# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement

Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

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| **Service Specification No.** |  |
| **Service** | Primary care Mental Health Facilitators ( part of Open Mind IAPT Service) |
| **Commissioner Lead** | Leicester City Clinical Commissioning Group |
| **Provider Lead** |  |
| **Period** | 1st April 2016- 31st March 2021 (with potential 2 year extension) |
| **Date of Review** | Yearly- April 2017 |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**

**National context**Improving mental health outcomes is a Government priority. In 2011 it published its mental health strategy, *No health without mental health which* set out our long-term ambitions for the transformation of mental health care. The strategy was built around six unambiguous objectives: • More people will have good mental health • More people with mental health problems will recover • More people with mental health problems will have good physical health • More people will have a positive experience of care and support • Fewer people will suffer avoidable harm • Fewer people will experience stigma and discrimination In line with recently released NHS England ‘Five year Forward View’ we need to dissolve traditional boundaries between primary care, community services and hospitals. This initiative supports parity of esteem by increasing the capacity and capability of primary care services to manage mental health conditions.**National data about physical health needs:**People with schizophrenia and bipolar disorder die an average 25 years earlier than the general population, largely due to physical health problems, (Parks et al, 2006[[1]](#footnote-1)). Standardised Mortality Rates for those with Serious Mental Illness are 150 all cause, respiratory disease 250, cardiovascular disease 250 and infectious disease 500. (McEvoy et al, 2005[[2]](#footnote-2)). Compared with the general population, among people with schizophrenia there is an increased prevalence of obesity (1.5–2 times), diabetes (2 times), dyslipidaemia (5 times), and smoking (2–3 times) (Newcomer, 2007[[3]](#footnote-3)).**Local context** Locally Leicester has high levels of risk factors for mental health, these can be found in the needs assessment at <http://www.leicester.gov.uk/media/178811/mental-health-jspna.pdf>. Key findings include:

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| Population | In 2010 Leicester had an estimated population of 306,600 people, with more younger and fewer older people compare with England. Projections suggest that the population will increase to 346,000 people by 2020. |
| Deprivation | Leicester has high levels of deprivation and is ranked 25th worse out of 326 local authority areas in England on the national Index of Deprivation 2010. Deprivation is wide cast; 41% of the Leicester population lives in the most deprived areas of England. There is wide variation of deprivation among different areas of the city. |
| Diversity | Leicester has a diverse population compared with England. 36% of Leicester residents are from black and minority ethnic (BME) backgrounds, compared with 13% for England as a whole. The age profile of people from BME ethnic backgrounds is younger than that of people from White/White British ethnic backgrounds. |
| Wider determinants of health | Leicester is significantly worse than the England values in: rate of working age adults who are unemployed per 1,000 percentage of 16-18 year olds not in education, employment or training, rate of episodes of violent crime per 1,000   |
| Risk factors for mental illness | Leicester is significantly worse than the England values in : percentage of population with a limiting long term illness first time entrants into the youth justice system of 10 - 17 year olds percentage of adults participating in recommended levels of physical activity   |
| Mental health in Leicester | * 3-5% of newly delivered mothers experience moderate to severe depressive illness equating to 150-250 women in Leicester each year
* 16-18% of working age adults experiences a common mental health problem at any time, equivalent to 34,358 to 38,652 people. The number registered with their GP as having depression is 30,831 suggesting that not all people with depression have health care support
* The number of new cases of adult depression in Leicester is estimated to be 11,000 per year
* It is estimated that there are 3,400 people in Leicester with a serious and enduring mental health condition such as schizophrenia, bipolar affective disorder and other psychoses
* An estimated 3,000 people aged over 65 years have depression and a further 1,500 have severe depression
* In Leicester each year approximately 32 people will take their own life
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**The needs of people with severe mental illness** People with severe and enduring mental illness have physical, psychological and social needs. To deliver high quality care it is essential that all are addressed. The table below shows the expected numbers of patients on the average GPs lists.

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| Diagnosis | Weekly prevalence per 1000 adults aged 16-64 years | No of patients on GP list of 1650 (assuming 63% of GP list is aged 16-64 years) | No of patients on GP list of 2000 |
| Psychotic illness  | 4 | 4 | 5 |
| Mixed anxiety and depression  | 92 | 96 | 116 |
| Generalised anxiety  | 47 | 49 | 59 |
| Depressive episode  | 28 | 29 | 24 |
| All phobias | 19 | 20 | 24 |
| Obsessive Compulsive disorder  | 12 | 12 | 15 |
| Panic disorder | 7 | 8 | 9 |
| All Neuroses  | 173 | 180 | 218 |
| Drug dependence | 42 | 44 | 53 |
| Alcohol dependence  | 81 | 84 | 102 |

The Sainsbury Centre for Mental Health (2004) A GP with a list of 1650 can expect:* One new presentation of schizophrenia every 5 years
* An average of 5-6 patients with a severe mental illness at any one time

Local factors that are likely to increase the number of patients with a severe mental illness who are registered with a GP Practice are:* The practice is in an urban or inner city location
* The practice looks after homeless people or asylum seekers
* There are group homes or hostels located near the practice

1 in 100 people (16-64 years) will suffer from schizophrenia in their lifetime. The peak age of onset of schizophrenia is 16-24 years and is earlier in males. The peak age onset for bipolar disorder is 32 years. The physical health of people with schizophrenia and bipolar disorder is significantly poorer than in a comparative population without these conditions. The ONS Survey, Psychiatric morbidity among adults living in practice households (ONS 2000) found that 62% of those with psychosis reported a physical condition, compared to 42% of those without psychosis. **Local data suggests:** Mental Health disorder (schizophrenia, bipolar affective disorder and other psychosis): 3,378 people - 0.9% (0.8% in England)**CCG Health Need Neigbourhoods**We are building a **new environment** for the provision of primary care in Leicester City. This is through the development of Health Need Neighbourhoods (HNNs), which will be four geographical areas of Leicester City, based on:* ward boundaries
* disease prevalence
* deprivation
* health need
* access
* patient experience
* population profile

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|  | **Group** | **HNN 1: North and West** | **HNN 2: South** | **HNN 3: Central** | **HNN 4: North and East** |
| **Population characteristics** | Registered Population | 105,020 | 84,784 | 121,968 | 65,017 |
| Ave Registered Population per practice June 14 | 6,564 | 6,056 | 6,419 | 5,001 |
| 75+ Registered Population | 5,954 | 3,130 | 5,790 | 5,032 |
| % 75+ Registered Population | 5.6% | 4.5% | 4.5% | 7.5% |
| **Practices’ infrastructure** | Total GPs | 52.4 | 44.3 | 74.5 | 37.0 |
| Ave List Size per GP | 2,052 | 1,888 | 1,816 | 1,961 |
| Number of Practices (including Branches) | 19 | 14 | 24 | 16 |

The HNNs form logical footprints on which to organise the delivery of services, with their main health challenges being: * **HNN 1: North and West** (total practice population 105,020)
	+ high infant mortality rates
	+ high smoking prevalence and COPD
* **HNN 2: South** (total practice population 84,784)
	+ high cancer rates
	+ high levels of adult obesity
	+ high number of patients registered with asthma
* **HNN 3: Central** (total practice population 125,203)
	+ high cardiovascular disease prevalence
	+ high diabetes prevalence
	+ high perinatal mortality rates, the lowest birth weights
	+ high number of patients with limiting long term problem or disabilities
* **HNN 4: North and East** (total practice population 61,782)
	+ high cancer rates
	+ high cardiovascular disease prevalence
	+ highest registered population with dementia

In relation to estimated prevalence of Severe and enduring illness:S:\Strategy & Planning\IAPT\IAPT reprocurement 2016\New Service specfication development\Health Needs Neigbourhoods\Prev of SEMI_HNN.jpg |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**The NHS Outcomes Framework 2014/15 also includes quality of life and outcome measures for mental health services, and there are similar proposals for outcome in social care

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| **Domain 1** | **Preventing people from dying prematurely** | **X** |
| **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **X** |
| **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **X** |
| **Domain 4** | **Ensuring people have a positive experience of care** | **X** |
| **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** |  |

**2.2 Local defined outcomes**Measuring outcomes, progress, recovery and relapse is vital to ensure that people's treatment is reviewed, and where appropriate stopped, in line with the stepped-care model, if there are signs of deterioration or no indications of improvement (See NICE clinical guideline 123)The Key Service Outcomes for the Mental Health Facilitators service are as follows:* Facilitated discharge of patients who are stable SEMI from secondary care
* Improved access to treatment for people with medically unexplained symptoms
* Patients will have personalised care plans and patient set goals
* Reduction in under-75 mortality in people with serious and enduring mental illness (outcome 1.5 of the NHS Outcomes framework)
* Improved assessment and management of the physical health of people with severe mental illness (objective 3 of the No Health without Mental Health strategy)
* Patient –reported recovery – use of Recovery Star and Warwick – Edinburgh mental well-being scale
* Improved service user choice and experience of services
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| 3. Scope |
| **3.1 Aims and objectives of service**The Primary care Mental Health Facilitator (MHF) is an experienced mental health practitioner providing a key role in the management and maintenance of monitoring for patients with serious Mental Illness (SMI), in Primary Mental Health Care. They are expected to focus primarily on stable patients within Mental Health Care clusters 4, 7, 8 and 11 (see Appendix 1).Their role involves ensuring that patients with severe and enduring mental health problems receive regular physical and mental state monitoring, health promotion and support to access appropriate treatments. The role involves directly supporting GP’s and primary care professionals in all care management relating to severe and enduring mental health. It includes support in clinical education, supervision and developing capacity for early interventions, watchful waiting and first level interventions for this client population at the primary care level. They will act as a gateway to secondary care as well as advise and assist regarding clinical care pathways, including information regarding the IAPT pathways.They enhance primary care capacity and capability be being able to provided early identification, support and referral back into CMHT’s as required.**3.2 Service description/care pathway****Service description**To work in partnership with GP Practices to: 1. Assists in managing the Severe and Enduring Mental Illness register; ensuring that there is an annual MH review, coordinating physical health checks and arrangements with secondary care where indicated
2. Cross referencing physical health registers (diabetes, CHD, COPD, epilepsy etc.) with mental health problems
3. Follow up patients who decline health checks
4. Assist with outcomes of health checks such as weight management programmes
5. Appointment making for those who require help with benefits or housing etc. if the person is unable to do this for themselves, acting as an agent for the patient if appropriate.
6. Work closely with Community mental health teams and GP Practices to ensure safe and appropriate step-up/step-down arrangements
7. Communication with GP’s when indicated throughout treatment.
8. Close liaison with the community and in- patient mental health services and health services for the “wellbeing programme” for physical health.
9. Offer advice and assistance when GP’s are making urgent referrals to psychiatric services during service hours
10. Close liaison with community and in- patient mental health services.
11. Use of the Care Programme Approach with those in secondary care services to whom this applies.
12. Lithium monitoring if required.
13. Brief/ supportive psychological interventions and supportive monitoring
14. Liaison with voluntary providers, education and employment resources where indicated.
15. Outreach monitoring of stable patients with psychosis (care cluster 11) who might otherwise not wish to engage with the surgery
16. Offering advice and information to GPs on the management of chaotic patients and frequent attenders (care cluster 8).

**Care pathway- Mental Health Register & Reviews**The MHF will, in discussion with the practice, manage the Mental Health Register as per Quality Outcome Framework (QOF)MH8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses;* The register includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses to avoid a generic phrase that is open to variations in interpretation.
* MHF’s should review all registers, notes and identify those individuals who do not need calling in and discuss with the practice.
* The accuracy of those on the register should be reviewed on an annual basis.

MH11. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months * MHF to review on a yearly basis ( and complete other indicators yearly)

MH13 The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months* MHF’s to take bloods as per PHC guidelines following discussion with practice
* If on lithium or clozaril check with clinics to avoid unnecessary repetition
* Please note; Lithium Register does not do glucose as routine!

MH16. The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 yearsMH17. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 monthsMH18. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months* Where possible discuss individuals on Lithium being on the Lithium Register

MH10. The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate * MHF to complete care plan and review form if individual in secondary care.

**3.3 Any acceptance and exclusion criteria** **Referral sources**Patients will have access to this part of the service through their GP/ practice nurse and other member of the primary healthcare teamReferrals will also be accepted for this part of the service from Secondary Care clinicians in line with a jointly agreed referral protocol. **Exclusion criteria**The service will not work with patients:1. Needing a crisis service
2. Who are currently open to Community Mental Health Teams or secondary care outpatient services.
3. not on the Mental Health Register but whose presentation appears complex ( they should be referred to appropriate local services best placed to meet their needs)
4. suitable for IAPT services ( Step 2 and 3 of MH stepped care model)
5. those primary difficulty is substance misuse (please refer to local Drug and Alcohol services
6. requiring pharmacological advice and initiation of an anti- psychotic is needed (refer to your local Psychiatry services)

**3.4 Population covered**Those people suitable for the Open Mind IAPT service will Include the following:* Residents in the City who are registered with a City GP
* Residents in the City who are not registered with a GP **this does not cover City Residents who are registered with a County GP**

**3.5 Interdependencies with other services**In addition, collaboration with secondary care professionals in specialist mental health and general health services (particularly health professionals involved in treating long term musculoskeletal, respiratory, dermatology, diabetes, heart disease, chronic pain services, neurology and cancer) is vital to ensure that psychological treatment needs are met across the pathway in an integrated, timely and responsive mannerPromotion of recovery and positive mental health provides an opportunity for collaboration and partnership with other community services and interventions as part of local service delivery (e.g. employment, social care, housing, environmental services, education, criminal justice agencies, substance misuse services, physical activity and leisure services, black and minority ethnic focused services etc.). This will help to build community resilience and opportunities for primary prevention of mental ill health and promotion of recovery.**3.6 Key Performance Indicators**The service will be required to provide monthly reports: * No. of practices supported per Health Needs Neighbourhood
* Contacts per staff
* Type of contact
* No of DNA’s
* No of cancellations
* Type of interventions

**3.7 Service user evaluations**The service will be required to establish a patient feedback evaluation system, allowing feedback to be taken from on a monthly basis from at least 10% of the managed caseload. A standard patient questionnaire will be agreed by commissioners and the provider. |
| **5. Applicable quality requirements and CQUIN goals**  |
| * 1. **Applicable quality requirements (See Schedule 4 Parts A-D)**

**1 Applicable national standards e.g. NICE, Royal College**

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| **Full guideline title** | **Publication date (full book)** | **LINKS to NICE web page** | **NICE Number** |
| [Service User Experience in Adult Mental Health](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781908020451.aspx) | June 2012 | [NICE page](http://guidance.nice.org.uk/CG136/Guidance) | CG136 |
| [Self-Harm (Longer Term Management)](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781908020413.aspx) | May 2012 | [NICE page](http://guidance.nice.org.uk/CG/WaveR/82) | CG133 |
| [Psychosis with Coexisting Substance Misuse](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781908020307.aspx) | Nov 2011 | [NICE page](http://www.nice.org.uk/Guidance/CG/Wave15/8) | CG120 |
| [Schizophrenia (Update)](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781854334794.aspx) | April 2010 | [NICE page](http://guidance.nice.org.uk/CG82) | CG82 |
| [Antisocial Personality Disorder](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781854334787.aspx) | Jan 2010 | [NICE page](http://www.nice.org.uk/Guidance/CG77) | CG77 |
| [Borderline Personality Disorder](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781854334770.aspx) | Sep 2009 | [NICE page](http://www.nice.org.uk/Guidance/CG78) | CG78 |
| [Drug Misuse: Psychosocial Interventions](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781854334688.aspx) | March 2008 | [NICE page](http://guidance.nice.org.uk/CG51) | CG51 |
| [Bipolar Disorder](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781854334411.aspx) | July 2006 | [NICE page](http://guidance.nice.org.uk/CG38)  | CG38 |
| Self-Harm | Jul 2004 | [NICE page](http://www.nice.org.uk/guidance/cg16)  | CG16 |
| [Eating Disorders](http://www.rcpsych.ac.uk/usefulresources/publications/niceguidelines/9781854333988.aspx) | Jan 2004 | [NICE page](http://www.nice.org.uk/guidance/cg9)  | CG9 |

Relevant Physical Health guidelines:[www.nice.org.uk/CG67](http://www.nice.org.uk/CG67) (lipids)[www.nice.org.uk/CG66](http://www.nice.org.uk/CG66) (diabetes)[www.nice.org.uk/CG43](http://www.nice.org.uk/CG43) (obesity)Other sources of reliable evidence will also be used to ensure the quality of the service. The service will be required to:* Use standardised and validated assessment tools to reduce variation and duplication of assessments
* Use of the validated outcome measures
* Promote the accessibility of services e.g.
	+ Hours of operation
	+ Accessible, non-stigmatised community venues (including home)
	+ Use of appropriate technology
* Embed workforce competencies to deliver psychological therapies
	+ Appropriate training
	+ Regular supervision

On-going personal development training* 1. **Applicable CQUIN goals (See Schedule 4 Part E)**

 **TBC**  |
| 6. Location of Provider Premises |
| The Provider’s Premises are expected to be located within a base in Leicestershire: |

Appendix - **Summary of Mental Health Care Clusters**

**Care Cluster 1:  Common Mental Health Problems (Low Severity)** - This group has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms

**Care Cluster 2:  Common Mental Health Problems (Low Severity with Greater Need)** - This group definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms

**Care Cluster 3:  Non-Psychotic (Moderate Severity)** - This group has moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)

**Care Cluster 4:  Non-Psychotic (Severe)** - This group is characterised by severe depression and/or anxiety and/or other disorders, and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

**Care Cluster 5:  Non-Psychotic Disorders (Very Severe)** - This group will be severely depressed and/or anxious and/or other. They will not present with hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.

**Care Cluster 6:  Non-Psychotic Disorder of Over-Valued Ideas** - This group suffers from moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorders, Obsessive Compulsive Disorder etc, where extreme beliefs are strongly held, some personality disorders, and enduring depression.

**Care Cluster 7:  Enduring Non-Psychotic Disorders (High Disability)** - This group suffer from moderate to severe disorders that are very disabling.  They will have received treatment for a number of years and although they may have an improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways.

**Care Cluster 8:  Non-Psychotic Chaotic and Challenging Disorders** - This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over-dependant engagement, and are often hostile with services.

**Care Cluster 9:  Cluster Under Review** - Note: This [Mental Health Care Cluster](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_care_cluster_de.asp?shownav=1) is under review and should not be used.

**Care Cluster 10:  First Episode Psychosis** - This group will be presenting to the Mental Health service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety and/or other behaviours. Drinking or drug taking may be present but *will not* be the only problem.

**Care Cluster 11:  Ongoing Recurrent Psychosis (Low Symptoms)** - This group have a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning.  However, there may be impairment in self-esteem and efficacy and vulnerability to life.

**Care Cluster 12:  Ongoing or Recurrent Psychosis (High Disability)** - This group have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.

**Care Cluster 13:  Ongoing or Recurrent Psychosis (High Symptoms and Disability)** - This group will have a history of psychotic symptoms which are not controlled. They will present with moderate to severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.

**Care Cluster 14:  Psychotic Crisis** - This group will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

**Care Cluster 15:  Severe Psychotic Depression** - This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.

**Care Cluster 16:  Dual Diagnosis** - This group have enduring, moderate to severe psychotic of affective symptoms with unstable, chaotic lifestyles and *co-existing* substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.

**Care Cluster 17:  Psychosis and Affective Disorder (Difficult to Engage)** - This group have moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable, and engage poorly with services.

**Care Cluster 18:  Cognitive Impairment (Low Need)** - People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment, but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.

**Care Cluster 19:  Cognitive Impairment or Dementia Complicated (Moderate Need)** - People who have problems with their memory, and/or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.

**Care Cluster 20:  Cognitive Impairment or Dementia (High Need)** - People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms, or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.

**Care Cluster 21:  Cognitive Impairment or Dementia (High Physical or Engagement)** - People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.

1. Parks J, Svendsen D, Singer P. Fort ME (2006). Morbidity and mortality in people with serious mental illness. National Association of State Mental health Mental health Mental health Programme Directors, 13th technical report. [↑](#footnote-ref-1)
2. McEvoy JP, Meyer JM, Goff DC, et al (2005). Prevalence of metabolic syndrome in patients with schizophrenia: Baseline results from the CATIE trial and comparison with national estimates from NHANES III. Schizophrenia Research [↑](#footnote-ref-2)
3. Newcomer JW (2007) Antipsychotic medications: Metabolic and cardiovascular risk. The Journal of Clinical Psychiatry (supplement) [↑](#footnote-ref-3)