

PUBLIC HEALTH INFORMATION REPORT MENTAL HEALTH

This report was written by Frankie Pidd and Karen Newbigging from the North West Mental Health Development Centre. It was produced by Oi Mei Li.

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Chapter One: Introduction

1.1 Purpose of the report

The North West Public Health Observatory is required by the NHS Executive North West to produce a range of Public Health Reports.

Public Health Information Reports aim to guide policy and practice by:-

- Providing a synthesis of local and national intelligence and knowledge.
- Encouraging and facilitating evidence based decision making by policy makers and key players within NHS and local government.
- Alerting policy makers and key players to the literature that may help to inform decision-making.
- Indicating where intelligence is weak, or significantly contentious or disputed.

This report will focus solely on adult mental health; it will not cover issues surrounding child and adolescent, or older peoples' mental health. The importance of mental health will be outlined, the scale of the problem and inequalities in the North West will be identified, and the evidence for effective interventions will be reviewed. The implications from this will be identified and the report is intended to provide a basis for local discussion and action.

1.2 Anticipated audience

The Public Health Information Reports are intended to inform a wide audience. They should be accessible and useful to senior managers, non-executives and clinicians who do not have specialist knowledge of the topics, but whose responsibilities include health improvement.

Adopting a public health perspective in relation to mental health, a "public mental health" approach means the range of potential actors and players becomes wide ranging. As "Making it Happen", the national strategy for mental health promotion, (DoH, 2001a), points out, the implementation of a wide range of policy programmes through housing, education, employment and regeneration initiatives, may all contribute to promoting positive mental health. At the same time, across the public health services this is a time of considerable organisational change, so there is potential for a significant uncertainty about potential action, programmes and organisational roles. This document therefore attempts to outline levels and types of action and roles and responsibilities. This is intended to be helpful to individuals in a range of settings and agencies.

1.3 Mental well being and mental ill health - importance and impact on society

Our concepts and language associated with mental health can be limiting. Later in this document it is argued that more comprehensive concepts are needed to describe and understand mental illness. However, within this document the terms that most people use and recognize have been used. At the same time, our concepts of positive mental health may need further development.

Mental well-being is not just the absence of mental disorder. It is a state in which a person is able to fulfil an active functioning role in society, interacting with others and overcoming difficulties without suffering major distress, or abnormal or disturbed behaviour (Donaldson & Donaldson, 1998). Mental well-being is known to be associated with physical health, emotional resilience, active participation in society, and economic productivity.

The focus of policy, debate, services and action have been dominated by concerns about mental *illness*. The term "mental health" itself usually implies problems, rather than health, and needs for treatment and care. It is important that our public health perspectives, which will inform and guide action, should be balanced, and include concepts of positive health as well as illness. The concept of mental well-being is discussed in more depth in chapter 4.

While the development of such thinking is still relatively recent, it is important because it implies a wider public health perspective than we have previously been accustomed to. It directs our attention towards action which aims to develop a mentally healthy society, as well as to action which aims to address mental ill health.

Mental ill health, in a variety of forms, has a serious impact on society.

Common mental health problems, including anxiety and depression, are suffered to a varying degree by more than 25 % of the UK population over the course of any one year (Audit Commission 1994, NHS Centre for Reviews and Dissemination, 2001). Major problems, including schizophrenia and other psychoses are less common but for some people may be very disabling, and for some, long term. Whilst people with severe mental illness form a small proportion of those with mental ill health, they tend to have very high rates of psychological and physical ill-health. The World Health Organisation has found that mental illness, including drug and alcohol misuse, accounted for almost 11% of the global burden of disease in 1990; this is expected to rise to 15% by 2020 (Department of Health, 1999a).

Suicide is more common among people known to have mental ill health than the rest of the population and most people who commit suicide have been suffering from some form of mental illness (Audit Commission, 1994). Although the overall rate of suicide is falling in the UK, it is the leading cause of death among men aged 15-24 years, and the second most common cause of death among people aged under 35 years (DoH 1999b).

As well as the impact on society as a whole, as policy makers within health and local government, we must be aware of the impact of mental ill health on individuals. Mental ill health can be a major cause of disruption and difficulty in peoples' lives: in sustaining supportive relationships with friends, family and colleagues; with parenting; with work and other daily activities (Audit Commission, 1994). These social consequences increase the stigma and social exclusion suffered by people with mental illness and that, in turn, can make the original condition worse (DoH, 1999a).

The impact on peoples' lives can be significantly different to the impact of other forms of disabling illnesses. People with mental illness can have their liberty restricted by the application of the Mental Health Act 1983, and be detained in hospital and treated without consent.

The increasing emphasis in policy and practice on managing risk and public safety can make it difficult for staff at all levels within the NHS to treat people with mental illness as citizens with civil rights and liberties. Further, mental illness remains stigmatised with a potentially serious effect on every-day life.

The National Service Framework for Mental Health, rightly, recognises the stigma and discrimination that people with mental illness experience. They may find employment prospects, relationships, credit ratings, housing options, access to health services and visa applications adversely affected by a history of psychiatric treatment.

Thus, mental health encompasses a significant public health agenda. And public health perspectives regarding mental health will cover a wide range of issues, from developing healthy cities and communities through work on inequalities; concerns with education, leisure, housing and the workplace; reducing stigma and discrimination; and ensuring that public services and initiatives address the quality of life, as well as relieving the symptoms, of people experiencing mental illness.

1.4 Types of data: types of evidence (including the "expert patient"); knowledge; associated problems

This report draws on and alerts readers to evidence, information and knowledge from a range of sources. Relevant data plus available evidence is presented through the report within the discussions of specific topics.

The concept of "evidence" itself and the specific philosophy, range and approach of medical and health service research is a matter of significant debate. The majority of evidence derived from health service research relates to the effectiveness of treatments or interventions by accepted practices. The strength and validity of evidence is commonly judged by classification systems largely developed in connection with drug and clinical trials. The National Service Framework for Mental Health (DoH, 1999a) uses the system outlined in Table 1.

Table 1: Types of evidence in the National Service Framework

I	At least one good systematic review, including at least one Randomised Control Trial (RCT)
II	At least one good RCT
III	At least one well designed study without randomization
IV	At least one well designed observational study
V	Expert Opinion

While this framework is helpful for considering the significance of information it presents some difficulties. Systematic reviews occupy the highest level of this hierarchy, although it is worth remembering that their value will be dependent on the individual studies used. Appendix 1 lists some systematic reviews on mental health topics.

The opinions of service users and carers are graded relatively low. The growth of service users agencies and the government's policies of involving patients and carers, means that key players and decision-makers are obliged to consider their views. Further, service users' views about treatment have a major impact on their co-operation and compliance; issues of real concern within mental health services. However, how do you judge whether what you are hearing represents a common concern to many people in your community, or the idiosyncratic views of one unusual individual? There is now a considerable volume of literature regarding the views of people using health services, highlights of which are summarised in chapter 10.

Randomised controlled trials (RCTs) are well suited to evaluations involving a clearly defined intervention in a controlled situation with defined outcomes. However as mentioned elsewhere in this report, the evaluation of some interventions applied to mental health promotion or treatment may be harder to evaluate through RCT design. In addition certain interventions may be situation or context dependent and less easy to dissociate from their context. This may be particularly the case for interventions at a community or population level. There is increasing interest in evidence that incorporates wider perspectives. For example Tilford et al (1997) point out that, while effectiveness reviews are "approaching the status of a holy grail", there are potential limitations in using traditional paradigms to assess effectiveness in health promotion. Similarly, it has been suggested that evaluation of multi-faceted, multi-agency programmes (such as Health Action Zones) requires radical research models, one such being "realistic evaluation", which focuses on the context, enablers and mechanisms for change (Judge 2000).

Decision makers and key players will also find themselves having to consider the ways in which services are delivered, and the relative merits of particular models of services. Indeed much of the evidence from service users is about processes and how services work, as well as treatments themselves.

There have been a considerable number of evaluative reports of services, although many do not find their way into national journals and evidence reviews. Where possible readers are alerted to such reports either in the main text or in the Appendix.

There are a number of important areas where our knowledge and evidence are quite limited, and key players may need to consider just what local information is available and what is needed. This is further discussed in Chapters 10 and 11.

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Chapter 2 – The Policy Context: Wider governmental policy

It is important to consider the major planks of mental health policy within the context of wider governmental policy. Much of that policy is intended to address the structural causes of ill health in British society, and to lay the foundations of a healthy society. It is also concerned to radically reshape the health and social care services. Both endeavours provide the framework within which mental health policy needs to be understood.

2.1. Social inclusion - "Opportunities for all"

Tackling social exclusion is a major priority for the current government. Social exclusion is a shorthand term for 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 environments, bad health and family breakdown (SEU, 2001). This emphasis on social exclusion is coupled with one on regeneration and renewal. Social exclusion is, therefore, not just recognition of the multi-faceted nature of poverty, but also an acceptance of equality and inequality as a proper concern of government. The key to achieving inclusion is seen in terms of comprehensive and sustainable strategies for regeneration and renewal, involving and empowering local communities in deprived neighbourhoods (Wistow, 2000).

Neighbourhood Renewal: National Strategy Action Plan (SEU, 2000) aims to renew the country's most deprived neighbourhoods and achieve the common goals of lower unemployment and crime, better health, education, housing and physical environment. The Strategy emphasises the need for organisations to join up at a local level and the enabling of local communities to have a part in this. Local Strategic Partnerships (LSPs) are the means by which it is proposed that this is done and in essence are non-statutory, non-executive organizations bringing key agencies to co-ordinate different services and initiatives.

2.2 Inequalities in health

The government has now established a clear policy framework for reducing inequalities in health based on the White Paper, Saving Lives: Our Healthier Nation (DoH, 1999a), the NHS Plan (DoH, 2000) and most recently Shifting the Balance of Power (DoH 2001a). Saving Lives is a comprehensive Government wide public health strategy for England and outlines a proposed contract for better health, to define what government and local organizations and individuals can do. It aims:

- to improve health;
- to reduce the health gap (health inequalities).

The strategy aims to prevent up to 300,000 untimely and unnecessary deaths by the year 2010. Saving Lives outlines four national priorities, including mental health and identifies a target for the period from 1996 to 2010 to:

- reduce the death rate from suicide and undetermined injury by at least a fifth by 2010 - saving up to 4,000 lives in total.

Each local area is also required to set additional local targets, including those to address health inequalities. These will be specifically tailored to local needs identified through local needs assessments. These will be identified by health and local authorities working together and with others to develop a local Health Improvement Programme. The emphasis is on reducing the inequalities in health status of people living in different parts of the country. Northern England is identified as having consistently higher mortality than other parts of the country throughout the last century (Annual Report of the Chief Medical Officer, Donaldson 2001).

2.3 Health promotion and tackling the root causes of ill health

The main ways in which health inequalities will be addressed include:

- A range of interventions to tackle the determinants of poor health – poverty reduction, environment, health promotion, disease prevention, screening and treatment
- Approaches focused on individuals and/ or those focused on areas
- Approaches focused on specific groups e.g. ethnic groups, gender and/or disadvantaged groups e.g. those living in deprived areas
- Age –group based interventions e.g. children, adolescents, working population, older people

Health inequalities and access will be measured and managed through the NHS Performance Assessment Framework and a key criterion for resource allocation will be a demonstrable commitment to reducing inequalities in health. Developing methodologies, for example equity audits, will be important to monitor progress. It is also proposed to develop a “basket” of inequality indicators which are likely to link to targets set in terms of specific service interventions outlined in National Service Frameworks (Donaldson, 2001).

2.4 Integrating care - the importance of partnerships

The emphasis on partnership runs right through the government's approach to health and social care. The focus of this is on the partnership between health and social services and the Health Act (DoH, 1999b) provides ways in which health and social services can pool their resources and coordinate their efforts. The NHS Plan (DoH, 2000) highlights Care Trusts as a new form of organisation to bring together health and social services. Health Action Zones have brought together a variety of partners to tackle inequalities and modernise services.

At the individual level, integrating care should allow the development of new care pathways, ensuring prompt and easy access to the variety of interventions and care needed, however that may be provided.

2.5 Care closer to home - the "shift from secondary to primary care"

Alongside integrated care and care pathways, throughout the vision for a modern health service, runs a theme of providing care closer to home. PCTs are intended to provide an essentially local, community-based driver in the reshaping of the NHS. The modernisation of primary care is intended to provide swift access to preventative care, diagnostic services, long term follow-up and review of chronic or disabling conditions, intermediate and crisis care, on

a local, community basis wherever possible. The vision implies a radical restructuring of traditional health service provision with much greater emphasis on services within primary and community care (DoH 2000).

2.6 Patient and public participation

Service users, carers and their families will have an increasing say in how health services are designed, developed and delivered, as the NHS moves towards a model of increased partnership. The creation of Patient Advice and Liaison Services (PALS) and Patients Forums in every NHS Trust and PCT will provide more support to patients and provide new ways for them to influence decision-making for individual care and for service change to local services. New structures alone will not deliver the necessary reform. It will be essential to support their development and in particular to provide adequate training and support to the patient or carer who will act as a non-executive Director. Involving Patients and the Public in Healthcare (DoH, 2001b) explores proposals for strengthening patient and public involvement in the NHS, including replacing Community Health Councils in England with new Patients' Forums and a new national body called 'Voice - the Commission for Public and Patient Involvement in Health' which will oversee the new arrangements.

In addition there is the development of an expert patient programme with a focus on empowering people with chronic diseases, including schizophrenia, to manage their ill health in partnership with professionals (DoH, 2001c). Enabling expert patients to work alongside professionals is not without tensions; recent experience of incorporating an expert patient perspective in developing national guidelines on chronic fatigue syndrome demonstrated real difficulties in reconciling patient and professional views.

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Chapter 3 Mental Health Policy

Mental health policy echoes the key themes of wider governmental policy outlined above, and heralds significant and comprehensive change in services and statutory initiatives.

3.1 The NSF - comprehensive standards for action at all levels

The NHS Plan (DoH, 2000a) and the National Service Framework (NSF) for Mental Health outline new ways of working and new models of service delivery for people with mental health problems. The NHS Plan outlined additional investment in secure beds, 24 hour staffed beds, extra assertive outreach teams and improving access to services 24 hours a day, 7 days a week. The NSF for Mental Health, (DoH, 1999), built on Modernising Mental Health Services (DoH, 1998) to set seven standards, which are comprehensive and have implications for action at all levels and across a broad range of organisations. These standards address:

Box 1: National Service Framework for Mental Health

- Mental health promotion and tackling the discrimination and social exclusion associated with mental health problems; (Standard One)
- Primary care and access to services for anyone who may have a mental health problem; (Standards Two and Three)
- Effective services for people with severe mental illness. (Standards Four and Five) This includes the requirement that Care Management and the Care Programme Approach (CPA) should be integrated and outlines expectations of a range of services including:
 - o Help with skills and social networks to address social isolation;
 - o Help to access employment, education and training;
 - o Assistance with daily living;
 - o Supported living, where the level of support is flexible so that more support can be provided at times of crisis.
- Individuals who care for people with mental health problems and requires carers who provide regular and substantial care for a person to have an assessment of their own needs and a care plan; (Standard Six)
- The action necessary to achieve the target to reduce suicides as set out in Saving Lives: Our Healthier Nation. (Standard Seven)

Last year, implementation guidance for the NSF was published (DoH 2001a). The guide emphasized the need for whole systems development and provided detailed information on the different components for this system namely:

- Crisis resolution team/home treatment teams to act as a gatekeeper to mental health services and provide immediate multidisciplinary community based treatment 24 hours seven days a week for individuals with acute severe mental health problems
- Assertive outreach service to support people with severe mental health problems with complex needs who have difficulty engaging with services and often require repeat admissions to hospital
- Early intervention in psychosis to provide evidence based interventions and promote recovery during the early phase of psychotic illness
- Effective partnerships between primary care, health, social and voluntary sector provision to ensure effective treatment and faster access for people with a range of mental health problems
- Primary care – new workers and new ways of working to provide an effective response to a range of mental health problems
- Mental health promotion outlined in more detail below.

Additional guidance is due to be published later this year and will include a Women's Mental Health Strategy, a Strategy for Black and Ethnic Minority Communities, guidance on community mental health teams and acute in-patient care, and a Strategy on Suicide Prevention.

The NSF for Mental Health describes the local action necessary for implementation and established Mental Health Local Implementation Teams (LITs) which will take the lead in the process of change needed to deliver the new models and new ways of working. During 2001/2002 local health and social care communities are expected to plan for full-scale implementation of the new models in 2002/2003 and 2003/2004. In Autumn 2001 all LITs had to submit the outcome of their comprehensive review of community mental health provision to ensure that new services will be delivered in a co-ordinated way. The local mental health implementation plan remains the key document for consolidating investment and service development, and for delivering NHS Plan and NSF for Mental Health requirements (DoH, 2001a).

The focus of the NSF for Mental Health and this report is on adults of working age. However the National Service Framework for Older People published last year (DoH, 2001b) includes mental health as one of eight standards which states that:

“Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers”.

It stresses the importance of accessible services which are community orientated and stresses that many people will be cared for within primary care whilst specialist services provide care and support to those with the greatest problems. Like the NSF for Mental Health this NSF also stresses the needs of carers and the importance of supporting

them. In addition to this standard on mental health there is also one on mental health promotion. This sets out the interventions at a population level to promote good mental health including educational activities, and creative and social pursuits.

Finally, work is underway in relation to an NSF for Children which is due for publication in 2003/04.

3.2 "Making it happen" - mental health promotion

Standard one of the National Service Framework for Mental Health, and the NSF for Older People, provide a real opportunity to promote positive mental health, tackle the causes of mental ill-health and address the stigma and discrimination surrounding mental ill-health to ensure access to opportunities and promote the social inclusion of those with a mental illness. This is the first time that health and social services have been given this clear remit and the publication of national guidance "Making It Happen" (DoH, 2001d) to support standard one together with specific performance targets means, "that mental health promotion is no longer optional" (DoH, 2001c). The performance targets for standard one for local services are:

- To develop and agree a mental health promotion strategy based on needs assessment by March 2002
- To build in to the strategy specific action to promote mental health in specific settings based on local needs by March 2002
- To build into the strategy action to reduce discrimination by March 2002

Mental health promotion strategies will need to consider interventions at three different levels: strengthening individuals, strengthening communities and reducing structural barriers to mental health. The strategies should address ways of strengthening protective factors and working to reduce risk factors at individual, community, structural or policy level. The development of these strategies will need to involve many different organisations as the factors, which influence mental health, lie outside health and social care. Links will need to be made with the policy initiatives described above.

3.3 Social inclusion

The discrimination and marginalisation suffered by people with mental health problems has been recognised for a long time and are now recognised as fundamental issues, which need addressing (Hutton, 2001). Sayce & Measey (1999) found people diagnosed with a significant mental illness to be "among the most excluded in society" based on an analysis which illustrates reduced employment rates and prospects (Office of National Statistics, 1998).

The current policy context is aiming to address this by establishing performance targets for local services, so in addition to those outlined for Standard one above:

- By March 2002, the written care plan for those on enhanced Care Programme Approach (CPA) must show plans to secure employment or other occupational activity; adequate housing and their appropriate entitlement to benefits.
- By March 2002, implement strategy to promote employment of people with mental health problems within health and social services.

The development of guidance on employment is currently being prepared (Mental Health Promotion Update, 2001). In addition the opportunities described above in relation to Local Strategic Partnerships and neighbourhood renewal provide an opportunity to tackle this marginalisation. The citizenship of people with serious mental health problems is also currently the focus of a Department of Health initiative (Morris, 2001).

3.4 Integrating care

So far, the performance targets for mental health services have focused on secondary care services for people with serious mental illness; e.g. integrating the Care Programme Approach and Care Management, and moves to integrate health and social care provision within "partnership" or Care Trusts. Given the important influence of social problems and perspectives in both mental well-being and mental ill health, it is to be hoped that integration will result in more holistic thinking and practice.

3.5 Care closer to home

In most parts of the country, mental health service provision is undergoing change to comply with policy which emphasises integrated specialist mental health trusts as the preferred organisational model for delivering services. At the same time, the establishment of a range of focused services, as described in 3.1, means that some community-focused services are now being provided on a wider geographical basis, and for larger population catchments than previously. In this respect, mental health services differ from the developments described above in 2.5. Achieving a sensible balance between focused services and local care, close to communities and home, will constitute a major challenge.

3.6 Reform of the 1983 Mental Health Act

The NHS Plan confirmed that the 1983 Mental Health Act would be reformed to create a new legislative framework reflecting modern patterns of care and treatment for severe mental illness. The focus will be on managing risk and providing better health outcomes for patients. The White Paper (HMSO, 2000) has a stronger emphasis on people's rights and will be fully compatible with the Human Rights legislation. The changes it identified are outlined in Box 2.

Box 2: Key elements in the reform of the 1983 Mental Health Act

Introduction of a new legal framework including:

- Safeguards for treatment
- A new independent tribunal to determine all longer term use of compulsory powers
- A new right to independent advocacy
- Safeguards for people with long-term mental incapacity
- A new Commission for Mental Health
- Statutory requirement to develop care plans
- Recognition of advance directives
- New procedures for the use of compulsory powers which involves a three stage approach

The proposals to extend compulsory treatment arrangements beyond hospital settings and into the community have proved controversial with service users and mental health professionals.

The government has also published proposals concerning "Dangerous People with Severe Personality Disorder", deemed to present a high risk to the public. Proposals concern both the statutory framework for treatment and the range of care (secure care and rehabilitation) to be provided.

3.7 Reshaping secure psychiatric services

Extensive assessments of high secure care (see chapter 9.3), have demonstrated that a significant proportion of people in high secure hospitals do not require that level of security but could move on to other forms of care, were that available. Additional funding has been made available by the government to allow the development of long-term secure beds, and other intensive community based services. By 2004 it is intended that up to 400 patients will have moved from high secure hospitals across the country into more appropriate accommodation.

3.8 NIMHE – A national infrastructure of development support

A National Institute for Mental Health (NIMHE) is currently being established to maintain the momentum of service development (DoH, 2001c). It will create an infrastructure of development support. The consultation paper published in 2001 outlined four elements which are:

- a small administrative centre which will oversee the work of NIMHE
- regionally based development centres
- a National Mental Health Research Network
- a series of time-limited programmes, for example, to develop mental health in primary care

The NIMHE North West Regional Development Centre will build on the foundations laid by the existing North West Mental Health Development Centre which has provided development support and information about practice and policy developments since 1999.

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Chapter 4 – A conceptual framework for action

Given the complexity and scope of the agenda there are a range of potential actions at different levels, and different contributions to be made by a broad range of key players to addressing public mental health. This section elucidates a framework for action for public health, bringing together these different contributions and roles with interventions at different levels. The issues are discussed below and summarised in Table 2.

4.1 Mental well-being and mental ill health

The focus of policy, debate, services and action has been dominated by mental *illness*. The term "mental health" itself usually implies problems and needs for treatment and care. It is important that our public health perspectives, (which will inform action) should be balanced and include concepts of positive health as well as illness. However the shift towards such thinking is still new and the literature, models and concepts, as yet developing.

Mental well-being may be defined in a variety of ways. Well being at an individual level will be affected by a range of influences including biological and psychological factors, the quality of the natural and built environmental, socio-economic factors such as income, access to health care, social factors such as the quality of relationships, spiritual influences such as sense of purpose and feelings of community with others.

Definitions of mental well-being highlight the individual's capacity to communicate, express his/her self, form and maintain relationships with others. Self-esteem and empathy for others are believed to be critical for mental well-being.

The CORE-OM (Barkham et al, 2001) is a standardised tool to measure outcomes for a range of psychotherapies. CORE uses the results of self-reported evaluations against a range of statements to key domains, subjective well-being, problems/symptoms, life functioning and risk. The resulting scores can be used to indicate the severity of mental health problems and the impact of treatments. While the measure is problem oriented, the positive statements provide an interesting "snapshot" of well-being. They are:

- "I have felt warmth and affection for someone"
- "I have felt able to cope when things go wrong"
- "I have been happy with the things I have done"
- "I have been able to do most things I needed to"

Mental ill health covers a very wide range of problems, many of which are complex and which may be associated with social, familial and relationship problems; physical ill health; physical symptoms which cannot be medically explained; drug and alcohol problems of varying severity, and behavioural problems which cause problems or risk either for the individual themselves or for others.

Mental ill health may be transient and short lived; intermittent or repetitive; or long term. The impact on people's lives may be limited, severe, or disabling.

Mental ill health includes:

- Depression - may affect mood, concentration, energy, appetite and sleep; individuals may feel suicidal and depression can be life threatening.
- Deliberate self harm - involves intentional self-poisoning or injury irrespective of the apparent purpose of the act.
- Suicidal behaviour - people who attempt suicide can vary in the degree of their wish to die, and different suicidal acts will have different degrees of risk to life.
- Anxiety, panic disorders, social anxiety and phobias – anxiety can be generalised or attached to a specific situation or object.
- Post traumatic stress disorders - psychological symptoms may emerge following the experience of a traumatic event affecting people's ability to live their lives.
- Eating disorders - include anorexia nervosa, with severe weight loss, and bulimia with both under and over eating. These compulsive behaviours can be highly distressing and dangerous.
- Somatic disorders - physical sensations and signs of ill-health which do not have an identifiable physical cause and which are likely to be a response to psychological difficulties.
- Chronic fatigue syndrome - sustained physical fatigue continuous over more than three months without clear physical cause.
- Personality disorders - are controversial diagnoses. They are characterised by very long-standing, inflexible and limiting attitudes and behaviours which may cause distress to the individual or others. They often begin or become noticeable in early adulthood and are thought to be linked to childhood experience.
- Affective psychosis - causes profound mood swings, either to severe depression and reduced activity, or to elation with over-active/excited behaviour.
- Schizophrenia - may involve thought disorder, auditory hallucinations, and delusions. The range of symptoms is wide and the term may cover a number of conditions.
- Dual diagnoses - people experiencing mental disorder and drug and/or alcohol problems.
- Mental health disorders associated with criminality (Mentally Disordered Offenders); people who need psychiatric care in secure settings.
- Complex needs - some people may experience complex combinations of mental disorder, substance misuse, offending, personality disorder, etc.

Following common practice, the NSF (DoH, 1999) distinguishes between "common mental health problems" and "severe mental illness". As pointed out in section 9.3, these common classifications have some limitations, and hence the use of "mental ill health". However this report uses the terms that most people will recognise throughout.

4.2 Different types and levels of action to promote mental well-being, and to address mental ill health

A range of different types of action is necessary if we are to promote mental well-being as well as addressing mental ill health. This will include:

- Action to promote mental well-being:

- Building a healthy society
- Developing healthy communities and neighbourhoods
- Promoting mental health in schools
- Strengthening families
- Social inclusion

- Action to prevent the development of mental ill-health

- Identification of vulnerable groups
- Selective action targeted to individuals or groups at increased risk
- Early recognition of mental distress and ill health and appropriate action

- Action to ensure appropriate and effective services for people experiencing mental ill health

- Ensuring effective response to the full range of mental ill health
- Comprehensive implementation of the NSF

- Action to improve the life prospects of people with mental illness

- Improving access to employment, housing, education, welfare benefits and personal relationships

- Action to address stigma and discrimination

- Reducing the problems experienced by people with mental ill health
- Raising the awareness of the general public about mental ill-health and the effects of stigma and discrimination on peoples' lives.

Action may be focused at national level; at the strategic level for large populations; at the community level for medium sized populations; at the level of services provided by primary and community health and social care; and at the level of mental health and social care services.

Action may potentially be taken by a range of key players described below. Most players will have varied roles and responsibilities though often with a particular focus. Ultimately, the onus to ensure comprehensive action across all levels is jointly shared.

4.3 Key players and their public health roles

Currently significant organisational change is underway across both health and social care, and roles and responsibilities are changing. "Shifting the Balance of Power" (DoH, 2001a) constitutes a radical attempt to shift the focus of commissioning and service delivery closer to local communities and neighbourhoods. The policy emphasis on social inclusion, and addressing inequalities and the root determinants of ill health, create the opportunity for new wider public health roles, more closely aligned to local government, and their concerns with regeneration, safer neighbourhoods, environmental health, and healthy communities. And the gradual integration of health and social care underlines the need for public health roles that look beyond clinical interventions and treatment and can apply rigour to knowledge about the social perspectives of people's lives.

4.4 Government and National Initiatives

Government and national initiatives are the main focus for providing the infrastructure for a mentally healthy society.

Chapter 6 considers a range of regeneration initiatives, carried out on a large population basis within national frameworks.

The development of regional government offices, and the location of Regional Directors of Public Health within them, should ensure appropriate links between public health and regional economic development initiatives.

4.5 Strategic Health Authorities

Strategic Health Authorities provide strategic leadership for populations of around 1.5 million, working with PCTs and Trusts to ensure appropriate community secondary and tertiary care. Specific responsibilities include development of clinical networks and establishing managed public health networks for specific functions which it is not effective or economic to provide in each PCT. Such networks might be established for mental health, or specialist mental health services such as drugs and alcohol, child and adolescent mental health services. They will also need to articulate with secure psychiatric services through the North West Regional Secure Services Commissioning Team.

Strategic Health Authorities need to face both ways, engaging with PCTs and local players but also ensuring links to more specialist services, planned and secured for larger population groups.

Strategic Health Authorities share responsibility with other agencies for action to prevent suicide.

4.6 Local Authorities and Social Services Departments

Local authorities are responsible for a broad range of services - housing, leisure, education, economic development, environmental improvements, community safety, welfare rights and social services. The policies and way in which services are provided have a role to play in securing mental well-being for a local area.

They therefore have a key role to play in action to build a healthy society, healthy communities and neighbourhoods through their responsibilities to improve the economic, social and environmental circumstances of their area. Local Authorities thus have an important responsibility for implementing Standard One of the NSF and share responsibility with other agencies for action to prevent suicide.

Box 3: The role of Local Authorities in influencing mental health

Local Authorities will influence mental health:

- Through their Community Strategies, which should include healthier communities, social and mental well being
- Through their joint work with PCTs on Health Improvement
- Through the role of Scrutiny Committees which provide an opportunity to review the impact on mental health of a range of local initiatives
- By ensuring that people with mental health problems are not disadvantaged in their access to local services
- By training staff (e.g. in housing departments so that they feel confident in responding to people with mental health needs
- By ensuring the early identification of mental health problems and the provision of appropriate support, for example in schools, without referring on to specialist services
- By building local participation and consultation processes which can be seen to improve "social capital", and involve people with mental health problems.

Within Local Authorities, Social Services Departments are specifically directed by the NSF to contribute to mental health promotion, and to support for carers.

Local Authorities are also linked to the Regional Government Offices, and Regional Development Agency. The Regional Development Agency's responsibility for developing the Regional Economic Strategy is a particularly important driver for economic redevelopment in the North West.

4.7 Local Strategic Partnerships (LSPs)

Local Strategic Partnerships are non-statutory, non-executive organisations that in a single body:

-
- Bring together at a local level the different parts of the public sector as well as the private, business, community and voluntary sectors so that different initiatives and services support each other and work together;
 - Operate at a level which enables strategic decisions to be taken and is close enough to individual neighbourhoods to allow actions to be determined at community level;
 - Should be aligned with local authority boundaries (Wistow, 2000).

LSPs will prepare and implement a community strategy to identify local needs and priorities and develop and deliver a local neighbourhood renewal strategy to secure more jobs, better education, improved health, reduced crime and better housing. To tackle these tasks effectively LSPs will need to secure genuine involvement from all sectors and the local community and need to make real efforts to involve people who are traditionally under-represented. Their potential impact on mental health, through general and focused action, could be significant.

4.8 Primary Care Trusts (PCTs)

Primary Care Trusts will increasingly become the driving organisations within local health economies, securing and delivering health care for neighbourhoods, communities, and medium size populations. Since April 2002, PCTs have become the lead organisation within the NHS in assessing need, planning and securing services.

Their enhanced functions encompass:

- Developing primary care and ensuring the provision of primary and community health care
- Lead role for assessing need, planning, commissioning/securing secondary health care services
- Lead role for Health Improvement for the local population
- Leading the NHS contribution to joint work with local government and other partners
- Ensuring local ownership - developing strong links with the communities they serve
- Integrating health and social care for the benefit of local populations.

PCTs are likely to work in managed public health networks to ensure effective fulfilment of the public health responsibilities across the broad and complex range of need and services.

PCTs' "public mental health" roles will encompass initiatives to promote mental well being; to prevent development of mental illness; and securing effective services to meet the range of NSF standards.

PCTs share responsibility with other agencies for action to prevent suicide.

PCTs have already begun to develop an infrastructure for health improvement, developing a range of health promotion initiatives and establishing important relationships with local authorities and other partners (National Tracker Survey of PCGs & Trusts, 2001) These arrangements will become increasingly important and offer the opportunity to strengthen the agenda for mental health promotion and preventative initiatives.

Through their roles in the development (and from April 2002) of primary care, PCTs have had important roles to play in providing appropriate services for people with common mental health problems (as defined by the NSF) who are likely to seek support and help from primary and community services. The NSF for Mental Health recommends lead responsibility for delivering standards 2 and 3 (primary care mental health services, and access through primary care to mental health services), be held by PCTs.

Through the cycle of activity for commissioning/securing secondary care services (needs assessment, negotiation and agreement of service level agreements to deliver care, development of clinical networks across organisations to ensure integrated care), PCTs, working closely with LITs, will thus carry a significant responsibility for ensuring effective mental health services including:

- Appropriate assessment of mental health need within the local population, covering the full range of population groups and the range of mental health problems and illnesses
- Ensuring the appropriate range of services tailored to local need
- Ensuring the effective delivery of mental health services.

4.9 Primary health and social care

Primary and community health care services are usually the most local and accessible, and the gateway into a complex range of services. Practices and locality based services can play an important part in providing health care for potentially excluded groups such as homeless people; improving recognition of vulnerable groups and providing support; in the early recognition of mental ill health and providing appropriate support; in identifying suicide risk and preventing suicide; in effective provision of health care for people with common mental health problems; and contributing to comprehensive care for people with serious mental illness.

In time, health and social care services will be integrated in community based services improving the opportunities for action to prevent the development of mental ill health, and in improving the first line services provided for people with mental illness.

4.10 Mental Health Services

Specialist mental health services will increasingly integrate health and social care and carry a significant range of roles and responsibilities for action in relation to services for people experiencing mental illness. Mental Health Trusts carry the lead responsibility for delivering the comprehensive range of services outlined in chapter 3.1 and described in the recent NSF Implementation Guidance (DoH, 2001b). They can also make a major contribution to addressing stigma and discrimination and improving the life prospects/quality of life for people with serious mental illness. They share responsibility for action to prevent suicide with other agencies and players.

Table 2 – Public mental health – Potential action at different levels of intervention

	Focus/level for action	Society/national focus	Strategic Large population focus (Regional offices, SHAs LSPs)	Community Medium population focus (PCTs LSPs SSDs, LITs)
Types of action/initiative	Developing the infra-structure for a healthy society	Inter-departmental links at government to ensure coordinated action	Strategic partnerships to tackle inequalities	Promoting mental health in schools and building emotional literacy
	Action to improve the economic and living conditions of socially excluded groups	Urban regeneration and environmental improvement	Action to improve access to employment	Strengthening community networks and voluntary services to build network of informal support
	Selective prevention – action targeted at groups vulnerable to mental ill health	Zero tolerance of abuse and harassment e.g. domestic violence, racism, bullying	Health Improvement Workplace initiatives	Homestart/Sure Start Programmes to strengthen families
	Action to address stigma and discrimination	Legal reform to tackle discrimination e.g. Disability Discrimination Act	Influencing the media e.g. media training for service users, positive stories about mental health	Ensuring equitable access for all and tackling barriers
	Early identification and intervention for mental health problems	Awareness raising initiatives	Development of early intervention services for young people with first onset psychosis	Information / directories of local and national support
	Ensuring appropriate help in crises		Provision of information and telephone helplines	Developing a range of responses to people with different types of crises
	Effective long term care and support for those who need it	Adequate investment in mental health service provision	Effective partnerships which focus on mental health and a comprehensive response. Effective partnerships	Providing support to access ordinary housing and employment
	Improving life prospects/quality of life for people serious long term problems	Addressing the benefit trap for people who wish to return to work	Securing housing, jobs, leisure and education for people with mental health problems	Ensuring people receive advice and information about entitlement to benefits

Table 2 continued

	Focus/level for action	Service Provision focus – primary and community health and social care	Service provision focus – specialist Health and social care
Types of action/initiative	Developing the infrastructure for a healthy society	Provision of information and networks to support good mental health	Empowerment and emphasis on self-management
	Action to improve the economic and living conditions of socially excluded groups	Ensuring access to health care for potentially excluded groups e.g. homeless people	Increasing coping and problem solving skills
	Selective prevention – action targeted at groups vulnerable to mental ill health	Improving recognition and support of vulnerable groups in general practice e.g. unemployed, bereaved people, young mothers, farmers etc.	
	Action to address stigma and discrimination		Person centred planning to improve personal autonomy and control
	Early identification and intervention for mental health problems	Training for primary care	Assertive outreach services to provide support to people who have complex problems and are at risk of exclusion
	Ensuring appropriate help in crises	Improving liaison between practices and mental health services for individual crisis planning	24 hour 7 days a week access to specialist assessment and support
	Effective long term care and support for those who need it	Improving recognition of and support of carers in general practice	Emphasis on recovery and wellness recovery action plans (WRAP)
	Improving the life prospects/quality of life for people with serious long term problems	Ensuring appropriate access to health care for physical as well as mental healthcare needs	Care programme to work Employment schemes

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Chapter 5: The North West Region

5.1 Introduction

The North West Health Region stretches from the plains of Cheshire in the South to the Southern part of the Lake District in the North and from the Welsh borders and Irish Sea in the West to the Pennines in the East. The counties of Greater Manchester, Lancashire, Merseyside, Cheshire, South Cumbria and the part of Derbyshire which includes Glossop cover the North West Region (Figure 1). From April 1st 2002 there have been three Strategic Health Authorities covering the three areas illustrated in Fig.1. The number of Primary Care Organisations will have reduced to 42 PCTs, and there are 22 Local Authorities. The population of the region is 6.5 million (ONS 1999 mid year population estimates), 40 per cent of the population reside in the Greater Manchester area with only 15 per cent living in the county of Cheshire.



Figure 1. The North West Health Region
Source: North West Region Office
(www.doh.gov.uk/nwro/region)

5.2 What do we know about the determinants of mental well-being in the North West?

The earlier discussion of mental well being noted characteristics of mental health in individuals. As has been noted by the Scottish Development Centre for Mental Health (SDCMH, 2002), to date policy debate and strategy for developing positive mental health for all has been limited. We consequently have few indicators for measuring mental health and well being nationally or in the North West. The SDCMH suggests that such indicators might include; positive self reported "overall health"; self reported sense of coherence; civic engagement; optimism for the future; proportion of children and young people who enjoy school; and that a range of survey initiatives are developing such measures in Scotland. They could usefully be developed in the North West.

5.3 Deprivation

The North West Health Region has some of the most deprived areas in the country, notably areas of Manchester and Liverpool, whilst also having some of the most affluent in parts of Cheshire and Lancashire. In relation to unemployment and lone parent households only London has higher rates. Deaths in the North West are higher than any other Region and 11% higher than the average rate for England and Wales. Approximately 4% of the population belong to ethnic minority groups (Table 3).

Housing is a major determinant in relation to physical and mental health. Housing may be of poor quality or inappropriate to an individual's needs. A shortage of housing in the North West is reflected in the numbers of people who are either homeless, resident in overcrowded housing or suffer insecure tenure. The English House Condition Survey in 1996 reported that 43% of private rented housing and 22% of owner occupied housing required addition of modern amenities, compared to the English averages of 31% and 18.6% respectively (DETR, 1998). In addition the North West had the highest proportion (23%) of elderly only households.

Table 3: North West compared to other Health Regions

	Northern & Yorkshire	Trent	West Midlands	Eastern	London	South East	South East	North West
Unemployment % of economically active population	10.1	9.6	9.6	7.0	11.6	6.7	7.6	10.7
Lone parent households as % of households with dependent children	20	17.4	18.1	15.0	25.3	15.1	16.1	22.6
White population %	96.5	95.8	91.8	96.8	79.8	96.9	98.6	96.2
Hospital episodes for schizophrenia. Rates per 100,000 population	67.9	92.6	52.0	55.4	118.4	56.4	67.1	86.0
Suicides and undetermined deaths. Rates per 100,000 population	10.2	9.0	8.9	7.9	9.4	8.8	9.3	11.0
Limiting Long Term Illness (%)	14.6	13.9	13.0	11.0	11.8	11.0	12.6	14.9
All causes Standardised Mortality Ratio	107	103	103	94	97	94	91	111

Source: Compendium of Clinical and Health Indicators 2001

While the deprivation levels across the region are high, there are significant variations between health authority areas as indicated by Townsend Deprivation scores.

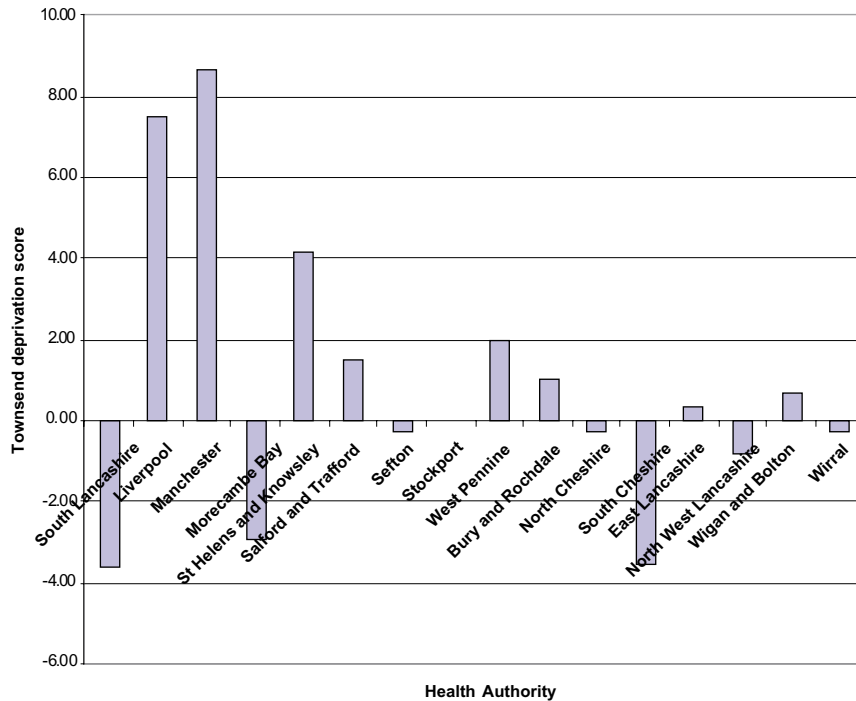


Figure 2 Townsend deprivation scores by Health Authority

Source: Compendium of Clinical and Health Indicators 2000

The North West has relatively poor health compared to England and Wales. Despite reductions over the last decade the North West experiences greater mortality than the other NHS regions. The Standardised Mortality Ratio (1997 - 1999) for all causes of death in the North West is 111, indicating that 11% more people die than if the region experienced similar mortality rates to the rest of England and Wales (DETR 1998).

In relation to mental health, the North West has the highest suicide rates in the country and only London and Trent have higher rates of hospital episodes for schizophrenia. In addition to higher mortality, the North West experiences increased morbidity (illness). For example the North West has the highest proportion of individuals (14.9%) reporting a long-standing illness which limited their daily function.

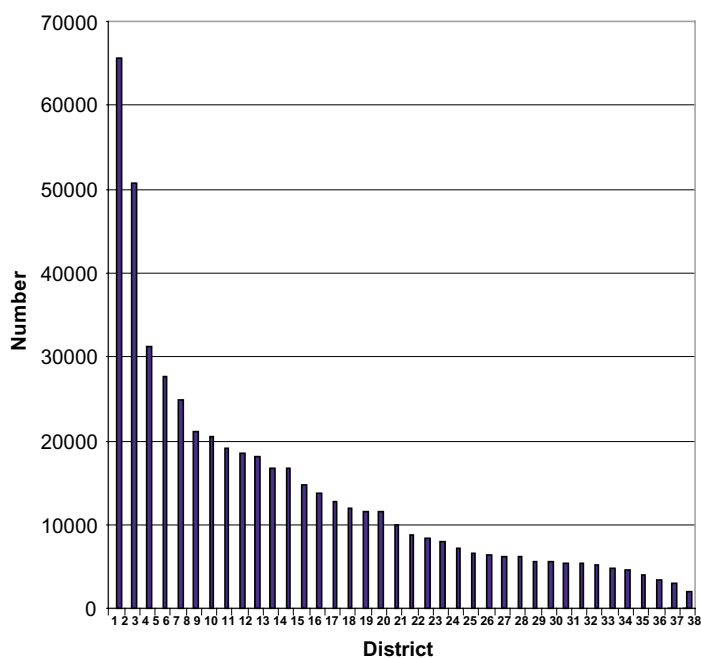
There is a significant evidence base indicating the socio-economic determinants of mental ill health. Social deprivation and income inequality; unemployment; poor housing and homelessness are all associated with mental ill health.

Although Health Authorities no longer exist and have been replaced by Primary Care Trusts and Strategic Health Authorities, comparative data is not yet available and therefore the information is being presented in terms of Health Authorities.

5.4 Employment

The Department of the Environment, Transport and the Regions have produced the Index of Multiple Deprivation (IMD) 2000. The IMD provides information in six domains; these are income, employment, health, housing, access and education. The Employment Scale is the number of people who are employment deprived at district level. Nearly 40% of the Districts (District Boroughs and Metropolitan Boroughs) in the North West fall into the most employment deprived districts in the country with a further 24% below the average.

Figure 3: Number of persons with employment deprivation at district level



Key							
Liverpool	1	Tameside	12	Burnley	23	Rossendale	34
Manchester	2	Stockport	13	Chester	24	South Lakeland	35
Wirral	3	Blackpool	14	Hyndburn	25	Congleton	36
Wigan	4	Halton	15	Pendle	26	Fylde	37
Sefton	5	Blackburn with Darwen	16	Vale Royal	27	Ribble Valley	38
Knowsley	6	Warrington	17	Chorley	28		
Salford	7	Bury	18	Wyre	29		
Bolton	8	Preston	19	Crewe and Nantwich	30		
Rochdale	9	Lancaster	20	Macclesfield	31		
St Helens	10	Barrow-in-Furness	21	Ellesmere Port & Neston	32		
Oldham	11	West Lancashire	22	South Ribble	33		

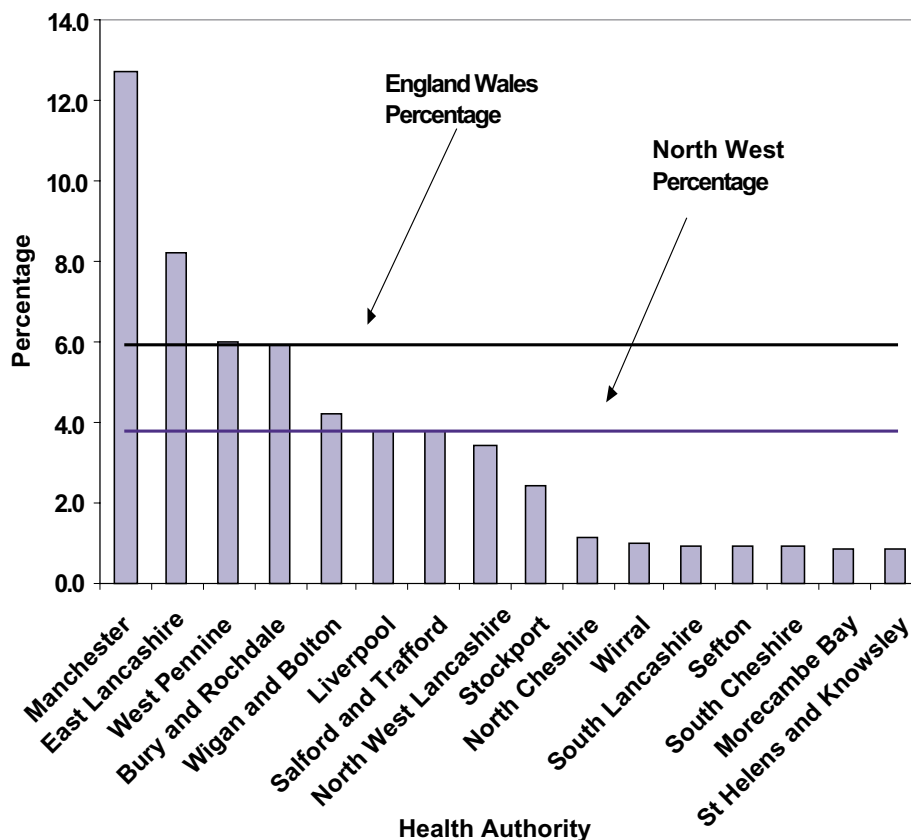
Source: DETR index of multiple deprivation 2000.

5.5 Black and ethnic minority communities

In relation to the rest of England and Wales the North West had a smaller minority ethnic population at the 1991 census (96.2% North West and 94.1% England and Wales is white). However there are areas with much higher ethnic populations such as Manchester, West Pennine, Bury and Rochdale and East Lancashire.

Figure 4 shows the black and ethnic minority population as a percentage of the total population in the North West.

Figure 4: Black and ethnic minority population as at 1991 census



Source: Compendium of Clinical and Health Indicators 2000

Table 4 illustrates the ethnic composition of the black and ethnic minority communities in the North West compared with Britain as a whole.

Table 4: Ethnic distribution of black and ethnic minority populations

	Britain	North West
	% of the total black and ethnic minority population	
Black Caribbean	17	9
Black African	7	4
Other Black	6	7
Indian	28	23
Pakistani	16	31
Bangladeshi	5	6
Chinese	5	7
Other Asian	7	4
Other Ethnic Minorities	10	10

Source: OPCS 1991 census

The age structure of this population was different at the OPCS 1991 census with fewer people over the age of 65 years and relatively larger numbers in the younger age groups.

There are also small populations of refugees and asylum seekers. Experience around the country has shown that both groups may be vulnerable to mental ill-health as a result of traumatic experience from the country of origin and through the process of seeking asylum (Ramsey, R et al., 1993, Carey-Wood, J et al, 1995).

5.6 Families and education

Children in the poorest households are three times more likely to have mental health problems than children in well off households (DoH 1999). Thirty six percent of wards in the North West fall into the bottom 1/5 th of wards with the most child poverty in England, with a further 19% in the bottom 2/5 ths . Children that live in poverty are especially vulnerable, may suffer social exclusion and therefore more likely to suffer mental health problems that will affect them in their adult life. The high percentage of wards in the North West with high levels of child poverty indicates there is probably a high level of child mental health morbidity in the North West. Children are more likely to experience the community and cultural risk factors associated with socioeconomic disadvantage.

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Chapter 6 - What can we do to promote mental well being?

6.1 Potential for action

As indicated there are a range of factors, which influence the mental well-being of individuals and communities. Interventions aimed at promoting mental health can therefore be focused on individuals, groups, community or population levels.

Interventions aimed at individuals and groups, who may be particularly vulnerable, are considered in Chapter 8. At strategic, large population level, a range of initiatives may be mounted to develop the infrastructure for a healthy society, with potential impact on mental well-being. Figure 5 summarises a range of regeneration initiatives, which aim to address some of the structural problems known to be determinants of mental ill health discussed above, and which are clearly highly significant in the North West.

Action may also be focused on smaller population groups or at community levels (see Table 2 in chapter 4). The World Health Organisation (WHO 1998) has identified a range of settings as having a role in supporting health, which have equal or greater impact on the health of local people than the availability of health care.

WHO healthy settings:

- Home, village, or neighbourhood
- School
- Workplace
- Food markets
- City and district
- Sport and leisure

Health Improvement Programmes may provide the opportunity for action focused on these various settings. "Making it Happen" provides information on the evidence of effectiveness of various settings approaches including: systemic approaches to reducing stress and improving mental health in the workplace; promoting mental health in schools; reducing alcohol consumption through brief interventions in primary care; and reducing the risk of depression in unemployed people.

Figure 5 - Analysis of six regeneration initiatives

POLICY	AIMS	CONTENT	PROCESS
Education Action Zones	Through partnership with leading businesses, parents and community, zones will use new skills, experience and funding to raise educational standards	Major innovations include: 24 hour class rooms, wrap school service, super teachers, new curriculum	Scholars involved will be prepared to work in partnership with each other, the LEA, local business, parents and community groups and TECs and existing local partnerships to develop a programme of action to address their difficulties.
Health Action Zones	Through working in partnership with NHS, local authorities, the voluntary sector and business to develop and implement a health strategy to deliver within their area measurable improvements in public health and in the outcomes and quality of treatment and care.	To address health inequalities: identifying and addressing health needs of the local area. Service modernisation: increasing effectiveness, efficiency and responsiveness of service.	HAZs are coordinated locally by a Partnership Board and performance managed by NHS Regional Offices through health authorities covered by the HAZ. HAZs will have to complete a self-assessment of their progress.
Employment Action Zones	To help long term unemployed people into sustainable work and independence.	Participation is mandatory for eligible clients. Referrals will be made by the Employment Service at restart interviews. People will be offered a personal adviser service. Payments to contractors will be by results.	Participation of all sectors of the community to run the schemes was encouraged. Each successful contractor has to work with other public and voluntary organisations locally.

POLICY	AIMS	CONTENT	PROCESS
New Deal for Communities	To tackle multiple deprivation in the very poorest areas, taking forward the Government's aim to tackle social exclusion through a national strategy for neighbourhood renewal.	To tackle problems in the most deprived neighbourhoods: Tackling worklessness Improving health Tackling crime Raising educational achievement.	Schemes are led by local partnerships and the New Deal for Communities is administered through Government offices.
New Deal for Disabled People	To help disabled people and those with long term illness into work and training. The scheme pilots a range of initiatives as part of the Government's Welfare to Work.	The programme involves a Personal Adviser Service to help disabled people overcome barriers to work; Innovative Schemes to explore best practice; an Information Campaign to improve knowledge and change attitudes; and a programme of Research and Evaluation.	Schemes are led nationally jointly by the Department for Education and Skills and the Department for Work and Pensions.
Connexions	To increase the achievements of young people by enabling them to participate effectively in appropriate learning. The service aims to raise the aspirations of young people, helping them to realise their full potential.	The service is delivered through Personal Advisers linking in with specialist support services. The Connexions partnerships deliver comprehensive services to young people to ensure access, support and guidance.	It is envisaged that Connexions will be delivered through a network, drawn from existing public, private, community and voluntary organisations.

Source: DOH (2001). Making it Happen - A Guide to Delivering Mental Health Promotion. Crown copyright material is reproduced with the permission of the Controller of HMSO and the Queen's Printer for Scotland.

While Health Impact Assessment tools can clarify the potential positive effects on health of such initiatives, evaluation of complex programmes at population levels is problematic and our knowledge of effectiveness is as yet limited.

6.2 Implications for action by key players

Socio-economic deprivation and unemployment, their impact on families and child health (and subsequently on adult health), are major challenges for the North West.

These structural problems influence the size of population groups at risk of mental ill health (discussed in Chapter 7), and they compound and exacerbate the difficulties faced by individuals with mental health problems and mental illness. They are also closely linked to patterns of drug and alcohol consumption and to rates of suicides and unexplained deaths (discussed in Chapter 7).

Action to promote mental well being needs to address these structural problems as the environmental and social infrastructure is the bedrock for positive mental health as it is for physical health. Investment in mental health services will need to be mirrored in action to address structural problems to reduce levels of mental ill health.

The key players here will be:

- Regional government
- Local Strategic Partnerships
- Borough Councils and Local Authorities

Partnership initiatives to tackle unemployment and promote regeneration, as outlined in figure 5, are likely to be significant priorities.

Unemployment rates also have implications for other key players. Where unemployment rates are high, the employment prospects for people who have experienced mental ill health will be particularly bleak. Action may therefore be indicated on the part of local communities and mental health services to maximise and promote work opportunities through employment training and placement schemes and work schemes. It may also be sensible for local players to initiate action to safeguard the employment prospects of people with mental ill health through work with local employers, occupational health, local GPs etc. to help prevent people losing their employment through mental ill health.

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Chapter 7 - What do we know about groups vulnerable to mental ill health in the North West?

Some groups face a high risk of mental illness, including individuals who have suffered severe abuse, black and minority ethnic groups, people who sleep rough, the unemployed, individuals in prison, and people with physical illnesses. Problems with alcohol and drugs can exacerbate mental health problems (DoH 1999). This section uses routine information to describe the distribution of some of these groups across the North West.

7.1 The impact of inequalities

Poor health is often experienced in areas of poor deprivation. Not only do people with mental health problems tend to experience restricted opportunities and an associated loss of social status but also those in the poorer areas are more likely to have poor health. Chronic health conditions such as many cancers and coronary heart disease are more prevalent in more deprived areas. Poor physical health increases the risk of poor mental health.

7.2 Unemployment

As shown in the previous section there are high rates of unemployment across the North West. The NSF for Mental Health indicates that unemployed people are twice as likely to have depression as people who are at work. The high rate of employment deprivation in the North West indicates that there is likely to be a correspondingly high level of vulnerable people who may require mental health services.

7.3 Social and material deprivation in childhood

As indicated in section 5.6 there are significant levels of child poverty in a number of localised areas in the North West. Experience indicates that people using mental health services have significant rates of childhood deprivation, and individuals with a history of having been in care as a child, may later experience mental ill health including self harm and offending.

Figure 6 – Risk factors potentially influencing the development of mental problems and mental disorders in individuals, particularly children

Individual factors	Family/social factors	School context	Life events and situations	Community and cultural factors
prenatal brain damage	having a teenage mother	bullying	physical, sexual and emotional abuse	socioeconomic disadvantage
prematurity	having a single parent	peer rejection	school transitions	social or cultural discrimination
birth injury	absence of father in childhood	poor school attachment	divorce and family breakup	isolation
low birth weight	large family size	inadequate behaviour management	death of family member	neighbourhood violence and crime
birth complications	antisocial role models (in childhood)	deviant peer group	physical illness/impairment	population density and housing conditions
physical and intellectual disability	family violence and disharmony	school failure	unemployment, homelessness	lack of support service including transport, recreational facilities etc.
poor health in infancy	marital discord in parents		incarceration	
Insecure attachment in infant/child	poor supervision and monitoring of child		poverty/economic insecurity	
low intelligence	low parental involvement in child's activities		job insecurity	
difficult temperament	neglect in childhood		unsatisfactory workplace relationships	
chronic illness	long-term parental unemployment		workplace accident/injury	
poor social skills	criminality in parent		caring for someone with an illness/disability	
low self-esteem	parental substance misuse		living in nursing home or aged care hostel	
alienation	parental mental disorder		war or natural disasters	
impulsivity	harsh or inconsistent discipline style			
	social isolation			
	experiencing rejection			
	lack of warmth and affection			

Reproduced from Source: DOH (2001). Making it Happen - A Guide to Delivering Mental Health Promotion. Crown copyright material is reproduced with the permission of the Controller of HMSO and the Queen's Printer for Scotland. Originally produced in Commonwealth Department of Health and Aged Care 2000. Promotion, Prevention and Early Intervention for Mental Health – A Monograph, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

7.4 Black and ethnic minority communities

A number of studies have indicated complex relationships between ethnic background, status, vulnerability to mental ill health, clinical perceptions mediating diagnosis, patterns of access to and use of health services, and the application of the Mental Health Act. Box 4 summarises findings in relation to black and ethnic minority communities.

Box 4: The mental health of the Black and Ethnic Minority population

- Admission rates to psychiatric hospitals for African-Caribbeans are higher than for the general population (Coker 1994, Cochrane & Bal 1989)
- Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are 3 to 6 times higher among African-Caribbeans than among the white population (Coker 1994, Cochrane & Bal 1989)
- Diagnoses of depression and anxiety are less likely among African-Caribbeans than among the general population (Lloyd 1993)
- African-Caribbeans are more likely to be subjected to harsh and invasive types of treatment including intramuscular injections and electro-convulsive therapy, more likely to be placed in secure units, to be described as aggressive and to be hospitalised compulsorily under the Mental Health Act (Dunn and Fahy 1990, Davies 1996, Bhat 1996)
- Caribbean-born people have lower rates for suicide and parasuicide than the general population (Burke 1976, Soni Raleigh 1992)
- Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are 3 times higher among Asian males than among the white population (Coker 1994, Bhat 1996)
- Suicide rates among women from the Indian sub-continent and men and women from East Africa are higher than those for the general population (Soni Raleigh 1992, 1990)
- Suicide rates among Asian women 15-24 years are more than twice the national rate and 60% higher in Asian women aged 25-34 years (Soni Raleigh 1992, 1990)
- Psychiatric patients from B&EM groups make less use of psychiatric services (Donovan 1992, Kareem 1989)
- The ethnicity of a patient influences the clinical predictions and attitudes of practising psychiatrists (Lewis 1990)

Source: Lee, B., Syed, Q., Bellis, M. (2001). Improving the Health of Black and Ethnic Minority Communities: A North West England Perspective. North West Public Health Observatory.

In addition racial discrimination of all groups may exacerbate the likelihood of depression (Rawaff & Bahl, 1998)

The profile of the black and ethnic minority population in the North West in 1991 illustrates that 60% of the black and ethnic minority population is of South Asian, particularly of Indian or Pakistani, origin. South Asian groups are generally less likely to be diagnosed with depression than the white population, however Asian women have high suicide rates. There are major issues in terms of access to appropriate and acceptable health services, both primary care and specialist mental health services, for South Asian populations in the North West (East Lancashire Health Authority, 1999).

In addition the mental needs of refugees and asylum seekers needs attention (Carey-Wood et al, 1995).

7.5 Gender differences

There are important differences in morbidity and mortality between men and women. The largest study of general practice involved an analysis of general practice records from 211 practices located in England and Wales corresponding to approximately 2.6% of the population (Moser, 2001) and revealed interesting gender differences. The suicide mortality rate is higher for men than for women with men living in the most deprived areas experiencing mortality rates 60% higher than those in the least deprived areas. However women were two and a half times more likely to be being treated for depression and/or anxiety, even in less deprived areas.

Previous work has indicated that women are 2-3 times more likely to receive ECT particularly without their consent and have higher rates of psychotropic medication and less responsive continuing care services (Williams, 1993).

The relationship between gender inequalities and negative mental health consequences, particularly anxiety and depression, has been well researched (Dinnerstein et al, 1993). There are demonstrable links between violence against women and psychological problems and psychiatric disorder, and several studies have demonstrated high rates of sexual, physical and/or emotional abuse amongst women using psychiatric services.

7.6 People in prisons

People in prison are particularly vulnerable to mental ill health (ONS 1997).

- 90% of prisoners have a diagnosable mental health problem.
- Often prisoners will have more than one type of mental health problem.
- Over a quarter of female remand patients had tried to kill themselves in the year before interview.
- 2% of remand prisoners attempt suicide in a given week.

Within the North West there are 14 prisons with a prison population of 7,488, suggesting that 6,739 individuals may have diagnosable mental health problems. As a result prisons are a key setting for delivering mental health promotion strategies. With the development of the Prison Health Policy Unit, prisons are now required to carry out health needs assessments for the prison population and develop a Prison Health Plan.

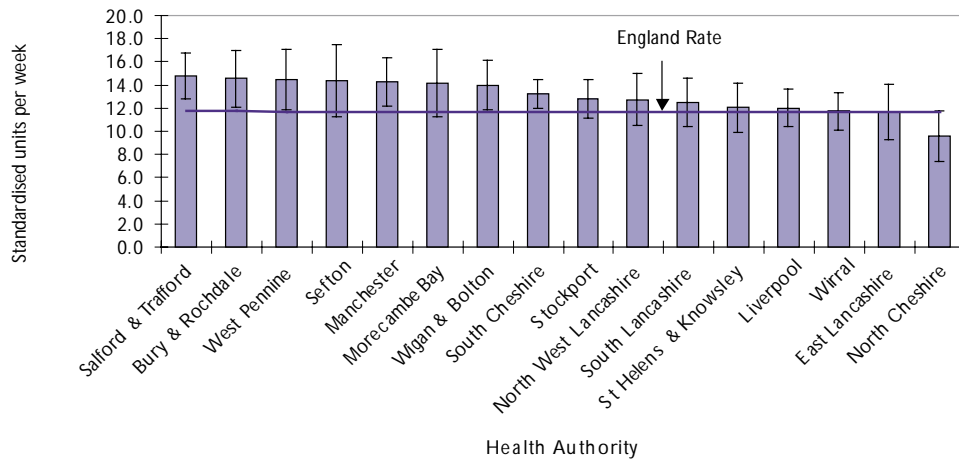
7.7 People using drugs and alcohol

Misuse of drugs and alcohol is frequently associated with mental ill health, with common mental health problems, with self harm and suicidal behavior, and with serious mental illnesses. It increases the risk of suicide, is likely to exacerbate any mental health problem, and may increase risk to others. A number of studies both in the US and in this country indicate that co-morbidity of mental illness and drug and alcohol misuse significantly raise all risk factors (IAHSP, 1998).

30 per cent of those seeking help for mental health problems are likely to be misusing substances (DoH, 1998). Information about the rates of drug and alcohol misuse is available from national surveys and local Drug Misuse databases.

The data in figure 7 is reproduced from data from the Health Survey for England aggregated data from the years 1994-1996. Apart from North Cheshire Health Authority, all Health Authorities in the North West had a higher rate of alcohol consumption than the England rate. Significantly high consumption was found in the survey in Salford and Trafford, Bury and Rochdale, West Pennine, Manchester, Morecambe Bay, Wigan & Bolton, South Cheshire, Stockport, North West Lancashire, South Lancashire, St Helens & Knowsley, Liverpool, Wirral, East Lancashire and North Cheshire.

Figure 7: Age standardised units of alcohol per week by Health Authority

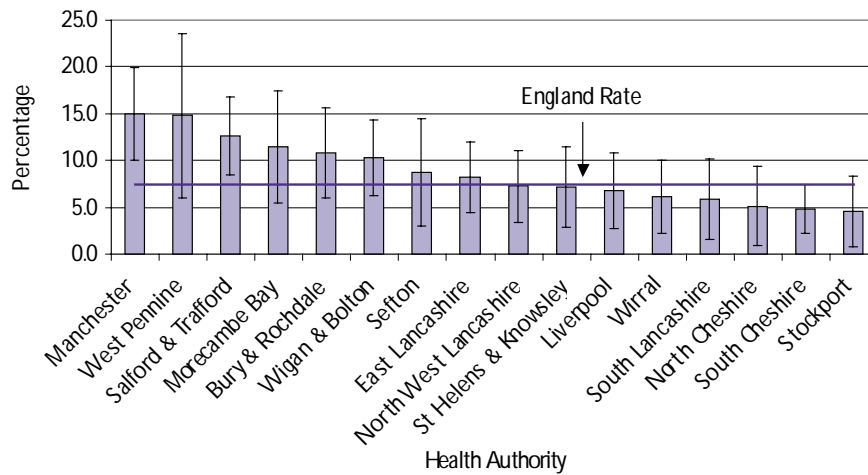


Source: Compendium of Clinical and Health Indicators 2000

Data presented in figure 8 reproduced from The Health Survey for England 1994-1996 shows information about excessive drinking in males. An Office for Population Censuses and Surveys study of psychiatric morbidity found that 19% of male heavy drinkers and 30% of female heavy drinkers had a neurotic disorder (Melzer et al, 1995).

Manchester and Salford and Trafford have significantly higher rates than England. High rates are also seen in West Pennine, Salford and Trafford, Morecambe Bay, Bury and Rochdale, Wigan and Bolton, Sefton and East Lancashire.

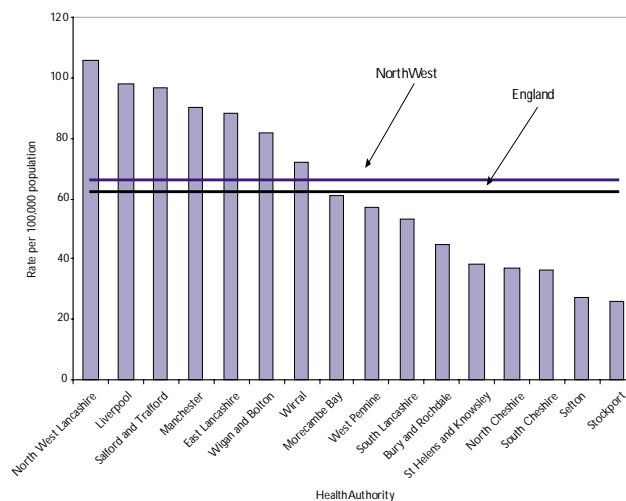
Figure 8: Proportion of men drinking 50+ units per week ¹



Source: Compendium of Clinical and Health Indicators 2000

Data from the drug misuse database (DoH, 2000) shows the rate of new drug users per 100,000 population (Figure 9). People with drug problems have a higher risk of suicide than the average population. (Appleby, 1999). High levels of new drug users are seen in North West Lancashire, Liverpool, Salford and Trafford, Manchester, East Lancashire, Wigan and Bolton and Wirral.

Figure 9: Rates of new drug users reporting to the North West DMD per 100,000 population, April to September 1999



Source: Hughes, K., Bellis, M.A. & Kilfoyle-Carrington, M. (2001). Alcohol, Tobacco and Drugs in North West England, Identifying a Shared Agenda. NWPHO.

¹Recommended weekly units of alcohol are 21 for men and 14 for women. Heavy drinking may be defined as in excess of 50 units per week, which is likely to have significant long term health impacts.

7.8 People at risk of suicide and self harm

Our Healthier Nation identified suicides as a major problem and Health Authorities were set targets to reduce deaths by active interventions. Table 5 shows those groups that are more likely to be at a high risk of suicide. There are some similarities between these groups and those identified in the Mental Health National Service Framework as vulnerable groups. Having a diagnosis of mental illness or a history of deliberate self harm increases the risk of suicide.

Table 5: High-risk groups for suicide in Britain

- Young men
- Young women from the Indian subcontinent
- Men from the Republic of Ireland
- Unemployed people
- People who have been in local authority care during childhood and adolescence
- People who have suffered bereavement or loss
- People detained in prison, particularly young men
- Vets, farmers, pharmacists, doctors, nurses and others who have ready access to means of killing themselves
- People with a previous episode of deliberate self harm
- People with severe mental illness

Source: Donaldson L J and Donaldson RJ (2000) Essential Public Health.

Figure 10 shows the rates of suicides and deaths undetermined for the years 1997-1999. It is not always apparent if a suicide is intended and for this reason suicides and deaths undetermined are considered together. High rates are found in Manchester, North West Lancashire, Wirral, East Lancashire and Liverpool. Although Stockport, North Cheshire, St. Helens and Knowsley and Sefton have lower rates than England, none have a significantly lower rate.

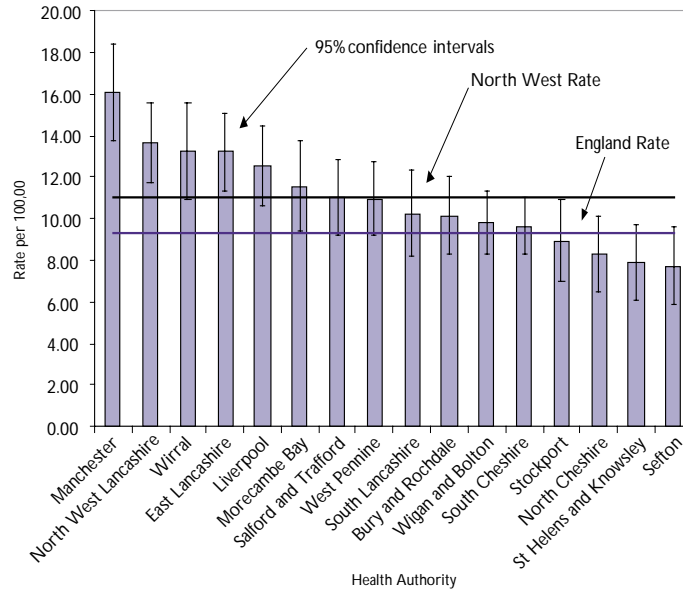


Figure 10: Mortality from suicide and injury undetermined, directly age standardised rates per 100,000 population (1997-1999) Source: Compendium of Clinical and Health Indicators 2000

Young men have been highlighted as a high risk group for suicide. During the 1980s when the overall rate of suicide was falling, the rate increased in males in the 25-34 year age group.

North West Lancashire has the highest rate in the country of young male suicide amongst the 15-34 age group, with Manchester the second highest. For Health Authorities in the North West, young men had particularly high rates of suicide and death undetermined in both the 15-34 age group and 35-64 age group. Five health authorities in the North West fell into the ten health authorities in England with the worst suicide and deaths undetermined rates in England, for males 15-34 (Table 6).

Table 6: Suicides and deaths undetermined, males 15-34, Health Authorities in the North West with the highest rates in the England (within the top 10)

Health Authority	Death rate per 100,000
North West Lancashire	39.1
Manchester	36.1
Wirral	31.8
East Lancashire	30.0
West Pennine	27.3

Source: Compendium of Clinical and Health Indicators 2000

Suicide and deliberate self-harm are closely associated. Of known risk factors for completed suicide, deliberate self-harm has the strongest association; in the year after deliberate self-harm, the suicide rate is 100 times that of the general population (NHS Centre for Reviews and Dissemination, 1998). In the majority of cases people report that they have harmed themselves in response to social problems, most commonly, housing, unemployment, debt, poor personal health, and conflict or loss in personal relationships. (NHS Centre for Reviews and Dissemination, 1998).

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Chapter 8 - What can we do to prevent the development of mental ill health?

8.1 Potential for action.

A systematic review (NHS Centre for Reviews & Dissemination 1997), identifies the following groups at particular risk of poor mental health, largely through association with stressful life events and social isolation/exclusion.

Table 7. High-risk groups considered in the CRD Review

Adults

- Unemployed
- Experiencing severe life events (e.g. separation, bereavement)
- Long term carers of people who are highly dependent
- Depression in pregnancy

Children

- Living in poverty
 - In families experiencing parental separation/divorce or bereavement
 - Exhibiting behavioural difficulties
-

Source: Effective Health Care Bulletin Mental Health Promotion in High Risk Groups (NHS CRD, 1997) Note: The review does not consider treatment of mental health problems or specifically cover other vulnerable groups (e.g. those with physical illness or disability)

A range of effective interventions are identified in the review, which include:

- Children exhibiting behavioural problems in home or school settings may benefit from a range of school based social skill training and from programmes offering parents training and support in developing parenting skills.
- A variety of Cognitive Behavioural Therapy (CBT) and socially based interventions can be of value for children suffering adverse life events such as parental divorce or bereavement.
- Specific interventions can help adults adjust to adverse life events such as job loss, divorce or bereavement.
- Carers of people who are highly dependent can benefit from the provision of respite care and some psychosocial interventions promoting support and coping skills.

Further useful sources of evidence regarding effectiveness of mental health promotion include the following:

- Effectiveness of Mental Health Promotion Interventions: A Review. Health Education Authority (1997)
 - Evidence from Systematic Review of Research Relevant to Implementing the Wider Public Health: A National Contract on Mental Health. A Review of the Impact of a Range of Policy Interventions on Mental Health.
 - Department of Health (2001b) Making it Happen. A Guide to Delivering Mental Health Promotion. Contains an extensive evidence base supporting Standard One leads in developing health promotion strategies.
 - International Union for Health Promotion and Education (1999). Examines the long-term health and social effects of interventions strengthening protective factors such as self esteem, social and coping skills and support.
-

There is increasing recognition that, in common with other health promotion interventions, mental health promotion is best achieved through a focus on the everyday settings in which people live. Making it Happen (DoH, 2001b) summarises evidence of what works at different levels and in different settings. In addition it illustrates a range of alternative health promotion frameworks on aspects such as policy or strengthening protective factors.

Table 8. Examples of a settings-based framework for health promotion interventions

Setting	Level of action	Action	Evidence strength
Home	Individual	Improving mental health of mothers	I/II
Workplace	Individual	Reducing the social exclusion of people with long term mental health problems	I
	Structural	Reducing stress and improving mental health in the workplace	I
School	Individual/ Structural/ Community	Promoting mental health in schools	I/II/III
	Structural/ Community	Reducing social disorder, criminal behaviour, anxiety, depression and suicidal behaviour in young girls	III/IV
Primary Care	Individual	Counselling in Primary Care Settings	I
	Individual	Reducing Alcohol Consumption	I
	Individual	Reducing the risk of depression in unemployed people	I
	Structural	Improving the mental health impact of health services	V
Primary Care/ Neighbourhood	Individual	Improving the physical health of people using mental health services	V
	Individual	Exercise	Health Services
	Individual	Support Networks/self help	
	Individual	Reducing marital breakdown and risk of depression	

Source: Adapted from Department of Health (2001b) Making it Happen. A guide to delivering mental health promotion.

Mental health promotion is an important part of a number of initiatives such as Sure Start, Healthy Living Centres (e.g. the Chinese National Healthy Living Centre) and Health Action Zones. Evaluation of these and other initiatives broadens the evidence base available. For example HAZnet (www.haznet.org.uk) has a mental health section.

There is evidence that good mental health impacts on physical health and increasing understanding of the ways that these links may operate. For example depression has been identified as a risk factor for stroke (Jonas & Mussolino 2000), heart disease (Turner & Kelly 2000, Hipsley-Cox et al 1998) and has an impact on the health outcomes in chronic diseases such as arthritis, asthma and diabetes (Marmot et al, 1991).

There is also growing interest in the relationship between the concept of social capital (Narayan & Cassidy 2001) and mental health with the suggestion of a positive relationship between good mental health and level of social capital.

8.2 Evidence on reducing suicide

At least a third of suicides do not belong to any high risk group and need to be reached as part of a broader strategy to reduce risk factors for mental health problems and to strengthen protective factors for mental health in the wider population. Therefore action to implement standard one of the NSF is expected to have an impact on the number of suicides. Other action to prevent suicide is outlined in table 9.

In particular, action should be targeted at children and young people to promote mental health and improve access to sources of support. Guidance on managing self help in young people is available (Royal College of Psychiatrists Council Report, 1998). Action in relation to older people, Asian adults and those bereaved by suicide should also be identified, as these groups are known to be particularly vulnerable.

Table 9: Action to prevent suicide

Action	Evidence
1. Reduce the availability and lethality of means of suicide e.g. measures introduced to limit paracetamol pack sizes.	Suicidal behaviour is sometimes impulsive and reducing access to lethal means of suicide is known to be effective (Gunell & Frankl, 1994, Amos et al, 2001, Hawton et al 2001).
2. Targeted measures to prevent suicide in high risk groups.	People with mental health problems and those who self harm are known to be at risk. Safer Services (DoH 2001a, Hawton & Fagg, 1998) provides a twelve part checklist for mental health services. The number of suicides amongst young men (aged 19-34) has increased dramatically (DoH 2001a). There are 85 deaths a year of people in prison and it is therefore important prisons promote the identification and response to those who are vulnerable. There are also a number of high risk occupational groups, notably farmers, nurses and doctors (DoH 2001a, Hawton et al 2001). Dissemination of helpline numbers, occupational health and supportive management practices as well as reducing the access to means all have a role to play.
3. Improve reporting of suicidal behaviour in the media.	There is evidence that the reporting of suicide can increase the risk of suicide (Phillips 1985, Schmidtke & Schalller 2000). The DOH Mind Out for Mental Health campaign aims to influence the way in which the media report mental health issues (www.mindout.net).
4. Improve the early identification and management of depression.	Primary care has a key role to play in the early identification and effective management of depression. Ensuring adequate risk assessment and access to information and further help is a key role. NHS Direct now also provides a gateway to local services. (www.nhsdirect.nhs.uk). There are other helplines, such as CALM, which provide access to support and information.

8.3 Deliberate self-harm

While clear high quality evidence is lacking, provision of crisis cards, brief problem solving therapy, and dialectic behaviour therapy look promising. Some interventions are also addressing the needs of people with personality disorders (NHS Centre for Reviews & Dissemination, 1997).

8.4 Implications for action for key players

There are wide ranging implications for action at the community, medium population level (see Table 2).

With the high levels of unemployment and drug and alcohol consumption across the North West, these are likely to be priority areas for mental health promotion, for identifying vulnerable groups and initiating targeted action.

Similarly suicide prevention will be a high priority in a number of North West local areas, and detailed local information on the population groups at risk, those presenting to local services with deliberate self harm etc. will be needed to inform local strategies. Localities where groups such as young men are known to be at risk, will need to devise strategies which engage groups who traditionally do not access mainstream services.

The ethnic minority profile indicates that in a number of areas, health promotion initiatives may need to be targeted, and access to services such as counselling in primary care, should be monitored.

Key players will include:

- Employers
- Primary care services
- PCTs
- Education authorities and schools
- Health services
- Community organisations

These players have important roles in

- Early identification of mental health problems
- Facilitating access to information and appropriate support
- Providing support and ensuring minimal disruption to an individual's life.

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Chapter 9 – What do we know about mental illness in the North West?

In this chapter we have outlined some of the information available about mental illness in the North West, also including information from national sources and studies where appropriate.

9.1 Understanding mental illness: beyond diagnosis

Traditional thinking about mental disorder has drawn distinctions between neurosis and psychosis, "serious" and "less serious" mental illness, "common mental disorders" and "severe and enduring mental illness", with the broad classifications corresponding to groups of psychiatric diagnoses. The NSF for Mental Health (DoH, 1999) follows this practice and uses the terms "common mental health problem" and "severe mental illness".

However many clinicians and academics now regard these traditional distinctions as unhelpful (Workforce Action Team, 2001). It is increasingly recognised that diagnosis alone is a poor indicator of severity, complexity, or disability in mental illness. The organisation and delivery of services has been significantly influenced by traditional classifications of mental disorder, but recent thinking and experience is pointing up a number of inherent problems.

- Common classifications poorly reflect the presentation, severity and impact of mental health problems encountered in primary care. It is increasingly recognised that people presenting in primary care may have complex problems that include physical health problems, emotional or mental health problems, social/familial problems, and drug and alcohol problems; and that their problems may have disabling effects.
- Traditional classifications may result in insufficient attention to suicide risk. A&E departments and psychiatric liaison services are often the access point to mental health services for people who have harmed themselves or attempted suicide. While tools to assess suicide risk are limited in predictive accuracy, support services for people at risk are few, and they may not be able to access mental health services, as, generally, they are not experiencing "serious mental illness".
- Complexity in serious mental illness is frequently not adequately reflected in traditional classifications. Studies of in-patient psychiatric services (Bernadt & Murray, 1986) indicate that high proportions of psychiatric in-patients have substance misuse problems as well as mental health problems. Some may also have a diagnosis of personality disorder and/or have a history of criminality, challenging behaviours, etc. While the numbers of people with such complex problems are small, classifications based on diagnosis alone make it hard to distinguish those with complex and severe problems. At the same time, many people diagnosed with schizophrenia, a serious mental illness, are able to live ordinary, stable lives, for long periods of time.

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- Personality disorder is recognised as a problematic concept and it is rarely included in traditional classifications of mental disorders. However, people whose early childhood experience has had significant effects on their adult capacity to cope and functioning, and who are understood to have personality disorder, have important mental health needs. Primary care and mental health services will see such people daily, and people diagnosed with personality disorders are significantly represented within secure psychiatric services. Personality disorder is often part of complex mental health needs alongside other mental disorders, substance misuse and social problems. However people with such difficulties may be excluded from specialist mental health care as they do not fit within existing service eligibilities and practice.
 - Severe mental illness is also a concept that faces some challenges. Traditional thinking about serious mental illness has emphasised chronicity and long term deterioration; "people with mental illness were not expected to recover". (Allot et al, unpublished). Developing thinking about "recovery" has grown out of the experience of people who have recovered from serious mental illness. It challenges traditional thinking highlighting:
 - A number of reviews indicate that significant numbers of people recover from schizophrenia, and that clinical expectations of inevitable progressive deterioration and long term disability may be unduly pessimistic (Harding & Zahuiser, 1994).
 - Information from service users indicating that hope, optimism and self-determination are key factors in recovery, and that professional attitudes may be pessimistic and engender hopelessness and dependency.

Thus, from a variety of sources, our traditional ways of thinking about mental illness are being questioned. Much of the thinking outlined here is relatively new, and more appropriate or comprehensive concepts and classifications have not as yet been developed. Within this document therefore we have continued to use the terms that most people use and recognise. However it is clear that while continuing to use concepts based on groups of diagnoses, we also need to incorporate perspectives (and measures, interventions and services), that address:

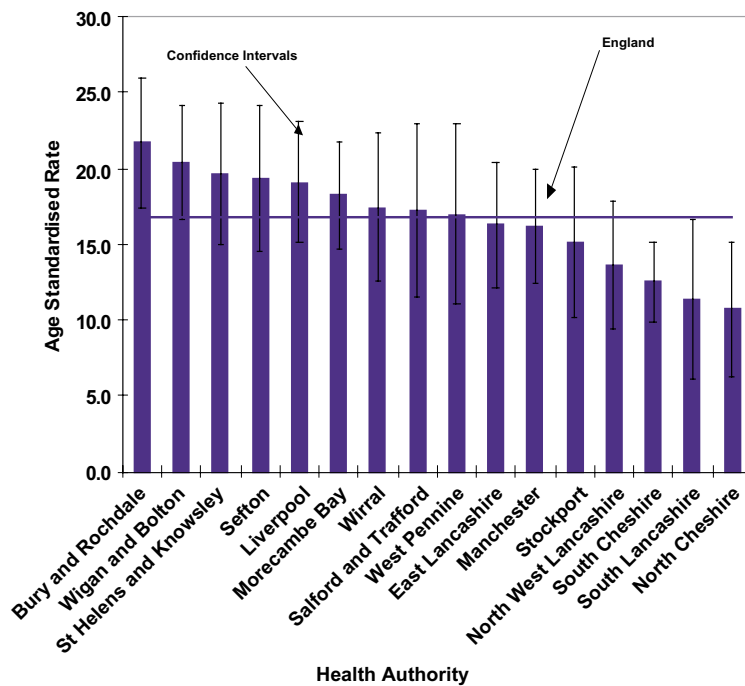
- Complexity - not only the co-existence of more than one form of mental ill health, but also the social and psychological context of peoples' lives
- Risk - the understanding of risk needs to continue to be underlined and in particular the interactions between substance misuse and mental ill health
- Disability - which may be short or long lived, and which can be associated with a range of conditions
- Potential for recovery - which will be present in varying degrees across the range of conditions and which interventions should aim to preserve and promote.

9.2 Information on mental illness in the North West

9.2.1 Mental Illness Morbidity

The Health Survey for England is an annual survey about the health of people in England and is representative of different age, sex, geographic area and socio-demographic circumstances of the population. Data from surveys in the years 1994-1996 were pooled together to provide data available at Health Authority level (DoH, 1996). As well as other health and lifestyle factors, the Health Survey gathers information about the mental ill health of the population. The information is collected using the General Health Questionnaire 12 (GHQ12) a validated tool to assess mental well being. The GHQ 12 is a self-administered questionnaire which identifies short term changes in mental health such as depression, anxiety, social dysfunction and somatic symptoms. Scores of four or more from the questionnaire indicate some mental health morbidity.

Figure 11: Health Survey for England 1994-96 age standardised rate per 100 population of persons with a score of 4 or more on GHQ



Source: Compendium of Clinical and Health Indicators 2001

Figure 11 shows the data for the Health Authorities in the North West of England. Nine Health Authorities have higher rates of mental health morbidity than the average for England, although only Bury and Rochdale Health Authority has a significantly higher rate. Three Health Authorities: South Cheshire, South Lancashire and North Cheshire have significantly lower mental health morbidity than England.

The information indicates the high levels of mental health morbidity in the North West of England although there are some surprising results; for example, Manchester Health Authority has a lower rate than England.

The OPCS survey of Psychiatric Morbidity assessed a number of mental illnesses using a standardised scale, the Clinical Interview Schedule (CIS-R). This schedule has 14 sections, which include areas such as anxiety, phobias, and panic disorders. From this information it was found that about 1 in 6 adults experiences some form of mental health problem. Prevalence rates as identified from this survey and the estimated burden in the North West are shown in Tables 10, 11 and 12.

Table 10: Estimated frequency of mental health disorders in the adult population over 16 years of age

Mental disorder	Mental disorder	Lifetime risk %
Schizophrenia	0.2-0.5%	0.7-0.9%
Affective psychosis	0.1-0.5%	1%
Depressive disorder	3-6%	>20%
Anxiety states	2-7%	N/A
Dementia (over 65)	5%	N/A
Dementia (over 80)	20%	N/A

Source: The Health of the Nation. London: HMSO 1992

Table 11: Estimated numbers of persons with mental health problems in the North West

Disorder	Estimated numbers in the North West*
Schizophrenia	10285 - 25712
Affective psychosis	5142 - 25712
Depressive disorder	154273 - 308546
Anxiety states	102849 - 359970
Dementia (over 65)	51179
Dementia (over 80)	52788

Source: Compendium of Clinical and Health Indicators 2000

Note: * The figures have been calculated using the ONS population estimates 1999. The over 16 population and over 80 year old population has been estimated from this data.

Table 12: Prevalence of Psychiatric Illness per 1,000 population (age 16-64)

Disorder	Prevalence per 1,000	Estimated numbers in the North West *
Mixed anxiety and depression	77	323303
Generalised anxiety disorder	31	130161
Depressive episode	21	88173
All phobias	11	46186
Obsessive compulsive disorder	12	50385
Panic disorder	8	33590
Any neurotic disorder (any of the above)	160	671798
Functional psychosis	4	16795

Source: OPCS Surveys of Psychiatric Morbidity in Great Britain Report 1 – the Prevalence of Psychiatric Morbidity Among Adults Living in Private Households

Note: *Figures are calculated using ONS population estimates 1999. The 16-64 population was calculated from the 15-64 data by estimating the number in the 15 year age group.

9.2.2 Mental health problems

Primary care information has often been both difficult to obtain and difficult to interpret. Within primary care, systematic coding of diseases is still being established at practice level, and while many organisations are working on implementation of such systems for mental health problems and illnesses, there is still a long way to go. There are also problems due to lack of standardised software and hardware and lack of training. Therefore while some information on the burden of disease experienced within primary care may be available at local levels, consistent general data is not available for the North West Health Region.

A number of studies have looked at individual practices or groups of practices and while it is difficult to generalise, the headlines now generally accepted are:

- The majority of people experiencing common mental health problems who seek help will receive it from primary health care teams (Goldberg & Huxley, 1992).
- Mental health problems are common; up to 40% of patients consulting their GP for any reason have a mental health problem and for 20-25% of patients, a mental health problem will be the sole reason for attending (Goldberg, 1991).
- Although there is no average practice, a typical GP with a list of 2,000 patients will see around 200 people with a common mental health problem each year; around 10 will have a severe depression; 4 people will harm themselves, and one person every five years will commit suicide (Fry, 1993)
- People seeking help from primary care will frequently present with a complex range of problems (Workforce Action Team, 2001).
- 30-50% of presentations of depression are undetected by GPs (Goldberg & Bridges, 1987)
- Practice Nurses may treat common mental health problems or serious illnesses with little appropriate training or supervision (Workforce Action Team, 2001)

It should not be assumed that all people consulting their GP with common mental health problems are experiencing mild conditions. Many will be significantly disabled by their problems. Major depression is increasing in the general population; the World Health Organisation estimates that it will be the world's second most debilitating disease by 2020. (DoH, 1999). People suffering major depression have nearly three times the consultation rates of people who are not depressed and lose four times more days off work.

The OPCS Morbidity Statistics from General Practice, Fourth National Study (1995) produced information on contacts in the primary care setting from 60 practices in England and Wales and graded contacts by the level of seriousness.

The survey found that over 7% of people consulted with mental health problems. Rates of consultations were higher in females than males in all ages. Table 13 indicates the rate of mental illness per 10,000 person years at risk defined by level of seriousness. If these consultation rates were replicated throughout the population of the North West we would expect over 1 million face to face consultations in primary care. This figure could be significantly more if all depression were recognised by GPs in primary care.

Table 13: Mental illness consultation rates per 10,000 person years at risk (all ages)

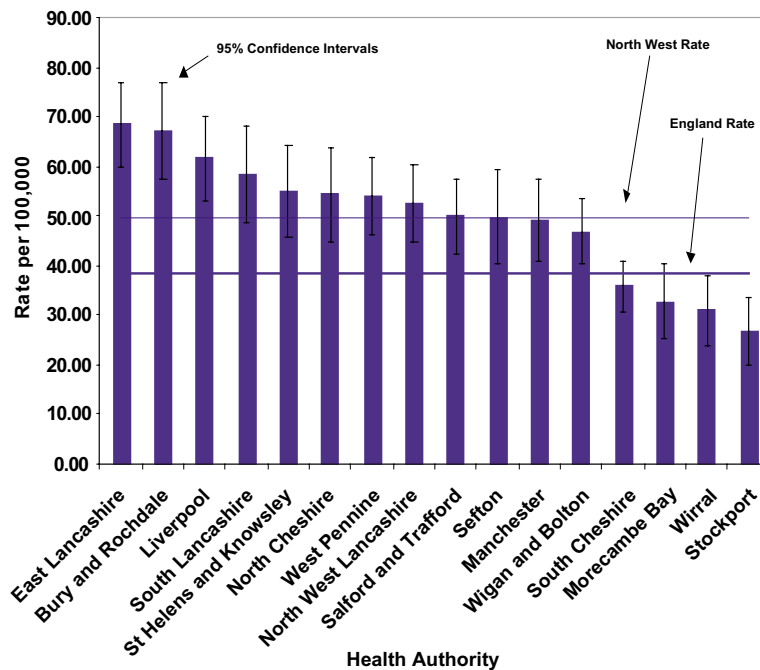
Classification	Rate	Estimated no of consultations in the North West annually
Serious	350	230837
Intermediate	1180	778249
Minor	231	152352
Total consultations	1761	1161438

Source: Compendium of Clinical and Health Indicators 2000

A small scale study in one PCT in the North West bears out this picture. Practitioners from 7 practices recorded information about mental health consultations over a period of a week, noting the severity, complexity, and chronicity of problems presented. Significant proportions of problems seen were severe and complex. Surveys of practice nurses and health visitors indicated that nursing staff also had a significant workload arising from mental health problems and that they believed this was rising.

Many people with common mental health problems may also be admitted to hospital, although policy and practice in recent years has emphasised that psychiatric admission is most appropriate for people with serious mental illnesses. Rates for admission are generally higher in the North West than the average for the country as a whole. This is open to a number of interpretations. It may indicate high overall levels of need; lack of capacity in primary and community-based mental health services to manage and contain mental health problems in the community; or it may be influenced by the organisation of services in the local areas.

Figure 12: Hospital episodes for common mental illness – age standardised rates per 100,000 population, ages 15-74, year 1998-99



Source: Compendium of Clinical and Health Indicators 2000

9.2.3 Serious mental illness

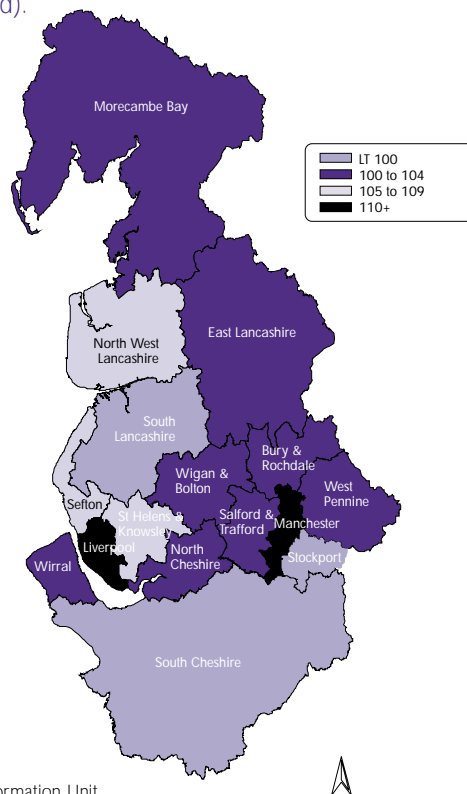
Currently no evidence about the prevalence of serious mental illness is routinely collected at population, specialist services, or primary care levels. This will be remedied by the forthcoming implementation of the Mental Health Minimum Data Set as indicated by the NSF for Mental Health (DoH, 1999). Greater consistency in the use of the Care Programme Approach, recently implemented across the country, may also allow such information to be used to document prevalence at local levels.

In the meantime, there are some measures (such as the MINI index and Townsend Deprivation Scores) which have been used to guide the allocation of resources, which may be used as a proxy for determining overall levels of serious mental illness. We can also look at psychiatric hospital admissions, including those made formally under the Mental Health Act.

The Mental Illness Needs Index is an index that gives a score to geographical areas and calculates the need for mental health services, in particular for acute psychiatric beds. The index, developed by Glover (DoH, 1995), uses census variables to identify areas of social isolation, poverty, unemployment, permanent sickness and temporary and insecure housing. The census variables used are single, widowed or divorced adults, population living in households with no access to a car, population over 16 registered permanently sick, adults who are available to work but are unemployed, adults living in households that are not self contained, population living in hostels, hotels, boarding houses, other communal establishments or sleeping rough. The MINI program calculates the MINI index at geographical levels that are aggregates of wards. Figure 13 shows the MINI scores at Health Authority level. High scores were found in Manchester, Liverpool, St Helens and Knowsley, Sefton, Salford and Trafford and North West Lancashire.

MINI scores can be broken down to borough and ward levels.

Figure 13: Mental Illness Needs Index (MINI) for Health Authorities in the North West, 1995 (higher scores indicate greater need).

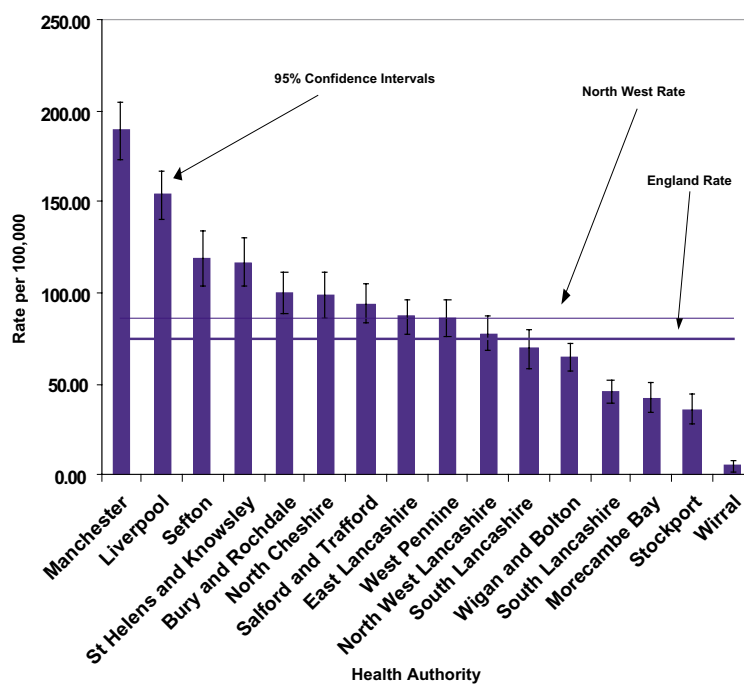


Source: NHS Executive North West, Regional Information Unit.

The MINI index and GHQ12 (see section 9.2.1) show the expected mental health morbidity at Health Authority level. However, these two methods highlight the greatest need in different areas. Bury and Rochdale Health Authority and Wigan and Bolton Health Authority scored high in the GHQ 12 whereas Manchester and Liverpool scored high in the MINI index. Neither is a direct measure of the total mental health morbidity in the North West. The GHQ 12 is a sample survey which may not be truly representative of the population. The MINI index however, uses census variables to highlight areas of greatest need and therefore is not a direct measure of mental health morbidity.

Hospital information for most illnesses only capture information about the most serious cases. For mental health services this is also influenced by local delivery of services. Variations in hospital episodes for mental health conditions may relate to where services are provided, the number of patients with serious mental health problems and variations in the diagnosis of mental illnesses. Some areas may have stronger community services thus reducing need for hospitalisation. So although the information provided on hospital episodes may give an indication of areas of high need, it is also likely to raise questions about service systems, design, and delivery.

Figure 14: Hospital episodes for Schizophrenia – age standardised rates per 100,000 population, ages 15-74, 1998-99 per 100



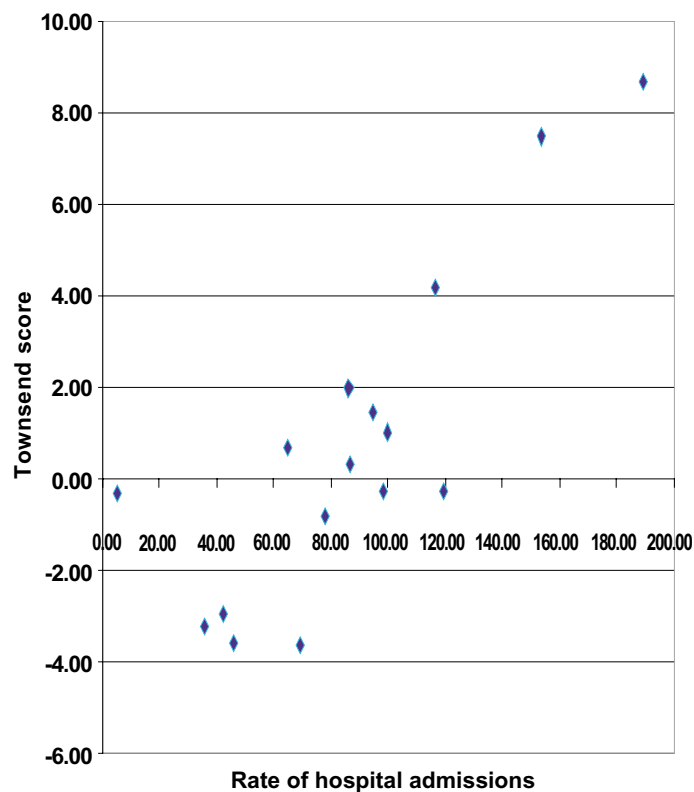
Source: Compendium of Clinical and Health Indicators, 2000

Figure 14 shows the high rates of hospital admissions for schizophrenia in areas with high deprivation, Manchester, Liverpool, Sefton and St. Helens and Knowsley.

Figure 15 shows the correlation between rates of hospital admissions for schizophrenia and deprivation using Townsend scores. There is a strong correlation between admission rates and deprivation; areas with higher deprivation have higher rates of admission.

The associations are complex. Deprivation is likely to be causally linked to serious mental illness. At the same time we know that the major disruption in peoples' lives, loss of employment, and social exclusion will result in people with serious mental illness being housed in deprived areas. (see section 9.6)

Figure 15: The relationship between hospital admission rates for schizophrenia and Townsend deprivation scores



Source: Compendium of Clinical and Health Indicators 2000

Formal admissions to hospital under sections of the Mental Health Act may also provide information on serious mental illness. Table 14 shows regional figures for formal admissions in 1999-00 and figures can be broken down to Health Authority and hospital level. The table indicates relatively high rates of formal admissions, with the North West having the third highest rate after London and the South East. The pattern of use of the various sections in the North West is similar to the averages for England, although use of section 4 (emergencies) is slightly higher than the England average (9% as against 7%).

Table 14: Formal admissions under the Mental Health Act 1983 to NHS and private facilities by legal status and Regional Office area, 1999-00

Admissions by RO area	Number of admissions							
	All facilities	Popn in millions	All admissions	Section 2	Section 3	Section 4	Part III	Other
England			26669	13476	9680	1856	1638	19
Northern & Yorkshire	6.3		2654	1575	798	96	179	6
Trent	5.2		1898	1162	546	83	106	1
Eastern	5.5		2199	1078	894	93	134	-
London	7.4		8265	3328	3408	1051	476	2
South East	8.7		3866	1905	1626	107	224	4
South West	5.0		2175	1316	675	73	108	3
West Midlands	5.3		2323	1382	742	67	132	-
North West	6.6		3199	1730	987	286	193	3
Special Hospitals			90	-	4	-	86	-

NHS facilities	Popn in millions	All admissions	Section 2	Section 3	Section 4	Part III	Other
England		25302	12940	9045	1837	1468	12
Northern & Yorkshire		2600	1565	779	95	156	5
Trent		1856	1162	524	83	86	1
Eastern		2125	1053	855	93	124	-
London		7540	2955	3081	1042	460	2
South East		3576	1811	1482	103	179	1
South West		2128	1311	639	73	103	2
West Midlands		2293	1376	733	67	117	-
North West		3094	1707	948	281	157	1
High Security Psychiatric Hospitals		90	-	4	-	86	-

Private facilities	Popn in millions	Number of admissions					Other
		All admissions	Section 2	Section 3	Section 4	Part III	
England		1367	536	635	19	170	7
Northern & Yorkshire		54	10	19	1	23	1
Trent		42	-	22	-	20	-
Eastern		74	25	39	-	10	-
London		725	373	327	9	16	-
South East		290	94	144	4	45	3
South West		47	5	36	-	5	1
West Midlands		30	6	9	-	15	-
North West		105	23	39	5	36	2

Includes private mental nursing homes registered to detain formal patients

Source: DoH (2001). Inpatients Formally Detained Under the Mental Health Act 1983. HMSO. London. Crown copyright material is reproduced with the permission of the Controller of HMSO and the Queen's Printer for Scotland.

It can be very instructive to look at local figures. High rates of emergency sections may indicate need in particular population sub-groups; or that community services are insufficiently developed to prevent and manage crises (see 9.2).

Some national work analysing formal admission figures (Churchill et al, 2000), notes a dramatic increase in the absolute number of formal admissions between 1984 and 1996 suggesting a correspondingly dramatic increase in the prevalence of psychiatric disorder.

This may be partly explained by increases in dual diagnosis and complex needs. It is likely that people with both mental illness and substance abuse problems will have poorer clinical and social outcomes, and greater service costs than individuals with severe mental illness only (Menezes et al., 1996). There is also evidence that people with dual diagnosis are significantly more likely than those with psychosis only, to report any history of committing an offence or recent hostile behaviour (Scott H et al 1998). The relatively recent emergence of a group of people with complex needs stemming from a combination of mental illness, substance abuse and offending, may have contributed to the rise in formal admissions.

While we do not have regional information on these issues, the high rates of drug and alcohol misuse in the North West reported in Chapter 7 indicate that these issues may be significant in parts of the North West.

9.2.4 Expenditure on mental health

The most up-to-date information on expenditure on mental health services is that revealed by a recent financial mapping exercise. This provides the first comprehensive picture of adult mental health finances, where spend by service categories is grouped by NSF standard. It:

- Identifies organisations' future investment plans
- Provides local information to inform local decisions
- Allows comparisons of locality investment profiles
- Supports comparative financial benchmarking
- Helps safeguard investment in mental health

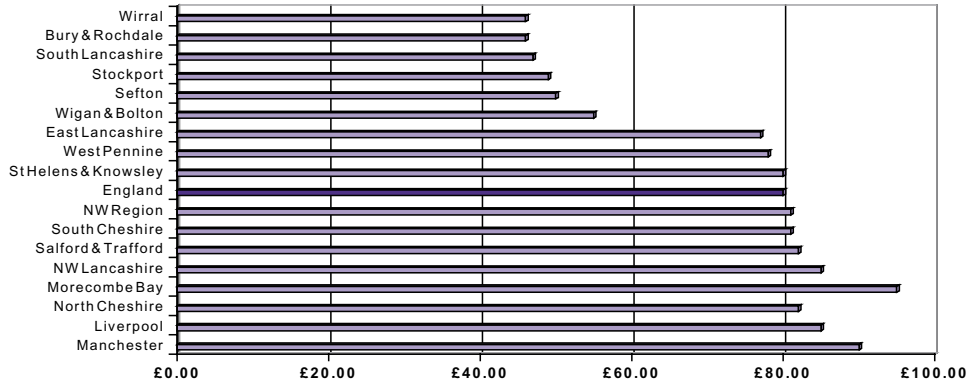
Investment in mental health in the North West is some £414m, comprising £320m on direct care, and £94m on indirect, overhead, and capital charges. However investment per head of weighted population in the North West, at £51.46, shows a -21.2 % variation from the average for England.

Spend per head of population also varies between the three Strategic Health Authorities in the North West - Greater Manchester (£71.37); Cheshire and Merseyside (£60.96); and Cumbria and Lancashire (£53.07). Moreover spend per head of population varies between the Local Implementation Teams (LITs) within individual Strategic Health Authorities. In Cumbria and Lancashire, for example, the spend per head of population ranges from Hyndburn and Ribble Valley (£30.17) to Lancaster (£94.78).

An earlier analysis of expenditure by Health Authorities in the North West on mental health services was produced in October 2000 and provides a guide to historical trends (Crilly, 2000).

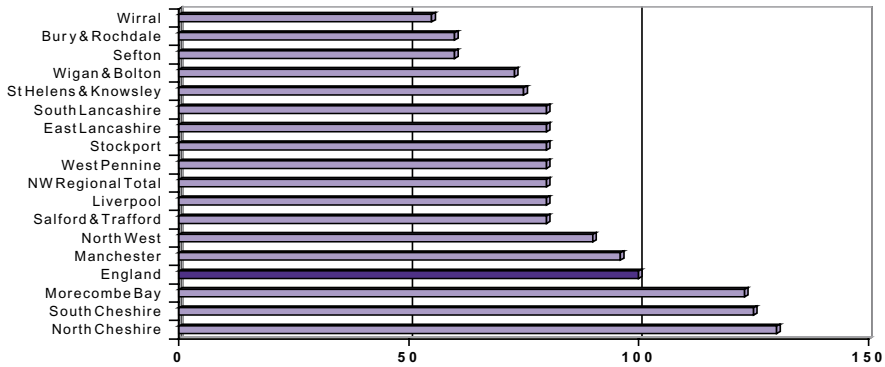
Comparisons were made using an audited set of external data based on Health Authority expenditure on secondary mental health services (i.e. hospital and community and excluding primary care) for 1998/9. The data is partial and doesn't include social services investment and grants made to non-statutory bodies. However it does provide a robust means of comparing investment between Health Authorities.

Figure 16: Unweighted Health Authority expenditure per resident on mental health services



Expenditure levels unweighted and weighted for deprivation using the Mental Illness Needs Index are shown. The England base is 100 weighted for deprivation using the MINI. Any spending below 100 (weighted) can be interpreted as lower than expected.

Figure 17: Weighted Health Authority expenditure per resident on mental health services



From this data Health Authority investment in mental health services within the North West region was estimated to be 13% lower than expected. There is variation between areas with North Cheshire, South Cheshire and Morecambe Bay in the upper quartile of the England range when adjusted for need. Sefton, Bury and Rochdale and Wirral have the lowest weighted expenditures in the country.

Table 15: Comparison of expenditure by Health Authority

Area National	Percentile Where 1 is highest	MINI	Weighted expenditure
North Cheshire HA	7	100.9	134
South Cheshire HA	17	95.1	124
Morecambe Bay HA	20	101	122
ENGLAND	47	100	100
Manchester HA	55	118.5	96
North West Lancashire HA	64	105.6	90
Salford & Trafford HA	68	105.8	87
Liverpool HA	69	118.2	87
NW Regional Total		104.9	87
West Pennine HA	70	103.6	86
Stockport HA	74	96.6	85
East Lancashire HA	75	103.4	84
South Lancashire HA	76	95.4	84
St Helens & Knowsley HA	81	108.7	77
Wigan & Bolton HA	87	103.7	74
Sefton HA	98	106.3	62
Bury & Rochdale HA	99	102.7	62
Wirral HA	100	104.8	58

9.3 Serious mental illness and risk – secure psychiatric services

Some people with mental illness will need to be treated in secure settings. This may be because their criminal behaviour has led to the courts directing their detention within secure care. They may present high levels of risk to themselves or others, and it is likely that previous efforts to provide treatment and care through mainstream mental health services will have had limited success. Most people who need treatment and care in secure settings will be subject to specific orders under the Mental Health Act, and sometimes to a range of restrictions governing their care, and discharge and transfer on to other placements and treatment.

Across the North West region, secure psychiatric services are provided on a zonal basis through an interdependent network of High Dependency Units (low secure) and Medium Secure units. High secure provision is at Ashworth Special Hospital, although some patients from the region are in other high secure hospitals around the country. Expenditure on secure mental health and learning disability services in the North West is approximately £70m a year.

Because these are highly specialist services, commissioning and service development are undertaken at regional level by the dedicated Secure Services Commissioning Team, working closely with national specialist services commissioning bodies.

Nationally, a number of needs assessment exercises and research studies have been undertaken looking at peoples' needs for secure psychiatric care and particularly at needs for high secure care. These studies have revealed significant discrepancies between patients' secure needs and the levels of security at which they are detained, and this applies across the range of secure service provision.

Needs assessment exercises have also proceeded in all regions. A study was undertaken in the North West region looking at all patients in secure psychiatric care (maximum secure hospitals, medium secure units, low secure units, secure learning disability services, and adolescent forensic services) on a census date in 1998. The main conclusions were:

- Only around 67% of patients were being treated at the correct level of security for their needs. 28% were placed at a higher level of security than needed and 5% at a lower level of security than needed
- Discrepancies between placement level and need were greatest in high secure hospitals
- Whilst the total number of beds in the region was thought to be roughly adequate, there are significant gaps in service provision and services need restructuring
- Service provision has largely concentrated on security and peoples' needs in relation to length of stay and dependency have not been adequately addressed
- Approximately 8% of patients had a primary diagnosis of personality disorder and a further 11% had a secondary diagnosis of personality disorder

Further assessment work has resulted in development plans to meet identified gaps in provision, most notably in various forms of longer stay services at low and medium security levels, and 24 hour nursed community accommodation to facilitate reintegration into the community.

A programme of research into women's needs in relation to high secure care is currently being undertaken looking at the needs of women across all levels of secure care including prison. National studies suggest that women in secure settings are less likely than men to have serious criminal offences; are more likely to have previous psychiatric admissions and mental health needs; are more likely to be diagnosed with personality disorder or borderline personality disorder; and are more likely to be on civil sections of the Mental Health Act (Lart et al, 1999). Many have experienced early deprivation and abuse; and have complex needs including drug and alcohol problems, serious risk of self-harm, and challenging or assaultive behaviours (Lart et al, 1999). There are some indications that women move more quickly up the levels of secure provision than men, and have more difficulties in moving back into society. Some clinical views within secure services in the North West suggest that most mainstream mental health services lack the capacity to address the needs of women with challenging behaviours.

This has been echoed by some service user views; in a recent UK survey of women service users, 22% felt that women with complex needs (dual diagnosis, personality disorders, eating disorders, self harming behaviours, challenging behaviours), "are often refused services or receive treatment that is inappropriate for their needs" (Williams et al, 2002).

While the commissioning of secure services is undertaken at regional level, there are a number of issues that will be of concern to key players at local levels within the North West.

- While many patients enter secure care as a result of court action or from prison, it is now becoming clearer that more could be done to prevent people with serious and complex mental health needs from entering secure services, and to ensure care at appropriate levels of security
- That a wider range of community based provision (accommodation, care and support) is needed so that people can move on appropriately from secure care when ready
- That mainstream mental health services may need strengthening to enable them to better address serious and complex mental health needs and challenging behaviours

9.4 Mental illness and social exclusion

As indicated earlier people diagnosed with a significant mental illness have been found to be among the most excluded in society (Sayce & Measey, 1999). Findings demonstrate that people with mental health problems, particularly those with severe and enduring problems, can experience:

- Increased risk of physical illnesses, including coronary heart disease, diabetes, infections and respiratory disease (Phelan, M et al., 2001)
- Poor access to appropriate physical health care and health promotion
- Exclusion from geographical communities and access to housing (Repper et al, 1997)
- Restricted access to mental health care through an inability to pay for transport or childcare (FOCUS, 2001)
- Limitations on access to financial services such as life insurance and mortgages (Read & Barker, 1996)
- Significant hurdles in trying to return to employment.

The evidence concerning employment difficulties is particularly significant given the information presented earlier on unemployment in the North West (sections 5.2.2, 7.1). Unemployment remains a serious structural problem affecting many population groups across the North West. We may therefore expect employment deprivation amongst people with serious mental illnesses to be relatively high. Initiatives to prevent people with mental illness losing their employment; and work schemes to support people in getting back into employment, are likely to be important areas for action.

An enquiry by MIND into social exclusion (Dunn, 1999) depicts the difficulties people with mental health problems experience in their daily lives on the basis of evidence collected from over 300 witnesses representing a broad range of perspectives – service users, psychiatrists, employers, voluntary sector, professional organisations etc. The main problems identified were:

- **Work:** evidence of discriminatory practices, a justified fear of discrimination, ill-prepared employers and failure on the part of mental health services to view promoting work as a relevant and legitimate role for services
- **Education and training:** little knowledge or understanding of mental health issues in many schools, colleges or universities, practical support almost non-existent and a lack of information about where to go for help
- **Daily living:** the role of psychiatric diagnosis in ostracising service users from mainstream opportunities, additional discrimination on the basis of race and gender compound the difficulties of having a mental health problem, disrupted support networks and the powerful role of the media in perpetuating stereotypes
- **Mental health services:** services focus on the clinical to the detriment of the social, psychiatric services can be experienced as ghettoising and stigmatising and there is evidence of discrimination within the NHS (Dunn, 1999)

This qualitative study is supported by the work of Huxley and Thornicroft (2000) who compared people living with serious mental illness to non-mentally ill people living in the community. They also concluded “all the available evidence points to the significant social exclusion of people with mental health problems in civic, economic, social and interpersonal terms. Compared to the rest of the population they are seriously disadvantaged with respect to employment, income and social relationships; they are almost three times as likely to live alone and in some places they are up to seven times more likely to be the victim of violent crime”.

9.5 What we know about how service users understand mental illness, treatment and services, and what they want.

People who use mental health services understand mental well-being and illness, and express what they want from services in particular ways. It is important that agencies and professionals involved in commissioning, planning and providing services understand the views of service users and their families. The priorities of service users and professionals are often different, as are definitions of success and effective care.

There have been a number of general reviews of information about service user perspectives on the quality of care across a range of health and social care services (Williamson, 1992; Swage, 2000). These identify some common themes, which emerge as key concerns for people using health and other care services including:

- **Information** - people using services need and want adequate information about their condition, treatments including advantages and disadvantages, how they could or should modify their lifestyle, and services available. Appropriate information can be crucial for people in adjusting to their condition, understanding and complying with treatment, and in securing support from carers
- **Choice** - people may wish to exercise choice about whether or not to have treatment; the different types of treatment or other services available; where and from whom to receive treatment; in which setting (home, day care, in-patient); and over what is the most important problem to tackle first
- **Control and decision-making** - being an active partner in making decisions about health care, and to a greater or lesser extent, in control of one's own health care
- **Quality of life and practical aspects of living** - while clinicians prioritise symptom relief and improving medical conditions for many service users, particularly those with disabling illnesses, practical aspects of living may be of greater importance
- **Respect** - being treated with respect by health service personnel

While these reviews apply to people using the full range of health services, the key themes are echoed by studies relating to people using mental health services and can be usefully viewed as basic quality standards.

A survey of community care needs of people with mental illness (Ritchie et al, 1988), explored service users' experiences and their views on what they needed. The needs most commonly recognised are outlined below:

Box 5: Service users' views on what they need

Restoration of confidence and self-esteem - many people reported strong feelings of inadequacy and little self-confidence. Restoring these was seen as an essential need.

Engaging in valued activities - people wanted to be involved in fulfilling activities valued by themselves and others

Personal contact and support - many people spoke of social isolation and loneliness, with needs both for general social activity, and closer intimate relationships

Help and support at critical times - most people experienced periods when their needs for help or support were particularly high.

Occasional sanctuary - from time to time people felt a need to seek refuge from everyday life either as a result of symptoms or being unable to cope with day to day events. Hospitals and hostels were the main places that people had used for refuge.

Some research into how users of acute psychiatric hospital care perceive outcomes (Godfrey, 1997), explored both experiences of acute hospital care, and what users want (desired outcomes). Different needs were evident at different stages of illness and these influenced the outcomes that users were looking for.

Table 16: Users' outcomes for acute care

Stage in illness	Examples of desired outcomes
Becoming ill	<ul style="list-style-type: none"> To maintain control over daily activities in order to manage a "normal" life To balance the positive effects of medication, such as symptom alleviation, against the negative aspects, such as side effects To relinquish some control over areas of life to carers
Seeking help	<ul style="list-style-type: none"> To have regular contact with empathic mental health workers who respond to the carer's perceptions of the changing nature of the user's illness To avoid health professionals reinforcing view that being ill is a personal failure To have symptoms recognised by GP and appropriate referral to be given
Receiving hospital care	<ul style="list-style-type: none"> To be provided with a refuge from the pressures of everyday life To have respect and understanding staff who do not stigmatise mental illness To have sufficient time to talk to staff To have access to meaningful and interesting leisure activities
Receiving community care	<ul style="list-style-type: none"> To have a trusting relationship with staff who understand the illness from the users' perspective To receive support from staff to avoid hospital referral and build confidence to go back into the real world.

Source: Godfrey 1997

The authors concluded that outcomes determined by service users should be incorporated in clinical concepts of effectiveness. This would encourage conceptualisations of outcomes that change with the course of illness; that are linked to maintaining a normal life; and that encourage the users' own coping strategies alongside professional expertise.

More recently, in various parts of the world, a growing literature on recovery from mental illness is focusing on the experience of individuals who have recovered from serious mental illness, exploring what recovery means and what factors people have felt contributed to their recovery. A recent literature review (Allot et al, 2002) suggests that the concept of recovery constitutes a paradigm shift in thinking and research about mental illness.

The following were identified as important themes or indicators of recovery:

- The ability to have hope
- Trusting my own thoughts
- Enjoying the environment
- Feeling alert and alive
- Increased self esteem
- Knowing I have a tomorrow
- Working with and relating to others
- Increased spirituality
- Having a job
- Having the ability to work

Factors people felt to be helpful in achieving significant recovery from schizophrenia were:

- The process of coming to terms with the disorder
- Activities that were helpful
- Environmental factors
- Medication
- Aspects of themselves that were helpful
- Their network
- Hospitalisation

The importance of the individual's determination to get better and manage the illness was the most frequently reported theme; accepting the illness, planning for crises, and "working with their ability to recover from the illness". Over half the participants named optimism and hope for recovery as significant. An equal number reported stigma as a negative factor acting against recovery.

This work has led to a variety of suggestions for changing and developing mental health services and practice to maximise the potential for recovery. Key themes are staff recognition of personal coping strategies; incorporating hopefulness in professional attitudes and relationships; management through tools such as Wellness Recovery Action Plans; and promoting self-determination.

This summary provides a brief outline of a large and growing literature on service users' views and it can be seen that there are a number of consistent themes. There is one area on which however there appears to be no research, namely the experience of being detained under the Mental Health Act. Barnes et al (2000), conducted a literature review and could not identify any studies of users' experiences of being subject to the Mental Health Act. They undertook small scale work to explore the impact of compulsion on people's lives; how compulsion affects relationships with mental health workers; and the impact of compulsion on people's sense of themselves. Initial indications were that these are complex issues but possibly of significant importance in terms of people's sense of worth and relationships with services. These appear to be key themes through the literature outlined in this section indicating that further research of this neglected area could be valuable.

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Chapter 10 - Addressing mental illness - potential for action

Key players are faced with a number of questions - What can we do to treat mental illness? What can we do to reduce risk? What can we do to promote social inclusion? What can we do to involve service users? Information about a range of potential action is outlined below.

10.1 Treatments for mental illness

There are a number of evidence based reviews upon which to draw when identifying appropriate treatments and services for people with mental illness.

- **Anxiety disorders**

The evidence suggests that panic disorder responds to both CBT and antidepressant medication, with a more sustained recovery following psychological treatment (BMJ). Simple phobias appear to respond best to exposure treatments. CBT is also indicated for social phobia and generalised anxiety disorder (DoH, 1999).

- **Depression**

Systematic reviews of the research evidence have found that antidepressant drugs are effective in the acute treatment of all grades of depressive disorders in all common treatment settings and in people with or without other physical illnesses (BMJ). It should be noted however that antidepressants are not always prescribed or taken in the correct doses (BMJ). Depressive disorders may be treated effectively with psychological therapies with best evidence for CBT and interpersonal therapy and there is some evidence for a number of other structured therapies (DoH, 2001). Electroconvulsive treatment (ECT) is effective in the acute treatment of life-threatening depressive illness (DoH, 1999).

- **Eating disorders**

Most mild eating disorders can be managed within primary care and dietary education and monitoring of food intake are effective components of treatment (DoH, 1999). Reviews of research evidence suggest that CBT and other psychotherapies reduce specific symptoms of bulimia nervosa, while antidepressants may be effective in the short term for bulimic symptoms (BMJ). Severe eating disorders should be referred for assessment (DoH, 1999) but there are, as yet, no systematic reviews that have evaluated health service delivery interventions for anorexia.

- **Obsessive compulsive disorder**

Reviews of research evidence have found that antidepressant therapy improves the symptoms although this may be restricted to the short term (BMJ). CBT also improves symptoms and one trial showed that improvement was maintained for 2 years (BMJ).

- **Personality disorder**

Little recognised high quality evidence is currently available for treatments for personality disorder. However there are recent promising developments in psychotherapeutic treatments. A meta-analysis of Therapeutic Community Treatment suggests these approaches can be effective. (DoH, 2001)

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- **Post traumatic stress disorder**
Reviews of research evidence suggest that post-traumatic stress disorder can be treated effectively by CBT or antidepressants (DoH, 2001).
 - **Schizophrenia**
Comprehensive care for schizophrenia involves not only drug treatments, but also the provision of ongoing support, valid information and, where appropriate, therapies for rehabilitative strategies (NHS CRD, 2000). The standard drugs for treatment, including Chlorpromazine, improve clinical outcomes but side effects make them unacceptable to many people (BMI). The newer 'atypical' antipsychotics are as effective as standard drugs and have different profiles of adverse effects (NHS CRD, 1999). The continuation of medication for 6-9 months after an acute episode significantly reduces the risk of further illness; this is also true of family and psycho-educational interventions. CBT and social skills interventions may also reduce relapse, readmission rates and the length of time in hospital, although further evidence is required to confirm this. (NHS CRD, 2000).

10.2 Service organisation and models

As noted above, mental health problems are common, and many mental health problems are primarily managed in primary care. Early diagnosis and prompt effective treatment are essential where the aim is to halt the progression of mental illness once it is established.

People with recurrent or severe and enduring mental disorder, severe anxiety disorders or severe eating disorders have complex needs, which may require the continuing care of specialist mental health services (DoH, 1999).

Self Management

Psychological approaches for mental health problems are increasingly popular with people and are increasingly used in primary care. Some psychological treatments can be used in a self-help format which has the potential to reduce the cost of treatment and increase access to specialist help. There are often lengthy waiting lists for psychologists and increasingly counsellors. A systematic review undertaken by the National Primary Care Research and Development Centre at the University of Manchester of studies of self management suggests that these treatments may be more clinically effective than GP care (Bower et al, 2001). However self help trials are limited both in quality and quantity and further evidence is needed to identify the implications for practice in primary care.

Evidence from other types of health care however indicates that self management can reduce the time lag between onset of symptoms and reduce the number of general practice and clinic visits patients make (Robinson et al., 2001). Further, people who live with problems long term often have a store of knowledge about how to cope and are often willing to use their experiences to help others.

Written information developed on the basis of this experience provides an invaluable resource and facilitates informed choice about various treatment options and a more person centred approach (Kennedy & Rogers, 2001).

A study undertaken by the Mental Health Foundation (1997) of over 400 people experiencing emotional distress identified a number of ways which people had developed to cope with their difficulties. These included:

- Finding ways of motivating myself
- Getting support from other people
- Taking life one day at a time
- Looking after myself
- Finding ways of managing symptoms

Services for those with severe mental illness

The NSF for Mental Health outlines standards for effective services for people with severe mental illness and the evidence for these recommendations has recently been reviewed (DoH 1999, NHS CRD 2000). The evidence generally supports the emphasis on the development of multi-disciplinary community mental health teams; teams offering specialist assessment, treatment and care to people in their own homes and the community. The team should ideally involve nursing, psychiatric, social work, clinical psychology and occupational therapy membership, with ready access to other therapies and expertise, for example specialist psychotherapy, art therapy, and pharmacy.

The Care Programme Approach (CPA) (case management) provides a framework for care co-ordination of service users under specialist mental health services. The main elements are a care co-ordinator, a written care plan, and at higher levels, regular reviews by the multi-disciplinary health team and integration with the social services care management system. CPA is less evidence based although it may help health and social services keep contact with people and may serve useful administrative functions (DoH 1999; NHS CRD, 2000).

Assertive Community Treatment (ACT) is an active form of treatment delivery, the key components of which are: multidisciplinary teams, case sharing, assertive outreach, low caseloads, and an emphasis on rehabilitation. The latest research reviews (Mueser et al, 1998; The Sainsbury Centre for Mental Health, 1998; Scott & Dixon, 1995; Holloway et al, 1995), into the efficacy of assertive community treatment for people with severe mental illness and complex needs suggest that this type of community care can deliver:

- Better engagement with community services
- Higher client satisfaction with services
- Improvement in quality of life and social relationships
- Greater housing stability
- Reduction in the number of hospital admissions

Care within the hospital setting has been reviewed with the conclusion that short stay was more effective than long stay or standard care (DoH, 1999). The evidence supporting day hospital and non-health service day care has not been fully evaluated (NHS CRD, 2000). There is currently no reliable evidence to support the development of patient held information. The evidence surrounding the best use of high and medium secure beds, the availability of intensive care beds, crisis and refuge places, 24 hour staffed places, hostel places and other residential places is incomplete and awaits further research and review.

Further research on crisis intervention is also required before specific strategies can be recommended, and the effectiveness of access to 24-hour care has proved hard to evaluate.

People may present in primary care with “undifferentiated problems” (Bower et al, 2001), that is, a complex mix of social, psychological and physical difficulties. Counselling is frequently used to address such problems. Counselling has been shown to reduce psychological distress more than usual GP care, in the short term, although overall benefits are modest in size.

10.3 What can we do to involve service users?

Section 9.5 above outlines some of what we know about how service users themselves consider their mental ill health, managing their lives, and treatment and care. Implications for action arise from that discussion as from the consideration of evidence for forms of self-management discussed above.

The involvement of service users is consistently promoted through policy and there is now experience around the country of a range of different types of initiative. It is suggested (CMHSD, 1999) that to be effective, service users need to be involved at all levels of the mental health system including:

- Involvement in planning their own care and treatment, self care and self management
- Planning and commissioning services
- Recruitment and training of staff delivering mental health services
- Monitoring, auditing and researching services
- Providing services

Service users can be involved in a variety of ways in their own care and treatment.

There are a number of self-assessment formats available (Nottingham, 1999; Changing Minds) which allow service users to articulate their priorities and aspirations and views of the help they need.

The Care Programme Approach is the major tool for care planning for people using mental health services and the process should involve and work with service users. However, "Users Voices" (SCMH, 2000), which reported on interviews with 500 service users, found that the majority of service users did not know what the CPA is for; who their CPA key worker was; or that they had a Care Plan.

The material quoted above on self-management techniques and skills also indicates useful approaches and experience.

Service user involvement in planning and commissioning services has spread through involvement in joint commissioning fora, Local Implementation Teams, Partnership Boards etc. Where possible, training for such representatives in committee officer roles, using agendas and minutes etc. is valuable and may be provided by user groups or through statutory authorities. Service users can also be successfully involved in developing specifications for services and in setting required quality standards. As indicated above, involving service users in defining the outcomes sought from services is essential in planning for effectiveness. The College of Health provides information on processes for defining user focused outcomes, and describes initiatives to involve service users in clinical audit processes within services (Kelson, 1998,1999).

Increasingly, voluntary sector agencies and occasionally statutory agencies have involved service users in staff selection. This can be important, particularly where staff will be involved with service users over long periods of time such as in hostels, group homes and day centres. Service users have effectively been involved in various forms of training, particularly training for Approved Social Workers (Hastings & Crepaz Keay, 1995). Such initiatives are relatively small scale and infrequent and user trainers need to be appropriately involved in planning training courses and may need support from co-trainers.

A large scale initiative involving service users in monitoring mental health services (User Focused Monitoring) was undertaken by the Sainsbury Centre for Mental Health (SCMH, 2000) in which 61 user interviewers were trained and carried out interviews with over 500 service users. Users were integrally involved with the development, implementation, and analysis of the research project. Such user led monitoring may be more likely to promote active user feedback on services, (Ford & Rose, 1997) and less likely to elicit the "halo" effect (exaggerated satisfaction ratings) sometimes seen from standard questionnaires. The "User Focused Monitoring" methodology developed through this project can be used for a variety of user-led evaluations of services.

10.4 Promoting social inclusion

It is possible to distinguish two approaches to promoting inclusion; the first is preventative and the second reintegrative. Table 17 provides an overview of potential action. Preventing social exclusion involves tackling stigma and discrimination in relation to mental health problems and addressing, for the population as a whole, the inequalities and issues such as poverty, unemployment and fear which impact upon mental health and may contribute to the experience of mental ill health. Clearly legislation and government policy is relevant here.

The introduction of the Disability Discrimination Act 1995 provides a basis for individuals to tackle discrimination on mental health grounds. There are many government initiatives, which aim to tackle social exclusion and improvements for the whole community will obviously benefit people with mental health problems. If this is to be achieved, however, there does need to be a focus on mental health and initiatives must incorporate mental health into the early planning and evaluation (Greatley, 2000). This is likely to involve raising awareness about mental health and ill health and addressing evident tensions. For example, in writing about Lambeth, Woodhead (2000) describes the tensions which have arisen in some neighbourhoods where there are conflicting views about the ways of tackling mental health problems. For example, some residents advocate the removal of individuals who are showing signs of mental illness and others want better support for all kinds of people experiencing distress. This throws into sharp relief the different ideas people may have about society, models of communities and social cohesion, as well as mental health. Whilst not explored here, it is worth noting the idea of 'inclusive diversity' as a way of conceptualising communities (Miller, 1998). This is the view that society is not homogenous and that diversity is a feature of all parts of all communities and therefore the achievement of social inclusion will be realised through exploiting the potential of people working together. The way in which this can be done is illustrated by community-based organisations which focus on community development to facilitate a synergy of effort around shared issues and promote community leadership to address these (SCMH, 2000).

It is evident that all services have a role to play, both in relation to preventing exclusion and promoting inclusion of people with mental health problems. In particular, mental health services, in the way they are designed and delivered, make a significant contribution to whether or not they contribute to promoting citizenship or perpetuating exclusion. The clear identification of outcomes by services in relation to promoting inclusion will help in refocusing efforts and there is a real opportunity in the development of new services such as assertive outreach teams, early intervention and crisis resolution teams to do this. Assertive outreach teams are aimed at those who are difficult to engage and are by definition excluded from many opportunities. In establishing such services there is enormous potential for identifying how the service can contribute to promoting citizenship e.g. through providing information, maximising choices, connecting the person with local networks in their community, ensuring they are an active partner in the support they receive, creating and realising opportunities in relation to work, good housing and a decent income, providing support to sustain and build relationships and friendships to name but a few. The ways in which mental health services can promote inclusion and citizenship is currently the focus of a national programme (Morris, 2001) and a workbook which illustrates how this might be applied recently published (Bates, 2002).

Table 17: Promoting social inclusion for people with mental health problem

Focus	Aim	Potential Action	Examples: national and regional
Society	To tackle stigma and discrimination	Legal reform to tackle discrimination Media campaign Challenging discrimination	Disability Discrimination Act 1995 North West Campaign (NWMHDC 2001) Disability Rights Commission
Health, local authorities and partner organisations	Improve economic and living conditions of vulnerable groups	Developing strategic partnerships to tackle inequalities e.g. in relation to health Access to employment Remove the barriers to access to ordinary services such as housing	Local strategic partnerships, as part of neighbourhood renewal strategy Urban regeneration Health Improvement Programmes Supported employment Tenancy support
Communities	Developing competent communities	Developing mental health literacy through raising awareness of the general public and promoting better understanding through schools – education for life Supporting community based action e.g. self help and local democracy Developing community leadership e.g. social entrepreneurs Promoting contact with people with mental health problems	Community organisations and mental health (SCMH, 2000)
Mental health services	1. Improving the personal autonomy and control of people with mental health problems 2. Design & provide mental health services which promote citizenship 3. Minimise the risks of exclusion on contact with mental health services	Person centred planning Advocacy User involvement Providing information about rights and opportunities Strengthening the voice of service users in shaping local services Promoting partnership between health, social services and the voluntary sector Addressing increased income through provision of welfare benefits advice Supported employment Care Programme to Work Developing new services based on citizenship Assessing the risks in relation to exclusion Building alliances with key agencies –housing, DSS etc.	Person centred planning and mental health (Hill, 2001) See Section 10.4 Direct payments (Davidson, 2001) Tameside Metropolitan Borough Council Mental Health Services of Salford Care Programme to Work National programme for social inclusion and community partnership (Morris, 2001)

Source: Newbigging, K (2001) Promoting Social Inclusion. First published in the Mental Health Review, Vol 6, Issue 3.

10.5 What we don't know - Areas where evidence is lacking

While the NSF (DoH, 1999) highlights the importance of 24-hour access to services and helplines, there are no evidence-based reviews that evaluate the effectiveness of these interventions. The potential liaison role of Accident and Emergency services has also been highlighted, but again there are, as yet, no evidence based reviews to support this. It has also been suggested that 24-hour access to specialist mental health service should be available not just to primary care but also to police.

There are many areas of diagnosis, treatment and organisation of services for mental health problems that have, historically, few research studies or reviews of evidence performed. A recent review highlighted areas that could be reviewed in the future. They include:

- Increasing knowledge about self-help and self-help groups
- More generic approaches to managing prescribing in primary care
- Detection versus disclosure on outcome of depression in general practice
- Liaison between psychiatry, psychiatrists, and other mental health professionals in primary care settings
- Case management of depression by clinical pharmacists in a primary care setting
- One stop shop clinics

Implications for action for key players

The data on mental ill health indicates significant rates of mental health problems and mental illness across the North West, with wide ranging implications for action for a number of stakeholders.

All individuals and organisations will be working on implementation of the National Service Framework standards and there will also be particular local issues.

The data on expenditure on mental health services indicates investment levels that are out of step with the profile of need; implying action needed on the part of Strategic Health Authorities and local commissioners to safeguard existing expenditure and to ensure more appropriate investment levels.

The information on drug and alcohol consumption across the North West implies that needs related to dual diagnosis and complex need will be high in some local areas, implying requirements for detailed intelligence and targeted action.

The ethnic minority profile indicates action to assess need, monitor access to mental health services and initiate targeted action in some local areas.

Social exclusion of people with mental ill health may be exacerbated by socio-economic deprivation, with the implication of raised priority for this area of action. Action will include initiatives at several levels, involving a range of key players (see Table 2).

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Chapter 11 – Concluding remarks

What information do you have locally and what do you need?

Public health information is intelligence to prompt and guide action. This report has provided an overview of the information available on a range of mental health issues; some information about the North West; and the general foundations for a framework for action. Some fairly general implications for action by key players have been drawn out but these will best be considered by local counterparts.

Health communities across the North West face particular problems and priorities, and the major themes implied by this report will be of varying importance in different localities. Local concerns and priorities will shape the particular needs for detailed information which issues raised in this report may have prompted. Some of these might be:

- Information on children and young people at risk of developing mental ill health
- Information on young people coming out of care at risk of mental ill health
- Information on people presenting to A&E departments because of self harm or suicidal behaviour
- Information on the mental health needs of specific groups. For example: black and ethnic minority communities, people living in rural communities, prisoners etc.
- Information on people with drug and alcohol problems presenting in primary care
- Information on the employment status of people using mental health services
- Information about people who have both mental ill health and substance misuse problems and the services they go to
- Information on people with complex needs and how those needs are addressed by services
- Information on formal admissions under the Mental Health Act and how patterns compare to other localities
- Users' and carers' views of the services people receive.

Some North West examples of developing local intelligence are provided below.

Box 6: Lancaster Farms Young Offender Institution (YOI) Health Needs Assessment for the prison population.

In terms of mental health needs, this identified that

- There was a need for Community Mental Health Team input into the prison
- A formal service level agreement with a provider of a full range of adolescent mental health services should be negotiated.
- Aftercare arrangements on discharge could be difficult to arrange.

Source: Health Needs Assessment of Lancaster Castle Prison & Lancaster Farms YOI

Box 7: Estimating GP Mental Health Consultations

Information on access to mental health services in general practice is not easily available. Wirral Health Authority developed a regression equation to enable us to estimate both consultation rates and prevalence of mental health disorders. When applied to census data at enumeration district level this will allow an assessment of the workload by GP, practice or PCO, or by geographical area. Since the source data is national the results will be adaptable to other districts. It is intended to distribute the equations for wider use, possibly by paper publication and on the web.

Source: Chris Harwood, Taher Qassim, Alex G Stewart. Public Health Department, Wirral Health Authority

Box 8: Severe and Enduring Mental Illness in Pendle

In order to estimate the prevalence of serious and enduring mental illness (SMI) in Pendle PCG, individuals aged 16-65 meeting the agreed criteria* were identified from secondary and primary care records. Sixteen practices, representing 85% of the registered population of the PCG collaborated in the project. Data was extracted from a range of sources, including the hospital PAS system and GP records. This allowed the prevalence to be estimated at 9.8 per 1000 adult population; broadly comparable to other surveys. However it is likely to be an underestimate as some individuals not in contact with services may have been missed and other sources of data, for example social services, were not used. The work identified a number of problems relating to the difficulty of using local data but provided valuable local information to aid the planning and delivery of services.

Criteria for SMI

One of the appropriate diagnoses of heavy use of mental health services in the previous five years or CPA level 11 or admission under section 2/3 of the Mental Health Act in the audit period or at the specific request of the GP.

Source: Debbie Gray, Operations Manager, Services for Older People. Rossendale, Burnley and Pendle PCGs

Box 9: Mental Health Needs Assessment for St Helens

This needs assessment aimed to provide a comprehensive overview of mental health needs in St Helens. It considered:

- Pathways to psychiatric care
- Factors affecting psychological morbidity
- Prevalence rates
- Local hospital data
- Mental health outcome indicators
- Suicide data
- Care programme approach data
- Community mental health team contacts
- Counselling provision
- Prescribing data
- Expenditure on mental health

It identified further areas of investigation and made recommendations for commissioning and provision of mental health services, workforce development and information systems in relation to improving the mental health of people in St Helens.

Source: Mental Health Needs Assessment in St Helens, St Helens PCGs

This report has described, using routinely available information, the size and range of mental health problems in the North West of England. The evidence for effective interventions has been summarised and the limitations of the data and evidence base have been discussed. This document is not intended to be a comprehensive review and for pragmatic reasons it has been written from the perspective of the health services. It should now be shared with other organisations and will, perhaps, be a stimulus to further work.

Appendix 1

The Cochrane Collaboration (accessed via NELH at <http://nwww.nelh.nhs.uk/>) has been particularly active in producing systematic reviews on a range of topics. Also the NHS Centre for Reviews and Dissemination (CRD) at York has produced systematic reviews relevant to mental health. (See table 4.2)

Table 4.2 Some Systematic reviews related to Mental Health from the Cochrane Collaboration and CRD.

Day care
Vocational rehabilitation for people with severe mental disorders
Professional emotional support of pregnant women
Medical, nursing or psychological support for mothers and families after perinatal death
Home based social support for disadvantaged mothers
Mental health promotion for high risk groups
Caregiver support for postpartum depression
Supporting carers of people with Alzheimer's type dementia
Assertive Community treatment for People with severe mental illness
Family interventions for schizophrenia
Case management for people with severe mental disorders

Glossary and abbreviations

Carers: Relatives or friends who voluntarily look after individuals who are sick, disabled, vulnerable or frail.

Commissioning: The process by which the health needs of the population are defined, priorities determined and appropriate services purchased and evaluated.

Community Health Councils: Independent statutory bodies which represent the interests of the public in the health service in their area.

Care Programme Approach: CPA – provides a framework for care co-ordination of service users under specialist mental health services.

Department of Health: DoH – government department responsible for health and personal social services in England, including the National Health Service.

Dual diagnosis: Dual diagnosis and complex needs are used to describe people with a combination of drug and alcohol misuse and mental illness.

GP: General Practitioner – the family doctor.

Health Action Zones: (HAZs) - designated by the Government and help bring together local health services and local authorities, community groups, the voluntary sector and local businesses to establish and foster strategies for improving the health of local people.

Health Authorities: Until April 1st 2002 these bodies were responsible for the strategic development of health care in their area, based on local needs assessment and national policy and for commissioning the services in a particular locality.

Health Improvement Programmes: HImPs are the local strategies for improving health and healthcare bringing together the local NHS with local authorities and others, including the voluntary sector, to set the strategic framework for improving health, tackling inequalities, and developing faster, more convenient services of a consistently high standard to meet the needs of local people.

Independent sector: Voluntary, charitable and private care providers.

Local Implementation Team(s): LIT(s) are responsible for the implementation of the National Service Framework for Mental Health. Typically they bring together a broad range of stakeholders to agree local priorities and action.

Local Strategic Partnership(s): LSPs - are non-statutory, non-executive organizations bringing key agencies to coordinate different services and initiatives.

Mental health: An individual's ability to manage and cope with the stresses and challenges of life.

Mental Health Act (1983): The Act concerns 'the reception, care and treatment of mentally disordered patients, the management of their property and other related matters'.

Mental illness: Range of diagnosable mental disorders that excludes learning disability and personality disorder.

National Institute of Clinical Excellence (NICE): Established in April 1999, the Institute is responsible for promoting clinical excellence and cost-effectiveness, producing and issuing clinical guidelines.

National Service Framework(s): NSF(s) outline standards for health services. The NSF for Mental Health describes seven standards, and targets for mental health.

NHS Executive: the body responsible for the management of the NHS. It had eight regional offices as well as head offices in London and Leeds.

NHSE-NW: North West office of the NHS Executive based in Warrington.

NHS Trusts: Responsible for providing health services in line with local strategy.

Primary Care: Health Services delivered in or near to a person's home to which the patients have direct access. These services include those provided in GP's surgeries, health centers and community hospitals or patients' homes by a team of professional staff including GPs, practice nurses, community nurses, and therapists

Primary Care Trust(s): PCTs – Statutory bodies which manage and provide a range of community services directly, and from April 1st 2002 have had the lead responsibility for commissioning health care from a range of organisations including NHS Trusts.

Psychological therapies: Talking therapies, including psychotherapy, counselling, family therapy, and cognitive-behaviour therapy.

Psychotropic drugs: Medication used in the treatment of mental disorder.

Secure services: These provide continuous specialist psychiatric care of mentally disordered adult men and women, who present with complex needs to the extent that they require care and treatment in secure conditions over varying periods of time. The degree of security ranges from:

Low: some local hospitals have wards with locked doors and above average staff ratios. Also known as intensive care or high dependency units

Medium: including Regional Secure Units which care for people whose behaviour is too difficult or dangerous for local hospitals but who do not require the higher levels of security available in special hospitals

High: provided by the three special hospitals in England - Ashworth, Broadmoor, and Rampton. Their people require intensive care, supervision and observation within the most secure surroundings.

Service user/s: People who use health and/or social care for their mental health problems.

Specialist Commissioning Team: Team with responsibility for commissioning a range of secure services on a regional basis.

Substance misuse: Includes illicit drug use, such as heroin and other opiates, amphetamines, ecstasy, cocaine and crack cocaine, hallucinogens, cannabis, and prescribed drugs such as benzodiazepines, as well as substances such as alcohol.

