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Welsh Government

Fulfilled Lives, Supported Communities

Mental Health Commissioning Data Set

February 2012

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1 Introduction

This report is intended to be a cross-agency aid to the development of good commissioning practice in adult mental health. It describes the information set required for commissioning services for adults with mental health problems and identifies current data sources, where available. It is relevant to statutory commissioning bodies across both local authorities and the National Health Service in Wales and is intended to support the development of joint commissioning approaches.

2 Format of the information

A key set of commissioning questions provide the structure for organising the information needed:

- What are the current and future levels of need?
- What is the capacity to meet that need?
- What is the quality, equity and outcome of provision?
- What is the cost of provision?

The report firstly provides the context and background for mental health services in Wales and then details what should be produced, where to find it and why. Much of the information will already be available and this is detailed in the sources of information column.

3 Who are we talking about?

Mental illness is common and disabling, affecting all people of ages (children, adults and older adults). Estimates of the overall prevalence of mental distress suggest that one in four British adults experience at least one diagnosable mental health problem in any one year, and one in six experiences this at any given time. Mental health problems range from common disorders of depression and anxiety, which affect between 8-12% of the population (depression is more common among older people than in

any other age group) in any year, to 2% with the less common serious mental illnesses such as schizophrenia. A broad range of services is needed to promote good mental health and to support people who develop a mental health problem. This is particularly the case for those with more serious mental health problems, who may often need support from such services as health, social services, housing and employment. The NHS, local authorities and the voluntary and private sectors all provide services for people with mental health problems.

It is important to note that there is a lack of a common language or shared terminology in relation to the area of mental health, although it often has a medical bias. This can create difficulties in communication across different agencies and organisations, so it may be useful to think about defining terms for the commissioning strategy. The World Health Organisation refers to mental health as "*related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders*."[1] The strategy for Adult Mental Health Services for Wales[2] uses the following terms:

- **Mental Health Problems** may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the development of concepts of right and wrong, and in distress and maladaptive behaviour. They may arise from any number or combination of congenital, constitutional, environmental, family or illness factors. Mental Health Problem describes a very broad range of emotional or behavioural difficulties that may cause concern or distress. They are relatively common, may or may not be transient but encompass mental disorders, which are more severe and/or persistent.
- **Mental Disorders** are those problems that meet the requirements of ICD 10, an internationally recognised classification system for disorder. The distinction between a Problem and a Disorder is not exact but turns on the severity, persistence, effects and combination of features found.
- In a small proportion of cases of mental disorders, the term **Mental Illness** might be used. Usually, it is reserved for the most severe cases. For example, more severe cases of depressive illness, psychotic disorders and severe cases of Anorexia Nervosa could be described in this way.

[1] http://www.who.int/topics/mental_health/en/
[2] National Assembly for Wales (2001). Adult Mental Health Services for Wales: Equity, empowerment, effectiveness, efficiency. Strategy Document.

3.1 Risk and protective factors

Research has shown there to be a wide range of risk and protective factors for mental disorders and poor mental health which should influence the design of interventions.[3]

Social, Environmental and Economic Determinants of Mental Health	
Risk Factors	**Protective Factors**
Isolation and alienation Lack of education, transport, housing, recreational facilities. Neighbourhood disorganisation, violence and crime. Socio-economic disadvantage. Poverty, poor social circumstances. Work stress, unemployment. Poor nutrition. Social or cultural injustice and discrimination. Peer rejection. Violence and anti-social behaviour.	Empowerment. Positive interpersonal interactions. Social support and attachment to community networks. Social responsibility and tolerance. Access to social services and a variety of leisure activities. Social participation and inclusion. Economic security and access to meaningful employment.
Individual and Family Determinants of Mental Health	
Risk Factors	**Protective Factors**
Parental mental illness. Loneliness, social isolation. Parental substance misuse. Low birth weight, birth complications. Personal loss – bereavement. Stressful life events.	Ability to cope with stress. Physical activity. Good parenting, stable and supportive family environments. Feelings of security, mastery and control. Self-esteem. Good physical health.

[3] This has been adapted from World Health Organisation (2004) Prevention of mental disorders: effective interventions and policy options: summary report

Physical, sexual and emotional abuse. Family conflict/discord/violence. Substance misuse	Social skills. Positive attachment and early bonding. Pro-social behaviour.

3.2 National policy and guidance

Overall policy guidance from the Welsh Government supports the continued provision of services in community settings away from large institutional services and further development on people's rights to respect and to independent, fulfilled lives. There is a move towards approaches that focus on recovery and maximising mental health and independent living rather than those that focus solely on treating mental ill health. People should have access to a range of high quality services which are person-centred and responsive, where people are empowered to meet the outcomes they wish to achieve.

It is important that mental health services are jointly planned, commissioned and delivered in an efficient co-ordinated manner in order to provide responsive, seamless care. Quality standards and what research and best practice say need to be considered in order to benchmark service provision and to ensure that what is provided meets the required need and outcomes for service users. National policy and guidance for mental health services provide an indication into the areas to be focused on as well as performance measures in some instances. Key areas include:

- Independence.
- Choice and control.
- Ensuring social inclusion.
- Mental health promotion.
- Focus on recovery.
- Early intervention.

However, for specialist services there may be more specific areas that need to be considered.

Key policy and guidance include:

- Wales Audit Office follow up report on Adult Mental Health Services.
- Mental Health (Wales) Measure 2010.

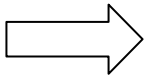
- National Programme Board: mental health.
- 1000 Lives Plus Programme.
- National Service Framework.
- Adult mental health services for Wales strategy document.
- National Inclusion Programme.
- Wales Audit Office - Housing services for adults with mental health needs.

For more detail on national policy and guidance see Appendix One.

3.3 Categorising mental health services and their users

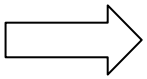
This section illustrates the range of groupings those with mental health problems may be perceived to fall into, where shared characteristics will influence the design of services. However people may fall into more than one category or receive support from more than one service, and increasingly services are provided on a needs led rather than an age basis. Furthermore, it is not always clear whether services work with some of the more vulnerable groups such as those who are homeless.

SUB-GROUPS
Older People Those in transition Prisoners Substance misusers Hard to reach groups (including homeless, roofless, no permanent residence, traveller communities, migrants etc)



ILLUSTRATIVE SERVICES
Mental Health Directorates/Divisions (including those in local authorities) and health boards
Primary Care, including primary mental health care
Adult CMHTs
Crisis resolution home treatment services
Assertive outreach teams (including rehabilitation and recovery)
Early intervention in psychosis

SUB-GROUPS



ILLUSTRATIVE SERVICES
Forensic mental health services (low and medium secure)[4]
Training, employment and day support
Accommodation and residential support services
Older people's mental health services
Police mental health units/liaison officers or custody court and diversion schemes, criminal justice liaison teams
Prison services
Acute inpatient care (including older people)
Advocacy services
Psychological therapies

4 Commissioning data set for mental health

This data set suggests the minimum data required, as well as where local requirements may identify areas which will need further investigation. Commissioners will need to consider the information below in relation to local priorities and demand, and explore the need for more detailed information as necessary.

4.1 What are the current and future levels of need?

To identify likely demand for services it is important to understand projected growth in population and obtain an understanding of the characteristics of the population in order to be aware of overall trends. Key questions for commissioners include:

[4] High secure services are commissioned nationally from England.

- What is the existing overall population and how will this change over time?
- What socio-economic risk factors may affect demand for services locally?
- What is the prevalence of mental health problems and how will this change over time?
- What is the breakdown of demand for services and provision (referrals and those in receipt of services including demand that has not been met).

More specific questions will also need to be considered for the sub-groups:

Older people

- What proportion of older people are at highest health and social care risk?
- What will be the future demand for dementia services?
- What will be the future demand for treatment of depression?
- What will the future demand be emanating from co-morbid physical frailty with dementia

Those in transition

- What numbers of adolescents may need support from adult mental health services?
- What number of adults may need support from old age psychiatric services?

Prisoners

- What is the prevalence of mental health problems in prisons?
- What is the demand for mental health services in prisons (referrals and those in receipt of services including demand not met)?
- What is the demand for NHS mental health services from prisons (referrals and those in receipt of services including demand not met) including from prisoners upon release

Substance misuse

- What is the prevalence of substance misuse (adults, children and children affected by parental substance misuse)?
- What is the demand for substance misuse services (referrals and those in receipt of services including demand not met)?

Co-morbidity

- What is the prevalence locally of co-morbidity such as mental illness with substance misuse, with learning disability, long term physical conditions, or the complexity of the diagnosis of mental illnesses?
- What is the impact of this prevalence on demand for services, the type of services needed, and the cost of service provision?

Hard to reach groups

- What are the hard to reach groups locally in terms of mental health services (for example, minority ethnic populations, asylum seekers, the roofless or homeless)?
- What is the demand for mental health services among these hard to reach groups (including demand not met)?

When analysing current and future needs, it will be necessary to consider whether actual numbers of people or proportions of the total population need to be used. In some instances for service planning it may be better to use actual numbers but for future planning the proportion of people will need to be known in order to be able to project forward future demand. Contrasts should be made between the population as a whole, and those using mental health services to understand specific needs in this group.

Current and future needs	Suggested information sources[5]	Notes/rationale
Census profile of population with at least 10 year projections, and broken down by age, gender, ethnicity, and sexuality.	Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk Age bands comprise: aged 0-17; aged 0-25 and aged 18 and over. Projections are annual for next five years, and in five year bands to 2030. • Population by age, projected to 2030. • Population by age and gender. • Population by age, gender and ethnic group, year 2009.	This information helps to establish likely trends in the population to which services will need to respond. This will include older people and those children in transition who may require adult services in the future. It will also provide an understanding of issues relating to sub-groups such as those from BME groups or who are from the LGBT community.
Information about socio-economic risk factors that may affect demand for services locally including: deprivation; education; unemployment; homelessness; offending rates, etc.	**Deprivation**: StatsWales: http://statswales.wales.gov.uk/index.htm Public reports: http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx • Social Inclusion – Poverty – Households below average income (by child, working age, pensioners). StatsWales: http://statswales.wales.gov.uk/index.htm Public reports: http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx • Social Inclusion - Welsh Index of Multiple Deprivation (WIMD) – WIMD Indicator Analysis – Deprivation Groups: WIMD Indicator Analysis - Deprivation Groups by area and indicators; eg:	Evidence suggests that those which are disadvantaged may be more likely to suffer health problems including mental health problems.

[5] All links as at February 2012

Current and future needs	Suggested information sources[5]	Notes/rationale

	10% most deprived areas by:
	• average travel time to a GPs surgery
	• average travel time to a leisure centre
	• average travel time to a Secondary School
	• average travel time to public transport
	• violent crime incidences
	• burglary incidences
	• theft incidences
	• criminal damage incidences
	• youth offenders (% of population aged 10 to 17)
	Education:
	StatsWales: http://statswales.wales.gov.uk/index.htm
	Public reports: http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx
	• Schools and teachers – General statistics:
	  • Absenteeism.
	  • Exclusions.
	• Schools and teachers - Key education statistics:
	  • Schools - General statistics.
	  • Qualifications.
	  • Proportion of young people not in education, employment or training (NEET).
	• Schools and teachers - School leavers without qualifications.
	• Schools and teachers - Schools census:	

Current and future needs	Suggested information sources[5]	Notes/rationale

	• English as an additional language.
	• Provision for the under 5s.
	• School Meals and Milk – Pupils aged 5-15 entitled to / taking free school meals.
	• Special Educational Needs.
	Unemployment:
	StatsWales: http://statswales.wales.gov.uk/index.htm
	Public reports:
	http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx
	• Economy and labour market – People and work:
	  • Unemployment.
	  • Workless households.
	Homelessness:
	StatsWales: http://statswales.wales.gov.uk/index.htm
	Public reports:
	http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx
	• Housing – Homelessness.
	Offending rates:
	StatsWales: http://statswales.wales.gov.uk/index.htm
	Public reports:
	http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx
	• Community Safety – Crime and Justice – British Crime Survey (charts and tables):
	  • Crime in Wales	

Current and future needs	Suggested information sources[5]	Notes/rationale
	• Personal Crime in Wales • Domestic Violence in Wales • Household Crime in Wales • Burglary in Wales • Vehicle-related theft in Wales • Perceptions of Crime in Wales • Anti-social behaviour in Wales • Confidence in Criminal Justice System in Wales • Drugs Misuse in Wales • Class A Drugs Misuse in Wales • Perception of drug use or dealing in Wales. • Community Safety – Crime and Justice – Recorded Crime (charts and tables): • Total Recorded Crime and Crime Rates and by police force areas in Wales. • Serious Acquisitive Crime in Wales • Violence against the person in Wales • Sexual Offences in Wales • Robbery in Wales • Burglary in Wales • Offences against vehicles in Wales • Other theft offences in Wales • Fraud and forgery in Wales • Criminal Damage in Wales • Drug Offences in Wales • Other Offences in Wales	

Current and future needs	Suggested information sources[5]	Notes/rationale
	• Recorded Crime in Wales • Homicide in Wales • Drug Offence Rates across Wales	
Information on wellbeing such as sickness absence rate, divorce, number living alone, number in a caring role etc.	**Sickness absence rate**: Office for National Statistics (ONS) Sickness Absence in the Labour Market, November 2008: Sickness Absence Rates - 2000 – 2010: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-251337 • Region: Number and percentage of employees absent from work due to sickness or injury by region, October-December 2010. **Divorce**: Office for National Statistics (ONS) Divorces in England and Wales, 2009 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-210936 • Age at marriage – Age at marriage, duration of marriage and cohort analyses. • Children of divorced couples. **Number in a caring role***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Living status – Provision of unpaid care – People aged 16 and over predicted to provide unpaid care, by age and hours of care provided, projected to	Evidence suggests that those who have poor wellbeing are more likely to be affected by poor mental health.

Current and future needs	Suggested information sources[5]	Notes/rationale
	2030. **Number living alone***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Living status – Living alone – People aged 16 and over predicted to be living alone, by age and gender, projected to 2030.	
Information on chronic physical illness.	Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Health/physical disability – Limiting long term illness – Population predicted to have a limiting long-term illness, by age and gender, projected to 2030. • Health/physical disability – Moderate or serious physical disability – People aged 18 and over, with a moderate or serious physical disability, projected to 2030. • (Children and young people's data) Health/disability – Disability DDA – Children aged 0-17 predicted to have a disability according to Disability Discrimination Act definitions, projected to 2030. • (Children and young people's data) Health/disability – Disability Severe – Children aged 0-17 predicted to have a severe disability, projected to 2030.	Evidence suggests that those suffering chronic physical illness are more likely to experience poor mental health.
Information about hard to reach groups including homelessness, rooflessness,	**Homelessness**: StatsWales: http://statswales.wales.gov.uk/index.htm	Evidence suggests a range of factors which may impact on engagement with mental health services, including

Current and future needs	Suggested information sources[5]	Notes/rationale

travellers/gypsy communities, immigrants and migrants.	Public reports:
	http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx
	• Housing – Homelessness (21 tables, including):
	  • Households by age and sex of applicant.
	  • Acceptances by priority need (priority, household, area – Households where a member is vulnerable due to: old age; mental illness; a former prisoner who after being released from custody has no accommodation to return to.
	Rooflessness:
	National Rough Sleeping Count, Wales, 2007 and 2008
	http://wales.gov.uk/docs/statistics/2009/090917roughsleep2007en.pdf
	• Rough sleeper count March 2007 and March 2008
	Immigrants and migrants:
	StatsWales: http://statswales.wales.gov.uk/index.htm
	Public reports:
	http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx
	• Population and migration – Migration – International migration – International migration flows between Wales and the rest of the World (Non-UK).
	Travellers/gypsy communities:
	StatsWales: http://statswales.wales.gov.uk/index.htm
	Public reports:
	http://www.statswales.wales.gov.uk/ReportFolders/rep
		social exclusion, cultural taboos and stigma.

Current and future needs	Suggested information sources[5]	Notes/rationale
	ortFolders.aspx • Social inclusion – Gypsy and Traveller Caravan Count – Table 1: Count of Gypsy and Traveller caravans (authorised and unauthorised).	
Number of people with mental health problems in the local population – broken down by age and diagnosis (eg depression, anxiety, schizophrenia, dual diagnosis, eating disorders, and dementia).	**Any mental health problem**: Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Mental health – Mental health problem - Children and adults predicted to have any mental health problem, by age and gender, projected to 2030. **Mental illness, by age and diagnosis**: Welsh Health Survey 2009: http://wales.gov.uk/docs/statistics/2010/100915healthsurvey09en.pdf Table 3.5 Adults who reported currently being treated for mental illnesses, by age and sex (and by type of illness: depression, anxiety, another mental illness, any mental illness). **Mental illness, by age and diagnosis:** Annual PEDW data tables (Annual Patient Episode Data for Wales tables) • Principal diagnosis Summary, Welsh providers 2010/2011 – Table 2 Primary diagnosis (Episodes grouped within broad ranges of Primary Diagnoses): including by number of finished episodes, number of admissions and bed days, broken down by gender and age group for:	This reflected as prevalence within the population will provide an understanding of current demand. Breakdown by age and diagnosis will enable an understanding of target populations where there may be greater demand.

Current and future needs	Suggested information sources[5]	Notes/rationale
	• Dementia • Other ... mental disorders • Mental and behavioural disorders due to psychoactive substances • Schizophrenia, schizotypal and delusional disorders • Mood disorders • Neurotic, behavioural & personality disorders. Annual PEDW data tables (Annual Patient Episode Data for Wales tables) • HRG v4, Welsh providers 2010/2011 – Table 6 Healthcare Resource Groups (HRG): including by number of finished episodes, number of admissions and bed days, broken down by gender and age group for: • Senile dementia • Presenile dementia • Schizophreniform Psychoses with and without Section • Mania with and without Section • Depression with and without Section • Alcohol or drugs use and /or dependency • Eating Disorders or Obsessive Compulsive Disorders • Acute Reactions or Personality Disorders. **Dementia**: Daffodil: Projecting the need for care services in Wales:	

Current and future needs	Suggested information sources[5]	Notes/rationale
	http://www.daffodilcymru.org.uk • Mental health – Dementia – People aged 30-64 predicted to have early onset dementia, and people aged 65 and over predicted to have dementia, by age and gender, projected to 2030.	
	Hospital Statistics for People with a Mental Illness: Health Statistics Wales 2011 http://new.wales.gov.uk/topics/statistics/publications/health2011/?lang=en • Chapter 10: Hospital Statistics for People with a Mental Illness Health Statistics Wales 2011 - Chapter 10: Hospital Statistics for People with a Mental Illness • Table 10.3 Hospital discharges, by sex and age • Table 10.4 Hospital discharges, by diagnostic group • Table 10.7 Resident patients, by sex and age • Table 10.8 Resident patients, by duration of stay	
Estimation of people who will experience a mental health problem over the next 10 years – broken down by age and diagnosis (eg depression, anxiety, schizophrenia, dual	**Any mental health problem**: Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Mental health – Mental health problem – Children	Prevalence rates for the different diagnoses/mental health problems can be applied to population projections to estimate likely future demand.

Current and future needs	Suggested information sources[5]	Notes/rationale
diagnosis, eating disorders, and dementia).	and adults predicted to have any mental health problem, by age and gender, projected to 2030. **Dementia***:* http://www.daffodilcymru.org.uk • Mental health – Dementia – People aged 30-64 predicted to have early onset dementia, and people aged 65 and over predicted to have dementia, by age and gender, projected to 2030.	Breakdown by age and diagnosis will enable an understanding of target populations where there may be greater demand.
Estimation of people who will experience comorbid mental health problems over the next 1o years broken down by age and diagnoses.		Psychiatric co-morbidity is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. Co-morbidity has practical implications for both the diagnosis and the treatment of each disorder: not only might the symptoms of one condition mask another, but they might also interfere with its treatment. Psychotic disorder and antisocial personality disorder were both very highly co-morbid conditions.[6]
Number of suicide admissions for self harm and recorded incidents of self harm (admissions form only a small	**Number of suicide admissions***:* Annual PEDW data tables (Annual Patient Episode Data for Wales tables)	Provides an indication of people at risk.

[6] Meltzer et al, Adult psychiatric morbidity in England, (2007) *Results of a household survey* http://www.ic.nhs.uk/pubs/psychiatricmorbidity07

Current and future needs	Suggested information sources[5]	Notes/rationale
proportion of people who self harm but who may be at raised risk of suicide and in need of psycho social support).	• External causes, Welsh providers, 2010/11 Table 11 - External Causes: including by number of finished episodes, number of admissions and bed days, broken down by gender and age group for: • Intentional self-poisoning • Intentional self-harm. **Number of suicides***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Mental health – Suicide – Mortalities of people aged 15 and over from suicide, by age and gender, projected to 2030.	
Number with mental health problems who are in employment/demand for employment opportunities: • Work experience. • Supported employment schemes. • Part and full-time paid employment.	Available locally from providers.	This information gives an indication of potential demand for work placements in the future.
Number of people reported as absent from work due to stress or mental illness and estimates of the impact of absenteeism as a result of	**Sickness absence from work due to stress, depression or anxiety**: Office for National Statistics (ONS) • Sickness absence in the labour market, February 2011:	This information gives an indication of demand for occupational mental health and the costs of common mental illness to business

Current and future needs	Suggested information sources[5]	Notes/rationale
stress and common mental illness Data on the availability of occupational health services.	http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-217104 • Number and percentage of employees absent from work due to sickness or injury by main reason, October-December 2010: Stress, depression, anxiety (figures are for England and Wales combined). **Availability of occupational health services:** Local data	The absence of occupational health services increases the potential for people to use primary mental heath services
Demand for access to mainstream community and leisure opportunities.	Local data – care and support plans	This information gives an indication of leisure and community needs.
Demand for supported tenancies amongst people with a mental health problem.	Supported housing providers and Supporting People commissioners	This information is needed in order to inform the planning of Registered Social Landlords and to improve the timeliness of appropriate accommodation.
Number of people claiming benefits/incapacity benefits for mental health problems.	**Number of people claiming benefits** (not by reason): Office for National Statistics (ONS) Region and Country Profiles, Key Statistics - October 2011 [7] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227724	This gives an indication of people who have a current or continuing mental health problem who may not be in receipt of services but are still limited by their condition.

[7] Office for National Statistics http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227724 *"Region and Country Profiles provides a source of essential statistics for the regions of England and the constituent countries of the UK (Scotland, Wales and Northern Ireland). The tables provide a wide range of demographic, social and economic statistics to compare the countries, regions and local authority areas. The Key Statistics tables cover the most useful figures for these areas."*

Current and future needs	Suggested information sources[5]	Notes/rationale

	• Table 6 Local authority education, labour market, benefits and housing, United Kingdom:
	  • Unemployment rates
	  • Number of people receiving Incapacity Benefit/Severe Disablement Allowance
	Number of people claiming benefits due to mental health problems:
	Department for Work and Pensions (DWP) Tabulation Tool
	http://research.dwp.gov.uk/asd/index.php?page=tabtool
	Select: "Click here for Benefit Caseload National Statistics (WPLS) data"
	To go direct to the Tabulation Tool:
	http://83.244.183.180/100pc/tabtool.html
	Select: Incapacity Benefit
	Select: Analysis: Caseload (Thousands)
	Select: Row: IB ICD (disease) code *(the medical reason for entitlement to Incapacity Benefit/Severe Disablement Allowance)*
	Select: Column: Region
	Select: Subset: None (or make selection)
	Select: Date: May 2011
	Incapacity Benefit Caseload (Thousands): IB ICD (disease) code by Region *(shows numbers of people in Wales with Mental and Behavioural disorders in receipt of incapacity benefit)*.	

Current and future needs	Suggested information sources[5]	Notes/rationale
	By making different selections the Tool will give other information, eg, numbers in receipt of Attendance Allowance, Disability Living Allowance, Carer's Allowance, etc.	
Number of people with pre disposing factors to young onset dementia e.g. high level alcohol use and people with downs syndrome.	**Binge drinking***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Mental health – Alcohol – binge drinking – People aged 16 and over predicted to binge drink, by age and gender, projected to 2030. **Drug use***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Mental health – Drugs - misuse – People aged 16-59 predicted to misuse drugs, by age, projected to 2030. **Hospital admissions re drug use***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk Mental health – Drugs – hospital admissions – People aged 15 and over predicted to be admitted to hospital for drug related conditions, by age and gender, projected to 2030. **Abuse and neglect***:* Daffodil: Projecting the need for care services in Wales:	This gives an indication of likely demand for young onset dementia services that may also require high intensity care due to complexity and challenging behaviour

Current and future needs	Suggested information sources[5]	Notes/rationale
	http://www.daffodilcymru.org.uk • Mental health – Survivors of sexual abuse – People aged 18-64 predicted to be survivors of childhood sexual abuse, projected to 2030. **Down's syndrome***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Learning disability – Down's syndrome – Children and adults predicted to have Down's syndrome, by age, projected to 2030. **Down's syndrome***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Learning disability – Down's syndrome – People aged 45-64 estimated to have Down's syndrome and dementia, projected to 2030.	
Older people		
Estimated number of older people at highest social care risk with three or more of the following characteristics: a) aged 85+years b) living alone c) claiming Attendance Allowance d) 2 or more hospital	Annual PEDW Data Tables http://www.infoandstats.wales.nhs.uk/page.cfm?pid=41010&orgid=869 • Principal diagnosis (3 character detail), Welsh Residents, 2010/11 • Principal diagnosis (4 character detail), Welsh Residents, 2001/10	This is the matrix of combined risk factors that the Nuffield Institute for Health devised for Community Care Needs in Wales (1998). This information can give an indication of the numbers of people at high risk of needing care, rather than just the numbers of older people receiving services.

Current and future needs	Suggested information sources[5]	Notes/rationale
admissions in last 12 months e) housing deprivation (in top 20% of most deprived areas according to Wales Index of Multiple Deprivation).		
Estimated number of older people at highest health risk with three or more of the following characteristics: a) 4 or more active long term conditions b) 4 or more medicines prescribed for 6 months or more c) 2 or more outpatient appointments in last 12 months d) in hospital more than 4 weeks in last 12 months e) 2 or more falls in last 2 months f) in top 3% of frequency of GP consultations g) death of carer in last 6 months.	Annual PEDW Data Tables http://www.infoandstats.wales.nhs.uk/page.cfm?pid=41010&orgid=869 • Principal diagnosis (3 character detail), Welsh Residents, 2010/11 • Principal diagnosis (4 character detail), Welsh Residents, 2010/11	This information offers an indication of actual numbers of people at high risk for whom preventative interventions might be appropriate.
Number of older people with long term life limiting illnesses.	Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk	Evidence suggests that those with chronic physical illness are more likely to experience mental health

Current and future needs	Suggested information sources[5]	Notes/rationale
	• Health/physical disability – Limiting long term illness – Population predicted to have a limiting long term illness, by age and gender, projected to 2030	problems.
Older people who currently have and will develop dementia over the next 10 years: • Mild. • Moderate. • Severe. • Dementia with challenging behaviour. Broken down by age.	**Dementia***:* Daffodil: Projecting the need for care services in Wales: http://www.daffodilcymru.org.uk • Mental health – Dementia – People aged 30-64 predicted to have early onset dementia, and people aged 65 and over predicted to have dementia, by age and gender, projected to 2030. **Males and females with dementia (by age)** http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=342 • Select: 2007 local statistics: Wales Dementia UK statistics for Wales (2007). **Dementia prevalence rates**: Who cares wins, 2005, Royal College of Psychiatrists: http://www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf Table 1.1 The common mental health problems that older people have and their community prevalence: Community prevalence rates for older people with: depression, dementia, delirium, anxiety disorders, alcohol misuse, drug misuse, schizophrenia. • Table 1.2 The prevalence of mental disorder in older people in general hospitals.	Audit Commission Report (2000) Forget Me Not – Mental Health Services for Older People estimated 1 in 25 over 65 years and 1 in 4 over 85 years. The North Wales Mental Health Authority in 1998 estimated 18.5% of those aged 85-89 years and 31.85% of those aged 90+ years would develop dementia. A small minority of older people with dementia develop challenging antisocial behaviour and require the highest level of care and supervision. Breakdown by age will pick up those younger adults diagnosed with dementia. These prevalence rates can be applied to population projections to estimate likely future demand.

Current and future needs	Suggested information sources[5]	Notes/rationale
Number and percentage of assessments for older people with dementia.	Local social care data records.	This allows a comparison to be made between the projected needs in the population considered above with the actual numbers of older people presenting with such needs.
Percentage of assessed older people with dementia whose carers have received a carer's assessment, compared to population prevalence.	Local social care data. For information about mental health of carers, see Welsh Health Survey 2008: Health of Carers http://wales.gov.uk/docs/statistics/2010/100224sb92010en.pdf • Table 1: Adults who reported key illnesses or health status, by age, sex and carer status – Any mental illness.	This gives an indication of the potential demand for services from carers compared with the level of actual uptake. Only a small minority of carers currently have their own care packages.
Older people who will develop depression over the next 10 years.	Apply prevalence (below) to local population projections. Projecting Older People Population Information (POPPI) System http://www.poppi.org.uk *(Although the POPPI System is for England, rates used are for England and Wales)* • Health – Depression – People aged 65 and over predicted to have depression, by age and gender, projected to 2030. Rates for men and women diagnosed with depression are as follows:	The Nuffield Institute for Health estimated in its study of Community Care Needs in Wales in 1998 that 15% of those aged 65 years and over would suffer from severe depression. These prevalence rates can be applied to population projections to estimate likely future demand.

<table>
<tr><th>Current and future needs</th><th>Suggested information sources[5]</th><th>Notes/rationale</th></tr>
<tr><td></td><td>
<table>
<tr><th>Age range</th><th>% males</th><th>% females</th></tr>
<tr><td>65-69</td><td>5.8</td><td>10.9</td></tr>
<tr><td>70-74</td><td>6.9</td><td>9.5</td></tr>
<tr><td>75-79</td><td>5.9</td><td>10.7</td></tr>
<tr><td>80-84</td><td>9.7</td><td>9.2</td></tr>
<tr><td>85+</td><td>5.1</td><td>11.1</td></tr>
</table>
Figures are taken from McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787–1795.
</td><td></td></tr>
<tr><th colspan="3">Those in transition (from children's to adults and adults to older people services)</th></tr>
<tr><td>Number of adolescents currently receiving CAMH services 14+ years with transition plans.</td><td>Local CAMHS data.</td><td>Knowing the number of children who may potentially need continued support from adult services helps forward planning especially for more specialist services.</td></tr>
<tr><td>Number of adults aged 64 years old who will need to transfer to old age psychiatric services when they reach 65 years of age.</td><td>Local data.</td><td>Knowing the number of adults who may need support from old age psychiatric services as they age helps forward planning especially for more specialist services.</td></tr>
</table>

Current and future needs	Suggested information sources[5]	Notes/rationale
Prisoners		
Number of prisoners with a mental health problem, broken down by age, diagnosis, and those newly diagnosed while in prison and number with an existing condition.	1. "More than 70% of the prison population has two or more mental health disorders." (Social Exclusion Unit, 2004, quoting Psychiatric Morbidity Among Prisoners In England And Wales, 1998) 2. Psychiatric morbidity among prisoners in England and Wales, 1997, National Statistics (ONS) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4007132 3. Psychiatric Morbidity among Women Prisoners in England and Wales, 2001, Office for National Statistics (ONS) http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-women-prisoners/psychiatric-morbidity-among-women-prisoners/index.html Apply percentages to prison population: Offender management statistics quarterly bulletin http://www.justice.gov.uk/publications/statistics-and-data/prisons-and-probation/oms-quarterly.htm (key statistics relating to offenders who are in prison or under Probation Service supervision) • Prison population tables (Table 1.1a: Total population in custody by type of custody and age group, on a quarterly basis, June 2010 to September 2011, England and Wales.) • Prison discharge tables.	This information provides an indication of the demand for services, the potential unmet need within and prior to entering prison, as well as demand for MH services upon release

Current and future needs	Suggested information sources[5]	Notes/rationale
Number of referrals for mental health services in prison and NHS services.	Psychiatric morbidity among prisoners in England and Wales, 1997, National Statistics (ONS) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4007132	
Number of prisoners in receipt of mental health services in prison.	http://www.mentalhealth.org.uk/help-information/mental-health-statistics/prisons/ Fundamental Facts is a handbook providing a comprehensive summary of mental health research with of key facts and figures, covering all key areas of mental health.	
Alcohol and substance misuse		
Breakdown of number of people with co-morbid mental illness and substance misuse		Research shows that GPs are facing a substantial increase in workload because of growing numbers of co-morbid patients with psychiatric disorders who are also abusing drugs and/or alcohol.[8] The estimated number of comorbid cases in the population for England and Wales rose from 24,226 in 1993 to 39,296 in 1998.[9] Information about local prevalence will enable commissioning of appropriate services.

[8] Royal College of Psychiatrists (2005). Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers. Council report CR131 http://www.rcpsych.ac.uk/files/pdfversion/cr131.pdf
[9] Frisher, M et al, Prevalence of comorbid psychiatric illness and substance misuse in primary care in England and Wales, Journal of Epidemiol Community Health 2004; 58:1036-1041 http://jech.bmj.com/content/58/12/1036.full

Current and future needs	Suggested information sources[5]	Notes/rationale
Breakdown of number of people with a substance misuse problem (broken down by age, and other diagnoses as appropriate).	Substance Misuse in Wales 2010-11, 27th October 2011, Welsh Government http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/stats/?lang=en Table 28: Estimate of problem drug use 2009-10: detailing total number of people (number observed plus number assumed), total population, rate per 1,000, profile of drug use per 1,000, by gender, age band and geographical area.	This information provides an indication of the demand for services and those at high risk for whom preventative interventions might be appropriate.
Number of children affected by parental substance misuse.	http://www.daffodilcymru.org.uk Children and young people – Special circumstances – Parental health – Children aged 0-17 whose mothers are predicted to: have a longstanding illness, smoke, drink, misuse drugs, have mental health problems, or who are obese, projected to 2030.	
Number of referrals for substance misuse services.	Substance Misuse in Wales 2010-11, 27th October 2011, Welsh Government http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/stats/?lang=en • Table 1: Referrals by main substance. • Tables 2a; 2b: Referrals by age: alcohol; drugs. • Tables 3a; 3b: Referrals by source of referral: alcohol; drugs. • Table 4: Referrals by individual main substance. • Tables 5a-g: Profile of referrals (age): main substance alcohol; heroin; cannabis; amphetamines; cocaine; crack cocaine; main or secondary substance crack cocaine.	

Current and future needs	Suggested information sources[5]	Notes/rationale
	• Table 6: Multiple referrals by main substance, age, gender and source of referral. • Table 7: Referrals by ethnic origin. • Table 8: Referrals by Community Safety Partnership. • Table 9: Referrals by Community Safety Partnership and individual drug. • Tables 10a; 10b: Multiple referrals by Community Safety Partnership: alcohol; drugs. • Tables 11a; 11b: Estimated incidence rates per 100,000 population: alcohol; drugs.	
Number in receipt of substance misuse services.	Substance Misuse in Wales 2010-11, 27th October 2011, Welsh Government http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/stats/?lang=en • Tables 17a-g: Profile of Treatments started: alcohol; heroin; cannabis; amphetamines; cocaine; crack cocaine; main or secondary substance crack cocaine – by age. • Table 32: Drug Interventions Programme: key caseload data by police force area (including number on caseload).	
Hard to reach groups		
Number of homeless and roofless people with a mental health problem broken down by age, reason for homelessness and other risk	Local homelessness data.	This information provides an indication of the demand for services and those at high risk for whom preventative interventions might be appropriate.

Current and future needs	Suggested information sources[5]	Notes/rationale
factors (eg relationship breakdown, ex forces etc).		
Number of travellers/gypsies with a mental health problem.	Local data.	
Number of migrants and immigrants with a mental health problem.	Local data.	

In addition to the statistical information outlined above, this can be supplemented with more in-depth information about the needs of those suffering from mental health problems. This information can be obtained from case file review and/or conversations with stakeholders including: social workers; team and senior managers; CMHTs; psychiatrists; service-related panels; and service users/carers as well as more formalised methods for capturing unmet need.

Case file review can provide a more detailed picture of local need and can also provide an understanding of the impact of decision making and internal processes on outcomes.

An audit tool will need to be developed locally reflecting local practices and areas for exploration that identifies:

- The demographic information for each individual (eg characteristics and need obtained from assessments, care plans and other key case file documents)
- Decision making and internal processes (eg application of eligibility criteria; link between the needs/outcomes identified at assessment and service provided; the extent to which the service provided met the identified needs/outcomes; and identification of any unmet need).

Furthermore, talking to service users and carers about need and unmet need can provide useful intelligence and insights. This can be undertaken in a number of ways using questionnaires, individual or group interviews or consultation exercises/stakeholder events tailored for the purpose. There may also be existing feedback information from stakeholders that could be useful in understanding the quality and appropriateness of services and the outcomes achieved.

4.2 What is the capacity to meet that need?

This section suggests service mapping and service quality information which can then be cross referenced with relevant information about local needs to identify, for example:

- The extent to which currently configured services are likely to meet local needs and deliver required outcomes.
- Gaps in provision, where local need is unmet or only partly met.
- The costs and effectiveness of existing provision.
- Potential models for providing new kinds of services and potential to use existing "mainstream" services as apart of a package of care alongside specialist mental health services e.g. education and lifelong learning services DWP employment support etc.

This section does not break down service mapping information by mental health sub-group as many of the services support people in all of the sub-groups. However where there is a particular local need for specialist services it will be important to consider if the services described below are appropriate or if there are any gaps in provision.

A variety of approaches to collecting the data required may be used including:

- Undertaking a mapping exercise to identify key providers.
- Sending questionnaires to provider services, requesting a range of data from service activity or outputs to costs and outcomes.
- Evaluating contract monitoring data.
- Analysing internal review or evaluation/inspection reports.
- Gathering and evaluating stakeholder feedback about service quality and impact.

Service mapping	Suggested information sources	Notes/rationale
What services are currently used to support people with a mental health problem? • Number and type of current services available (see section 3.3 for list of key services but this is not an exhaustive list). • How many people accessed/were treated by these services? (Broken down by service and service user demographics eg age and diagnosis). • What are the referral criteria/ pathways? • Waiting times for services (by service). • What is the level of capacity of the service (eg how many people are they able to treat at any one time, or how many inpatient beds available) and is there any spare capacity/what are the occupancy levels?	Locally available For example: • Mental Health Directorates / Divisions (including those in local authorities) and health boards • Primary Care, including primary mental health care • Adult CMHTs • Crisis resolution home treatment services • Assertive outreach teams • Early intervention in psychosis • Forensic mental health services • Training, employment and day support • Accommodation and residential support services • Older people's mental health services • Police mental health units/liaison officers or custody court and diversion schemes, criminal justice liaison teams • Prison services • Acute inpatient care • Advocacy services • Psychological therapies	This information helps to establish what services are currently available locally to those people with a mental health problem. More detailed information about individual services enables an understanding of the capacity which can be compared against the need/demand identified above. It also enables an understanding of how services are currently configured compared to how they could be. So for example it could help: • To help identify how people access services, where referral criteria may limit access, and where there are gaps in services when compared with need/demand. • The breakdown of those who accessed services by age and diagnosis which may identify gaps in provision for sub-groups of people. • More detail for each service in terms of number of hours care provided, the age covered, and if they work with particular diagnoses only (eg dementia, eating disorders, schizophrenia/psychosis). • Knowledge of waiting times for each service will indicate if there is a shortfall in current capacity. • Knowledge of the capacity available by each service would provide an indication of resources and could be compared against need/demand and with other local authority

Service mapping	Suggested information sources	Notes/rationale
		areas. • Knowledge of the balance between types of services (eg institutional v. community based services or primary v. secondary health care)
Where there is over-demand for services, what is the recent or predicted likely growth in availability?	Local data.	This information will help future planning of services and provide an indication of new kinds of services which may be available.
Number receiving services broken down by service, provider (ie LA/NHS/other).	Local data.	This will help to understand the contribution to mental health services beyond statutory provision.
Number of out of area placements.	Local data.	Drive to reduce the number of out of area placements
Who are the non statutory providers of services, what do they provide and how are they funded?	Local data.	This (along with the above) provides an understanding of other services available and whether commissioners need to consider more alternatives or how existing services could work more closely with other agencies to provide more efficient and cost effective provision.
How many people are being prescribed medication for mental health problems and what is the cost?	Prescriptions Dispensed in the Community, 2000 to 2010 and Prescription Cost Analysis (PCA) Data http://wales.gov.uk/topics/statistics/headlines/health2011/1103301/?lang=en Prescription Cost Analysis Data Totals – Prescription Cost Analysis: Wales 2010 - Overall Totals *(shows type and names of drugs and cost; lists amount of drugs, not number*	Medication is a huge cost therefore it will be important to know how many people are being prescribed medication for their mental health problems whether in primary or secondary care. It is also important to understand the efficacy of prescribing practice.

Service mapping	Suggested information sources	Notes/rationale
	of people)	
Workforce profiling	**Suggested information sources**	**Notes/rationale**
Demographic information about the MH workforce including age and gender.	Local data.	Profile of workforce against population demography to reflect impact of aging population and more people retiring than entering the workforce and what impact this might have in the future.
Breakdown of MH workforce by skill mix: Number of years of practising/experience and level of qualifications.	Local data	Need to consider the skill mix for future services of qualified versus unskilled and the role of qualified in supervision of those unskilled.

4.3 What is the quality, equity and outcome of provision?

This section seeks to provide an understanding of the quality of provision.

What is the quality, equity and outcome of provision?	Suggested information sources	Notes/rationale
What choice in treatment/intervention/ therapy options is there? And is it sufficient to meet demand?	Local NHS / Local authority / voluntary sector data.	Service users should have access to a range of treatment/intervention/therapy options in order to meet their needs (including psychological therapies).
Percentage receiving support where the person's first language is Welsh, compared to the population share of Welsh speakers.	Local data.	This measure, applied across all services, would identify the extent to which Welsh speakers have an equitable choice of service provision.
Percentage receiving culturally sensitive services, if necessary in a foreign	Local data	This measure would identify the extent to which people, particularly from ethnic

What is the quality, equity and outcome of provision?	Suggested information sources	Notes/rationale
language.		minority populations, are receiving an equitable choice of service provision.
Percentage where an initial needs assessment has been completed.	Local data.	This gives a measure of the efficiency and responsiveness of service provision.
Percentage where a risk assessment has been completed in the last 12 months.	Local data.	
Percentage where a risk assessment has been reviewed in the last 12 months.	Local data.	
Percentage where a carer's assessment has been offered, where appropriate.	Local data.	
Percentage where there is a completed care plan.	Local data.	
Percentage of care plans • Reviewed. • Not reviewed.	Local data.	This gives an indication of the extent to which the services are revised to meet individual changing needs.
Percentage of reviews by service area reporting that outcomes of care plans met: • In full. • In part. • Not at all.	Local data.	This gives an indication of the extent to which service providers achieve defined care plan objectives for individuals.
Percentage of services users travelling to receive or be provided with services (by service area): • 0-5 miles.	Local data.	This indicator provides an indication of geographical inequity of provision.

What is the quality, equity and outcome of provision?	Suggested information sources	Notes/rationale
• 6-10 miles. • 11-20 miles • 20+ miles.		
What has been the impact of existing MH services on people with mental health problems? This could be considered in relation to jointly agreed quality standards including for example recommendations from the Wales Audit Office report, Mental Health National Intelligent Targets or those identified in the NSF. It will be necessary to develop more specific outcomes for specific service areas which will be influenced by LA priorities.	Local data.	Service providers will need to be able to provide evidence to show that the service they are providing improves the lives of service users and addresses areas in relation to performance management.
How have MH service providers enabled service users to influence any changes/improvements to the service? (ie are service users involved in co-producing the service?).	Local data.	This information gives an indication of service user involvement in service design and review and how empowered they feel to make changes/improvements if necessary (co-production).
Do partnership planning forums exist?	Local data.	
What are the views of users and carers about the quality/effectiveness of services?	Local data.	This provides more detail regarding individuals views of the service provided including how well the service met their outcomes.
Feedback from service users and their families/carers including their experiences of co-production in individual care and	Local data.	This information gives an indication of the extent to which services are currently acceptable to services users and how

What is the quality, equity and outcome of provision?	Suggested information sources	Notes/rationale
treatment plans, services, acceptability and accessibility of services (questionnaires and interviews), feedback from compliments and complaints procedures.		involved they are in planning delivery and evaluation of outcomes.
Feedback from stakeholders through exit interviews/feedback documents; focus groups; individual interviews and case file reviews.	Local data.	Provides the perspectives of other key stakeholders about the quality of services delivered.
What other information is there about the quality of services provided?	Local data.	Provides further detail regarding the quality of service provision.
Data from inspection reports; internal audit and review; regular provider reporting frameworks.	Local data.	

4.4 What is the cost of provision/use of resources?

This section provides information about the cost of provision.

What is the cost of provision?	Suggested information sources	Notes/rationale
What are the overall budgets and actual spend on mental health services with clarity about what is included and what is not? Broken down by LA, NHS and other. Breakdown by primary care versus secondary care funding.	StatsWales: http://statswales.wales.gov.uk/index.htm Public reports: http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx Health and Care – Health Finance – NHS Programme Budget 2009-10: • NHS expenditure by Local Health Board:	This provides an indication of the overall commitment to this client group and also enables a comparison of the money allocated and money actually spent.

What is the cost of provision?	Suggested information sources	Notes/rationale
This will also need to reflect funding that is used for out of area placements.	• Mental health problems • General mental illness • Elderly mental illness • Child & adolescent mental health • Other mental health • NHS expenditure per head of population: • Mental health problems • General mental illness • Elderly mental illness • Child & adolescent mental health • Other mental health • Percentage NHS Expenditure by programme budget category and sub-category: • Mental health problems • General mental illness • Elderly mental illness • Child & adolescent mental health • Other mental health By LHB Primary Care, Secondary Care and by 'Other'; Expenditure, Expenditure per head of population, percentage of total budget.	
What is the cost of each service and who funds it?	Local data.	This information breaks down the over budget and provides detail of where they money is being spent.
What is the drug budget for mental	Local NHS data.	It will be important to consider the

What is the cost of provision?	Suggested information sources	Notes/rationale
health services? And what proportion of the total budget for mental health is this?		allocated drug budget in relation to the number of prescriptions for medication/cost.
Percentage of spend on assessment and care management.	Local data.	This quantifies the budget share allocated to assessment and care management and hence the relationship to spend on service provision.
Expenditure on mental health services across other agencies (eg Health)	Local data.	Provides an indication of resources available from all other agencies.
What grant funding is available from the LA for voluntary services for people with mental health problems?	Local data.	
Trend in staffing costs: LA; NHS; other.	StatsWales: http://statswales.wales.gov.uk/index.htm Public reports: http://www.statswales.wales.gov.uk/ReportFolders/reportFolders.aspx Health and Care – Staffing - Medical and dental: • Hospital Medical and dental staff by speciality • Community / Public Health staff by speciality	Staffing costs account for over 70% of overall costs, and this information indicates comparative trends across sectors.
Trend in staff turnover rates.	StatsWales: http://statswales.wales.gov.uk/index.htm Public reports: http://www.statswales.wales.gov.uk/ReportFo	This is another indicator of market trends. Staff turnover impacts not only on quality of care but also costs such as recruitment and training.

What is the cost of provision?	Suggested information sources	Notes/rationale
	lders/reportFolders.aspx Health and Care – Staffing - Medical and dental: • Vacancies	
Market prices charged by independent and voluntary sector providers.	Local data.	This information informs likely trends in provider costs.
Number and size of service contractors entering the market	Local data.	This information gives an indication of whether commissioning arrangements are encouraging supplier investment.
Number and size of service contractors exiting the market	Local data.	Indicator of market trends.
What Supporting People funding is available for those with mental health problems?	Local data.	This information provides information on housing related support.
What funding is provided for supported housing for those with mental health problems?	Local data.	
Number of people with mental health problems on incapacity benefit.	**Number of people claiming benefits due to mental health problems:** Department for Work and Pensions (DWP) Tabulation Tool http://research.dwp.gov.uk/asd/index.php?page=tabtool Select: "Click here for Benefit Caseload National Statistics (WPLS) data" To go direct to the Tabulation Tool: http://83.244.183.180/100pc/tabtool.html Select: Incapacity Benefit Select: Analysis: Caseload (Thousands)	This provides an indication of money spent supporting people with mental health problems.

What is the cost of provision?	Suggested information sources	Notes/rationale
	Select: Row: IB ICD (disease) code *(the medical reason for entitlement to Incapacity Benefit/Severe Disablement Allowance)* Select: Column: Region Select: Subset: None (or make selection) Select: Date: May 2011 Incapacity Benefit Caseload (Thousands): IB ICD (disease) code by Region (shows numbers of people in Wales with Mental and Behavioural disorders in receipt of incapacity benefit). *By making different selections the Tool will give other information, eg, numbers in receipt of Attendance Allowance, Disability Living Allowance, Carer's Allowance, etc.*	
Number of people with mental health problems receiving direct payments?	Direct Payments: A National Survey of Direct Payments Policy and Practice, May 2007, PSSRU http://www.pssru.ac.uk/archive/pdf/dprla.pdf Table 2.1: Average and maximum numbers of direct payments local authority, per user group within UK countries. Wales, by client group (older people, mental health, etc).	

5 APPENDIX ONE

This section provides a summary of the key Welsh national legislation, policy and guidance in relation to mental health.

5.1.1 Wales Audit Office follow up report on Adult Mental Health Services[10]

This report identified improvements in adult mental health services since the 2005 baseline audit although progress has been variable and some service gaps and inequalities remain. Problems with staff training, support provided by specialist services, inadequate capacity in community services and very long waiting times for psychological therapies (in excess of the Welsh Government's 12 week target and in some cases were in excess of 12 months) were highlighted.

The audit office suggested changes that needed to be addressed by the Welsh Government including: focusing on embedding key services in all parts of Wales and ensuring they have appropriate capacity and operate effectively; reviewing the impact on costs and service outcomes; working with other parts of the UK to share learning; and adopting a recovery and outcomes-based approach to mental health.

The report identified new challenges faced by mental health services including; fundamental change to service culture and delivery in adopting a recovery approach to mental health that focuses on maximising mental health and independent living rather than an approach that focuses on treating mental ill health; sustaining and building on the improvements made in recent years during a period of financial restraint and increasing demand for services; finding funds to invest in early intervention for psychosis; and changes to the way services are delivered in order to implement the Mental Health Measure (Wales) which covers primary care support services, care planning and advocacy services.

5.1.2 Mental Health Measure Wales[11]

The Mental Health (Wales) Measure aims to:

- Ensure the provision of local primary health schemes.
- Provide mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health.

[10] Wales Audit Office (2011). Adult Mental Health Services follow up report. WAO.
[11] National Assembly for Wales (2010). Mental Health (Wales) Measure.

- Make provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating.
- Extend mental health advocacy provision beyond that which is currently required.

5.1.3 Primary mental health[12]

This national service model seeks to assist the delivery of local primary mental health services across Wales, both to improve access to mental health services within primary care but also to improve the outcomes for individuals accessing these services. This should be achieved both "*by improving increasing the availability of mental health services in primary care and, where possible, providing support for individuals in relation to their non-medical needs (such as support in accessing employment, housing and education services). There will also be increased support for primary care providers to help them improve the health and well-being of people with mental health problems*."

5.1.4 National Programme Board: mental health

The Mental Health Programme Board is a forum that is helping to drive the national agenda around mental health. It has now been in place for just over a year. The three priorities agreed for 2011 were:

- Collaborative Procurement: Target Health Care packages with independent providers to drive up quality, safety and value for money.
- Improving the Management of High Risk Patients: Supporting changes to pathways to enhance medium secure services and expand community support in Wales.
- Improving Hospital Based Care: Helping to reduce variation, harm and waste for example ratio of beds to population prevalence, rate of beds admission and length of stay.

5.1.5 1000 lives plus programme

This is a national programme to improve Welsh healthcare. One of the programme areas is mental health which aims to improve treatment for depression, patients with dementia, first episode psychosis (FEP), and eating disorders by ensuring

[12] Welsh Government 2011). National Service Model for Primary Mental Health Support Services

consistent measurement and appropriate treatment for individuals. For each of these aims there are a number of associated targets to be achieved.

5.1.6 National Service Framework[13]

The life span of the National Service Framework is coming to a close, and the Framework is to be replaced during 2011 with a revised strategy for mental health.

The NSF aims to set standards for services in Wales, drive up quality and reduce unacceptable variations in health and social services provision. Key principles underpinning the standards and key actions set out in the NSF are: equity; empowerment; effectiveness; and efficiency. This NSF covers public health challenges, health promotion and social inclusion, the needs of service users and carers, access to services and provision of comprehensive assessment and treatment. It links with issues for children's mental health services, older people's mental health services, drug and alcohol misuse provision and those with mental health problems in the criminal justice system.

Standards are set for 8 key activities:

- Social inclusion, health promotion and tackling stigma (Standard 1).
- Service user and carer empowerment (Standard 2).
- Promotion of opportunities for a normal pattern of daily life (Standard 3).
- Providing equitable and accessible services (Standard 4).
- Commissioning effective, comprehensive and responsive services (Standard 5).
- Delivering effective, comprehensive and responsive services (Standard 6).
- Effective client assessment and care pathways (Standard 7).
- Ensuring a well staffed, skilled and supported workforce (Standard 8).

[13] WAG (2005). Raising the Standard: The revised Adult Mental Health National Service Framework and an action plan for Wales.

5.1.7 Adult Mental Health Services for Wales – strategy document[14]

Much of the policy around mental health services including this strategy document adopts principles which reflect: equity; empowerment; effectiveness; and efficiency. This strategy also calls for mental health promotion and the prevention of mental illness to be addressed as central elements of the public health agenda.

Key objectives of this strategy are:

- The closure of remaining institutions and replacement with modern facilities which are fit for purpose.
- Availability of psychological services in all areas.
- Strengthening of advocacy services.
- Timely and appropriate assessment for all patients, and for those with complex needs, the provision of formal written care plans, subject to regular review.
- Additional staff to ensure effective liaison between mental health teams and primary care, criminal justice, district general hospital and drugs and alcohol services.
- The establishment of a multidisciplinary group to oversee implementation.

5.1.8 Promoting mental health and preventing mental illness

This report illustrates the economic case for greater investment in mental health promotion. Improving mental health, that is promoting the circumstances, skills and attributes associated with positive mental health, is a worthwhile goal in itself: most people place a high value on a sense of emotional and social wellbeing. In addition, positive mental health also:

- Contributes to preventing mental illness.
- Leads to better outcomes, for example in physical health, health behaviours, educational performance, employability and earnings, crime reduction.

[14] National Assembly for Wales (2001). Adult Mental Health Services for Wales: Equity, empowerment, effectiveness, efficiency. Strategy Document.

5.1.9 Social inclusion[15]

Many health and social care services are being refocused to promote social inclusion, including the role of work and gaining skills, in line with current policy and legislation. This framework sets out suggested outcomes for inclusion as a resource to commissioners and providers looking to advance inclusion practice through locally established outcomes for monitoring and evaluating service effectiveness.

5.1.10 Housing services for adults with mental health needs[16]

This report describes how progress in delivering housing targets set out in the NSF has been poor. Strategic planning of housing and support services for people with mental health needs has remained poor quality, largely because of inadequate analyses of the need for services and ineffective joint planning between local partners. Access to housing of an appropriate quality and related care and support services is critical in ensuring the independence and social inclusion of people who have a mental illness.

5.1.11 Employment Support for people with mental health conditions[17]

This report reviews employment support for people with mental health conditions on the understanding that:

- Appropriate employment actively improves mental health and well-being.
- People with mental health conditions can and do pursue successful careers.
- Most people with a mental health condition who are out of work would like to be in paid employment.

It explores the challenges facing people with mental health conditions and provides a number of recommendations about how these may be addressed.

5.1.12 Psychological therapies for anxiety and depression[18]

This audit of psychological therapies across England and Wales measures services against ten standards (including patient satisfaction, effectiveness of therapy, waiting times and number of treatment sessions offered), and provides a series of

[15] National Social Inclusion Programme (2009). Outcomes framework for mental health services.
[16] Wales Audit Office (2010). Housing services for adults with mental health needs.
[17] Department for Work and Pensions (2009). Realising ambitions: better employment support for people with mental health conditions
[18] Healthcare Quality Improvement Partnership (2011). National Audit of psychological therapies for anxiety and depression

recommendations for improvement. Key findings include the inconsistency of what are seen to be very effective services and unacceptable waiting times before patients receive therapies.

5.1.13 Secure services[19]

This review of secure mental health services in Wales was carried out with the aim of ensuring there is "an efficient interagency, multi-agency, multi disciplinary whole system is in place to deliver effective treatment, care and reablement for people with mental health problems, who require this care to be delivered in secure environments due to the risk they may pose to the safety of themselves or others." It provides a range of strategic objectives which set out how this system is to be designed and delivered.

5.1.14 Suicide and self harm reduction[20]

This five year action plan seeks to raise awareness about suicide and self harm, and is aimed at people at the highest risks. It sets out seven commitments:

- Helping people to feel good about themselves.
- Providing help early to those in need.
- Responding to crises in people's lives.
- Dealing with the effects of suicide and self harm.
- Increasing research and improving information on suicide.
- Working with the media to make sure reporting on mental health and suicide is sensitive.
- Making sure that, where possible, people at risk do not have access to things which could be used for suicide.

[19] Welsh Assembly Government (2009). Review of Secure Mental Health Services
[20] Welsh Assembly Government (2008). Talk to me: A national action plan to reduce suicide and self harm 2008-2013

6 APPENDIX TWO

This section provides details of the sub-groups of people with mental health problems and recognises the potential contributing factors that may need services to be delivered differently. There will obviously be other ways of categorising (such as clinical diagnosis) which will also impact on the service or intervention provided. However, it was felt that these categories were most appropriate when considering service provision from a commissioning perspective. This section also provides detail of the services that could be provided.

6.1 Mental health sub-groups

6.1.1 Older people[21]

Addressing the needs of older people with mental health problems is a significant challenge for public sector agencies in Wales. One of the key mental health problems faced by those aged over 65 years (though it can affect younger adults) is dementia. Functional illness such as depression also affects older people and is often poorly diagnosed. It is acknowledged that social isolation, loneliness and poverty experienced by older people contribute to the incidence of mental illness, particularly depression[22]. The Welsh Government Strategy for Older People in Wales emphasises the need for a universal approach to social inclusion and the promotion of good mental health.

A report by the Audit Commission in Wales identified key areas that need to be addressed:

- Getting early help and assessment.
- Helping people to stay at home.
- Services for people who can no longer stay at home.
- Local commissioning and planning arrangements.

Dementia[23]

Over the next 20 years there will be a 31% increase in the numbers of people who have dementia in Wales. Joint solutions between health and social care will be needed to develop the skills and capacity of staff, and to develop an integrated,

[21] Audit Commission in Wales (2004). Developing mental health services for older people in Wales: A follow up to Losing Time.
[22] WAG (2008). The Strategy for Older People in Wales: 2008-2013.
[23] WAG (2009). National dementia action plan for Wales.

comprehensive range of care to help maintain people's independence in their own homes. In order to meet the challenge the Welsh Government has developed a National Dementia Vision for Wales[24] which identifies a number of levels for action:

- Improved service provision through better joint working across health, social care, the third sector and other agencies.
- Improved early diagnosis and timely interventions.
- Improved access to better information and support for people with the illness and their carers, including a greater awareness of the need for advocacy.
- Improved training for those delivering care, including research.

Furthermore, the 1000 lives plus programme[25] has a specific aim to improve the quality of life and care for people with dementia and their care givers with associated targets:

- Target 1: Memory Assessment Services/First point of contact – reduce time between onset of symptoms & diagnosis being communicated.
- Target 2: Improved quality of general hospital care for people with dementia and reduced length of stay.
- Target 3: Reduced inappropriate use of anti-psychotic medications in accordance with NICE/SCIE guidelines.
- Target 4: Improved support for care givers.
- Target 5: Improved quality of care in NHS dementia inpatient units.

6.1.2 Those in transition

Although the mental health measure reflects the need for mental health provision to be 'ageless' those in transition between children's services and adult services, and adult services and older people's services can experience problems. For children these problems include:

- Adult mental health services (AMHS) usually focus on provision to people with specific and severe mental disorders. Child and Adolescent Mental Health Services (CAMHS) have a different approach with the result that young people who have been receiving CAMHS sometimes find that they are not eligible for AMHS:

[24] WG (2011). National Dementia Vision for Wales: Dementia Supportive Communities.
[25] http://www.1000livesplus.wales.nhs.uk/

"... many young people who have received a service from CAMHS do not fit the criteria for ongoing care in AMH. Many service protocols imply that young people who have been treated by CAMHS, but do not fit the criteria for adult services ... should be discharged back to their GP when they reach 18." [26]

"I think what our thresholds would be for being involved in a young person's care and treatment and thresholds for Adult Services are very different." [27]

- Lack of transition support and limited access to information about transition processes means that young people may Lose contact with statutory services.
- A publication by the British Medical Association suggests that a lack of support and confusion about what will happen next at point of transition may serve to actually compound young people's mental health problems.

Research on good practice suggests responding to the mental health needs of young people requires: [28]

- Provision of person-centred, holistic and inclusive services with access to services whatever the entry point.
- Services designed for 16 to 25 year olds to address need and transition issues.
- The participation of young people in service planning, training for professionals and peer support.

The evidence demonstrates that by making services accessible, user friendly and broad based in their information and service provision, it is possible to address the needs of those with serious mental health problems more effectively, but also to offer preventative work to young people.

[26] DH (2006). Report on the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services, Promoting the Mental Health and Psychological Well-being of Children and Young People.
[27] National Institute for Health Research Service Delivery and Organisation programme (2010). Transition from CAMHS to Adult Mental Health Services (TRACK): A Study of Service Organisation, Policies, Process and User and Carer Perspectives.
[28] Mental Health Promotion Wales, November 2008, Issue 4. http://www.publicmentalhealth.org/Documents/749/Newsletter%20-%20Issue%204%20%28E%29.pdf

6.1.3 Mental health services in Prison[29] [30] [31]

The quality of mental health care available in prisons is often poor. A report by the DH, HMPS and National Assembly for Wales states that "Prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS". This is an enormous challenge. Most prisons in England and Wales have a mental health in-reach team to support those with the most serious mental health problems but those with less serious conditions who would otherwise be supported by primary care in the community are often disadvantaged.

A better mental health care service in prisons could be achieved with:

- The use of more effective and consistent models of diversion.
- Developing primary care services in prison to treat and support common mental health problems.
- Co-ordinated services for prisoners with a 'dual diagnosis' of mental health problems and substance misuse.
- Policy guidelines and national standards for inreach teams.
- Support and training for health care staff to develop specialist skills.
- An improved process of transfers from prison to NHS care.
- Better co-ordination and team work among the agencies in the prison and with the NHS outside prison.
- Improved resettlement programmes to reduce the number of re-offenders.
- The development of user involvement in prison mental health care.

6.1.4 Substance misuse[32]

'Working Together to Reduce Harm' is the Welsh Government's 10 year strategy which aims to set out a clear national agenda for tackling and reducing the harm associated with substance misuse in Wales. The strategy describes how the actions we will take are underpinned by four key aims:

[29] DH, HMPS and National Assembly for Wales (2001). Changing the Outlook: A strategy for developing and modernising mental health services in Prisons.
[30] Royal College of Psychiatrists (2007). Prison Psychiatry: adult prisons in England and Wales. College Report: CR141.
[31] Sainsbury Centre for Mental Health (2007). Mental Health care in Prisons: Briefing 32.
[32] WAG (20?). Working together to reduce harm: The substance misuse strategy for Wales 2008-2018.

- Reducing the harm to individuals (particularly children and young people), their families and wider communities from the misuse of drugs and alcohol, whilst not stigmatising substance misuse.
- Improving the availability and quality of education, prevention and treatment services and related support, with a greater priority given than under the previous strategy to those related to alcohol.
- Making better use of resources - supporting evidenced based decision making, improving treatment outcomes, developing the skills base of partners and service providers by giving a greater focus to workforce development and joining up agencies and services more effectively in line with 'Making the Connections'.
- Embedding the core Welsh Assembly Government values of sustainability, equality and diversity, support for the Welsh language and developing user focused services and a rights basis for children and young people in both the development and delivery of the strategy.

There is increasing evidence of co-morbid substance misuse and mental illness.[33] For example, people with psychosis commonly use alcohol and illicit drugs in a problematic manner. Prevalence estimates for recent (e.g. last six months) problematic substance misuse range from 25-40% with rates among young men with schizophrenia often exceeding 50%. People with schizophrenia who also misuse substances generally have a worse prognosis. They respond less well to treatment and relapse more often. They adhere more poorly to treatment and have more frequent and longer hospitalisations and a more significant forensic history and exhibit more violent behaviour and they may however show fewer negative symptoms.

6.1.5 Improving the health and wellbeing of homeless and specific vulnerable groups[34]

People disadvantaged by homelessness or vulnerability may experience a wide-range of health problems and differing health needs. Homelessness may exacerbate and be a causal factor in mental health problems. If health issues are not treated effectively then a person's health will deteriorate, increasing the likelihood of continual homelessness or inability to move-on from homelessness or vulnerability.

The approach to tackling the health needs of homeless and vulnerable groups will involve:

- Improved services and delivery.

[33] MIDAS (Motivational Interventions for Drugs and Alcohol misuse in Schizophrenia) (2004-2007) Clinician's Management Handbook http://www.midastrial.ac.uk/cmh.asp

[34] WAG (2009). Improving the health and wellbeing of homeless and specific vulnerable groups: standards 2009/2014.

- Improved strategic direction within the health services.

The standards are:

- Standard 1: Leadership.
- Standard 2: Joint Working.
- Standard 3: Health Intelligence.
- Standard 4: Access to Healthcare.
- Standard 5: Homeless and Vulnerable Groups' Health Action Plans (HaVGHAPs).