Mental Health Options Outline

Scenario

Irate man rings the offices of NHS England to complain. He is subject to a Violence and Attack order and is unable to attend any healthcare facility near to his place of residence. Increasingly angry, he complains loudly to the Complaints Officer about his many physical problems. The only health facility open to him is miles away. Unemployed, he has neither the means (bus fare being too expensive), nor with his physical difficulties, the ability to attend. His medication for his physical health problems has run out and all options offered by the Complaints Officer are either unacceptable or do not offer easy access.

The scenario outlined above is the common place experience of many mental health service users. Several papers (attached) outline the difficulties encountered by the separation between physical and mental health services.

Mental health: the numbers

The most often quoted number is that 1in 4 adults will have a mental health problem at some time in their lives. Some figures quote that 60% of morbidity may be related to mental health issues. The literature suggests that due to the paucity of resources, many mental health problems remain undiagnosed and untreated. However, it is difficult to ascertain the true incidence and prevalence of mental health conditions, though better data are available for service users with serious and enduring mental illness e.g. psychosis.

The Mental Health Dataset has been collecting data on service users in contact with secondary and community mental health services for over 10 years. Since 2013, the dataset has been expanded to include learning difficulties. The most recent annual report from the Mental Health and Learning Difficulties Dataset 2014/15 suggests that

- 1,835,996 people were in contact with mental health and learning disability services at some point in the year. This means that 3,617 people per 100,000 of the population in England accessed mental health and learning disability services (approximately one person in 28).

File path:

- 5.7 per cent (103,840) of people in contact with mental health and learning disability services spent time in hospital during 2014/15. This is a decrease compared to 2013/14, when 6.0 per cent (105,270) of people in contact with mental health services spent time in hospital and is a continuation of the trend seen in earlier years.
- 13.6% of the NHS budget is spent on mental health, the largest proportion of the 23 programme budget codes.

Further details of usage of secondary and community mental health services are provided in the attached report.

For other patients and service users, the majority of mental health care is delivered in primary care. It is not known how many contacts in primary care are due to mental illness, but some estimates suggest that 50% of consultations are for mental health conditions. It is not known what proportions of these are as a result of co-morbid physical illness e.g. diabetes, but the literature suggests a strong link between chronic conditions and co-morbid mental health problems.

Since the publication of the Mental Health National Service Framework in 2000, and as a result of the large scale reconfiguration of the mental health bed base in the 1990s, much of mental health service provision is provided in the community.

Community Mental Health Teams provide the core services alongside a plethora of other teams which include Crisis Teams, Early Intervention in Psychosis Teams, mental health liaison services etc. The paper by Chew-Graham et al (attached) outline the difficulties that other professionals, especially GPs who remain the primary carers of the majority of service users, face in navigating this complex system of gate-keeping.

More recently, and in order to tackle some of the expressed morbidity resulting from mental health problems, the government has invested large sums into IAPT programmes. Perhaps the most rigorously measured of any mental health service, IAPT has nevertheless struggled with the promise of access and it is not clear whether the ambitions of the programme for 2015 had been achieved. “IAPT – The Three Year Report” – November 2012 (attached) outlined the ambition that in the South West SHA area, of **613,546 patients (prevalence conducive to IAPT) by March 2015:**

- 90,312 should have entered IAPT services
- 60,208 should have completed treatment by March 2015

File path:

- 30,104 should be in recovery by March 2015
- 2509 should have moved off sick pay and benefits by March 2015

It is not known if the trajectories have been completed or exceeded as national data collection has had difficulties.

At any rate, mental health services have remained largely unchanged since their last reconfiguration in 2000. Demand for services, however, continues to rise, particularly for mild to moderate mental illness and the Parity of Esteem agenda and reduction of stigma has brought mental health to the forefront.

Senate Question:
As seen through the experience of service users and their family/carers is the current provision of mental health services and their configuration appropriate?
How and where should services best be accessed for early help, ongoing support and in crises and what changes would the senate therefore recommend?

Option 1: Do nothing – Retain the current shape and size of services, including NHS and private mental health beds and mental health teams.

Option 2: Integrate and co-locate mental health teams in redesigned primary care – As the model for primary care changes with vertical integration and horizontal integration being promoted via the vanguards, seize the opportunity to design in mental health provision for the majority of service users including those with co-morbid physical problems. Alongside primary provision, integrate urgent care provision into the urgent care system – liaison and crisis services alongside other urgent providers within the Integrated Clinical Advice Hub (promoted by the Urgent and Emergency Care Review). Mental health liaison co-located within acute hospitals to serve EDs and wards.

Option 3: Integrate secondary specialist mental health services with other specialist provision

- Question – How should low to medium secure provision be managed and how is mental health support to be provided in prisons?
- Should beds be co-located with physical health acute services