

Mental Health & Well-being Commissioning Strategy 2009-2014

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FOREWARD

This document outlines the strategic direction for the commissioning of Manchester's Mental Health Services for the next five years. The document's development was led by NHS Manchester in full collaboration with its partner commissioners in the City Council and via ongoing engagement with service providers and representatives of the City's service user and carer groups.

The document has been written in the context of both local and national drivers including: Lord Darzi's report *High Quality Care for All*, John Boyington CBE's reports on Manchester and the North West's mental health services; NHS Manchester's *Improving Health In Manchester the Commissioning Strategic Plan*; World Class Commissioning, the personalisation agenda, the forthcoming *New Horizon's* document that is currently being consulted on

Manchester's mental health services have had a troubled history over the past decade. The financial investment in mental health services is one of the nations highest yet its health outcomes are some of the poorest. In the midst of the current recession there is unlikely to be any additional investment into mental health services in the near future and so improvements must be achieved by redistributing current resources so they become more effective and provide greater value for money. Meanwhile the demand on services continues to increase in all service areas.

Despite these challenges it is hoped that this document will build upon John Boyington CBE's Report last year and set the context for a better future.

The strategy has the vision to "improve the mental health of Manchester" in line with NHS Manchester's Strategic Commissioning Plan and has the three aims of,

- Delivering preventative services which deliver and promote mental well being and in turn:
- Reducing the risk of people developing mental health problems
- Reducing the damaging effect of mental health problems on those who experience them

The strategy identifies six priority groups for particular action but identifies an overarching service model that places greater emphasis on community based resources that reach out to all the diverse communities in Manchester in terms of *promotion* of positive mental health and wellbeing, *prevention* of mental health problems and where required *early intervention* to treat mental health conditions.

For those people who do require treatment, whichever care pathway they require, it will be easy to access via a clear single point of access. It will focus on the personalised recovery and outcomes negotiated with the service user, and it will be provided on the basis of the person's needs not their age (The only exception to this will be when the specific service is age specific such as the CAMHS).

The six priority areas are as follows: There is an explanation later Under Section 3 explaining the reasons for the chosen priority areas

1. Children and young people
2. People new to mental health services
3. People with short term mental health needs
4. People with ongoing mental health needs
5. People with dementia
6. People with complex needs

Section 3 of the Strategy takes each of these priority areas and applies Manchester's commissioning values to national policy drivers before articulating specific measurable actions as commissioning intentions for the next five years.

The Strategy ends with the Roadmap for the Improvement of Mental Health Services.

SECTION 1
THE VISION FOR MANCHESTER

1.1 INTRODUCTION

This document is the Commissioning Strategy for Manchester's Mental Health Services by NHS Manchester and Manchester City Council. It builds upon the previous joint commissioning strategy (2007) by recognising the changing demands of national and local factors including the following.

The publication of *High Quality Care for All* (Department of Health, July 2008), the final report of Professor the Lord Darzi KBE, following his review of the NHS

The assessment of Manchester's mental health services by a team led by John Boyington CBE in July 2008, and the resulting multi-agency action plan

The report of the North West Mental Health Commission, also led by John Boyington CBE (October 2008)

The publication of *Improving Health in Manchester the Commissioning Strategic Plan of NHS Manchester* (October 2008)

Continued developments in commissioning policy and practice by NHS Manchester (World Class Commissioning) and Manchester City Council (the personalisation agenda)

Manchester's Health and Wellbeing Agenda

Commissioning for Health and Well being Guidance Framework

New Horizons: Towards A Shared Vision for Mental Health Consultation (DH, 2009)

The report is also informed by a wide number of stakeholders' views gathered by public events, workshops, ongoing dialogue with service user and carer groups, consulting with statutory and Third Sector partners, and with the frontline staff who work in our services.

The document has 4 distinct sections as follows.

- **Section 1** (this section) identifies the vision, aims, scope, financial resources and key drivers for the commissioning function and outlines our overarching service model
- **Section 2** sets the strategy in context by identifying key national drivers in mental health and the local population needs assessment for Manchester as well as Manchester's finance and performance measures.
- **Section 3** focuses on the six groups that we have identified as priority areas for action
- **Section 4** outlines the next stages for the strategy's approval and implementation.

1.2 VISION AND AIMS OF THE STRATEGY

In line with the overarching Commissioning Strategic Plan 2009-2014 for Manchester this document's vision is to:

“Improve the mental health and well-being of Manchester”

It aims to achieve this vision by

- Delivering preventative services which strengthen and promote mental well-being which in turn
- Reduce the risk of people developing mental health problems
- Reduce the damaging effect of mental health problems on those who experience them

These three aims complement each other. We recognise that mental well-being is multi-faceted, it is at the core of our approach and includes an individual's psychological, social, physical and spiritual well-being. Mental well-being is more than the absence of mental illness and is a state “in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”¹

We want to create healthy environments for all those who live in Manchester. Environments that are inclusive, environments that promote positive self esteem and are non-stigmatising: in short, environments that prevent the onset of mental health problems. Providing services which meet these objectives are fundamental in shifting the focus from diagnosis and treatment to prevention and well-being

However, we also recognise that some people will develop mental health needs that require more support and so we want to enable these

¹ World Health Organisation (2001)

individuals to receive the help they need as quickly and effectively as possible to reduce the impact their mental distress has on their day to day lives.

1.3 THE SCOPE OF THE STRATEGY

This strategy covers the mental health and well-being needs of Manchester's whole population including children, adults of working age and older age adults. It includes people who live in their own homes and people without a home, those in hospital, in residential care or nursing care, those in prison, or any other type of 'residency' within Manchester's boundaries.

The scope and focus of the strategy may require revision in response to changing national policy.

Except for specific services, (e.g., children's and young people's services), eligibility to receive support will be based on an individual's need not their age.

The strategy covers the next five years (2009-2014) and will be regularly reviewed by the commissioning partners through robust engagement and performance management to ensure it remains appropriate and is being delivered upon. The strategy identifies six priority groups as follows.

- Children and young people
- People new to mental health services
- People with short term mental health needs
- People with ongoing mental health needs
- People with dementia
- People with complex needs

1.4 FINANCIAL CONTEXT

Prior to the current global recession the financial investment in Manchester's mental health services was amongst the highest in the country. Yet despite this high level of investment Manchester is associated with some of the poorest outcomes for people. There is an acknowledgement that the financial investment has been and remains significant however the distribution of resources remains questionable as the current service provision is inefficient. There will be a mapping of investment against provision in order to facilitate transformational change.

We do not yet know what the full impact of the current financial downturn will have on future investment and savings, however, public sector finances will be required to produce value for money over the next five years and mental health services will not necessarily be exempt from system wide reductions in investment.

1.5 COMMISSIONING: THE DRIVERS, OUR APPROACH AND VALUES

In developing this strategy, we recognised both the wider national imperatives driving the development of commissioning and services, as well as local strategic priorities including the following:

■ World Class Commissioning

This places Primary Care Trusts and their commissioning partners at the forefront of leading the future NHS at a local level. Great emphasis is placed on quality interventions that meet the local demand, provide value for money and are measured by their outcome rather than service activity.

■ The 'Darzi' Review

Lord Darzi's review of the NHS, *High Quality Care For All*, sets the agenda for future NHS services, ensuring they are fair, effective, personal and safe. It called for PCTs to commission

comprehensive well-being and prevention services, in partnership with local authorities and local partners, based on local identification of need.

■ Strong and Prosperous Communities

Is a strategy for a new direction for Local Government which includes the need to cooperate with non local authority partners in planning, consultation and the creation of a Health and Well-Being Partnership and which encourages greater use of personalised budgets for Local Authority services.

■ Choosing Health

This outlines three core principles (informed choice, personalisation and working together) that underpin a new public health approach.

■ A Commissioning Framework for Health and Wellbeing

Identification of the eight steps which, when followed, provide personalised services which are flexible, integrated and responsive to individual need and choice.

■ Putting People First *and* Transforming Social Care

This sets the vision for the radical reform of social care by promoting strong local leadership in the promotion of individualised care built upon the principles laid out in **Our Health, Our Care, Our Say**.

■ Integration of Health and Social Care

The national policy on public service and the NHS Constitution encourages joined up working and the delivery of care and support that is coordinated, and delivered through cooperation at an organisational and practitioner level. Joint plans for the commissioning and provision of services are encouraged and there is a commitment for all parties in Manchester to achieve this. The purpose of integration is to improve service user

experience and outcomes. This is done by minimising organisational barriers between different services, and between services and commissioners.

“Providing effectively integrated care, achieving better outcomes for service users in a cost effective way, is a key priority for the NHS. In particular, improving integration between health and social care is an important ambition, as signalled in the White Paper Our Health, Our Care, Our Say and in Putting People First, the recent cross-government agreement on adult social care...”

The NHS has a duty to work in partnership with local authorities to provide you with effective, integrated and personalised services to meet your health and well-being needs”

The NHS Constitution, 2009

Single Equalities Scheme

The Single Equality Scheme (SES) is a public commitment of how the Department of Health intends to meet the duties placed on it by the equality legislation. The SES is relevant to all operations of the NHS, patients and employees.

The SES is based around six equality strands (race, gender, disability, age, sexual orientation and religion and belief), and is also part of the DoH human rights programme. The Scheme covers the period 2007 - 2010.

Delivering Race Equality (DoH 2005) specifically addresses very serious issues pertaining to race and mental health. Whilst this policy has been subsumed within the SES never the less we are mindful that Manchester’s BME communities can require specific cultural, faith and equality of access needs and we will provide services that are accessible, culturally appropriate and that meet the needs of all Mancunians.

A framework for City Regions February 2006

Devolving to City regions means “creating a new national geometry of city region governance to which powers and resources would be decentralised on a comprehensive basis as part of wider government reform”².

City regions are enlarged territories from which core urban areas draw people for work and services such as shopping, education, health, leisure and entertainment. Manchester has been selected as a pathfinder site.

Manchester Joint Strategic Needs Assessment 2008-2013

“The means by which Primary Care Trusts (PCTs) and local authorities will describe future health, care and well-being needs of the local population and the strategic direction of service delivery to meet these needs”. The JSNA is expected to influence the commissioning process across both health and social care and to underpin the development and implementation of the Local Area Agreement (LAA) and the Commissioning Strategic Plan (CSP) of NHS Manchester over the next 3 – 5 years.

Manchester City Council Adult Social Care Business Plan 2009/10-2011/12

“Our starting point is the principle that everyone in society has a positive contribution to make to society and that they should have the right control over their lives. Our Vision is to ensure that these values drive the way we provide social care” The plan will deliver targeted prevention to reduce delay or dependence, Individual budget for all and create a market place of services to choose from.

² Office of the Deputy Prime Minister – creating sustainable communities February 2006

meeting all of its NSF (1999) requirements and has been able to celebrate some awards in health and social care.

Manchester Joint Dementia Strategy 2009 -2012

Responding to the health and social care needs of people with dementia in Manchester. The local strategy will cover NHS and Adult Social Care as well as those voluntary, commercial and charitable organisations from which services may be commissioned. The strategy is primarily intended to guide planning and commissioning by NHS and Adult Social Care staff although it may be of interest to other organisations, service users and carers of people with dementia. (See 3.5)

Reaching Out: Think Family June 2007

Creating opportunities and potential for systems and services to 'think family'. It introduces models of whole family approaches to better coordinate all services working with families at risk.

Cordis Bright – Manchester JCT Review and Needs assessment – Older Peoples Mental Health

A review of older peoples' mental health services in Manchester completed between July and October 2008, recognising current and future service provision for dementia and functional mental health problems.

Mental Capacity Act 2005 – incorporating Deprivation of Liberty safeguards

Provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions – someone who lacks capacity.

We are proud that Manchester already has an integrated Joint Mental Health Commissioning Team and together NHS Manchester and the City Council are making a difference, this is evident in the recent Autumn Assessment 2008, where Manchester has been seen to make significant improvements across a range of services. Manchester has also reported

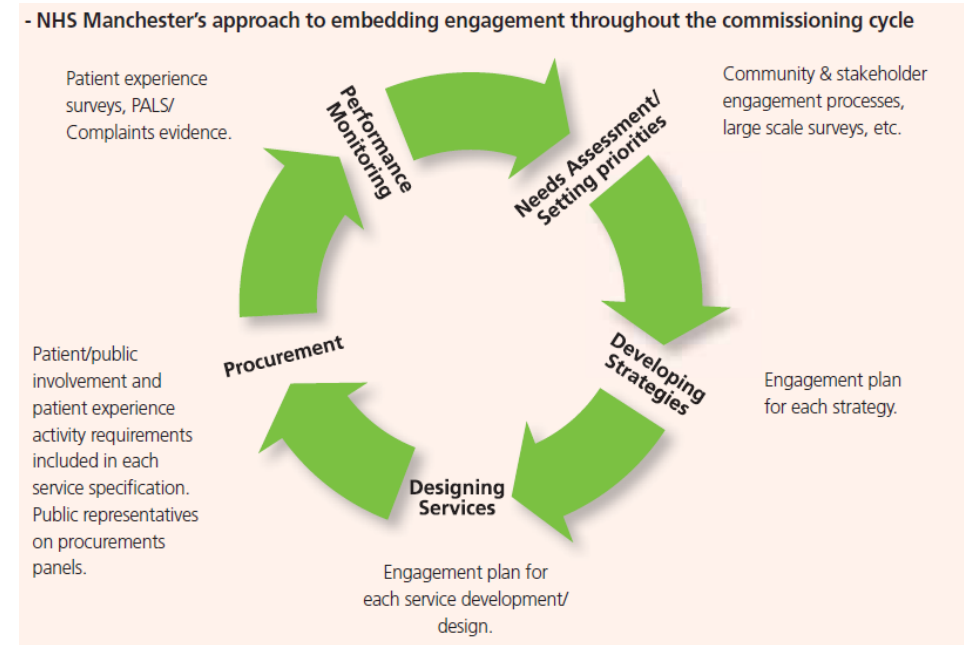
1.6 ENGAGEMENT: OUR APPROACH TO COMMISSIONING

Strong relationships between NHS Manchester, Manchester City Council, third and voluntary sector organisations enable valuable opportunities to improve the mental health and wellbeing of the people of the city. NHS Manchester and Manchester City Council intend:

- To develop a mental health impact assessment system that will forecast future demand and assess the needs of Manchester's residents. This will also assess the likely benefits of future initiatives within the city in terms of its citizen's mental health and wellbeing.
- To jointly develop and commission preventative services which improve resilience and well-being and have a strong focus on self care, maintenance and recovery.
- To actively engage with sectors of the population who may be under or over-represented in mental health services and seek to develop actions to address identified issues.
- To continue to support access to leisure and exercise facilities across the city
- To continue to support the city's crime reduction initiatives to reduce psychological distress and subsequent mental health problems
- To reduce the impact of substance misuse on the city, by systematic implementation of the initiatives specified in the Commissioning Strategic Plan and via engagement with the Manchester Alcohol Strategy 2008-2011, Adult Drug Treatment Plan, and Young People's Substance Misuse Plan.

The approach by which we are committed to achieving these aspirations is illustrated in the diagram below taken from the JSNA 2008 - 2013. It

clearly demonstrates at every point in the commissioning cycle that we seek to engage with local communities, partners and key stakeholders including service users and their carers.



Mental Health Engagement Plan -Service User and Carer Involvement

The ongoing involvement and input of service users and carers will remain critical in improving service quality, enhancing patient experience, developing a recovery model for Manchester and ensuring a family focus in planning and delivery.

Excellent links already exist between mental health commissioners and Patient/Public Involvement advocates. The Mental Health Joint Commissioning Team will continue to consolidate these links and improve the ongoing interface with service users and carers through the development and agreement of a Mental Health Engagement Plan which will:

- Ensure mental health services remain needs led and responsive to individuals and families
- Audit and appraise service user, carer and public engagement in mental health to address identified barriers to effective engagement.
- Involve users and carers in the design and decision making processes when procuring or re-tendering services including innovative engagement with those who are homeless.
- Include the views and experiences of users and carers in the performance monitoring and quality assurance of commissioned services

- Support mental health services in being accessible, attractive and appropriate to all, whilst taking into account particular needs in terms of culture, gender, sexuality, disability, age and faith.
- Continue to develop robust links with a range of community groups and advocacy services to support service users and carers throughout the care pathways
- Require services to publish complaints procedures which are clear, accessible, easily understood, inclusive; that complaints are processed within the agreed timeframes and that outcomes of complaints facilitate positive change in services.
- Require services to conduct regular service user satisfaction surveys and provide evidence of improvements as part of the contract monitoring process
- Develop rapid responses and support mechanisms for families who are caring for, and affected by individuals experiencing mental health problems.
- Enhance access to involvement and support for young people affected by mental health or caring for someone with mental health problems.
- Continue to support and strengthen stakeholder engagement.

1.7 OUR COMMISSIONING VALUES AND PRINCIPLES

The underpinning values in which we will commission services are as important as the processes themselves. In addition to the values articulated in the Commissioning Strategic Plan of being *open, fair, respectful, ambitious, challenging, and accountable*. This section identifies key values that will be central to all mental health services that we commission.

The central emphasis will be upon ***promotion of mental well-being, prevention and early intervention*** and will incorporate the following values.

Services will be inclusive and non-stigmatizing

Positive images of mental health will be promoted, and cultural diversity will be respected. Service specifications will be written from a perspective of inclusion. This will be implemented through the new mental health contracting process

Services will be needs led not age specific

The needs of service users rather than their age should be the primary reason for people accessing services. The only exception to this is where services are specifically and appropriately developed for a defined age group such as children and young people.

Services will be personal

Whether through the ‘personalisation’ agenda of the health service or the ‘individualisation’ agenda of social care, service users will be central to their own care pathway. They will be empowered to navigate pathways and service offerings by being fully informed of the available resources and options.

Services will be integrated where value can be added.

Where opportunity exists and clear value can be added, we will develop a holistic approach to improve physical and mental health and well-being. For example, developing multi-agency referrals to strategic partners in health, employment, 3rd sector and voluntary organisations, education, training and social care

Services will promote recovery

Service users will be encouraged to define the outcomes they desire and be supported to achieve their own recovery. This will be individual to them and based on positive outcomes.

Services will deliver quality

Lord Darzi’s report, *High Quality Care For All*, has set the tone for future service standards. The current operating framework for the NHS says quality should be the ‘organising principle’ of commissioning. The implications of quality becoming the organising principle of commissioning are far-reaching and include:

- Efficiency and value for money driven by quality improvement
- Stretching expectations of quality in all providers
- Intolerance of persistent poor quality
- Incentivising and rewarding quality that is equitable across all sectors
- Measuring quality more comprehensively including through the experience of users

Our success will be measurable

At every stage of this strategy’s development and perhaps more importantly in its implementation is the key question ***“what does success look like?”*** We want to be able to articulate where we are going and demonstrate with tangible results when we have got there. To do this we must measure what we do and raise our expectations and standards.

1.8 OUR OVERARCHING SERVICE MODEL

We know through feedback that getting access to services can at times be bewildering: different services have different eligibility criteria, routes and methods of referral and responses depending on where you live, what time of day, or the day of the week that a request is made. There is also inequity with waiting times. Conversely, we also know that too many people feel 'stuck' in services, especially in inpatient services. We recognise that this has to change.

We will develop preventative services and promote these through Manchester's diverse communities, improve access for all and enable people to remain as resilient and as independent as possible, or desired, in the community. Collectively, all commissioned services will be designed to provide a preventative element, shifting our focus further "down stream" reducing the demand for more acute interventions "up stream".

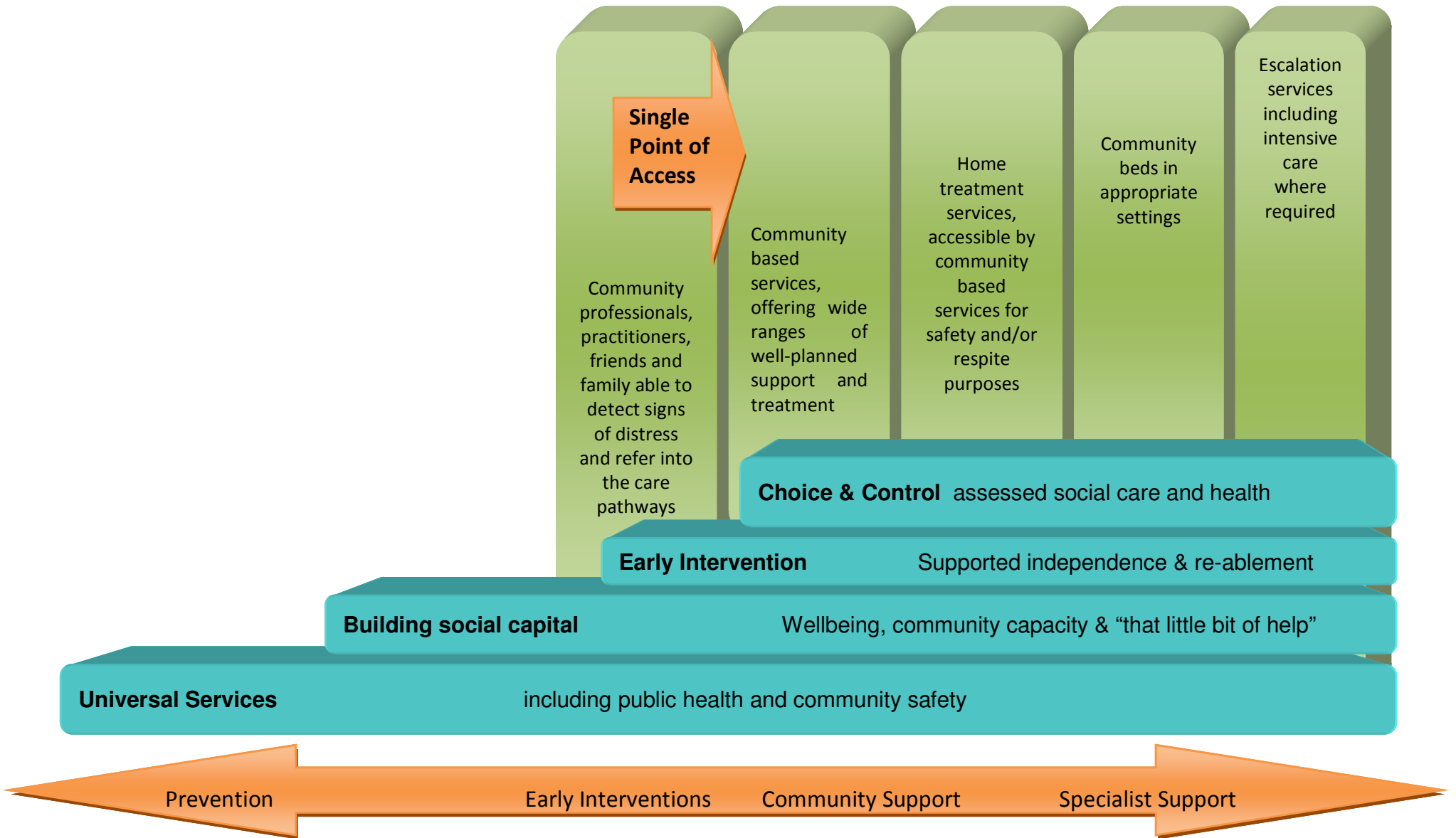
We propose to develop a tiered model of adult services and will commission a 'Single Point of Contact for primary care mental health services across the city. This will be available 24/7 and will provide information and advice and use a common assessment framework by

which people over the age of 16 new to services will have their needs assessed. Existing clients will be able to contact the services they use directly and will also be able to seek advice and information from the single point of access.

The underlying principle is that of access to culturally appropriate community based, well-being and preventative services, improved multi-agency holistic interventions and the right people, delivering the right support, in the right place, in a timely manner.

Only those whose needs cannot be met by the expanded community based support services will progress to the highly specialist mental health services. The specialist services will have greater capacity due to the reduced demand that is a result of more people having their needs met at an earlier level.

By implementing this model over the next five years we will be able to transform Manchester's mental health services into those fit for a world class city. This will be the overall measure of our success and the degree to which we achieve the collective aspirations.



2009 Where we are now	2014 Where we want to be	How we are going to get there
Services heavily weighted towards hospital based services and inpatient beds	Service weighted towards the community and people's own homes if appropriate	An example that has been successful at other Trusts is by physically reducing the hospital based inpatient capacity by offering a real alternative to hospital admission through home treatment. This can only be achieved once appropriate alternatives are available and being effectively utilised.
Services unequally focused on providing support as opposed to preventing ill health	Services more equally balanced between prevention and care	Consideration needs to be given to the breadth and focus of the prevention agenda and working under the remit of the Adult Health and Well being Board consider the possible relocation of resource allocated to the prevention agenda.
Services unevenly and inconsistently enabling service users to recover and maintain their place within the community	All services focused on culturally appropriate recovery and inclusion	There will be a reconfiguration of current day service provision and a review of operational policies for all services with the emphasis on re-ablement and recovery and consideration to the development of culturally sensitive recovery teams.
Services unclear about intended outcomes for individuals, families and the community as a whole	Explicit, clear outcomes for all services supported by concrete metrics	A detailed mental health economy performance framework will be introduced to all services and specific metrics and focussed outcomes. This will aim to improve the user experience with every contact.
Services for people with dementia having a lower profile than those services for adults of working age	All services to be non-age specific; services for people with dementia to have equal profile to all other services	There will be a reconfiguration of age led service provision and a system that promotes needs led service provision that is accessible and equitable.
Statutory mental health services organised largely by function	All mental health services organised around client need	This will be part of the key milestones in the roadmap for improvement.
Services reached through multiple points of entry	Single point of access arrangement	A co-ordinated approach for access will be established aligning primary and secondary care services ensuring pathways are robust and entry and exit criteria is clearly established and joint agreed
Long waiting times for access into some services with no support in the interim	Shorter waiting times with low level holding support available in the interim to help prevent deterioration	This will be a by product of the review of the urgent care system and the redesign of primary care mental health services

SECTION 2
SETTING THE STRATEGY IN CONTEXT

2.1 SETTING THE CONTEXT

This section identifies the key national policy drivers and best practice issues impacting upon general mental health services. (More specific drivers can be found in each of the priority groups sections later).

It then identifies the demographics and needs of Manchester both now and the future and establishes the need for change.

2.2 KEY THEMES OF NATIONAL POLICY

The last ten years have been significant in the development of mental health services – too many to document here. However, there are clear themes and directions which are:

- Core national minimum standards for all modern mental health services
- A focus on prevention and universal well-being services
- A move away from a medical model to one where health and social support is integrated
- Increased attention to empowering individuals with personal budgets, increased personal choice and control, consultation, representation and independence.
- Innovation in social care and a move away from traditional services to more flexible person centred services.
- The recovery model of care and support to be promoted, not a disabling model of illness
- A need to place services in mainstream health and social care and any other relevant settings
- A need to reduce stigma
- A need to provide equal access to services for older people, particularly those with depression and dementia
- Services must work to prevent admission to hospital, and reduce the length of stay in hospital when it does occur

- A recognition that people with mental health problems need special attention for their holistic well-being , not just their mental health
- Concerted efforts to address issues of Race Equality in terms of under/over representation of people from BME communities as well as their experiences of gaps in services and barriers to access of Mental Health services. (DRE 2005)

Other key themes, initiatives and activities include the following priority points.

Anti – stigma

Time to Change is an England-wide anti-stigma social marketing campaign run by leading mental health charities Mental Health Media, Mind, and Rethink. The Time to Change campaign aims to break down the myths that surround mental health problems and give people the facts. People with mental health problems remain one of the most marginalised groups. The most extensive survey ever of the impact of discrimination on people affected by mental health problems, carried out by Time to Change in 2008, revealed that nine out of ten mental health service users reported the negative impact of stigma and discrimination on their lives.

Time to Change hopes to:

- Create a 5% positive shift in attitudes towards mental health problems by 2012
- Achieve a 5% reduction in discrimination by 2012
- Increase the ability of 100,000 people with mental health problems to address discrimination
- Engage more than a quarter of a million people in physical activity
- Produce a powerful evidence base of successful interventions across the six priority groups and all age ranges

Manchester health and social care commissioners support these aspirations.

Public Health and Wellbeing

The public health and well-being agenda in relation to mental health is wide ranging. Issues of poverty, appropriate housing, a respect for the communities we live in, employment, access to leisure facilities, crime and safety and green spaces are just a few of the areas that are required to establish and sustain 'mentally healthy communities'. We know that for most people, whether they have mental health problems or not, the things that matter are their immediate environment e.g. a sense of belonging to friends and family, a safe place to live, and a sense of purpose, either through work or education. **"A New Vision for Mental Health"** a discussion paper by "The Future Vision Coalition" (composed of seven national mental health organisations), sets out their underlying aims for what future mental health policy should be:

- To overcome persistent barriers to social inclusion that continue to affect those with experience of mental health problems
- To improve the whole life outcomes of those with experience of mental health problems
- To improve the whole populations' mental health

The Future Vision Coalition sees the vision being addressed in four key change areas, being:

- An integrated model driving policy
- Greater importance placed on public mental health
- Services being united in supporting the recovery of a good quality of life and the achievement of goals and ambitions
- Emphasis on self determination through a system of support built by the individual and their advocates.

The emphasis of these documents is on organisations working together with individuals and those who care for them.

The Association of Directors of Adult Social Services (ADASS) in their paper **'Mental Health into the Mainstream'** (2008) included the following statements in their vision for mental health services.

"By 2015, mental wellbeing will be a concern of all public services. Undoubtedly there will still be people who live with debilitating mental health conditions, but the focus of public services will be on mental wellbeing rather than on mental ill health. The balance of power will no longer be so much with the system, but instead there will be more of an equal partnership between services and the individual who uses, or even chooses, them."

... "Mental health services will be integrated into ordinary health and other services: in libraries, GP surgeries and schools. People seeing their GP with mental health problems will be able to choose from a range of treatment options based on authenticated research evidence without facing long waiting times. For those with the most serious problems, acute care will be available in crisis houses or even 'hotels' as well as hospitals. They will receive care that is well planned and that aims to support them in achieving their personal goals for recovery. They will have a comprehensive care plan, with the option to buy their own services through direct payments or an individual budget, and will be advised by an 'associate' with expertise in employment, benefits and housing as well as treatment and care."

**Mental Health into the Mainstream
2008**

Manchester's Mental Health and Well Being Commissioning Strategy is committed to enshrining principles of prevention and enhancing the well being of those affected by mental health problems. Main target areas are:

- Physical Health: Targeted prevention and education materials via GP's and community centres for smoking, heart disease, obesity, substance misuse, etc
- Illness Prevention: Literature, development of peer support mechanisms, improved access to free telephone helplines, self management courses, access to psychological therapies (via Primary Care Mental Health service).
- Suicide Prevention: Prevention campaigns, distribution of crisis support information and a social marketing initiative "there is another way" message disseminated through eg GPs, Pharmacies, Accident and Emergency. Target Campaigns will be addressed to and modified for identified vulnerable groups.
- Domestic Abuse: Clearer pathways to specific counselling and support for children, young people and adults who are affected by mental health problems and/or who have experienced domestic and sexual abuse.
- Support: Improved information and marketing of Manchester Advice Centre, Manchester Contact Centre, Manchester Carers Strategy,
- Accommodation: Working more closely with Supporting People to review the current floating support and bed provision for people with mental health problems and/or experiencing domestic violence. Work with Manchester City

Council Licensing Unit to improve hostel and bed and breakfast conditions for people with mental health problems

- Manchester Safeguarding Adults Board (MSAB): is a multi-agency partnership attended by ASC, NHS Manchester, Greater Manchester Police force, Manchester Mental Health and Social Care Trust, NHS Hospital Trusts and voluntary sector representatives. The MSAB promotes good practice in safeguarding and aims to make use of learning from current practice to improve the outcomes for those at risk of abuse and neglect.

Personalised services: Direct Payments, Personal and Individual budgets

Direct payments, personal budgets and individual budgets are at the core of the Government's aim of personalising adult social care services around the needs of users. Through the **Putting People First initiative**, councils are expected to significantly increase the number of people receiving direct payments and roll out a system of personal budgets for all users of adult social care from 2008-11. In the long-term it is anticipated that all users should have a personal budget from which to pay for their social care services, apart from in emergencies.

Direct payments are cash payments given to service users in lieu of community care services they have been assessed as needing, and are intended to give users greater choice in their care. The payment must be sufficient to enable the service user to purchase social care services to meet their needs, and must be spent on services that users need.

Personal budgets are an allocation of funding given to users after an assessment which should be sufficient to meet their assessed needs. Users can either take their personal budget as a direct payment or,

while still choosing how their care needs are met and by whom, leave councils with the responsibility to commission the services. Or they can have some combination of the two.

Individual budgets differ from personal budgets in covering a multitude of funding streams, besides adult social care including Supporting People, Disabled Facilities Grant, Independent Living Funds, Access to Work and community equipment services.

Individual budgets are seen as a way of personalising services and have been further boosted by the **In Control Programme**, and its 13 pilot sites.

In Control is based on allocating a budget to an individual, on a self-assessment of their care needs, and enables them to choose the best mix of services and/or cash to suit their needs or wishes.

The 13 pilots were evaluated by York University's social policy research unit and King's College London's social care workforce research unit. Their key findings were that:-

- There was little difference in the average costs of Individual Budgets and conventional social care support.
- People using Individual Budgets were more likely to feel in control of their lives than people receiving conventional social care support.
- Satisfaction varied between client groups and was highest among mental health service users and physically disabled people.
- Staff encountered significant barriers to integrating funding streams.

Take-up nationally of direct payments has risen significantly in recent years but still remains low as a proportion of people receiving services.

Individual budgets will remain a fundamental priority for Adult Social Care in delivering the personalisation and choice agenda. With this

in mind, all Commissioners of mental health and well-being services in the strategic partnership will be required to support the creation of a "local market place for Manchester" by working with innovative local providers to deliver personalised services which can be paid for from people who choose an individual budget.

The Recovery Model

'Recovery' is a process that is unique to the individual. It moves away from traditional concepts of treatment of the symptoms of an illness in which mental health practitioners are seen as the experts. One approach identifies four key components to recovery (Anderson, Oades and Caputi):

- Finding and maintaining hope – believing in oneself; having a sense of personal agency; optimistic about the future
- Re-establishment of a positive identity – finding a new identity which incorporates illness, but retains a core, positive sense of self
- Building a meaningful life – making sense of illness; finding a meaning in life, despite illness, engaged in life
- Taking responsibility and control – feeling in control of illness and in control of life

Essentially recovery means that the individual is supported to "recover" their life so that it feels worthwhile; so that they are working towards aspirations and goals that give value and meaning to their lives, although they may not "recover" fully from their illness. They find themselves living in and contributing to the community, not segregated from it in in-patient or residential care services for most of their lives. In practice this means that housing, employment, education and participation in mainstream leisure and community activities become the focus of treatment and care. People are treated in familiar settings and in a manner that is sensitive to cultural needs. Inpatient admissions become less frequent and shorter as services

are established that provide acute and/or intensive treatment in the community.

To achieve recovery, the individual must be at the centre of their treatment and care planning process and have greater power in determining the supports and inputs that will assist their recovery.

In order to facilitate recovery, services have to be much more sensitive to the needs of the individual; the individual's uniqueness

and culture has to be understood and acknowledged. This means that services have to focus to a much greater extent on the holistic needs that may arise from religious beliefs and diverse cultural norms, differences in gender and sexual orientation, age and needs arising from disability.

2.3 MANCHESTER'S POPULATION AND HEALTH NEEDS ASSESSMENT

This section of the strategy reviews the needs and demographics of Manchester in the context of mental health. For a more general population needs analysis we recommend Manchester's Joint Strategic Needs Assessment document. Several mental health needs assessment have been completed in recent years. These are summarised below:

Needs Assessment	Focus
Children and adolescent mental health. Led by Dr Latha Hackett, CAMHS Consultant Psychiatrist, October 2005	Needs of children and young people
Mental health needs of under represented groups in Manchester Central PCT	Focused on mild/moderate problems in primary care and undertook a qualitative assessment of the needs of Asian women and attempted suicide and self harm; young men; the Irish Community. Also looked at the GP referral process.
Mental health needs in Manchester: Adults of working age. Report by MHSC Trust, chaired by Professor Francis Creed, September 2003.	Adults of working age: need for treatment for mental health problems. Comparison with other areas. Limited time and capacity to consider needs of specific groups; BME groups, particular age groups, gender, gay and lesbian groups, the prison community, homeless people and unemployed people, carers.
Supporting Women in Manchester. Led by Liz Thomas, Manchester JCE in partnership with Manchester University and HASCAS. October 2003.	Women living in Manchester. Estimates from National data plus detailed views from over 500 women living in Manchester on their needs and preferred style of service provision.
Adults of working age in contact with CMHTs in Manchester by Frank Hanily and Dr. Judy Harrison, MHSC Trust (2003). Updated 2005.	Survey of the caseloads of community mental health teams in Manchester

Young people and adults of working age presenting with psychosis by Drake, R., TARRIER, N. & Lewis, S. (2005). University of Manchester.	Prospective study of first episode psychosis in Manchester providing information about incidence, detail on demographic and psychiatric profile and the extent to which people's needs were met.
Carers of people with mental illness in Manchester. MACC and Manchester Carer's Forum (2005)	Estimate of numbers of carers in Manchester from National and North West data and carers of people with a mental illness from local data. Overview of the priorities identified by local carers.
Older people with mental health needs	The Report of the Acute Care Visioning Group (2004) refers to a current needs assessment process being undertaken by Professor Alastair Burns.
A study of the point prevalence of the in-patient population in Autumn 2005	Aims to establish the reasons for admission and the scope for alternative arrangements
Black and minority ethnic elders commissioned from PRIAE in October 2005.	Developing a strategy to improve the care and quality of life of Manchester's black and minority ethnic elders.
HASCAS: Strategic review 2006	Summarised recent reviews and developed new evidence
Manchester Needs Assessment of People with concurrent substance misuse and mental health issues in Manchester, Steve Kenny Associates 2007	Mapping and analysis of need across the mental health treatment system in Manchester including primary care, the third sector and access to psychological therapies.
Evaluation report of the Manchester Mentally Disordered Offenders Pilot 2008.	An evaluation of the pilot programme for mentally disordered offenders in Manchester, commissioned jointly between NHS Manchester and Manchester Drug and Alcohol Strategy Team, and provided by Greater Manchester West Mental Health NHS Foundation Trust.
Cordis Bright – Manchester Joint Commissioning Team Review and Needs Assessment of Older People and Mental Health, 2008	A review of Older people's mental health services in Manchester looking at current and future service provision for dementia and functional mental health problems.

Health Needs of Offenders

It is widely accepted that the mental health need in the 'offender' population is higher than in that of the general population as seen in the table below by Singleton et al. (1998)

	Prison Population	General population
Schizophrenia and delusional disorder	8%	0.5%
Personality disorder	66%	5.3%
Neurotic disorder	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

Despite this disproportionate amount of mental ill health amongst prisoners it is suggested that majority of prisoners with mental health

problems are often unable to get help from mental health services in the year before going to prison (Farrell *et al.*, 2006).

The document *Inside Out: The case for improving mental healthcare across the criminal justice system* found the following.

- Prisoners and recently released prisoners are far more likely to self-harm or commit suicide and attempted suicide is greater than the general population.
- male prisoners are five times more likely to attempt suicide than the general population.
- recently released male prisoners are eight times as likely to attempt suicide, and women prisoners recently released 36 times more likely.

2.4 CHILDREN AND ADOLESCENTS

Manchester CAMHS Partnership in 2005 undertook a mental health needs assessment for school aged children (i.e. 5 – 16). The Strengths and Difficulties Questionnaire which is internationally accredited was used

Data for 5 – 11 year olds:

Disorders	Gender	Normal (Disorder unlikely)	Borderline (Disorder possible)	Abnormal (Disorder probable)	Missing	Total
Emotional Disorders	Male	160 (40%)	10 (2.5%)	13 (3.2%)	**	183 (45.4%)
	Female	172 (42.7%)	16 (4%)	15 (3.7%)	**	203 (50.4%)
Total		332 (82.4%)	26 (6.5%)	28 (6.9%)	17 (4.2%)	403 (100%)
Conduct Disorders	Male	116 (28.8%)	18 (4.5%)	50 (12.4%)	**	184 (45.7%)
	Female	171 (42.4%)	10 (2.5%)	21 (5.2%)	**	202 (50.1%)
Total		287 (71.2%)	28 (6.9%)	71 (17.6%)	17 (4.2%)	403 (100%)
Hyperkinetic Disorders	Male	118 (29.3%)	15 (3.7%)	51 (12.7%)	**	184 (42.7%)
	Female	180 (44.7%)	7 (1.7%)	17 (4.2%)	**	204 (50.6%)
Total		298 (73.9%)	22 (5.4%)	68 (16.9%)	15 (3.7%)	403 (100%)
Peer Problems	Male	155 (38.5%)	11 (2.7%)	18 (4.5%)	**	184 (42.7%)
	Female	169 (41.9%)	20 (4.9%)	14 (3.5%)	**	203 (50.4%)
Total		324 (80.4%)	31 (7.7%)	32 (7.9%)	16 (4%)	403 (100%)
Pro-social Behaviour	Male	112 (27.8%)	29 (7.2%)	42 (10.4%)	**	183 (45.4%)
	Female	164 (40.7%)	25 (6.2%)	14 (3.5%)	**	203 (50.4%)
Total		276 (68.5%)	54 (13.4%)	56 (13.9%)	17 (4.2%)	403 (100%)

Data for 11 – 16 year olds:

Disorders	Gender	Normal (disorder unlikely)	Borderline (disorder possible)	Abnormal (disorder probable)	Missing	Total
Emotional Disorders	Male	106 (35.3%)	5 (1.7%)	10 (3.3%)	**	121 (40.3%)
	Female	110 (36.7%)	12 (4%)	12 (4%)	**	134 (44.7%)
Total		216 (72%)	17 (5.7%)	22 (7.3%)	45 (15%)	300 (100%)
Conduct Disorders	Male	80 (26.7%)	10 (3.3%)	27 (9%)	**	117 (39%)
	Female	100 (33.3%)	5 (1.7%)	23 (7.7%)	**	128 (42.7%)
Total		180 (60%)	15 (5%)	50 (16.7%)	55 (18.3%)	300 (100%)
Hyperkinetic Disorders	Male	82 (27.3%)	9 (3%)	31 (10.3%)	**	122 (40.7%)
	Female	104 (34.7%)	6 (2%)	23 (7.7%)	**	133 (44.3%)
Total		186 (62%)	15 (5%)	54 (18%)	45 (15%)	300 (100%)
Peer Problems	Male	91 (30.3%)	10 (3.3%)	18 (6%)	**	119 (39.7%)
	Female	109 (36.3%)	3 (1%)	14 (4.7%)	**	126 (42%)
Total		200 (66.6%)	13 (4.3%)	32 (10.7%)	55 (18.3%)	300 (100%)
Pro-social Behaviour	Male	59 (19.7%)	18 (6%)	40 (13.3%)	**	117 (39%)
	Female	87 (29%)	18 (6%)	24 (8%)	**	129 (43%)
Total		146 (48.7%)	36 (12%)	64 (21.3%)	54 (18%)	300 (100%)

Other smaller single school based studies have supported these figures which demonstrate approximately double the national average which equates to the adult figures.

The reasons for this are undoubtedly complex but will include the high rates vulnerable children and young people in the city, notably looked after children (LAC), young offenders, children and young people with a learning disability, newly arrived children and children of parents with a mental illness.

2.5 ADULTS OF WORKING AGE

Socio-economic impacts of the economic downturn

Government predictions in the Budget are that the recession will continue throughout 2009.

Unemployment has gradually increased both nationally and locally over the last 12 months and in all wards across the city, but there are large variations between wards. More positively, the number of new claims between February and March decreased compared with previous months. It is difficult to quantify the impact of the economic downturn on local mental health,

however it is well established that this is intrinsically linked to the local economic environment and overall mental well-being. Subsequently, supporting the local population (in conjunction with our strategic partners) to remain in work or regain employment or training during the economic down turn will be an ongoing focus of this strategy along with consumer advice from 3rd sector providers.

Consumer advice services across Manchester have seen an increase in demand during this period specifically with mortgage, utility and credit related guidance. This strategy recognises the important contribution that these services make in terms of their primary function and additionally, the positive effect that they have to an individual's resilience, sense of purpose and over all well-being.

Prevalence of mental health problems in Manchester

The National Psychiatric Morbidity Survey is regarded as the most authoritative evidence on the prevalence of mental ill-health in private households³. In this survey people were asked about their experience of symptoms the week before the interview. 16.4 % of adults nationally reported symptoms significant enough to be classified as experiencing a neurotic disorder. The rate for the North West Region is higher than the national average and indeed the highest in England at 20.3%. Based on this and adjusting the population and the estimated prevalence of neurotic disorders in Manchester for the population aged 16-74 is 71,798. This figure is only an estimate and it is possible that individuals may have more than one disorder. In any event this represents a significant level of need.

³ Glover (2004).Glover, G., Barnes, D. & Darlington, A. (2004). *Information about mental health and mental health service use in England*. North East Public health Observatory

Prevalence of neurotic disorder per 1000 adults aged 16-74 in the North West Region, 2000

Neurotic Disorder	Women NW	Men NW	NW Total	Estimated nos. for Manchester ⁴
Mixed anxiety and depressive disorder	132 (108)	88 (70)	110 (89)	38,906
Generalised anxiety disorder	75 (46)	51 (44)	63 (45)	22,282
Depressive episode	44 (27)	12 (23)	28 (25)	9,903
All phobias	27 (22)	26 (14)	27 (18)	9,550
Obsessive compulsive disorder	20 (13)	15 (9)	18 (11)	6,366
Panic disorder	5 (7)	1 (6)	3 (7)	1,061
Any neurotic disorder	252 (195)	154 (136)	203 (165)	71,798

Bracketed figures relate to national prevalence.

From mental health surveys it is possible to identify the characteristics associated with the prevalence of common mental health problems. They are more common in :

- Bereaved, separated or divorced people
- Those with lower educational attainment and from Social Class 5 (V)
- People who are unemployed i.e. economically inactive

⁴ Based on population estimated at 353,688 aged 16-74

- Tenants of Local Authority or housing associations living in urban areas and who have moved home frequently

It is much harder to provide estimates of serious mental illness. The table below provides the estimated prevalence for psychosis from the National Psychiatric Morbidity Survey. Based on this there would be approximately 2,100 people living in Manchester with a psychotic disorder. However this may be an underestimate because of the sampling difficulties experienced by the National Survey.

Prevalence of probable psychotic disorder per 1000 adults aged 16-74 in the North West Region, 2000

	North West	England
Women	5	5
Men	8	6

A recent review of the epidemiology of severe mental illness⁵ concludes that between 4.8 and 11.3 people per 1,000 population will have schizophrenia. This suggests that there will be between 1,700 and 4,000 people with these symptoms living in Manchester, although because of the socio-economic profile of the city it is more likely to be towards the upper end of this range.

It is also possible to estimate the incidence (i.e. the number of new cases which will arise in a population in a year). This is useful in establishing the need in relation to early intervention services. The average incidence of schizophrenia from epidemiological studies has been estimated at 0.11 per 1,000 using a narrow definition and 0.24 per 1,000 using a wider one⁶. This means that there will be between 40

⁵ Lewis, G., Thomas, H., Cannon, M. Jones, P. (2001). *The application of epidemiology to mental disorders*. In Thornicroft, G. & Szumukler, G. (eds). *Textbook of Community Psychiatry*. Oxford University Press.
⁶ Jablensky, A., Sartorius, N. & Emberg, G. (1992). *Schizophrenia: manifestations, incidence and course in different cultures*. *Psychological Medicine* 20: 1-97

and 87 new cases each year, consistent with the findings from the study of first onset psychosis in Manchester⁷ which identified 90 new cases a year, 12 of which came through CAMHS.

Key findings from local needs assessments

- The greatest unmet need is found in people presenting to primary care with anxiety disorders and depressive and related disorders who have additional co-existing problems such as personality disorder or other psychiatric disorders⁸.
- The most common unmet needs for people on CPA include further treatment for symptoms such as occupation and leisure, safety to self and others, self care and diet, physical health and accommodation⁹.
- Overall, 86% of clients were single and 60% were unemployed. Half (47%) lived with their parents; 5% were homeless.
- People from ethnic minorities were over-represented, as has been found in other UK studies. One quarter (24%) of people were from Black African/Caribbean/other groups, compared to proportion in the city population of 7%.
- On the basis of a survey of 2,440 people under the care of CMHTs in Manchester, it is estimated that approximately 300 people would fulfil the criteria for assertive outreach¹⁰.
- The suicide rate in Manchester is persistently higher than in other cities and there is local evidence indicating a high rate of self harm¹¹ Highlighted was the vulnerability of young men, refugees and asylum seekers and South Asian women.

⁷ Drake, R., Tarrrier, N. & Lewis, S. (2005). *First episode psychosis in Manchester*. Divisions of Psychiatry and Clinical Psychology, University of Manchester.
⁸ MHSCT (2003). *Mental health needs in Manchester*. Working Group report 2003
⁹ As for 1(this is confusing as ref no. 1 is about learning disability. I assume you mean no. 1 in the paragraph above/ this needs making clearer
¹⁰ As for 1
¹¹ As for 1

Needs of specific groups

Women: A recent needs assessment of women's mental health needs in Manchester¹² indicated the increased risk to women's mental health arising from greater inequality as women in general are poorer and experience greater deprivation, have less social and political power and have less access to health, education and employment than men. National data indicates that women who have experienced domestic abuse are more likely to present with post traumatic stress disorder and depression.

Carers: Carers are at increased risk of mental health problems, particularly anxiety and depression¹³ In the North West of England it is estimated that 17% of the adult population over 16 are carers which would mean there are 58,000 carers over the age of 16 living in Manchester and 1,715 young carers¹⁴ Of these only 7% (4180) are known to services. Families of people diagnosed with a mental illness form a significant proportion of this group with 1,173 out of 5,062 carers receiving a break funded by the Carers' Special Grant¹⁵.

BME Communities: There is little systematic assessment of the needs of black and minority ethnic communities living in Manchester. There is a widespread concern about this lack of focus and a strong sense that existing service provision fails to meet the needs of Manchester's diverse and changing communities. In line with 'Delivering Race Equality' (DoH 2005) 8 community development workers were recruited in 2008 to work with Manchester's black and ethnic minority communities to raise awareness of mental health issues, to work with services to improve access to services and to address identified faith or cultural barriers that may prevent engagement with services.

Refugees and asylum seekers: Refugees and asylum seekers may experience poverty, homelessness, unemployment, loss of social status, racism and many also have experienced politically motivated physical or sexual violence in their country of origin. All of these factors have a significant impact upon their mental health. A community engagement project was led by NIMHE and HARP (April 2007) in conjunction with Refugees and Asylum Seekers in Manchester. This community-led research project focussed on the mental health needs of refugees and asylum seekers in Manchester. The report found that 'respondents had little or no knowledge of local services nor of what 'mental illness' actually was.' They stated that "support from family and friends" was the most important thing in maintaining good mental health, the most common experience was "separation from family and friends". When this profound social loss is compounded by mental health difficulties, racism and discrimination, language difficulties and lack of information the result (as stated by the respondents) becomes obvious - Isolation.

A mapping exercise undertaken in London¹⁶ indicated that services for asylum seekers and refugees were difficult to locate; that there is a widespread lack of awareness that refugees and asylum seekers have distinct and multiple needs that require specialist knowledge and there are only a small number of 'specialist' organisations outside the NHS that provide culturally appropriate services to this group. This process identified the need for:

- Access to crisis services
- Mental health trained interpreters
- Training for mental health providers including tackling racism
- Preventative services to stop a normal reaction turning into a mental health issue
- A culturally appropriate response and an acceptance that western methods are not appropriate
- Timely intervention as waiting lists are inappropriate

¹² Thomas, L. Newbigging, K. & Abel, K. (2003). Supporting Women in Manchester

¹³ ONS

¹⁴ MACC and Manchester Carer's Forum (2005). Carers of people with mental illness in Manchester

¹⁵ Department of Health (2003)

¹⁶ Ward, K. & Palmer, D. (2005). Mapping the provision of mental health services, for asylum seekers and refugees in London. Information Centre about Asylum and Refugees in the UK. King's college. London

■ A network and information about sources of support
There is no evidence to suggest that the situation in Manchester is any different.

Homeless People: The relationship between homelessness and mental health has been well documented in a number of (national) studies as follows:

- 30-50% of homeless people experience mental health problems¹⁷
- Problems with mental health were the most common need. Almost half of people without children interviewed had applied to the local authority as vulnerable on these grounds. Most of them thought they would need continuing support after being re-housed¹⁸.
- Psychosis is estimated to be experienced by around one in 12 hostel residents compared to one in 250 of the housed population¹⁹. Of the estimated 136,000 people with schizophrenia in England 15% are estimated to be in specialist accommodation (similar number to those in hospitals) and 11% are estimated to be in homeless provision, hostels or similar²⁰.

Dual diagnosis

Dual Diagnosis is commonly referred to as complex needs or co-morbid substance misuse and mental illness. The Policy Implementation Guidance on Dual Diagnosis acknowledges that “it is hard to assess the exact levels of substance misuse both in the general population and in those with mental health problems”²¹ In the severe and enduring mental health population it is reported that approximately 33% to 50% of people experience it at some point in their lives.

¹⁷ Griffiths. S. (2002). Addressing the health needs of Rough Sleepers

¹⁸ ODPM (2003). The Support Needs of Homeless Households

¹⁹ OPCS Surveys of Psychiatric Morbidity in Great Britain, (1996) Mental Health and Housing: October

²⁰ MHF Briefing No. 3: (1996) Mental Health and Housing: October

²¹ Mental health policy implementation guide: Dual diagnosis good practice guide (DoH) (2002)

A recent survey in Central London reported that of CMHT patients, 44% reported past-year problem drug use and/or harmful alcohol use²². Within the same study, in substance misuse treatment services between 75%-85% of patients had a past year psychiatric disorder, mainly depression and anxiety related disorders. Co-existing psychosis and substance dependence is problematic because people with multiple morbidity tend to have a worse outcome than people with only one disorder and consequently are more likely to spend time as in-patients, have higher rates of suicide be involved within the criminal justice system and “drop out” of treatment.

There is also concern about the people with common but debilitating mental health problems who misuse substances and experience exclusion from services, especially where early treatment or intervention can reduce the potential for escalation.²³ A local needs assessment in 2007 concluded that that there was evidence of higher numbers of substance mis-users with concurrent and untreated mental health (mild to moderate) problems throughout the primary care and mental health system. These were more likely to be identified by their substance misuse than their mental health presentation and more likely by substance misuse services than mental health services. These individuals would tend to have less access to preventative services and would more likely to present to mental health services in crisis. The needs assessment concluded that there was a general consensus amongst mental health and primary care professionals that the prevalence of co-morbidity appears to be continuing to rise.

The needs assessment also identified that people from BME communities experienced additional hurdles in obtaining appropriate services as a result of patchy access to translation and interpretation

²² Weaver, T. Et al Br. J. Psychiatry, Oct 2003; 183: 304-313

²³ Manchester Drug and Alcohol Team (2005). Manchester Mental Health Needs Assessment: Responses from the Drug and Alcohol Team

services, professionals' levels of understanding of cultural perceptions of substance misuse and mental health and the impact of "labelling" and diagnosis within some communities.²⁴ Rapid access to psychological therapies for those with mild to moderate co-morbidity was indicated as a basic intervention together with joint assessments/care planning and intensive family support for those presenting with severe and enduring problems.

Lesbian Gay and Bisexual People

Research indicates disproportionately high rates of suicide, self harm and substance misuse amongst Lesbian, Gay and Bisexual people²⁵. Of the users of the counselling service run by the Lesbian and Gay Foundation (LGF) in Manchester, 6% state suicide and 10% self harm as their reasons for contacting LGF²⁶. This is compounded by findings²⁷ indicating high levels of homophobia within both mainstream service provision and wider society and the negative impact on mental health. Both studies highlight the need for specialist provision and a more gay affirmative approach within mainstream delivery. Further work by the Manchester Drug Action Team (DAT)²⁸ found over 30% of service-users of the Lesbian and Gay Foundation (LGF) state that they would not access mainstream services.

²⁴ Manchester Needs Assessment of People with concurrent substance misuse and mental health problems, SK Associates, 2007²⁴ Manchester Drug and Alcohol Team (2005). Manchester Mental Health Needs Assessment: Responses from the Drug and Alcohol Team

²⁵ Augelli, 1993, Bagley & Tremblay, 1996 Rivers, 1999

²⁶ LGF business plan (2005/6). LGF provide services to greater Manchester and although the percentages are higher actual figures are small overall.

²⁷ MIND 1998, 2003; PACE 1998

²⁸ LGF (2004) A study to explore drug use amongst Lesbian, Gay and Bisexual People within Manchester

2.7 Older adults

Population projections

The following data, prepared by Manchester's Joint Health Unit offers a helpful insight into the anticipated increase in numbers of older people living in Manchester between 2008 and 2016.

Manchester's population of older people

Population (000's)									
Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016
55-59	19.0	18.7	18.7	18.9	19.3	19.9	20.4	20.9	21.4
60-64	16.8	17.5	17.8	17.9	17.5	17.1	16.8	16.8	17.0
65-69	13.7	13.5	13.4	13.5	14.2	14.8	15.4	15.7	15.8
70-74	12.2	12.3	12.2	12.1	11.9	11.8	11.6	11.6	11.7
75-79	10.3	10.0	9.9	9.8	9.9	10.0	10.1	10.1	10.1
80-84	7.7	7.6	7.6	7.5	7.4	7.4	7.3	7.3	7.4
85+	7.4	7.5	7.6	7.6	7.8	7.8	7.9	8.0	8.1

Manchester can therefore expect to see an increase in the number of older people between 2008 and 2016, with the greatest increases occurring in the age group 55-69 and 85+.

Further data prepared by Manchester's Joint Health Unit indicates that around 27% of the older population will have a mental health problem

Dementia prevalence

The data made available to us by Manchester's Joint Health Unit suggest that the number of cases of dementia will increase between now and 2016 by around 300 (or about 6%). Young onset dementia increases particularly quickly over this period (just under 13%)¹⁹ but the increase in the number of cases remains relatively low (possibly as low as 11 cases over this time).

Dementia cases in Manchester

Year	Young onset dementia (30-64 years)	Other dementia (65+)	Total
2006	90	4,464	4,554
2007	91	4,484	4,575
2008	92	4,510	4,602
2009	94	4,515	4,609
2010	95	4,540	4,635
2011	96	4,528	4,624
2012	97	4,589	4,686
2013	97	4,611	4,708
2014	98	4,645	4,743
2015	100	4,689	4,789
2016	101	4,746	4,847

Functional mental health and other relevant conditions

Data prepared by the Joint Health Unit indicate that functional mental health cases in older people will also increase during this time by around 4%:

Functional mental health conditions in Manchester: projections

Year	Depression	Schizophrenia		Bipolar Disorder		Generalised anxiety	Panic disorder	OCD	Personality Disorder
		Lower	Upper	Lower	Upper				
2006	5,781	58	289	231	578	2,659	173	289	5,453
2007	5,728	57	286	229	573	2,635	172	286	5,399
2008	5,708	57	285	228	571	2,626	171	285	5,377
2009	5,679	57	284	227	568	2,613	170	284	5,348
2010	5,671	57	284	227	567	2,608	170	284	5,337
2011	5,662	57	283	226	566	2,604	170	283	5,330
2012	5,756	58	288	230	576	2,648	173	288	5,419
2013	5,836	58	292	233	584	2,684	175	292	5,497
2014	5,901	59	295	236	590	2,715	177	295	5,560
2015	5,955	60	298	238	596	2,739	179	298	5,610
2016	6,006	60	300	240	601	2,763	180	300	5,657

Depression and anxiety

The Survey of Psychiatric Morbidity²⁹ found that 10% of respondents aged 60-74 had significant levels of neurotic symptoms and half of these reported levels of symptoms of a severity equivalent to that found among people being treated in secondary care.

Neil Bendel's research indicates that generalised anxiety occurs in nearly 5% of the over 65 population,³⁰ and depression occurs in 10% of the over 65 population.³¹

2001 Census data also indicates that depression may be higher than average in Manchester, since a significant proportion of older people live alone. Census data shows that in Manchester 73% of pensioners live in "one person households" as compared to an England-wide average of 60.63%.

Schizophrenia, bipolar disorder & severe functional mental health problems

Research by the Manchester Joint Health Team Unit indicates that schizophrenia arises in around 0.1% and 0.5% of the over 65 population³². They have also found evidence to indicate that bipolar disorder arises in between 0.1- 1.0% of those aged 65 and over.³³ The Joint Health Unit's research also indicates that OCD (Obsessive Compulsive Disorder) occurs in around 0.5% of the older population³⁴ and that panic disorder arises in around 0.3% of the older population³⁵.

²⁹ As quoted in Manchester Health Promotion Specialist Service (undated) Older People and Depression: draft paper for discussion

³⁰ Ritchie et al as quoted in Byrne J (2008) prevalence of OAP Disorders - update

³¹ Wilson et al (1999) as cited in Bendel, N (2007) Mental Health Problems in Older People in Manchester, Manchester Joint Health Unit

³² Howard et al 2000(International Consensus) American Journal of Psychiatry 157; 172-178, as quoted in Byrne J (2008) Prevalence of OAP disorders - update.

³³ Ritchie et al 2004,Goldstein et al 2006 as quoted in Byrne J (2008) Prevalence of OAP disorders -update.

³⁴ Ritchie et al (as above)

³⁵ Ritchie et al (as above)

Whilst the numbers remain relatively small, it is important to note that clients with severe functional mental health problems tend to make higher demands on services.

Personality Disorder

This diagnosis is notoriously difficult to evidence, which makes it difficult to draw definitive conclusions from the available data. The best available information (Wattis 1998 as quoted by Byrne 2008³⁶) suggests that around 10% of the older population have a personality disorder, which is in keeping with the data presented in the previous table. This is a surprisingly high figure; however it should be noted that:

Recent evidence suggests that personality disorders are common (10-30%) as a co-morbid condition in Depression in Old Age (review by Devanad 2002)³⁷

³⁶ Ritchie et al (as above)

³⁷ Ritchie et al (as above)

2.8 FINANCIAL AND SERVICE PERFORMANCE

The level of resources, their utilisation and value for money have been common themes across the economy. The recent Boyington review (reference) highlighted:-

- For 2006/2007 indicates that Manchester PCT spent significantly more than most other PCTs in the North West on mental health overall,
- Spending per head was well above average on CAMHS, adult services, secondary care, specialised commissioning, prevention and health promotion, user engagement, the voluntary sector and the private sector both separately and when combined and,
- Manchester records one of the lowest spends on primary care absolutely and on a per head basis, whilst levels of need are amongst the highest in the country current levels of investment appear to be broadly in line with need.

That report also goes on to state -

“However, this does **not** mean:

- That there is not room for efficiencies (KPMG)
- That the balance of investment between services and client groups is right (2006/07 Annual Assessment)
- That there was not under-investment in the past”

The review concluded that ‘the focus of the Care Trust, Local Authority and Joint Commissioning Executive and Team should now be firmly focused on resource utilisation and not overall availability’.

Prior to the current global recession the financial investment in Manchester’s mental health services was amongst the highest in the country. Yet despite this high level of investment Manchester is associated with some of the poorest outcomes for people. There is an acknowledgement that the financial investment has been and remains significant but the distribution of resources remains questionable as

the current service provision is inefficient. There will be a mapping of investment against provision in order to facilitate transformational change.

We do not yet know what the full impact of the current financial downturn will have on future investment and savings, however, public sector finances will be required to produce value for money over the next five years and mental health services will not necessarily be exempt from system wide reductions in investment.

Two major efficiency issues have been identified:

1. Ongoing high length of stay for inpatients in acute adult beds, and
2. Significant level of spend on secure services and other out-of-area placements with a level of spend of over 25% of the total NHS mental health spend

These findings were broadly confirmed by a benchmarking exercise by Mental Health Strategies which compared investment levels against comparable areas and areas where a good performing mental health provider was in situ.

The analysis highlighted:-

- A high comparative investment in adult services and within this the ‘new’ service areas of crisis resolution/Home treatment and Early Intervention in Psychosis together with CMHT investment
- Low comparative spend in primary care services
- Average comparative bed numbers though with poor performance
- Poor community investment returns for the investment committed
- Poor qualitative measures of performance

SECTION 3
PRIORITY GROUPS

WHY THE SIX PRIORITY GROUPS?

To decide upon the six priority groups a pragmatic approach was adopted. There are a variety of reasons as to why the groups have been themed but put simply the six priority groups cover the spectrum of mental health problems that the city of Manchester currently experiences. The priority groups map across to the current commissioning commitments in mental health but they also consider future developments, areas for change, the need for growth and national and local drivers.

3.1 CHILDREN AND YOUNG PEOPLE

The last ten years have seen significant changes in the way children and young peoples' mental health services have developed. In 1999 the Government made new funds available to the NHS for improving CAMHS via the NHS Modernisation Fund. The first Sure Start local programmes were introduced for pre-school children. These focused on bringing together early years education, childcare, health and family support for the benefit of young children and their parents in disadvantaged neighbourhoods. Also in 1999, the National Healthy Schools Programme was launched by the Department of Health and the Department for Education and Employment. This included promoting a whole school approach to promoting emotional health and well-being.

In 2000 The NHS Plan Implementation Programme included a requirement that health authorities and local authorities worked together to produce a local CAMHS strategy to include 24-hour cover, and increased early intervention and prevention programmes for children.

Every Child Matters (2003) and the supporting Children Act 2004 set out the Government's agenda for the reform of children's services. This included a requirement for agencies to work together through

Children's Trust arrangements to achieve improved outcomes in five key areas of:

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- achieving economic wellbeing

The Children's National Service Framework (2004) set out a 10-year programme to raise standards including a specific focus on the mental health and psychological well-being of children and young people in Standard 9 which includes a number of 'markers of good practice'.

The following year the Social and Emotional Aspects of Learning (SEAL) programme was introduced. It provides a comprehensive approach to promoting the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and well-being of all who learn and work in schools.

The **Children's Plan** (2008) sets out the new aims and objectives for achieving the Every Child Matters outcomes and announced the National CAMHS Review which reported in November 2008. The key areas that the Children's Plan addressed related to mental health outcomes were as follows:

- early years settings, schools and colleges sitting at the heart of a preventive system, promoting wellbeing and looking for early warnings that children might need more help and by providing facilities for specialist services to provide better support for parents and families coping with a range of needs
- improvements in the local delivery of high-quality services for young people, focusing on the faster integration of services for the most vulnerable, and a renewed focus on early intervention and prevention to stop problems becoming entrenched, and

- stronger action to tackle behaviour that puts young people at risk – in particular in relation to substance misuse.

In Manchester the delivery of mental health services to children and young people will continue to be based on the well-established tiered system originally recommended nationally by the Health and Social Care Advisory Service. In keeping with the Children's Trust vision schools will be the centre point for identifying emotional, behavioural and psychological needs and will be the main location where support is provided. Child and adolescent mental health professionals will in-reach into schools providing support and advice to staff, individuals and family work with pupils.

The focus of the work with children, young people and their families should always be to ensure that there are a range of early identification and intervention services in place. In order to promote this we will continue to support parenting skills training across the city, using the internationally evidence based Incredible Years Programme for children aged under 8 and through the Think Family Board contribute to the development of programmes for children aged 8 – 12 and adolescents. Schools will continue to play a key role in the early identification and intervention agenda for all children and young people.

This will be led through ensuring that all schools undertake and embed the SEAL programme, identify lead staff to manage emotional well-being issues in each school, school nurses and other school based staff have the skills to undertake appropriate assessments and ensure that all schools have agreed pathways into CAMHS. Through close liaison with existing school based services, under representation in referrals to CAMHS services of children from BME communities is being addressed by the DRE CDW's

A key focus over the next 12 months is ensuring that a range of services to meet the needs of 16/17 year olds are in place and working together.

For the past two years Manchester has in place a small 16/17 community mental health team (CMHT) to work with new cases, CAMHS teams continue to work with over 16s if they are already in contact with CAMHS and the Early Intervention in Psychosis (EIP) team manages young people from the age of 14 following on from their first episode of psychosis.

From April 2010 there is a change in the Mental Health Act which in effect means that no 16/17 year old should be treated on an adult psychiatric ward, though there are caveats in the guidance which would allow a 16/17 year old to be admitted onto an adult ward in an emergency and if it is developmentally appropriate. Any longer term treatment plan should be delivered in an environment appropriate to their developmental needs and be able to meet a young person's education requirements.

NHS Manchester has begun to work to ensure that no 16/17 year old is treated inappropriately on an adult ward and will commission a network of adolescent units to provide inpatient care. This will only work in conjunction with close working relationships with the crisis resolution home treatment team, EIP team and 16/17 CMHT to ensure that admissions are appropriate and lengths of stay as short as possible. We also need to ensure that for the group of young people who need to transfer into adult services there are no barriers and planning for this transfer begins at as early an opportunity as is appropriate.

Safeguarding children

At the heart of commissioning mental health services for children and young people in ensuring that they are safe. We will insure the following:

- Competencies across the mental health workforce around understanding Safeguarding Children will be developed

- embedding key questions in comprehensive assessments around parental status,
- working with Children and Families services to ensure rapid referral and responses,
- monitoring mental health involvement in serious case reviews

Our Commissioning Intentions

- We will ensure that all mainstream and special schools have identified staff who are skilled to identify children and young people with mental health problems and manage mild to moderate needs. We will extend the role of school nurses, via training, to prioritise mental health promotion, prevention and early prevention in every high school by June 2011 and target key primary school staff to access the existing tier 1 training programme;
- All schools will have an agreed pathway into mental health services using the Common Assessment Framework by September 2011 starting with all high schools, then specialist schools and then primary schools.
- The emerging stepped model of training currently being piloted in six high schools will be evaluated and rolled out to interested schools from September 2010.
- Every child aged 14 upwards thought to meet the Early Intervention in Psychosis criteria will be assessed within two working days by October 2009.
- All children and families social workers, residential staff and foster carers will receive basic mental health training by April 2011 and repeated every two years.
- We will continue to monitor the uptake and effectiveness of the range of mental health services that are targeted at looked after children to ensure that this most vulnerable group of children and young people remain a key priority for the range of services we commission;

- During 2009 the therapeutic foster care service for children aged under 5 will be reviewed and a decision taken as to its sustainability;
- We will enable the establishment of a Young People's Forum to provide feedback to services on how services can be improved and provide support and opportunities for them to mentor others, by January 2010 and ongoing thereafter and this will be in partnership with the Young People's Council;
- We will monitor the uptake of dedicated mental health services for young offenders to ensure that they are able to access appropriate services at the appropriate time;
- We will monitor the provision and uptake of inpatient services for 16/17 year olds to ensure that we are compliant with the Mental Health Act by April 2010;
- We will review the range of provision available for 16/17 year olds to ensure that it meets the continuum of need and that appropriate services are working together to ensure that the pathway is clear and accessible for young people and their families. This will report by April 2010;
- In partnership with the Young People's Substance MisUse Joint Commissioning Group we will review the level of need and specialist mental health input required to meet this group of young people's needs as there are poor referral rates to CAMHS for substance misusing young people which is distinct from what we would expect to see from the available national evidence.

The key outcomes for this group are:

- All high schools have identified a school lead for emotional health and well-being and identified the school's training needs;
- NHS Manchester is compliant with the new Mental Health Act by April 2010;
- All foster carers and residential workers have accessed mental health training by April 2011

3.2 PEOPLE ACCESSING MENTAL HEALTH SERVICES FOR THE FIRST TIME

Mental health services are only accessed when you or a loved one are experiencing some form of mental or emotional distress. It is of the utmost importance that the information that you receive is as clear and as easily accessible as possible. A good treatment pathway gives you the right information about mental health conditions and interventions as well as information on how to access services

For too long Manchester's access to services has been too complicated. Depending on where you live in the city the day or time of day that you contact services, or which services you contact first, the response that you could get could be very different. There is already a 'single point of access' to secondary care services and we will develop a single point of contact to our primary care services too. Together we will be able to provide a clear point of access – even in times of crisis – 24 hours a day, seven days a week.

Services are usually accessed in the first instance through your GP and this facility will continue. However, for those people who are not registered with a GP or choose to bypass this route, future services will be accessible via our primary care single point of contact. We are mindful of the particular needs of newly arrived communities who may specific help or language support to understand and access services in Manchester

From the first point of contact with services quality assessments will be undertaken that will direct the service user to the appropriate level or tier of service whether that is with primary care, social care, the third sector or secondary care services.

For people with short term conditions such as some forms of depression and anxiety they will be able to choose between attending an appointment with their GP or directly accessing our expanding primary

care mental health service. More details of this group's future pathway can be found in section 3.3. The remainder of this section addresses the needs of people who are new to services who have a psychosis.

For some people their first contact with mental health services may be at times of an acute crisis in their lives. Where it is safe to do so community resources such as Crisis Resolution Home Treatment Services will be made available to treat people in their own home, or close to their home if this is their preferred option. An inpatient bed will only be sought for those who cannot be supported in a community setting.

People new to services with a psychosis

Early Intervention in Psychosis (EIP) services were introduced nationally with the Adult Mental Health National Service Framework document (1999). EIP services are primarily aimed at:

- People aged between 14 and 35 with a first presentation of psychotic symptoms
- People aged 14 to 35 during the first three years of psychotic illness

Early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal harm. One in ten people with psychosis commits suicide - two thirds of these deaths occur within the first five years of illness. Intervening early in the course of the condition can prevent initial problems and improve long term outcomes. If treatment is given early in the course of the illness and the right services are in place, the prospect for recovery is improved.

Although the EIP Service focuses on younger people the principles of intervening at the earliest opportunity to prevent further deterioration is an approach that will be pursued for every condition.

Students

Manchester has a large population of university students who travel from other areas and countries in order to study in Manchester and many opt to remain in Manchester to contribute to the local economy. Educational Welfare services exist in all colleges to provide supportive and pastoral interventions for students experiencing difficulties. More focus will be given in working with colleges and universities in promoting prevention messages amongst students and clarifying pathways to appropriate services.

We aim to ensure that:

- There is improved joint working between Early Intervention in Psychosis Team and Educational Welfare services in providing early detection and intervention for students
- Mental Health and Substance Misuse training available to all educational welfare officers (colleges, high schools and universities) and support in providing prevention programmes (eating disorders, depression and anxiety) and literature in a number of further and higher educational sites as a “pilot”

Our Commissioning Intentions

- We intend to make it easier for people to find out how to get help when they need it by improved information about mental health conditions, available services and how to access these services as well as the level and range of treatments that service users and carers should expect
- A wider and broader range of professionals in community based settings will be trained to recognise the signs of psychosis in order to enable swifter referrals to community teams.
- We will agree a care plan with every service user setting out the steps to achieve their recovery according to their level of need, and taking into account their particular needs in terms of faith and culture.

- We will enable rapid assessments, support and treatment from community teams able to access the latest in anti-psychotic medication but additionally drawing on a wide range of interventions and techniques to support the individual, their family and friends to optimise their life opportunities.
- We will place a strong emphasis on supporting an individual to remain in their current employment, promote education and personal development with access to life coaches, fitness coaches and others who will support people in their recovery in a culturally appropriate manner.
- Community Early Intervention in Psychosis Teams will work closely with community substance misuse services to identify and address people’s substance misusing behaviours.
- Community teams will work from a wide range of settings and in time will have greater access to community-based accommodation in non-institutional settings. To achieve this, an implementation plan would need to be agreed by the partners in order for a reduction in inpatient capacity.
- The key outcome and measure for success for this care pathway will be significantly fewer people requiring ongoing care and support.

3.3 PEOPLE WITH SHORT TERM NEEDS

Although very distressing at the time, most people's mental health problems are, with the right interventions, short term and can be treated in primary care settings.

Conditions like depression, anxiety and phobias can often be effectively treated by talking therapies as well as (and increasingly instead of) medication. The general direction of healthcare policy for the past ten years has been that of increasing the provision of primary care services and to intervene at the earliest opportunity to prevent further deterioration.

Manchester is redesigning its mental health primary care service to

- develop a stepped care evidence based primary care mental health service model for the city of Manchester
- integrate existing primary care mental health service provision into seamless care pathways between statutory and third sector providers
- address the historical inequalities in current service provision, highlighted in the review
- develop a single point of access to primary care mental health services across the city and widen and simplify the referral system for people from the age of 16upwards
- reduce waiting times from referral to assessment and treatment across the city
- develop a single mental health legally binding contract for the service provision
- ensure a state of readiness for the introduction of Improving access to Psychological Therapies
- integrate the Gateway workers into the primary care mental health service

- demonstrate improvements in clinical outcomes, quality of service, patient experience and well being, value for money, prescribing, appropriate referral rates and ratio of need to capacity

The key outcome for this care pathway will be the number of people being discharged from the care pathway without distressing effects of depression, anxiety or obsession and achieving measurable goals of social inclusion including education, employment, stable relationships, and personal fulfilment.

Our Commissioning Intentions

- We will develop a stepped care model that offers a graduated series of interventions and support, (including access to psychological and drug therapies), on a planned basis to all clients, regardless of how and where they contact services.
- We will appoint a wide range of accredited practitioners to deliver 'modules' of the stepped care model from health, social care, education and criminal justice backgrounds.
- We will ensure all mental health and primary care practitioners will have basic training in substance misuse screening, be better equipped to recognise early signs of mental health and substance misuse problems, be able to refer clients rapidly into substance misuse support services and work within shared care plans when appropriate
- Escalation plans will be in place for all clients at risk of harm either to themselves or others, and designated practitioners will in time be able to access a small resource of community based accommodation in non-institutional settings when they are required for reasons of safety.
- Designated practitioners will be able to provide services closer to home by drawing on additional resources from community services for example Crisis Resolution and Home Treatment Teams.

3.4 PEOPLE WITH ONGOING MENTAL HEALTH NEEDS

This section addresses the needs of people with ongoing mental health needs that require coordinated support packages of care by specialist secondary care teams. Usually these people have a diagnosis of a psychosis, a bi-polar affective disorder or a personality disorder. However it should be noted that it is the complexity of their situation or the impact the condition has on their day to day lives that makes it an ongoing need not the diagnosis alone, as noted by Kai et al below.

Definition: a person with an enduring mental illness

“A patient who for two years or more has been disabled by impaired social behaviour as a consequence of mental illness.

- Disability is the defining criterion. The patient is unable to fulfil any one of four roles; holding down a job, maintaining self care and personal hygiene, performing necessary domestic chores or participating in recreational activities.
- The disability must be due to any one of four types of impairment of social behaviour; withdrawal and inactivity, responses to hallucinations or delusions, bizarre or embarrassing behaviour or violence towards others or self.
- The diagnosis may be one of the following: One of the psychoses, a severe and chronic non psychotic disorder, including depression and anxiety and phobic disorders, obsessional neurosis, severe personality disorder, eating disorder, alcohol or drug misuse, or a mental illness which has not been given a specific label”

(Kai et al 2000)

Relevant key documents in terms of national policy and good practice guidance around service provision for people with severe and enduring mental health problems, include:

- **National Service Framework for Mental Health (Department of Health 1999):** This document set out seven standards including improved access to services, the delivery of effective services for people with a severe mental illness, caring for carers and suicide prevention.
- **National Service Framework for Mental Health: Five years on (Department of health 2004):** This document identified outstanding areas for attention improvement including patient choice, social inclusion, treatment of long term conditions and the care of people with a dual diagnosis (see section 3.6).
- **Mental Health & Social Exclusion Report (Social Exclusion Unit 2004):** This report identified 27 action points to reduce the social exclusion of people with mental health issues.
- **Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside services and the Government’s response to the independent inquiry into the death of David Bennett (Department of Health 2005):** This five year programme set out how it intends to reduce inequality and discrimination within mental health services for people from BME communities.
- **Direct Payments for people with mental health problems: A guide to action (Department of Health 2006):** This guide sets out how to make direct payments more accessible to people with mental health problems. The aim of Direct Payments is to give individuals independence, to foster social inclusion and to help enhance their self esteem.

- **Choosing Health: Supporting the physical health needs of people with severe mental illness (Department of Health 2006):** This document emphasises the need for all service providers to take steps to ensure that the physical health needs of people with enduring mental health problems are identified and met.
- **The future of mental health: A vision for 2015 (Sainsbury Centre for Mental Health et al 2006)** .The vision is that by 2010 mental well being will be a concern of everyone. The vision includes the fact that people with severe mental illness should have their own budgets to purchase the services they need and want, including a range of alternatives to hospital admission.
- **Our Health, Our Care, Our Say: A new direction to community services (Department of Health 2006):** This White Paper sets out a vision for health and social care in the community. The vision involves:
 - Improving health and emotional well being
 - Improving quality of life
 - Making a positive contribution
 - Increasing choice and control
 - Freedom from discrimination or harassment
 - Economic well being
 - Maintaining personal dignity and respect
- **Joint Position Paper: A Common Purpose: Recovery in Future Mental Health Services (CSIP, RCP, SCIE, 2007):** This publication highlights the value of the recovery model and the role of service providers in supporting people in their recovery.
- **Putting People First: A shared vision and commitment for the transformation of adult social care:** This highlights the fact that in future the focus will be on prevention, early intervention, and enablement and on the delivery of high quality personally tailored services.

Additionally, over recent years NICE have published guidance on the assessment and treatment of a number of ongoing mental disorders including:

- Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care (NICE 2002)
- Depression: Management of depression in primary and secondary care (NICE 2004)
- The management of Bipolar disorder in adults, children and adolescents in primary and secondary care (NICE 2006)
- Borderline Personality Disorder: Treatment & management (NICE 2009)

Our Commissioning Intentions

Although at the moment we have a good range of services, there are too many different services with too many different ways of getting help and being assessed, and too many people are not getting the service that they need.

- We will review the role and function of our community mental health teams.
- We will expand the role, skills and capacity of primary care services in managing long term mental health conditions.
- We will work with the voluntary and independent sector and other statutory agencies to expand our range of vocational and day services to deliver a more empowering service that supports our ethos of independence and recovery. We will ensure that services are able to meet the diverse cultural and faith needs of the various Manchester communities.
- We will work with people who use our services to expand the use of Individual Budgets and Direct Payments for people with

enduring mental health problems so that they can have a greater say in how their care is provided.

- We will work with our primary care health services to ensure that the physical health needs of people with severe and enduring mental health problems are not forgotten. The assessment of physical health needs of all people with severe and enduring mental health problems-to take place within agreed timescales.
- Every person with ongoing mental health needs living within the community will have an agreed, recovery-focused, culturally appropriate care plan drawing on community based support and resources.
- Regular monitoring will be provided at a level agreed to be appropriate for and with the individual, including intensive monitoring (e.g., under the Mental Health Act 2007). All monitoring to be purposeful and linked to steps within their care plan.
- There will be a strong emphasis on education and personal development, with access to life coaches, fitness coaches and others who will support clients to maximise their life opportunities.
- The community teams will also have access to the best available anti-psychotic medication as well as appropriate psychological support.
- Community teams will work closely with community substance misuse services to address client's substance misusing behaviour.

- Community teams will work from a wide range of settings but in time will have greater access to community based provision that is closer to home. To achieve this, an implementation plan would need to be agreed for a reduction in inpatient capacity and appropriate alternative provision must be available and effectively utilised.
- Escalation plans will be in place for all clients at risk of harm either to themselves or others, with an emphasis on a joint pathway with intensive care and other secure services which will be provided on a zonal (i.e., Greater Manchester) basis.
- There will be a strong emphasis on addressing the needs of Carers for this complex group. This will ensure that the needs of Carers are not consumed by the challenges of people with complex health problems.

The key outcomes for this care pathway will be the number of clients achieving measurable goals including appropriate accommodation, education, training, employment, family re-integration, and increased socialisation. Key indicators will also be established to monitor the impact on clients and families of the shift from inpatient treatment and care as a primary option to more effective services that are community based and closer to home.

3.5 PEOPLE WITH DEMENTIA

For too long a diagnosis of dementia has been seen as a diagnosis of despair and as a condition it is often misunderstood.

The term 'dementia' is used to describe a syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of functioning, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering which cause problems in themselves, which complicate care and which can occur at any stage of the illness.

The different types of dementias all share the same devastating impact on those affected and their carers. Dementias affect all in society irrespective of gender, ethnicity and class. They can affect adults of working age as well as older adults, but people with learning disabilities are a group at particular risk. Another high risk group is that of people with AIDS.

The causes of these illnesses are still not well understood but they all result in structural and chemical changes in the brain. The main sub-types of dementia are: Alzheimer's disease, vascular dementia, mixtures of these two pathologies ('mixed dementia') and rarer types such as Lewy body dementia, dementia in Parkinson's disease, fronto-temporal dementia and Korsakoff's Syndrome. The term 'Alzheimer's disease' is used sometimes as a shorthand term to cover all forms of dementia.

The most significant policy affecting people with dementia and dementia services is **Living Well with Dementia: the National Dementia Strategy** (2009). This outlines 17 objectives to be taken forward at national, regional and local levels as follows.

- 1: Improving public and professional awareness and understanding of dementia.
- 2: Good-quality early diagnosis and intervention for all.
- 3: Good-quality information for those with diagnosed dementia and their carers.
- 4: Enabling easy access to care, support and advice following diagnosis.
- 5: Development of structured peer support and learning networks.
- 6: Improved community personal support services.
- 7: Implementing the Carers' Strategy.
- 8: Improved quality of care for people with dementia in general hospitals.
- 9: Improved intermediate care for people with dementia.
- 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.
- 11: Living well with dementia in care homes.
- 12: Improved end of life care for people with dementia.
- 13: An informed and effective workforce for people with dementia.
- 14: A joint commissioning strategy for dementia.
- 15: Improved assessment and regulation of health and care services and of how systems are working for people with dementia and their carers.
- 16: A clear picture of research evidence and needs.
- 17: Effective national and regional support for implementation of the Strategy.

Living Well with Dementia: the National Dementia Strategy (2009)

There is currently a Joint Manchester Dementia Strategy (in its final draft) which addresses the objectives in the National Dementia Strategy, what the gaps are in Manchester and key recommendations to address these gaps.

Dementia is traditionally thought of as an older person's condition but this is not always the case. We know that nationally there will be a 6% increase in the number of people with 'early onset dementia' (i.e. under the age of 65) over the next 10 years, and that the number of people with late onset dementia (over the age of 65) will increase by 40%. Manchester's Joint Health Unit estimates that there are currently 4,602 people with dementia in Manchester, 4,510 aged 65+ and 92 young onset cases and this is predicted to rise to 4847 by 2016. These are not huge numbers, but the numbers of people with moderate to severe illness is predicted to increase more as the population ages and caring for people with dementia can be expensive. *The UK Inquiry into Mental Health and Well-being in Later Life (2007)* found that dementia costs the health and social care economy more than cancer, heart disease and stroke combined.

We know that we need to improve rates of detection and recognition, to ensure people get the support they need at the earliest stages of the condition. We also know that our current information systems are not sufficient to enable the accurate recording of investment and activity for people with dementia and their carers. We are also aware that the needs of BME Elders is under-articulated in Manchester. We will be working with partner agencies to ensure that commissioning information is sufficiently robust to enable more accurate monitoring of services, ascertain impact and to help with future commissioning plans.

Whilst we place great emphasis on supporting people in their own homes and recognise that in many cultures this is the preferred option, we also recognise the valuable role played by care homes. We will be working with care homes to help them in the management of people with dementia and behaviour that challenges.

We want to improve the range and availability of supportive services for people with dementia and their carers, and will be working to improve the number of carers assessments and the number of people with dementia supported to live in their own home, with a range of intermediate and home care based services, including ensuring that people with dementia are not excluded from rehabilitation, intermediate care and crisis resolution services.

We will increase access to Memory Clinics and provide increase support for people with dementia and delirium in general hospitals, to improve access to supportive services, to avoid inappropriate admission to general hospital and then to reduce lengths of stay and where appropriate avoid unnecessary admissions to residential care.

Additionally, in line with the national strategy we will be increasing the range of information for people with dementia and their carers and improving the skills and knowledge of managing dementia amongst statutory health and social care professionals.

We will address the need for this information to be available in Manchester's communities' languages as well as the need for verbal communication to raise awareness of the mental health needs of elders.

Our Commissioning Intentions

- To address the recommendations in the Joint Manchester Dementia Strategy, these recommendations include:
 1. Health and social care commissioners require providers to routinely record the incidence of dementia in people using their services.
 2. NHS Manchester requires their acute hospital providers to put in place comprehensive old people's psychiatric liaison services across their hospitals. There will be Dementia Leads in the acute

hospitals who will fulfil the role outlined in the National Dementia Strategy

3. A clear care pathway will be developed including GPs, primary and secondary health staff and social care staff (this will include increasing the profile of the GP Dementia Protocols).

4. Dementia awareness training will be extended to all people working with older people and training be further developed on how to work successfully with people with dementia for care home staff, care staff and others.

5. All care homes to nominate a named dementia lead who will fulfil the role outlined in the National Dementia Strategy.

6. Following the evaluation of the Unified Dementia Service, and if deemed successful, develop specifications for further specialist community services to ensure parity across the city and put out to tender.

7. Work will continue with RSLs to develop bids for specialist dementia extra care housing schemes.

8. Clear links are established with the work going on around palliative and end of life care, the Dignity Campaign and the Carers' Strategy.

9. Cross referencing with the Manchester Dementia Strategy recommendations will need to be fed into the roadmap.

- We will ensure access for all those who require it; dedicated community support by a skilled practitioner who will agree with the person concerned and their carers, a care plan setting out the steps to achieve their maximum quality of life, for as long as possible, in a state of independence without fear or anxiety and in safety.

- We will ensure regular reviews are undertaken for those who require it at as appropriate for each person, including intensive monitoring. All monitoring will be culturally sensitive, purposeful and linked to steps within their care plan.

- We will adopt a strong emphasis on each person's life fulfilment with access to community support, dietary and fitness coaching and advice and support to carers, friends and relatives.

- Community teams will work from a wide range of settings but will, in time, have greater access to community based provision that is closer to home

- We will work with our primary care health services to ensure that the physical health needs of people with severe and enduring mental health problems are not forgotten. The assessment of physical health needs of all people with dementia take place and reviewed within agreed timescales.

- Community teams will provide services closer to home by drawing on additional resources from community home treatment teams.

- Escalation plans will be in place for all clients at risk of harm either to themselves or others.

- For clients whose safety and wellbeing is at such risk that they cannot be supported in a setting without 24-hour supervision or care there will be continued access to a range of residential and nursing care services.

The key outcome for this care pathway will be the number of people and the number of years people are able to remain supported in their

own homes, achieving measurable levels of fulfilment and safety for themselves and carers.

3.6 PEOPLE WITH COMPLEX NEEDS

People with complex needs are often those people who have a range of problems, or their problems make it hard for them to engage with services.

This can range from a criminal record and recent offending to alcohol or drug problems, alongside mental health problems. It can also mean some people with a history of eating disorders or a very small number of mothers with severe mental health problems after the birth of their baby.

The authors of **Meeting Complex Needs: The future of social care (2004)** suggested that:

“Too many health and social care services fail to recognise the interconnected nature of people’s needs.”

They go on to suggest that this results in a significant gap in service provision for people with complex needs. When considering service provision for those deemed complex they clearly suggest that complex needs should not “function as another service label to determine eligibility”.

In 2006 the Government published **Reaching Out: An Action Plan on Social Exclusion**. This policy paper set out the guiding principles of how we should engage with socially excluded groups and the ‘hard to reach’. The guiding principles were:

- Better identification and earlier intervention

- Systematically identifying ‘what works’
- Promoting multi-agency working
- Personalisation, rights and responsibilities
- Supporting achievement and managing underperformance

If we do not succeed in reaching those in ‘need’, we will continue to have to support increasing numbers of people who:

- Are chronically unemployed, lacking skills or qualifications,
- develop mental health problems or personality disorders,
- become persistent offenders and drug or alcohol misusers, and
- become parents who are unable to parent effectively, therefore perpetuating the cycle of problems in their children.

Adults facing severe or multiple disadvantages tend to be less likely to access services and, when they do, they are less likely to benefit from them. Most challenging of all are those adults with chaotic lives who have multiple needs. They can find it difficult to engage with multiple public services in order to improve their lives and often live at the margins of society.

Health Needs of Offenders

The Social Inclusion Unit (2002) suggested that half of sentenced prisoners are not registered with a GP prior to being sent to prison and finding GP’s prepared to take on released prisoners prior to release is a great concern for health services in prison.

In 2005 NACRO published its findings of their 2004 survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales. Some key issues reported included:

- 25% of schemes surveyed said they had seen a decrease in staffing levels in the last year.
- 50% of schemes had no sessional input from either a psychiatrist or a psychologist.
- 41% of schemes reported difficulties in obtaining psychiatric reports.
- 72% of schemes cited lack of beds as a barrier to their scheme operating successfully.
- Almost a quarter of schemes felt that mentally disordered offenders were a low priority for agencies in their area.

The Sainsbury Centre (2008) suggest that prison is just one part of a pathway along which the majority of offenders pass and that services need to be commissioned with this in mind.

In March 2009 the Department of Health published the Offender Health & Social Care Strategy Data Report. The strategy aims to examine how services can work, to ensure that offenders receive appropriate, sensitive and effective care throughout the criminal justice pathway. It found that:

- PCTs should be working with probation services and local authorities to meet the needs of offenders.
- Local health and criminal justice commissioners should ensure that health and social care interventions are accessible to offenders, especially aspects like crisis intervention or ongoing community psychiatric nurse support.

In May 2009 the Department of Health launched the long awaited 'Bradley Report'. The report was headed by Lord Bradley and focuses on the complex needs of meeting the health needs of offenders. The report makes 80 recommendations including that more mentally disordered offenders be treated in community settings rather than in prison, that staff in the criminal justice system should receive more training related to mental health conditions and that the NHS should assume control of health services in police custody suites.

Antisocial Personality Disorder

In January 2009 NICE issued their comprehensive guidance on antisocial personality disorder. The guidance offers recommendations for the treatment, management and prevention of antisocial personality disorder in primary, secondary and forensic healthcare.

- The prevalence of antisocial personality disorder in the general population is suggested to be 3% in men and 1% in women.
- Antisocial personality disorder is most often associated with criminal and offending behaviour.
- The prevalence of antisocial personality disorder among prisoners is just less than 50%.

NICE Guidance suggests a need for a general increase in the level of services for people with antisocial personality disorder including the health and social care sector, the non-statutory sector and the criminal justice system agencies. The guidance suggests that provision of services for people with antisocial personality disorder often involves significant inter-agency working and clear pathways.

Dual Diagnosis (Mental health problems and substance/alcohol dependency)

There is no clear, agreed definition of dual diagnosis amongst clinicians and researchers, although the term usually refers to the co-existence of mental and substance misuse disorders. The Department of Health's 'Dual Diagnosis Good Practice Guide', advises services to view dual diagnosis as 'usual rather than exceptional'.

People present with differing degrees of severity in relation to their substance misuse and also their mental health problems. A total of four sub groups of people with co-existing disorders have been identified as follows identified in the adjacent table (Minkoff, 2002).

Services should be provided to people in any of the four quadrants, not just those with severe mental and substance misuse problems. However we recognise that due to the associated risk issues those in the higher quadrants will be the focus for many services' activities.

PSYCH HIGH SUBSTANCE HIGH Serious & persistent mental illness with substance dependence	PSYCH LOW SUBSTANCE HIGH Psychiatrically complicated Substance dependent
PSYCH HIGH SUBSTANCE LOW Serious & persistent mental illness with substance misuse	PSYCH LOW SUBSTANCE LOW Mild psychopathology with substance misuse

Prevalence studies undertaken in the UK indicate that around one third of people with psychosis have co-morbid substance misuse problems (Weaver et al 2001, Hughes et al 2008). In a recent systematic review of co-morbid substance misuse in psychosis in mental health settings in different geographical settings across the UK, Carra & Johnson (2008) identified that rates of 20% to 37% in mental health settings and 6% to 15% in addiction settings were found. Higher rates were seen in urban areas like Manchester.

Rethink and Turning Point (2004) identified four treatment stages in relation to caring for people with dual diagnosis:

- Engagement

- Persuasion
- Active treatment
- Relapse prevention

The physical healthcare needs of people with a dual diagnosis are another key area of intervention.

The “**Mental health policy implementation guide: Dual Diagnosis Guide**” (Department of Health 2002) states that the right place for people with dual diagnosis is within mental health services and that mental health services need to work closely with substance misuse services to ensure that care is well co-ordinated in an integrated clinical pathway.

Our Commissioning Intentions

As part of the ongoing development of community mental health services we will be working to streamline the number of services and ensuring that our community teams have the skills and capacity to work alongside people with a recent history of offending, substance misuse problems and or personality disorders, rather than create a range of specialist teams that have different criteria for working with people.

- We will work with our primary care health services to ensure that the physical health needs of people with complex mental health problems are not forgotten. An assessment of physical health needs of all people with severe and enduring mental health problems to take place within agreed timescales.
- We will commission specialist eating disorder services that focus on delivering effective and evidence based interventions and that unless needed for urgent reasons will avoid the need for prolonged and expensive admission.

- We will work with our regional partners to ensure that mother and baby mental health services are commissioned to meet the needs of local people.
- We will ensure every one who accesses our complex care services will have an agreed detailed care plan, setting out goals for change and development, emphasising positive relationships, self esteem and maximising life opportunities.
- We will commission a range of specific interventions and support including advice to families, friends and other practitioners and professionals, specific therapies will include psychological therapies and support in self-management.
- We will ensure all mental health and primary care practitioners will have basic training in substance misuse screening, be better equipped to recognise early signs of mental health and substance misuse problems, be able to refer clients rapidly into substance misuse support services and work within shared care plans when appropriate.
- Brief therapy is currently provided to people presenting with alcohol problems via MRI Accident and Emergency department. We will look at extending this service to include those presenting with drug related crises.
- Escalation plans will be in place for all clients at risk of harm either to themselves or others and in time designated practitioners will be able to access a small resource of community based accommodation in non-institutional settings when they are required for reasons of safety.

- Prison and community based mental health services will ensure that offenders receive timely and ongoing risk assessment and treatment for mental health and concurrent problems during custody; and linkages between prison in reach, substance misuse, healthcare teams, Assertive Outreach services, criminal justice liaison and aftercare services in the community are improved.
- We will continue to develop the new Mental Health Criminal Justice Services in line with the recent Lord Bradley review with the aim of Manchester becoming a beacon site.

The key outcome for this care pathway will be the number of clients being discharged from the care pathway without distressing effects of their personality or condition impacting negatively on their lives, and achieving measurable goals of social inclusion including education, employment, stable relationships and personal fulfilment.

**SECTION 4:
THE NEXT STEPS**

THE WAY FORWARD

Achieving change in Manchester's mental health services has historically been very difficult. Achieving the changes articulated in our commissioning intentions in this strategy will also have its challenges but it is anticipated that the vision which it sets out will command broad support and that there will be goodwill and commitment amongst all stakeholders who recognise that the *status quo* for mental health services in Manchester cannot be sustained.

It is expected that the two key principles of transition from current arrangements to the future will be as follows:

- The safety and wellbeing of service users will be the paramount objective of commissioners and providers
- Services will change or close in their current form only when alternative services are available and properly functioning

The transition from current arrangements to the future vision will therefore be achieved in phases as shown in this table.

HOW WILL WE DELIVER CHANGE AND IMPROVEMENT?

We recognise that robust systems and structures, and improved collaboration, needs to be established in order to ensure that this challenging programme achieves the outcomes for residents who experience mental health services in Manchester. We will be accountable to you for this programme of modernisation in the following ways:

1. A new partnership structure has been established which will ensure participation and involvement from key stakeholders including service users, carers, providers and partnership agencies committed to contributing to the objectives stated in this strategy .

2. Increased scrutiny by the Adult Health and Well being Overview and Scrutiny Committee and NHS Manchester Board which are made up of senior officers from a range of key agencies including Police, Probation, NHS Manchester, Manchester City Council and local councillors representing the views of residents.
3. Broader opportunities for service users and carers to be closer to the point of strategic decision making including their views on the review and redesign of services enshrined within the Engagement Plan.
4. Improved performance management of mental health services by commissioners which will include specific emphasis on the achievement of targets and quality indicators, and will require radical plans for improvement from services which fail to achieve these including the redistribution of resources or de-commissioning current provision.
5. Increased engagement with the public to ensure that commissioners understand the needs of those who require and use mental health services.
6. Commissioning intentions may require revision in response to changing national policy and these will be publicised so that local residents and providers are aware if the impact on service provision.

Overleaf is a road map for improving mental health services. Key milestones have been identified for each year of the five years with specific actions for delivery and defined, measureable outcomes. This will be the implementation plan that will collate the commissioning intentions and describe the way forward.

Roadmap for Improvement Year 1

Roadmap for Improvement - Year 1

Milestone 1	Outcomes	How success will be measured
<p>Priority Group 1: Children & Young People All 16/17 year olds are managed in developmentally appropriate environments in accordance with relevant legislation.</p>	<ul style="list-style-type: none"> • NHS Manchester compliant with New Mental Health Act requirement • Young people able to continue with their education • Reduction in risk for 16/17 year olds whilst managed in an adolescent provision • Young people always being managed by staff with developmentally appropriate skills 	<ul style="list-style-type: none"> • No 16/17 admitted to an adult psychiatric ward (unless such an admission is in accordance with their developmental need)

Milestone 2	Outcomes	How success will be measured
<p>Priority Group 1: Children & Young People All staff working with looked after children are appropriately skilled to manage mental health problems.</p>	<ul style="list-style-type: none"> • Staff are better able to identify children and young people with mental health problems that should be referred to CAMHS • Improved understanding of the range of problems that CAMHS can manage • Better and more consistent joint working arrangements between CAMHS and children’s services • Looked after children have access to a continuum of services that promote their emotional well-being. 	<ul style="list-style-type: none"> • By monitoring referral data an increase in appropriate referrals and a decrease in inappropriate referrals to CAHMS • Logged staff training programme supported by “before and after” questionnaires. • Monitoring placement breakdowns

Milestone 3	Outcomes	How success will be measured
<p>Priority Group 1: Children & Young People Every young person aged 14 to 18 thought to meet the Early Intervention in Psychosis criteria will be assessed within two working days</p>	<ul style="list-style-type: none"> • Young people and their families receive rapid access to appropriate support • Reduction in the number of young people suffering a second psychotic episode • Reduction in lengths of stay • Reduction in admissions 	<ul style="list-style-type: none"> • Exception reporting in respect of the number of multi-disciplinary assessments undertaken outside two working days • Exception reporting in respect of number of young people suffering a second psychotic episode • Monitoring lengths of stay following achievement of milestone.

Milestone 4	Outcomes	How success will be measured
<p>Priority Group 2: People New to Mental Health Services We will ensure we provide a comprehensive primary care mental health service with a stepped care model that will be delivered by appropriately skilled staff.</p>	<ul style="list-style-type: none"> • There is equity of provision across the city. • There is a single point of access for all primary care services. • Users have a single care plan which is transferable across a range of services. • Primary care services manage a greater acuity and diversity of need. 	<ul style="list-style-type: none"> • Annual service user / carer experience surveys. • Monitoring of service complaints / compliments. • Clinical audit of care pathways. • Monitoring of referral logs in respect of geographic/ referral source / referral outcome / and waiting times.

Milestone 5	Outcomes	How success will be measured
<p>Priority Group 2: People New to Mental Health Services We will ensure rapid assessment, support, treatment and a care plan appropriate to need from all community services.</p>	<ul style="list-style-type: none"> • Assessments are completed within agreed timescales. • All service users have an agreed care plan which is appropriate to their needs. • Assessments will consider the whole range of needs as present. • Community services will ensure information is shared within other agencies where appropriate. 	<ul style="list-style-type: none"> • Exception reporting on breaches in relation to assessments undertaken outside the agreed timescale. • Audit of care plans to ensure all service users have an agreed care plan in line with their needs that is reviewed and updated as appropriate.

Milestone 6	Outcomes	How success will be measured
<p>Priority Group 6: People with Complex Needs We will continue to provide appropriate services to address the offender mental health agenda</p>	<ul style="list-style-type: none"> • A mental health criminal justice service will be available for complex clients who meet the criteria for this service. • The recommendations from the Lord Bradley Review 2009 will be addressed and an action plan to deliver the recommendations will be phased in commencing in 2009. • Mental health services will have clearly defined pathways for clients who are in the criminal justice system. • There will be robust and comprehensive assessments for mental health clients in relation to risk management supported by specialist teams where necessary for example forensics services, Assertive Outreach services and the Mental health Criminal Just Liaison Service. • There will be a strategic agreement with all partner agencies for the implementation and roll out of the offender health agenda. • Prison mental healthcare will provide timely and ongoing risk assessment and treatment for mental health and concurrent problems during custody. • Pre release plans will ensure offenders care released into the care of community services, with an initial appointment, if appropriate. • Manchester will model integrated prison healthcare services and aspire towards being a centre of excellence in addressing poor levels of health, including mental health amongst offenders. • Families and carers of offenders will have access to help in supporting the offender as well receiving interventions to relieve on going family distress. 	<ul style="list-style-type: none"> • Once milestone achieved marked increase in individuals receiving mental health assessments during custody. • Once milestone achieved marked reduction in number of deaths in custody. • Improved mental health amongst offenders during custody monitored via an accredited mental health and well being toolkit. • Once milestone achieved a marked increase in individuals receiving primary care mental health and more intensive treatment during custody evidenced by Prison Health Monitoring Returns. • Exception reporting in respect of offenders released without community support plans together with scheduled / random clinical audits of said plans.

Milestone 7	Outcomes	How success will be measured
<p>Priority Group 2: People new to Mental Health Services Responsive urgent care system that facilitates early intervention and better access</p>	<ul style="list-style-type: none"> • Reduced waiting times, zero tolerance for A&E breaches. • Fully functional CRHT. • Comprehensive psychiatric liaison service. • Reduced readmissions. • Improved length of stay to within the national average. 	<ul style="list-style-type: none"> • Patient reported better access to acute services. • Patient experience of crisis journey is improved. • Patients report reduced waiting times. • Patients report more services available in the community.

Milestone 8	Outcomes	How success will be measured
<p>Generic Theme: Health & Wellbeing Mental wellbeing will be integrated through all health and wellbeing preventative agendas, across all age groups with a specific focus on family intervention</p>	<ul style="list-style-type: none"> • A more joined up strategic approach to ensuring the mental health and wellbeing agenda is truly embedded. • Greater recognition of agenda from all clinicians, practitioners and stakeholders. • Capitalise on regional expertise in public sector. • Bigger contribution to social capital and mental wellbeing in the city. • Prevent interventions for higher risk group. 	<ul style="list-style-type: none"> • Extending 'family think' service across all services. • Increased family cohesion and reliance. • Noticeable earlier intervention for families at risk. • Greater understanding for the health and wellbeing agenda. • More commissioned services targeting prevention and early intervention.

Roadmap for Improvement Year 2

Roadmap for Improvement - Year 2

Milestone 1	Outcomes	How success will be measured
<p>Priority Group 1: Children & Young People All schools have an appropriately skilled workforce to manage children and young people with mental health problems</p>	<ul style="list-style-type: none"> • School-based staff have a better understanding of the impact of mental health problems on the behaviour of children and young people. • Children and young people are able to continue to access mainstream education. • Better and more consistent working relationship between health services and education settings. • Improved access to mental health services for children, young people and their families. 	<ul style="list-style-type: none"> • By monitoring referral data a increase in appropriate referrals and a decrease in inappropriate referrals to CAHMS • Monitoring exclusion rates via data provided by the city council • Monitoring referrals to the Pupil Referral Unit and to education off site provision. • Monitoring school staff's training programmes in respect of sessions directed towards the understanding of managing mental health problems • Collecting data in respect of number and nature of mental health interventions delivered in a school setting collected via the school nursing service.
Milestone 2	Outcomes	How success will be measured
<p>Priority Group 1: Children & Young People Establishment of a young people's forum to provide feedback to services on how services could be improved</p>	<ul style="list-style-type: none"> • Young people involved in service reviews. • Young people inform performance monitoring frameworks. • Young people receive feedback on their views. • Young people involved on appropriate interview panels. 	<ul style="list-style-type: none"> • Number of young people attending all forums • Number of new young people attending forums • Age ranges of young people attending • Invited feedback from young people attending forums.

Milestone 3	Outcomes	How success will be measured
<p>Priority Group 5: People with Dementia We will ensure we address the recommendations in the Joint Manchester Dementia Strategy</p>	<ul style="list-style-type: none"> • All providers will routinely record the incidence of dementia in people using their services. • Acute hospital providers ensure a comprehensive Psychiatric Liaison Service is facilitated in acute settings. • An effective model will be developed and implemented to ensure good quality early diagnosis. • A clear health and social care pathway will have been developed to meet current and future needs of those with dementia and their carers. • Dementia awareness training will be utilised by all health and social care staff working with older people. • All care homes will have a nominated Dementia lead. • Subject to a successful evaluation, a city wide 'unified dementia service will be procured. • In conjunction with Registered Social Landlords, bids will be developed for specialist dementia extra care housing schemes in the north and centre of the city. • Clear links will have been established with palliative and end of life care, the dignity campaign and the carers' strategy. • All people with a diagnosis of Young Onset Dementia will have been identified and a care pathway put in place to meet their current and future needs. 	<ul style="list-style-type: none"> • All providers to be able to evidence when required the maintenance of "Dementia Registers" • Monitoring of waiting time four hour breaches in respect of older people presenting at Acute Hospitals. Monitoring of length of stay for older people who are identified as having a co-morbid mental health diagnosis... Monitoring of discharge planning for older people who are identified as having a co-morbid mental health diagnosis. • Monitoring and audit of outcomes delivered in respect of the implemented early diagnosis model • Monitoring and audit of outcomes delivered in respect of the adopted health and social care pathway. • Monitoring of health and social care staff training.

Milestone 4	Outcomes	How success will be measured
<p>Generic Theme: Carers There will be a strong emphasis on meeting the needs of carers</p>	<ul style="list-style-type: none"> We will maximise the resources and help available to carers through the deployment of the carers strategy. The development and take up of carer's individual budgets will increase choice, flexibility and will promote personalise resilience. Carers accessing services will feel supported and understood. Carer assessments will be delivered where appropriate in a timely fashion. 	<ul style="list-style-type: none"> The performance of mental health against the targets / recommendations outlined in the Carers Strategy. Monitoring and recording the take up of carers individual budgets within the city. Invited feedback in respect of whether carers feel "supported and understood " from carer engagement forums and from providers annual carer experience surveys. Exception reporting when carer assessments are not delivered where appropriate in a timely fashion.

Milestone 5	Outcomes	How success will be measured
<p>Generic Theme: Health & Wellbeing All people in mental health services will have access to support to address their physical health</p>	<ul style="list-style-type: none"> Physical health screening will be available for mental health individuals There will be clearly defined pathways between physical health and mental health services Robust Comprehensive physical health assessments will be developed within mental health services Mental health services will have an appropriately skilled workforce to address the physical health conditions of mental health clients All mental health services will ensure the environment is fit for purpose in meeting the requirements of mental health individuals with physical health conditions 	

Milestone 6	Outcomes	How success will be measured
<p>Priority Group 4: People with Ongoing Needs There will be a responsive and accessible hospital-based inpatient provision with approved efficiencies resulting in better outcomes for patients.</p>	<ul style="list-style-type: none"> Reduction in hospital-based inpatient capacity for MMHSCT by 30% over three years with a minimum of 10% per year. There will be better access to hospital beds for patients when needed. A decrease in the number of beds does not mean less service provision therefore crisis services and access to urgent care will need to be responsive and effective. 	<ul style="list-style-type: none"> More patients will report they have received treatment at home Patients will report improved waiting times when hospital admission is required Patients report high levels of satisfaction and improved hospital experience

Milestone 7	Outcomes	How success will be measured
<p>Generic Theme: Suicide The effects of suicide on families and the community are immeasurable. The prevention of harm to self and families as a result of suicide will be a top priority for all mental health services in Manchester</p>	<ul style="list-style-type: none"> • Staff trained in assessing and recognising triggers of self harm and providing diversion from actions which may lead to suicide. • Local campaigns, utilising all forms of popular media to de-stigmatise feelings of suicide and encourage active use of confidential help lines and primary care services. • Access to therapies and interventions which provide alternative ways of dealing with depression, hopelessness, anxiety and stress. • Improved joint working across mental health , urgent care and substance misuse services. • Access to peer support and therapies for families and carers affected by suicide or the fear of suicide. 	<ul style="list-style-type: none"> • Reduction of suicides on a year on year basis • Increase of people accessing help lines for support and advice. • All mental health staff trained in recognising the signs and triggers for suicide. • Increase in reporting by families and carers of concerns for loved ones at risk of self harm. • Increased information sharing across services regarding incidence of self harm or risk laden lifestyle choices.

Roadmap for Improvement Year 3

Roadmap for Improvement - Year 3

Milestone 1	Outcomes	How success will be measured
<p>Priority Group 3: People with Short Term Mental Health Needs Every client at risk of harm to themselves or others will have an escalation plan</p>	<ul style="list-style-type: none"> • All clients will have a crisis plan • Following an episode of self harm all clients will be offered an appointment with an appropriate skilled practitioner within an agreed timescale • All clients who are deemed to be a risk to self harm will have contact details for helplines and out-of-hours services • All clients will have a named key worker 	<ul style="list-style-type: none"> • Client crisis plans subject to random / scheduled audit. • Exception reporting in respect of all clients who following an episode of self harm are not offered an appointment with an appropriate skilled practitioner within an agreed timescale. • Monitoring via checklists that all clients who are deemed to be a risk to self harm will have contact details for helplines and out of hours services. • Client records to record named key worker and be subject to schedule / random audit.
Milestone 2	Outcomes	How success will be measured
<p>Priority Group 2: People New to Mental Health Services There will be a wide range of community based provision delivered by appropriately trained staff</p>	<ul style="list-style-type: none"> • There is a sufficient range of services in the community to meet assessed need. • Service users have access to appropriately trained staff. • A wider range of community services will be developed. • A review of community based accommodation will be undertaken. 	<ul style="list-style-type: none"> • Publication of results of needs assessment against service availability. • Publication of a review and recommendations in respect of the availability of community based accommodation.

Milestone 3	Outcomes	How success will be measured
<p>Priority Group 6: People with Complex Needs We will work with our regional partners to ensure that mother and baby mental health services are commissioned to meet the needs of local people</p>	<ul style="list-style-type: none"> • Mother and baby services will be reviewed and options considered. • A local needs assessment will be undertaken in relation to this group. • Clearly defined pathway will be identified between mental health services and mother and baby specialist mental health services, maternity and children's services. • The development of a perinatal service will be considered as part of the review. • Robust screening and assessment will be available for mothers who are experiencing mental health problems pre and post pregnancy. 	<ul style="list-style-type: none"> • Publication of service review and option appraisal • Publication of results of needs assessment against service availability. • Publication of clearly defined care pathway and subsequent monitoring and audit of outcomes delivered in respect said pathway. • Screening and assessment to meet need is provided and monitored.

Milestone 4	Outcomes	How success will be measured
<p>Priority Group 6: People with Complex Needs We will review with our commissioning partners the level of provision in our eating disorder services across all age ranges</p>	<ul style="list-style-type: none"> • Community eating disorders will be reviewed and options considered • In patient eating disorder services will be reviewed and options considered. • Clearly defined pathways will be identified between mental health and eating disorder services. • Lower level support information and advice for those suffering from an eating disorder will be readily available. 	<ul style="list-style-type: none"> • Publication of community service review and option appraisal. • Publication of results of in patient service review and option appraisal. • Publication of clearly defined care pathway and subsequent monitoring and audit of outcomes delivered in respect said pathway.

Milestone 5	Outcomes	How success will be measured
<p>Priority Group 6: People with Complex Needs People experiencing mental health problems in conjunction with substance misuse will access mental health services which are competent and responsive to their needs.</p>	<ul style="list-style-type: none"> • People experiencing mental health problems in conjunction with substance misuse will access mental health services which are competent and responsive to their needs. • Mental health and primary care practitioners will receive training in substance misuse screening. • Mental Health screening and assessment will incorporate substance misuse and staff will be able to recognise and respond to signs of distress at an earlier stage. • Mental health services will assess clients appropriately and work in a “joined up” way with substance misuse services in order to maximise opportunities for treatment. • Welfare and support officers in colleges, secondary schools and universities will receive training in mental health and substance misuse, and information to ensure referral to appropriate services. • Families and carers will receive support in managing substance misuse and mental health related crises. 	<ul style="list-style-type: none"> • Increased numbers of referrals as a rapid response between mental health and substance misuse services. • Increased numbers of people successfully completing treatment. • Fewer admissions to hospital as a result of “crisis” • More people with substance misuse and mental health problems accessing psychological therapies.

Milestone 6	Outcomes	How success will be measured
<p>Generic Theme: Safeguarding Mental health services will work together in a more joined up way to protect vulnerable adults and children from harm, and provide support to alleviate the effects of harm so that individuals and families can recover and thrive</p>	<ul style="list-style-type: none"> • Commissioned services implementing good practice in safeguarding, and demonstrating compliance with agreed local policies and procedures. • Workforce development plans including specific training for staff to be able to recognise those at risk, signs of domestic and other abuse, make rapid referrals to appropriate services, and support all involved. • Policies about the sharing of information with other services, made available to service users and carers. • Mental health support given to the victims of domestic and other abuse and their children. 	<ul style="list-style-type: none"> • More adults and young people will be referred for help and support. • More services will evidence that recommendations from serious case reviews and SUIs have been implemented within the agreed timeframes. • All services adhere to safeguarding children procedures. • More people receiving parenting support.

Roadmap for Improvement Year 4

Roadmap for Improvement - Year 4

Milestone 1	Outcomes	How success will be measured
<p>Priority Group 1: Children & Young People All young people with substance misuse and/ or involved with criminal justice services receive appropriate mental health support</p>	<ul style="list-style-type: none"> • Staff are better able to identify children and young people with mental health problems that should be referred to CAMHS • Improved understanding of the range of problems that CAMHS can manage • Better and more consistent joint working arrangements between CAMHS and YOS and Eclipse • Young offenders and young people with substance misuse problems have access to a continuum of services that promote their emotional well-being 	<ul style="list-style-type: none"> • By monitoring referral data an increase in appropriate referrals and a decrease in inappropriate referrals to CAMHS • Logged staff training programme supported by “before and after” questionnaires to ensure an increase in staff’s understanding of managing mental health problems

Milestone 2	Outcomes	How success will be measured
<p>Priority Group 2: People New to Mental Health Services We will ensure all individuals are supported to remain in their current employment and have access to meaningful activity that promotes recovery, that is socially and culturally appropriate</p>	<ul style="list-style-type: none"> • People remain in employment whilst accessing services • Care plans include information about access to meaningful activities • Reduction in length of time people remain in services 	<ul style="list-style-type: none"> • Relevant Care plans record employment status and are subject to random / scheduled audit. Relevant providers to record employment status of patients / service users as part of routine contract monitoring • Relevant care plans record access to meaningful activities and are subject to random / scheduled audit. Relevant providers to access to activities as part of routine contract monitoring • Monitoring of provider records to monitor and trend length of time people remain in service.

Milestone 3	Outcomes	How success will be measured
<p>Priority Group 2: People New to Mental Health Service All people will have improved and easier access to information to mental health services and treatment options available to them</p>	<ul style="list-style-type: none"> • People are satisfied with information available, it is understandable and culturally appropriate • Improved access to services for all, 24/7 • Information will be available in different formats, web, telephone face to face etc • People will have a clear explanation with accompanying literature for what treatment options are available • Information will be updated on a regular basis 	<ul style="list-style-type: none"> • Results of annual patient / carer satisfaction surveys • Relevant providers to provide data on access and be monitored as part of routine contract monitoring • Results of audit / review of availability and content of information in various formats and the up take of said information

Milestone 4	Outcomes	How success will be measured
<p>Priority Group 4: People with Ongoing Mental Health Needs We will review the role and function of community mental health services and ensure they meet the needs of a diverse population</p>	<ul style="list-style-type: none"> • Services will be flexible and will provide relevant and person centred interventions at the right time. • Services will develop and review longer term plans to help customers maintain their independence; improve the self management of conditions while working holistically with strategic partners to maximise protective social factors. • Services will promote a model of recovery based on the ability and potential of each customer. 	<ul style="list-style-type: none"> • Results of annual patient / carer satisfaction surveys • Results of service reviews in respect of their ability to meet the outcomes detailed

Milestone 5	Outcomes	How success will be measured
<p>Priority Group 4: People with Ongoing Mental Health Needs A more extensive market place will have been created so that individuals who choose to have individual and personal budgets can access a range of services in line with their needs and personal choice</p>	<ul style="list-style-type: none"> • An increase of smaller, innovative localised providers offering greater choice and flexibility. • Increased choice, control and independence through the delivery of person-centred care and planning. • Providers will work in partnership and collaboration to meet the needs of the city. • There will be an increased number of individuals with individual and personal budgets. • Empowered, socially included customers accessing a full range of community services and leisure activities. • A reduction in the commissioning of traditional type home services. • Providers demonstrate greater value for money. 	<ul style="list-style-type: none"> • More individuals will report a positive experience of individual and personal budget. • The number of people with individual and personal budgets will increase year on year. • Increased numbers and range of services for Manchester’s residents on a year on year basis.

Roadmap for Improvement Year 5

Roadmap for Improvement - Year 5

Milestone 1	Outcomes	How success will be measured
A full review of all completed milestones will be undertaken	<ul style="list-style-type: none"> 	<ul style="list-style-type: none">
Milestone 2	Outcomes	How success will be measured
An assessment of remaining milestones will be undertaken with options appraisal for the development of the next mental health and well being strategy	<ul style="list-style-type: none"> 	<ul style="list-style-type: none">

READING LIST

- Darzi, A. (1988) *High Quality Care for All*, Department of Health.
- Boyington, J (2008) *Mental Health Services in Manchester*.
- A better future in mind – Mental Health Sources in the North West* (2008), NHS North West.
- World Class Commissioning Vision*, Department of Health.
- Commissioning Strategic Plan of NHS Manchester* (2008).
- Our Health, Our Care, Our Say* (2007), Department of Health.
- Delivering Race Equality* (2005), Department of Health.
- National Service Framework for Mental Health: Five Years On* (2004), Department of Health.
- Mental Health & Social Exclusion Report* (2004) Social Exclusion Unit
- Choosing Health: Supporting the Physical Health Needs of People with Severe Mental Illness* (2006) Department of Health.
- The Future of Mental Health: A vision for 2015* (2006), Sainsbury Centre for Mental Health.
- The National Dementia Strategy* (2009) Department of Health.
- The Bradley Report* (2009) Department of Health.
- Dual Diagnosis Good Practice Guide* (2002) Department of Health.
- New Horizons : Towards a Shared Vision for Mental Health Consultation* (2009) Department of Health

GLOSSARY OF TERMS

ADASS	Association of Directors for Adult Social Services
AIDS	Acquired Immune Deficiency Syndrome
ASC	Adult Social Care
BME	Black Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CMHT	Community Mental Health Teams
CPA	Care Programme Approach
CSIP	Care Services Improvement Partnership
CSP	Commissioning Strategic Plan
DAT	Drug Action Team
DOH	Department of Health
DRE	Delivering Race Equality
DRE CDW	Delivering Race Equality Community Development Workers
EIP	Early Intervention in Psychosis
HARP	Health Advocacy and Resource Project
HASCAS	Health and Social Care Advisory Service
JSNA	Joint Strategic Needs Assessment
LAA	Local Authority Agreement
LAC	Looked After Children
LGF	Lesbian Gay Foundation
MHSC	Manchester Mental Health and Social Care Trust
MSAB	Multi Agency Safeguarding Adults Board
NACRO	National Association for the Care and Resettlement of Offenders
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NIMHE	National Institute for Mental Health in England
NSF	National Service Framework

OCD	Obsessive Compulsive Disorder
PCT	Primary Care Trust
RCP	Royal College of Physicians
SCIE	Social Care Institute of Excellence
SEAL	Social and Emotional Aspects of Learning
SES	Single Equality Scheme