Adult Mental Health Joint Strategic Needs Assessment

Westminster City Partnership

This document contributes to
Westminster's Joint Strategic Needs Assessment

1. Executive Summary

Mental health problems are common – it is estimated that one in six adults will experience mental health problems at any one time. For some, mental health problems are treated and never return, however, for some people, mental health problems last for many years, especially if not appropriately treated.

The prevalence of neurotic and psychotic disorders is higher in Westminster than in England as a whole and also higher than in our neighbouring boroughs. Accordingly, Westminster has a higher than average need for mental health services.

The reasons for this high level of need are most likely associated with the diverse demographics of the Westminster population and also the pockets of high deprivation in the borough.

Not everyone who is expected to have a mental health problem has been diagnosed; furthermore, not everyone who has been diagnosed with a mental health problem accesses appropriate care. Whilst limited data is available describing those persons accessing services in primary care, data for community mental health team shows that men are more likely to access services for psychosis, as are persons from Black and minority ethnic groups (BME).

2. Introduction

Mental health problems are common – it is estimated that one in six adults will experience mental health problems at any one time. For some, mental health problems are treated and never return, however, for some people, mental health problems last for many years, especially if not appropriately treated.

Not everyone who is expected to have a mental health problem has been diagnosed; furthermore, not everyone who has been diagnosed with a mental health problem accesses appropriate care.

Therefore, this needs assessments aims to:

- better understand the population with mental health problems in Westminster, describing the epidemiology of mental health by time, person and place;
- describe existing service provision and understand who is currently accessing services and who is not accessing services, but has the capacity to benefit from services;
- identify areas of unmet need, recommending areas for action.

The spectrum and severity of conditions that encompass mental health disorders is both broad and complex. This needs assessment will consider psychotic disorders and neuroses. If further information on other mental health problems is required, for example on post traumatic stress disorder or personality disorder, please see the JSNA website. This is available at: http://westminstercitypartnership.org.uk/Partnerships/Health%20and%20Wellbeing/Pages/JSNA.aspx

3. What is mental health and well-being?

The World Health Organisation (WHO, 2001) states that good mental health can be "conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

As well as the positive definition of mental health, the WHO (2001) also describes mental health and behavioural disorders, "as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behaviour associated with personal distress and/or impaired functioning…such abnormalities must be sustained or recurring and they must result in some personal distress or impaired functioning in one or more areas of life ...they are also characterized by specific symptoms and signs, and usually follow a more or less predictable natural course, unless interventions are made". The disorders are pathological phenomena rather than variations on what is perceived as "normal" by the prevailing culture.

The diagnostic categories for Mental Health are described in the International Classification of Disease Version 10 (WHO, 2007).

For practical purposes, a number of diagnostic codings are grouped together. The National Psychiatric Morbidity (NPMS) study (Singleton et al., 2001), which is the main UK prevalence study, uses three main categories, to describe mental health problems (table 2).

Table 1: ICD-10 Mental and Behavioural Disorders

ICD 10 Code	Category	Sub category
F00-F09	Organic, including symptomatic, mental disorders	Dementia in Alzheimer's Disease
F10-F19	Mental and behavioural disorders due to psychoactive substance use	Harmful use of alcohol, opiate dependence syndrome
F20-F29	Schizophrenia, schizotypal and delusional disorders	Paranoid schizophrenia, delusional disorders, acute and transient psychotic disorders.
F30-F39	Mood [affective] disorders	Bipolar affective disorder, depressive episode
F40-F48	Neurotic, stress-related and somatoform disorders	Generalized anxiety disorders, obsessive-compulsive disorders
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	Eating disorders, non-organic sleep disorders
F60-F69	Disorders of adult personality and behaviour	Personality disorders
F70-F79	Mental retardation	Mild mental retardation
F80-F89	Disorders of psychological development	Specific reading disorders, childhood autism
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Hyperkinetic disorders
F99	Unspecified mental disorder	

Source: World Health Organisation

Table 2: NPMS classification of mental health problems

NPMS Category	ICD 10 Disorders Included

Psychotic Disorder	• Schizophrenia • Schizotypal and other delusional disorders • Manic episodes and bipolar affective disorder • Other affective disorders with psychotic symptoms
Neurotic Disorder (common mental health problems)	• Mixed anxiety and depressive disorder • Generalised anxiety disorder • Depressive episode • All phobias • Obsessive compulsive disorder • Panic disorder
Personality Disorders	• Obsessive-compulsive • Avoidant • Schizoid • Paranoid • Borderline • Antisocial • Dependent • Schizotypal • Histrionic • Narcissistic

Source: National Psychiatric Morbidity Survey

4. What is the issue and why is it important for Westminster?

People with mental health disorders experience significant difficulties in leading ordinary lives. Even those with disorders at the milder end of the spectrum can have problems in their social interactions and occupations (Kings Fund, 2008). This can result in reductions in both quality and length of life.

The WHO (2001) estimates that 12.3% of the global total of the UK burden of disease (measured using DALYs[1]) results from neuropsychiatric conditions. Unipolar depressive disorder ranks number four in the list of DALY contributions for individual diseases attributing to 4.4% of global DALYs (WHO, 2001). This burden of disease is reflected in the level of funding for mental health services, 12.4% of the total spend on the NHS is on specialist mental health services, however this is thought to be an underestimation of the actual spend as it does not include the cost of care provided in primary care (Kings Fund, 2008).

People with psychosis are also at greater risk of worse physical health, meaning as a group they contribute to health inequalities in Westminster. People with severe mental illness die on average 10 years earlier than the general population. Furthermore, there are higher rates of diabetes, cardiovascular disease and respiratory diseases in this group than the rest of the population. There are a number of reasons for this; the first is that people with severe mental illness tend to have less healthy lifestyles than their peers, such as poor diets, less physical activity and higher rates of smoking; secondly, they are likely to have long term effects of antipsychotic medication use and higher rates of substance misuse. The presence of mental illness may also prevent people seeking help, or persons with mental illness may

[1] The DALY is a health gap measure, which combines information on the impact of premature death and of disability and other nonfatal health outcomes. One DALY can be thought of as one lost year of 'healthy' life, and the burden of disease as a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability.

lack the skills to adequately communicate their symptoms to healthcare professionals. When people with mental health disorders do access care, particularly primary care, physical symptoms may be overlooked in favour of the mental illness (which is seen as a priority) (Phelan at al., 2001).

Mental health and mental disorders are associated with a complex web of interacting factors, including social, psychological, behavioural and biological factors. Deprivation is also an important contributing factor to consider; this is comprised of a number of variables including low levels of education, low income and poor housing. Specific groups with higher risks of mental health problems include those with chronic diseases, substance misuse issues and the homeless.

4.1 Mental Health in Westminster

In Westminster there are population characteristics which mean that the number of people with mental health disorders and specifically serious mental health problems is much greater than in other parts of the country. These characteristics include:

- *Deprivation* –evidence suggests that people from lower social classes are at an increased risk of schizophrenia. Furthermore, they are also at a greater risk of delayed recovery, which can result in a poorer responses to treatment. Neurotic disorders have similarly been linked with social class. As a whole Westminster is ranked as the 69th most deprived borough (out of 354) in the country. Westminster has areas experiencing considerable deprivation, which are ranked within the most deprived 10% in the country. These are located in the north west and south of the borough;
- *Age structure and gender* – the first presentation of serious mental illness is usually before the age of 45, and the average age of the first episode of major depression is often in the mid 20s (in about half there is no recurrence). Westminster has a proportionally larger population in this younger age group than elsewhere in the country and, therefore, there are likely to be a greater number of people who have depression or experience psychosis in Westminster than elsewhere in the country;

- *Ethnic mix* – rates of psychotic disorder differ by ethnic group. The prevalence has been found to be highest in Black Caribbean and Black African populations. The reasons for this are thought to be a complex interaction of social and environmental factors and issues around accessing the right care in a timely manner. Overall in Westminster there is a larger, more diverse BME population than elsewhere in the country;
- *Unemployment* – unemployment can have an adverse effect on mental health and mental health issues can also prevent people accessing employment. There is a clear relationship between unemployment and common mental health disorders. Westminster has a higher than average rate of unemployment;
- *Housing and Homelessness* - mental illness is associated with overcrowding and homelessness. This is thought to be an independent factor of deprivation, although linked. In Westminster 30% of housing is overcrowded, which is the third highest in the country. Additionally, Westminster has the largest rough sleeping population in the country. Among other statistics it is estimated that there is approximately twice the rate of neurotic disorders amongst rough sleeper than the general population;
- *Substance Misuse* – substance misuse is associated with mental illness, particularly personality disorder. The rate of people accessing treatment services for substance misuse in Westminster is above the national and London averages. Consequently greater levels of mental illness are expected. It is also estimated that 67.6% of the drug treatment population and 80.6% alcohol treatment population have depression and/or anxiety disorder.

There have been various models produced to provide comparative indices of need for mental health services. These indices all suggest that Westminster has greater levels of mental health disorders (both severe and common) than other areas and consequently a greater need for services.

4.2. Population Groups and Mental Health

Age, sex and ethnicity will be considered in the separate sections for neurotic and psychotic disorders. Sexual orientation and disability will be considered in this section.

4.2.1 Sexual Orientation

Research evidence suggests that lesbian, gay, bisexual and transgender (LGBT) people are at a greater risk of poor mental health than the general population. This includes anxiety, depression, self harm and suicidal feelings. Drug and alcohol abuse have also been found to be more common among LGB people (Mind, 2004).

Lesbian and bisexual women have been found to be more at risk of suicidal feelings and drug or alcohol dependence. Stonewall (Hunt, R and Fish, J, 2008) found that as many as 20% of lesbian and bisexual women have harmed themselves in some way compared to 0.4% in the general population. This increased to 50% in women under the age of 20 (Hunt and Fish, 2008).

For gay and bisexual men, a higher risk related to suicide has been identified. These risks will be compounded when other inequalities such as poverty and ethnicity are taken into account (Dodds et al., 2005). A recent survey in Westminster found that 3% of gay and bisexual men had attempted suicide in the last 5 years and 19% had considered suicide (Gold and Cowan, 2008).

A number of social factors have been linked to the increased risk of mental health issues in LGBT people. The majority of these are related to homophobia and heterosexism[2]. Despite progress being made in recent years to improve this situation, there remain elements of these factors in most societies. Examples of this can include homophobic exchanges between people (ranging from "jokes" to physical violence), homosexuality being ignored or negatively portrayed in society, or institutional homophobia where heterosexuality is presented as the norm. A survey in Lambeth found that

[2]The social or structural manifestations of discrimination of LGBT people. (Dodds et al, 2005)

46% of LGB individuals who took part in the survey felt that they had experienced homophobic discrimination from strangers (Keogh et al., 2006). Family and friends reactions are also an important potential life stressor.

These factors can lead to internalised homophobia, were individuals develop negative feelings towards their own sexuality. This then can act as the risk factor for the mental health issues briefly outlined above. Bullying, verbal and physical violence can also be risk factors.

Research evidence suggests that there are inequities in access and discrimination in mental health services for LGBT people. The latter is thought to stem predominantly from a lack of awareness among practitioners and service providers rather than an intention to discriminate (Mind, 2008b)

There are no reliable prevalence estimates of mental health disorder in the LGB population in Westminster. Furthermore, there is also a lack of data regarding the number of people who live in the borough who are lesbian, gay or bisexual. A study in Lambeth estimated the LGBT population in the borough to be 5% (Keogh et al., 2006). Using the 5% estimate and applying this to the population over 15 years old in Westminster, suggests that 10,165 LGBT people live in Westminster. This may be a conservative estimate for Westminster due to observations that there is a stable and large LGBT community in the borough. This is a sizeable proportion of the community, who may have unmet needs for mental health services.

As information is not routinely collected about prevalence or sexuality of service users it is difficult to assess equity. This may be an area for further consideration in the future.

4.2.2 Learning Disability

People with learning disabilities are vulnerable to all mental health problems. It is estimated that 25–40% of people with learning disabilities also have additional mental health needs (Foundation for Learning Disabilities, 2008). This has been attributed to genetic elements of the disability, the impact of

brain trauma, traumatic life events and social restrictions. Schizophrenia is three times more prevalent in people with learning disabilities than in those without learning disabilities (18% prevalence). People with learning disabilities can experience the full range of psychotic symptoms associated with schizophrenia.

The combination of learning disabilities and mental health problems can result in very complex needs. These needs may not be well defined, so that individuals are passed between different agencies. Challenging behaviour may also make it difficult to find a service and can put undue pressure on the individual and their carer. Services need to work together to ensure that the needs of people with learning disabilities can be met (MIND, 2007). Diagnosing mental health conditions in people with learning disabilities can also be challenging, and it is often undiagnosed.

Psychiatry services are available within the specialist learning disabilities services. However, there may be unmet needs for those people who do not access the specialist services to access specialist mental health services. Work is underway to develop a pathway.

4.2.3 Physical Disability

The Disability Discrimination Act (2005) defines a physically disabled person as someone who has a physical impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. A physical impairment is a condition affecting the body, perhaps through sight or hearing loss, a mobility difficulty or a health condition. The Social Model of Disability (Oliver, M, 1990) defines disability in terms of the way in which society functions which causes the adverse effect on his or her ability to carry out day-to-day activities.

These definitions encompass a wide range of conditions experienced by an individual, including long term neurological conditions, sensory impairments, injuries or events such as stoke and conditions from birth. There are associations between a number of conditions and mental health disorders,

noticeably depression and anxiety. For example, 40% in the observed variation of quality of life in Parkinson's disease is due to depression. Depression is also a major risk factor in those who have had a stroke and anxiety is associated with people who have had a traumatic brain injury (NHS Evidence, 2008).

There can also be issues with people who have disabilities accessing services in terms of physical barriers to attending services and diagnostic overshadowing as is the case with learning disabilities. This is where symptoms are assumed to be related to the overarching condition rather than identified as another disorder.

Primary care data on common mental health disorders is not available. As the majority of common mental health disorders are treated in primary care it is difficult to assess how many people with a physical disability are presenting with common mental health disorders or psychotic disorders and whether there are inequalities in this group accessing care. There is also limited information available on routine returns from specialist mental health providers, therefore levels of access and severity are also unable to be ascertained through this route. To ensure equity, further work could be undertaken to look at the specific mental health needs of this group.

5. Psychoses

5.1 Expected numbers, distribution and pattern by person, place and time.

5.1.1 Prevalence – How many people are expected to have psychosis in Westminster?

Ascertaining the number of people with psychotic disorders in Westminster is problematic and, therefore, this needs assessment draws on data from a range of sources. These include the National Psychiatric Morbidity Study, indices of need produced by the Mental Health Observatory and GP practice data.

National Psychiatric Morbidity Survey

The National Psychiatric Morbidity Survey (NPMS) is one of the main sources of information on the number of people with psychosis. Latest available data suggests that that 0.5% of persons aged 15-74 years old have a psychotic disorder; this is equivalent to 988 persons in Westminster.

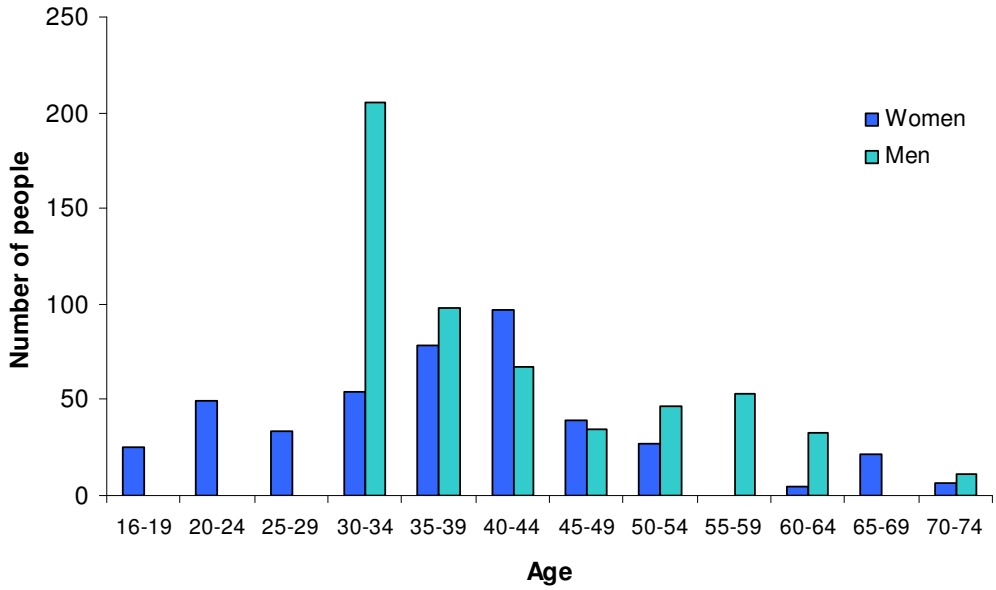
More men than women are expected to have psychosis; it is estimated that men account for 55% of all persons with psychosis in Westminster (equivalent to 548 men) and women 45% (equivalent to 440 women).

In terms of age, the majority of men with psychosis are likely to be aged between 30 and 34 years old, whilst for women the majority are likely to be aged between 35 and 44 years old, with lower numbers of people in the younger and older age groups.

Evidence suggests that NPMS prevalence estimates are likely to be conservative and underestimate the actual number of people experiencing psychosis in Westminster. There are two reasons for this. Firstly, the sample size of the NPMS is relatively small and thus produces imprecise estimates. For some age-sex categories in Westminster this resulted in zero estimates where in reality there are likely to be cases. Secondly, as previously described, the characteristics of Westminster suggest that there is likely to be

a higher prevalence of psychosis in Westminster than for other areas – the NPMS produces national level data and, therefore, does not take into account local characteristics.

Figure 1: Estimated number of people with psychosis by age and sex, Westminster, 2008



Source: National Psychiatric Morbidity Survey and Office of National Statistics 2007 mid-year estimates

To give a more accurate and robust estimate of the number of people with psychoses in Westminster, a number of predictive indices of need have been explored- these include the MINI2K, MINI2K Schizophrenia and the Local Index of Need. Whilst these indices do not produce an estimate of the number of people with psychosis in Westminster, they allow comparisons with other areas and inferences can be drawn on the likely level of need in Westminster.

Table 3: Indices of Need for Psychosis in Westminster

	MINI2K	MINI2K Schizophrenia	Local Index of Need
Westminster	1.59	2.6	104.83
Kensington and Chelsea	1.34	2.17	73.74
Hammersmith and Fulham	1.89	3.10	92.94
Camden	2.09	3.48	95.46
England	1	1	0

Source: Mental Health Observatory

MINI2K

The MINI2K index examines a number of factors (including information on employment, housing, marital status and education) to compile an comparative index for each local authority area estimating the need for inpatient hospital admissions. The index allows each local authority to be compared to the England average, although local authority areas are not directly compared to each other.

The MINI2K Index suggests that Westminster is likely to experience 59% more hospital inpatient admissions than England. This is higher than Kensington and Chelsea (compared to the England average) but lower than Hammersmith and Fulham and Camden.

Although the MINI2K Index is widely used, a recent study reported that the index could only explain 32% of the differences in spend on severe mental illness between PCTs. This suggests that the index is potentially explaining only a small difference in demand for services, and the number of people with a need for mental health services as a result of severe mental illness is actually much higher (McCrone, 2006).

Local Index of Need

The Local Index of Need (LIN) is a more recent construction using a different set of variables to estimate need – these variables include living alone, crime and ethnicity). Instead of estimating the number of inpatient admissions, the LIN aims to provide a comparative figure for actual need. According to McCrone (2006) the LIN could potentially explain 56% of the variation in spending on mental health between PCTs, suggesting that it might be a more accurate measure.

According to the LIN, Westminster is ranked 10th highest for mental health need in England, with a need greater than Kensington and Chelsea, Hammersmith and Fulham and Camden; this is in contrast to the MINI2K. This most likely reflects the different factors used to compile the two indices and the fact that the LIN uses more recent data.

MINI2K Schizophrenia Score and National Psychiatric Morbidity Survey

Whilst the LIN provides a comparative estimate of need, it cannot be used to provide local prevalence estimates. The London Health Observatory (2008) suggests using a combination of the MINI2K schizophrenia score and NPMS prevalence estimates to provide more robust local estimates.

Based on this methodology, an estimated 2,564 people in Westminster are likely to experience probable psychosis – this is significantly higher than the 988 suggested by NPMS prevalence estimates alone.

This figure should be considered to be the best local estimate, however, despite taking into account a range of local factors, the index does not take into account the size of the homeless population in Westminster or the number of people in drug treatment and so even this estimate is likely to be low.

Quality Outcomes and Framework

All GP Practices in Westminster keep a register of people who have schizophrenia, bipolar affective disorder and other psychoses. In 2007/2008 2,366 people were on these registers – this is consistent with the previous weighted estimate derived using London Health Observatory methodology.

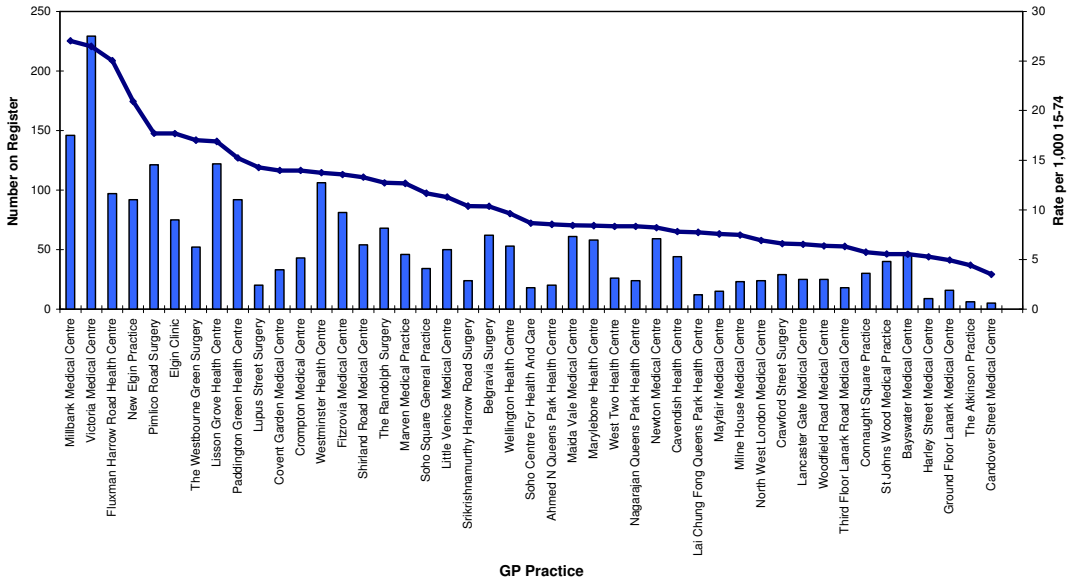
As the estimate based on the London Health Observatory is thought to be an underestimate it is possible that there is an unmet need in Westminster in terms of identification of psychoses in general practice.

The prevalence of serious mental health disorders differs between practices, ranging from 0.4% to 2.7% of registered patients. Figure 8 below shows the number of people on mental health registers, the differences in absolute numbers between practices and the rate of serious mental illness per 1,000 population aged 15-74 (the latter takes into account the size of the practice).

The rate of serious mental illness per 1,000 population differs widely between practices, from 27 per 1,000 in the Millbank Medical Centre to 3.5 at the Candover Street Practice. It is unlikely that all of the variation is explained by differences in need by practice as the ranking of practices does not reflect geographical need, or choice by people with longer standing mental health problems to attend certain general practices. It is likely that in some practices that there is an element of under recording and in some practices there is likely to be a need for better recognition and diagnosis of persons with severe mental health problems.

In order to ascertain at practice level whether the number of people on a register for severe mental illness is as expected, the expected size of practice registers was calculated by applying prevalence estimates from the national NPMS to the age-sex specific population of each practice as at 1 April 2008. These estimates were then adjusted using the MINI2K Schizophrenia score for the ward in which the general practice is located.

Figure 2: Number of people registered with a serious mental health problem by GP practice, Westminster 2007/08

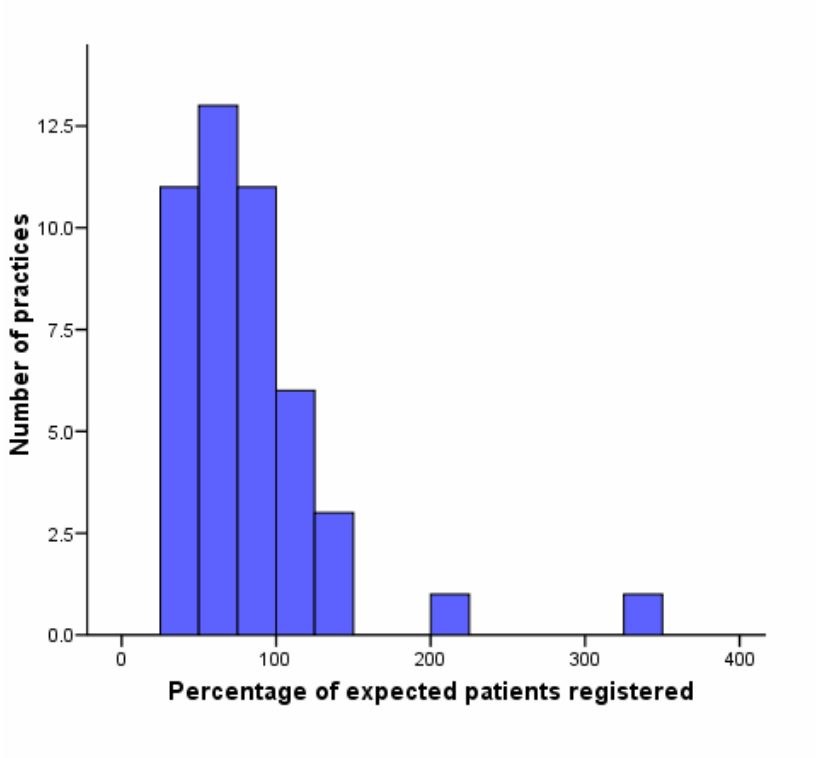


Source: QMAS

There are, however, a number of issues with this methodology. Although a GP may be located in one particular ward, the catchment area of the practice may encompass other wards whose characteristics may differ from the ward in which the GP is located. This suggests that a MINI2K score from a particular ward does not necessarily correspond to the MINI2K score of the GP practice population. Furthermore, there are a number of weaknesses associated with estimates of prevalence and need derived from the NPMS and MINI2K – as previously discussed.

Figure 4 shows the results of this analysis – practices are grouped according to the percentage of persons who would be expected to be recorded on the mental health register that actually are recorded on a register.

Figure 3: Proportion of expected population who are recorded on a mental health register



Source: National Psychiatric Morbidity Survey, Mental Health Observatory, QMAS and Office of National Statistics 2007 mid-year estimates

For some practices there are more patients on the register than would be expected from prevalence estimates (11 practices are over 100%) and for other practices there are fewer patients recorded on the register than expected (35 practices are under 100%). There are two practices with over twice as many people on their register as expected (over 200%); Belgravia Surgery has over three times the number of people on the register than expected and the Victoria Medical centre has just over twice. These practices are located in similar areas of Westminster.

Both of these practices, although located in areas of relative affluence, serve catchment areas of high deprivation – furthermore there is a large homeless population residing in the south of the borough; the latter is not captured by

the MINI2K index. Over half of the practices with a greater number of people on their registers than expected are in the south of the borough.

There are 12 practices with fewer than 50% of the people expected to be on a register actually on a register. These practices are all in the north of the borough. The reasons for this are unclear, however, it may suggest that the indices and prevalence estimates used to ascertain the number of people in Westminster with psychotic disorders do not accurately reflect local numbers. Furthermore, the data may be a result of miscoding in general practice or represent an actual issue of unidentified need. The latter is difficult to be certain of because of the robustness of the methods used. However, it is clear that some practices have very large caseloads of people with mental health disorders. This issue requires further investigation.

5.1.2 What are the features of the population affected?

(i) Age/Sex

As described previously the number of men affected by psychosis is higher than the number of women. The majority of cases are relatively young with 55% of people expected to have psychosis aged 40 and under.

(ii) Ethnicity

Prevalence of psychoses is known to differ by ethnicity. Table 4 shows the prevalence of psychoses by ethnic group from the Ethnic Minority Psychiatric Rates in the Community (EMPIRIC) Survey (Sproston and Nazroo, 2002). This shows that the prevalence of psychosis is highest amongst persons from African Caribbean ethnic groups, with the lowest prevalence found in the Bangladeshi population.

Table 4: Prevalence of psychosis by ethnic group

		White	Irish	Caribbean	Bangladeshi	Indian	Pakistani
Annual Prevalence	**Male**	1	1	1.6	0.6	0.9	1.4
	Female	0.7	1	1.7	0.6	1.3	1.3

of any psychoses (%)	**16 to 34**	1.0	2.1	1.7	0.7	1.3	1.3
	35 to 54	1.0	0.9	1.6	0.3	0.9	1.9
	55 to 74	0.3	0.0	1.6	0.5	1.1	0.2
Estimated number of people with disorder in Westminster	**Age based estimate**	1,131 (including White Irish)		72	19	86	22

Source: Ethnic Minority Psychiatric Rates in the Community Survey

Applying the age and ethnicity specific prevalence rates to the Westminster population suggests that the majority of people in Westminster with psychoses will be from the 'White' ethnic group (equivalent to 1,131 individuals). All other ethnic groups are estimated to have numbers under 100. However, we are unable to complete the picture due to the limited ethnic categories for both prevalence estimates (especially with Black African categories and locally Arab populations) and for the population estimates.

The Aetiology and Ethnicity in Schizophrenia and Other Psychoses (AESOP) Study provides alternative prevalence estimates by ethnicity. This study reported that the incidence of psychoses was substantially higher in particular BME groups compared to the White population - the incidence being highest amongst persons from Black ethnic groups (Kirkbride et al., 2006).

The reasons why there are higher rates of mental health issues in black and minority ethnic groups are complex. Studies in the Caribbean and UK found lower rates of schizophrenia in Jamaica than in Caribbean immigrants to the UK, suggesting that social and environmental factors contribute to the higher prevalence rates rather than genetics (Hickling et al., 1995 and Sharpley, 2001).

The health inequalities experienced by BME are well documented; using the wider determinants of health including social and environmental factors to

explain differences in health status. In the UK persons from black and minority ethnic groups generally occupy more disadvantaged positions in society, they live in poorer housing, have higher rates of unemployment, have lower levels of academic achievement and higher rates of exclusion from schools (White, 2002). These factors are often used as an explanation of poorer general health, including the observed higher prevalence of mental health problems. Other suggested explanations include the impact of racial discrimination as a stressor in life which effects emotional and subsequently physical well-being (Keating, 2007).

It has also been suggested that more people from BME groups are referred to treatment because of the way that symptoms of mental health problems are expressed. Another notable difference in the access of mental health services is the method of referral; rates of referrals originating from the criminal justice system and under the Mental Health Act are higher for Black Caribbean and Black African groups than other ethnic groups.

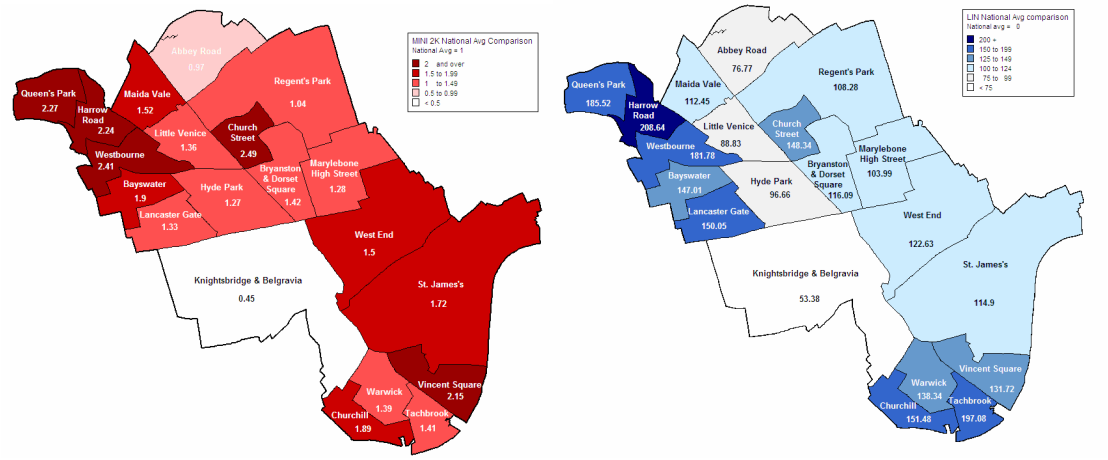
(iii) Place

The prevalence of psychotic disorders is not uniform across Westminster and varies between wards largely because of the distribution of the demographic factors associated with psychosis described previously. For example areas of high deprivation are likely to have a higher prevalence of mental health problems than areas of affluence.

Both the MINI2K and the LIN indices describe the varying need for mental health services by ward. Although the two scores are not directly comparable, they show similar results in terms of ranking of need by ward. According to both indices the need for mental health services is highest in the North West and far South of the borough- this is consistent with the pattern of deprivation in Westminster.

Figure 4: Indices of Need for Psychosis in Westminster by ward

MINI2K **LIN**



Source: Mental Health Observatory

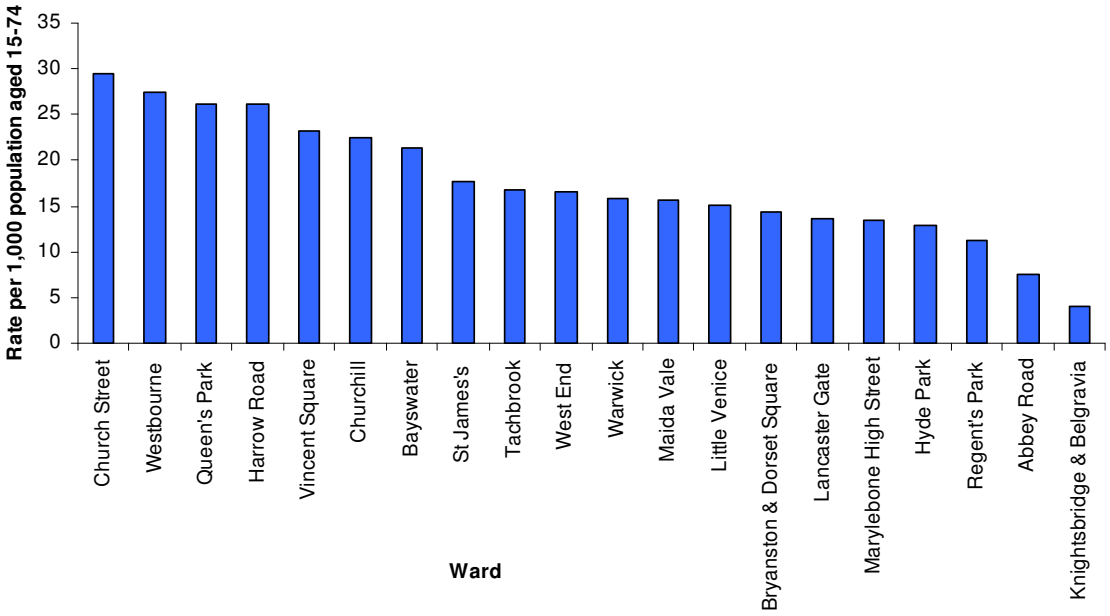
There are, however, a number of ward level differences between the two indices. The MINI2K estimates that Church Street ward has the highest need, whereas the LIN ranks Church Street ward 7th with Harrow Road ward having the highest level of need. In the south of the borough MINI2K suggests that Vincent Square ward has the highest level of need whereas LIN predicts suggests that Churchill and Tachbrook have the highest level of need.

Although there are differences between the MINI2K and LIN at ward level, what is clear is that the more deprived areas of the borough have the highest need for mental health services.

Using data derived from the NPMS and MINI2K Schizophrenia estimates, the number of people expected to have psychosis at ward level can be estimated. Although useful for illustration, ward level estimates should not be used for planning as they are based on small numbers and, therefore, may be imprecise.

Figure 6 shows that the prevalence of psychosis is highest in Church Street, Westbourne and Harrow Road wards and lowest in Abbey Road and Knightsbridge and Belgravia.

Figure 6: Estimated number of people with psychosis per 1,000 population aged 15-74 by ward, 2008

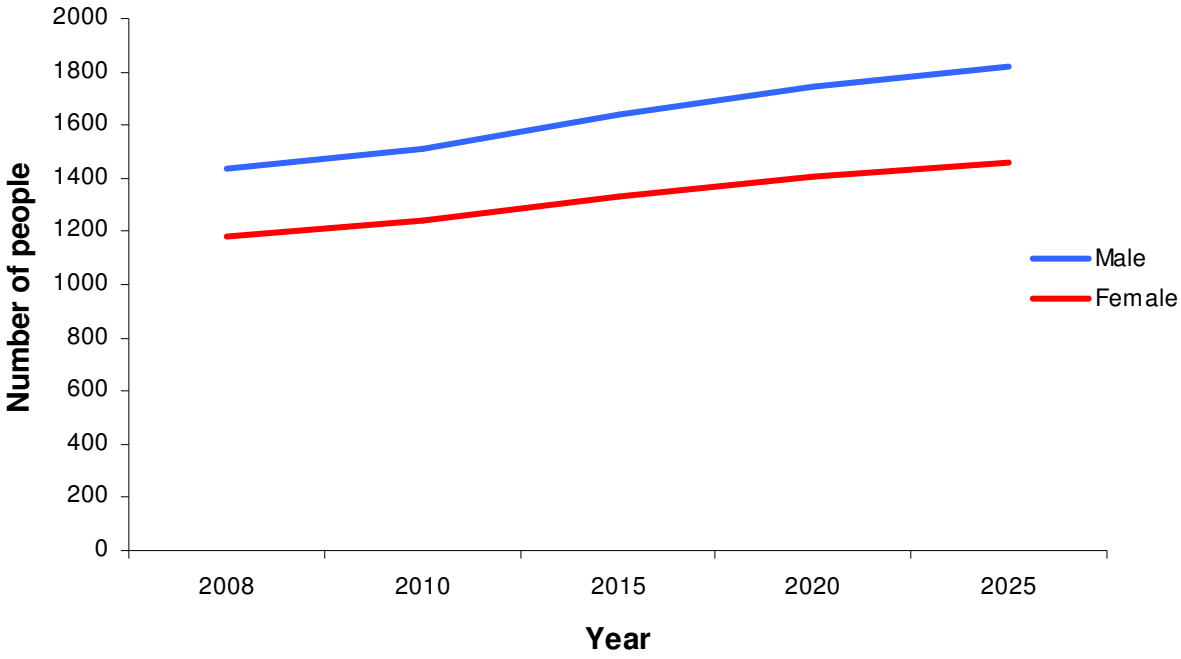


Source: National Psychiatric Morbidity Survey, Mental Health Observatory and Office of National Statistics 2007 mid-year estimates

5.1.3 Time trends

Based on population projections alone the number of people in Westminster with a psychotic disorder is expected to increase in the future- between 2008 and 2025 the number of people with a psychotic disorder is predicted to increase by 25%. However, these predictions do not take into account any changes in the characteristics of the local population which will also impact on future numbers of people with psychotic disorders.

Figure: Projected number of people with psychotic disorder in Westminster adults aged 15-64, 2008-2025 (MINI2K weighted)



Source: Mental Health Observatory, National Psychiatric Morbidity Study and Office of National Statistics Population Projections

5.1.3 Psychotic disorder associated mortality

Between 2003 and 2007 there were 18 deaths where an underlying cause of a psychotic disorder was recorded - these deaths were attributed to schizophrenia and bipolar disorder. As these deaths were over a period of 5 years, it appears that relatively few people die as a direct result of mental illness, however, there is a possibility that this number is an underestimate due to miscoding on the certification of death.

Mental health disorders also have an impact on the likelihood of committing suicide and developing other long term conditions. In the UK as many as 1 in 10 victims of psychosis die by suicide, often within the first 5 years of developing the disorder. In Westminster during 2003-2007 40 people died of a suicide where a mental health condition was recorded. This represents around one-third of the total number of people who died from suicide.

As mentioned previously, people with mental health disorders often have worse overall physical health than those without and this is likely to impact on the number and rate of deaths in this population group.

5.2 Existing Services

5.2.1 Mental health services in Westminster for persons with severe mental illness

Services are available at primary, secondary and tertiary care level. With psychotic disorders it is expected that the majority of people will be known by primary or secondary care or social services. The Psychiatric Morbidity Survey estimates that 51% of people with probable psychosis have been in contact with a community service in the last year (this includes mental health nurses and psychiatrists).

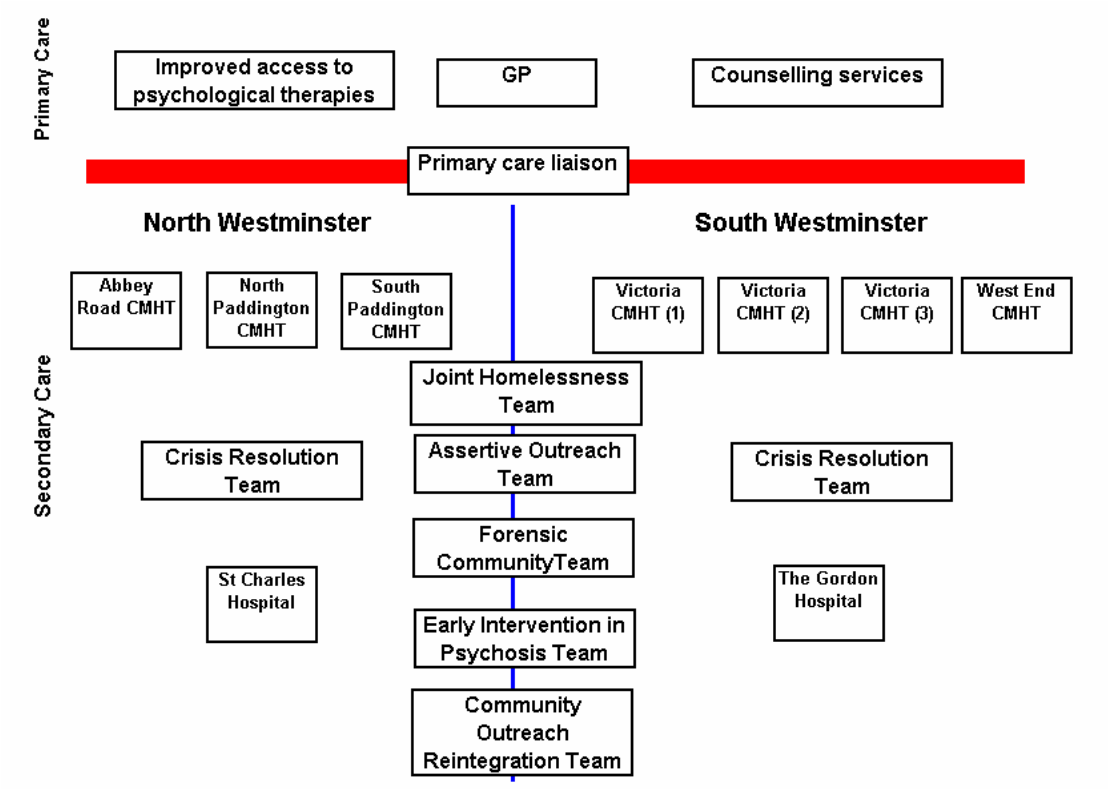
Services for persons with psychosis include those that respond to and prevent crises, those that stabilise a person's mental health and those that facilitate reintegration (figure 6).

Mental health services are provided in the community by a number of providers. Community Mental Health Teams (CMHTs) are multidisciplinary teams that provide core community care. They have 3 main functions which are; to provide professional advice to other healthcare providers; to provide specialist treatment and; to provide care for those with time limited disorders or those with more complex and enduring needs. Other community services include the Early Intervention Service. This service follows a national model, working with people aged between 14 and 35 years, who have experienced a first episode of psychosis.

The team is multi-disciplinary, comprising clinical psychology, CAMHS (Community Adult Mental Health Service) and adult medical staff, occupational therapy and nursing and social work staff. The team works with people for 3 years following their first psychotic episode. The Community Outreach Rehabilitation Team (CORT) is an assertive outreach team working

with the long-term mentally ill who are hard to engage. The team take referrals from CMHTs (Community Mental Health Teams) and acute wards. In Westminster there is also the Joint Homelessness Team (JHT) which is aimed at rough sleepers in Westminster who have no other access to services. Contacts are made by outreach and street work, and regular contacts within day centres and other voluntary sector initiatives.

Figure 6: Overview of mental health services in Westminster



5.2.2 Ascertaining the number of people with psychosis accessing services

The majority of persons with a psychotic disorder would be expected to be managed by community mental health services.

In 2007, an audit of case notes from CMHTs, the CORT, JHT and Early Intervention Service was conducted to ascertain the number of persons with severe mental illness in touch with services. The audit found that an estimated 1,689 people with psychoses were accessing community care across

Westminster. This is 71% of the 2,366 identified on GP's registers and 69% of the 2,456 (aged 20-64) expected to have a psychotic disorder in Westminster. In both cases the proportion accessing specialist mental health services is higher than the 51% suggested to be in touch with services in the NPMS.

The criteria for accessing these teams is set at a high clinical threshold, which suggests that the people being seen by the team are those in need and that there is not a source of over provision of services. However, it remains possible that due to the demographic factors in Westminster and subsequent difficulties ascertaining the number of people with psychosis in the borough, there are likely to be some persons not currently engaging with services that meet the clinical thresholds for management and have the capacity to benefit.

This data provided some detail regarding the characteristics of the people who access CMHT care.

5.2.3 What are the features of the population accessing care?

(i)Age and Sex

Comparing the age and sex profiles of persons accessing mental health services with the age and sex profiles of persons thought to have psychotic disorder in Westminster helps better understand who in Westminster is not accessing services, but has the capacity to benefit from services i.e. unmet need.

Of those accessing care, 64% were male and 36% female; this is different to expected given that prevalence estimates suggest that 55% of persons with psychosis in Westminster are thought to be male.

The exact reasons for this are unclear, however, one of the reasons for this could be because there is an unmet need for women i.e. not all women who would be expected to be in touch with services are actually engaged with services. However, it could also be a result of the fact that men may be more likely to come to the attention of mental health services through the criminal

justice system and may express their symptoms in a way that enables them to access care. Furthermore, the homeless population in Westminster which is predominately male may also contribute to the higher proportion of males accessing services.

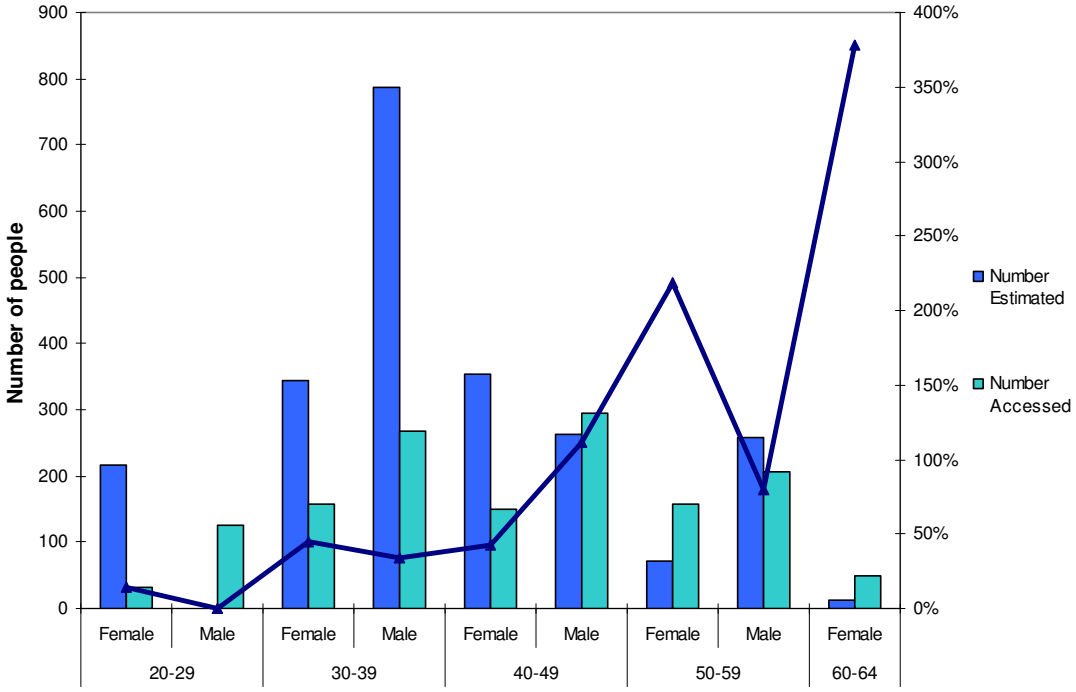
In terms of the age profile of persons accessing services, the majority are men and women aged 30-59. Comparing data on those persons accessing services to data on those persons expected to have a psychotic disorder, men aged 20-29 and 40-59 and women aged 50-64 are most likely to access services. Women aged 20-49 and men aged 30-49 are least likely to access mental health services. This suggests that further work is needed to engage these groups.

As discussed earlier, NPMS age and sex specific prevalence rates for psychosis are not necessarily generalisable to the Westminster population and, therefore, all results presented should be interpreted with caution. This is evident from the lack of estimates for men age 20-29 and 60-64.

(ii) Ethnicity

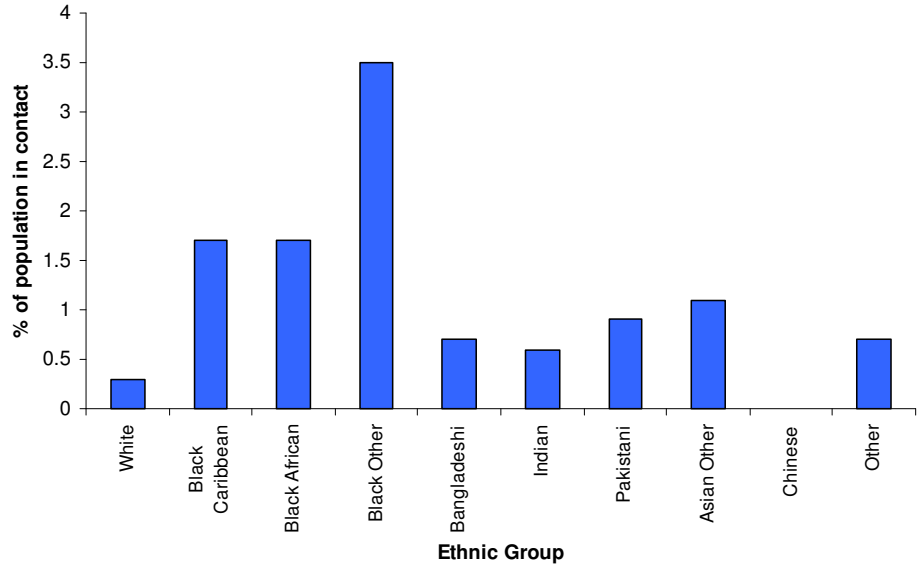
Persons from Black ethnic groups are most likely to be in contact with community mental health services, whilst persons from White ethnic groups are least likely (figure 10). Overall, 3.5% of persons from Black Other ethnic groups are in contact with community mental health teams, whilst 0.3% of the total White population in Westminster is in touch with community mental health services. This is generally as expected as the prevalence of severe mental health problems are highest amongst persons from Black ethnic groups.

Figure 7: Proportion of expected persons with psychotic disorder accessing care by age and sex



Source: Mental Health Observatory, National Psychiatric Morbidity Study and CNWL

Figure 8: Proportion of population in contact with community mental health services by ethnic group

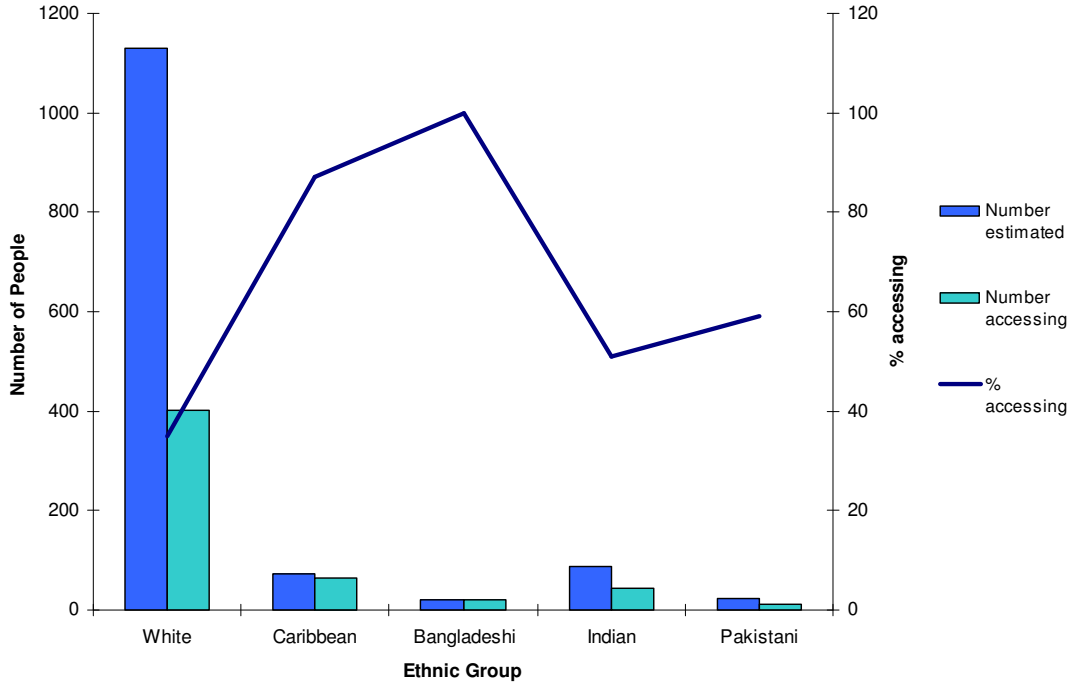


Source: Mental Health Observatory, National Psychiatric Morbidity Study and CNWL

Comparing the number of people with psychoses by ethnic group with actual numbers of people accessing services by ethnic group shows that there is variation. 87% of persons from Black ethnic groups and 100% of persons from Bangladeshi ethnic groups in Westminster who are thought to have a psychotic disorder are accessing community mental health services, whilst only 35% of persons from White ethnic groups and 51% from Indian ethnic groups are accessing community mental health services.

The reasons for this are unclear. Therefore, further investigation to better understand how the prevalence of severe mental illness varies in Westminster by ethnic groups and accordingly why patterns of access vary by ethnic group.

Figure 9: Proportion of expected persons with psychotic disorder accessing care by ethnicity



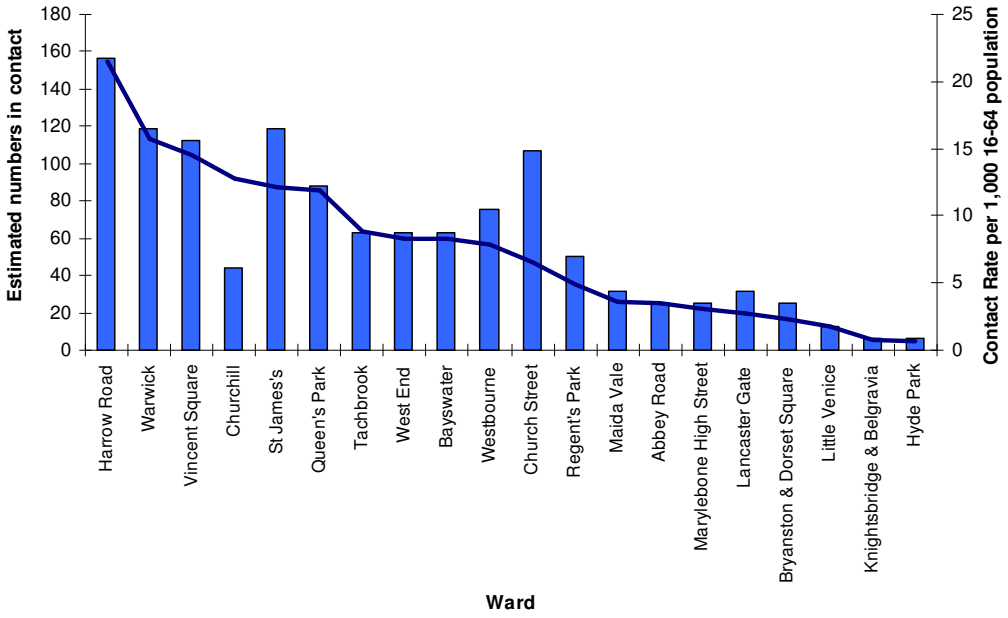
Source: Mental Health Observatory, National Psychiatric Morbidity Study and CNWL

(iii) Ward of Residence

There is wide variation across Westminster in terms of individuals accessing community mental health services (both in terms of absolute numbers and

comparative rates). Harrow Road has the highest absolute numbers accessing community mental health services (157) and rates (22 per 1,000 population). The lowest is in Hyde Park (6 people, 0.6 per 1,000 Population). Whilst this analysis is useful in looking at how access to services varies geographically in Westminster, it should be noted that not every person has a Westminster postcode and, therefore, will not be captured in this analysis.

Figure 10: Accessing to community mental health services by ward of residence



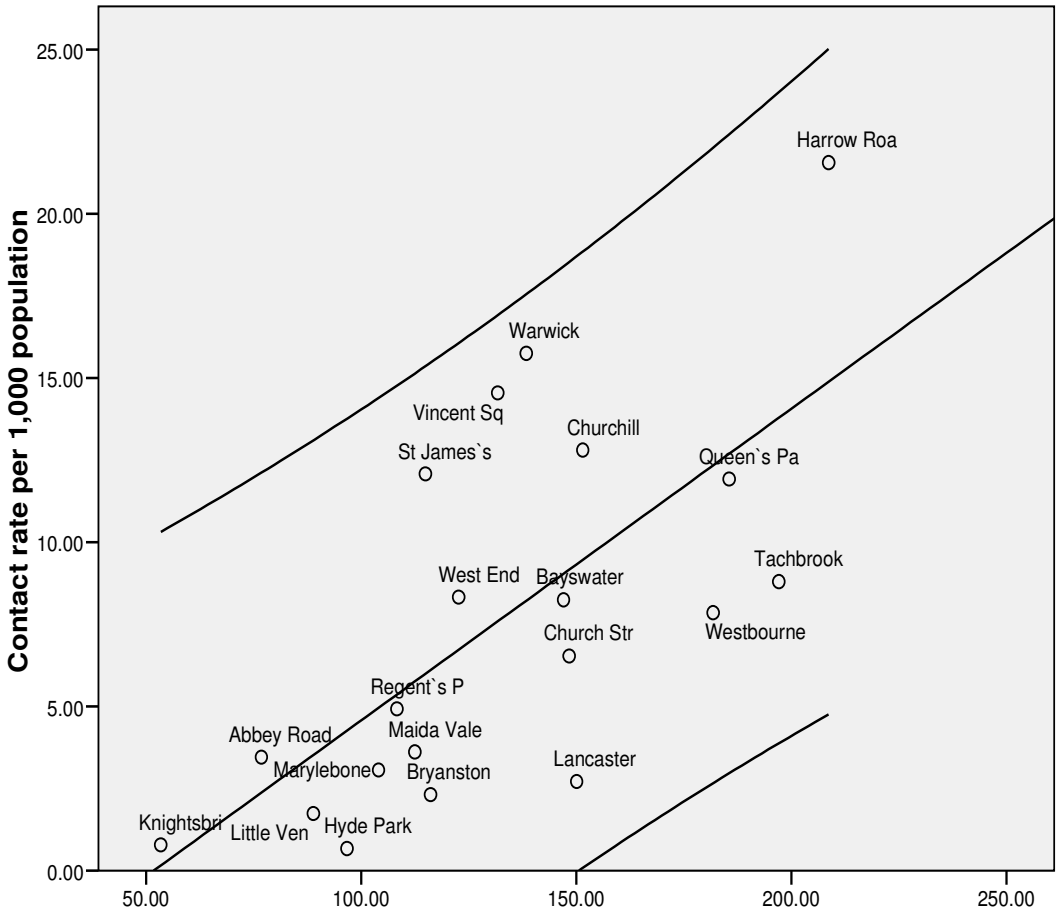
Source: Mental Health Observatory, National Psychiatric Morbidity Study and CNWL

As previously discussed, geographical variation is expected due to the different levels of need for services as a result of the demographical differences across the borough. Figure 13 shows the number of persons in contact with community services mapped to the LIN score (an index to estimate need) for that ward. Correlation between the LIN score and wards is shown, confirming that generally in Westminster access to community mental health services correlates with need (geographically).

The LIN score is estimated to explain 46% of the variation in contact rates between Westminster wards, suggesting that other factors (such as specific historic patterns, homelessness and substance misuse) account for most of the variation between wards.

The line through the middle of figure 13 is the line of best fit, this is the point where all the wards would be if they were perfectly correlated. The two lines either side denote that there are no significant outliers from the middle, which otherwise could suggest high levels of unmet or over met need.

Figure 11: Correlation between ward LIN score and rate of contact with community mental health services



The highest LIN score is for Harrow Road ward, which also has the highest rate of contact with community mental health services. Knightsbridge and

Belgravia has the lowest LIN score and the second lowest rate of contact with services.

Some wards have higher contact rates than others with similarly expected need (as denoted by the LIN score). For example, Church Street and Lancaster Gate have similar LIN scores denoting similar levels of need for mental health services, however, Church Street has a much higher contact rate.

Further investigation may be necessary to better understand why there is a difference in access to mental health services where there appears to be a similar level of need. For example, is the variation in the south of the borough a result of the large number of homeless persons accessing care or the location of the Gordon Hospital, or is it attributable to a greater level of access to private care for those in the most affluent areas?

5.3 Inpatient care

5.3.1 Ascertaining the number of people with psychosis accessing inpatient care

During 2007/2008 there were 423 inpatient admissions for psychotic disorders (where coding indicated psychosis), attributed to 338 people. This is equivalent to 13% of all of the people expected to have psychotic disorder and 14% of the number of people recorded on GP registers as having a psychotic disorder.

Schizophrenia accounted for the majority of admissions (61% of all admissions) followed by bipolar affective disorder (20% of all admissions).

Mental health inpatient admissions are often associated with relatively long hospital stays; the median length of stay was 35 bed nights where the reason for admission was schizophrenia, 40 bed nights where the reason for admission was schizoaffective disorder and 32 bed nights where the reason for admission was bipolar affective disorder. The maximum number of bed nights recorded was 366; this indicates that one person spent more than a

year as an inpatient, reflecting the complexity of mental health inpatient admissions. The shortest stays recorded were one or two bed nights, suggesting that there are some short term interventions being delivered in inpatient settings.

Table 5: Inpatient admissions for psychotic disorders, 2007/08

ICD- 10 Code	ICD10 Description	Number of people admitted	Median bed nights
F20	Schizophrenia	212	35
F22	Delusional disorder	13	38
F23	Acute & transient psychotic disorders	21	17
F25	Schizoaffective disorders	20	40
F29	Unspecified non-organic psychosis	<5	13
F30	Manic episodes	9	19
F31	Bipolar affective disorder	61	32

Source: CNWL

There were 1.6 episodes for every admission suggesting that there are some inter-ward transfers. In some cases this reflects the fact that there has been an emergency admission followed by an admission to a more suitable permanent bed, however, in some cases there are several inter-ward transfers. The nature of such inter-ward transfers is poorly understood and accordingly further investigation is needed to ascertain the reason for these moves and the potential impact on quality of care.

Some of the features of the inpatient admissions are discussed in more depth below.

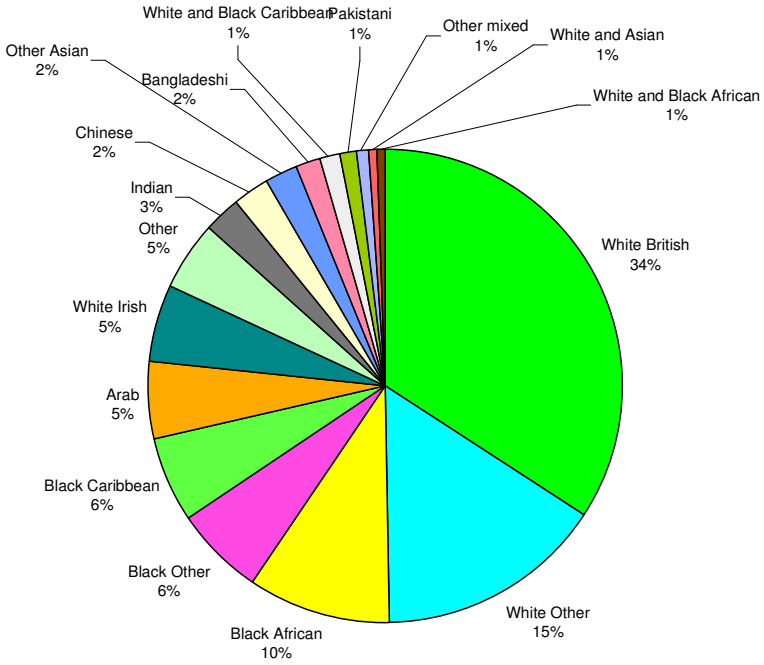
5.3.2 What are the features of people accessing care?

(i) Ethnicity of Inpatient Admissions

White British ethnic groups accounted for the majority of inpatient admissions (34%), followed by White Other (15%) Black African ethnic groups accounted for a further 10% of admissions.

Also of note is that 5% of as admissions were for persons from Arab ethnic groups. As this group are not included in the census or population estimates, little information is available regarding the size of this population in Westminster.

Figure 12: Inpatient admissions by ethnic group



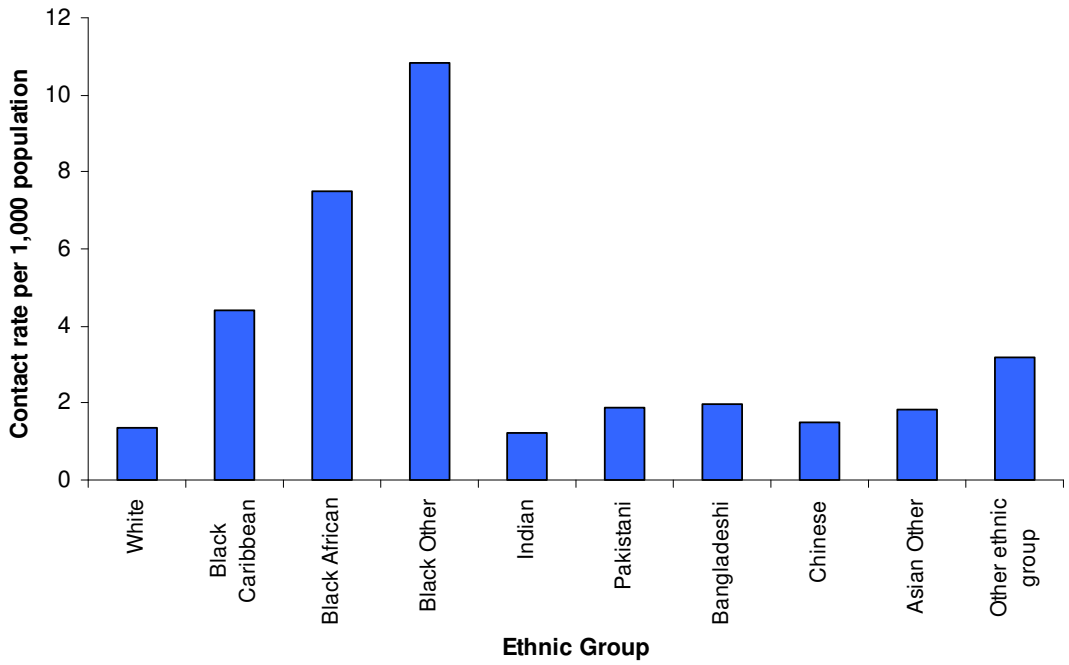
Source: CNWL

Figure 15 shows the rate of inpatient contacts per 1,000 population by ethnic group population - this is the number of people who have had one or more inpatient contacts per 1,000 population). There is variation in the rates by

ethnic groups. The highest contact rates are for the Black Other group (10.81 per 1,000 population), followed by Black African (7.50) and Black Caribbean (4.40). The lowest contact rate is for Indian groups (1.23) followed by White ethnic groups (1.35).

Overall, these findings are broadly similar pattern to those found in the national Count Me In census of mental health inpatients (Healthcare Commission, 2008). This report makes a number of recommendations to increase race equality by improving services specifically for BME groups and to better understand the mental health needs of BME populations.

Figure 13: Inpatient contact rates per 1,000 population by ethnic group



Source: CNWL

(ii) Homelessness

Homeless persons are disproportionately represented amongst inpatients for psychosis. 49 (14%) of the 338 people admitted to hospital for psychosis were registered as having no fixed abode or their documented address was a temporary Westminster hostel.

5.3.3 National Measurement of Admission Rates

One of the national outcome measures for mental health is the use of a comparison of indirectly age sex standardised rates of emergency admissions for schizophrenia. This measure shows that Westminster has a higher rate of admissions for schizophrenia than England as a whole. In 2006/07 the rate in Westminster was 71 per 100,000 population compared to 31 per 1,000 in England.

6 Neuroses

6.1 Expected numbers, distribution and pattern by person, place and time

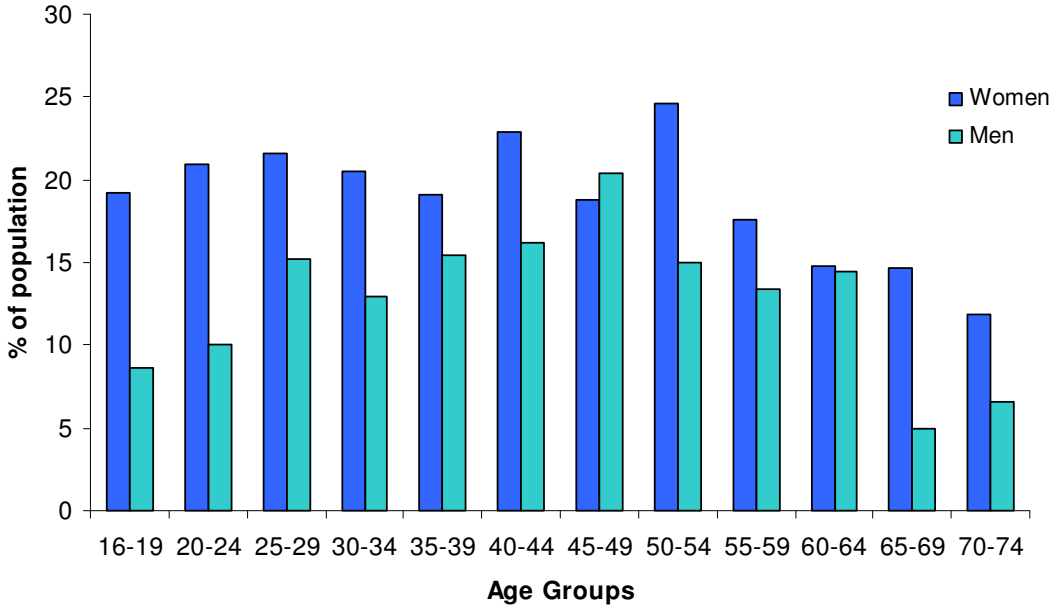
6.1.1 How many are expected to experience neuroses in Westminster?

National Psychiatric Morbidity Survey

The NPMS found that 16.4% of the adult population had displayed neurotic symptoms the week before the survey. Mixed anxiety and depressive disorders were the most common with 8.8% of respondents experiencing mixed anxiety of depression.

More women (59% of total) than men are expected to experience neuroses; it is estimated that women account for 59% of all persons with neuroses in Westminster.

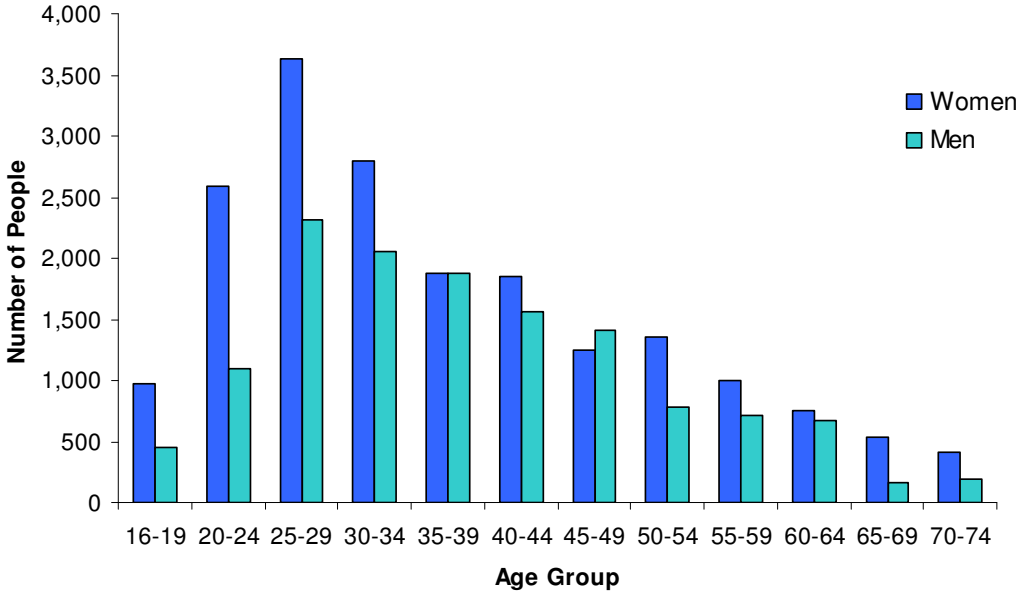
Figure 14: Prevalence of neuroses by age and sex, Westminster, 2008



Source: National Psychiatric Morbidity Survey

In terms of age, the prevalence of neuroses is similar across all age groups up until the age of 50-54, in which the prevalence of neuroses peaks. After this age the prevalence of neuroses in women decreases. In men the prevalence of neuroses increases from the 16-19 age group, peaking at the 45-49 age group and then steadily declining.

Figure 15: Estimated number of people with neuroses by age and sex, Westminster, 2008



Source: National Psychiatric Morbidity Survey

Overall 32,275 people are estimated to have a neurotic disorder in Westminster.

National Psychiatric Morbidity Survey Index

The NPMS has produced an index to adjust nationally produced estimates to account for local demographic differences. The NPMS index for Westminster as a whole is 1.38; this suggests that the mental health need for neuroses is 38% higher than in England as a whole.

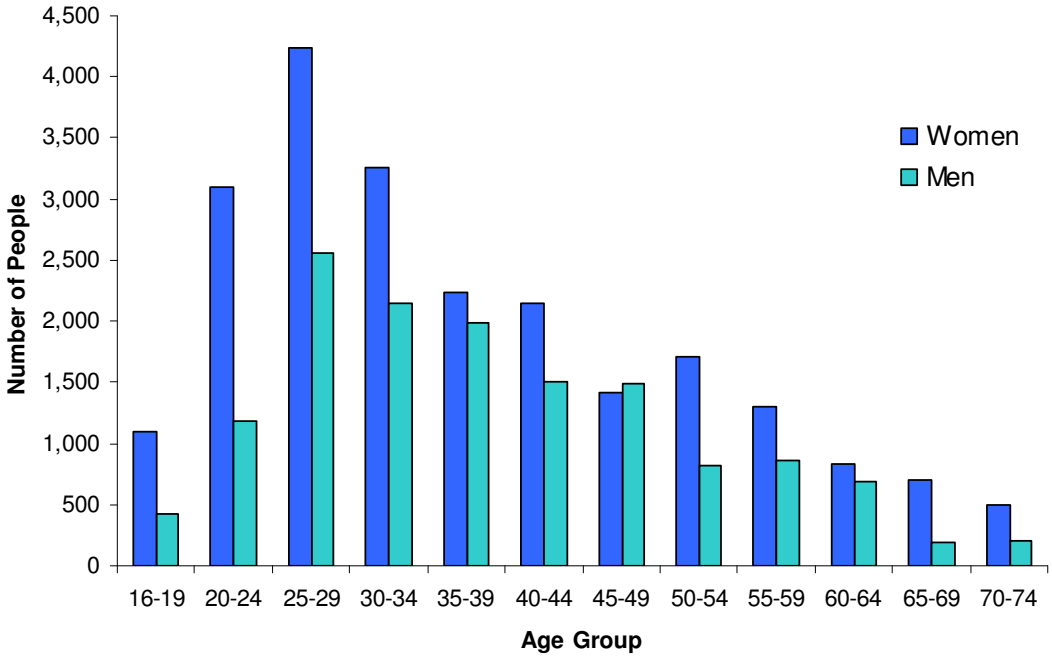
Table 6: NPMS Index for neurotic disorders

Local Authority	NPMS Index
Westminster	1.38
Kensington and Chelsea	1.06
Hammersmith and Fulham	1.32
England	1

Source: Mental Health Observatory

Using the NPMS index, the North Eastern Public Health Observatory have provided local estimates of the number of people with common mental health problems. Using this index it is estimated that 36,582 people in Westminster have a neurotic disorder – this is higher than the NPMS estimate (which does not take into account local population characteristics).

Figure 16: Estimated number of people with neuroses by age and sex, Westminster, 2008 (adjusted NPMS Index)



Source: National Psychiatric Morbidity Survey and Mental Health Observatory

Whilst these figures provide a more accurate assessment of the number of people likely to experience neuroses in Westminster, these figures are likely to be an underestimate as the NPMS Index does not take into account a number of factors such as substance misuse and homelessness.

6.1.2 What are the features of the population affected?

(i) Age, sex and ethnicity

The variations in rates of common mental health disorders by age, sex and ethnicity are not so marked as they were for psychotic disorders. The EMPIRIC survey found modest differences; for example some differences between age and sex were found. Irish men, Indian and Pakistani women were found to be more likely to experience neuroses whilst Bangladeshi women were less likely.

The estimates show that as a result of Westminster's population distribution, the majority of people with a neurotic disorder are White; it is estimated that over 20,000 persons from White ethnic groups in Westminster experience neuroses. However, as with psychotic disorders the limited number of ethnic groups does not reflect the diversity in Westminster and, therefore, does not present the most accurate picture of ethnicity and neuroses in the borough.

Table 7: Prevalence of neuroses by ethnic group

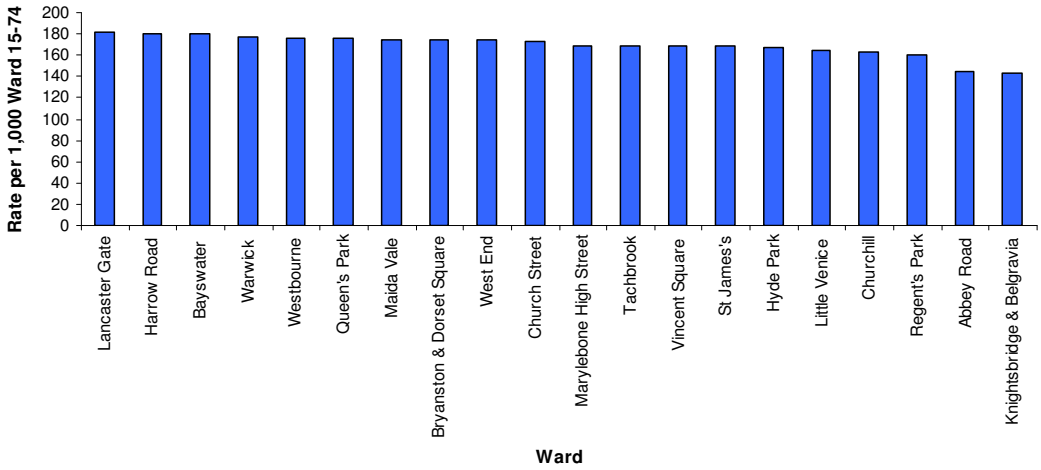
	White	Irish	Black Caribbean	Bangladeshi	Indian	Pakistani
Men (%)	11.6	18.4	13.8	12.9	12.1	12.6
Women (%)	19.0	18.6	19.8	12.3	23.8	26
Expected number with neuroses	20,437 (inc. White Other and Irish)		763	422	1,275	334

Source: Ethnic Minority Psychiatric Rates in the Community Survey

(ii) Place

There is little variation in the prevalence of neuroses between Westminster wards. Rates are lowest in Abbey Road and Knightsbridge and Belgravia wards, whilst Lancaster Gate is expected to have the highest rates of neuroses (181 per 1,000 15-74 year olds). The lowest rate is in Knightsbridge and Belgravia at 143 per 1,000 15-74 year olds.

Figure 17: Prevalence of neuroses by ward

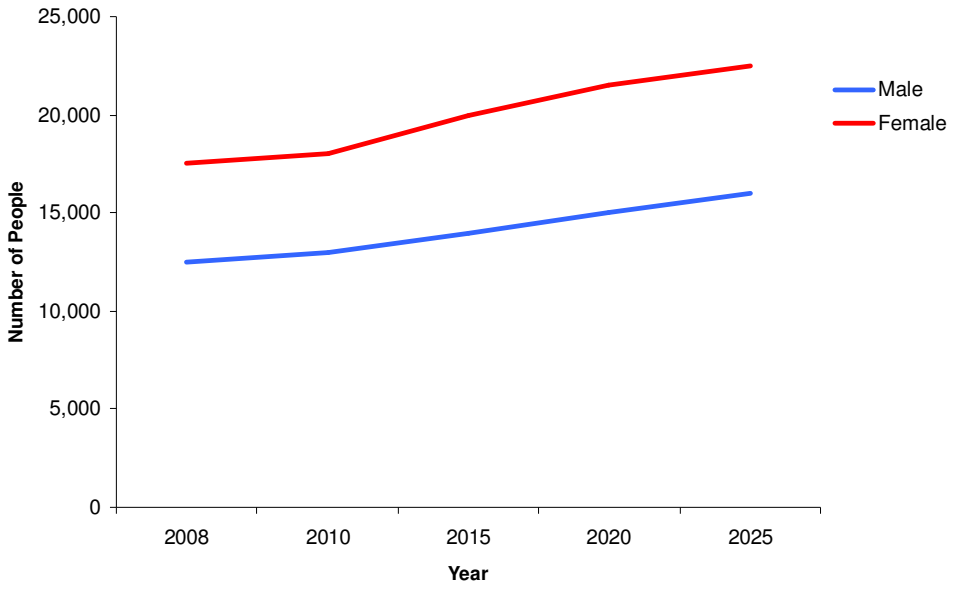


Source: National Psychiatric Morbidity Survey and Mental Health Observatory

6.13 Time trends

As a result of population projections alone, the number of people experiencing neuroses is expected to increase. By 2015 the number of people experiencing neuroses is expected to increase by 13% and by 2025 this increases to 24%. Services will need to consider this potential increase in demand for services, although a population increase of this size may be questionable.

Figure 18: Projected number of people with neuroses in Westminster adults aged 15-64, 2008-2025 (NPMS weighted)



Source: National Psychiatric Morbidity Survey, Mental Health Observatory and Office of National Statistics Population Projections

6.2 Existing Services

Services for neuroses can be provided at primary, secondary and tertiary care levels. An estimated 50% of people with neuroses access mental health services, usually services in primary care. Around 20-25% of these people are then referred on to specialist mental health services (a total of 4% of all those with a neurotic disorder) (NICE, 2004).

A large proportion of people experiencing neuroses recover without intervention, with approximately 50% having no recurrent episodes.

6.2.1 Primary Care

The majority of people with neuroses are managed in primary care, however, currently little data is available describing access to primary care for neuroses. Accordingly, to appropriately assess whether mental health services in primary care are meeting the needs of the Westminster population, further data is required.

New Horizons highlights the requirement to meet the mental health needs of persons aged 65 and over. Evidence suggests that although as many as 40% of older people in the community display signs of depression, only 4%-8% actually consult their GP as a result of depression – this is particularly true for older men.

NICE (2004) has recommended a stepped care model within primary care which takes into account individual characteristics of depression and personal and social circumstances when responding to treatment needs. This model of care for depression is shown in Table 8 – this model is similar to the model of care recommended for treatment of anxiety disorders.

Currently there are a number of issues which may prevent the full implementation of the stepped care model. These barriers include the lack of attendance of people with depression to primary care, the recognition of depression by primary care and the capacity within primary care to deliver psychological interventions.

There is a national programme to increase access to psychological therapies – IAPT – this is currently being rolled out in Westminster. Accordingly, IAPT should be monitored and reviewed with reference to the needs identified in this needs assessment.

Table 8: Stepped care model for depression

Who is responsible for care?	What is the focus?	What do they do?
Step 1: GP, practice nurse	Recognition	Assessment
Step 2: Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self help, computerised Cognitive Behavioural Therapy, exercise, brief psychological interventions
Step 3: Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 4: Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk.	Medication, complex, psychological, interventions, combined treatments
Step 5: Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, Electroconvulsive Therapy.

Source: NICE Guidance for Depression, 2004

6.2.2 Secondary Care

Community Care

Community mental health services are provided through the same (with the exception of the early intervention service) services as those who have

psychoses. The audit of notes in 2007 found that an estimated 696 people with neuroses were accessing community care across Westminster. This is equivalent to 2.1% of the 33,474 people (aged 20-64 the age provision of CMHT) expected to have a neurotic disorder in Westminster; this is lower than observed nationally (5%).

The low proportion of persons with neuroses is as expected as most persons would be expected to be managed in primary care; however it could suggest some unmet need.

Characteristics of people accessing community care

In the absence of primary care data, it is useful to look at the characteristics of persons accessing community mental health teams as a result of neuroses to determine if particular population subgroups are more likely to be managed by community mental health teams. However, it should be noted that from such data it is not possible to understand the reasons for this; for example, is management by community mental health teams appropriate, or is it a result of an unmet need in primary care.

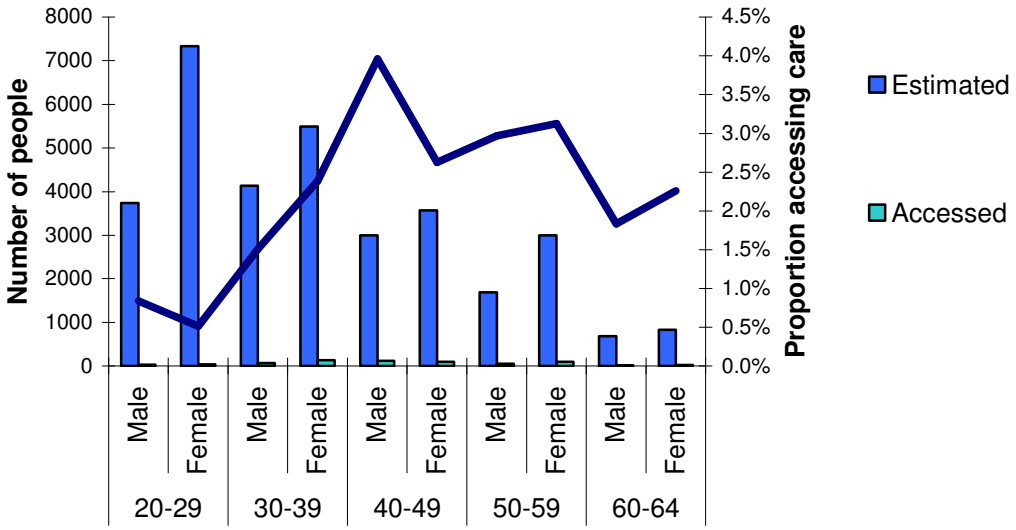
(i) Age and Sex

Men and women aged 40-59 years old are most likely to accessing community mental health services as a result of neuroses, with males and females aged 20-29 least likely.

(ii) Ethnicity

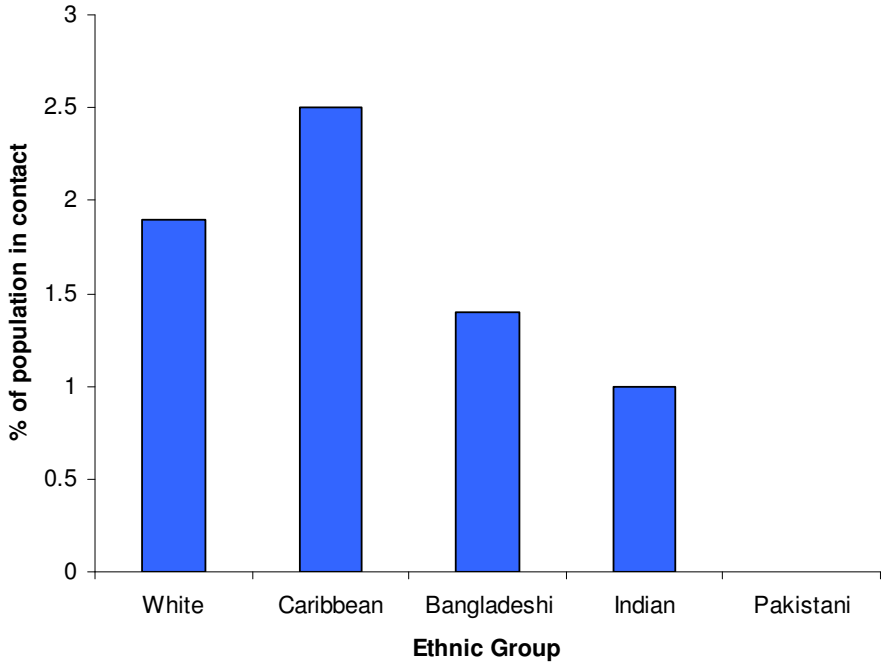
Persons from Black Other and Asian Other ethnic groups were most likely to access community mental health services as a result of neuroses, whilst persons from Pakistani and Chinese ethnic groups were least likely.

Figure 19: Proportion of expected persons with neuroses accessing community care by age and sex



Source: National Psychiatric Morbidity Survey, Mental Health Observatory and CNWL

Figure 20: Proportion of population in contact with community mental health services by ethnic group

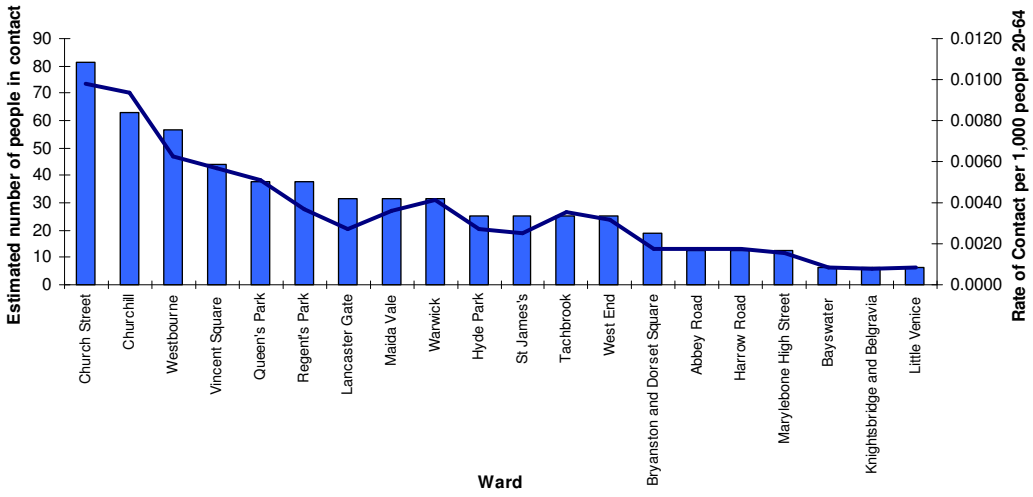


Source: National Psychiatric Morbidity Survey, Mental Health Observatory and CNWL

(iii) Ward of Residence

There is wide variation across Westminster in terms of individuals accessing community mental health services as a result of neuroses (both in terms of absolute numbers and comparative rates Church Street has the highest absolute numbers accessing community mental health services (81) and rates (0.0098 per 1,000 population). The lowest is in Little Venice (6 people, 0.0009 per 1,000 population).

Figure 21: Accessing community mental health services by ward of residence



Source: National Psychiatric Morbidity Survey, Mental Health Observatory and CNWL

6.2.3 Inpatient Care

During 2007/08 there were 69 inpatient admissions for neurotic disorders (where coding indicated neurosis), attributed to 57 people. This is a small proportion to the total number of persons expected to experience neuroses, suggesting that persons with neuroses rarely require inpatient care. The majority of admission were for depressive episodes, accounting for 64% of all admissions.

As is the case for psychosis, the majority of admissions require relatively long bed stays; the median length of admission is approximately 25 bed nights.

Table 9: Inpatient admissions for neurotic disorders, 2007/08

ICD 10 Code	ICD 10 Description	Number of People admitted	Median Bed Nights
F32	Depressive episode	37	12(1,351)
F33	Recurrent depressive disorder	16	19(1,124)
F41	Other anxiety disorder	2	71 (8,134)
F42	Obsessive compulsive disorder	2	31 (1,161)

Source: CNWL

6.3 National Measurement of Admission Rates

One of the national outcome measures for mental health is the use of a comparison of indirectly age sex standardised rates of emergency admissions for neuroses. This measure shows that Westminster has a lower rate of admissions for neuroses than England as a whole. In 2006/07 the rate in Westminster was 7.1 per 100,000 population compared to 18.07 per 100,000 in England.

7 Information gaps

Currently little is known about the numbers of people accessing care for neurotic disorders. This needs assessment has analysed data from community mental health teams, however, persons with neurotic disorders would not usually be expected to be managed in primary care and so such data does not provide a true reflections of activity.

Accordingly, with the roll out of the IAPT programme, it is essential that activity data is collected and analysed with reference to the expected numbers of people with neuroses in Westminster (by time, person and place).

This needs assessment highlighted the issue of mental health and homelessness in Westminster, however, assessing met and unmet need specifically was beyond the scope of this needs assessment. Accordingly, a further, more detailed piece of work on homelessness and mental health is required – this most likely will form part of the overarching homelessness needs assessment.

There is a growing body of evidence describing the links between substance misuse and mental health problems (dual diagnosis). However, this needs assessment did not specifically address this area. There is a need to better understand patterns of substance misuse and mental health problems in Westminster and examine how current services are meeting this area of need.

This needs assessment highlighted the disproportionately high number of inpatient admissions amongst person from BME groups. The reasons for this are unclear and require further investigation. Local analysis of the Count Me In dataset should be undertaken and reported on.

The association between disability and sexual orientation and mental health was described using national data and published literature, however, little is

known about the local picture of need. Accordingly, further work is needed to better understand met and unmet needs in Westminster.

Whilst the association between poor physical health and mental health was highlighted, it was beyond the scope of this needs assessment to consider this association in detail with regards to the Westminster population. However, there is a clear need for a better understanding of the association between poor physical and mental health in Westminster.

8 Conclusions

The prevalence of neurotic and psychotic disorders is higher in Westminster than in England as a whole and also higher than in our neighbouring boroughs. Accordingly, Westminster has a higher than average need for mental health services.

The reasons for this high level of need are most likely associated with diverse demographics of the Westminster population and also the pockets of high deprivation in the borough.

Little data is available pertaining to how well services in primary care are meeting the needs of persons with neurotic disorders and accordingly further information is needed.

In terms of psychotic disorders, the number of people expected to have some form of psychosis is similar to the number recorded on GP registers suggesting that under-diagnosis is unlikely to be an issue, however, there is variation between GP practices which warrants further investigation. In terms of accessing services, an estimated 71% of people with psychosis are being managed in a community setting, however, there are wide variations (in terms of age, gender, ethnicity and place of residence) amongst those accessing care. Accordingly, this unmet need for some population subgroups requires further attention.

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