

Mental health needs assessment for adults of working age in Oxfordshire

May 2008



Contents

	Page
List of tables.....	4
List of figures.....	7
Executive Summary.....	8
Acknowledgements.....	11
Section 1 - Introduction	12
What is mental health?.....	12
What is the effect of poor mental health?	12
Positive attributes of mental health and mental well-being	12
Oxfordshire Mental Health Strategy 2007 – 2012	12
Supporting the strategy and monitoring progress	14
Setting the scene for the mental health needs assessment	14
Oxfordshire PCT organisational strategy 2008 – 2013.....	15
What is mental health needs assessment.....	16
How does mental health needs assessment fit into the commissioning cycle?.....	17
Aim of this research	18
Inclusions	18
Exclusions	18
Tasks	19
Section 2 - Methodology.....	19
Setting & Investigator	19
Normative needs	20
Comparative needs.....	20
Epidemiological needs and choosing indicators of mental health and well-being to benchmark against the objectives in the Oxfordshire Mental Health Strategy.....	20
Corporate needs	21
Section 3 - Results	22
Section 3A - The population within Oxfordshire	22
Section 3B - Number of people in our vulnerable populations	23
Ethnic minority population	23
Asylum seekers and prison population in Oxfordshire.....	24
Homeless population.....	25
Carers	26
Section 3C - Population based risk factors for mental illness	27
Summary of the population characteristics and the prevalence of population based risk factors for mental illness.....	30
Section 3D - Prevalence of symptoms of psychological distress that do not meet the threshold for a diagnosis of mental illness.....	30
Section 3E - Prevalence of mental illness in the local community.....	32
Section 3F - Prevalence of mental illness in general practice	34
Section 3G - Prescribing for mental illness in primary care.....	35
Section 3H - Use of secondary mental health services	36
Summary of the prevalence of mental illness in Oxfordshire and the use of mental health services	42
Section 3I - Wider impact of mental illness on the population of Oxfordshire.....	43
Section 3J – The mental health workforce and the provision of mental health services in Oxfordshire including gaps in service provision	43
Section 3K - Cost of mental health services	46

Summary of the direct costs of mental illness in Oxfordshire and the provision of mental health services	48
Section 4 - Indicators used to benchmark progress towards better mental health services in 2012.....	49
Section 5 - Conclusion and Discussion.....	50
Appendix 1 - Selecting metrics to benchmark against the objectives in the Oxfordshire Mental Health Strategy and PCT strategy	52
Appendix 2 - Mental Health Needs Assessment Steering Group	56
Appendix 3 - What is mental health needs assessment?	57
Appendix 4 - Normative and comparative needs assessment.....	59
Appendix 5 - Composite indicators used to assess mental health needs	67
Appendix 6 - Prevalence of symptoms of psychological distress that do not meet the threshold for a diagnosis of mental illness.....	71
Appendix 7 - Prevalence of mental illness in the local community	77
Appendix 8 - Difficulties with Activities of Daily Living associated with mental illness	89
Appendix 9 - Prevalence of mental illness in general practice	91
Appendix 10 - Prescribing of mental health medications in primary care	96
Appendix 11 - Physical illness in those with mental ill-health.....	100
Appendix 12 – Utilisation of specialist mental health services	103
Appendix 13 - Mental health services and mental health workforce in Oxfordshire	110
Appendix 14 - Current spending on mental health services in Oxfordshire	129
Section 6 - Glossary	134
Section 7 - References	136

List of tables

	Page
Table 1: Oxfordshire Mental Health Strategy 2007 – 2012: objectives[10].....	13
Table 2: Oxfordshire PCT Strategy 2008 – 2013: aims[11].....	16
Table 3: Key criteria for indicators of mental health amongst the local population....	21
Table 4: Population projections for Oxfordshire (all ages)	22
Table 5: Population projections for Oxfordshire divided by age group	22
Table 6: Number of ethnic minorities of working age (16-64 years) in Oxfordshire and % of different ethnic groups by District council.....	23
Table 7: Estimated change in ethnic minority population in Oxfordshire.....	23
Table 8: Asylum seekers within Oxfordshire	24
Table 9: Prison population in Oxfordshire.....	25
Table 10: Trends in the number of rough sleepers in Oxfordshire	25
Table 11: Most deprived SOAs in terms of income deprivation compared with all SOAs in England, 2007.....	29
Table 12: Estimated prevalence of common neurotic symptoms over the past week in the working age population (16-64 years) in Oxfordshire, 2006, and the trend in symptoms up to 2026	31
Table 13: Estimated annual prevalence of mental illness in Oxfordshire (16-64 yrs) and change in prevalence from 2006 – 2026	32
Table 14: % of people with mental illness who complain of concurrent physical problems.....	33
Table 15: Estimated annual number of cases of mental illness in the working age population in general practice within Oxfordshire, 2006	34
Table 16: Prevalence of mental illness in GP QoF mental health registers as of 14 th Feb 2007 (all ages).....	35
Table 17: Prescribing of all psychiatric medications in primary care for all ages, 2004 - 2007	36
Table 18: Prescribing of anti-depressants in primary care for all ages, 2004 – 07.....	36
Table 19: Prescribing of anxiolytics/ hypnotics in primary care for all ages, 2004 – 07	36
Table 20: Routes of admission for clients with mental illness, 2006-07.....	37
Table 21: Predicted and actual rates of admissions for mental illness in Oxfordshire	37
Table 22: Expected trends in admissions for mental illness in the working age population 2002-26, all providers	37
Table 23: Expected percentage change in admissions for mental illness, 2006-26, all providers	38
Table 24: Self-reported ethnicity of clients admitted to OBMH, 2006	39
Table 25: Length of inpatient stay for all mental health clients of working age admitted to OBMH, 2006	39
Table 26: Length of inpatient stay for mental health clients of working age admitted to PICU, acute psychiatric inpatient wards and eating disorders unit, OBMH, 2006	40
Table 27: Length of inpatient stay for mental health clients of working age admitted to acute psychiatric inpatient wards only, OBMH, 2007/ 08.....	40
Table 28: Comparison of length of stay in Oxfordshire with South Central SHA average and UK average, 2006-07	41
Table 29: Information about prescribing in secondary care – having a say about the medications prescribed.....	41

Table 30: Information about prescribing in secondary care – purpose of the medications explained to clients	41
Table 31: Ambulatory mental health care in Oxfordshire, 2006	41
Table 32: Information about prescribing in secondary care – side effects of medications explained to clients	41
Table 33: Overall satisfaction with mental health services	41
Table 34: Healthcare Commission Annual Review.....	42
Table 35: Mental health annual self-assessment of services within Oxfordshire LIT, 2006/07	44
Table 36: Recommendations of the Joint Review of Adult Mental Health Services in Oxfordshire, June 2006.....	45
Table 37: Current spending on mental health services for people of working age in Oxfordshire	47
Table 38: Spending pattern for mental health services in Oxfordshire, 2003-06	48
Table 39: Indicators selected to monitor performance against the objectives within the Oxfordshire Mental Health Strategy[10]	49
Table 40: Indicators selected to benchmark progress against the OMHS[10].....	52
Table 41: Components of the Index of Multiple Deprivation.....	67
Table 43: Components of the Health Poverty Index.....	68
Table 43: Estimated prevalence of working age adults with a score of two or more on each Clinical Interview Schedule (CIS-R) symptom, 2006-26	71
Table 44: Estimated prevalence of working age adults with a score of two or more on each Clinical Interview Schedule (CIS-R) symptom, 2006 – 2026 and % change in prevalence up to 2026	72
Table 45: Estimated prevalence of working age adults with a score of two or more on each Clinical Interview Schedule (CIS-R) symptom, 2006-26	73
Table 46: Annual prevalence of Neurotic Disorders in the community (rate per 1,000 population)	77
Table 47: Estimated number of working age people with mental illness in Oxfordshire 2006-26	77
Table 48: Annual prevalence of probable psychotic disorder in the community (rate per 1,000 population)	81
Table 49: Estimated number of working age people with probable psychotic disorder in Oxfordshire 2006-26.....	81
Table 50: Annual prevalence of any personality disorder in the community, age 16-74 years (rate per 1,000 population)	82
Table 51: Estimated number of people aged 16-74 years with any personality disorder in Oxfordshire, 2006 – 2026	82
Table 52: Annual prevalence of alcohol dependence in the community (rate per 1,000 population)	83
Table 53: Estimated number of cases of alcohol dependence in people of working age in Oxfordshire, 2006-2026.....	83
Table 54: Annual prevalence of drug dependence in the community (rate per 1,000 population)	85
Table 55: Estimated annual number of cases of drug dependence in people of working age in Oxfordshire, 2006-2006	85
Table 56: Annual prevalence of Activities of Daily Living (ADL) difficulties amongst people with mental illness.....	89
Table 57: Estimated number of people with mental illness in Oxfordshire, 2006	89

Table 58: Estimated number of people with mental illness with ADL difficulties in Oxfordshire, 2006	89
Table 59: Annual prevalence rate per 10,000 persons of mental illness in general practice, first 3 ICD digits by age	91
Table 60: Estimated prevalence of mental illness in working age population in general practice in Oxfordshire, 2006	92
Table 61: Prevalence of mental illness in GP QoF mental health registers as of 14 th Feb 2007 (all ages).....	93
Table 62: Prescribing of all mental health medications in primary care 2004 - 2007 ..	96
Table 63: Prescribing of anti-depressants in general practice 2004 - 2007	97
Table 64: Prescribing of anxiolytics and/ or hypnotics in general practice 2004 - 2007	98
Table 65: Prescribing of anti-dementia medications in general practice 2004 - 2007 ..	99
Table 66: Prevalence of longstanding physical illness in those with any type of neurosis	100
Table 67: Prevalence of longstanding physical illness in those with probable psychosis	100
Table 68: Prevalence of longstanding physical illness in those with alcohol dependence.....	101
Table 69: Prevalence of longstanding physical illness in those with drug dependence	102
Table 70: Secondary care utilisation of mental health services in Oxfordshire, for clients aged 15-64 years, 2006.....	103
Table 71: Estimated use of secondary care mental health services, for clients aged 15-64 years, upto 2026	103
Table 72: Secondary care utilisation of mental health services in Oxfordshire, for clients aged 15-64 years, 2006.....	106
Table 73: In-patient admission for mental illness via general acute providers only, 2006.....	106
Table 74: Total admissions to general acute providers, as a percentage of total number of admissions to secondary care, 2006	107
Table 75: Summary of mental health services in Oxfordshire	110
Table 76: Whole time equivalent mental health staff in Oxon LIT, 2007	117
Table 77: Range and number of staff providing mental health services in Oxfordshire, Berkshire and Buckinghamshire	118
Table 78: Range of mental health services in Oxfordshire.....	119
Table 79: Results of mental health annual self-assessment of services within Oxfordshire LIT, 2006/07	121
Table 80: Criteria for mental health self-assessment of the Oxfordshire Local Implementation Team (LIT), 2007/08	126
Table 81: Spending on mental health services for adults of working age in Oxfordshire, 2007/08	131
Table 82: Spending on 3rd sector providers who care for mental health clients of working age in Oxfordshire, 2008/09	132

List of figures

	Page
Figure 1: Key tasks within the commissioning cycle mapped onto timeline for Oxfordshire commissioning strategy	17
Figure 2: Proportion of non-white ethnic groups in Oxfordshire by District Council.	24
Figure 3: Number of people of all ages who provide unpaid care in SE England.....	26
Figure 4: Percentage of people of all ages who provide 50+ hours of unpaid care per week in SE England	27
Figure 5: Distribution of IMD scores by lower super output area (LSOA) in Oxfordshire 2007	28
Figure 6: Health Poverty Index (HPI) for Oxfordshire compared with England, 2003	29
Figure 7: HPI Indicator for psychological morbidity, 2003	30
Figure 8: Trends in the prevalence of neurotic symptoms in the working age population within Oxfordshire, 2006-2026.....	31
Figure 9: Annual number of in-patient admissions for mental illness in Oxfordshire by age, all providers, 2006	38
Figure 10: Trend in the prevalence of symptoms of psychological distress that do not meet the threshold for a diagnosis of mental illness	73
Figure 11: Trends in the prevalence of neurotic conditions in Oxfordshire, 2006-26.	78
Figure 12: Trend in the prevalence of probable psychosis in Oxfordshire, 2002-26 ..	81
Figure 13: Trend in the prevalence of personality disorders in Oxfordshire, 2006-26	82
Figure 14: Trend in the prevalence of alcohol dependence in Oxfordshire, 2006-2026	84
Figure 15: Trend in the prevalence of drug dependence in Oxfordshire, 2006-26.....	86
Figure 16: Estimated number of people with mental illness and difficulties with ADLs in Oxfordshire, 2006	90
Figure 17: Prescribing and cost of all psychiatric medications in general practices in Oxfordshire, 2004-07	96
Figure 18: Prescribing and cost of anti-depressant medications in general practices in Oxfordshire, 2004-07	97
Figure 19: Prescribing and cost of anxiolytic/ hypnotic medications in general practices in Oxfordshire , 2004-07.....	98
Figure 20: Prescribing and cost of anti-dementia medications in general practices in Oxfordshire , 2004-07	99
Figure 21: Trends in in-patient admissions for mental illness within Oxfordshire, 2006-26	104
Figure 22: In-patient admissions for mental illness in Oxfordshire, stratified by type of provider, 2007.....	107
Figure 23: Annual budget for mental health services in Oxfordshire, 2007/2008.....	129
Figure 24: Budget for MH services in Oxfordshire, 2007/2008, divided by services	130
Figure 25: Budget for MH services provided by the 3 rd sector in Oxfordshire, 2008/09	133

Executive Summary

Following a joint review of adult mental health services in Oxfordshire by the Healthcare Commission (HCC) and the Commission for Social Care Inspection (CSCI) in June 2006, work was done to ensure that local mental health services were fit for purpose, and the opportunity was taken to develop a vision for mental health services in Oxfordshire going forward, which was laid out in a Mental Health Strategy for Oxfordshire 2007-2012. The document left detailed commissioning priorities to individual organisations in the Local Implementation Team (LIT) based upon an assessment of needs.

The remit of this work is to assess the mental health needs of the working age population (17-64 years) in Oxfordshire in order to influence the commissioning priorities of Oxfordshire PCT and Oxfordshire County Council. A further aim is to agree indicators to benchmark progress in the development of local mental health services against the outcomes in the Oxfordshire Mental Health Strategy 2007-12. Residents over the age of 65 and under the age of 17 were excluded from this research, as were clients with a diagnosis of drug & alcohol misuse, and clients from the forensic psychiatry services whose care is commissioned by specialist services and not as part of the general adult mental health services commissioning budget.

Method

The mental health needs of the working age population was assessed between January 2008 – August 2008, using the standard methodology recommended by the National Institute of Clinical Excellence (NICE), incorporating an assessment of routinely available data (epidemiological needs), comparing current services with best practice in the provision of mental health services (normative needs), comparing our current practices with those in our neighbouring counties (comparative needs) and collating evidence from key stakeholders including service users, carers, voluntary/ advocacy organisations and 3rd sector (not-for-profit)/ statutory providers (corporate needs).

Results

The results showed the following about our local population;

- The current working age population of 430,400 people in Oxfordshire is expected to increase by 3.58% over the next 10 years, whereas the number of households expected to increase by 10.51% over the same period
- There is a bimodal age increase expected with the largest population increases in the 25-29 and 50-54 year age bands
- The ethnic minority population is concentrated in Oxford City and is expected to increase at a greater rate than the county average
- Carers in Cherwell report the greatest burden of unpaid caring responsibility (>50 hours per week), and thus are most vulnerable to psychological distress themselves. However there is a need for more local, up-to-date information on carers of working age
- There is no evidence of an increase in other populations that are at increased risk of mental illness in Oxfordshire, including asylum seekers, the prison population or homeless population. However there is a need for more local information on these difficult to reach groups, especially the young homeless population

- Population based indicators suggest that the prevalence of risk factors associated with mental illness within Oxfordshire is below the national average, these risk factors are concentrated in urban wards within Banbury and Oxford

The following results were obtained about mental illness within our local community;

- Up to 20% of the PCT's population are affected by common neurotic symptoms such as sleep problems, fatigue and anxiety that do not meet the threshold for a diagnosis of mental illness
- This is expected to increase by up to 3% in the next decade, especially amongst those over the age of 50 years
- The prevalence of most mental illnesses is also set to increase over the next decade by 3-4%, especially the number of cases of psychosis over the age of 35, the number of people with obsessive compulsive and panic disorders as well as the prevalence of people with personality disorders
- Data from general practice indicates that 0.8% of the GP registered population in Oxfordshire have a severe and enduring mental illness (SMI) which equates to 5,144 people, of which 4,094 are of working age (0.96% of the population registered with GP practices in Oxfordshire)
- There are up to 30,864 people of working age with a diagnosis of depression/anxiety in general practice, this equates to 7.2% of the working age population registered with GP practices in Oxfordshire
- Prescribing information shows that during 2006/07 1,312,211 psychiatric medications were prescribed in general practice and community hospitals at a cost of £15,419,548.22 for all age groups. Over the past 3 years the number of psychiatric medications has increased by almost 11% and the cost by almost 10%
- There were 1,339 admissions to in-patient psychiatric care in 2006 with the average length of stay of 47.5 days (excluding stays in Assertive Outreach and the Rehabilitation Wards - Willow House and Phoenix)
- Last year (2007) the average length of stay for inpatients on Allen, Vaughan Thomas and Wintle wards was 30.3 days.
- Given the current pattern of service use admissions are expected to increase by 2% over the next decade and just over 4% in the next twenty years. However this masks considerable variation in the expected trends in inpatient admissions for clients with different types of mental illness
- Overall client satisfaction with mental health services has remained stable if somewhat increased slightly over the last three years and remains roughly equal to the national average. HCC appraisals of local mental health services has reflected this with fair ratings over the past 2 years for the quality of services provided and good ratings for the use of local resources

The following results were obtained about our mental health workforce, and the current provision of mental health services within our locality, including the gaps in provision;

- Within Oxfordshire, services commissioned by Oxfordshire PCT and Oxfordshire County Council for people of working age with mental illness cost £37,284,001 (excluding prescribing costs) which equates to 8% of the PCT's gross operating costs
- This includes £3,422,337 in a pooled budget between the PCT and OCC used for commissioning mental health services

- Funding for services from the 3rd sector is approximately 8% of the total MH budget
- Current gaps in service provision include the lack of a sufficient number of graduate mental health workers who are working within local primary care services; the need for a fully developed early intervention in psychosis service; the need for better access to Psychological Therapy Services; the need for better information about services, including access to out of hours services, for service users and carers; the need for a higher profile for mental health promotion and the need to promote the use of Direct Payments by mental health clients
- Future needs will be influenced by the expected increase in prevalence of mental illness, especially the increase in the number of cases of psychosis over the age of 35, the number of people with obsessive-compulsive disorder and panic disorders as well as the increase in people with personality disorders.
- The argument for a prevention model must be considered[1]
- Future service provision will need to reflect demographic changes, and move towards the model of care outlined by the 10 high impact changes and the Oxfordshire Mental Health Strategy.

Conclusion

The findings show that both the population and prevalence of mental illness is set to increase over the next decade if status quo is maintained. Upto 23% of the population will be affected by common mental illness, mainly neurotic symptoms. Currently less than half of these people are known to health services and thus there is a need to consider better methods of identifying these people and targeting interventions at this group.

However of more concern is the expected increase in cases of psychosis over the age of 35, the number of people with obsessive-compulsive and panic disorders, and those with personality disorders.

Treatment costs for people with mental illness including prescribing costs in both primary and secondary care have increased over the past 3 years. Currently the PCT spends £37M on mental health service provision (including contributions from the pooled commissioning budget between OCC/ PCT), which equates to roughly 8% of the gross operating costs of the PCT.

Future service provision will need to reflect these expected changes, and move towards a model of care outlined by the 10 high impact changes and the Oxfordshire Mental Health Strategy. This should incorporate a prevention/ mental well-being strategy, and possibly some targeted additional investment to develop services within primary care, and strengthen the role of new teams such as the early intervention in psychosis teams which intervene at a earlier stage of the illness. However any additional funding must be tied to a robust framework to monitor service performance and patient outcome to ensure commissioning decisions finance the most cost-effective services, and produce positive outcomes for clients. Additionally, consideration should be given to widening the choice of mental health services for clients in the local mental health economy by increasing the proportion of services commissioned from local 3rd sector providers especially where they may add value to existing services provided by statutory services or where they fulfil an unmet need.

Dr Uy Hoang, Specialist Registrar in Public Health, Oxfordshire PCT
Paul Ralph, Service Development Manager, Joint Commissioning Team for mental health, Oxfordshire PCT

Acknowledgements

We would like to extend our thanks to the following for their contribution to this work;

The needs assessment steering group including;

- Eddie McLaughlin, Director of Operations at OBMH
- Dr Rob Bale, Clinical Director at OBMH
- Alison Burton, Mental Health Lead for public health, Oxfordshire PCT
- Chris Morris, Sue Trinder, and the Decision Support Team at Oxfordshire PCT
- Jackie Thomas, Project Manager at OBMH
- Jane Kershaw, Performance Manager at OBMH
- Fiona Mullins, Head of the Research and Intelligence Department at The Oxfordshire Data Observatory
- Paul Purnell, Head of Social Care for Adults at Oxfordshire County Council
- Fenella Trevillion, Head of Joint Commissioning at Oxfordshire PCT
- Julia Boyce, Finance Manager (Contracting), Oxfordshire PCT
- Robert Majilton, Deputy Director of Finance, Oxfordshire PCT
- Pat Chard, Management Accountant, SCS Management Accounts & Oxfordshire County Council
- Danny Bruce, Management Accountant, OBMH
- Abigail Irving, Senior Accountant, OBMH
- Julie Dandridge, Head of Medicines Management, Oxfordshire PCT
- Derys Pragnell, Health Improvement Practitioner, Oxfordshire PCT
- Aly Valli, Service Development and Commissioning Manager (Prison Health), Oxfordshire PCT
- Juliet Long, Service Development Manager for Mental Health, Oxfordshire PCT
- Inga Doherty, Research & Information Officer (demography and monitoring), Strategic Policy & Economic Development , Oxfordshire County Council
- Mental Health Programme Board, Mental Health Strategy Implementation Group, Oxfordshire LIT Stakeholder Improvement Plan Steering Committee
- Robin Lorimer, Health and Social Care Change Agent Team, Department of Health
- Dennis Preece, Carers representative
- Judy McCulloch, Public Involvement Manager, Oxfordshire PCT
- All the service users, carers, members of the public and health & social care professionals who attended our engagement events around the commissioning of mental health services in Oxfordshire and/ or contributed their views to this document

Section 1 - Introduction

What is mental health?

1.1 Mental health has been defined by the WHO as “A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”. (www.who.int/features/qa/62/en/index.html). It forms an integral part of the WHO's definition of health: “A state of complete physical, mental and social well-being, and not merely the absence of disease” (www.who.int/topics/mental_health/en)

What is the effect of poor mental health?

1.2 A considerable body of evidence has shown that mental health problems are common and can have substantial effects on individuals, families, communities, healthcare services and society as a whole.

1.3 Two national prevalence surveys have been carried out in the UK since 1993 and suggest that approximately 1-in-6 of the adult population experiences mental ill-health at any one time, causing an estimated 23% burden of overall disease, depending upon the prevalence of risk factors for mental illness within the local population[2, 3].

1.4 Research has also shown that there is close interaction between mental health problems and physical illness.

Positive attributes of mental health and mental well-being

1.5 However the WHO definition stresses that mental health is more than the absence of mental illness, but also the presence of positive attributes of mental health. These positive attributes include; self-esteem, the presence of an internal locus of control or mastery, resilience, satisfaction with life, optimism, social integration, sense of coherence and the attainment of satisfying relationships[4-7].

1.6 This concept of positive attributes to mental health has become increasingly popular over the last decade since the publication of the World Health Report 2001, entitled ‘Mental Health: new understandings, new hope’. This report outlined a new public health approach to mental health which incorporated the wider determinants of mental health, the broad range of effects of mental illness and the numerous interventions used to strengthen mental health, improve mental well-being, prevent mental disorders, and treat or rehabilitate those affected by mental illness[8, 9].

Oxfordshire Mental Health Strategy 2007 – 2012

1.7 This new interpretation of mental health has had a significant influence on mental health policy and the configuration of mental health services in the UK. Within Oxfordshire these principles underlie the vision for improving mental health

and mental health services over the next five years (2007-2012) set out in the Oxfordshire Mental Health Strategy[10]. This strategy was widely consulted on with members of the public and other stakeholders.

1.8 The strategy envisaged that by 2012 the full range of organisations and agencies involved in mental health in Oxfordshire will be working together to deliver high quality, good value, sustainable services which meet the needs of service users and carers. The strategy suggested that this should be accomplished by focusing on six priority areas, namely;

1. Improving access to services
2. Improving choice and flexibility of treatment and care
3. Improving partnership working between agencies responsible for the provision of care to clients with mental health problems
4. Improving social inclusion of service users
5. Supporting carers
6. Improving the quality of mental health services locally

Table 1: Oxfordshire Mental Health Strategy 2007 – 2012: objectives[10]

Objective 1	Improve access to mental health services for all those who need them, regardless of gender, ethnicity, disability, sexual orientation, age, economic status or where they live in the county
Objective 2	Create and deliver clearly defined care pathways, that are informed by the needs, and choices of service users, and their carers, and which aim to deliver care within a framework of least possible restriction
Objective 3	Tackle the social exclusion of service users and their carers
Objective 4	Improve partnership working between all organisations and individuals whose work impacts on mental health service users, and between those organisations, service users and their carers
Objective 5	Improve the quality, dissemination and use of information about mental health in Oxfordshire, and to improve information sharing between organisations and individuals
Objective 6	Create flexible, appropriately skilled and representative mental health workforce able to deliver agreed priorities and service models. Comprising carers, volunteers and paid staff
Objective 7	Deliver effective and efficient services which demonstrably make the best use of all available resources
Objective 8	Invest in developing more mental health services in primary care and community settings across Oxfordshire (where appropriate disinvesting in acute inpatient services, and reducing expenditure on capital charges to achieve this)
Objective 9	Invest in mental health promotion work that is designed to prevent mental illness, and to reduce the stigma attached to being mentally unwell
Objective 10	Invest in flexible services, that are designed to support recovery, and sustainable independent living for people who have used, or are using mental health services, whatever their age
Objective 11	Ensure that investment enables delivery of national targets for mental health services in ways which meet national quality standards

1.9 Success in accomplishing the vision would be judged against eleven objectives outlined in Table 1, and within Appendix 1.

1.10 Since the publication of the strategy much work has already been accomplished in order to meet the objectives outlined in the strategy. However much work remains to ensure that the vision of better mental health for the people of Oxfordshire is accomplished by 2012. With this in mind, the PCT as lead commissioner for mental health services has been tasked with the responsibility of formulating a detailed commissioning strategy that should clearly lay out the mental health needs of the local population, outline current service capacity and set a clear agenda to ensure the delivery of better mental health services by 2012.

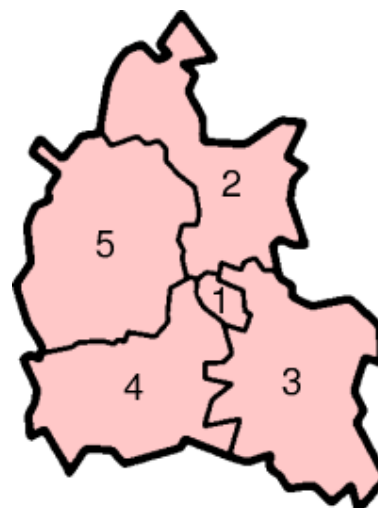
1.11 In addition, the strategy tasked the PCT with leading the creation of a comprehensive, easily accessible bank of high quality data about the need, usage, quality, and cost effectiveness of all mental health, and related social care services. This data would be used to evaluate existing programmes, support mental health commissioning and the development of services locally.



Supporting the strategy and monitoring progress

1.12 A mental health strategy implementation group (MHSIG) was convened and tasked with translating the strategy into cost effective programmes of work which would deliver on the objectives in the strategy. It was also mandated to review the progress made on delivering the strategy and to advise the Oxfordshire Commissioning Board (OCB) on an annual basis.

1.13 A mental health needs assessment steering group was established by the Mental Health Joint commissioning team at the PCT under the aegis of MHSIG in December 2007 to oversee the needs assessment. The membership and terms of reference of the mental health needs assessment steering group can be found in Appendix 2.



District Councils

1	Oxford City
2	Cherwell
3	WODC
4	Vale
5	SODC

Setting the scene for the mental health needs assessment

1.14 Oxfordshire (abbreviated Oxon) is a county in the South East of England, bordering on Northamptonshire, Buckinghamshire, Berkshire, Wiltshire, Gloucestershire, and Warwickshire.

1.15 Within Oxfordshire a two tier government system exists, Oxfordshire County Council provides certain services for the whole county whilst District Councils provide local services to the population. There are five local districts council: Oxford, Cherwell, Vale of White Horse (after the Uffington White Horse), West Oxfordshire and South Oxfordshire. Oxfordshire County Council is responsible for providing social care services across the county.

1.16 The area is noted for its world-leading educational establishments, headed by Oxford University. Around the county there are also numerous print and publishing firms, biotechnology companies and other high-technology/ engineering industries including a concentration of high performance motor sport companies. The county also has a thriving tourist industry.

1.17 The main centre of population is the city of Oxford. Other significant settlements are: Bicester, Banbury, Kidlington, and Chipping Norton to the north of Oxford; Witney to the west; Thame and Chinnor to the east; and Abingdon, Wantage, Didcot and Henley-on-Thames to the south. Future population growth in the county is expected to be concentrated around Banbury, Bicester, Didcot and Witney and Grove.

1.18 The highest point of the county is Whitehorse Hill, in the Vale of White Horse, reaching 856 feet (261m). The river Thames is a major geographical feature.

Oxfordshire PCT organisational strategy 2008 – 2013

1.19 In October 2006, five legacy PCT's (South West Oxon, South East Oxon, North East Oxon, Cherwell Vale and Oxford City PCT's) joined together to create an Oxfordshire wide PCT known as Oxfordshire PCT. The boundaries of the PCT roughly overlaps that of Oxfordshire County Council, except the towns of Thame and Shrivenham which are not included in the population covered by Oxfordshire PCT.

1.20 Over the past year, Oxfordshire PCT has conducted a wide-ranging consultation with members of the public, clients, carers, voluntary organisations, health and social care providers including local councils, voluntary organisations and the private sector to formulate its priorities for the coming five years which overlaps with the timescale for the mental health strategy.

1.21 The vision laid out in the PCT's organisational strategy is that by 2012, the people of Oxfordshire will[11];

- Be healthier – particularly if they live in our most deprived communities.
- Be working with the PCT to promote well being and prevent ill health.
- Be actively supported to manage their own health and care needs at home, when this is appropriate.
- Have access to a choice of high quality, safe and appropriate health services.
- Get excellent value for money from their local health services.

1.22 This will be accomplished by focusing on the following aims (objectives – see table 2);

Table 2: Oxfordshire PCT Strategy 2008 – 2013: aims[11]

Objective 1	Commissioning safe, high quality services that promote wellbeing, reduce health inequalities, deliver improved health outcomes and secure excellent levels of patient satisfaction
Objective 2	Engaging the public effectively in the development of healthcare and wellbeing services in Oxfordshire.
Objective 3	Strengthening the role and influence of clinicians in improving services, through the development of Practice Based and other forms of commissioning.
Objective 4	Improving partnership working in order to deliver properly integrated services and to improve health outcomes for vulnerable communities
Objective 5	Supporting the development of PCT, wider NHS and other providers of health and social care services, so that they and their staff can meet our commissioning requirements and there is greater choice available to clients
Objective 6	Establishing a highly effective and innovative organisation – one that has a workforce that is well placed to deliver on its strategy

1.23 Many of these priorities are similar to those outlined in the Oxfordshire Mental Health Strategy, and it is envisaged that work towards these aims will contribute towards the vision of better mental health services for the population of Oxfordshire. However, the PCT's strategy goes further in emphasizing the public health goals of improving the mental health and well-being of our local population, and reducing inequalities in health. These aims should also be taken into account in drawing up any mental health commissioning strategy for the county.

What is mental health needs assessment

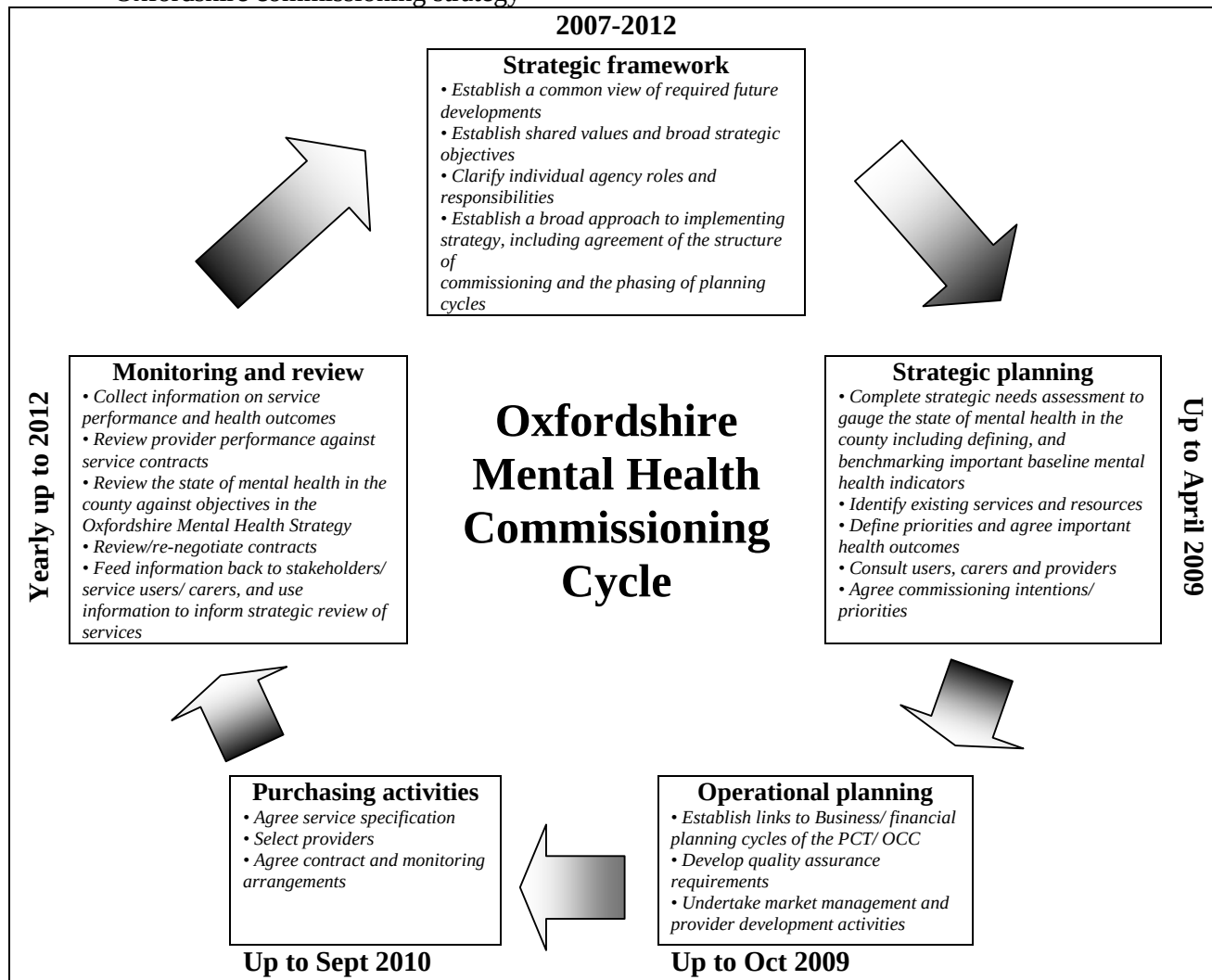
1.24 Mental health needs assessment is a process that aims to form the rational basis for commissioning health and social services, ensuring that the development of services addresses the needs of the local community and the gaps in provision, thus maximising the benefit to health, and reducing health inequalities[12, 13].

1.25 It involves engaging with members of the local population, including service users, carers, those involved in commissioning and providing health and social care for a locality as well as members of the public to identify health and social care needs, the configuration of current services and gaps in provision.

1.26 As part of this work, an extensive period of engagement with local service users, carers, providers including voluntary organisations and other stakeholders will be undertaken from May until August 2008 to validate the information from this needs assessment, and agree the commissioning priorities that will be taken forward by the Mental Health Programme Board into a detailed commissioning strategy and service development plan for the PCT and Oxfordshire County Council. This will form the basis of the corporate needs assessment. Further details about Mental Health Needs Assessment can be found in Appendix 3.

How does mental health needs assessment fit into the commissioning cycle?

Figure 1: Key tasks within the commissioning cycle mapped onto timeline for Oxfordshire commissioning strategy



Source: Adapted from - Commissioning definitions and frameworks, Commissioning Resource Pack – section 1, National Treatment Agency for Substance Misuse, 2003[14]

1.27 Commissioning has been at the forefront of the modernisation agenda within the NHS over the past few years. The white paper from the Department of Health entitled Commissioning a patient led NHS laid out the vision for locally commissioned services which provide more choice for clients, more personalised care and real empowerment of people to improve their health, in other words, it envisaged a move from a service that does things to and for its clients to one which is patient led, where the service works with clients to support them with their health needs[15-17].

1.28 Health needs assessment is therefore seen as an integral part of the commissioning process to ensure that the resources allocated to mental health secure the best value for clients and taxpayers[14, 18-20], namely;

- the best possible health outcomes, including reduced health inequalities
- the best possible healthcare, in terms of the range of services provided, the level of choice for clients, the quality, effectiveness and responsiveness of services

1.29 Figure 1 shows the commissioning cycle outlined by the NHS National Treatment Agency for Substance Misuse and the Department of Health which locates the place of health needs assessment within the commissioning process[14]. The figure also shows the importance of objective metrics to support the commissioning process, especially in identifying needs/ services and resources, specifying contracts and monitoring performance.

1.30 It is envisaged that all or some of the measures used to assess need in this document will also form part of a balanced scorecard (www.balancedscorecard.org) to measure organisational performance against the vision set out in the Oxfordshire Mental Health Strategy and the strategies of the different stakeholders.

Aim of this research

1.31 The aim of this research is to develop an understanding of the burden of mental ill-health amongst the working age population within Oxfordshire, and the current provision of health and social services provided for people with mental illness. The information gathered will be used to inform mental health commissioning, and service development for Oxfordshire PCT and Oxfordshire County Council.

1.32 A further aim is to recommend a basket of high quality indicators of mental health need, mental health service quality, and usage that could be used to inform the development of mental health commissioning and services locally, and allow progress to be benchmarked against the objectives in the Oxfordshire Mental Health Strategy.

Inclusions

- Residents within the county of Oxfordshire
- Residents of working age between 17 - 64 years of age

Exclusions¹

- Incarcerated populations, as separate health needs analysis will be conducted on these populations
- Clients with learning difficulties and no evidence of mental health co-morbidity, as learning difficulties services are commissioned through a separate commissioning budget

¹ Note that these specific groups and conditions have been selected as exclusions for this study meaning that commissioning recommendations for these groups/ conditions will not be a result of this study. However, information about these conditions will be collected as part of this work to allow us to draw a holistic picture of mental health needs in Oxfordshire and to enable commissioning decisions to be made in the light of this information.

- Clients with drug or alcohol abuse problems with no evidence of mental health co-morbidity, as drug and alcohol services are commissioned through a separate commissioning budget
- Residents equal to or over the age of 65 years (a separate Older people's mental health needs assessment has been completed as part of the development of the PCT's older people's commissioning and service development plan)[29]
- Psychiatric forensic services which are commissioned through specialist services

Tasks

1.33 The tasks for this project are as follows;

- a) To gauge the burden of mental ill-health amongst the working age population within Oxfordshire, benchmarked against the objectives within the Oxfordshire Mental Health Strategy 2007- 2012
- b) To map the current provision and spend on mental health services for adults of working in Oxfordshire
- c) To model the future burden of mental ill-health within Oxfordshire
- d) To contribute to the commissioning agenda for mental health services within Oxfordshire
- e) To advise on any further indicators that would be required to support mental health commissioning and the development of services locally

Section 2 - Methodology

Setting & Investigator

2.1 The mental health needs assessment was carried out between December 2007 and April 2008. The process was lead by Dr Uy Hoang, Specialist Registrar in Public Health at Oxfordshire PCT with the assistance and advice of a steering committee composed of representatives from a wide range of local stakeholders as well as experts in local data sources on mental health (see Appendix 2).

2.2 Chris Morris, Senior Information Analyst and Alison Burton, Public Health lead for mental health for Oxfordshire PCT provided advice on the methodology and data sources to support the needs assessment.

2.3 The researchers also received invaluable advice and assistance from Fenella Trevillion, Head of Joint Commissioning for mental health services at the PCT and Paul Purnell, Head of Social Care for Adults at Oxfordshire County Council, and numerous members of staff at Oxfordshire County Council, Oxfordshire Data Observatory, Oxfordshire PCT and Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust whose contributions are acknowledged at the beginning of this document

2.4 Paul Ralph, Service Development Manager for the joint commissioning team at Oxfordshire PCT project managed this work including helping to organise the many engagement events with stakeholders throughout the county, as part of his role in overseeing the development of commissioning for mental health services locally.

The members of the Oxfordshire LIT stakeholder improvement plan steering committee helped organise the launch event for this work and are gratefully thanked.

Normative needs

2.5 In scoping the mental needs of the population a review of national policies, regional, and local guidance, and research relevant to this area of health services was conducted to allow us to formulate a picture of normative needs, i.e. needs deduced from comparing the present provision of services with best practice. This included documents utilised by the South Central Mental Health Clinical Pathway Group for the NHS Next Stage Review and local guidance/ policies recommended by the steering committee. The policies reviewed are outlined and summarised in Appendix 4.

Comparative needs

2.6 For the comparative needs assessment, it was agreed by the steering committee that the current configuration of mental health services should be benchmarked against the configuration of commissioned services in neighbouring PCTs within Buckinghamshire and Berkshire. A copy of the latest Berkshire PCT Mental Health Needs Assessment and Commissioning Strategy[21] was obtained and summarised in Appendix 4. Buckinghamshire PCT has not yet completed its mental health commissioning strategy. However one must be cognisant that these PCTs have different populations, and are accountable to different local political structures which will have an effect on the configuration of mental health, and social support that are available.

2.7 Regional comparisons can also be made against the recent review of mental health and well-being in the south east conducted by the Care Services Improvement Partnership (CSIP) in October 2006[22].

Epidemiological needs and choosing indicators of mental health and well-being to benchmark against the objectives in the Oxfordshire Mental Health Strategy

2.8 The cause and consequences of mental illness are extensive, and the number of indicators that are collected about people with mental illness is broad and varied.

2.9 As mentioned above traditional measures of mental health used to assess populations have largely focused on the levels of psychiatric morbidity. In a recent study undertaken by NHS Scotland to establish a core set of national, sustainable mental health indicators for adults in Scotland, the researchers outlined a framework to assess suitable measures of positive mental health and well-being[6, 7].

2.10 This methodology allows the current state of mental health to be assessed both from a public health standpoint (at the population level) and against the objectives set out in the Oxfordshire Mental Health Strategy[10].

2.11 We have made use of this framework to select measures that would help us to gauge our progress towards reducing mental illness, and allow the PCT to benchmark its progress against objectives set out in the Oxfordshire Mental Health Strategy (see Appendix 1) and the PCT's own organisational strategy. An outline of the framework is shown in table 3.

Table 3: Key criteria for indicators of mental health amongst the local population

Criteria	Definition
Priority areas within the vision statement that are addressed	Which priority areas within the OMHS does the indicator measure? Which specific construct does the indicator measure?
Validity	Is there evidence that the indicator measures what it purports to measure, namely is there evidence of validity? Including whether changes in the indicator predicts changes in the construct – criterion validity, and whether the indicator distinguishes between separate constructs – discriminant validity.
Currently collected	Is the indicator currently collected, and available to the PCT/ OCC? What method is used to collect the indicator? Where can the indicator be sourced from? Is the information from this indicator relevant at the local (PCT/ OCC) level?
Sustainable	Is the indicator collected on a routine or ad-hoc basis? Is the indicator comparable over time?
Representativeness	Does the indicator include information about minority groups within Oxfordshire?
Interventions	Are there suitable evidenced interventions that can be implemented by the PCT/ OCC or their partners to affect change in this indicator?

2.12 A list of mental health indicators recommended by the Association of Public Health Observatories[23] and other measures of mental health available at a local level such as those collected by the Audit Commission, and the Healthcare Commission and as part of the service specifications between OBMH and the PCT/ OCC were mapped to this framework.

2.13 The final list of indicators chosen for this study was agreed by the steering committee, and further validated as part of the engagement process on the mental health needs of the population and the PCT/ OCC mental health commissioning strategy. Details of these indicators is shown in Appendix 1. This process will also allow us to identify areas where further indicators are needed.

Corporate needs

2.14 As mentioned above, an extensive period of engagement with local service users, carers, providers including voluntary organisations and other stakeholders will be undertaken from May until August 2008 to validate the information from this needs assessment, garner further information on the needs of our local population, and agree the commissioning priorities that will be taken forward by the Mental Health

Programme Board into a detailed commissioning strategy and service development plan for the PCT/ OCC. This will be guided by an engagement strategy which has been formulated in line with world class commissioning principles[20], and with the recent recommendations from Jeremy Sapford's review[24] into involving service users and carers in the commissioning, and development of local mental health services. This will form the basis of the corporate needs assessment.

Section 3 - Results

Section 3A - The population within Oxfordshire

3.1 The population of Oxfordshire in 2006 was 620,406 of which 430,400 people are between the ages of 15-64 years. The working age population is expected to increase by approximately 3% over the next 5 years and approximately 6% in the next 20 years to 456,100 in 2026. However the crude ONS population projections do not reflect the housing growth in the county over the next ten years which is expected to increase at double the rate of increase in the population. This is reflected in the pattern of population increase over the next decade which is expected to show a bimodal age distribution, with the largest increases in the 25-29 age group, and the 50-54 age groups.

Table 4: Population projections for Oxfordshire (all ages)

	All persons				Households			
	2006	2011	2016	%change 2006-16	2006	2011	2016	%change 2006-16
Oxfordshire	620,406	643,881	654,829	5.55%	260,103	276,779	287,436	10.51%
Cherwell	132,277	137,816	138,406	4.63%	57,121	61,710	64,060	12.15%
Oxford City	141,265	147,574	149,158	5.59%	56,104	60,021	61,191	9.07%
South Oxon	127,757	130,330	134,080	4.95%	55,101	57,625	60,677	10.12%
Vale	118,447	123,028	127,142	7.34%	48,924	51,750	54,545	11.49%
West Oxon	100,660	105,134	106,044	5.35%	42,853	45,673	46,963	9.59%

Source: Oxfordshire County Council, 2007. Oxfordshire forecasts of population and households at county, district and ward, 2001 to 2016

Table 5: Population projections for Oxfordshire divided by age group

Age Group	2006	2016	Change in nos (thousands)	% change males	% change females
15-19	44.1	41.2	-6.58	-7.36	-6.19
20-24	50.4	53.6	6.35	7.63	4.96
25-29	42.7	50.2	17.56	18.72	16.83
30-34	43.6	46.7	7.11	8.26	6.42
35-39	49.1	43.7	-11.00	-11.02	-10.98
40-44	49.8	43.6	-12.45	-13.60	-11.29
45-49	43.2	47.1	9.03	7.87	9.68
50-54	37.0	46.8	26.49	26.09	26.34
55-59	39.0	39.8	2.05	2.59	2.04
60-64	31.5	33.1	5.08	5.19	4.32

Source: ONS subnational population projections. The latest projections are based on the revised 2004 mid year estimates

Section 3B - Number of people in our vulnerable populations

3.2 In addition to demographic factors, previous research has shown that the prevalence of mental illness is more likely to occur in certain populations, and within certain communities that are affected by risk factors for mental ill-health[13]. Thus we have sought data on the size of these populations, and the extent of these population-based risk factors to gauge whether there are pockets of higher need for services within the county.

Ethnic minority population

3.3 Research has shown that ethnicity can influence the prevalence of mental illness, and the utilisation of mental health services. For example population surveys conducted on ethnic minority populations have found that the prevalence of psychosis is more common in Afro-Caribbean men whilst Pakistani men, and older Indian and Pakistani women, are more likely to have common mental disorders such as anxiety and depression than their White counterparts. South Asian populations, especially Bangladeshi are also more likely to utilise mental health services, especially GP services for mental health complaints[25-27]. Within Oxfordshire the majority of the ethnic population is concentrated within Oxford City and it is envisaged that the greatest need for BME services will be within the city of Oxford, although further information on the size of new groups of immigrants from Eastern Europe, and the prevalence of mental illness within these groups in Oxfordshire was not available for this needs assessment. Estimates from Oxfordshire County Council shows that the percentage increase in the population of certain ethnic groups within Oxfordshire is far greater than the county average, although the absolute numbers are small.

Table 6: Number of ethnic minorities of working age (16-64 years) in Oxfordshire and % of different ethnic groups by District council

District Council	Number in Non-White Ethnic Groups	% Mixed Ethnic Groups	% Asian Ethnic Groups	% Black Ethnic Groups	% Chinese Ethnic Groups	% Other Ethnic Groups
Cherwell	3,262	19.2	43.8	18.0	9.4	9.7
Oxford City	12,426	14.1	36.8	19.8	17.2	12.0
South Oxfordshire	1,756	25.6	30.0	18.8	12.9	12.7
Vale of White Horse	1,816	21.8	30.6	11.8	20.9	14.9
West Oxfordshire	989	29.8	23.8	15.9	14.0	16.6

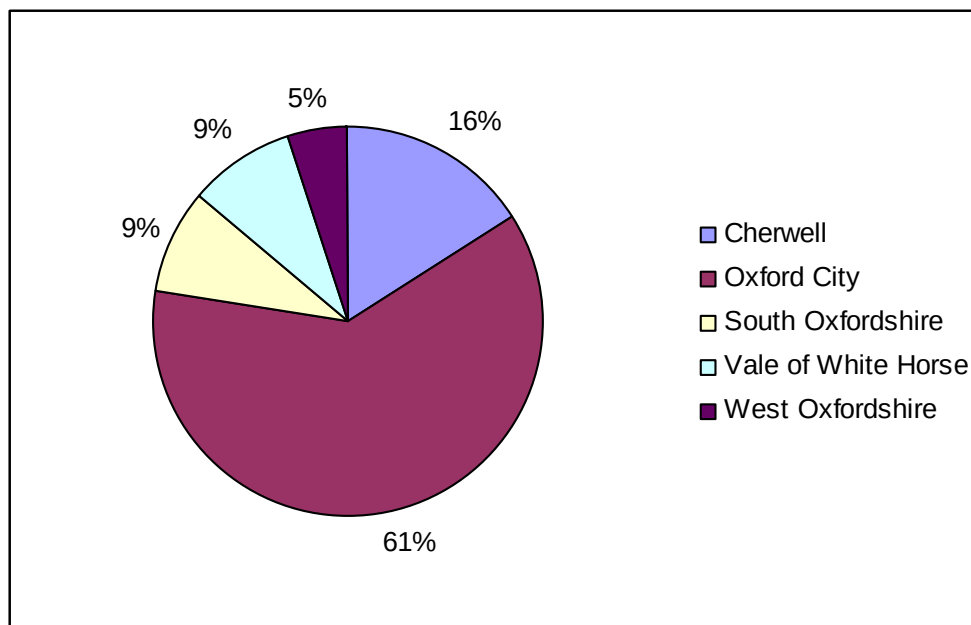
Source: ONS Census, 2001

Table 7: Estimated change in ethnic minority population in Oxfordshire

Ethnicity	2006	2011	change in number	% change
Mixed	8,591	10,273	1,681	19.57
Caribbean Black	2,447	2,398	-49	-1.98
Other Black	2,882	3,133	251	8.69
Indian	4,314	4,520	205	4.76
Pakistani	4,163	4,329	166	3.98
Other Asian	2,552	2,683	132	5.15
Chinese	4,644	5,275	631	13.58
Other	3,426	3,765	339	9.90

Source: Oxfordshire County Council, experimental population estimates, Nov 2006

Figure 2: Proportion of non-white ethnic groups in Oxfordshire by District Council



Source: ONS Census, 2001

Asylum seekers and prison population in Oxfordshire

3.4 Asylum seekers and prisoners or ex-offenders are known to be populations at high risk of mental ill-health. Within Oxfordshire, Bullingdon prison holds people on remand and offenders on short-term sentences. Approximately 10% of its inmates are residents of the Thames Valley. Details from the caseload probably under-estimate the true prevalence of illness but suggest that the prevalence of severe mental illness is approximately 4%. There is not expected to be any significant increase in this population within the next few years. Huntercombe serves a population that is younger than the age group covered in this needs assessment. Health services for both these institutions, including mental health services are commissioned by the PCT based on an annual assessment of need which should take into account any expected changes in the population or prevalence of illness in these institutions.

Table 8: Asylum seekers within Oxfordshire

Date	Number of asylum seekers in receipt of subsistence only support	Number of asylum seekers in supported accommodation
4 th quarter 2007	20	15
3 rd Quarter 2007	25	15
2 nd quarter 2007	30	15
1 st quarter 2007	30	5

Source: Home Office asylum statistics

3.5 According to Home Office statistics, the number of identified asylum seekers in the county has steadily decreased over the past few years. Although future trends in the number of asylum seekers is difficult to predict, there is not expected to be any significant changes in the next few years. Mental health services for residents of the immigration reception centre at Campsfield House is provided by the Home Office and not commissioned by the PCT.

Table 9: Prison population in Oxfordshire

Prison	Operational capacity	Residents of Oxfordshire	Prevalence of mental illness
Bullington prison	962	~10%	Estimated prevalence of psychosis – 33, neurosis – 116, personality disorder – 20 (Caseload reveals that appropriately 4% of prison population has severe mental illness)
Huntercombe (young offenders institution)	365	2.4%	Number with past psychiatric history – 95, number assessed by the mental health teams annually – 71
Campsfield House	215	-	-

Sources: HMP Bullington Prison, HNA final report, March 2008 and A health needs assessment at Huntercombe Young Offenders' Institution, March-May 2005

Homeless population

3.6 Homelessness, that is the where a person has no accommodation that they are entitled to occupy, or where they have accommodation, but it is not in a reasonable for them to continue to occupy (www.crisis.org.uk), is associated with health and mental health problems in a number of ways. Firstly, being homeless or not having a safe and secure place to stay can make people more vulnerable to mental health problems, and securing accommodation is often a key step in dealing with mental health problems (www.shelter.org.uk)[28]. Secondly, many homeless people have emotional and mental health problems. Lastly, mental ill-health can make independent living very difficult and contributes to homelessness and difficulties with finding accommodation.

3.7 In 2006/07, 180 young peoples housing assessments were completed across Oxfordshire, fifty-three of these 16 - 17 year olds were accepted as homeless. Thirty were housed by Oxford District Council into temporary accommodation. The 180 includes young people who may end up staying at home, going into the private sector, or into supported housing projects such as The Bridge, Windmill House, Foyer or Gateway. Many of those who are not in supported housing will be referred to floating support services (source: personal communication from Derys Pragnell). Data indicates that the visible population of homeless people has decreased significantly over the past 5 years, largely due to the homelessness strategy adopted by Oxford City Council in 2003 and the rigorous application of the homelessness prevention agenda in this strategy. Unfortunately at the time of this needs assessment there was no trend data on the number of people registered as homeless with district councils in Oxfordshire or the predicted numbers over the next few years.

Table 10: Trends in the number of rough sleepers in Oxfordshire

LA Area	June 2007	June 2006	June 2005	June 2004	June 2003	June 2002	June 2001	June 2000	June 1999	June 1998
Cherwell	0	0	0	0	0	0	0	0	0	0
Oxford	11	11	5	7	5	7	24	31	52	39
South Oxfordshire	0	0	0	0	0	0	0	0	0	0
Vale of White Horse	0	0	0	0	0	0	0	0	0	0
West Oxfordshire	0	0	0	0	0	0	4	4	0	0
Totals for Oxfordshire	11	11	5	7	5	7	28	35	52	39

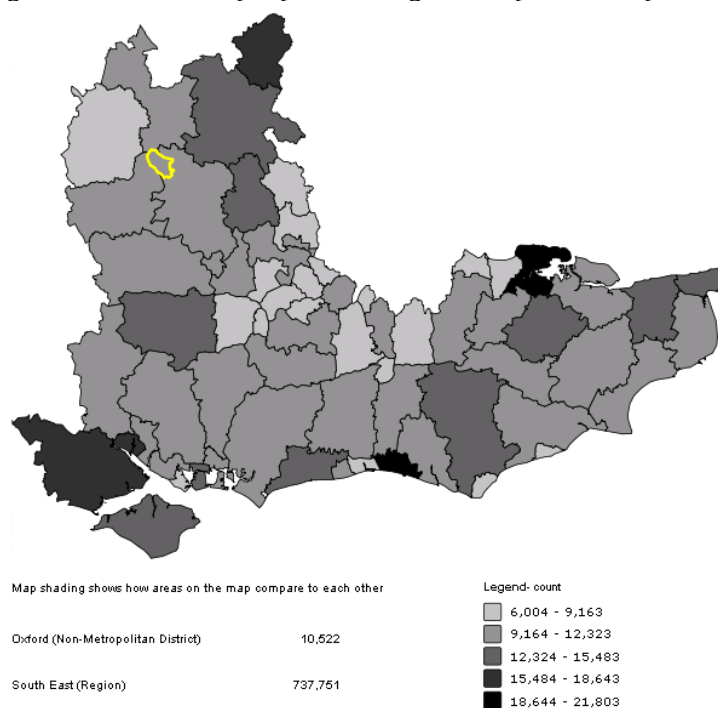
Source: Local Authority Housing Strategy Statistical Appendix (HSSA, formerly HIP returns) made in June 2007

Carers

3.8 The impact of looking after another person, particularly when that person requires very substantial help, may have a negative effect on carers' lives. Although it is difficult to show that it leads directly to poor psychological health, there is strong evidence that some carers are in poorer psychological health than people of a similar age and gender without any caring responsibilities in the general population.

3.9 Carers frequently report that they feel social isolation and loneliness, either because they no longer have the time to meet with family members and friends, or pursue hobbies or other interests, or because their relationship with the person from whom they care has altered. Practical help and interventions aimed at helping carers to cope with day-to-day situations that they find difficult can make a positive difference to their lives, and to the lives of those whom they care for.

Figure 3: Number of people of all ages who provide unpaid care in SE England



Source: ONS Census Neighbourhood Statistics, 2001

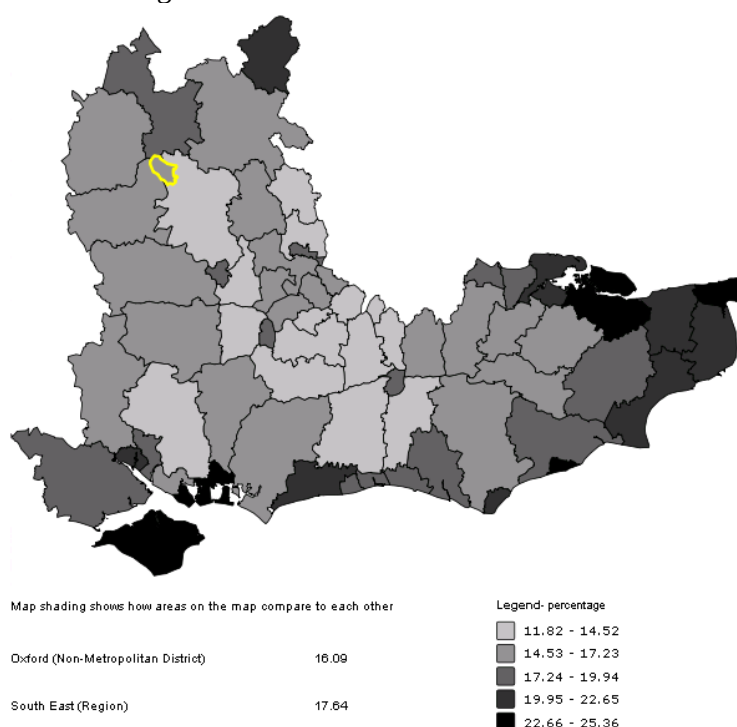
3.10 Locally, a recent report by the Oxfordshire Data Observatory found that the proportion of people of all ages in rural Oxfordshire providing unpaid care is above the rate in urban areas. 9.8% (23,300) of people in rural areas were providing unpaid care - above the Oxfordshire average (8.8%) according to the 2001 Census survey. Seven areas of rural Oxfordshire are ranked in the top 10% nationally in terms of the percentage of people providing unpaid care, namely;

- | | |
|-------------------------------|-----------------------|
| 1. Kidlington North | (Cherwell) |
| 2. Faringdon and The Coxwells | (Vale of White Horse) |
| 3. Sunningwell and Wootton | (Vale of White Horse) |
| 4. Chiltern Woods | (South Oxfordshire) |
| 5. Sonning Common | (South Oxfordshire) |

- | | |
|-------------------|---------------------|
| 6. Chinnor | (South Oxfordshire) |
| 7. Sonning Common | (South Oxfordshire) |

3.11 Figures 3 and 4 also indicates that most carers are distributed within the south of the county, however those carers who report the greatest burden of caring responsibility (>50 hours per week), and thus are most vulnerable to psychological distress themselves are located within Cherwell. However these statistics were recorded in 2001 and cover carers of all ages. Thus there is a need for more up-to-date information on carers in our locality that identifies the burden of care for different age groups and genders to allow us to more accurately assess the extent of need amongst this population.

Figure 4: Percentage of people of all ages who provide 50+ hours of unpaid care per week in SE England



Source: ONS Census Neighbourhood Statistics, 2001

Section 3C - Population based risk factors for mental illness

3.12 A number of other population factors have been associated with the prevalence of mental illness either as risk or protective factors for mental ill-health. Several composite indicators have been designed to gauge the extent of these indicators within local communities, facilitate the adjustment of rates of mental illness, and allow comparison between local authorities. The most often cited is the Index of Multiple Deprivation (IMD) which uses a number of indicators across several different domains to gauge the relative deprivation of small areas with consistent population sizes (Super Output Areas) to facilitate comparison of rates and allocation of funding. The components of the IMD and other composite indicators are shown in Appendix 5. Research has shown that IMD scores are reflective of the prevalence of mental ill-

health and the use of health services at a local level which can help us identify where preventative interventions and mental health services should be targeted.

3.13 Figure 5 shows that deprivation and other risk factors for mental illness are concentrated in urban wards around Oxford City and Banbury. Table 11 identifies the 9 SOAs where we would expect the greatest needs for mental health services.

Figure 5: Distribution of IMD scores by lower super output area (LSOA) in Oxfordshire 2007

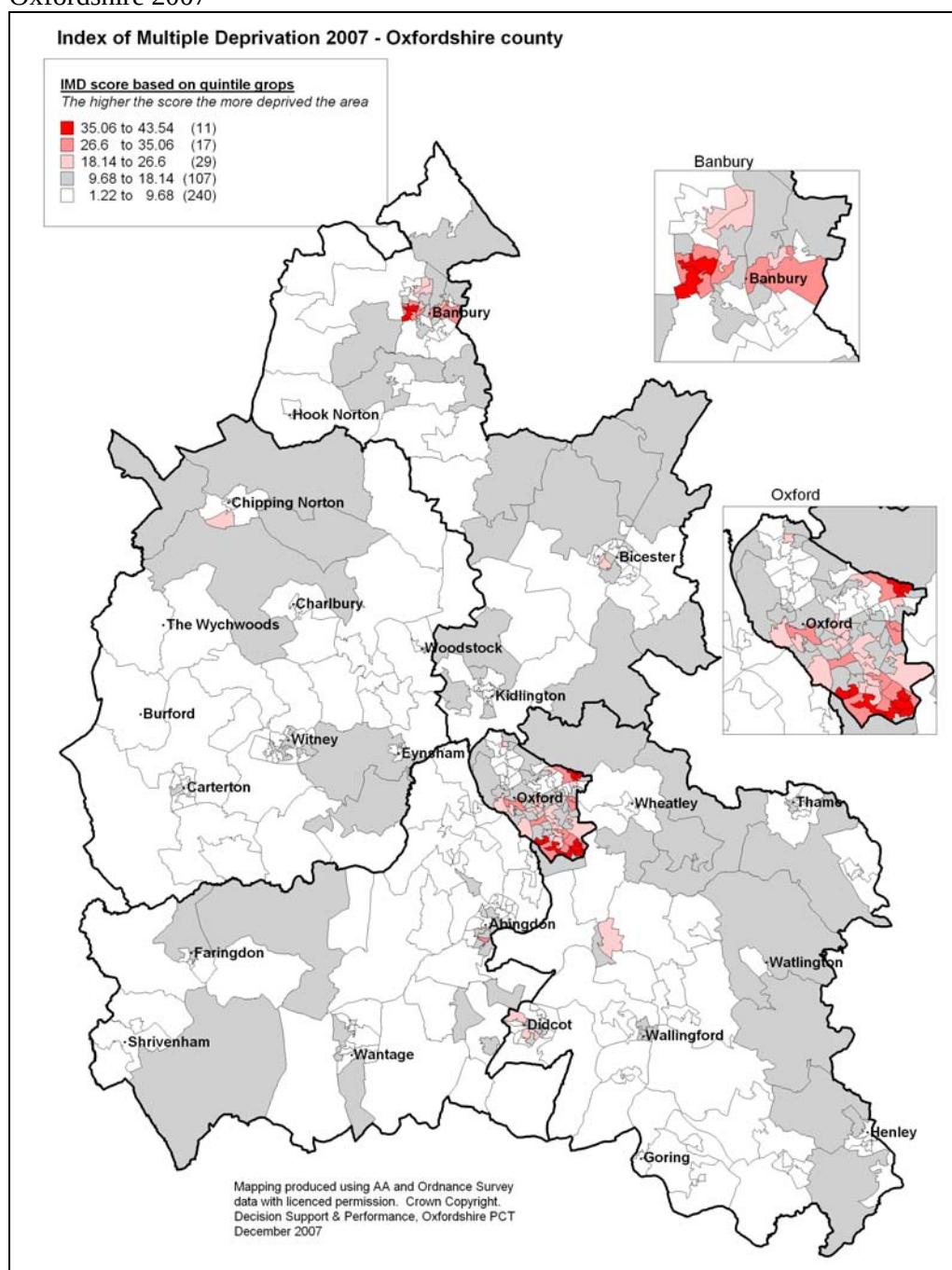
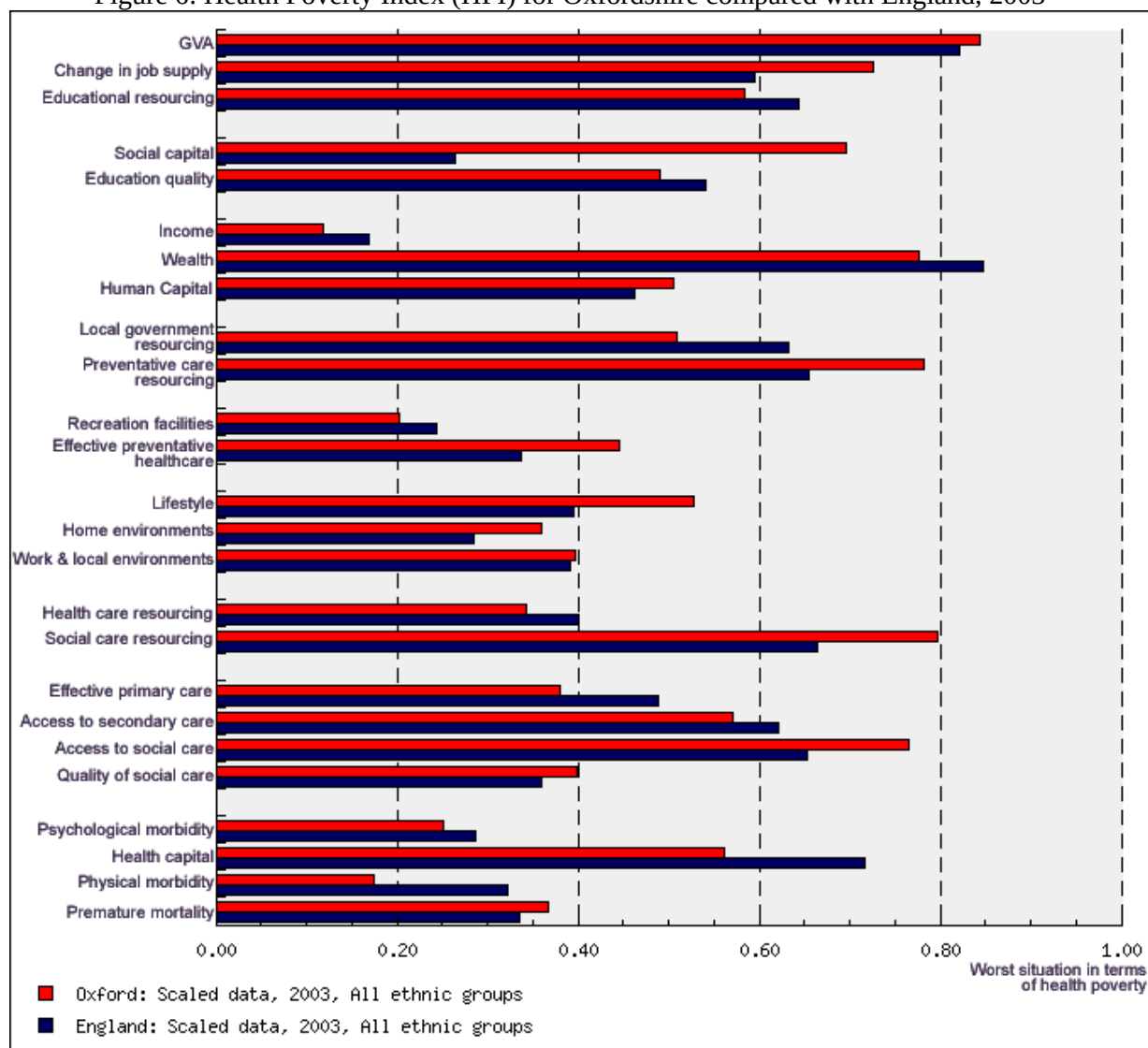


Table 11: Most deprived SOAs in terms of income deprivation compared with all SOAs in England, 2007

Super Output Area	Deprivation rank (where 1 is most deprived, 32,482 is least deprived)	Rank as % of all areas in England
Barton and Sandhills	1,012	3.1% from bottom
Cowley Marsh	2,283	7.0% from bottom
Northfield Brook	2,440	7.5% from bottom
St Mary's	2,579	7.9% from bottom
Rose Hill and Iffley	2,700	8.3% from bottom
Churchill	2,851	8.8% from bottom
Banbury Grimsbury & Castle	3,018	9.3% from bottom
St Clement's	3,059	9.4% from bottom
Blackbird Leys	3,122	9.6% from bottom

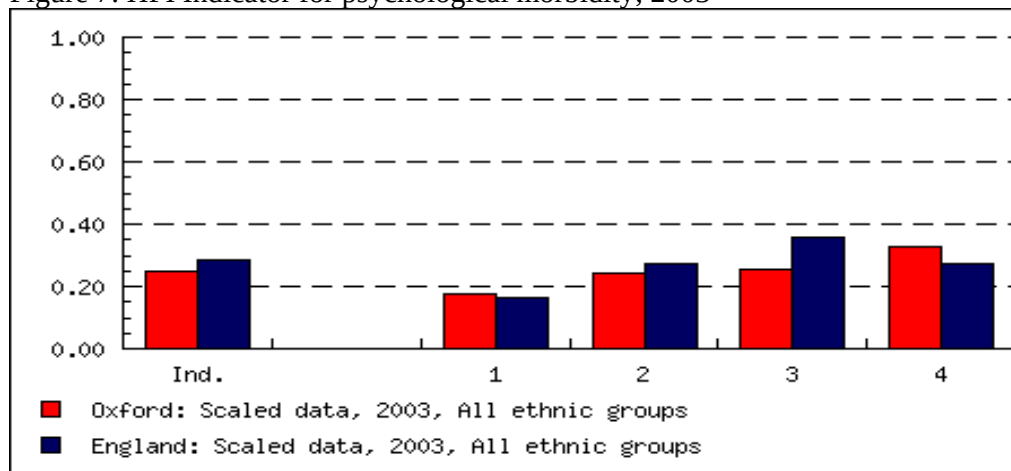
Source: Index of Multiple Deprivation, 2007

Figure 6: Health Poverty Index (HPI) for Oxfordshire compared with England, 2003



3.14 The Health Poverty Index suggests that the rate of psychological morbidity in Oxfordshire is below the national average taking into account the local suicide rates, psychiatric admissions, psychiatric prescribing rates and benefits claimed for mental health conditions.

Figure 7: HPI Indicator for psychological morbidity, 2003



Source of this composite indicator is made up from 4 sub-indicators; 1. Suicide rates, 2. Benefits for mental health conditions, 3. Prescribing for anxiety/depression, 4. Psychiatric admissions

Summary of the population characteristics and the prevalence of population based risk factors for mental illness

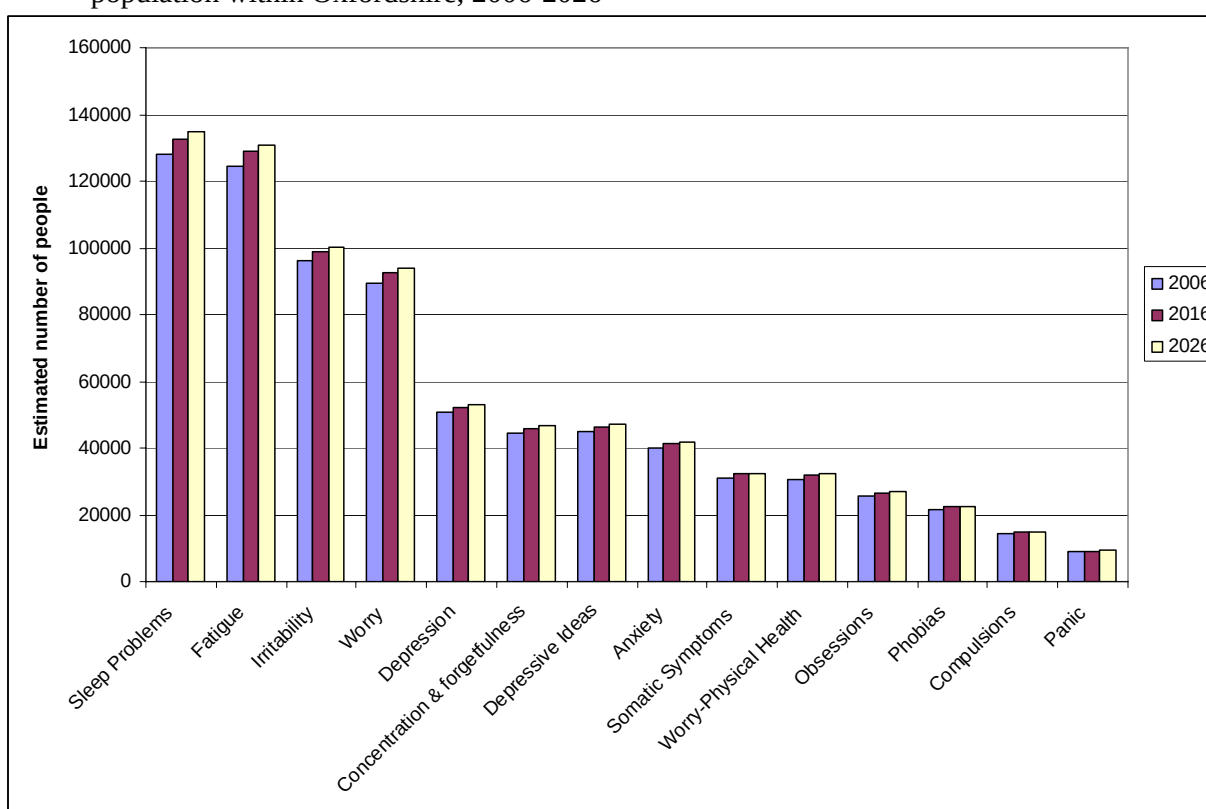
- The current working age population of 430,400 people in Oxfordshire is expected to increase by 3.58% over the next 10 years, whereas the number of households expected to increase by 10.51% over the same period
- There is a bimodal age increase expected with the largest population increases in the 25-29 and 50-54 year age bands
- The ethnic minority population is concentrated in Oxford City and is expected to increase at a greater rate than the county average
- Carers in Cherwell report the greatest burden of unpaid caring responsibility (>50 hours per week), and thus are most vulnerable to psychological distress themselves. However there is a need for more local, up-to-date information on carers of working age
- There is no evidence of an increase in other populations that are at increased risk of mental illness in Oxfordshire, including asylum seekers, the prison population or homeless population. However there is a need for more local information on these difficult to reach groups, especially the young homeless population
- Population based indicators suggest that the prevalence of risk factors associated with mental illness within Oxfordshire is below the national average, these risk factors are concentrated in urban wards within Banbury and Oxford

Section 3D - Prevalence of symptoms of psychological distress that do not meet the threshold for a diagnosis of mental illness

3.15 According to surveys by the ONS, over the period of any one week, upto 20% of the PCT's population can be affected by common neurotic symptoms such as sleep

problems, fatigue and anxiety. Within Oxfordshire this equates to approximately 128,211 people of working age with sleep problems, and 124,588 who complain of fatigue/ tiredness in the last week. However only 7% of the sample would have symptoms that would be consistent with a neurotic diagnosis, although it is not known how many would consult their healthcare practitioner, and it is not known what proportion of these people will eventually progress to more severe symptoms that would warrant a formal psychiatric diagnosis. Mapping these prevalence figures onto the projected population figures for Oxfordshire suggests that there will be an increase of approximately 3% in those reporting neurotic symptoms in the next decade, which equates to 4,222 more people reporting sleep problems and 4,276 people complaining of fatigue/ tiredness by 2016, with the majority of the increase in those over the age of 50 years (see Appendix 6).

Figure 8: Trends in the prevalence of neurotic symptoms in the working age population within Oxfordshire, 2006-2026



Source: (Derived) Oxfordshire PCT population (2006) applied to UK Survey estimates (2000)[3]

Table 12: Estimated prevalence of common neurotic symptoms over the past week in the working age population (16-64 years) in Oxfordshire, 2006, and the trend in symptoms up to 2026

Type of symptom	Estimated number of people in Oxfordshire, 2006	change in number between 2006-2016	change in number between 2006-26	%change 2006-26
Sleep Problems	128,211	4,222	6,671	5.20
Fatigue	124,588	4,276	6,349	5.10
Irritability	96,116	2,819	4,016	4.18
Worry	89,607	3,022	4,163	4.65
Depression	50,921	1,216	2,245	4.41

Type of symptom	Estimated number of people in Oxfordshire, 2006	change in number between 2006-2016	change in number between 2006-26	%change 2006-26
Concentration & forgetfulness	44,484	1,559	2,256	5.07
Depressive Ideas	45,084	1,214	1,916	4.25
Anxiety	40,055	1,442	1,858	4.64
Somatic Symptoms	31,122	1,032	1,427	4.59
Worry-Physical Health	30,773	1,050	1,669	5.42
Obsessions	25,705	745	1,173	4.56
Phobias	21,526	739	906	4.21
Compulsions	14,203	433	766	5.39
Panic	8,984	204	280	3.12

Source: (Derived) Oxfordshire PCT population (2006) applied to UK Survey estimates (2000)[3]

Section 3E - Prevalence of mental illness in the local community

Table 13: Estimated annual prevalence of mental illness in Oxfordshire (16-64 yrs) and change in prevalence from 2006 – 2026

Psychiatric Diagnosis	2006	2016	2026	Change 2006-26	% change 2006-26
Any neurotic disorder (ICD10 code – F32-42)	76,206	78,928	79,873	3,667	4.8
Mixed anxiety and depressive disorder (ICD10 code – F41.2)	40,608	41,979	42,506	1,898	4.7
Generalised anxiety disorder (ICD10 code – F41.1)	20,312	21,038	21,311	999	4.9
Depressive episode (ICD10 code – F32-33)	12,316	12,695	12,924	608	4.9
All Phobias (ICD10 code – F40)	8,421	8,660	8,781	359	4.3
Obsessive compulsive disorder (ICD10 code – F42)	5,599	5,747	5,886	287	5.1
Panic disorder (ICD10 code – F41.0)	3,255	3,442	3,422	167	5.1
Probable (functional) Psychotic Disorder (ICD10 code – F20-29, F30, F31)	2,454	2,475	2,554	100	4.1
Any Personality Disorder (16-74 yrs) (ICD10 code – F60-69)	21,625	24,410	25,146	3,521	16.3
Mild Alcohol Dependence – (SAD-Q score 4-19)	35,158	36,200	36,329	1,170	3.3
Moderate Alcohol Dependence – (SAD-Q score 20-34)	1,853	1,821	1,859	6	0.3
Severe Alcohol Dependence – (SAD-Q score 35-60)	320	318	331	11	3.5
Any drug dependence	20,178	21,092	20,788	609	3.0
Cannabis dependence only	13,672	14,372	14,127	455	3.3
Other drug dependence with or without cannabis dependence	6,550	6,750	6,701	151	2.3

Source: (Derived) Oxfordshire PCT population estimates (2006-26) applied to UK Survey estimates (2001)[3]

3.16 Table 13 and Appendix 7 indicates that within Oxfordshire the annual prevalence of neurotic disorders (ICD10 code F32-42) in those of working age will increase by 4.8 % across Oxfordshire over the next 20 years, with the prevalence of

Obsessive Compulsive Disorders (ICD10 code F42) and Panic Disorders (ICD10 code F41) expected to increase at the greatest rate over the next two decades. In absolute terms the number of clients with mixed anxiety and depressive disorder is expected to increase the most over the next 20 years. Appendix 8 indicates that these conditions can be disabling for many people with up to 45% of those with neurotic symptoms saying that they have some difficulties with the ordinary activities of daily living such as managing money, dealing with paperwork and managing any medications they may be prescribed, whereas up to 60% of those with psychotic symptoms complained of similar problems in dealing with day-to-day chores. In addition, Table 14 shows that a high proportion of people with mental illness are also afflicted by longstanding physical problems such as musculo-skeletal complaints and heart/ circulatory system complaints.

3.17 Combined with information on the growing prevalence of symptoms, these statistics highlight the case for a comprehensive mental health and well-being strategy, especially targeted at those over the age of 50 years, to identify and intervene in people with symptoms of neurosis who may be at risk of progressing onto more severe illness. This was a recommendation of the recent report by the Director of Public Health for Oxfordshire and a strategy is expected later this year[1]. The first point of contact for many of these people is their local GP, thus the PCT should work with mental health leads for Practice Based Commissioning (PBCs) to increase awareness of mental illness amongst local GPs and practice nurse staff, increase confidence in managing clients with common mental health problems, and ensure the range of therapies that are provided in primary care reflect the expected burden of illness and cater for the high prevalence of physical co-morbidity amongst this population.

Table 14: % of people with mental illness who complain of concurrent physical problems

Type of physical complaint	Any Neurotic Disorder	Probable Psychosis	Hazardous Drinking (Not Dependent)	Alcohol Dependent	Dependent on Cannabis only	Dependent on other Drugs with or without Cannabis
Musculo-skeletal complaints	29%	21%	15%	14%	11%	11%
Respiratory System complaints	11%	9%	7%	8%	10%	3%
Heart and Circulatory System complaints	13%	21%	6%	7%	3%	2%
Digestive System complaints	9%	8%	4%	4%	3%	0%
Nervous System complaints	9%	15%	3%	5%	5%	4%
Endocrine disorders	6%	3%	4%	2%	1%	1%
Genito-urinary System complaints	4%	3%	1%	2%	1%	1%
Skin complaints	3%	1%	2%	2%	4%	2%
Ear complaints	2%	0%	2%	2%	2%	5%
Eye complaints	2%	4%	1%	2%	1%	0%
Neoplasms	2%	3%	1%	0%	1%	1%
Blood disorders	1%	0%	0%	0%	0%	0%
Infectious and Parasitic diseases	1%	0%	0%	0%	0%	0%
Any Longstanding Physical complaint	58%	62%	37%	38%	34%	28%

Source: Survey of Psychiatric Morbidity among Adults living in Private Households, 2000[3]

3.18 The number of cases of probable psychosis is expected to increase by 4.1% over the next 20 years, or 100 cases per year, especially in those groups over the age of 35 (more details can be found in Appendix 7). This may have significant impact on

the need for specialist provision as these clients are more likely to require secondary care and/ or specialist mental health treatments than clients with other mental illnesses. There may also be a need to look at the transitions of clients with severe and enduring mental illness from adult services to old age psychiatry, as evidence shows that this population is living longer with more likely to reach retirement age than in the past.

3.19 The prevalence of personality disorders are also expected to increase by 16.3%, (although this includes groups between the ages of 15-74 years) the majority of which will be of obsessive-compulsive type. However these prevalence rates must be approached with caution as the prevalence surveys from which these figures were extrapolated included only a very small sample size, and thus the confidence interval around the rates may not be as robust other prevalence figures. However commissioners may consider reviewing service capacity for these clients as comparative information indicates that specialist services for clients with personality disorders is below the SHA average and considerably below those of our neighbouring PCTs. This review should also take into account information on the effectiveness of services for this group of clients.

3.20 Stratification by race and ethnicity are problematic due to the small number of cases in the original sample, and thus the instability of the rate estimates. Thus figures on the prevalence of mental illness in the community by ethnic group are not presented in this report.

Section 3F - Prevalence of mental illness in general practice

Table 15: Estimated annual number of cases of mental illness in the working age population in general practice within Oxfordshire, 2006

Psychiatric Diagnosis	Estimated annual number of cases of mental illness in general practice within Oxfordshire, 2006
Organic psychoses (ICD9 – 290 -294)	120
Functional psychosis (ICD9 – 295 – 299)	1,366
Neurotic disorder (ICD9 – 300)	9,165
Depressive disorder NEC (ICD9 – 311)	3,332
Acute reaction to stress (ICD9 -308)	591
Adjustment reaction (ICD9 – 309)	803
Personality disorder (ICD9 – 301)	222
Alcohol dependence syndrome (ICD9 – 303)	1,154
Drug dependence (ICD9 – 304)	923

Source: (Derived) Oxfordshire PCT population (2006) applied to RCGP Birmingham Research Unit, Weekly Returns Service, Annual Prevalence Report 2006

3.21 Table 16 shows the information from mental health registers in local general practices within Oxfordshire, which suggests that the number of people of all ages with severe mental illness (SMI), namely those with schizophrenia, bipolar disorder, severe depression, and those taking lithium therapy is 5,144 which is approximately 0.8% of the registered general practice population. Information from the mental health needs assessment for older people conducted in August 2007[29] found that 1,050 older people were diagnosed with severe mental illness, thus suggesting that there are 4,094 people of working age with severe mental illness in Oxfordshire, equivalent to 0.96% of the working age population registered with general practices in Oxfordshire (see Appendix 9).

3.22 Information from depression registers within local GP practices in Oxfordshire (Table 16) and from the mental health needs assessment for older people conducted in August 2007[29] suggests that 30,864 people of working age (i.e. 33,694 - 2,830) have anxiety/ depression in general practice in Oxfordshire, which equates to 7.2% of the working age population registered with general practices in Oxfordshire.

3.23 Comparing the number of clients on these registers (Table 16) with the number of people estimated to have a neurotic disorder in the local community (Table 13) suggests that approximately half of these people are being seen within local general practices. However more work needs to be done to understand the composition of these GP mental health registers locally before comparisons can be made between the rate of diagnosis of mental illness in general practice versus the estimated community prevalence. Additionally the utility of using these registers for monitoring the burden of depression or neurotic disorder in the community, and as the basis for monitoring any mental health and wellbeing program should be investigated.

Table 16: Prevalence of mental illness in GP QoF mental health registers as of 14th Feb 2007 (all ages)

PBC Consortia	Practice List Size	Mental Health		Depression	
		nos	%	nos	%
North East Oxfordshire PBC Consortium	76,299	393	0.5%	4,200	5.5%
North Oxfordshire Commissioning Consortium	101,637	787	0.77%	5,765	5.7%
Oxford City	193,832	1,826	0.94%	8,174	4.2%
SE Locality Group	81,899	522	0.64%	4,348	5.3%
Vale Locality Group	128,331	1,172	0.91%	7,021	5.47%
West Oxon Locality Group	74,410	444	0.6%	4,186	5.6%
Grand Total	656,408	5,144	0.8%	33,694	5.1%

Source: Oxfordshire PCT Decision Support Team, extract from Oxfordshire GP practices on 14th Feb 2007, (Practice list size taken from PBC practice populations on 1st Jan 2007)

3.24 Table 15 estimates that a very small proportion of people with personality disorder are seen within general practice. This would indicate that an increase in the number of cases of personality disorder within the community may not impact greatly on the need for mental health services unless there was a concomitant change in the severity of the disorder, the need for treatment, or the rate of co-morbid mental illness/ substance misuse. However the increase in people with personality disorders may have more impact on social services, policing/ probation services, and drug treatment services that needs to be quantified.

Section 3G - Prescribing for mental illness in primary care

3.25 Tables 17-19 below show that prescribing for all psychiatric medications, for all ages in primary care, including general practice, and specialist community services provided by the PCT has increased by 10.94% over the last 3 years from a rate of 1,917 items per 1,000 population to 2,126 items per 1,000 population. At the same time the cost of psychiatric prescribing has increased by 9.71% over the same period from £14.055m to £15.420m. The rate and cost of prescribing for anti-dementia drugs

has risen by greater than this average, a result that was described in the recent Older People's mental health needs assessment[29].

Table 17: Prescribing of all psychiatric medications in primary care for all ages, 2004 - 2007

2004/5		2005/6		2006/7		% change since 04/05	
items	cost	items	cost	items	cost	items	cost
1,182,807	14,055,002.21	1,233,837	14,732,668.38	1,312,211	15,419,548.22	10.94	9.71

Source: Oxfordshire PCT prescribing team

3.26 The number of anti-depressants prescribed has increased at a faster rate than other psychiatric medications. These medications have a number of other indications besides the treatment of depression and anxiety, especially tricyclic anti-depressants (TCAs) which are used for neuralgia, chronic pain syndromes, 'isolated' sleep disorders, irritable bowel syndrome, migraine prophylaxis and other persistent headaches. However, it is interesting to note that the total number of anti-depressants prescribed is more than four times the number of working age people estimated within the community with any neurotic disorder, and 22 times the estimated number of clients of working age in general practice with neurotic or depressive illness. Again this reflects a finding shown in the older people's mental health needs assessment which identified a substantial disparity between the total number of psychiatric medications prescribed in general practice, and the registered patient population with mental illness[29]. However before the same conclusion is made from this result further work needs to be done to identify anti-depressant prescribing rates for the working age population, and conduct more detailed analysis to compare the prescribing rates for selective serotonin reuptake inhibitors (SSRIs), and serotonin-norepinephrine reuptake inhibitors (SNRIs) with the rates of diagnosis of depression, as these modern anti-depressants have a more specific indication for clients with depressive illness. However the anti-depressant prescribing rates could paint a more accurate picture of the burden of illness due to depression/ anxiety in primary care than GP depressions registers and this should be further investigated.

Table 18: Prescribing of anti-depressants in primary care for all ages, 2004 – 07

2004/5		2005/6		2006/7		% change since 04/05	
Items	cost	items	cost	items	cost	items	cost
349,748	4,439,251	363,509	3,704,610	391,774	3,343,747	12.02	-24.68

Source: Oxfordshire PCT prescribing team

3.27 The prescribing of anxiolytic/ hypnotic medications has decreased over the past three years, reflecting a move away from these medications towards other forms of management such as psychotherapies in primary care.

Table 19: Prescribing of anxiolytics/ hypnotics in primary care for all ages, 2004 – 07

2004/5		2005/6		2006/7		% change since 04/05	
Items	cost	items	cost	items	cost	items	cost
138,265	261,950	134,891	304,982	137,224	398,761	- 0.75	52.23

Source: Oxfordshire PCT prescribing team

Section 3H - Use of secondary mental health services

3.28 Clients with depression were most likely to be referred to specialist mental health services by their GP or through A&E than from outpatients, whereas clients with

schizophrenia and bipolar affective disorder were more likely to more likely to access specialist mental health services via outpatient consultation (Table 20).

Table 20: Routes of admission for clients with mental illness, 2006-07

Route	Depression			Schizophrenia			Bipolar affective dis		
	Oxon	SHA	Eng	Oxon	SHA	Eng	Oxon	SHA	Eng
A&E	16%	25%	38%	4%	8%	17%	7%	10%	14%
GP	19%	9%	9%	7%	4%	4%	11%	6%	6%
OP	15%	6%	6%	19%	10%	8%	16%	10%	9%
Other	50%	60%	48%	70%	78%	71%	65%	73%	71%

Source: DMIT, 2007

Table 21: Predicted and actual rates of admissions for mental illness in Oxfordshire

	Predicted admission rate per 100,000 population based on MINI2000	Actual admission rate per 100,000 population for the working age population
Schizophrenia	54.9	74.27
Mood (affective) disorders	74.75	82
Total admissions for mental illness	198.96	313.73

Source: predicted admission rates calculated from MINI2000, actual admission rates from OBMH and Secondary User Service

3.29 Table 22 and Figure 9 show that during 2006 there were 1,339 admissions for mental illness within Oxfordshire. Given the current patterns of service use, the number of inpatient admissions can be expected to increase by approximately 2% over the next decade and just over 4% in the next twenty years. However this masks considerable variation in the expected trends in in-patient admissions for clients with different types of mental illness, with a reduction of between 4 - 7% in admissions for Learning Difficulties, and approximately 5% increase in admissions for clients with schizophrenia, and mood (affective) disorders in the next twenty years (see Table 23).

Table 22: Expected trends in admissions for mental illness in the working age population 2002-26, all providers

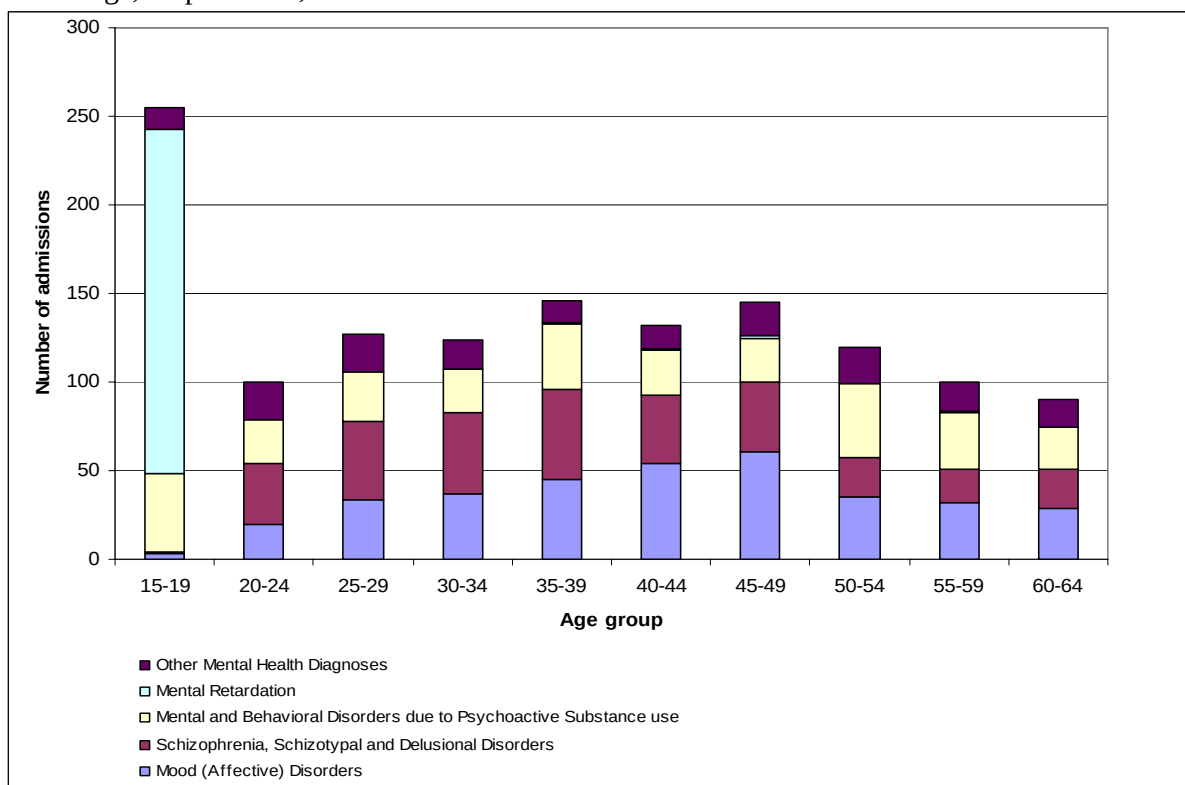
Mental disorder	2006	2016	2026
Mood (Affective) Disorders	350	362	368
Schizophrenia, Schizotypal and Delusional Disorders	317	328	335
Mental and Behavioural Disorders due to Psychoactive Substance use	306	317	323
Learning Difficulties	199	185	189
Other Mental Health Diagnoses	167	177	178
Total admissions for mental illness in Oxfordshire, all providers	1,339	1,369	1,393

Source: OBMHT and Secondary Uses Service (SUS)

3.30 Admission data from Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust (OBMH) shows that 88.4% of clients admitted to OBMH classified themselves as white, 3.11% as Asian or British Asian, 0.57% as Chinese, 1.13% as mixed, whilst 5.52% of those admitted described themselves Black or Black British, more than double the rate at which this ethnic group occurs in the local population (see Table 24). These results accord with those of the 'Count me in Census' conducted by Race and Mental Health Partnership Group (RAMPAG) in March 2007 which found that the proportion of inpatients reporting that they were 'White British' had decreased slightly since 2005 whilst those from the 'Black Caribbean' group had increased. 'Other White' representation had increased proportionally within Oxfordshire (numbers have more than doubled from 6 in 2005 to 15 in 2006), this

may be the result of the recent influx of populations from Eastern Europe, although the data is not detailed enough to prove this conclusively. The 'Indian' ethnic group has increased proportionally since 2005, although there are still very small numbers of inpatients. There appeared to be better recording of ethnic groups in 2006 for Oxfordshire with fewer responses being 'invalid' or 'not stated') [30].

Figure 9: Annual number of in-patient admissions for mental illness in Oxfordshire by age, all providers, 2006



Source: OBMHT and Secondary Uses Service (SUS)

3.31 Tables 25 - 27 show that the mean length of stay for clients admitted to OBMH was 84.7 days in 2006, although this result was possibly skewed by an outlying case in September. Without this case the average length of stay in 2006 was 47.5 days. More recent data from acute adult in-patient wards only shows that the average length of stay in 2006 was 30.3 days.

Table 23: Expected percentage change in admissions for mental illness, 2006-26, all providers

Mental Disorder	2006	2016	2026
Mood (Affective) Disorders	-	3.6%	5.2%
Schizophrenia, Schizotypal and Delusional Disorders	-	3.5%	5.5%
Mental and Behavioural Disorders due to Psychoactive Substance use	-	3.7%	5.5%
Learning Difficulties	-	-7.2%	-4.9%
Other Mental Health Diagnoses	-	5.8%	6.6%

Source: OBMHT and Secondary Uses Service (SUS)

3.32 Data shows that the length of stay varies substantially for clients admitted with different diagnoses (see Table 79). For clients admitted with a diagnosis of schizophrenia or dementia, the length of stay was above the national average and the

average for other PCTs in the South Central SHA. These figures are of concern given the information on expected increases in the community prevalence of functional psychosis (Table 13), as well as the expected increase in admissions (Table 23).

Table 24: Self-reported ethnicity of clients admitted to OBMH, 2006

Ethnic Group	Admissions to OBMH in 2006	% of total admissions to OBMH in 2006	% total population (ONS census, 2001)
White	625	88.40	92.1
Mixed	8	1.13	1.2
Indian	6	0.85	1.8
Pakistani	6	0.85	1.3
Bangladeshi	2	0.28	0.5
Other Asian	8	1.13	0.4
All Asian or British Asian	22	3.11	4.0
Black Caribbean	12	1.70	1.0
Black African	21	2.97	0.8
Black other	6	0.85	0.2
All Black or Black British	39	5.52	2.0
Chinese	4	0.57	0.4
Other ethnic group	2	0.28	0.4
Not stated	7	0.99	-
Grand total	707	-	-

Source: OBMH, 2006 mapped to standard ONS ethnic groups

Table 25: Length of inpatient stay for all mental health clients of working age admitted to OBMH, 2006

	Discharges	Length of Stay (days)	
		Median	Mean
Jan-06	67	24.1	59.8
Feb-06	66	19.1	47.6
Mar-06	60	28.3	59.3
Apr-06	59	20.7	41.1
May-06	68	35.5	56.7
Jun-06	66	27.2	50.7
Jul-06	63	21.6	70.4
Aug-06	43	33.5	57.9
Sep-06	60	41.7	387.7*
Oct-06	67	20.8	57.1
Nov-06	42	27.3	45.3
Dec-06	46	19.5	78.5
Total	707	24.7	84.7

Source: OBMH, 2006 (Wards included (past and present): Psychiatric Intensive Care Unit (Ashurst & Runis), Adult Acute Wards (Neil, Allen, Vaughan Thomas and Wintle), Assertive Outreach and Rehabilitation Ward (Willow House and Phoenix)

3.33 Prescribing within specialist mental healthcare services is an important part of the management of clients with mental and behavioural disorders. However routinely collected information on prescribing practices within specialist mental health services is currently not collected by the PCT, and thus this needs to be a consideration within any future commissioning strategy so that progress can be accurately measured against NICE guidance. This was reiterated in the recent Healthcare Commission Annual Review of the mental health services that are provided by OBMH. Data from

the recent survey of service users does shed some light on prescribing in specialist care, indicating that an increasing number of clients are informed and involved in devising their care plan including having a say in decisions about the medications that they take. However these results must also be viewed with caution given the small sample size of these surveys conducted by the Healthcare Commission and the nature of the sample taken, which may not be representative of the patient population. Of concern is the low number of clients who reported that they were definitely informed of the side effects of medications. This reflects the national average, but still leaves considerable room for improvement to ensure that clients are fully informed of the risk, and benefits of the psychiatric medications they are recommended.

Table 26: Length of inpatient stay for mental health clients of working age admitted to PICU, acute psychiatric inpatient wards and eating disorders unit, OBMH, 2006

	Discharges	Length of Stay (days)	
		Median	Mean
Jan-06	55	24.1	50.1
Feb-06	50	14.1	38.3
Mar-06	44	28.3	51.1
Apr-06	50	22.1	36.7
May-06	60	27	59.1
Jun-06	54	26.2	46.9
Jul-06	57	19.7	40.2
Aug-06	38	38.4	51.6
Sep-06	44	26.3	51.6
Oct-06	58	18.3	32
Nov-06	39	26.8	40.4
Dec-06	44	18.5	76.4
Total	593	21.9	47.5

Source: OBMH, 2006, (Excludes Assertive Outreach and Rehabilitation Ward (Willow House and Phoenix))

Table 27: Length of inpatient stay for mental health clients of working age admitted to acute psychiatric inpatient wards only, OBMH, 2007/ 08

	Discharges	Length of Stay (days)	
		Median	Mean
Apr-07	67	9.8	30
May-07	58	9.9	27
Jun-07	52	7.2	32
Jul-07	54	9.7	26
Aug-07	49	9.6	29
Sep-07	40	8.4	31
Oct-07	71	8.3	30
Nov-07	68	8.2	30
Dec-07	44	13.8	23
Jan-08	54	13.8	40
Feb-08	51	19.5	40
Mar-08	44	7.6	24
Total	652	9.7	30.3

Source: OBMH, 2007/ 08, Adult Acute Wards (Allen, Vaughan Thomas and Wintle)

Table 28: Comparison of length of stay in Oxfordshire with South Central SHA average and UK average, 2006-07

Depression			Schizophrenia			Bipolar affective dis		
Oxon	SHA	Eng	Oxon	SHA	Eng	Oxon	SHA	Eng
-	-14.7%	-2.9%	-	-47.4%	-58.9%	-	-8.9%	-19.6%
LOS in Oxon more than SHA/UK average			LOS in Oxon more than SHA/UK average			LOS in Oxon more than SHA average and less than UK average		

Source: DMT

Table 29: Information about prescribing in secondary care – having a say about the medications prescribed

Do you have a say in decisions about the medication you take?	OMHT/ OMBH			England			
	Yes definitely	Yes to some extent	No	Yes definitely	Yes to some extent	No	
	49%	41%	10%	43%	39%	17%	
	45%	41%	14%	42%	40%	17%	
	44%	41%	15%	39%	42%	19%	2005

Source: Survey of users of mental health services, Healthcare Commission

Table 30: Information about prescribing in secondary care – purpose of the medications explained to clients

Were the purposes of the medications explained to you?	OMHT/ OMBH			England			
	Yes definitely	Yes to some extent	No	Yes definitely	Yes to some extent	No	
	72%	22%	7%	65%	27%	8%	
	68%	23%	9%	63%	27%	9%	
	63%	29%	7%	62%	28%	9%	2005

Source: Survey of users of mental health services, Healthcare Commission

Table 31: Ambulatory mental health care in Oxfordshire, 2006

OP attendances	OP attendances per 100,000 population aged 18 to 64 years	CPN Contacts	CPN contacts per 100,000 population aged 18 to 64 years	Clinical psychologist contacts	Clinical psychologist contacts per 100,000 population aged 18 to 64 years
14,409	2,932	26,827	5,458	9,032.	1,838

Source: Adult mental health service mapping, 2006

Table 32: Information about prescribing in secondary care – side effects of medications explained to clients

Were you told about possible side effects of the medications?	OMHT/ OMBH			England			
	Yes definitely	Yes to some extent	No	Yes definitely	Yes to some extent	No	
	32%	40%	28%	39%	28%	33%	
	44%	38%	19%	38%	28%	34%	
	39%	33%	27%	37%	28%	35%	2005

Source: Survey of users of mental health services, Healthcare Commission

Table 33: Overall satisfaction with mental health services

Overall, how would you rate the care you have received from Mental Health Services in the last 12 months?	OMHT/ OMBH						England						
	Excellent	Very good	Good	Fair	Poor	Very poor	Excellent	Very good	Good	Fair	Poor	Very poor	
	25	29	26	12	5	4	26	29	22	14	6	4	
	25	31	24	11	5	4	26	28	23	14	5	4	
	29	27	20	15	5	3	25	29	23	14	5	4	2005

Source: Survey of users of mental health services, Healthcare Commission

3.34 The overall quality of specialist mental health services provided by OMBH and general health services by Oxfordshire PCT has recently been assessed as fair. However the recent annual health check conducted by the Healthcare Commission highlighted a few areas for improvement including ensuring that there is adequate information given to clients about their care, and the treatment they receive, and

where appropriate, informing clients of what they can expect after discharge from hospital (2007ratings.healthcarecommission.org.uk).

Table 34: Healthcare Commission Annual Review

	Oxfordshire Mental Health Trust		Oxfordshire & Buckinghamshire Mental Health Trust		Oxfordshire Learning Disabilities NHS Trust	
	Quality of services	Use of resources	Quality of services	Use of resources	Quality of services	Use of resources
2007	-	-	Fair	Good	Excellent	Good
2006	Fair	Fair	-	-	Excellent	Good

Source: Healthcare Commission

Summary of the prevalence of mental illness in Oxfordshire and the use of mental health services

- Up to 20% of the PCT's population are affected by common neurotic symptoms such as sleep problems, fatigue and anxiety that do not meet the threshold for a diagnosis of mental illness
- This is expected to increase by up to 3% in the next decade, especially amongst those over the age of 50 years
- The prevalence of most mental illnesses is also set to increase over the next decade by 3-4%, especially the number of cases of psychosis over the age of 35, the number of people with obsessive compulsive and panic disorders as well as the prevalence of people with personality disorders
- Data from general practice indicates that 0.8% of the GP registered population in Oxfordshire have a severe and enduring mental illness (SMI) which equates to 5,144 people, of which 4,094 are of working age (0.96% of the population registered with GP practices in Oxfordshire)
- There are up to 30,864 people of working age with a diagnosis of depression/anxiety in general practice, this equates to 7.2% of the working age population registered with GP practices in Oxfordshire
- Prescribing information shows that during 2006/07 1,312,211 psychiatric medications were prescribed in general practice and community hospitals at a cost of £15,419,548.22 for all age groups. Over the past 3 years the number of psychiatric medications has increased by almost 11% and the cost by almost 10%
- There were 1,339 admissions to in-patient psychiatric care in 2006 with the average length of stay of 47.5 days (excluding stays in Assertive Outreach and the Rehabilitation Wards - Willow House and Phoenix)
- Last year (2007) the average length of stay for inpatients on Allen, Vaughan Thomas and Wintle wards was 30.3 days.
- Given the current pattern of service use admissions are expected to increase by 2% over the next decade and just over 4% in the next twenty years. However this masks considerable variation in the expected trends in in-patient admissions for clients with different types of mental illness
- Overall client satisfaction with mental health services has remained stable if somewhat increased slightly over the last three years and remains roughly equal to the national average. HCC appraisals of local mental health services has reflected this with fair ratings over the past 2 years for the quality of services provided and good ratings for the use of local resources

Section 3I - Wider impact of mental illness on the population of Oxfordshire

3.35 In addition to the direct impact of mental illness on local health and social services, the wider impacts of mental health on the wellbeing, safety and productivity of our population must be taken into account in considering the needs for services that improve the mental health of our population. Indicators that measure key health and wellbeing outcomes for our population are currently being measured as part of the Joint Strategic Needs Assessment (JSNA) for Oxfordshire which is due to be released shortly[17, 31]. Relevant information from the JSNA will be incorporated into this needs assessment when it becomes available to ensure that commissioning priorities take into account the needs identified in the JSNA, and that local mental health services make a contribution to improving the overall health and well-being of our local population.

Section 3J – The mental health workforce and the provision of mental health services in Oxfordshire including gaps in service provision

3.36 Appendix 13 gives a detailed list of the current provision of mental health services, and services for those with learning difficulties, including the distribution of the specialist mental health workforce across the county.

3.37 Gaps in the current provision of services have been identified using four methods, namely;

1. information about local services from the annual mental health self-assessment conducted by CSIP, and the joint review of Oxfordshire Adult Community Mental Health Services in June 2006 by the Healthcare Commission (HCC) and the Commission for Social Care Inspection
2. information about local services and comparative data from neighbouring PCTs from the Adult Mental Health Service Mapping Exercise undertaken by Mental Health Strategies (<http://www.mentalhealthstrategies.co.uk/>)
3. information from this needs assessment including data from the prevalence of mental illness, the use of mental health services, the national and local priorities, and the preferences of stakeholders including service users, and carers.
4. information from the Joint Strategic Needs Assessment for Oxfordshire (forthcoming)

3.38 Table 35 shows the results of the CSIP mental health annual self-assessment of services within Oxfordshire LIT in 2006/07. Since then much work has been done to address these issues, however there is still work to ensure the following gaps in service provision are addressed;

- a) there needs to be more work done to ensure that a sufficient number of graduate mental health workers are in place, working operating effectively, and are well integrated with local primary care services;

- b) there is an EIS service which had achieved its two year activity target, although further work and targeted investment may be required to deliver the full three year targets
- c) here has been a great deal of work done so far to develop mental health and social inclusion strategies for OBMH and the PCT, this work requires further effort to ensure a fully co-ordinated approach is adopted between agencies
- d) protocols have been developed to ensure effective joint-working between local mental health service providers, however there needs to be a review of their ongoing efficacy

Table 35: Mental health annual self-assessment of services within Oxfordshire LIT, 2006/07

Domain	Result
Graduate workers	Amber
Primary-secondary interface	Green
Key services - Crisis Resolution	Green
Early Intervention in Psychosis	Amber
Secure Places/ Intensive Care	Green
STaR workers	Green
Social inclusion - Local Strategic Partnerships	Amber
The mental health of people with Learning Disabilities	Amber
Vocational Support	Green
Delivering race equality - Black and Minority Ethnic People's Services	Green
Implementing the policy Delivering Race Equality in Mental Health Care	Green
Community Development workers (Black and Minority Ethnic Communities)	Green
Planning and integration of care - Co-ordination between age specific services	Green
Governance	Green
Service user Involvement	Green
Carer involvement	Green
Not for profit Sector involvement	Green
Employment of service users	Green
Other priorities - Suicide Prevention	Green
Advocacy	Green
Mental Health Promotion - Standard one strategy	Green
Provision of specialist services	Green
Specialist Services - Personality Disorder	Green
Mental Health Act 1983 Section 135/136/Places of Safety	Green
Improving Access to Psychological Therapies	Green
Choice	Green

Source: CSIP (see Appendix 13), Note-Early Intervention in Psychosis achieved a green rating in the latest assessment, 2007-08

3.39 In addition to these improvements identified in the 2006/07 annual self assessment, the annual review in 2007/08 includes additional assessment areas around the provision of assertive outreach services, acute in-patient services, mental health services for older people, services that promote recovery, commissioning services from the 3rd (not-for-profit) sector, implementation of the Mental Health Capacity Act 2007 and the Mental Health Act 2007, and the provision of services for those with a dual diagnosis (see Appendix 13).

3.40 Information from the Adult Mental Health Service Mapping Exercise in 2006 and from this needs assessment (see Table 77 & 78) shows that within Oxfordshire there are less mental health staff per head of population than the regional average, particularly nurses, social workers and other support staff. Recruitment difficulties

within the local health economy are well known, and possibly relate to the proximity of the county to London, and the larger job markets within the capital.

Table 36: Recommendations of the Joint Review of Adult Mental Health Services in Oxfordshire, June 2006

Highlighted areas
Provision and availability of the range of services was not consistent throughout the county
Understanding and promotion of Direct Payments
Review Assertive Outreach and Rehabilitation Service
Consistency of access to and waiting times for Psychological Therapy Services
Availability of information about services, including access to out of hours services, for service users and carers
Inpatient discharge arrangements are not always compliant with good practice
Improve involvement of carers in care planning and service development.
Improve engagement with families
Develop whole systems thinking and approach to service planning and commissioning in a flexible way, to include the voluntary sector, county council, BME etc...
Safeguarding Vulnerable Adult arrangements need to be improved by ensuring a new overarching cross-county policy is written and adopted
Interface arrangements, specifically between Mental Health services with Physical Disability and Learning Disability Services*
Development of the recovery approach and Social Inclusion Strategy across all mental health services*
Development of an Early Intervention Service*
Membership of the Mental Health Strategic Implementation Group*
Implementation, use and quality of the Care Programme Approach (assessment, care planning and review).
Strategy and development of services within Black and Minority Ethnic (BME) communities
Promotion of interpreting services available

Source: HCC and CSCI (see Appendix 13). Note-the HCC/CSCI review action plan has been completed and signed off by the South Central SHA. * Indicate tasks within the action plan that have already completed since the review.

3.41 Detailed information from the Adult Mental Health Service Mapping Exercise in 2006 about the location of staff within different services (Table 79) shows that compared with the regional average, there are more staff per head of population in the following settings in Oxfordshire;

- Assertive Outreach services
- Day Centres/ Resource Centres/ Drop-ins
- Employment schemes for clients with mental health difficulties
- Local low secure services
- Local medium secure services
- NHS Day care facilities
- Psychiatric Outpatients
- Psychological therapies and counselling services
- Support services – other types
- Voluntary/ private counselling

And less staff per head of population in the following settings compared with the regional average;

- Accommodation – other services

- Acute inpatient units/ wards
- Carers support services
- Community Mental Health Teams
- Crisis Home Resolution Teams
- Local Psychiatric Intensive Care Unit
- Primary Care Mental Health Services
- Personality Disorder services
- Self-help and mutual aid groups
- Supported housing

These staffing figures shed some light on the current configuration of mental health services in the county, however before interpreting these results one must be aware of different naming conventions for mental health services across the regional, and that Oxfordshire is host to the regional medium secure unit.

3.42 Over the past 5 years OBMH has made significant strides to invest in community services, such as CMHTs, and the modernisation teams.

Information from the Trust indicates that in-patient rehabilitation beds have reduced from 74 beds to approximately half of the beds in the remaining in-patient unit (Phoenix Ward).

During this time there has been an expansion of the community assertive outreach service across the county, as well as investment on community rehabilitation residential and supported housing. In addition, over the past 3 years the number of acute adult beds has reduced from 102 beds to 62, whilst the number of PICU beds have been maintained at 8 in Oxfordshire.

There has also been increased investment in services that provide an alternative to inpatient admission such as Crisis Resolution and Home treatment teams, and 7 day crisis day hospitals, focussed CMHTs and early intervention services. In addition there has been no out of area referrals for general adult or intensive care treatment over the past 4 years.

Section 3K - Cost of mental health services

3.43 The amount spent on mental health services in the past year 2007/08 was £37M, which includes £3 ½ M spent from a pooled budget for mental health service commissioning between Oxfordshire PCT and Oxfordshire County Council, £31M spent by Oxfordshire PCT alone and £2 ½M spent by Oxfordshire County Council alone on mental health service provision. These figures exclude prescribing costs which is not broken down by age or diagnosis, and the costs of mental health services delivered in general practices as part of the general medical services (GMS) provided by GPs in their GMS contract. It also excludes non-recurrent funding from Oxfordshire PCT's Choosing health budget for mental health promotion programmes, and accommodation subsidised by OBMH for 3rd sector providers. However if prescribing costs from 2006/07 are included then the total mental health spend over the past year is almost £52 ½M (£50M if the commissioning budget for OCC only is excluded). This equates to approximately 8% of the Oxfordshire PCT's gross

operating costs if the finance for the pooled commissioning budget is included (see Table 37 and Appendix 14).

Table 37: Current spending on mental health services for people of working age in Oxfordshire

Description	Annual Budget 2007/08
-------------	--------------------------

WITHIN the Mental Health Commissioning pooled budget – financed by OCC & PCT

Payments by PCT/ OCC to the MH pool for Voluntary organisations (see Appendix 14 for detailed budget for voluntary organisations in Oxfordshire)	3,033,837
Support team to the pool supplied by OCC	159,000
Support team to the pool provided by PCT	98,000
MH Carry forward (non recurrent)	111,000
MH Challenge Fund – for service users and carers	20,500
Subtotal	3,422,337

NOT within the Mental Health Commissioning pooled budget – financed by the PCT

Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust (including funding for adult mental health directorate, psychological therapies for people of working age, complex needs funding and prison in-reach services, excluding forensic services)	27,867,079
Thames Valley Wide initiative for clients with Complex Personality Disorders	947,000
MH Continuing Care	936,840
Counselling & psychological therapies in primary care	612,151
Mental Health Act reimbursements	289,080
Mental Health Act training costs	5,052
MH section 28a respite care	18,876
Complex Care Packages	714,274
Clinical Nurse Specialist	6,324
Post Natal Depression	6,672
Specialist Clinical Psychology services	2,316
Subtotal	31,405,664

NOT within the Mental Health Commissioning pooled budget – financed by OCC

Base funding (for seconded staff costs)	1,540,000
MH Grant (funds from national grants)	824,000
Overhead contributions	92,000
Subtotal	2,456,000
Total	37,284,001

Source: Oxfordshire PCT Finance Team, Oxfordshire County Council Finance Team, and OBMH Finance Team (excludes 1-prescribing costs, 2-costs for care of clients with mental illness treated as part of the GP general medical services contract, 3-non-recurrent funding from the PCT Department of Public Health Choosing Health funds for mental health promotion and post-natal depression, and 4-subsidized accommodation costs for 3rd sector providers funded by OBMH)

3.44 Funding for services from the 3rd (not-for-profit, non-statutory) sector amount to approximately equal to 8% of the mental health budget for the working age population (including the pooled commissioning finances, but excluding prescribing costs). Note that if this equates to the proportion of services actually provided by the 3rd sector then we are then some considerable distance from the recommendations of CSIP which is that more than 15% of local services should be commissioned from the

3rd sector. Its guidance suggests that tenders for the provision of services focused on housing support; alternatives to hospital admission; resource centres; counselling and psychotherapy services and employment services should be routinely invited from 3rd sector providers. Work will need to be done to learn where services provided by local organisations from the 3rd sector can usefully enhance current service provision for people with mental illness within Oxfordshire.

Table 38: Spending pattern for mental health services in Oxfordshire, 2003-06

Type of service	% of total PCT MH budget		
	2003-04	2004-05	2005-06
In-patient units	16.9	15.1	14.8
Care outside IP units	22.2	19.6	17.1
New teams, inc assertive outreach, crisis resolution home treatment teams, Early Intervention in Psychosis Services, Gateway Workers and Primary Care Mental Health Worker	4.4	5.3	4.9
Day time social care	4.0	3.2	3.9
Residential	8.6	7.8	6.1
MDO non-residential	0.9	1.3	0.6
Secure care	13.9	15.5	12.4
Other	5.8	6.1	6.8
Indirect costs	22	25.5	32.2

Source: Adult mental health service mapping, 2006

Summary of the direct costs of mental illness in Oxfordshire and the provision of mental health services

- Within Oxfordshire, services commissioned by Oxfordshire PCT and Oxfordshire County Council for people of working age with mental illness cost £37,284,001 (excluding prescribing costs) which equates to 8% of the PCT's gross operating costs
- This includes £3,422,337 in a pooled budget between the PCT and OCC used for commissioning mental health services
- Funding for services from the 3rd sector is approximately 8% of the total MH budget
- Current gaps in service provision include the lack of a sufficient number of graduate mental health workers who are working within local primary care services; the need for a fully developed early intervention in psychosis service; the need for better access to psychological therapy services; the need for better information about services, including access to out of hours services, for service users and carers; the need for a higher profile for mental health promotion and the need to promote the use of Direct Payments by mental health clients
- Future needs will be influenced by the expected increase in prevalence of mental illness, especially the increase in the number of cases of psychosis over the age of 35, the number of people with obsessive-compulsive disorder and panic disorders as well as the increase in people with personality disorders.
- The argument for a prevention model must be considered[1]
- Future service provision will need to reflect demographic changes, and move towards the model of care outlined by the 10 high impact changes and the Oxfordshire Mental Health Strategy.

Section 4 - Indicators used to benchmark progress towards better mental health services in 2012

4.1 The Oxfordshire Mental Health Strategy set ambitious goals for the next three years aimed at driving the modernisation of local mental health services around the needs of the service user and carer[10]. These outcomes will be an integral part of the service model, and will be used to benchmark the performance of the full range of mental health services that are commissioned within the local health economy. Table 38 and Appendix 1 outlines the indicators selected to monitor the performance against the objectives in the OMHS.

Table 39: Indicators selected to monitor performance against the objectives within the Oxfordshire Mental Health Strategy[10]

OMHS objective	Indicator (General Adult Services Only)	Source
1. Improve access to mental health services regardless of gender, ethnicity, disability, sexual orientation, age, economic status or where a person lives in the county	Named CMHT link worker with each housing provider and GP to provide support and enable easy access to secondary MH services.	OBMH
	Number of routine referrals from GPs waiting more than 8 weeks to be seen (non urgent referrals)	OBMH
	Crisis Response Home Treatment teams in place to deliver services 24/ 7 (includes liaison with A&E)	OBMH
2. Create and deliver clearly defined care pathways	Continued reduction of delayed transfers of care (DTCs)	SITREP Returns (OBMH)
	Ensure 100% of appropriate discharges on enhanced CPA receive a follow up in the community within 0-7 days.	OBMH
3. Tackle social exclusion of service users and their carers	Increase the proportion of adults in contact with secondary MH services in employment	OBMH/ OCC
	Proportion of adults in contact with secondary MH services in settled accommodation	OBMH/ OCC
4. Improve partnership working	Evidence of clear partnership agreements in place between main commissioners of care	OCC/ PCT
	Discharge questionnaires in place for inpatient services and results where appropriate actioned.	OBMH/ PCT
5. Improve the quality, dissemination and use of information about MH services	ICD10 and HoNOS+ implemented across all community and inpatient services to collect information about service user's diagnosis and outcome scale.	OBMH
	Service user and carers help to develop OBMH/ PCT information leaflets. Leaflets updated and revised annually.	OBMH/ PCT
6. Create flexible, appropriately skilled and representative mental health workforce	Key workforce national targets achieved for Support, Time and Recovery Workers, Community Development Worker and Graduate Workers.	OBMH/ PCT
	HR strategies in place for all organisations providing mental healthcare services including evidence of CRB checks at induction, regular appraisals and CPD for staff members who work with mental health clients	OBMH/ PCT/ OCC
7. Deliver effective and efficient services which demonstrably make the best use of all available resources	Achieve financial surplus of 2% each year	OBMH
	Evidence that commissioned services are based upon regular, updated assessment of the mental health needs of the population	PCT/ OCC
8. Invest in developing more mental health services in primary care and community settings across Oxfordshire	Service specifications in place for all provider services including outcome measures.	OBMH
	Increase the number of direct payments being used by MH service users	OBMH/ RAP Returns
9. Invest in mental health promotion	Percentage of mental health service users who are smokers and have accessed smoking cessation services	OBMH
	Percentage of organisations that provide residential or domiciliary care for mental health service users who have a healthy eating policy	OBMH/ OCC
10. Invest in flexible services	Modernisation services in place - EIS, CRHT and AOR.	OBMH

OMHS objective	Indicator (General Adult Services Only)	Source
that are designed to support recovery and sustainable independent living		
11. Ensure that investment enables delivery of national targets for mental health services in ways which meet national quality standards	Evidence of robust performance monitoring in place to report performance against targets at board level	OBMH/ OCC/ PCT

Section 5 - Conclusion and Discussion

5.1 A joint review of local specialist mental health services in Oxfordshire by the Healthcare Commission (HCC) and the Commission for Social Care Inspection (CSCI) in June 2006 identified seventeen points for further improvement (see Table 34). Significant work has already been completed to ensure that these issues are addressed, and that mental health service provision in Oxfordshire is made fit for purpose. However, over the next decade, there will be significant challenges to ensure that local mental health services within the county continue to be fit for purpose. This needs assessment has sought to map out the current provision of services and identify future challenges to the local mental health economy in order to ensure that commissioning efforts are adequately focused and that outcomes are aligned to the vision of better mental health laid out in the Oxfordshire Mental Health Strategy.

5.2 The findings show that both the population and prevalence of mental illness is set to increase over the next decade if status quo is maintained. Upto 23% of the population will be affected by common mental illness, mainly neurotic symptoms. Currently less than half of these people are known to health services and thus there is a need to consider better methods of identifying these people and targeting interventions at this group.

5.3 However of more concern is the expected increase in cases of psychosis over the age of 35, the number of people with obsessive-compulsive and panic disorders, as well as those with personality disorders.

5.4 Treatment costs for people with mental illness including prescribing costs in both primary and secondary care have increased over the past 3 years. Currently the PCT spends £37M on mental health service provision (including contributions from the pooled budget between OCC/ PCT) which equates to roughly 8% of the gross operating costs of the PCT.

5.5 Future service provision will need to reflect these expected changes, and move towards a model of care outlined by the 10 high impact changes and the Oxfordshire Mental Health Strategy. This should incorporate a prevention/ mental well-being strategy which should aim to raise the profile of mental health and reduce the stigma of mental illness.

5.6 Commissioners should also consider targeted additional investment to develop services within primary care and increase the role of new teams such as the early psychosis intervention service and the crisis response treatment teams which intervene at an earlier stage of the illness, and have been shown to reduce unintended in-patient admissions, reduce healthcare expenditure and increase client satisfaction. However,

any additional investment must be tied to validated performance and outcome indicators that can demonstrate new services are cost-effective, that they are having a positive impact on the mental health of our population, and helping us to reach the goal of better mental health outlined in the OMHS.

5.7 Additionally, consideration should be given to increasing the proportion of services commissioned from the 3rd sector especially where these services may add value to the existing statutory service provision, or where there is unmet need in our local communities. This recommendation is in line with current government initiatives to build capacity in the 3rd sector, and increase choice for clients in their local mental health economies.

Appendix 1 - Selecting metrics to benchmark against the objectives in the Oxfordshire Mental Health Strategy and PCT strategy

Table 40: Indicators selected to benchmark progress against the OMHS[10]

Objectives in the OMHS	Outcome by 2012	Indicators selected and source	Source
1. Improve access to mental health services regardless of gender, ethnicity, disability, sexual orientation, age, economic status or where a person lives in the county	Anyone in need of a Mental Health service, or their carer, would be able to find out what services are available and how to access them quickly and efficiently – whatever their background and whether they were accessing services for the first time, or had used services before.	Named CMHT link worker with each housing provider and GP to provide support and enable easy access to secondary MH services.	OBMH
	Carers of all ages would have their own mental health needs met, as well as being enabled to support their friends and/or relatives.		
	Fear of other people's reactions (friends, family and employers), would not be a barrier to seeking help early before problems accelerate.		
	People who need access to Mental Health services for the first time, and their carers, would be able to talk to their GP, and their GP would be able to refer them on to the right service provider quickly, if s/he can't meet their needs.		
	Service users and carers who need rapid access to support and services at times of crisis would be able to get the support they need quickly, from appropriately trained and qualified staff and in appropriate locations.	Number of routine referrals from GPs waiting more than 8 weeks to be seen (non urgent referrals)	OBMH
	People who need ongoing access to Mental Health services over many years would feel secure in the knowledge that the care they need will be available to them in appropriate and safe environments.		
	Some choice would be available to people about the mental health care and support they get, and the choices available would recognise the particular needs of people from BME communities and other hard to reach patient groups.		
	Commissioners would know which sections of the population found it particularly difficult to access services, and why, and would have adapted provision of information and services to meet their needs.	Crisis Response Home Treatment teams in place to deliver services 24/ 7 (includes liaison with A&E)	OBMH
	Staff in a wide range of agencies would be able to understand and meet the basic mental health needs of their service users – and/or would know what Mental Health services are available and how they can be accessed.		
	The primary care CAMHS service would be providing a single point of access and referral for all young people with emotional and mental health problems in Oxfordshire.		
2. Create and deliver clearly defined care pathways	Service users would know what to expect from their treatment and care.	Continued reduction of delayed transfers of care (DTCs)	SITREP Returns (OBMH)
	The particular needs of people from BME communities and other traditionally hard to reach patient groups would be met.		
	We would ensure that the care offered maximises the independence and social inclusion of service users and meets the needs of carers.		
	The Care Programme Approach (CPA) would be working, and would be central for users, carers and providers of Mental Health services – regardless of the age of the service user or who the lead service provider was.		
	It would be easier to identify points in a care pathway where real choice is possible and to offer that.	Ensure 100% of appropriate discharges on	OBpMH

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Objectives in the OMHS	Outcome by 2012	Indicators selected and source	Source
	It would be easier to identify when and how practice based commissioning and/or direct payments could be used to purchase parts of that care pathway.	enhanced CPA receive a follow up in the community within 0-7 days.	
	Service users would be more likely to get equity of care regardless of where in the County they live.		
	Carers would have a clear understanding of what was likely to happen to their relative, and about their role in supporting that person.		
3. Tackle social exclusion of service users and their carers	People with mental health problems would not be discriminated against in any area of their lives.	Increase the proportion of adults in contact with secondary MH services in employment	OBMH/ OCC
	The public would understand the nature of most common mental illnesses and there would no longer be any stigma attached to having a mental illness.		
	People with mental health problems could access the same leisure, education, training, employment, housing and other services as everyone else.	Proportion of adults in contact with secondary MH services in settled accommodation	OBMH/ OCC
4. Improve partnership working	The County Council, the PCT, GPs, Supporting People and the DAAT would plan, commission and contract services in partnership with each other.	Evidence of clear partnership agreements in place between main commissioners of care	OCC/ PCT
	People using mental health services, and their carers, would find that the different agencies supporting them work collaboratively in response to their needs.		
	When people first needed a service, they would only be assessed once, and that information would then be passed on to whoever it is agreed needs access to it.		
	Organisations delivering mental health care and support would be taking a partnership approach to supporting and meeting the needs of people from the BME communities.		
	Anyone getting services from primary and secondary care would always have an identified key worker at both care providers, and they would communicate well.	Discharge questionnaires in place for inpatient services and results where appropriate actioned.	OBMH/ PCT
	Carers would be actively and appropriately involved as partners in the provision of care and support to service users.		
	People with mental health problems would find that there is a range of help available to support them with housing, education, employment and leisure.		
	Statutory and voluntary sector organisations would be working to deliver services together – where that represented the best care and the best value for money for a user.		
	Practice based Commissioning (PbC) for mental health would be established and contributing effectively to delivery of this strategy.		
5. Improve the quality, dissemination and use of information about MH services	Decision making about commissioning and service delivery would be informed by an improved understanding about the needs of the local population for mental health service provision and the development of clearly understood outcome targets.	ICD10 and HoNOS+ implemented across all community and inpatient services to collect information about service user's diagnosis and outcome scale.	OBMH
	Service users and carers would be effectively involved in the design, development, delivery and evaluation of services.		
	Mental health and other health service providers would be sharing information with each other effectively, when caring for individuals who have physical as well as mental health needs.		
	The data collected about mental health services and the people who need and use them, would be of high quality, would be readily accessible to the organisations that need it, and would be used effectively by them to inform commissioning and development of services.	Service user and carers help to develop OBMH/ PCT information leaflets. Leaflets updated and revised annually.	OBMH/ PCT
	Service users and carers would be involved in monitoring and measuring the effectiveness of services.		

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Objectives in the OMHS	Outcome by 2012	Indicators selected and source	Source
6. Create flexible, appropriately skilled and representative mental health workforce	People would be able to get the care and support they need, when and where they need it, from appropriately trained people.	Key workforce national targets achieved for Support, Time and Recovery Workers, Community Development Worker and Graduate Workers.	OBMH/ PCT
	Carers would be recognised as an important part of the mental health workforce, and would get the training and support they need to fulfil their role.		
	If you were at risk of developing a mental health problem, or were in the early stage of a mental illness it would be more likely that this would be detected and that appropriate prevention or early intervention services would be available to you – even if you were not in regular contact with a mental health service provider or your GP.		
	All Mental Health service commissioners and providers would be working together to identify and meet training needs.		
	Staff in a wide range of agencies – from early years services to the police – would have the skills to recognise basic mental health needs and either to offer basic mental health care or to refer a person on to an appropriate service.	HR strategies in place for all organisations providing mental healthcare services including evidence of CRB checks at induction, regular appraisals and CPD for staff members who work with mental health clients	OBMH/ PCT/ OCC
	People with long term mental illnesses would be able to access the support they need to manage their conditions outside hospital where this was appropriate for them.		
	People from BME communities and other hard to reach patient groups would be able to access mental health care and support from staff able to meet their particular needs.		
	Staff working in mental health services would be supported to develop their careers, and more people would identify themselves as being able to offer a mental health service.		
7. Deliver effective and efficient services which demonstrably make the best use of all available resources	Service providers and commissioners would be able to demonstrate that the services offered in Oxfordshire delivered the best possible care, according to available evidence.	Achieve financial surplus of 2% each year	OBMH
	Service providers and commissioners would be able to demonstrate that the services offered in Oxfordshire represent good value for money in comparison to services provided in similar parts of England.	Evidence that commissioned services are based upon regular, updated assessment of the mental health needs of the population	PCT/ OCC
	We would reduce the amount of money spent on capital charges, and reinvest the savings in patient care.		
8. Invest in developing more mental health services in primary care and community settings across Oxfordshire	Commissioners would have defined the need for services in primary care and for community based services, and would be commissioning services that meet these.	Service specifications in place for all provider services including outcome measures.	OBMH
	Fewer people would be referred for treatment in hospital.		
	Wherever you lived in Oxfordshire short term counselling and/or appropriate medication would be easily available to you from your GP if you had a mild or moderate mental health problem.		
	For people who needed a more extensive service, but who did not need the services of a CMHT or admission to a ward, there would be an extended range of psychological therapies and other services available. These would be accessible either by referral from a GP or directly from suitably qualified voluntary sector organisations, across Oxfordshire.	Increase the number of direct payments being used by MH service users	OBMH/ RAP Returns
	People with long term mental illnesses would be able to access the support they need to manage their conditions outside hospital where this is appropriate for them.		
	Carers would be able to access respite and other services that are flexible enough to meet their needs.		
9. Invest in mental health promotion	Anyone in need of a Mental Health service, or their carer, would be able to find out what services are available and how to access them quickly and efficiently – whatever their background and whether they were accessing services for the first time, or had used services before.	Percentage of mental health service users who are smokers and have accessed smoking cessation services	OBMH

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Objectives in the OMHS	Outcome by 2012	Indicators selected and source	Source
	The public would understand the nature of most common mental illnesses and there would no longer be any stigma attached to having a mental illness.	Percentage of organisations that provide residential or domiciliary care for mental health service users who have a healthy eating policy	OBMH/ OCC
	People with mental health problems would be less discriminated against in all areas of their lives.		
	More people with mental illness could stay in their employment.		
10. Invest in flexible services that are designed to support recovery and sustainable independent living	Floating support would be more readily available to people when and where they needed it, and would not necessarily be linked to provision of housing or beds.	Modernisation services in place - EIS, CRHT and AOR.	OBMH
	A wider range of effective support to aid recovery would be available and might include – for example talking treatments, nutritional advice, welfare support, help with housing problems, physical health care.		
	The wider community would recognise that poor mental health impacts on many aspects of a person's life, and that a lot of different agencies and individuals can play a role in supporting people's recovery. This would mean that service users could find, for example, that schools, art groups, sports organisations, faith or neighbourhood groups might be involved in supporting their recovery.		
	A ladder of opportunities would be available to service users, enabling them to move gradually away from Mental Health led rehabilitation services and to take up services and opportunities provided by other organisations, so that it was possible for someone with a Mental Health problem to access the same leisure, education, housing, training, employment and health services as everyone else.		
11. Ensure that investment enables delivery of national targets for mental health services in ways which meet national quality standards	Patient and carer satisfaction levels would be rising.	Evidence of robust performance monitoring in place to report performance against targets at board level	OBMH/ PCT/ OCC
	There would be greater public understanding about mental health and it would be easier to find out about mental health services.		
	We would see a reduction in suicides in Oxfordshire.		
	It would be easy for all interested parties to find out how well Oxfordshire is delivering NSF targets and NICE guidelines for all age groups, when compared to other areas which share similar sociodemographic characteristics.		
	Commissioners and service providers would have access to robust data on known and unknown need for Mental Health services in Oxfordshire.		
	Commissioners and service providers would have access to good information on outcomes for clients resulting from service change and development, would be able to assess the value for money of different services, and would be using this information to inform spending and service development decisions.		
	All Mental Health service providers and commissioners would agree local priorities for action to improve performance against NSF targets, and would be commissioning or developing services accordingly.		
	There would be more genuine opportunities for a range of providers to compete for contracts to provide services.		

Appendix 2 - Mental Health Needs Assessment Steering Group

Mental Health Needs Assessment for Oxfordshire Terms of Reference for the Steering Group

Members

Name	Organisation
Paul Ralph	Service Development Manager-joint commissioning team, Oxfordshire PCT
Alison Burton	Health Improvement Principal, Dept of Public Health, Oxfordshire PCT
Uy Hoang	Specialist Registrar in Public Health, Oxfordshire PCT
Sue Trinder	Decision Support Team, Oxfordshire PCT
Rob Bale	Clinical Director of Adult Services, OBMH
Jackie Thomas	Project Manager, OBMH
Jane Kershaw	Performance Manager, OBMH
Fiona Mullins	Research and Intelligence Department, Oxfordshire Data Observatory
Eddie McLaughlin	Director of Operations, OBMH

Purpose: The purpose of setting up a Steering Group for this project is to facilitate discussion on the technical aspects and the assessment process - and provide support to the researcher during the course of the assessment.

Roles and responsibilities

- To represent the views of the various agencies represented within the group
- To advise on the overall direction and implementation of the project
- To monitor progress and ensure adherence to the project plan
- To provide specialist advice where appropriate
- To receive regular reports from the researcher and provide comment on the contents – as appropriate
- To discuss the finding of the final report and reached agreement on the priority areas and service improvement
- Advice on which recommendations to take forward in the light of resource constraint and level of needs
- Present the report and advise the local mental health implementation group on the findings
- Take up communication and dissemination of results to each of the PCT's partner agencies

Reporting and Governance

Reportable to the Director of Joint Commissioning, Oxfordshire PCT and the Mental Health Programme Board

Appendix 3 - What is mental health needs assessment?

Mental health needs assessment is a process that aims to form the rational basis for commissioning health and social services, ensuring that the development of local services addresses the needs of the local community and the gaps in provision, thus maximising the benefit to health and reducing health inequalities[12].

Mental health needs assessment will often utilise the following information;

1. An outline of the current population in the locality
2. An examination of the current burden of illness from mental health problems, and the mental healthcare needs of people in the locality
3. A map of the current provision of statutory and non-statutory services for people with mental health problems in the locality
4. Predictions regarding the burden of mental illness

A number of techniques can be used to collect this information for the mental health needs assessment, including;

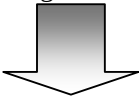
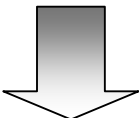
Epidemiological Needs Assessment, is a method of identifying needs by examining shortfalls in current practices using routinely collected data. The needs identified using this method are likely to be representative of the average older person within Oxfordshire as this method uses data collected from the entire population of Oxfordshire or alternatively a representative sample of people. The Association of Public Health Observatories (APHO) recently published guidance on the use of routine indicators to support mental health needs assessment[23]. A list of evidence-based indicators was suggested that aimed to gauge the risk factors for mental ill-health and the prevalence of mental disorders. Unfortunately, indicators to assess the positive attributes of mental health were not reviewed, and are often not routinely collected. Another consideration in using this method to assess mental health needs is to ensure that the data sources used to collate epidemiological information are agreed with other relevant stakeholders, especially where services will be commissioned from a pooled budget.

Normative Needs Assessment, is a method of identifying needs by comparing current practices to improve health with recommended best practices from regional/ national or international guidelines. The needs identified by this method are stipulations by local and national organisations, and may not be representative of the views and needs of all residents within Oxfordshire. As above care must be taken to incorporate relevant guidance and targets from other stakeholders, especially where services will be commissioned from a pooled budget, to ensure that the priorities for all partner agencies are taken into consideration.

Comparative Needs Assessment, is a method of identifying needs by comparing the current provision of services with those in neighbouring PCTs or with the services provided by trusts with similar populations. However the current provision of services may not reflect local need but be a result of other incentives/ disincentives.

A number of frameworks have been recommended to undertake health needs assessment. The most frequently cited is the HNA guide written by the Health

Development Agency which sets out five steps to Health Needs Assessment[33, 34], namely;

Step 1 – getting started 	• What population is being assessed? • What are you trying to achieve? • Who needs to be involved? • What resources are required? • What are the risks?
Step 2 – identifying health priorities 	• Population profiling • Gathering data • Perceptions of need • Identifying and assessing health conditions and determinant factors • Identifying current service provision • Gap analysis
Step 3 – assessing a health priority for action	• Choosing health conditions and determinant factors with the most significant size and severity impact
Step 4 – planning for change 	• Determining effective and acceptable interventions and actions • Forecasting predicted needs in 10 years • Ensuring recommendations are feed into the relevant policies and strategies
Step 5 – moving on/ review	• Learning from the project • Measuring impact • Choosing the next priority

Source: Health Needs Assessment Toolkit, Health Development Agency[33, 34]

Corporate Needs Assessment, is a method of identifying needs by interviewing interested parties (stakeholders) including service users and carers for subjective opinions on where services could be improved. These needs are perceived by the mental health service users, carers, service providers and members of the public who are interviewed, and may not be representative of the mental health needs of the general population of residents within Oxfordshire.

Appendix 4 - Normative and comparative needs assessment

Date	Title	Summary
1999	National Service Framework for Mental Health; modern standards and service models, Department of Health	Building on the principles outlined in modernising mental health services (1998), for the first time it sets out national standards, service models and priorities for improvement. Aimed at the adult population up to age 65, the framework covers five areas; - mental health promotion - primary care - access to services - effective care for those with severe mental illness, and prevention of suicide - support for carers
2000	NHS Plan: a plan for investment, a plan for reform, Department of Health	Sets out a vision of patient centred health services with a ten-year plan promising financial investment for reforms, including; - Contracts that commit consultants to working up to seven years for the NHS with reward for further commitment - Faster access to care - Nurses to gain greater prescribing powers as well as powers to admit and discharge clients - A new level of PCT to commission total health and social care packages - Commitment to the development of intermediate care services - Community health councils to be replaced by patient advocacy services and patient forums - Appointment of modern matrons with authority to intervene to sort out discharge delays and poor hospital hygiene - Commitments to improve services for clients with mental illness and older people
2002	Developing services for carers and families of people with mental illness, Department of Health	Aimed at local mental health services to be read alongside standard six of the National Service Framework for Mental Health: caring for carers. The report focuses on carers of people with severe mental illness and who are on the Care Program Approach. Support is vital, for the impact of mental illness on the carer can be similar in terms of affecting work, education, finances and social life as well as their own physical and emotional health. Carers are also vital as the first point of contact at the onset of illness. Service providers should recognise the valuable role of carers and the stress they are under, provide timely support or help if they can no longer carry on and involve carers in planning and developing future services Support should include information and advice, including advocacy, breaks and access to interventions such as family therapy. Services should be based on four principles; - positive and inclusive - flexible and needs led - accessible and responsive - integrated and coordinated
2002	The Journey to Recovery; the government's vision for mental health care, Department of Health	Sets out the government's vision for modernised mental health services within the context of an optimistic, positive approach to people who have mental health problems, where recovery is based on service users and carers aspirations. Plans included; - closer working with social services and the criminal justice system - new services tailored to meet local needs, paying particular attention to women's mental health, support for carers and personality disorders - National Institute of Mental Health to support research, and improve and disseminate the evidence base for effective treatments and therapies - Emphasis on staff recruitment, retention and training. Staff should be employed to reflect the communities they serve - Services to consider basic human needs, the need for social networks and friends, and removing the stigma of mental illness by changing society's attitudes to it

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Date	Title	Summary
2002	NICE clinical guidelines no. 1. Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care	Outlines ideal management for clients with schizophrenia in primary and secondary care. Included treatment algorithms for managing clients within the acute phase of illness, including rapid tranquilisation, managing treatment non-response/ resistance and physical care, as well as promoting recovery.
2004	Organising and delivering psychological therapies, National Institute of Mental Health	Found that the provision of psychological services was patchy and inadequate in spite of convincing evidence of their effectiveness in treating mild to moderate mental health problems. Recommended that there should be; - more information about what therapies are available and how they may be accessed - development of care pathways for different problems and diseases - address the needs of specific groups especially the elderly and ethnic minorities
2004	Choosing Health; making healthier life choices, Department of Health	Public health white paper setting out priority areas for new funding, including; - smoking cessation - tackling obesity and increasing exercise - sexual health - alcohol - address mental health issues including extending the sure start programs and tackling mild to moderate mental health problems in the workplace - public health research
2004	NICE clinical guidelines no. 23. Depression: the management of depression in primary and secondary care	Made the following recommendations for the management of depression in primary and secondary care; - Screening should be undertaken in primary care and general hospital settings for depression in high-risk groups – for example, those with a past history of depression, significant physical illnesses causing disability, or other mental health problems, such as dementia. - For clients with mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, a further assessment should be arranged, normally within 2 weeks ('watchful waiting'). - Antidepressants are not recommended for the initial treatment of mild depression, because the risk–benefit ratio is poor. - For clients with mild depression, healthcare professionals should consider recommending a guided self-help programme based on cognitive behavioural therapy (CBT). - In both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered. - When an antidepressant is to be prescribed in routine care, it should be a selective serotonin reuptake inhibitor (SSRI), because SSRIs are as effective as tricyclic antidepressants and are less likely to be discontinued because of side effects. - All clients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but can occasionally be severe, particularly if the drug is stopped abruptly. - When clients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own. - Clients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes, should be advised to continue antidepressants for 2 years. - For clients whose depression is treatment resistant, the combination of antidepressant medication with CBT should be considered. - CBT should be considered for clients with recurrent depression who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions
2004	NICE clinical guidelines no. 9. Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders	Recommended that for clients with Anorexia Nervosa; - Most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders. - People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) in combination with psychosocial interventions. - Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa. Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders.

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Date	Title	Summary
		For clients with Bulimia nervosa, it recommended; - As a possible first step, clients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme. - As an alternative or additional first step to using an evidence-based self-help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug. -Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with bulimia nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months. -Adolescents with bulimia nervosa may be treated with CBT-BN, adapted as needed to suit their age, circumstances and level of development, and including the family as appropriate.
2004	NICE clinical guidelines no. 22. Anxiety: The management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care	Recommended a stepped approach to treating clients with anxiety disorders in primary, secondary and community care, including; - better recognition of symptoms of anxiety/ neurosis - shared decision making between healthcare professionals and clients - better information about the nature, course and treatment/ support for clients with anxiety disorders - prompt treatment in primary care, including better access to the use of psychotherapies, pharmacotherapies and self-help options - referral to specialist mental health services for short periods if these interventions are not effective
2004	The National Service Framework for Mental Health - Five Years on	Concluded that much had done since the launch of the NSF, and that the concentration upto 2009 was to be on the need to tackle the following issues; - social exclusion in people with mental health problems, improving their employment prospects and opposing stigma and discrimination - services for ethnic minorities, abolishing inequalities in care and earning the confidence of people from minority communities; - the care of long-term mental disorders, setting out a new model of mental health care in primary care; - the availability of psychological therapies. - improving information on mental health and information systems within mental healthcare services - workforce re-design, with new roles for key staff.
2004	Mental health and social exclusion: a social exclusion unit report, Office of the Deputy Prime Minister	Recognises that loneliness, social isolation and poverty constitute major problems for older people as both a precursor and precipitant of mental health problems. It recommends actions to build community capacity so that individuals and families have options other than professional services for their symptoms of distress, including; - a program to dispel to negative attitudes about mental illness - supporting families and communities - addressing access to basics such as housing, transport, money advice, etc. - target-setting to increase the employment rates of people with disabilities, reduce child poverty and reduce deaths from suicide
2005	National Service Framework for long term conditions, Department of Health	Sets eleven quality requirements for services to support people with long term conditions including; - person centred care - early recognition and diagnosis - appropriate emergency management - community support - attention to special needs in hospital - palliative care - support for carers
2005	Delivering Quality and Value: The ISIP Guide to Strategy and Benefits, NHS Integrated Service Improvement Programme (ISIP)	The NHS Integrated Service Improvement Programme (ISIP) promotes collaboration across Local Health Communities towards five goals, namely - delivering a patient-led NHS, delivering quality and value, promoting local action; national voice, spreading best practice, facilitating integration of healthcare services at different levels and localities

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Date	Title	Summary
2005	NICE clinical guidelines no. 26. PTSD: the management of PTSD in primary and secondary care	Made the following recommendations for the treatment of PTSD in primary and secondary care; - For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident, should not be routine practice when delivering services. - Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by people with post-traumatic stress disorder (PTSD), should be considered. A follow-up contact should be arranged within 1 month. - Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis. - All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]). These treatments should normally be provided on an individual outpatient basis. - Trauma-focused CBT should be offered to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. - Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused CBT adapted appropriately to suit their age, circumstances and level of development. - Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy. - Drug treatments (paroxetine or mirtazapine for general use, and amitriptyline or phenelzine for initiation only by mental health specialists) should be considered for the treatment of PTSD in adults who express a preference not to engage in trauma-focused psychological treatment². - For individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month after the disaster.
2005	NICE clinical guideline no 31. Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder	Made the following the following recommendations for the management of clients with OCD; - Each PCT, mental healthcare trust and children's trust that provides mental health services should have access to a specialist obsessive-compulsive disorder (OCD)/ body dysmorphic disorder (BDD) multidisciplinary team offering age-appropriate care. This team would perform the following functions: increase the skills of mental health professionals in the assessment and evidence-based treatment of people with OCD or BDD, provide high-quality advice, understand family and developmental needs, and, when appropriate, conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment. - people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list. For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment programme to identify any need for continuing support and appropriate services to address it. - in the initial treatment of adults with OCD, low intensity psychological treatments (including exposure and response prevention [ERP]) (up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach - adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of a selective serotonin re-uptake inhibitor (SSRI) or more intensive CBT - adults with OCD/ BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT
2005	The state of social care in England 2004-2005, Commission for Social Care Inspection	First comprehensive overview of social care in England. Suggested that more work needs to be done by councils working closely with partners to avoid unnecessary admissions to hospital and drive up the quality of services
2006	Choosing Health: supporting the physical health needs of people with severe mental illness; commissioning framework, Department of Health	This document describes how PCTs can plan for, design, commission, and monitor services that will deliver improved physical health and well-being for people living with SMI. It describes the necessary leadership for a successful physical healthcare programme, suggests who might be best placed to deliver the programme, outlines the roles and responsibilities of those involved with the programme, provides case studies along with outcomes achieved and gives details of a range of promising practice that promotes physical healthcare and treatment and health promotion for people with SMI.

² Paroxetine is the only drug listed with a current UK product licence for PTSD at the date of publication (March 2005).

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Date	Title	Summary
2006	Supporting people – promoting independence, Commission for Social Care Inspection	Reviewed the impact that the Government's Supporting People programme had had on the lives of social care service users in terms of allowing more to live independently. Found that many people had benefited where high performing councils had used the programme to improve joint working with housing and health services. But older people had received the least amount of grant despite making up the largest group in the programme. Development of "extra-care" housing for older people had generally excluded those with mental health needs. Step-down support was not sufficiently developed. More information about the programme needed to be provided to users and advocacy services that assist people.
2006	10 High Impact Changes for mental health services by NIMHE & CSIP	Reviewed case studies and collated the latest research evidence on effective 'whole-system changes' to mental health services and outlined the high impact changes in 10 areas of service improvement in mental health that have the greatest positive impact on service user and carer experience, service delivery, outcomes, staff and organisations and that can be used to guide any service improvement activity. They include; 1. Treat home based care and support as the norm for the delivery of mental health services. 2. Improve flow of service users and carers across health and social care by improving access to screening and assessment. 3. Manage variation in service user discharge processes. 4. Manage variation in access to all mental health services. 5. Avoid unnecessary contact for service users and provide necessary contact in the right setting. 6. Increase the reliability of interventions by designing care around what is known to work and that service users and carers inform and influence. 7. Apply a systematic approach to enable the recovery of people with long term conditions. 8. Improve service user flow by removing queues. 9. Optimise service user and carer flow through the service using an integrated care pathway approach. 10. Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce.
2006	NICE technology appraisal no. 51. Computerised CBT for depression and anxiety	Made the following recommendations about computerised CBT; - 'Beating the Blues' is recommended as an option for delivering cognitive behaviour therapy (CBT) in the management of mild and moderate depression - There is insufficient evidence to recommend the use of 'COPE and Overcoming Depression' as a clinically or cost-effective option for the management of depression, except as part of ongoing or new clinical trials that are designed to generate robust and relevant data on the clinical effectiveness of these specific CCBT packages. - 'FearFighter' is recommended as an option for delivering CBT in the management of panic and phobia. - OCFighter (previously known as BTSteps) is not recommended as an option for delivering CBT in the management of OCD. People currently using OCFighter, whether as routine therapy or as part of a clinical trial, should have the option to continue on therapy until the person, or the GP and/or specialist, consider it appropriate to stop
2006	Designing Primary Care Mental Health Services, CSIP	Guidebook designed to assist those wishing to plan, organise and manage primary care mental health services. Found that the current provision of mental health services in primary care is extremely varied and suggested key steps to designing primary care mental health services
2006	With Safety in Mind; Patient Safety in Mental Health Services, National Patient Safety Agency (NPSA)	Report by NPSA containing an analysis which covers almost 45,000 mental health incidents reported to the agency's National Reporting and Learning System (NRLS) by mental health staff between November 2003 and the end of September 2005
2006	Standards for better health, Dept of Health	Lays out a new framework of Health Care Standards, with a focus on health and well-being across the whole system, giving the individual - the patient, service user or client - more power to improve their care and drive the whole system, highlighting the need to improving both quality and equality, to addressing the needs of children as well as the adult population and to review and change the way we work to improve delivery.
2007	No voice, no choice. A joint review of adult community mental health services in England by the Healthcare Commission and the Commission for Social Care Inspection	Found that too many people who use services were not fully involved in decisions about their own care, that too few people are being offered or are receiving a written copy of their care plan, people are not always aware of who their care co-ordinator is, not enough care reviews are being carried out, Too few people are involved in decisions about their medication, more focus is needed on physical health, people need help with employment, there were problems with dual diagnosis, there was work to ensure delivery of equality in mental health services, as well as the implementation of direct payments. There was also considerable variation in the provision of out-of-hours crisis services and access to psychological therapies

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Date	Title	Summary
2007	Indicators of Public Health in the English Regions – No 7. Mental Health, Association of Public Health Observatories	Part of a series of reports looking at indicators on a major health policy area that would help to present information on the relative positions of the English Regions and inform the implementation of national and regional priorities. Selected over 70 indicators to help inform commissioning, local specialist providers, GPs, service users and carers.
2007	Commissioning a brighter future - Improving access to psychological therapy, CSIP	Sets out a framework and key principles for expanding services to improve access and choice of psychological therapies to those with depression and anxiety who may need them, within dedicated pathfinder sites. Gives examples of best practice in improving access to psychological therapies (IAPT)
2007	Commissioning framework for Health and well-being, Department of Health	Document is to help commissioners to negotiate personalised services, promote health and well-being, proactively prevent ill health, and work in partnership to reduce health inequalities by focusing on outcomes for children and adults. The framework identifies nine steps to more effective commissioning: - Putting people at the centre of commissioning by giving people greater choice and control over services and treatments (including self-care), and access to good information and advice to support these choices. - Understanding the needs of populations and individuals through joint strategic needs assessments - Sharing and using information more effectively - Assuring high quality providers for all services - Recognising the interdependence between work, health and well-being - Developing incentives for commissioning for health and well-being - Local accountability - Addressing capability and leadership
2007	Time and Trouble : towards proper and compassionate mental healthcare, NHS Confederation Mental Health Network paper	This report reviews the 'time and trouble' - from asylum closures to community-based care - with a special focus on two major Government initiatives: the 1999 Mental Health National Service Framework and the 2000 NHS Plan. The report does not seek to paint a rosy picture of mental healthcare, but to tell a story of change, highlighting success where possible, conveying important messages about what works for whom, and setting out key challenges.
2007	Talking about medicines; the management of medicines in trusts providing mental health services by the Healthcare Commission	Review of medicines used in the management of clients in mental health trusts, found that a very high proportion of people treated in mental health trusts were prescribed medicines, however there was more work to be done to involve clients in their medical management, including choosing their medications. Also there was work to be done to ensure that medications were supplied in a timely manner to facilitate management in the community, including ensuring that new ways of working take into account the need for adequately trained pharmacy staff to discharge the prescribing function
2007	Our NHS - Our Future, NHS Next Stage Review, Interim Report	Sets out a vision for a world class NHS which is fairer, more personalised to individual patient needs, effective in terms of outcomes for clients that are among the best in the world, and safe giving clients and carers confidence in the care that they receive. Lays for groundwork for the final report on progress since the launch of the NHS plan in 2000
2007	Delivering the government's mental health policies; services, staffing and costs, The Sainsbury Centre for Mental Health	This report assesses what needs to be done in delivering the key objectives of current mental health policy, organised around the seven standards of the NSF-MH, in terms of service provision, staffing and funding. It concludes; - Some of the present service models integral to the NSF-MH require more detailed specification, in particular those relating to mental health promotion and services in primary care - the planning of services for the rehabilitation of those with severe mental illness and the interface with services for young people, those with learning difficulties (including autistic spectrum disorders) and those with alcohol and drug misuse require policy initiatives to promote their improvement - the development of services and staff competencies should have as a central objective the promotion of social inclusion of people with mental health problems. - There is a clear need to increase staff numbers in both professionally and non-professionally affiliated groups and attention should be paid to their recruitment, training and standards. - The provision of evidence-based treatments, services and policy is crucial. - The momentum gained and the present priority status for mental health services need to be maintained. This calls for a successor to the NSF-MH, setting out a clear plan for the future direction, standards, delivery and structure of mental health services, including a published analysis of the staffing and other resource implications

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Date	Title	Summary
Regional and local documents		
Date	Title	Summary
1999	Annual report of the Director of Public Health; Mental Health in Oxfordshire, Oxfordshire Health Authority	Oxfordshire Health Authority DPH Annual Report focused on mental health in the county and highlighted 31 specific needs that should be considered in the development of the Oxfordshire Health Improvement Programs (HImP)
2006	Mental Health and Well-being in the South East, Department of Health and Care Services Improvement Partnership	Reviewed mental illness and mental health service provision across the South East region. Only included working age population. Recommended; the need for a greater emphasis on promoting well-being in children exploit opportunities for earlier prevention to tackle alcohol related violence an integrated approach balancing tackling risk factors with an emphasis on promoting protective factors for mental, physical and social well-being in a comprehensive way challenge stigma and discrimination
2006	An integrated commissioning strategy for adult mental health for Buckinghamshire 2007 – 2010, draft version	Draft document that outlined the mental health needs of the working age population in Buckinghamshire and set to define commissioning priorities
2007	Oxfordshire Mental Health Strategy 2007 – 2012	County-wide strategy looking at a shared vision for the development of mental health services, especially focusing on; access to services choice and flexibility of treatment and care partnership working social inclusion of service users support for carers quality of services Suggests that the priorities for development include; Need for health and social care commissioners and providers to work together to develop detailed strategy for the development of services for older people in Oxfordshire. Need to establish services for older people with mental illness including mental health promotion Need for early assessment and diagnosis Need to address issues of access to specialist services Need to address the presentation of social care performance data so that a proper analysis of how well older adults mental health social care target are being met Need to develop links with learning disabilities services for older people with learning difficulties Need for a 'whole system commissioning strategy'
2007	Oxfordshire Primary Care Trust Strategy 2007 – 2012	Outlines the PCT's vision, aims and strategic commissioning priorities for the next five years (2007 – 2012), aiming to move from a reactive 'sickness' service towards a pro-active health and well-being service for the county. Includes the aim to provide 'a better deal' for older people by focusing on older peoples physical and mental health services, particularly; Tackling avoidable admissions to hospital by developing single referral pathways and intermediate care services for older people with mental health problems. Preventing people from becoming unwell. Providing more services in the community. Improving our understanding of the economic impact of the growing population and of how we might get a better return for older people on the investment we make in services for them.

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Date	Title	Summary
2007	Report from the South Central Mental Health Clinical Pathway Group	Identified a number of priorities for further improvement of mental health provision across the south central region, and developed five of these in detail, namely; - An outcomes framework for mental health and well-being - Bridging the gaps between care pathways and services - Primary care mental health services - Access to psychological therapies - Dementia care pathways
2008	Director of Public Health Annual Report, 2008	Reported on progress since the 2007 Annual Public Health Report and outlined five main threats to the future health, wellbeing and prosperity of Oxfordshire, namely; - the need to break the cycle of deprivation - the ageing population – the ‘demographic timebomb’ - improving mental health and wellbeing of the population; avoiding a Cinderella service - preventing obesity; a major cause of chronic - fighting killer

Appendix 5 - Composite indicators used to assess mental health needs

Table 41: Components of the Index of Multiple Deprivation

Domain of IMD	Indicators
Income	• Adults and children in Income Support Households (Source: DWP 2005) • Adults and children in Income-Based Job Seekers Allowance Households (Source: DWP 2005) • Adults and children in Pension Credit (Guarantee) Households (Source: DWP 2005) • Adults and children in those Working Tax Credit households where there are children in receipt of Child Tax Credit whose equivalised income (excluding housing benefits) is below 60 per cent of the median before housing costs (Source: HMRC 2005) • Adults and children in Child Tax Credit Households (who are not eligible for IS, Income-Based JSA, Pension Credit or Working Tax Credit) whose equivalised income (excluding housing benefits) is below 60 per cent of the median before housing costs (Source: HMRC 2005) • National Asylum Support Service (NASS) supported asylum seekers in England in receipt of subsistence support, accommodation support, or both (Source: NASS 2005)
Employment	• Recipients of Jobseekers Allowance (both contribution-based and income-based) for men aged 18–64 and women aged 18–59 (Source: DWP 2005) • Participants in the New Deal for the 18–24s who are not in receipt of JSA (Source: DWP 2005) • Participants in the New Deal for 25+ who are not in receipt of JSA (Source: DWP 2005) • Participants in the New Deal for Lone Parents (after initial interview) (Source: DWP 2005) • Incapacity Benefit recipients aged 18–59 (women); 18–64 (men) (Source: DWP 2005) • Severe Disablement Allowance recipients aged 18–59 (women); 18–64 (men) (Source: DWP 2005)
Health and Disability	• Years of Potential Life Lost (YPLL) (2001 to 2005, Source: ONS) • Comparative Illness and Disability Ratio (CIDR) (2005, Source: DWP) • Measures of acute morbidity, derived from Hospital Episode Statistics (April 2003 to March 2005, Source: Department of Health) • The proportion of adults under 60 suffering from mood or anxiety disorders based on prescribing (2005, Source: Prescribing Pricing Authority), suicide mortality rate (2001 to 2005, source: ONS), hospital episode (ICD-10 F3–F4) (April 2003 to March 2005, Source: Department of Health) and health benefits data (ICD-10 F3–F4) (2005, Source: DWP)
Education, skills and training	<i>Sub Domain: Children / Young People</i> • Average test score of pupils at Key Stage 2 (2 year weighted average, 2004–2005), Source: Pupil Level Annual School Census (PLASC), National Pupil Database (NPD) • Average test score of pupils at Key Stage 3 (2 year weighted average, 2004–2005), Source: PLASC, NPD • Best of 8 average capped points score at Key Stage 4 (this includes results of GCSEs, GNVQs and other vocational equivalents) (2 year weighted average, 2004–2005), Source: PLASC, NPD • Proportion of young people not staying on in school or non-advanced education above the age of 16 (2005), Source: HMRC Child Benefit (CB) data • Secondary school absence rate (2 year average 2004–2005), Source: DCSF absence data, PLASC • Proportion of those aged under 21 not entering higher education (4 year average, 2002–2005), Source: Universities and Colleges Admission Service (UCAS), Higher Education Statistics Agency (HESA) <i>Sub Domain: Skills</i> • Proportion of working age adults with no or low qualifications (2001) Source: Census 2001
Barriers to housing and services	Sub Domain: Wider Barriers • Household overcrowding (Source: 2001 Census) • District level rate of acceptances under the homelessness provisions of the 1996 Housing Act, assigned to the constituent LSOAs (Source: Communities and Local

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

	Government, 2005) • Difficulty of Access to owner-occupation (Source: modeled estimates produced by Herriot-Watt University, 2005) Sub Domain: Geographical Barriers • Road distance to a GP surgery (Source: National Health Service Information Authority, 2005) • Road distance to a general store or supermarket (Source: MapInfo Ltd, 2005) • Road distance to a primary school (Source: DfES, 2004–05) • Road distance to a Post Office or sub post office (Source: Post Office Ltd, 2005)
Crime and disorder	• Burglary (4 recorded crime offence types, Police Force data for April 2004-March 2005, constrained to Crime and Disorder Reduction Partnership (CDRP) level) • Theft (5 recorded crime offence types, Police Force data for April 2004-March 2005, constrained to CDRP level) • Criminal damage (10 recorded crime offence types, Police Force data for April 2004-March 2005, constrained to CDRP level) • Violence (14 recorded crime offence types, Police Force data for April 2004-March 2005, constrained to CDRP level).
The living environment	Sub-Domain: The ‘indoors’ living environment • Social and private housing in poor condition (2003 – 2005 average, Source BRE and Communities and Local Government, modeled EHCS) • Houses without central heating (2001, Source: ONS, Census) Sub-Domain: The ‘outdoors’ living environment • Air quality (2005, Source: Geography Department at Staffordshire University and NAEI modeled at LSOA level) • Road traffic accidents involving injury to pedestrians and cyclists (2004–2006 average, Source: DfT, STATS19 (Road Accident Data) smoothed to LSOA level)

Table 43: Components of the Health Poverty Index

			Indicator of health situation
Root causes of ill-health	Regional prospects	Gross Value Added per capita	- Gross Value Added per capita (ONS, 2003)
		Change in job supply	- Percentage increases in full time equivalent employee jobs between 1991-2001 by place of work (Annual Employment Survey, ONS, 1991)
		Educational resourcing	- Average expenditure per pupil
	Local conditions	Social capital	- Levels of social capital (ONS Census, 2001) - Measure of the size of out-migration from an area - Modelled estimate of proportion who trust their neighbours
		Education quality	- The quality of education provided to children at primary and secondary schools, in terms of numbers of pupils per teacher and the value added to pupils - The number of pupils to each teacher (PLASC, 2002/03 and DfSE, 2002/03) - The value added to children as they progress from Key Stage 2 to Key Stage 3 - The value added to children as they progress between Key Stage 2 and Key Stage 4 - The value added to children as they progress between Key Stage 3 and Key Stage 4
	Housing conditions	Income	- Proportions of the population experiencing income deprivation in an area
		Wealth	- Measures of high value property areas - Number of dwellings falling in Council Tax Bands F and above as a proportion of all dwellings - Average house prices by property type weighted by number of sales in each property type

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

		Human capital	- Average examination results at three stages - Average Key Stage 2 result - Average Key Stage 3 result - Average Key Stage 4 result
Intervening factors	Resourcing to support health	Local government resources	Local government expenditure per capita to produce healthy local and home environments (excluding any social security spend)
		Preventative care resourcing	Health service expenditure per capita on services promoting healthy areas
	Healthy areas	Recreational facilities	Access to recreational facilities per capita
		Access to preventative healthcare	- Flu vaccine uptake - Effective vaccination service - Breast screening uptake - Cervical screening uptake - Family Planning - Low birth weight - Use of statins
	Behaviours and environments	Lifestyle	- Smoking prevalence - Fresh fruit intake - Alcohol abuse - Drug misuse - Doing under 3 hours of physical activity in a week
		Home environments	- Proportion of households containing only one person - Modelled estimate of severe lack of social support - Air quality - Proportion of social and private housing in poor condition
		Work and local environments	- Proportion of people working in semi-routine and routine employment - Proportion of working age population involuntarily excluded from the world of work - Proportion of working age population involuntarily excluded from the world of work - Rate of recorded offences of burglary from a dwelling per 1,000 population - Theft rate per 1,000 population - Criminal damage rate per 1,000 population
Situation of Health	Resourcing for health & social care	Health care resourcing	- Spend on medical specialties - Spend on surgical specialties - Spend on psychiatric specialties
		Social care resourcing	- Personal social services expenditure per capita
	Appropriate Care	Effective primary care	- The ratio of GPs to clients - Directly age and gender standardised rate of all avoidable mortality amenable to primary healthcare - Directly age and gender standardised rate of all emergency admissions to hospital for asthma and diabetes
		Access to secondary care	- Directly age and gender standardised rate of operations for joint replacement - Directly age and gender standardised rate of operations for cataract removal - Directly age and gender standardised rate of operations for coronary heart disease

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

		Access to social care	- Weighted Whole Time Equivalent (WTE) social services staff (in operational divisions) per capita - Indirectly standardised residential and nursing beds ratio
		Quality of social care	- Proportion of the population committing suicide in a year - Directly age and gender standardised rate of allemergency (i.e. non elective) admissions to hospital for people over the age of 75 - Proportion of readmissions to hospital for psychiatric conditions within 90 days of discharge, out of all discharges for psychiatric conditions
	Health status	Psychological morbidity	- Proportion of the population committing suicide in a year - Proportion of the working age population claiming benefits for depression or anxiety - Proportion of the population receiving drug therapies for depression and/or anxiety - Admissions to hospital for depression or anxiety
		Health capital	- Modelled estimate of proportion with a Body Mass Index greater than 30. Body Mass Index is calculated from height and weight data (i.e. the ratio of weight (kg)/height (m2)) - Modelled estimate of proportion with high blood pressure - SBP>=160 mmHg or DBP>=95 mmHg. - Modelled estimate of proportion with high cholesterol - if valid cholesterol result >=6.5 mmol/l - Number of singleton live births under 2500 grams as a percentage of total live births
		Physical morbidity	- Directly age and gender standarised Illness and Disability Ratio - Proportion of the working age population claiming Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) for diseases of the Respiratory or Circulatory system - Proportion of the working age population claiming Incapacity Benefit (IB) for injury, poisoning and other consequences of external causes - Proportion of the working population claiming Incapacity Benefit (IB) for mental and behavioural disorders - Proportion of the working population claiming Incapacity Benefit (IB) for diseases of the musculoskeletal system - Proportion of the working population claiming Incapacity Benefit (IB) for diseases of the nervous system - Proportion of the working population claiming Incapacity Benefit (IB) for other conditions
		Premature mortality	- Directly age and gender standardised rate of average annual years of life lost up to age 75 per 10,000 resident population

Appendix 6 - Prevalence of symptoms of psychological distress that do not meet the threshold for a diagnosis of mental illness

Table 43: Estimated prevalence of working age adults with a score of two or more on each Clinical Interview Schedule (CIS-R) symptom, 2006-26

2006	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Sleep Problems	10,401	14,607	13,896	12,281	14,448	15,095	13,957	11,190	12,704	9,631	128,211
Fatigue	8,608	12,520	14,375	13,226	14,964	16,136	13,057	12,348	10,719	8,635	124,588
Irritability	8,608	11,998	11,979	11,337	12,900	11,452	9,455	7,717	6,352	4,317	96,116
Worry	6,815	10,433	10,541	9,919	10,836	11,452	9,455	8,489	6,352	5,314	89,607
Depression	4,304	5,217	5,271	5,196	6,708	7,287	5,403	4,245	3,970	3,321	50,921
Concentration & forgetfulness	2,869	4,173	4,312	5,196	5,676	5,726	4,953	5,016	3,573	2,989	44,484
Depressive Ideas	4,663	5,217	5,271	4,724	5,676	5,726	4,052	3,859	3,573	2,325	45,084
Anxiety	2,511	3,130	4,312	4,251	4,644	5,726	4,953	4,630	3,573	2,325	40,055
Somatic Symptoms	1,076	2,608	3,354	3,306	4,128	4,685	4,502	3,087	2,382	1,993	31,122
Worry-Physical Health	2,152	3,130	2,875	2,834	3,096	4,164	3,602	3,087	3,176	2,657	30,773
Obsessions	2,152	3,652	3,354	2,834	3,096	3,123	2,701	1,543	1,588	1,661	25,705
Phobias	2,152	3,130	2,396	2,362	2,580	2,603	1,801	2,315	1,191	996	21,526
Compulsions	1,435	2,087	1,437	1,889	1,548	1,562	900	1,158	1,191	996	14,203
Panic	717	522	958	945	1,032	1,562	1,351	772	794	332	8,984

2016	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Sleep Problems	9,643	15,572	16,036	13,020	12,817	13,113	15,091	14,026	12,964	10,151	132,433
Fatigue	7,981	13,348	16,589	14,022	13,274	14,017	14,117	15,477	10,939	9,101	128,864
Irritability	7,981	12,792	13,824	12,019	11,443	9,948	10,223	9,673	6,482	4,550	98,935
Worry	6,318	11,123	12,165	10,516	9,613	9,948	10,223	10,640	6,482	5,601	92,629
Depression	3,990	5,562	6,083	5,509	5,951	6,330	5,842	5,320	4,051	3,500	52,137
Concentration & forgetfulness	2,660	4,449	4,977	5,509	5,035	4,974	5,355	6,287	3,646	3,150	46,042
Depressive Ideas	4,323	5,562	6,083	5,008	5,035	4,974	4,381	4,836	3,646	2,450	46,298
Anxiety	2,328	3,337	4,977	4,507	4,120	4,974	5,355	5,804	3,646	2,450	41,497
Somatic Symptoms	998	2,781	3,871	3,505	3,662	4,070	4,868	3,869	2,431	2,100	32,154
Worry-Physical Health	1,995	3,337	3,318	3,005	2,746	3,617	3,894	3,869	3,241	2,800	31,823
Obsessions	1,995	3,893	3,871	3,005	2,746	2,713	2,921	1,935	1,621	1,750	26,449
Phobias	1,995	3,337	2,765	2,504	2,289	2,261	1,947	2,902	1,215	1,050	22,265
Compulsions	1,330	2,225	1,659	2,003	1,373	1,357	974	1,451	1,215	1,050	14,637
Panic	665	556	1,106	1,002	915	1,357	1,460	967	810	350	9,189

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

2026	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Sleep Problems	9,880	15,089	14,949	13,646	14,686	13,875	13,472	12,306	14,137	12,842	134,883
Fatigue	8,177	12,934	15,465	14,695	15,210	14,832	12,603	13,579	11,928	11,513	130,937
Irritability	8,177	12,395	12,887	12,596	13,112	10,526	9,126	8,487	7,068	5,757	100,132
Worry	6,473	10,778	11,341	11,022	11,014	10,526	9,126	9,336	7,068	7,085	93,770
Depression	4,088	5,389	5,670	5,773	6,818	6,698	5,215	4,668	4,418	4,428	53,167
Concentration & forgetfulness	2,726	4,311	4,639	5,773	5,769	5,263	4,780	5,517	3,976	3,985	46,740
Depressive Ideas	4,429	5,389	5,670	5,248	5,769	5,263	3,911	4,244	3,976	3,100	47,000
Anxiety	2,385	3,233	4,639	4,724	4,720	5,263	4,780	5,092	3,976	3,100	41,913
Somatic Symptoms	1,022	2,695	3,608	3,674	4,196	4,306	4,346	3,395	2,651	2,657	32,549
Worry-Physical Health	2,044	3,233	3,093	3,149	3,147	3,828	3,477	3,395	3,534	3,543	32,442
Obsessions	2,044	3,772	3,608	3,149	3,147	2,871	2,607	1,697	1,767	2,214	26,878
Phobias	2,044	3,233	2,577	2,624	2,622	2,392	1,738	2,546	1,325	1,328	22,432
Compulsions	1,363	2,156	1,546	2,099	1,573	1,435	869	1,273	1,325	1,328	14,969
Panic	681	539	1,031	1,050	1,049	1,435	1,304	849	884	443	9,264

Source: (Derived) 2006 Oxfordshire estimate applied to expected change in Oxfordshire population

Table 44: Estimated prevalence of working age adults with a score of two or more on each Clinical Interview Schedule (CIS-R) symptom, 2006 – 2026 and % change in prevalence up to 2026

	2,006	2,016	2,026	change 2006-16	change 2006-26	%change 2006-16	%change 2006-26
Sleep Problems	128,211	132,433	134,883	4,222	6,671	3.29	5.20
Fatigue	124,588	128,864	130,937	4,276	6,349	3.43	5.10
Irritability	96,116	98,935	100,132	2,819	4,016	2.93	4.18
Worry	89,607	92,629	93,770	3,022	4,163	3.37	4.65
Depression	50,921	52,137	53,167	1,216	2,245	2.39	4.41
Concentration & forgetfulness	44,484	46,042	46,740	1,559	2,256	3.50	5.07
Depressive Ideas	45,084	46,298	47,000	1,214	1,916	2.69	4.25
Anxiety	40,055	41,497	41,913	1,442	1,858	3.60	4.64
Somatic Symptoms	31,122	32,154	32,549	1,032	1,427	3.32	4.59
Worry-Physical Health	30,773	31,823	32,442	1,050	1,669	3.41	5.42
Obsessions	25,705	26,449	26,878	745	1,173	2.90	4.56
Phobias	21,526	22,265	22,432	739	906	3.43	4.21
Compulsions	14,203	14,637	14,969	433	766	3.05	5.39
Panic	8,984	9,189	9,264	204	280	2.28	3.12

Source: (Derived) 2006 Oxfordshire estimate applied to expected change in Oxfordshire population

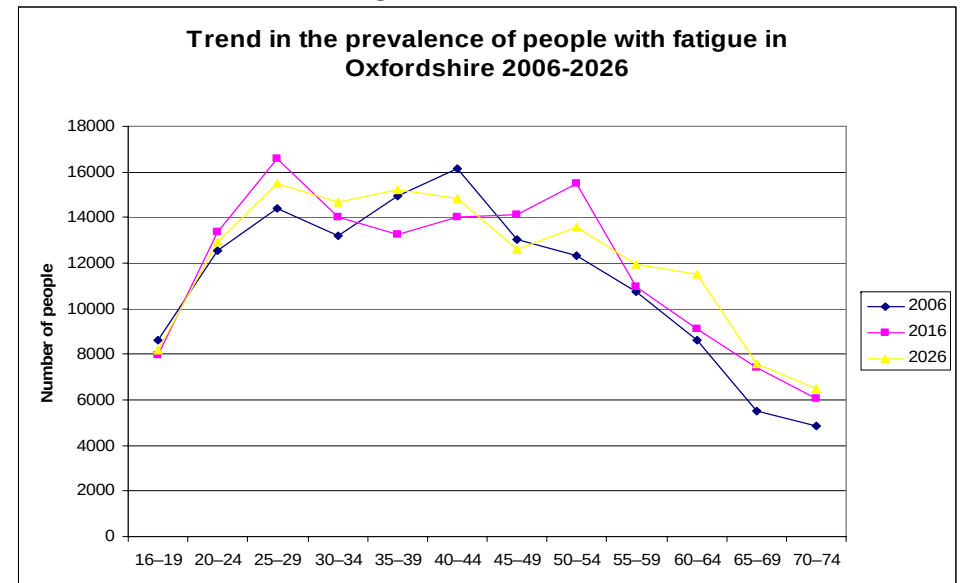
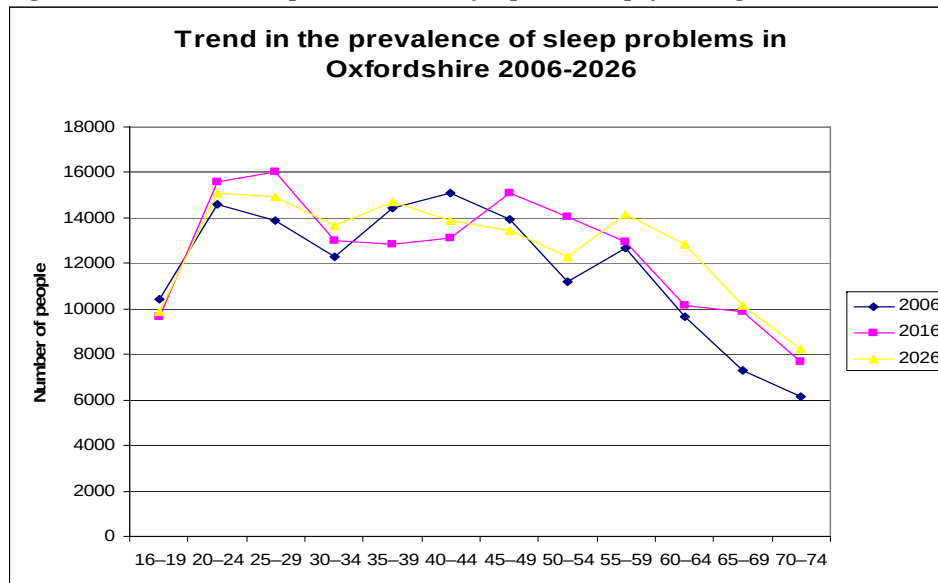
Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 45: Estimated prevalence of working age adults with a score of two or more on each Clinical Interview Schedule (CIS-R) symptom, 2006-26

	2006	2016	2026	change 2006-2016	change 2006-26	%change 2006-16	%change 2006-26
Sleep Problems	128,211	132,433	134,883	4,222	6,671	3.29	5.20
Fatigue	124,588	128,864	130,937	4,276	6,349	3.43	5.10
Irritability	96,116	98,935	100,132	2,819	4,016	2.93	4.18
Worry	89,607	92,629	93,770	3,022	4,163	3.37	4.65
Depression	50,921	52,137	53,167	1,216	2,245	2.39	4.41
Concentration & forgetfulness	44,484	46,042	46,740	1,559	2,256	3.50	5.07
Depressive Ideas	45,084	46,298	47,000	1,214	1,916	2.69	4.25
Anxiety	40,055	41,497	41,913	1,442	1,858	3.60	4.64
Somatic Symptoms	31,122	32,154	32,549	1,032	1,427	3.32	4.59
Worry-Physical Health	30,773	31,823	32,442	1,050	1,669	3.41	5.42
Obsessions	25,705	26,449	26,878	745	1,173	2.90	4.56
Phobias	21,526	22,265	22,432	739	906	3.43	4.21
Compulsions	14,203	14,637	14,969	433	766	3.05	5.39
Panic	8,984	9,189	9,264	205	280	2.28	3.12

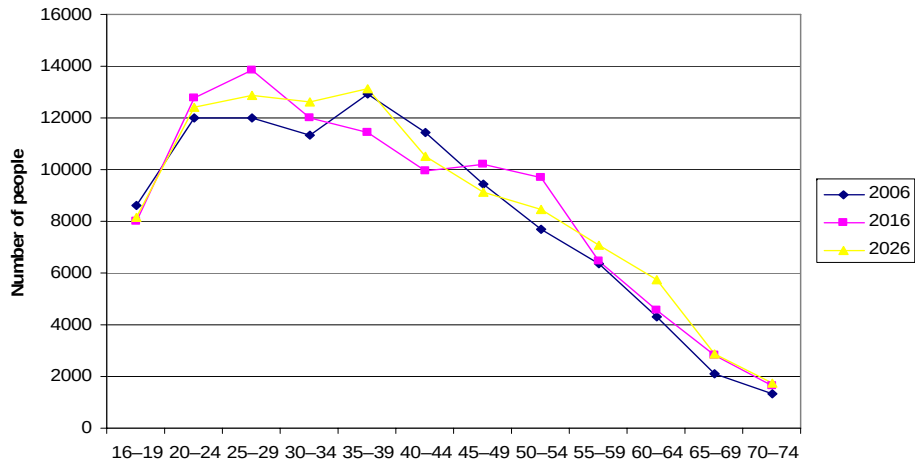
Source: (Derived) Oxfordshire PCT population (2006) applied to UK Survey estimates (2000)

Figure 10: Trend in the prevalence of symptoms of psychological distress that do not meet the threshold for a diagnosis of mental illness

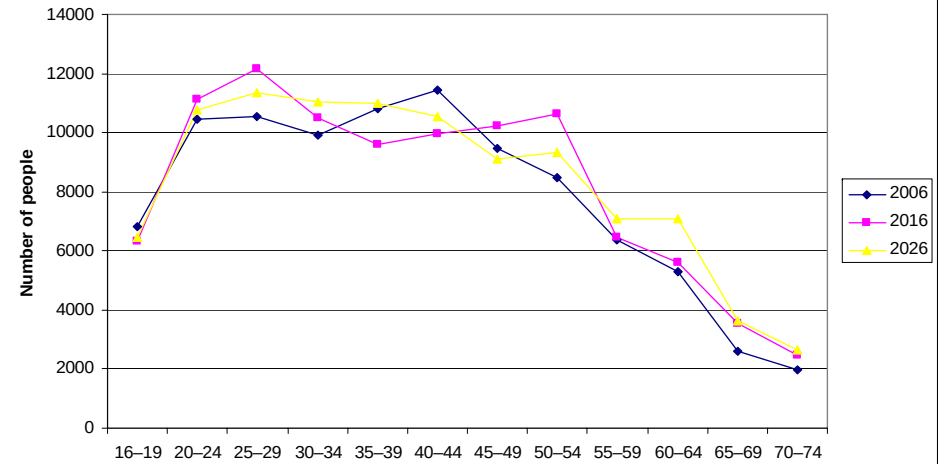


Mental Health Needs Assessment for working age population in Oxfordshire, May 08

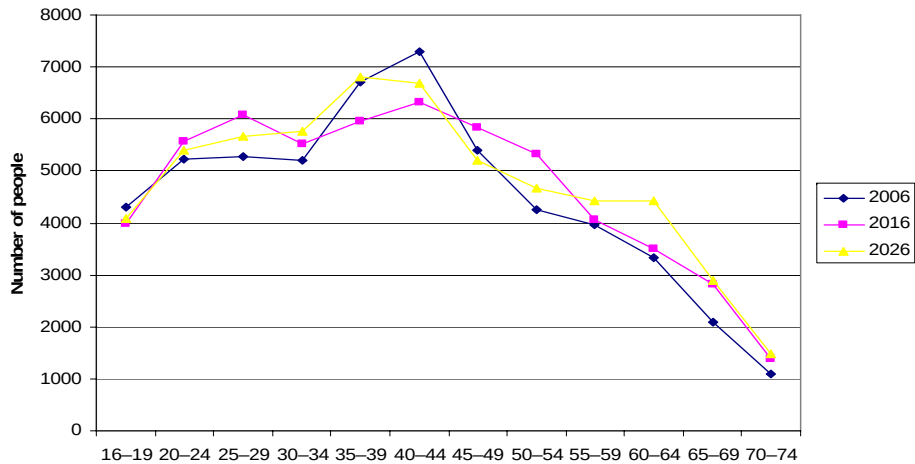
Trend in the number of people in Oxfordshire who c/o irritability, 2006-2026



Trend in the number of people in Oxfordshire who c/o worries, 2006-2026



Trend in the number of people in Oxfordshire who c/o depression, 2006-2026

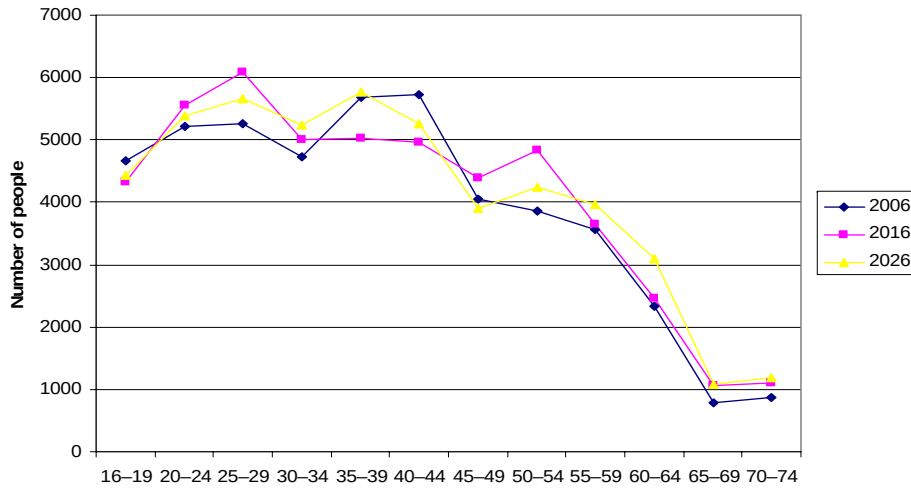


Trend in the number of people who c/o difficulty concentrating/ forgetfulness in Oxfordshire 2006-2026

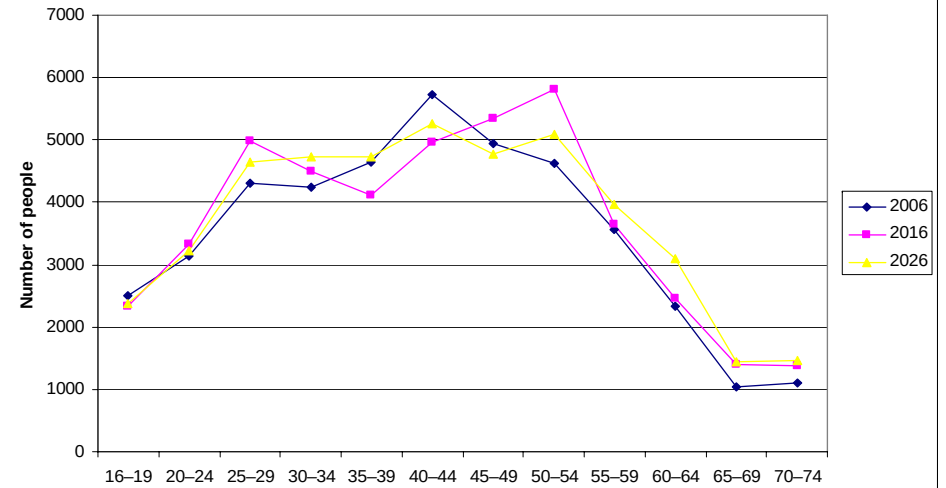


Mental Health Needs Assessment for working age population in Oxfordshire, May 08

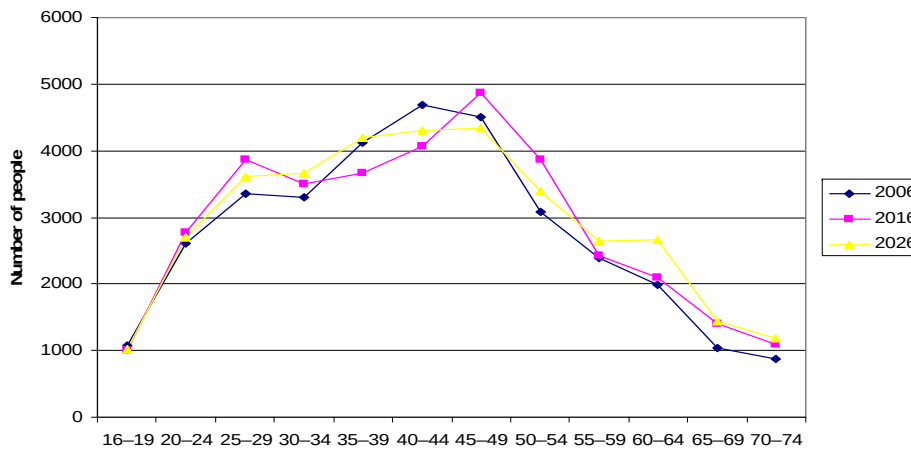
Trend in the number of people in Oxfordshire who c/o depressive ideas, 2006-2026



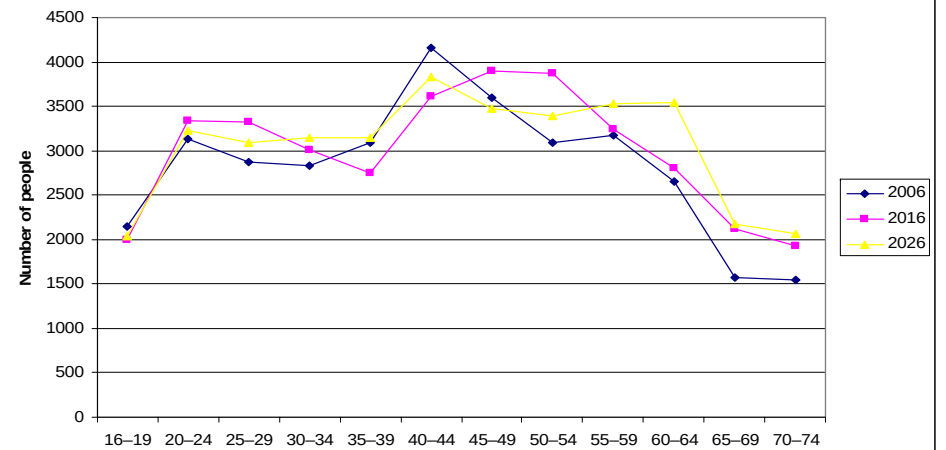
Trend in the number of people in Oxfordshire who c/o anxiety, 2006-2026



Trend in the number of people in Oxfordshire who c/o somatic symptoms, 2006-2026

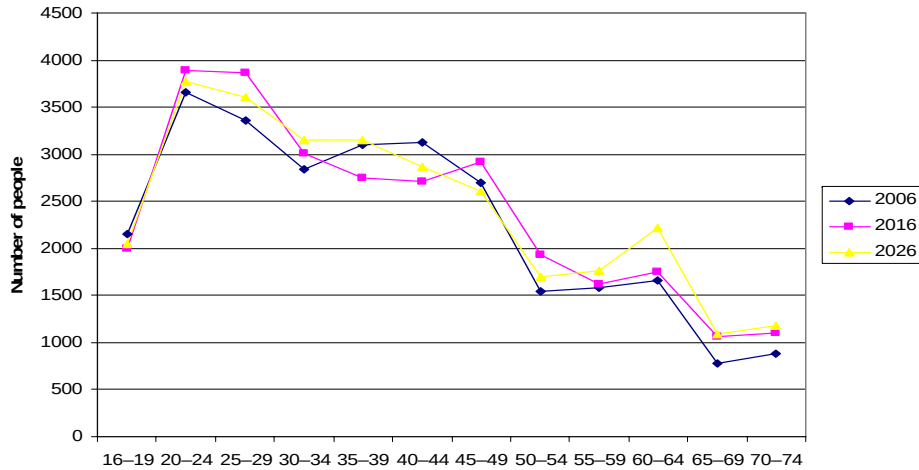


Trend in the number of people who c/o worries about their physical health in Oxfordshire 2006-2026

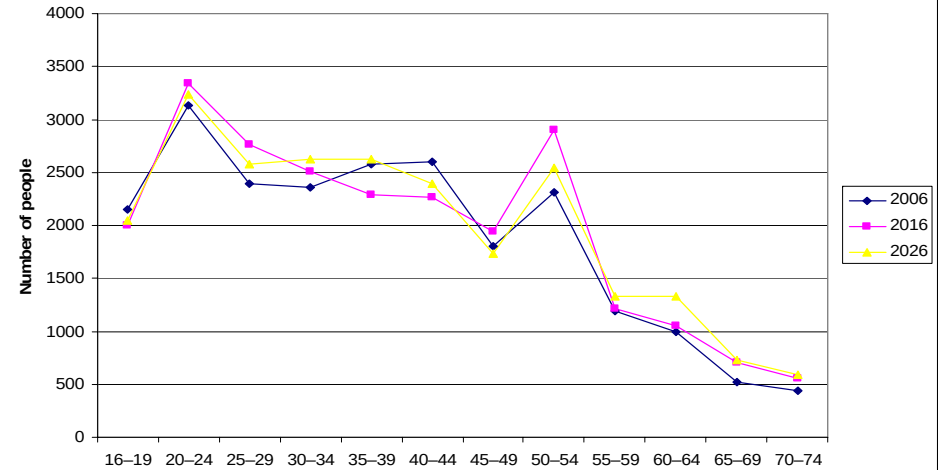


Mental Health Needs Assessment for working age population in Oxfordshire, May 08

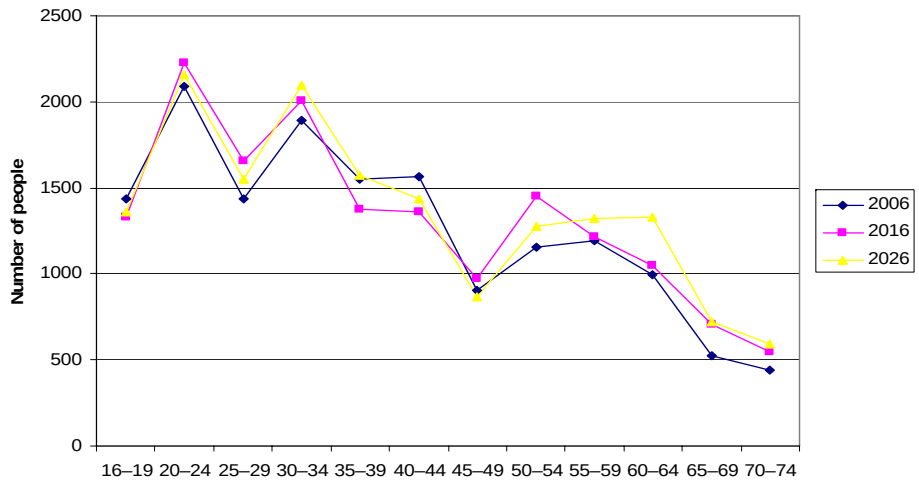
Trend in the number of people in Oxfordshire who c/o obsessions, 2006-2026



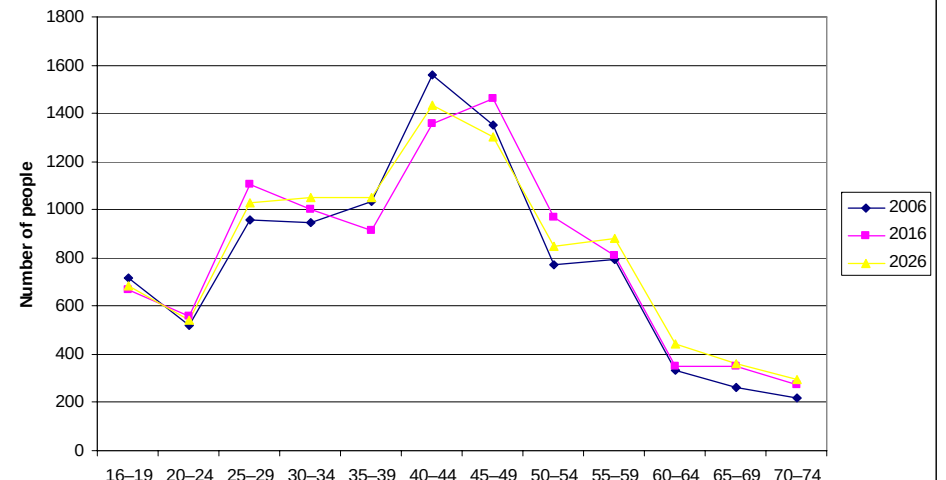
Trend in the number of people in Oxfordshire who c/o phobias, 2006-2026



Trend in the number of people in Oxfordshire who c/o compulsions, 2006-2026



Trend in the number of people in Oxfordshire who c/o panic, 2006-2026



Appendix 7 - Prevalence of mental illness in the local community

Table 46: Annual prevalence of Neurotic Disorders in the community (rate per 1,000 population)

All Adults	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	All
Mixed anxiety and depressive disorder (ICD10 code - F41.2)	83	94	110	88	89	108	91	95	68	79	60	55	88
Generalised anxiety disorder (ICD10 code - F41.1)	14	15	39	45	53	61	71	66	50	42	26	23	44
Depressive episode (ICD10 code - F32-33)	17	22	24	22	37	28	36	32	34	24	6	11	26
All Phobias (ICD10 code - F40)	13	16	18	20	26	21	25	20	13	14	7	4	18
Obsessive compulsive disorder (ICD10 code - F42)	9	19	12	11	13	13	13	7	14	13	2	2	11
Panic disorder (ICD10 code - F41.0)	5	4	9	7	6	5	10	12	14	2	4	4	7
Any neurotic disorder	133	158	181	169	172	195	197	198	155	146	102	94	164

Source: Survey of Psychiatric Morbidity among Adults living in Private Households, 2000

Table 47: Estimated number of working age people with mental illness in Oxfordshire 2006-26

2006	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	All
Mixed anxiety and depressive disorder (ICD10 code - F41.2)	2,977	4,904	5,271	4,157	4,593	5,622	4,097	3,666	2,700	2,624	40,608
Generalised anxiety disorder (ICD10 code - F41.1)	502	782	1,869	2,126	2,735	3,175	3,197	2,547	1,985	1,395	20,312
Depressive episode (ICD10 code - F32-33)	610	1,148	1,150	1,039	1,909	1,457	1,621	1,235	1,350	797	12,316
All Phobias (ICD10 code - F40)	466	835	862	945	1,342	1,093	1,126	772	516	465	8,421
Obsessive compulsive disorder (ICD10 code - F42)	323	991	575	520	671	677	585	270	556	432	5,599
Panic disorder (ICD10 code - F41.0)	179	209	431	331	310	260	450	463	556	66	3,255
Any neurotic disorder	4,770	8,242	8,673	7,983	8,875	10,150	8,870	7,640	6,153	4,849	76,206

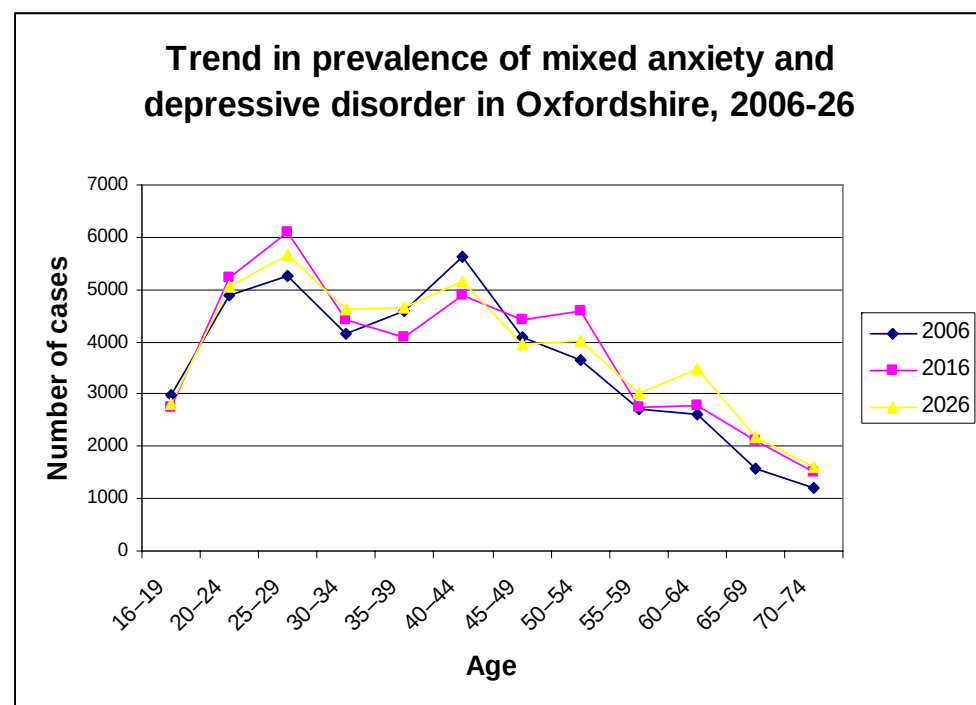
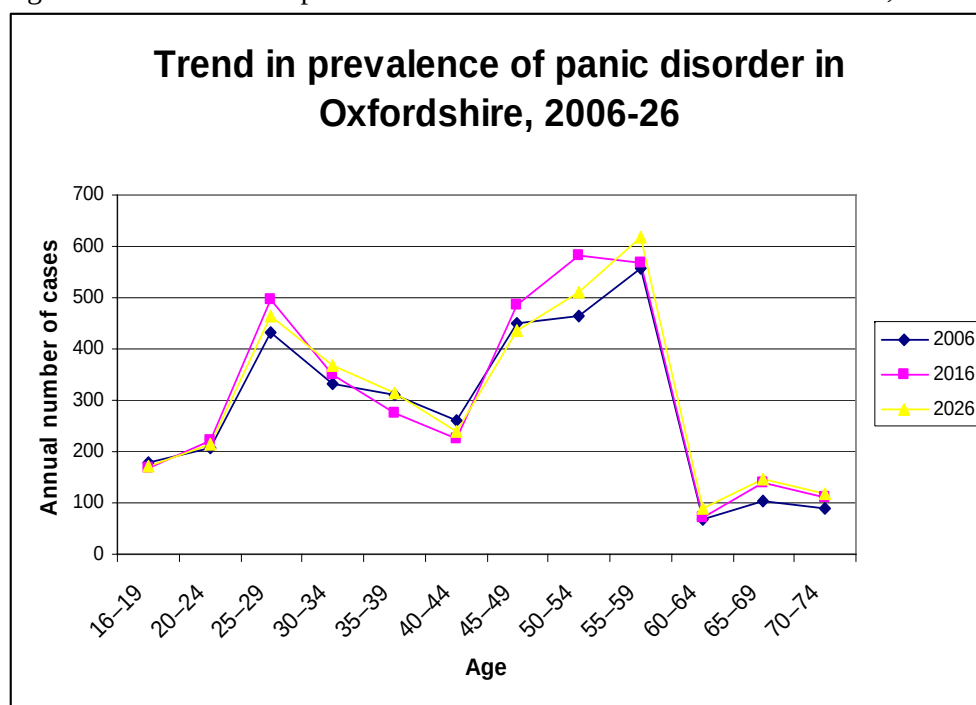
2016	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	All
Mixed anxiety and depressive disorder (ICD10 code - F41.2)	2,760	5,228	6,083	4,407	4,074	4,883	4,430	4,595	2,755	2,765	41,979
Generalised anxiety disorder (ICD10 code - F41.1)	466	834	2,157	2,254	2,426	2,758	3,456	3,192	2,026	1,470	21,038
Depressive episode (ICD10 code - F32-33)	565	1,224	1,327	1,102	1,694	1,266	1,752	1,548	1,377	840	12,695
All Phobias (ICD10 code - F40)	432	890	995	1,002	1,190	950	1,217	967	527	490	8,660
Obsessive compulsive disorder (ICD10 code - F42)	299	1,057	664	551	595	588	633	339	567	455	5,747
Panic disorder (ICD10 code - F41.0)	166	222	498	351	275	226	487	580	567	70	3,442
Any neurotic disorder	4,423	8,787	10,009	8,463	7,873	8,817	9,590	9,576	6,280	5,111	78,928

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

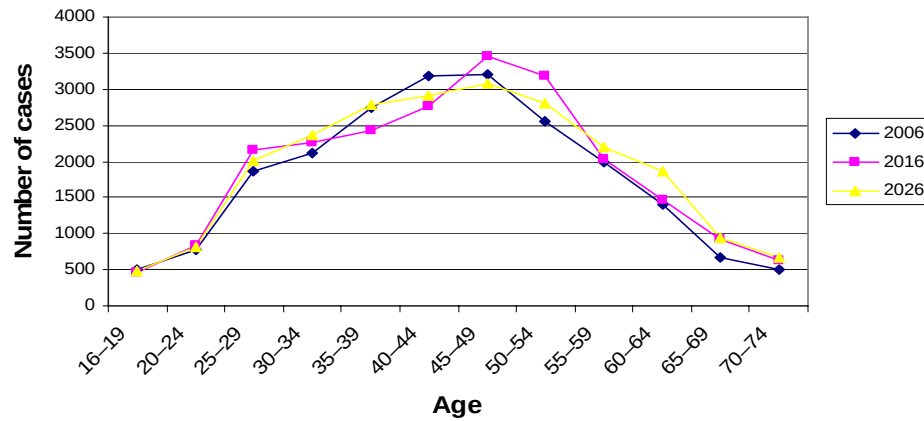
2026	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Mixed anxiety and depressive disorder (ICD10 code - F41.2)	2,828	5,066	5,670	4,619	4,668	5,167	3,955	4,031	3,004	3,498	42,506
Generalised anxiety disorder (ICD10 code - F41.1)	477	808	2,010	2,362	2,780	2,919	3,085	2,801	2,209	1,860	21,311
Depressive episode (ICD10 code - F32-33)	579	1,186	1,237	1,155	1,941	1,340	1,564	1,358	1,502	1,063	12,924
All Phobias (ICD10 code - F40)	443	862	928	1,050	1,364	1,005	1,086	849	574	620	8,781
Obsessive compulsive disorder (ICD10 code - F42)	307	1,024	619	577	682	622	565	297	618	576	5,886
Panic disorder (ICD10 code - F41.0)	170	216	464	367	315	239	435	509	618	89	3,422
Any neurotic disorder	4,531	8,515	9,330	8,870	9,021	9,330	8,561	8,402	6,848	6,465	79,873

Source: (Derived) 2006 Oxfordshire estimate applied to expected change in Oxfordshire population

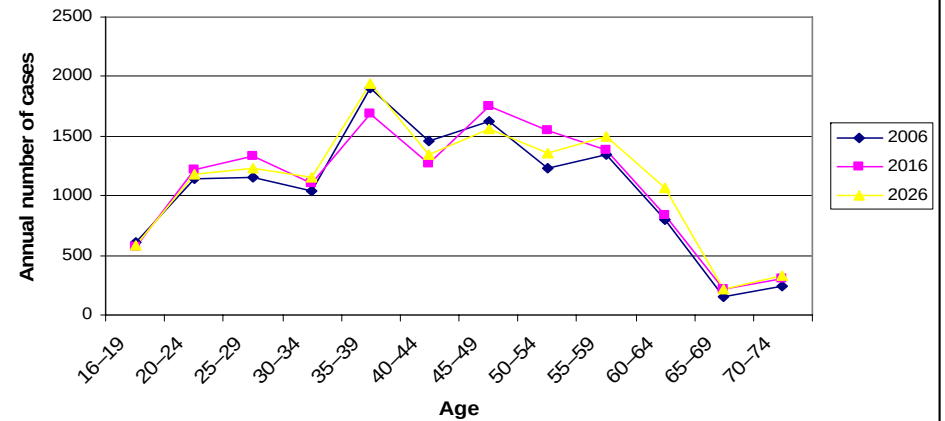
Figure 11: Trends in the prevalence of neurotic conditions in Oxfordshire, 2006-26



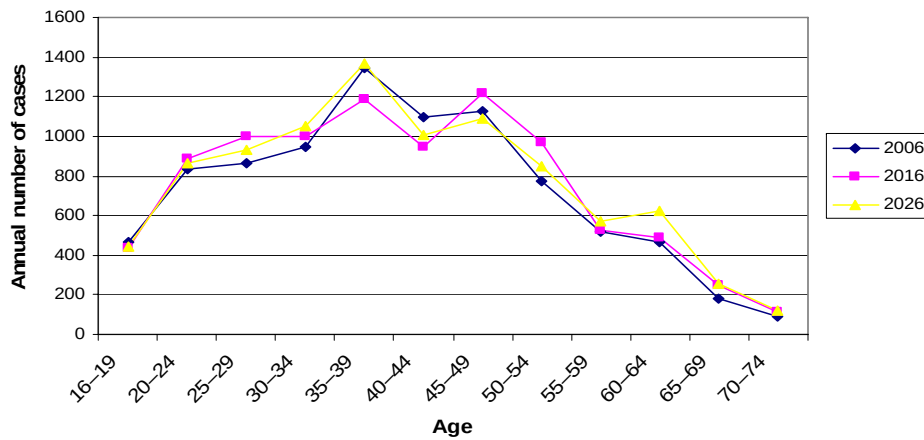
Trend in prevalence of generalised anxiety disorder in Oxfordshire, 2006-26



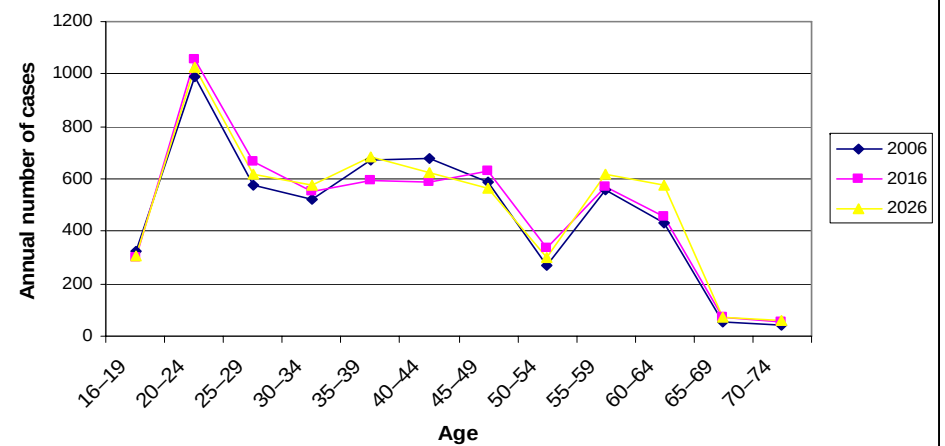
Trend in prevalence of depressive episodes in Oxfordshire, 2006-26



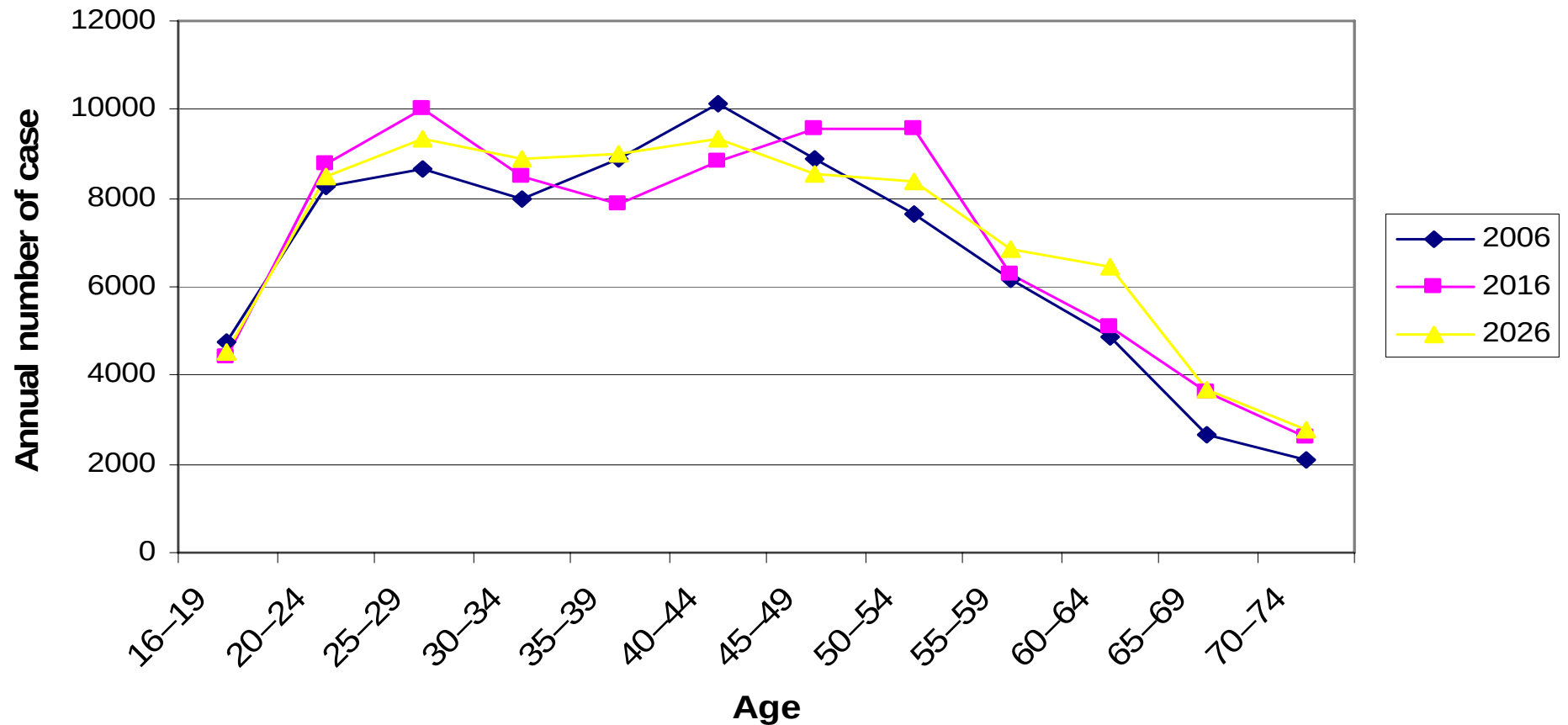
Trend in prevalence of all phobias in Oxfordshire, 2006-26



Trend in prevalence of obsessive compulsive disorder in Oxfordshire, 2006-26



Trend in prevalence of any neurotic disorder in Oxfordshire, 2006-26



Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 48: Annual prevalence of probable psychotic disorder in the community (rate per 1,000 population)

All Adults	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	All
Probable Psychotic Disorder (ICD10 code - F20-29, F30, F31)	2	2	1	9	8	10	6	7	5	4	3	3	5

Source: Survey of Psychiatric Morbidity among Adults living in Private Households, 2000

Table 49: Estimated number of working age people with probable psychotic disorder in Oxfordshire 2006-26

2006	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Probable Psychotic Disorder (ICD10 code - F20-29, F30, F31)	72	104	48	425	413	521	270	270	198	133	2,454

2016	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Probable Psychotic Disorder (ICD10 code - F20-29, F30, F31)	67	111	55	451	366	452	292	339	203	140	2,475

2026	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Probable Psychotic Disorder (ICD10 code - F20-29, F30, F31)	68	108	52	472	420	478	261	297	221	177	2,554

Source: (Derived) 2006 Oxfordshire estimate applied to expected change in Oxfordshire population

Figure 12: Trend in the prevalence of probable psychosis in Oxfordshire, 2002-26

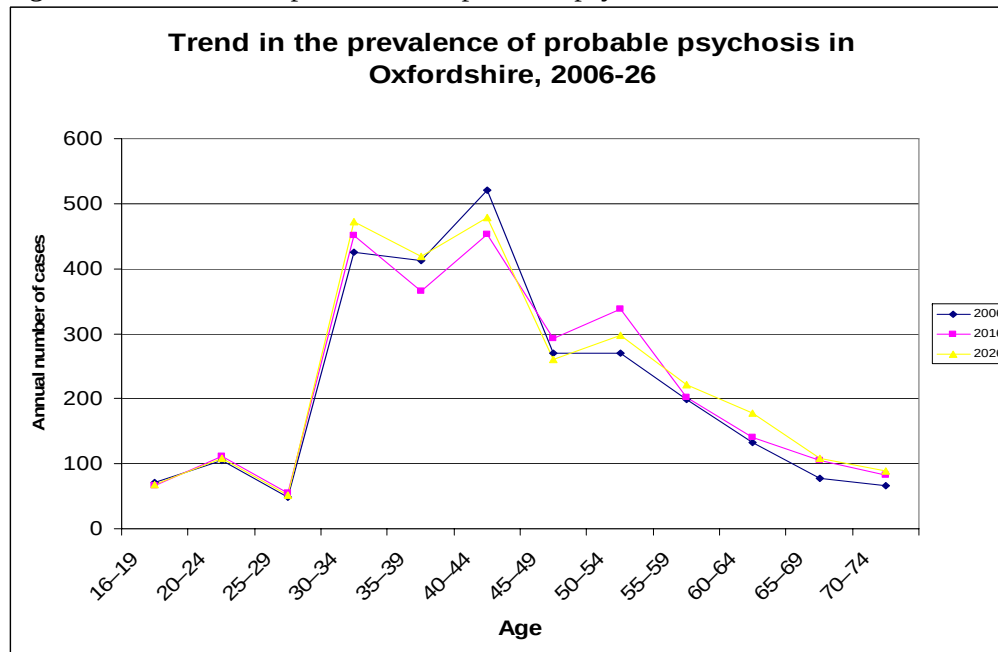


Table 50: Annual prevalence of any personality disorder in the community, age 16-74 years (rate per 1,000 population)

All Adults	16-34	35-54	55-74	All
Any Personality Disorder	34	44	58	44

Source: Survey of Psychiatric Morbidity among Adults living in Private Households, 2000

Table 51: Estimated number of people aged 16-74 years with any personality disorder in Oxfordshire, 2006 – 2026

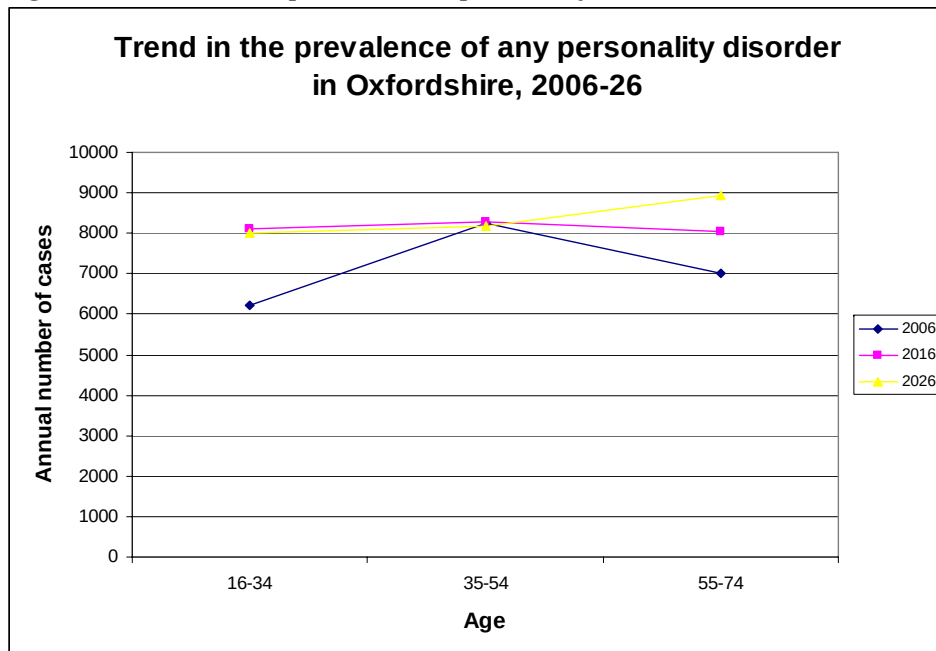
2006	16-34	35-54	55-74	All
Any Personality Disorder	6,228	8,240	7,020	21,625

2016	16-34	35-54	55-74	All
Any Personality Disorder	8,104	8,281	8,025	24,410

2026	16-34	35-54	55-74	All
Any Personality Disorder	8,018	8,193	8,935	25,146

Source: (Derived) 2006 Oxfordshire estimate applied to expected change in Oxfordshire population

Figure 13: Trend in the prevalence of personality disorders in Oxfordshire, 2006-26



Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 52: Annual prevalence of alcohol dependence in the community (rate per 1,000 population)

All Adults	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	All
No Dependence - (SAD-Q score 0-3)	862	847	861	929	897	935	962	955	958	984	983	991	926
Mild Dependence - (SAD-Q score 4-19)	124	150	137	66	96	56	36	41	42	14	17	9	69
Moderate Dependence - (SAD-Q score 20-34)	14	3	3	4	5	7	2	3	0	1	0	0	4
Severe Dependence - (SAD-Q score 35-60)	0	0	0	1	1	2	1	1	0	1	0	0	1

Source: Survey of Psychiatric Morbidity among Adults living in Private Households, 2000

Table 53: Estimated number of cases of alcohol dependence in people of working age in Oxfordshire, 2006-2026

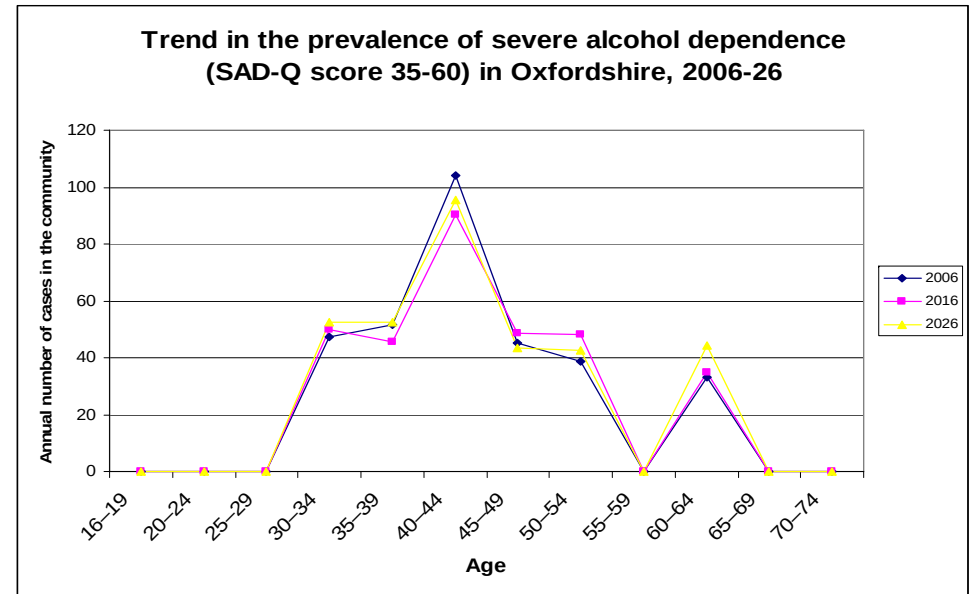
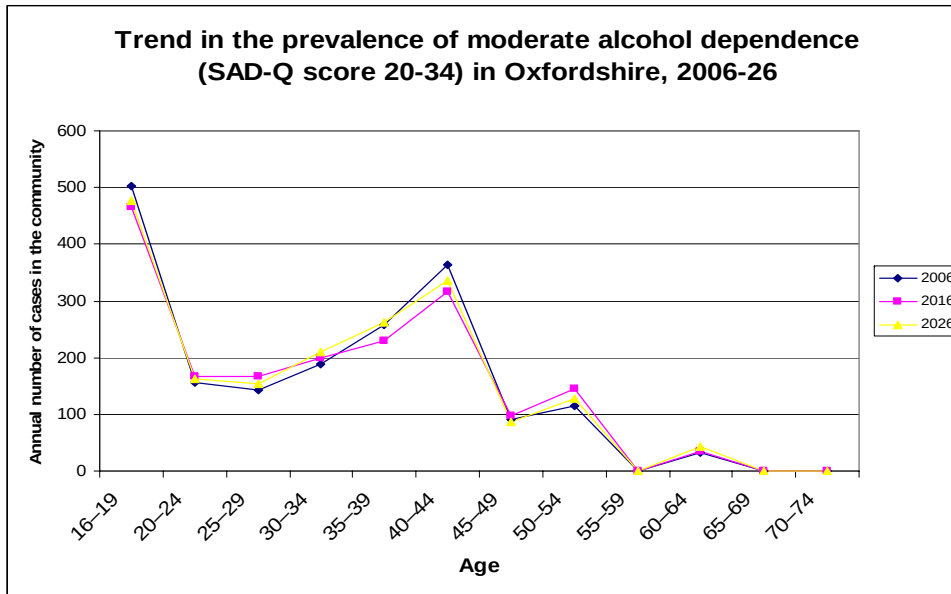
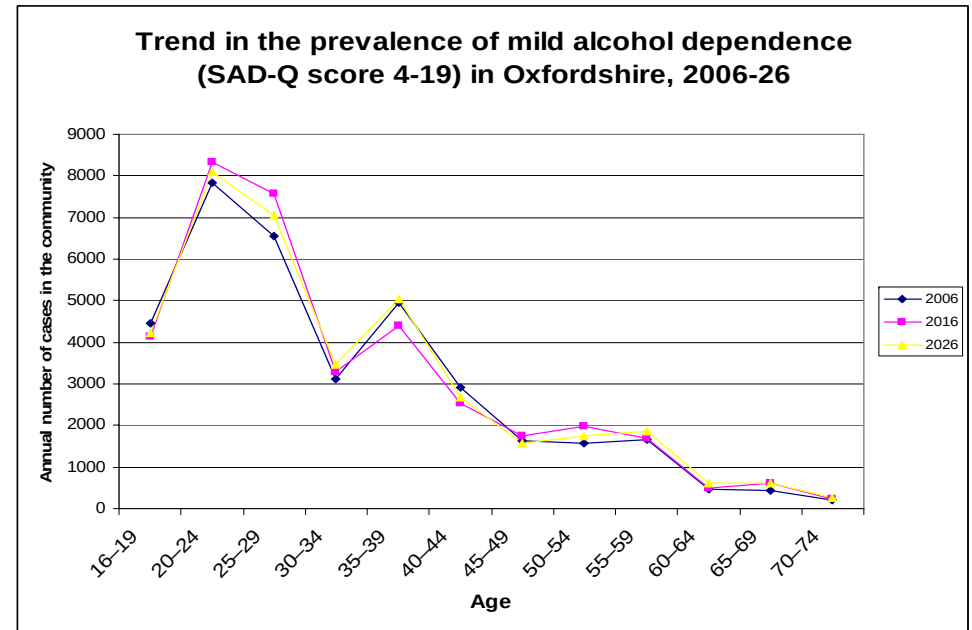
2006	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	All
No Dependence - (SAD-Q score 0-3)	30,917	44,185	41,255	43,882	46,287	48,669	43,313	36,851	38,032	32,680	406,071
Mild Dependence - (SAD-Q score 4-19)	4,448	7,825	6,564	3,118	4,954	2,915	1,621	1,582	1,667	465	35,158
Moderate Dependence - (SAD-Q score 20-34)	502	156	144	189	258	364	90	116	0	33	1,853
Severe Dependence - (SAD-Q score 35-60)	0	0	0	47	52	104	45	39	0	33	320

2016	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	All
No Dependence - (SAD-Q score 0-3)	28,664	47,106	47,610	46,523	41,059	42,278	46,831	46,188	38,812	34,444	419,514
Mild Dependence - (SAD-Q score 4-19)	4,123	8,342	7,576	3,305	4,394	2,532	1,752	1,983	1,702	490	36,200
Moderate Dependence - (SAD-Q score 20-34)	466	167	166	200	229	317	97	145	0	35	1,821
Severe Dependence - (SAD-Q score 35-60)	0	0	0	50	46	90	49	48	0	35	318

2026	16–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	All
No Dependence - (SAD-Q score 0-3)	29,368	45,646	44,384	48,758	47,047	44,736	41,806	40,526	42,322	43,573	428,166
Mild Dependence - (SAD-Q score 4-19)	4,225	8,084	7,062	3,464	5,035	2,679	1,564	1,740	1,855	620	36,329
Moderate Dependence - (SAD-Q score 20-34)	477	162	155	210	262	335	87	127	0	44	1,859
Severe Dependence - (SAD-Q score 35-60)	0	0	0	52	52	96	43	42	0	44	331

Source: (Derived) 2006 Oxfordshire estimate applied to expected change in Oxfordshire population

Figure 14: Trend in the prevalence of alcohol dependence in Oxfordshire, 2006-2026



Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 54: Annual prevalence of drug dependence in the community (rate per 1,000 population)

All Adults	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	All
Cannabis	78	125	77	34	18	8	17	3	2	1	0	0	31
Amphetamines	14	18	11	1	2	0	0	2	0	0	0	0	4
Cocaine	6	8	4	1	3	4	0	0	0	0	0	0	2
Crack	5	2	0	2	2	0	0	0	2	0	0	0	1
Ecstasy	26	29	16	2	1	0	0	0	0	0	0	0	6
Heroin/Methadone	7	4	1	1	3	0	1	0	0	0	0	0	1
Tranquillisers	2	3	2	2	5	1	0	2	1	2	4	1	2
Volatile substances	1	0	0	0	0	0	0	0	0	0	0	0	0
Cannabis only	51	100	62	31	16	8	16	3	2	1	0	0	25
Other drugs with or without cannabis dependence	45	44	27	5	8	6	1	3	4	2	4	1	12
Any drug	96	144	90	36	24	13	17	6	5	3	4	1	37

Source: Survey of Psychiatric Morbidity among Adults living in Private Households, 2000

Table 55: Estimated annual number of cases of drug dependence in people of working age in Oxfordshire, 2006-2006

2006	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Cannabis	2,798	6,521	3,689	1,606	929	416	765	116	79	33	16,953
Amphetamines	502	939	527	47	103	0	0	77	0	0	2,196
Cocaine	215	417	192	47	155	208	0	0	0	0	1,234
Crack	179	104	0	94	103	0	0	0	79	0	561
Ecstasy	933	1,513	767	94	52	0	0	0	0	0	3,358
Heroin/Methadone	251	209	48	47	155	0	45	0	0	0	755
Tranquillisers	72	156	96	94	258	52	0	77	40	66	912
Volatile substances	36	0	0	0	0	0	0	0	0	0	36
Cannabis only	1,829	5,217	2,971	1,464	826	416	720	116	79	33	13,672
Other drugs with or without cannabis dependence	1,614	2,295	1,294	236	413	312	45	116	159	66	6,550
Any drug	3,443	7,512	4,312	1,700	1,238	677	765	232	198	100	20,178

2016	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Cannabis	2,594	6,952	4,258	1,703	824	362	828	145	81	35	17,780
Amphetamines	466	1,001	608	50	92	0	0	97	0	0	2,313
Cocaine	200	445	221	50	137	181	0	0	0	0	1,234
Crack	166	111	0	100	92	0	0	0	81	0	550
Ecstasy	865	1,613	885	100	46	0	0	0	0	0	3,508
Heroin/Methadone	233	222	55	50	137	0	49	0	0	0	747
Tranquillisers	67	167	111	100	229	45	0	97	41	70	925
Volatile substances	33	0	0	0	0	0	0	0	0	0	33

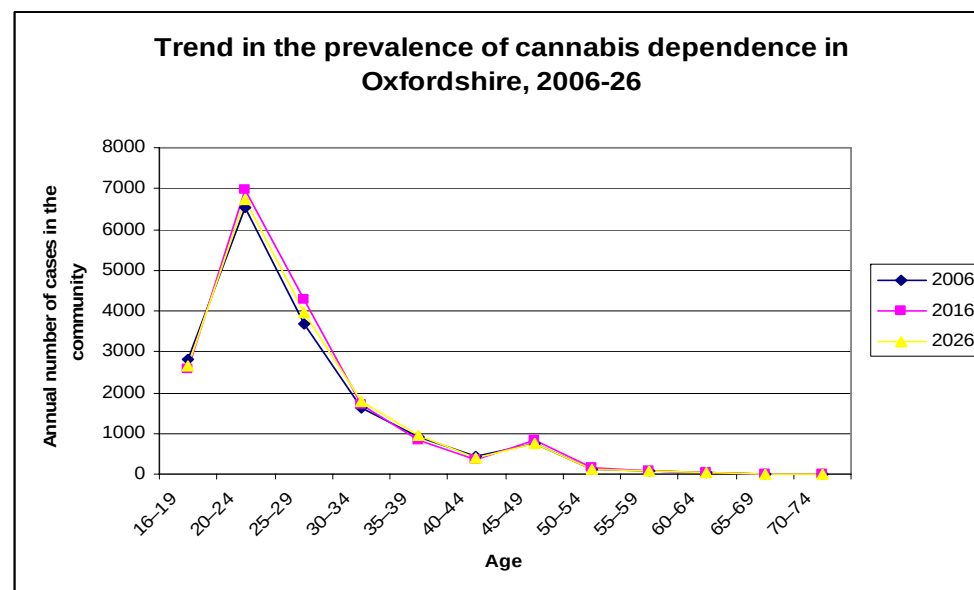
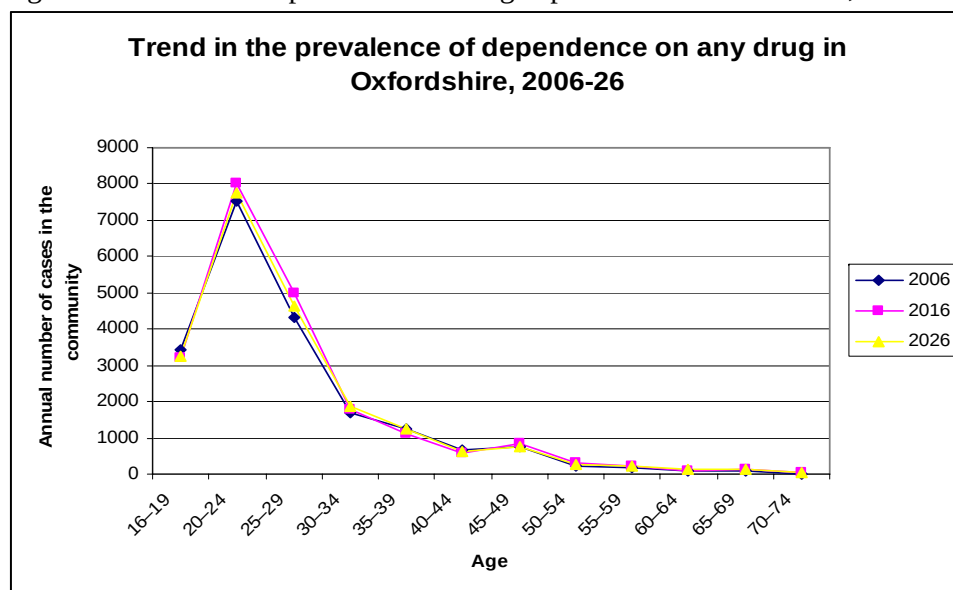
Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Cannabis only	1,696	5,562	3,428	1,552	732	362	779	145	81	35	14,372
Other drugs with or without cannabis dependence	1,496	2,447	1,493	250	366	271	49	145	162	70	6,750
Any drug	3,192	8,009	4,977	1,803	1,099	588	828	290	203	105	21,092

2026	16-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	All
Cannabis	2,657	6,736	3,969	1,784	944	383	739	127	88	44	17,473
Amphetamines	477	970	567	52	105	0	0	85	0	0	2,256
Cocaine	204	431	206	52	157	191	0	0	0	0	1,243
Crack	170	108	0	105	105	0	0	0	88	0	576
Ecstasy	886	1,563	825	105	52	0	0	0	0	0	3,431
Heroin/Methadone	238	216	52	52	157	0	43	0	0	0	759
Tranquillisers	68	162	103	105	262	48	0	85	44	89	966
Volatile substances	34	0	0	0	0	0	0	0	0	0	34
Cannabis only	1,738	5,389	3,196	1,627	839	383	695	127	88	44	14,127
Other drugs with or without cannabis dependence	1,533	2,371	1,392	262	420	287	43	127	177	89	6,701
Any drug	3,271	7,760	4,639	1,889	1,259	622	739	255	221	133	20,788

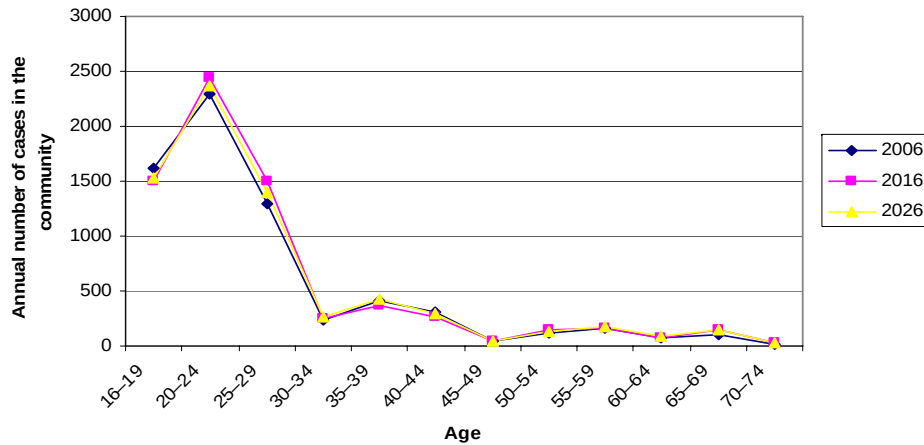
Source: (Derived) 2006 Oxfordshire estimate applied to expected change in Oxfordshire population

Figure 15: Trend in the prevalence of drug dependence in Oxfordshire, 2006-26

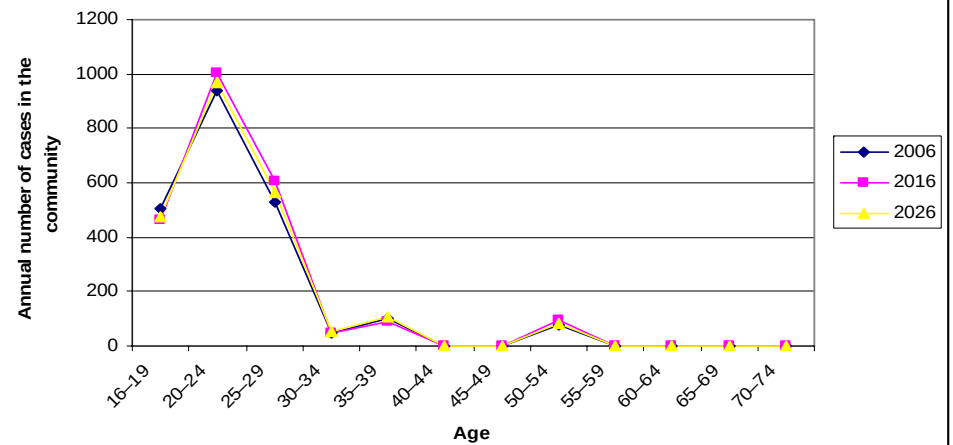


Mental Health Needs Assessment for working age population in Oxfordshire, May 08

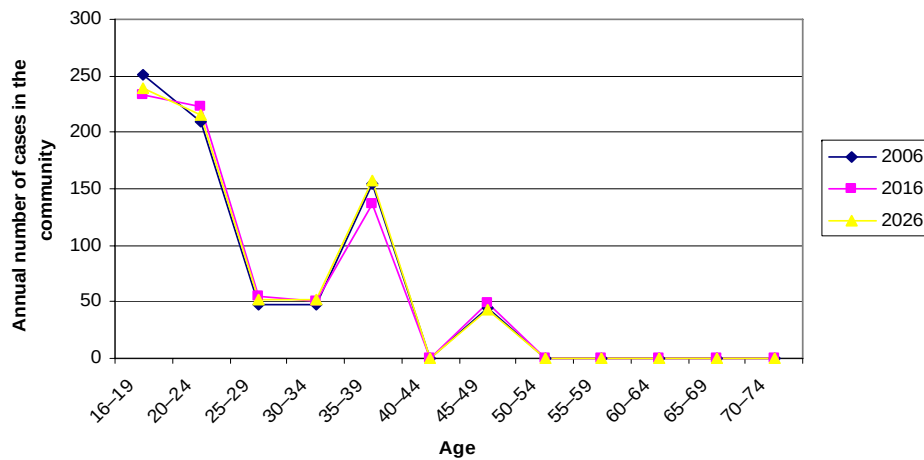
Trend in the prevalence of other drugs with or without cannabis dependence in Oxfordshire, 2006-26



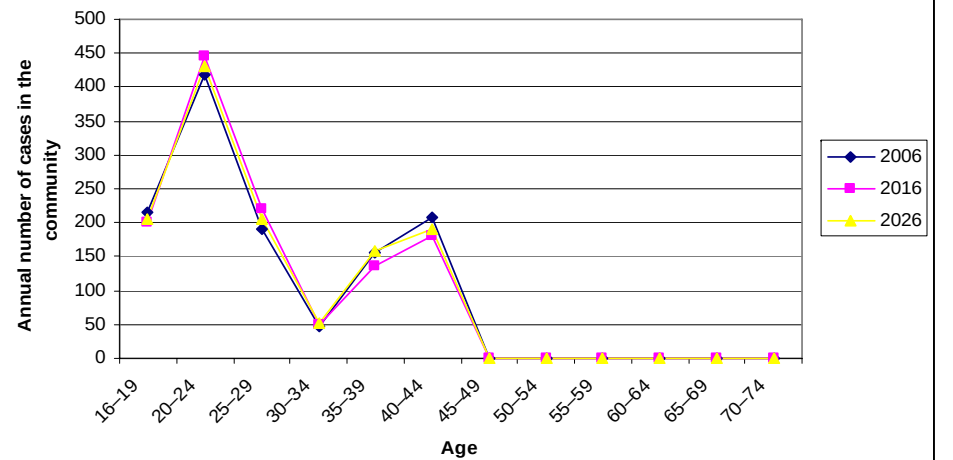
Trend in the prevalence of amphetamine dependence in Oxfordshire, 2006-26



Trend in the prevalence of heroin/ methadone dependence in Oxfordshire, 2006-26

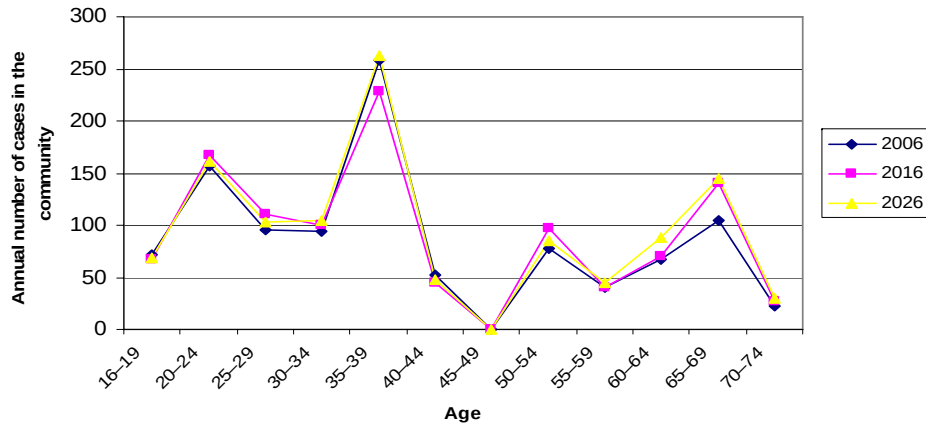


Trend in the prevalence of cocaine dependence in Oxfordshire, 2006-26

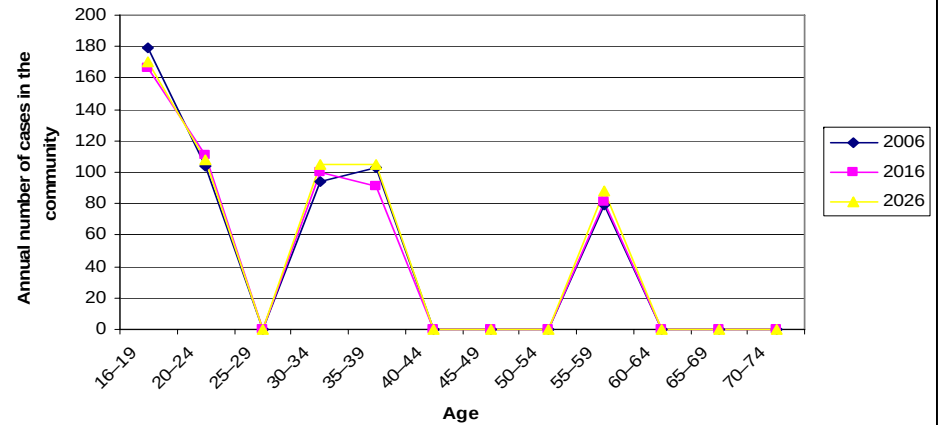


Mental Health Needs Assessment for working age population in Oxfordshire, May 08

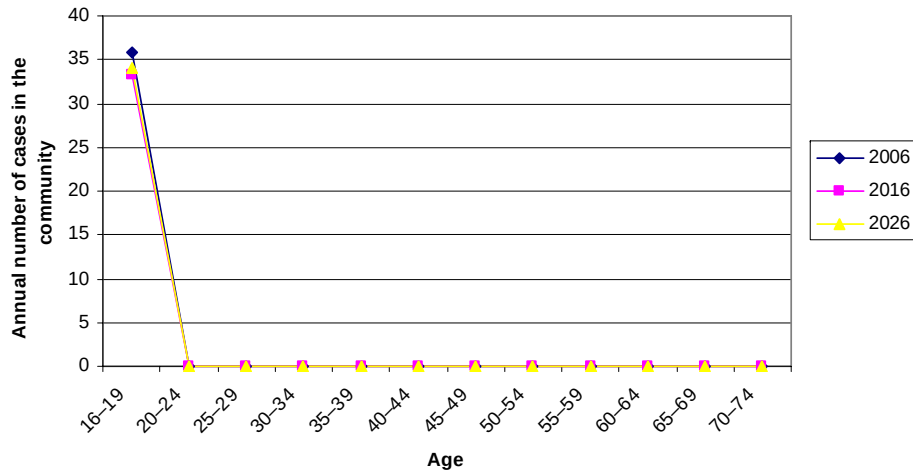
Trend in the prevalence of tranquilliser dependence in Oxfordshire, 2006-26



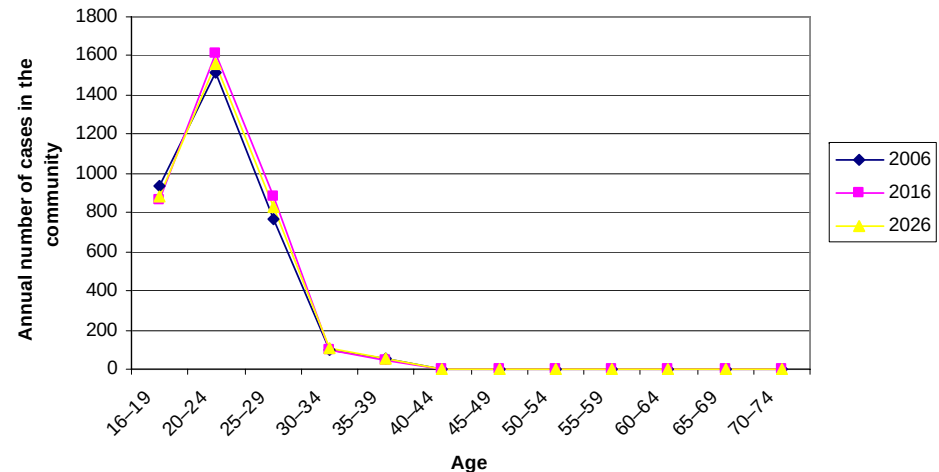
Trend in the prevalence of crack dependence in Oxfordshire, 2006-26



Trend in the prevalence of dependence on volatile substances in Oxfordshire, 2006-26



Trend in the prevalence of ecstasy dependence in Oxfordshire, 2006-26



Appendix 8 - Difficulties with Activities of Daily Living associated with mental illness

Table 56: Annual prevalence of Activities of Daily Living (ADL) difficulties amongst people with mental illness

All Adults	current neurotic disorder	probable psychotic disorder	alcohol dependent	drug dependent (any drug)
Practical Activities	26%	30%	8%	6%
Dealing with Paperwork	18%	38%	11%	11%
Household Activities	18%	26%	5%	5%
Using Transport	16%	20%	4%	4%
Managing Money	14%	22%	16%	26%
Personal Care	10%	12%	3%	1%
Medical Care	4%	10%	2%	3%
Any Type of Difficulty	45%	60%	28%	34%

Source: The Social and Economic Circumstances of Adults with Mental Disorders, ONS, 2002

Table 57: Estimated number of people with mental illness in Oxfordshire, 2006

Oxfordshire PCT	current neurotic disorder	probable psychotic disorder	alcohol dependent	drug dependent (any drug)
Estimated Number	80,603	2,457	36,370	18,185

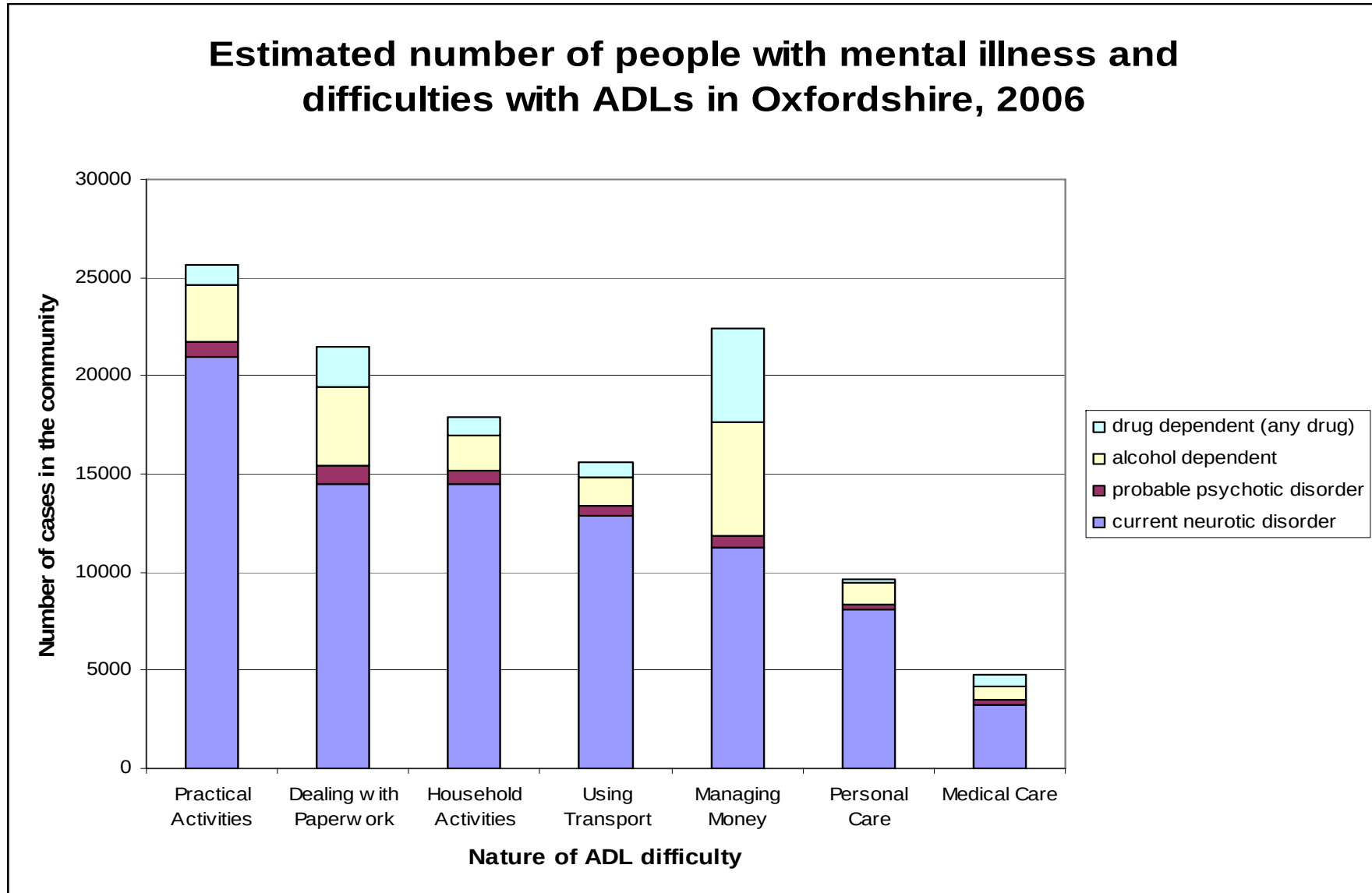
Source: Derived) Oxfordshire PCT population (2006) applied to UK Survey estimates (2000)

Table 58: Estimated number of people with mental illness with ADL difficulties in Oxfordshire, 2006

All Adults	current neurotic disorder	probable psychotic disorder	alcohol dependent	drug dependent (any drug)
Practical Activities	20,957	737	2,910	1,091
Dealing with Paperwork	14,509	934	4,001	2,000
Household Activities	14,509	639	1,819	909
Using Transport	12,896	491	1,455	727
Managing Money	11,284	541	5,819	4,728
Personal Care	8,060	295	1,091	182
Medical Care	3,224	246	727	546
Any Type of Difficulty	36,271	1,474	10,184	6,183

Source: (Derived) Oxfordshire PCT derived estimates applied to UK Survey estimates (2000)

Figure 16: Estimated number of people with mental illness and difficulties with ADLs in Oxfordshire, 2006



Appendix 9 - Prevalence of mental illness in general practice

Table 59: Annual prevalence rate per 10,000 persons of mental illness in general practice, first 3 ICD digits by age

ICD9 Code	All Ages	<1	1 ~ 4	5 ~ 14	15 ~ 24	25 ~ 44	45 ~ 64	65 ~ 74	75+
Senile PreSenile Organic Psychotic Condition (290)	22	0	0	0	0	0	2	29	259
Alcoholic Psychoses (291)	2	0	0	0	1	1	3	1	1
Drug Psychoses (292)	1	0	0	0	2	2	0	0	2
Transient Organic Psychotic Conditions (293)	6	0	0	0	0	0	2	10	60
Organic Psychotic Conditions Chronic Other (294)	0	0	0	0	0	0	0	1	5
Schizophrenic Psychoses (295)	15	0	0	0	4	21	21	21	15
Affective Psychoses (296)	25	0	0	0	11	30	37	30	36
Paranoid states (297)	3	0	0	0	3	4	3	4	9
NonOrganic Psychoses Other (298)	4	0	2	0	3	4	5	5	9
Autism Infantile (299.0)	1	0	2	3	2	0	0	0	0
Neurotic Disorders (300)	283	2	3	25	248	393	352	275	301
Personality Disorders (301)	6	0	0	0	7	11	6	4	4
Sexual Deviations and Disorders (302)	58	0	0	0	14	41	120	133	39
Alcohol Dependence Syndrome (303)	34	0	0	0	18	54	53	21	8
Drug Dependence (304)	26	0	0	0	28	57	15	11	12
Non-dependent Abuse of Drugs (305)	2	0	0	0	5	4	1	0	1
Physiological Malfunction due to mental factors (306)	2	0	2	1	2		2	4	2
Special Symptoms Syndromes NEC (307)	51	2	20	25	68	60	51	50	59
Acute reaction to Stress (308)	16	0	0	0	16	26	22	8	7
Adjustment reaction (309)	28	0	1	4	19	30	38	38	44
Non-psychotic Mental Disorder following Brain Damage (310)	7	0	0	1	1	2	4	13	48
Depressive Disorder NEC (311)	105	0	0	1	64	151	146	96	110
Disturbance of Conduct NEC (312)	11	6	14	43	22	5	2	2	5
Disturbance Emotions specific Childhood (313)	1	32	5	2	2	0	0	0	0
Hyperkinetic Syndrome of Childhood (314)	3	0	1	16	9	0	0	0	0
Specific Delays in Development (315)	5	4	30	19	4	1	1	1	0
Mild Learning Difficulties (317)	0	0	0	0	0	0	0	0	0
Learning Difficulties Moderate IQ 35~49 (318.0)	0	0	0	0	0	0	0	0	0
Learning Difficulties Severe IQ 20~34 (318.1)	0	0	0	0	0	0	1	0	0
Learning Difficulties Unspecified (319)	0	0	0	0	0	0	0	0	0

Source: RCGP Birmingham Research Unit, Weekly Returns Service, Annual Prevalence Report 2006

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 60: Estimated prevalence of mental illness in working age population in general practice in Oxfordshire, 2006

ICD9 Code	15 ~ 24	25 ~ 44	45 ~ 64	Total
Senile PreSenile Organic Psychotic Condition (290)	0	0	18	18
Alcoholic Psychoses (291)	9	9	28	46
Drug Psychoses (292)	18	18	0	37
Transient Organic Psychotic Conditions (293)	0	0	18	18
Organic Psychotic Conditions Chronic Other (294)	0	0	0	0
Schizophrenic Psychoses (295)	37	194	194	425
Affective Psychoses (296)	102	277	342	720
Paranoid states (297)	28	37	28	92
NonOrganic Psychoses Other (298)	28	37	46	111
Autism Infantile (299.0)	18	0	0	18
Neurotic Disorders (300)	2,289	3,627	3,249	9,165
Personality Disorders (301)	65	102	55	222
Sexual Deviations and Disorders (302)	129	378	1,108	1,615
Alcohol Dependence Syndrome (303)	166	498	489	1,154
Drug Dependence (304)	258	526	138	923
Non-dependent Abuse of Drugs (305)	46	37	9	92
Physiological Malfunction due to mental factors (306)	18	0	18	37
Special Symptoms Syndromes NEC (307)	628	554	471	1,652
Acute reaction to Stress (308)	148	240	203	591
Adjustment reaction (309)	175	277	351	803
Non-psychotic Mental Disorder following Brain Damage (310)	9	18	37	65
Depressive Disorder NEC (311)	591	1,394	1,348	3,332
Disturbance of Conduct NEC (312)	203	46	18	268
Disturbance Emotions specific Childhood (313)	18	0	0	18
Hyperkinetic Syndrome of Childhood (314)	83	0	0	83
Specific Delays in Development (315)	37	9	9	55
Mild Learning Difficulties (317)	0	0	0	0
Learning Difficulties Moderate IQ 35~49 (318.0)	0	0	0	0
Learning Difficulties Severe IQ 20~34 (318.1)	0	0	9	9
Learning Difficulties Unspecified (319)	0	0	0	0

Source: (Derived) Oxfordshire PCT population (2006) applied to RCGP prevalence rates (2006)

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 61: Prevalence of mental illness in GP QoF mental health registers as of 14th Feb 2007 (all ages)

	Practice List Size	Mental Health		Depression	
		Numbers	%	Numbers	%
North East Oxfordshire PBC Consortium	5,747	30	0.5%	322	5.6%
North East Oxfordshire PBC Consortium	4,596	37	0.8%	237	5.2%
North East Oxfordshire PBC Consortium	11,951	74	0.6%	815	6.8%
North East Oxfordshire PBC Consortium	9,537	46	0.5%	659	6.9%
North East Oxfordshire PBC Consortium	7,063	33	0.5%	529	7.5%
North East Oxfordshire PBC Consortium	11,392	64	0.6%	573	5.0%
North East Oxfordshire PBC Consortium	6,522	28	0.4%	270	4.1%
North East Oxfordshire PBC Consortium	6,116	25	0.4%	390	6.4%
North East Oxfordshire PBC Consortium	9,180	39	0.4%	270	2.9%
North East Oxfordshire PBC Consortium	4,195	17	0.4%	135	3.2%
North East Oxfordshire PBC Consortium total	76,299	393	0.5%	4,200	5.5%
North Oxfordshire Commissioning Consortium	8,157	50	0.6%	519	6.4%
North Oxfordshire Commissioning Consortium	18,448	141	0.8%	1,228	6.7%
North Oxfordshire Commissioning Consortium	6,833	250	3.7%	420	6.1%
North Oxfordshire Commissioning Consortium	7,588	51	0.7%	393	5.2%
North Oxfordshire Commissioning Consortium	16,152	69	0.4%	982	6.1%
North Oxfordshire Commissioning Consortium	5,246	21	0.4%	296	5.6%
North Oxfordshire Commissioning Consortium	9,010	43	0.5%	467	5.2%
North Oxfordshire Commissioning Consortium	3,270	10	0.3%	174	5.3%
North Oxfordshire Commissioning Consortium	6,893	19	0.3%	345	5.0%
North Oxfordshire Commissioning Consortium	10,437	65	0.6%	476	4.6%
North Oxfordshire Commissioning Consortium	7,045	61	0.9%	303	4.3%
North Oxfordshire Commissioning Consortium	2,558	7	0.3%	162	6.3%
North Oxfordshire Commissioning Consortium total	101,637	787	0.77%	5,765	5.7%
Oxford City	12,502	173	1.4%	760	6.1%
Oxford City	6,618	32	0.5%	440	6.6%
Oxford City	8,699	115	1.3%	524	6.0%
Oxford City	10,736	94	0.9%	526	4.9%
Oxford City	12,544	70	0.6%	349	2.8%
Oxford City	17,094	126	0.7%	357	2.1%
Oxford City	12,738	130	1.0%	253	2.0%
Oxford City	7,173	78	1.1%	183	2.6%
Oxford City	8,410	28	0.3%	467	5.6%
Oxford City	6,292	55	0.9%	261	4.1%
Oxford City	5,894	47	0.8%	183	3.1%

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

	Practice List Size	Mental Health		Depression	
		Numbers	%	Numbers	%
Oxford City	9,912	95	1.0%	610	6.2%
Oxford City	7,683	125	1.6%	462	6.0%
Oxford City	12,178	75	0.6%	587	4.8%
Oxford City	7,542	81	1.1%	421	5.6%
Oxford City	7,383	65	0.9%	158	2.1%
Oxford City	4,054	40	1.0%	238	5.9%
Oxford City	5,212	74	1.4%	206	4.0%
Oxford City	577	55	9.5%	22	3.8%
Oxford City	4,364	28	0.6%	222	5.1%
Oxford City	5,858	52	0.9%	97	1.7%
Oxford City	4,785	31	0.6%	165	3.4%
Oxford City	3,646	21	0.6%	62	1.7%
Oxford City	2,538	22	0.9%	140	5.5%
Oxford City	2,057	29	1.4%	107	5.2%
Oxford City	3,637	43	1.2%	140	3.8%
Oxford City	1,816	23	1.3%	116	6.4%
Oxford City	1,890	19	1.0%	118	6.2%
Oxford City total	193,832	1,826	0.94%	8,174	4.2%
SE Locality Group	9,754	59	0.6%	471	4.8%
SE Locality Group	7,490	45	0.6%	412	5.5%
SE Locality Group	10,022	54	0.5%	530	5.3%
SE Locality Group	3,475	21	0.6%	210	6.0%
SE Locality Group	8,353	59	0.7%	445	5.3%
SE Locality Group	5,179	26	0.5%	344	6.6%
SE Locality Group	8,717	48	0.6%	371	4.3%
SE Locality Group	4,529	18	0.4%	241	5.3%
SE Locality Group	14,967	115	0.8%	797	5.3%
SE Locality Group	9,413	77	0.8%	527	5.6%
SE Locality Group total	81,899	522	0.64%	4,348	5.3%
Vale Locality Group	15,515	92	0.6%	869	5.6%
Vale Locality Group	10,442	43	0.4%	654	6.3%
Vale Locality Group	20,102	131	0.7%	1,346	6.7%
Vale Locality Group	12,381	517	4.2%	812	6.6%
Vale Locality Group	3,502	10	0.3%	171	4.9%
Vale Locality Group	12,531	72	0.6%	626	5.0%
Vale Locality Group	10,161	58	0.6%	663	6.5%

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

	Practice List Size	Mental Health		Depression	
		Numbers	%	Numbers	%
Vale Locality Group	9,277	63	0.7%	558	6.0%
Vale Locality Group	10,092	74	0.7%	426	4.2%
Vale Locality Group	4,477	44	1.0%	192	4.3%
Vale Locality Group	4,147	11	0.3%	197	4.8%
Vale Locality Group	8,297	30	0.4%	249	3.0%
Vale Locality Group	7,407	27	0.4%	258	3.5%
Vale Locality Group total	128,331	1,172	0.91%	7,021	5.47%
West Oxon Locality Group	12,901	78	0.6%	783	6.1%
West Oxon Locality Group	8,143	33	0.4%	549	6.7%
West Oxon Locality Group	12,753	80	0.6%	696	5.5%
West Oxon Locality Group	6,212	33	0.5%	369	5.9%
West Oxon Locality Group	10,685	85	0.8%	709	6.6%
West Oxon Locality Group	8,225	45	0.5%	320	3.9%
West Oxon Locality Group	4,859	30	0.6%	288	5.9%
West Oxon Locality Group	6,007	39	0.6%	273	4.5%
West Oxon Locality Group	4,625	21	0.5%	199	4.3%
West Oxon Locality Group total	74,410	444	0.6%	4,186	5.6%
Grand total	656,408	5,144	0.8%	33,694	5.1%

Source: Oxfordshire PCT Decision Support Team, extract from Oxfordshire GP practices on 14th Feb 2007

Appendix 10 - Prescribing of mental health medications in primary care

Table 62: Prescribing of all mental health medications in primary care 2004 - 2007

PBC consortia	2004/5		2005/6		2006/7		% change since 04/05	
	items	Cost (£)	items	Cost (£)	items	Cost (£)	items	Cost (£)
North East Oxon locality PBC Consortia	142,669	1,540,466.34	151,138	1,640,217.73	164,225	1,711,728.95	15.11	11.12
North Oxon locality PBC Consortia	205,232	2,318,704.06	219,252	2,537,568.9	233,328	26,688,39.36	13.69	15.10
Oxford City PBC Consortia	314,415	4,046,719.63	334,763	4,244,757.51	353,453	4,370,411.94	12.42	8.00
South East Oxon locality PBC Consortia	122,400	1,445,713.69	123,434	1,473,012.55	131,755	1,605,332.02	7.64	11.04
Vale locality PBC Consortia	231,206	2,775,948.56	231,047	2,795,766.88	241,696	2,973,845.19	4.54	7.13
West Oxon locality PBC Consortia	138,694	1,618,197.22	139,957	1,662,697.35	151,476	1,690,323.89	9.22	4.46
Other specialist services in primary care	28,191	309,252.71	34,246	378,647.46	36,278	399,066.87	28.69	29.04
Total Oxfordshire	118,2807	14,055,002.21	1,233,837	14,732,668.38	1,312,211	15,419,548.22	10.94	9.71

Source: Oxfordshire PCT prescribing team

Figure 17: Prescribing and cost of all psychiatric medications in general practices in Oxfordshire, 2004-07

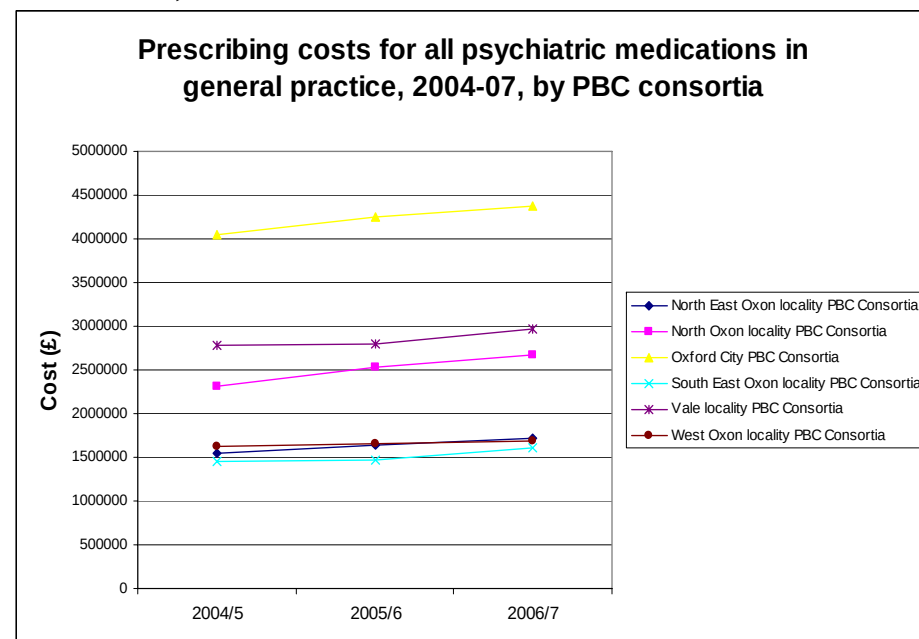
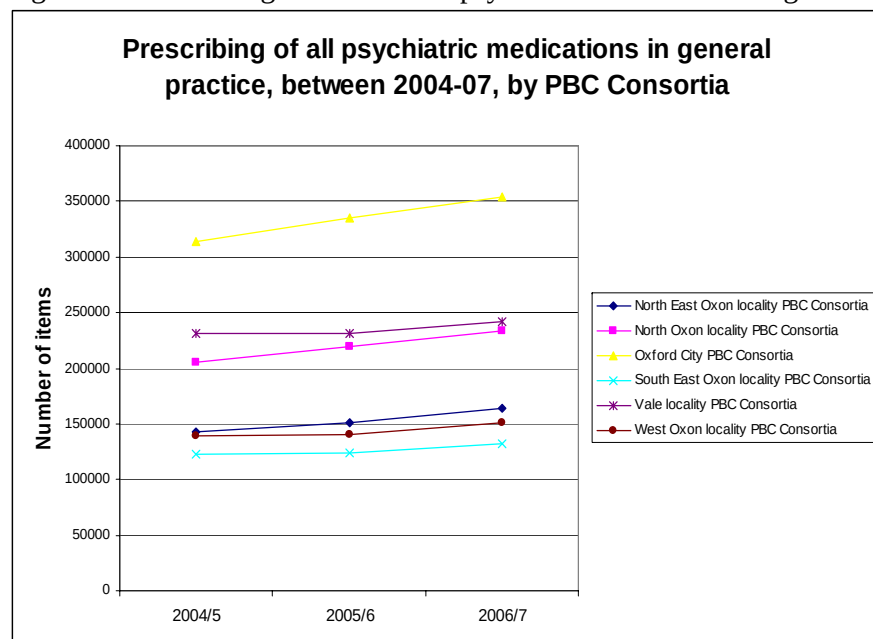


Table 63: Prescribing of anti-depressants in general practice 2004 - 2007

PBC consortia	2004/5		2005/6		2006/7		% change since 04/05	
	items	Cost (£)	items	Cost (£)	items	Cost (£)	items	Cost (£)
North East Oxon locality PBC Consortia	49,506	542,323	52,722	466,420	57,474	426,109	16.10	-21.43
North Oxon locality PBC Consortia	57,543	759,900	62,803	669,594	68,123	615,600	18.39	-18.99
Oxford City PBC Consortia	84,168	1,154,666	87,901	970,617	93,134	838,112	10.65	-27.42
South East Oxon locality PBC Consortia	36,916	442,533	37,643	358,099	41,276	344,276	11.81	-22.20
Vale locality PBC Consortia	70,580	923,705	70,468	735,767	74,501	660,880	5.56	-28.45
West Oxon locality PBC Consortia	42,774	534,390	42,985	429,108	48,154	390,587	12.58	-26.91
Other specialist services in primary care	8,261	81,734	8,987	75,005	9,112	68,183	10.30	-16.58
Total Oxfordshire	349,748	4,439,251	363,509	3,704,610	391,774	3,343,747	12.02	-24.68

Source: Oxfordshire PCT prescribing team

Figure 18: Prescribing and cost of anti-depressant medications in general practices in Oxfordshire, 2004-07

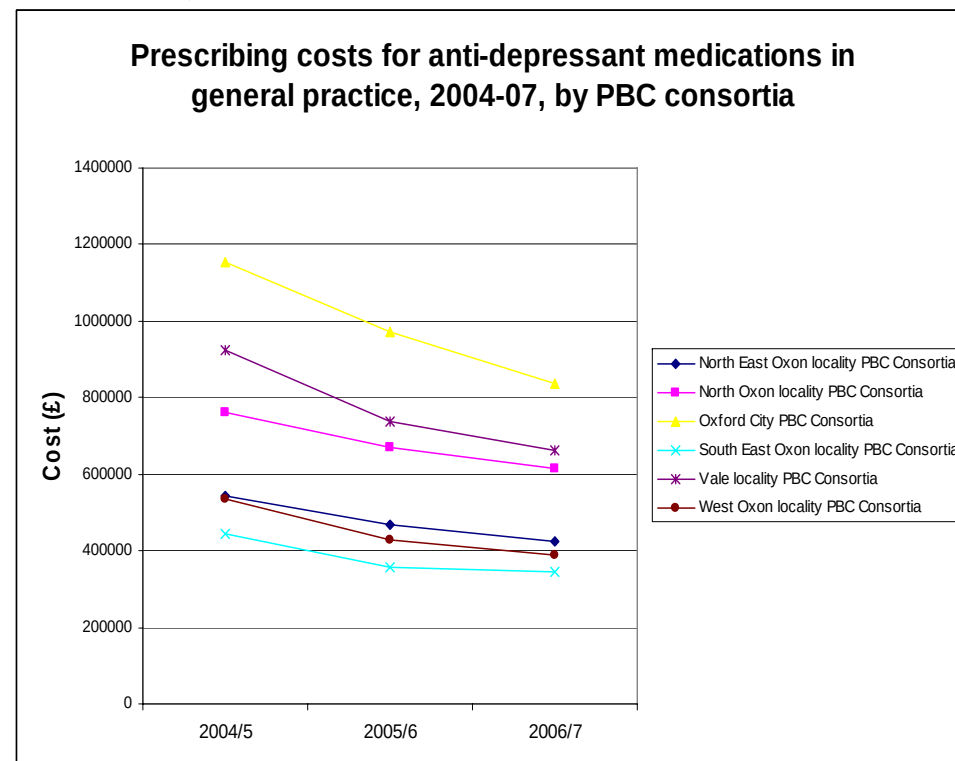
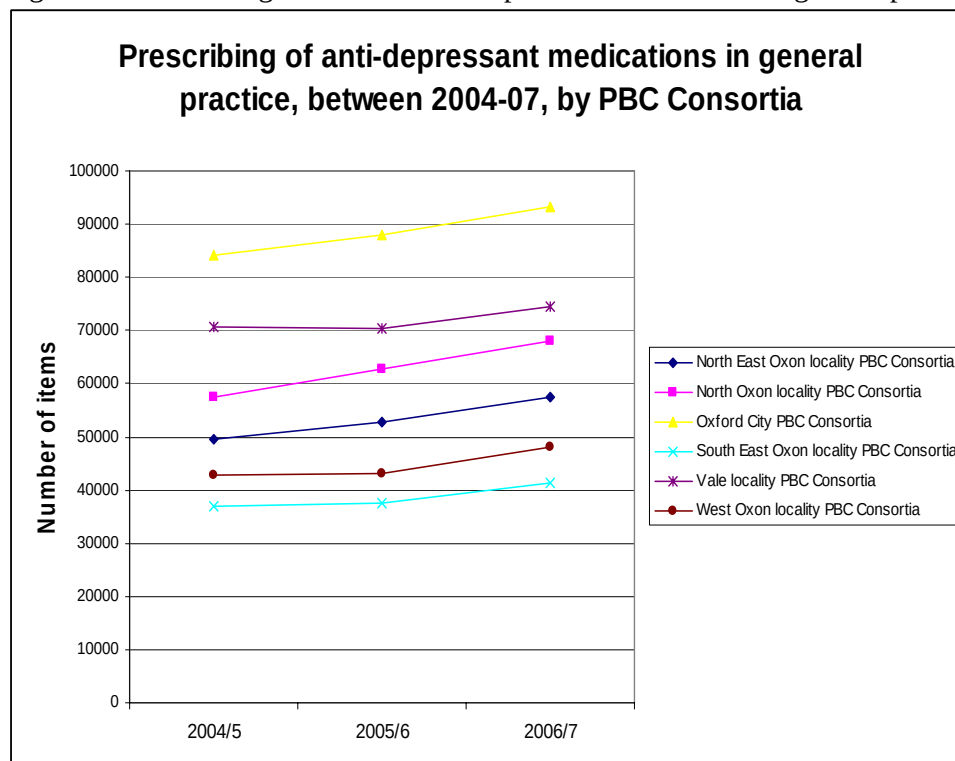
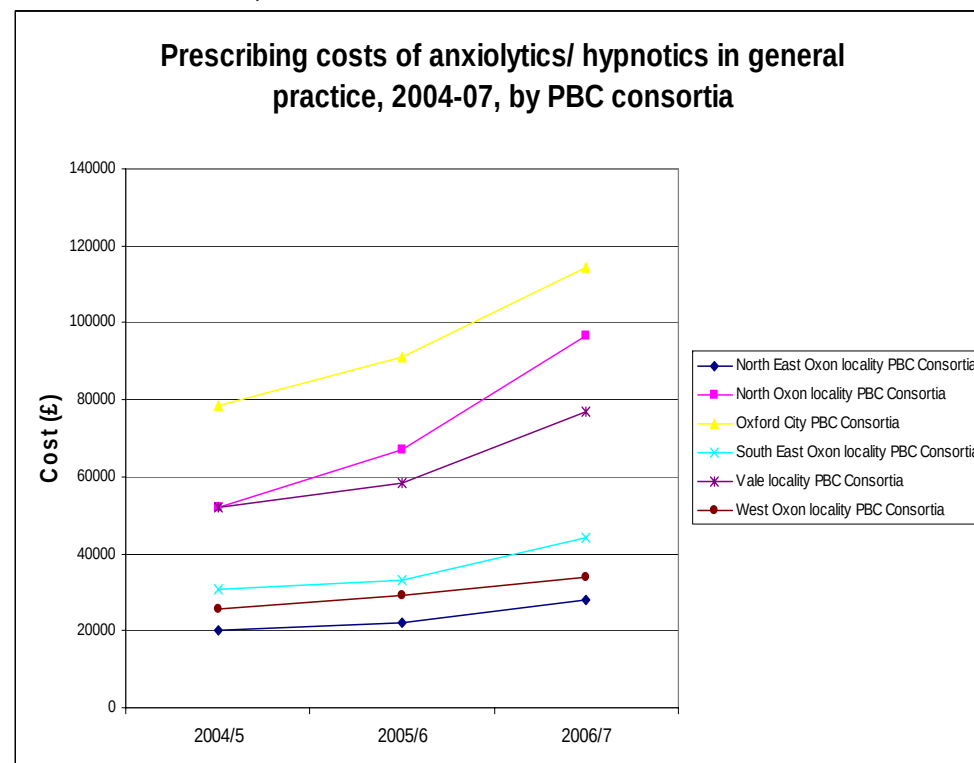
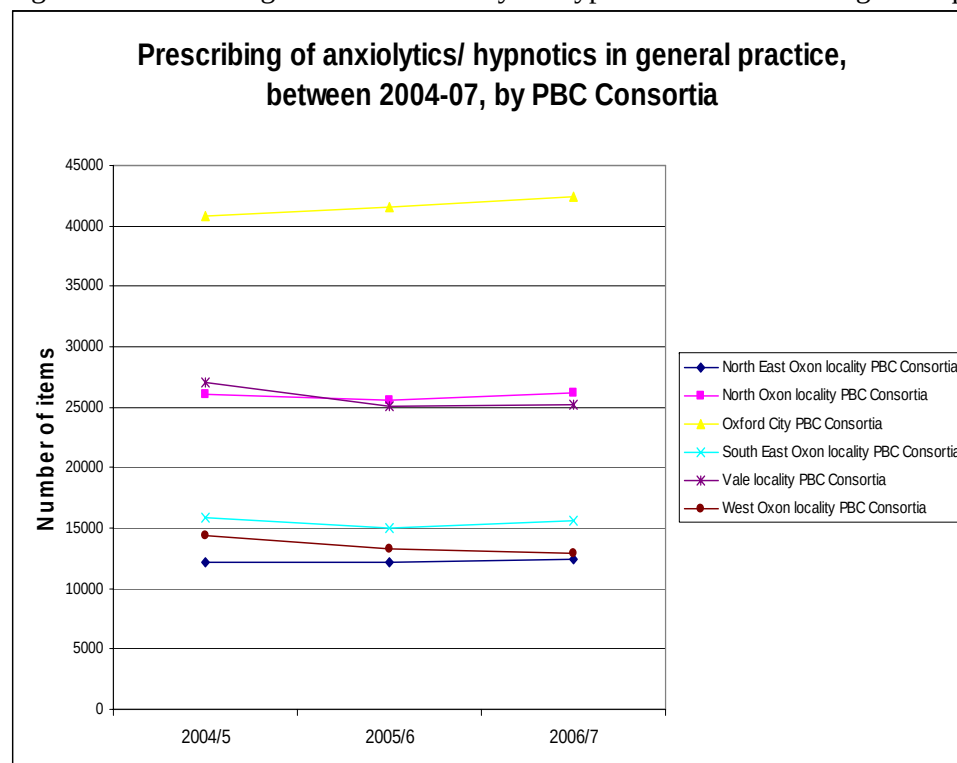


Table 64: Prescribing of anxiolytics and/ or hypnotics in general practice 2004 - 2007

PBC consortia	2004/5		2005/6		2006/7		% change since 04/05	
	items	Cost (£)	items	Cost (£)	Cost (£)	Cost (£)	items	Cost (£)
North East Oxon locality PBC Consortia	12,222	20,100	12,215	21,904	12,442	28,162	1.80	40.11
North Oxon locality PBC Consortia	26,055	52,074	25,570	67,037	26,223	96,807	0.64	85.90
Oxford City PBC Consortia	40,816	78,574	41,544	91,225	42,474	114,371	4.06	45.56
South East Oxon locality PBC Consortia	15,836	30,831	14,985	33,213	15,636	44,030	-1.26	42.81
Vale locality PBC Consortia	27,106	51,874	25,093	58,370	25,219	77,042	-6.96	48.52
West Oxon locality PBC Consortia	14,394	25,781	13,292	29,204	12,910	33,908	-10.31	31.52
Other specialist services in primary care	1,836	2,716	2,192	4,029	2,320	4,441	26.36	63.48
Total Oxfordshire	138,265	261,950	134,891	304,982	137,224	398,761	-0.75	52.23

Source: Oxfordshire PCT prescribing team

Figure 19: Prescribing and cost of anxiolytic/ hypnotic medications in general practices in Oxfordshire , 2004-07



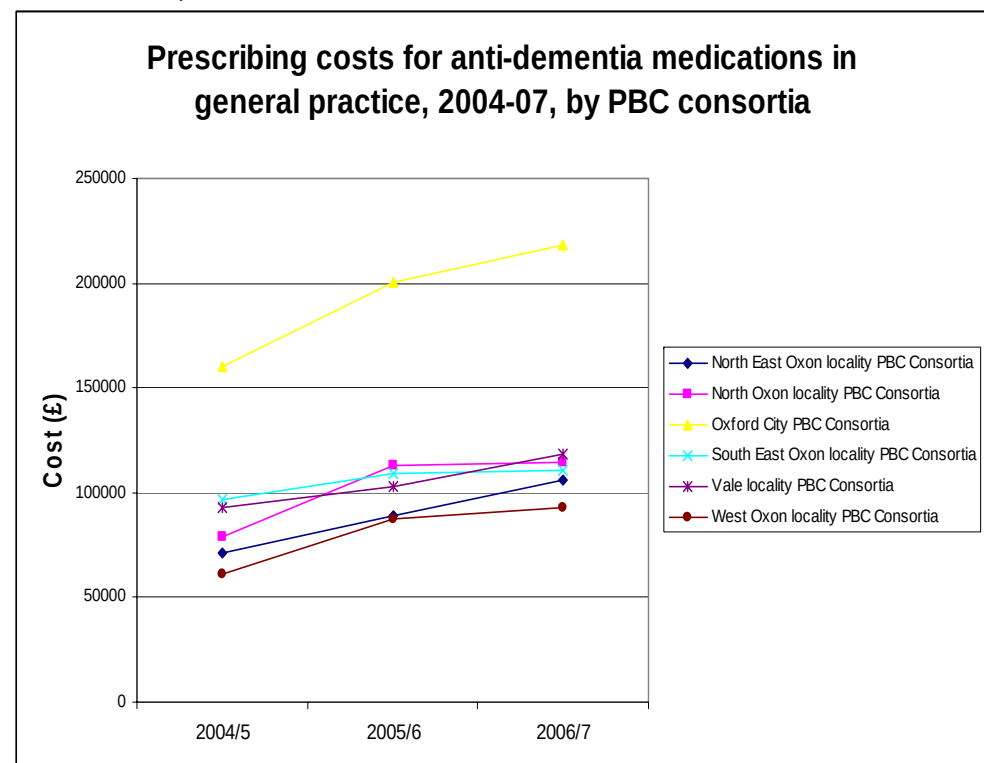
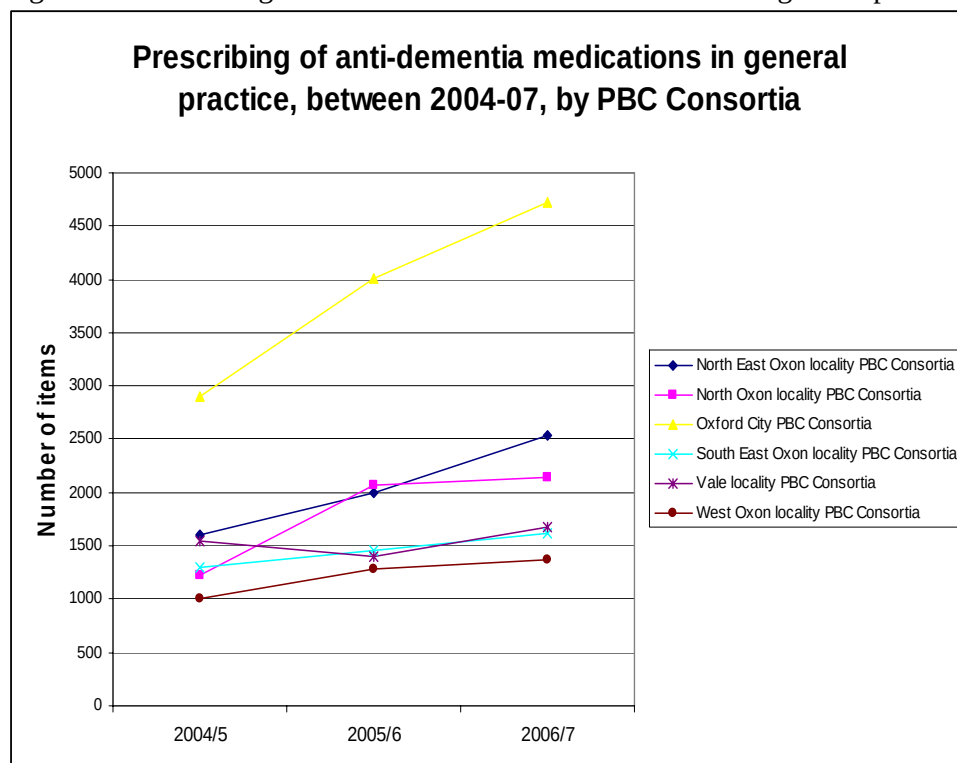
Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 65: Prescribing of anti-dementia medications in general practice 2004 - 2007

PBC consortia	2004/5		2005/6		2006/7		% change since 04/05	
	items	Cost (£)	items	Cost (£)	items	Cost (£)	items	Cost (£)
North East Oxon locality PBC Consortia	1,606	71,083.59	1,991	88,826.64	2,537	106,006.49	57.97	49.13
North Oxon locality PBC Consortia	1,230	788,98.85	2,070	113,083.2	2,150	114,427.73	74.80	45.03
Oxford City PBC Consortia	2,894	160,318.16	4,015	200,548.08	4,721	218,107.77	63.13	36.05
South East Oxon locality PBC Consortia	1,302	96,756.27	1,463	109,133.57	1,621	110,597.96	24.50	14.31
Vale locality PBC Consortia	1,544	92,944.94	1,397	103,278.35	1,673	118,079.21	8.35	27.04
West Oxon locality PBC Consortia	1,012	61,229.66	1,287	87,099.05	1,375	92,656.2	35.87	51.33
Other specialist services in primary care	205	13,267.96	367	18,575.13	437	19,344.45	113.17	45.80
Total Oxfordshire	9,793	574,499.43	12,590	720,544.02	14,514	779,219.81	48.21	35.63

Source: Oxfordshire PCT prescribing team

Figure 20: Prescribing and cost of anti-dementia medications in general practices in Oxfordshire , 2004-07



Appendix 11 - Physical illness in those with mental ill-health

a. Neurotic disorder

Table 66: Prevalence of longstanding physical illness in those with any type of neurosis

Type of physical complaint	% of people with physical disorder and any neurotic disorder	Number of people with physical illness and any neurotic disorder
Musculo-skeletal complaints	29%	23,375
Respiratory System complaints	11%	8,866
Heart and Circulatory System complaints	13%	10,478
Digestive System complaints	9%	7,254
Nervous System complaints	9%	7,254
Endocrine disorders	6%	4,836
Genito-urinary System complaints	4%	3,224
Skin complaints	3%	2,418
Ear complaints	2%	1,612
Eye complaints	2%	1,612
Neoplasms	2%	1,612
Blood disorders	1%	806
Infectious and Parasitic diseases	1%	806
Any Longstanding Physical complaint	58%	46,750
Estimated number of total number of people between 16-74 years with any neurosis	-	80,603

Source: (Derived) Oxfordshire PCT population (2006) applied to UK Survey estimates (2000)

b. Probable psychosis

Table 67: Prevalence of longstanding physical illness in those with probable psychosis

Type of physical complaint	% of people with physical disorder and probable psychosis	Number of people with physical illness and probable psychosis
Musculo-skeletal complaints	18%	516
Respiratory System complaints	8%	221
Heart and Circulatory System complaints	9%	516
Digestive System complaints	5%	197
Nervous System complaints	4%	369
Endocrine disorders	5%	74
Genito-urinary System complaints	2%	74
Skin complaints	2%	25
Ear complaints	2%	0

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Type of physical complaint	% of people with physical disorder and probable psychosis	Number of people with physical illness and probable psychosis
Eye complaints	1%	98
Neoplasms	1%	74
Blood disorders	0%	0
Infectious and Parasitic diseases	0%	0
Any Longstanding Physical complaint	42%	1,523
Estimated number of total number of people between 16-74 years with probable psychosis	-	2,457

Source: (Derived) Oxfordshire PCT population (2006) applied to UK Survey estimates (2000)

c. Alcohol dependence

Table 68: Prevalence of longstanding physical illness in those with alcohol dependence

Type of physical complaint	% of people with physical disorder and alcohol dependence	Number of people with physical illness and alcohol dependence
Musculo-skeletal complaints	14%	5,092
Respiratory System complaints	8%	2,910
Heart and Circulatory System complaints	7%	2,546
Digestive System complaints	4%	1,455
Nervous System complaints	5%	1,819
Endocrine disorders	2%	727
Genito-urinary System complaints	2%	727
Skin complaints	2%	727
Ear complaints	2%	727
Eye complaints	2%	727
Neoplasms	0%	0
Blood disorders	0%	0
Infectious and Parasitic diseases	0%	0
Any Longstanding Physical complaint	38%	13,821
Estimated number of total number of people between 16-74 years with alcohol dependence (any severity)	-	36,370

Source: (Derived) Oxfordshire PCT population (2006) applied to UK Survey estimates (2000)

d. Drug dependence

Table 69: Prevalence of longstanding physical illness in those with drug dependence

2006	% of people with physical disorder and drug dependence on cannabis only	Number of people with physical illness and drug dependence on Cannabis only	% of people with physical disorder and dependence on other drugs with or without cannabis	Number of people with physical illness and dependence on drugs with or without Cannabis
Musculo-skeletal complaints	11%	1,352	11%	649
Respiratory System complaints	10%	1,229	3%	177
Heart and Circulatory System complaints	3%	369	2%	118
Digestive System complaints	3%	369	0%	0
Nervous System complaints	5%	614	4%	236
Endocrine disorders	1%	123	1%	59
Genito-urinary System complaints	1%	123	1%	59
Skin complaints	4%	491	2%	118
Ear complaints	2%	246	5%	295
Eye complaints	1%	123	0%	0
Neoplasms	1%	123	1%	59
Blood disorders	0%	0	0%	0
Infectious and Parasitic diseases	0%	0	0%	0
Any Longstanding Physical complaint	34%	4,178	28%	1,651
Estimated number of total number of people between 16-74 years with drug dependence	-	12,287	-	5,898

Source: (Derived) Oxfordshire PCT population (2006) applied to UK Survey estimates (2000)

Appendix 12 – Utilisation of specialist mental health services

Table 70: Secondary care utilisation of mental health services in Oxfordshire, for clients aged 15-64 years, 2006

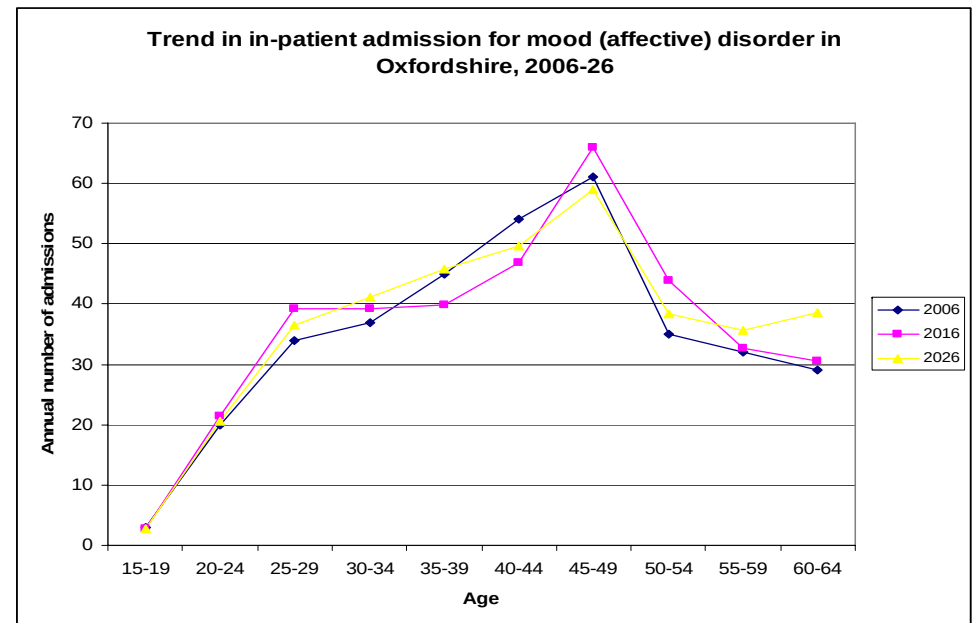
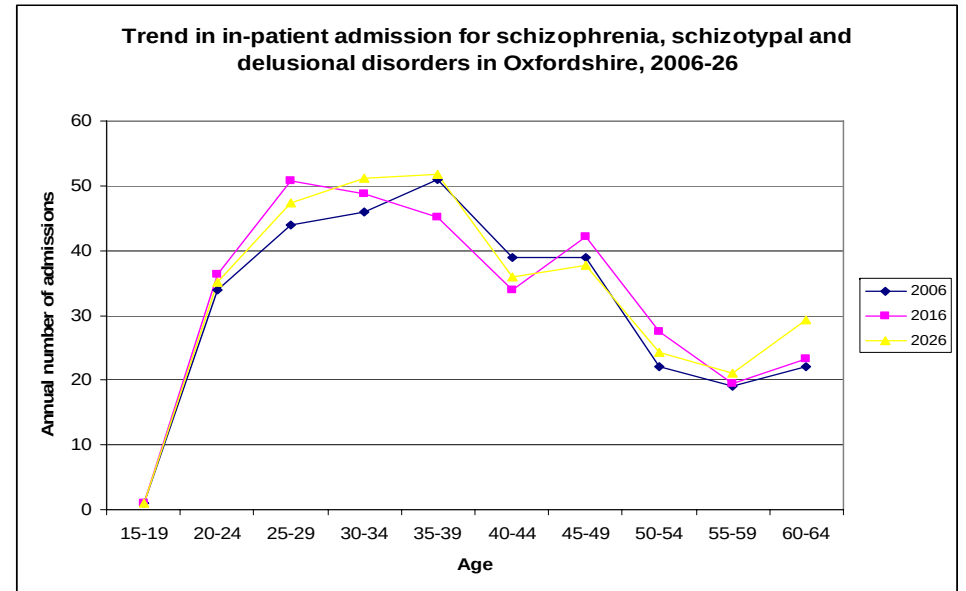
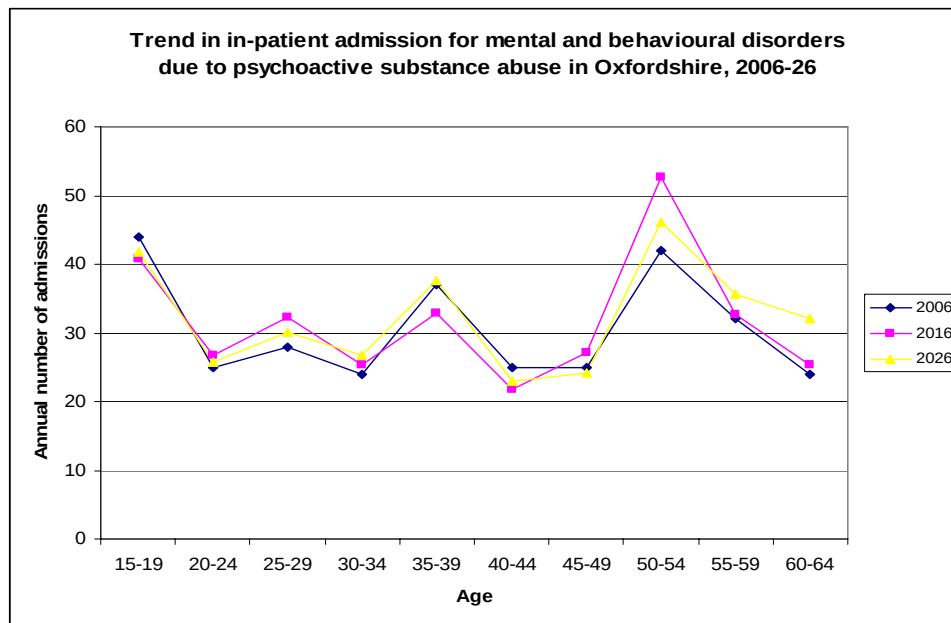
Diagnosis Group	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Grand Total
Mood (Affective) Disorders	3	20	34	37	45	54	61	35	32	29	350
Schizophrenia, Schizotypal and Delusional Disorders	1	34	44	46	51	39	39	22	19	22	317
Mental and Behavioral Disorders due to Psychoactive Substance use	44	25	28	24	37	25	25	42	32	24	306
Learning Difficulties	195	0	0	0	1	1	1	0	1	0	199
Other Mental Health Diagnoses	12	21	21	17	12	13	19	21	16	15	167
<i>Source: Combined data for OBMHT plus general acute providers</i>											1,339

Table 71: Estimated use of secondary care mental health services, for clients aged 15-64 years, upto 2026

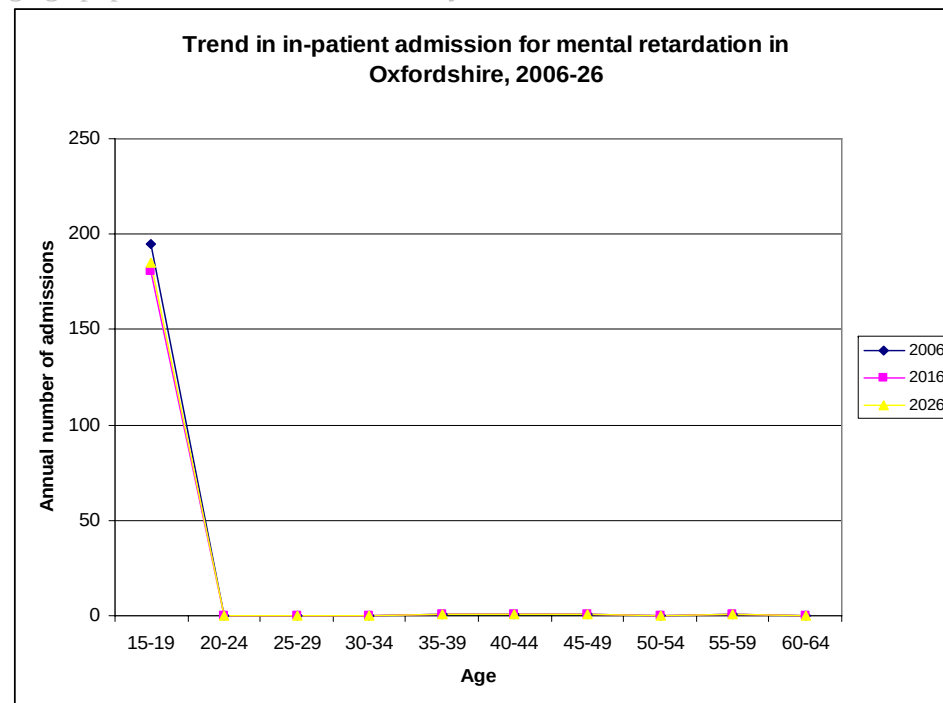
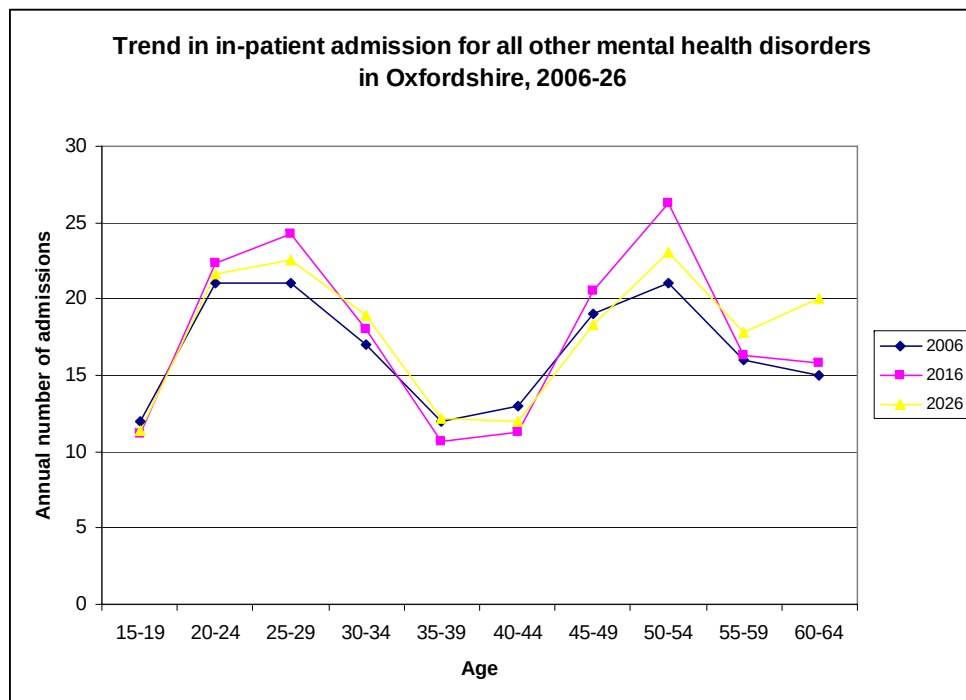
2016 Estimates	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Grand Total	% Change on 2006
Mood (Affective) Disorders	3	21	39	39	40	47	66	44	33	31	362	3.55%
Schizophrenia, Schizotypal and Delusional Disorders	1	36	51	49	45	34	42	28	19	23	328	3.52%
Mental and Behavioral Disorders due to Psychoactive Substance use	41	27	32	25	33	22	27	53	33	25	317	3.71%
Learning Difficulties	181	0	0	0	1	1	1	0	1	0	185	-7.21%
Other Mental Health Diagnoses	11	22	24	18	11	11	21	26	16	16	177	5.81%
<i>Source: (Derived) 2006 Utilisation applied to expected population change</i>											1,369	2.26%

2026 Estimates	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Grand Total	% Change on 2006
Mood (Affective) Disorders	3	21	37	41	46	50	59	38	36	39	368	5.21%
Schizophrenia, Schizotypal and Delusional Disorders	1	35	47	51	52	36	38	24	21	29	335	5.53%
Mental and Behavioral Disorders due to Psychoactive Substance use	42	26	30	27	38	23	24	46	36	32	323	5.53%
Learning Difficulties	185	0	0	0	1	1	1	0	1	0	189	-4.90%
Other Mental Health Diagnoses	11	22	23	19	12	12	18	23	18	20	178	6.56%
<i>Source: (Derived) 2006 Utilisation applied to expected population change</i>											1,393	4.02%

Figure 21: Trends in in-patient admissions for mental illness within Oxfordshire, 2006-26



Mental Health Needs Assessment for working age population in Oxfordshire, May 08



Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 72: Secondary care utilisation of mental health services in Oxfordshire, for clients aged 15-64 years, 2006

Diagnosis Group	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Grand Total
Organic, Including Symptomatic, Mental Disorders	1	2	1	0	1	0	0	0	5	9	19
Mental and Behavioural Disorders due to Psychoactive Substance Use	44	25	28	24	37	25	25	42	32	24	306
Schizophrenia, Schizotypal, and Delusional Disorders	1	34	44	46	51	39	39	22	19	22	317
Mood (Affective) Disorders	3	20	34	37	45	54	61	35	32	29	350
Neurotic, Stress-related, and Somatoform Disorders	3	3	3	4	3	3	8	4	4	6	41
Behavioural Syndromes associated with Physiological Disturbances and Physical Factors	5	8	5	1	3	2	1	0	3	0	28
Disorders of Adult Personality and Behaviour	0	1	7	8	5	7	6	14	2	0	50
Learning Difficulties	195	0	0	0	1	1	1	0	1	0	199
Disorders of Psychological Development	1	3	1	1	0	0	1	0	1	0	8
Unspecified Mental Disorder	1		2	2			2	3	1		11
Other or Unknown	1	4	2	1	0	1	1	0	0	0	10

Source: Combined data for OBMHT plus general acute providers

Table 73: In-patient admission for mental illness via general acute providers only, 2006

Diagnosis Group	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Grand Total
Organic, Including Symptomatic, Mental Disorders	1	2	1	0	1	0	0	0	2	4	11
Mental and Behavioural Disorders due to Psychoactive Substance Use	44	23	24	20	34	22	22	39	31	23	282
Schizophrenia, Schizotypal, and Delusional Disorders	0	5	2	5	7	7	3	0	1	3	33
Mood (Affective) Disorders	2	5	5	6	5	3	8	4	0	2	40
Neurotic, Stress-related, and Somatoform Disorders	3	3	2	3	3	2	5	1	4	5	31
Behavioural Syndromes associated with Physiological Disturbances and Physical Factors	4	3	1	0	2	1	1	0	0	0	12
Disorders of Adult Personality and Behaviour	0	0	1	2	0	2	0	5	1	0	11
Learning Difficulties	195	0	0	0	1	1	1	0	1	0	199
Disorders of Psychological Development	1	0	1	0	0	0	0	0	0	0	2
Unspecified Mental Disorder	1	0	2	2	0	0	2	3	1	0	11
Other or Unknown	0	0	0	0	0	0	0	0	0	0	0

Source: SUS, as at Feb 2008

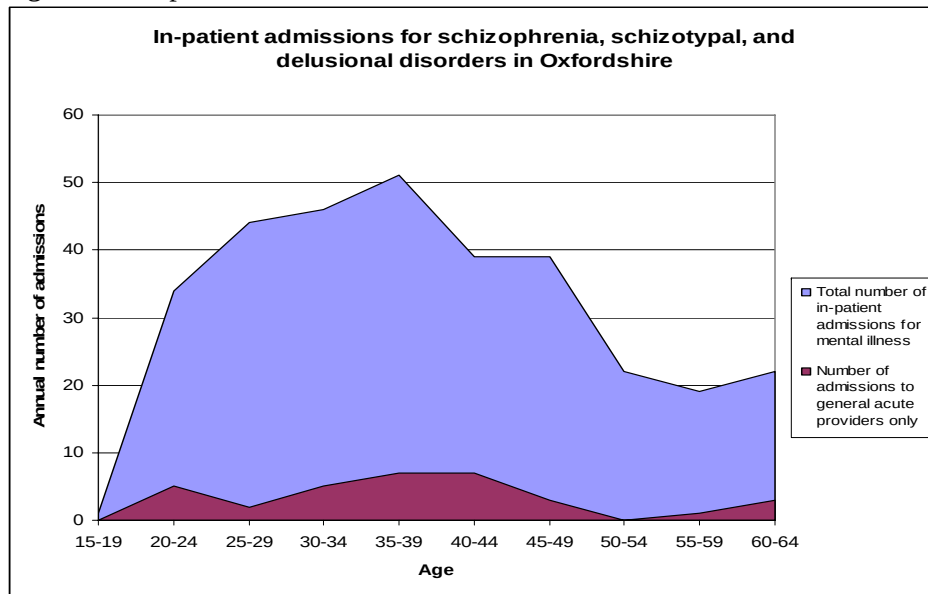
Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Table 74: Total admissions to general acute providers, as a percentage of total number of admissions to secondary care, 2006

Diagnosis Group	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Grand Total
Organic, Including Symptomatic, Mental Disorders	100%	100%	100%	n/a	100%	n/a	n/a	n/a	40%	44%	57.9%
Mental and Behavioural Disorders due to Psychoactive Substance Use	100%	92%	86%	83%	92%	88%	88%	93%	97%	96%	92.2%
Schizophrenia, Schizotypal, and Delusional Disorders	0%	15%	5%	11%	14%	18%	8%	0%	5%	14%	10.4%
Mood (Affective) Disorders	67%	25%	15%	16%	11%	6%	13%	11%	0%	7%	11.4%
Neurotic, Stress-related, and Somatoform Disorders	100%	100%	67%	75%	100%	67%	63%	25%	100%	83%	75.6%
Behavioural Syndromes associated with Physiological Disturbances and Physical Factors	80%	38%	20%	0%	67%	50%	100%	n/a	0%	n/a	42.9%
Disorders of Adult Personality and Behaviour	n/a	0%	14%	25%	0%	29%	0%	36%	50%	n/a	22.0%
Learning Difficulties	100%	n/a	n/a	n/a	100%	100%	100%	n/a	100%	n/a	100.0%
Disorders of Psychological Development	100%	0%	100%	0%	n/a	n/a	0%	n/a	0%	n/a	25.0%
Unspecified Mental Disorder	100%	n/a	100%	100%	n/a	n/a	100%	100%	100%	n/a	100.0%
Other or Unknown	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

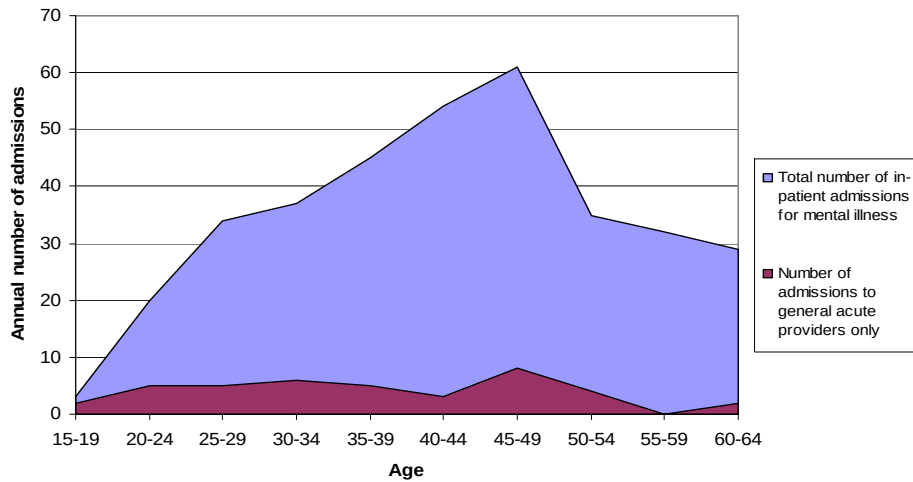
Source: Combined data for OBMHT (PCIS, as at Jan 2007), plus general acute providers (SUS, as at Feb 2008)

Figure 22: In-patient admissions for mental illness in Oxfordshire, stratified by type of provider, 2007

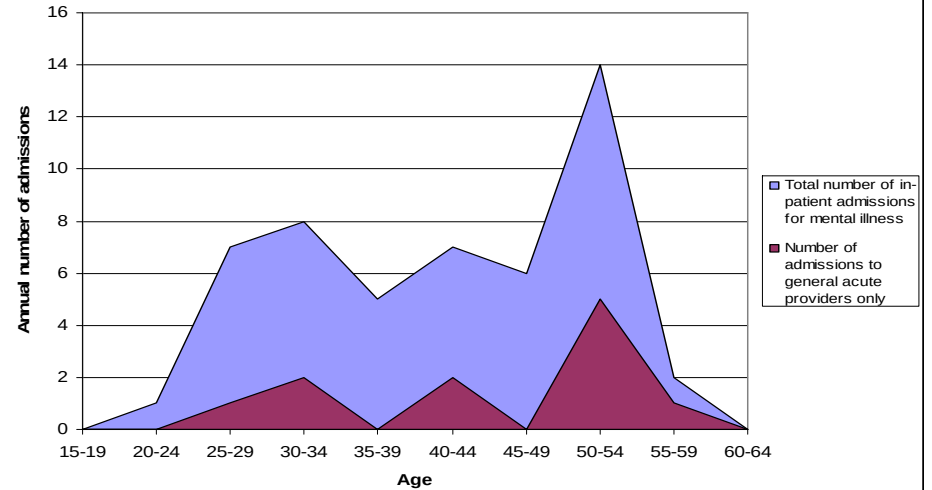


Mental Health Needs Assessment for working age population in Oxfordshire, May 08

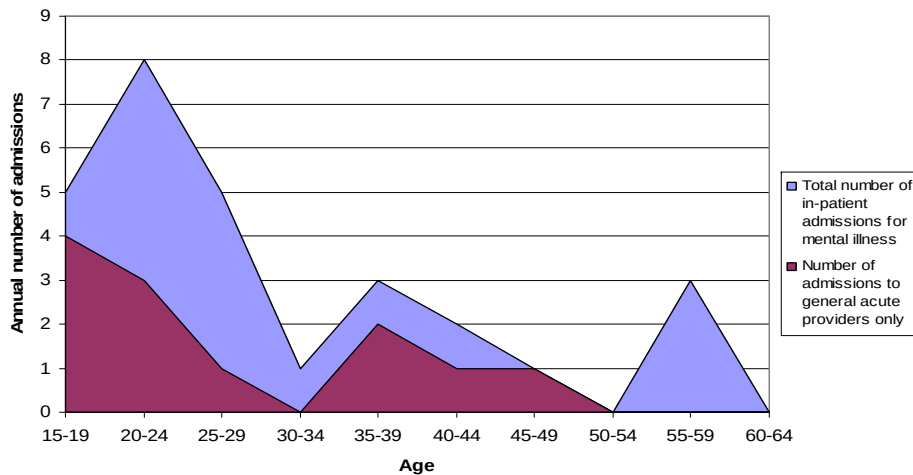
In-patient admissions for mood (affective) disorders in Oxfordshire



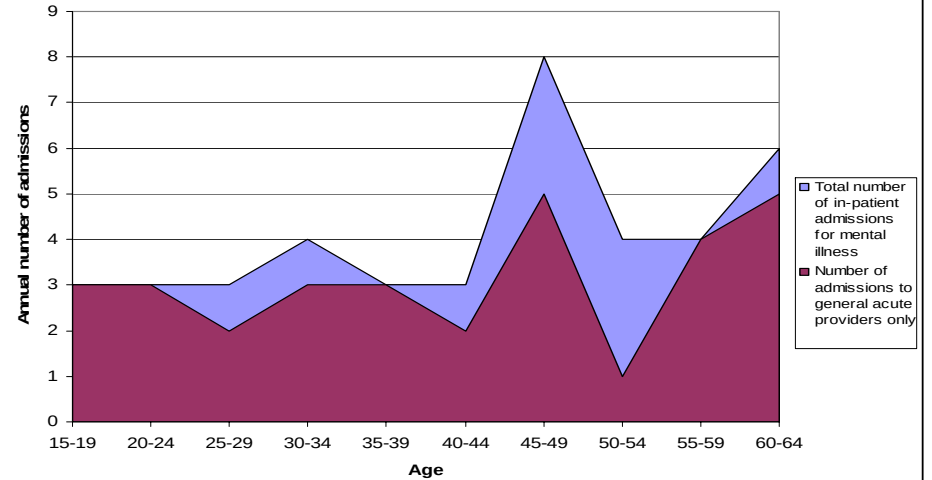
In-patient admissions for adult personality and behavioural disorders in Oxfordshire



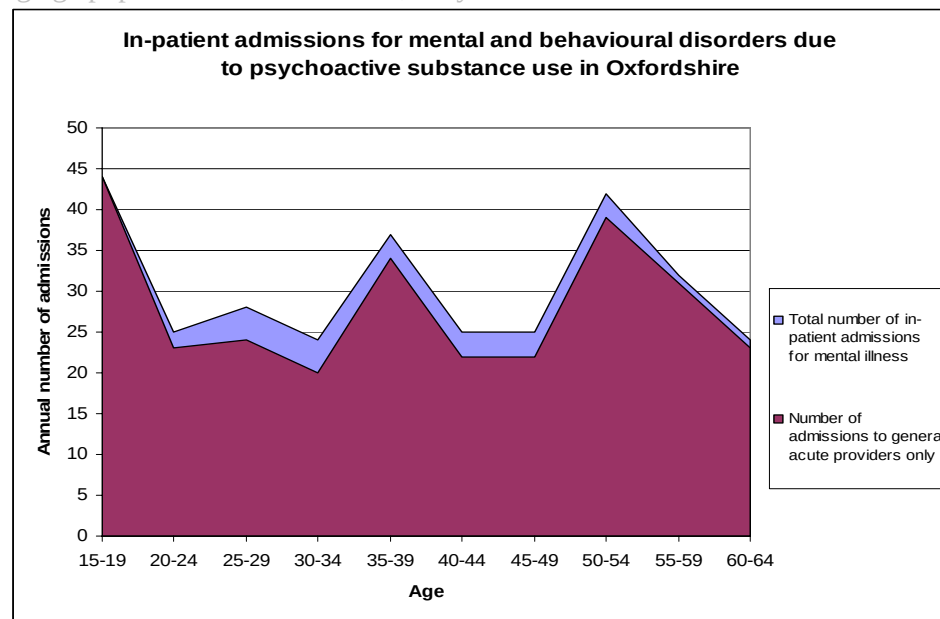
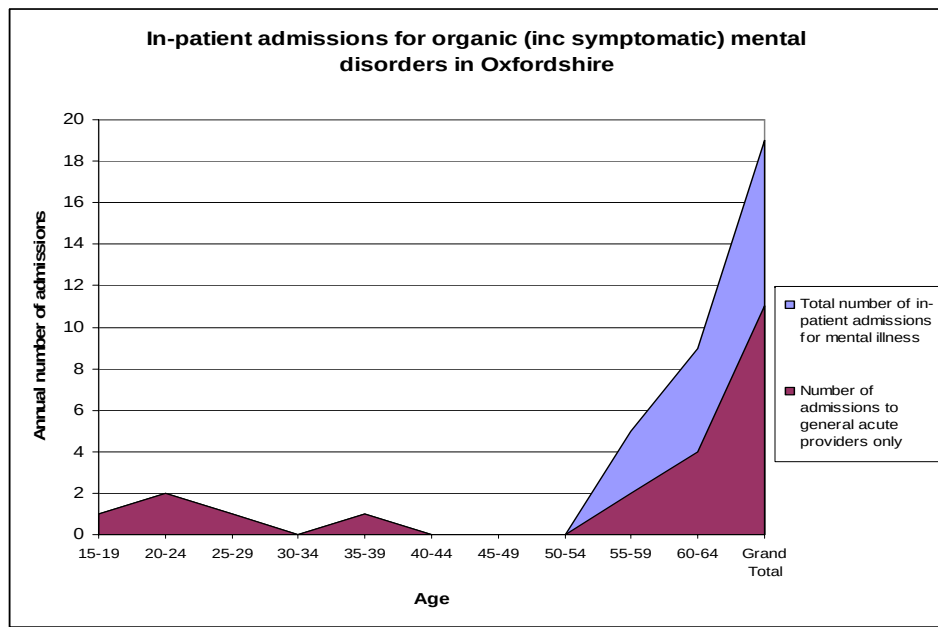
In-patient admissions for behavioural syndromes associated with physiological disturbances and physical factors in Oxfordshire



In-patient admissions for neurotic, stress-related, and somatoform disorders in Oxfordshire



Mental Health Needs Assessment for working age population in Oxfordshire, May 08



Appendix 13 - Mental health services and mental health workforce in Oxfordshire

Table 75: Summary of mental health services in Oxfordshire

Service group	Service type	Service name	Provider name	Base/postcode	Caseload 2007/ 08	Bed numbers	Total staff (in post as of 31st March 2006)	Age inclusion	Availability	Summary of functions provided
Access and crisis services	A&E mental health liaison service	Psychiatric Liaison (JRH)	OBMH	OX3 9DU	45	0	3 - (1 consultant psychiatrist, 1 psychiatric trainee, 1 admin)	18-65 yrs	all	In-reach support to general hospital - providing emergency psychiatric assessments and consultation for the acute sector hospitals in Oxford.
		Self Harm Service (John Radcliffe and Horton General Hospital)	OBMH	OX3 9DU	0	0	see Crisis Resolution Home treatment (CRHT) figures for staff in post	13-65 yrs	weekdays	In-reach support to general hospital - part of the Crisis Resolution and Home Treatment
		Approved Social Work Service (ASW)	OBMH	OX3 7JX	0	0	3 WTE (staff from CMHTs on ASW rota)			
Accommodation	Accommodation - other service	English Churches Housing Group	ECHG	OX1 1PX	0	0	0	18-65 yrs	all	
	Hostels	Simon House, Oxford	Cherwell Housing	OX1 1LD	0	6	0 (non-NHS staff, care workers 14.5 WTE, night staff 5 WTE, chef 1.5 WTE, kitchen staff 1.5 WTE, managers 4 WTE, admin 1 WTE, cleaner 2 WTE, receptionist 1 WTE, life skills worker 1 WTE)	18-65 yrs	all	accommodation with support for vulnerable homeless adults where mental health is an identified need ; there are 6 beds specifically for clients with complex needs; rest of hostel approx 120 beds - staff work across whole service to provide 24/7 cover
	Supported Housing	Oxfordshire MIND Housing	MIND	OX4 1HZ	0	54 (6 female)	14		all	
		Morrell Crescent Supported Housing	Response	OX4 4XH	0	33	0 (non-NHS staff, support workers 16 WTE)	18 - 95 yrs	all	24hr high support housing project
		St Gabriel's, Oxford	Response	OX4 4XH	0	33	0	18 - 95 yrs	all	24hr high support housing project -
Carers' services	Carers' support service	Rethink Carers Support Service	Rethink	OX4 1XE	355	0	0 non-NHS staff, Manager: 1 WTE, Carers Support Workers: 5.2 WTE)	18-65 yrs	weekdays	Carers Support service offering 1:1 emotional support , group work, relaxation groups, respite, advocacy, carers educational courses -

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Service group	Service type	Service name	Provider name	Base/postcode	Caseload 2007/ 08	Bed numbers	Total staff (in post as of 31st March 2006)	Age inclusion	Availability	Summary of functions provided
Clinical services	Acute inpatient unit/ ward	Allen Ward, Warneford Hospital	OBMH	OX3 7JX	-	21 (9 female)	21.6 WTE	18-65 yrs	all	Specialist intensive care mental health service
		Phoenix Ward (rehab), Littlemore Mental Health Centre	OBMH	OX4 4XN	-	24 (6 female)	29.15 WTE	18-65 yrs	all	Specialist intensive care mental health service
		Vaughan Thomas Ward, Warneford Hospital	OBMH	OX3 7JX	-	21 (7 female)	26.79 WTE	18-65 yrs	all	Specialist intensive care mental health service
		Wintle Ward, Warneford Hospital	OBMH	OX3 7JX	-	20 (5 female)	29.18 WTE	18-65 yrs	all	Specialist intensive care mental health service
	NHS Daycare facility	Banbury Crisis Day Centre (part of CRHT)	OBMH	OX16 9AL	0	0	10 WTE	18-65 yrs	daytime on weekdays and weekends	part of the Crisis Resolution and Home Treatment Service
		Warneford Hospital Crisis Day Centre (part of CRHT), also includes Bridge Building Team	OBMH	OX3 7JX	67	0	11.34 WTE	18-65 yrs	daytime on weekdays and weekends	Managed by the Crisis Resolution and Home Treatment Service. Includes Bridge Building Team
	Psychiatric Out-patient clinics	Specialist Community Addictions Service (SCAS)	OBMH	OX4 1DU	315	0	33.1 WTE	18-65 yrs	weekdays	community and specialist addictions (drug and alcohol) assessment and treatment service.
		Warneford Outpatient Clinic (University Department of Psychiatry)	OBMH	OX3 7JX	207	0	1 WTE (Consultant Psychiatrists and Senior Registrars are included within the CMHT or Assertive Outreach service entries)	18-65 yrs	weekdays	Psychiatric Outpatient Clinic providing medical assessment, treatment and review of referred clients
CMHT	CMHT	Abindon CMHT	OBMH	OX14 1AG	344	0	9.3 WTE	18-65 yrs	weekdays	community focused mental health and social care service to adults with mental health problems of sufficient severity or complexity to require specialist intervention
		Banbury CMHT	OBMH	OX16 9AL	418	0	18.07 WTE	18-65 yrs	weekdays	
		City Central CMHT	OBMH	OX3 7JX	539	0	17 WTE	18-65 yrs	weekdays	

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Service group	Service type	Service name	Provider name	Base/postcode	Caseload 2007/ 08	Bed numbers	Total staff (in post as of 31st March 2006)	Age inclusion	Availability	Summary of functions provided
		City East CMHT	OBMH	OX3 7JX	509	0	22.7 WTE	18-65 yrs	weekdays	
		Didcot and Wallingford CMHT	OBMH	OX11 8AS	232	0	9.01 WTE	18-65 yrs	weekdays	
		Henley CMHT	OBMH	RG9 2EB	190	0	5.03 WTE	18-65 yrs	weekdays	
		South Cherwell CMHT	OBMH	OX26 6AE	274	0	10.19 WTE	18-65 yrs	weekdays	
		Thame CMHT	OBMH	OX9 3BN	171	0	6.09 WTE	18-65 yrs	weekdays	
		Witney CMHT	OBMH	OX28 6JQ	334	0	11 WTE	18-65 yrs	weekdays	
		Early Intervention Service	OBMH	OX3 7JX	147		15.77 WTE			
		Crisis Resolution and Home Treatment Team	OBMH	OX3 7JX	City/ South - 15 North - 12		18.4 WTE			
		City and County Assertive Outreach and Rehabilitation Service	OBMH		310		39.09 WTE			
Day services	Day Centres/ Resource Centre/ Drop-in	The Archway Foundation	Archway	OX3 0DL	-	0	12 WTE	18-99 yrs	weekdays	Befriending service and activities to reduce social isolation;
		Oxfordshire Chinese Community and Advice Centre	OACCAC	OX4 1DD	-	0	0.5 WTE	18-80 yrs	weekdays	employs a half time bilingual worker to provide care and support for the non-English speaking chinese living with long term health and mental health problems
		Bicester CRP	MIND	OX26 6AN	-	0	1.2 WTE		some weekdays	
		Didcot CRP	MIND	OX11 8PY	-	0	1.4 WTE		some weekdays	

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Service group	Service type	Service name	Provider name	Base/postcode	Caseload 2007/ 08	Bed numbers	Total staff (in post as of 31st March 2006)	Age inclusion	Availability	Summary of functions provided
		Kidlington CRP	MIND	OX5 1AB	-	0	0		some weekdays	
		Abingdon CRP	MIND	OX14 3LZ	-	0	2.8 WTE		weekdays	
		Banbury CRP	MIND	OX16 2AN	28	0	2 WTE		some weekdays	
		Carterton CRP	MIND	OX18 3AA	-	0	1.4 WTE		some weekdays	
		Chipping Norton CRP	MIND	OX7 5NT	-	0	1.4 WTE		some weekdays	
		Henley CRP	MIND	RG9 1AG	-	0	1.4 WTE		some weekdays	
		Cowley CRP	MIND	OX4 3RQ	-	0	4.2 WTE		some weekdays	
		Wallingford CRP	MIND	OX10 0DT	-	0	1.4 WTE		some weekdays	
		Oasis Women's Project	MIND	OX4 2AQ	-	0	1.4 WTE		some weekdays	
		Thame CRP	MIND	OX9 2DN	-	0	1.4 WTE		some weekdays	
		The Mill CRP	MIND	OX4 1HZ	-	0	5 WTE		some weekdays and weekends	
		Wantage CRP	MIND	OX12 8DA	-	0	1.4 WTE		some weekdays	
		Witney CRP	MIND	OX28 6LE	-	0	1.4 WTE		some weekdays	
		Railway Lane Club, Littlemore	Response	OX4 4SU	-	0	2.5 WTE	18-99 yrs	some weekdays	Day Centre for adult with mental health problems
		The Gemini, Oxford	RETHINK	OX14 3JF	-	0	0 (non-NHS staff, Technical Instructors (OT) 2.4 WTE, Community Mental Health Workers 3 WTE, Team leader 0.8 WTE, Manager 1 WTE	16-65 yrs	weekdays	Service for people with severe and enduring illness with focus on recovery and social inclusion
		Springboard Family Project		OX18 3DW	-	0	4 WTE	0-99 yrs	weekdays	Provides support to families under stress; this WTE sounds too high - more like 2 WTE

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Service group	Service type	Service name	Provider name	Base/postcode	Caseload 2007/ 08	Bed numbers	Total staff (in post as of 31st March 2006)	Age inclusion	Availability	Summary of functions provided
	Education and leisure opportunities	Activities Development Team (located with Warneford Hospital Crisis Day Centre)	OBMH	OX3 7JX	65	0	1 WTE	18-65 yrs	weekdays	set up Coasters which is a network of service users, ex-service users and staff of mental health services. Coasters organises sports activities, football, badminton, walks, climbing, abseils, sponsored events and bike rides, and represents a complementary
	Employment schemes	Bridewell Organic Gardens		OX7 3EB	50	0	9 WTE	18-99 yrs	some weekdays	to improve the emotional well being of adults who have suffered from a range of health problems, primarily mental illness through therapeutic horticulture and craft activities
		Root and Branch	Oxford LA	SN6 8TH	30	0	0 (non-NHS staff, manager 1 WTE, activities co-ordinator 0.6 WTE, admin 0.16 WTE)	18-99 yrs	some weekdays	Therapeutic gardening and craft preoject that supports people who experience mental health difficulties
		Elder Stubbs Garden Group	RESTORE	OX4 3LB	32	0	4.98 WTE	18-65 yrs	weekdays	horticulture, woodwork, retail and catering work
		Fleet Meadow, South Oxon	RESTORE	OX11 8TP	30	0	4.93 TWE	18-65 yrs	weekdays	horticulture, woodwork, retail and catering work
		The Beehive	RESTORE	OX4 1YH	69	0	6.1 WTE	18-65 yrs	weekdays	horticulture, woodwork, retail and catering work
		Employment Support Worker	OBMH/ RESTORE	OX3 7JX	-		1 WTE		18-65 yrs	weekdays
Other community and hospital professional/ specialist teams	Community Development Workers (CDW) - Black and Minority Ethnic	Oxfordshire Primary Care Trust - Oxford City	Oxfordshire PCT	OX3 1XD	10	0	1 WTE		weekdays	
		Oxfordshire Primary Care Trust (CDWs)	Oxfordshire PCT	OX5 2AL	317	0	3 WTE		weekdays	
	Other service	Complex Needs Service, Manzil Way, Oxford	OBMH	OX4 1XE	443	0	14.74 WTE	18-65 yrs	weekdays	Four days per week therapeutic community, five days per week groups for the treatment of people with personality disorders
		Eating Disorders Service (Cotswold House)	OBMH	OX3 7JX	-	6 (Oxon)	25.5 WTE	17-65 yrs	all	tertiary specialist inpatient and outpatient service for sufferers of severe eating disorders
		Electro-Convulsive Therapy (ECT) service	OBMH	OX3 7JX	-	0	1.76 WTE	18-100 yrs	weekdays	The ECT clinic is based at the Warneford Hospital and provides treatment twice weekly to in-clients and out-clients of the Trust

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Service group	Service type	Service name	Provider name	Base/postcode	Caseload 2007/ 08	Bed numbers	Total staff (in post as of 31st March 2006)	Age inclusion	Availability	Summary of functions provided
		Section 136 Place of Safety (Psychiatric Intensive Care Unit)	OBMH	OX3 7JX	-	1	See Psychiatric Intensive Care Unit	16-100 yrs	all	See Psychiatric Intensive Care Unit, Littlemore Mental Health Centre. S136 Place of Safety provided within PICU.
Psychological Therapies Services	Psychology Therapies and Counselling Services	Oxfordshire Counselling Services, Cherwell, Vale, and North	Independent contractors	OX17 3NS	-	0	3.7 WTE	18-65 yrs	weekdays	These services are provided by qualified and accredited primary care contracted counsellors who provide person centred counselling and aspects of CBT in all GP surgeries in North Oxfordshire
		ISIS Centre Oxford	OBMH	OX1 2HS	280	0	7.9 WTE	18-65 yrs	weekdays	Community based counselling and psychotherapy service
		Primary Care Psychological Treatment and Counselling Service (City/ South)	OBMH	OX3 7JX	520	0	10.65 WTE	18-65 yrs	weekdays	Primary care based counselling and psychology service provided within GP practices in Oxford City and South Oxfordshire
		Psychology Service, Warneford Hospital	OBMH	OX3 7JX	162	0	25.23 WTE	18-65 yrs	weekdays	
		Oxfordshire Primary Care Trust Counselling and Psychology Service (Graduate Workers)	OBMH	RG9 5SB	100	0	2 WTE	15-18 yrs	weekdays	Psychology and counselling services for young offenders
	Voluntary/ private counselling and psychotherapy	Relate (Oxfordshire)	Relate	OX4 1EA	200	0	12.8 WTE	0-99 yrs	weekdays	Relationship counselling for individuals & couples, family counselling, psychosexual therapy, (+life skills training)
Secure and high dependency provision	Local Low Secure Service	Lambourn House (Pre-discharge Unit serving regional secure unit)	OBMH	OX4 4XN	-	5 (Oxon – TILT funded)	21.6 WTE	18-65 yrs	all	Slow stream rehabilitation ward for mentally disordered offenders

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Service group	Service type	Service name	Provider name	Base/postcode	Caseload 2007/ 08	Bed numbers	Total staff (in post as of 31st March 2006)	Age inclusion	Availability	Summary of functions provided
		Wenric Ward, Littlemore Mental Health Centre	OBMH	OX4 4XN	-	22 (Oxon)	41 WTE	18-65 yrs	all	Mixed ward providing low secure services for Mentally Disorders Offenders and similar clients requiring care under conditions of low security
	Local Medium Secure Service	Oxford Clinic	OBMH	OX4 4XN	-	25 (Oxon)	82.9 WTE	18-65 yrs	all	Mixed bedded Medium Secure Unit
	Local Psychiatric Intensive Care Unit	Psychiatric Intensive Care Unit, Littlemore Mental Health Centre	OBMH	OX4 4XN	-	15 (8 Oxfordshire beds)	26.6 WTE	18-65 yrs	all	Specialist intensive care mental health service
Services for mentally disordered offenders	Community Forensic Service	Social and Community Services Forensic Team (Littlemore)	OBMH	OX4 4XN	48	0	6 WTE	18-65 yrs	all	
	Prison Psychiatric Inreach Service	Bullingdon prison	OBMH	OX26 6AE	64	0	5.0 WTE	18-65 yrs	weekdays	Multi-disciplinary team offering offenders in Bullingdon Prison mental health care and treatment, with a particular focus on people with a severe and enduring mental health illness
Support Services	Advice and Information Services - Adult'	Oxfordshire Mental Health Matters Information Service, Oxford	OMHM	OX1 1LD	-	0	0 (non-NHS staff, Manager 0.8 WTE, Information and Advocacy Co-ordinators 3.5 WTE, Training Co-ordinator 0.6 WTE)	18-65 yrs	weekdays	Provision of mental health information services, through phone line run jointly with Oxfordshire Mind, and drop-in service
	Telephone support	Crisis Line Service	MIND	OX	-	0	1 part time Manager - rest are volunteers	All	Evenings 7pm - 1am	
	Advocacy Services - Adult'	Allies Advocacy and Information Service	OMHM	OX1 1LD	25	0	0 (non-NHS staff, Manager 0.8 WTE, Information and Advocacy Co-ordinators 3.5 WTE, Training Co-ordinator 0.6 WTE)	18-65 yrs	weekdays	Provision of advocacy service on the Adult Psychiatric Wards at Littlemore and Warneford Hospital, and community advocacy based in Oxford, Didcot and Banbury
	Service User Groups	Oxford Survivors	Oxford Survivors	OX4 1XE	-	0	0 (user led group)	18-65 yrs	some weekdays	
		Patient Council, Wenric Ward	OBMH	OX4 4XN	-	0	0.2 WTE	18-65 yrs	some weekdays	Service User forum to discuss general service issues including service delivery, quality and service improvement

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Service group	Service type	Service name	Provider name	Base/postcode	Caseload 2007/ 08	Bed numbers	Total staff (in post as of 31st March 2006)	Age inclusion	Availability	Summary of functions provided
	Support Services - Other Service Type	Advance Support, Oxford	Advance	OX28 6FH	-	0	0	18-65 yrs	all weekdays and some weekends	charitable organisation providing housing, support and employment services to meet the needs of people in the community who have either a learning disability or a mental health problem
		Connection floating support	Connection	OX4 7EX	131	0	8.06 WTE	19-99 yrs	weekdays	Floating support to enable people to maintain accommodation and access services and engage with life

Source: Adult mental health service mapping, 2007, caseload figures from OBMH accurate up to 31st March 2008

Table 76: Whole time equivalent mental health staff in Oxon LIT, 2007

Staff	WTE (2007)	No. of staff per 100,000 population aged 16 to 64yrs in 2007
Total staff	763.1	155.27
Managers	83.15	16.92
Nurses	262.01	53.31
All medical staff	52.1	10.60
Consultants psychiatrists	30.4	6.19
Career grade psychiatrists	5	1.02
Psychiatric trainees	16.7	3.40
All psychologists	36.49	7.42
Consultant psychologists	9.9	2.01
Clinical psychologists	26.09	5.31
Assistant psychologists	0.5	0.10
Counselling psychologists	0	0.00
All psychotherapists	9.45	1.92
Psychotherapists	7.4	1.51
Medical psychotherapists	2.05	0.42
All therapists	47.39	9.64
Counsellors	17.2	3.50
Occupational therapists	28.59	5.82
Assistant occupational therapists	1.4	0.28
Physiotherapists	0	0.00
Art/ drama/ music therapists	0.2	0.04

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Staff	WTE (2007)	No. of staff per 100,000 population aged 16 to 64yrs in 2007
Speech & language therapists	0	0.00
Complimentary therapists	0	0.00
All social workers	42	8.55
Social workers	17.1	3.48
Approved social worker	11.9	2.42
Residential social work staff	13	2.65
All officers	27.8	5.66
Day care officers	27.8	5.66
Employment officers	0	0.00
Education officers	0	0.00
Care support workers	0	0.00
Gateway workers	0	0.00
Support care workers	72.06	14.66
Dieticians	1.66	0.34
Support time recovery workers	28.65	5.83
Graduate primary care workers	2	0.41
Development workers	0.8	0.16
Community development workers	5	1.02
Administrative workers	70.11	14.27
Volunteer staff	18	3.66
Pharmacists	0	0.00
others	4.43	0.90

Source: Adult mental health service mapping, 2007

Table 77: Range and number of staff providing mental health services in Oxfordshire, Berkshire and Buckinghamshire

Staff	WTE (2007) staff in Oxon LIT	No. of staff per 100,000 population aged 16 to 64yrs in 2007 in Oxon LIT	No. of staff per 100,000 population aged 16 to 64yrs in 2007 in West Berkshire LIT	No. of staff per 100,000 population aged 16 to 64yrs in 2007 in East Berkshire LIT	No. of staff per 100,000 population aged 16 to 64yrs in 2007 in Buckinghamshire LIT	No of staff per 100,000 population aged 16-64yrs in South Central SHA
<i>Total staff</i>	763.1	196.68	181.25	232.37	198.22	225.35
All medical staff	52.1	13.43	12.77	15.39	7.80	11.09
Nurses	262.01	67.53	72.56	65.38	67.38	77.26

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Staff	WTE (2007) staff in Oxon LIT	No. of staff per 100,000 population aged 16 to 64yrs in 2007 in Oxon LIT	No. of staff per 100,000 population aged 16 to 64yrs in 2007 in West Berkshire LIT	No. of staff per 100,000 population aged 16 to 64yrs in 2007 in East Berkshire LIT	No. of staff per 100,000 population aged 16 to 64yrs in 2007 in Buckinghamshire LIT	No of staff per 100,000 population aged 16-64yrs in South Central SHA
All psychologists	36.49	9.40	8.01	6.31	5.11	5.83
All psychotherapists	9.45	2.44	6.15	2.07	3.05	1.99
All therapists	47.39	12.21	6.34	12.89	10.57	10.57
All social workers	42	10.82	14.47	19.04	13.0	15.74
All officers	27.8	7.16	5.23	7.27	6.92	4.73
Managers	83.15	21.43	8.26	10.54	16.85	14.08
Other staff	202.71	52.24	47.47	93.49	67.54	84.04

Source: Adult mental health service mapping, 2007, denominator population figures from the Provisional Mid-2006 Population Estimates, Office of National statistics

Table 78: Range of mental health services in Oxfordshire

Type of service	No. in Oxon LIT	Staff (WTE) in Oxon LIT	Staff per 100,000 population aged 18-64 yrs in Oxon LIT	Staff per 100,000 population aged 18-64 yrs in West Berks LIT	Staff per 100,000 population aged 18-64 yrs in East Berks LIT	Staff per 100,000 population aged 18-64 yrs in Bucks LIT	Staff per 100,000 population aged 18-64 yrs in South Central SHA
24 Hour Nurse Staffed Care	-	-	-	14.38		3.97	2.76
24 Hour Staffed Care - Non NHS Registered Nursing Home	-	-	-	-			0.56
A&E liaison CPN	-	-	-	-			1.32
A&E liaison service	1	3	0.77	2.77			
Access & crisis services – other service type	1	3	0.77	-		24.43	3.86
Accommodation - Other Service Type	-	-	-	-		2.62	1.45
Acute inpatient unit/ ward	4	88.23	22.74	28.58	52.52		26.07
Adult/family Placement Schemes	-	-	-	-			0.14
Advice & information service – adults	-	-	-	-			0.29
Advocacy services – adults	-	-	-	1.74	3.05	1.17	1.20
Assertive outreach services	2	40.9	10.54	4.98	6.66	7.49	7.67
Approved social workers (ASW)	-	-	-	1.81	5.60		3.01
Befriending and Volunteering Schemes - Adult	-	-	-			0.64	0.27
Carers' Support Group – Adult	-	-	-		3.65		0.36
Carers' Support Service – Adult	-	-	-	0.42	0.85	0.78	0.41
Carers' Support Workers	-	-	-	1.79	1.22	1.79	0.65
Clinical Services - Other Service Type	-	-	-	0.98		0.98	2.68
CMHT	9	133.42	34.39	39.81	48.48	44.20	44.73
Community Development Workers - Black and Minority Ethnic (BME)	-	-	-	1	0.41		0.61
Community Forensic Service	-	-	-				0.24

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Type of service	No. in Oxon LIT	Staff (WTE) in Oxon LIT	Staff per 100,000 population aged 18-64 yrs in Oxon LIT	Staff per 100,000 population aged 18-64 yrs in West Berks LIT	Staff per 100,000 population aged 18-64 yrs in East Berks LIT	Staff per 100,000 population aged 18-64 yrs in Bucks LIT	Staff per 100,000 population aged 18-64 yrs in South Central SHA
Continuing Care - Other Service Type	-	-	-				0.38
Criminal Justice Liaison and Diversion Service	-	-	-	1.46			1.20
Crisis Accommodation	-	-	-		0.81	0.07	0.33
Crisis Resolution Home Treatment Team (CRHT)	2	40.4	10.41	13.94	19	13.16	13.98
Day Centres/Resource Centre/Drop-in	18	46.8	12.06	13.49	6.37	10.43	10.22
Early intervention in Psychosis Service	1	14.6	3.76	1.98	2.72	3.26	3.74
Education and Leisure Opportunity	-	-	-	1.04			0.91
Emergency Clinics / Walk-in Clinic	-	-	-				2.07
Emergency Duty Team	-	-	-		2.03	3.90	0.94
Employment schemes for clients with mental health difficulties	4	25.01	6.45	6.27	9.54	4.17	5.15
Gateway Workers	-	-	-	0.35	0.41		0.45
GP Counselling Service	-	-	-	2.45	7.31		1.52
Graduate Primary Care Workers - Adult	-	-	-	0.35	2.81		0.48
Home/Community Support Service	-	-	-			1.72	0.62
Homeless Mental Health Service	-	-	-				0.41
Hostel	-	-	-		4.66		1.18
Independent Hospital - Mental Health Establishment	-	-	-		16.24		1.59
Local Authority and Registered Residential Care Home	-	-	-	2.63	5.28	17.05	6.27
Local Low Secure Service	2	62.6	16.13			6.70	5.16
Local Medium Secure Service	1	82.9	21.37				3.71
Local Psychiatric Intensive Care Unit	1	23.6	6.08	5.24	6.13	5.68	8.85
Mental Health Crisis Intervention Service	-	-	-				0.41
Mental Health Promotion	-	-	-		0.41		1.16
Mother and Baby Facility	-	-	-				0.55
NHS Day Care Facility	6	21.29	5.49	3.32	3.65		1.65
Other community and/or hospital professional team/specialist - Other Service Type	3	42	10.82	1	4.24	10.24	10.72
Patient Advice and Liaison Service – PALS	-	-	-				0.14
Personality Disorder Service	-	-	-	2.13	0.79	2.12	0.82
Primary Care Mental Health Service - Adult	-	-	-	2.08	2.44	7.72	1.86
Prison Psychiatric In-reach Service	1	3.9	1.01	1.70		2.48	1.22
Psychiatric Liaison Service - Gen Med, Surg & Palliative Care	-	-	-		1.85		0.18
Psychiatric Outpatient Clinics	2	34.1	8.79	3.06	6.50		2.82

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Type of service	No. in Oxon LIT	Staff (WTE) in Oxon LIT	Staff per 100,000 population aged 18-64 yrs in Oxon LIT	Staff per 100,000 population aged 18-64 yrs in West Berks LIT	Staff per 100,000 population aged 18-64 yrs in East Berks LIT	Staff per 100,000 population aged 18-64 yrs in Bucks LIT	Staff per 100,000 population aged 18-64 yrs in South Central SHA
Psychological Therapy Service - Other Service Type	-	-	-	2.67		2.67	0.70
Psychology Therapies and Counselling Services	5	49.48	12.75	2.62	4.38	3.52	3.94
Regional Medium Secure Service	-	-	-			6	0.73
Rehabilitation or Continuing Care Team	-	-	-				0.10
Residential Rehabilitation Unit	-	-	-				6.43
Self-help and Mutual Aid Group – Adult	-	-	-			0.1	0.18
Service User Groups	-	-	-	1.84	3.45		0.76
Services for Mentally Disordered Offenders - Other Service Type	-	-	-			0.65	0.16
Short-term Breaks/Respite Care Service	-	-	-		8.20		0.81
Specialist Psychotherapy Service	-	-	-	4.07	1.57		0.87
Staffed Group Home	-	-	-				1.23
Staff-facilitated Support Groups	-	-	-			0.03	0.10
Support Services - Other Service Type	1	8.06	2.08			2.21	1.59
Support Time and Recovery Worker	-	-	-	0.69	1.22		1.20
Supported Housing	1	14	3.61	9.38	10.76	0.33	13.59
Unstaffed Group Home	-	-	-		0.61	1.14	1.22
Voluntary/Private Counselling and/or Psychotherapy Service	1	12.8	3.30		9.74	4.45	2.75
Women-only community day services	-	-	-			0.36	0.04

Source: Adult mental health service mapping, 2007, denominator population figures from the Provisional Mid-2006 Population Estimates, Office of National statistics

Table 79: Results of mental health annual self-assessment of services within Oxfordshire LIT, 2006/07

Domain	Result	Explanation	Other notes
Graduate workers	Amber	The target number of graduate workers is in place. There remains work to be done to ensure that workers are operating effectively, and are well integrated with local primary care services. There are plans in place to address these needs.	There are 2 Graduate Workers in post in Huntercombe Young Offenders Institute. There is a proposal to include additional Graduate Workers within Tier 2 (T2) services and a model is currently being developed as part of the Oxfordshire Psychological Therapies Review. There are systems in place to ensure that workers operate effectively, and are integrated into local primary care services. Day to day contact with GPs who visit clients in Huntercombe. The psychologist based at Huntercombe is responsible for the GWs clinical supervision, education and development. The Healthcare Manager at Huntercombe is responsible for the general management of GWs.
Primary-secondary interface	Green	Each of the systems that were stipulated in the self-assessment are in place	Including – 1) an agreed model for mental health treatment in primary care, 2) agreed and implemented care pathways between primary-secondary care, 3) QOF registers in primary care for SMI, depression and dementia, 4) referral agreements (protocols) to be reviewed to ensure they are operating effectively, 5) protocols in place on the exchange of information between primary and secondary care, 6) systems in place for delivering specialised services on the primary care site (out-

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Domain	Result	Explanation	Other notes
			posted clinics, primary care liaison teams, etc).
Key services - Crisis Resolution	Green	There is a crisis resolution service available which fully meets the definition within the Policy Implementation Guide criteria or which has been accepted through the fidelity and flexibility process and is at a level, which is sufficient to meet the defined caseload target set for 2005/06.	The Oxfordshire Crisis Resolution and Home Treatment (CRHT) Service model was agreed through the DOH fidelity and flexibility process. The CRHT service has been implemented since October 04. The forecast is that the home treatment annual 06/07 target of 931 episodes will be achieved. The CRHT Service is being reviewed in Jan 07 and further investment is planned
Early Intervention in Psychosis	Amber	There is a service available which meets the definition of early intervention in psychosis or which has been accepted through the fidelity and flexibility process, but which is provided at a level which is unlikely to meet the defined caseload target	Currently the Early Intervention Service is provided through the Community Mental Health Teams. Audits in both 2005/2006 showed caseload figures which meet 06/07 targets of 82 episodes. A stand alone EIS Service is planned to commence March 2007 which will pick up the identified caseload
Secure Places/ Intensive Care	Green	There are no deficiencies in the availability of medium and low secure beds, or PICU beds for local residents	In Oxfordshire there is an 8 bedded PICU called the Runis Unit based on the Warneford Hospital site. From April 07 the unit will increase to a 15 bedded unit.
STaR workers	Green	The target number of 'Star' workers is now in place in all local areas, and they are all working effectively	The target number of Support, Time and Recovery Workers in Oxfordshire has been achieved. Workers are working to the recovery model.
Social inclusion - Local Strategic Partnerships	Amber	The LIT has developed a strategy for meeting the needs of people with mental distress and social exclusion issues taking account of the SEU report. All LSP's or commissioners in the patch have focussed on needs, but none or only some LSPs and commissioners have an agreed action plan	A number of social inclusion schemes have been developed between the PCT, OBMH, the Voluntary Sectors and Social and Community Service to focus on the needs of people with mental illness. These schemes include: the Bridge Building Project, Coasters Charity, Physiotherapy Service, Connexions, Restore, Abingdon Open Door, Advance Housing Support Ltd, Archway Foundation, Bicester Day Care Centre, The Lilacs Day Centre Blackbird Leys, MIND Services, Root and Branch, Tandem Befriending Scheme, Restore and the Learning Centre at Gemini.
The mental health of people with Learning Disabilities	Amber	There are some joint protocols between mental health and learning disability services and work is in progress to achieve effective joint working	The following joint protocols with LD are available: Oxfordshire Mental Health Strategy 2007-2012, OBMH CMHT Operation Policy, and OBMH policy on Shared Care for People with Mental Health Problems and a Learning Disability
Vocational Support	Green	There is an effective/strong number of high quality services available to enable people with mental health problems to maintain or return to employment, education or volunteering	The following services are available to help people return to employment, education or volunteering: Job Centre Plus in number of locations in Oxfordshire, Connexions, "Way Out" Project, aBc2 (& Baby came too!), ACE Family Centre, Asylum Welcome, Carers Support Service, Ethnic Minority Business Service, Faringdon Family Centre, Leys Linx Centre, Ruskin College, Restore Beehive Project, The Beacon in Henley on Thames, Association for Supported Employment, Bridewell Organic Gardens, Business in the Community, Citizens Advice Bureaus across Oxfordshire, Community Job source, and Workers Education Association Southern Region in Chipping Norton
Delivering race equality - Black and Minority Ethnic People's Services	Green	Data is collected and reported regularly at board level. A baseline assessment has been made and an improvement plan developed for the commissioning and/or provision of services	OBMH Race Equality Scheme 2005/2008, and Carers Strategy ensures inclusion of BME service users and Carers. Data on ethnicity is reported monthly to the OBMH Board, and quarterly to the PCT.
Implementing the policy Delivering Race Equality in Mental Health Care	Green	Plans for implementing Delivering Race Equality in Mental Health Care are already being taken forward	OBMH Race Equality Scheme 2005-2008 is being implemented and led by the Diversity Coordinator. RAMPAG (race and mental health partnership action group) have a clear plan for 06/07 for Delivering Race Equality. Oxfordshire County Council has a Race Equality Scheme in place and an action plan monitored

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Domain	Result	Explanation	Other notes
Community Development workers (Black and Minority Ethnic Communities)	Green	The WTE target number of community development workers is now in place and are functioning in accordance with central guidance	There is 1 wte CDW in post and there are plans to achieve the target for 2.5 wte by March and 5 wte by December 2007. Therefore, green will be achieved by March 07.
Planning and integration of care - Co-ordination between age specific services	Green	All criteria met	Namely, OBMH interface protocols with Forensic Services, Children and Adolescents and Older Peoples services available.
Governance	Green	The LIT's work and planning is actively informed by regular monitoring reports about service delivery or unmet need and by the contents and recommendations of key external reports	The Oxfordshire Taskforce Group (LIT) is monitoring the action plan following the June 2006 review of Oxfordshire Adult Community Mental Health Services. Minutes from the last three Taskforce Meetings (Aug – Dec 06) show the LITs involvement in the planning and delivery of services e.g. Mental Health Strategy, CPA, STaR Worker Role, EIS, Suicide Prevention Strategy, Supporting People Programme, development of Crisis Information Leaflet. Governance performance reports are discussed at OBMH and PCT performance meetings and JMG meetings. In addition ad hoc reports are discussed at JMG and Taskforce meetings as required.
Service user Involvement	Green	There are effective structures and systems for ensuring that a wide network of service users is involved in the planning and monitoring of services	There is a wide involvement of service users at all levels within the Trust. There are Service User representation on the following Groups: Taskforce (LIT), Steering Groups for EIS, STR Workers, consultation on new CPA documentation, development of Mental Health Strategy 2007-2012, Carers Strategy, Taskforce (LIT) set up SURP (service users reference panel), Mental Health Service Development Workers employed to support service users and carers. Workshops held to review service user and carer involvement, next workshop on 16th Feb 07. Represented in a number of meetings including: Mental Health Act Forum, Service User and Carer Steering Group. Funding for user and care involvement available for time and expenses
Carer involvement	Green	There are effective structures and systems for ensuring that a wide network of carers is involved in the planning and monitoring of services	Please see above under service user's involvement, carers are also involved in each of the meeting mentioned. In addition a Carers Strategy has been developed, and a Carers Reference Group, which has increased the number of carers involved. Service Development Workers and Carers are involved in design of services and feedback to appropriate groups.
Not for profit Sector involvement	Green	Local mental health voluntary sector providers are routinely involved in the work of the LIT. Involvement is undertaken by representatives supported by a network or forum. Not for profit agencies are integral to the local mental health service and are routinely considered by commissioners as potential providers of key services.	The voluntary/not for profit organisations are represented on the Taskforce (LIT) Group. In addition representatives from MIND, Restore, Mental Health Matters and Rethink-Gemini are routinely involved in service developments and service changes. A meeting for local housing providers has been set up. The local mental health voluntary/not for profit organisations in Oxfordshire include: English Churches Housing Group, Advance Support, Oxford Survivors, Response, Rethink-Gemini, Connexions, Mental Health Matters, Relate, Coasters, MIND, 2Care – The Know, Bromford Housing Group.
Employment of Service Users	Green	There is an adequate range of schemes available locally to enable or promote the employment of service users within mental health services	There are plans to employ services users into the STR worker role and work is ongoing to develop a policy for employing service users in Oxfordshire. The schemes available include: Able Types Ltd, Association for Support Employment, Bridewell Organic Gardens, Business in the Community, Citizens Advice Bureau, Community Jobsource, Connexions, Disability Employment Advisor, Ethnic Minority Business Service, First Step Trust, Restore, Root and Branch, Gemini, and Woodpath and

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Domain	Result	Explanation	Other notes
	Green		Access First
Other priorities - Suicide Prevention	Green	There is a local suicide prevention strategy (based on the goals of the national strategy) being implemented, with good systems for measuring its impact and effectiveness, including comprehensive suicide audit	A Suicide Prevention Strategy is in place. The Suicide Strategy follows the national strategy which was developed by Professor Keith Hawton as part of the Centre for Suicide Research and based on statistics for Oxfordshire. Robust monitoring is in place including the Oxford Monitoring System for monitoring attempted suicide which publishes national findings, and OBMHs procedure for reporting, reviewing and learning from serious untoward incidents
Advocacy	Green	Service users' have access to independent advocacy to a level, and in ways which are sufficient for local need	Advocacy in Oxfordshire: Advocates Advice Line/Legal Advice Line, Allies Advocacy Service, Asylum Welcome, Carers Centre, Citizens Advice Bureau, Connexions, Independent Complaints Advocacy Service, Mediation Oxfordshire, Oxfordshire Advocacy Development Group, Oxfordshire Befriending Network, Oxfordshire Short Term Advocacy Scheme, Revolving Doors Agency, Stonham Rectory Road Project, Witness (formally POPAN).
Mental Health Promotion - Standard one strategy	Green	The Standard One strategy and action plan identifies joint working and priorities for all ages, with close working arrangements between the adult and older people's LITs and the CAMHS strategy group. There is an evaluation process with clear indicators to measure the impact and effectiveness of the action plan	There is an action plan although it is not implemented. However, there are many initiatives for example: talks in schools and training with Coasters, and the Bridge Building Project. The Taskforce (LIT) is representative of the services for adults, older adults and children and adolescents. Good health promotion evidenced in GP reporting in 2005/06 through the Quality and Outcome Framework that 95% of people with severe long term mental health problems have recorded in their primary care record that they have received a physical health check in the last 15 months
Provision of specialist services	Green	Local residents have access to services for people with sensory impairment and mental illness, eating disorder services, and mother & baby services.	PCT has recently appointed a CPN to provide a service specifically for people with sensory impairment and mental illness. In addition assessment and treatment for sensory impairment and mother and baby are also purchased for example from Birmingham Sensory Impairment Centre. There is a 14 bed Eating Disorder Unit in Oxfordshire
Specialist Services - Personality Disorder	Green	For people with a Personality Disorder there is 1) a locally agreed strategy for the delivery of services to people with personality disorders which has been, 2) largely or fully implemented, 3) Personality disorder appropriate provision within all local mainstream mental health services, 4) a range of local specialist personality disorder services	The Thames Valley Initiative Complex Needs Service was launched in Oct 2004 across Berkshire, Buckinghamshire and Oxfordshire. The service in 2006 won extended funding and a SHA award for "Health Improvement and Reducing Health Inequality". The Complex Needs Service receives referrals from the CMHTs, Assertive Outreach and Rehab Service, in 2005 33% of referrals were received from CMHTs.
Mental Health Act 1983 Section 135/136/Places of Safety	Green	There is a written policy in place for Section 135/136 which meets the needs of the MH Act code of practice and is demonstrated by regular monitoring within the LIT catchment area to be working well in practice. The policy is sensitive to the needs of clients in terms of: geographic distribution; minimal reliance on use of police-based places of safety; and in terms of powers considered by ethnicity or gender	Policies in place for Sections 135 and 136. There is successful joint working with a number of agencies through the MH Act Forum, Problems in Practice Group, and the Multi-Agency Public Protection Group. Monthly activity reports produced to show breakdown and use of sections. MH Act commission regularly reviews the Oxfordshire ASW Service; in 2006 report feedback was very positive. The Place of Safety is established on the PICU within a hospital setting.
Improving Access to Psychological Therapies	Green	Systems should develop a plan by March 2007 to deliver an 18-week target for all Psychological Therapies services by March 2008:Waiting times (from referral to assessment and from assessment to treatment) are being measured, and a strategy to ensure that clients do not	Psychological Therapies Review 2006/07 has developed a strategy to improve access to psychological therapy services, staff consultation completed and public consultation to complete on 23rd Feb 07. Psychological therapy waiting times have been monitored for the last 18 months.

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Domain	Result	Explanation	Other notes
		have to wait longer than the 18-week target has been developed. Waiting time data analysis shows that the average waiting times for both assessment and treatment are within the 18-week envelope	
Choice	Green	There is significant progress against the following four themed choice areas 1 - Life Choices, Choice in accessing and engaging with services, Choices in assessment, Choice of care pathway/options	Life Choices – 2005-06 Adult and Older Adult Day Services Review completed resulting in two adult day services offering alternatives to admissions 7 days a week, including a bridge building project, and 4 older adult day service teams which are jointly working with Social & Community Services and the Voluntary Sector. From April 07 there is investment for mental health to be integrated into intermediate care services for older adults. Number of options and choices available, including an option to make an Advance Directive. Accessing and Engaging with Services – The Crisis Resolution Home Treatment Service (CRHT) operates 24 hours 365 days a year. The City and South areas of the county are serviced by a team operating from an administrative base in Oxford, co-located with the county Approved Social Work service. The North of the county is serviced by a team based in Banbury. Both teams are on the same location as their respective Crisis Day Hospitals which also operate 7 days a week 365 days of the year. Currently the overnight CRHT work is managed through an on-call rota with 2 staff available at any time overnight; this is being changed to a 24 hour on-duty rota as from the 1st April 2007, when a further investment of community mental health workers will be employed in the service. In April there will also be the deployment of 1.5 Consultant Psychiatrist teams into the existing CRHTs. OBMH is also reviewing the wider Out of Hours provision of all clinical and support rotas to ensure that the different elements are being deployed in the most effective and efficient manner. Both the Self Harm Service (part of the CRHT Service) and the Psychiatric Liaison Team (part of the whole systems Single Point of Access to the Care and Rehabilitation Team) are based at the John Radcliffe A&E Hospital to offering access to secondary mental health services. Assessment – CPA is in place across all care groups; Adults, Older Adults and Children and Adolescent Services. The CPA documentation was reviewed in 2006 and following consultation new electronic documentation was launched in Oct 06. A choice of care coordinator is available as well as choices around inpatient services including; single room or gender sensitive areas. The development of the Choose and Book Programme for mental health is not supported by the SHA at this stage, however since Dec 05 on average 98% of outpatient first appointments for adult or older adult services have been offered a choice of appointments. Care Pathway – Future plans include improvement in access to psychological therapies across services for adults of working age and for increased access to CBT training for all professionals within CAMHs. CPA is based on a patient centred approach to ensure choice throughout the patient pathway. The Psychological Therapies Service has been reviewed to improve access to therapies,

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Domain	Result	Explanation	Other notes
			particularly CBT, in the outpatient, day and community services. The waiting times for therapies are continuing to be monitored. Number of options and choices available.

Source: CSIP, Note- Early Intervention in Psychosis achieved a green rating in the latest assessment, 2007-08

Table 80: Criteria for mental health self-assessment of the Oxfordshire Local Implementation Team (LIT), 2007/08

Domain	Criteria assessed
Primary/ secondary interface	All of the following systems are in place: An agreed model for primary mental health care, including; - Agreed target groups to receive primary mental health interventions - Agreed and implemented interventions and care pathways - QOF registers (SMI, Depression, Dementia) - Referral agreements (protocols) - Protocols on exchange of information - Systems for delivering specialist mental health services in primary care settings (out-posted clinics, primary mental health care liaison teams, etc)
Crisis resolution service	The CRHT service is fully functional. The commissioner has established that it is Mental Health Policy Implementation Guide (MHPIG) compliant and adequately meets the needs of its population. That is, - It has multi-disciplinary input - provides 24/7 access - 'gate keeps' all admissions - facilitates early discharges - meets the defined caseload target; and there is an effective care pathway that ensures admission to hospital is appropriate and that discharge from hospital is timely
Early intervention in psychosis	The Mental Health Policy Implementation Guide (DH, 2002) provides a detailed specification for this service. For a 'Green' rating, services should be able to demonstrate the following minimum criteria as featured in the Service Map and LDP guidance. The EI service, - has the capacity to intervene over a period of 3 years with first episode psychosis cases (FEP); - is accessible to the full age ranges from 14 to 35 years (acknowledging that services to under-18s may be provided from a separate CAMHS EI team) - offers active monitoring of individuals who are considered at high risk of psychosis or with suspected FEP for a minimum of 6 months - has caseloads of no more than 15 FEP cases per case manager - employs a multidisciplinary staff mix including practitioners with specialist skills and experience in working with adolescents, family interventions, low dose medication, cognitive behavioral therapy, relapse prevention and substance misuse interventions; - has systems in place to cover out-of-hours and weekends; - has a strategy for early detection and engagement of high risk and suspected FEP cases; - monitors DUP and collects data to demonstrate its effectiveness in relation to key outcomes including engagement rates, relapse rates, hospital readmission, suicide and parasuicide, education and employment functioning. and, - the target for total caseload is between 91% and 100%.
Assertive outreach	There is a service available which meets the definition of Assertive Outreach within the Policy Implementation Guide or which has been accepted by performance managers through the fidelity and flexibility process. This service is provided at a level which is sufficient to meet the defined caseload target
Acute In-patient care	There is a locally agreed action plan in place between the commissioner and mental health provider which addresses the key deficits identified in the 2006/07Healthcare Commission's assessment of acute inpatient services; and - the action plan sets out lead responsibilities and a timetable including review dates; - it has been negotiated and agreed with the service commissioner, and approved by the provider's Board; - governance arrangements have been agreed and established to monitor progress against the improvement plan
Mental health of older people	1) A strategy has been agreed with key stakeholders, and it is line with 'Everybody's Business'. It is fully implemented. 2) Commissioning arrangements are in place for older adults who have organic and functional mental health needs. A lead commissioner has been identified. The commissioning arrangements utilize the commissioning checklist contained within 'Everybody's Business'

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Domain	Criteria assessed
	3) Services to meet the mental health needs of older adults are provided in line with the service development guide, 'Everybody's Business'
Recovery	The mental health commissioning strategy for mental health services stipulates the provision of services which are recovery oriented; and - recovery principles are embedded within service provider recruitment and workforce development plans; - it is the view of people who use services and their carers that local mental health providers are delivering services that are recovery oriented; - outcomes monitoring is in place which includes indicators for attainment of personal goals, choice, self directed support, and social inclusion; - these outcomes are reviewed routinely within, and inform the local commissioning cycle for primary and secondary mental health services.
Social inclusion	There is a mental health commissioning strategy for meeting the needs of people who have mental health problems and who are socially excluded. This strategy is reflected in the, - Local Delivery Plan - Local Area Agreement - A social inclusion action plan is in place, and is being implemented to deliver this strategy The strategy should include substantial evidence of benefits deriving from practical partnerships between mental health services and local non-specialist community, voluntary or private organisations (to promote, for example, social support, leisure or employment opportunities); implementation of the Capabilities for Inclusive Practice (DH 2007), and Vocational Services for People with Severe Mental Health Problems: commissioning Guidance (DH, 2006)
Learning disabilities and mental health	There is effective joint working between mental health and learning disability services. People who have learning disabilities and mental health problems receive the standard of care set out in the NSF for Mental Health and in 'Valuing People', and the local CPA protocol. Robust governance mechanisms are in place. Standards of care have been demonstrated by local audit and reviewed by service commissioners, and this has established that people who have learning disabilities and mental health problems routinely, - receive assessments from the specialist mental health service; - receive treatment and care in line with local Care Programme Approach standards; - have their care co-ordinated jointly by their Care Co-ordinator in the specialist mental health service and key worker in the community learning disability team
Vocational support	An effective and sufficient number of high quality services have been commissioned to enable people with mental health problems to maintain or return to employment, education and volunteering. It has been established that these services meet local needs; and service users have been consulted in determining this
Delivering race equality	1) There is evidence that data is being collected in accordance with the guidelines in the Race Relations (Amendment) Act and that it is being used by the boards of local services to construct a baseline assessment 2) The LIT has considered this data to inform the mental health commissioning strategy and service improvement priorities for BME groups - the mental health commissioner and/or LIT or other stakeholders have established that there is, - the capacity and capability of leadership to progress this work within the provider organizations; and, - the effective engagement with local minority ethnic groups; and, - the effectiveness and impact of the DRE action plan, and governance of its delivery 3) The WTE target number of Community Development Workers is in place; their roles adhere to policy guidance; and funding has been identified to secure the posts for 2008/09
Governance	The LIT's work and planning are actively informed by regular monitoring reports about service delivery or unmet need and by the contents and recommendations of key external reports
Service user involvement	1) Service users consider that they are meaningfully involved in the planning and monitoring of services. 2) There are effective structures and systems for ensuring that a wide network of service users are involved in the planning and monitoring of services
Carer involvement	1) Carers consider that they are meaningfully involved in the planning and monitoring of services. 2) There are effective structures and systems for ensuring that a wide network of carers is involved in the planning and monitoring of services
Commissioning from the 3 rd sector	More than 15% of mental health services are commissioned from the Third Sector, and the following criteria apply: - Third sector agencies are routinely invited to tender for work. - the LIT monitors the involvement of Third Sector organizations in the planning and delivery of services; - the mental health commissioner ensures that Third Sector organizations are supported and resourced to engage in commissioning; - the mental health commissioning strategy includes a plan to increase commissioning of mental health services from Third Sector organizations, and, - the principles of the local Compact are actively promoted and safeguarded; - Third Sector provider development is under way; - regular liaison takes place with the full range of relevant local Third Sector organizations to ensure that they have equal opportunity to engage with the commissioning process; - Third Sector contracts/Service Level Agreements include the scope for flexibility to innovate to respond more effectively and appropriately to meet service user and carer outcomes
Employment of service users	There is an adequate range of schemes available locally to enable or promote the employment of service users within mental health services

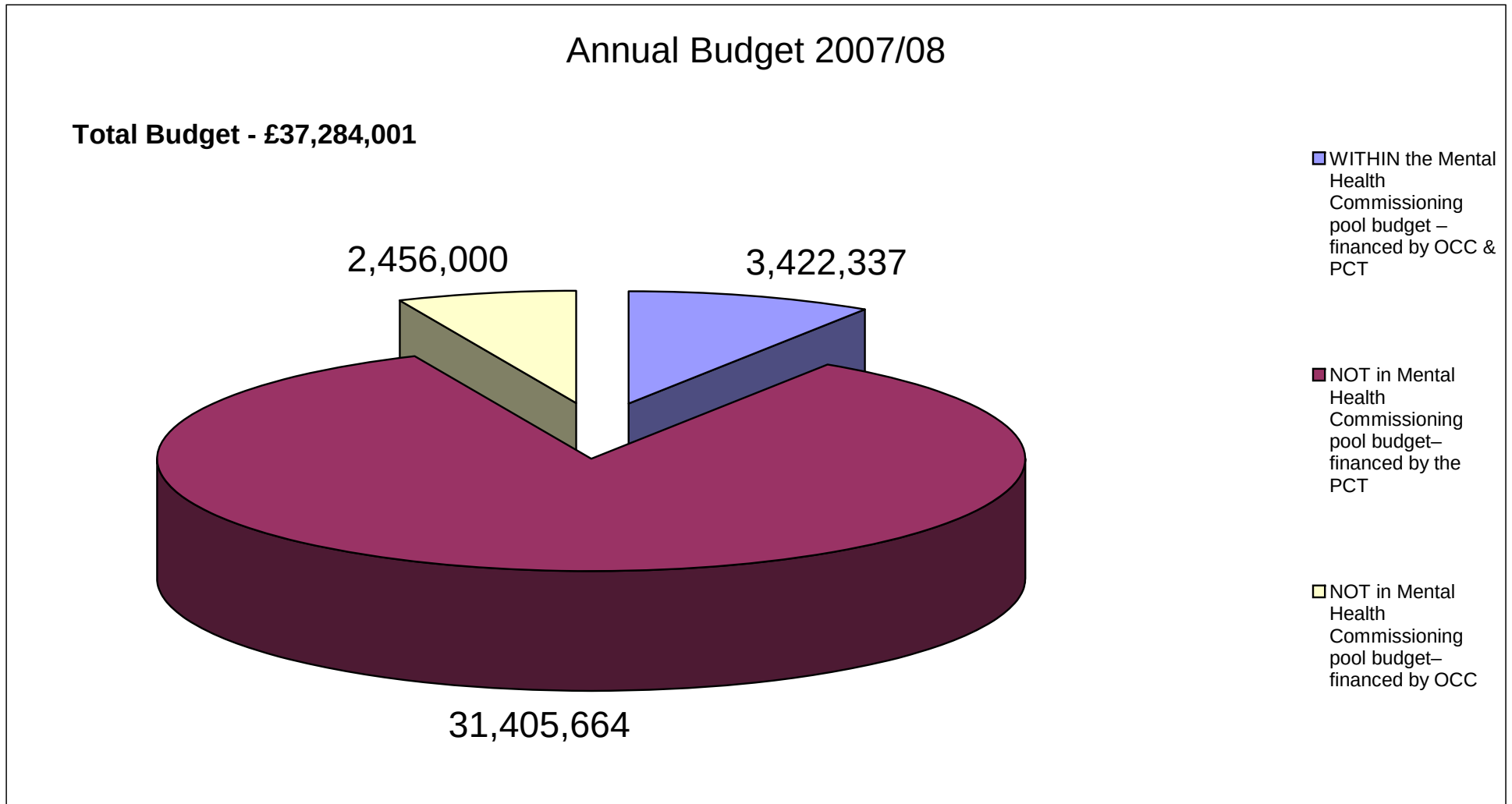
Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Domain	Criteria assessed
Suicide prevention	The PCT has a suicide prevention policy in place, with good systems for measuring its impact and effectiveness, including comprehensive suicide audit. Additionally, - interagency liaison is in place to review the audit findings and identify improvements to be made; - the suicide audit results and action plans are reviewed by the PCT Board, and the Mental Health LIT, routinely Mental health providers have a suicide prevention policy in place, with good systems for measuring its impact and effectiveness, including comprehensive suicide audit. Additionally, - interagency liaison is in place to review the audit findings and identify improvements to be made; - the suicide audit results and action plans are reviewed by the Trust Clinical Governance Committee, the Trust Board, and the Mental Health LIT, routinely.
Advocacy	Service users' have access to independent advocacy to a level, and in ways which are sufficient for local need
Mental health promotion: Standard One strategy and implementation	1) There is a Standard One strategy and action plan in place, 2) There are sufficient resources and leadership to progress this work. 3) The strategy and action plan identify joint working and priorities for all ages, reflecting 'Making it Possible' priority areas. 4) There are close working arrangements between the adult and older people's LITs and the CAMHS partnerships. 5) There is an evaluation process in place with clear indicators to measure the impact and effectiveness of the action plan
Personality disorders service	A local assessment of need for PD services has been undertaken. There is a locally agreed strategy for the delivery of services to people with personality disorders in place; and - this strategy has been funded and implemented; - the strategy includes PD appropriate provision within local mainstream mental health services, and local specialist PD services, and - it has been established that current service provision meets local needs for PD services
Mental Health Act 1983 Section 135/136/Places of Safety	1) There is a written policy in place for Section 135/136 which meets the needs of the MH Act Code of Practice. The policy is sensitive to the needs of service users who, with carers, are involved in its development and review. 2) There are locally available Places of Safety within psychiatric facilities which are accessible 24/7 and sufficiently staffed to allow them to manage people who have disturbed behavior, outside of police custody. 3) Compliance with the Code of Practice is demonstrated by regular monitoring within the LIT area to be working well in practice; this is supported by reliable data collection. Practice focuses on minimal reliance on the use of police-based places of safety; adequate distribution of places of safety; prompt assessments; and review in terms of ethnicity, age and gender
Mental Health Capacity Act, 2007	Mental health services are actively represented on the Mental Capacity Act Local Implementation Network, and the majority of staff within the local mental health and social care system are aware of their responsibilities in relation to the Act and complying with the Code of Practice
Mental Health Act, 2007	There is a Board level lead for the implementation of the MHA 2007 who is supported by a designated project manager, and there is an implementation plan which has been agreed with local partner organisations and which addresses the. - workforce implications of the new roles identified by the MHA 2007 - governance arrangements under the MHA 2007 - staff training requirements - a range of local policies and procedures required under the MHA 2007. - engagement of service users and carers (including those from BME communities) in local implementation - provision of information relating to the MHA 2007 to service users, carers - and nearest relatives
Improving Access to Psychological Therapies	There is a strategy in place to increase access to psychological therapies for people who have mild-to-moderate mental health problems, in line with national policy. This strategy is based on a local needs assessment. Additionally, - the strategy addresses workforce redesign and development needs, - data collection mechanisms for monitoring and evaluation - funding has been identified sufficient to implement this strategy
Dual diagnosis	There is a current, funded commissioning strategy in place to respond to the needs of people who have mental health and substance misuse problems, and - the strategy has been developed with key stakeholders - the strategy is based on a current needs assessment for this group - and it has been established that the services commissioned are sufficient to meet local needs

Source: CSIP

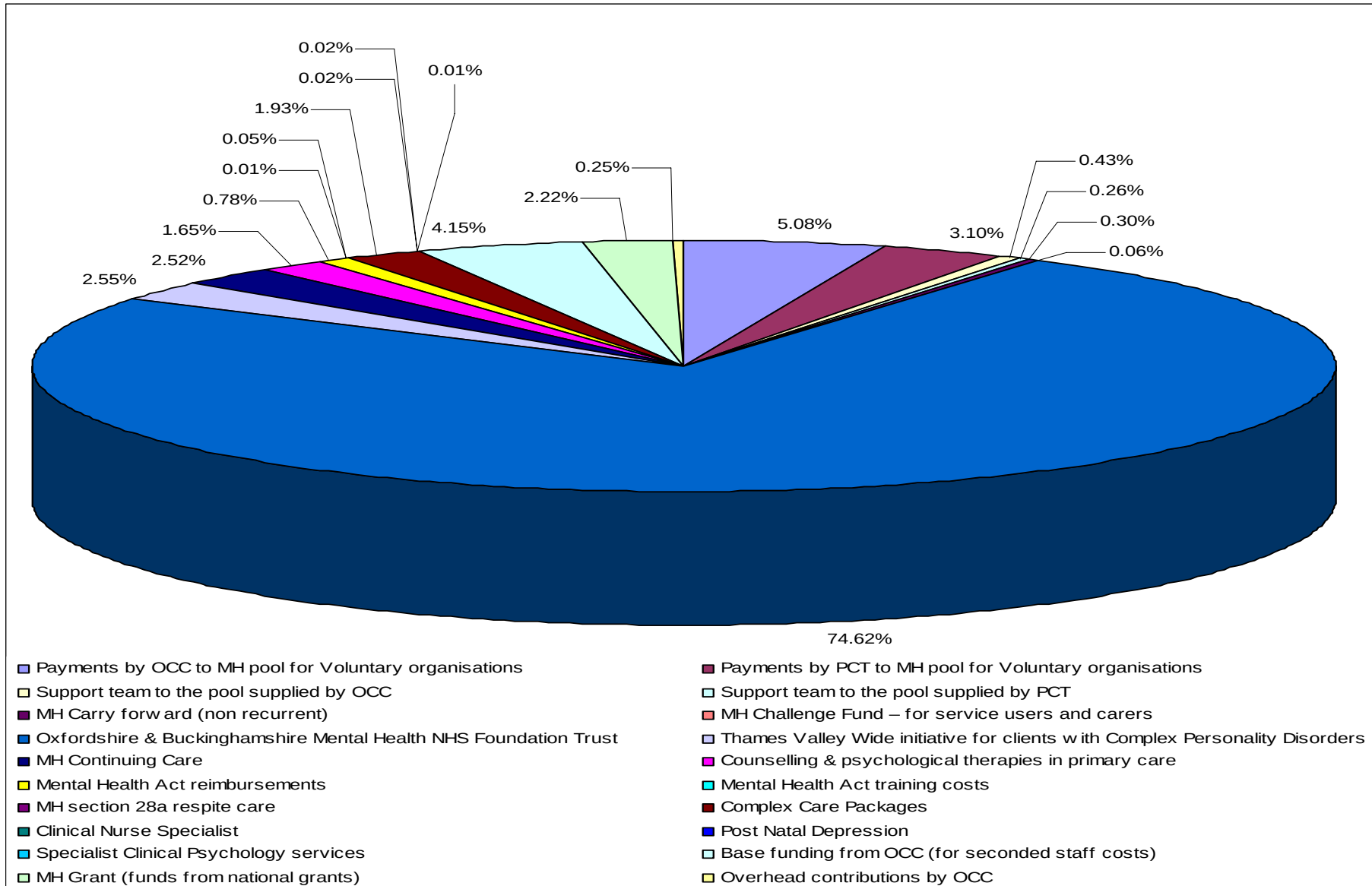
Appendix 14 - Current spending on mental health services in Oxfordshire

Figure 23: Annual budget for mental health services in Oxfordshire, 2007/2008



Source: Oxfordshire PCT Finance Team and Oxfordshire County Council Finance Team (excludes prescribing costs and costs for care of clients with mental illness treated as part of the general medical services contract)

Figure 24: Budget for MH services in Oxfordshire, 2007/2008, divided by services



Source: Oxfordshire PCT Finance Team and Oxfordshire County Council Finance Team (excludes prescribing costs and costs for care of clients with mental illness treated as part of the general medical services contract)

Table 81: Spending on mental health services for adults of working age in Oxfordshire, 2007/08

Description	Annual Budget 2007/08	Month 13 Actuals 2007/08	Variance 2007/08
-------------	-----------------------	--------------------------	------------------

WITHIN the Mental Health Commissioning pool budget – financed by OCC & PCT

Payments by OCC to MH pool for Voluntary organisations (see below for further details)	1,885,000	1,818,013	-66,987
Payments by PCT to MH pool for Voluntary organisations (see below for further details)	1,148,837	1,423,261	274,424
Support team to the pool supplied by OCC	159,000	93,962	-65,038
Support team to the pool provided by PCT	98,000	89,199	-8,801
MH Carry forward (non recurrent)	111,000	-88,100	-199,100
MH Challenge Fund – for service users and carers	20,500	16,991	-3,509
Sub total	3,422,337	3,353,326	-69,011

NOT in Mental Health Commissioning pool budget– financed by the PCT

Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust (including funding for adult mental health directorate, psychological therapies for people of working age, complex needs funding and prison in-reach services, excluding forensic services)	27,867,079	30,158,232	-2,291,153
Thames Valley Wide initiative for clients with Complex Personality Disorders	947,000	947,000	0
MH Continuing Care	936,840	759,353	-177,487
Counselling & psychological therapies in primary care	612,151	613,931	1,780
Mental Health Act reimbursements	289,080	231,604	-57,476
Mental Health Act training costs	5,052	7,165	2,113
MH section 28a respite care	18,876	0	-18,876
Complex Care Packages	714,274	800,093	85,818
Clinical Nurse Specialist	6,324	23,057	16,733
Post Natal Depression	6,672	2,488	-4,184
Specialist Clinical Psychology services	2,316	0	-2,316
Sub total	31,405,664	33,542,923	-2,445,048

NOT in Mental Health Commissioning pool budget– financed by OCC

Base funding (for seconded staff costs)	1,540,000	2,267,389	96,921
MH Grant (funds from national grants)	824,000		
Overhead contributions	92,000	92,000	0
Subtotal	2,456,000	2,359,389	96,921
Total	37,284,001	39,255,638	-2,417,138

Source: Oxfordshire PCT Finance Team, Oxfordshire County Council Finance Team, and OBMH Finance Team (excludes 1-prescribing costs, 2-costs for care of clients with mental illness treated as part of the GP general medical services contract, 3-non-recurrent funding from the PCT Department of Public Health Choosing Health funds for mental health promotion and post-natal depression, and 4-subsidized accommodation costs for 3rd sector providers funded by OBMH)

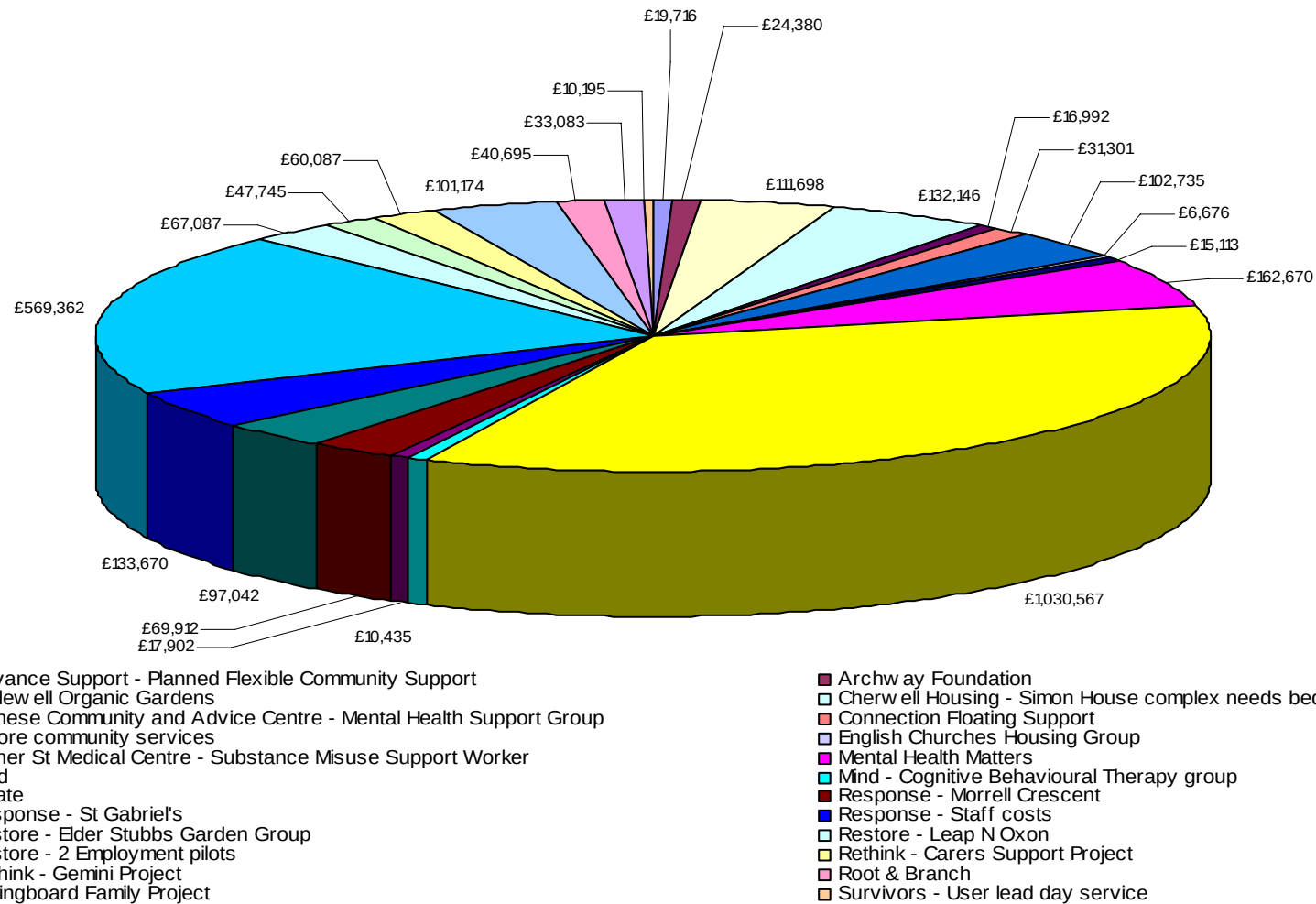
Table 82: Spending on 3rd sector providers who care for mental health clients of working age in Oxfordshire, 2008/09

Service/ Organisation name	Description	Service Value 08/09
Advance Support - Planned Flexible Community Support	Floating support service	£19,716
Archway Foundation	Community service	£24,380
Bridewell Organic Gardens	Therapeutic work project	£111,698
Cherwell Housing - Simon House complex needs beds	Residential service	£132,146
Chinese Community and Advice Centre - Mental Health Support Group	Community service	£16,992
Connection Floating Support	Floating support service	£31,301
Elmore community services	Floating support service	£102,735
English Churches Housing Group	Community service	£6,676
Luther St Medical Centre - Substance Misuse Support Worker	Community service	£15,113
Mental Health Matters	Advice and information	£162,670
Mind	Day service (including day centres in Abingdon, Banbury, Bicester, Carterton, Chipping Norton, Didcot, Henley, Kidlington, Cowley, Oxford – The Mill and Oasis Women's Day centre, Thame, Wallingford, Wantage)	£1,030,567
Mind - Cognitive Behavioural Therapy group	Group work	£10,435
Relate	Consultation service	£17,902
Response - Morrell Crescent	Residential service	£69,912
Response - St Gabriel's	Residential service	£97,042
Response - Staff costs	Residential service	£133,670
Restore - Elder Stubbs Garden Group	Therapeutic work project	£569,362
Restore – Leap, North Oxon	Therapeutic work project	£67,087
Restore - 2 Employment pilots	Therapeutic work project	£47,745
Rethink - Carers Support Project	Carers service	£60,087
Rethink - Gemini Project	Day service	£101,174
Root & Branch	Day service	£40,695
Springboard Family Project	Day service	£33,083
Survivors - User lead day service	Day service	£10,195

Source: Oxfordshire PCT, Joint Commissioning Team

Mental Health Needs Assessment for working age population in Oxfordshire, May 08

Figure25: Budget for MH services provided by the 3rd sector in Oxfordshire, 2008/09



Source: Oxfordshire PCT, Joint Commissioning Team

Section 6 - Glossary

A&E	Accident & Emergency
ADL	Activities of Daily Living
AOR	Assertive Outreach
APHO	Association of Public Health Observatories
ASW	Approved Social Worker
BDD	Body Dysmorphic Disorder
BME	Black and Minority Ethnic
CBT	Cognitive Behavioural Therapy
CDW	Community Development Worker
CIS-R	Clinical Interview Schedule - Research
CMHT	Community Mental Health Treatment Centres
c/o	Complains of
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution Home Treatment
CRP	Community Resource Project
CSCI	Commission for Social Care Inspection
CSIP	Care Services Improvement Partnership
DfES	Department for Education and Skills
DH/ DoH	Department of Health
DMIT	Disease Management Information Toolkit
DPH	Director of Public Health
DTC	Delayed Transfers of Care
DWP	Department of Work and Pensions
ECT	Electro-Convulsive Therapy
EDT	Emergency Duty Team
EIS/ EIP	Early Intervention in Psychosis
EMDR	Eye Movement Desensitisation and Reprocessing
EU	European Union
FCE	Finished Consultant Episode
FEP	First Episode Psychosis
FPH	Faculty of Public Health
GHS	General Household Survey
GMS	General Medical Services
GP	General Practitioner
HCC	Healthcare Commission
HCNA	Healthcare Needs Assessment
HDA	Health Development Agency
HICS	High Impact Changes (for mental health services)
HNA	Health Needs Assessment
HoNOS	Health of the Nation Outcome Scales
HPI	Health Poverty Index
HRG	Health Resource Group
HSE	Health Survey for England
ICD10	International Classification of Disease, Version 10
IAPT	Improving Access to Psychological Therapies
IMD	Index of Multiple Deprivation
ISIP	NHS Integrated Service Improvement Programme
JR/ JRH	John Radcliffe Hospital
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LDP	Local delivery plans
LIT	Local Implementation Team
LOS	Length of stay
LSOA	Lower Super Output Areas
LSP	Local Service Provider

MHMDS	Mental Health Minimum Dataset
MH	Mental Health
MHPIG	Mental Health Policy Implementation Guide
MHSIG	Mental Health Strategy Implementation Group
NASS	National Asylum Support Service
NCCOD	National Centre for Health Outcomes Development
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
NSF	National Service Framework
NSF-MH	National Service Framework for Mental Health
NRLS	National Reporting and Learning System
OBMH	Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust
OCB	Oxfordshire Commissioning Board
OCC	Oxfordshire County Council
OCD	Obsessive Compulsive Disorder
ODPM	Office of the Deputy Prime Minister
OMHM	Oxfordshire Mental Health Matters
OMHT	Oxfordshire Mental Health Trust
ONS	Office of National Statistics
OP	Out-clients
OPCS	Office for Population Censuses and Surveys, now ONS
OPCT	Oxfordshire Primary Care Trust
ORH	Oxford Radcliffe Hospitals NHS Trust
PALS	Patient Advice and Liaison Service
PBC	Practice Based Commissioning
PEAT	Patient Environmental Action Teams
PICU	Psychiatric Intensive Care Unit
PCT	Primary Care Trust
PD	Parkinson Disease
PLASC	Pupil Level Annual School Census
POPAN	Prevention Of Professional Abuse Network
PTSD	Post-Traumatic Stress Disorder
QMAS	Quality Management Analysis System
QoF	Quality and Outcomes Framework
RAMPAG	Race and Mental Health Partnership Group
RAP	Referrals, Assessments and Packages of care
RCGP	Royal College of General Practice
RITA	Record of In-Training Assessment
SCAS	Specialist Community Addictions Service
SE	South East
SHA	Strategic Health Authority
SITREP	Situation Reports
SMI	Severe (and enduring) Mental Illness
SNRIs	Serotonin-Norepinephrine Reuptake Inhibitors
SOA	Super Output Area
SODC	South Oxfordshire District Council
SpR	Specialist Registrar
SSRIs	Serotonin Reuptake Inhibitors
STaR	Support, Time and Recovery
SUS	Secondary Uses Service
TCA	Tricyclic anti-depressants
WHO	World Health Organisation
WTE	Whole time equivalent
Yr	Year

Section 7 - References

1. McWilliam, J., *Director of Public Health for Oxfordshire - Annual Report II*. 2008, Oxfordshire PCT.
2. Meltzer, H. and B. Gill, *OPCS Surveys of Psychiatric Morbidity: Private Household Survey, 1993*
3. Singleton, N., K. Bumpstead, and M. O'Brien, *Psychiatric morbidity among adults living in private households 2000*. 2001, Stationary Office, London.
4. *What is wellbeing? a brief review of current literature and concepts*. 2003.
5. *Wellbeing concepts and challenges: discussion paper*. 2005.
6. Parkinson, J., *Establishing a core set of national, sustainable mental health indicators for adults in Scotland: final report*. 2007, NHS Health Scotland.
7. Parkinson, J., *Establishing a core set of national, sustainable mental health indicators for adults in Scotland: Rationale paper*. 2007, NHS Health Scotland.
8. *WHO Factsheet number 220. Mental health: strengthening mental health promotion*. 2001
9. *The World Health Report 2001: Mental Health: new understanding, new hope*. 2001
10. *Oxfordshire Mental Health Strategy 2007 – 2012*
11. *Oxfordshire Primary Care Trust Draft Strategy 2007 – 2012*
12. Stevens, A., J. Raftery, and J. Mant, *An Introduction to HCNA: the epidemiological approach to healthcare needs assessment*. Healthcare Needs Assessment: The epidemiologically based needs assessment reviews. Vol. 1. 2004. p1 - p16.
13. Thornicroft, G., *Measuring Mental Health Needs*. 2001, London: Gaskell.
14. *Commissioners resource pack*. 2003, National Treatment Agency for Substance Misuse.
15. *Commissioning a patient led NHS*. 2005, Department of Health.
16. *Creating a Patient-led NHS*. 2005, Department of Health.
17. *Commissioning framework for Health and well-being*. 2007, Department of Health.
18. *Health reform in England: Update and commissioning framework. Annex: the commissioning framework*. 2006, Department of Health.
19. *Commissioning eBook*. 2006, Department of Health and the Care Services Improvement Partnership.
20. *World Class Commissioning: vision*. 2007, Department of Health.
21. *An integrated commissioning strategy for adult mental health for Buckinghamshire 2007 - 2010*. 2006, Buckinghamshire Primary Care Trust & Buckinghamshire County Council.
22. *Mental Health and Well-being in the South East*. 2006, Care Services Improvement Partnership.
23. *Indicators of Public Health in the English Regions – No 7. Mental Health*. 2007, Association of Public Health Observatories.
24. Safford, J., *Service User and Carer Involvement in Mental Health Service Commissioning: A review meeting*. 2007: Asian Cultural Centre, Manzil Way, Oxford.
25. King, M., et al., *Psychotic symptoms in the general population of England--a comparison of ethnic groups (The EMPIRIC study)*. [erratum appears in Soc

- Psychiatry Psychiatr Epidemiol.* 2005 Jun;40(6):509 Note: Karlson, Saffron [corrected to Karlsen, Saffron]]. *Social Psychiatry & Psychiatric Epidemiology*, 2005. **40**(5): p. 375-81.
26. Bhui, K., et al., *Racial/ethnic discrimination and common mental disorders among workers: findings from the EMPIRIC Study of Ethnic Minority Groups in the United Kingdom*. *American Journal of Public Health*, 2005. **95**(3): p. 496-501.
 27. Weich, S., et al., *Common mental disorders and ethnicity in England: the EMPIRIC study*. *Psychological Medicine*, 2004. **34**(8): p. 1543-51.
 28. Griffiths, S., *Addressing the health needs of rough sleepers*. 2002, Office of the Deputy Prime Minister (ODPM).
 29. Hoang, U., *Mental Health Needs Assessment of Older People in Oxfordshire*, Dept of Public Health, Oxfordshire Primary Care Trust, Oct 2007
 30. *Count Me In Census, 2005 & 2006 - A National and Oxfordshire level ethnicity census of mental health inpatients*. 2007, Race and Mental Health Partnership Group.
 31. *Guidance on Joint Strategic Needs Assessment*. 2007, Department of Health.
 32. *10 High Impact Changes for mental health services*. 2006, NIME & CSIP.
 33. Cavanagh, S. and K. Chadwick, *Health Needs Assessment - A practical guide*. 2005, Health Development Agency.
 34. Hooper, J. and P. Longworth, *Health Needs Assessment Workbook*. 2002, Health Development Agency.

Have your say

Does this information fit with your experience of mental health issues in your community?

What have we missed out?

Are there mental health issues in your community that you want to highlight to us.

You can submit comments on the mental health needs assessment by;

1. Filling in the form below and posting/ emailing it to;

✉ Paul Ralph
Service Development Manager for the Joint Commissioning Team
Oxfordshire Primary Care Trust
Jubilee House
5510 John Smith Drive
Oxford Business Park South
Oxford OX4 2LH

☎ 01865-336800

💻 paul.ralph@oxfordshirepct.nhs.uk.

2. A web-based comments form is also available for you to submit comments at the following address (www.oxfordshirepct.nhs.uk)

Thank you for taking time to read this report. Together we can ensure that the mental health needs of our population are addressed



Comments on the 'Mental health needs assessment for adults of working age in Oxfordshire, May 2008'

1. Comments on the document

What section and paragraph does your comment refer to?

Section number:	Paragraph number:
-----------------	-------------------

What is your comment?

--	--

2. What have we missed out?

Case No.	Case Name	Case Type	Case Status	Case Date	Case Time	Case Location	Case Description	Case Notes	Case Comments
1	John Doe	Medical	Open	2023-01-01	10:00	Room 101	John Doe, 45 years old, male, presented with chest pain and shortness of breath. Vital signs: BP 120/80, HR 90, RR 20, SpO2 98%.	ECG: Sinus tachycardia. CXR: Clear lungs. Bloodwork: Troponin negative, BNP 100.	Admitted to medical ward for further observation.
2	Jane Smith	Medical	Closed	2023-01-02	14:30	Room 202	Jane Smith, 60 years old, female, presented with abdominal pain and nausea. Vital signs: BP 110/70, HR 75, RR 18, SpO2 96%.	ECG: Normal. CXR: No free air. Bloodwork: Amylase 120, Lipase 150.	Discharged home with pain management.
3	Michael Brown	Medical	Open	2023-01-03	08:15	Room 303	Michael Brown, 30 years old, male, presented with severe headache and vomiting. Vital signs: BP 130/90, HR 100, RR 22, SpO2 97%.	ECG: Sinus tachycardia. CXR: No abnormalities. Bloodwork: Negative toxicology screen.	Admitted to medical ward for further evaluation.
4	Sarah Johnson	Medical	Closed	2023-01-04	16:45	Room 404	Sarah Johnson, 55 years old, female, presented with dizziness and lightheadedness. Vital signs: BP 100/60, HR 60, RR 16, SpO2 95%.	ECG: Sinus bradycardia. CXR: No abnormalities. Bloodwork: Hemoglobin 12.5, Hematocrit 38%.	Discharged home with instructions to monitor symptoms.
5	David Wilson	Medical	Open	2023-01-05	11:20	Room 505	David Wilson, 70 years old, male, presented with confusion and memory loss. Vital signs: BP 140/100, HR 85, RR 20, SpO2 98%.	ECG: Normal. CXR: No abnormalities. Bloodwork: B12 150, Folate 10.	Admitted to medical ward for further evaluation.
6	Emily Davis	Medical	Closed	2023-01-06	09:30	Room 606	Emily Davis, 25 years old, female, presented with fever and cough. Vital signs: BP 115/75, HR 95, RR 24, SpO2 96%.	ECG: Normal. CXR: Consolidation in right lung. Bloodwork: WBC 15,000, CRP 10.	Discharged home with antibiotics and cough syrup.
7	Robert Miller	Medical	Open	2023-01-07	13:10	Room 707	Robert Miller, 65 years old, male, presented with chest pain and sweating. Vital signs: BP 150/100, HR 110, RR 22, SpO2 97%.	ECG: ST-segment elevation. CXR: No abnormalities. Bloodwork: Troponin positive.	Admitted to cardiac ward for further evaluation.
8	Lisa Anderson	Medical	Closed	2023-01-08	15:00	Room 808	Lisa Anderson, 40 years old, female, presented with joint pain and swelling. Vital signs: BP 125/80, HR 70, RR 18, SpO2 98%.	ECG: Normal. CXR: No abnormalities. Bloodwork: Rheumatoid factor positive, ESR 40.	Discharged home with pain management and referral to rheumatology.
9	James Taylor	Medical	Open	2023-01-09	10:45	Room 909	James Taylor, 50 years old, male, presented with fatigue and weight loss. Vital signs: BP 135/90, HR 80, RR 18, SpO2 97%.	ECG: Normal. CXR: No abnormalities. Bloodwork: TSH 10, Free T4 0.8.	Admitted to medical ward for further evaluation.
10	Amanda White	Medical	Closed	2023-01-10	12:30	Room 1010	Amanda White, 35 years old, female, presented with skin rash and itching. Vital signs: BP 110/70, HR 75, RR 18, SpO2 98%.	ECG: Normal. CXR: No abnormalities. Bloodwork: Negative allergy tests.	Discharged home with antihistamines.

Your details:

Name: _____

Organisation: _____

Contact details: