Dudley Adult Mental Health Joint Commissioning Strategy 2010-2013

Between 1998-2008, patients with psychiatric disorders occupied around 15% of total bed days in the NHS and have a longer length of stay than people with other medical conditions.
Pillay P & Moncrieff J (2009)

The NHS spends 14% of its annual budget on mental health services.
(DH 2009)
Recent estimates put the full economic cost of mental ill health at around £77 billion, mostly due to lost productivity.
Sainsbury's (2003)

The World Health Organisation has recently undertaken the largest ever population based study on the physical effects of several illnesses. The results showed that depression had more impact on sufferers than angina, asthma, arthritis or diabetes. When depression co-existed with these other conditions the score was worse than with any other combination of conditions.
Moussavi et al (2007)

Good mental health is more than the absence or management of mental health problems: it is the foundation for well being and effective functioning both for individuals and their communities.

Mental well-being is about our ability to cope with life's problems and make the most of life's opportunities: it's about feeling good and functioning well, as individuals and collectively.
New Horizons (2009)

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1. Introduction

1.1 This Joint Commissioning Strategy for Mental Health sets out the strategic direction of Dudley Metropolitan Borough Council and Dudley Primary Care Trust (PCT) in respect of services for people with mental health.

1.2 This strategy has been developed through the Dudley Mental Health Partnership Board - consisting of people with mental health support needs, carers and providers of services in Dudley. The Board's role is to develop the strategic direction for commissioned services and monitor the implementation of commissioning strategies.

1.3 This strategy is based on a new approach to whole population mental health. The focus on prevention and maintaining good mental health is particularly relevant today with people leading more hectic lifestyles and going through the economic downturn.

1.4 **Mental health is 'everybody's business" because**:

- around one in four people will suffer from a form of mental illness at some point in their lives;
- one sixth of the population suffers from a common mental health problem at any time;
- 1 in 100 people suffers from a serious mental illness such as psychosis;
- more than 1.3 million older people suffer from depression or other mental illness;
- 6 million people in Britain have depression and/or anxiety disorders - few get effective treatment;
- one in ten mothers suffer from post-natal depression

Dept of Health (2009)

1.5 The strategy acknowledges that people can be helped to protect themselves against mental illnesses like depression and anxiety and that mental ill health not only causes untold personal suffering and distress, but also affects people's relationships, ability to work and family life. It can also lead to a range of physical health problems.

1.6 The strategy also addresses the needs of those who experience disproportionately high levels of mental ill health including older people, those living in poverty and people from black and minority ethnic communities.

1.7 A draft strategy was launched on the 23rd November 2009 with a Stakeholder event at Himley Hall, attended by 49 delegates. The strategy included an executive summary together with a number of consultation questions (see Appendix 3). The stakeholders were asked to give their initial views on the draft strategy and an initial period of consultation lasted until the 14th February 2010.

2. Scope and Purpose of the Joint Commissioning Strategy

2.1 This Joint Commissioning Strategy explains how the Council and the PCT plan to commission mental health services for the people of Dudley.

2.2 Dudley PCT has the lead commissioning role for mental health services, but there is no Section 75 agreement in place. The Council commissions all care and support services whilst the PCT commissions mental health services and ensures access for people with a mental health issue to mainstream primary and secondary NHS provision.

2.3 This strategy complements the strategies for children and young people, dementia, mental health promotion, older people with mental health problems, substance misuse, as well as the PCT's Strategic Plan and the Borough Council's Plan.

2.4 It has also been developed in line with the Dudley Community Strategy and alongside strategies covering Supporting People, housing, leisure and regeneration.

2.5 The Strategy builds upon the previous Joint Mental Health Strategy 2005 – 2010 and the National Service Framework for mental health - widely acknowledged as the catalyst for a transformation in mental health care over the last ten years - which came to an end in 2009 to be replaced by "New Horizons".

2.6 The main policy drivers for commissioning adult mental health services in the next few years will be:

- "New Horizons"
- the transformation of social care and personalisation
- social inclusion
- the development of and access to psychological therapies
- responding to the health impact of economic recession by getting people back to work
- dealing with the impact of domestic violence
- responding to the health needs of offenders
- West Midlands Care Pathways/Yorkshire Care Pathways
- Payments by Results

2.7 The strategy covers the following people with mental health conditions:-

- adults aged between 18-64 except for Early Intervention and Eating Disorder services only the strategy covers the age group 14+
- people in *transition* from child to adult and from adult mental health services into services for those aged 65 and over
- adults with a mental health condition and a *dual diagnosis* of drug or alcohol problems.
- adults with a mental health condition and a *dual diagnosis* of learning disability.

3. Dudley

3.1 Dudley is a large Metropolitan Borough (98 square kilometres / 38 square miles) located on the western part of the West Midlands conurbation, approximately 9 miles west of Birmingham and 6 miles south of Wolverhampton. Dudley is composed of a number of townships, each with its own identity and culture. The main town centres are Dudley, Stourbridge in the south west, Halesowen to the south east and Brierley Hill in the centre.

3.2 There are 24 wards in Dudley and the current GP responsible population (patients registered with Dudley GPs) as of February 2010 was 314,552.

3.3 Dudley is the second largest area, in terms of population in the West Midlands after Birmingham (2001 Census)

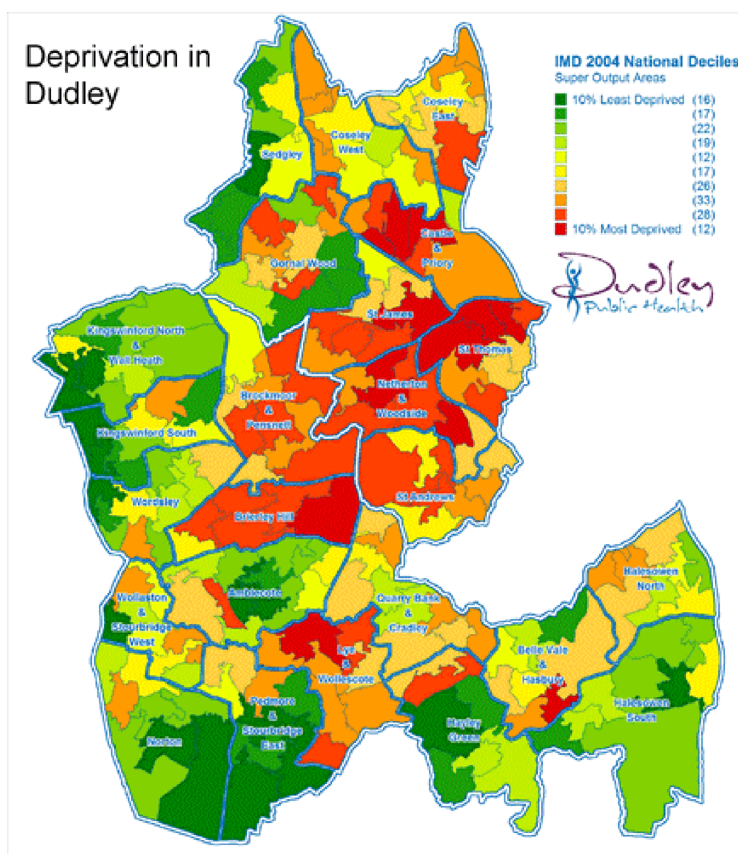
3.4 According to the 2006 Mid Year Estimates, the gender split of the Dudley population is even with males accounting for 49.1% of residents and females 50.9%, with the overall ethnicity split at 92% white and 8% BME.

3.5 Deprivation

3.5.1 The deprived areas are largely found in an area from Brierley Hill, through Netherton to Castle and Priory, with some also in Lye and one or two small pockets elsewhere. Conversely the most affluent areas are found on the southern and western edges of the Borough.

3.5.2 Dudley's overall deprivation status differs little from the national average.

- Deprivation is concentrated in an inner urban core
- 8 wards fall into the most deprived 25% nationally



Population-weighted average rank per LSOA for Index of Multiple Deprivation by PCT

- *30% of GP first consultations and 50% follow up consultations are related to mental health issues.(Sainsbury Centre 2002)*
- *In 2003 the Sainsbury Centre calculated the total cost of mental health problems to be:*
  - *health and social care costs £12.5 billion*
  - *cost to individuals £41.8 billion*
  - *lost employment opportunities £23.1 billion*
  - *total cost of £77.4 billion pounds per annum*

Sainsbury Centre (2003)

4. The Extent of Mental Health

4.1 The National Perspective

4.1.1 Estimates of the prevalence of mental health problems in Britain are difficult to determine. The latest figures, which are available, come from the Adult Psychiatric Morbidity Survey (APMS) 2007, the third survey of psychiatric morbidity among adults living in private households commissioned by The NHS Information Centre for Health and Social Care.

4.1.2 The main aim of the 2007 survey was to collect data on mental health among adults aged 16 and over living in private households in England. It is the primary source of information on the prevalence of both treated and untreated psychiatric disorders

4.1.3 Suicidal thoughts, suicide attempts and self-harm

- overall 16.7% of people reported in the self-completion that they had thought about committing suicide at some point in their life;
- 5.6% said that they had attempted suicide and 4.9% said that they had engaged in self-harm;
- 63% of men and 58% of women who reported having attempted suicide said that they had sought help following the last attempt. The most common sources of help sought were a GP or family doctor; hospital or other specialist medical or psychiatric services and family, friends or neighbours;

- younger adults were more likely than older adults to have sought help after their most recent suicide attempt: 70% of those aged 16-34 reported that they had sought help, compared with 51% of those aged 55 or over;
- of those who reported self-harm, 42% of men and 53% of women received medical or psychiatric help as a result.

4.1.3 Psychosis

4.1.3.1 Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. Symptoms include auditory hallucinations, delusional beliefs and disorganised thinking. The main types are schizophrenia and affective psychoses such as bipolar disorder and manic depression.

- The overall prevalence of psychotic disorder in the past year was 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).
- 80% of service users aged 16-74 with probable psychosis received some form of treatment (medication or counselling) for a mental or emotional problem.
- The prevalence of psychotic disorder varied by household income, increasing from 0.1% of adults in the highest income quintile to 0.9% of adults in the lowest income quintile. This trend was more prominent among men than women.
- Two-thirds (65%) of adults with a psychotic disorder in the past year were receiving some form of medication and/or counselling at the time of the phase one interview, compared with 7% of those without a psychotic disorder. Levels of medication use were about ten times higher in adults with psychotic disorder than in those with no psychotic disorder (56% and 6% respectively).

4.1.4 Antisocial and borderline personality disorders

4.1.4.1 Personality disorders are longstanding, ingrained distortions of personality that interfere 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.

4.1.4.2 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. BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, self-harm and suicidal behaviour is common.

- ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women).
- 1.7% of men aged 18-34 had ASPD, while no cases were identified in men aged 55 or over. 0.4%of women aged 16-34 had ASPD, while no cases were identified in those aged over 35.

4.1.5 Eating disorder

4.1.5.1 Eating disorders, including anorexia nervosa, bulimia nervosa and related conditions, generally have an onset in childhood or adolescence. They include a variety of types of disordered eating, and range greatly in severity. People with eating disorders often experience acute psychological distress, as well as severe physical complications.

- Overall, 6.4% of adults screened positive for an eating disorder. The proportion who screened positive and also reported that their feelings about food had a significant negative impact on their life was 1.6%.
- At 9.2%, women were more likely than men (3.5%) to screen positive for an eating disorder.
- The prevalence of screening positive for an eating disorder decreased with age, and the pattern was particularly pronounced for women. One woman in five (20.3%) age 16-24 screened positive, compared with one woman in a hundred (0.9%) aged 75 and over.

4.1.6 Autism including Asperger's

Autism is a lifelong developmental disability. It is part of the autism spectrum and is sometimes referred to as an autism spectrum disorder, or an ASD. The word 'spectrum' is used because, while all people with autism share three main areas of difficulty, their condition will affect them in very different ways. Some are able to

live relatively 'everyday' lives; others will require a lifetime of specialist support.

The three main areas of difficulty which all people with autism share are sometimes known as the 'triad of impairments'. They are:

- difficulty with social communication
- difficulty with social interaction
- difficulty with social imagination.

While there are similarities with autism, people with Asperger's syndrome have fewer problems with speaking and are often of average, or above average, intelligence. They do not usually have the accompanying learning disabilities associated with autism, but they may have specific learning difficulties. These may include dyslexia and dyspraxia or other conditions such as attention deficit hyperactivity disorder (ADHD) and epilepsy.

The prevalence of autism is around 1% of the population.

4.2 Dudley Data

4.2.1 Prevalence of Mental Health in the Dudley Population aged 16-74.

Estimated Prevalence of Neurotic Symptoms in Dudley as % and number of total population aged 16-74 (

	Sleep Problems	Fatigue	Irritability	Worry	Depression	Concentration & Forgetfulness	Depressive ideas	Anxiety	Somatic symptoms	Worry physica health				
Men	22%	18%	17%	15%	9%	8%	7%	7%	6%	4%				
Men	23900	19900	18700	16300	9900	8900	7600	7800	6700	4300				
Women	38%	27%	22%	24%	8%	8%	8%	7%	9%	8%				
Women	42800	30100	24000	26200	8700	8700	8600	7700	9800	8600				

Key Health data for W Midlands 2005 (Birmingham University)

Estimated Prevalence of Neurotic Disorders in Dudley as % and number of total population aged 16-74 (2

	Mixed anxiety & depression disorder	Generalised anxiety disorder	Depressive episode	All phobias	Obsessive compulsive disorder	Panic disorder	Any neurotic disorder
Men	7.00%	3.60%	1.20%	1.20%	0.30%	0.20%	11.90%
Men	7700	3900	1300	1300	300	200	13100
Women	10.40%	3.70%	2.30%	1.70%	1.30%	0.10%	17.00%
Women	11600	4100	2500	1400	1500	100	1900

Key Health data for W Midlands 2005 (Birmingham University)

Estimated prevalence of Personality Disorder Dudley as % and number of total population aged 16-74 20

	Obsessive compulsive	Avoidant	Schizoid	Paranoid	Borderline	Antisocial	Dependent	Schizotypal	Histi		
Men	2.60%	1.00%	0.90%	1.20%	1.00%	0.90%	0.20%	0.00%	0.0		
Men	2850	1050	1030	1290	1100	1020	180	0			
Women	1.40%	0.70%	0.80%	0.30%	0.40%	0.20%	0.00%	0.10%	0.0		
Women	1560	770	940	320	480	180	30	110			

Key Health data for W Mids 2005 (Birmingham University)

4.2.2 The estimated prevalaence of probable psychotic disorder in Dudley as % of total Population aged 16-74, 2005

Men	0.30%	300
Women	0.40%	400

5 Joint Strategic Needs Assessment

5.1 The Strategy complements the local Joint Health and Social Care Commissioning Framework and has been informed by the Joint Strategic Needs Assessment (JSNA). This sets out the broader context in which we are commissioning mental health services.

5.2 The Dudley Joint Strategic Needs Assessment (JSNA) is a detailed analysis of population demographics, need, demand, capacity and resources and how the PCT and Borough Council will plan for the future health, care and well-being needs of the population. The aims of the JSNA are:

i) to build a picture of current services i.e. baseline

ii) to gather information to plan, negotiate and change services for the better and improve outcomes for the population

5.3 Key messages from the JSNA:

- The Population in Dudley is projected to increase by 2.6% overall by 2020.
- The population aged 65+ is projected to increase by 24% by 2020.
- The number aged 85+ are projected to increase by 55% over the same time.
- Births are currently projected to remain relatively static up to 2020.
- In and out migration is small in relation to the total population, but is the major contributor to the projected population rise.

- Black ethnic group are 3x and Mixed ethnic group 4x more likely to be lone parent households (15% & 20% vs 5% of White households).
- 43% of Asian households have 2 or more children (compared to 16% for White).
- 15% of white, 5% of Mixed, 3% of Asian and 8% of Black households are lone pensioners.
- The BME population has a younger age profile which may influence future service provision.
- Life expectancy in Dudley has risen in the last 20 years, but at a slower rate than nationally in more recent years.
- There has been some narrowing of within Borough differences in life expectancy over the last 20 years.
- There is still a gap of 8.6 years between the Dudley wards with the highest and lowest life expectancy.
- Alcohol-related diseases have risen rapidly in recent years.
- Soon more people in Dudley will die from alcohol-related diseases than die from all strokes.
- The level of crime is the top priority area of concern
- There has been a rapid rise in those claiming Job Seekers Allowance, this has been worse for young people in the most deprived areas. This has consequences for drug and alcohol misuse and mental health problems

6. National Drivers

6.1 New Horizons - Towards a shared vision for mental health (2009).

6.1.1 New Horizons is a Policy document (Dec 2009) which sets out the next stage of the Government's strategy for improving mental health in England. It takes a cross Government approach and aims to:

- tackle the causes of ill health through prevention and earlier intervention, reduce stigma and promote well-being

- improve accessibility and the quality of services for those with poor mental health
- take forward what was learnt in the lifetime of the National Service Framework 1999-2009 (NSF) about what works, and broaden our scope to include all groups in society, including children, young people and older people.
- build on the principles and values set out in the NHS Constitution and support the delivery of the NHS Next Stage Review (the Darzi Report) and its vision of local commissioners working with providers, the public and service users to devise local approaches to mental health and mental health care
- use the growing understanding of the wider determinants and social consequences of mental health problems and mental well-being to influence priorities in other parts of central and local government
- Reinforce a commitment to key mental health policy aims, including delivering race equality and improving access to psychological therapies.

The New Horizons approach to whole population mental health is a key feature of this strategy.

6.2 Darzi Review – Key Themes

6.2.1 In 2008 Lord Darzi the Health Minister set out the vision for the NHS for the next 10 years, which is to ensure that the NHS works towards: preventing ill health, improving access, saving lives and improves the quality of people's lives, whilst taking account of changing demography and opportunities shaped by new technologies. This is to be achieved by empowering staff and giving patients' choice, to ensure that health care will be personalised, effective and safe treatments to help patients to stay healthy.

6.2.2 The NHS Next Stage Review was organised regionally around 8 clinical pathways including mental health. In each Strategic Health Authority, clinicians were selected for Clinical Pathway Groups which identified examples of good practice, the barriers to service development, and key priorities for future service improvement and innovation.

(What was the outcome????)

6.3 Yorkshire Clusters/Care Pathways

6.3.1 These have been introduced to support the Darzi plans for the introduction of Payment by Results in mental health and are based on care pathways work originally developed in Yorkshire.

6.3.2 The model, originally established to support clinical decision making and effective care delivery, includes:

- a standard needs assessment tool;
- standardised aims for interventions and activities;
- a set of 21 care pathways/clusters for all people who use adult and older people's mental health services (Appendix 4).

6.3.3 The allocation of a service user to a cluster should lead to them entering a pathway where the services and treatment that will be offered are clear, as is the exit from that pathway. The service user will be told what clinician they will be working with, such as psychologist, social worker etc and which team the clinician is a member of such as a CMHT or Assertive Outreach Team. For this to be implemented a redesign of some services in Dudley will be required.

6. 3 Transforming Social Care/Personalisation

6.3.1 Across Government, the shared ambition is to “put people first” through a radical reform of public services. It will mean that people are able to live their own lives as they wish; confident that services are of high quality, are safe and promote their own individual needs for independence, well-being, and dignity.

6.3.2 This holistic approach is set out in 'Putting People First: a shared vision and commitment to the transformation of adult social care', the ministerial concordat launched on 10 December 2007.

6.3.3 Personalisation, including a strategic shift towards early intervention and prevention, will be the cornerstone of public services. This means that every person who receives support, whether provided by statutory services or funded by them, will have choice and control over the shape of that support in all care settings.

6.3.4 The expectation is that by 2010/11 councils will have made significant steps towards redesign and reshaping their adult social care services, with the majority having most of the core components of a personalised system in place. Councils should be able to demonstrate to their partners better use of resources across the entire system by investing in early intervention to ensure that the new systems are embedded at a local level.

6.3.5. Personalisation comprises a number of key elements:

- a common assessment of the person’s social care needs, based on a self-assessment wherever possible
- the assessment identifies care and support needs, which relate to an allocation of funding known as the personal budget. The client takes control of the personal budget or may ask that this be

administered by a relative, carer, an organisation or the Council

- knowing the money available, the person takes control of their own care through a support plan to be funded within the available personal budget. This is sometimes called ‘self-directed’ support
- self directed support allows more choice and control for people, identifying what is personally important to them and how they would like to see their support delivered in a way which best suits their individual needs, priorities and circumstances
- the role of social workers will change emphasis from assessment and gate keeping of resources to advocacy, information, advice and ‘brokerage’, helping people to arrange their own services.

Personalisation will enable users to develop their own packages of care to meet their needs rather than having to use services which are “one size fits all”.

6.4 **Social Inclusion**

6.4.1 The Government has introduced a requirement for Local Strategic Partnerships, such as the Dudley Community Partnership, to ensure that the most socially excluded adults are offered the chance to get back on a path to a more successful life by increasing the number of adults in contact with secondary mental health services who are in settled accommodation and in employment, education or training (PSA16).

6.4.2 This is because people with mental health problems experience a greater degree of social exclusion than the general population. For example, only 24% of adults with long-term mental health problems are in work.

6.4.3 Many people experience their first episode of mental ill health in their late teens or early twenties, with serious consequences for education and employment prospects. People with mental health problems are nearly 3 times more likely to be in debt than the general population.

6.4.4 For people with more severe and enduring mental health problems, the experience of social isolation is greater. In general people with severe mental health problems are much more likely to be unemployed, have lower educational attainment, are more likely to be separated or divorced and less likely to own their own home.

6.5 **NICE Guidelines**

6.5.1 The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

6.5.2 NICE set out clear recommendations based on the best available evidence, for health care professionals on how to work with and implement physical, psychological and service-level interventions for people with various mental health conditions (Appendix 5)

6.5.3 All commissioned services are to be evidence based, in accordance with NICE guidelines

6.6 Measuring Outcomes in Mental Health

6.6.1 When reviewing mental health services commissioners can use a variety of tools, which can include HoNoS(the Health of the Nation Scale) and the Recovery Star.

6.6.1.1 In 1993 the UK Department of Health commissioned the Royal College of Psychiatrists' Research Unit (CRU) to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards

the Health of the Nation target ‘to improve significantly the health and social functioning of mentally ill people’

6.6.1.2 These are the 12 scales used to rate mental health 6service users of working age adults. They consider different aspects of mental and social health, each on a scale of 0-4. They are designed to be used by clinicians before and after interventions, so that changes attributable to the interventions (outcomes) can be measured.

6.6.1.3 The scales are as follows:

1. Overactive, aggressive, disruptive or agitated behaviour
2. Non-accidental self-injury
3. Problem Drinking or Drug-taking
4. Cognitive Problems
5. Physical illness or disability problems
6. Problems associated with hallucinations and delusions
7. Problems with depressed mood
8. Other mental and behavioural problems
9. Problems with relationships
10. Problems with activities of daily living
11. Problems with living conditions
12. Problems with occupation and activities

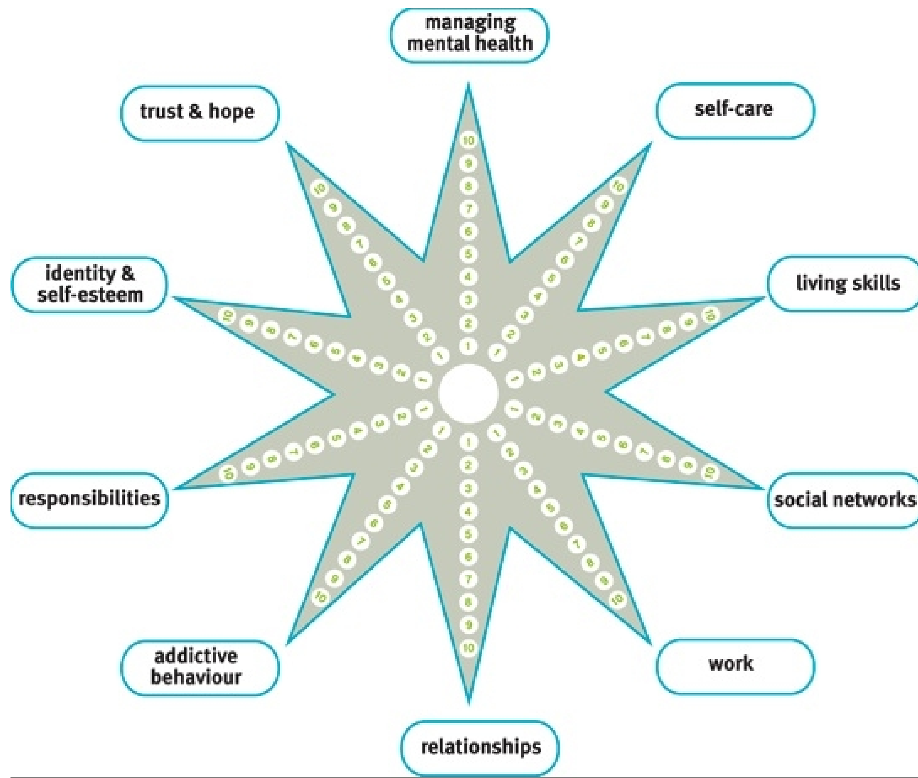
6.6.1.4 Each scale is rated as follows:

0 No problem
1 Minor problem requiring no action
2 Mild problem but definitely present
3 Moderately severe problem
4 Severe to very severe problem

6.6.2 **The Recovery Star**

6.6.2.1 The Recovery Star is a tool for supporting and measuring change when working with adults of working age who are accessing mental health support services. As an

outcomes measurement tool it enables organisations to measure and summarise:



6.9.2.2 The Recovery Star identifies and measures ten core areas of life:

1. Managing mental health
2. Self-care
3. Living skills
4. Social networks
5. Work
6. Relationships
7. Addictive behaviour
8. Responsibilities
9. Identity and self-esteem
10. Trust and hope

6.7 The Commissioning Process

6.7.1 The commissioning process in Dudley is based on the following model developed by the Institute of Public Care.

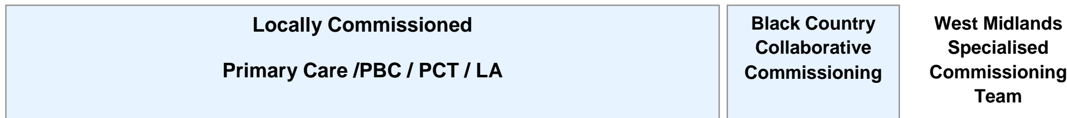
6.7.2 Joint commissioning model for public care

Commissioning
Analyse
Plan
Legislation and guidance
Gap analysis
Population needs assessment
Commissioning strategy/ prospectus
Purchasing/ Contracting
Review service provision
Assess individual needs
Develop specification and contract / SLA
Service design
Resource analysis
Analyse providers
Purchasing plan
Contract monitoring
Secure service/ treatment
Market/ supplier devevlopment
Review individual outcomes
Contact management
Review strategy and market performance
Capactiy building
Manage provider relationships
Review
Do

6.7.3 The principles of the model are:

- ❖ That all of the four elements of the commissioning cycle (analyse, plan, do and review) are sequential and of equal importance.
- ❖ A written joint commissioning strategy per user group should be developed, which focuses on need.
- ❖ The commissioning cycle (the outer circle in the diagram) should drive the purchasing and contracting activities (the inner circle). However, the contracting experience must inform the ongoing development of commissioning.
- ❖ The commissioning process should be equitable and transparent, and open to influence from all stakeholders via an on-going dialogue with patients/service users and providers.

6.7.4 For commissioning to be effective it has to be integral to the Local Authority and PCT, how this is achieved, in Dudley is outlined in the next diagram. An integrated approach ensures that there are no gaps or duplication in service provision.



West Midlands Specialised Commissioning Team

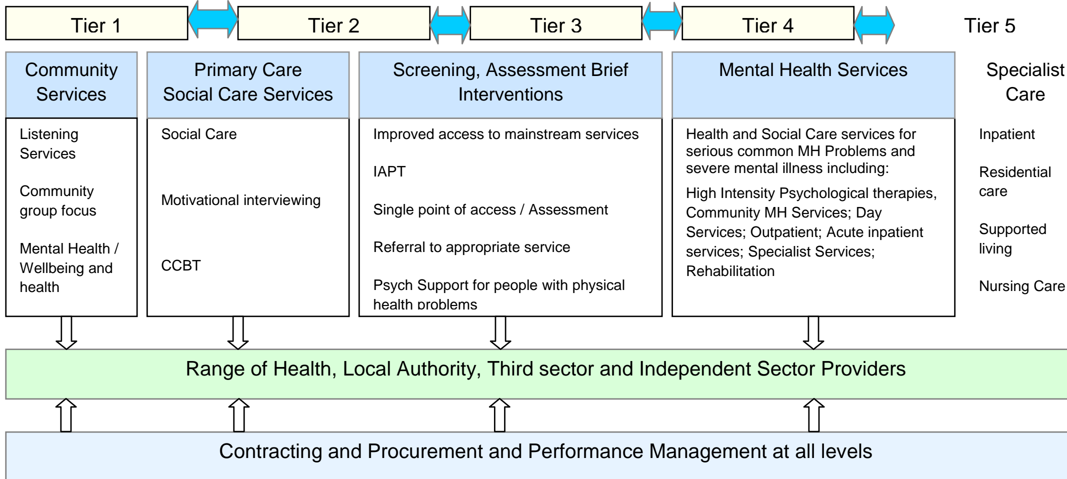
Mental Health Joint Commissioning Strategy

Strategic Goals Principles & Outcomes

- To promote good mental health and well-being, whilst improving services for people who have mental health problems.
- Help people to look after their mental health and prevent them from becoming ill.
- Tackle the stigma that's associated with mental ill health by focussing on whole population mental health
- Recognising that individuals and the community have a role to play in helping to achieve good mental health for all.
- To work in partnership with service users and their carers throughout the commissioning process
- Commissioned services will be of a high quality and will meet the needs of the service users
- Mental Health services will become more closely integrated with ordinary health services, as well as with services provided through Dudley Council

Pathway

Whole



Tier 5

Specialist Care

Inpatient

Residential care

Supported living

Nursing Care

6,8 World Class Commissioning

6.8.1 All PCTs have signed up to World Class Commissioning, which has been developed as a framework of competencies for PCTs to achieve better health and wellbeing for all, better care for all and better value for all. Dudley commissioners will aim to meet all the World Class Commissioning competencies when commissioning all mental health services.

6.8.2 The principles of World Class Commissioning are that commissioned services will be evidence-based and of the best quality. People will have choice and control over the services that they use, so they become more personalised. It will deliver better value for all as Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources

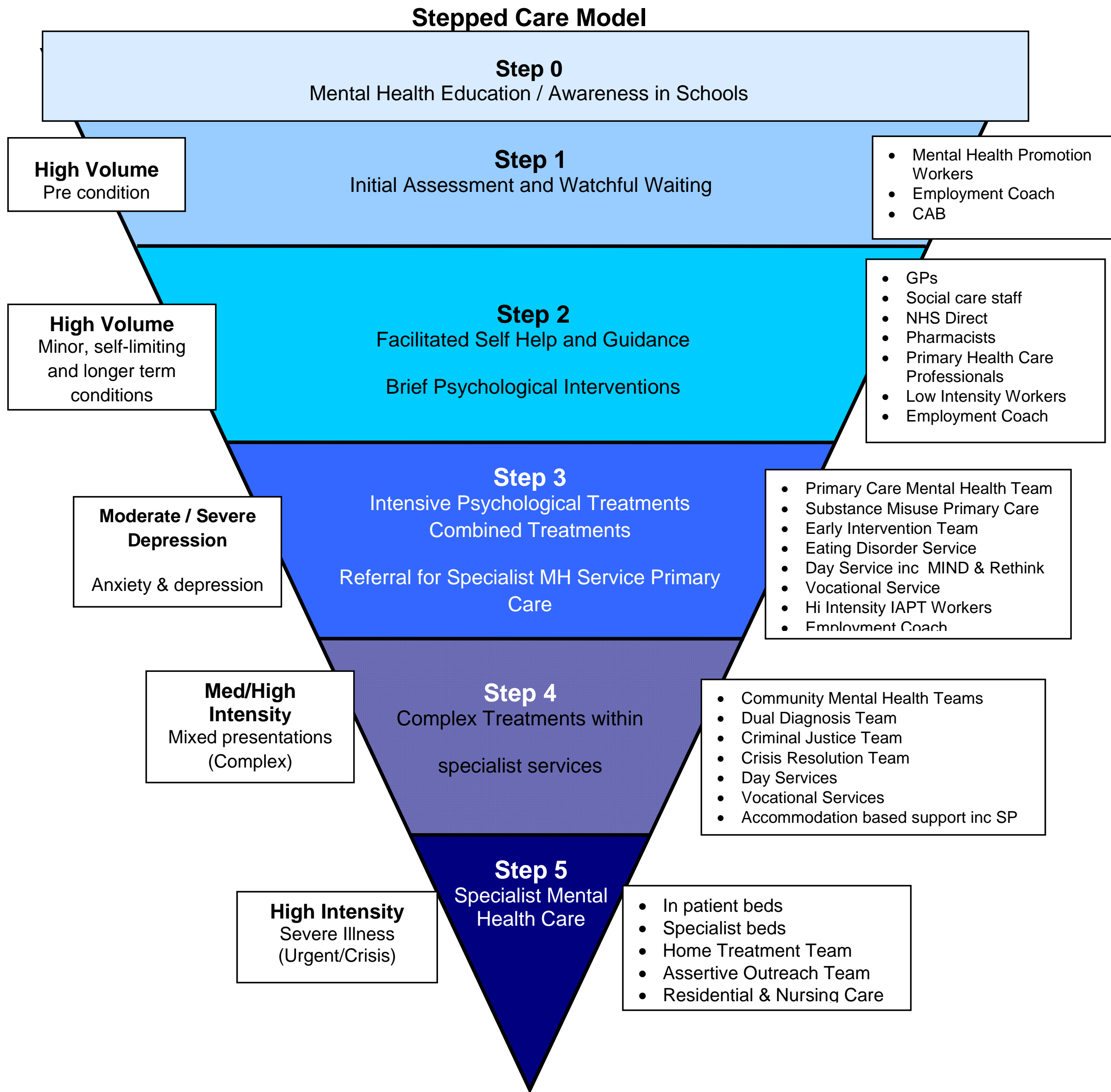
6.8.3 For World class commissioning to be effective the involvement and collaboration of people with knowledge of services from across the spectrum – commissioners, providers, service users and carers is required. It requires an understanding of people's needs at the individual level; greater emphasis on the role of primary care; integrating mental and physical health; stronger joint working between public and voluntary services; creative approaches to workforce development; and better performance management.

6.8.4 These requirements will be addressed in our approach to commissioning services.

7. Mental Health Services in Dudley

7.1 The modernisation of mental health services in Dudley commenced with the implementation of the National Service Framework for Mental Health (1999). In general this involved a move away from hospital based service to community based services including services provided through primary care, including GPs. The stepped care model below seeks to treat service users at the lowest appropriate service tier in the first instance, only 'stepping up' to intensive/specialist services as clinically required. For example the

number of Psychiatric beds for adults aged 16-65 in Dudley in 2000 was 75 and by 2009 it was 48. A number of patients also access beds outside Dudley, for example specialist beds.



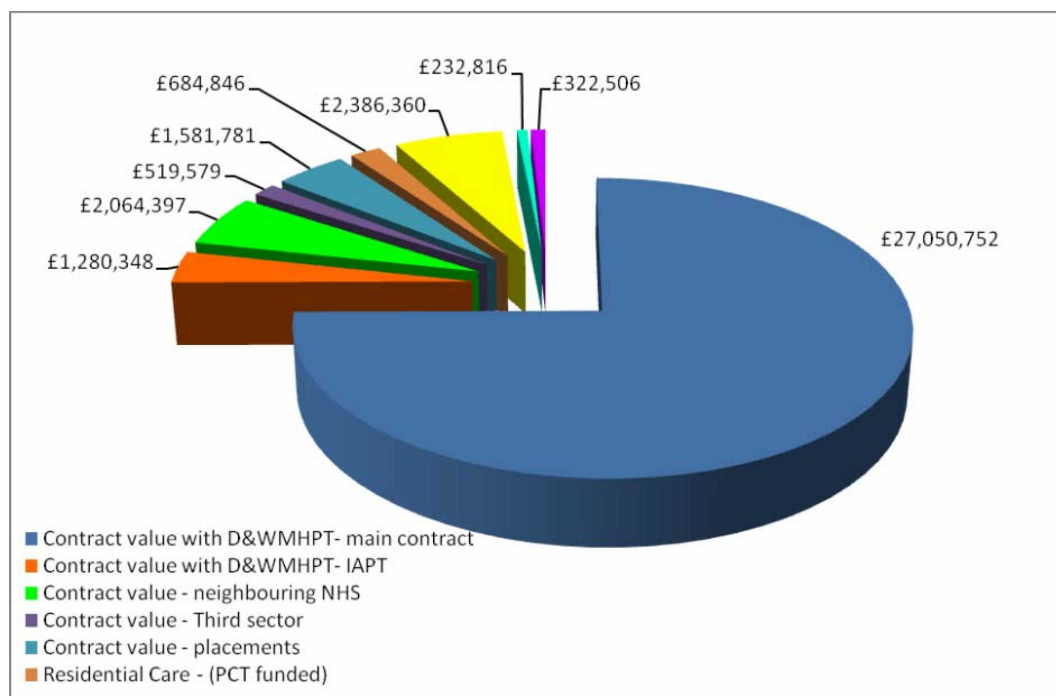
7.2 Over the past few years Dudley Primary Care Trust and Dudley Council have commissioned well-integrated mental health services, provided initially by the PCT and from 1st October 2008 through the newly formed Dudley and Walsall Mental Health Partnership Trust.

7.3 Although the PCT are the Lead strategic commissioners for mental health Services in Dudley there is no pooled budget therefore the Borough Council and the PCT have separate budgets and separate contracts.

77.3.1 Mental Health services commissioned by Dudley PCT

	Total Mental Health budget from Dudley PCT 2009/10	£36,123,385	
1	Contract value with D&WMHPT- main contract	£27,050,752	74.88%
2	Contract value with D&WMHPT- IAPT	£1,280,348	3.54%
3	Contract value - neighbouring NHS	£2,064,397	5.71%
4	Contract value - Third sector	£519,579	1.44%
5	Contract value – placements	£1,581,781	4.38%
6	Residential Care - (PCT funded)	£684,846	1.90%
7	Drug Treatment	£2,386,360	6.61%
9	Other	£555,322	1.53%
		£36,123,385	100.00%

Mental Health budget from Dudley PCT 2009/10



7.3.2 Services Commissioned from Dudley & Walsall Mental Health Partnership Trust

1. Assertive Outreach
2. Child & Adolescent Mental Health service (CAMHS)
3. Community mental Health Teams (CMHTs)
4. Criminal Justice
5. Crisis Resolution/Home Treatment
6. Day services
7. Dual Diagnosis
8. Early Interventions
9. Eating Disorders
10. Electro-convulsive Therapy
11. Employment
12. Improved Access to Psychological Therapies (IAPT)
13. In-patients
14. Older Adults
15. Primary Care

16. Psychology
17. Domestic abuse
18. DBT

Dudley PCT commissions specialist mental health services from other NHS providers in the West Midlands which include: Mother & Baby, Deaf services; Psychiatric Intensive Care (PICU).

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7.3.4 Services commissioned from the Third sector include day services, advice and support and advocacy. The current Third Sector providers are

- Alzheimer's Society- advice and support
- Dudley Advocacy- advocacy
- MIND- day services
- Rethink- day services

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7.3.5 The Total Mental Health Budget for Dudley Metropolitan Borough Council Adult & Community Services (DACHS), for 2009/10 was £6.3m which funded:

- Alzheimer's Society
- Family Care Trust
- MIND
- Rethink
- Residential
- Social Work staff
- Placements

7.4.1. The aim of social care services are to provide help and support to adults and those who care for them so that they can live independently in the community.

7.4.2. FACS (Fair Access to Care Services) provides a framework for all Councils as to how they should undertake assessments and reviews, support individuals through these processes and provide or commission services to meet the needs of adults, subject to available resources.

7.4.3 There are four bands of eligibility: critical; substantial; moderate and low need. Dudley provides services for the first two and offer advice and information to the low and moderate needs group.

7.4.4 Given the current financial challenges faced by the local health economy, any planned changes to service provision will require commissioners and providers to seek, in the first instance, opportunities for service redesign which are cost neutral. In addition, commissioners will be looking to review existing service provision and identify opportunities for de-commissioning and re-commissioning services

8. Vision

8.1 Demographic and societal changes identified in the JSNA present challenges in terms of how services should be commissioned for the future. In particular:-

- worsening levels of deprivation
- the younger profile of the BME population
- an increase in the population aged 85 and over
- the growth in those seeking employment
- the perceived fear of crime

8.2 In turn, these factors have to be viewed alongside national policy considerations:-

- whole population mental health
- personalisation
- increasing access to therapies
- addressing the impact of economic recession
- responding to the health needs of offenders

8.3 The 2005/2010 joint strategy sought to:-

- deliver patient focussed services
- develop services outside hospital
- prevent avoidable admission to hospital
- reduce delays in discharge
- support clinical decision-making in primary care

8.4 This model still applies. In addition, this revised strategy will emphasise the need to:-

- promote good mental health and well-being, whilst improving services for people who have mental health problems.
- make good mental health and well-being an achievable goal for everyone.
- help people to look after their mental health and prevent them from becoming ill.
- tackle the stigma that's associated with mental ill health by focussing on whole population (need to explain what this means) mental health, recognising that individuals, employers and other stakeholders have a role to play in helping to achieve good mental health for all.
- more closely integrate mental health with other health and social care services
- provide services closer to home, wherever possible.
- plan care well and support people in achieving recovery.
- provide a personalised care plan for people assessed as needing services with service users encouraged and supported to purchase some or all of their services through Direct Payments or an Individual Budget.
- improve access to psychological therapies in primary care
- continue to develop primary care services and reduce the need for in patient admission
- address the mental health needs of the most vulnerable, including adolescents, victims of domestic violence and offenders.
- support those with mental health needs to get into employment
- develop services that respond to the needs of a young BME population
- work in partnership with service users and their carers throughout the commissioning process, ensure services are of a high quality and respond to the needs of service users.

9. User & Carer Involvement

9.1 User and carer involvement in the commissioning of mental health services is vital due to their experience of receiving mental health services. They can contribute to commissioning through the planning, delivery and monitoring of services.

9.2 To ensure user and carer involvement in commissioning the PCT commission SAMH (Support Association for Mental Health) a service user led organisation to ensure user involvement in commissioning. Also from June 2009 the Commissioners have begun to hold bi-monthly to share information with carer representatives and to undertake both goal setting and action planning.

9.3 User and carer involvement should also be encouraged at the service delivery level to ensure that the needs of individual level users and carers are met. This can be achieved by:-

- every service user receiving a care plan, which is reviewed and updated at least very 3 months
- all users to be involved in the completion of the care plan and understand and agree actions and have ownership.

- every carer to receive information about treatments and services to support their involvement in care planning
- every carer to be given the opportunity to provide feed back to care coordinators about users care and treatment, and raise issues of concern.

9.4 In monitoring service delivery, we will seek to ensure that carers' assessments are carried out and their needs responded to.

10. Safeguarding

10.1 In fulfilling our responsibilities as a Commissioner we need to be ensured that policies and procedures in respect of safeguarding are in place. In Dudley safeguarding is coordinated by the Adult Safeguarding Unit.

10.2 Safeguarding of vulnerable adults is based on the premise that all adults should be able to live their lives that are free from fear or harm and have their rights and choices respected. It is acknowledge that some people are more vulnerable to abuse and so need additional protection

10.3 Vulnerable adults include: older people, people with mental health needs; people with physical disability or illness; people with a learning disability.

10.4 Abuse can take many forms and includes:

- Physical
- Sexual
- Financial
- Psychological
- Discriminatory
- Neglect or acts of omission

10.5 Abuse can occur in the home, care homes, nursing homes, hospital, day centres; abusers (perpetrators) are often known to the person they abuse .

10.6 In commissioning services, we will seek assurance that safeguarding requirements are met.

11. Workforce

11.1 Dudley Borough Council and the PCT have developed a workforce strategy which acknowledges the vital role the workforce have in the delivery of quality services. The key issues are the move to personalised services, including personalised budgets and the increasing emphasis on primary rather than secondary care.

11.2 In relation to the mental health workforce they need to have the competencies to provide person-centred, socially inclusive and recovery-oriented services, primarily in a multi-disciplinary setting and provide a clear pathway for the service user and carer.

11.3 Furthermore in aiming to develop the skills and knowledge of staff who work with people with mental health problems the emphasis must be on placing the service user at the centre of

the process and recognising that their perspective is of equal importance to that of the practitioner.

12 Strategy Implementation and Governance

12.1 An implementation plan for this strategy is set out at Appendix 1. This will be monitored and reviewed by the Mental Health Partnership Board.

12.2 The membership of the Board consists of PCT and Local Authority commissioning staff as well as users, carers and providers - their role is to use their experience to influence service commissioning and provision.

13. Conclusion

13.1 This strategy builds upon the 2005-2010 strategy which incorporated the National Service Framework for Mental Health. Its three main drivers were to develop services closer to home and prevent as many users as possible from having to go to hospital or access care outside of Dudley; increase the range of community based services to prevent hospital admissions and increase the capacity of primary care to prevent an escalation in to secondary care and for care to be delivered in settings which were more accessible.

13.2 These changes to mental health services, in Dudley, have largely been achieved. The consultation has highlighted the need to continue to develop the range of services available in primary care. In addition, the strategy seeks to:-

- promote good mental health and well-being, whilst improving services for people who have mental health problems.
- make good mental health and well-being an achievable goal for everyone.
- help people to look after their mental health and prevent them from becoming ill.
- tackle the stigma that's associated with mental ill health by focussing on whole population (need to explain what this means)

mental health, recognising that individuals, employers and other stakeholders have a role to play in helping to achieve good mental health for all.

- more closely integrate mental health with other health and social care services

- plan care well and support people in achieving recovery.
- provide a personalised care plan for people assessed as needing services with service users encouraged and supported to purchase some or all of their services through Direct Payments or an Individual Budget.
- improve access to psychological therapies in primary care
- continue to develop primary care services and reduce the need for in patient admission
- address the mental health needs of the most vulnerable, including adolescents, victims of domestic violence and offenders.
- support those with mental health needs to get into employment
- develop services that respond to the needs of a young BME population
- work in partnership with service users and their carers throughout the commissioning process, ensure services are of a high quality and respond to the needs of service users.

Appendix 1

Strategy Implementation Plan for Mental Health Services for Adults of Working

Objective 1: Promoting mental health and well-being and reducing inequalities

No.	PRIORITIES	ACTIONS		
1.1	Information, advice and guidance will be accessible to people with mental health problems and their families.	• Review current information materials and access to services with partners and service users • Develop a strategy to make information more accessible and remove barriers to take up • Design and commission appropriate materials in accessible formats where needed, with particular focus on BME and harc reach groups.		
1.2	Services will become preventative by focusing on early intervention, preventing deterioration and reducing hospital admissions.	• Develop a Psychiatric Liaison Service to enable early identification and diversion of MH service users from Acute General Hospital care. • Ensure a clear care pathway from Primary Care MH services and other locally-based preventative and self-help services. • Work closely with the DWMHPT to monitor the performance c the Early Intervention in Psychosis Service (EIPS) to ensure \ sign targets are met.		

No.	PRIORITIES	ACTIONS		
1.3	Services will promote healthy lifestyles and improve the health and well-being of people with mental health problems.	• Audit health promotion initiatives to ensure accessibility for people with mental health problems, and especially for BME a hard to reach groups. • Establish joint working with primary care services regarding health and well-being initiatives to ensure the inclusion of peo with mental health needs • Establish a system of physical health checks/screening for MH service users on CPA and people with learning disabilities /MI problems • Ensure that exercise and leisure advice is incorporated into assessments and CPA plans • Inpatient services conduct a physical health/ healthy lifestyle assessment for every patient admitted.		
1.4	Challenge the stigma of mental illness to support the inclusion of people with mental health problems in community life.	• Dudley Strategic Partnership to engage public and private sector partners in initiatives to include MH service users in mainstream services.		
1.5	Ensure Carers receive the support required to enable them to continue in their caring role	• Carers assessment to be available for carers • Packages of care and support to be available, based on neec		

Objective 2: Transforming care and personalising services

No.	PRIORITIES	ACTIONS		
2.1	Services will become more user-centred and based on individual needs. People with mental health problems will be offered greater choice and control over the support they receive	• Providers will review the current practice of MH teams to identify changes required to meet personalisation goals • Training needs analysis will identify training required to delive new best practice • Providers to arrange appropriate inputs to meet training requirements identified • Increase the numbers of user-controlled services through Dir Payments and Personal budgets • Through commissioning, support the growth of advocacy services, including IMCAs working under the Mental Capacity Act		
2.2	Services will be delivered in local, non-stigmatising settings	• Services/clinics currently provided in specialist settings will b reviewed to identify if alternative, less stigmatising settings a available • Identify available venues in each locality with Primary Care a other partners		

No.	PRIORITIES	ACTIONS		
2.3	Promote access to mainstream community opportunities for people with mental health problems.	• Continue to review all existing day services with partners anc service users • Ensure a joint approach by all MH providers of day opportunities to ensure: ⇨ programmes are linked to mainstream community service providers, employment agencies etc, ensuring accessibil for groups currently excluded ⇨ use personal budgets to support access to opportunities focused on meeting the user's individual needs and choic		
2.4	Care pathways will be clarified to improve access to services for patients and carers.	⇨ Implementation of the West Midlands Care Pathways Programme		

Objective 3: Service Improvement

No.	PRIORITIES	ACTIONS		
3.1	Provide timely access to a range of effective clinical services	• Review access arrangements for each locality in the Borough and ensure care pathways comply with the West Midlands Pathway model.		
3.2	Implement effective Safeguarding practice	• Establish a section 136 Suite at Bushey Fields, inc policies a procedures to offer protection for vulnerable offenders in a sa and appropriate setting. • Ensure Safeguarding Adults procedures are effectively implemented by provider services and through partner agencies.		
3.3	Increase opportunities for paid employment for people with mental health problems	• Further develop partnerships with employment services and voluntary sector organisations to create increased employme opportunities for people recovering from mental illness.		
3.4	The range of accommodation available for adults with mental health problems will increase to promote choice, control and independence.	• In partnership with Supporting People and DACHS, ensure a strategy is in place to identify and meet the housing needs of people with mental health problems.		

Objective 4: Building the capacity of local services

No.	PRIORITIES	ACTIONS		

4.1	Develop good quality local treatment and support services within the Borough	• Commission a specialist low secure in-patient service for Dudley patients through a budget pooled with Black Country commissioning partners
		• In partnership with other Black Country Commissioners, brok the development of a specialist Eating Disorders Resource a to work intensively with patients for a minimum of 6 months.
		• Review/Improve/Develop services for those Mental Health users who have Dual Diagnosis – ie Mental Health and substance Misuse or Learning Disabilities such as ASD
		• Ensure that the mental health needs of offenders are met especially for those in custody
		• Develop services for young adults 16-25
		• Ensure effective Governance arrangements to:
		  • implement in local services the findings &recommendation of inspections and reviews
		  • monitor outcomes of services to ensure quality and safety are maintained
		  • disseminate best practice from NICE Guidance and other sources		

No.	PRIORITIES	ACTIONS		
4.2	Continue to promote Primary Care Services as the access point for the identification, treatment and support people with mental health problems.	• Work with Primary care colleagues to ensure that the wide range of services currently available through the primary c mental health teams are known and utilised		
4.3	Increase community support available: ⇨ to reduce care home placements ⇨ to make home-based care the norm	• Work with DACHS to ensure services and funding availabl such as domiciliary care to prevent users from having to enter residential, nursing or in-patient care		
4.4	Extend the range of treatment options available	• Conduct a scoping exercise to identify the range of treatm options currently available in Dudley • Review and disseminate through clinical services the best practice guidance available through NICE • Identify gaps in locally available service		
4.5	Continue the integration of services to create seamless care pathways for service users and carers	• Embed the West Midlands Care Pathway as the basis for integrated service delivery in Dudley's mental health care.		

No.	PRIORITIES	ACTIONS		
4.6	Enable service users placed out of borough to return to live closer to their local communities	• Continue with the current arrangement of the Joint Short Term Placement panel supported by the role of the Short Term Placement Manager- who ensures that only those requiring an out of area placement are moved out of area and works with clinicians to ensure a safe return for those currently placed outside Dudley • Work with the west Midlands Specialised Commissioning Team to ensure that Dudley residents placed by them hav reviews etc • Through commissioning/procurement practice, stimulate tl local market to provide placements for other residents for whom there is currently no local provision • Work with local managers and clinicians to review and rev protocols on future out of Dudley placements to minimise their use. • Develop joint commissioning practice with Dudley MBC budget holders to ensure a joint approach to care		
4.7	Ensure the workforce is equipped to deliver the services required for the future	• Ensure providers undertake a training needs analysis of th workforce • Ensure providers develop and deliver recruitment and training necessary to meet the challenges for future servic		

Objective 5: Improving Commissioning for mental health and well-being

No.	PRIORITIES	ACTIONS		
5.1	Develop commissioning capacity in partnership, to: ❑ meet the challenges of World Class Commissioning ❑ re-shape services ❑ ensure the most effective use of resources	• Achieve the change from block contracted services to cost ar volume contracts • Review the Dudley MH Strategic Plan to ensure the objective of "New Horizons" are fully incorporated and addressed • Work collaboratively with Black Country Commissioning partners to commission services jointly where this is benefici • Support contract monitoring processes with clinical quality audits in conjunction with Walsall PCT		
5.2	Strengthen the involvement of people with mental health problems in commissioning, service delivery and monitoring to ensure quality	• Develop the role of the Dudley MH Partnership Board in lead on consultation and user involvement in commissioning. • Develop with service users, advocates and carers a plan for improvement of user/carer involvement processes. • Meet regularly with Users and Carers to share information ar ideas • Develop mechanisms for the inclusion of BME communities, people with learning disabilities and other excluded groups ir consultation processes. • Review the options for embedding the findings of the user survey from 2009/10, to monitor and evaluate the service use experience in mental health services.		
5.3	Improve the performance	• Ensure all provider provide robust data that reflects the activi		

	management of all contracted providers	and quality of all services provided		

Appendix 2: Glossary

The following terms are highlighted in the text in italics.

Acute Care
The treatment of an illness for a relatively short period of time for a severe episode of illness.

Bi-polar disorder
A psychiatric condition that causes recurrent episodes of significant disturbance in a person's mood, energy, and ability to function. Also known as manic-depressive illness

Care plan
A plan of the treatment for an individual who is receiving health or social care. It will normally follow an assessment and be agreed between the person receiving care and the assessor.

Care Programme Approach
*(CPA)*A way of co-ordinating community health services for people with mental health problems in which one person co-ordinates all aspects of your care -including health and social care.

Carer/ carers
A person who provides support and looks after someone. In this document we only refer to informal carers (e.g. a member of the family) not paid carers.

Direct payments
A payment for people assessed as needing help from social services, who then arrange and pay for their own care and support.

Dual diagnosis
This term applies to people who have both mental heath and drug or alcohol problems.

Economically Inactive
People who are not in work, but who do not satisfy all the criteria for unemployment i.e. wanting a job, seeking a job in the last four weeks and available to start in the next two. The main groups classed as economically inactive are those looking after the family and home, students and those who are long-term sick or disabled.

Enabling/enable
To make possible or give support to help make something happen

FACS (Fair Access to Care Services)
Provides a framework for all Councils as to how they should undertake assessments and reviews, support individuals through these processes and provide or purchase in service to meet the needs of adults, subject to available resources. There are four bands of eligibility criteria: critical; substantial; moderate; low.

Individual budget
A scheme that allows people needing social care and associated services to decide the nature of the services they need. A key feature is a transparent allocation of resources that gives the individual a clear cash or notional sum for them to use on their care or support package.

Intervention
An action that is intended to alter the course of an illness.

Partnership board
A forum that brings together statutory and non statutory representatives together with user, carer and provider groups in order improve the experience of needs assessment, planning, delivery and service performance assessment for improvement. There are four partnership boards for health and social care for Learning Disabilities Services, Older People Services, Physical Disabilities and Sensory Impairment and Mental Health Services.

Outcome
The consequence of an intervention. (See above)

Pathway or integrated care pathway
A multi-disciplinary outline of planned care designed to help a patient achieve a positive outcome during and after treatment.

Personalised
Services that are delivered to people in line with their wishes and their convenience.

Personality Disorder
Features of an individual's personality that forms a pattern of behaviour that does not help an individual adjust and function well within a social environment. A personality disorder can create problems for the individual

because it causes conflict between that person and others or causes conflict within themselves.

Promoting Independence
A principle that underpins the delivery of health and social care services and stresses that care should aim to maintain and develop independence and respect people's dignity.

Provider
An agency that provides services to people – in this strategy it will normally refer to an agency offering health, social care or housing services. The agency can be a public sector, voluntary or private sector organisation.

Psychosis/Psychoses
A mental health disorder/s that produces disturbances in thinking and perception severe enough to distort an individual's perception of the world and of events within it.

Purchaser
An agency that purchases services on behalf of the population for which they are responsible. It may refer to a GP practice, a primary care trust, or a social services department.

Review
The periodic re-examination of a client's case to consider what changes to services or treatment are desirable.

Schizophrenia
A mental illness characterized by impairment in the perception or expression of reality, most commonly manifesting as auditory hallucinations, paranoid or bizarre delusions or disorganized speech and thinking in the context of significant social or occupational dysfunction.

Third Sector
Organisations that are independent of the Government, that work to achieve social, environmental or cultural aims, mainly reinvest any profits they make to help achieve those social, environmental or cultural aims. It includes community groups, co-operative, voluntary groups, charities and social enterprises.

Social exclusion
The government has defined social exclusion as "what can happen when people or areas suffer from a combination of linked problems such as

unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown".

Stigma/stigmatised
The prejudice or bigotry experienced by an individual who has a condition that society at large finds difficult to accept.

Transition
A time of significant change for a person e.g. where a person is moving from childhood (and being at school) to adulthood (and going to work or college)

Wellbeing The state of feeling healthy and happy

Appendix 3: The Consultation process including the Stakeholder Event 23rd November 2009

Attendees on 23rd November 2009

- PCT Commissioning- 4
- PCT Public Health-2
- D&WMHPT- 6
- Dudley MH Carers in Partnership-4
- Housing- RSL/DMBC 4
- Social Care- 2
- Dudley MBC Councillors- 2
- MH service users 9
- Third sector MH providers 6
- Carers 4
- BME Reps 8

The event undertook an analysis of current mental health provision in Dudley, the findings were :

Strengths

- PCT is approachable and responsive
- Feedback to providers is easy and they listen
- Stepped Care **can** work as movement can be up and down
- There is good community network in Dudley
- Well established specialist services exist such as EI/AO
- The acute hospital is local
- The use of the recovery model and its acceptance by MH providers

Weaknesses

- GPs- lack of knowledge and services/Pathways available from GPs even though they are the main route into MH services
- The dementia pathway inc assessments
- What is more important the service or the individual ?
- Users can get stuck as the services aren't always available/appropriate
- Stigma and labeling exists
- The pathways aren't well defined inc entrance and exit criteria
- Some issues with the standards of care available at Bushey Fields eg staff skills and accommodation
- Communication between professionals- GPs, Psychiatrists

- Translation

Opportunities

- Acknowledgment of intervention at an early stage eg with young people at school/college
- Improve personalization of recovery
- Increase social inclusion/recovery eg employment
- Need for MH Champions in each GP surgery to increase awareness etc
- Use of the media for positive stories
- Increased use of complex assessment in the community rather than in hospital cf EI
- Improve staff training to include user and carer input and focus
- Improved outcomes for users
- Improve the relationship between MH and ED @RHH- need for improved facilites at ED eg a calm area

Threats/Risks/Fears

- Reduced funding- how will it effect existing services
- The current system is confusing- relationship between D&W/Third sector/PCT and may become more confusing
- Reduced funding may lead to increased relapse and increased difficulty in accessing services
- Focus on reduced money rather than focusing on the positives
- Reduction in joint working inc joint funded posts
- Local services may be taken over by larger services- economy of scale- may lead to reduced local autonomy

The Consultation Period 23rd November 2009- 14th February 2010

And the following Questions were asked :

Question 1 - *Do you agree with the Strategy being based on the 4 main Government Policy drivers?*

- West Midlands Care Pathways/Yorkshire Care Pathways
- "New Horizons", which is due to be published in December 2009
- The Transformation of Social Care/Personalisation
- Social Inclusion

YES/NO

Additional Comments

Question 2 ***- Do you agree with the Vision on page 4? –***

YES/NO

Additional Comments

Question 3 ***- Do you think that the proposals in the Mental Health Strategy Implementation Plan 2010-2013 will meet the needs of people with mental health conditions and their families & carers?***

YES/NO

Additional Comments

Question 4 - ***Is there anything additional in the detailed proposals that you would like to see or anything not required?***

YES/NO

Additional Comments

Question 5 – Are there any other comments that you would like to add*?*

YES/NO

Additional Comments

During this period replies were received from:

- Strategy Manager supporting People and Housing DMBC
- Assistant Director for Mental Health and Learning Disabilities- DMBC
- Head of Partnership Commissioning – Dudley PCT
- Chief Executive D&WMHPT
- Carers Lead- D&WMHPT
- Co Director- Dudley Alzheimer's Society
- Unknown
- Public Health Colleagues Dudley PCT
- Child Psychiatrist – D&WMHPT
- Adult Psychologist- D&WMHPT

Their comments have been included in the revised version of the strategy and included :

- The need for the strategy to include health inequality and a whole population approach

- Need to strengthen the role of GPs/primary care
- Ensure this strategy is integrated with other strategies and initiatives
- A whole population approach will weaken an anti- stigma approach
- The use of individualized budget will increase vulnerability and inequality
- Please to see a service for 16-25 is being developed
- Good to see the emphasis on New Horizons and MH as everybodies business
- Don't see YCP as a driver but as a means of delivery
- Good to see the increasing role for users and carers
- Good to see a specific reference to employment
- Need to extend to 65+ so based on need not age
- Good to see an acknowldgement of the needs of LD within MH
- As new services are development what ceases should cease?
- Would like regular updates
- What is the future for drop in centres?
- Good to see the link between physical and mental health
- Where are the range of services for working age dementia
- More help for carers
- Improve the joint working with DGoH
- Need to improve access for vulnerable users- such as those not registered with a GP, those in hostels
- Concern for those who disengage from services but still have needs
- Lack of psychological services and poor communication between primary and secondary care
- Need to link achievements and gaps of the last strategy to this new strategy
- Why are most target dates 2010?
- Good to see that the strategy is non medical
- How realistic is the vision
- Need for better communication
- Why are most actions for the MH commissioner and not others?
- Need for an emphasis on recovery and early intervention and prevention. I believe the vision should also include mental health located in a social not medical framework and that the vision should signal to vulnerable people that they are a priority.

Appendix 4: Yorkshire Care Clusters/Pathways

The 21 clusters are as follows:

1 **Common Mental Health Problems (Low Severity)**
This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any psychotic symptoms.

2 **Common Mental Health problems (Low Severity with Greater Need)**
This group has definite but minor problems of depressed mood, anxiety or other disorder but not with any psychotic symptoms. They may have already received care associated with cluster I and require more specific intervention or previously been successful symptoms related to their substance misuse. It is possible that this group will suffer from cognitive impairment and/or physical problems as a result of long-term substance misuse.

3 **Non-Psychotic (Moderate Severity)**
Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)

4 **Non-Psychotic (Severe)**
This group is characterised by severe depression and/or anxiety and/or other and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

5 **Non-Psychotic (Very Severe)**
This group will be severely depressed and/or anxious and/or other. They will not present with hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.

6 **Non-Psychotic Disorders of Overvalued Ideas**
Moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc, where extreme beliefs are strongly held, some personality disorders and enduring depression.

7 **Enduring Non-Psychotic Disorders (High Disability)**
This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number

of years and although they may have improvement in positive symptoms considerable disability remains that is likely to affect role functioning in many ways.

8 **Non-Psychotic Chaotic and Challenging Disorders**
This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.

9 **Substance Misuse**
The main problem of this group is their misuse of alcohol or drugs. They may have some anxiety or depression and transient psychiatric symptoms related to their substance misuse. It is possible that this group will suffer from cognitive impairment and/or physical problems as a result of long-term substance misuse.

10 **First Episode in Psychosis**
This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety or other behaviours. Drinking or drug-taking may be present but *will* not be the only problem.

11 **Recurrent Psychosis (Low Symptoms)**
This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.

12 **Ongoing or Recurrent Psychosis (High Disability)**
This group have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.

13 **Ongoing or Recurrent Psychosis (High Symptom and Disability)**
This group will have a history of psychotic symptoms which are not controlled. They will present with moderate to severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.

14 **Psychotic Crisis**

They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

15 **Severe Psychotic Depression**
This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.

16 **Dual Diagnosis**
This group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles *and coexisting* substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.

17 **Psychosis and Affective Disorder Difficult to Engage**
This group has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable & engage poorly with services.

18 **Cognitive Impairment (Low need)**
People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but who are still managing to cope reasonably well. Underlying reversible physical causes have been rule out.

19 **Cognitive Impairment (Moderate Need)**
People who have problems with their memory and or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.

20 **Cognitive Impairment (High need with functional complications)**
People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of

their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.

21 **Cognitive Impairment (High need with physical complications)**
People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.

Appendix 5: NICE guidelines

The guidelines currently available, in relation to mental health include:

- antenatal and postnatal care
- antisocial personality disorders
- anxiety
- bipolar disorder
- Borderline personality disorder (January 2009)
- dementia
- depression
- drug misuse- opiod
- drug misuse- psychological interventions
- eating disorders
- Medicines concordance and adherence
- obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)
- Schizophrenia
- Self harm
- Violence

6.8.4 The following guidelines are in development

- NICE is updating its schizophrenia and depression in 2009
- Depression in chronic health problems (June 2009)
- When to suspect child maltreatment (July 2009)
- Alcohol use disorders (March 2010)
- Delirium (April 2010)
- Pregnancy and complex social factors (June 2010)
- Nocturnal enuresis in children (August 2010)
- Autism in children and adolescents (May 2011)
- Alcohol dependence (tbc)
- Severe mental illness with problematic substance misuse (tbc

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NICE guidelines

Our Health Our care Our Say (2006)

Our NHS Our Future DoH (2007)

Putting People First (2007)

The World Health Survey (2007)

This Strategy was written by Elaine Woodward,
Strategic Commissioning Lead, Mental Health.

Mental illness affects us all. Whether it is ourselves, a family member or a friend, lots of us will experience a mental health problem at some point in our lives.

Mental ill health not only causes untold personal suffering and distress, but also affects people's relationships, ability to work, family life. It can lead to a range of physical health problems.