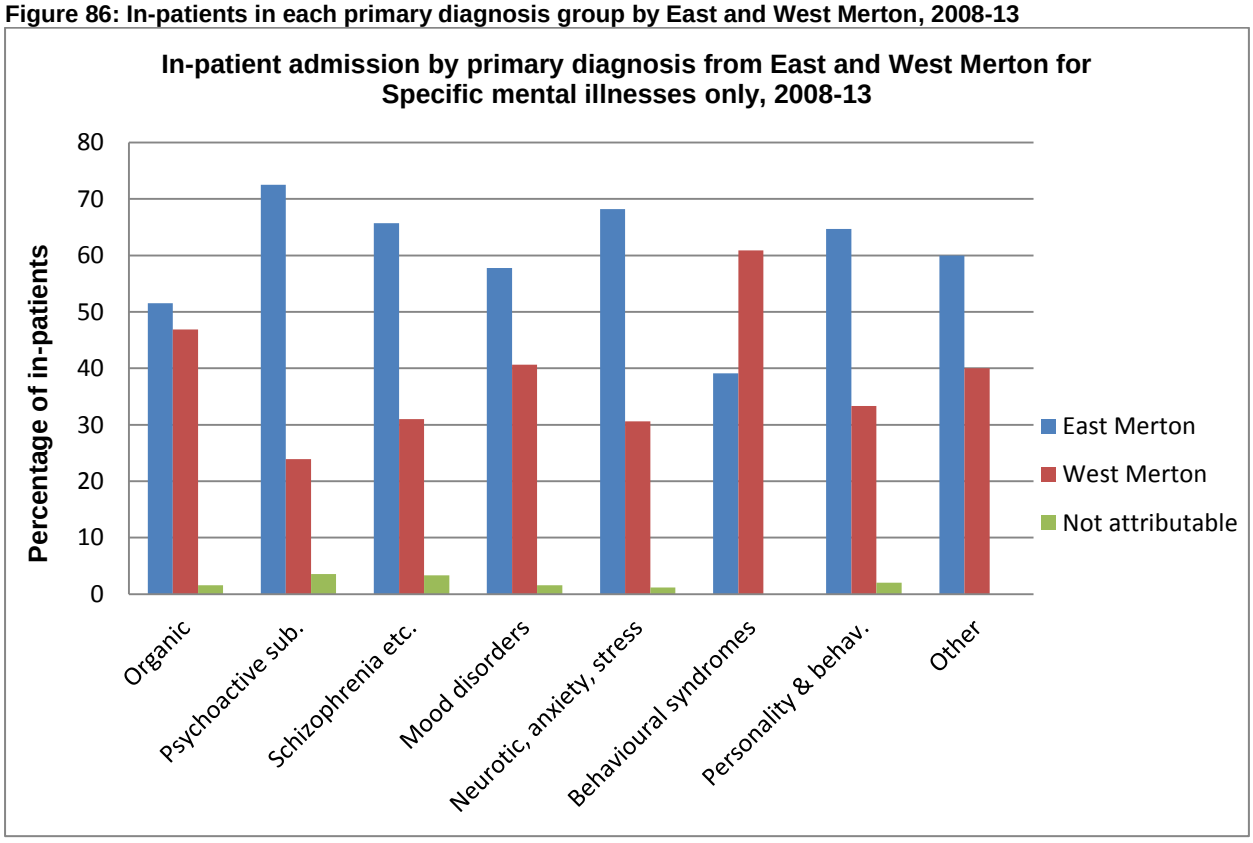
Figure 85: Merton CMHS patients by deprivation in each primary diagnosis group, 2008-13



Cause of admission by East versus West Merton

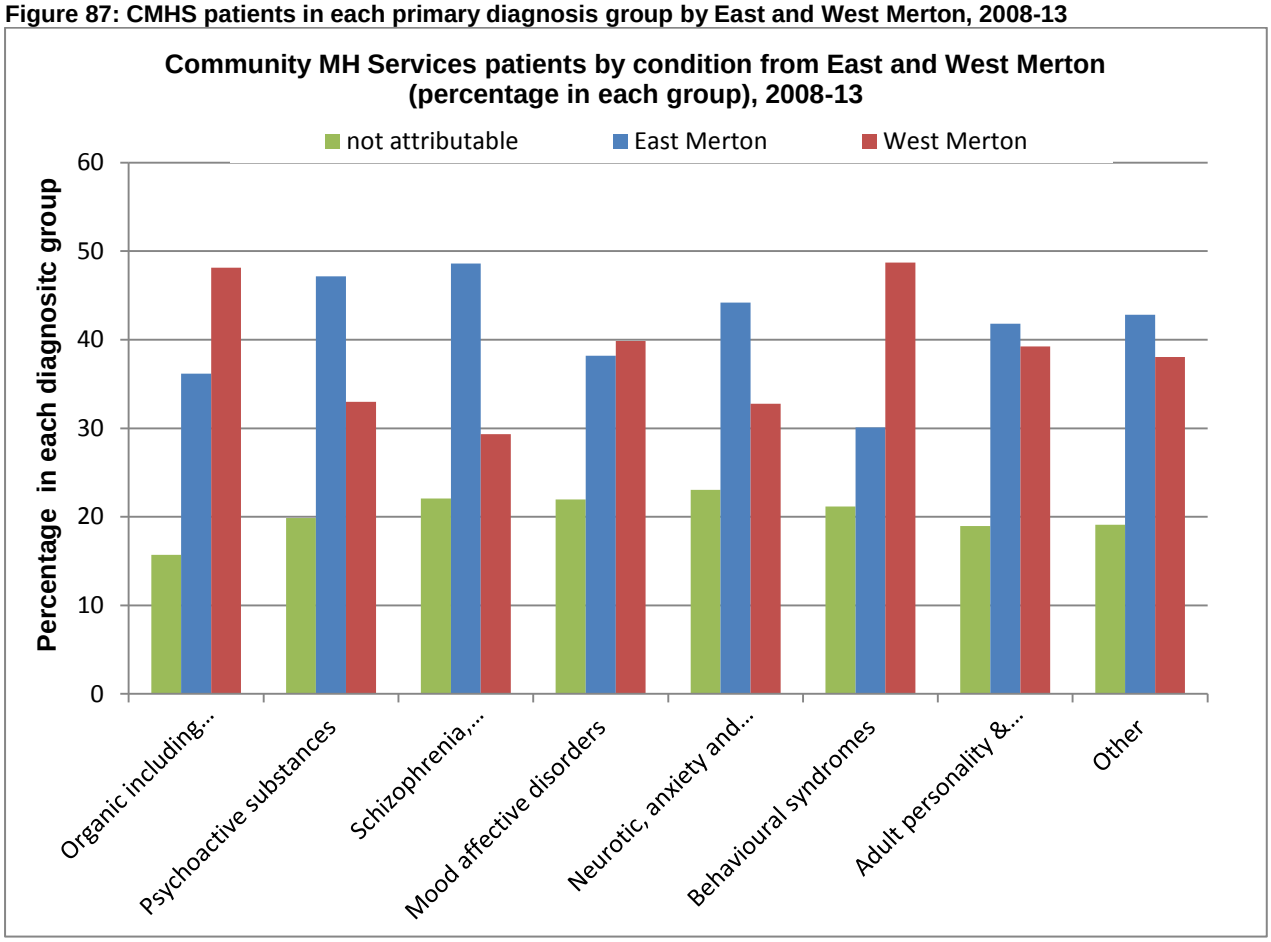
When in-patient records are analysed within each primary diagnosis by whether the patient is from East or West Merton, in all the major primary diagnostic groups there are a higher proportion of patients from East Merton compared with West Merton.

Figure 86: In-patients in each primary diagnosis group by East and West Merton, 2008-13



For the CMHS this is not the case however- a large proportion of cases are not attributable to any locality so this might be skewing the data. As it stands, there are more referrals for organic disorders and mood disorders from West than East Merton. For schizophrenia, psychoactive substances, neurotic, anxiety and stress disorders and personality disorders, East dominates West Merton.

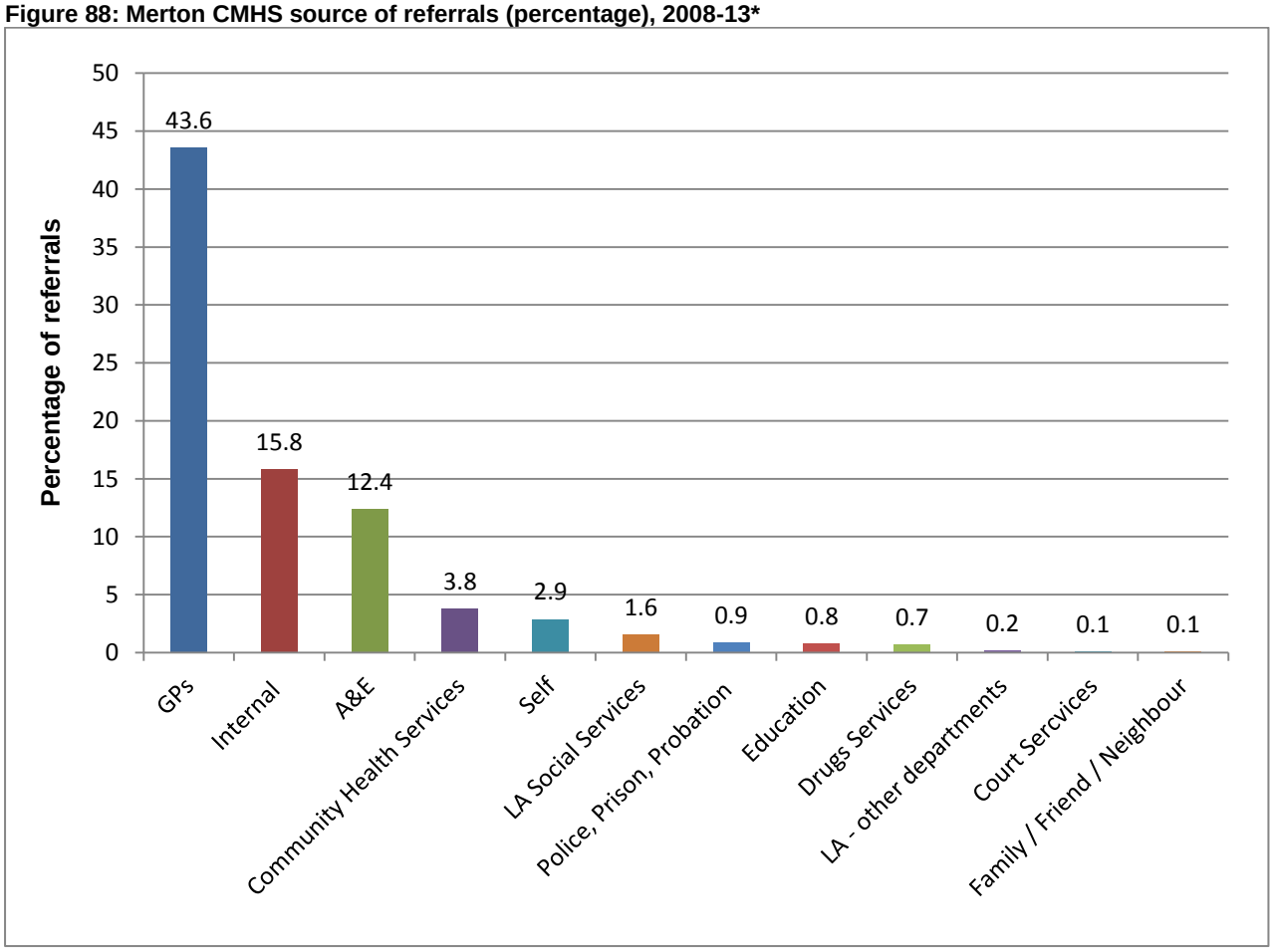
Figure 87: CMHS patients in each primary diagnosis group by East and West Merton, 2008-13



Where did referrals to CMHS come from?

It was possible to analyse all the referrals by where they were sent from. Figure 88 highlights the main sources of referrals for all causes in adults from 2008 to 2013. GP were the main source of the referrals to CMHS with 44% of the referrals coming from them. The profile of these referrals is analysed further below. The next largest source of referrals was internal- these were within the SWLStG Mental Health NHS Trust services either from one CMHS team to another or from in-patient service to CMHS. The third largest source of referrals was the Accident & Emergency departments at Acute NHS Trusts. There were really small proportions of referrals from social services and other departments in the Local Authority – less than the number of self-referrals. Perhaps this needs to be explored further and this might highlight the need to raise awareness of mental health issues and the referral pathways to front-line staff in the Local Authority. GP referrals while being in the majority could be increased further.

Figure 88: Merton CMHS source of referrals (percentage), 2008-13*



*Graph does not include all referral sources, only main ones of interest.

GP referrals to CMHS

In terms of the referrals made by GPs to CMHS in Merton from 2008 to 2013, there were more than five times the number of referrals in working age adults compared with older age groups (figure 89). This difference is more than the overall differences in the number of referrals for working age adults compared with older adults. There were more females referred than males (similar to the overall picture) and there were marginally more referrals from West Merton than East Merton which is the reverse of the overall trend where there were more referrals from East than West Merton. Predictably most referrals were from white ethnicities with Asians being the next highest. In terms of the deprivation quintiles of the referrals- most were from the second most deprived (IMD 4) with only marginally less from the least deprived quintile (IMD1) - this contrasts with the overall picture where the least deprived quintile has the least number of referrals.

What this tells us is that GPs are making more referrals from the wealthier and working age populations and more of these referrals are in females and whites. Also that there are more referrals by GPs in West Merton- while this is only marginal, it becomes significant when the overall referrals are viewed and we see that more came from East Merton.

Figure 89: CMHS referrals from GPs by age group, 2008-13

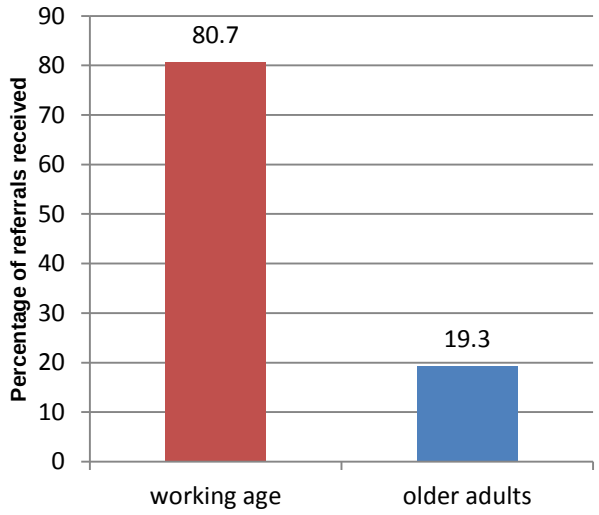


Figure 90: CMHS referrals from GPs by sex, 2008-13

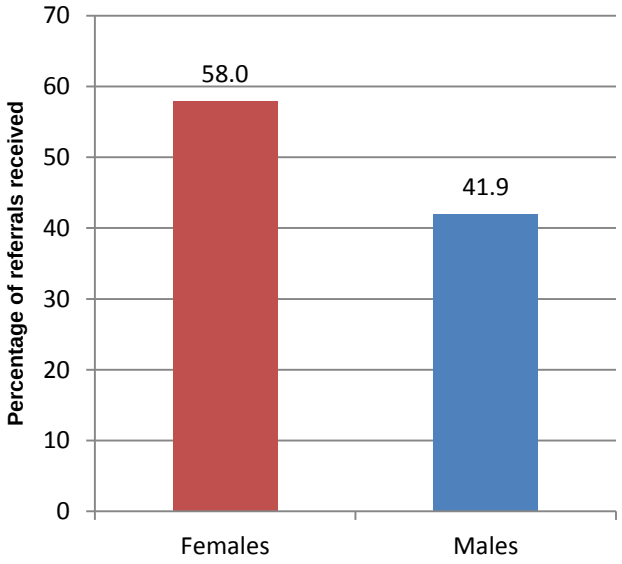


Figure 91: CMHS referrals from GPs by E-W Merton, 2008-13

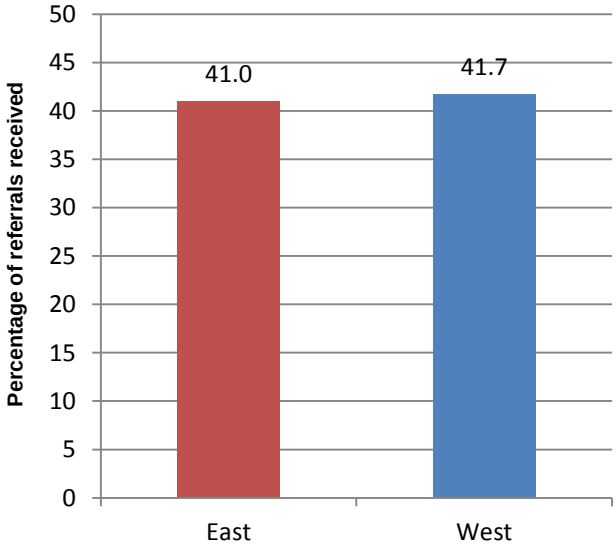


Figure 92: CMHS referrals from GPs by ethnicity, 2008-13

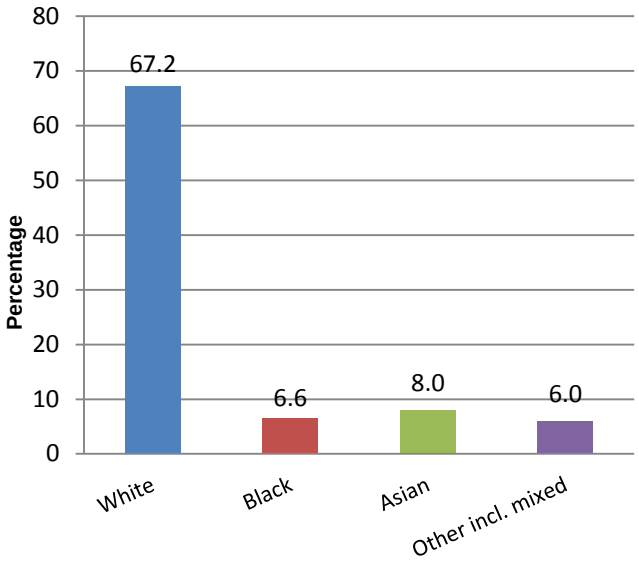
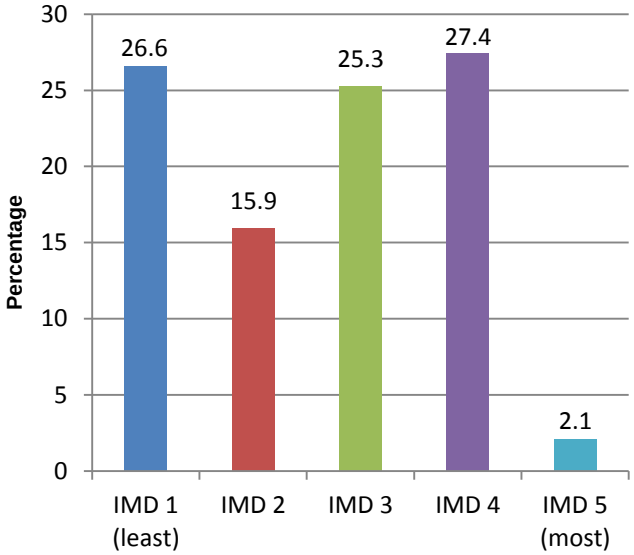


Figure 93: CMHS referrals from GPs by deprivation quintile (1=least deprived), 2008-13



IAPT (Improved Access to Psychological Therapies) services data

IAPT services are provided by a number of statutory and voluntary sector providers in Merton, the main provider being the SWLStG MH NHS Trust. Comparing the data for Merton (in 2012 this was reported as Sutton & Merton combined) of a number of key performance indicators for 2012, with neighbouring IAPT services reveals a number of facts.

Table 13: Sutton & Merton PCT IAPT activity compared with 3 neighbouring London IAPT services (April 2012 – March 2013) (Source: NHS Information Centre)

KPIs	Sutton & Merton	Lambeth	Lewisham	Wandsworth	London average
KPI 1: The number of people in the local population who have depression and/or anxiety disorders (taken from the Psychiatric Morbidity Survey)	**46,764**	44,168	37,757	44,013	33,333
KPI 3a: The number of people who have been referred for psychological therapies during the reporting period	**8001**	8300	7455	4962	4632
KPI 3b: The number of active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session (at the end of the reporting period)	**777**	2608	6048	3023	2430
PHQ13-5: People who have entered (i.e. received) treatment as a proportion of people with anxiety or depression in the population (%)	**10.48**	10.73	11.63	5.77	8.36
KPI 4: The number of people who have entered (i.e. received) psychological therapies during the reporting period	**4988**	4763	4362	2562	2779
KPI 5: The number of people who have completed treatment (minimum two contacts) during the reporting period	**3408**	3154	3197	1815	1583
KPI 6a: The number of people who are “moving to recovery” (of those who have completed treatment, those who at initial assessment achieved "caseness" and at final session did not) during the reporting period	**1175**	1277	986	662	567
PHQ13_06: Number of people not at caseness at their last session, as a proportion of people who were at caseness at their first session (%)	**37.94**	44.62	35.91	39.64	41.13
KPI 7: The number of people moving off sick pay or benefits during the reporting period	**269**	191	169	149	107

Compared with neighbouring IAPT services, S & M had the highest number of people with depression &/or anxiety disorders, second highest (after Lambeth) numbers of cases referred and the highest numbers moving off sick pay and benefits- the last KPI was also higher than the London average. It also had one of the lowest proportion of cases that moved to recovery (as a percentage), second lowest only to Lewisham.

Data for Merton alone (as opposed to Sutton and Merton) was obtained for SWLStG MH NHS Trust for the period from 01/08/2012 to 31/08/2013- as accessed on 16/10/2013. Table 14 depicts the KPIs for this period.

Table 14: Merton SWLStG MHT IAPT services KPIs from August 2012- August 2013

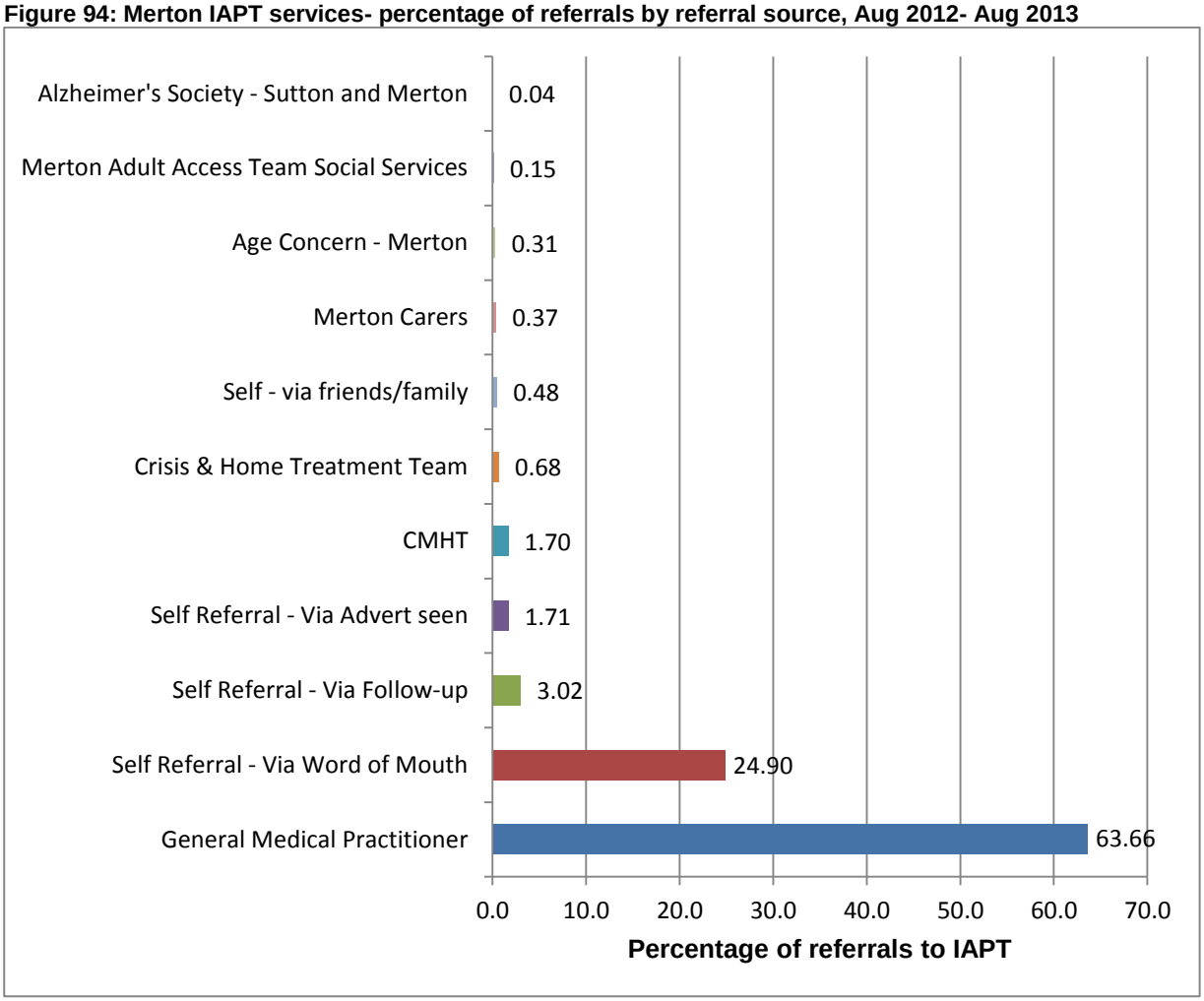
Activity	**KPI**	2012/2013 v3 KPIs	**Local Target**	**National Target**
Referrals Received	KPI 3a - The number of people who have been referred for psychological therapies	4574	13%	15%
	KPI 3b to Treatment - The number of active referrals who have waited more than 28days from referral to treatment (first therapeutic session)	922		
Entering Treatment	KPI 4 - The number of people who have entered psychological therapies	2509		
Received/ Completed Treatment	KPI 5 - The number of people who have completed treatment with at least one therapeutic session and a treatment session	1516		
Moving to Recovery	KPI 6 - The number of people who are 'moving to recovery'	498		
	KPI 6b - The number of people who have completed treatment not at clinical caseness at treatment commencement	119		
Moving off Sick Pay	KPI 7 - The number of people moving off sick pay and benefits	73		
	Recovery Rate	35.65%	43%	50%

Merton IAPT services assignment of steps, Aug 2012-13

Step	**Contacts**
No Step Assigned	1058
Step 2	6817
Step 3	5768

Of the referrals received by the IAPT services from 01 August 2012- 31 August 2013 the majority of referrals were from GPs (64%). Figure 94 depicts the main sources of referrals and the percentages of referrals from these sources. After GPs the next largest percentage of referrals was self-referrals. The proportions of referrals received from any other agencies in the statutory and voluntary sector including the local authority, were very low and this is perhaps an area that needs to be improved.

Figure 94: Merton IAPT services- percentage of referrals by referral source, Aug 2012- Aug 2013



Smoking data SWLStG MHT

There is a strong association between smoking and mental health disorders. Overall, smoking prevalence among psychiatric patients is two to three times higher than among the general population, ranging from 40-50% among people with depressive and anxiety disorders to 70% or higher among patients with schizophrenia[82].

If someone has a mental health problem and smokes, s/he is more likely to have poor general health – it is one of the main reasons why people with a mental illness tend to die younger. Smoking can interfere with some medication (antidepressants, antipsychotics, benzodiazepines and opiates etc.) and a patient might have to take a higher dose than s/he otherwise would have if they were not smoking[83].

SWLStG MHT started a smoking cessation project in 2010 that continues to date. Since 2010-11 there have been CQUINs (Commissioning for Quality Innovation) related to smoking. The rationale behind the CQUIN smoking cessation targets (indicators) for 2010/11 was to improve the health of the local population by delivery of effective stop smoking advice to smokers, especially those with

[82] Olivier D, Lubman DI, Fraser R. Tobacco smoking within psychiatric inpatient settings: biopsychosocial perspective. Aust & NZ J Psych 2007; 41: 572-580, http://www.ash.org.uk/files/documents/ASH_120.pdf
[83] http://www.rcpsych.ac.uk/mentalhealthinfo/problems/smokingandmentalhealth.aspx

higher rates of smoking[84]. The 2010/11 CQUIN smoking cessation indicators focused on establishing the number of smokers, training staff to deliver brief interventions to these smokers and then referring those who were willing to the SCAs (Smoking Cessation Advisers), thus increasing access to support. Once the smokers had been referred, the SCAs needed to encourage them to start a course of Nicotine Replacement Therapy (NRT) in order to facilitate their quit attempt. Targets for these included:

5a - Training to give effective stop smoking advice to professionals
75% of all appropriate clinical and professional staff to be trained
5b – Data recording of smoking status
75% of all admissions to be recorded on client files and in house system
5c – Provision of service: Number of referrals to Stop Smoking Service
50% of smokers to be referred to the PCT Stop Smoking Service (Trust SCAs)
5d – Provision of service: Number of NRT (Nicotine Replacement Therapy) referrals
45% of referred smokers to be prescribed NRT

By March 2011 the targets had been reached for the training (5a), data recording (5b) and provision of service, NRT (5d) targets with the following figures-
5a - over 90% of all appropriate clinical staff trained to Level 1 Smoking Cessation competence
5b - 80% of smoking status recorded
5d - 49% of all smokers referred to a SCA prescribed NRT.

In November 2011 the Trust had 10,400 service users (this is from across all the boroughs the Trust has patients from- Merton, Sutton, Wandsworth, Richmond & Kingston) who were appropriate to be included in its smoking cessation work (i.e. over 16yrs old and never diagnosed with dementia). Clinicians established and recorded the smoking status for 8,457 (81%) of these; just over 50% were recorded as smokers.

In 2013/14, the SWLStG Smoking Cessation Team continues to achieve all their CQUIN targets (100% for Q1 and Q2).

Table 15: SWLStG MHT CQUIN 2013/14, Q1 & Q2 data

		Q1	Q2
CQUIN 2013/14	5b) % of service users completing full 12 weeks support	16.4% (Target 6%)	44.7% (Target 7%)
Smoking Cessation Indicator 5	5c) % of smoking status recorded, referrals, quit dates set	84.6% 22.4% 35% (Targets: 80%, 20% & 17.5%)	85.7% 24.7% 32% (Targets: 80%, 20% & 17.5%)

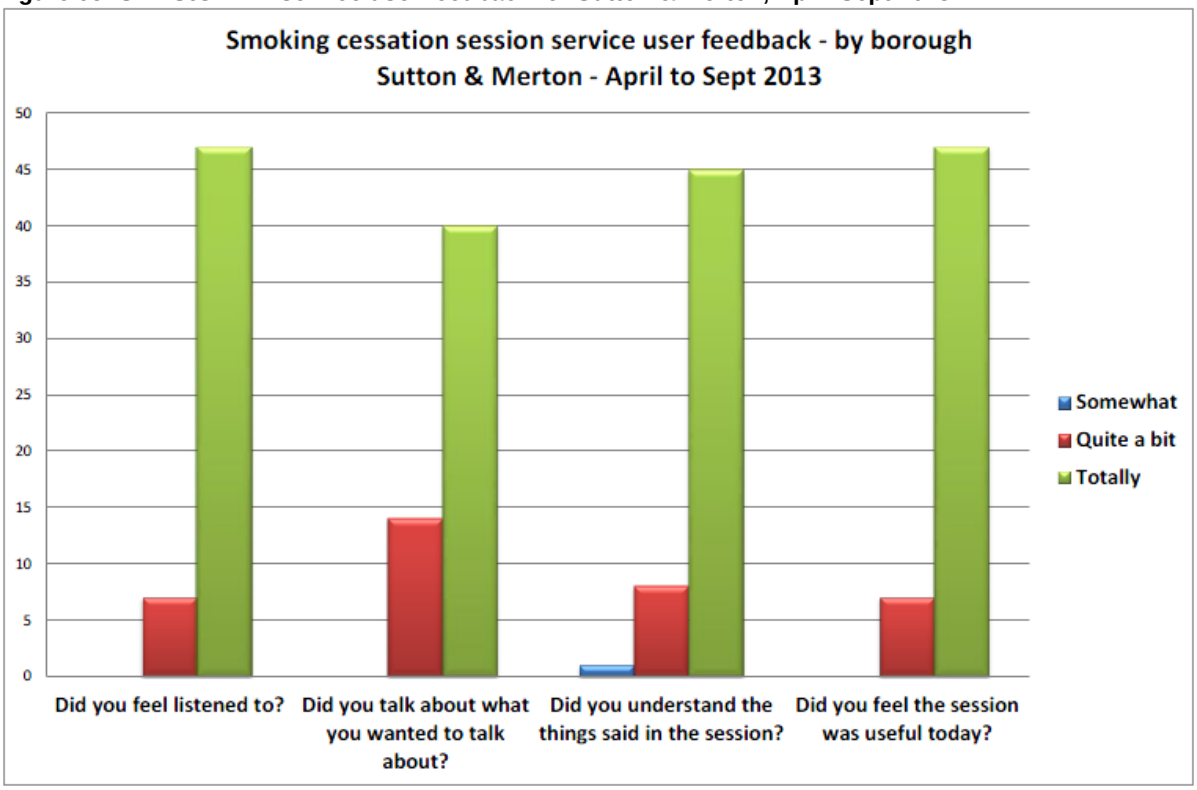
The qualitative element of the indicators this year (5a) required the implementation of service user feedback surveys. Now part of everyday working practice, this system enables smokers engaged in the Trust's 12 week expert smoking cessation support package to tell the Trust what they think of the support they receive, if they value it and any improvements they would like to see.

[84] Schedule 4 Part 2: National Incentive Framework for Commissioning for Quality and Innovation (CQUIN) Payment Framework 2010/11

Feedback from service users continues to be very positive regarding:

- Feeling listened to
- Talking about what they want to talk about
- Understanding things said during sessions
- Feeling that the session that day was useful

Figure 95: SWLStG MHT service user feedback for Sutton & Merton, April-Sept 2013



This year, the SCAs have been monitoring the number of service users who have completed the full 12 weeks expert support package they offer. The percentage of service users who completed the full 12 weeks support package improved quarter on quarter in 2013-14:
Q1 – 27.6%
Q2 – 44.8%
Q3 – 58.6%

This data is for all the 5 boroughs SWLStG MH NHS Trust serves.

Primary Care Mental Health Prescriptions in Merton

Merton CCG mental health prescribing data was obtained for all practices in the period between quarters 1-4 for 2009-10 to 2012-13 and quarters 1 & 2 for 2013-14. Over that period the total spend on mental health prescribing was £7,268,955. Table 16 below shows the overall volumes of prescriptions by number of prescriptions (Total Items Rx in the table), the total number of pills dispensed (Quantity in table) and total actual cost.

Table 16: Merton CCG prescribing for mental health, 2009/10 - Q2 2013/14

Drug Group	Total Items (Rx)	Quantity	Total Cost
Antipsychotics	105763	1449189	£3,279,667.05
Antidepressants	479574	3483636	£2,440,088.31
Dementia	38946	181315	£1,341,562.03
Anxiolytics	69458	532780	£162,107.89
Antimanic	11234	293732	£45,529.91
Grand Total	704975	5940652	£7,268,955.19

Merton GPs are organised into three locality groups- East Merton, Raynes Park and West Merton. When the grand totals are broken down by these GP Locality Groups, East Merton has the highest volume and cost for mental health prescribing, followed by West Merton and then Raynes Park. This is expected, considering the epidemiological data suggests that most of the burden of mental illness is in East Merton.

Table 17: Merton CCG prescribing for mental health by GP Locality Group, 2009/10 - Q2 2013/14

GP Locality Group	Total Items (Rx)	Quantity	Total Cost
East Merton	324,774	2,616,312	£3,047,206.8
Raynes Park	145,932	1,331,762	£1,797,816.2
West Merton	234,269	1,992,578	£2,423,932.2

When the prescribing volumes for mental health are viewed for each year separately, the trends in prescribing for the different drug groups can be established. In terms of costs, antipsychotics had the highest cost for the Merton CCG but since 2011/12 there has been a sharp decline in these costs. It is not the highest volume item in terms of prescriptions- which is by far the anti-depressants and the second costliest drug group for MCCG. Prescription volumes both in terms of cost and prescriptions are on a downward trend overall. There was a sharp drop in dementia drug prescription costs since 2011/12 as well.

Figure 96: Merton CCG Total Prescription Costs in £100,000's, 2009/10 - Q2 2013/14

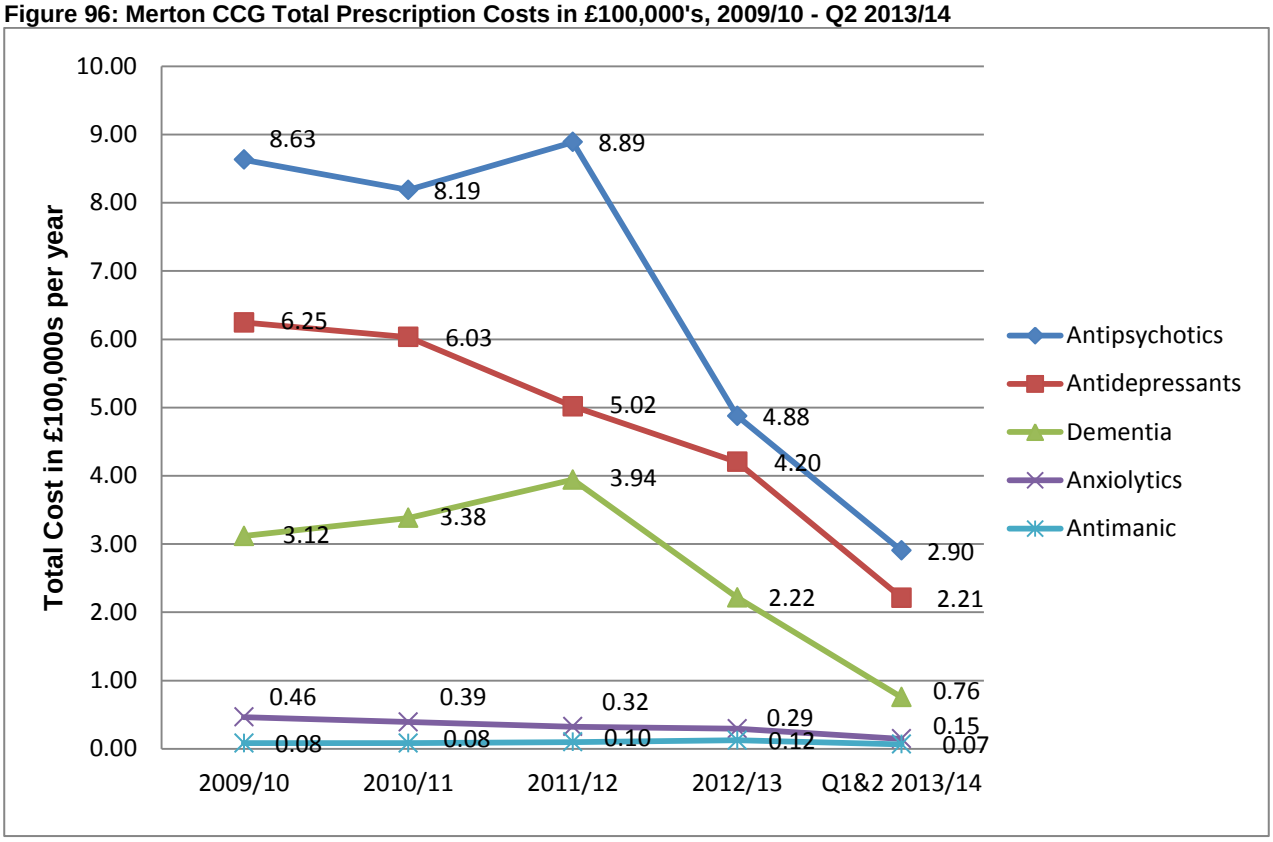
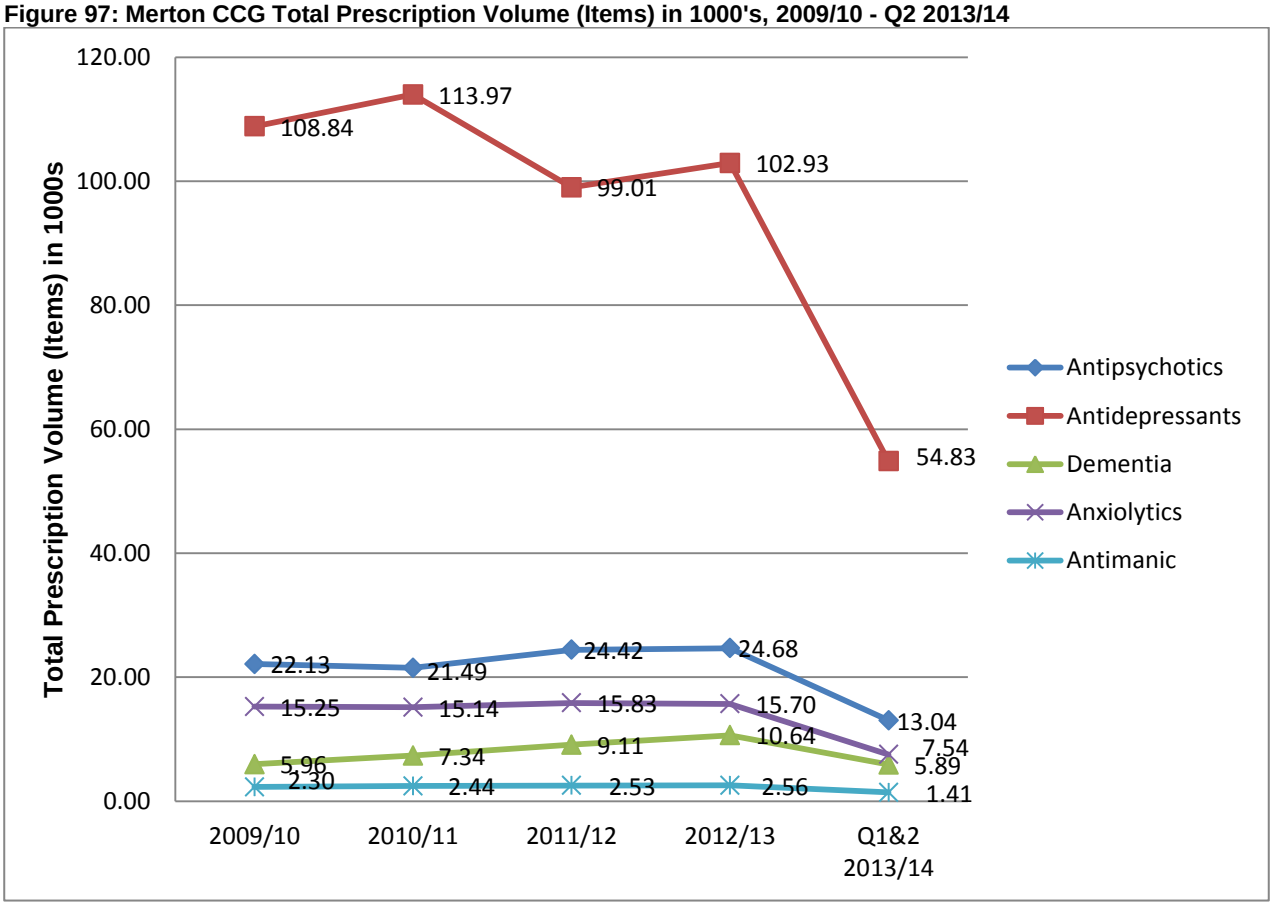


Figure 97: Merton CCG Total Prescription Volume (Items) in 1000's, 2009/10 - Q2 2013/14



Parental and child mental health

Evidence from small studies of people with mental health difficulties shows that a high proportion of adults in acute psychiatric hospital settings may be parents – at least 25% and probably substantially more, especially among young women, although shortcomings have been identified in the quality of this research.[85] Research published in 2011 by the National Society for the Prevention of Cruelty to Children (NSPCC) estimates that 144,000 babies less than 1 year old live with a parent who has a common mental health problem.[86]

The National Treatment Agency for Substance Abuse collects national data on the take-up of drug and alcohol services and requires local areas to report on the number of service users who are parents. It estimates that around 200,000 adults are currently receiving treatment for substance misuse problems and of these, one third are parents and have children living with them, although details of the number of children are not known.[87] A recent survey of parental alcohol and drug use reported that 8% of parents had taken illegal drugs over the past year and 7% drink alcohol every day.[88] The NSPCC's review of evidence estimates that 19,500 babies less than 1 year old are living with a parent who has used Class A drugs in the last year; 93,500 babies less than 1 year old live with a parent who is a problem drinker.[89]

The extent to which these difficulties impact on parenting capacity varies enormously. Research shows that the impact can be mitigated by a second parent, or care by extended family involvement and early community support.[90] However, without this support children may be neglected and/or emotionally harmed. Alcohol misuse by parents, particularly by fathers, can also result in violence and risks of physical harm to children. Analyses by Ofsted of serious case reviews between 2007 and 2011 where children had either died or been seriously harmed, showed that mental health difficulties, drug and alcohol problems and domestic abuse were the most common characteristics of the families involved.[91] Studies in the field of child protection suggest that the prevalence of identified mental illness, which in many cases exists alongside other parental difficulties, increases with the level of enquiry. At the referral stage prevalence is low. A study[92] of 2,248 referrals to children's social care found, on re-analysing their data, that parental mental illness was recorded in 10.4% of referrals, a finding similar to the 13% identified by another key study.[93] However, prevalence increases with greater knowledge of the family circumstances.

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[85] G Parker, B Beresford, S Clarke, K Gridley, R Pitman, G Spiers, K Light, *Research reviews on prevalence, detection and interventions in parental mental health and child welfare: Summary report*,
Social Policy Research Unit, York University, 2008; http://php.york.ac.uk/inst/spru/pubs/1125/.

[86] C Cuthbert, G Rayns, K Stanley, *All babies count, prevention and protection for vulnerable babies: a review of the evidence*, National Society for the Prevention of Cruelty to Children, 2011;.
www.nspcc.org.uk/inform/resourcesforprofessionals/underones/all_babies_count_wda85568.html.

[87] *Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services*, National Treatment Agency for Substance Misuse, supported by Department for Education, 2011;
www.nta.nhs.uk/publications.aspx.

[88] *Over the limit. The truth about families and alcohol,* 4Children, 2012; www.4children.org.uk/Resources/Detail/Over-the-Limit.

[89] C Cuthbert, G Rayns, K Stanley, *All babies count, prevention and protection for vulnerable babies: a review of the evidence*, National Society for the Prevention of Cruelty to Children, 2011;
www.nspcc.org.uk/inform/resourcesforprofessionals/underones/all_babies_count_wda85568.html.

[90] E Sawyer and S Burton, *Building resilience in families under stress,*
National Children's Bureau, 2012; www.ncb.org.uk/resources/publications.

[91] *Ages of concern: learning lessons from serious case reviews* (110080), Ofsted, 2011;
www.ofsted.gov.uk/resources/110080.

[92] Cleaver, H. and Walker, S. with Meadows, P. (2004) *Assessing Children's Needs and Circumstances: The Impact of the Assessment Framework*. London: Jessica Kingsley Publishers.

[93] Gibbons, J., Conroy, S. and Bell, C. (1995) *Operating the Child Protection System: A Study of Child Protection Practices in English Local Authorities*. London: HMSO.

Parental mental illness was identified in a quarter of cases coming to conference.[94] Parental mental illness had been noted in some 43% of cases where children are the subject of care proceedings.[95] [96]

Research on child sexual abuse also suggests a greater association with parental mental illness. A study of child sexual abuse[97] found 71% of families, where there were suspicions of abuse, were in a 'poor psychological state' using the General Health Questionnaire[98] and there was a further increase when suspicions were confirmed. These findings are in line with a study[99] of families attending a specialised treatment and assessment day clinic for child sexual abuse. They found 86% of mothers (assessed using the General Health Questionnaire) showed symptoms of depression or anxiety and, for a considerable proportion, the symptoms had been of long duration.

Caution, however, must be exercised in relation to these findings because studies of physical abuse and neglect have tended not to use standardised measures of mental health and it is not possible to compare like with like.

The Children Act 2004 places a duty on partner organisations to safeguard and promote the welfare of children, and current statutory guidance sets clear and explicit expectations that adult and children's services should work cooperatively together to safeguard and promote the welfare of children.[100] The Children Act 1989 defines children 'in need' under section 17 as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services. If children's parents or carers have serious mental health difficulties and /or drug or alcohol problems then consideration needs to be given as to how and whether this will affect their ability to care for their children, to determine if the children are 'in need'.[101]

However, historically, joint working between adult and children's services has not been strong. The issues, challenges and barriers to effective cooperation are well documented in inspections, research and serious case reviews. Reports by Ofsted of serious case reviews from 1 April 2007 to 31 March 2011 highlighted repeated examples of ways in which the risks resulting from the parents' own needs were underestimated – including when parents had mental health difficulties and/or drug and alcohol problems.[102]

Nationally, Ofsted reports[103] that the extent to which adult and children's services worked effectively together to assess concerns and support and challenge parents and carers varied considerably. Overall, the quality of joint working was much stronger between children's social care

[94] Farmer, E. and Owen, M. (1995) *Child Protection Practice: Private Risks and Public Remedies*. London: HMSO.
[95] Hunt, J., Macleod, A. and Thomas, C. (1999) *The Last Resort: Child Protection, the Courts and the 1989 Children Act*. London: The Stationery Office.
[96] Brophy, J., Jhutti-Johal, J. and Owen, C. (2003) 'Assessing and documenting child ill-treatment in minority ethnic households.' *Family Law* 33, 756–764.
[97] Sharland, E., Seal, H., Croucher, M., Aldgate, J. and Jones, D. (1996) *Professional Intervention in Child Sexual Abuse.* London: HMSO.
[98] Goldberg, D.P. and Williams, P. (1988) *A User's Guide to the General Health Questionnaire.* Windsor: NFER-Nelson.
[99] Monck, E., Bentovin, A., Goodall, G., Hyde, C., Lwin, R., Sharland, E. with Elton, A. (1995) *Child Sexual Abuse: A Descriptive and Treatment Study.* London: HMSO.
[100] Children Act 2004 sections 10 and 11; www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1
[101] Children Act 1989 section 17(10); www.opsi.gov.uk/acts/acts1989/ukpga_19890041_en_1.
[102] Ofsted publications: www.ofsted.gov.uk/resources/results/serious%20case%20reviews.
[103] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems; Ofsted March 2013, Ref no. 130066.

and drug and alcohol services than between children's social care and adult mental health services.

Furthermore, the report found that considerations on the impact of parents' or carers' difficulties on children was more strongly embedded in drug and alcohol services than in adult mental health services. Mental health services did not consistently consider the impact of the adult mental health difficulties on children. Questions about children were included in recording systems, but the clarity and detail of these varied and they were not always consistently completed.

SWLStG MH NHS Trust undertake internal assessments of their patients for safeguarding issues, and in that regard record if a patient is a parent (having dependent children). Table XX below depicts the number of adult patients (Column B) needing such an assessment of risk (called SF) (Column C), and the number where this assessment was completed (Column D). This gives the percentage completion rate (Column E). In March 2013 this completion rate was 74% and this rose to 92% the following year. As of 29/08/2014 it stands at 88% completion, and this dip is explained by the Trust as due to the fact that they recently extended this indicator to include patients not on the Care programme approach, as well as patients on the Care Programme Approach. Column F depicts the number of patients who were identified as parents with any dependent children and Column G the number of such parents where the SF was completed. In all adult patients with dependent children, a safeguarding risk assessment was completed. As on 29.8.14 the Trust was treating 5,538 adults, of which 88% had been assessed as to whether or not they had dependent children. Of the 4867 adults assessed, 515 were identified as having dependent children.

Table 18: SWLStG MHT data on safeguarding assessments and patients identified as having dependent children

Date (A)	Number of Adults (B)	All Clients			Clients marked as Pregnant/Parent/Carer/Primary Carer		
		Clients needing SF (C)	Number SF complete (D)	% complete (E)	Clients needing SF (F)	Number SF complete (G)	% complete (H)
31/03/2013	4894	4894	3601	74%	420	420	100%
31/03/2014	5160	5160	4754	92%	481	481	100%
29/08/2014	5538	5538	4867	88%	515	515	100%

The number of parents in Column F is a subset of the total patient population in Column B. Therefore the percentage of mental health patients with dependent children in each year is:
As of 31/03/2013 - 8.6%
As of 31/03/2014 – 9.3%
As of 29/08/2014 – 9.2%
This percentage is of course dependent on the completion rate in Column E, but gives a reasonable indication of the number and percentage of mental health patients in Merton at any given time, that have dependent children.

Nationally, in assessments where there were issues of parent or carer mental ill health professionals did not routinely approach the assessment as a shared activity between children's

social workers and adult mental health practitioners, in which each professional drew on the other's expertise. As a result, the majority of assessments did not provide a comprehensive and reflective analysis of the impact on the child of living with a parent or carer with mental health difficulties. In most cases seen when parents or carers had been admitted to hospital, joint working was poor in ensuring that plans for discharge took the children's needs into account. As a result, children had sometimes been returned too early to the care of parents or carers who were unable to meet their needs at that time. This is the national picture and may or may not reflect ground realties in Merton.

In most of the long-term cases there was a history of involvement by children's social care. These cases were complex and challenging. Parents' and carers' difficulties were not easily, and sometimes never, resolved and progress was often not sustained. Cases were opened and closed, and families were supported for a time, sometimes over substantial periods and sometimes intermittently. This raised questions about the sustainability of change, and the timeliness and robustness of previous decision-making and planning.

Impact of parenting[104]

Parenting can be defined as those activities and behaviours of caregiving adults that are needed by children to enable them to function successfully as adults, within their culture.[105]

In order to achieve this, those who are responsible for parenting must provide the child with basic care, ensure their safety, provide emotional warmth, provide appropriate stimulation, offer guidance and boundaries and provide the child with stability.

To suggest that all parents who suffer from mental illness, learning disability, problem alcohol/drug use or are subjected to or perpetrate domestic violence present a danger to their children is misleading and dangerous. Indeed, much research indicates that, with adequate support, parents who are experiencing a single disorder are often able to be effective and loving parents and present little risk of significant harm to children. A four-year follow-up study[106] of children, found two-thirds of those in families where there was parental mental illness suffered no long-term behavioural or emotional difficulties. In fact, many parents with mental illness regard the bond between themselves and their children as especially strong and close[107] and negative effects can be offset with adequate support.

Although a single issue such as mental illness may not detrimentally affect parenting capacity, there is considerable evidence that many parents also experience other difficulties.[108] [109] For example, adults with mental health problems are more likely than those without to abuse drugs or

[104] Cleaver H, Unell I and Aldgate J; Children's Needs- Parenting Capacity, Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence; 2nd Edition, TSO (The Stationery Office); Norwich, 2011.
[105] Jones, D.P.H. (2009) 'Assessment of parenting', in Horwath, J. (ed.) *The Child's World: The Comprehensive Guide to Assessing Children in Need.* 2nd edition. London: Jessica Kingsley Publishers.
[106] Rutter, M. and Quinton, D. (1984) 'Parental psychiatric disorder; effects on children.' *Psychological Medicine* 14, 853–880.
[107] Ackerson, B.J. (2003) 'Coping with the dual demands of severe mental illness and parenting: The parents' perspective.' *Families in Society* 84, 1, 109–119.
[108] Cleaver, H. and Walker, S. with Meadows, P. (2004) *Assessing Children's Needs and Circumstances: The Impact of the Assessment Framework*. London: Jessica Kingsley Publishers.
[109] Velleman, R. and Reuber, D. (2007) *Domestic Violence and Abuse Experienced by Children and Young People Living in Families with Alcohol Problems: Results of a Cross European Study.* ENCARE. (www.apua.info/File/fb9c3027-2698-48b3994c-349a0e491c7c/ALC_VIOL_ParentalAlcoholProblems_EN.pdf) accessed 03.03.2011.

alcohol; similarly, those who abuse drugs have a markedly increased lifetime occurrence of diagnosable psychopathology.[110] [111] It is the 'multiplicative' impact of combinations of factors that have been found to increase the risk of harm to children. For example, the risk of child abuse increased 14-fold when parents had themselves been abused in childhood, if the parent was under twenty-one, had been treated for mental health problems or had a partner with violent tendencies.[112] [113] Research has shown that mothers who experience depression after childbirth, compared to those who do not, are 20% more dependent on alcohol. Alcohol dependence linked to depression is generally associated with poorer, less consistent parenting. Research suggests that in such cases women's capacity to empathise with and respond to their children's needs is overwhelmed by their own needs where *'alcohol dependence is present alongside depression, there is greater concern about the 'dangerousness' of the situation'.* [114]

Impact on children

A disorganised lifestyle will have a differential impact on children depending on their age, development and personality. A lack of supervision leaves babies, young children and disabled children particularly vulnerable, but older children are also at risk of neglect. For example, some parents who are opiate dependent allow others to inject heroin in their homes, despite believing that their drug dependence and associated lifestyle are potentially harmful to their children.[115] Parental mental health has well-documented impacts on the development of children from pre-birth onwards.

In most cases parental problems influence how parents relate to their child. Weissman and Paykel[116] observed that *'at the simplest level, the helplessness and hostility which are associated with acute depression interfere with the ability to be a warm and consistent mother'*. A psychopathic personality disorder may manifest itself in a *'callous unconcern for others, a low threshold for frustration, a discharge of aggression and an inability to feel remorse'.*[117] Similarly, excessive drinking or drug misuse can result in the parent being emotionally unavailable to the child. Mothers who have a problem with drugs are less responsive to their babies, less willing to engage in meaningful play and more likely to respond in a manner that curtails further engagement.[118] Parents with learning disabilities may not readily recognise their baby's cues nor

[110] Spotts, J.V., and Shontz, F. C. (1991) 'Drugs and personality: Comparison of drug users, nonusers, and other clinical groups on the 16PF.' *International Journal of Addiction* 26, 10, 1019–1054.
[111] Beckwith, L., Howard, J., Espinosa, M. and Tyler, R. (1999) 'Psychopathology, mother-child interaction, and infant development: Substance-abusing mothers and their offspring.' *Development and Psychopatholog y* 11, 4, 715–725.
[112] Dixon, L., Browne, K.D., Hamilton-Giacritsis, C. (2005a) 'Risk factors of parents abused as children national analysis of the intergenerational continuity of child maltreatment (part 1).' *Journal of Psychology and Psychiatry* 46, 1, 47–57.
[113] Dixon, L., Hamilton-Giacritsis, C. and Browne, K.D. (2005b) 'Risk factors and behavioural measures of abused as children: a meditational analysis of the intergenerational continuity of child maltreatment (part 11).' *Journal of Child Psycholog y and Psychiatry* 46, 1, 58–68.
[114] Woodcock, J. and Sheppard, M. (2002) 'Double trouble: Maternal depression and alcohol dependence as combined factors in child and family social work.' *Children & Society* 16, 4, 232–245.
[115] Hogan, D.M. (2003) 'Parenting beliefs and practices of opiate-addicted parents: Concealment and taboo.' *European Addiction Research* 9, 113–119.
[116] Weissman, M.M. and Paykel, E.S. (1974) *The Depressed Woman: A Study of Social Relationships*. Chicago: University of Chicago Press.
[117] Stroud, J. (1997) 'Mental disorder and the homicide of children.' *Social Work and Social Sciences Review: An International Journal of Applied Research* 6, 3, 149–162.
[118] Kroll, B. and Taylor, A. (2003) *Parental Substance Misuse and Child Welfare.* London: Jessica Kingsley Publishers.

have sufficient understanding to know how to respond appropriately to reassure the baby and encourage further interaction.[119]

All these issues pose a considerable risk to the process of attachment and more general relationships between children and their parents. Insecure patterns of attachment may mean that children develop shaky internal working models, which can have adverse consequences for later relationships. [120] Moreover, when children experience a degree of rejection this may have implications for the child's sense of connectedness. This, in turn, can affect intellectual, emotional, social and psychological functioning.[121] [122] Attachment begins during the first year of life, and the major characteristic of this relationship is the presence of a consistent person who is able to reduce the baby's anxiety in stressful situations. Babies who become securely attached feel sufficiently confident to explore their world.[123] The process of attachment is not confined to a single adult. Babies can develop secure attachments to more than one adult as long as they are constant figures in the baby's life.[124] [125] [126]

Separation of children and parents

When parents' problems become extreme, they may result in children being separated from one or both parents. For example, drug dealing to sustain a 'habit' may lead to the parent's imprisonment, domestic violence to a mother's escape to a refuge, or an acute episode of mental illness to hospitalisation. If the other parent or a close relative can provide a stable environment and the time and attention the children require, the risk of negative outcomes is much reduced. However, the luxury of a second caring parent or relative is not always available. For these children the hospitalisation or imprisonment of one parent results in the child being 'looked after' by the local authority. Although professionals are reluctant to place children in local authority care because of the well-publicised difficulties surrounding placement, there is growing evidence to suggest that *'foster care provides a positive service to many children. Often it is both valued and, as far as research has been able to assess, valuable'.*[127]

Recurrent separations have the potential to disrupt the continuity of care provided to children and the formation of harmonious stable family relationships. Approximately three-quarters of children (76%) living with domestic violence, a similar proportion (73%) of those living with parental substance misuse and half the children (48%) living with a parent with a learning disability were assessed as not having a stable family environment in which to develop and maintain a secure attachment to a parent figure. [128] [129]

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[119] Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.
[120] Howe, D. (1995) *Attachment Theory for Social Work Practice*. London: Macmillan.
[121] Owusu-Bempah, K. (1995) 'Information about the absent parent as a factor in the well-being of children of single-parent families.' *International Social Work* 38, 253–275.
[122] Owusu-Bempah, K. and Howitt, J. (1997) 'Self-identity and black children in care', in Davies, M. (ed.) *The Blackwell Companion to Social Work*. London: Blackwell.
[123] Bowlby, J. (1973) *Attachment and Loss, Volume 11, Separation, anxiety and anger.* London: Hogarth Press.
[124] Rutter, M. (1985) 'Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder.' *British Journal of Psychiatry* 147, 598–611.
[125] Thoburn, J. (1996) 'Psychological parenting and child placement: "But we want to have our cake and eat it"', in Howe, D. (ed.) *Attachment and Loss in Child and Family Social Work.* Aldershot: Avebury.
[126] Bowlby, J. (1973) *Attachment and Loss, Volume 11, Separation, anxiety and anger.* London: Hogarth Press
[127] Wilson K. (2006) 'Foster care in the UK', in McAuley, C., Pecora, P.J. and Rose, W. (eds) *Enhancing the Well-Being of Children and Families through Effective Interventions*. London: Jessica Kingsley Publishers.
[128] Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

The fear of separation or fear of children being removed from parental care may be a critical factor in a parent with a mental illness not presenting to a mental health service, possibly resulting in the parent then being seen at the point of crisis resulting in the very thing occurring that the parent was wishing to avoid. This cycle can be circumvented if parents with mental illnesses have confidence in the services.[130]

For recommendations related to parent and child mental health, please refer to the main health and social care recommendation at the end of this report.

[129] Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.
[130] From personal communications with the Merton Children Schools and Families department.

Qualitative data: Focus Groups and Semi-structured interviews

Summary of key learning from consultations

Although the consultations in this study identified a variety of both positive and negative experiences of mental health services in Merton, the views expressed by service users and carers were for the most part critical. This is by no means unusual and is typical of much of the user experience documented in the mental health literature.

Service users' main concerns in this study were around continuing attitudes to mental illness, experience of care, and cuts in services. Their most prominently expressed issues with Merton's mental health provision were the loss of drop-in/day centres, perceived powerlessness in influencing their care and services that were dominated by a medical approach to treatment.

The most important issues for carers were their poor involvement in decisions about the care, properly informed sessions and providing support/ training in managing specific situations.

BME service users and carers reported particular challenges in different areas, exposing the importance of developing cultural competence within the mainstream services along with targeted provision specifically tailored to their unique needs. BME groups are under-represented in research[131] and their experiences and expectations of services will continue to be priorities for further investigation.

When service users and carers talked about their experiences of primary, acute and hospital care, their views were largely framed by four perspectives:

a. Relationships with health professionals.
b. Communication – consisting of listening, talking and understanding.
c. Cultural competence of the service (particularly in the case of BME service users)
d. Comparisons with services in adjoining boroughs (especially Sutton and Wandsworth) which were generally seen as providing better care and a wider range of services).

Service providers offered insights into the main strategies they employed to deliver more user-responsive services. These were:

a. Adopting a more open and candid approach with users informed by the policy recommendations of the Francis report.
b. Established feedback and stepped complaints procedures
c. Developing different ways of working, and
d. Fostering partnership working.

Staff training and education underpinned all four approaches.

Regarding perceptions of an ideal mental health service, central to the narratives of both service user and carers were issues of relationship, involvement, and empowerment. For service providers, priority areas for attention were largely related to more effective collaboration and better integration of services across domains of care.

[131] Bee P, Playle J, Lovell K, Barnes P, Gray R, Keeley P (2008). *Service user views and expectations of UK-registered mental health nurses: A systematic review of empirical research.* International Journal of Nursing Studies, 45 (3). pp. 442-457

When **service users** were asked what a good service would look like, high on the list of essential qualities were informed and understanding staff, longer periods of follow-up, a broad range of services and better integration between different teams of workers.

Carers were invited to describe what a good mental health service for them would look like. Prominent among the services and design features they expressed a desire to have were day centres, meaningful consultation on service commissioning and delivery, pro-active information-sharing and guidance, a more user and carer-responsive approach and less emphasis on medical (i.e. drug) treatment and hospitalisation.

Providers were asked what they would like to see included in the current services being delivered. Many responded by identifying a need for better integration of services across domains of care. They further recognised that this would require closer partnership working.

Details of findings from the consultations

A number of prominent themes emerged from the analysis of informants accounts of their experiences and perceptions of engaging with (services users and carers) or delivering services (mental health providers). They are presented below arranged by the responses of the three stakeholder groups.

Service Users

Three aggregate themes emerged from the focus group discussions with service users:

1. Attitudes to mental illness
2. Experience of care
3. Loss of services

1. Attitudes to mental illness

Two distinct sub-themes were identified from participants' responses: stigma and discrimination, and parity of esteem.

Stigma and discrimination

This issue was raised by almost all the participants and this was experienced in four settings: society, family, workplace and the health services. In *society*, few participants were convinced that mental health-related stigma and discrimination had improved. The picture of poor progress was echoed by most of the service users, with several observing that the situation had even worsened. In *family settings*, several participants, mainly from BME backgrounds, related personal experiences of the shame their mental health problems had brought on their families.

"My family…it's like they don't talk about mental health. Like they told the rest of my family and friends that I'm on a sabbatical for the last three years, because it (mental illness) brings shame on the family."

In the *workplace* many participants admitted that they would be reluctant to disclose their condition to their employer. In the *health services* the attitudes and behaviours of professionals in the health services were generally was felt to be satisfactory by most informants.

Parity of esteem

"You just make an appointment and get to your GP and that's what they're there for. But the GPs aren't always good with mental health problems, especially if you don't understand [how to explain the problem yourself]."

There was a general view that the health service still gave less attention to mental illness than to physical problems. While stigma and discrimination were blamed for the disparity in care, the *invisibility* of mental problems was mentioned as an important underpinning factor. Except for acute episodes, mental illness was not felt to have the obvious external signs of physical disorders that attracted early attention by the health service. Hence, people presenting at the clinic seeking care were not deemed to have a serious problem that needed to be treated as a priority. There was general agreement that it was more straightforward getting an appointment for a physical problem than for a mental health complaint.

2. Experience of care

Participants' views about mental health services in Merton highlighted two subordinate themes of interest: access to services and quality of care.

Access to services

Two types of barriers were mentioned by service users in terms of access: *accessing the right type of care* and *transportation*.

Accessing the right type of care

In terms of the first barrier, while participants had no problems getting appointments with their GPs, they did not feel this was always the most appropriate point of contact in many circumstances, and would have preferred to have direct specialist access. Primary care professionals were also perceived by some to have an inadequate understanding of mental illness.

"I don't think they're fully trained or they don't know (primary care professionals)...or mental health issues is too much for them to cope with."

Some service users had resorted to using A&E services but were left frustrated by the process. The Crisis line (telephone service) was also not regarded as helpful.

"I've used the Crisis line. They told me to take a milky drink and go to bed…. And it doesn't help, and in the end I have to go to A&E at one a.m. in the morning because I'm feeling so bad, and then I get sent away."

Participants also stressed that they lacked good information about services they could access and were not adequately signposted by health workers.

Some informants mentioned the difficulty they had in accessing Improving Access to Psychological Therapies (IAPT) services. Their complaints were related to the length of time it could take to get an appointment following referral by their GP, up to 6 months in one instance, and being dropped from the service if they missed scheduled appointments. The IAPT service seemed to be specially mentioned because it was one that many users found helpful. Other

service users identified the closure of hospital wards as compounding the situation, as well as reduced number of health professionals.

"Well, I did have a psychiatrist, in those days, and suddenly, you go in and say, and suddenly your psychiatrist is taken away. And you would like to see a psychiatrist, so I don't know how you go about seeing one, and suddenly you no longer have that psychiatrist. …before I would see a psychiatrist every 6 months or a year…but now, em, they've started saying sorry, you have to sort your own problems out."

Transportation & Discretionary Freedom Passes

Transportation was the other main barrier to access that was an issue of clear concern and generated a great deal of discussion about the decision to withdraw Discretionary Freedom Passes. Participants felt this would severely limit their ability to get around and lead to a worsening of their problems. It was pointed out that many mental health service users were not in employment or on low incomes and they would struggle with the cost of transport. While the Council had given reassurance that people would be able to retain their freedom passes if they had any mobility problems, the process did not appear to work well. Several informants noted that the information they were given about people who would be exempted from withdrawal was different to their actual experience.

"*Freedom pass…it's been withdrawn for a lot of people with mental health problems. I phoned the Council and they said that if I had a mobility problem of any sort, I would retain it."*

"They (the Council) had a consultation. I think a lot of people were told they wouldn't lose theirs so long as they got a letter from their GP saying they was unable to drive. But it wasn't the case; a lot of people had their bus passes withdrawn."

Quality of care

There were four sub-themes in relation to quality of care: *relationship with care giver*, *communication*, *involvement in decisions on care*, and *service integration*.

Relationship with care giver

At primary care level, opinions about services were mixed and strongly linked to people's relationship with their care givers. Some service users had good relationships with their GPs, and cited examples of the impact that effective support from primary care had on their engagement with other parts of the health service. However, many more reported less positive experiences.

"Well the thing is, when I got ill, I was put into hospital, then I came out to see my GP and he just gave me a sick note and he said 'There you are', and I said 'What is this?', and he told me, he didn't explain to me what it was. I was diagnosed of having polymorphic psychosis of [with] symptoms of schizophrenia, and I said to him 'What is this?', and he said 'Well, it's many forms of….', and he didn't know; he had to look it up in a text book. So…and, and then I went to see my psychiatrist, and I was on the books for a couple of years; then they referred me back to my GP, and this has been four years and I've seen my doctor twice in the last four years, and this is just for my yearly reviews, and he just say's 'How are you? Anything different?', ticks a box, and that's it."

Communication

Communication was frequently mentioned and service users who said they were given time to talk, paid attention and listened to, held more positive views about the service as a whole. They described themselves as feeling respected, not judged or patronised. Conversely, those who did not talked of having to *'fight'* and *'shout'* to be heard.

Involvement in decisions on care

Responses to whether service users had significant input into decisions about their care were **all negative**. Meetings with health professionals were described as being a *'monologue'* rather than dialogue, and many informants felt that they were indifferent to their concerns.

The tendency for health professionals to over-emphasis medication and ignore peoples' preference for non-drug forms of therapy was mentioned several times to illustrate service users lack of power to influence their care.

"I don't think to get referred is that easy from your GP.... [They] just medicate you. It's not always the answer, is it? I mean medication sometimes with a bit of other help, or... but I don't think medication is always the answer."

Service integration

Participants voiced concerns about the poor liaison between their GPs, hospitals and key workers (care coordinators). One reason for this was felt to be an inadequate number of mental health workers which was having an impact on the quality of care.

When asked what a good service would look like, high on the list of essential qualities were informed and understanding staff, longer periods of follow-up, a broad range of services and better integration between different teams of workers.

3. Loss of services

Cuts in Merton's mental health services generated considerable discussion. Participants were unanimous in their view that the closures had affected services that they frequently accessed and found helpful in various ways. Several examples were mentioned including Fanon, Beehive, Cottage Day and Mind. Social interaction and motivation to get out and about were some of the features of the services that were particularly valued. Fanon, a BME-focused service, was noted by BME users for its culturally sensitive approach.

"I used to go to Chapel Orchard, which was the day centre specifically for people with mental health problems, and that was open seven days a week. And that was really good, because I stayed in bed for one year; I had nowhere to go. And then I was referred to this place, and that shut down. And a lot of people had breakdowns after it shut down. So there was nowhere for them to go. And then I was introduced to Fanon, went to Fanon for a few years, and that shut down. There's St Marks which is a church open group, erm, every Thursday, but that's shutting down in September, yeah, it's shutting down in September. So the only groups left is Imagine, Focus-4-1 and Wimbledon Guild, on a Wednesday evening."

There was dissatisfaction with some of the services that had replaced the lost ones. Various reasons were given for this including insufficient activity sessions. Several informants mentioned not feeling *'safe'*, using the term to describe service settings that were unfamiliar

and in which they did not feel comfortable. In the case of third sector providers, they were seen as being too expensive to access.

"The problem with Imagine is that it has one-off days you can go to; like a library…they have a hall you can go to, where you socialise or whatever and your needs are sort of met. But the problem with Imagine is that it's not like Fanon. Fanon was like a safe haven to go to. So if you're in the stress or something, you've got five days a week you can go there. But Imagine is…is like an office, you go to an office and then they talk about how they can help you, but they're not really engaging with you during the week, or, they're not really, erm, meeting your needs; they're not meeting your needs. And it's funny how they took away Fanon, but Imagine is still running. So my question is, not question, but my fear is that they're putting across that the way forwards for services especially in Merton, they're putting across that it's going to be built up in offices and places where people don't go to, to engage with each other and know each other and feel that they are part of something……So this is.. this is the…the..the sort of thing where things turn into other things. But Imagine was supposed to take over Fanon, but it never."

Table 19 summarises service users' views about what they felt had worked well and what had not.

Table 19: What has worked well and what has not

What has worked well	Positive service attributes/ mechanisms	Negative service attributes/ mechanisms
Service level		
Day centres	Easy access, understanding staff, something to do, somewhere to go, reduced loneliness through social contact and providing motivation to go out.	Loss of services that were valued.
GP care	Take time to listen, readily refer to IAPT.	Poor communication/relationship building.
IAPT	Easy access, non-drug therapy.	-
Hospital/community care		Resort too readily to medication, inadequate follow up by key worker, difficult to transit between services.
Physical activity (football, tennis, etc)	Opportunity to get out and about.	
Recovery College	Using the Five Ways to Wellbeing approach and Mindfulness techniques.	
Rethink	Open, non-judgemental, social contact.	
Fanon	Open, non-judgemental, culturally sensitive.	
Structural level		
Revocation of Freedom Pass		Limited ability to go out and do things with others.
Unemployment		Lack of opportunities

Carers

Seven themes were identified from the interviews with carers:

1. Attitudes to mental illness
2. Engagement with services

3. Needs assessment
4. Support mechanisms
5. Respite
6. Culturally competent services
7. Expectations

1. Attitudes to mental illness

Similar to service users, carers observed that ignorance about, and negative attitudes to mental illness were still very much pervasive. They all concurred that it was much easier to disclose a physical illness than a mental one.

2. Engagement with services

Two subordinate themes framed the perspectives through which carers' described their experience of engaging with Merton's mental health services: their *relationship with health professionals* and the *quality of care* provided.

Relationship with health professionals

Effective information sharing was considered an important aspect of the relationship with health professionals- the general opinion expressed was that carers did not feel that they were adequately informed about the service users they cared for. Information-sharing is a two-way process of communication, and carers stressed the need to be '*listened to'* when they tried to make inputs. While there was an acknowledgement of professionals' concerns about patient confidentiality and the pressures they were under, especially when having to manage acute episodes, a desire to be better drawn into the management process was expressed.

The other important aspect of this relationship was *professional's attitudes*- most often psychiatrists, community teams and GPs. In all cases, there were wide differences in views, similar to the varying responses given by service users, with opinions ranging from *'fantastic'* to *'useless'*.

Quality of care

Discontinuity of care was seen as an important aspect of quality of care. Carers said that under the current system, there were so many care providers involved that it made it more difficult to coordinate care across primary, community and hospital services.

Inflexibility in service response was another important aspect. A common observation was that there seemed to be a standard response regardless of service users' circumstances and the context of presentation. Health professionals were perceived as not willing to consider all possible treatment options. It was suggested that if carers were better equipped with coping skills, they could offer feasible alternatives to hospitalisation.

"You see always, if I cried for help and called the police, of if I called the doctor, it was the same scenario. No matter what happened, whoever I called for help, it always ended up in him being carted off in an ambulance to Springfield hospital. It was always, Oh I knew the moment I picked the phone to call the GP, he would arrive, probably with the police in tow, or with the, you know, the ambulance, at least, in tow. The moment he got a call to my address, he would come with an entourage of other people, and my son would be taken away from the home. So you try and try and try as much as you could to keep the sick person at home, knowing the consequences of ringing, asking for help. But you

need help. But there was sort of no, nothing in the middle where I could go and talk to somebody who could give me some advice on some strategies, coping strategies, so that it didn't became that critical that he had to be carted away from the home. And it was quite dramatic and I still cry just talking about it, but I thought it was bigger than that."

*Health professionals' personal qualities***:** When asked to assess the quality of service provision, most responses particularly emphasised the characteristics of the health professionals involved in delivering the care. Personal attributes of professionals were therefore a principal proxy indicator of care quality. As described in the relationship sub-theme above, there were varying perceptions about the quality of care depending on whether an informant had encountered 'good' professionals or not. The divergent perceptions were summed up in comments of one carer who described the situation as *'a bit of hit or miss'*.

3. Needs assessment

Most of the carers seemed uncertain of what was meant or replied in the negative when asked if a formal assessment of their needs had ever been undertaken and how frequently follow up assessments were carried out. However, following further probing over the course of the interview, some recalled informal enquiries made about their requirements, but did not seem to associate this with a needs assessment. The initial contact with the mental health service was an especially crucial period and most of the carers recalled being left in the dark about what was happening at a time when they would have welcomed guidance and support.

"But no professional in the mental health told me that any services were out there for me; looked after me. They were looking after my son fine in the hospital, but nobody ever..., I just went down there at visiting time to visit him and came home. There was nothing given to me by way of a pack or one-to-one with anybody. It was always about my son and how he was progressing or digressing [regressing]. But they never once asked me how I was coping with his issue and the broader aspect of my life as a whole; juggling work, juggling other children, juggling my son being ill, you know. It was very traumatic for me."

4. Support mechanisms

Several effective mechanisms were identified by carers that supported them in their role. Non-statutory services and self-help groups (such as Carer Support Merton and Rethink) were a key source of support and provided a range of services including counselling, information, help with filling forms and signposting to useful local services. They also offered vital social and emotional support. Social activities are varied and include games (scrabble, quizzes, bingo), creative writing, day trips, and theatre trips.

5. Respite

Breaks for carers were an important issue. The pressure of the role was stressed and how carers struggled just to keep up that they had little time to focus on their own needs. Comparisons were made between looking after people with physical health conditions and those with mental health conditions to emphasize the added burden mental health carers faced, and consequently the importance of adequate respite.

6. Culturally competent services

Cultural competence was a prominent cross-cutting theme that was interwoven with all the other themes such as **stigma**; **seeking help; support mechanisms** where the effectiveness of

support is enhanced if the support service had an understanding of the carer's cultural values and behaviours; & **respite** where BME carers were seen as losing out on respite benefits because they were outside of the influential social networks, were less knowledgeable about how to access information and how to effectively navigate the system.

7. Expectations

Carers were invited to describe what a good mental health service for them would look like. Prominent among the services and design features they expressed a desire to have were day centres, meaningful consultation on service commissioning and delivery, pro-active information-sharing and guidance, a more user and carer-responsive approach and less emphasis on medical (i.e. drug) treatment and hospitalisation.

"We've taken away what was important to the service user without actually engaging them in the consultation processes, and if you ask them what they want; they need centres, they need somewhere to go, somewhere to talk. Not the hospital, because often going to the hospital means having to be an inpatient of the hospital and that's not where the service user wants. Not professionals per se that I don't make judgements for and then decide what's good for them and put them away; but independent people like myself who are not particularly qualified but have the tee shirt, been there, done that, know what it's like to be a carer; can identify what it's like to be a service user, because you've cared for one yourself, you know where they're coming from, you realise when they're getting ill and you realise when they are just lonely and distressed or frustrated, and that they're crying out for help."

Service providers

Interviews with statutory and voluntary sector service providers were used to discuss pre-identified service issues and, crucially, explore provider perspectives on the themes emerging from the other two stakeholder groups. Informants' responses were grouped under four overarching themes:

1. Attitudes to mental illness
2. Service responsiveness
3. Changing health seeking behaviour
4. Service cuts and capacity
5. Service gaps

1. Attitudes to mental illness

"*It is more respectable to say I have an alcohol or drug problem, than to say I am schizophrenic."*

Informants observed that in many parts of society, unlike mental illness, attitudes to drunken behaviour and drug use were increasingly tolerant, with such behaviours broadly accepted and/or excused. Nevertheless, service providers generally held slightly more positive views to users and carers about improvement in societal and family attitudes regarding mental illness. It was further suggested that there may be variations in attitudes depending on the age group affected and the type of mental illness.

2. Service responsiveness

The interviews identified four approaches services employed to address the needs of service users and carers: responding to policy guidance, feedback and complaints procedures, different ways of working, and fostering partnership working. Training and education underpinned all four approaches.

Responding to policy guidance

Statutory providers talked about a number of strategies that were recently established to deliver a more responsive and patient-centred service. *Staff training, openness* and *honesty* were frequently mentioned terms, reflecting the language of key NHS policy guidance: *Being open* and *Duty of candour*. The Francis report[132] was also mentioned.

Feedback and complaints procedures

Alongside implementing the guidance, statutory providers described other forms of responding to users' complaints, typically by establishing a feedback and complaints system, usually with a designated complaint's officer that users' could access by phone, email or directly visiting the service. The process was stepped so that complaints could be escalated if not satisfactorily resolved informally or at lower levels. They also mentioned running patient and carer surveys at intervals to obtain feedback on the services.

Different ways of working

Service providers mentioned that they were beginning to explore non-traditional forms of service delivery as a way of improving engagement and uptake of services by users. An example from a GP surgery described how the practice was taking interventions outside the walls of the surgery (Zumba classes for the elderly in a nearby park).

Fostering partnership working

This approach was well illustrated in the work of the IAPT service where it was used to enhance access to BME groups. An informant observed:

> *"We also work very closely with various key organisations in our area. So, erm, for example, we've got a very high Tamil population, erm, in Merton. Erm, we've also got a very large Polish population in Merton; and with their key organisations. For example we have a Shree Ghanapathy temple in Wimbledon, and we work very closely with them, we run depression groups directly in their premises. We also work with the Polish Families Association population in Colliers Wood, and we are trying to..., we are aware that that is a very under-represented population in the area, despite that we've got a very large population there. They don't make use of the services that we have to offer as much as they ought to do, and this is something that we are currently looking at."*

Another informant highlighted collaborations between primary care and the voluntary sector, citing an example of several voluntary sector providers using surgery settings to deliver activities.

[132] The Francis report describes the findings of an inquiry that had been set up to examine the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. The Inquiry looked at why the serious problems at the Trust were not identified and acted on sooner, to identify important lessons to be learnt for the future of patient care. http://www.midstaffspublicinquiry.com/home

3. *Changing health seeking behaviour*

From a provider perspective, the IAPT service was a key mechanism for encouraging earlier engagement with the mental health service. It was favourably viewed by service users for its ease of access and non-drug approaches to treatment, and the service provider further highlighted the different ways the service worked to improve access especially for BME people and ensure that service users presented early. These include pro-active education and training for GPs and practice managers to alert them to the presenting complaints that might signal mental distress.

4. *Service cuts and capacity*

There was a common view that the demand for mental health services would increase, given both the profile of the local population and the wider economic pressures and cost-cutting drive. Voluntary sector providers were especially concerned that cuts in services and the lack of adequate options would have adverse impacts on service users.

5. *Service gaps*

Providers were asked what they would like to see included in the current services being delivered. Many responded by identifying a need for better integration of services across domains of care. They further recognised that this would require closer partnership working.

The table below summarises the gaps identified by service providers.

Table 20: Gaps identified by service providers

Statutory sector providers	Voluntary/community providers
• Integration between primary care and community services • Improved partnership working with voluntary sector to help deliver services in community settings. • Specialist liaison psychiatry for older adults (rather than the current generic system). • Targeting low referral GP practices	• More holistic approaches that emphasise all aspects of care, not just the medical. • Better coordination of services and collaboration with the statutory sector. • Effective voluntary sector representation on commissioning groups. • Targeted services for BME groups • Strengthening early interventions (i.e. for schools & young people). • Peer volunteering • improve housing support

Adult Mental Health services in Merton

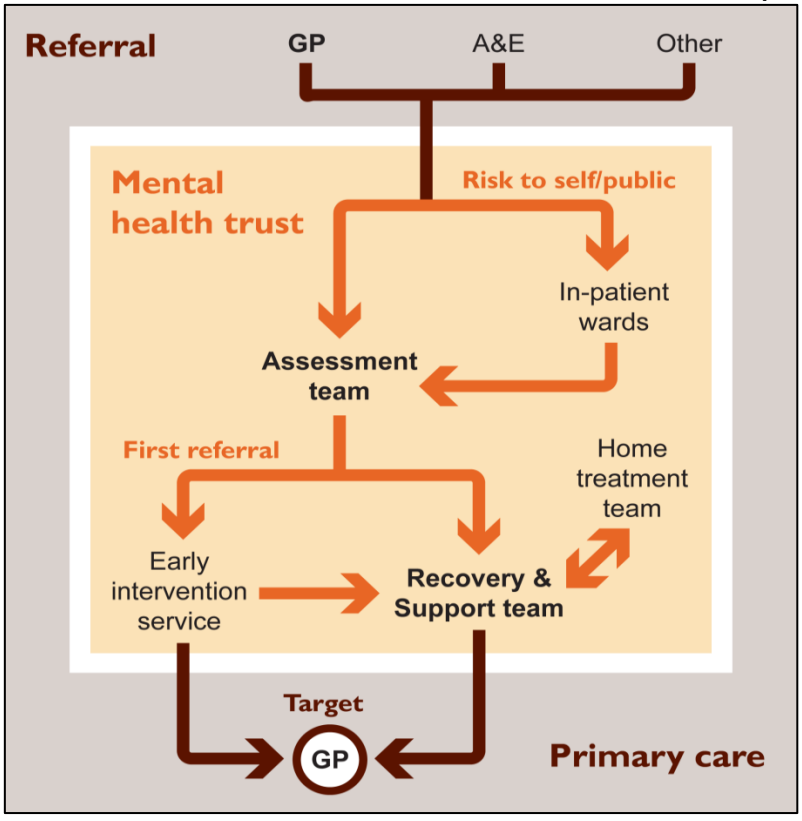
How services are structured in Merton

South West London and St George's Mental Health NHS Trust

The local mental health trust for Merton is the South West London and St George's Mental Health Trust. The Trust has its main in-patient base at Springfield Psychiatric Hospital in Tooting, with local community mental health services based at The Wilson Hospital, and a community 'spoke' also provided in the west of the Borough. The Wilson Hospital site is temporary and due for redevelopment.

The demand for in-patient beds for working age adults will normally vary within a range of 20-27 beds, and this is normally absorbed within Jupiter, the dedicated Merton ward. The demand for older person's beds is significantly less and is absorbed within Crocus, which also accommodates in-patient demand from Wandsworth and Sutton.

Figure 98: Journey of a service user from referral to the Mental Health Trust to return to primary care



The care pathway for working age adults being referred to secondary care in Merton incorporates a single Assessment service for all referrals; with three locality based Recovery and Support Teams, and Early Intervention Service, a Personality Disorder Service and a Crisis and Home Treatment Team in place for those people with more complex needs (see figure above).

When someone is referred to the Trust their first contact is with the Assessment Team, who assesses their needs and either advises the GP about their treatment and physical care, or signposts to the appropriate secondary care service. Referrals to the Mental Health Trust could come through GPs, the in-patient wards or other health services like Accident and Emergency.

People are admitted to the in-patient wards where their needs/risk require 24/7 care, and can be detained under the Mental Health Act if they present a risk to themselves or the public that could not be managed in the community. As soon as patients are admitted, the Trust begins to consider their discharge and the services they can use after discharge from the ward. Information is given to patients and services signposted where possible.

If someone experiences a psychosis for the first time, they will receive intensive treatment from the Early Intervention Service using a psycho-social model for a 2-3 year period to help the service user to best manage their illness and to prevent their illness progressing further. Service users will then either be referred onto the Recovery & Support team or, if they have stabilised, back to their GP.

IAPT (improved Access to Psychological Therapies) service

In 2009 NHS Sutton & Merton (which was a combined Primary Care Trust) established a local IAPT service in line with the IAPT programme's design principles and operating standards. The current provider of this IAPT service is SWLStG Mental Health NHS Trust.

S&M IAPT provide assessment and treatment for the common mental health problems such as depression, generalised anxiety disorder, panic disorder, social phobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), bulimia nervosa, and other diagnosable mental health disorders defined by NICE (the National Institute for Health and Clinical Excellence). They also provide a service to people with long term medical conditions and depression and/or anxiety and people experiencing difficulties retaining or returning to employment.

The service applies a stepped care model of care which provides each client with the level of treatment that is appropriate to their current needs.

Initial triage assessment which is often carried out over the telephone, this is a structured interview specifically designed to identify current mental health problems. A further assessment may be required in some cases. The following may then be offered:

- Signposted to a service that more closely matches their needs
- Psycho-educational group programme (LI)
- Guided CBT or computerised CBT (LI)
- CBT (group / individual) (HI)
- Dynamic Interpersonal Therapy (HI)
- Referred on to a specialist service

The Sutton & Merton IAPT team consist of 40 WTE psychological therapists, made up of 25 wte high intensity workers and 15 wte low intensity workers (psychological well-being practitioners).

The service reports locally on IAPT KPIs, access data and patient experience data. Two KPIs are included in Merton CCGs operating plan:

- The local 'enter treatment' target is 13% (6079 people seen) for 2013-14, leading to the 15% National target in 2015
- The local recovery rate target is 45% for 2013-14, leading to the 50% National target in 2015

Although S&M IAPT do work in partnership with local organisations to increase access for their diverse communities (e.g. Age UK, carers organisations, Tamil and Polish community groups)

more needs to be done with BME communities to ensure equity of access. BME communities make up 35% of Merton's total population. Recent data (Q2 13-14) states that 25% of Merton referrals are from BME communities.

Recovery & Support Team

The three Recovery & Support teams provide on-going care for people with SMI (Severe Mental Illnesses) in Merton. The team is mainly staffed by Community Psychiatric Nurses, Social Workers, doctors, psychologists, employment workers and Recovery & Support workers (RSWs).

The nurses, social workers and occupational therapists undertake the role of the Care Co-ordinators and establish an overview of the service user's care; ensuring appropriate linkages are made into other services such as supported housing or social services.

Care Co-ordinators will work with service users on enabling recovery and agreed outcomes within agreed timescales and specific goals for their service users. The intention is to ensure people's independence wherever possible and for them to be supported in the least restrictive manner consequent to their needs. Care Co-ordinators see their service users about once every two weeks on average although this will vary with service user need. Recovery & Support Workers (RSWs) will undertake many of the practical tasks in delivering care under the supervision of the care coordinator, and may see service users more frequently. . Most service users are seen in their homes but they may also come to the team base, especially if they need blood tests for their medication.

The Mental Health Trust tries to maintain consistency in providing care workers for service users but due to the impact of people changing jobs and restructuring within the organisation, this is not always possible.

Recovery College

The South West London Recovery College, operated by the Mental Health Trust, runs self-management courses to give service users to develop the skills to manage their own recovery. Carers and staff can also attend the courses. The Recovery College approach is to help people recognise and develop their personal resourcefulness and the message is 'hope' – that service users can recover a meaningful life.

There are short introductory courses (half a day) and longer term ones (3-10 weeks, half day weekly sessions), e.g. about spirituality and five ways to wellbeing. There are also more practical courses such as an introduction to the internet.

The college runs on a hub and spoke model with courses delivered both at Springfield Hospital as the hub and at a variety of places within the community - libraries, adult education and community halls across south west London. The community venue in Merton is Vestry Hall in Mitcham.

Merton Adult Substance Misuse Services

London Borough of Merton commissions The Mental Health Trust and Merton Adult Crack Service (MACS), a Voluntary Sector organisation to provide structured treatment for adults (over 18s) presenting with substance misuse problems. The services are located at The Wilson hospital and Wimbledon Chase and provide a range of interventions including full comprehensive assessment, prescribing and psycho-social interventions including structured Group-Therapy. The services also provide aftercare, work with the Criminal Justice System, and referral into in-patient detoxification,

and residential rehabilitation services where required/appropriate. Access to “recovery capital (ETE and Housing) may also be achieved through these services.

Drop-in for Merton residents with mental ill health

There are no LBM commissioned day centres in Merton for residents with mental ill health. LBM has commissioned Imagine Merton to provide multiple drop-ins- one drop-in is located in Wimbledon and the other in Mitcham. The Mitcham drop-in is specifically for BME groups and the remit of these drop-ins is to offer support in terms of employment, advocacy, peer support and to undertake needs assessments of clients. The service works closely with the IAPT team and CMH in Merton.

How care is structured

Care Plan Approach (CPA)

Each service user normally has a Care Plan Approach (CPA) Review every six months. The care coordinator will organize this meeting and involve the service user, carer (if appropriate) and any other professionals or agencies involved in the care to review the care plan in a collaborative manner, and agree the future care plan, or indeed, discharge.

Each service user on CPA also has a personalised care plan that should include identifying and achieving their recovery goals. These goals are agreed with the service users – they are about moving their life forward and building the life they want to live

Care clusters and care packages

New mental health care clusters and care packages were introduced in April 2013, as a process of bringing greater definition to care groups, and payment for the inputs delivered to these. but have not yet been agreed at a national level as the model for contracting. The care clusters have yet to be fully implemented nationally, are divided between three super clusters – psychosis, non-psychosis and organic. Care packages are written descriptions of the care that service users in each of the care clusters will receive.

The care packages include information about the amount of time spent by different Mental Health Trust staff with the service user, therapeutic services that should be offered (e.g. “physical health monitoring and intervention”) and enabling services (such as the Recovery College – mentioned above). However, given the individuality of patient need, many patients do not neatly fit the prescribed clusters and their care plans will also vary as a result.

Age affects the type of caseload for mental health services. In older adults there is higher demand for acute services by patients with organic mental health conditions. These include conditions such as dementia and Alzheimer’s. In working age adults there is a high demand for acute services by patients with schizophrenia or mood disorders.

Local services in Merton to support dementia care

NHS

For medical diagnosis, treatment and management of dementia the NHS provides services through primary care (GPs) and secondary/ tertiary/ specialised services through the South West London and St. George's Mental Health NHS Trust.

The Mental Health Trust also provides community support through a Community Mental Health Team, which assesses and treats people (normally, though not exclusively over 75) with both dementia and functional mental illnesses such as depression, schizophrenia or bipolar disorder. The service also operates:

- Intensive Home Treatment Service to support people in their own homes over a crisis, as an alternative to hospital admission
- Challenging Behaviour Service which works with nursing homes to help them review and deliver care to residents with challenging behaviour using cognitive approaches, and minimizing the need for psychotropic medication or admission to hospital
- A Memory Clinic at Clare House, St George's Hospital, which provides an initial assessment and diagnosis of dementia, and review, in partnership with the Alzheimer's Society

Merton Council Social care

The Merton Council provides a variety of services for people with mild to moderate dementia, who need opportunities for additional social support and contact, and respite for carers- these needs are predominantly met through non-specialist day centres.

Merton Dementia Hub, Mitcham

The main dementia service commissioned in 2013 by Merton Council is the Merton Dementia Hub situated in Mitcham with additional outreach services held across the borough by the Alzheimer's Society. The Alzheimer's Society works in partnership with the Merton older peoples CMHT (Community Mental health Trust) Memory Clinic. They are available to meet and talk with patients and their carers providing advice and support about how best to live well and strong with dementia. The Alzheimer's Society provides a range of activities and by working in partnership with the Memory Clinic enables everyone to engage into the many activities they provide. The emphasis of the Dementia Hub is very much on early diagnosis improving prognosis promoting a dementia friendly Borough, providing a weekly 'one stop shop' facility through a dedicated team.

The Dementia Hub aims to:

- Raise awareness & understanding
  The information worker raises awareness and promotes the benefits of diagnosis amongst professionals and the local community. This includes presentations to community groups and information provision in community settings such as libraries, supermarkets, local shops and places of worship. Developing volunteer capacity across the borough will enhance this activity, particularly within specific communities.

- Provide Early Diagnosis and support
  The Dementia Adviser service supports individuals to obtain a diagnosis and works with newly diagnosed individuals to identify their specific needs and preferred sources and styles of support. An individual support plan then allows identification and signposting to the most appropriate services. Service users are encouraged to return for further planning support when

they feel their needs have changed, with the service being accessible to them throughout their dementia journey.

Facilitated peer support was identified through the consultation for the NDSE (National Dementia Strategy for England) as important to many people affected by dementia following a diagnosis and the Hub offers peer support appropriate for people at this stage as well as further on in the dementia journey. Training provided for carers through CrISP (Carers Support and Information programme) sessions helps in understanding the condition, developing coping strategies and knowing sources of support.

- Support Living Well with Dementia
  Both Dementia Adviser Service (DAS) and Dementia Support Workers (DSWs) develop support plans with people and the DSWs continue with those who need more support to achieve their identified outcomes. They give an individualised service, often through home visits, and provide continuity of service by being available as a person's condition progresses and their needs change.

Continuing information and support is provided also through peer support activities such as the Dementia Cafes. These, along with activities like Singing for the Brain, also address the social needs of people with dementia and their carers. They can be an opportunity for both parties to enjoy a more social activity together.

The Hub provides:
Dementia Support Service, which is a service for people with dementia and their carers, providing:

- Information, including a welcome pack with details of local support and services, information sheets, Alzheimer's Society leaflets and our newsletter
- Telephone and email support and home visits if required
- Signposting to other local support services
- Encouragement to become socially active
- Information and support available weekly at St George's Hospital Memory clinic

Peer Support Service

- *Support groups for carers*: Friendly informal meetings where carers can support each other and share experiences, information and advice
- *Younger persons' group*: A group designed specifically for people under 65 with a diagnosis of dementia
- *The Friday Club*: A meeting place for people with dementia, carers and family members to meet in a relaxed atmosphere to get information and support, to talk freely about dementia and enjoy a range of activities

Information Service
Raising awareness and understanding of dementia in the community through talks, presentations, information stands, forums, media articles and access to a library of factsheets, books and DVDs.

Workshops
(CRISP) Carers' Information and Support Programme
A series of workshops for people caring for a family member or friend with dementia.

Singing for the Brain
A stimulating group activity, for people in the early to moderate stages of dementia and their carers, which can help with general well being and confidence.

Life After Diagnosis (LAD)
Support for people with a new diagnosis of dementia.

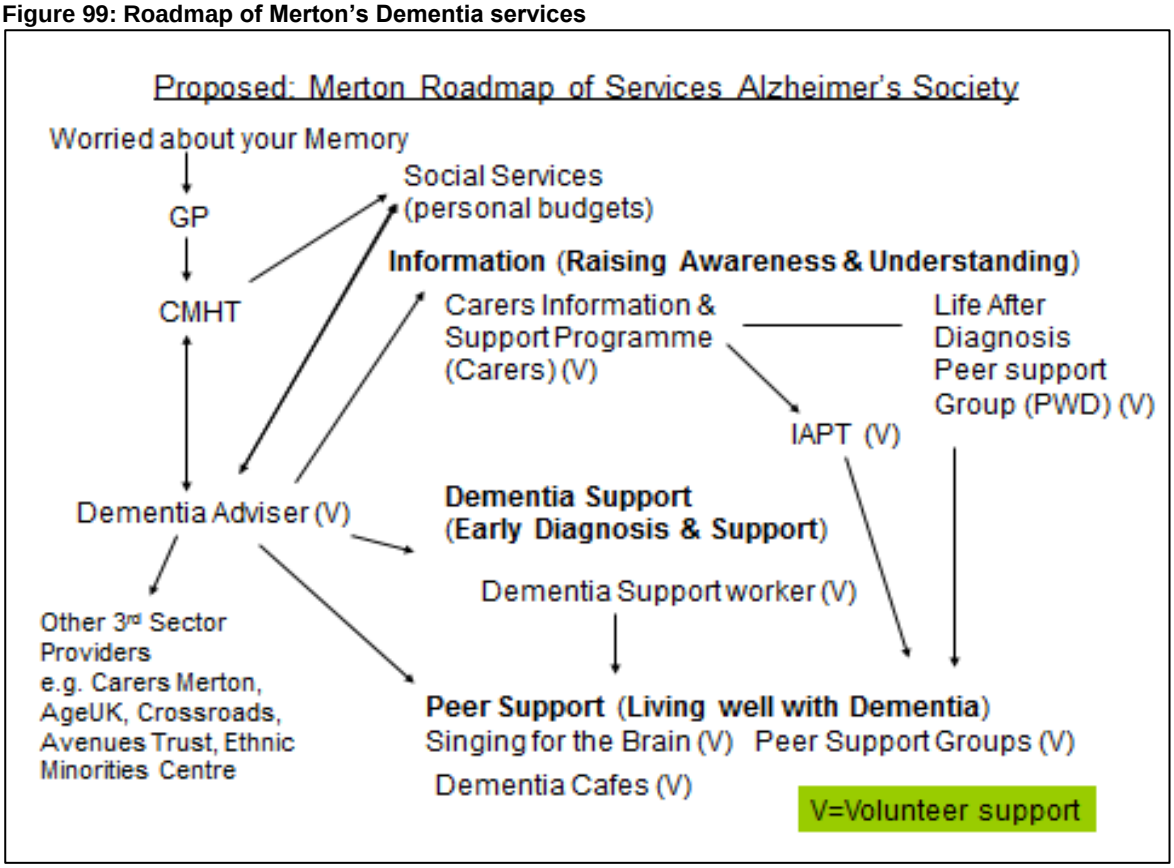
Other Dementia services commissioned by the Council are-
Day Centres (Woodlands and Eastways Day Centres) to provide:

- Social support to people with dementia and long-term mental health problems
- Short breaks for carers (respite) for carers
- Information and support to carers

*South Thames Crossroads***:** Provides practical support and respite care to carers
Carers Support Merton: Provides support for Carers

Figure 99 below describes the Merton roadmap of Dementia services.

Figure 99: Roadmap of Merton's Dementia services



Prevention and support for mental ill-health in the elderly

Community involvement and voluntary action are essential to the quality of life in Merton, and the voluntary and community sector makes a valuable contribution to the borough's economic, environmental and social development. The Merton 'Compact' is a partnership agreement between Merton Council, the Merton CCG and the voluntary and community sector. The 'Compact' is a

national framework for how councils should work with the voluntary sector. The partnership offers joint services including:

Ageing Well Programme

The Adult Social Care Ageing Well Programme was launched on 30 April 2013. The key features of the programme are:

- Enables people to live for longer in their own homes and delaying or reducing spend on Council funded social care
- Is based on the evidence of triggers that cause people to go into care homes – such as incontinence, dementia, isolation, loss of mobility, and depression/anxiety.
- Is outcomes-focused and takes an asset based approach
- Builds social connectedness - instead of relying on services which keep older people segregated from others, it actively encourages people to mix
- Promotes stronger local neighbourhoods, putting older people in touch with local people and opportunities
- Its effectiveness will be measured by a set of metrics - a combination of inputs by voluntary groups, individuals or objective assessment of "wellbeing" among older people against certain key factors and whether the services are actually having a "preventive" effect
- Cross-borough coverage for outcomes, whether by one organisation or through collaboration between organisations
- Consultations with older people on what they actually want

The services funded by the Ageing Well Programme are:

Age UK Merton – Life after Stroke; continence awareness and support service

Carers Support Merton - Neighbourhood peer support groups/networks; self-financed activities for carers as respite; Carry on caring workshops; emotional support and coaching

Merton & Morden Guild of Social Service - 'Fit for Life' exercise programme; falls prevention programme; opportunities for volunteering

Merton Community Transport - Volunteer community car service

Merton Mencap – 'Evolutions' support service for non-FACs eligible people with autism; activities club and carers community advice service

Merton Vision - Buddying programme, emotional support and counselling, training to use equipment

Volunteer Centre Merton - Supported Volunteering Programme for mental health service users and people with learning, physical or sensory disabilities

Wimbledon Guild of Social Welfare - Community coaching sessions; menu of services; informal drop-in café

Smoking cessation

People with mental health conditions have a higher rates of smoking which contributes to shorter life expectancies.

Local smoking cessation services

A major factor in reducing smoking prevalence is to ensure ready access to Stop Smoking Services and support. The smoking cessation services in Merton are delivered by Hounslow and Richmond Community Healthcare NHS Trust. This is integrated into the LiveWell health improvement programme, resulting in a service that can support smokers to stop and also provide

support around other health behaviours e.g. increasing physical activity levels to reduce potential weight gain that is sometimes seen by those who stop smoking.
https://www.live-well.org.uk/merton/

Smoking cessation services in SWLStG MH NHS Trust
South West London and St George's Mental Health NHS Trust's (SWLStG) smoking cessation project was established in 2010 to deliver the CQUIN1 local goal 2010/11 Indicators (detailed in an earlier section). The ultimate aim of the project, and the intention of the CQUIN targets, was to improve access to, and the quality of, smoking cessation support for service users with a view to improving their physical health. Over the past three years, the Trust has built up an in-house smoking cessation service for its service users who are now easily able to access the help and support they need if they choose to stop smoking or even just reduce the number of cigarettes they smoke each day.

As of 01/04/2014 the CQUIN on smoking cessation will cease and it is expected that the SWLStG MHT will have integrated the service into the overall provision for its service users.

Types of housing for people with mental health conditions

A mental health condition does not necessarily mean that a person will require housing services. A lot of people continue to function sufficiently well, so that it does not come to the attention of others and they carry on with their lives, work and maintain accommodation. For other people a mental health condition can have a devastating effect on their lives and impact on all aspects particularly employment, finances and housing. People may lose their homes as a result of illness, but recover well and have sufficient skills to manage anew tenancy and live independently or they may not make such a quick recovery and require different accommodation to what they had previously

If a person with a mental illness becomes homeless they may be considered to be vulnerable and therefore have a priority need for accommodation in accordance with the Housing Act 1996 Part 7 (as amended by the Homelessness Act 2002). In reaching a decision as to whether a person with a mental illness is in priority need, regard to advice from medical professionals, social care or current providers of care and support is considered and close working between the housing service and mental health agencies is crucial

The Council also takes a proactive approach to the prevention of homelessness and offers a range of options to resolve a persons housing needs. This includes rent rescue, advice on security of tenure, defending possession proceedings , increasing housing supply by working closely with private sector Landlords, improving housing conditions through advice and enforcement, and welfare and money advice

In situations where the Council accepts that a person with a mental illness is owed a housing duty because they are unintentionally homeless, in priority need, eligible for assistance and have a local connection with the borough, they will be provided with temporary accommodation until a permanent housing solution can be found. This might be an offer of a social housing tenancy through a registered provider (Housing Association) or a private sector Landlord.

Alternatively assistance may be required to help a person with a mental health condition to live in the community and a range of supported accommodation exists in Merton run by specialist housing

and support providers. These dwellings can be accessed through a supported housing panel set up to assess and process referrals into these services

These include

- Ability Housing 24 self contained flats in the Mitcham area
- Family Mosaic 8 bedsits in Colliers Woods
- Shared Lives 47 units at various locations

As stated previously many people with mental health conditions live in ordinary accommodation, that they own or rent and they continue to do this even if there are times when they become unwell. Where people live is, based on their preferences, needs and an assessment of what support is required to help them keep safe and well.

Table 21: Details of housing schemes funded through London Borough of Merton

Provider	Scheme Name	Short Term Or Long Term	Number of Units
Ability	Layton House	Short Term Housing Related Support	23
Ability	Merton Move-on	Long Term Housing Related Support	41
Ability	Malcolm Road	Long Term Housing Related Support: Very long term. (The Mental Health Accommodation Panel rarely makes placements here).	4
Casa Support	Norfolk Rd	Long Term Housing Related Support: The service users in this scheme invariably occupy the accommodation under permanent residence. (The Mental Health Accommodation Panel does not ordinarily make placements here).	2
Casa Support	Grenfell Rd	Long Term Housing Related Support: The service users in this scheme invariably occupy the accommodation under permanent residence. (The Mental Health Accommodation Panel does not ordinarily make placements here).	2
Comfort Care	ex HST	Long Term Housing Related Support Now spot purchase. (The Mental Health Accommodation Panel no longer make placements here).	10
Family Mosaic	Waldemar Rd	Long Term Housing Related Support	8
Metro Support Trust	Quicks and Latimer	Long Term Housing Related Support: The service users in this scheme invariably occupy the accommodation under permanent residence. (The	3

		Mental Health Accommodation Panel does not ordinarily make placements here).	

In terms of 'day resources', London Borough of Merton funds the following:

Table 22: Day resources funded by London Borough of Merton

Provider	Scheme Name	Price	Units
Rethink	Independent Mental Health Advocacy	£28,000 per annum	Not Specified
Voiceability	Independent Mental Capacity Advocacy	IMCA @ £20,000 per annum DoLS @ £20 per hour up to 200 hours and £17.50 per hour above 200 hours.	Not Specified
Imagine	General Advocacy & Support for Mental Health Clients	£210,000 per annum	Not Specified
Alzheimer's Society	Dementia Hub (wide range of services including outreach support)	£231,554 per annum	Not Specified

The care programme approach (CPA) was introduced in 1990 (reviewed in 2008) to provide a framework for effective mental health care for people with severe mental health problems.

Its four main elements are:

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services
- The formation of a care plan which identifies the health and social care required from a variety of providers
- The appointment of a (care co-ordinator) to keep in close touch with the service user and to monitor and co-ordinate care reviews and where necessary agree changes to the care plan.
- Reviews and where necessary, agree changes to the care plan

The CPA meeting should include the individual and all relevant people contributing to meeting their needs e.g. carer, care co-ordinator, housing provider, resettlement worker.

If a change to accommodation is identified in a CPA meeting, the care co-ordinator is pivotal to the process of helping the person access other accommodation. They make a referral to the Housing Needs Service for advice and assistance on gaining appropriate accommodation. If a person with a mental health condition is so severe that the person cannot be housed in mainstream/ supported

housing, a health-funded placement is required. These placements are mostly funded through the NHS Merton Clinical Commissioning Group (MCCG).

Registered, residential and nursing home placements are “purchased” usually through Adult Social Care and include:

- A local step down facility, Norfolk Lodge- This is an 11 bedded unit for male patients. The unit provides step down after inpatient stays where the person requires further rehabilitation before moving to supported or independent accommodation and also where people are homeless and have no other arranged accommodation and will require support to access the right next step
- Burntwood Villas- a 15 bedded facility across three houses which provides step down for males and females with complex needs and challenging behaviour

Additionally the CCG procures and funds other health needs level mental health placements for those who require a high level of support. NHS England also funds a small number of high level secure placements.

There is also an annual quota of rehousing in general needs housing association stock for people with a mental health condition. The Community care act 1990 puts a duty on the council to consider and where possible meet accommodation needs as part of any care package.

Mental health nominations are to assist a small number of people who are not eligible for rehousing through any other route. Care Managers can nominate persons who require accommodation as part of their care package or who have other general needs where:

- Move on from supported accommodation is needed
- A person is living with relatives and needs independent housing and where other routes to appropriate accommodation have been explored and exhausted

What does the literature say?

Mental health promotion and prevention

Health systems aim to improve health and health-related well-being, but are always constrained by the resources available to them. They also need to be aware of the resources available in adjacent systems which can have such an impact on health, such as housing, employment and education. Careful choices therefore have to be made about how to utilise what is available. One immediate corollary is to ask whether investment in the prevention of mental health needs and the promotion of mental wellbeing might represent a good use of available resources. An economic evaluation was undertaken by London School of Economics and Political Sciences on behalf of the Department of Health in 2011 that modelled different interventions[133].

Health visiting and reducing post-natal depression

Context

Moderate to severe post-natal depression affects around one in eight women in the early months following childbirth[134] [135]. The condition has an adverse impact on the mother-infant relationship, a woman's quality of life, and the behavioural, emotional and intellectual development of children; it also increases the likelihood that fathers become depressed after birth[136]. The National Institute for Health and Clinical Excellence (NICE) recommends the screening of post-natal depression as part of routine care, and the use of psychosocial interventions and psychological therapy for women depending on the severity of depressive symptoms[137].However, research suggests that in practice a significant proportion of women with post-natal depression are missed in primary care[138] [139]. The economic costs of post-natal depression are conservatively estimated at £45m for England and Wales[140].

Intervention

Health visitors are well placed to identify mothers suffering from postnatal depression and to provide preventative screening and early interventions. A range of UK trials with interventions provided by health visitors have been positive: women were more likely to recover fully after 3 months[141]; targeted ante-natal intervention with high-risk groups was shown to reduce the average time mothers spent in a depressed state; and a combination of screening and psychologically

[133] Knapp M, McDaid D, Parsonage M; Mental Health Promotion and Prevention: The Economic Case; Department of Health, January 2011

[134] Petrou S, Cooper P, Murray L, Davidson LL (2006) Cost-effectiveness of a preventive counselling and support package for postnatal depression. International Journal of Technology Assessment in Health Care 22:443–453.

[135] O'Hara MW, Swain AM (1996) Rates and risk of postpartum depression: a meta-analysis. International Review of Psychiatry 8:37–54.

[136] Paulson JF, Bazemore SD (2010) Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. Journal of the American Medical Association 303(19):1961-1969.

[137] NICE (2007) Antenatal and postnatal mental health: clinical management and service guideline, Clinical Guideline 45, developed by the National Collaborating Centre for Mental Health, London.

[138] Kessler D, Bennewith O, Lewis G, Sharp D (2002) Detection of depression and anxiety in primary care: follow up study. British Medical Journal 325:1016.

[139] Murray L, Woolgar M, Cooper P (2004) Detection and treatment of postpartum depression. Community Practitioner 77:13–17.

[140] Derived from Petrou S, Cooper P, Murray P, Davidson LL (2002) Economic costs of post-natal depression in a high-risk British cohort. British Journal of Psychiatry 181:505–512.

[141] Holden JM, Sagovsky JL, Cox JL (1989) Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. British Medical Journal 298:223–226.

informed sessions with health visitors was clinically effective 6 and 12 months after childbirth[142]. The biggest direct costs of the interventions were associated with training (estimated at £1,400 per health visitor), plus the additional time spent by health visitors with mothers for screening and counselling.

Impact
When quality of life benefits to women are incorporated, the health visiting intervention provides a positive net benefit with an incremental cost-effectiveness ratio (ICER) of around £4,500 per quality-adjusted life year (QALY).

Key points
- Findings of a significant improvement in quality of life for mothers and of cost-effectiveness of the health visiting intervention mirror those of Morrell[143]. Our model suggests wider application of this approach.
- On a one-year horizon, health visiting interventions to reduce post-natal depression do not reduce net costs, but do increase productivity for those who return to work.
- The intervention may produce cost savings in the medium- and long-term but this possibility remains to be evaluated.

Early detection for psychosis

Context
The first symptoms of psychosis typically present in the late teenage and early adult years. It is estimated that each year in England 15,763 people exhibit early (prodromal) symptoms before the onset of full psychosis[144]. However, early detection services are not routinely provided and provision is currently very limited. Progression of the disease is associated with higher costs to public services (including health, social care, and criminal justice), lost employment, and greatly diminished quality of life for the patient and their family. A 2008 analysis estimated the average annual direct costs per average patient with schizophrenia at £10,605, and total costs (including lost employment) at £19,078. The corresponding costs for bipolar disorder and related conditions were £1,424 and £4,568. Total costs for these conditions combined were estimated at £3.9bn for services and £9.2bn for services and lost employment.

Intervention
Early detection services aim to identify the early symptoms of psychosis, reduce the risk of transition to full psychosis and shorten the duration of untreated psychosis for those who do develop it. Such services include the provision of sessions of cognitive behavioural therapy, psychotropic medication, and contact with psychiatrists; this contrasts with treatment as usual which typically consists of GP and counsellor contacts. There is some evidence that such services can reduce the rate of transition to full psychosis. One year of early detection intervention has been estimated to cost £2,948 (2008/9 prices) per patient, compared with £743 for standard care[145]. The

[142] Morrell CJ, Warner R, Slade P et al (2009) Psychological interventions for postnatal depression: cluster randomised trial and economic evaluation: the PONDER trial. Health Technology Assessment 13(30).
[143] Morrell CJ, Warner R, Slade P et al (2009) Psychological interventions for postnatal depression: cluster randomised trial and economic evaluation: the PONDER trial. Health Technology Assessment 13(30).
[144] McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S (2008) Paying the Price: the Cost of Mental Health Care in England to 2026. London: King's Fund.
[145] Valmaggia LR, McCrone P, Knapp M et al (2009) Economic impact of early intervention in people at high risk of psychosis. Psychological Medicine 39:1617–1626.

costs of community mental health care and inpatient admissions (formal and informal) were included.

Impact

The savings associated with early detection are, in the model, entirely driven by reduced numbers of people making a transition to psychosis. The assumed 'success rate' in the model is 15 percentage points (20% compared to 35%). If the difference was only 5 percentage points, the annual saving in years 2–5 would fall to around £16m, but would increase to around £79m if the success rate were 25 percentage points. Using these two extreme scenarios, the annual savings over years 6–10 are approximately £14m and £68m, respectively. The assumed difference of 15 percentage points is in fact similar to the impact reported elsewhere[146] [147] [148].

Key points

- Early detection services for patients with prodromal symptoms of schizophrenia are cost-saving overall, and also cost-saving from the perspective of the NHS from year 2.
- Further evidence is needed on the impact of different models of early detection services.

Early intervention for psychosis

Context

The number of young people each year aged 15–35 who experience a first episode of psychosis is estimated at 6,900 in England. Psychosis related to schizophrenia is associated with higher costs to public services (including health, social care, and criminal justice), lost employment, and greatly diminished quality of life for the individual with the illness and their family. Estimates of the costs of schizophrenia and bipolar disorder are given in the report on early detection for psychosis (see previous model).

Intervention

Early intervention teams aim to reduce relapse and readmission rates for patients who have suffered a first episode of psychosis, and to improve their chances of returning to employment, education or training, and more generally their future quality of life. Such intervention involves a multidisciplinary team that could include a range of professionals (psychiatrists, psychologists, occupational therapists, community support workers, social workers, vocational workers). The emphasis is on an assertive approach to maintaining contact with the patient and on encouraging a return to normal vocational pursuits. In the UK evidence has shown that early intervention can reduce relapse and readmission to hospital and to improve quality of life[149] [150].

The annual direct cost per patient of this type of service in terms of input from an early intervention team plus other community psychiatric services and inpatient care has been estimated at £10,927

[146] McGlashan T, Zipursky R, Perkins D et al (2006) Randomized, double-blind trial of olanzapine versus placebo in patients prodromally symptomatic for psychosis. American Journal of Psychiatry 163:790–799.
[147] McGorry P, Yung A, Phillips L et al (2002) Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. Archives of General Psychiatry 59:921–928.
[148] Morrison A, French P, Walford L, et al (2004) Cognitive therapy for the prevention of psychosis in people at ultra-high risk: randomised controlled trial. British Journal of Psychiatry 185:291–297.
[149] Craig TKJ, Garety P, Power P et al (2004) The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. British Medical Journal 329:1067–1070.
[150] Garety PA, Craig TKJ, Dunn G et al (2006) Specialised care for early psychosis: symptoms, social functioning, and patient satisfaction: randomised controlled trial. British Journal of Psychiatry 188:37–45.

at 2008/09 prices, considerably less than that of standard care at £16,704[151]. The reduction in overall service costs is primarily due to the lower demand for inpatient care when specialist early intervention is provided; the first year of the actual early intervention team's input (including contacts with psychiatrists, social workers and community mental health nurses) is estimated to cost £2,282 per patient, which is higher than the £1,284 for standard care.

Impact

The model looks at whether investments in specialist early intervention services can be cost-saving in terms of use of health care services, criminal justice services, suicide, homicide and lost employment. The target group is young people aged 15 to 35 years old in the general population experiencing a first episode of psychosis.

Table 20 shows the impact on annual costs/savings of full coverage by early intervention services of a one-year cohort of patients, compared to standard care. Savings are reduced after three years (when discharge to standard care is assumed to occur) because it is conservatively assumed that, from then on, the inpatient admission rates for early intervention services are the same as for standard care.

Table 23: Impact of early intervention services on annual costs/pay-offs, based on a one-year cohort of patients (2008/09 prices)

	Year 1	Years 2–5	Year 6–10
Per person	**(£)**	**(£)**	**(£)**
Services	-5,777	-2,408	-60
Productivity losses		-2,052	-1,912
Intangibles (negative impact on quality of life)		-314	-628
Total	-5,777	-4,774	-2,600
By sector	**(£m)**	**(£m)**	**(£m)**
NHS	-39.1	-16.0	0
Other public sector	-0.8	-0.6	-0.4
Productivity losses	0	-14.2	-13.2
Intangible	0	-2.2	-4.3
Total	-39.9	-32.9	-17.9

Key points

- The expansion of the coverage of early intervention services to all patients experiencing a first episode of psychosis is cost-saving overall, and also cost-saving from the perspective of the NHS alone, from year 1.

[151] McCrone P, Knapp M, Dhanasiri S (2009) Economic impact of services for first episode psychosis: a decision model approach. Early Intervention in Psychiatry 3:266–273.

- Savings are estimated to decrease over time because there is no current evidence to suggest that reductions in inpatient stays are maintained when patients are discharged from the early intervention team.

Screening and brief intervention in primary care for alcohol misuse

Context

In 2010 it was estimated that 6.6 million adults in England consumed alcohol at hazardous levels and 2.3 million at harmful levels[152]. Hazardous drinking is defined as weekly alcohol consumption of 21–50 and 14–35 units for men and women, respectively, and harmful drinking 50 and 35 units, respectively.

The total costs of alcohol misuse in England, based on inflation-adjusted Department of Health data[153], can be estimated in 2009/10 prices at around £23.1bn, comprising: £3.0bn in NHS costs, £7.2bn in output losses and £12.9bn from the costs of crime. In practice, these figures understate the costs falling on the NHS as more than £1bn allocated to crime covers medical treatment for injuries suffered by the victims of alcohol-related violence. Harmful alcohol misuse is disproportionately costly: analysis for this study estimates that the overall average annual costs of a harmful drinker are around 3.4 times that of a hazardous drinker.

Intervention

Effective strategies to reduce alcohol-related harm require a combination of measures, covering both population-level approaches (such as price increases and advertising controls) and interventions aimed at individuals[154]. In the latter category, evidence indicates that brief interventions in primary care settings achieve an average 12.3% reduction in alcohol consumption per individual[155]. However, this is a short-term effect and evidence about its duration is less clear cut.

An inexpensive intervention in primary care combines universal screening by GPs of all patients, followed by a 5-minute advice session for those who screen positive. The total cost of the intervention averaged over all those screened is £17.41 per head in 2009/10 prices[156].

Impact

Given the £17.41 cost of the intervention, the results demonstrate that savings after seven years exceed costs by a factor of nearly 12 to 1 (Table 21). Purely in terms of public expenditure, the intervention offers good value for money over the same period as combined savings in the NHS and criminal justice system exceed the costs of the intervention by a factor of more than 3 to 1. Estimated savings in the NHS alone exceed costs by more than 2 to 1.

[152] Riley C (2010) The Cost of Alcohol Misuse. Unpublished report prepared for the Department of Health.
[153] Department of Health (2008) Safe, Sensible, Social – Consultation on Further Action: Impact Assessments. London: Department of Health.
[154] National Institute for Health and Clinical Excellence (2010) Alcohol Use Disorders: Preventing the Development of Hazardous and Harmful Drinking. London: NICE.
[155] Kaner E, Dickinson H, Beyer F et al (2007) Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database of Systematic Reviews 2007, Issue 2.
[156] Purshouse R, Brennan A, Latimer N et al (2009) Modelling to Assess the Effectiveness and Cost-Effectiveness of Public Health Related Strategies and Interventions to Reduce Alcohol Attributable Harm in England. Report to the NICE Public Health Development Group.

Table 24: Cost/pay-offs per head for screening and brief advice based on a representative sample of 1,000 adults attending their next GP consultation (2009/10 prices)

	Year 1 (£)	Years 2–5 (£)	Years 6–7 (£)	Total (£)
NHS	-10.55	-24.61	-3.91	-39.07
Crime	-28.49	-66.02	-10.49	-105.00
Productivity losses	-16.20	-38.24	-6.05	-60.48
Total	-55.23	-128.87	-20.45	-204.55

Key points

- There is a robust economic case: low-cost interventions in primary care offer good value for money in reducing alcohol-related harm.
- The main constraint on national implementation is one of scale; options to consider include targeted approaches (e.g. focusing on young males), screening people only when they change GP rather than at next consultation, or using practice nurses rather than GPs to provide the screening and/or follow-up advice.

Workplace screening for depression and anxiety disorders

Context

Substantial potential economic costs arise for employers from productivity losses due to depression and anxiety in the workforce. The main costs occur due to staff absenteeism and presenteeism (lost productivity while at work). From the perspective of the public purse, failure to intervene also risks higher future health and social care costs.

If these conditions are not treated, additional costs are also likely to arise from related physical health problems. In the longer term, wider costs may also be incurred, such as from acute care, the impact on family members and premature death. There may also be additional recruitment and training costs for employers if their employees permanently withdraw from the workforce.

Intervention

Workplace-based enhanced depression care consists of completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing, depression and/or anxiety disorders. Those identified as being at risk of depression or anxiety disorders are offered a course of cognitive behavioural therapy (CBT) delivered in six sessions over 12 weeks. This intervention has been shown in a number of studies to be effective in tackling depression and reducing productivity losses in various workplaces. In a similar approach in Australia, productivity improvements outweighed the costs of the intervention[157].

It was estimated that £30.90 (at 2009 prices) covered the cost of facilitating the completion of the screening questionnaire, follow-up assessment to confirm depression, and care management

[157] Hilton M (2007) Assessing the Financial Return on Investment of Good Management Strategies and the WORC Project. Brisbane: University of Queensland.

costs[158]. For those identified as being at risk, the cost of six sessions of face-to-face CBT is £240. Computerised CBT courses are cheaper, and may be less stigmatising to individual workers, but less is known about their longer-term effectiveness.

Impact

The results show that from a business perspective the intervention appears cost-saving, despite the cost of screening all employees (Table 22). Benefits are gained through both a reduction in the level of absenteeism and improved levels of workplace productivity through a reduction in presenteeism. However, the impact may differ across industries; the case may be less strong where staff turnover is high and skill requirements low. From a health and personal social services perspective the model is cost-saving, assuming the costs of the programme are indeed borne by the enterprise.

Table 25: Total net costs/pay-offs from business and societal perspectives for a company with 500 employees (2009 prices)

	Year 1 (£)	Year 2 (£)
Intervention cost	20,676	0
Health (including social care)	0	-10,522
Absenteeism (productivity losses)	-17,508	-23,006
Presenteeism (productivity losses)	-22,868	-30,050
Total	-19,700	-63,578

Key points

- The intervention is cost-saving from the perspectives of both business and the health system, on the assumption that all costs are borne by business.
- The costs of the intervention are more than outweighed by gains to business due to a reduction in both presenteeism and levels of absenteeism.
- Public sector employers also have the potential to benefit from investing in universal workplace depression and anxiety screening interventions.

Promoting well-being in the workplace

Context

The workplace provides a convenient location for addressing the physical and mental health of a large proportion of the adult population. Problems inside and beyond work can be identified and tackled, and there is also scope for general health promotion. Aside from the potential benefits to public health, this type of well-being intervention can improve an organisation's productivity, image and workplace safety. It may also reduce the vulnerability of employees to work-related mental health problems.

[158] Wang PS, Patrick A, Avorn J et al (2006) The costs and benefits of enhanced depression care to employers. Archives of General Psychiatry 63:1345–1353.

Deteriorating well-being in the workplace is potentially costly for businesses as it may increase absenteeism and presenteeism (lost productivity while at work), and in the longer term potentially leads to premature withdrawal from the labour market. From a health system perspective, improved well-being potentially will help avoid the use of services for some mental and physical health problems.

Intervention

There are a wide range of approaches to mental health promotion in the workplace, including healthy workplace schemes[159]. These include flexible working arrangements; career progression opportunities; ergonomics and environment; stress audits; and improved recognition of risk factors for poor mental health by line managers. Other measures targeted at general well-being can include access to gyms, exercise and sports opportunities and changes to the canteen food. One study found that Scottish health care workers who were helped to adopt more active commuting habits showed significantly improved mental health[160].

A multi-component health promotion intervention of the sort modelled in the current study consists of personalised health and well-being information and advice; a health risk appraisal questionnaire; access to a tailored health improvement web portal; wellness literature; and seminars and workshops focused on identified wellness issues. A quasi-experimental evaluation of this type of programme has reported significantly reduced stress levels, reduced absenteeism and reduced presenteeism, compared with a control group[161]. Promotion of long-term mental well-being may be associated with reduced longer term risk of poor mental health, although the evidence for this remains weak[162] [163].

The cost of a multi-component intervention is estimated at £80 per employee per year.

Impact

From a business perspective the model appears cost saving compared to taking no action (Table 23). In year 1, the initial costs of £40,000 for the programme are outweighed by gains arising from reduced presenteeism and absenteeism of £387,722. This represents a substantial annual return on investment of more than 9 to 1. In addition there are likely to be benefits to the health system from reduced physical and mental health problems as a result of the intervention, but these are not quantified here.

[159] http://www.london.gov.uk/priorities/health/focus-issues/health-work-and-wellbeing

[160] Mutrie N, Carney D, Blamey A et al (2002) "Walk in to Work Out": a randomised controlled trial of a self help intervention to promote active commuting. Journal of Epidemiology and Community Health 56:407–412.

[161] Mills P, Kessler R, Cooper J, Sullivan S (2007) Impact of a health promotion program on employee health risks and work productivity. American Journal of Health Promotion 22:45–53.

[162] Westerhof GJ, Keyes CL (2010) Mental illness and mental health: the two continua model across the lifespan. Journal of Adult Development 17:110–119.

[163] Keyes C (2007) Promoting and protecting mental health as flourishing: a complementary strategy for improving national mental health. American Psychologist 62:95–108.

Table 26: Total net costs/pay-offs from a business perspective for a company with 500 employees (2009 prices)

	Year 1 (£)
Intervention cost	40,000
Absenteeism (productivity losses)	-110,527
Presenteeism (productivity losses)	-277,195
Total	-347,722

Key points

- A strong case can be made to businesses that workplace well-being interventions can be significantly cost-saving in the short term, but some smaller companies may need public support to implement such schemes.
- The public sector, including the NHS, can also benefit as an employer from improved investment in workplace well-being programmes.

Debt and mental health

Context

Even before the current global financial crisis, it was estimated that 8% of the population had serious financial problems and another 9% showed signs of financial stress[164]. These problems have wide-ranging implications. In particular, research has demonstrated a link between debt and mental health; individuals who initially have no mental health problems but find themselves having unmanageable debts within a 12-month period have a 33% higher risk of developing depression and anxiety-related problems compared to the general population who do not experience financial problems[165].

The vast majority of these mental health problems take the form of depression and anxiety-related disorders. These conditions are associated with significant costs arising from health service use, legal fees, debt recovery and lost productivity. On average, the lost employment costs of each case of poor mental health are £11,432 per annum, while the annual costs of health and social service use are £1,508[166].

Only about half of all people with debt problems seek advice[167], and without intervention almost two-thirds of people with unmanageable debt problems will still face such problems 12 months later.

[164] Fearnley J (2007) Gauging Demand for Free to Access Money Advice: a Discussion Paper. London: Money Advice Trust.
[165] Skapinakis P, Weich, S et al (2006) Socio-economic position and common mental disorders. Longitudinal study in the general population in the UK. British Journal of Psychiatry 189:109–117.
[166] McCrone P, Dhanasiri,S et al (2008) Paying the Price. The Cost of Mental Health Care in England to 2026. London: Kings Fund.
[167] Pleasence P, Buck A et al (2004) Causes of Action: Civil Law and Social Justice. London: Legal Services Commission.

Intervention

The current evidence suggests that there is potential for debt advice interventions to alleviate financial debt, and hence reduce mental health problems resulting from debt. For the general population, contact with face-to-face advice services is associated with a 56% likelihood of debt becoming manageable[168], while telephone services achieve 47%[169]. In comparison, around one-third of problem debt may be resolved without any intervention.

The costs of this type of intervention vary significantly, depending on whether it is through face-to-face, telephone or internet-based services. The Department for Business, Innovation and Skills suggests expenditure of £250 per client for face-to-face debt advice; telephone and internet-based services are cheaper. Funding for debt advice comes from a range of sources including government, NHS, charities and creditors.

Impact

Even under conservative assumptions, investment in debt advice services can both lower expected costs and reduce the risk of developing mental health problems. The intervention appears to be cost-effective from most societal and public expenditure perspectives. However, face-to-face services will only be the most cost-effective option if a high proportion of the costs of providing the service is recovered from creditors. This is feasible: one major not-for-profit debt advice service covers more than 90% of its costs in this way. In other scenarios, where cost recovery is lower, either telephone or web-delivered services will be most cost-effective. Table 24 shows the impact on costs/savings of face-to-face intervention for a hypothetical population of 100,000, compared with no intervention, assuming that one third of the cost of the debt advice is borne by the NHS, with the rest paid for by creditors.

In practice, this type of intervention could be targeted at specific groups who may be particularly vulnerable to financial debt and mental health problems, for example low-income communities.

Table 27: Impact on costs/pay-offs of face-to-face debt intervention (with NHS paying one-third of the costs of the debt advice services) (2009 prices)

	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)
Health and social care	151,512	-13,209	-13,017	-12,829	-12,643
Legal	-87,908	-	-	-	-
Productivity losses	-7,827	-100,128	-98,677	-97,426	-95,837
Net costs/pay-offs	55,777	-113,336	-111,694	-110,075	-108,480

Key points

- In nearly all modelled scenarios, at least one type of debt management intervention has better outcomes and lower costs over a two-year period compared to no action.
- For greatest cost-effectiveness, careful consideration needs to be given to models of financing and to the mix between face-to-face, telephone and web-based provision.

[168] Williams K, Sansom A (2007) Twelve Months Later: Does Advice Help? The Impact of Debt Advice: Advice Agency Client Study. London: Ministry of Justice.

[169] Pleasence P, Balmer NJ (2007) Changing fortunes: results from a randomized trial of the offer of debt advice in England and Wales. Journal of Empirical Legal Studies 4:465–475.

Collaborative care for depression in individuals with Type II diabetes

Context

Depression is commonly associated with chronic physical health problems. NICE has estimated that 20% of individuals with a chronic physical problem are likely to have depression[170], while US data indicate that 13% of all new cases of Type II diabetes will also have clinical depression[171]. These patterns are important as evidence shows that co-morbid depression exacerbates the complications and adverse consequences of diabetes[172], in part because patients may more poorly manage their diabetes. Not only does this increase the risk of disability and premature mortality, it also has substantial economic consequences.

In the UK, compared to people with diabetes alone, individuals with co-morbid depression and diabetes are four times more likely to have difficulties in self-managing their health and seven times more likely to have days off work[173]. In the US, health care costs for those with severe depression and diabetes are almost double those with diabetes alone[174].

Intervention

'Collaborative care' can be delivered in a primary care setting to individuals with co-morbid diabetes and depression. Like 'usual care', collaborative care includes GP advice and care, the use of antidepressants and cognitive behavioural therapy (CBT) for some patients. The difference is that for collaborative care a GP practice nurse acts as a case manager for patients receiving care; GPs also incur additional time costs liaising with practice nurses.

Using a NICE analysis, it is estimated that the total cost of six months of collaborative care is £682, compared with £346 for usual care. A two-year evaluation in the US found that, on average, collaborative care achieved an additional 115 depression-free days per individual; total medical costs were higher in year 1, but there were cost savings in year 2[175].

Impact

Table 25 shows the estimated costs/savings for 119,150 new cases of Type II diabetes in England in 2009, assuming 20% screen positive for co-morbid depression. Completing and successfully responding to collaborative care leads to an additional 117,850 depression-free days in year 1 and 111,860 depression-free days in year 2. According to the model, the intervention results in substantial additional net costs in year 1 due to the costs of the treatment. In year 2, however, there are net savings for the health and social care system due to lower costs associated with depression in the intervention group, plus further benefits from reduced productivity losses. Using a lower 13% rate of co-morbid diabetes and depression, total net costs in year 1 would be more than £4.5m, while net savings in year 2 would be more than £450,000.

[170] NICE (2009) Depression in Adults with Chronic Physical Health Problem: Treatment and Management. London: NICE.
[171] Katon WJ, Von Korff M, Lin EHB et al (2004) The Pathways study: a randomized trial of collaborative care in patients with diabetes and depression. Archives of General Psychiatry 61:1042–1049.
[172] Lloyd CE (2010) Diabetes and mental health: the problem of co-morbidity. Diabetic Medicine 27:853–854.
[173] Das Munshi J, Stewart R, Ismail K et al (2007) Diabetes, common mental disorders, and disability: findings from the UK National Psychiatric Morbidity Survey. Psychosomatic Medicine 69:543–550.
[174] Simon GE, Katon W, Lin EHB et al (2007) Cost effectiveness of systematic depression treatment among people with diabetes mellitus. Archives of General Psychiatry 64:65–72.
[175] Katon W, Unützer J, Fan M et al (2006) Cost-effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression. Diabetes Care 29:265–270.

The study also estimated the incremental cost per Quality-Adjusted Life Year (QALY) gained, which over two years was £3,614. This is highly cost-effective in an English context.

Table 28: Costs/pay-offs of collaborative care for new cases of Type II diabetes screened positive for depression in England (2009 prices)

	Year 1 (£)	Year 2 (£)
Health and social care	7,298,860	-385,240
Productivity losses	-331,170	-314,330
Net cost/pay-off	6,967,690	-699,570

These estimates of the potential benefits are, however, very conservative. The model does not factor in productivity losses due to premature mortality, nor further quality of life gains associated with avoidance of the complications of diabetes, such as amputations, heart disease and renal failure. Nor does the analysis include long-term cost savings from reduced complications. These are potentially substantial: research in 2003 showed that for diabetes-relates cases the average initial health care costs of an amputation were £8,500 and for a non-fatal myocardial infarction £4,000[176]. If, on average, costs of just £150 per year could be avoided for the intervention group, then investment in collaborative care would overall be cost-saving from a health and social care perspective after just two years.

Key points

- The intervention is cost-effective in an English context after two years, but has high net additional costs in the short term due to implementation costs.
- A wider-ranging analysis is merited to demonstrate the potential longer-term savings in health and social care costs due to reduced complications of diabetes.

Befriending of older adults

Context

Befriending initiatives, often delivered by volunteers, provide an 'upstream' intervention that is potentially of value both to the person being befriended and the 'befriender'. For those receiving the intervention, particularly older people, it promotes social inclusion and reduces loneliness[177]; for the befriender, there is the personal satisfaction of contributing to the local community by offering support and skills. Specific potential benefits include the improved mental well-being of the person receiving the intervention, a reduced risk of depression, and associated savings in health care costs.

Intervention

In a typical befriending intervention, a befriender visits a person in their home, usually on a one-to-one basis, where that individual has requested and agreed to such a contact. The intervention is not usually structured and nor does it have formally-defined goals. Instead an informal, natural

[176] Clarke P, Gray A, Legood R, Briggs A, Holman R (2003) The impact of diabetes-related complications on healthcare costs: results from the United Kingdom Prospective Diabetes Study. Diabetic Medicine 20:442–450.
[177] Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA (2006) Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analysis. Psychology and Aging 26:140–151.

relationship develops between the participants, who will usually have been matched for interests and preferences. This relationship facilitates improved mental health, reduced loneliness and greater social inclusion. A recent research review confirmed that, compared with usual care and support (which may mean no intervention at all), befriending has a modest but significant effect on depressive symptoms, at least in the short term[178]. Another evaluation showed decreased depression and anxiety in 5% of people receiving socio-emotional interventions, including befriending[179]. The contact is generally for an hour per week or fortnight. The cost to public services of 12 hours of befriending contact is estimated at £85, based on the lower end of the cost range for befriending interventions[180].

Impact

Using existing estimates of savings associated with reduced treatment of depression[181], the model found total gross cost savings to the NHS were around £40 (at 2008/9 prices) in year 1 for every £85 invested in the intervention. Thus, befriending schemes do not appear to be cost-saving from a public expenditure perspective.

If the analysis includes the quality of life benefits associated with reduced depressive symptoms, then befriending schemes have the potential to create further improvements worth £270 per person and are likely to be cost-effective with an incremental cost effectiveness ratio (ICER) of around £2,900.

Key points

- Befriending interventions are unlikely to achieve cost savings to the public purse, but they do improve an individual's quality of life at a low cost.
- The targeting of at-risk groups (e.g. older people discharged from hospital or mothers at risk of post-natal depression) would potentially offer better returns on an investment in befriending, and this could be explored through further research.

[178] Mead N, Lester H, Chew-Graham C, Gask L, Bower P (2010) Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. British Journal of Psychiatry 196:96–101.
[179] Department of Health (2009) Partnerships for Older People Projects Final Report. London: Department of Health.
[180] Knapp M. Henderson C, Perkins M, Roman A (2009) Brighter Futures Group final report (unpublished). Maidstone: Kent County Council.
[181] Beecham J, Knapp M, Fernandez JL et al (2008) Age Discrimination in Mental Health Services, Discussion Paper. London: PSSRU, LSE.

Policies, strategies, NICE Guidance & best practice

There is a vast array of NICE publications on mental health and related conditions. It is not possible to list them all here but the reader is advised to look these up at the NICE website.
See: http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

However there are some key points on what works to improve mental health and well-being of people with mental health problems:

- Employment support for people with mental health problems
- Information and support for people with mental health problems to improve access to work and social opportunities (for example through day care or primary care services)
- Promotion of positive mental health in schools
- Improved diagnosis and management of common mental disorders in primary care, for example anxiety and depression
- Equitable access to mental health services, for example for BAME communities
- Supporting community involvement for people who are at risk of social isolation or where they are disaffected

Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011.
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)
This strategy focuses on six shared objectives:

i. More people will have good mental health.
ii. More people with mental health problems will recover.
iii. More people with mental health problems will have good physical health.
iv. More people will have a positive experience of care and support.
v. Fewer people will suffer avoidable harm.
vi. Fewer people will experience stigma and discrimination.

The objectives are based on 3 guiding principles.

1. Freedom
2. Fairness
3. Responsibility

The strategy aims to bring about significant change in people's lives. Bringing the changes, for everyone, across the country and in the most effective way, will mean that:

1. Mental health has 'parity of esteem' with physical health within the health and care system.
2. People with mental health problems, their families and carers, are involved in all aspects of service design and delivery.
3. Public services improve equality and tackle inequality.
4. More people have access to evidence-based treatments.
5. The new public health system includes mental health from day one.
6. Public services intervene early.
7. Public services work together around people's needs and aspirations.
8. Health services tackle smoking, obesity and co-morbidity for people with mental health problems.

9. People with mental health problems have a better experience of employment.
10. We tackle the stigma and discrimination faced by people with mental health problems.

DH Analysis of the Impact on Equality (AIE) of the strategy.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135459/dh_123989.pdf.pdf
This document explains and analyses the impact of Equality on six shared objectives identified in the Strategy. The Equality Act 2010 covers nine protected characteristics, and there is a public sector duty to advance equality and reduce inequality for people with these protected characteristics.

There are three aspects to reduce mental health inequality:
1. tackling the inequalities that lead to poor mental health;
2. tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and
3. tackling the inequalities in service provision – in access, experience and outcomes.

Department of Health "No Health Without Mental Health: Implementation framework".
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf

The national policy integrates mental health and physical health and suggests that there should be a collaborative programme of action to achieve the ambition that mental health is on a par with physical health:
1. Local planning and priority setting should reflect the mental health needs of the population. Mental health and wellbeing is integral to the work of CCGs, health and wellbeing boards and other local organisations.
2. To translate the vision into reality, people with mental health, their families and carers should be fully involved in planning, priority setting and delivery of services.
3. Services actively promote equality and are accessible, acceptable, and culturally appropriate to all the communities. Public Bodies meet their obligations under the Equality Act 2010. People including children, young person, older people, and people from ethnic minority should have access to Psychological Therapies.
4. All people receive evidence-based mental health promotion. Schools and colleges promote good mental health for all children and young people, alongside targeted support for those at risk of mental health problems.
5. The Public Health Outcomes Framework (PHOF) includes mental health measures. Local public health services deliver clear plans for mental health.
6. All organisations should recognise the value of promoting good mental health.
7. Public services should recognise and identify people at risk of mental health problems and take appropriate, timely action, including using innovative service models. Early recognition and intervention will enable stopping serious consequences from occurring.
8. Public health campaigns should include people' mental health as well physical health. Services tackle and support people with dual diagnosis and substance misuse to achieve better outcomes and reduce cost.
9. Services working together support people with mental health problems to maintain, or to return to employment.

10. Frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health.

No health without public mental health: The case for action, Royal College of Psychiatrists, 2010

http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

This report describes the key points and features that should be part of a public mental health strategy:

1. There is no public health without public mental health. Investment is needed to promote public mental health. This will enhance population well-being and resilience against illness, promote recovery, and reduce stigma and the prevalence of mental illness.
2. The Royal College of Psychiatrists strongly supports the findings of the Marmot Strategic Review of Health Inequalities in England post 2010. It recognises that inequality is a key determinant of illness, which then leads to even further inequality. Government policy and actions should effectively address inequalities to promote population mental health, prevent mental ill health and promote recovery.
3. Physical health is inextricably linked to mental health. Poor mental health is associated with other priority public health conditions such as obesity, alcohol misuse and smoking, and with diseases such as cancer, cardiovascular disease and diabetes. Poor physical health also increases the risk of mental illness.
4. Interventions which apply across the life course need to be provided. Since the majority of mental illnesses have childhood antecedents, childhood interventions which protect health and well-being and promote resilience to adversity should be implemented. If mental health problems occur there should be early and appropriate intervention. Strategies to promote parental mental health and effectively treat parental mental illness are important since parental mental health has a direct influence on child mental health.
5. Older people also require targeted approaches to promote mental health and prevent mental disorder, including dementia. Action is needed to promote awareness of the importance of mental health and well-being in older age as well as ways to safeguard it. Ageist attitudes need to be challenged and values promoted that recognise the contributions older people make to communities, valuing unpaid, voluntary work as we do economic productivity.
6. An effective public health strategy requires both universal interventions, applied to the entire population, and interventions targeted at those people who are less likely to benefit from universal approaches and are at higher risk, including the most socially excluded groups. Such groups include children in care or subject to bullying and abuse, people of low socioeconomic status, those who are unemployed or homeless, those with addictions or intellectual disability, and other groups subject to discrimination, stigma or social exclusion. Health promotion interventions are particularly important for those recovering from mental illness or addiction problems. Those with poor mental health as well as poor physical health require effective targeted health promotion interventions.
7. The prevention of alcohol-related problems and other addictions is an important component of promoting population health and well-being. The College supports the development of a minimum alcohol pricing policy and a cross-government, evidence-based addictions policy.
8. Smoking is the largest single cause of preventable death and health inequality. It occurs at much higher rates in those with mental illness, with almost half of total tobacco consumption and smoking-related deaths occurring in those with mental disorder. Therefore, mental health needs to be mainstreamed within smoking prevention and cessation programmes.

9. A suicide prevention strategy should remain a government priority and should include strategies to address and reduce the incidence of self-harm.
10. Collaborative working is required across all government departments in view of the cross-government benefits of public mental health interventions across a range of portfolios, such as education, housing, employment, crime, social cohesion, culture, sports, environment and local government. Actions to combat stigma related to mental illness should be included in these strategies.
11. Doctors can be important leaders in facilitating local and national implementation of public mental health strategies. Many psychiatrists already adopt a public mental health approach in their work and influence national and local strategy. Psychiatrists should be supported in assessing the needs of their local population for health promotion.
12. Psychiatrists should be engaged in the commissioning process and inform commissioners of the expected prevalence of specific disorders to anticipate levels of service provision and unmet need, and to help prioritise resource allocation. Support and training are required to facilitate this.
13. Commissioners should take into account the effects of mental health and mental illness across the life course as well as the economic benefits of protecting and promoting mental health and well-being.
14. Commissioners should consider the existing arrangements and adequacy of services for comorbid disorders and unexplained medical symptoms where cost-effective interventions could be provided.

Closing the Gap: Priorities for essential change in mental health, Department of Health, February 2014 (V2)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

This document aims to bridge the gap between the governments' long-term ambition (as stated in No Health Without Mental Health) and shorter-term action. It seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems.

It sets out 25 areas where people can expect to see, and experience, the fastest changes. These are the priorities for action: issues that current programmes are beginning to address and where the strategy is coming to life. The 25 areas are:

1. Commissioning high-quality mental health services with an emphasis on recovery in all areas, reflecting local need
2. Leading an information revolution around mental health and wellbeing
3. Establishing clear waiting time limits for mental health services
4. Tackling inequalities around access to mental health services
5. Over 900,000 people benefitting from psychological therapies every year
6. Improving access to psychological therapies for children and young people across the whole of England
7. The most effective services will get the most funding
8. Giving adults the right to make choices about the mental health care they receive
9. Radically reducing the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor
10. Using the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services

11. Identifying poor quality services sooner and taking action to improve care and where necessary protect patients
12. Supporting carers better and being more closely involved in decisions about mental health service provision
13. Integrating mental health care and physical health care better at every level
14. Changing the way frontline health services respond to self-harm
15. Ensuring that no-one experiencing a mental health crisis is turned away from services
16. Offering better support to new mothers to minimise the risks and impacts of postnatal depression
17. Supporting schools to identify mental health problems sooner
18. Ending the cliff-edge of lost support as children and young people with mental health needs reach the age of 18
19. People with mental health problems will live healthier lives and longer lives
20. More people with mental health problems will live in homes that support recovery
21. Introducing a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided
22. Offering anyone with a mental health problem who is a victim of crime enhanced support
23. Supporting employers to help more people with mental health problems to remain in or move into work
24. Developing new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work
25. Stamping out discrimination around mental health

NICE Clinical Guideline CG 178: Psychosis and schizophrenia in adults: treatment and management, Feb 2014
http://www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf

This guideline covers the treatment and management of psychosis and schizophrenia and related disorders in adults (18 years and older) with onset before 60 years. The term psychosis' is used in this guideline to refer to the group of psychotic disorders that includes schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder**.**

A summary of the key recommendations are:

Care across all phases

- Health care professionals should work in partnership with people with schizophrenia and their carers, offer help; treatment and care in an atmosphere of hope and optimism; take time to build supportive and empathic relationships.
- Healthcare professionals inexperienced in working with people with psychosis or schizophrenia from diverse ethnic and cultural backgrounds should seek advice and supervision from healthcare professionals who are experienced in working transculturally.
- Mental health services should work with local voluntary black, Asian and minority ethnic groups to jointly ensure that culturally appropriate psychological and psychosocial treatment, consistent with this guideline and delivered by competent practitioners, is provided to people from diverse ethnic and cultural backgrounds.
- People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.

- Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential impact of reducing nicotine on the metabolism of other drugs, particularly clozapine and olanzapine.
- Consider one of the following to help people stop smoking:
  - nicotine replacement therapy (usually a combination of transdermal patches with a short-acting product such as an inhalator, gum, lozenges or spray) for people with psychosis or schizophrenia **or**
  - bupropion[1] for people with a diagnosis of schizophrenia **or**
  - varenicline for people with psychosis or schizophrenia.
- For people in inpatient settings who do not want to stop smoking, offer nicotine replacement therapy to help them to reduce or temporarily stop smoking.

Support for carers

- Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.
- Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.
  - Give carers written and verbal information in an accessible format about:
  - diagnosis and management of psychosis and schizophrenia
  - positive outcomes and recovery
  - types of support for carers
  - role of teams and services
  - getting help in a crisis.
- When providing information, offer the carer support if necessary.
- As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers, and respects their individual needs and interdependence.
- Offer a carer-focused education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should:
  - be available as needed
  - have a positive message about recovery.

Preventing psychosis

- Refer a person without delay to a specialist mental health service or an early intervention in psychosis service for assessment of risk of developing psychosis if the person is distressed, has a decline in social functioning and has:
  - transient or attenuated psychotic symptoms or
  - other experiences or behaviour suggestive of possible psychosis or
  - a first-degree relative with psychosis or schizophrenia
- If a person is considered to be at increased risk of developing psychosis:
  - offer individual cognitive behavioral therapy (CBT) with or without family intervention **and**

  - offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse.
- Do not offer antipsychotic medication:
  - to people considered to be at increased risk of developing psychosis **or**
  - with the aim of decreasing the risk of or preventing psychosis.

First episode psychosis

- Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis.
- Assess for post-traumatic stress disorder and other reactions to trauma because people with psychosis or schizophrenia are likely to have experienced previous adverse events or trauma associated with the development of the psychosis or as a result of the psychosis itself. For people who show signs of post-traumatic stress, follow the recommendations in Post-traumatic stress disorder (NICE clinical guideline 26).
- Write a care plan in collaboration with the service user as soon as possible following assessment, based on a psychiatric and psychological formulation, and a full assessment of their physical health. Send a copy of the care plan to the primary healthcare professional who made the referral and the service user.
- For people who are unable to attend mainstream education, training or work, facilitate alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.
- The secondary care team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.
- Discuss any non-prescribed therapies the service user wishes to use (including complementary therapies), and the use of alcohol, tobacco, prescription and non-prescription medication and illicit drugs with the service user, and carer if appropriate.

Subsequent acute episodes of psychosis or schizophrenia and referral in crisis

- Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it.
- Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals.
- Offer:
  - CBT to all people with psychosis or schizophrenia
  - family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user

  This can be started either during the acute phase or later, including in inpatient settings.

Promoting recovery and possible future care

- GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive,

focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in “Before starting antipsychotic medication” section of this guidance and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist, and put in the secondary care notes.

- Identify people with psychosis or schizophrenia who have high blood pressure, have abnormal lipid levels, are obese or at risk of obesity, have diabetes or are at risk of diabetes (as indicated by abnormal blood glucose levels), or are physically inactive, at the earliest opportunity following relevant NICE guidance (CG 67, 38, 43, 127, 25, 44).
- Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.

NICE Quality Standard QS53: Anxiety disorders, Feb 2014
http://publications.nice.org.uk/anxiety-disorders-qs53

Many anxiety disorders go unrecognised or undiagnosed. Most of those that are diagnosed are treated in primary care. However, recognition of anxiety disorders in primary care is poor and only a small minority of people experiencing anxiety disorders ever receive treatment. When anxiety disorders coexist with depression, the depressive episode may be recognised without detecting the underlying and more persistent anxiety disorder. For people who use services for anxiety disorders, treatment is often limited to the prescription of drugs. This may be partly because evidence-based psychological services are not universally available.

The quality standard for anxiety disorders specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole anxiety disorders care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with anxiety disorders in primary and secondary care.

List of quality statements
Statement 1: People with a suspected anxiety disorder receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.
Statement 2: People with an anxiety disorder are offered evidence-based psychological interventions.
Statement 3: People with an anxiety disorder are not prescribed benzodiazepines or antipsychotics unless specifically indicated.
Statement 4: People receiving treatment for an anxiety disorder have their response to treatment recorded at each treatment session.

NICE public health guidance PH48: Smoking cessation in secondary care: acute, maternity and mental health services, Nov 2013
http://www.nice.org.uk/nicemedia/live/14306/65863/65863.pdf

Stopping smoking at any time has considerable health benefits for people who smoke, and for those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.

Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services.

This guidance aims to support smoking cessation, temporary abstinence from smoking and Smoke free policies in all secondary care settings. It recommends:

- Strong leadership and management to ensure secondary care premises (including grounds, vehicles and other settings involved in delivery of secondary care services) remain smoke free – to help to promote non-smoking as the norm for people using these services.
- All hospitals have an on-site stop smoking service.
- Identifying people who smoke at the first opportunity, advising them to stop, providing pharmacotherapy to support abstinence, offering and arranging intensive behavioural support, and following up with them at the next opportunity.
- Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care, to help people abstain from smoking, at least while using secondary care services.
- Ensuring continuity of care by integrating stop smoking support in secondary care with support provided by community-based and primary care services.
- Ensuring staff are trained to support people to stop smoking while using secondary care services.
- Supporting all staff to stop smoking or to abstain while at work.
- Ensuring there are no designated smoking areas, no exceptions for particular groups, and no staff-supervised or staff-facilitated smoking breaks for people using secondary care services.

NICE Clinical Guideline CG 120: Psychosis with coexisting substance misuse, 2011
http://www.nice.org.uk/nicemedia/live/13414/53731/53731.pdf

Key priorities for implementation

Working with adults and young people with psychosis and coexisting substance misuse

- When working with adults and young people with known or suspected psychosis and coexisting substance misuse, take time to engage the person from the start, and build a respectful, trusting, non-judgemental relationship in an atmosphere of hope and optimism. Be direct in your communications, use a flexible and motivational approach, and take into account that:
  - stigma and discrimination are associated with both psychosis and substance misuse
  - some people will try to conceal either one or both of their conditions
  - many people with psychosis and coexisting substance misuse fear being detained or imprisoned, being given psychiatric medication forcibly or having their children taken into care, and some fear that they may be ‘mad’.

Recognition of psychosis with coexisting substance misuse in adults and young people

- Healthcare professionals in all settings, including primary care, secondary care mental health services, child and adolescent mental health services (CAMHS) and accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs. If the person has used substances ask them about all of the following:
  - the particular substance(s) used

- the quantity, frequency and pattern of use
- route of administration
- duration of current level of use.

In addition, conduct an assessment of dependency (see 'Drug misuse: opioid detoxification' [NICE clinical guideline 52] and 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence' [NICE clinical guideline 115]) and also seek corroborative evidence from families, carers or significant others1, where this is possible and permission is given.

Secondary care mental health services

- Healthcare professionals working within secondary care mental health services should ensure they are competent in the recognition, treatment and care of adults and young people with psychosis and coexisting substance misuse.
- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental healthcare because of their substance misuse.
- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate substance misuse services because of a diagnosis of psychosis.
- Consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services for adults and young people with psychosis being treated by community mental health teams, and known to be:
  - severely dependent on alcohol or
  - dependent on both alcohol and benzodiazepines or
  - dependent on opioids and/or cocaine or crack cocaine.

  Adult community mental health services or CAMHS should continue to provide care coordination and treatment for the psychosis within joint working arrangements.

Substance misuse services

- Healthcare professionals in substance misuse services should be competent to:
  - recognise the signs and symptoms of psychosis
  - undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services.

Inpatient mental health services

- All inpatient mental health services should ensure that they have policies and procedures for promoting a therapeutic environment free from drugs and alcohol that have been developed together with service users and their families, carers or significant others. These should include: search procedures, visiting arrangements, planning and reviewing leave, drug and alcohol testing, disposal of legal and illicit substances, and other security measures. Soon after admission, provide all service users, and their families, carers or significant others, with information about the policies and procedures.

Specific issues for young people with psychosis and coexisting substance misuse

- Those providing and commissioning services should ensure that:
  - age-appropriate mental health services are available for young people with psychosis and coexisting substance misuse and
  - transition arrangements to adult mental health services are in place where appropriate.

Hidden Harm, Advisory Council on the Misuse of Drugs (AMCD) , June 2011
https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users
A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them- the "hidden harms" of substance misuse. In June 2011, the Advisory Council on the Misuse of Drugs (AMCD) published an enquiry "Hidden Harm", which sets out 48 recommendations and 6 key messages.

The six key messages were:
1. We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user.
2. Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.
3. Reducing the harm to children from parental problem drug use should become a main objective of policy and practice.
4. Effective treatment of the parent can have major benefits for the child.
5. By working together, services can take many practical steps to protect and improve the health and well-being of affected children.
6. The number of affected children is only likely to decrease when the number of problem drug users decreases.

What works to improve mental wellbeing in older people (NICE 2008)
- Occupational therapy involvement in the design and development of locally relevant training schemes for those working with older people
- Advice and support to older people and carers
- Regular sessions based on occupational therapy principles to aid daily routine activities
- Advice and information on health, personal care, safety and other issues
- Commissioning tailored exercise programmes
- Developing, organising and promoting walking schemes

Follow the link for further information on the guidance
http://pathways.nice.org.uk/pathways/mental-wellbeing-and-older-people

NICE Clinical Guideline CG 123: Common mental health disorders: Identification and pathways to care, 2011
http://www.nice.org.uk/guidance/CG123
This guideline offers advice on the identification and the care of adults who have common mental health disorders with a particular focus on primary care.

The priorities for implementation are:
1. Improving access to services: Services need to be integrated for delivery, with clear explicit criteria for entry to the services, focused on entry and not on exclusion criteria. There should be multiple ways to entry to the services including self-referral, multiple points of access with links to wider health care system. People with common mental health problem should be provided with information about services and available treatments according to their knowledge and understanding of mental health disorders appropriate to the communities. Local care pathways should promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system and ex-service personnel.

2. Stepped care: Use of stepped-care model to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals, is the most effective way of interventions.
3. Identification and assessment: It is important to identify early possible depression particularly in people with a past history, and assessment should be done by competent staff and provide appropriate treatment and referral accordingly.
4. Treatment and referral for treatment
5. Developing local care pathways: Collaborative local care pathway needs to be developed for people with common mental health problems. Local care pathway should promote implementation of the key principles of good care. It should be negotiable, workable, accessible and acceptable by wider communities who are in need of the services. It should be outcome focused.

NICE Quality Standard QS8: Depression in adults, 2011

http://www.nice.org.uk/guidance/QS8

This quality standard covers the assessment and clinical management of persistent subthreshold depressive symptoms, or mild, moderate or severe depression in adults (including people with a chronic physical health problem).

NICE Quality Standard QS14: Service user Experience in adult mental health, 2011

http://guidance.nice.org.uk/QS14

This quality standard outlines the level of service that people using the NHS mental health services should expect to receive. It covers improving the experience of people using adult NHS mental health services. It does not cover mental health service users using NHS services for physical health problems, or the experiences of families or carers of people using NHS services specifically.

National Dementia Strategy, "Living Well with Dementia", 2009

https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

The National Dementia Strategy, 'Living Well with Dementia' (2009) provides a 5 year plan toward the development of dementia care services that are fit for the 21st Century. The aim of the Strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. The Strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia.

NICE Quality Standard for supporting people to live well with dementia (QS30), April 2013

http://publications.nice.org.uk/quality-standard-for-supporting-people-to-live-well-with-dementia-qs30

This quality standard covers supporting people to live well with dementia. It applies to all social care settings and services working with and caring for people with dementia. It should be read alongside the NICE dementia quality standard (QS1) (below), which covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings.

NICE Dementia Quality Standard (QS1), June 2010

http://publications.nice.org.uk/dementia-quality-standard-qs1

This quality standard covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist

care settings. It should be read alongside the NICE supporting people to live well with dementia quality standard (QS30), which applies to all social care settings and services working with and caring for people with dementia.

Guidance for commissioners of older people's mental health services, Joint Commissioning Panel for Mental Health, 2013
http://www.helplines.org/uploads/1/1/2/5/11258169/jcpmh-olderpeople-guide.pdf

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities.

The guidance provides key recommendations to commissioners:
Older people's mental health services in particular benefit from an integrated approach with social care services. Most patients in older age mental health services have complex social needs. Commissioners should ensure service providers across agencies work together if they are to meet people's needs and aspirations effectively. A whole system approach that draws together the expertise of health and social care agencies and those in the voluntary sector will deliver a comprehensive, balanced range of services, which places as much emphasis on services that promote independence as on care services.

Older people's mental health services need to work closely with primary care and community services. Models that include primary care 'in-reach' or joint working with community physical health care services, provide more co-ordinated care and should be the norm.

Services must be commissioned on the basis of need and not age alone. Older people's mental health services should not be subsumed into a broader 'adult mental health' or 'ageless service'. The needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people.

Older people's mental health services must address the needs of people with functional illnesses such as depression and psychosis as well as dementia. The majority of the mental illness experienced by older people is not dementia and there is significant crossover between dementia and functional illnesses such as depression and psychosis.

Older people often have a combination of mental and physical health problems. Commissioners and service providers need to seek and exploit opportunities for joint working and service delivery that can address both physical and mental health needs. Older people with long-term health conditions make up the greater proportion of this care group. Having more than one long-term condition greatly increases the risk of depression. Planning and delivering an integrated service to manage service delivery to this group through joint working protocols will be the best and most cost-effective way to manage care.

Older people's mental health services must be multidisciplinary. Medical doctors are important because of the complex physical and treatment issues common in older people, but given the complex needs of this group, integrated input from nurses, psychologists, physiotherapists, occupational therapists and speech and language therapists is necessary.

Older people with mental health needs should have access to community crisis or home treatment services. With extended hours of working and intensive crisis management, home treatment workers help to reduce the need for admission, facilitate early discharge and reduce transfer to residential care.

Older people with mental health needs respond well to psychological input. Evidence shows that response rates amongst older people are as good as those of younger adults. The spectrum of psychological service provision at all tiers needs to reflect this.

Older people should have dedicated liaison services in acute hospitals. Over 60% of older people in acute hospital wards have a serious mental disorder which is often unrecognised and delays rehabilitation and discharge. Commissioners must ensure appropriate specialist liaison services are in place with relevant discharge care plans and support from secondary care mental health teams.

Merton's Joint Commissioning Strategy 2010-2015 is built around the outcome objectives of the National Dementia Strategy, 'Living Well with Dementia' (2009). In particular Merton is focussing on raising awareness and understanding of dementia, and ensuring early diagnosis and support. A newly commissioned 'Dementia Hub' delivered with the Alzheimer's Society will implement these objectives. Service outcomes will include enhanced quality of life for people with care and support, ensuring people have a positive experience of this care and support, and delaying or reducing the need for council funded social care.

The Triangle of Care- Carers Included: A Guide to Best Practice in Mental Health Care in England, Second Edition, 2013.
http://static.carers.org/files/the-triangle-of-care-carers-included-final-6748.pdf

The Triangle of Care is a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing.

The key elements to achieving a Triangle of Care
The essence of this guide is to clearly identify the six key elements (standards) required to achieve better collaboration and partnership with carers in the service user and carer's journey through mental health services. For each element we suggest good practice examples and resources that may be helpful. The six key standards state that:
1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols re: confidentiality and sharing information are in place.
4) Defined post(s) responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available.

In addition to the above, there also needs to be regular assessing and auditing to ensure these six key standards of carer engagement exist and remain in place. A self-assessment audit tool for carer engagement is included in the report.

What are the gaps in Merton?

1. **Equity issue: Under-representation of Asians and over-representation of black minority ethnic groups**
   Analysis of the data clearly indicates which groups are the most vulnerable in Merton and which groups needs to be therefore targeted more effectively. Black ethnicities are over-represented (in-patients) and Asians significantly under-represented (both in-patients and Community Mental Health Services-CMHS) in our mental health services. In the case of Asian communities this under-representation suggests inequity in access and cultural taboos and stigma associated with mental illness. In Black ethnicities the over-representation could be due to the underlying risks of mental illness in different ethnicities, but it is possible that a number of patients are being diagnosed later and with more severe symptoms, who could have otherwise been managed in the community. More targeted work is required with these communities and there is a need to develop services that are more accessible to BME groups- especially Asians.

2. **Services that address the dual diagnosis of substance misuse and mental ill-health and hidden harms**
   Psychoactive substances are the most common cause for community mental health referrals and the second most common cause for in-patient admissions in working age adults in Merton. The overwhelming majority of these were for alcohol related problems. The issue of dual diagnosis is a significant one for Merton - with so many admissions and referrals due to psychoactive substances, increased focus is required on prevention and early detection in addition to treatment. The 'hidden harms' aspects of this are likely to be considerable, i.e. the impact on children living with parent(s) with dual diagnosis. There could be potential safe-guarding risks, crime-related issues and a wider reputational risk to both London Borough of Merton and the NHS. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

3. **Personality disorders (PD)**
   Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

4. **Primary care variation by practice, variable quality outcomes and under-diagnosis**
   Findings suggest that in primary care there is considerable variation by practice, variable quality of outcomes and under-diagnosis. The 2012-13 QOF data for both depression and dementia suggest that at primary care level, there is under-diagnosis of both in Merton, and that there is considerable variation between GP practices especially when comparing the GPs in East Merton (where the data indicates even more under-diagnosis) with those in West Merton.

   While the latest HSCIC data on further assessment of depression severity is reported for 2011-12 and is for Sutton and Merton PCT, it suggests that we have the lowest percentage of patients undergoing further assessment of depression in SW London, lower than some statistical neighbours and lower than England. 2012-13 QOF data suggests considerable variation by GP practices in Merton, and that in East Merton especially for MH 17 - The

percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, and MH 18 - The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months- there are more practices which have low percentages compared to GP practices elsewhere in Merton.

NHS Dementia Prevalence Calculator indicates that the current detection rate of dementia in Merton is 47% (CQUIN data Q3 2013-14) which is better than many of our geographical and statistical neighbours but still means that there are estimated to be 1,057 undiagnosed dementia cases in Merton in 2014-15. There is an on-going refresh of the Merton dementia strategy to deal effectively with this.

5. **Primary Care management of the physical health of Merton residents with schizophrenia**
Findings suggest that more work is required to ensure the physical health of Merton residents with schizophrenia is better managed at primary care level. While emergency hospital admissions for schizophrenia in Merton are among the lowest in London and lower than all our SW London and statistical neighbours, the 2014 NEPHO SMI profile for Merton indicates that Merton has a significantly higher than average percentage of mental health service users who were inpatients in a psychiatric hospital and that Merton has a significantly higher than average (England) percentage of mental health service users who were inpatients in a psychiatric hospital. Local data indicates that admissions and referrals for schizophrenia are also increasing. This could be reflecting an increase in the prevalence of psychosis in Merton. HSCIC data indicates that in Merton the follow-up of non-attendance at annual review among patients with psychoses is among the lowest in SW London (especially considering that Kingston and Richmond PCTs achieved 100%), lower than Ealing and Harrow PCTs among statistical neighbours, and lower than England. For 2012-13 QOF indicators MH 16 (The percentage of patients aged from 25 to 64 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years) and MH19 (The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 15 months) the GP practices in Merton do not perform very well and there is considerable variation between practices and by East-West Merton.

6. **Referrals to community mental health services**
In terms of referrals to community mental health services in Merton, 44% were from GPs & the next largest sources of referrals were internal (16%) and then Accident & Emergency services (12%). While it is encouraging that GP referrals were the highest, this could be improved further. Furthermore it appears that GPs in East Merton are making fewer referrals than West Merton GPs. There were fewer referrals from the Merton Local Authority (including Adult Social Care, Education & other departments) combined (2.6%) than Merton residents who self-referred (2.9%) . This perhaps indicates that more training and awareness raising is required for front-line staff (in all sectors including Metropolitan Police) on detecting the signs of mental ill health, local services and pathways, and how and where to refer someone to. The DH policy "No Health Without Mental Health" states that frontline workers, across the full range of services, are to be trained to understand better about mental health, the principles of recovery and be able to tackle any stigma related to mental health[182].

[182] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

7. IAPT services

In terms of IAPT services, Merton has the lowest proportion of cases that moved to recovery in SW London and compared with the London average. From August 2012- August 2013, the recovery rate for Merton was 35.7% against a local target of 43% and a national target of 50%. This has been the case for some years as the NEPHO 2014 community MH profile indicates that in 2012/13 the IAPT recovery rate at 37.9% was significantly worse than England (45.9%). The percentage of referrals waiting less than 28 days for IAPT services are significantly lower than average but in contrast for waiting times greater than 90 days Merton has significantly higher than average percentages. This could mean that more referrals are waiting over 90 days than they are less than 28 days. Merton CCG is undertaking a specific project to look at the IAPT service and how it can be made more effective.

8. Smoking and mental health

Smoking and mental health have very strong and significant links. SWLStG MH NHS Trust has had a CQUIN on smoking since 2010-11 and this ends in March 2014. Data provided by the Trust suggests that an effective smoking cessation service had been established although it was unclear from the data what the disaggregated figures for Merton were. This service is meant to be mainstreamed into SWLStG MHT but there is a risk to the service till it is assured that this has indeed happened.

9. Gaps expressed by service users in consultations

Although the consultations in the qualitative study identified a variety of both positive and negative experiences of mental health services in Merton, the views expressed by service users and carers were for the most part critical. Service users' main concerns in this study were around continuing attitudes to mental illness, experience of care, and cuts in services. Their most prominently expressed issues with Merton's mental health provision were the loss of drop-in/day centres, perceived powerlessness in influencing their care and services that where dominated by a medical approach to treatment.

10. Gaps expressed by carers in consultations

The most important issues for carers were their poor involvement in decisions about the care, properly informed sessions, providing support in the areas of training in managing specific situations. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

11. Cultural competence of services

BME service users and carers reported particular challenges in different areas, exposing the importance of developing cultural competence within the mainstream services along with targeted provision specifically tailored to their unique needs. The data stated earlier, which shows that black ethnicities were over-represented and Asians significantly under-represented, back this expressed need. Furthermore this is specifically emphasized in the DH policy, "No Health without Mental Health"[183] and the implementation framework[184] which state that services should actively promote equality and must be accessible, acceptable, and culturally appropriate to all the communities. Public Bodies must meet their obligations under the Equality Act 2010.

[183] Department of Health published a cross-government strategy on mental health "No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages" in 2011. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/135457/dh_124058.pdf.pdf)

[184] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156084/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf.pdf

Service providers offered insights into the main strategies they employed to deliver more user-responsive services. These were:

e. Adopting a more open and candid approach with users informed by the policy recommendations of the Francis report.
f. Established feedback and stepped complaints procedures
g. Developing different ways of working, and
h. Fostering partnership working.

Staff training and education underpinned all four approaches.

Health and social care recommendations

The recommendations stem from the gaps identified in the previous section. The recommendations are directed towards all commissioners, health planners, service providers, the voluntary sector and other relevant professionals and organisations. All decisions on mental health and social care should be underpinned by the principles that follow.

Overarching principles

Life-course, "stepped-down" approach to mental health
Services should be based around individuals to promote recovery and enable independence. A life-course, "stepped-down" approach should be adopted to mental health that takes into account the economic benefits of protecting and promoting mental health and well-being. Such approaches should encompass early intervention, prevention, recovery, well-being and reducing mortality, and should consider care pathways from childhood through older adulthood, providing age and culturally appropriate, evidence-based prevention and care at the earliest stage possible, with a view of acting early and effectively, so that care at subsequent stages can be stepped down.

Prevention, early detection, rehabilitation
Services should span across the whole spectrum, from prevention, early detection, intervention and treatment through to rehabilitation. Since the majority of mental illnesses have childhood antecedents, childhood interventions which protect health and well-being and promote resilience to adversity should be implemented.

Care pathway development
Clear and unambiguous care pathways must be developed that cover all facets of mental health support and services in Merton, extending back to the community to ensure that prevention is included and that all front-line workers are aware of how Merton residents can be referred to these services.

"Whole family" approach
Since parental mental health has a direct influence on child mental health, strategies to promote parental mental health and effectively treat parental mental illness are important[185]. The treatment of parent(s) with mental ill health needs to address the needs of dependent children as well, enabling parent(s) to fulfil their role(s) as primary carer(s). This requires a "whole family" approach to treating mental illness.

Whole systems approach
A whole system approach should be adopted, that draws together the expertise of health and social care agencies and those in the voluntary sector to deliver a comprehensive, balanced range of services, placing as much emphasis on services that promote independence as it does on care services, as well as the physical health of those with mental health conditions.

Mental health inequalities
In designing mental health services, care should be paid to addressing any health inequalities in service provision and the access to these services. An effective public health strategy requires

[185] No health without public mental health: The case for action, Royal College of Psychiatrists, 2010; http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

both universal interventions, applied to the entire population, and interventions focussed at those people who are less likely to benefit from universal approaches and are at higher risk[186].

Service user and carer involvement
People with mental health problems, their families and carers, should continue to be involved in all aspects of service design and delivery.

Re-aligning services and budgets to deliver a stream-lined, integrated care pathway
Opportunities for joint working and service delivery that can address both physical and mental health needs must be sought and exploited. This includes re-aligning budgets where feasible, so that the appropriate services and interventions can be commissioned jointly by multiple partners in the most cost-effective way.

Quality and safety standards of commissioned services
Services must meet national quality and safety standards laid down by bodies such as NICE & CQC. The report of the current CQC inspection of SWLStG MHT will help to determine the quality and safety of our mental health services.

Recommendations

1. Promoting Mental Health and Wellbeing

1.1. **Promoting public mental health**

There is growing emphasis to promote mental wellbeing of the whole population, as well as an on-going commitment to reducing health inequalities in health (there are separate recommendations on health inequalities included in recommendation 4).

a. It is recommended that steps are taken to promote positive mental health and wellbeing and prevent mental ill-health, taking a life-course approach.

b. This encompasses taking a whole community approach to recovery, addressing factors that influence mental wellbeing for everyone, whether or not they have a diagnosis; and creating environments and cultures that support wellbeing from schools and colleges, to work places and on the streets.

1.2. **Smoking cessation and healthy lifestyles**

a. As of 31st March 2014, the CQUIN on smoking cessation services for SWLStG MHT will cease to exist. It must be ensured that the Trust embeds this service in line with NICE public health guidance PH48 and that an on-site stop smoking services continues to be provided.
b. Smoking cessation support to Merton residents with mental ill-health must also be provided by community-based and primary care service and mental health should be mainstreamed within general smoking prevention and cessation programmes in the borough.

[186] No health without public mental health: The case for action, Royal College of Psychiatrists, 2010 http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf

c. It is recommended that all patients on GP Practice's SMI register who smoke should be routinely referred to LiveWell for smoking cessation advice.

d. It must be ensured that people with diagnosed mental illnesses, especially psychosis or schizophrenia and those taking antipsychotics are offered a combined healthy eating and physical activity programme by their mental healthcare provider[187].

e. The percentage of adults participating in recommended levels of physical activity is lower in Merton than the London and England averages and this percentage must be increased as the link between physical activity and mental health and wellbeing is well established.

1.3. **Promoting mental wellbeing early in life**

a. The most important opportunities for prevention of mental illness and promotion of mental health wellbeing lie in childhood, many of them in the context of the family. *The most important modifiable risk factor for mental health problems in childhood, and thus in adult life in general, is parenting*[188].

b. The key way to reduce risk in very early childhood is to promote healthy parenting focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating). Parental mental illness and parental lifestyle behaviours such as smoking, and drug and alcohol misuse are important risk factors for childhood mental health problems[189].

c. Schools offer another important opportunity for promotion and prevention. School, school ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health[190]. Mental health promotion programmes that can modify these factors, and also mitigate mental health problems initiated from within the family, must be provided in schools in Merton.

1.4. **Enabling more people with mental ill-health to remain in or move into work**

People with mental ill health frequently experience high levels of unemployment. Conversely people who are not in employment are more susceptible to mental ill health. For people with mental ill health who are unable to attend mainstream education, training or work, London Borough of Merton should ensure that commissioned services are effective in providing alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.

[187] NICE Clinical Guideline CG 178: Psychosis and schizophrenia in adults: treatment and management, Feb 2014 http://www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf

[188] http://www.fph.org.uk/parenting

[189] Göpfert M, Webster J, Seema MV, (eds). Parental psychiatric disorder: distressed parents and their families. Cambridge, CUP 2004

[190] Weare K. Promoting mental, emotional, and social health: a whole school approach. Psychology Press, 2000

1.5. **Providing good quality housing**

a. There is an extensive body of academic, policy-related and community based literature that describes the powerful nature of housing as a social determinant of population health. The relationship that exists between poor housing (or a lack of housing) and poor mental and physical health is well-documented[191][192]. The spectrum of accommodation in Merton, from high to low dependency and independent accommodation for people with mental health need should be reviewed, in order to establish the current needs, to enable forward planning for the future provision of housing and support options for people with mental health needs.

b. LBM should consider how Merton can benefit from the Department of Health recently allocating up to £43 million from the Care and Support Specialised Housing (CASSH) Fund[193] to support the construction of a small number of housing projects for people with mental health problems or learning disabilities. These projects will be designed in close conjunction with mental health and learning disability policy experts and representatives of relevant charities. Their ambition is to receive bids from potential developers by 2015 and seeing some homes available by 2017.

1.6. **Workplace wellbeing**

a. All employers in Merton (including in LBM and MCCG) should be sensitive to the potential mental health issues underlying sickness absence. They should ensure adequate occupational health provision, and through employee assistance programmes, employees are supported to prevent the build-up of unmanageable stress, and healthy workplaces are actively promoted. Evidence states that workplace screening for depression and anxiety disorders is cost-effective, with the benefits gained through the reduction in levels of absenteeism, and improved productivity through reduction in presenteeism.

b. Public Health Merton is currently developing a Merton workforce strategy based on absence research that is looking at the reasons behind the sickness absence rates in the London Borough of Merton (Council). Work related stress comes up in the findings as an important reason. It is recommended that the findings of this report are taken into account while considering measures to create a healthy workplace.

2. Parental and child mental health

The following generic recommendations are sourced from national policy documents[194] [195] and it is suggested that the Merton Local Safeguarding Children's Board (LSCB) partners should assure themselves and the LSCB that these are embedded in local practice.

[191] Jacobs DE, Wilson J, Dixon SL, Smith J, Evens A. *The Relationship of Housing and Population Health: A 30-Year Retrospective Analysis Environmental Health Perspectives*. 2009;117(4):597–604

[192] Canadian Institute for Health Information. *Improving the Health of Canadians: Mental Health and Homelessness*. Ottawa: Canadian Institute for Health Information; 2007.

[193] Closing the gap: priorities for essential change in mental health, February 2014; Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

[194] What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems; Ofsted March 2013, Ref no. 130066.

[195] Cleaver H, Unell I and Aldgate J; Children's Needs- Parenting Capacity, Child Abuse: Parental mental illness, learning disability, substance misuse, and domestic violence; 2nd Edition, TSO (The Stationery Office); Norwich, 2011.

2.1 **The Local Safeguarding Children's Board (LSCB) should assure that**:
Structures are in place for joint training and joint supervision to ensure that all children's and adult services practitioners working with families affected by mental health difficulties and/or drug and alcohol problems have a thorough understanding of the impact of these difficulties on children and the opportunity to reflect together on their joint responsibilities in tackling concerns.

2.2 **Adult mental health services should:**

a. increase awareness of the role of adult mental health professionals in safeguarding the children of adult service users

b. orient early identification and assessment to ensure children and young people living with parental mental illness, learning disability, substance misuse and domestic violence, are not left in dangerous and abusive situations. Early identification depends on ensuring children and young people have opportunities to discuss their experiences with a trusted adult.

c. review recording systems to ensure that information about children is set out clearly and in sufficient detail to establish children's needs and risks, to identify young carers and to assess whether there is a need for early support

d. collate data and report to the LSCB on the numbers of children affected by adult mental health difficulties

e. ensure that managers are aware of all cases in which adults with mental health difficulties have children, or where there are children in the household, and that all these cases have appropriate and recorded oversight.

2.3 **Commissioners of adult mental health services should:**

a. ensure that the role of adult mental health services in safeguarding and protecting children is set out comprehensively and explicitly in all relevant tender documents and in contracts

b. have systems in place to monitor the extent to which adult mental health services meet their responsibilities to safeguard and protect children

c. Ensure stable funding for voluntary and community based programmes is required to provide the necessary long-term support to ensure children living with families with complex needs are safe

2.4 **Adult mental health services and drug and alcohol services should**:

a. ensure that practitioners consistently challenge decisions by children's social care to take no further action if in their judgement action is warranted, using escalation processes where necessary

b. review recording systems to ensure that children and young people who are undertaking inappropriate caring responsibilities for parents or siblings are identified, and that their needs are explicitly considered and referred for support when necessary

c. ensure that adult assessments consider the need for early support for parents, carers and children and that action is taken to put this in place.

2.5 **Local authorities (Adult and Child Social Services), mental health services and drug and alcohol services should:**
Ensure that staff liaise with each other and agree a joint plan of action when parents or carers do not attend appointments with adult services.

2.6 **Local authorities (Adult and Child Social Services) and mental health services should**:

a. improve the quality of assessments of the impact of mental health difficulties on children, ensuring that children's social workers and adult mental health practitioners work together to assess and agree effective action plans

b. review arrangements for discharging patients from hospitals to ensure that discharge meetings involve children's social workers where appropriate; that the needs of the children are considered and that discharge plans set out clearly when/if parents or carers will be ready to resume the care of their children.

3. Tackling Dementia in Merton

3.1. **Supporting the Dementia Hub**
With the launch of the Dementia Hub in Merton[196] it must be ensured that relevant services are aware of this centre and how patients with dementia can be referred to it. This is particularly applicable to GP practices as GPs have a pivotal role to play in the early detection and referral of residents of Merton with dementia.

3.2. **Dementia awareness and training**
Dementia awareness and training sessions with relevant services, especially in primary care must be organised in a rolling programme that is repeated at regular intervals.

3.3. **Dementia strategy refresh**
The current five year dementia strategy (for Sutton and Merton) which is due to end in 2015, must be refreshed to reflect the current organisational changes in health and social care, and the dementia strategy implementation plan must be updated.

3.4. **Preventing dementia**
Awareness must be raised of evidence-based measures to prevent dementia (the six pillars of a brain-healthy lifestyle: regular exercise, healthy diet, mental stimulation, quality sleep, stress management and an active social life[197]) to relevant services, professionals and lay public in Merton. Community-based projects or pilots to prevent dementia and promote dementia awareness should be considered.

[196] http://www.alzheimers.org.uk/site/custom_scripts/branch.php?branch=true&branchCode=13596&areaBC=EALO
[197] http://www.helpguide.org/elder/alzheimers_prevention_slowing_down_treatment.htm

4. Improving services for people with a dual diagnosis of substance misuse and mental ill-health

4.1. **Early identification of dual diagnosis and prevention work**

Developing &/or strengthening services should be considered, to ensure that dual diagnosis of substance misuse and mental ill health is identified early and that there are clear eligibility criteria, referral and care pathways, and robust outcome measures for dual diagnosis

4.2. **Joint service provision and pathways for dual diagnosis**

a. Joint commissioning of mental health and drug or alcohol services needs to become the norm in the areas of general health, mental health, substance misuse (including alcohol), social care, education, community safety, crime (including domestic violence) and safeguarding in both children and adults, linking promotion and prevention much more closely with treatment and care for substance use and mental health.

b. To ensure 4.2a above, all contracts with providers need to stipulate effective joint working and clear pathways, to meet the needs of people with co-existing mental health needs and substance misuse problems.

4.3. **"Hidden harms" of substance misuse**

LBM is planning a needs assessment on Hidden Harm in Merton. It is recommended that appropriate services are jointly developed; to tackle hidden harm and support this needs assessment, considering its recommendations in the development of this work. A dual diagnosis in one or both parents or caregivers has significant impacts on children living with them. The hidden harms aspect is not just about dual diagnosis but extends to parents with mental illnesses (and not substance misuse) as well.

4.4. **Personality disorders (PD)- with and without dual diagnosis**

Around 8-9% of all in-patient cases and patients in CMHS are seen because of personality disorders. Anecdotal evidence suggests that there are significant numbers of undiagnosed cases of PD in the community, and there needs to be more and better access to psychological treatment (DBT/MBT) for cases of PD and dual diagnosis with PD. Considerable preparatory work is required to get PD cases ready for such therapies.

5. Addressing Health inequalities and inequity

5.1. **Black and Minority Ethnic groups**

The findings from this report indicate that black communities are over-represented in in-patient services (but not in CMHS) and Asians are significantly under-represented in both in-patient and community mental health services. A range of early intervention and support services should be considered that are culturally sensitive to Merton's BME groups that promote mental health wellbeing and reduce stigma. The services should be targeted and outcome specific.

5.2. **Local care pathways**

It should be ensured that local care pathways promote access to the services by wider communities including socially excluded groups such as black and minority ethnic groups, older people, those in prison or in contact with the criminal justice system and ex-service personnel.

5.3. **Services for older people**

a. It has been estimated that at any given time in a typical 500-bed district general hospital, 220 beds are occupied by older people with mental health problems: 102 with dementia and 96 with depression[198]. Services and pathways should be developed to address the specific needs of older adults in Merton and these services should be appropriate for this age group, helping to reduce the demand on acute beds by increasing care for the frail and elderly in community settings, providing a holistic assessment in the community, and ensuring that both mental and physical health are addressed..

b. Rather than the current generic system in Merton, a specialist liaison psychiatry service for older people based in acute hospitals could be developed. Mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates[199].

c. Development in this area should be linked with the on-going integration work in Merton under the Better Care Fund.

6. Improving engagement with and support for service users and carers

6.1. **Education and Training of front-line staff**

It must be ensured that frontline workers, across the full range of services, are trained to understand better about mental health, the principles of recovery and are able to tackle any stigma related to mental health. Furthermore training must be provided on the services that exist in Merton, the care pathways and how to refer a person to the appropriate mental health services.

6.2. **Education and Training of healthcare professionals in primary care**

Healthcare professionals in primary care including GPs need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health. Consultations with service users revealed that primary care professionals were perceived by some to have an inadequate understanding of mental illness, and service users reporting a negative experience on the whole.

6.3. **Carer needs**

Consultations with carers revealed that pro-active information-sharing and guidance, their involvement in decisions about the care provided, properly informed sessions and providing support/training in managing specific conditions were the most important issues for them. Feedback from the carers indicated that these arrangements and provisions were not as good as they needed to be. It needs to be ensured that these provisions are improved for carers. There is no up-to-date carer's strategy for Merton and this needs to be addressed. The triangle of care model must be sustained.

[198] Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H, Seymour J (2009). The Need to Tackle Age Discrimination in Mental Health: A compendium of evidence. London: Faculty of Old Age Psychiatry, Royal College of Psychiatrists. Available at: www.rcpsych.ac.uk/pdf/Royal%20College%20of%20Psychiatrists%20%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf

[199] Naylor C, Bell A (2010); Mental Health And The Productivity Challenge, Improving quality and value for money; The King's Fund and Centre for Mental Health.

6.4. **Enabling access to services for Merton residents with mental health conditions**

Service users and carers in our consultations felt that not having the Freedom Pass severely limited their ability to get around and could contribute to a worsening of their problems. Many mental health service users are not in employment or on low incomes and they struggle with the cost of transport. It is recommended that the London Borough of Merton takes steps to enable Merton residents with mental ill-health to access services that are so vital for their wellbeing, bearing in mind that the Freedom Pass is no longer available.

7. Primary care and IAPT services

7.1. **Variation in quality and under-diagnosis in Primary Care**

Variations in quality and under-diagnosis need to be understood in greater depth (i.e. how much is due to differences in coding and how much is actual) and minimised in primary care, particularly in GP practices in East Merton. In the consultations in this needs assessment both service users and carers expressed the view that health services continue to give less attention to mental illnesses than to physical illnesses and primary care professionals had an inadequate understanding of mental illness. Health professionals in primary care (including GPs) need training and education in order to better recognise mental ill health, engage and support patients on this, and accord parity of esteem to mental ill health.

7.2. **Physical health of Merton residents with mental ill-health**

The physical health of Merton residents with mental health conditions needs to be monitored regularly. NICE guidance CG 178 recommends that GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The physical health of patients with schizophrenia in particular needs to be better managed in Primary Care.

7.3. **Transfer of care from secondary to primary care**

The transition between secondary care and primary care in relation to all mental illnesses but specially schizophrenia must be well managed.

7.4. **Primary Care integration**

There must be more integration of mental health related services in primary care between health, social care, housing, employment, legal services and community services. This includes greater integration between physical and mental health, and the early identification of illness and comorbidity, reduced stigma, and social inclusion.

7.5. **Psychological therapies**

There are a number of issues around the current IAPT service that are being addressed by the Merton CCG. These include consistently low recovery rates against local and national targets, and the profile of cases being seen tending to belong to the more severe spectrum of mental disorders. Merton CCG is undertaking a specific programme of work that is reviewing the IAPT service and considering how to make it more effective.

8. Improving rehabilitation and stepped down provision

8.1. There is a need to undertake a more detailed piece of work to understand the current step-down provision from acute services when patients are well enough to be discharged from an acute bed but not well enough to live independently at home. This work will help to consider alternative options and to design a provision that is fit for purpose, mindful of the principle of "Right Care at the Right Place" and commissioning services closer to home and in the least restrictive environment.

8.2. Co-ordinated working with LB Merton will be required to understand the demand and capacity for step-down placements for social care needs, including housing.

9. Areas where more research required

While this report covers a wide expanse of issues pertinent to adult mental health in Merton, there are some areas that are not covered and need more work. These areas are learning disabilities, the interface between children and adult mental health services (especially the transition) and in general there is need for a CAMHS health needs assessment.

Appendix 1: Qualitative work: Information Sheet

Merton Mental Health Review
Information Sheet

What is the review about?

Merton Council Public Health team is currently carrying out a review of Mental Health services for adults and elderly people in the borough. The aim is to get a clearer picture of mental health needs and identify what services are lacking.

What will it involve?

We wish to get feedback from people who use mental health services, the people who care for them and the services that provide their care. We plan to do this through consultations where we will ask your views about current services. The questions will cover a range of areas such as knowledge of what services are available, problems with accessing them, and the quality of care provided. We are also interested to know what has worked well, what you value about the services, and what you would like to see improved.

How will it be carried out?

If you are happy to take part, we will discuss with you either one-to-one or as part of a small group of about six to eight people at a time and location convenient for you. The discussion will last about 30-40 minutes for individuals and about 60-90 minutes for the groups. With your permission, we will record what you say to ensure that we correctly understand it. Refreshment will be provided at the group events.

Who will see my information?

Whatever you tell us will be used only for the review. Any personal information you provide will be treated in confidence and will not be able to be used to identify you. You have the right to refuse to answer any questions you are not comfortable with and to withdraw from the discussion at any time without having to give a reason.

How will the information be used?

The information you provide, alongside other statistical information we are reviewing, will be included in a report that will describe how well current services are meeting people's needs and how they can be improved.

Where can I get further information or make a complaint about the consultation?

You can contact the following people from Merton Council Public Health and the Consultation team.

Merton Council Public Health

Dr. Anjan Ghosh
Interim Consultant in Public Health
Public Health Team
London Borough of Merton
phone: 020 8545 4848
email: anjan.ghosh@merton.gov.uk

Consultation team

Dr Patrick Tobi
Institute for health and Human Development
University of East London
Water Lane, Stratford
phone: 020 8223 4473
email: p.tobi@uel.ac.uk

Thank you for taking part.

Appendix 2: Qualitative work: Consent form

Merton Mental Health Review
Consent form

	tick
The purpose of the consultation has been explained to me and I know where to get further information. I understand what is being proposed and why I have been approached.	
I understand that any personal information I provide will remain strictly confidential and will not be able to be used to identify me. Only those directly involved in carrying out the review will have access to the information.	
I understand that the answers I provide will be recorded with my consent. The reason for recording has been explained to me.	
I understand that I have the right to refuse to answer any questions I am not comfortable with and to withdraw at any time without disadvantage to myself and without being obliged to give a reason.	

I am a *(tick one)*: Mental health service user ☐

Carer of a mental health service user ☐

Mental health service provider ☐

Participant's name: …… Signature: ……

(BLOCK CAPITALS)

Interviewer's name: …… Signature: ……

(BLOCK CAPITALS)

Date: ……

Appendix 3: Qualitative work: Interview schedule for service users

Focus Group Topic Guide for Service Users

Discussion theme	Probes
1. KNOWLEDGE OF SERVICES	
Can you briefly tell me what mental health services in Merton you know about?	*Range of provision* *Sources of knowledge*
2. ACCESS	
What is your experience of attending an appointment?	*What is the average waiting time?* *Do the times/dates of appointments suit you? Is there flexibility in scheduling appointments?*
How well does the referral process work?	*Distance to services* *Transport support (Freedom Pass)* *Physical barriers in the service setting*
3. QUALITY OF CARE	
How effective do you find the care you receive?	*How confident are you in the competence of the health professionals?*
How would you describe your relationship with the health professionals who provide your care?	*Professionalism of the staff* *Sensitivity of the service to your cultural values*
4. WIDER SUPPORT	
In what ways does the service involve your family and carer in your care?	*How are they supported to care for you?*
5. CONTINUITY OF CARE	
What is your experience of being referred between different services, for instance from primary to secondary care?	*In what ways are you involved in and kept informed during transition or referral?*
6. DECISION MAKING	
To what extent do you think your views and preferences are taken on board in decisions about your care?	*Sense of coercion?*
7. COMMUNICATION	
How understandable is the information you receive from your health professional?	*How is information usually communicated to you – phone, text, email, etc?* *From whom do you get the information?*
Are you able to contribute your views?	*Are there any particular words or phrases used that you find inappropriate or objectionable?* *Are you able to question, seek clarification or give feedback?*
8. STIGMA/DISCRIMINATION	
What do you think of current attitudes to mental illness?	*How open are you about discussing your mental illness?* *How has that changed from the past?* *Do you feel that you would be treated differently if you had a physical illness?*
9. GENERAL	
Finally, can I ask what aspects of mental health services overall you like and do not like and why?	*Service barriers/facilitators*

Appendix 4: Qualitative work: Interview schedule for carers

Merton Mental Health Review
Topic guide for Carers

Theme	*Questions*
1. Role	• Tell me about your role as a carer? • What type of support do you provide - role at the beginning, accessing care, planning care, involvement in meetings, role in medication, etc)?
2. Service user's relationship with the service	• Views about performance of the service and quality of care provided • Contact with service – comfortable/uncomfortable • Kind of care needed/wanted versus care received/not received • Crises and response of service(s) • Communication with service providers
3. Your own relationship with the service	• Views about performance of the service and quality of care provided • Contact with service – comfortable/uncomfortable • Kind of support needed/wanted versus support received/not received • Crises and response of service(s) • Communication with service providers
4. Your needs	• What problems do you face (e.g. stigma, lack of time/resources, changes to relationships/social networks, mental and physical health)? • Have your needs ever been assessed? • What kind of support would be helpful to you?
5. Information needs	• Understanding of information given by providers (e.g. care arrangements, discharge plans, medication and side effects) • Carers groups/services • Cultural competence
6. Improvement	• With current services, what has worked well for you and what hasn't? • What would you see as an ideal service for you?

Appendix 5: Qualitative work: Interview schedule for service providers

Merton Mental Health Review
Interview guide for service providers

Theme	*Questions*
7. Attitudes	• How do you think attitudes to mental illness have changed (a) in the wider society, and (b) among health professionals? (e.g. openness about mental illness, recognition of it as being at par with physical conditions)? • How have mental health services themselves changed in the way they deal with service users?
8. Provision	• Who are the main users of your services? • What do you think are their barriers to accessing care and how does your service minimise these barriers? • How are relationships developed with service users? • How do you involve users, their families and carers in the provision of care? • When it is needed, in what ways are you able to provide culturally competent care? • What is your view about the demand for mental health care in Merton and the capacity to meet it by (a) your organisation, and (b) Mental Health services more generally? • What links/relationships do you have with other Mental Health services, and how can these be strengthened?
9. Service assessment	• How do you evaluate your service – in terms of user experience and service performance? • What complaints process do you have in place?
10. Gaps	• Who are you currently not reaching that you would like to? • What are you not currently providing that you would like to?
11. Development	• What new services are you planning for the future? • What suggestions do you have for how services might be better commissioned?

Appendix 6: ICD 10 Codes for mental illnesses

ICD10 code range chapter F	Broad code grouping
F01 - F09	Organic including symptomatic disorders
F10-F19	Psychoactive substances
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood affective disorders
F40-F49	Neurotic, anxiety and stress disorders
F50-F59	Behavioural syndromes
F60-F69	Adult personality & behavioural disorders
F70-F79	Mental retardation
F80-F89	Disorders of psychological development
F90-F98	Behavioural and emotional disorders with onset usually in childhood or adolescence
F99	Unspecified mental disorders
Source: World Health Organisation The ICD-10 Classification of Mental and Behavioural Disorders	