Public Health

Luton

Mental Health Needs Assessment
V1.7 Final, February 2018

Luton

Business Intelligence

Together for a *healthier Luton*

NHS Luton
Clinical Commissioning Group

Foreword

Good mental health underpins our physical health and wellbeing, and is fundamental to how we live our lives through relationships, work, leisure, and in achieving our full potential. Mental health and wellbeing is influenced by many underlying factors, and as Professor Stuart-Brown has said, "Good mental wellbeing does not mean that you never experience feelings or situations that you find difficult, but it does mean that you feel you have the resilience to cope when times are tougher than usual."

The purpose of this report is to increase our understanding of the mental health and wellbeing needs of Luton, in order to shape the decisions we take and the priorities we set. It is part of an active process around decision-making which is informed by need, and focused on outcomes which will influence the future needs of our population. Our challenge is how we use this knowledge of need to influence the complex breadth of factors involved in making a positive difference to the mental health and wellbeing of the people of Luton.

This report aims to contribute to a better understanding of local mental health and wellbeing needs of the people of Luton, and also raises some questions about areas we need to further explore and understand better. The report is not comprehensive, has many gaps and there are limitations in each of the data sources which inform our understanding of our town's mental health and wellbeing. It does however, aim to increase our understanding of how mental health and wellbeing is distributed amongst the population of Luton, and give us a greater insight into some of our key challenges to improve population mental health and wellbeing locally.

ACKNOWLEDGEMENTS

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INTRODUCTION

Aims and Objectives

The overarching aim of this Mental Health Needs Assessment (MHNA) is to explore whether services in Luton are meeting the needs of people with mental health problems and how likely it is that prevention measures will achieve their aims. The assessment is therefore concerned with current need and future demand. Specifically, it seeks to:

- Identify the wider determinants of mental health and well-being, including those risk and protective factors that have already been identified nationally
- Examine the prevalence of common mental health conditions and severe mental illness, highlighting any indicators which suggest that Luton differs from the benchmark
- Identify vulnerable groups who are at a higher risk of mental disorder and/ or low wellbeing
- Map the current service provision for adult and older adult mental health in Luton, identifying any gaps in service or specific hard-to-reach populations
- Engage with a wide range of stakeholders, service users, carers and the general public to seek to understand different user perspectives
- Identify evidence-based approaches to prevention and early intervention
- Provide recommendations that will support the public health commissioning cycle, direct activity over the next two years and that will inform the longer term strategy delivered by the Healthier Lifestyle model.

It does this primarily by examining where Luton sits in relation to issues identified in the 'Five Year Forward View for Mental Health' and 'Five Year Forward View for Mental Health: one year on'.

This Mental Health Needs Assessment sets out the national view for each issue as outlined in the Five Year Forward. This national context is followed by the local picture, informed wherever possible by local data to ensure that we improve our understanding of what are often complex and interrelated issues and that we fully understand the local factors which affect mental health.

National Context

In its 2010 publication 'No health without public mental health', the Royal College of Psychiatrists set forward a number of recommendations for a public health policy with mental health at its core. The report argued that nearly a quarter of the total burden of disease in the UK was attributable to mental disorder and that public mental health should focus on the wider prevention of mental illness and promotion of mental health across the life course.

Public mental health is increasingly recognised as both a core determinant and a consequence of physical health, as well as a key resource for living. The Faculty of Public Health publication, 'Better Mental Health For All | A public health approach to mental health improvement', sets out the case for prioritising public mental health through measures which aim to promote mental wellbeing, prevent future mental health problems and enable recovery from existing mental health problems.

Better Mental Health for All champions the use of three inter-related approaches to public mental health:

- Psychological, sociological and interpersonal approaches;

- Interventions that acknowledge the central role of the social context in which people live, including infant development and family relationships;

- Intersectional and cumulative impacts of discrimination, poverty and exclusion.

The Five Year Forward View for Mental Health, published in February 2016, set out the agenda for the reform of mental health care. The strategy aims to significantly increase the availability and quality of care and treatment for people with mental health problems, to improve their outcomes and wellbeing, but also to tackle the wider costs of mental ill health to the health service and society as a whole.

EXECUTIVE SUMMARY

Key Findings and Recommendations

The need for a Public Mental Health Strategy

- The high prevalence of some mental health issues in Luton, together with other risk factors set out in this report, illustrate the challenge to achieving positive mental health outcomes in the town. There are economic, social and cultural factors that make it more challenging for individuals to achieve good mental health and for services to implement preventative and protective measures at the same time as providing good quality care for people with existing mental health conditions.

- Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. In Luton, physical health population risk factors are evident. For example, Luton has higher rates of obesity, diabetes and Chronic Obstructive Pulmonary disease (COPD). Analysis also suggests that there inequalities across these conditions in Luton in terms of gender, ethnicity, age and disability.

- People with severe mental illness in Luton are 2.6 times more likely to die prematurely than the rest of the Luton population, which already has a higher mortality rate when compared to the rest of England.

1. Implement a Public Mental Health Strategy, including suicide prevention. This should include a range of universal and targeted interventions to protect mental health and wellbeing and provide appropriate support and prevention measures to the most vulnerable. Public Health will ensure that mental health is integrated with the physical activity agenda.

Equality Factors

- Equality factors are key determinants of positive mental health and there a number of factors in Luton that determine rates and experiences of mental health problems. Age, gender, ethnicity, the effects of stigma and cultural experiences of mental health all play an important part in the likelihood of an individual seeking help, receiving a diagnosis and receiving and completing treatment with successful outcomes.

- Other equality issues relate to more vulnerable and marginalised groups such as rough sleepers and veterans and there are people in Luton who have lived in war zones and escaped conflict and horror. Some of these people will have post-traumatic stress syndrome (PTSD). Luton psychological services have particularly high recovery rates (60-63%) for PTSD and it is important to ensure that people are aware that effective help is available and should be sought.

- There is a clear relationship between mental health and contact with the criminal justice system. Whilst local prevalence is unclear, socio-economic factors in Luton and a particularly high crime deprivation score suggest this is a key risk group. Targeting mental health services at this group should result in financial savings across the public sector as well as giving some of the most vulnerable people in Luton a chance to turn their lives around.

- Childhood sexual abuse is a significant factor in mental health and is, by its nature, a particularly hidden problem. Disclosure may be hindered by denial, fear, shame, stigma and taboo. Cultural factors in Luton may compound issues relating to disclosure and also successful treatment following disclosure. Mental health practitioners are aware of cultural factors within the Asian community that create barriers, but it is important to develop an understanding of how other communities experience these issues and work to address any barriers.

- Being a carer is another identified risk factor; caring is often a long-term and time-consuming commitment with significant personal, emotional, physical and financial costs to the carer.

- Stigma, discrimination and social exclusion related to mental health are significant barriers to quality of life and mental wellbeing. In short, stigma, sometimes compounded by cultural beliefs, prevents people from seeking help. Despite the protective factors that come from living in close-knit family networks, families can also be a source of taboo, shame or stigma around mental disorder. The need to break down these barriers has been recognised and good work is being done by statutory and community services. This work needs to be supported to create the best chance possible for people to receive the help they need.

2. Equality issues are fundamental to improving mental health in Luton. Recommendations are therefore to:

   - Ensure that Mental Health First Aid training is mandatory for key front line staff

   - Ensure that services are available to all and are de-stigmatised. Sustainable Transformation Plan (STP) project groups must be cognisant of the inequalities raised in this assessment, specifically in relation to gender, ethnicity, people who are vulnerable or marginalised, veterans, people involved in the criminal justice system, survivors of sexual abuse and carers.

Mental Health Outliers in Luton • Luton has higher rates of Mixed Anxiety & Depressive Disorder, Depressive Disorder, Panic Disorder and Obsessive Compulsive Disorder. It has a higher prevalence of severe mental illness and the trend is increasing.	3. Public Health to commission further research into aspects of local mental health identified as outliers in this assessment. This should apply across the STP areas to better understand local mental health patterns.
Personality Disorder • People with Personality Disorder are a high cost group and are particularly at risk of crisis, self-harm and suicide and are likely to have co-morbid mental health difficulties. Despite this, waiting lists for secondary care are too long for many people with Personality Disorder to receive the care they need.	4. Collect and share data to better understand Personality Disorder, including the scale of this issue in Luton and across the STP areas. Public Health to commission a detailed needs analysis of Personality Disorder (Deep Dive) in order to better understand local morbidity rates.
Suicide and Self-Harm • Luton's suicide prevalence is not high, but one preventable death is one too many and the prevalence of male suicides nationally and locally is particularly concerning. Over a third of the people who committed suicide in Luton during 2014-2016 had previously attempted suicide and nationally this is known to be the greatest predictor of suicide. This provides a discrete group to target with specific interventions, although data that are currently available do not allow for estimations of the numbers involved and how achievable such interventions could be. • Self-harm is also a predictor of suicide, although difficulties in estimating prevalence are compounded by its hidden nature. In Luton, particular risk factors for self-harm are a high proportion of looked after children and a high proportion of young people in the criminal justice system. Nationally it has been found that young south Asian women are at greater risk of self-harm, a point to note in relation to the high proportion of young south Asian women in Luton.	5. Self-harm is an important indicator of mental disorder and a predictor of suicide. Alongside a campaign to highlight the issue of self-harm, there is the need to develop an understanding of which local agencies are already capturing self-harm data and how this can be shared for analysis. In particular there is a need to understand the scale of the issue and whether it affects particular populations in Luton and the wider STP areas.
Smoking • Smoking is closely correlated with mental ill-health and a third of all smokers nationally have evidence of mental disorder. Smoking rates amongst people with mental health issues compare poorly against the national decline in smoking prevalence over the past 20 years. National findings suggest that smokers with mental health issues are likely to be heavily addicted to smoking, but are just as likely to want to quit as other smokers. • Although smoking rates appear low in Luton compared nationally and to comparator areas, data are only available for the whole of Luton, which masks pockets of entrenched and heavy smokers who may be contributing to the high rate of smoking related hospital admissions in Luton. Smoking is a key determinant in the high mortality rate of people with mental health issues. Although smoking rates tend to be higher in areas with significant levels of deprivation, the relationship between smoking and deprivation is not linear. Instead it is part of the interplay with other social, cultural and environmental factors, including mental health. People with mental health issues in Luton are likely to be one of the pockets of entrenched and heavy smokers and are likely to need additional support in stopping smoking to ensure long term quitting success and also that mental health conditions are not worsened as a result of stopping smoking.	6. People with mental health issues are not only more likely to smoke, but also more likely to smoke heavily when compared with the general population, despite having the same desire to quit. This is an unacceptable disparity and is a contributory factor in lower life expectancy for people with mental health conditions. Front line staff must be proactive in supporting this target group to access stop smoking services. The Wellbeing Model Assessment in Luton must be in-depth and flexible enough respond to individual smoking motives.

Substance Misuse • Research shows that substance misuse may cause or increase symptoms of mental illness. Mental illness may also lead to substance misuse as people use drugs or alcohol to self-medicate against unpleasant symptoms or side-effects of prescribed drugs. Depression, anxiety and schizophrenia are more likely to be linked to substance misuse and result in a dual diagnosis and may prevent people from making a full recovery. For common mental health disorders, dealing with the substance misuse is a pre-requisite for access to local psychological therapy services, but there is a need to determine the primary need for all cases of dual diagnosis and deliver a combination of treatment that will lead to the most positive and enduring outcomes for the patient.	7. Substance abuse is often co-morbid with a mental health condition and there is a complex interplay between the two. In order to improve joint working and avoid duplication, a dual diagnosis protocol has been agreed. All services must work together to ensure that needs are properly met in line with the protocol.
Employment • Stable employment is a key contributory factor to someone being able to maintain good mental health and, along with other factors such as housing, is an important outcome for their recovery if they have developed a mental health problem. As a preventative factor, addressing mental health and supporting positive mental health at work ensures a healthier, more supported and more productive workforce. From a local perspective, encouraging employers to provide protective factors around mental health can be seen to positively influence the health of the wider Luton population directly (Luton people who work in the town) and indirectly (through the 'ripple effect' as employees adopt healthier behaviours which influence those around them).	8. The workplace can be a protective factor for mental health as well as, potentially, a source of stress or stigma for people with an existing mental health condition. Public Health to lead on provision of support to Luton companies and Luton employees, with the aim of tackling stigma and maintaining / improving employee wellbeing.
Transition from Children's to Adults' Mental Health Services • A separate Child & Adolescent Mental Health Needs Assessment was completed earlier this year. This assessment has therefore focussed on the transition phase from child to adult services, which is known to be problematic. There is currently an unacceptable risk that mental health conditions will deteriorate as young people transition to adult mental health services. Contrary to this, however, some national studies have shown that inpatient experience can be enhanced for young people in adult wards due to the presence of older role models that would not have been available in child and adolescent wards. • Going forward, it is important to properly understand the transition period and to capitalise on any positive factors, whilst mitigating those that put young people's mental health at risk. The aim is to eliminate the need for transition and to provide age-inclusive services, although it is recognised that there is also the need for a transition function. It is also recognised that children's mental health is a key determinant of adult mental health and it is important to implement measures that will help to develop resilience in young children starting nursery or school to prevent mental health conditions from developing.	9. Public Health and the Clinical Commissioning Group (CCG), along with wider partners, must develop strategies that will help young children to develop resilience to prevent mental health conditions from developing. 10. The transition from children's to adult services can cause setbacks or deterioration in mental health. The aim, therefore, is to eliminate transition and age inclusive services should be established alongside a transition function.
Accountability • A number of mental health-related strategic documents and needs assessments are already in existence, but there is currently a lack of robustness in processes that will ensure delivery and evaluation.	11. Ensure that action plans for all needs assessments affecting mental health are subject to regular review, accountability and evaluation, and that they are delivering equality. Build this accountability in to future work as business as usual. Currently this will include the Perinatal Mental Health Needs Assessment, the Child and Adolescent Mental Health Needs Assessment, the Dementia Commissioning Strategy and the Suicide Audit. Progress reports to be delivered to the Health and Wellbeing Board at regular intervals.

Commissioning

- There are currently estimated to be between 3,000 and 4,000 people receiving mental health services in Luton. At present, services tend to operate in silo and the need for more joined up working is recognised. Future plans are for a more cohesive and efficient service though actual and virtual partnership working under the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP) which consists of twelve local NHS organisations and four local authorities in Bedfordshire, Luton and Milton Keynes who are working together to improve health services and better join up with social care. Services affecting mental health care in Luton are going through a number of transformation and re-commissioning processes in the near future, which provides opportunity to ensure that services are integrated, co-ordinated and the have the needs of service users and patients at their core. A number of the issues noted for Luton will have implications for the BLMK STP and many of the recommendations made in this assessment will also be relevant to the STP area or will have an STP focus.

- Improving Access to Psychologic Therapies (IAPT) is a core aspect of mental health in the primary care setting. Access rates in Luton are lower than the England average, although not notably below England or comparator area rates. Luton has particularly high recovery rates for Post-Traumatic Stress Disorder (PTSD) and Obsessive Compulsive Disorder (OCD) and is in the top three nationally. Historically, there were particularly low rates of referral to psychological therapies for depression and anxiety. It is not clear whether this is still the case, but the difference previously was stark compared to most other areas in England.

- In line with national targets relating to secondary care, there are high proportions of people with a personalised Care Programme Approach plan and high proportions of people who receive a follow up within 7 days of discharge from psychiatric in-patient care. Nationally, there are known to be long waits for key services such as psychological therapies for people accessing secondary services and there are some indications that this is also the case locally.

- Information is included in this assessment about psychiatric in-patient bed days, which shows that nearly three quarters of occupied bed days are acute adult beds. However, the data do not give an indication of how well need is being met, nor does it allow for an analysis of equality issues. It would be useful to understand more about the mental health diagnoses, along with personal characteristics such as gender, age and ethnicity.

- Nationally, crisis care is recognised as being patchy and not always appropriate to need. In Luton the street triage initiative has produced better outcomes and reduced instances of detention under section 136 of the Mental Health Act as well as reducing pressure on A&E. However, there remain a number of factors which need to be addressed to better meet the needs of people in crisis. There is a need for a greater focus on prevention before people reach crisis and also for an approach which keeps the person in mind. There is a need to provide safe and calm environments and scenarios for people in crisis. Suggestions are for an appropriate room as an alternative to A&E when people present with a crisis. This may reduce anxiety and potentially reduce the need for a bed on an acute ward. Alternatively, a safe or crisis house could provide an alternative place of safety avoiding Accident and Emergency, police cells and S136 suites. Crisis care needs to be part of a system that is able to give the time it needs to encourage self-management in the long-term.

- Whilst there is some understanding of the non-statutory services and mental health support organisations that are available in Luton, a comprehensive view has not been made available for this assessment. In addition to statutory organisations, Luton has a wealth of charity and third sector organisations with an interest in mental health whose strengths and specialisms should be harnessed to improve the wellbeing of people with specific mental health needs. These should not take the place of professionally-delivered therapeutic interventions, but work alongside and enhance them. In particular, there is a need to provide statutory and non-statutory services that are culturally-specific or culturally adaptable. Services should be holistic, and support the whole person (physical, mental, emotional and spiritual).

- This assessment has recognised that integrated care is good for people and may provide opportunities for financial savings as gaps and inefficiencies are identified and mitigated. Although further work is needed to map current services, it may be more useful to start by bringing together mental health professionals from different organisations and asking them "what would a fully integrated mental health service look like and how can it be achieved?"

12. Commissioners must be informed by the findings of this Needs Assessment when commissioning services. When developing commissioning intentions, the CCG must address issues identified in previous contracts.

Commissioning for Dementia, Learning Disabilities and Autistic Spectrum Disorder	
• Older people have specific needs in relation to mental health, particularly as lived experience of any mental health issues is likely to intersect with declining physical health. In addition to meeting the needs of older people with existing mental health conditions, dementia and depression are key concerns. Life expectancy in Luton is significantly lower when compared nationally and Luton has a younger age profile generally, which is likely to be a factor in lower prevalence of dementia.	13. Commissioners must consider the specific mental health needs of people with dementia, learning disabilities and autistic spectrum disorder and make clear commissioning decisions relating to these groups.
• However, as life expectancy increases and the population ages, it could be that Luton begins to see an increase in people living with dementia. This is already being seen as recorded prevalence increases slightly amongst over 65s. Whilst not completely preventable, there are modifiable risk factors for dementia, such as diabetes, drinking, cholesterol, depression, hypertension, low educational attainment, obesity, inactivity and smoking. Nationally, it is known that one in five older people living in the community and 40% of older people living in care homes are affected by depression. This assessment has not explored this locally, but it is important to remain cognisant of this and of the fact that there are barriers to diagnosing and treating depression in older people.	
• More needs to be done to join up services to ensure that the intersecting needs of people with mental health issues who also have Learning Disabilities and / or Autistic Spectrum Disorder are properly met. Up to 40% of people with Learning Disabilities also have mental health problems, with higher prevalence than people without Learning Disabilities across the complete spectrum of mental health problems. Around 40% of people with Autistic Spectrum Disorder are estimated to have a co-existing anxiety disorder compared with up to 15% of the general population. For both groups, there is a greater potential for mental health problems to remain hidden or undiagnosed and it is almost impossible to give accurate estimates.	
• It is likely that mental health prevalence in these groups will increase in the future as people with Learning Disabilities are both surviving beyond early years and living longer into old age. This is particularly pertinent in relation to dementia services as people with Downs Syndrome are significantly more likely than the population without Downs Syndrome to have dementia, particularly early onset dementia. Service data that tells us about current demand will help to estimate and plan for the future, but this has not been available for this assessment.	

Data Gaps	14. Data issues have been a significant barrier in this needs assessment and there are intelligence gaps in most of the topics that have been covered. It is imperative to address these data issues for future assessments. This could be achieved through the creation of a data sharing group responsible for implementing a plan that will drive improvements in data, creating better mental health delivery and ensuring a joined up approach. Data needs must form an integral part of future commissioning decisions.
• This assessment has been structured around the 'Five Year Forward View for Mental Health' and shares the concerns about data that were set out in the national document. Local data have not always been captured or made available for analysis. This has made it hard to properly understand any gaps in service provision and hard to reach or vulnerable groups. Improved data are needed on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services. In particular, there is a need to properly implement the Public Mental Health Commissioning Cycle, ensuring it is a process that drives activity and provides effective assessment and evaluation that will better meet the mental health needs of the people of Luton.	

ASSESSMENT

Demographic Considerations

- The 2016 population figure for Luton has been published by the ONS and is 216,800 which has increased by 2,100 on the previous year (1 per cent increase)

- Population increases due to combination of high birth rate and high migration rate

- Particularly dense population in some parts of Luton. Even compared to London boroughs, population density is high

- Luton has a younger population compared to the UK. Under15s account for 24% of the Luton population compared with 19% nationally. At the other end of the spectrum Luton has less older people. The over 65s represent 12% of the Luton population compared with 18% nationally

- Luton is ethnically diverse, with approximately 55% of the population being of Black and Minority Ethnic (BME) origin, with significant Pakistani, Bangladeshi, Indian, East European and African Caribbean communities. In recent years, there has been a significant shift in the population with more people from Eastern Europe, particularly Poland, Romania and Bulgaria. A study by Mayhew Harper Associates in 2011 showed concentrations of new communities of Congolese, Somali, Ghanaians, Nigerians, Turks and Zimbabweans in Luton. Foreign students coming to the University of Bedfordshire has also increased diversity. There is increasing acceptance that Luton is a "super-diverse" community

- Luton is ranked as the 59th (out of 326) most deprived local authority. In 2010 Luton was ranked as the 69th most deprived local authority and in 2007 as the 87th. This indicates that Luton is becoming relatively more deprived in comparison to the other local authorities of England. Research by the Centre for Research in Social Policy showed that about a third of children in Luton are living in poverty

- Luton has nine output areas in the top ten% most deprived areas in the country. Three of these are in Northwell ward, two each in Farley and South and one in Biscot and Dallow wards.

- Economic research shows that the claimant count unemployment rate in Luton is 1.3% which is the higher than the national rate (1.2%) and the regional (0.8%) rate. Unemployment is highest in South (2.2%) and Northwell (2%) wards. Whilst unemployment is lowest in Bramingham (0.5%) and Barnfield (0.3%) wards.

SECTION 1: ADULT MENTAL HEALTH

The adjacent table shows Pansi estimates in relation to Mental Health. At the time of writing, this is the best source of local information available and the table content is used throughout this assessment in the sections where it is relevant.

Availability of data that would better enable us to understand local prevalence is patchy. Understanding local incidence and prevalence is particularly important to help to determine under-reporting, under-diagnosis (or over-diagnoses), hard to reach groups and gaps in service provision.

According to the Pansi estimates, **between 22,872 and 23,971 Luton people have some sort of mental health problem and between 9,559 and 10,036 have two or more psychiatric disorders**.

People aged 18-64 predicted to have a mental health problem, projected to 2030					
	2014	2015	2020	2025	2030
People aged 18-64 predicted to have a common mental disorder	21,055	21,278	22,296	23,063	23,800
People aged 18-64 predicted to have a borderline personality disorder	587	593	621	641	662
People aged 18-64 predicted to have an antisocial personality disorder	467	473	501	523	542
People aged 18-64 predicted to have psychotic disorder	523	528	553	572	591
People aged 18-64 predicted to have two or more psychiatric disorders	9,452	9,559	10,036	10,399	10,742

Table produced on 05/04/17 16:14 from www.pansi.org.uk version 8.0

Pansi data are based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009. Pansi calculate estimated prevalence using more recent population figures. More information is included at Appendix B

COMMON MENTAL HEALTH DISORDERS

National Context

- Common mental health disorders (CMD) include depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety.
- Estimated to affect up to 15% of the population at any one time
- Often characterised by lifelong course of relapse and remission and is associated with significant long-term disability
- Associated with high levels of morbidity and mortality, and is the most common disorder contributing to suicide
- Most people are treated in primary care, but many individuals do not seek help and under-recognition is common. Stigma also affects people's willingness to seek professional help and 75% of people with mental illness receive no help at all
- Only 16% of adults with CMD access treatment each year

PREVALENCE & LOCAL PICTURE

Current CMD estimates: **Between 21,278 and 22,296** - anticipated to rise to almost **24,000** by 2030.

Females more likely to be diagnosed with a CMD. 19.7% compared to 12.5% of males.

Luton has **higher estimated prevalence** compared to England and comparator areas for Depression, Mixed Anxiety and Depression, Phobias, Panic Disorders and Obsessive Compulsive Disorder (OCD).

Despite higher prevalence estimates, QOF data show statistically lower incidence and prevalence **suggesting under-diagnosis** which may be compounded by GP shortages in Luton.

Luton has a particularly **low percentage of people entering IAPT** compared to England and comparator areas. Reasons for this may be harder to reach groups in the population.

One adult in six has a common mental health disorder…..

That's one woman in five and one man in eight

75% do not get the help they need

KEY FINDINGS

- Higher rates of CMD in Luton when compared to England and comparator boroughs
- Higher rates of CMD amongst women
- Stigma, under-reporting, and under-diagnosis affecting diagnosis and access to treatment. This may be exacerbated by a shortage of GPs in Luton
- Data Gaps mean there is a lack of locally-specific understanding
- Nationally, 75% of people do not receive any help for a common mental health disorder

NICE GUIDANCE

(See next page for full list)

CONSIDERATIONS

- Seek to understand why Luton is an outlier in relation to Common Mental Health Disorder
- Implement a Public Mental Health Strategy

Section Continues

NICE GUIDANCE

Title	NICE Guidance with brief description
Depression in adults: recognition and management	https://www.nice.org.uk/guidance/cg90
	This guideline covers identifying and managing depression in adults aged 18 years and older, in primary and secondary looked. It aims to improve care for people with depression by promoting improved recognition and treatment
Repetitive transcranial magnetic stimulation for depression	https://www.nice.org.uk/guidance/ipg542
	The National Institute for Health and Care Excellence (NICE) has issued full guidance to the NHS in England, Wales, Scotland and Northern Ireland on repetitive transcranial magnetic stimulation for depression in December 2015.
Computerised cognitive behaviour therapy for depression and anxiety	https://www.nice.org.uk/Search?q=depression
	This review concerns five specific packages for the delivery of computerised cognitive behaviour therapy (CCBT) accessed via a referral from a general practitioner (GP): three for depression (Beating the Blues, COPE and Overcoming Depression), one for panic/phobia (FearFighter) and one for obsessive-compulsive disorder (OCD) (OCFighter, previously known as BTSteps).
Social anxiety disorder: recognition, assessment and treatment	https://www.nice.org.uk/guidance/cg159
	This guideline covers recognising, assessing and treating social anxiety disorder (also known as 'social phobia') in children and young people (from school age to 17 years) and adults (aged 18 years and older). It aims to improve symptoms, educational, occupational and social functioning, and quality of life in people with social anxiety disorder.
Generalised anxiety disorder and panic disorder in adults: management	https://www.nice.org.uk/guidance/cg113
	This guideline covers the care and treatment of people aged 18 and over with generalised anxiety disorder (chronic anxiety) or panic disorder (with or without agoraphobia or panic attacks). It aims to help people achieve complete relief of symptoms (remission), which is associated with better functioning and a lower likelihood of relapse.
Post-traumatic stress disorder: management	https://www.nice.org.uk/guidance/cg26
	This guideline covers recognising, assessing and treating post-traumatic stress disorder (PTSD) in children, young people and adults. It aims to improve quality of life by reducing symptoms of PTSD such as anxiety, sleep problems and difficulties with concentration. Recommendations also aim to raise awareness of the condition and improve coordination of care.
Obsessive-compulsive disorder and body dysmorphic disorder overview	https://pathways.nice.org.uk/pathways/obsessive-compulsive-disorder
	Comprehensive overview: Principles of care, Recognition and Assessment, Treatment Options
Eating disorders overview	https://pathways.nice.org.uk/pathways/eating-disorders
	Comprehensive overview: Care across all eating disorders, Anorexia Nervosa, Bulimia Nervosa, Atypical disorders including binge eating disorder, Service User experience in adult mental health services

PERSONALITY DISORDERS

National Context

- Borderline personality disorder is present in just under 1% of the population, and is most common in early adulthood. Women present to services more often than men
- Characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour
- Pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm
- Transient psychotic symptoms, including brief delusions and hallucinations, may also be present
- Substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide
- Varying degrees, but people with more severe forms experience very high levels of emotional distress and repeated crises, which can involve self-harm and impulsive aggression. People with Personality Disorders are frequent users of psychiatric and acute hospital emergency services
- Often co-morbid with depression, anxiety, eating disorders, post-traumatic stress disorder, alcohol and drug misuse, and bipolar disorder
- People with borderline personality disorder have sometimes been excluded from any health or social care services because of their diagnosis. This may be because staff lack the confidence and skills to work with this group of people
- Anti-Social Behaviour Disorder (ASPD) is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed

LOCAL PICTURE

Prevalence Estimates

Local data are not currently available, but Pansi estimates show the following:

Between 593 and 621 people are predicted to have a Borderline Personality Disorder, with this figure anticipated to rise to 662 by 2030.

Between 473 and 501 people are predicted to have an Anti-Social Personality Disorder, with this figure anticipated to rise to 542 by 2030.

Local perceptions are that there is a particularly high number of people presenting for IAPT treatment with personality disorder features when compared with other parts of the country.

Local estimates are that between 10% and 20% of IAPT referrals have Personality Disorder features.

Luton Wellbeing Service highlights the need for a specialist Personality Disorder Service. Personality Disorders need to be addressed using a multi-agency and long-term approach.

The long waiting list for Community Mental Health Teams (CMHT) means that CMHT send people with Personality Disorders back to Primary Care for IAPT services. Whilst some aspects of a Personality Disorder can be treated successfully using IAPT services, IAPT is always limited in the number of sessions it can offer and working with complex cases has an adverse effect on IAPT performance.

NICE GUIDANCE

Title	NICE Guidance with brief description
Antisocial personality disorder: prevention and management	https://www.nice.org.uk/guidance/cg77 This guideline covers principles for working with people with antisocial personality disorder, including dealing with crises (crisis resolution). It aims to help people with antisocial personality disorder manage feelings of anger, distress, anxiety and depression, and to reduce offending and antisocial behaviour.
Borderline personality disorder: recognition and management	https://www.nice.org.uk/guidance/cg78 This guideline covers recognising and managing borderline personality disorder. It aims to help people with borderline personality disorder to manage feelings of distress, anxiety, worthlessness and anger, and to maintain stable and close relationships with others.

KEY FINDINGS

- Personality Disorder carries significant personal and social risks and costs. People with personality disorder are particularly at risk of crisis, self-harm and suicide and are likely to have co-morbid mental health difficulties. People with Personality Disorder are a high cost group with frequent crises and A & E attendance. Anti-Social Personality Disorder is associated with a disproportionate amount of crime and violence
- The proportion of people diagnosed with a personality disorder is small, but under-diagnosis and mis-diagnosis are features. The prevalence in Luton is believed higher than other parts of the country
- People with Personality Disorders are known to be excluded from health or social care services because of a lack of skills and confidence in relation to this condition. In Luton, people with Personality Disorder often fall between the IAPT and CMHT gap. Waiting lists for CMHT services are too long and Personality Disorder cases are often too complex for IAPT services to effectively treat. This highlights the need for a specialist and locally-based Personality Disorder Service
- Data are needed to drill down into the local population with Personality Disorder to understand the needs of specific groups

CONSIDERATIONS

- Collect and share data to better understand Personality Disorder, including the scale of this issue in Luton. Public Health to commission a detailed needs analysis of Personality Disorder in Luton (Deep Dive) in order to better understand how to equip and fund mental health services to provide an effective service to people.

SEVERE MENTAL ILLNESS

National Context

Severe mental illness (SMI) includes diagnoses which typically involve psychosis (losing touch with reality or experiencing delusions) or high levels of care, and which may require hospital treatment. Two of the most common severe mental illnesses are schizophrenia and bipolar disorder.

PREVALENCE AND LOCAL PICTURE

Current SMI estimates: **Between 528 and 553** - anticipated to rise to almost **591** by 2030.

Females slightly more likely to be diagnosed with a SMI. 0.5% compared to 0.3% of males.

Luton has **higher rates** of Psychosis prevalence and of admissions for Schizophrenia when compared to England and most of its comparator areas (although data are from 2011/12)

Observed mortality in Luton is **2.6 times more** in adults with severe mental health disorders.

People in Luton are more likely to have psychosis or to be admitted to hospital for schizophrenia

People in Luton with severe mental health disorders are nearly 3 times as likely to die prematurely

Luton Early Intervention Service provides a range of specialist interventions for people who are experiencing or have recently experienced a first episode of psychosis. Social and personal disability develops aggressively in this early critical period so the service aims to minimise harm, care costs, revolving door problems and treatment resistance.

"Psychosis is treatable, Recovery is expected"

NICE GUIDELINES

Title	NICE Guidance with brief description
Bipolar disorder: assessment and management	https://www.nice.org.uk/guidance/cg185
	This guideline covers recognising, assessing and treating bipolar disorder (formerly known as manic depression) in children, young people and adults. The recommendations apply to bipolar I, bipolar II, mixed affective and rapid cycling disorders. It aims to improve access to treatment and quality of life in people with bipolar disorder.
Psychosis and schizophrenia in adults	https://www.nice.org.uk/guidance/qs80
	NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

This quality standard covers the treatment and management of psychosis and schizophrenia (including related psychotic disorders such as schizoaffective disorder, schizophreniform disorder and delusional disorder) in adults (18 years and older) with onset before the age of 60 years in primary, secondary and community care. It will not cover adults with transient psychotic symptoms. |
Psychosis and schizophrenia in adults: prevention and management	https://www.nice.org.uk/guidance/cg178
	This guideline covers recognising and managing psychosis and schizophrenia in adults. It aims to improve care through early recognition and treatment, and by focusing on long-term recovery. It also recommends checking for coexisting health problems and providing support for family members and carers.
Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings	https://www.nice.org.uk/guidance/cg120
	This guideline covers assessing and managing people aged 14 years and over with coexisting severe mental illness (psychosis) and substance misuse. It aims to help healthcare professionals guide people with psychosis with coexisting substance misuse to stabilise, reduce or stop their substance misuse, to improve treatment adherence and outcomes, and to enhance their lives.

KEY FINDINGS

- Higher prevalence of serious mental illness compared to England and comparator areas

- Increasing trend

- People with SMI in Luton are 2.6 times more likely to die prematurely than the rest of the Luton population, which already has a higher mortality rate when compared to the rest of England.

- Higher rate of hospital admissions for schizophrenia

CONSIDERATIONS

- Seek to understand why Luton is an outlier in relation to Severe Mental Illness

SUICIDE

National Context

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death. Self-harm is an expression of personal distress. It can result from a wide range of psychiatric, psychological, social and physical problems and self-harm can be a risk for subsequent suicide.

Males are three times more likely to take their own lives	Contact with health professionals in days or weeks prior to suicide	A previous suicide attempt is the greatest predictor of suicide	Help is needed to ensure the most vulnerable can attend appointments	Around a third of Luton suicides were known to the Criminal Justice system

KEY FINDINGS

In 2017, Business Intelligence conducted a suicide audit and found the following:

- Numbers are small, but there appears to have been a rise in suicides in Luton during 2016.

- Suicides follow clear seasonal trends, peaking in the spring

- Nationally, three out of every four suicides is by males. This pattern was, until 2016, reflected in Luton and male suicides remain higher than females. However, although based on small numbers, female suicides in Luton have more than doubled when 2016 is compared with previous years. There is some national evidence that male suicides are decreasing and females increasing, but the rate of increase in Luton is greater than would be expected.

- Male suicides in Luton, as nationally, remain a key concern.

- Suicide rates did not appear to be proportionately higher when factors such as ethnicity, being born outside of the UK or being a recent UK resident were analysed. However, what was apparent was that people who were not from a White, European-born environment were much less likely to have sought or received help for depression. Improving the ability of minority ethnic communities to seek help for mental health issues could have a notable impact on suicides in Luton as well as having much wider benefits.

- Economic adversity was hard to judge from the data available and was likely to be more prevalent than the findings suggest. 21% of the individuals had clear economic difficulties at the time of their death. 35% were not working and were unemployed, sick or retired.

- Mental health was a significant factor and 56% of the individuals had had psychiatric intervention or treatment at some point.

- According to the Samaritans, the greatest prediction of suicides is a previous suicide attempt. 35% of the Luton individuals had previously attempted suicide. Knowing this, and assuming this trend will continue in the future, means that it is possible to identify a discrete group that may benefit from specific interventions.

- Many of the individuals who chose to end their lives led 'chaotic' lives and were unable to attend appointments, to commit to regular appointments or to comply with the expectations of service providers.

- Alcohol and/ or drugs were a significant factor

- Around a third of individuals were known to the Criminal Justice system

RECOMMENDATIONS

1. Reduce the risk of suicide in key high risk groups
   - Develop a male-specific suicide prevention plan which considers the following:
   - Develop a comprehensive intervention plan to identify and support people who have previously attempted suicide.
   - Ensure family, carers and friends of individuals being cared for by mental health, primary care or social services know how to contact services if they become concerned about the risk of suicide and that they are appropriately involved in care planning.
   - Continue to fund Court Liaison and Diversion Team interventions, evaluating effectiveness, particularly in relation to suicide prevention.
   - Consider how to better support people with mental health vulnerabilities who lead chaotic lives and find it difficult to attend appointments or to comply with the expectations of service providers.
2. Tailor approaches to improve mental health in specific groups (community approaches)
   - Promote mental well-being across the lifecourse by commissioning multi-agency community-based interventions.
   - Drug & Alcohol services must link with mental health services and continue to play a key part in preventing suicide. Data held by Drug & Alcohol services will help to fill intelligence gaps and understand who may be at risk.
   - Provide training to ensure that front line community staff are able to talk about mental health and well-being alongside other lifestyle issues. Ensure they are able to identify needs and signpost appropriately.
   - Seek to understand and address any barriers that exist in relation to early identification of depression by GPs. GP awareness training should encourage the implementation of NICE guidelines to improve the identification, treatment and management of depression in primary care.
   - Ensure that other front-line staff, such as those working with people who may be vulnerable due to social or economic circumstances, are aware of suicide risk factors such as depression or alcohol problems and that they are informed of appropriate referral pathways.
   - Ensure that front-line community staff are aware there may only be a very small window of opportunity when someone has stated that they intend to take their own life. One example in this audit shows this may, on occasion, be a matter of minutes. Ensure they are properly equipped to signpost appropriately and effectively at this point.
   - Seek advice/ resources from the National Suicide Prevention Alliance to develop local initiatives.
   - Consider the use of social media to promote positive mental health and signpost to services and sources of help. Tailor appropriately for specific groups, especially the hard to reach.
   - Ensure that services are culturally sensitive and adaptable enough to adopt a 'whole person' approach whereby physical, emotional and spiritual needs are considered as part of mental health.
   - Economic adversity is a known contributory factor in cases of suicide. Policy makers to be aware of this impact of when developing wider social and economic strategies.
   - Consider pre-emptive partnership work with Vauxhall/IBC and other local firms where there is job uncertainty. Particularly relevant for occupations by males that were historically considered to be a 'job for life'.
3. Support research, data collection and monitoring
   - Continue to work with partners to improve access to data sources ensuring that contextual information can be obtained in addition to numbers.
   - Suicide prevention group to consider specifically how it can obtain data on suicide attempts and self-harm.
   - Consideration of obtaining data on female suicides as they occur to help to determine if the rise in female suicides is part of an on-going trend. This would help to determine if a female-specific suicide prevention plan is also necessary.
   - Monitor/ develop intelligence gaps through access to national literature and bespoke local analysis.

- Ensure that the suicide prevention action plan is subject to regular review and accountability.

SELF-HARM

National Context

- Self-harm is common, especially among younger people

- For all age groups, annual prevalence is approximately 0.5%

- Self-harm increases the likelihood that the person will eventually die by suicide by between 50 and 100 fold

- Psychiatric problems such as borderline personality disorder, depression, bipolar disorder, schizophrenia and drug and alcohol-use disorders are associated with self-harm

- Young South Asian women in the United Kingdom seem to have a raised risk of self-harm. Intercultural stresses and consequent family conflicts may be relevant factors

- Self-harm is very common in people with Autism Spectrum Disorders and in people with learning disabilities. It is thought that between 20-30% of people with autism will self-harm in some way

PREVALENCE

Prevalence Estimates

It is not possible to accurately assess self-harming rates in Luton, but there are a number of risk factors which mean that the prevalence in Luton is likely to be worse than the England average.

Particular risk factors in Luton are a high proportion of looked after children and young people in the criminal justice system, however local data are not available relating to self-harm and this remains an intelligence gap.

Anecdotal reporting is that self-harm in Luton is increasing.

Self-harm is an intentional act of self-poisoning or self-injury

Self-harm greatly increases the risk of suicide

Self-harm is strongly associated with more serious mental health problems and with autism and learning disabilities

NICE GUIDANCE

Title	NICE Guidance with brief description
Self-harm in over 8s: short-term management and prevention of recurrence	https://www.nice.org.uk/guidance/CG16
	This guideline covers the short-term management and prevention of self-harm in people aged 8 and over, regardless of whether accompanied by mental illness. It covers the first 48 hours following an act of self-harm, but does not address the longer-term psychiatric care of people who self-harm.

KEY FINDINGS

- Self-harming is a key risk factor for suicide

- Self-harm is often a covert activity, which means that it is impossible to accurately assess prevalence rates. There are, however, a number of social and economic factors in Luton which suggest that self-harm is likely to be a greater issue in Luton compared to other areas.

- Vulnerable groups in Luton who may be at risk of self-harming include looked after children (and adults who were previously looked after), young people who have had contact with the criminal justice system and young south Asian women

- Anecdotally, it is reported that self-harm is increasing, but this may be due to increased awareness and recognition.

CONSIDERATIONS

- Develop an understanding of which agencies are already capturing self-harm data and how this can be shared for analysis. In particular there is a need to understand the scale of the issue and whether it affects particular populations in Luton
- Campaign to highlight the issue of self-harm

EXPECTANT & NEW MOTHERS

National Context

One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have longstanding effects on children's emotional, social and cognitive development. Costs of perinatal mental ill health are estimated at £8.1 billion for each annual birth cohort, or almost £10,000 per birth. Yet fewer than 15% of localities provide effective specialist community perinatal services for women with severe or complex conditions, and more than 40% provide no service at all.

PREVALENCE (2013/14)

Description	Estimated count
Estimated number of women with postpartum psychosis	10
Estimated number of women with chronic SMI	10
Estimated number of women with severe depressive illness	100
Estimated number of women with mild-moderate depressive illness and anxiety	335-500
Estimated number of women with PTSD	500
Estimated number of women with adjustment disorders and distress	500-995

Mental health has longstanding effects on children's emotional, social and cognitive development.

Services that target mothers during the pre or post-birth period are key to later childhood wellbeing

NICE GUIDANCE

Title	NICE Guidance with brief description
Antenatal and postnatal mental health	https://www.nice.org.uk/guidance/cg192/ifp/chapter/severe-mental-illness
	Full NICE Guideline on Clinical Management and Service Guidance for a Antenatal and postnatal mental health
Antenatal and postnatal mental health: clinical management and service guidance	https://www.nice.org.uk/guidance/cg192
	This guideline covers recognising, assessing and treating mental health problems in women who are planning to have a baby, are pregnant, or have had a baby or been pregnant in the past year. It covers depression, anxiety disorders, eating disorders, drug- and alcohol-use disorders and severe mental illness (such as psychosis, bipolar disorder and schizophrenia). It promotes early detection and good management of mental health problems to improve women's quality of life during pregnancy and in the year after giving birth.

KEY FINDINGS

In 2014, Luton Public Health department completed a perinatal needs assessment and found the following:

- 15% of all women giving birth had a mental health issue [as a "main cause for concern"]

- Variation by ethnic group with White British women having significantly higher prevalence of mental health issues when compared with the Luton average. Conversely, prevalence is significantly lower for Indian, Bangladeshi, Pakistani, African and Other White women which suggests undiagnosed / unmet needs for women in these ethnic groups

- Round Green, Leagrave and Northwell had high prevalence of mental health issues whereas Biscot and Lewsey had low prevalence. There did not appear to be a relationship between socio-economic disadvantage and perinatal mental health issues, but this may be due to cultural factors which have a greater impact

- Little is known about treatment or outcomes in relation to women with perinatal mental health issues, with this identified as a notable intelligence gap

- Data sharing was identified as an issue and it was identified that improvements to data sharing protocols would improve continuity of care for women and increase opportunities to prevent, identify or intervene

- The effectiveness of postnatal care was particular unclear in relation to new mothers experiencing mental health problems. The consensus view was that targeted primary (e.g. pre-birth parenting skills) and secondary (e.g. crisis support or family key worker) prevention is required

RECOMMENDATIONS

The following recommendations were put forward in the 2014 assessment:

- Develop perinatal mental health strategy/network

- Audit existing care pathways and consider widening scope

- Focus on the relationship between mother and baby

- Consider establishing a community perinatal mental health team and / or parent-infant mental health team or developing specialised roles

- Review psychological interventions

- Investigate disparity between expected prevalence and service uptake among BME group

- Review social support type initiatives and interventions

- Improve data collection, monitoring and sharing

The current recommendation is to ensure that the Perinatal Needs Assessment action plan is subject to regular review and accountability.

KEY FINDINGS

Luton has recently completed a Child and Adolescent Mental Health Needs Assessment which identified the following:

- Factors causing increased local risk were a high proportion of young people in the population, high deprivation, and a relatively high percentage of young people in vulnerable groups such as looked after children and young people in the youth justice system

- Estimated overall prevalence of mental health issues in young people in Luton is 9.8%, and estimated of prevalence of emotional, conduct, and hyperkinetic disorders for Luton in 2014 as 3.7, 6.1, and 1.7% respectively. Self-harm is an important issue locally. Issues such as anxiety are seen frequently in schools, care and other settings

- Tier 2 services in Luton are provided by a variety of providers, and tier 3 services is provided by East London Foundation Trust

- The tier 2 service provision is fragmented and has instabilities in funding. Referral pathways are not clear for all in the system. Data suggests that these services are not meeting the needs of some of the more vulnerable population groups, specifically looked after children, for lower level mental health and emotional support needs. The role of ELFT CAMHS as a partner in some of the tier 2 service provision, such as the Flying Start strategy, and in provision of training to carers, lacks clarity

- The tier 3 services in Luton have had recent changes to some of the teams and eligibility criteria. Professionals in the system are getting used to these changes and to the referral criteria. Communication and clarity of roles could be improved upon, where individuals have dual need such as social work or learning disabilities and mental health. There is limited evidence of CAMH services working with ASD children

- As part of transformation plans, a crisis team has been recently established, this seems to be working well. Data to quantify benefits in terms of admissions and costs avoided is currently minimal and needs to continue to be developed

- Service data available has improved in recent months, but there are still challenges in being able to look back over previous months to compare data, and having clarity on numerators and denominators in indicators. Part of the challenge is the length of time some individuals are in the service

- The number of young people requiring tier 4 beds has been very small. However, there continues to be a challenge in accessing tier 4 beds when required

RECOMMENDATIONS

The following recommendations were made:

- A strategic approach to mental health in children and young people is required across Luton and across settings and providers

- There are high levels of anxiety, self-harm, and emotional needs in young people across Luton. High levels of need in vulnerable groups such as looked after children should be addressed by increasing focus on a system-wide strategic approach to early intervention and prevention services

- A strategic approach should view mental health as a continuum of need, ensuring appropriate attention is given to emotional wellbeing and resilience, prevention and early intervention

- Early intervention and prevention needs to be prioritised, to prevent demand on tier 3 and 4 services increasing to an unsustainable level

- All schools should have access to children and youth counselling and be looking at providing a whole-school approach to issues such as anxiety, bullying, and self-harm

- There should be adequate service provision across Luton to meet the needs of individuals not meeting the threshold for specialist services

- All professionals that work with or are in contact with children and young people should be able to recognise the signs and symptoms of mental health needs, including eating disorders, early to enable early intervention and support and appropriate timely referral

- All professionals that work with or are in contact with children and young people should have clarity on referral options, pathways both into and out of specialist services, and referral criteria. The role of the specialist mental health service within the spectrum of mental health needs in the borough needs to be clear

- Expert advice should be available to professionals working with children and young people with complex needs if required

- Partners across the system should have clear ways of working to enable communication when dealing with individuals who require dual support

- Improvements to ELFT data collection and reporting should continue, and indicators should continue to be developed that are of use in reviewing whether services are meeting population need. Mechanisms to report on achievements of new service developments such as the crisis team should be particularly reviewed. An approach to reporting on individuals who have been in the service for a particularly long period of time should be considered

- The pathway for Autistic Spectrum Disorder (ASD) children should be reviewed, ensured is in place and NICE compliant

- Further work will be undertaken to inform a system-wide approach to mental health in children and young people: to understand the evidence of what works in terms of early intervention and prevention; gather best practice from elsewhere; mapping service provision and outcomes in other areas

The current recommendation is to review the Child & Adolescent Mental Health Needs Assessment on a 6 monthly basis and present progress report to the Health & Wellbeing Board

National Context

- Half of all mental health problems have been established by the age of 14, rising to 75% by age 24

- The transition to Adult Mental Health Services (AMHS) from Child and Adolescent Mental Health Services (CAMHS) is challenging and may cause a deterioration in mental health for some young people

- Recent research into mental health inpatient care of the young adult population suggests that there is a lack of good quality data around young people's inpatient experience. Admissions follow similar paths as to adults; admission reasons are largely unknown beyond simple descriptors; admission lengths are unknown; staff feel confident yet lack resources

- The research also highlights some positive findings in relation to the transition. Findings showed that young people feel the transition from CAMHS ward to adult ward can be beneficial if done sensitively and that young people have some positive experiences of adult wards due factors that may not be present on CAMHS wards, such as role modelling by older patients

- The most recent Adult Psychiatric Morbidity Survey found that young women have become a key high risk group. The gender gap in mental illness had become most pronounced in young people, and there is evidence that this gap has widened in recent years

- While a decline in rates of harmful and probable dependent drinking since 2000 is clear in young men, such improvements are less evident in young women. Survey data on drug dependence trends in young people are likely to be incomplete, due to changes in the types of drugs becoming available, in particular the emergence of new psychoactive substances which are challenging to research and regulate

There is an unacceptable risk that mental health conditions will deteriorate as young people transition to adult mental health services

NICE GUIDANCE	Title	NICE Guidance with brief description
	Transition from children's to adults' services for young people using health or social care services	https://www.nice.org.uk/guidance/ng43
		This guideline covers the period before, during and after a young person moves from children's to adults' services. It aims to help young people and their carers have a better experience of transition by improving the way it's planned and carried out. It covers both health and social care.

KEY FINDINGS

- Good management of the transition stage is key to good adult mental health and wellbeing

- The transition from CAMHS to AMHS has long been recognised as a national problem

- Factors affecting children that cause increased local MH risk that were identified in the CAMHS Needs Assessment will continue to influence mental health prevalence in Luton and should be taken into account in future planning. This includes a high proportion of young people in the population, high deprivation, and a relatively high percentage of young people in vulnerable groups such as looked after children and young people in the youth justice system. Schools play a crucial part in developing resilience in these higher risk children as well as the general child population. Early intervention - before mental health problems develop - is key

- Nationally, it has become evident that young women are a key high risk group and that the gender gap is widening. It is important to consider factors that would prevent young men reporting a mental health issue at the same time as providing services that will meet the growing needs of young women

- Nationally and locally, there is a lack of good quality data with which to understand this cohort and their needs. Local data are needed to properly understand the needs of young people aged 18-24

- Nationally, there is some evidence that inpatient experience can be enhanced for young people in adult wards due to the presence of older role models that would not have been available in CAMHS wards

CONSIDERATIONS

- Consider what can be done to develop resilience in young children starting nursery or school to prevent mental health conditions from developing

- Aim to eliminate transition and to establish age inclusive services alongside a transition function.

National Context

One in five older people living in the community and 40% of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.

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 function, 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 dementias all share the same devastating impact on those affected and their family carers. Dementias affect all in society irrespective of gender, ethnicity and class. They can affect adults of working age as well as older adults. People with learning disabilities are a group at particular risk

Dementia affects about 850,000 people in the UK. It describes a clinical syndrome with features of loss of memory, problems with activities of daily living and emotional changes. Dementia has a number of causes - Alzheimer's disease is the most common followed by vascular dementia. There are other types of dementia such as Lewy Body disease (associated with Parkinson's disease) and frontal lobe dementia (which causes changes in personality and behaviour). Dementia has overtaken heart disease and is now the biggest cause of death in England and Wales. Women are significantly more affected by dementia with double the number of women dying of dementia compared to men. This could, however, also be a result of women generally living longer.

PREVALENCE

Prevalence Estimates

Dementia

Luton sits around the middle when compared to the rest of England on a number of dementia indicators. However, there may be factors affecting these figures and therefore lower dementia prevalence might be expected. For example, life expectancy in Luton is significantly lower when compared nationally and Luton has a younger age profile generally.

As life expectancy increases and the population ages, it could be that Luton begins to see an increase in people living with dementia. This is already being seen as recorded prevalence increases slightly amongst over 65s.

Luton recently completed a Commissioning Strategy for people with dementia and their carers.

Estimated prevalence rates reported in the strategy show that 1,676 people were living with dementia compared to 1,119 on the dementia register.

Depression

Poppi predictions show that between 709 and 761 Luton people over the age of 65 have severe depression.

Women are significantly more likely to be affected by dementia than men

People with learning disabilities are a group at particular risk of dementia

Dementia has overtaken heart disease and is now the biggest cause of death in England and Wales

There are modifiable risk factors for dementia, such as diabetes, drinking, cholesterol, depression, hypertension, low educational attainment, obesity, inactivity and smoking

As life expectancy increases and the population ages, Luton may see an increase in people living with dementia

NICE GUIDANCE

Title	NICE Guidance with brief description
Mental wellbeing and independence for older people	https://www.nice.org.uk/guidance/qs137
	This quality standard covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older, and how to identify those at risk of a decline. It describes high-quality care in priority areas for improvement. It does not cover the mental wellbeing and independence of people who live in a care home or attend one on a day-only basis.
Older people: independence and mental wellbeing	https://www.nice.org.uk/guidance/ng32
	This guideline covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline.
Social care for older people with multiple long-term conditions	https://www.nice.org.uk/guidance/qs132
	This quality standard covers the planning and delivery of coordinated, person-centered social care and support for older people with multiple long-term conditions. The quality standard is focused on people aged over 65 as this is the largest group of people affected by multiple long-term conditions. It includes older people living in their own homes, in specialist settings or in care homes, and those who receive support with funding for their social care and those who do not.
Mental wellbeing in over 65s: occupational therapy and physical activity interventions	https://www.nice.org.uk/guidance/ph16
	This guideline covers promoting mental wellbeing in people aged over 65. It focuses on practical support for everyday activities, based on occupational therapy principles and methods. This includes working with older people and their carers to agree what kind of support they need.

OLDER PEOPLE AND PEOPLE WITH DEMENTIA - Continued

KEY FINDINGS

The Dementia Commissioning Strategy highlighted the following:

- Difference in prevalence and recognition of dementia among different ethnic groups. In particular, higher rates among Black Caribbean older people

- Effects of stigma, particularly where community culture places emphasis on self-reliance

- Language as a barrier to receiving help

- Unfamiliarity with services as a barrier to getting help, especially for people in minority cultures. Medical services, which are better understood, and free from stigma, are often considered more acceptable than social care services

- Standard diagnostic tests may not be culturally appropriate and may lead to inaccurate diagnosis

- The need for interpreters

- People for whom English is a second language may lose their English as their memory deteriorates

- Alcohol Related Dementia is a significant factor in Luton. Although the National Alcohol Strategy does not make reference to alcohol-related brain damage or dementia, it is estimated that up to 10% of dementias are related to alcohol. Standard dementia services will not meet the needs of an individual with problematic alcohol use, particularly if the individual is still in an acute phase of drinking

- Alcohol related brain injury (ARBI) is an increasing problem and there are thought to be about 30-40 people who have ARBI in Luton, many of whom make high demands on community and acute health care services, as well as a small group of younger people who are placed in residential or nursing homes. These placements are often age inappropriate, but age specific services which meet their needs are not currently available.

RECOMMENDATIONS

A number of recommendations were made in the Dementia Strategy, framed around the following areas. A full list of these recommendations is included at Appendix D.

- Enabling equal, timely access to diagnosis and support

- Promoting health and well-being

- Developing a dementia friendly town

- Supporting carers of people with dementia

- Preventing and responding to crisis

- Evidence-based commissioning

OLDER PEOPLE WITH DEPRESSION

KEY FINDINGS

- Nationally, it is known that one in five older people living in the community and 40% of older people living in care homes are affected by depression. This assessment has not explored this locally, but it is important to remain cognisant of this and of the fact that there are barriers to diagnosing and treating depression in older people

- Social care data show 242 people with Mental Health Disorders in receipt of social care services, of which 67% are aged over 65. There tends to be more people with mental health issues receiving social care in the age ranges 76-85. It is not clear whether this figure includes people with depression.

CONSIDERATIONS

- Review Dementia Commissioning Strategy on a 6 monthly basis and present progress report to the Health & Wellbeing Board
- Public Health to review the recently released toolkit for preventing dementia, comparing with local practices

PEOPLE WITH LEARNING DISABILITIES AND / OR AUTISTIC SPECTRUM DISORDER

National Context

Between 25 and 40% of people with learning disabilities also experience mental health problems. People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities. Data are old, based mainly on findings from academic work in the late 1990s, but show the following:

Reported prevalence rates for anxiety and depression amongst people with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general population and higher amongst people with Down's syndrome

- Challenging behaviours (aggression, destruction, self-injury and others) are shown by 10%-15% of people with learning disabilities, with age-specific prevalence peaking between ages 20 and 49
- The prevalence of dementia is much higher amongst older adults with LD compared to the general population (21.6% vs 5.7% aged 65+) and people with Down's syndrome are at particularly high risk of developing dementia, with an age of onset 30-40 years younger than the general population
- Prevalence rates for schizophrenia in people with learning disabilities are approximately three times greater than for the general population (3% vs 1%)

The National Autistic Society highlights the reasons that anxiety disorders are very common amongst people on the autism spectrum. Roughly 40% have symptoms of at least one anxiety disorder at any time, compared with up to 15% in the general population. Understandably, this can lead to sadness or depression – one reason why a mixture of anxiety and depression is common.

It is thought that a combination of factors, leading to vulnerability to stress, is likely to explain why anxiety disorders are so common in autistic people. Biological differences in brain structure and function, a history of social difficulties (leading to decreased self-esteem and a tendency to think of threats as greater than they are) and problems with finding flexible responses to apparent threats are all likely to contribute.

- Mental health services for people with LD and people with ASD should provide specialist and personalised assessment, and care, treatment and support. The aim is to both minimise the impact of mental illness and behavioural problems in order to achieve an individual's maximum potential and a life that that is fulfilling and integrated with the rest of society. The Green Light Toolkit, developed by the National Development Team for Inclusion (NDTi), are practical new materials designed to help improve the quality of mental health services for adults with learning disabilities and/or autism.

PREVALENCE And LOCAL PICTURE

Prevalence Estimates

Applying mental health prevalence estimates to 2015 estimates suggest the following for Luton:

- Between 21and 33 people aged 18-64 with a learning disability are also estimated to have a mental health disorder (25% to 40%)
- 2.4 people aged 18-64 with a learning disability are estimated to have a Schizophrenia (3%)
- 542 people aged 18-64 with an Autistic Spectrum Disorder are estimated to have a co-existing anxiety disorder at any given time (40%)

Anecdotal evidence suggests that there are hidden mental health problems in some people with LD or ASD.

A case study example shows an individual with ASD who is exhibiting risky behaviour and a lack of personal care who is a danger to others and himself. He has a fixation with the police and makes hoax calls, but he will not agree to a mental health assessment and his behaviour is not sufficiently concerning to be able to detain him against his will. He is likely to have unmet mental health needs in addition to his ASD.

ELFT currently provides services for people who experience Mental Health in isolation and also manages those services where Mental Health intersects with LD or ASD where mental health is the primary need.

Medical advances mean that children with Learning Disability are more likely to survive and, although the primary pressure will be on services which support extreme needs, it is also likely that there will be increased pressure on mental health services as this population cohort moves into adulthood and beyond. Inpatient figures at the Coppice for the last 6 months show 19 admissions and there are currently 8 inpatients, but it is not possible to differentiate between people from Bedford and people from Luton.

There is a need to access more comprehensive and specific ELFT data to illustrate current demand for mental health services by people with LD and ASD in order to estimate likely future levels.

The Venn diagram (below) shows the interplay between Learning Disability (LD), Mental Health and Autistic Spectrum Disorder (ASD). People may have one of these conditions in isolation, or may have LD and a mental health issue or ASD and a mental health issue. For a minority, the intersection may be across all three conditions. Care is given according to the primary need of the individual and may shift from one area of the diagram to another according to changing need, which for each aspect is on a sliding scale.

NICE GUIDANCE

Title	NICE Guidance with brief description
Mental health problems in people with learning disabilities: prevention, assessment and management	https://w00ww.nice.org.uk/guidance/ng54 This guideline covers preventing, assessing and managing mental health problems in people with learning disabilities in all settings (including health, social care, education, and forensic and criminal justice). It aims to improve assessment and support for mental health conditions, and help people with learning disabilities and their families and carers to be involved in their care.
Improving Access to Psychological Therapies (IAPT): Learning Disabilities Positive Practice Guide	https://www.mentalhealth.org.uk/sites/default/files/FPLD-positive-practice-guide.pdf This Positive Practice Guide, which is written by experts in learning disabilities, summarises the needs of people with learning disabilities and clearly outlines the reasonable adjustments that are recommended to ensure that people with learning disabilities get the maximum benefit from treatment within an IAPT service.

PEOPLE WITH LEARNING DISABILITIES AND / OR AUTISTIC SPECTRUM DISORDER - continued

KEY FINDINGS

- Up to 40% of people with LD also have mental health problems with higher prevalence than people without LD across the complete spectrum of mental health problems.

- Around 40% of people with ASD are estimated to have a co-existing anxiety disorder compared with up to 15% of the population without ASD.

- There is greater potential for mental health problems to remain hidden or undiagnosed in people with LD and ASD and it is almost impossible to give accurate estimates. It is estimated that prevalence will increase in the future as people with LD are both surviving beyond early years and living longer into old age. Service data that tells us about current demand will help to estimate and plan for the future, but this has not been available for this assessment.

- People with Downs Syndrome are significantly more likely than the population without Downs Syndrome to have dementia, particularly early onset dementia.

- People with mental health issues who also have LD may have specific needs when it comes to accessing psychological therapies.

- The nationally-developed Green Light Tool for local services to review their own quality and share and replicate good practice and it is important to raise organisational awareness of this tool.

CONSIDERATIONS

- Consider adding a separate schedule in any future mental health contract that will cover specialist Learning Disability Services

- When Community Mental Health Services are recommissioned, review the Ten Key Messages for Commissioners (mental health services for people with learning disabilities), comparing against local practice and ensuring a joined up approach which meets intersecting needs (mental health, LD, ASD). The Ten Key Messages are included in this document at Appendix E.

SECTION 2: RISK & PROTECTIVE FACTORS

MARGINALISED GROUPS: The effects of inequality on Mental Health

National Context

- People in marginalised groups are at greater risk of mental health issues, including black, Asian and minority ethnic (BME) people, lesbian, gay, bisexual and transgender (LGBT) people, disabled people, and people who have had contact with the criminal justice system
- Rates of schizophrenia are 5.6 times higher in black Caribbean people, 4.7 in black Africans and 2.4 times higher in Asian groups. Black populations have highest rates of PTSD, suicide attempts, psychotic disorder and any drug use/ dependence. White populations have highest rates of suicidal thoughts, self-harm and alcohol dependence. South Asian women have highest rates for common mental disorders.
- People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk.
- Rates of mental disorder are several times higher for refugees and asylum seekers.

A number of indicators suggest that there are additional mental health risk factors in Luton. Wider determinants such as domestic abuse, low educational attainment and housing issues are all higher when compared to England and to its comparator peer areas.

Accurate data are not available to estimate the number of people living in Luton in groups with an identified higher risk of mental health issues. This includes LGBT people, refugees and asylum seekers and people in contact with the criminal justice system. However, it is likely that there are sizable populations of each of these groups living in Luton and it is important that services consider how to meet these specific needs and extend to those who may be harder to reach.

There are data around ethnicity, so we know that Luton is a super-diverse town and the approximate proportions that make up each ethnic group. Data are not, however, available to help us to understand how well local services are meeting the needs of each ethnic group, or whether there has been a reduction in inequality in relation to mental health.

Ethnicity is a key factor in determining rates and experiences of mental health problems. Local data would provide a more accurate assessment of local need, a view of how well Luton does in providing culturally appropriate treatments and reducing inequality gaps in relation to mental health. Indications from this assessment include the following:

- Local suicide rates do not appear affected by ethnicity
- Amongst the cases analysed for the suicide audit, people who were not from a White, European-born environment were much less likely to have sought or received help for depression
- There are high numbers of young South Asian women in Luton – this has been identified nationally as a key and growing risk for self-harm
- Serious mental illness may be a contributory factor in the vulnerability or rough sleeping status of NOAH service users who are of Asian ethnicity
- There are differences in prevalence and recognition of dementia among different ethnic groups. There are higher rates among Black Caribbean older people
- The majority of people who are assessed for diversion to mental health services through the criminal justice system are White British males. Asian males are particularly under-represented, although the reasons for this are not understood (data is for the whole of Bedfordshire so may distort the Luton picture)
- White people appear over-represented in IAPT treatment and Asian people under-represented

National Findings on MH Experience by ethnicity

People from black and minority ethnic groups living in the UK are more likely to be:

- diagnosed with mental health problems
- diagnosed and admitted to hospital
- experience a poor outcome from treatment
- disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health

Factors include poverty and racism. Mainstream mental health services often fail to understand or provide services that are acceptable and accessible to non-white British communities and meet their particular cultural and other needs.

Likelihood of mental health problems being unreported and untreated because people in some ethnic minority groups are reluctant to engage with mainstream health services. Mental health problems may also be over-diagnosed in people whose first language is not English.

KEY FINDINGS

- Intelligence gaps remain in relation to people living in Luton in groups with an identified higher risk of mental health issues. For example, we do not have access to data about LGBT people, refugees and asylum seekers and people in contact with the criminal justice system

- As detailed below ("Local Findings on MH Experience by ethnicity"), ethnicity is a key factor in determining rates and experiences of mental health problems

- There are people in Luton who have lived in war zones and escaped conflict and horror and some of these people will have post-traumatic stress syndrome. It is important to ensure that these people are aware that help is available and should be sought

- There is a high prevalence of mental health conditions amongst the most vulnerable individuals such as rough sleepers. An aggravating factor is that Luton is 5th highest when compared nationally for rough sleeping rates illustrating the need for a 'whole council' approach to this public health concern

- The most vulnerable homeless people and rough sleepers (NOAH service users) are more likely to have a mental health condition when compared with the Luton population and five times more likely to have been diagnosed with a psychosis, particularly schizophrenia. Other vulnerable people (Penrose service users) are also more likely to have a mental health condition when compared with the Luton population, but further granular detail is not available. 26% of service users in both NOAH and Penrose are reported to have a mental health condition

- Female service users, although much smaller in number compared to males, are most affected and there is variation across different ethnic groups. For women and some ethnic groups, Mental Health appears to be a key contributory factor in their vulnerability or rough sleeping status

- Only 12% of the NOAH service users who have self-reported to have mental health difficulties stated that they were supported with their mental health and that it supports their needs. Some users stated that they were receiving help but needed more and 20% stated that they needed help with their mental health but were not receiving any

- Drug and Alcohol use and dependence are a significant factor, affecting up to half of all NOAH service users with a mental health condition

Findings from Mental Health Foundation on MH Experience by ethnicity

ETHNICITY

The statistics on the numbers of Asian people in the United Kingdom with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognised or not diagnosed in this ethnic group.

Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support.

Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups. Indian men have a high rate of alcohol-related problems.

Research has suggested that Western approaches to mental health treatment are often unsuitable and culturally inappropriate to the needs of Asian communities. Asian people tend to view the individual in a holistic way, as a physical, emotional, mental and spiritual being.

Irish people living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups. In particular they have higher rates of depression and alcohol problems and are at greater risk of suicide.

These higher rates may, in part, be caused by social disadvantage among Irish people in the UK, including poor housing and social isolation. Despite these high rates, the particular needs of Irish people are rarely taken into account in planning and delivering mental health services.

African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African-Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia.

However, most of the research in this area has been based on service use statistics. Some research suggests that the actual numbers of African-Caribbean people with schizophrenia is much lower than originally thought.

African Caribbean people are also more likely to enter the mental health services via the courts or the police, rather than from primary care, which is the main route to treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication, rather than be offered talking treatments such as psychotherapy, and are over-represented in high and medium secure units and prisons.

This may be because they are reluctant to engage with services, and so are much more ill when they do. It may also be that services use more coercive approaches to treatment.

There is very little knowledge of the extent of mental health problems in the Chinese community.

It has been suggested that the close-knit family structure of the Chinese community provides strong support for its members. While this may be beneficial, it may generate feelings of guilt and shame, resulting in people feeling stigmatised and unable to seek help.

https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities

BME Autism
Trauma Refugee
Learning Disability
Inequality LGBT
Housing Asylum Seeker
Offender Homelessness
Disability
Marginalisation

Inequality is a key factor in determining mental health

There are identifiable risk populations where interventions should be targeted

CONSIDERATIONS

- Mental Health First Aid training to be mandatory for key front line staff

- Ensure that services are available to all and are de-stigmatised. Sustainable Transformation Plan (STP) project groups must be cognisant of the inequalities raised in this assessment, specifically in relation to gender, ethnicity, people who are vulnerable or marginalised, veterans, people involved in the criminal justice system, survivors of sexual abuse and carers.

- Need to improve intelligence collection / recording of data to help to evaluate the specific needs of the various populations that have been identified as at risk. Make use of partnership links to better identify needs.

- Need to tailor approaches to improve mental health in specific groups (community approaches)

- Consider the use of social and other media to promote positive mental health and signpost to services and sources of help. Tailor appropriately for specific groups, especially the hard to reach.

- Ensure that services are culturally sensitive and adaptable enough to adopt a 'whole person' approach whereby physical, emotional and spiritual needs are considered as part of mental health.

- Consider how to meet the needs of those who find it hard to attend appointments, to commit to regular appointments or to comply with the expectations of service providers. For example, adopt more effective outreach services. Take services to organisations such as Noah's where vulnerable individuals already feel safe rather than expecting them to attend specific locations where mental health services have traditionally been delivered.

- Train key individuals in faith and other community groups to recognise mental health problems and signpost appropriately

VETERANS

National Context

- Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder (PTSD) seek help from the NHS and those that do are rarely referred to the right specialist care. NHS England is currently consulting on the future of mental health support for this group and it is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly.

- A study in 2015 found that Veterans aged 16 to 54 are more likely to experience common mental health problems, such as depression and anxiety, than comparable age groups in the general population and that veterans who have experienced combat are more likely to experience PTSD. There is growing evidence that some cases of PTSD occur years after they have left the services.

PREVALENCE

Prevalence Estimates

Data provided by NOAH suggests that veterans form only a very small fraction of the rough sleeping population in Luton (3%). The data also show that 50% (n=23) of the NOAH service users who are ex-military have self-reported mental health issues compared to 26% of all NOAH service users. Although very low in number, being ex-military appears to be a contributory factor in mental health amongst rough sleepers in Luton.

Other local data are not available relating to veterans and this remains an intelligence gap.

Veterans are at greater risk of mental health problems…..

but less likely to seek help ….

And less likely to receive the help they need

KEY FINDINGS

- It is not clear whether Luton has a sizeable veteran population, whether Luton veterans are vulnerable to mental health issues or whether the needs of any veteran population that does exist in Luton are being met by local services. However, data do show that rough sleepers in Luton who are veterans, are almost twice as likely to self-report a mental health issue than the general rough sleeping population in Luton

- A Veteran MHNA was completed in 2012 on behalf of NHS Bedfordshire and covering Bedford and Central Bedfordshire. It would be important to review this document when considering any new recommendations

- People other than veterans (such as refugees or asylum seekers) are living in Luton who also may have previously been in conflict zones or experienced horrific events on a mass scale

- Mental Health problems such as PTSD may occur many years after the events that caused them

- Recovery rates for IAPT services for PTSD are in the top three nationally. Between 60 and 63% achieve recovery

CONSIDERATIONS

- Review the NHS Bedfordshire Veteran Mental Health Needs Assessment (September 2012) with a view to developing the Luton picture.

- Explore within Luton Borough Council and partner organisations to determine how the size and composition of the veteran population can be captured to further determine whether there is a need for veteran-specific signposting or tailored mental health services in Luton. GPs, for example, may already be collating this data.

National Context

- Mental health problems are very common in people in contact with the criminal justice system.
- An estimated 39% of people detained in police custody have some form of mental disorder, and over 25% of residents in approved premises (previously known as bail hostels) have been found to have a psychiatric diagnosis.
- It has been estimated that over 90% of prisoners have at least one of the following psychiatric disorders as well as there being a very high smoking rate amongst prisoners (80% of prisoners are smokers): psychosis; anxiety or depression; personality disorder; alcohol misuse; drug dependence
- Self-harm is very common among people in contact with the criminal justice system and the risk of suicide is much higher when compared to the general population

PREVALENCE

Prevalence Estimates

The crime deprivation score for Luton is statistically higher when compared to England as is violent crime (hospital admissions for violence). Mental health service demand created by people who have been in contact with the criminal justice system is likely to be higher when compared to England if such people have a mental health diagnosis. Liaison & Diversion Service (L&DS) Team data provides some insight (Feb to Apr 2017 – 353 individuals, 194 Luton-based):

- 85% of individuals were male and 15% female. One individual was transgender
- 74% were aged between 25-55; 12% between 18-24; 10% were aged 55+
- The majority were White British (60%). 10% were Black, but only 7% were Asian, which is particularly low when compared to the Asian population in Luton
- 7 of the individuals (2%) were identified as having a learning disability
- 20% reported difficulties with substance use (problematic use or dependence). A link has been noted between use of synthetic cannabis and violent crime which sometimes results in diversion under. Part II or Part III of the MHA
- 16% reported difficulties with alcohol use (harmful, hazardous or dependent)
- 16% had an accommodation need
- 14% were identified as being at risk of self-harm and/or suicide
- 17% of clients had a depressive illness, but the proportion of people identified as having schizophrenia or another delusional disorder is high, particular given a much lower prevalence of schizophrenia in the general population compared to the depression prevalence
- 36% had previous contact with mental health services

Among prisoners, 46% of men and 21% of women said they had attempted suicide at some point in their lives

This is considerably higher than in the general UK population, with 6% of people saying they have ever attempted suicide

NICE GUIDANCE

Title	NICE Guidance with brief description
Mental health of adults in contact with the criminal justice system	https://www.nice.org.uk/guidance/ng66
	This guideline covers assessing, diagnosing and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system. It aims to improve mental health and wellbeing in this population by establishing principles for assessment and management, and promoting more coordinated care planning and service organisation across the criminal justice system.
Physical health of people in prison (includes Mental Health)	https://www.nice.org.uk/guidance/ng57
	This guideline covers assessing, diagnosing and managing physical health problems of people in prison. It aims to improve health and wellbeing in the prison population by promoting more coordinated care and more effective approaches to prescribing, dispensing and supervising medicines.

KEY FINDINGS

- National evidence shows a clear relationship between mental health and contact with the criminal justice system, which is being tacked locally through L&DS work
- Local prevalence is unclear, but is likely to be higher compared to England due to socio-economic factors in Luton and a particularly high crime deprivation score
- Targeting mental health services at this group should result in financial savings across the public sector as well as giving some of the most vulnerable people in Luton a chance to live more fulfilling lives
- There is a need for local data to properly understand this group of people and their mental health needs. L&DS evidence suggests most are White British males. Asian males are particularly under-represented, although the reasons for this are not understood (data is for the whole of Bedfordshire so may distort the Luton picture)
- There are clear links with alcohol or drug misuse and concerns about increasingly violent offences due to use of synthetic cannabis
- 14% were identified as being at risk of self-harm and / or suicide
- The proportion of people identified as having schizophrenia or another delusional disorder is high (10%) given that there is a much lower prevalence of schizophrenia in the general population. The highest proportion of L&DS clients (17%) had depressive illness
- People leaving prison need to be registered with a GP so that any mental health needs are appropriately treated.

CONSIDERATIONS

- Find out release arrangements, particularly around obtaining a GP and explore any factors that would improve this process for future releases

SURVIVORS OF CHILDHOOD SEXUAL ABUSE

National Context

Not everyone who experiences abuse will suffer a mental health issue and it is important to distinguish normal responses to 'abnormal' events, from mental health problems. It is very common and in fact quite normal to experience confusion, fear, low self-esteem, shame, anger, sadness and other extremes of emotion following abuse. It is important that help in the form of a counsellor or professional, or even a supportive friend is given, so that these feelings can be worked through before any more lasting issues may present.

For many survivors however, there will be more serious difficulties. Many survivors experience anxiety, depression and post-traumatic stress disorder as they struggle to come to terms with the traumas they have endured.

PREVALENCE

Prevalence Estimates

Pansi estimates show that between 15,135 and 15,829 people in Luton are survivors of childhood sexual abuse with the majority (68%) being female, compared to 32% who are male.

Whilst actual rates are hard to capture, local estimations[1] suggest that half of all IAPT referrals present with a set of symptoms indicating Post-Traumatic Stress Disorder (PTSD) and that PTSD rates are much higher in Luton than other areas. Although not currently recorded, it is believed that half of these relate to sexual abuse or sexual abuse from childhood. A similar rate of childhood sexual abuse is believed to be a factor in referrals presenting with other common mental health conditions such as Generalised Anxiety Disorder, Depression or Insomnia.

Local estimates are that around half of all females presenting for IAPT treatment have experienced childhood sexual abuse. Ideas of masculinity add to the stigma for males and they may be less willing to disclose as a result, although males are known to be much less likely to have experienced childhood sexual abuse.

Childhood sexual abuse is a key factor in poor mental health in adults.

More than twice as many females affected compared to males although issues around disclosure may be compounded for males

Denial, fear of disclosure, stigma and societal or cultural taboos all work to prevent people getting the help they need

BARRIERS

Societal and family taboos mean that childhood sexual abuse is often a particularly hidden problem and may remain hidden throughout a course of treatment, which means that it can never be properly addressed.

A further barrier to successful treatment is the individualised approach to what is a familial or systemic issue. This is a particular issue in Luton where cultural factors in some communities compound stigma and taboo, and where disclosure and family acceptance of disclosure would lead to a dismantling of family systems. There are some systemic therapists in Luton Wellbeing Services, but these can only help where families are willing to engage in the process, which often will not be the case.

NICE GUIDANCE

REF	Title	NICE Guidance with brief description
CG89	Child maltreatment: when to suspect maltreatment in under 18s	https://www.nice.org.uk/Guidance/CG89 This guideline covers the signs of possible child maltreatment in children and young people aged under 18 years. It aims to raise awareness and help health professionals who are not child protection specialists to identify the features of physical, sexual and emotional abuse, neglect and fabricated or induced illness.

KEY FINDINGS

- Childhood sexual abuse is a significant factor in mental health and is, by its nature, a particularly hidden problem. Factors hindering disclosure are denial, shame, fear of disclosure, stigma and taboo

- Luton has particularly high rates of PTSD compared to other areas and around half of these are believed to be due to childhood sexual abuse

- Cultural factors in Luton may compound issues relating to disclosure and also successful treatment following disclosure. These issues relate to the systemic nature of the problem and individualised treatment options

CONSIDERATIONS

- Luton Wellbeing Service to record childhood sexual abuse in order to better identify prevalence and assessment of need

- The effects of stigma are of paramount importance in tackling mental health issues that stem from childhood sexual abuse. Reducing stigma should be a core part of mental health strategy (see section in this assessment on stigma)

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[1] Dr Syed Ali Naqvi, 07 July 2017, Luton Wellbeing Service

CARERS

National Context

- Carers have a unique role to play for some people with mental health problems, and are often responsible for navigating complex health and social care systems and providing support to help the person manage. This includes the children of parents with mental health problems, who are likely to provide a caring role. Mental health practitioners should have the knowledge and skill to involve carers appropriately, including working with the person using the service and carers to determine what information can be shared between the three parties.

- National work by Time to Change has found that carers are affected by stigma and discrimination in a similar way as service users, albeit at a lower level. Carers felt that they were prevented from participating in 'normal' life activities, but also that they were afraid to disclose the mental health status of the person they were caring for in anticipation of stigma and discrimination. Examples given in the study include carers pretending to be sick in order to take a day of work to care for someone with a mental health problem.

Prevalence Estimates

National data suggests that Luton compares well in terms of indicators on carer rates and wellbeing levels. The proportion of unpaid carers in Luton is significantly lower than the England average. It is, however, not possible to accurately assess levels as much of caring is done as family duty and may not be officially recognised.

The results of the Personal Social Services Survey of Adult Carers in England 2016/17 add some context, although the response rate of 41% should be noted. 420 Luton carer responses were received, of which 69 stated that the person they cared for had a mental health problem. This is a fraction of the actual carers in Luton, but never-the-less survey responses for this group may provide some insight. Caring is often a long-term and time-consuming commitment with significant personal, emotional, physical and financial costs to the carer.

- 65% of the carers who responded were between the ages of 30 and 59 and there were still people caring between the ages of 80 and 89 (6%)
- The majority (73%) were women
- 58% of carers were White British, 33% Asian, 6% Black and 3% White Irish
- 28% of carers provided 100 or more hours of care each week. Nearly all (92%) were providing 35 or more hours of care each week
- Over a quarter (28%) had been caring for over 5 years, but less than 10 and nearly a quarter (24%) had been caring for over 10 years, but less than 15.

Factors affecting Carers	Percent "Yes"
Feeling tired	80%
Depression	52%
Disturbed sleep	76%
Stress	56%
Back pain / other physical stress	44%
Financial Difficulties	48%
Employed full time	8%
Mental Illness	12%
Respite Care	8%

These tables show some of the issues highlighted in the survey results. The results are specifically for people caring for someone with a mental health issue.

Despite these factors, which suggest significant personal cost, only 12% of respondents expressed dissatisfaction with Social Services support and services

Every carer should have a personal assessment and Luton is in the average range when compared to England on this measure.

Public Health England (PHE) data for 2013/14 show that 1,460 adult carers in Luton received an assessment with this equating to a crude rate of 946 assessments per 100,000 people. For 2011, PHE data shows that 4,445 people are providing unpaid care.

Activity / support	Percent "Not enough" or "none"
Spend time doing things I enjoy	84%
Have control over daily life	84%
Care for self	56%
Feel safe	36%
Have social contact	68%
Have carer support and encouragement	72%

- Carers are affected by stigma and discrimination to the extent that some would rather take a day off sick from work than admit to an employer that they need time to care for a person with a mental health issue

- Luton compares well nationally in relation to carer and carer assessment rates and well-being levels.

- Responses to the Adult Carer survey by people who care for people with mental health issues indicate that caring is often a long-term and time-consuming commitment with significant personal, emotional, physical and financial costs to the carer. Despite this, most respondents were satisfied with Social Services support and services

- Adult Social Care to explore how we can move into the top quartile for carer assessment rates

National Context

Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45%. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. In spite of this, fewer than 15% of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25%.

Wellbeing can be used as a measure of social progress and relates to creating the conditions in society for individuals to thrive. The World Health Organization (WHO) defines wellbeing as a state where everyone is able to realise their potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.

LOCAL PICTURE

Compared with benchmark ● Better ● Similar ● Worse ○ Not Compared

Indicator	Period	Luton Recent Trend	Luton Count	Luton Value	Region Value	England Value	England Worst/ Lowest	England Range	England Best/ Highest
2.11iii - Average number of portions of vegetables consumed daily (adults)	2015	–	-	2.04	2.34	2.27	1.70	●	3.00
Percentage of adults who do any walking, at least once per week	2014/15	–	-	76.0	80.2	80.6	70.4	●	92.6
Percentage of adults who do any walking, at least five times per week	2014/15	–	-	41.5%	49.1%	50.6%	39.9%	●	68.1%
Percentage of adults who do any cycling, at least three times per week	2014/15	–	-	3.2%	5.4%	4.4%	0.7%	●	19.0%
Percentage of adults who do any cycling, at least once per month	2014/15	–	-	9.4%	16.9%	14.7%	5.6%	●	34.2%

Where prevalence data are available, they show that sections of the Luton population are more likely to be obese, to have a sedentary lifestyle and poor diet and to suffer from related health conditions.

The table above shows information from Public Health England relating to healthy lifestyle. It shows that, generally, Luton has statistically worse rates when compared to England.

The adult obesity rate (64.6%) in Luton is similar to England. However, the rates of childhood obesity are statistically greater when compared to England, which suggests the potential of worsening future problems.

Current adult obesity rates show inequalities across a range of social factors. White and Black populations are most likely to be obese; the adult obesity rate for White people in Luton is 66% and for Black people it is 67%.

People aged over 35 are most likely to overweight or obese with between 70% and 73% of the over 35 age groups falling into this category. Males are more likely to be overweight or obese than females with 68% of males being overweight or obese compared to 61% of females.

Disabled people are more likely than any other group to be overweight or obese; 76% of disabled people are shown as being overweight or obese compared to 63% of non-disabled people.

The rate of emergency admission for COPD (542 per 100,000 population) is statistically higher than England and there is a clear relationship with deprivation. The rate is 719 per 100,000 population in the most deprived decile. There is also a gender disparity with the rate for males being 438 per thousand population and for females 395 per thousand population.

Diabetes prevalence is statistically higher (7.6%) in Luton when compared to England. The rate rose steadily between 2009/10 and 2014/15, but has since levelled out (2015/16).

According to self-reported satisfaction surveys, the people of Luton have similar feelings of well-being when compared with England and comparator areas. However, there are a number of known risk factors that have been discussed throughout this assessment which are likely to affect wellbeing for specific groups, particularly those with adverse social and economic circumstances.

Luton Council and Luton CCG Commission a range of Mental Health and Wellbeing services from a number of providers through different contracts:

- IAPT – East London Foundation Mental Health Trust
- Primary Care Link Workers – East London Foundation Mental Health Trust
- Healthy Lifestyles – Live Well Luton
- Weight Management – Live Well Luton
- Smoking Cessation – Live Well Luton
- Social Prescription – Live Well Luton and Active Luton

WHO - RISKS TO MENTAL HEALTH: AN OVERVIEW OF VULNERABILITIES AND RISK FACTORS
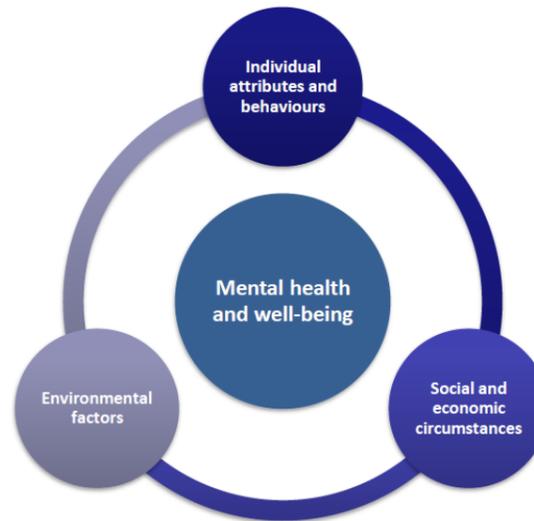
Level	Adverse factors		Protective factors
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety

Luton wellbeing service is currently in the process of being re-tendered, moving to a prime provider model where one provider co-ordinates all wellbeing services, working with local partners ('home grown partnerships') to deliver a range of services. The service is due to start in April 2018 and commissioning requirements include:

- Single access point / central hub for all services / co-ordinated approach
- Integrated approach to physical and mental health
- Bespoke packages with whole person approach to health
- Targetted services with digitised signposting for those who can self-serve, move away from funding people who are already self-motivated
- Peer support and connection to local resources
- Prevention of crisis
- Reduction of stigma
- Care close to home
- Focus on outcomes
- Improved pathways to other services (e.g. Drug and Alcohol Services)

Draft Wellbeing Model (Luton)
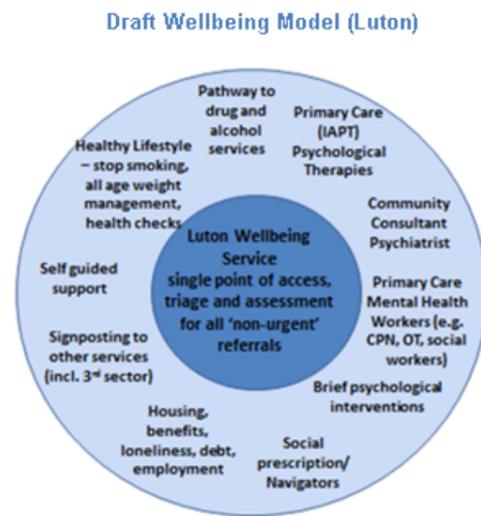
Expected benefits:

- Improved recovery and personal resilience
- Digital offer
- Reduction in GP and A&E attendances
- Reduced referrals into mental health trust
- Optimise community involvement
- Consistency of service offer across Luton
- Improved pathways to other services and activity
- Maximise use of all community assets

NICE GUIDANCE

Title	NICE Guidance with brief description
Depression in adults with a chronic physical health problem: recognition and management	https://www.nice.org.uk/guidance/CG91
	This guideline covers identifying, treating and managing depression in people aged 18 and over who also have a chronic physical health problem such as cancer, heart disease or diabetes. It aims to improve the care of people with a long-term physical health problem, which can cause or exacerbate depression. This had the potential to increase their quality of life and life expectancy.
Healthy workplaces: improving employee mental and physical health and wellbeing	https://www.nice.org.uk/guidance/qs147
	This quality standard covers the health and wellbeing of all employees, including their mental health. It describes high-quality care in priority areas for improvement. It does not cover managing long-term sickness absence.
Behaviour change: individual approaches	https://www.nice.org.uk/guidance/ph49
	This guideline covers changing health-damaging behaviours among people aged 16 and over using interventions such as goals and planning, feedback and monitoring, and social support. It aims to help tackle a range of behaviours including alcohol misuse, poor eating patterns, lack of physical activity, unsafe sexual behaviour and smoking.
Alcohol-use disorders: prevention	https://www.nice.org.uk/guidance/ph24
	This guideline covers alcohol problems among people over 10. It aims to prevent and identify such problems as early as possible using a mix of policy and practice

CURRENT RESPONSE

The next phase of IAPT will focus on the interplay between physical and mental health, but Essex Partnership University NHS Foundation Trust (EPUT) already provides a range of clinical health psychology services in recognition of this. Services include the following:

- Bariatric and Obesity
- Chronic Obstructive Pulmonary Disease (COPD) and Diabetes
- Cancer and Palliative Care Psychology
- Centre for all families positive health
- Chronic Fatigue Syndrome
- Musculoskeletal Pain Management

KEY FINDINGS

- Physical and Mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people

- Population risk factors are present in Luton, with inequalities evident in terms of gender, ethnicity, age and disability

- Data not available to support evaluation of clinical health psychology services

CONSIDERATIONS

- Public Health to ensure that mental health is integrated in the Physical Activity Strategy

National Context

NICE have published a study on smoking rates among people with Mental Health problems and found that smoking is substantially more prevalent among people with mental disorders compared to the general population and that:
- o Up to 3 million smokers in the UK, approximately one third of all UK smokers, also have evidence of mental disorder
- o In contrast to the progressive decline in smoking prevalence over time in the general population, smoking among those with mental disorder has declined only minimally in nearly 20 years
- o Smokers with mental disorders are more likely to be heavily addicted to smoking
- o Smokers with mental disorders are just as likely to want to quit as those without, but are more likely to anticipate difficulty in doing so

PREVALENCE

Prevalence Estimates

Smoking rates in Luton compare favourably to England and comparator areas. This looks surprising when other indicators, such as deprivation or smoking related hospital admissions are taken into account. There is expected to be a correlation between high levels of deprivation and high smoking rates. This is not seen in Luton where there are high deprivation levels and relatively low smoking rates.

It is likely that the 'whole Luton' population approach masks pockets of particular types of deprivation, influenced by cultural factors such as ethnicity that lead to particularly high smoking rates in some groups of people, with the overall picture distorted by particularly low rates in other groups.

Given the national findings around smoking rates amongst people with mental illness, it is likely that people with mental illness in Luton are one of these subsets (pockets) of people who have high and heavy smoking rates.

Smoking is likely to be used as a coping mechanism for people with mental health problems and stopping smoking may lead to a decrease in coping and / or an increase in symptoms such as anxiety. However, smoking is likely to be a key determinant in higher mortality rates in people with mental health issues. It is therefore crucial that services explore how best to support people with mental health problems who want to stop smoking.

NICE GUIDANCE

REF	Title	NICE Guidance with brief description
PH48	Smoking: acute, maternity and mental health services	https://www.nice.org.uk/guidance/ph48 This guideline covers helping people to stop smoking in acute, maternity and mental health services. It promotes smoke free policies and services and recommends effective ways to help people stop smoking or to abstain from smoking while using or working in secondary care settings.
PH39	Smokeless tobacco: South Asian communities	https://www.nice.org.uk/guidance/ph39 This guideline covers people living in England with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka who use traditional South Asian varieties of smokeless tobacco. The aim is to help them stop using tobacco that is placed in the mouth or nose (but not burned). It does not include oral snuff products that are sucked.
PH1	Smoking: brief interventions and referrals	https://www.nice.org.uk/guidance/ph1 This guideline covers brief interventions and referrals in primary care and community settings for people who smoke. It aims to ensure that everyone who smokes is advised and encouraged to stop and given the support they need. It emphasises the importance of targeting people in hard to reach and deprived groups in which smoking rates are higher.
PH10	Stop smoking services	https://www.nice.org.uk/guidance/ph10 This guideline covers services to help people quit smoking. It aims to reduce the number of people who smoke by ensuring that stop smoking services are as effective as possible. It seeks to raise awareness of the range and types of support available.

KEY FINDINGS

- A third of all smokers nationally have evidence of mental disorder. Smokers are significantly much more likely to have mental health issues. Smoking rates amongst people with mental health issues compare poorly against the national decline in smoking prevalence over the past 20 years.
- Smokers with mental health issues are likely to be heavily addicted to smoking, but are just as likely to want to quit as other smokers.
- Locally, smoking rates appear low compared nationally and to comparator areas, but data is only available for the whole of Luton, which masks pockets of entrenched and heavy smokers who may be contributing to the high rate of smoking related hospital admissions in Luton. Smoking is likely to be a key determinant in the high mortality rate of people with mental health issues.
- The relationship between smoking and deprivation is not linear, but part of the interplay with other social, cultural and environmental factors. People with mental health issues in Luton are likely to be one of the pockets of entrenched and heavy smokers and are likely to need additional support in stopping smoking to ensure long-term quitting success and that mental health conditions are not worsened as a result of quitting.

CONSIDERATIONS

- Front line staff must be proactive in supporting this target group to access stop smoking services.

- The Wellbeing Model Assessment in Luton must be in-depth and flexible enough respond to individual smoking motives.

SUBSTANCE ABUSE

National Context

Substance misuse is the taking of a drug or alcohol in such a way that it leads to harm such as addiction, debt, physical harm, criminal actions and relationship problems. The drugs used may be legal substances (e.g. alcohol), illegal substances, such as opiates (e.g. heroin), stimulants (e.g. cocaine, crack, amphetamines and ecstasy) and cannabis, prescription drugs used in a way not intended by the doctor (e.g. benzodiazepines).

Research shows that substance misuse may cause or increase symptoms of mental illness. On the other hand, mental illness may lead someone to abuse substances as people with mental health issues try to block out their symptoms or the side-effects of medication.

Depression, anxiety and schizophrenia are more likely to be linked to substance misuse and result in a dual diagnosis. The drug use can stop people making a full recovery. It is also more likely to lead to becoming unwell again or to have to be re-admitted to hospital. Dual diagnosis is associated with other problems such as loneliness, homelessness, criminality and having a history of abuse.

LOCAL PICTURE

Luton Borough Council has recently recommissioned its Drug and Alcohol Treatment Services and the new integrated alcohol and drug service, ResoLUTiONs, has been in operation since April 2017. ResoLUTiONs services include health and wellbeing interventions, assessment and recovery planning, training and education, recovery support and substance misuse training for Luton Council and other local organisations.

Delivered by the social care and health charity Change, Grow, Live (CGL), ResoLUTiONs works with a number of partners, including KIKIT, Luton LGBT Links, NOAH, Intuitive Thinking Skills, Stepping Stones and Luton GOAL, to deliver a comprehensive range of services to meet the needs of people in Luton:

- Structured treatment interventions including groups and counselling
- Access to pathways into inpatient and community detox/residential rehabilitation
- Criminal Justice Interventions
- Hospital Alcohol Liaison Service
- Online support
- Substitute Opiate Prescribing
- Blood Borne Virus Interventions & Needle Exchange
- Access to Education, Training & Employment
- Aftercare Support

NICE GUIDANCE

REF	Title	NICE Guidance with brief description
NG58	Coexisting severe mental illness and substance misuse: community health and social care services	https://www.nice.org.uk/guidance/ng58 This guideline covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse. The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.
CG120	Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings	https://www.nice.org.uk/guidance/cg120 This guideline covers assessing and managing people aged 14 years and over with coexisting severe mental illness (psychosis) and substance misuse. It aims to help healthcare professionals guide people with psychosis with coexisting substance misuse to stabilise, reduce or stop their substance misuse, to improve treatment adherence and outcomes, and to enhance their lives.

KEY FINDINGS

- It is recognised that it is good practice to work together where individuals have a dual diagnosis. The implementation of a new Drug and Alcohol Treatment Service is an opportunity for developing a shared understanding of who does what, joint working and shared care plans

CONSIDERATIONS

- In order to improve joint working and avoid duplication, a dual diagnosis protocol has been agreed. All services must work together to ensure that needs are properly met in line with the protocol.

National Context

- Stable employment is a key contributory factor to someone being able to maintain good mental health and, along with other factors such as housing, is an important outcome for their recovery if they have developed a mental health problem.
- Between 60–70% of people with common mental health problems are in work, yet few employees have access to specialist occupational health services.
- For people being supported by secondary mental health services, there is a 65% employment gap compared with the general population.
- People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high.
- Children living in poor housing have increased chances of experiencing stress, anxiety and depression.
- It is widely recognised that work can enrich mental health and provide a sense of well-being. It can prevent mental ill health as well as acting as a positive environment for people recovering from mental ill health. Conversely, however, poor working conditions including job security, low support, workplace bullying and high stress / low reward have been linked to increased sickness.
- Mental health is a leading cause for sickness absence and ill health in the UK and costs employers in the UK £30 billion a year through lost production, recruitment and absence

Support into employment for MH Service users

The East London Foundation Trust (ELFT) Board agreed to partner with the Centre for Mental Health (CMH) and host the Department of Health "Making IPS Work" pilot in June 2015. The pilot officially started on 28 September 2015 and ended 28 March 2017. The pilot developed a new Individual Placement and Support (IPS) service in Luton and converted an existing employment service in Bedfordshire to an IPS service.

The CMH funded two posts using Department of Health Funding for 12 months initially, then extended to 18 month period. At the end of the pilot there were 406 new referrals plus 55 service users transferred from an existing employment service which equates to almost four times the original target. There were 114 paid job outcomes with 6 planned April 2017 job starts, effectively doubling the original target.

IPS has been well established in the Trust and funding will continue for four Employment Specialists and a Manager in Bedfordshire. In Luton there are on-going negotiations to secure permanent funding and the contracts have been extended for three months for the IPS team.

The Key Principles of the IPS Model

Competitive paid employment – if a person can work then they should be paid to.

Zero Exclusion – anyone who is motivated to work should have access irrespective of mental health diagnosis.

Preference led job search – individual choice in job type, hours, environment etc.

Rapid job search – first employer contact with 28 days of programme entry.

Employment Specialists are based in clinical teams.

Time unlimited support – support not just to obtain work but to remain in work.

Benefits advice - Back to Work Calculations so people are aware of financial implications of working.

Job development – Employment Specialists engage with employers to create new opportunities.

TOOLS TO SUPPORT WORKPLACE MENTAL HEALTH

ACAS highlight the need to avoid the anxious organisation: organisations need to recognise the factors that can cause them to become 'anxious organisations', such as ongoing disruptive change and lack of people management skills. The adjacent figure, taken from the ACAS report, shows the types of approach that will assist across the continuum of mental health. It recognises the value of both prevention and support in the workplace.

Mind has developed a 'Workplace Wellbeing Index' which is a benchmark of best policy and practice which allows employers to assess their performance relating to positive mental health and identify areas for improvement. The index highlights the gaps between an organisation's approach to workplace wellbeing and staff perceptions of this.

Mind: Workplace Wellbeing Index, Our benchmark of best policy and practice in workplace mental health https://mind.org.uk/workplace/workplace-wellbeing-index/

Organisational Aims under the continuum of mental health

Employees with positive mental health and no diagnosis of a mental health condition	Employees with positive mental health and a diagnosis of a mental health condition
Trying to prevent the development of negative mental health through preventative approaches, e.g. managing workloads, mindfulness initiatives, awareness of work-life balance issues	*Where the health condition is disclosed, providing support and encouraging self-help in response to diagnosis. Trying to support the ongoing management of the mental health condition through strong leadership and fighting stigma.*
Employees with poor mental health and no diagnosis of a mental health condition	Employees with poor mental health and a diagnosis of a mental health condition
Trying to promote better mental health through good management practices around effective communication, normalisation of mental health issues and coaching for 'coping strategies'	*Trying to encourage a dialogue with individuals about mental health and what reasonable adjustments might help to improve their working life, and provide outside sources of support and advice where appropriate*

Source: ACAS: Dr Maria Hudson 'The Management of Mental Health at Work', 2016
http://www.acas.org.uk/media/pdf/2/p/Mental_health_report_11_Nov_2016.pdf accessed 12 June 2017

Addressing mental health at work ensures a healthier, more supported and more productive workforce.

It can also positively influence the health of the wider Luton population directly (Luton people who work in the town) and indirectly (through the 'ripple effect' as employees adopt healthier behaviours which influence those around them)

Section Continues

EY FINDINGS

- The Individual Placement and Support pilot in Luton exceeded its targets and is the preferred employment model for people accessing mental health services. ELFT aims to widen access to IPS for all its service users.

- Addressing mental health at work ensures a healthier, more supported and more productive workforce. It can also positively influence the health of the wider Luton population directly (Luton people who work in the town) and indirectly (through the 'ripple effect' as employees adopt healthier behaviours which influence those around them)

- ACAS and Mind have produced informative, supportive guides to help employers support employees with their mental health

- Line managers play a crucial role in the promotion of positive mental health at work and need the right level of support and training. This is essential to promote early detection of mental health problems, encourage early disclosure, where appropriate, and facilitate and accommodate an early return to work following sickness absence

- Luton Borough Council regularly run mental health awareness courses (Mental Health First Aid) and offers support with mental health a part of its Employee Assistance Programme. Employees can also access support by self-referring to the Luton Wellbeing Service. Outreach services are available with tailored (e.g. males only) wellbeing services available for teams with topics covered such as stress management or sleep hygiene

CONSIDERATIONS

- Public Health to lead on provision of support to Luton companies and in supporting Luton employees with the aim of tackling stigma and maintaining / improving employee wellbeing.

- Support the expansion of the Individual Placement and Support service in Luton so that all mental health service users can benefit

- Explore the information options produced by national bodies such as ACAS or Mind. Consider joining Mind's Workplace Wellbeing Index to drive forward initiatives that support positive mental health and avoid 'the anxious organisation'. Mental health to be considered during ongoing disruptive change.

- Consider a Luton Wellbeing Service outreach session for teams. This will have positive effects in terms of prevention and productivity. It will also help to tackle the wider issue of stigma

- Continue to run a mental health first aid courses and for managers and ensure that mental health is a part of manager induction

- Encourage line managers to explore how the empowerment of staff can help to promote positive mental health, helping to provide more control over working lives in the context of organisational uncertainty and change. This may help to foster a workplace culture where individuals feel more comfortable and a sense that there is trust in the workplace, helping to minimise anxiety. Small things may make a big difference to people's mental health while at work. Encouraging teams to create a small library of positive books or to go for lunchtime walks all foster a spirit of teamwork as well as creating an environment that is conducive to positive mental health

SECTION 3: CURRENT EXPERIENCES OF MENTAL HEALTH CARE

Preceding sections in this document have sought to understand experience of mental health and mental ill health in Luton. This section, and those that follow, aims to explore the structures and services that currently exist for the Luton population with mental health issues.

National Context

Nearly two million adults were in contact with specialist mental health and learning disability services at some point in 2014/15 – though we know little about the quality of their care and there remains extensive unmet need for mental health care. Three quarters of people with mental health problems receive no support at all. Among those who are helped, too few have access to the full range of interventions recommended by National Institute for Health and Care Excellence (NICE), including properly prescribed medication and psychological therapy.

LOCAL PICTURE

In Luton, there are believed to be between 3,000 and 4,000 people receiving mental health services. Noting the nationally recognised fact that 75% of people with a mental health condition do not receive the help they need, the gap between this and the estimated prevalence of mental health disorders is substantial. Estimated mental health disorder prevalence for Luton is between 21,278 and 22,296.

In addition to retendering the Wellbeing contract, future plans are for a more cohesive and efficient service though actual and virtual partnership working under the Bedfordshire, Luton and Milton Keynes (BLMK) Sustainability and Transformation Plan (STP). Twelve local NHS organisations and four local authorities in Bedfordshire, Luton and Milton Keynes are working together to develop the STP for the area, which aims to improve health services and better join up with social care.

BLMK STP Area

Source: http://www.cnwl.nhs.uk/wp-content/uploads/BLMK-STP-news-Issue-1-2017.pdf
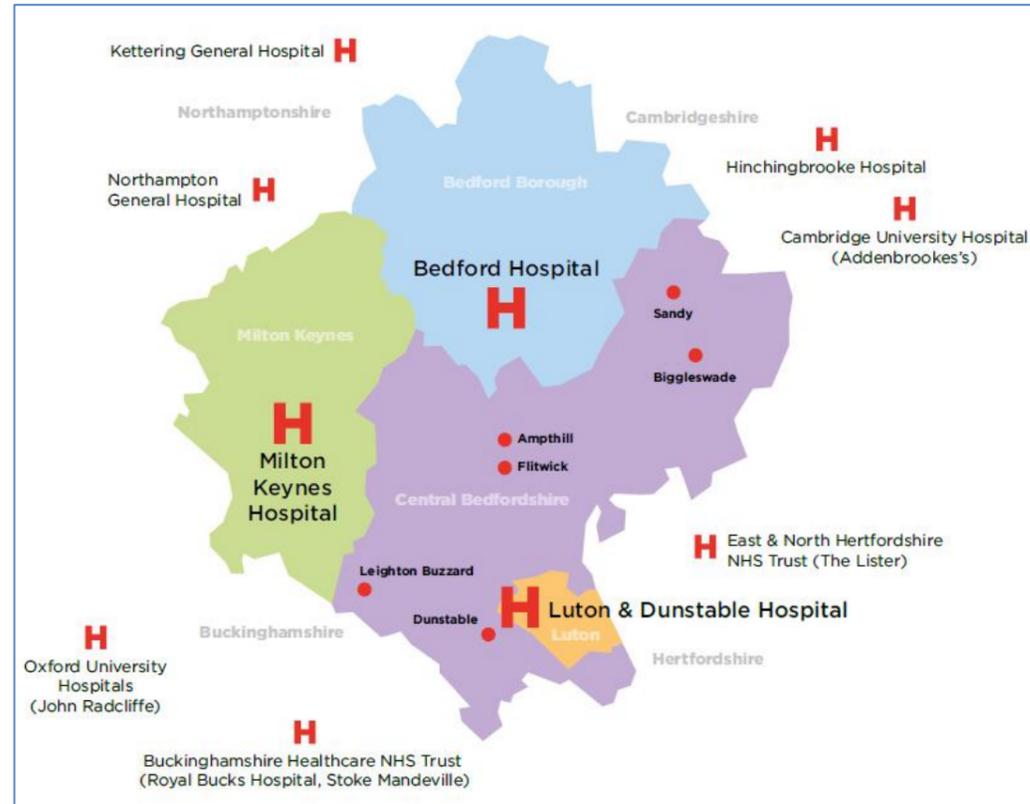
Currently there may be 4 or 5 organisations providing care for one individual, but each working in silo. STP plans aim to streamline services to improve patient experiences and provide one cohesive service. Digitalisation will form a key part of the STP.

Whist recognising that plans for change are happening, the following sections of this assessment explore some of the issues emerging from current Primary, Secondary and Crisis Care services, along with other factors affecting mental health service delivery such as spend, stigma and social prescription. It is not intended to provide a comprehensive analysis of each of these, but instead articulates some of the issues that have been highlighted by data or professional opinion during the writing of this assessment

NICE GUIDANCE

Title	NICE Guidance with brief description
Service user experience in adult mental health services overview	https://pathways.nice.org.uk/pathways/service-user-experience-in-adult-mental-health-services Overview: service user experience in adult mental health services, Care and support of service users across all points on care pathway, Patient experience in adult NHS services

National Context

Nine out of ten adults with mental health problems are supported in primary care.

There has been a significant expansion in access to psychological therapies, following the introduction of the national Improving Access to Psychological Therapies (IAPT) programme. National findings:

- Approximate 50% recovery rate, with month on month improvements
- 48.7% of females and 49.3% of males achieve recovery
- Recovery rates are higher in those aged over 65 (64.7%) than those aged 18-64 (47.6%)
- Recovery rates are higher for White British people (49.5%) than for BME ethnicities (45.7%)
- Females were more likely to finish a course of treatment. 64.9% of females finished a course of treatment compared to 34.1% of males
- Older people were much less likely to finish a course of treatment. Just 7.5% of people aged 65 plus finished a course of treatment compared to 91.4% of people aged 18-64
- Black and Minority Ethnic (BME) people were much less likely to finish a course of treatment. 14.8% of BME people completed treatment compared to 78.6% of White British people

IAPT (LOCAL EXPERIENCE)

- 56% of IAPT referrals are for depression
- White people appear over-represented in treatment and Asian people under-represented (63% of IAPT cohort is White whereas 55% or less of the Luton population are White. For Asian people these figures are 19% and 30%)
- Women are much more likely to be in IAPT treatment than men. Women are 2-3 times more likely to present with most disorders
- The three areas where men are represented more than women are disorders due to alcohol use, mental disorders 'not otherwise specified' and somatoform disorders.
- Adults aged 25 to 44 are most likely to present across a range of disorders relating to anxiety and depression and 60% of the people presenting with alcohol related mental disorder are within this age group
- Young people (16-24 year olds) are more likely to present with Obsessive-compulsive Disorder or a social phobia
- Recovery rates for PTSD (60-63%) and OCD (72%) are in the top 3 in the country

Gender disparity in IAPT treatment may reflect how men view their mental health differently to women. It may be easier to present with a physical symptom (somatoform disorder) or an alcohol problem than break through the stigma associated in particular with men's mental health.

Given that men are three times more likely to commit suicide than women, addressing any barriers to men accessing IAPT services is imperative

Title	NICE Guidance with brief description
Common mental health problems: identification and pathways to care	https://www.nice.org.uk/guidance/CG123/chapter/introduction
	The intention of this guideline, which is focused on primary care, is to improve access to services (including primary care services themselves), improve identification and recognition, and provide advice on the principles that need to be adopted to develop appropriate referral and local care pathways. It brings together advice from existing guidelines and combines it with new recommendations concerning access, assessment and local care pathways for common mental health disorders.
Common mental health disorders in primary care overview	https://pathways.nice.org.uk/pathways/common-mental-health-disorders-in-primary-care
	Overview: Care pathways, identification, treatment and referral (Antenatal and postnatal mental health, depression, generalized anxiety disorder, Obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, social anxiety disorder)

In line with NICE guidance, common mental health disorders in Luton are targeted through Improving Access to Psychological Therapies (IAPT) services. In Luton, this is delivered through Luton Wellbeing Service run by the NHS Foundation Trust. The service allows for professional, as well as self-referral to a range of treatments including talking therapies, Cognitive Behavioural Therapy (CBT), group work and guided self-help. Luton Wellbeing Service is currently delivered by a team of 25-30 clinicians

The chart below is based on data from 2014/15. It shows that **Luton has a particularly low proportion of people estimated to have anxiety / depression entering treatment** when compared nationally.

England	1.4

Similar 10 Average	1.3

North Kirklees	Redbridge	Luton	Bradford Districts	Hounslow	Hillingdon	Slough	Birmingham South and Central	Blackburn with Darwen	Oldham	Sandwell and West Birmingham
0.54	0.93	1.02	1.28	1.32	1.37	1.42	1.57	1.65	1.66	1.7

This indicator shows that the number of those people entering IAPT services as a proportion of those estimated to have anxiety and/or depression. It aims to show access to IAPT services. CCGs with a low percentage compared to similar CCGs should explore local reasons for this - for example, hard to reach groups in the population.

Definition: People entering IAPT as percentage of those estimated to have anxiety/depression
Source: IAPT, PHE Fingertips Common Mental Health Disorders Profile
Year: Oct-Mar1516

Section Continues

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SERVICE USERS

Feedback from Stepping Stones, Victim Support Independent Domestic Violence Advocacy (IDVA) and a mental health service user forum suggest that initial assessments are done quickly, but the waiting time for specific treatments is too long, with examples given of individuals waiting months for some treatments.

KEY FINDINGS

- Local IAPT rates are lower than England average and, although not notably below England or comparator area rates. Luton particularly high recovery rates for PTSD and OCD and is in the top 3 nationally

- Feedback suggests that triage / initial appointments are timely, but that there can be long waits for some therapies. It is possible that national indicators mask some local issues with IAPT services that need to be further explored

- Historically, there were particularly low rates of referral to IAPT for depression and anxiety. It is not clear whether this is still the case, but the difference previously was stark compared to most other areas in England

- Men are significantly less likely to access IAPT treatment and when they do, it is more likely to be recorded as being alcohol related, a somatoform disorder or an unspecified mental health condition

- Asian people appear less likely to access IAPT treatment, which may be due to stigma or differences in how people of different ethnic backgrounds view mental health / illness. The data suggest that Asian people are less likely to recognise a mental health issue and seek help for it or that professionals such as GPs are less likely to signpost or refer Asian people for IAPT treatment

- Nationally, there is disparity in treatment recovery and completion rates which adversely affect older people, women and BME people. Completion rates are much lower for BME people (15% compared to 79% for White British people)

CONSIDERATIONS

- Use local data to better understand whether national differences in IAPT completion rates hold true in Luton
- Consider how to address low take-up and low completion rates amongst men and BME communities (see also recommendations to tackle stigma that are put forward later in this assessment)
- Continue to fund psychological therapies in line with NICE guidance, ensuring that equality issues are addressed

National Context

90% of adults with more severe mental health problems are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and many people never have access to these interventions. One-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months.

The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.
The CPA framework includes arrangements for two types of support:

- CPA for people who have more complex needs, are at most risk or have mental health problems compounded by disadvantage, and need support from multiple agencies
- Lead Professional Care (LPC) for people who need secondary mental health services but have more straightforward needs involving contact with only one professional or one agency

Patients might be offered CPA support if they:	
▪ are diagnosed as having a severe mental condition ▪ are at risk of suicide, self-harm, or harm to others ▪ are vulnerable; this could be for various reasons, such as physical or emotional abuse, financial difficulties because of mental illness or cognitive impairment ▪ have misused drugs or alcohol	▪ have learning disabilities ▪ rely significantly on the support of a carer, or have their own caring responsibilities ▪ have recently been detained under the Mental Health Act ▪ have parenting responsibilities ▪ have a history of violence or self-harm

Admissions to inpatient care have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.

The number of adult inpatient psychiatric beds reduced by 39% overall in the years between 1998 and 2012. For children and young people, average admissions per provider increased from 94 in 2013/14 to 106 in 2014/15. Bed occupancy has risen for the fourth consecutive year to 94%. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances outside of their area.

LOCAL PICTURE

All people in Luton who are receiving services under Secondary Care should have a personalised Care Programme Approach (CPA) plan. This is a personalised and joined up plan which takes the wishes of service users into account. The plan should 'journey up' to acute and, importantly, 'journey back down' ideally to self-management, albeit supported.

Performance data shows high rates of people on a CPA plan with a written plan which is in date and being reviewed annually. During the financial year 2016/17 an average of 95% fell into this category, with the proportion being higher in more recent months. Performance data also shows a high percentage (96%) of follow up within 7 days of discharge from psychiatric in-patient care.

The performance data provided for this assessment does not contain enough of the detail that would help to understand how well secondary mental health services are meeting local experience of need.

Data have not been available relating to secondary care beyond fairly broad performance categories.

It would be useful to understand more about the mental health diagnoses, along with personal characteristics such as gender, age and ethnicity.

Monthly rates (2016/17) for occupied bed days for people with Mental Health (MH) and MH & Learning Difficulties fluctuate between 2,049 and 2,697. The most recent figure (March 2017) is 2,050. During the year, there has been an average of 2,448 occupied bed days with this mainly relating to Adult Acute wards (74%). Just 1% are Learning Disability, 10% Recovery and Rehabilitation and 15% Older Persons. An average of 1,809 occupied bed days each month are in an Adult Acute Ward, with monthly rates fluctuating between 1,653 and 1,994. The most recent figure (March 2017) is 1,656.

NICE GUIDANCE

Title	NICE Guidance with brief description
Transition between inpatient mental health settings and community or care home settings	https://www.nice.org.uk/guidance/ng53 This guideline covers the period before, during and after a person is admitted to, and discharged from, a mental health hospital. It aims to help people who use mental health services, and their families and carers, to have a better experience of transition by improving the way it's planned and carried out.

KEY FINDINGS

- Local data have not been available for this assessment that would allow for a local analysis of equality in relation to secondary services
- Performance data suggest high proportions of people with a personalised Care Programme Approach plan and that these are up to date and subject as required to annual review
- Performance data also show high proportions of people who receive a follow up within 7 days of discharge from psychiatric in-patient care
- Nearly three quarters of occupied bed days are acute adult beds with an average of 1,809 acute bed days every month
- Nationally, there are known to be long waits for key services for people who are accessing secondary services. This factor was also identified locally by Luton Wellbeing Services in relation specifically to people with Personality Disorder and is likely to be a key factor affecting other people in Luton accessing secondary care services

CONSIDERATIONS

- For future assessments, it would be useful to understand more about the mental health diagnoses of people in secondary care, along with personal characteristics such as gender, age and ethnicity

National Context

In its recent review of crisis care, the Care Quality Commission found that only 14% of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am.

Too often, people in mental health crisis are still accessing mental health care via contact with the police. The inquiry found that while adults were seen promptly where liaison mental health services were available in an A&E department and there were clear pathways through to community services, those aged under 16 were referred directly to children and young people's services but seen only when services were open during office hours. This could involve waiting a full weekend and lead to a significant variation in the quality of care on the basis of someone's age.

LOCAL PICTURE

Luton has gone some way towards addressing some of the national findings. Street triage, for example, now established in Luton and Bedfordshire has produced better outcomes and reduced instances of detention under section 136 of the Mental Health Act as well as reducing pressure on A&E.

However, there is also recognition of services that could be implemented that would further improve patient experience and, simultaneously, reduce demand on services. This includes the introduction of an appropriate room at the Luton and Dunstable Hospital A&E department in which to look after people who are in crisis. This avoids heightened anxiety and worsening crisis through sitting in a busy A&E department. Patients may step up from here to an acute ward, or they may step down, perhaps to a less acute facility, such as a crisis house, although this facility does not currently exist in Luton.

In Luton, there is a lack of acute beds generally and a particular lack of children's and older people's beds, which leads to people being hospitalised some distance away from home causing disruption to families / carers as well as potential distress to the hospitalised person . The lack of a crisis or 'safe house' facility means that there are people on wards who do not need to be there and the additional burdens on acute wards mean that the admission process may be more traumatic than it needs to be.

The chart below is based on data from 2014/15, shows that **Luton has one of the highest rates of hospital admissions for people aged 18+ who do not have a crisis plan** when compared nationally. It also shows that Luton is over two times higher on this measure than the next highest comparator area.

England	228.1
Similar 10 Average	178.5

Birmingham South and Central	Hounslow	Redbridge	Sandwell and West Birmingham	Oldham	Hillingdon	Slough	Bradford Districts	Blackburn with Darwen	North Kirklees	Luton
50.1	105.6	139.2	173.6	185.7	192.4	206.6	222.6	227.9	281.7	558.3

These indicators show admissions whether a patient had a crisis plan. These should be considered in context of overall rates and proportions of people with a crisis plan and wider outcomes. There may be variation across CCGs in the quality of those crisis plans in place.

Definition: Rate of admissions to hospital for people aged 18+ who do not have a crisis plan in place per 100,000
Source: MHLDDS
Year: 2014/15

Guidance (Mental Health.org)

Crisis care has to be:

- Person-centred and tailored around the strengths and assets available individually or within the family unit.
- As flexible as possible, aiming for minimal coercion where possible.
- Service options made available that allow for assessment to ensure the immediate and short term support is tailored to the crisis at hand.
- Actively seeks feedback from service users and their carers to see what works well, and what doesn't.
- Encourages self-management in the long-term.
- Provided by NHS acute and mental health trusts. NHS and independent ambulance providers. Primary medical services (including GPs).

KEY FINDINGS

- Nationally, care during a mental health crisis is recognised as patchy and not always appropriate to need
- The street triage initiative in Luton has produced better outcomes and reduced instances of detention under section 136 of the Mental Health Act as well as reducing pressure on A&E
- In 2014/15 the rate of admission to hospital for adults without a crisis plan in place was one of the highest in England and just under double the rate of its nearest comparator area. New data are not available to assess the current picture
- Lack of acute beds generally in Luton, and particularly beds for children and older people mean that people sometimes have to be cared for out of the area
- Provision of an appropriate room as an alternative to A&E when people present with a crisis may reduce anxiety and potentially reduce the need for a bed on an acute ward
- As noted in the MHST evaluation, a safe or crisis house would provide an alternative place of safety which avoids Accident and Emergency, police cells and S136 suites.

CONSIDERATIONS

- Continue to fund the street triage initiative
- Fund a crisis house that will relieve pressure on acute wards and provide a temporary safe space. Alternatively, make use of existing third sector partners, such as Penrose, funding crisis rooms that can be utilised when required
- There is a need to join up early intervention – more resources in primary care reduce pressure on, and cost of, acute care
- Continuation of work to establish a local help line and hub and spoke crisis response, along with publicity about what to do in a mental health crisis.

SOCIAL PRESCRIPTION

National Context

Social prescribing is a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems. Social prescribing is usually delivered via primary care – for example, through 'exercise on prescription' or 'prescription for earning', although there is a range of different models and referral options.

Social prescribing for mental health provides a framework for:

- developing alternative responses to mental distress
- a wider recognition of the influence of social, economic and cultural factors on mental health outcomes across the whole spectrum of disorders
- improving access to mainstream services and opportunities for people with long-term mental health problems

There are no specific NICE guidelines relating to social prescription, but it is a nationally recognised approach which is being adopted in local authorities across the UK.

LOCAL PICTURE

Social Prescription in Luton:

- Focus on preventing or delaying the onset of ill health and enabling self-care
- Give GP's 'prescribing' options to address social determinants of health and well being
- A community infrastructure/local network to help patients embrace healthier life style choices, and engage in activities that promote wellbeing and social inclusion
- Initial Focus: Diabetes; Anxiety, Depression & Loneliness; Chronic Obstructive Pulmonary Disease (COPD); Carers

Luton Social Prescription Model
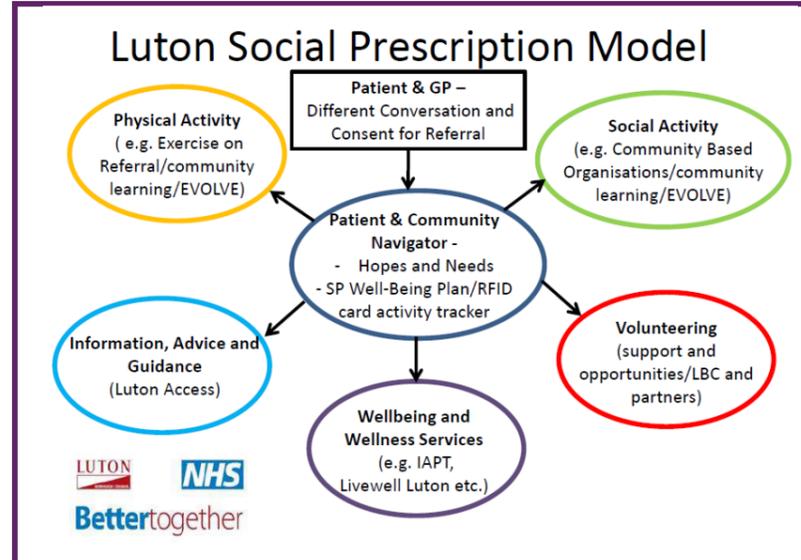
The social prescription data have been limited, but suggest that it is already proving to be an important mechanism for reaching groups that have traditionally been 'hard to reach' in relation to mental health.

Analysis of data from Blenheim & Woodside GP practice, located within the Biscot ward, suggests that, because social prescription need is locally identified, it is able to reach people who have traditionally been considered 'hard to reach'.

In this ward, with its high Asian population, 65% of the people prescribed for a social need are Asian and 47% are Asian women. National studies and local IAPT data indicate that this is a group less likely to access mental health services so it is encouraging if social prescription can act as a gateway for those who may be in greater need.

The dropout rate is around a quarter for this GP practice. For those identified as being mental health related, the rate is slightly higher (27%). There are further variations in the mental health cohort by gender and ethnicity. 16% of men are recorded as having dropped out, compared to 30% of women. White British people have the highest dropout rate (58%). For Asian people, the rate is 24%, Other ethnic groups are too small in number for this to be a useful measure.

KEY FINDINGS

- Current data do not allow for a complete analysis of social prescription in Luton and how well it is helping to meet mental health need. The social prescription data do however, contain important insight that would help in planning mental health services
- Despite the above, indications from one of the pilot areas suggest it has been particularly successful in identifying and trying to address the needs of Asian women, who are a traditionally hard to reach group. Most of these women are aged between 51 and 70, which is reflective of the wider social prescription cohort at this practice
- High proportions of the social prescription cohort in the pilot area have a mental health issue. 53% have a common mental health issue - Anxiety, Stress and / or Depression
- The need for social engagement is also key, affecting over a third of the people for whom social prescriptions have been made
- Drop-out rates vary by gender and ethnicity. Women and White British people have the highest drop-out rates.

CONSIDERATIONS

- Ensure that social prescription data continues to evolve and is made available to allow for evaluation of social prescription interventions in relation to mental health

- Continue to widen out and evaluate the social prescription model

National Context

Stigma, discrimination and social exclusion related to mental health are significant barriers to quality of life and mental wellbeing. People who experience mental health problems face more stigma and discrimination than those with physical health conditions, with the exception of those with HIV/AIDS.

Many people will not seek support due to the stigma they expect to face and the self-stigma of feeling a burden, and believing they have undesirable attributes. Although disability discrimination laws prohibit discrimination against people with lived experience, research has shown time and again that there have been clear examples of people being disadvantaged in terms of accessing health care, welfare benefits, housing, education and employment. The stigma attached to mental health multiplies the difficulties for older people with mental health problems.

Mental health related stigma and discrimination can be compounded by discrimination related to the other inequality issues, such as race, gender, sexual orientation and disability. More than half (55%) of younger LGB people experience homophobic bullying in Britain's schools. The majority of pupils who experience homophobic bullying have symptoms consistent with depression.

Universal approaches to promoting mental wellbeing complement existing approaches to tackling stigma because, in improving the capacity for healthy relationships, for compassion and for trust in others, they reduce the fear difference and the need to do better than others, which fuels stigma and discrimination.

Tackling stigma is important both in terms of reducing the negative experiences of individuals affected, but also in helping facilitate more equitable focus by policy makers and commissioners on mental health.

LOCAL PICTURE

Stigma and discrimination:
- prevents people seeking help
- delays treatment
- impairs recovery
- isolates people
- excludes people from day-to-day activities
- stops people getting jobs

Luton is a small town with close-knit communities and, as such, has particular cultural factors which may compound issues of stigma in relation to mental health. Traditional, close-knit family networks provide protective factors around mental health, but families can also be a source of taboo, shame or stigma around mental disorder. In some cultures mental illness is seen as spiritual, therefore individuals and families may be more receptive to solutions presented with a 'spiritual angle' or from a spiritual viewpoint.

Luton Wellbeing Service advocates community outreach, which is considered helpful for many reasons, but particularly in reducing stigma around mental health. Community outreach should offer a preventative and universal function (showing people how to look after their mental health / reducing the effects of stigma by openly talking about mental health as something normal and positive). Community outreach is also an effective means of offering mental health support in an 'ordinary' setting, thus removing the stigma attached to having a mental health illness. Replicating nationally recognised best practice, there are attempts in Luton to improve outreach services whereby a therapist is available in GP surgeries. It is recognised, however, that a more cohesive and comprehensive approach is required for this to be effective in reducing the inequalities created by stigma.
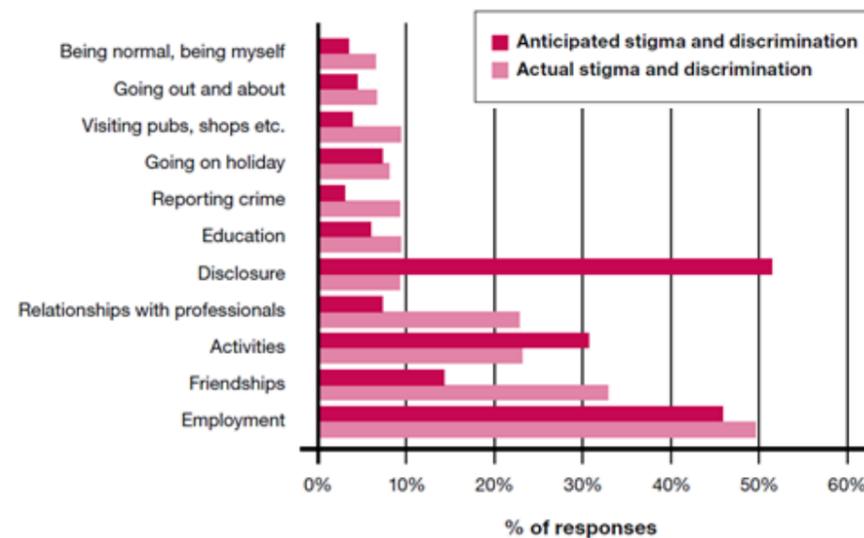
Source: Time to Change, Stigma Shout: Service user and carer experiences of stigma and discrimination' 2008

National work by Time to Change (see above chart) highlights the effects of stigma and discrimination for people with mental health issues. Although this study is old, it is worth mentioning and noting in particular the effects of anticipated stigma and discrimination on disclosure.

Having a specialist IAPT service in a separate location may create barriers, rather than break them down. For example, its location close to Bury Park in Luton, which has a large Asian population, may exacerbate the effects of stigma within this community.

The effects of stigma and culture are believed to work together and prevent disclosure and diagnosis of mental health related issues. Outreach therapy in GP surgeries may help to break down barriers to accessing mental health treatment and it brings additional benefits around shared learning and collaborative and holistic working practices.

Community outreach (in a variety of settings) brings additional benefits such as connecting with harder to reach groups (in particular those identified in the section of this assessment 'Marginalised Groups').

In essence, taking services to the locations that people already gather will minimise the effects of stigma while making it easier for people with mental health issues to access the help they need at a time when they may not be capable of complying with the expectations of services (e.g. the expectation to be at a certain place at a certain time).

Section Continues

COMMUNITY APPROACHES

Our Minds Matter (OMM) highlight the effects of belief in some faith-based communities around mental health as a spiritual condition. This is simplified in the diagram on this page, which shows how a focus on the problem (the mental health label or diagnosis) may act as a barrier when the individual views their symptoms as being spiritual in nature. In the solution approach, the starting point shifts from the problem or diagnosis and instead focuses on the 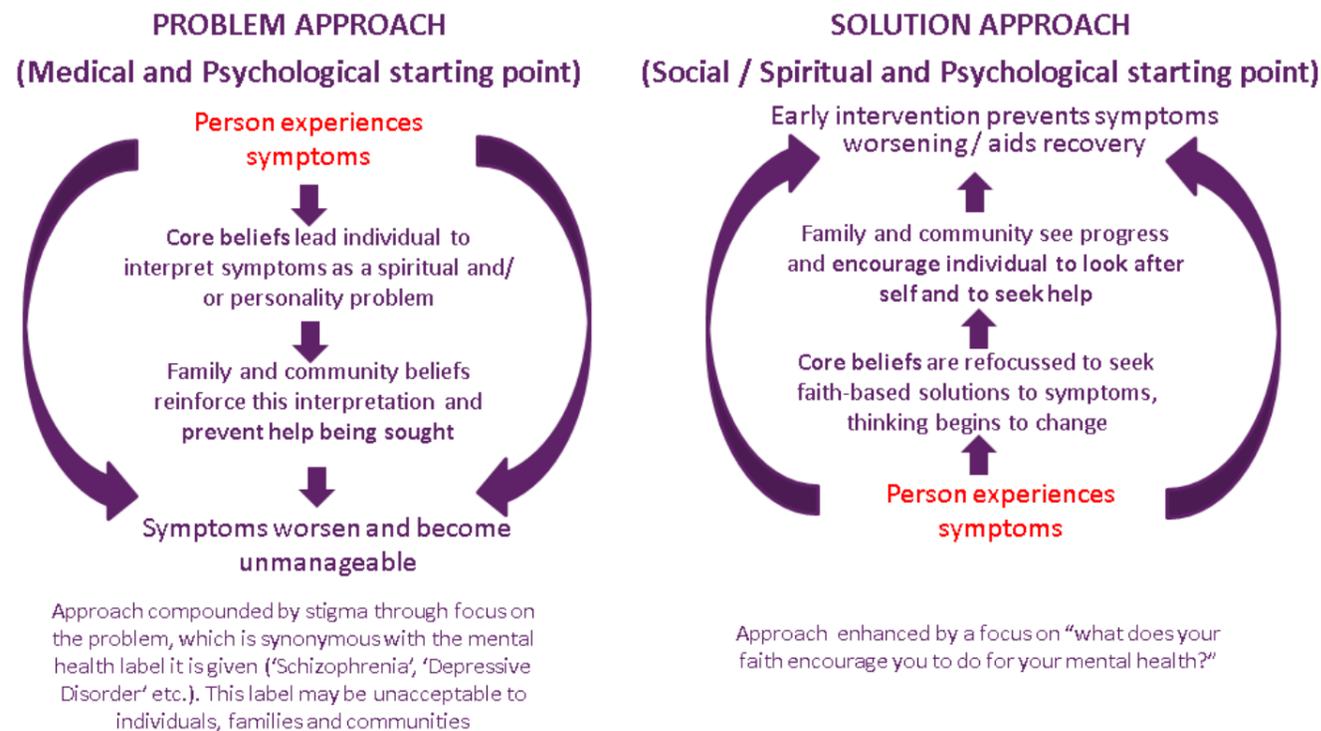social and spiritual aspects of a person. This aids recovery because it addresses the barriers to seeking help and therefore allows for early intervention.

Work continues by third sector and community organisations to tackle stigma in Luton. OMM work extensively to counter the effects of stigma through a variety of media.

PROBLEM APPROACH
(Medical and Psychological starting point)

Person experiences symptoms

↓

Core beliefs lead individual to interpret symptoms as a spiritual and/ or personality problem

↓

Family and community beliefs reinforce this interpretation and prevent help being sought

↓

Symptoms worsen and become unmanageable

Approach compounded by stigma through focus on the problem, which is synonymous with the mental health label it is given ('Schizophrenia', 'Depressive Disorder' etc.). This label may be unacceptable to individuals, families and communities

SOLUTION APPROACH
(Social / Spiritual and Psychological starting point)

Early intervention prevents symptoms worsening / aids recovery

↑

Family and community see progress and encourage individual to look after self and to seek help

↑

Core beliefs are refocussed to seek faith-based solutions to symptoms, thinking begins to change

↑

Person experiences symptoms

Approach enhanced by a focus on "what does your faith encourage you to do for your mental health?"

(Model developed based on conversation with Chair of Our Minds Matter)

OMM delivers community as well as faith-based mental health courses. The organisation provides outreach, education and advice to groups and individuals in how to seek support by acknowledging their faith and background.

ELFT currently fund the Break the Stigma Campaign, which tackles stigma primarily through virtual and real world visibility. The campaign was created[2] in order to help people understand more about mental health and to tackle common misconceptions about the subject.

The public are encouraged to write a message on a white board headed 'Let's be open about mental health to Break the Stigma'. Individuals are then pictured with their comment and the image is shared through @LetsBreakStigma on Twitter and the Let's Be Open About Mental Health Facebook page.

KEY FINDINGS

- Stigma, discrimination and social exclusion related to mental health are significant barriers to quality of life and mental wellbeing. Stigma prevents people from seeking the help that they need

- Mental health related stigma and discrimination can be compounded by discrimination related to the other inequality issues, such as race, gender, sexual orientation and disability

- Stigma and mental health are both culturally experienced and, as a 'super diverse' town, Luton will have a range of cultural factors affecting their experience of mental health. Despite the protective factors that come from living in close-knit family networks, families can also be a source of taboo, shame or stigma around mental disorder

- Some faith-based communities will approach mental health with the view that it is spiritual in nature. There have been some successes in redefining mental health with this in mind and moving from a problem-based approach that begins with diagnosis before help can be accessed to a solution-based approach that incorporates the view "what does your faith encourage you to do for your mental health?" which allows individuals to move towards accessing the psychological help they need as part of a spiritual focus

- Community outreach is recognised as being an effective tool in the reduction of stigma. In particular having therapists located in the 'ordinary' GP surgery setting means that attending a mental health appointment is not visible to family, friends, work colleagues or the wider community

CONSIDERAATIONS

- Delivery of an integrated communication strategy to create power and clarity in the messages being delivered around stigma
- Embed psychological therapists in Luton GP surgeries
- Explore other possibilities for outreach at existing organisations where people with mental health services attend (NOAH, Penrose, ResoLUTiONs for example)
- Ensure that services are culturally sensitive and adaptable enough to adopt a 'whole person' approach whereby physical, emotional and spiritual needs are considered as part of mental health.
- Support community-based approaches that work to challenge stigma and redefine mental health in hard to reach communities
- Continue to fund the Break the Stigma campaign, seeking opportunities to extend this work where possible
- Tackling stigma should form a core part of addressing mental health inequalities

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[2] Campaign launched in 2015 by service user Ben Salmons. Ben created the Break the Stigma initiative which was backed and is now funded by ELFT https://www.elft.nhs.uk/Get-Involved/Break-the-Stigma-campaign

National Context

People benefit from care that is person-centred and co-ordinated within healthcare settings, across mental and physical health and across health and social care. For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs.

A person's care may be provided by several different health and social care professionals, across different providers. As a result people can experience health and social care services that are fragmented, difficult to access and not based around their (or their carers') needs. However, good integrated care can reduce:

- o confusion
- o repetition
- o delay
- o duplication and gaps in service delivery
- o people getting lost in the system

Delivering integrated care is essential to improving outcomes for people who use health and social care services. Reducing gaps and inefficiencies in care should also be able to offer some opportunities for financial savings.

LOCAL PICTURE

Whilst there is some understanding of the services and support organisations that are available in Luton, a cohesive and comprehensive view has not been made available for this assessment. In addition to statutory organisations, Luton has a wealth of charity and third sector organisations with an interest in mental health, whose strengths and specialisms should be harnessed to improve the wellbeing of people with specific mental health needs. These should not take the place of professionally-delivered therapeutic interventions, but work alongside and enhance them.

What would a fully integrated mental health service for Luton look like?

KEY FINDINGS

- Integrated care is good for people and may provide opportunities for financial savings as gaps and inefficiencies are identified and mitigated

- Further work is needed to map current support organisations. However, it may be useful to start by bringing together mental health professionals from different organisations and asking them "what would a fully integrated mental health service look like and how can it be achieved?"

- Collaborative working, knowledge sharing and mutual respect are crucial, along with a framework that supports and strengthens organisations and provides the clarity that is needed for them to effectively deliver services

- Well-being services and other services that support good mental health should work alongside services that provide professionally-delivered therapeutic services

CONSIDERATIONS

- Commission a project to identify and map current statutory and non-statutory mental health services and support organisations so that pathways, gaps and duplication are clearly identified

- Bring together a range of mental health professionals to determine what a fully integrated mental health service for Luton would look like and how it can be achieved. Utilise and build on learning from other areas

- Implement a model to deliver integrated mental health services that are effective and person-centred

- Identify a lead agency for responsibility for oversight

- Ensure that service providers, whether statutory or third sector, are clear on the services they are meant provide and are accountable for them. Standards and performance indicators are needed to provide clarity and to support organisations to meet expectations and deliver within defined parameters

- Develop a single system to signpost individuals to the most appropriate services

- Develop services that are culturally-specific or culturally adaptable. Services should be holistic, understanding the need to support the whole person (physical, mental, emotional, spiritual)

National Context

Mental health accounts for 23% of NHS activity but NHS spending on secondary mental health services is equivalent to just half of this. Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services but the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need.

£19 billion of this is made up of government spend, though there is little or no national data available for how up to 67% of mental health funding is used at a local level. Most of the remainder (£14bn) is for the support provided by unpaid carers, plus a relatively small share that is funded through the private and voluntary sectors. Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be re-invested to meet the significant unmet mental health needs of people of all ages across England, and to improve their experiences and outcomes.

The Five Year Forward View highlights the need for more 'step-down' help from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams. By April 2017, population-based budgets should be in place for those CCGs who wish to commission specialised services for people of all ages, in partnership with local government and national specialised commissioners. It is recommended, as set out in NHS England Planning Guidance 2016/17 – 2020/21, for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve full community and inpatient care pathways.

Guidance for public mental health commissioners outlines how investment in the promotion of mental wellbeing, prevention of mental disorder and early treatment of mental disorder results in significant economic savings even in the short term. Due to the broad impact of mental disorder and wellbeing, these savings occur in health, social care, criminal justice and other public sectors.
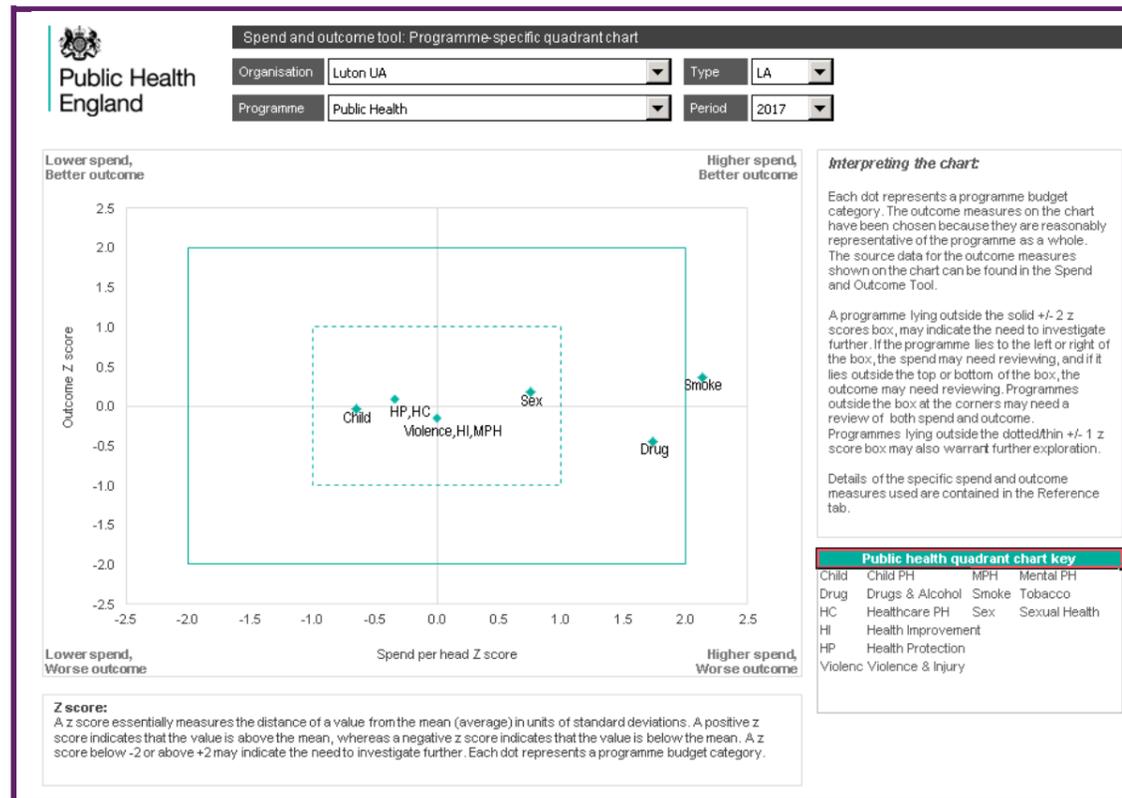
LOCAL PICTURE

The adjacent chart shows that Luton sits almost in the centre when compared with other local authority areas on both spend and outcomes in relation to public mental health (MPH).

It sits very slightly in the quadrant 'lower spend, worse outcomes', but is not significantly different compared to England and other areas.

As recommended in the Five Year Forward View for Mental Health, local plans are to move away from block payments. At present, ELFT operates using funding from a £28 million block payment. Future plans are for money to follow the patient, who will be funded according to need.

There is also a move locally towards Integrated Personal Commissioning (IPC) and person-centred planning and personal budgets that offer choice to service users and a level of autonomy in meeting their own needs. The CCG estimates that 300 people that receive ELFT services should have IPC.

Spend and outcome tool: Programme-specific quadrant chart

Public Health England

Organisation: Luton UA   Type: LA
Programme: Public Health   Period: 2017

Interpreting the chart:

Each dot represents a programme budget category. The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.

A programme lying outside the solid +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome. Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.

Details of the specific spend and outcome measures used are contained in the Reference tab.

Public health quadrant chart key

Child	Child PH	MPH Mental PH
Drug	Drugs & Alcohol	Smoke Tobacco
HC	Healthcare PH	Sex Sexual Health
HI	Health Improvement	
HP	Health Protection	
Violenc	Violence & Injury	

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

KEY FINDINGS

- Nationally, there has been a chronic under-spend on public mental health, despite the impact that mental health has on physical health and general wellbeing, as well as the wider societal impact of unaddressed mental health issues.

- A well planned and appropriately funded public mental health system will realise savings in health, social care, criminal justice and other public sectors.

- Local plans will see more service user choice and a greater emphasis on need. There will be a move away from block payments and instead money will follow patients.

- Wherever appropriate, service users will have autonomy over their own budgets through Integrated Personal Commissioning.

SECTION 4: Data Issues

THE DATA BLACK HOLE

National Context

- It is nationally recognised that an important barrier to good care is the lack of appropriate data sharing to enable organisations to identify co-morbidities, anticipate problems and plan care in a holistic fashion. People with poor mental health may require primary care, secondary physical care and social care, as well as mental health services, but the lack of linked datasets hinders effective provision.

- Data and transparency are critical aspects of a system that delivers good outcomes. Work needs to happen to link data from different public services and agencies (the NHS, social care, education, criminal justice and others) to help identify and meet the full needs of people with mental health problems. There should also be more national support with the analysis and presentation of raw data to support good commissioning and local planning

Data and transparency are critical aspects of a system that delivers good outcomes

LOCAL PICTURE

- Data issues have hindered the writing of this assessment and it has become apparent that data are not consistently available that allow for analysis and evaluation. In particular, the lack of data has made it difficult to properly identify and understand vulnerable groups who are at a higher risk of mental disorder and/ or low wellbeing.

- A further difficulty has been the mapping of current service provision for adult and older adult mental health in Luton, identifying any gaps in service or specific hard-to-reach populations. This is in part due to the complexity of the services which have developed over time. It is, however, important to ensure a joined up and cohesive approach going forward, and one which is amenable to evaluation.

- Understanding how quickly people are able to access services, what sort of care they are receiving and what outcomes they are experiencing is vital to good care. Whilst national work is taking place to support local commissioners, it is important that the local picture is captured and made accessible to allow for evaluation.

KEY FINDINGS

- There are issues with data nationally and locally. Local data have not always been captured or made available for analysis which has made it hard to properly understand any gaps in service provision and hard to reach or vulnerable groups

- Improved data are needed on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services

CONSIDERATIONS

- Encourage all stakeholders to "**think data**" and to understand that capturing and sharing good quality data is a key aspect of good service delivery

- Create a data sharing group responsible for implementing a plan that will drive improvements in data, creating better mental health delivery and ensuring a joined up approach

- Implement the **Public Mental Health Commissioning Cycle** and ensure it is a process that drives activity and provides effective assessment and evaluation

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THE PUBLIC MENTAL HEALTH COMMISSIONING CYCLE

1 Local assessment of need

This involves using public health intelligence to assess the following areas:

- levels of risk and protective factors
- numbers from higher risk groups
- levels of mental disorder and wellbeing
- numbers with different mental disorder and levels of low wellbeing in both the overall local population and particular high risk groups.

2 Assessment of assets

Assessment of assets available in an area to improve health and social care outcomes.

3 Assessment of current service provision

This involves examining information about the quality, effectiveness and cost of current services to treat and prevent mental disorder as well as promote mental health. It also requires the following information about higher risk groups:

- proportion with different mental disorder receiving intervention
- proportion receiving interventions to prevent mental disorder and promote wellbeing
- numbers still requiring intervention for mental disorder, prevention of mental disorder and promotion of mental wellbeing.

4 Intervention analysis

This estimates the combination and level of coverage of interventions required to meet the identified treatment of mental disorder, prevention of mental disorder and promotion of mental health.

5 Intervention plan

- deciding which PMH interventions and at what level of coverage
- a strategic plan regarding delivery of this set of PMH interventions.

6 Procurement of interventions

7 Evaluation of impact of interventions

Appendices

Appendix A: The Public Mental Health Commissioning Cycle

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Appendix B: PANSI Mental Health Estimates

Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder. The report found that 19.7% of women and 12.5% of men surveyed met the diagnostic criteria for at least one CMD.

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

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

BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour is common. The overall prevalence of BPD was similar to that of ASPD, at 0.4% of adults aged 16 or over (0.3% of men, 0.6% of women).

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

Psychiatric comorbidity - or meeting the diagnostic criteria for two or more psychiatric disorders - is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. Disorders included the most common mental disorders (namely anxiety and depressive disorders) as well as: psychotic disorder; antisocial and borderline personality disorders; eating disorder; posttraumatic stress disorder (PTSD); attention deficit hyperactivity disorder (ADHD); alcohol and drug dependency; and problem behaviours such as problem gambling and suicide attempts. Just under a quarter of adults (23.0%) met the criteria or screened positive for at least one of the psychiatric conditions under study. Of those with at least one condition: 68.7% met the criteria for only one condition, 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions. Numbers of identified conditions were not significantly different for men and women.

Summary:

	% males	% females
Common mental disorder	12.5	19.7
Borderline personality disorder	0.3	0.6
Antisocial personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5
Two or more psychiatric disorders	6.9	7.5

The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2030.

Appendix C: Ten key messages for commissioners

Guidance for commissioning public mental health services http://jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf December 2015

Ten key messages for commissioners

1 Mental disorder is responsible for the largest burden of disease in England – 23% of the total burden, compared to 16% for cancer and 16% for heart disease[1].

2 Mental disorder affects more than 1 in 4 of the population at any one time[2,3] and costs the English economy an estimated £105 billion a year[4].

3 Mental wellbeing is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour.

4 Mental disorder starts at an early age and can have lifetime consequences. Opportunities to promote and protect good mental health begin at conception and continue throughout the life-course, from childhood to old age.

5 Improved mental wellbeing and reduced mental disorder are associated with:

- better physical health
- longer life expectancy
- reduced inequalities
- healthier lifestyles
- improved social functioning
- better quality of life

6 Public mental health involves:

a) an assessment of the risk factors for mental disorder, the protective factors for wellbeing, and the levels of mental disorder and wellbeing in the local population

b) the delivery of appropriate interventions to promote wellbeing, prevent mental disorder, and treat mental disorder early

c) ensuring that people at 'higher risk' of mental disorder and poor wellbeing are proportionately prioritised in assessment and intervention delivery.

7 Good evidence exists for a range of public mental health interventions. These can reduce the burden of mental disorder, enhance mental wellbeing, and support the delivery of a broad range of outcomes relating to health, education and employment.

8 Public mental health is a central part of the work of Health and Wellbeing Boards, which are responsible for developing strategic plans to address the public health of a local population.

9 Despite evidence based interventions with a broad range of impacts, only a minority of people with a mental disorder currently receive any treatment. However, there has been a 1% real reduction in spend on mental health services in the past year[6]. Furthermore, spending on the prevention of mental disorder and promotion of mental health represents less than 0.1% of the annual NHS mental health budget[6].

10 Investment in the promotion of mental wellbeing, prevention of mental disorder and early treatment of mental disorder results in significant economic savings even in the short term[5]. Due to the broad impact of mental disorder and wellbeing, these savings occur in health, social care, criminal justice and other public sectors.

Appendix D: Full Recommendations from the Dementia Strategy Commissioning Strategy

1. Enabling equal, timely access to diagnosis and support

    1. Ensure Luton continues to meet the national target for dementia diagnosis of 66.9% registered on QOF register - Luton currently meets this target – September 2016

    2. An expectation that the average time for an initial assessment should be six weeks following a referral from a GP (where clinically appropriate)

    3. Improved quality of contacts with patients and carers from diagnosis, throughout their dementia experience

    4. An increase in the numbers of people of Black, Asian and Minority Ethnic origin who receive a diagnosis of dementia, enabled through greater use by health professionals of diagnostic tools that are linguistically or culturally appropriate

    5. GPs playing a leading role in ensuring coordination and continuity of care for people with dementia, as part of the existing commitment that from 1 April 2015 everyone will have access to a named GP with overall responsibility and oversight for their care

    6. Every person diagnosed with dementia having meaningful care following their diagnosis, which supports them and those around them including:

        o receiving information on what post-diagnosis services are available locally and how these can be accessed
        o access to relevant advice and support to help and advise on what happens after a diagnosis and the support available when living with dementia
        o every newly diagnosed person with dementia and their carer receiving information on what research opportunities are available and how they can access these through 'Join Dementia Research'.

    7. All people with a diagnosis of dementia being given the opportunity for advanced care planning early in the course of their illness, including plans for end of life

    8. A right to stay for relatives when a person with dementia is nearing the end of their life, either in hospital or in the care home

    9. All relevant social care staff working with adults and older people accessing social care services being supported to spot the early signs and symptoms of dementia and helping people with the condition to access high quality care and support

    10. All relevant staff able to signpost interested individuals to research via 'Join Dementia Research'

    11. People with dementia, including people with more severe dementia, are able to express their views about what is important to their quality of life

    12. All LBC Housing staff to have completed dementia awareness training appropriate to their role and the level of their interaction with people living with dementia and their carers

    13. Access to suitable housing with the appropriate levels of care and support

    • Explore the need and provision of services for people with alcohol related dementia and brain injury. Alcohol-related dementia and ARBI remain areas for further research as well as service development. Health and Social Care commissioners will work with colleagues responsible for commissioning services for these groups on a local and regional level to assess local needs and develop appropriate services to meet these needs

2. Promoting health and wellbeing

    14. Improved public awareness and understanding of the factors which increase the risk of developing dementia and how people can reduce their risk by living more healthily

3. Developing a dementia friendly town

    15. Luton to be a Dementia Friendly Community, according to the BSI guidance, working towards the highest level of achievement under these standards

    16. All hospitals and care homes meeting agreed criteria to becoming a dementia friendly health and care setting

    17. Support the Alzheimer's Society to deliver an additional 3 million Dementia Friends in England. Locally to Increase dementia friends & champions by 25% annually, Luton currently has over 3,500 dementia friends

    18. All businesses encouraged and supported to become dementia friendly. Locally we have 30 business signed up and intend to increase this by 100% annually

4. Supporting carers of people with dementia

   19. Carers of people with dementia being made aware of and offered the opportunity for respite, education, training, emotional and psychological support so that they feel able to cope with their caring responsibilities and to have a life alongside caring

   20. More employers having carer friendly policies and practice enabling more carers to continue working and caring

5. Ensuring Excellent Quality of Care

   21. A continued significant reduction in the inappropriate prescribing of antipsychotic medication for people with dementia and less variation across the country in prescribing levels

   22. All people with a diagnosis of dementia being given the opportunity for advanced care planning early in the course of their illness, including plans for end of life

   23. All relevant health and care staff who care for people with dementia being educated about why challenging behaviours can occur and how to most effectively manage these

   24. All NHS staff having received training on dementia appropriate to their role - newly appointed healthcare assistants and social care support workers, including those providing care and support to people with dementia and their carers, having undergone appropriate training as part of the national implementation of the Care Certificate, with the Care Quality Commission asking for evidence of compliance with the Care Certificate as part of their inspection regime. An expectation that social care providers provide appropriate training to all other relevant staff

6. Preventing and Responding to Crisis

   25. Fewer people with dementia being inappropriately admitted to hospital as an emergency through better provision of support in community settings, which enables people to live independently for longer

   26. Ensuring people with dementia are appropriately supported if they ring 111 or 999 through sharing of care plans throughout urgent care services

   27. Increased numbers of people with dementia being able to live longer in their own homes when it is in their interests to do so, with a greater focus on independent living

   28. Increase access, awareness & knowledge of the benefits of assistive technology to those living with dementia

7. Evidence based commissioning

   29. It is important and possible to commission services that are based on strong local evidence of need, using evidence based models of care and involving people with dementia and their carers' in design and production and this should be the basis of how all commissioning is undertaken

Appendix E: Ten Key Messages for Commissioners (mental health services for people with learning disabilities)

Joint Commissioning Panel for Mental Health (JCPMH): Guidance for commissioners of mental health services for people with learning disabilities http://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf

Many people with learning disabilities live full and rewarding lives as part of their local communities. In order to do this, they need support to have good mental health and wellbeing. Commissioners need to think about the following:

1   The prevalence of mental health problems in people with learning disabilities is considerably higher than the general population

   - commissioning for mental health problems must therefore be informed by a Joint Strategic Needs Assessment (JSNA) which takes into account the needs of people with learning disabilities

2   In addition to mental illness, people with learning disabilities often have coexisting autistic spectrum disorders, behaviours that challenge services, offending behaviour, or physical health conditions It is often hard to distinguish between these conditions especially when people have more severe intellectual impairments.

   - the JSNA must therefore provide detail about the number and needs of people with learning disabilities who have mental illnesses, as well as autism and behaviours that challenge services.

3   While there is no universally agreed commissioning model for mental health services supporting people with learning disabilities, the NHS Mandate[1] states that an NHS England objective is to:

   - ensure that Clinical Commissioning Groups (CCGs) work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities, and that a substantial reduction should occur in the reliance on inpatient care for these groups of people.

4   It is often difficult for people with learning disabilities to access generic and specialised mental health services. Consequently:

   - reasonable adjustments are a legal requirement and should be put in place to enable access to all mainstream services where appropriate

   - learning disability services should be provided alongside mainstream mental health services so that the skills and expertise from both services can be utilised in order to respond to individual need

   - there should be clarity with regard to commissioning arrangements between learning disability and mental health commissioners, with a presumption of accessing generic services wherever possible and there should be protocols setting out clear pathways between mainstream and specialist services.

5   The quality of mental health services should be measured from the perspective of the individual with learning disabilities and their family. Clinical effectiveness and outcomes, and patient safety, are also key

6   A positive experience for the individual with learning disabilities and their family is achieved by building a partnership through early involvement in service planning, delivery and evaluation as well as the provision of timely and seamless advice and support especially during periods of transition. Involving people with learning disabilities, their families and advocates in service planning, enables the provision of individualised services, one of the key characteristics of exemplary care or support[2].

7   Successful services provide individualised pathways of care, based on a thorough understanding of the individual and their experience. It should be person-centred and consist of a coordinated assessment of need, agreement of expected outcomes, provision of care and treatment, followed by a joint review of achieved outcomes with the people receiving services and their carers[2].

8   Commissioners should work in partnership with provider services in primary and acute care, and with local authorities including public health. This is a crucial first step to a better understanding of the needs of the population with learning disabilities and achieving an improvement in overall health and well being.

   - It is important to remember that NHS England should be promoting and facilitating joint and collaborative commissioning by local authorities and CCGs to support the development of better services.

9   Commissioning of mental health services should support the development of local, person-centred services, leading to the development of skilled local providers

10 Commissioners should evaluate the outcomes of the service models they are providing, checking for evidence of effectiveness, safety and user satisfaction. They should use this to agree priorities for investment as the commissioning landscape changes and personal budgets become more popular

Appendix F: List of references

The unabridged MHNA contains the information that supports the findings in this summary version. The sources in the table below were used to inform the unabridged version and are referenced appropriately within it. The references are also listed here for information:

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Details were not recorded in 16% of cases – reasons for this are reluctance of individuals to give personal data and 'light touch' work which deliberately avoids excess administration (Doug Hiscock, ELFT, June 2017)	NSPCC 'Infant mental health starts before birth'12 June 2017, https://www.nspcc.org.uk/services-and-resources/impact-evidence-evaluation-child-protection/impact-and-evidence-insights/infant-mental-health-starts-before-birth/
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