NHS
Herefordshire
Clinical Commissioning Group

Mental Health Needs Assessment

March 2015

Opening Messages

I am very pleased to see the results of many months of hard work come to fruition.

Over the last few years there has been increasing recognition of the impact of mental illness, while the concept of 'mental wellbeing' has become a way of describing a positive or ideal state of mental health. The movement towards parity of esteem has compared mental and physical health, and highlighted the differences in provision and resources allocated to each. Documents such as 'No Health without Mental Health' have described the societal and healthcare costs of mental ill health, and exposed the true economic costs of not tackling the issue. The overlap between physical and psychological symptoms is becoming better understood, and attention is focusing more on prevention of mental illness and addressing the societal determinants of mental ill health.

Mental health care within Herefordshire has changed significantly over the last few years, with a move away from a reliance on bed-based care, towards a model where patients are cared for closer to home, and an increased role for primary care in supporting patients with mental ill health. To ensure that these changes are appropriate for the county, and to plan for the future, we need to understand where and how mental ill health affects our population.

This document is a comprehensive attempt to define the prevalence of mental ill health within the population, trying to understand the size of the whole iceberg, rather than just the visible tip. We know that many patients with mental ill health do not seek help, and that milder symptoms can often go undetected or be hidden behind physical complaints. Using national prevalence data, we can estimate levels of illness, which will then inform decisions around where and what care is best provided.

Numbers, of course, can only give part of the story. This document attempts to address these concerns by looking at the experience of service users, carers and healthcare professionals, to add depth and understanding to the pictures that the numerical data give us. Understanding the current state of mental health within our population is the key to providing effective services in the future. I hope this document explains, provokes and challenges us all to make the changes we can to improve the mental health and wellbeing of the people of Herefordshire.

Dr Simon Lennane, GP Mental Health Lead
Herefordshire Clinical Commissioning Group

Mental ill health is a challenge for individuals, families and communities. Nearly a quarter of ill health in England is mental ill-health: a greater "burden of disease" than either cancer or heart disease. Unfortunately, it is a topic that people are often afraid to talk about and that stigma can often make things seem worse, preventing people from accessing the help they need.

Healthwatch Herefordshire is very pleased to be part of the CCG mental health needs assessment. We welcome the inclusion of patient, service user and carer voices in developing the evidence base and recommendations.

Mental health deserves the same attention and support as that given to physical health. We strongly support these first steps in a larger, system wide effort to ensure that people in Herefordshire have a sufficient, effective and accessible provision that promotes good mental health, prevents mental ill health and provides early intervention and rehabilitation when we need it.

Ian Stead, Mental Health Lead

Herefordshire Healthwatch

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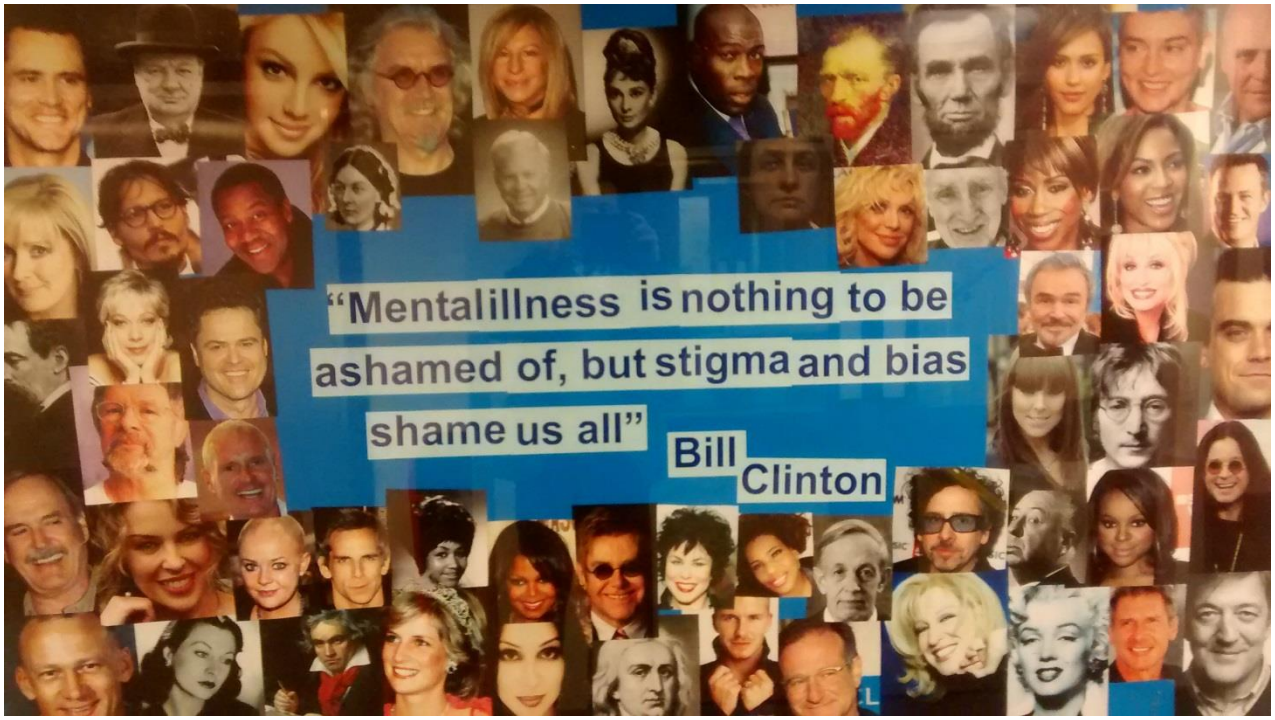
Chapter 1: Introduction



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Chapter 1: Introduction

This Assessment is about mental health in Herefordshire. It has been constructed with each chapter addressing an aspect of mental health. The chapters cover broad areas formulated so that they can be read together or in isolation from other chapters. A summary of the findings are contained in chapter 12, focussing on the outcomes that are needed for people in Herefordshire, rather than prescribing services that may achieve them.

1.1. What do we mean by Mental Health?

Improved mental health is associated with better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life. The effect of impaired mental health can be seen on many levels, for the individual, within families, communities and across society as a whole.

Understanding what is meant by mental health helps to frame action to support it. The World Health Organisation (WHO) defines mental health as a positive health position as:

> *"A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community… it is not merely the absence of disease or infirmity"* (2013).

Within this definition, having good mental health is about more than "not being ill", but rather describes how an individual experiences and engages with the world around them. Someone with symptoms of mental illness may have relatively high levels of wellbeing and vice versa. The model below (figure 1.1) illustrates the types of mental health that this needs assessment is concerned with.

Figure 1.1: The relationship between mental illness and wellbeing [i]

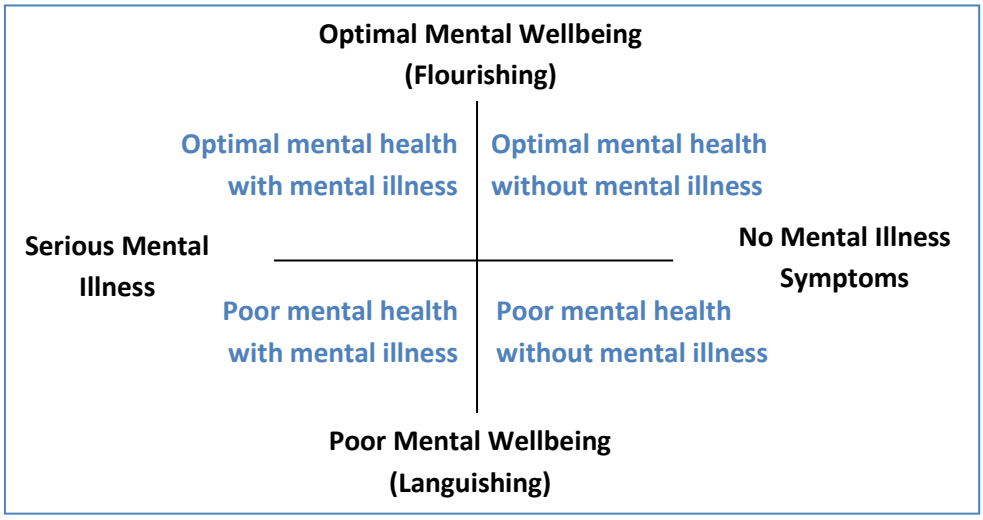


Figure 1.1 has a synergy with what people in Herefordshire said about what good mental health meant to them. In most cases, this had nothing to do with a diagnosed condition, but rather how they were able to live their lives, experience relationships and view the world. Many spoke of mental health as something that enabled them to deal with "life's ups and downs", and simply come to terms with their own self.

"Being happy and able to be a full part of your family, work and community."

"I have bipolar so good mental health & wellbeing for me means a stable mood, content with life and having an equal balance between work, rest and play."

"Being able to cope with life's ups and downs in an ordinary way. Not feeling swept away, frightened and unable to cope."

"Having the confidence to feel (and maybe know), that these problems can be solved or improved..."

"To be happy and appreciate the things I have; To be able to accept the appreciation of others."

"Having an enjoyment and appreciation of living."

"Being able to cope with a certain amount of stress but to do this one has to look after oneself i.e. diet, sleep, exercise and friendships."

"To live what you consider a good and fulfilling life accepting yourself for who you are."

Box 1.1: What Mental Health Means to Patients and Service-users in Herefordshire

The views, experience and expectations of people are a fundamental part of this needs assessment. By listening to people that have received support from local services; or work in and with mental health services offers a perspective of what is working well, requires improvement or the extent of unmet need.

1.2. Why a Mental Health Needs Assessment?

Mental health issues are responsible for a larger burden of disease than any other health problem (23% of the total burden of disease in England compared to to 16% each for cardiovascular disease and cancer)[ii]. Mental ill health affects 18% of working age adults at any one point in time and over a third of adults during the course of a year. Lifetime risks vary from one in four of the population to one in two in different settings. However, it is estimated that only 32% of those with clinical levels of mental illness receive treatment[iii].

A health needs assessment is the first stage in understanding an issue or topic. A health needs assessment (HNA) is:

> "A systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities." (Cavanagh and Chadwick, 2005 p.6).

Within a HNA, need may be identified as "capacity to benefit"[iv], to contrast with what populations may demand, but which may be of no practical benefit. An HNA identifies the needs of a population, drawn from statistical and demographic data sources; maps current service provision and service use and reviews evidence of effectiveness of services in the form of national or local guidance of "what works". An HNA therefore is intended as a practical document to guide the allocation of resources to improve outcomes and identified need within a population.

Within its 5 year plan, Herefordshire Clinical Commissioning Group is committed to achieving parity of esteem in the provision of mental and physical health services. In 2015, Herefordshire Clinical Commissioning Group will be considering the future provision of secondary and community mental health services in the county.

The aim of this piece of work is to provide a robust evidence base to enable reprocurement of Herefordshire Clinical Commissioning Group commissioned mental health services, using an outcome based approach to focus on those outcomes that those services must achieve.

This needs assessment begins and ends with consideration of service user and provider views. Given the system-wide implications of mental health provision, it was intended that any recommendations:

- Ensure that HCCG commissioned services fit seamlessly within a future mental health and wellbeing strategy;
- Integrate with other services and other system resources, including the voluntary and community sectors; and
- Contribute to the achievement of improved outcomes, for the individual and for Herefordshire, in terms of good mental health.

Inclusions and Exclusions

This needs assessment is a comprehensive examination of mental health illness affecting people of all ages. The scope of this Needs Assessment does not include the needs of:

- People with learning disabilities
- People with acquired brain injury
- People with autism.
- People with substance misuse

1.3. National Policy Context

There are a number of key documents that provide the strategic context for this Needs Assessment. These will be discussed briefly below:

a) New Horizons (December 2009)[v] , the cross-government programme of action, had the twin aims of improving the mental health and well-being of the population and improving the quality and accessibility of services for people with poor mental health by 2020. It set out a vision to move towards a society where people understand that their mental well-being is as important to their physical health if they are to live their lives to the full.

b) Healthy Lives, Healthy People: Our strategy for public health in England[vi] (2010) noted the need to improve children's development and health to reduce risk of mental ill health.

c) In February 2011 the Department of Health published the national public health strategy *'No Health without Mental Health: A cross government mental health outcomes strategy for people of all ages'*[vii]. This provided objectives and principles to guide all commissioning of mental health Services in England. Underpinning these principles was the concept of "parity of esteem" between mental and physical health. The six objectives are:

   - 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 good experience of care and support
   - Fewer people will suffer avoidable harm
   - Fewer people will experience stigma and discrimination

d) The Health and Social Care Act (2012) put parity of esteem into legal context, securing explicit recognition of the Secretary of State for Health's duty towards both physical and mental health.

e) In the same year, the Prime Minister's dementia challenge was launched[viii] to drive improvements in health and social care, encourage the development of dementia friendly communities and support research.

f) In addition, a number of crisis documents have been produced. *Transforming care: A national response to Winterbourne View Hospital* (December 2012)[ix] highlighted the need for vulnerable people to receive appropriate care and the highlighted that it is the responsibility of commissioners and provider staff, at all levels, to ensure that this is achieved.

g) In February 2014 the Crisis Care Concordat[x] was published, laying out key principles for health staff, police officers and approved mental health practitioners to work together to support people in crisis.

h) The Care Act 2014 has the intention of reforming, simplifying and making more equitable the laws around care in England, improving support for carers, including those who care for people with mental health issues. Critically, it introduced and national minimum threshold for eligibility for carer support.

1.4. Local Policy Context

Reflecting the national policies outlined above, as well as a commitment to parity of esteem between mental and physical health, the following local policy frameworks inform and guide this needs assessment. It should be noted that this in turn will feed into and inform wider partnership work to develop an all age, system wide mental health strategy.

- Herefordshire Joint Strategic Needs Assessment, 2013[xi]
- Herefordshire Carers Strategy 2012-2015[xii]
- Living well with Dementia in Herefordshire 2010-2013[xiii], updated May 2014
- Herefordshire Council's Local Investment Delivery Plan 2011-2026[xiv]
- The Herefordshire Sustainable Communities Strategy 2010[xv]
- Herefordshire Clinical Commissioning Group 2 year plan
- Herefordshire Clinical Commissioning Group 5 Year Strategic Plan
- NHS Herefordshire CCG Medicines Optimisation strategy highlights:
    - Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need
    - 30-50% of medicines are not taken as intended and that ten days after starting a new medicine 30% of patients will be non-adherent
    - Sub-optimal use of medicines leads to extensive waste in the system and lost opportunities in improving health.

1.5. Methodology

The Mental Health Needs Assessment has been undertaken by Herefordshire Clinical Commissioning Group, with support from Herefordshire Council Public Health Department. The contribution of patients/ service users, carers and 2gether NHS Foundation Trust was a crucial source of expertise and experience. The large number of contributing organisations who supported the needs assessment have resulted in a rich breath of expertise for this largely qualitative needs assessment.

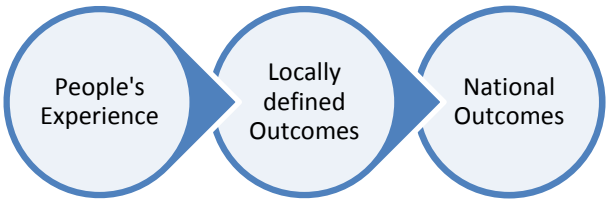
Governance for the Mental Health Needs Assessment was provided by the HCCG Mental Health Steering Group and an expert stakeholder group (see Appendix 1 for details) that met frequently to advise on research design, methodology and information sources. An Authors' group (see Appendix 2) met fortnightly to discuss and collate data collected.

Outcomes

People's experience, whether as a patient, carer or practitioner have all contributed to our local understanding of what it is to live with a mental health condition and how to ensure good mental health. People's experience has been used to identify the outcomes most valued by service users. These outcomes link to the national six objectives published in 'No Health without Mental Health: A cross government mental health outcomes strategy for people of all ages' (2011).

The model for outcomes can be illustrated as in figure 1.2. The draft outcomes are outlined in Chapter 12.

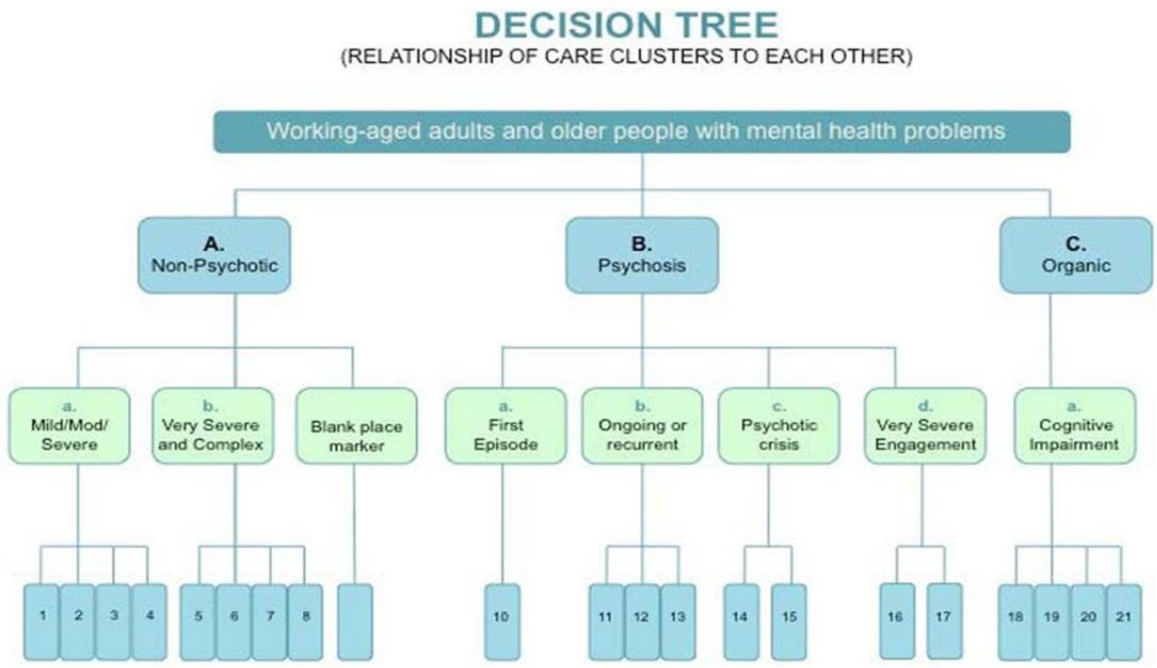
Figure 1.2: Local process for Outcomes determination



Structure of Mental Health Needs Assessment

The national payment by results classification of mental health clusters (adults) underpins the content of this Needs Assessment (with the exception of the chapter on children and young people). The clusters are a global description of a group of people with similar characteristics. It is important to note that people's needs change, as will the allocation of individuals to a cluster as people can move through clusters. Figure 1.3 illustrates the 21 mental health clusters. Appendix 3 provides a definition of the clusters 1- 21.

Figure 1.3: Mental Health Clusters



The arrangement of this Needs Assessment has grouped together Mental Health Clusters as follows:

- Common Mental Health: Clusters 1-4
- Severe and enduring mental health: Clusters 5-17
- Dementia: Clusters 18-21.

Assessment of projected population need and current usage of secondary and community mental health services, including expenditure was undertaken using national and local population data sets and service statistics.

Evidence of effectiveness of service models was identified from national guidance and evidence of best practice.

Chapter 7 is an update of the Dementia Needs Assessment conducted in 2012.

Chapter 9 reports on groups known to require additional support to secure good mental health and includes an audit into the number of people within Herefordshire who are homelessness and experiencing issues with mental health and substance misuse. This was conducted by Homeless Link, in 2012. The audit gathered data from a variety of sources including presentations to the housing solutions team at Herefordshire Council, information from 2gether NHS Foundation Trust and information from the Winter Shelter 2011/12 and 2012/13.

Chapter 10 reflects an audit of historical suicides in the county. In addition to nationally held data, coroners records were reviewed for the period 1994-2014 to produce a twenty year data set that was analysed for trends, including age, sex and occupation grouping. Small numbers and

inconsistent recording of occupation mean that a proprietry aggregate coding has been used to group people into occupational categories (see appendix 4). This issue with small numbers means that proportional mortality rates cannot be calculated for the occupational groups above, so frequencies may reflect numbers employed in particular professions.

Service Mapping

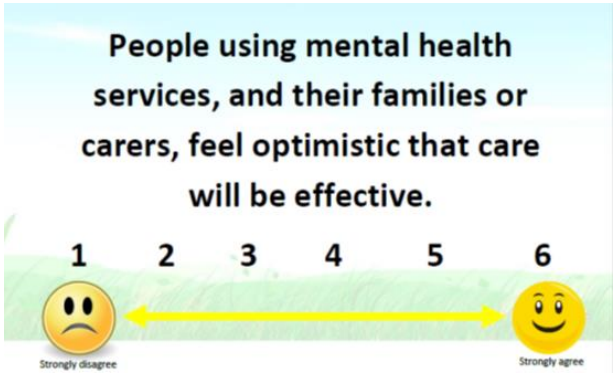
Local services were identified via searches of the Charity Commission register and CQC care directory as of 1 July 2014. This was supplemented with a review of known contacts and discussions with providers and community organisations. Identified services were provided with a questionnaire detailing their service provision and client group (See appendix 5 for the questionnaire). The analysis of the service mapping is presented in Chapter 3.

Engagement

Engagement with key stakeholders, including practitioners, service users, carers and the public, was undertaken via structured interviews, online questionnaires, and workshops (see box 1.2 for organisations engaged). Wider public and stakeholder engagement was achieved via press releases and online communities, e.g. the HCCG website, twitter and facebook. Input was gained from over 100 organisations, including advocates for "hard to reach" groups, via electronic questionnaire. In total, over 400 hours were spent in direct co-production with stakeholders, including over 300 service users, carers and young people.

One of the tools used was the NICE quality standards for mental health services. The fifteen quality standards statements were used to ask patients how strongly they agreed based on their experience using a six point likert scale.

Figure 1.4 [1] NICE (2011) Quality Standard for Service user experience in Adult Mental Health (QS14).



Workshops were held with Herefordshire Young Farmers, Herefordshire Sixth Form College, Carers in Mind, Mind Service Users and residents at residential and rehabilitation homes. These workshops used activities, discussions, voting and case studies to identify what service users, carers and the

public in Herefordshire thought “good” mental health was and how this could be best supported. In addition, visits were made to inpatient mental health wards to obtain the views of current patients.

The contributions from stakeholders have been used to validate or challenge local data or assumptions.

2gether NHS Foundation Trust	Hereford Hive
Age UK Hereford & Localities	Hereford Rapid Response
Alton Street Surgery	Hereford Sixth Form College
Belmont Medical Centre	Herefordshire Carers in Mind
Blanchworth Care	Herefordshire Carers Support
Bobblestock GP Surgery	Herefordshire Council Adults Wellbeing
Breast Cancer Haven	Herefordshire Council Children's Wellbeing
Bright Stripe	Herefordshire Council Sustainable Communities
British Red Cross	Herefordshire Disability United
Broomy Hills	Herefordshire Headway
Butterflies Children and Young People's Counselling and Play Therapy Service	Herefordshire Health Watch
Cantilupe Surgery	Herefordshire Heartstart
Citizens Advice Bureau	Herefordshire Housing Limited
Cruse Bereavement Care	Herefordshire Libraries
Department for Work and Pensions	Herefordshire Mind
Drug and Alcohol Service Herefordshire (DASH)	Herefordshire Services for Independent Living
Eastnor School	Herefordshire Venture
Echo	Herefordshire Voluntary Organisations Support Service (HVOSS)
Elizabeth Halls Counselling	Herefordshire Young Farmers
Fownhope Surgery	Home Group
Halo Leisure	Hope Support Services
Hereford Cathedral School	Houghton Project
Hereford Community Farm	Kingstone Surgery

Jane Pendlebury Counselling	Stanley House
Marches Counselling Service	Stonham
Marches Surgery	Surecare
Martha Trust	The CLD Trust
MindFulness Counselling	The Houghton Project
Moorfield House General Practice	The Royal British Legion
Motor Neurone Disease Association, Hereford Group	Warwickshire and West Mercia CRC (Probation)
Newstead House Nursing Home	Weobley High School
Onside Advocacy	West Mercia Police
Orchard Origins	West Mercia Probation Trust
Penny Jolly Yoga	Westfield School
Phoenix Bereavement Support Services	Worcestershire Rape & Sexual Abuse Support Centre
Red Spark Learning	Wye Valley NHS Trust
Salters Hill Charity	
Services for Independent Living	
SHYPP	

Box 1.2: Organisations engaged in the course of this Needs Assessment

Chapter 2: Herefordshire Profile

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Chapter 2: Mental Health: Herefordshire Profile

2.1. Herefordshire

Herefordshire is a predominantly rural county, with the 4th lowest population density in England. It is situated in the south-west of the West Midlands region bordering Wales. The city of Hereford, in the middle of the county, is the centre for most facilities; other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington.

Herefordshire produces an annual overview of the health and well-being needs of the county ("Understanding Herefordshire"), the content of which will not be rehearsed in this document.

The current (mid-2012) resident population is 184,900, with 22 per cent of the population aged 65 years or above (40,800 people), compared to 17 per cent nationally. This includes 5,500 residents aged 85 and over. There is a similar proportion of under-16s as nationally (17 compared to 19 per cent).

2.1.1. Rurality and Mental Health

There is some evidence to suggest that levels of mental illness are lower in rural areas, particularly relating to psychosis[xvi], depression and anxiety[xvii]. However, many of these studies fail to adjust for confounders such as unemployment, socio-economic status, ethnicity, educational status and marital status. In studies where these factors are adjusted for, the differences between rural and urban rates of mental ill health become less pronounced[xviii]. As will be discussed in chapter 10, people employed in agricultural industries are at higher than average risk of suicide, suggestive of under-detection of mental health need in rural areas, as well as indicating risk factors such as cultural stoicism, social isolation and lack of access to supporting services[xix].

As with all areas, stigma around mental health (see chapter 4) remains an issue in rural areas, but may be compounded by small, close social networks and a lack of anonymity (an aversion to "people knowing your business") which might discourage help seeking behaviour[xx].

As part of this needs assessment, service users and mental health professionals were asked about issues relating to the rural context of Herefordshire. Rurality was seen as a barrier to accessing services and engaging with patients, a point particularly raised in relation to young people's services (see chapter 8). It also results in services that cost more per head of population than a comparable urban area. There is a potential for technological solutions to overcome some of the issues.

What was offered was often dependent on how far you lived out from the city patient.
Patient/ Service User

There are more opportunities for support groups in the city; people living in rural areas struggle to locate local support groups
Patient/ Service User

People suffer from isolation in outlying areas and have little opportunity to access support.
Voluntary Organisation

In rural areas, there is difficulty in finding continuation of care from local agencies
Private Organisation

The Large geographical area means that there is a lot of travel. You cannot get the economies of scale in Herefordshire so you don't get the same cost per patient
Mental Health Practitioner

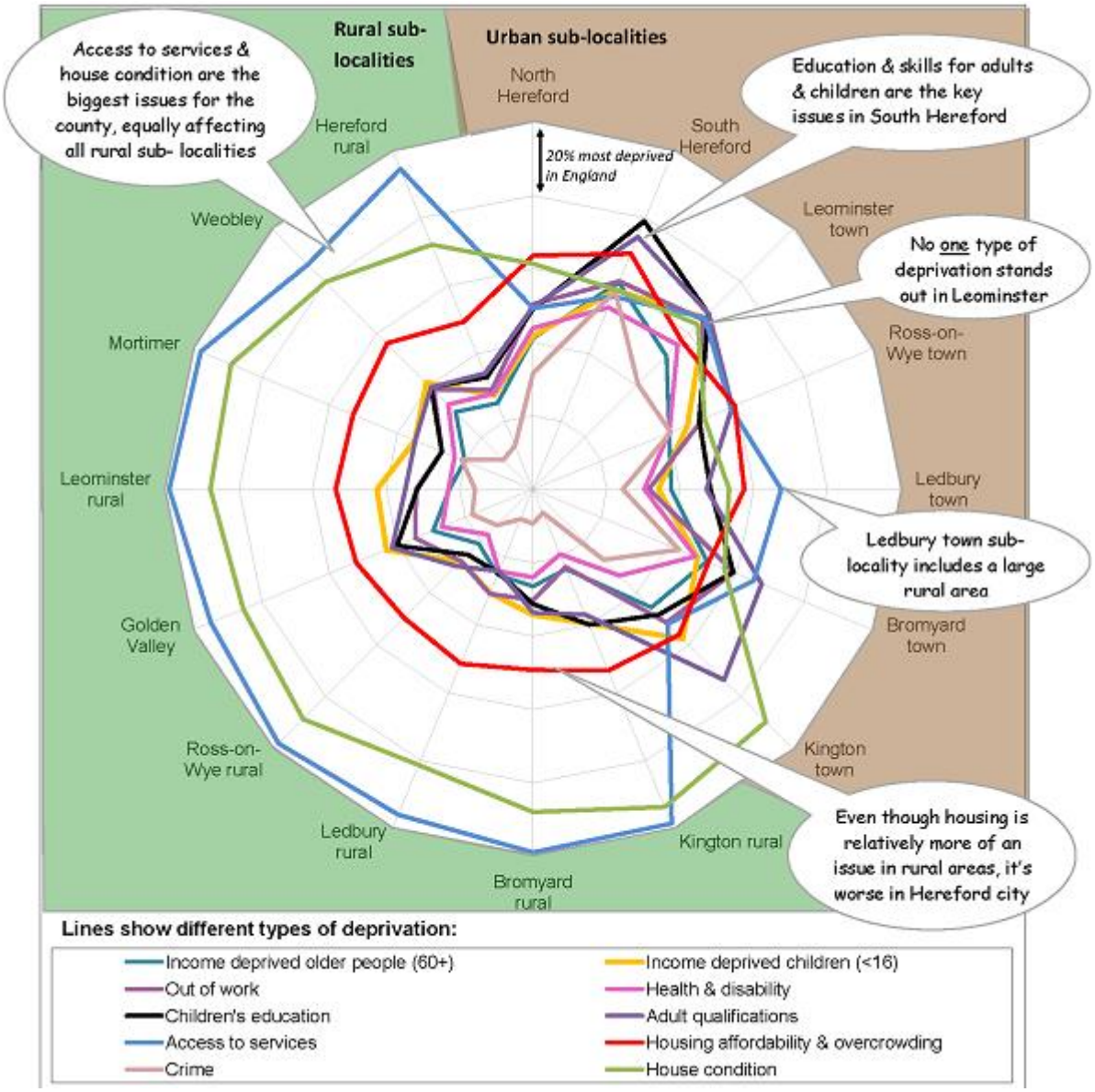
We should be able to remotely upload notes rather than returning to the office.
Mental Health Practitioner

2.2. Risk Factors for Mental Ill Health in Herefordshire

2.2.1. Socio-Economic Determinants of Mental Health

As a whole, Herefordshire has relatively low levels of deprivation. In general people are healthy, live longer compared with nationally, and have positive experiences of the things that affect their lives and well-being. However, some areas of South Hereford, Leominster and Ross are amongst the 25 per cent most deprived in England and have become more deprived relative to other areas. Different types of deprivation affect different areas, which function as determinants of various physical and mental health outcomes– figure 2.1 shows how the issues vary around the county.

Figure 2.1: Deprivation in Herefordshire localities relative to all of England (a point nearer the outside of the chart indicates greater relative average deprivation)



Source: Understanding Herefordshire, 2013

Information on determinants affecting mental health in Herefordshire are presented below:

People with no Qualifications

- In total, just under a third (30 per cent) did not have the equivalent of five GCSEs grades A*-C (up to Level 2 qualification).
- The last few years has seen an apparent increase in the proportion of Herefordshire's working age population without qualifications, although analysis of the 2011 Census shows that qualification rates are very similar to those across England. There are however noticeable differences by age: generally speaking younger county residents are less well qualified than older residents when compared to England as a whole.

Absenteeism (Children and Young People)

- Pupil absenteeism (the % of half days missed by pupils due to overall absence authorised and unauthorised) was at 5.5% in 2012/13; a reduction from 5.8% in 2010/11, though up from 5.1% in 2011/12.
- Persistent absenteeism rate was almost 10% in 2010/11 though the rate decreased to less than 4% in 2012/13, similar to national rates (*Source, CINA 2014*)

People living alone

- 15% of adults living alone equating to 1 in 7 adults. Across the county, there were now 11,200 pensioners (aged 65+) living alone – 700 more than in 2001 (+7%). This equated to three in every ten pensioners. (*2011 census*)

Lone parents claiming benefits

- The lone parent group accounted for 10% of out of work benefits claimants, accounting to approximately 900 people. (*Herefordshire Facts and Figure, 2014*)

People providing unpaid care

- The 2011 Census recorded that 21,000 residents (11 per cent) were providers of at least an hour a week of unpaid care to family members, friends, neighbours or others because of long-term ill-health or disability or problems related to old age – an increase of over 3,000 and one percentage point since 2001. This included 6,700 who were providing 20 hours or more. *(Carers Analysis, Strategic Intelligence Team, 2014)*

Young Carers

- There were approximately 400 children aged under 16 providing unpaid care in Herefordshire, which represented 1per cent of all children in this age group in the county. This proportion was similar to nationally. (*2011 Census, Carers Analysis, Strategic Intelligence Team, 2014*)
- The Herefordshire Carer's Support has approximately 300 children and young people registered with them (*Carers Analysis, Strategic Intelligence Team, 2014*)

Homeless Families

- The county's homelessness rate is one of the worse when compared to the statistical local authority neighbours, the best performing rate is 0.68 per 1,000 households (East Riding of Yorkshire) compared to 3.23 per 1,000 households in Herefordshire. In the last three quarters (Q1-Q3 2013/14), there were 200 families labelled as homeless in Herefordshire *(Source: Department for Communities and Local Government, Homelessness Statistics.*

Table 2.1 provides a summary of some further socio-economic determinants in relation to Herefordshire.

Table 2.1: Socio-Economic Determinants of Mental Health within Herefordshire

Socio-Economic Determinants of Mental Health		Compared to England
Employment and income	9,120 people out of work claiming benefits (2013)	Same
	14,500 Households on low incomes (2007/8)	Same
Education	55,050 People with no qualifications	-
	840 People aged 18 and over with learning disabilities and are known to the GP (2011/12)	Higher
	1,025 Children achieved a good level of development at the end of reception (2012/13)	Significantly better
	1,024 Children GCSEs achieved (5 A*-C inc. English and maths) (2012/13)	Significantly worse
Family and caring	27,525 People living alone (2011 Census)	-
	900 lone parents claiming benefits (2007/8)	-
	21,000 People providing unpaid care (2011)	-
	240 Looked after children and young people (Dec 2013)	-
Crime and antisocial behaviour	92 (547/100,00 population)First time entrant to the youth justice system	Worse
	7,800 crimes recorded by West Mercia Police in 2013/14	-
	15.92/1000 population, 18+ domestic violence incidents reported to West Mercia Police in 2012/13.	Significantly better
Housing	200 homeless families (3.2/1000 population)	-
Health	6,400 people self-reporting long-term mental health	Same

Table 2.2 outlines how a number of wider determinants may inform mental health outcomes.

Table 2.2: Main factors associated with different types of mental health needs (Jenkins et al, 2008)[xxi]

	Childhood Disorders	Adult Common Mental Disorders	Psychosis	Dementia	Personality disorders	Suicidal thoughts	Addictions		
							Alcohol abuse	Substance abuse	Tobacco
Age	Increases with increasing age	Highest rates in 35-54 age group	Highest rates 20-34 age group	Increase with age, 5% of over 65s, 20% of over 80s.	Increased in younger people	Highest in young adults	Highest in 16-24 age group	Highest in 16-24 age group	Increased onset in 16-24 age group. Highest rates 25-55 age group.
Gender	M>F	F>M	M>F but secondary peak in women 40-45 age group	M=F	M>F	F>M, but actual suicide M>F	M>F	M>F	M=F
Ethnicity	Lower rates in young Indian girls	Higher rates in Irish and Black Caribbean	Higher rates in several BME groups						
Marital status	n/a	Increased in separated & divorced			Increased in single	Increased in single, separated and divorced	Increased in single, separated and divorced	Increased in single	Increased in single, separated and divorced
Family Composition	Increased in lone parents and reconstituted families	Increased in lone parents				Increased rates in those living alone	Couple with children have lower rates		

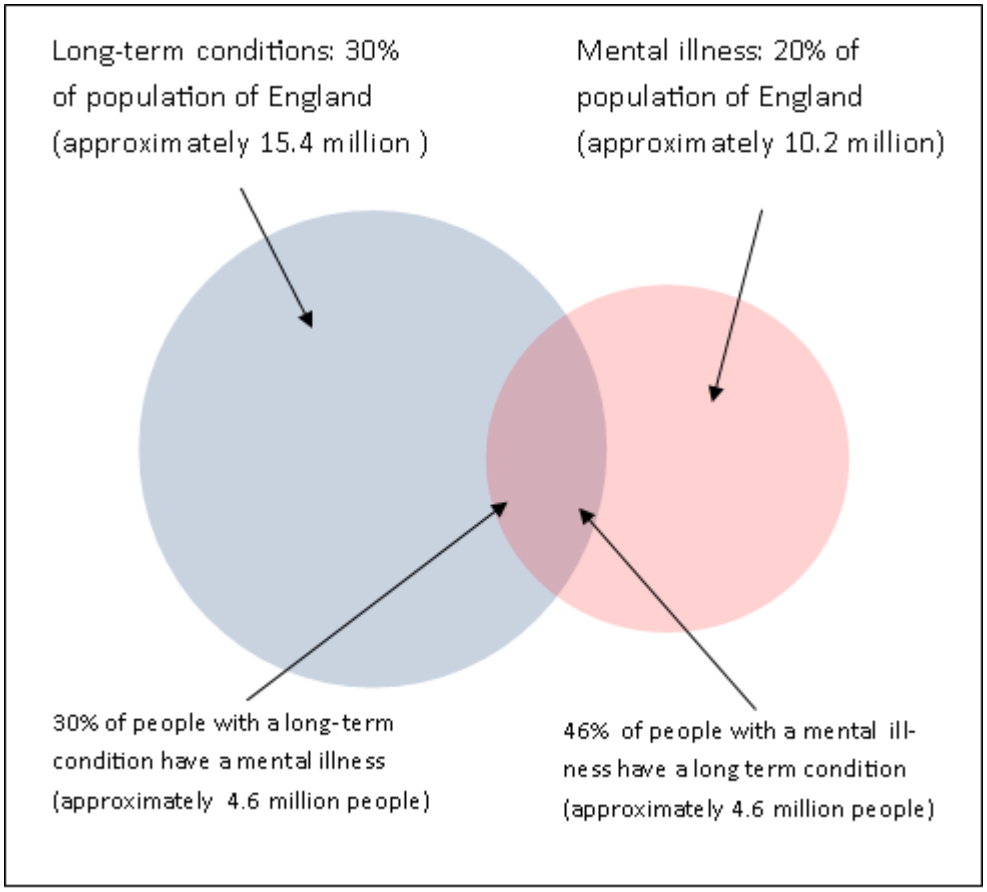
	Childhood Disorders	Adult Common Mental Disorders	Psychosis	Dementia	Personality disorders	Suicidal thoughts	Addictions		
							Alcohol abuse	Substance abuse	Tobacco
Employment	Increased in poor education of parents, lack of employment and low incomes of parents	Increased in social class V and unemployed.	Increased in social class IV & V, and in economically inactive. Little evidence that parental social class is influential.		Increased in those with lower socio-economic status and poorly educated	Higher rates in lower educational qualifications and lower social class	Increased in manual occupations	Increased in unemployed	Higher rates with lower educational qualification, nursing and teaching, lower social class.
Housing tenure	n/a	Increased rates in people who rent rather than own home.	Increased rates in people who rent			Increased rates in those living alone	Increased rates in those who rent from LA or housing association and in those with a mortgage	Increased rates in those who rent	
Social supports	Increased with psychological distress in mother and family discord	Increased in those with few social supports	Increased in those with few social supports			Increased rates with few social supports			
Immigration status			Higher rates in immigrants, probably due to increased stressful life events, urban						

	Childhood Disorders	Adult Common Mental Disorders	Psychosis	Dementia	Personality disorders	Suicidal thoughts	Addictions		
							Alcohol abuse	Substance abuse	Tobacco
			living, discrimination & social isolation.						
Deprivation	Increased rates with neighbourhood deprivation and lack of social cohesion		Increased rates with neighbourhood deprivation and lack of social cohesion, both in childhood neighbourhood and current neighbourhood.					Increased rates with neighbourhood deprivation and lack of social cohesion.	

2.2.2. Links between Physical and Mental Health

There is a complex, dynamic relationship between mental and physical health. People with a chronic medical condition have a 2.6-fold increase in the likelihood of having a mental illness, compared to those without a chronic medical condition[xxii]. Conversely, people with mental illness experience poor physical health with higher than expected mortality, which is not explained by suicide[xxiiixxiv]. Much of this excess mortality is potentially avoidable[xxv].

Figure 2.2: Overlap between long-term conditions and mental illness



Source: Adapted from Naylor C., Parsonage M., McDaid D., Knapp M., Fossey M., Galea A., 2012. Long-term conditions and mental health: the cost of co-morbidities. London. The King's Fund.

A number of reasons have been suggested for the increase in mortality of people with mental illness:

- Health behaviours e.g. smoking, diet, exercise, alcohol and drugs[xxvi]
- Altered help seeking e.g. delayed presentation,
- Reduced treatment adherence, poor uptake of health screening, impaired mental capacity leading to treatment refusal
- 'Diagnostic overshadowing' e.g. failure by health professionals to recognise physical health problems in people with mental disorders.

- Discriminatory policies
- Iatrogenic factors e.g. obesity caused by antipsychotic medication[xxvii].
- Social conditions e.g. homelessness, unemployment,
- poverty
- Suicide and violent victimisation
- Direct physical impacts of mental disorders e.g. changes to immune function.

Within Herefordshire therefore there is a need to identify and address these contributory factors and so reduce the prevalence of mental ill-health in the county. Further information on this topic can be located in chapter 4.

2.3. What are the costs of Mental Ill Health?

2.3.1. Primary Care Costs

In a group of 2000 patients at any one time, a GP with an average list will be treating:

- 352 people with a common mental health problem
- 8 with psychosis
- 120 with alcohol dependency
- 60 with drug dependency
- 352 with a sub-threshold common mental health problem
- 120 with a sub-threshold psychosis
- 176 with a diagnosed personality disorder
- 125 (out of the 500 on an average GP practice list) with a long-term condition
- with a co-morbid mental illness
- 100 with medically unexplained symptoms not attributable to any other psychiatric problem (MUS).

This means about one in four of a full- time GP's patients will need treatment for mental health problems in primary care[xxviii]. Reducing the prevalence of mental ill health and addressing the contributory factors (outlined above), whilst supporting GPs in Herefordshire to better support people experiencing mental ill health will improve outcomes and quality of service for all patients.

2.3.2. Secondary Care Costs

More than £2billion is spent every year on secondary care services for people with poor mental health[xxix]. In 2013/14, HCCG allocated £15.3 million to its contract with the current provider of secondary and community mental health services, 2Gether NHS Foundation Trust (HCCG, 2014)[xxx]. Spend on other areas of mental health spend are laid out in table 2.3, below. As a result of demographic changes in the population, particularly in the number of older people, the cost of mental ill health could double over the next 20 years.[xxxi]

Table 2.3 Programme budgeting detail- components of Mental Health spend, Herefordshire CCG 2013/14

Categories of Spend	Mental health disorders
	£ '000s
Main Mental Health Provider	15,366
Other NHS Providers	823
Continuing Health Care	3,171
Funded Nursing Care	1,559
Nursing Home	277
Additional Dementia services	210
Other (Zero Priced Mental Health)	1,195
Total ex. Overheads	**25,104**

2.3.3. Societal Costs

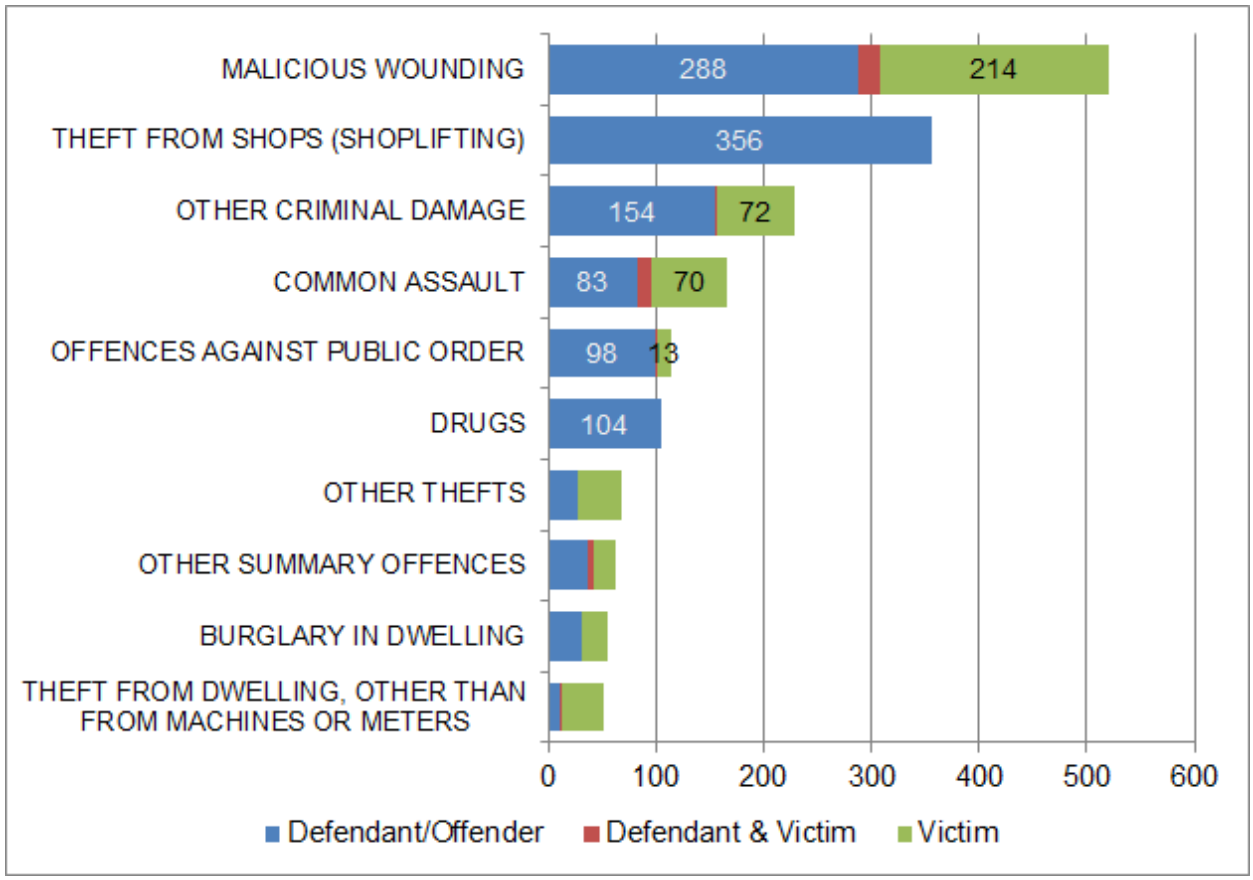
Mental ill health also has an enormous negative impact on the quality of life. In 2010 the Centre for Mental Health estimated these costs at £53.6 billion per year.

The latest figures available (Centre for Mental Health, October 2010) suggest that mental ill-health costs in England approximately £105 billion each year once its impact on work, benefits and the criminal justice system have been taken into account[xxxii] . Approximately £30 billion of this estimate is work related, a result of sickness absence and reduced productivity; mental illness is responsible for more sickness absence than any other illness [xxxiii]. Government figures show that 43% of those on long-term benefits due to health issues have a primary mental health problem[xxxiv] .

Links between crime and mental health are contentious, given the complexity surrounding crime, deprivation, social exclusion and offending. Notwithstanding, the costs of criminal activity related to conduct disorder in England and Wales alone amounts to £22.5 billion each year, with a further annual cost of £37.5 billion attributable to sub-threshold conduct disorder[xxxv]. Over 25 years, the total return from parenting programmes for children with conduct disorder is between 2.8 and 6.1 times the intervention cost, much of this through reduced crime[xxxvi].

Figure 2.3 below shows the number of crime and disorder incidents in Herefordshire flagged as having a mental health component between 2011 and 2014. As can be seen, people with mental health are represented as both victims and perpetrators of crime. Indeed, people with a recorded mental health issue are as likely to be victims of violent crime, and more likely to be victims of theft (other than shoplifting), than they are to be perpetrators.

Figure 2.3. Pooled Data of Incidents with a Mental Health flagging for financial years between 2011-14 in Herefordshire

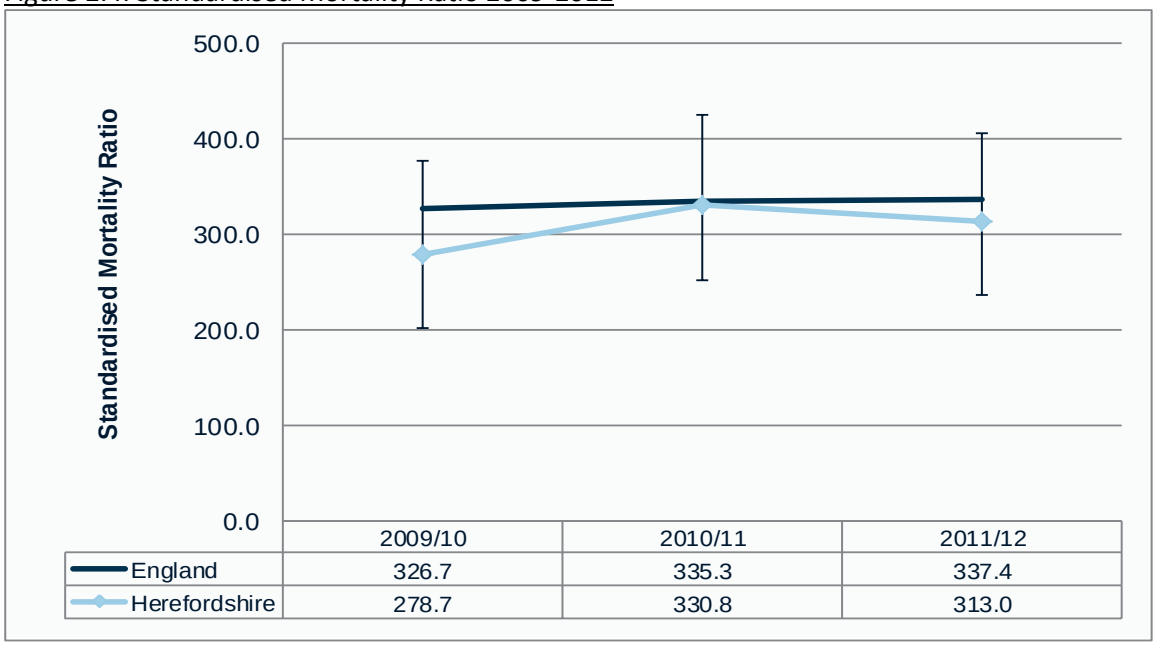


Source: Herefordshire Community Partnership, (2014)

2.3.4 Mental Health Mortality

Approximately 12% of all deaths in Herefordshire (around 230 per annum) in 2012-13 have a mental health-related diagnosis as a cause (underlying or contributory) on the death certificate. The vast majority of this mortality is coded to various forms of senility and organic mental disorder, with almost 40% having a code of vascular dementia (ICD10 F01) specifically. A further 5% of deaths reference alcohol or substance misuse as a contributory factor.

Figure 2.4: Standardised Mortality Ratio 2009-2012



Source: NHS Outcomes Framework

The ratio of the directly age standardised mortality rate for people aged 18 to 74 in contact with secondary mental health services to the directly age-standardised mortality rate for the general population of the same age expressed as a percentage.

Generally mortality rates among those with a serious mental illness are around 300% greater than among the general population in Herefordshire. This is not significantly different from the national picture.

2.4. Conclusion

This Chapter provides some background to Herefordshire and its people. The risk factors show a number of determinants that affect the number and severity of mental health conditions. These are present in the communities of Herefordshire therefore the design of services and consideration of the local population's needs requires an understanding of these risk factors and active targeting to overcome them. This stretches beyond the NHS to the whole system. The financial and human cost of mental health is also a reminder why this issue is important. Years can be added to life if the mental health needs of the population are addressed.

Chapter 3: Services and Support in Herefordshire

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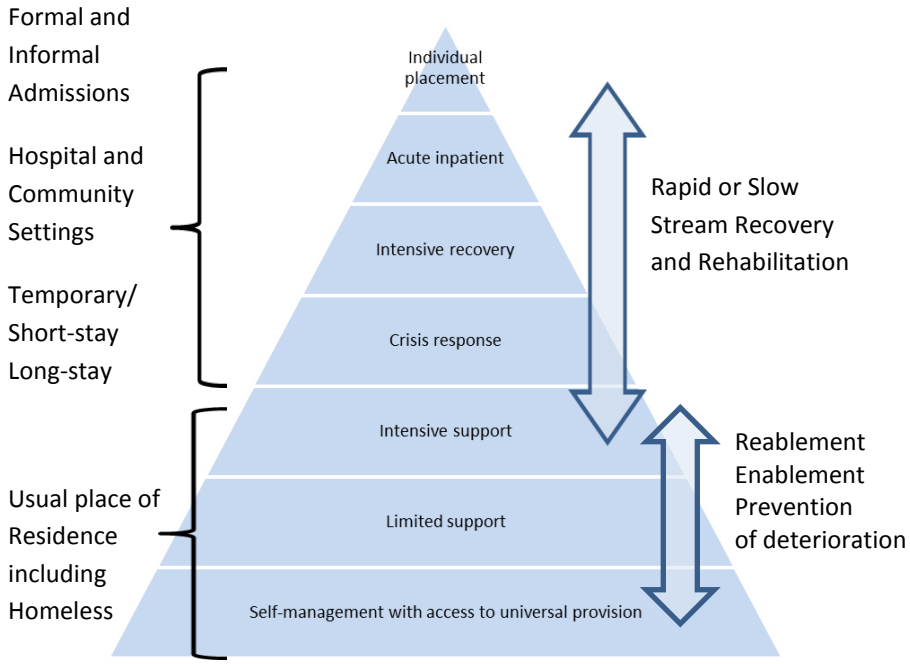
Contents

Chapter 3: Services and Support in Herefordshire

3.1. Services Overview

A search was conducted to identify organisations providing care, treatment and support to people with mental health conditions. The search methodology involved an analysis of the Charity Commission register as of the 1 July 2014; CQC care directory as of 1 July 2014; survey of organisations and collation of available literature on local services (through the internet and community directories). Further information came from discussion with practitioners and representatives of organisations. The survey was completed by 31 organisations and provides supporting evidence of the quantity and quality of provision.

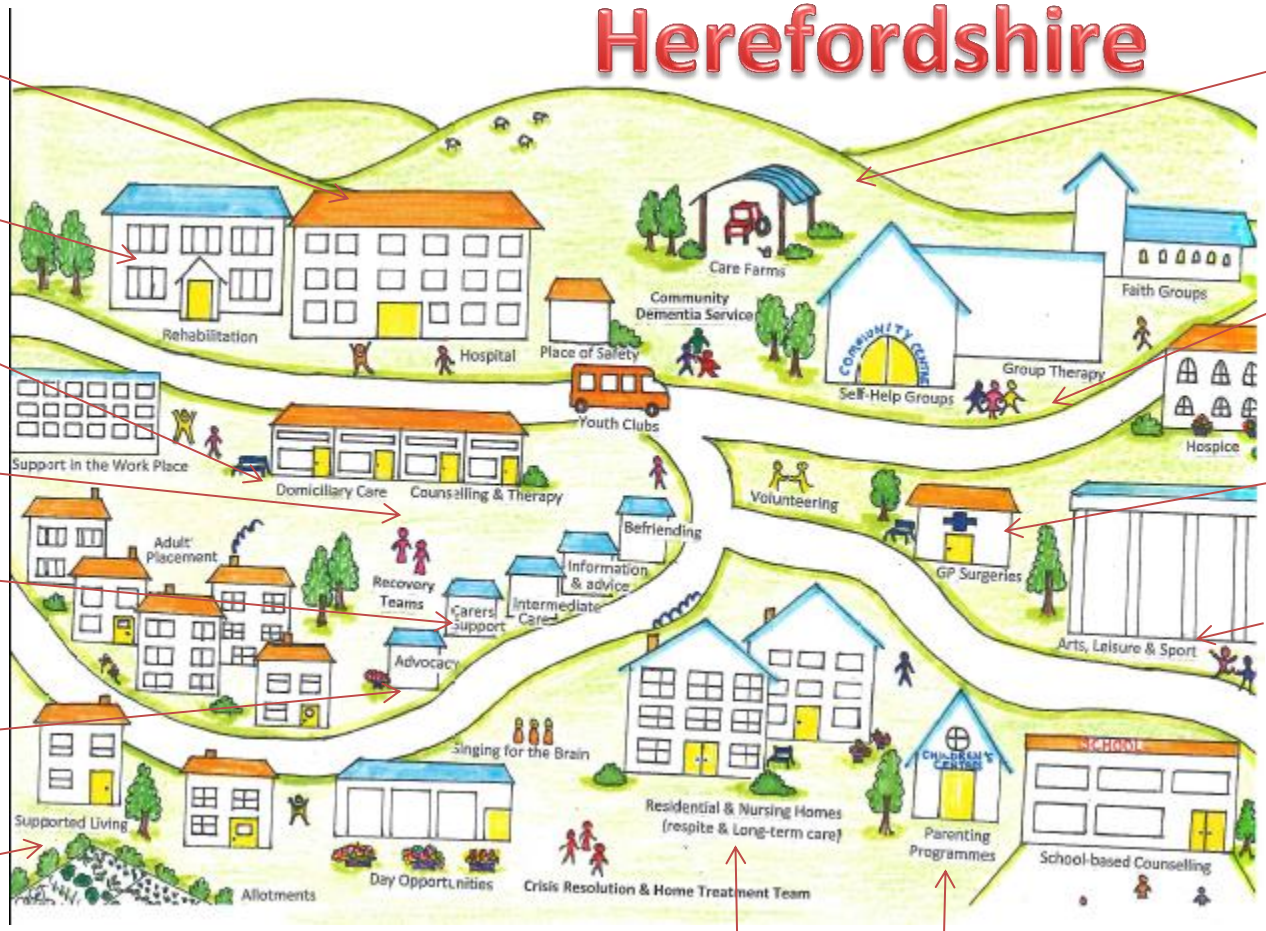
Figure 3.1 shows an overview of services for children, young people and adults with mental health conditions.



The provision of children's services is also commonly arranged in nationally defined tiers (see chapter 8).

The results of the service mapping revealed a number of sources of support and services available in Herefordshire. Figure 3.2 provides an overview of the provision for children, young people and people with mental health needs. All services marked by * indicates funding (all or partially) from Herefordshire Clinical Commissioning Group.

Figure 3.2: Herefordshire Community and Resources for People with Mental Health Needs



1 Mental Health hospital with 39 beds

Rehabilitation Unit with 10 beds

27 providers of domiciliary care

25 providers

900+ carers care for someone with a mental health condition

1 provider of statutory advocacy

6 providers of short-term accommodation and Extra Care

6 Care Farms

5 self-help groups

24 Practices, 183,500 practice population

Targeted provision available

42 Care Homes

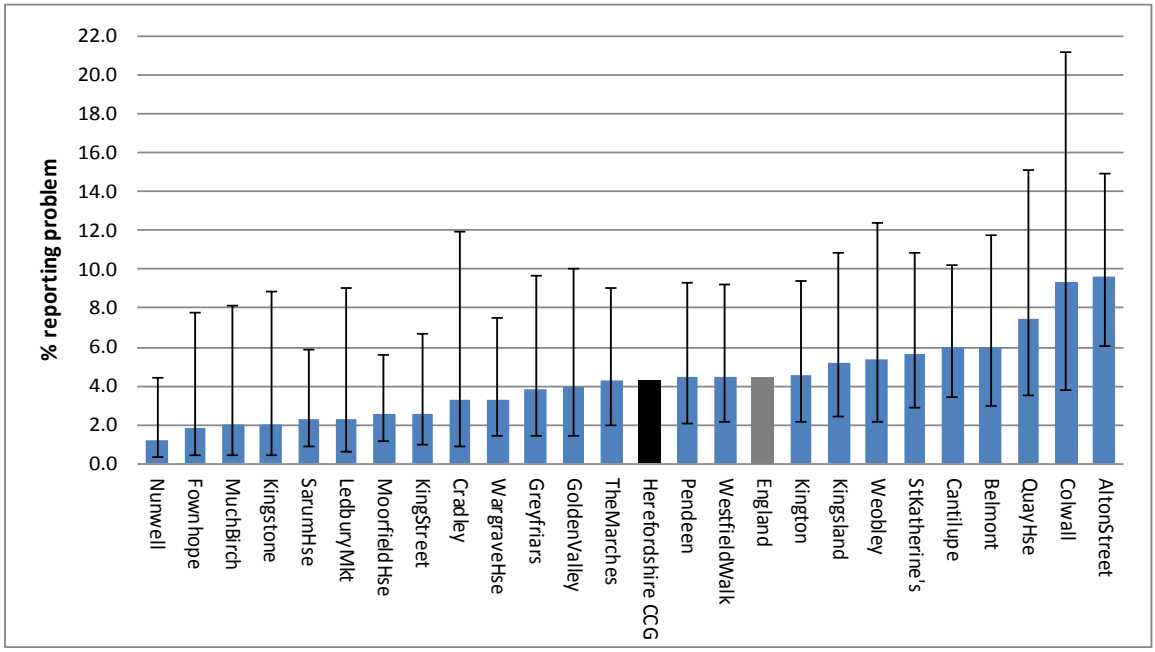
3 programmes

3.2. Self-Management and Universal Provision

3.2.1. Primary Care

There are 24 **GP surgeries**, with 183,500 registered patients. According to GP records, there were 1403 children and young people presenting with mental health need (under-18's in January 2013) and around 6,400 adults with a long-term mental health problem across Herefordshire practices in 12/13 based on survey result. HCCG average prevalence is 4.29%, compared to 4.5% nationally. There was variation in self-reported prevalence of a long-term mental health condition across practices, from Alton Street (9.6%) to Nunwell (1.2%).

Figure 3.3: Proportion of People reporting a Long-Term Mental Health Problem



Source: GP Patient Survey, 2012/13.

Community pharmacies have long opening hours and are often available without appointment for patients seeking advice on self-care, minor ailments as well as the traditional advice and supply of prescription medicines. Community pharmacies provide a number of locally commissioned services such as support for stopping smoking. National community pharmacy initiatives to improve support for patients with long term conditions such as the New Medicines Service (NMS) and Medicines Use Review (MUR) do not target mental health medicines specifically. Currently support for mental health service users with use of medicines is primarily provided from mental health community recovery teams and the wider primary care team.

Patients requiring additional practical help with taking their medicines from community pharmacists are assessed under the Disability Discrimination Act (DDA) and if they meet certain criteria are eligible for a range of help including **provision of compliance aids** such as monitored dosage systems.

The DDA identifies that a person may have physical or mental conditions that impact upon their day-to-day function. The range of support provided to patients may extend to re-packaging medicines into “weekly boxes” from Pharmacies free of charge where patients qualify under the terms of the DDA assessment and MDS is felt appropriate to that individual’s needs. The assessment does not include the assessment of needs associated with mental functioning.

3.2.2. Self-Help

There are eleven **telephone advice** services, six of which are nationally available. The focus includes specific dedicated telephone advice on addictions, debt, mental health conditions for people affected as well as carers. Herefordshire Libraries run **Books on prescription**, including self-help books to borrow. Recent research shows that people see their library as safe, trusted and non-stigmatised place to go for help with and information about health problems.

There are a number of **self-help groups** running in the county:

- Independent HUG (Herefordshire users group)
- Hereford MDF Bipolar Self-help Group
- The Cameo Club
- Carers In Mind Group
- Out and About Group (Early Onset Dementia)

Hereford Courtyard run a **community arts** programme targeted or inclusive for people with dementia, including:

- Dementia Poetry/In The Pink – delivered in care settings people living with dementia work with a poet to create group and individual poems
- The Friday Club – in conjunction with the Alzheimer’s Society day centre, an arts session on a monthly basis.
- Sharing Joy – working with the Vamos Theatre Company to deliver masked theatre sessions in care settings.
- Mayfair – oral history project working with various community groups/AGE UK.
- The Red Suitcase Project – an intergenerational project working with 12 students from HCA and 3 care homes across Herefordshire to create three quilts.
- Rural Pub arts – community arts classes using village pubs as community venues.
- Find Your Feet – Dance and movement class for people with dementia and their carers.
- Stories on Our Doorstep – an intergenerational project working with The Courtyard’s Senior Youth Theatre and three care homes to create a show performed in the main house at the Courtyard.
- Garrick singers –over 60’s choir.
- The Wye Tea Dance – a tea dance for older people held in the Lion Theatre in Ross-on-Wye.
- Extend – Chair based movement and dance class delivered in community settings across Herefordshire.
- Toni’s Drama ‘Fudge’ – an oral history & drama project working with 3 Age UK groups inspired by images from the Herefordshire archive.

- Remember Me – An annual event held at the venue as part of Dementia Awareness Week. A full programme of arts activities for people living with dementia. Also offering advice, guidance and support to carers from partner organisations.
- Fashion reminiscence – a tailor made resource designed to stimulate memories and conversation through an opportunity to get interactive with fashion through the ages items.

In 2013/14, a total of 8975 people participated in the above programme of activities.

The Alzheimer's Society runs **dementia cafes** for people with dementia and their carers to meet together in a relaxed cafe setting. Local professionals are invited to give short talks on a wide variety of topics related to dementia and its impact on daily living and to answer questions. The cafes run in Hereford, Leominster and Ross-on-Wye.

Brightstripe Cultural Health Community Interest Company offers a menu of activities as part of a healthy lifestyle programme. This includes physical activity consultation that takes into consideration their health condition and support to identify appropriate activity for the person, e.g. walking group, tai chi or sport. They lead on implementation of the national walking for health scheme in Herefordshire, this includes group walking, opportunities for volunteering and training. One of the schemes is a joint project with Herefordshire Mind providing Tai Chi to people with mental health conditions.

It is not possible to document all community services that provide a form of self-help. There will be local community, faith-based and voluntary activities that support people within their communities, serving to keep people well.

3.3. Support

3.3.1. Therapies

Group therapy is available county-wide on emotional well-being, low mood, stress and anxiety, panic, low self-esteem and obsessive compulsive-disorder. Mindfulness courses are available in Hereford. (need a description of mindfulness).

There are 25 people operating private practices that are registered members of the British Association of **Counsellors and psychotherapists**, with 17 people accredited in Herefordshire. In terms of location, the majority are based in Hereford (56%), Leominster (16%) and Ross-on-Wye (12%).

There are a number of organisations providing counselling and therapy. The remit of the organisations focus on CBT, children's, families, mediation, work-related /employee stress, relationships.

There are a small number of private psychologists operating in the area.

The **Improving Access to Psychological Therapy (IAPT)** provision in Herefordshire is called Lets Talk. The target group is the adult population (18+) suffering from at least one of the following conditions, either as a sole or co-morbid diagnosis:

- Mild depression (4 ICD-10 symptoms and/or PHQ-9 score of 5-9)
- Moderate depression (5-6 ICD-10 symptoms and/or PHQ-9 score of 10-14)
- Moderate-severe depression (7 ICD-10 symptoms and/or PHQ-9 score of 15-19) where a level 3 intervention is appropriate and there is no significant risk.
- Any of the anxiety disorders
- Links with long-term conditions- diabetes, cardiac, Parkinsons Disease, stroke, COPD
- Maternal health
- Veterans of armed forces and families
- Older adults

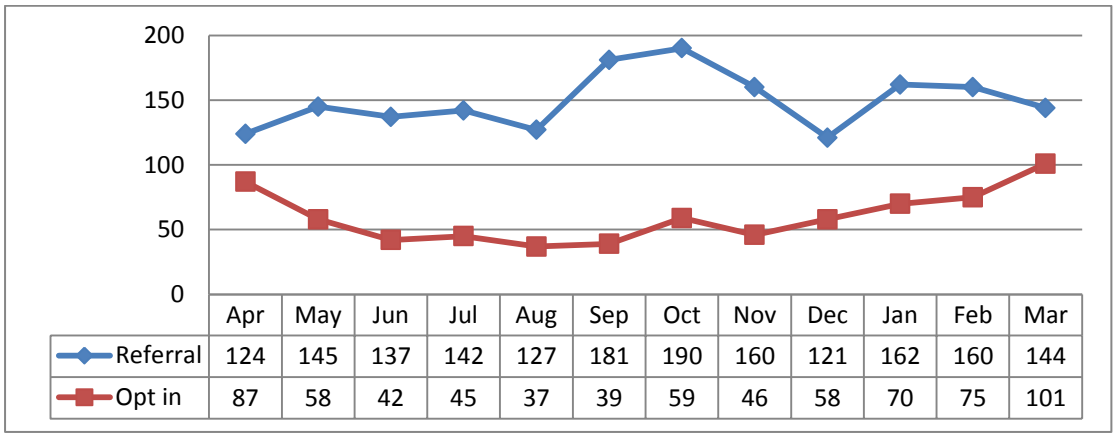
Two types of support available:

(1) Self-referral to local courses
- Emotional well-being
- Manage your Stress and Anxiety (A Polish version also)
- Boost your Mood
- Overcoming Panic
- Lift your Low Self Esteem
- Managing OCD

(2) Referral for assessment and treatment options
- Group Courses
- One to one help (face to face/telephone)

The team is made up of 5 High intensity (CBT trained); 4 Psychological Wellbeing Practitioners (PWPs); 3 trainee PWPs; 2 Assistant PWPs; 2.5 Admin and a Clinical Team lead. In 2013/14, the service received 1793 referrals (av. 150 per month) that resulted in 717 people taking up the service (av. 60 per month). This is a 40% opt-in.

Figure 3.4. Referral and opt in for IAPT 2013/2014.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Referral	124	145	137	142	127	181	190	160	121	162	160	144
Opt in	87	58	42	45	37	39	59	46	58	70	75	101

Source: 2gether NHS Foundation Trust

A number of courses or one to one support exist for people with a physical health condition to support coming to terms with their condition or as part of their treatment plan. There is some **health psychology** available to people receiving treatment for physical conditions. The General Hospital has a small health psychology team of 4.2 wte (excluding administrative support). It provides:

Acquired Brain Injury

Provision of Neuropsychological assessment, intervention and psychological therapy for adults with acquired brain injury alongside / as part of Herefordshire Acquired Brain Injury Team (HABIT).
Adjustment work and carer support

Cancer / Palliative Care
Individual / couple work
Palliative care Multi-Disciplinary Team membership, consultation/advice to teams, regular supervision of other practitioners, training, and advice on research.

Long-term conditions
Individual work to enable coping / adjustment / self-management for range of Long-Term Physical Health Conditions, such as diabetes; spine surgery/back pain/other pain; asthma /Bronchiectasis/COPD; Parkinson's Disease.

Stroke
Individual work for referrals across the stroke pathway (ward, Hillside, Community Stroke Team)

ACT with Mindfulness course' (all Health Psychology conditions) with 3 Courses per year, 7 x2 hour weekly meetings with daily practice, mixed group, max size c 12, typically 6-9 participants.

In addition to this, 2Gether NHS Foundation Trust are working with Wye Valley NHS Trust to deliver a new service for **young people with diabetes** that has made psychological support available for young people during transition. So far, seven individuals have used this service by August 2014.

Gloucester Hospital Trust operates Herefordshire **Pain Management** Service. The pain self-management service is a multi-disciplinary service for people with chronic pain in Herefordshire. Clinics are offered at Gaol Street and the Kindle Centre in Hereford and at the community hospital in Ross-on-Wye. The team includes a pain management nurse, physiotherapist, clinical psychologist and occupational therapist. The team is supported by the Pain Management Consultants at Gloucestershire Hospitals NHS Trust.

Breast Cancer Haven offers counselling and hypnotherapy by a mental health nurse for people diagnosed with **breast cancer** and their family members. The service provides emotional support, counselling and examines anxiety and phobia issues with people.

3.3.2. Parenting Support and Programmes

There are 10 **Children Centres** within Herefordshire and across these settings a high number of staff have been trained in the Solihull Approach. The Approach promotes emotional health and wellbeing in children and families. The model supports practitioners to work with children and families and supports parents and foster carers to understand their child.

A small number have also been trained to deliver Triple P (under 5's module). Triple P gives parents simple and practical strategies to help them confidently manage their children's behaviour, prevent problems developing and build strong, healthy relationships.

Delivery of these 'formal' **parenting programmes** is organised across centres and coordinated to meet local need. Health Visitors jointly deliver Solihull with a Centre Worker.

In addition Children's centres have **'nurture' groups** running which include focus on parenting, communication and attachment. These groups are provided to the more vulnerable families as identified by either the Children Centre staff, Social Care and / or Health Visitors. CAMHS delivers Webster Stratton parenting programmes particularly in response to work with under 5s and/ or foster carers.

Homestart has been established in Herefordshire since 1982. It provides support to families with 1 or more children and has in the last year increased its age range beyond 0-5's up to 19 years. This extension is to provide targeted family/ befriending support to vulnerable families and young people who may be struggling with various issues such as isolation, parenting skills or parents health.

In 2012/13 it provided support to 163 families (339 children including 199 under 5's) in Herefordshire through the provision of 2-3 hours per week home-visiting support provided by 68 trained volunteers.

Health Visitors provide universal and targeted support to families with pre-school children. Health Visitors are well placed to identify and support mothers who are experiencing poorer mental health, particularly post birth. All Health Visitors in Herefordshire have been trained to deliver the Solihull Approach and work in partnership with the local Children Centres for delivery.

Herefordshire Council is taking the lead role in reviewing its **Early Help** provision in the county. The Early Help programme could address the following elements of mental health:

- Promoting maternal mental health and reducing depression
- Supporting parents to parent effectively, using evidence-based parenting programmes.
- Providing Public Health and early years education programme
- Promoting mental health and developing social and emotional skills in schools and colleges.
- Provide early access to information, advice and support.

Herefordshire Council provide **family support** workers as part of their Social Work Teams. Some of the role of the family support worker is considered to be tier 2 emotional and mental health well-

being, i.e. parenting skills and attachment activities. Intensive family support work is available to families identified through the Troubled Families programme.

3.3.3. Young People's Services

School Nurses aim to provide a weekly drop-in at each secondary school for young people to access health advice, which includes emotional well-being support. A recent review of school nursing (Herefordshire Council, 2013) identified that the level of safeguarding work is high and is prioritised over these sessions therefore delivery of drop-ins are sporadic at times.

A number of Herefordshire's Schools and colleges either employ or buy in **counselling** provision to work with young people on a 1-1 basis. Herefordshire Council's **Educational psychologists** work at preventative, early intervention and direct intervention levels as well as statutory assessments of special educational needs. These functions are delivered in three ways:

- At an individual level; by working to reduce levels of concern about a child or young person
- At group or whole school levels: by helping others develop effective systems
- At a local authority level to support the development and implementation of policies.

Phoenix Bereavement support services works with children and young people up to the age of 21years and their family following the death of someone close to them. It is based in Hereford.

Hope Support Services works with young people aged 11 and over that are experiencing a family health crisis such as when a close family member is diagnosed with cancer or another life-threatening illness. Activities include youth sessions, online support and trips. The provision is in recognition that young people can develop anxiety, depression and other mental health responses as a result of the uncertainty that they are facing.

Crucial Crew (local name for an annual event) provides education to approximately 1600 of Herefordshire's year 6 pupils each year on how to stay healthy as they prepare to move onto secondary school. It includes subjects such as personal safety, alcohol and drug awareness and emotional wellbeing.

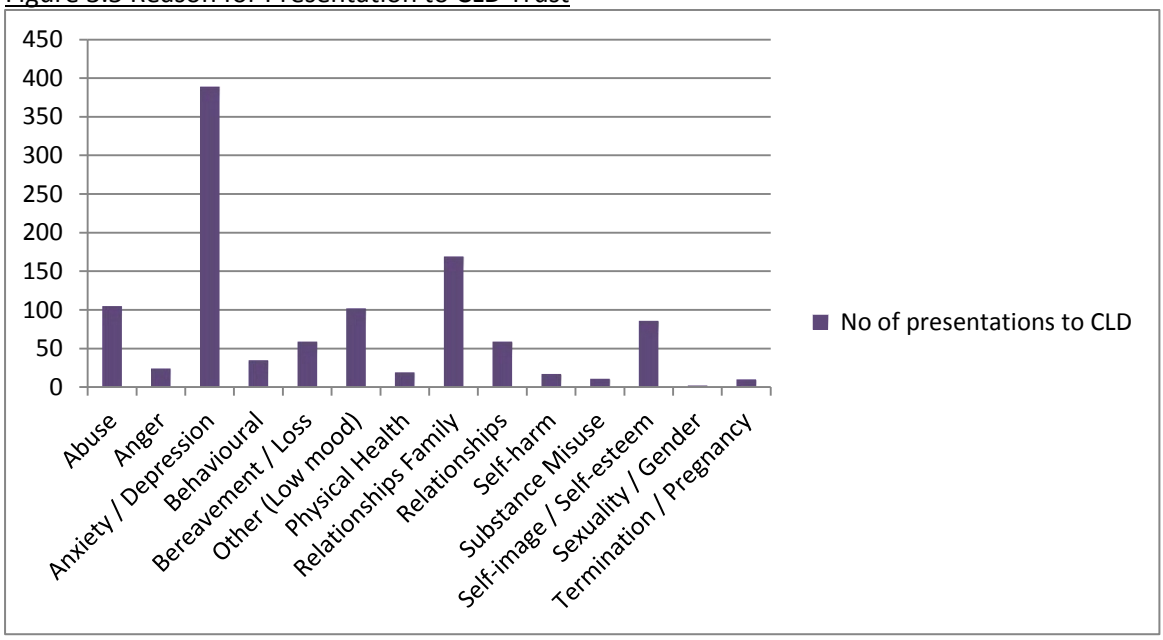
The **NSPCC** provides school based sessions across in Herefordshire to raise children's awareness of abuse and the Childline phone-line for support if they wanted to talk to someone.

West Mercia Women's Aid supported 525 women and 805 unique children in their core service plus 291 service users and 225 children assisted by the IDVA service (April 2012 to end March 2013). Women's Aid is a commissioned service that provides dedicated and specific domestic abuse and violence interventions including help line, crisis assessment, Independent Domestic Violence Advisor (IDVA), Community Support, Supporting Change, Refuge and other services including 'Crush' a service for 13 to 19 year olds

The **Counselling / Learning / Development Trust** (CLD) is located in Hereford city centre but provides outreach into local market towns, particularly Ross and Ledbury. It provides up to 6 sessions of counselling, funded by the CCG, to young people aged 10 years to 21 years who are

experiencing MH difficulties. It uses a range of counselling techniques, including cognitive behavioural therapy (CBT), based on the needs of the young person provide counselling for children and young people who are victims of domestic abuse.

Figure 3.5 Reason for Presentation to CLD Trust



Source: CLD annual report 2013/14

In 2013/14 it received 737 referrals (471 above its commissioned expectation). This averaged at 61 per month but with October, April and January presenting the highest volume (80, 79 and 76 respectively). At the end of March 2014 it had a waiting list of 389 young people. The majority of young people referred come from the HR2, HR1 and HR4 postcode area.

Of the referrals 64% were female, with a gender split starting at age 13, prior to this point male and female referrals were very similar (age 12 shows 22 females and 23 males whereas by age 14 it presents as 67 females to 32 males).

158 of the referrals came from CAMHS (21.4%) 469 were from a total of 27 GP practices, some referred over 30 patients in that year, (Alton Street, Cantilupe, Kings Street, The Marches, Moorfield and Sarum House), 18 came via adult mental health services and 80 were from non-medical services. 1 was a self referral and the remainder were from hospital or Out of Hours service.

Young People's drugs and alcohol service (**ZIGZAG**) is for 13-18 year olds, based in Hereford City and operating countywide. They provide 1:1 structured intervention, targeted education, harm reduction advice, information and support around legal and illicit drugs and alcohol.

Early Intervention Community Service will work with young people aged 14years and over where a suspected or confirmed first episode of psychosis has occurred (see 3.4.4. for description).

3.3.4. Families First

The **Families First Programme** in Herefordshire is a significant local programme with the ambition to make lasting positive changes to the lives of some of the most vulnerable families and communities across Herefordshire. It is Herefordshire's approach to the national Troubled Families Programme, launched in April 2012; a £448 million scheme to incentivise local authorities and their partners to turn around the lives of 120,000 troubled families by May 2015.

In Herefordshire, there are 310 families identified, and as at the end of August 2014, from 174 Families:

- 43 % had Crime & anti-social behaviour
- 47 % had poor school attendance
- 28 % are out of work
- 43% had domestic abuse in the household
- 35% have drug/alcohol misuse issues
- 39% have mental health issues within the household

In June 2013, the Government announced plans to expand the Troubled Families Programme for a further five years from 2015/16. The expanded Troubled Families Programme will retain the current programme focus but will also reach out to families with a broader range of problems, including those affected by domestic violence and abuse, younger children who need help and families with a range of physical and mental health problems, for example, adults with parenting responsibilities or a child with mental health problems, young mothers that suffer from mental health issues which impacts on their parenting capacities, or unhealthy behaviours resulting in obesity, malnutrition or diabetes.

Health problems for families in the current Troubled Families Programme are costly and pervasive. Findings from the National Programme's independent evaluation indicate that, on entry to the programme, 71% of families included someone with at least one health problem; 46% included an adult with a mental health problem; a third (33%) of children were suffering from a mental health problem; nearly a third (32%) of families included an adult with a long-standing illness or disability; and one-in-five (20%) families included a child or children with a long-standing illness or disability. Building on these findings, the expanded Programme will place an even greater emphasis on reaching families with a range of physical and mental health problems.

3.3.5. Carers Support

The main source of independent carers support is from **Herefordshire Carers Support**. Other organisations acknowledge the needs of carers, e.g. through signing up to the local Carers Charter or have dedicated provision, e.g. Carers In Mind. 22 out of 24 GP practice have a carers lead.

Herefordshire Carers Support run an enquiry line, website support, peer support groups, closed facebook groups, one-to-one assistance, training for carers and carers events. The organisation champions Carers rights as well as participates in a number of strategic forums to advocate for the

voice of carers. This work is assisted by having carers as trustees, engagement groups such as Parents Carers Voice group.

One of the training courses was 'Understanding Dementia for Carers' and recently the organisation is hosting a **Dementia Carers Nurse Trainer** from Tauras Healthcare to offer advice to carers. The purpose is to work with a specific group of people with dementia and train their Carers as appropriate to prevent emergency admissions.

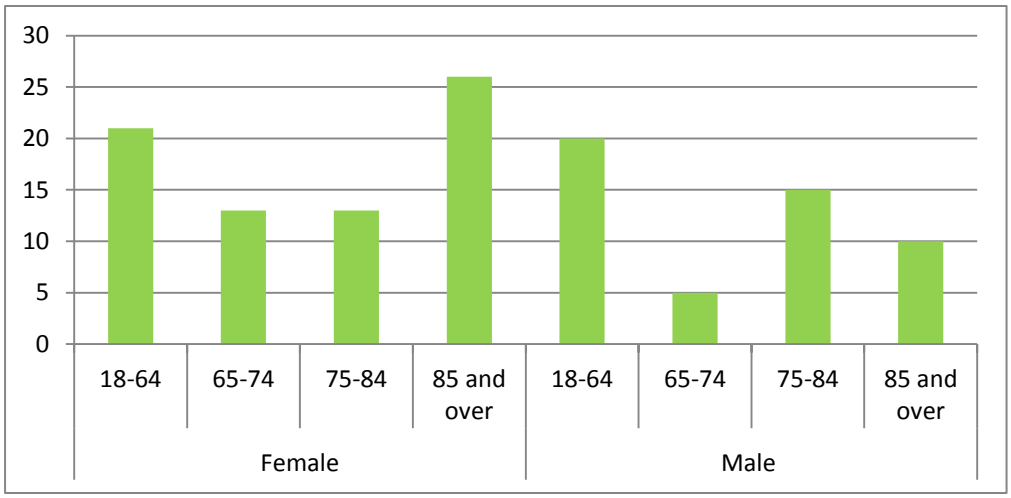
As of June 2014, there were 4052 carers registered, of which 844 new carers registered during 2013/14. The peer support groups had over 300 carers attending with 17 groups set up. 586 carers were supported through one to one support.

The organisation is accredited with ISO 9001, PQASSO level 2 and hold the centre of Excellence with the Carers Trust.

3.3.6 Care at Home

In the community, there are 25 **domiciliary care agencies** registered with Care Quality Commission as providing assistance in the home for people with mental health needs. There are three day care establishments for people with mental health needs excluding dementia (Aspire, Headway and Herefordshire Mind) and a number of providers offering support with activities such as training, befriending, and social activities.

Figure 3.6: Number of Adult Social Care with Mental Health Problem receiving Home Care by Age and Sex 2013/14



Source HC Adult and Well-being, Performance Team 2014

Support at home is available from the Red Cross to provide a visit once a week by a volunteer for up to six weeks for adults aged 18 and over. 465 people were supported in Herefordshire in 2013/14. A **mobility aids loan** service provides equipment to support a return to home (or for visitors to the county). This scheme benefitted 763 people in 2013/14.

3.3.7. Support in the Community

There are a number of organisations that operate in the county that provide community support including to people with mental health conditions and their carers. For example, **Age UK Hereford and Localities** is a voluntary organisation assisting older people and their carers. Through their activities, they see people with mental health needs and their carers therefore one function is to signpost to sources of support and another function is to deliver activities that serve to maintain people's good mental health. As the activities reduce social isolation and maintain people to remain independent at home, these can be classed as preventative and early intervention activities. The range of services include an information and advice service, foot care, day opportunities including lunch clubs, men's group, IT training and life-long learning, telephone befriending and home visiting, and transport. In 2013/14, 3,700 people were supported.

In Leominster, ECHO for Extra Choices in Herefordshire facilitates a **Rural Crafts Group**. This group is open to people referred by mental health services who have mental and emotional mental health needs. It is a small group so that people can grow in confidence – seven people were supported in 2013/14. They meet once or twice a week to enjoy gardening, environmental and craft activities in a relaxing, safe and supportive environment. The group participants have reported the development of work-based skills, reduction in social isolation and improved fitness and well-being. Families and carers are encouraged to visit Rural Crafts and people attending the Rural Crafts Group can elected to sit on Echo's The Rep Group.

Echo provides opportunities for people to take part in activities within the community. The work is mainly with people with moderate or severe learning disabilities, but also people with mental health needs and people with physical or sensory impairments. The organisation uses PQASSO quality scheme. In 2013/14, 90 people were supported, to participate in day opportunities, leisure and social activities and community connections.

Herefordshire Volunteer Centre helps organisations and volunteers find each other, matching individuals and groups interested in **volunteering** with appropriate opportunities in the local community. Volunteering has been shown to be beneficial to the mental health of individuals. It can improve overall mental health and also help to protect from mental health problems.
The Mental Health Foundation lists the following as some of the benefits of volunteering:

- It provides structure and routine
- It can help people feel good about themselves
- It can improve feelings of self-esteem
- It provides opportunities to make friends and take part in social activities
- It can provide learning opportunities which can help to protect mental health.

There is some **supported employment** by two providers, with a broad range of organisations making **Adult and Community learning** available. For example, Brightstripes provides training for independent living skills such as falls prevention and relaxation techniques. Red Spark learning

Community Interest Company runs accredited and non-accredited adult learning courses, workshops and projects in community venues. 150 people were supported in 2013/14.

There are 6 **care farms** in the county. Hereford Community Farm provides a structured therapeutic land based activities in a collaborative approach in recovery and rehabilitation for people affected by mental health. Such farms offer skill development, confidence building and supported employment programme. Hereford Community Farm has the capacity for 100 people per week. The Houghton Project offers people the opportunity to engage in animal husbandry, horticulture, carpentry, woodland management and orchard management. 60 people were supported in 2013/14.

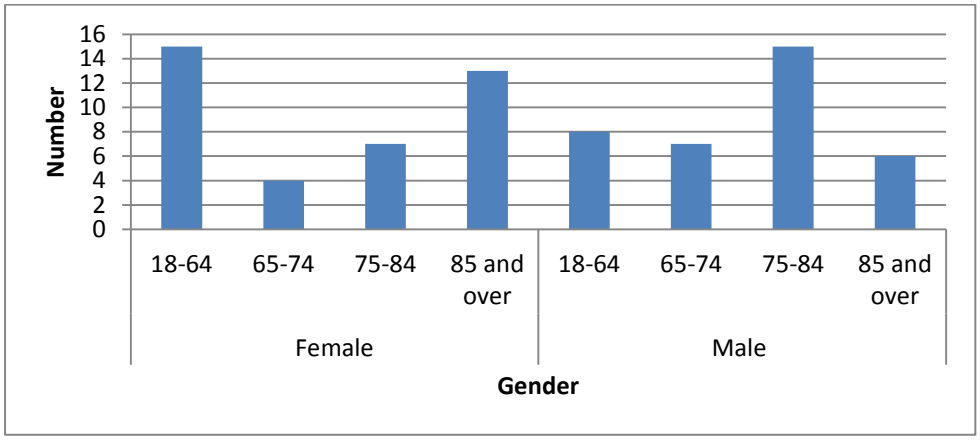
The Alzheimer Society delivers **Singing for the Brain** is a stimulating, social activity designed to enhance the wellbeing of people living with dementia. Sessions are available in Ledbury and Hereford. They also run a day centre for people with dementia.

Herefordshire Headway provides a day centre that is a therapeutic community for people over the age of 18 with acquired brain injury including those who have had a stroke. The Centre provides support for people to come to terms with their injury, set recovery targets and rehabilitate. In 2013/14 60 people were supported on a regular basis and 35 carers.

Engagement by people with ABI in the running of the organisation is acknowledged as important. A monthly client forum encourages people to make suggestions on service improvement and raise issues. Clients can become voting members, including voting at the AGM and having a say in the Charity's strategy and delivery direction.

The organisation meets Headway UK quality standard and learning programmes are Ofsted inspected.

Figure 3.7: Number of Adult Social Care Clients with Mental Health Problem using Day Care by Age and Sex 2013/14



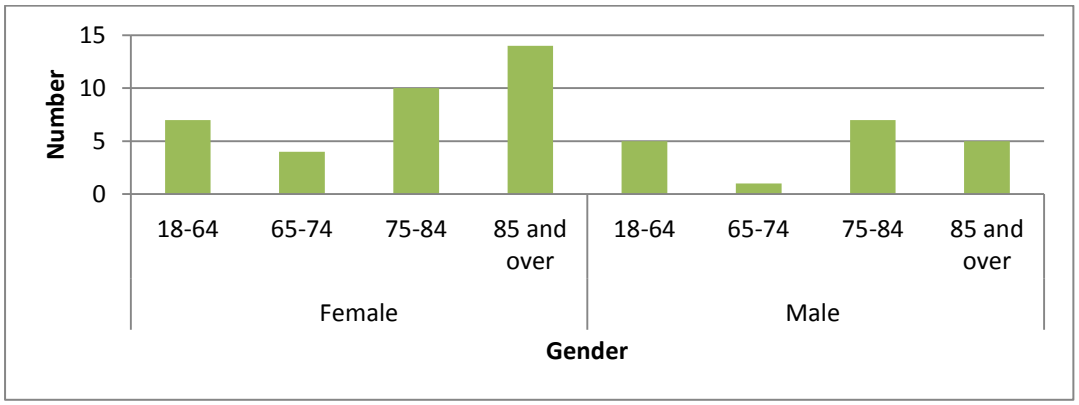
Source HC Adult and Well-being, Performance Team 2014

Herefordshire Mind provide a range of support based on a recovery and wellbeing model. This includes through Heffernan House in Hereford and the Grange in Leominster, as well as community facilities in Ross, Ledbury and the Golden Valley. Some of the support is delivered as outreach to

support people in their own homes. Group work, therapy sessions, education and one to one support is available. As of July 2014, 350 people were receiving support.

Figure 3.8. shows the number of people needing **equipment** during 2013/14 known to Herefordshire Council.

Figure 3.8: Number of adult social care clients with mental health problem needing equipment and adaptations by age and sex 2013/14



Source HC Adult and Well-being, Performance Team 2014

There are a number of small homes that people agree to co-live with others. It is not possible to map all of these homes. There is a new development in Hereford to provide **extra care** facilities for people with dementia. This is in addition to the existing extra care, Rose Gardens in Hereford.

People with mental health conditions can experience homelessness. In Hereford, single homeless people aged 16-65 years old are supported by Home Group through **supported accommodation**. From January 2013 to June 2014, 56 people accessed Pomona Place. Herefordshire Mind also offer housing related support through their **community support team** and their housing facility of 11 flats/bedsits.

A specific provision exists for young people aged 16-25 who are homelessness, with **Foyers** and accommodation across the market towns. Called Supported Housing Young People's Project (SHYPP), part of Kemble Housing, the provision supported 339 young people in 2013/14 with housing support, accommodation and adult learning.

3.4. Intensive Support

3.4.1. Advocacy

There are two organisations that provides formal advocacy for vulnerable people.

Onside provide one to one advocacy support for issue based and crisis advocacy, including **statutory advocacy** under the Mental Health Act and Mental Health Capacity Act. In 2013/14, Onside worked

with 46 people requiring mental health advocacy; 74 people needed mental capacity advocacy and 102 people received general advocacy. The organisation also provided an **independent visitors** service to looked after children.

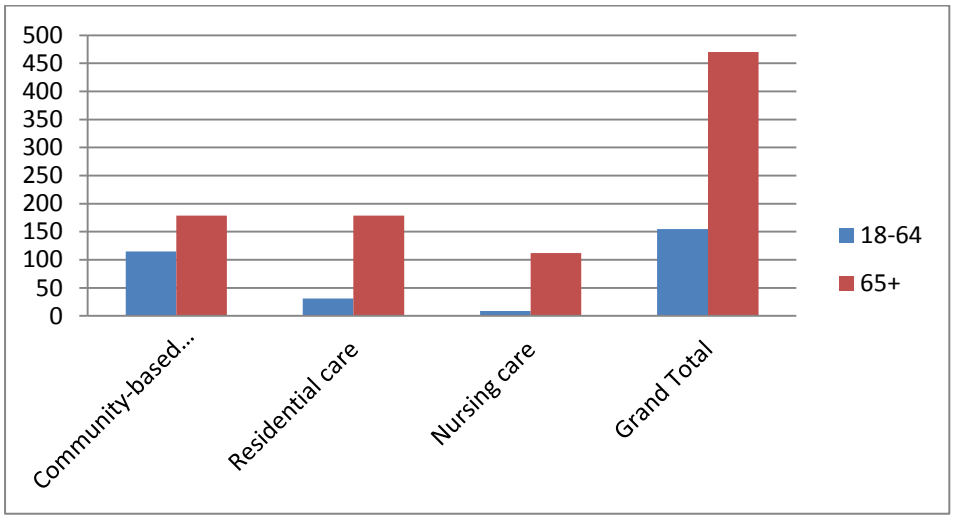
NYAS provide an advocacy service to children on a child protection plan and Looked After Children.

3.4.2. Adult Social Care

In 2012/13 288 people with a mental health illness were receiving support from **Adult Social Care** (Herefordshire Council, RAP report). Some of these people would have taken their support in the form of a personal budget. This is an allocation of resources to meet the assessed eligible need. People can choose to take directly commissioned services from the Council or opt for a direct payment. A direct payment is a payment made to either the service user or their carer direct so that they can directly purchase care and support themselves following an assessment of need. This approach promotes choice and enables individuals to help manage their own conditions.

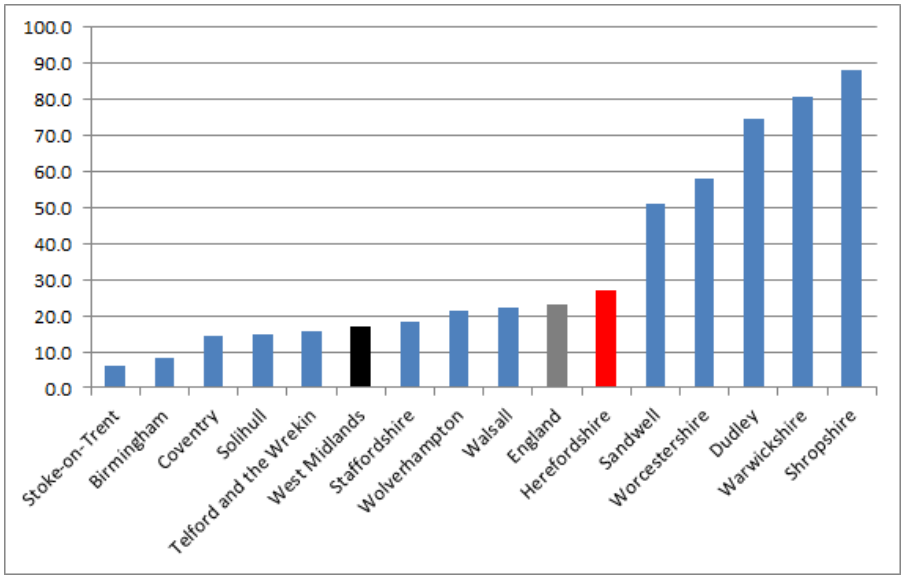
Out of the 288 that received support, 98 people were in residential placements and 85 people were in nursing care. The majority of people with mental health in residential and nursing care were aged over 65 (93%) with 7% aged 64 and under. All people aged 64 and under were in residential care with no-one placed in nursing care.

Figure 3.9: Overall Adult Social Care Clients by Primary Care Type 'Mental Health' 2013/14



Source HC Adult and Well-being, Performance Team 2014

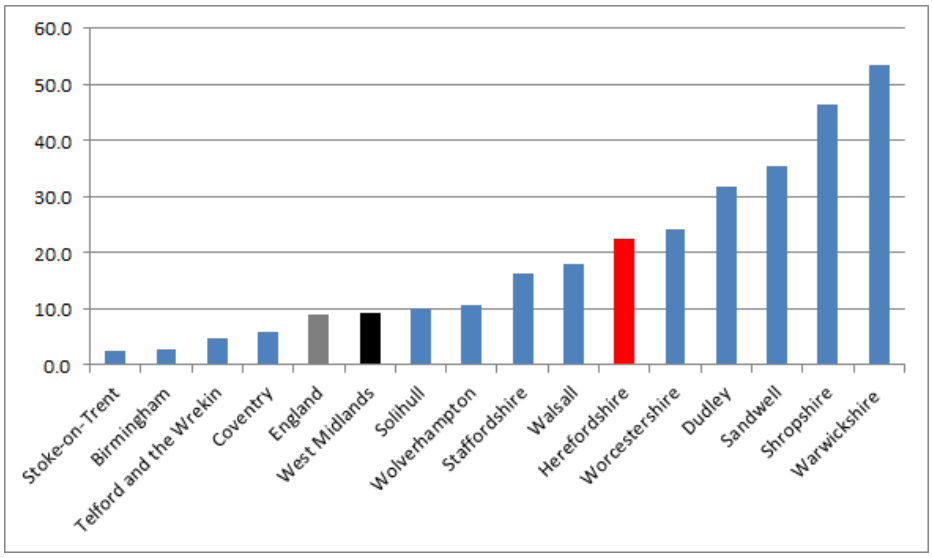
Figure 3.10: Proportion (%) of people with Mental Health problem using social care who receive self-directed support 2012/13



Source: Adult Social Care Outcomes Framework, HSCIC

The above graph illustrates the proportion of people with mental health problems using community-based social care services receiving self-directed support, such as a personal budget. Self-directed support gives people more choice over how their care and support works. A higher score is better. Herefordshire is performing better than both England (based on 152 local authorities) and regional averages for those with mental health problems. However, the proportion of those receiving self-directed supported is very small at 27 per cent compared to almost 90 per cent for the best performing local authority.

Figure 3.11: Proportion (%) of people aged 18-64 with Mental Health problem using social care who receive direct payments 2012/13



Source: Adult Social Care Outcomes Framework, HSCIC

Receiving payments directly lets recipients of care and their carers spend money on care and support in ways and at times that make sense to them. A higher score is better shows that more people have direct payments. Herefordshire is performing better than England and West Midlands.

Overall 1635 people and carers received self-directed support in the year to 31 March 2014 out of a total number of 4145 people receiving community-based services and carers receiving carer specific services in the year to 31 March (aged 18 and over).

Herefordshire Services for Independent Living run a **Direct Payments Support Service (DPSS)** that provides information, advice and guidance to people employing their own staff through a direct payment. As of 2013/14, 5 people with mental health needs were using this service as part of their direct payment arrangements.

3.4.3. Residential Care (in-county)

Of the forty-two **nursing and residential homes**, most care for older people with dementia or Alzheimers Disease (thirty-nine homes in Herefordshire as of August 2014). There are a total of nineteen registered care homes for people with other mental health needs such as schizophrenia, or dual presentation of learning disabilities and mental health.

There are seven care homes that provide long-term provision specifically for younger people with mental health (under 60 years of age). The specialisms listed include eating disorders, bipolar, challenging behaviours, autism and complex neurological presentations.

Table 3.1 shows the location and occupancy available for residential placements.

Table 3.1: Care Home provision in Herefordshire for people with Mental Health conditions

Care Home	Location	Occupancy	Eligibility / Specialism
Abbey Grange	Hereford	29	Dementia, mental health, over 65
Aston House	Hereford	16	Schizophrenia, Aspergers, bipolar and eating disorders.
Blackwells	Hereford	7	Primary diagnosis of Learning disability, with challenging behaviours or autism
Broomy Hill	Hereford	40	Dementia, mental health, over 65
Chepstow House	Ross on wye	14	Primary diagnosis of learning disability, with Aspergers, autism bipolar and eating disorders.
Chesfield House	Leominister	5	Schizophrenia, Prader-wii, acquired brain injury
Coldwells House	Hereford	33	Dementia, mental health, over 65
Credenhill Court	Hereford	35	Dementia, mental health, over 65
Field Farm House	Hampton Bishop	65	Dementia, mental health, over 65
Holmer	Hereford	49	Dementia, over 65
Hunters Lodge	Hereford	10	Autism, acquired brain injury
Lyndale	Hereford	10	Schizophrenia, eating disorders, Autism.
Oaklands	Withington	28	Dementia, mental health, over 65
Pencombe Hall	Bromyard	32	Dementia, mental health, over 65
Stanley House	Ledbury	41	Complex organic mental health, ABI and complex neurological illness for people aged 13-65.
The Shires	Hereford	11	Mental health

The Forbury	Leominster	40	Dementia, mental health, over 65
The Manor Rest House	Hereford	23	Dementia, mental health, over 65
Whitegates	Bromyard	37	Dementia, mental health, over 65
Wykenhurst residential home	Hereford	25	People aged 45 and over with Alzheimer, challenging behaviour, schizophrenia.

Source: Care Quality Commission

3.4.4. Mental Health Pharmacist Input (Herefordshire)

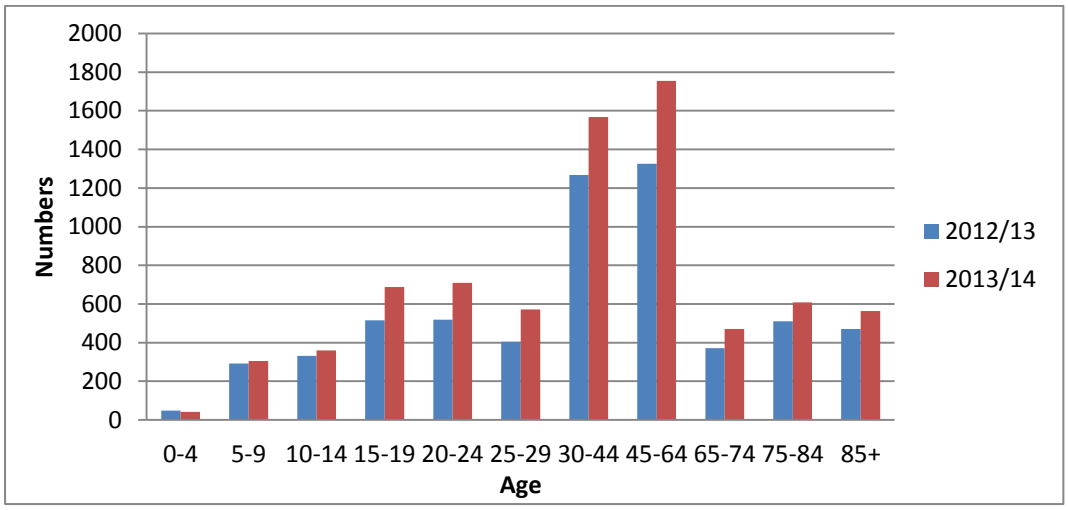
- 0.2 WTE specialist clinical pharmacist based in Hereford (SLA 2g/HCCG)
- Strategic oversight and governance: 2gether Pharmacy team
- General pharmaceutical advice and supply function: WVT Pharmacy (SLA 2g/WVT)

3.4.5. Assessment and Treatment

There were 4,924 referrals to mental health services in 2012/13 and 6450 in 2013/14. In addition, the provider made 1,100 referrals between its teams. It is not possible to break down into classifications of mental health as people change or have more than one condition.

The figure below shows the difference in referrals by age band.

Figure 3.12: Referrals to Mental Health Services by Age 2012/13 and 2013/14



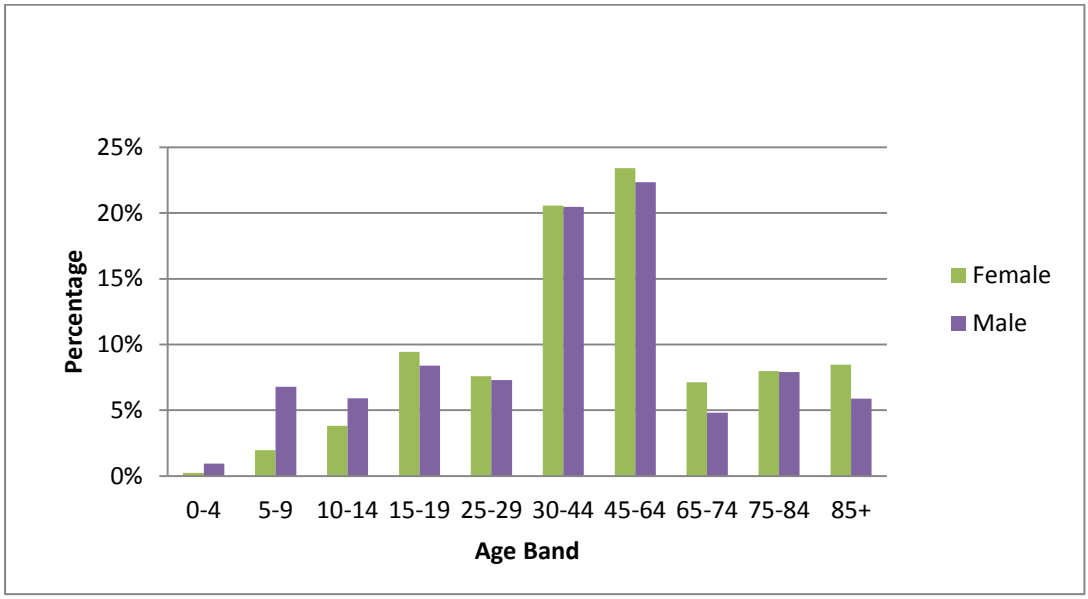
Source: 2gether NHS Foundation Trust

There were more referrals made in 2013/14 compared to 2012/13. Most referrals were aged between 45-64 years (23%) and 30-44 years (21%).

- Data only available for 2 years therefore trend analysis cannot be made
- Overall there were more referrals made in 2013/14 compared to 2012/13 (for all ages) with an increase of 21%
- Most referrals were aged between 45-64 years (23%) and 30-44 years (21%)

- Very few children (0-4) were referred to the mental health services accounting for 1% of all referrals
- Most of the referrals to CAHMS over the 2 years were aged between 15-19 years accounting for 47% of all CAHMS referrals

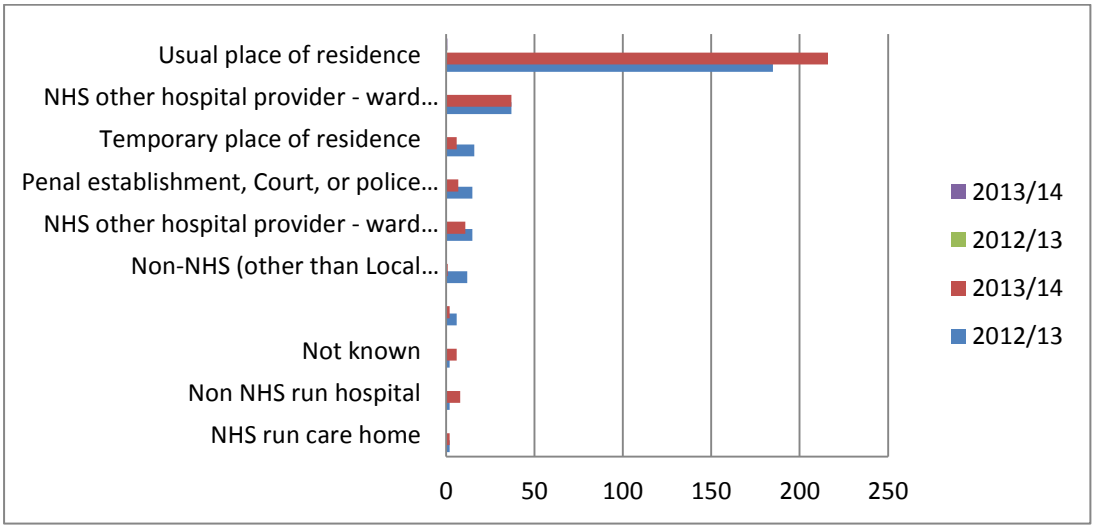
Figure 3.13: Age distribution by Sex of Referrals made to Mental Health Services 2013/14



Source: 2gether NHS Foundation Trust, 2014

Overall the majority of referrals are women accounting for 55% of referrals in 2012/13 and 58% in 2013/14. There was no major difference between the proportions of age distribution by sex between the 2 years

Figure 3.14: Sources of referrals to 2Gether NHS Foundation Trust Services



Source: 2gether Data, 2014

The majority of referrals leading to admissions are made from the services users usual place of residence 63% and 73% for the years 2012/13 and 2013/14 respectively.

The majority of people seen by community mental health teams are seen by Recovery Teams for working aged adults and for older people. They work with two broad groups of patients:

- People with conditions that require time-limited interventions of weeks or months, with discharge on completion of the intervention
- People who require ongoing treatment, and care and monitoring for prolonged periods, but should be managed within the recovery model with an expectation of eventually improved functioning to allow discharge. These individuals may have complications including risk of harm to self or others and/ or be poorly concordant with treatment. These individuals may be managed by assertive outreach team.

Herefordshire has an Assertive outreach team (AOT) with the aim of keeping people with serious mental health problems in contact with services. Mental health problems are often combined with additional needs relating to drug or alcohol misuse, offending and social relationships. AOTs have the following features:

- A multi-disciplinary team-based approach to care (involving a psychiatrist with dedicated sessions)
- Care provided for those with serious mental illness
- Team members shared responsibility for clients
- Provide all the psychiatric and social care for each client rather than referring on to other agencies (i.e. intensive case management)
- Care is provided at home or in the work place as far as this is possible
- Treatment and care is offered assertively to uncooperative or reluctant service users
- Medication concordance is emphasised.

3.4.6. CAMHS

The CAMHS service is a **multi-disciplinary, community-based therapeutic and assessment** service that works with children and young people up to the age of 18 years with mental health needs and forms part of a continuum of emotional health and wellbeing services in Herefordshire. The service provides Tier 2 and Tier 3 services for children up to the age of 18 in partnership with the CLD Trust, to improve emotional wellbeing by providing early intervention and utilising a 'stepped care' approach to provide intervention and support options to meet the needs of our younger population who require secondary care.

In order to meet these specialist needs care pathways have been developed in a number of areas within the service, including Autistic Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Eating Disorders. Appropriately skilled Staff lead on these areas.

CAMHS also provide paediatric psychology services to young people with diabetes in an arrangement with Wye Valley Trust on a 12 month fixed term basis.

The Service provides a rolling programme of 'The Incredible Years' parenting programme and psycho-education seminars for parents of those young people diagnosed with ASD.

The Choice and Partnership Approach (CAPA) model (Choice and Partnership Approach is now fully embedded within the service and is seen as a valued approach to practice.

The model:

- Focuses on engagement, therapeutic alliance, choice, strengths, goals and care planning
- It improves access by ensuring timely appointments, with no waiting list
- Families are seen by a clinician with the right skills to meet their needs
- Uses Outcome measures

CAMHS Learning Disability Service

The Service works to improve the quality of life of children with learning disabilities who have additional emotional/behavioural or other mental health difficulties in Herefordshire providing a range of interventions. This includes behaviour support and modification, psychological interventions, provision of intensive home/school based interventions to alleviate crisis and to prevent family breakdown.
The Team are currently based at the Kite Centre enabling them to liaise across agencies who work with children and young people with Learning Disabilities.

CAMH Service

CAMHS is based within Hereford city centre and offers most of its appointments there. There is currently a small level of outreach provision by 2 staff.

An equivalent of 16 full time staff deliver the service, a high number of which are part-time. a critical mass of staffing is essential – standard 9 of the National Service Framework recommended that a generic specialist multi-disciplinary CAMHS at Tier 3 without teaching responsibilities providing evidence-based interventions for 0-17 year olds would need a minimum of 15 whole time equivalent clinical staff (WTEs) per 100,000 total population.

It is open between 9-5 Monday to Friday and there is someone on 'duty' for urgent cases during this time. Outside of office hours; if admitted to hospital for mental health emergency paediatric ward staff will liaise with on-call hospital psychiatrist. If not admitted but mental health concerns are raised then referral made to CAMHS duty and follow up assessment will be completed during office hours.

CAMHS received 109 duty referrals from the hospital ward during 2013/14 (data taken from duty record book) Adult Crisis team do at times work with CYP over the weekends and then forward onto CAMHS. Follow-up is within 7 days.

CAMHS received 1027 referrals in 2013/14, of which 62 were for children in care and 99 were through the 'duty' route as new cases. 8 referrals were already open. Of the total 1027 referrals 296 (28.8%) were declined by CAMHS as not meeting the threshold.

Table 3.2: CAMHS activity data 2013/14

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number of referrals to specialist CAMHS services	41	37	50	57	41	61	83	80	71	66	96	101
% of children waiting 18 weeks and over	8%	12%	14%	16%	19%	15%	1%	1%	2%	1%	0%	0%
Number of people on a waiting list to be seen by CAMHS	111	110	102	101	83	98	109	114	137	131	127	130
Number of children admitted into Tier 4 services	0	1	0	2	0	0	1	0	0	0	0	0
Number of children discharged from CAMHS services	105	106	101	115	92	91	121	76	80	85	90	90

Source: 2gether NHS Foundation Trust

Based on CHIMAT's (2012) estimate there should be 630 CYP requiring tier 3 intervention Herefordshire accepted 731 referrals, 101 (16%) above the estimate. A note of caution is required however due to a lack of tier / ICD-10 code use within CAMHS it is not possible to extrapolate as to whether some CYP are receiving Tier 2 intervention rather than Tier 3 within this number.

A total of 1187 children and young people were discharged from CAMHS in 2013/14. In regard to waiting list CAMHS began 2013/14 with 8% waiting for than 18 weeks, this then peaked in August 2013 at 19%. Since this point it has dramatically decreased and was for the last 2 months of the year showing a 0% 18 week wait. Numbers of children and young people waiting less than 18 weeks has ranged between 83 in August 2013 to 137 in December 2013.

Some of the reduction in waiting lists could be attributed to the implementation of Choice and Partnership Approach (CAPA), which has been shown as a proficient system in managing service demand and capacity. It also supports and empowers service users participation in clinical decision-making.

In regard to **medication** a total of 119 females and 238 males are on medication prescribed by CAMHS, mainly for ADHD or Neurodevelopmental disorders (table 3.3). Other children and young people may be receiving pharmacological treatment through their GP so this figure is not necessarily a true reflection of pharmacological use amongst children and young people.

Table 3.3: Pharmacological provision in CAMHS

	0-5	6-10	11-16	>16	Total
Female		16	67	36	119
Male	1	59	152	26	238
Total	1	75	219	62	357

CAMHS provides specific clinics for Eating Disorders, ADHD, ASD -Psychoeducation, under 5's Psychotherapy, Incredible Years and a diabetes group.

Herefordshire Council has recently established a therapeutic service for looked after children. The **Herefordshire Intensive Placement Support Service (HIPSS)** works with children and young people aged between 7 and 18 years whose needs lie within Level 4 of the Herefordshire Levels of Need Pathway and are at the threshold of being placed in, are already within some form of institutional care or have recently left such care. It will support young person to develop greater emotional well-being and control over their behaviours such that they can engage in meaningful relationships, participate positively in the community, take advantage of opportunities in education and learning and live appropriately in ordinary independent living. The service will provide individually –tailored intensive wrap-around (multi-systemic) therapeutic intervention packages as an alternative to institutional care. The service will support children and their carers in foster placements, kinship care, special guardianship arrangements or those stepping-down from residential care.

Therapeutic Intervention Support Service (TISS) which will support and promote the use of direct work models to be applied with the full range children and families being supported by Children's Social Services department in need as defined within Level 3 and 4 of the Herefordshire Levels of Need Pathway. The Service undertakes some direct work with families but will primarily be required to guide and support the department's own staff to provide individually–tailored intensive wrap-around (multi-systemic) therapeutic intervention packages aimed at meeting the requirements of Children in Need, LAC and Child Protection Plans.

Forensic Assessments for children are not available locally. These are conducted by a number of assessment units in the UK. The nearest provider is in Birmingham.

3.4.7. Dementia

The **community dementia service** is made up of three elements: Memory Clinic, Community Dementia Team including **dementia advisers** from the Alzheimer's Society and a Care Home In-reach Team.

The Memory Clinic delivers specialist assessments for people with a possible diagnosis of dementia.

The Community Dementia Team provides on-going support from diagnosis to end of life. The service is based in primary Care to work in partnership with GP surgeries. The Alzheimer's Society provides dementia advisers and volunteers that can support people to access local, regional and national sources of support. The Advisers are named point of contact for the person with dementia and their carers, enriching the support plan for the individual.

The Care Home In-reach Team provides support to people living in long term care settings, to avoid interventions such as anti-psychotic prescribing.

3.4.8. Palliative Care

People with palliative care needs receive support from St Michael's Hospice. The multi-disciplinary team at St Michael's Hospice work together to help patients and their families adjust to the inevitable changes that life-limiting illnesses bring; help to relieve symptoms and control pain; find techniques to remain living independently; able to assist with worries about money or housing, offer spiritual guidance and support with emotional upheaval.

The services include: 16 bed In-Patient Unit; Day Hospice; Physiotherapy and occupational therapy; Support groups and workshops for patients and carers; Complementary therapies; Saturday Club for children affected by the illness of a loved one; Bereavement support; Family support;24-hour advise line; and training for practitioners.

3.5. Crisis Response

3.5.1. Crisis and Emergency Care

The **Crisis Resolution and Home Treatment Service** is a specialist team of mental health professionals who provide a crisis resolution and home treatment (excluding the hours of 10pm until 7am) service for adults who would be at immediate risk of being admitted into a psychiatric hospital. They also facilitate all admissions to in-patient care (excluding those presenting with an organic mental health problem). People can be referred to the team through different routes including through the Recovery Teams, GPs and also In-patient wards to support and facilitate discharge home. The aims of the Service are:

- To help to manage and resolve service users mental health problem's / crisis, through assessment and treatment in their own home environment as an alternative to hospital admission.

- Short term involvement in patient care until the crisis has been minimised after which referral to appropriate services will be made.

- To actively involve patients / their families, or carer's as appropriate, to promote recovery.

The Team operate a duty rota and are currently called upon for urgent assessment of those who need a same day assessment due to imminent risk of hospitalisation. The team will respond to A &E hospital referral post triage indicating high risk and who are medically fit for discharge .The team are

not involved in assessment of people detained under 135/136 unless post assessment they are identified as requiring a possible informal admission, in which case the team will assess to see if they are suitable for home treatment or do require admission.

People with self-harm incidents are usually taken to **Accident and Emergency Department** whereby their physical presentation is addressed first, followed by a referral to Mental Health Services. Children and Young People are admitted to the **Paediatric Ward** until medically stable and a referral to CAMHS made prior to discharge.

There is a rota of **Approved Mental Health Professionals** (AMPH) for the county in the event that assessments are required as part of admission to hospital. AMPHs are approved by their local authority social services department to organise and carry out assessments under the Mental Health Act 1983.

3.5.2. Place of Safety

The term "place of safety" is used in the Mental Health Act 1983, Section 136 of the Act gives police officers the power to remove an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a "place of safety" where they may be assessed by a doctor. Section 135 of the Act gives police powers to remove a person who is not in a public place to a place of safety after the issue of a warrant by a Justice of the Peace.

Herefordshire's designated **Place of Safety** is an area within the Mental Health Hospital. This is non-staffed area that is utilised when required. A local agreement between Herefordshire Council, NHS Trusts and West Mercia Police Force is in place, regarding the place of safety.

The owners or managers of an establishment acting as a place of safety have a legal obligation to ensure that a detained person cannot leave the premises until he or she has been fully assessed, which may take up to 72 hours.

3.6. Intensive Recovery

3.6.1. Inpatient Rehabilitation

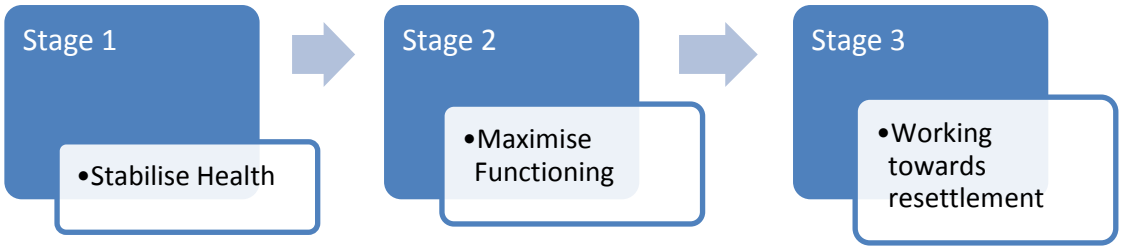
Herefordshire has one NHS-funded **rehabilitation unit**. This is an open unit supporting people's recovery as an inpatient. 2gether NHS Foundation Trust currently provides an inpatient facility for rehabilitation and recovery of service users with severe and enduring mental health needs.
The Unit is an ageing Victorian building situated in Hereford, near the Town Centre and has ten inpatient beds (5 male, 4 female, and an annexe room which can be used to support patients of either be either gender) providing 24-hour care; the accommodation is arranged over three floors with male bedrooms on the first floor and female on the second with single gender bathroom facilities.

Service users' needs include a range of issues related to living with severe and enduring mental illness. Diagnosis is primarily that of psychoses. Service users usually stay at the Unit for between 12-24 months.

A wide range of therapeutic interventions are available to service users based around the principles of recovery. These include the use of The Recovery Star programme of recovery, psychosocial interventions with psychosis and family work.

The care pathway at the Unit is described in Figure 3.15 below:

Figure 3.15: Three staged patient journey at the Rehabilitative Unit



Other rehabilitation units are:

Step up and step down services are provided through a range of providers, environments and modalities. These include nursing and residential homes, small group homes, specialised placements and packages of care and support delivered in a person's own tenancy.

There is a need for supported accommodation for people who experience mental health issues as a stepdown from hospital placements.

Professional

3.7. Acute Inpatient

3.7.1. Inpatient Assessment and Treatment

There is a local **mental health hospital** in Hereford that has three wards: One for people under 65; one for people with organic illnesses over 65 and one for older adults with functional illnesses. There is some flexibility across the wards to ensure that people are treated locally. There are 39 beds in total. People admitted to the hospital are either detained under the civil provisions of the Mental Health Act 1983 (as amended by Mental Health Act 2007) or informally.

The nearest **Psychiatric Intensive Care Unit** for Herefordshire patients is based in Gloucestershire.

There are no high, medium or low secure units in Herefordshire. Patients requiring assessment and treatment detained under the civil or criminal provisions of the Mental Health Act 1983 (as amended by Mental Health Act 2007) are placed at specialist services throughout the UK.

Children and young people requiring inpatient admissions receive care out of the county. There is no provision in-county for children needing an inpatient bed. The list below shows the regional placements available for Herefordshire children. Bed availability is a national issue and there are occasions when children and young people are sent further afield as a result of bed / treatment availability.

Regional **CAMHS inpatient providers**:

- Park View Clinic Birmingham
- Japonica Ward Birmingham
- Ardenleigh Forensic CAMHS Birmingham
- Woodbourne Priory Birmingham
- Huntercombe Cotswold Spa, Broadway
- Brooklands LD CAMHS, Solihull
- Huntercombe Stafford
- Darwin Unit, Stoke
- Newbridge Eating Disorders CAMHS, Streetly

3.8. Individual Placements

As at 30th June 2013, there are 34 adult service users currently being supported by Herefordshire in **out of county place**ments because of their mental illness.

- 16 Health funded
- 6 Social Care funded
- 12 regional funded

Herefordshire residents access out of county placements mainly to access levels of service not available within the county. These specialist services include a range of bed based functions from forensic mental health, specialist neurological providers to simply intensive levels of support.

These service users are cared for in a range of venues across the country, e.g. Bristol, Northampton, Cardiff, Birmingham, Wolverhampton. These are all specialist bed based care.

3.9. Quality

Thirty-one organisations responded to the questionnaire for the purpose of mapping local services for people with mental health needs. 65% were from the voluntary sector; 32% private and 3% public organisations.

Very few organisations operated a waiting list.

The range of Quality standards varied from bespoke service specific to nationally accredited schemes. The majority of organisations held accredited quality standards.

3.9.1. Voluntary Sector

A number of patients and Carers praised the work of voluntary sector support organisations in providing care, with patients/ service users particularly highlighting the work of MIND. However, voluntary support organisations highlighted that their capacity to provide support was affected by cuts in their funding.

Services should link to organisations such as the young farmers, women's institute and the rural crisis network

Young People

Charities like the Alzheimer's Society and Community Service Volunteers are plugging gaps in Mental Health provision.

Carer

Many people rely on [voluntary sector support] but given the reduction in funding, they cannot get the support they need.

Significant amounts of third sector floating support has been removed and nothing put in its place. £1m has been removed from low level and social mental health support and changes in access to support via change in eligibility criteria; The removal of support organisations mean that we are finding people moving into crisis.

Informal Networks offer access to activities such as green working, music, dance & the arts work well. These should be available on prescription and include local groups, classes & activities.
Voluntary Organisations

3.10. Resources

In 2013/14, HCCG allocated £15.3 million for secondary and community mental health services, (HCCG, 2014)[xxxvii]. Spend on other areas of mental health spend are laid out in table 2.3, below.

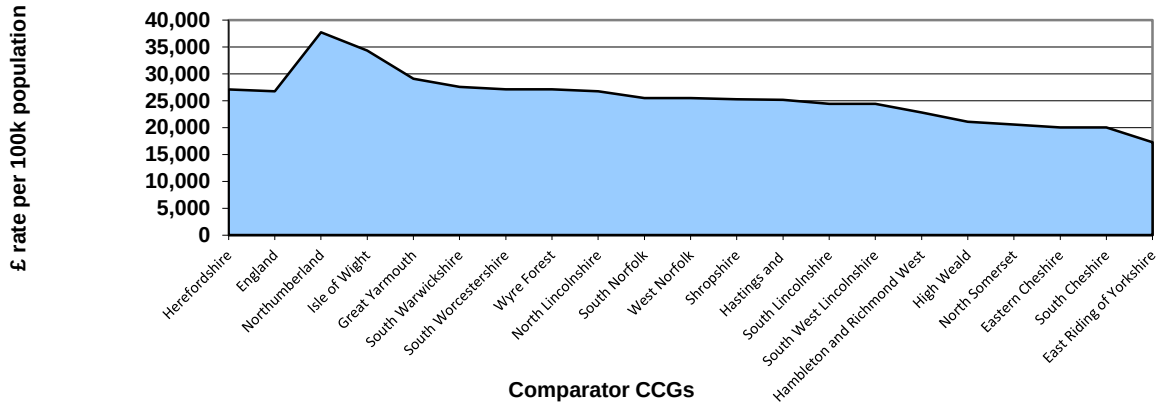
Table 3.4 Programme budgeting detail- components of Mental Health spend, Herefordshire CCG 2013/14

Categories of Spend	Mental health disorders
	£ '000s
Main Mental Health Provider	15,366
Other NHS Providers	823
Continuing Health Care	3,171
Funded Nursing Care	1,559
Nursing Home	277
Additional Dementia services	210
Other (Zero Priced Mental Health)	1,195
Total ex. Overheads	**25,104**

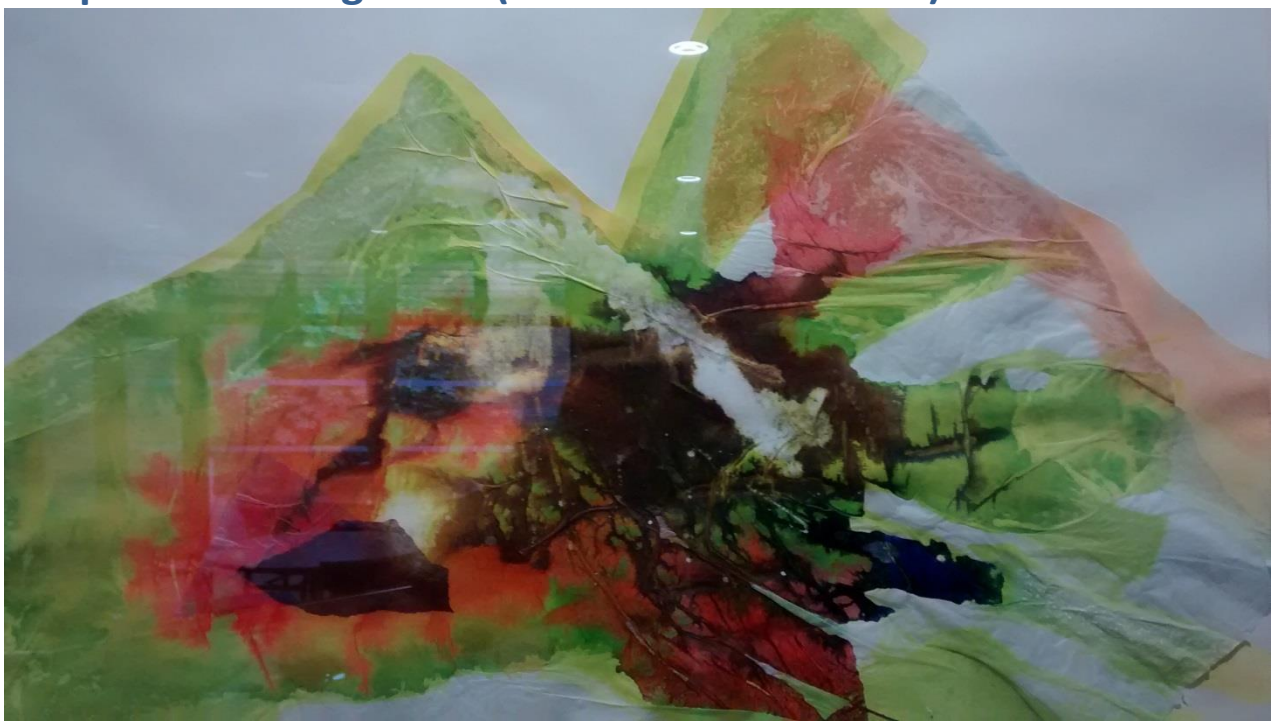
Herefordshire Clinical Commissioning Group spent approximately £1.78m on prescribed medicines for patients with mental health conditions in 2013/14. These costs do not include drugs used for more than one indication e.g. epilepsy drugs used in mental health conditions as the data are not specific to indication. Secondary care drug costs of approximately £300k pa fluctuate due to pricing arrangements and are primarily from 2gether NHS Trust with some Wye Valley NHS Trust activity.

There is limited comparator information however figures are available from CCG comparable with Herefordshire. Figure 3.16 provides an illustration of the levels of spending on specialist mental health services by each CCG in 2012/13.

Figure 3.16: Comparison of spending on specialist mental health services by CCG (2012/13)



Chapter 4: Feeling Good (Public Mental Health)



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Contents

Chapter 4: Feeling Good (Public Mental Health)

4.1 Introduction

Within this document, 'public mental health' is taken to mean: *a public health or population health science approach to mental health and the mental health variations exhibited by populations*[xxxviii]. As highlighted in earlier chapters, mental illness presents a significant burden of disease, accompanied by huge personal and economic cost. Contrasting this, good mental health has the potential to enable people to live "a state of complete physical, mental and social well-being" (WHO, 2002).

Whilst wellbeing as a concept may be hard to measure (See below for discussion), there is ample evidence for interventions to prevent mental illness, promote good mental health and support early intervention where required.

As discussed in chapter 2, there is a strong economic argument that, as a society, we need to work proactively to support and improve population mental health. Despite this, spending on the prevention of mental disorder and promotion of mental health represents less than 0.001% of the annual NHS mental health budget (JCPMH, 2014)[xxxix]. Proactive identification of wider determinants of mental ill health and intervention to address them will therefore play a key role in a system wide strategy to meet the current and future mental health needs of the people of Herefordshire.

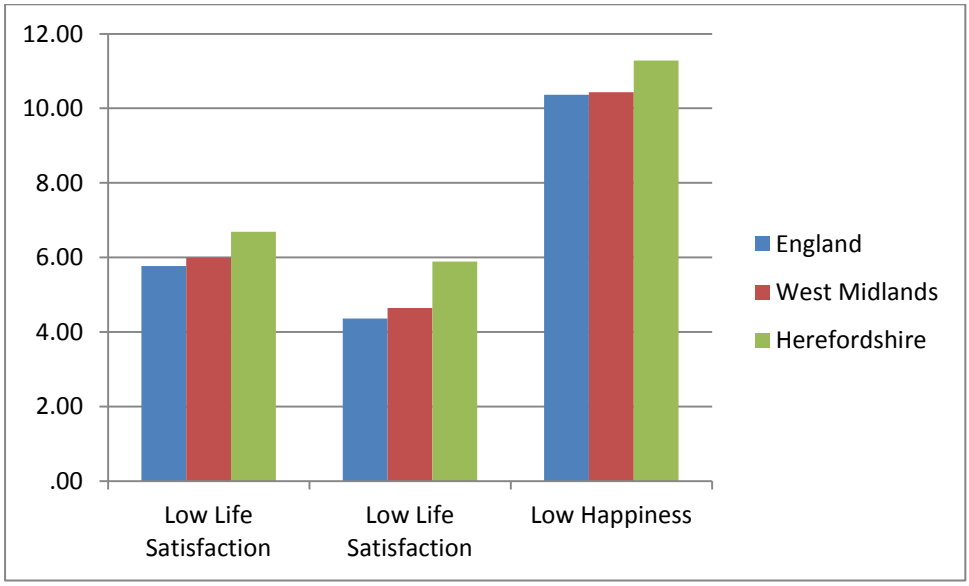
4.2. Prevalence

There is limited information to describe preventative mental health activity and well-being in the county. The ONS Annual Population Survey, and Herefordshire's Health and Wellbeing Survey (2011) offers proxy measures into people's wellbeing.

A West Midlands survey measured people's perception of satisfaction, feeling that their life is worthwhile and happiness. People surveyed were asked

- "Overall, how satisfied are you with your life nowadays?"
- "Overall, to what extent do you feel the things you do in your life are worthwhile?"
- "Overall, how happy did you feel yesterday?"

Figure 4.1: Proportion of Respondents expressing low life worth, Satisfaction and Happiness



Source: Annual Population Survey, ONS, 2012/13

Of respondents in Herefordshire, 6.7% (4.8% - 8.6%) report low levels of satisfaction with life (up from 5.2% in 11/12), 5.9% (3.6% - 8.2%) report low levels of life worth (up from 3.6% in 11/12) and 11.3% (8.9% - 13.7%) report low levels of happiness (up from 8.6% in 11/12). Although all of these indicators show an upward progression from the previous year, none differ significantly from the national averages or regional average (See Figure 4.1).

From this, we can conclude that Herefordshire is no different from other areas.

Herefordshire's Health and well-being Survey (2011) is based on a sample of the general adult population (aged 16 years and over) living in private households in Herefordshire.

- Overall around 8% of adults reported currently being treated for any form of mental illness.
- Women were nearly twice as likely to respond that they were receiving treatment for a mental illness – 10.6% compared to 5.9% of men and this figure was statistically significant.
- 6% of adults reported currently being treated for depression and 5% for anxiety.

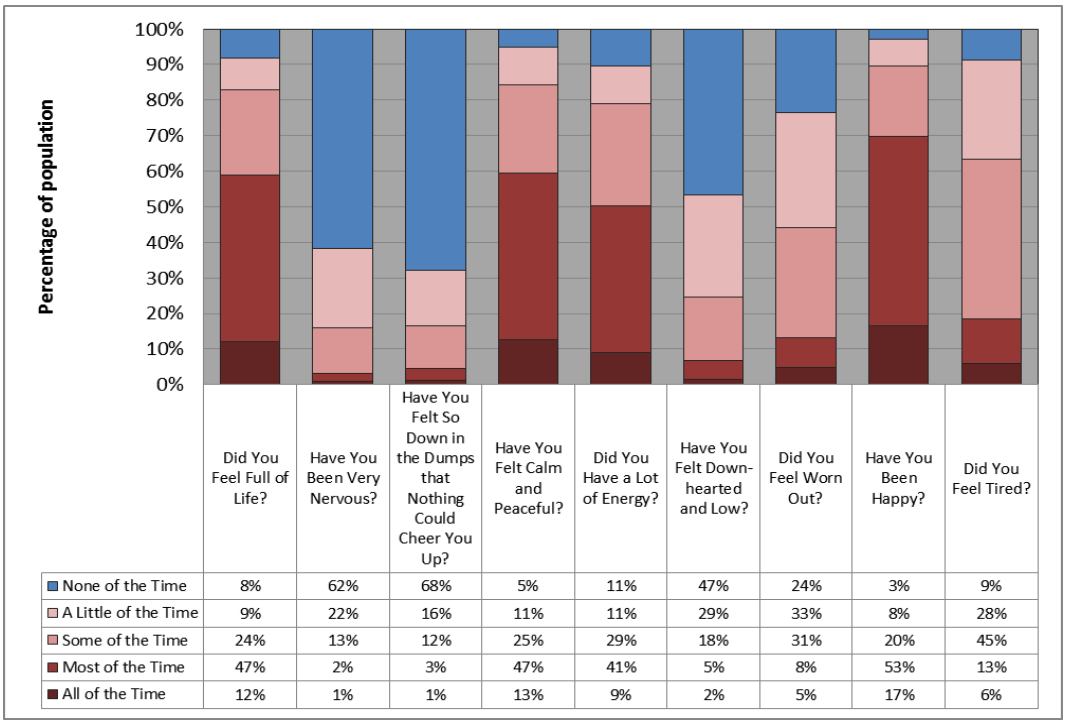
Respondents were asked a series of nine questions relating to their moods in the past four weeks;

- Over half (59%) felt 'full of life' all or most of the time but 8% did not feel 'full of life' at all.
- 50% had 'a lot of energy' all or most of the time, but 11% did not feel this way any of the time.
- 8% had not been happy any of the time; at the other end of the spectrum 70% had been happy at least most, if not all, of the time.
- 60% had felt 'calm and peaceful' most or all of the time, but 5% reported they had not felt like this any of the time.

- 3% had felt 'very nervous' all or most of the time but 62% had not felt 'very nervous' any of the time.
- 7% of individuals felt 'downhearted and low' all or most of the time. Just under half (46%) had not felt this way any of the time.
- 4% had been 'so down in the dumps that nothing could cheer you up' either all or most of the time but 68% had not experienced this mood at all.
- 13% said they felt 'worn out' all or most of the time and 19% had been 'tired' for all or most of the time.

Figure 4.2 summaries the results that the survey respondents gave to the nine questions.

Figure 4.2: Herefordshire Self-Reported Mood state in the past four weeks



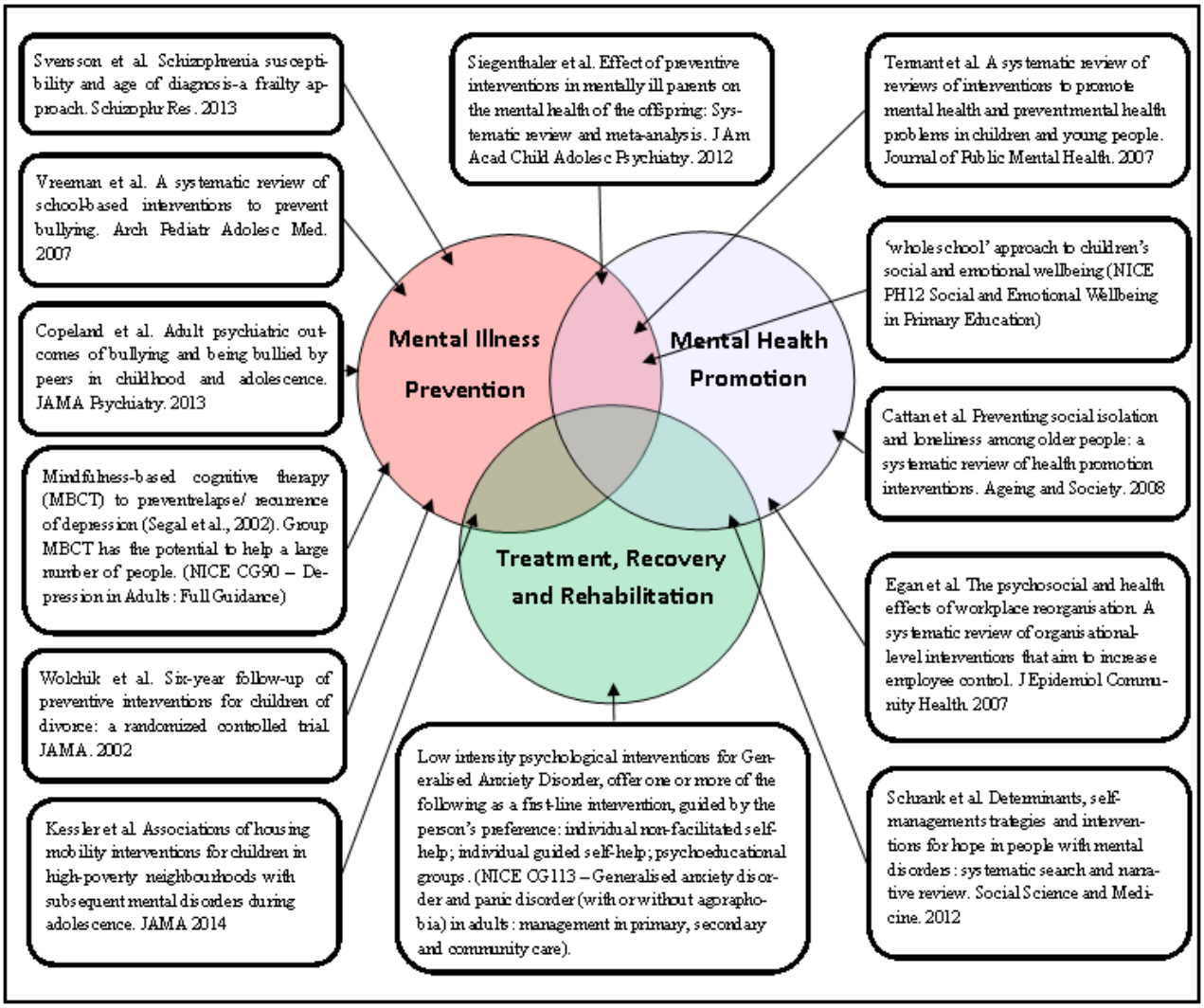
	Did You Feel Full of Life?	Have You Been Very Nervous?	Have You Felt So Down in the Dumps that Nothing Could Cheer You Up?	Have You Felt Calm and Peaceful?	Did You Have a Lot of Energy?	Have You Felt Down-hearted and Low?	Did You Feel Worn Out?	Have You Been Happy?	Did You Feel Tired?
None of the Time	8%	62%	68%	5%	11%	47%	24%	3%	9%
A Little of the Time	9%	22%	16%	11%	11%	29%	33%	8%	28%
Some of the Time	24%	13%	12%	25%	29%	18%	31%	20%	45%
Most of the Time	47%	2%	3%	47%	41%	5%	8%	53%	13%
All of the Time	12%	1%	1%	13%	9%	2%	5%	17%	6%

Source: Herefordshire's Health and Wellbeing Survey (2011)

4.3. National Evidence

England's Chief Medical Officer (CMO) published a review of the evidence for public Mental Health in September 2014[xl]. The document builds on the model of mental health improvement developed by the World Health Organisation in their Mental Health Action Plan 2013–2020, with overlapping elements of mental health promotion, mental ill-health prevention and treatment, recovery and rehabilitation (see figure 4.3 below) to inform future local research and investment strategies.

Figure 4.3: Public Mental Health: a conceptual model derived from the WHO framework and illustrated with evidence based examples (CMO, 2014)



Source: Chief Medical Officer's Report, 2014

4.3.1 Wellbeing

Five ways to wellbeing was published in 2008 by the New Economics Foundation (NEF).

Figure 4.4: Five ways to Wellbeing

However, despite its widespread use, a lack of clarity over boundaries, definitions, tools for evaluation and evidence of effectiveness render "wellbeing" a contentious concept[xli].

The CMO report found that, whilst tools such as the ONS measures of national wellbeing are developing, linkages between these and other tools is underdeveloped, definitions are inconsistent and studies and reviews demonstrating wellbeing are poorly designed.

Given these issues, the CMO recommends that;

"*Unless and until robust evidence of effectiveness is forthcoming, interventions based on the concept of 'mental well-being' should not be funded*"[xlii].

Rather, the NHS and Public Health England should focus on commissioning services for which there is evidence framed according to the World Health Organisation model of mental illness prevention, mental health promotion and treatment, recovery and rehabilitation.

4.3.2 Commissioning Public Mental Health

The focus on prevention, promotion and treatment is reflected in guidance for commissioners produced by the Joint Commission Panel for Mental Health[xliii].

Promotion of Good Mental Health

Mental health promotion may take place across the entire life course, from supporting parents prior to the birth of a child to promoting wellbeing in later life and aim to address the determinants of health, occurring at the individual, group or structural level. Primary promotion involves promoting the health and wellbeing of the whole population. Secondary promotion involves targeted approaches to groups at higher risk of poor health and wellbeing. Tertiary promotion targets groups with established health problems to help promote their recovery and prevent recurrence.
The JCPMH identifies a number of opportunities for the promotion of good mental health. A full review of the evidence underpinning these recommendations can be found in the JCPMH document. The JCPMH has identified key areas, linked to all points along the life course where commissioned programmes would improve mental health outcomes as stated in Box 4.1.

Box 4.1 Interventions to promote Good Mental Health

Starting well:

- Promotion of parental mental and physical health
- Support after birth, breastfeeding support
- Parenting support, SureStart
- Family Nurse Partnership.

Developing well

- Pre-school and early education programmes (improved school readiness, academic achievement, positive effect on family outcomes)
- School-based mental health promotion programmes (reduced levels of mental disorder, improved academic performance, social and emotional skills).

Living well

- Improved housing and reduced fuel poverty
- Neighbourhood interventions including activities which facilitate cohesion
- Debt advice and enhanced financial capability
- Physical activity through active travel, walkable neighbourhoods and active leisure
- Interventions to enhance social interaction (capital) activities such as arts, music, creativity, learning, volunteering and timebanks
- Positive psychology and mindfulness interventions
- Spiritual awareness, practices and beliefs.

Working well

- Work-based mental health promotion
- Work-based stress management
- Support for unemployed people.

Ageing well

- Psychosocial interventions
- Socialisation and prevention of social isolation
- Addressing hearing loss
- Interventions for 'living well'

As well as promoting wellbeing in different age groups across the life course, interventions can be targeted at particular groups:

- **Caring well** – support and psycho-education for carers
- **Recovering well** – mental promotion as a key component of recovery from mental disorder
- **Engaging well** – involvement in planning, design and delivery of interventions

Prevention of Mental Ill Health

Prevention aims to avoid, delay or decrease the impact of mental illness on individuals and populations. Prevention can occur at three levels. Primary prevention aims to *prevent ill health happening* in the first place by addressing the wider determinants of illness and using 'upstream' approaches that target the majority of the population. Secondary prevention involves the early identification of health problems and *early intervention to treat and prevent* their progression. Tertiary prevention involves working with people with established ill health to *promote recovery and prevent (or reduce the risk of) recurrence*.

It is acknowledged that contributors to the development and manifestation of mental illness, including biological, social and traumatogenic factors, operate across the lifecourse and may require intervention my multiple partners. Whilst some prevention activities may be the specific responsibility of particular commissioners, some elements regarding universal primary and secondary prevention activities, (such as supporting smoking cessation and signposting towards specialists) should be part of ALL professionals working in the system, specifically acknowledging that prevention at an early stage may produce cost savings at a stage.

The JCPMH identifies opportunities for the prevention of mental ill health. A summary of the evidence underpinning these recommendations can be found in the JCPMH document. The opportunities are listed in box 4.2.

Prevention of mental illness and dementia

- childhood conduct and emotional disorder prevention through reduced maternal smoking during pregnancy, parenting programmes, school and pre- school programmes (e.g. Family Nurse Partnership)
- maternal depression prevention through post-partum psychosocial support, home visitation, health visitor training and peer support
- depression prevention in older people through targeted interventions for groups at high risk
- Dementia prevention via access to physical activities, social engagement, cognitive exercise and antihypertensive treatment.

Prevention of health risk behaviours including smoking, alcohol and drug misuse through:

- promotion of mental health and prevention/early intervention for mental disorder prevents a large proportion of associated health risk behaviour
- integration and mainstreaming of mental health into existing programmes (including smoking, alcohol, drugs, obesity, nutrition and physical activity)
- interventions for different health risk behaviours with targeted approaches for those with mental disorder
- Interventions to prevent and intervene early with mental disorder.

Prevention of inequality

- addressing inequality can prevent mental disorder
- prevention of mental disorder and promotion of mental health
- addressing results of mental disorder such as smoking
- increasing availability of early intervention for mental disorder
- Addressing inequalities in service provision.

Prevention of stigma and discrimination:

- Mass media campaigns
- social contact between individuals subject to discrimination and members of the public
- educational programmes to increase mental health literacy

Prevention of suicide

- improved management of depression
- general practitioner education
- Population-based programmes to promote mental health.

Prevention of violence and abuse

- school based programmes to prevent abuse
- targeted interventions for children with conduct disorder and adults with personality disorder, substance dependence and/or hazardous drinking

Box 4.2: Opportunities for Prevention of Mental Health

People and organisations in Herefordshire regarded prevention of mental health problems as preferable to treating problems once they had developed. However, some felt that to funding cuts to Tier 1 and 2 support had hindered low level issues being picked up more efficiently.

[We want] staff in schools to know about mental health, wellbeing and understand when help is needed.
Young Person

There is a need for professionals to have a deeply embedded understanding of how to promote good mental health and wellbeing.
Carer

We should be investing a lot more in schools to equip young people with life skills. There should be opportunities, not necessarily through mental health services, that enable people to deal with issues in their lives. It needs to be taken upstream.
General Practitioner

We have no preventative mental health work in the county. There is no tier one and very little tier 2. We are lacking in early intervention and this has a massive knock on effect later - by the time adults present with personality disorder effective treatment is much too late even though warning signs have been present often from early school years.
General Practitioner

There is a lack of preventative work at tier 1. There has been a whole tier of professionals who have been removed who would have had those conversations prior to the problems getting serious. Early intervention work has moved to a more critical end (e.g. troubled families) so for the general population, early intervention has disappeared.
Voluntary Organisation

Early Intervention

Early intervention is associated with improved outcomes as well as economic savings. Early intervention takes a number of different forms.

- Early treatment of mental disorders particularly for children and adolescents since most mental disorders starts before adulthood. Early effective treatment of mental disorder can prevent a significant proportion of adult mental disorder. Intervention during psychosis prodrome can also prevent development of psychosis.
- Early interventions for sub- threshold disorder (a set of symptoms which are not severe enough to result in a diagnosis) to address these symptoms and promote mental health.
- Early promotion of physical health as well as prevention and early intervention for health risk behaviour and associated physical illness in those developing a mental disorder.
- Promotion of recovery through early provision of activities such as supported employment, housing support, and debt advice.

- Early recognition of mental disorder through improved detection by screening and health professional education programmes as well as improved mental health literacy among the population to facilitate prompt help seeking.
- Support for victims of of proximal and historic interpersonal violence and abuse, both in terms of managing its effects and addressing the trauma directly.

Effective early intervention could negate the need for intensive work in the future as illustrated by the following comments:

Delays in getting support mean that a person's mental health has deteriorated until a lot more support is needed.
Patient/ Service User

Currently, people who are not critical and substantial fall through the gaps. A small amount of support at tier 2 may prevent people from needing more help further on down the line.
Housing Practitioner

There is a strong need for early intervention work to prevent increased activities in other services in the future.
Mental Health Practitioner

The removal of support organisations mean that we are finding people moving into crisis. People who were stable for years are now worse than ever.
Voluntary Organisation

There has been a loss of tiers 1 and 2 provision across the county. Voluntary sector and youth organisations used to pick up a lot of [low level] issues, but they have been lost.
Mental Health Practitioner

4.4. Mental Health and Stigma

Reducing mental health-related stigma and discrimination is one of the six objectives of the Government's Mental Health Strategy, No Health without Mental Health (2011).

The 2013 Mental Health (Discrimination) Act and Equalities Act (2010) have rendered many aspects of discrimination on the basis of mental (ill) health unlawful. Despite this, such discrimination can be still be felt by the individuals, preventing or delaying their access to help and impairing their recovery. Discrimination may also be enacted, directly or indirectly, limiting housing, employment, education and physical health. A 2013 study[xliv] found that 87% of mental health users had experienced discrimination in the past year, 70% felt the need to conceal their illness and half reported having been shunned.

Tackling stigma and discrimination remains a key barrier in ensuring fair, prompt and equal treatment for people affected by mental health issues. And whilst economic costs of stigma regarding mental health are difficult to quantify, there is growing evidence that addressing the

discrimination experienced by individuals as a result of their mental health is both effective and produces economic benefit[xlv].

A number of inter-related approaches may be identified to address stigma and increase public awareness of mental health issues.

- Engaging the local population in the commissioning process
- Information about effective interventions should be given to the public, as it can help promote the uptake of such interventions.
- Raising awareness of mental disorder and wellbeing among public sector staff and the general public through community training programmes and interventions such as Mental Health First Aid.

Initiatives such as Mental Health Awareness Day (October 10th) and Time to Change play an important role in raising awareness of mental health issues. . A multifaceted programme comprising national and local-level actions to engage individuals, communities and stakeholder organisations, Time to Change (www.time-to-change.org.uk) run by Mind and Rethink Mental Illness, is the largest ever programme to reduce stigma and discrimination against people with mental illness.

Evidence from the first year of the Time to Change anti-stigma programme in England[xlvi] showed significant improvements in life areas in which relationships are informal, i.e. family, friends and social life. In some areas where discrimination may occur at a structural level (e.g. via regulations, laws or institutions) there were no improvements, including mental and physical healthcare and welfare benefits; in others, including those in seeking and gaining employment, early improvements have since plateaued or been lost[xlvii]

Involving organisations across Herefordshire to 'pledge support' to Time to Change would enable local cascading of anti-discrimination messages. This would be a response to what people said about the effect of stigma- how society views mental health and mental health service users and how people felt about themselves which in turn impacts on people's willingness to engage with services.

It's important to not feel stigmatised and be able to talk about how you are feeling.
Patient/ Service User

There is still a stigma around mental health and a lot of labelling. People aren't "a Schizophrenic", they may have schizophrenia. You don't hear someone described as "a breast cancer". People have mental health problems, it shouldn't define them.
Carer

There is still significant stigma around mental health, including from patients themselves. This can lead to delays in obtaining treatment which can result in there being more of an issue at a later date
Mental Health Practitioner

There needs to be more awareness and understanding, through education in schools and workplaces.
Carer

4.5. Unemployment, Work and Mental Health

Unemployment is consistently related to higher rates of depression, anxiety and suicide, particularly when compounded by inadequate benefits[xlviii]. Several studies have identified increased rates of depression in the unemployed, particularly in young men[xlix, l].

The following outlines the profile of people out of work claiming benefits in Herefordshire.

- On average 9,120 people within Herefordshire were claiming an out-of-work benefit in 2013, equal to 8.1% of the working age population (16-64). This was a decrease from an average of 9,870 claiming in 2012. Claimants of Employment Support Allowance and Incapacity Benefit made up 61% of all claimants; double the proportion of Jobseekers (28%). The lone parent group accounted for 10% of claimants and others on income related benefits 4%.
- The number of claimants of out-of-work benefits is still slightly above what it was prior to the recession despite having seen notable decreases as the number of Jobseekers has declined post-recession. A decrease in the lone parent and ESA and incapacity benefits groups has offset the increase in jobseekers (since 2007) to some extent.
- The claimant rate for out-of-work benefits in Herefordshire (8.1% in 2013) is lower than for England (10.8%), the West Midlands (12.2%) and The Marches Local Enterprise area (9.1%).
- Long term (over 5 years) claimants of Employment and Support Allowance (ESA) and Incapacity Benefits and short term claimants (less than 6 months) of Jobseekers Allowance are the largest groups of claimants by duration, accounting for 38% and 14% of claimants respectively. It was the same groups across England who accounted for most claimants.
- Looking at the conditions of people claiming Incapacity Benefit (IB) or Severe Disablement Allowance (SDA), the most prevalent condition was a 'mental or behavioural disorder' (43% of all claimants). 12% of claimants had a 'disease of the musculoskeletal system and connective tissue', 10% a 'disease of the nervous system' and 15% had 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified'.
- The areas of Herefordshire that have the highest rates of claiming out-of-work benefits are in Hereford City, Leominster, Ross-on-Wye and Bromyard. Within Hereford City the areas with the highest rate of claiming are in the South of the city

Source: Facts and figures Herefordshire(2014)

Poor working conditions, including job insecurity, low support, workplace bullying and high stress/ low reward have been linked to increased sickness and premature mortality[lilii]. Mental health is the leading reason for days of work lost due to ill health, with 13.1million days lost due to stress and anxiety in 2011 in the UK. Within Herefordshire's main statutory employers (Wye Valley Trust and Herefordshire County Council) in 2012/13, a total of 261 employees were absent from work for mental health reasons, totalling 10,585 days of work lost. This is the equivalent of 29 people off work at any one time.

However, work can also positively enrich people's mental health, increasing life satisfaction, preventing mental ill health and act as a positive environment for people recovering from mental ill health. Nice Guideline (PL22) outlines the promotion of mental health at work and there is

evidence to link such activities to greater productivity at work, increased commitment and staff retention as well as effects on health and longevity[liii]

The role of work and training was identified by local stakeholders as having an important role in maintaining and improving a person's mental health. However, respondents were keen to stress that this would not always mean paid work.

Employment and training can speed up the healing process. However, the individual with the mental health issues should dictate the introduction of employment and training.
Patient/ Service User

Within a "goldstar" mental health service, employers would be educated in knowing how to support people with mental health needs and people would be helped into employment- what to expect and how to cope with working life.
Patient/ Service User

Work, as paid or unpaid vocational activity, including things such as supported placements, is one of the best ways to support a person's mental health.
Mental Health Practitioner

The above comments reflect the value of volunteering and access to support with employment and training. These activities offer social inclusion as well as positive engagement to aid recovery.

4.6. Social Prescribing

Strategies for preventing mental ill health, promoting good mental health and providing early intervention and low-level continuing support have found form in 'social prescribing'.

The term *'social prescribing'* describes a range of mechanisms for linking patients to nonmedical sources of support in the community[liv]. Such support may include provision of self-help books or gym membership, but may also comprise referral to support organisations undertaking such activities as guided walks for health, creative activities and low level agriculture and maintenance. Central to all approaches is a focus on reducing social exclusion and isolation.

Due to the heterogeneous nature of social prescribing, the evidence base for specific interventions is limited. There is anecdotal evidence of better social and clinical outcomes for people with long term conditions and their carers, more cost efficient and effective use of NHS and social care resources and a wider, more diverse and responsive local provider base. The JCPMH commends social prescribing as presenting potential benefits for improved mental health outcomes, improved community wellbeing and reduced social exclusion[lv]. An evaluation by Bristol Health and Wellbeing Board[lvi] indicates a minimum return on investment of 120% for social prescribing projects, with high acceptability from GPs and service users.

Overall therefore, whilst evidence for specifically commissioning 'social prescribing' is limited, as an approach it contains elements of tackling stigma and social exclusion, preventing mental ill health, promoting good mental health and providing low level support to people who require it. The diversity of approaches also enable patient choice, avoid labelling that may result from engagement with formal mental health services and provide opportunities to combine mental and physical activities within a social environment.

Many mental health problems are associated with social isolation, either leading to worsening symptoms or preventing recovery from episodes of mental ill health. Social prescribing has been most visible within Herefordshire in the shape of two ventures, the LIFT exercise on prescription scheme run by Halo, and the Books on Prescription scheme at Herefordshire libraries, but there are many other interventions which would be covered by the definition. MIND run projects involving service users with activities such as orchard maintenance and archaeology, and this has lead to significant improvements in confidence for attendees. Orchard Origins found significant improvements on wellbeing scales in volunteers attending orchard management projects[lvii]. This fits with a small but encouraging evidence base for benefits from horticulture and arts projects[lviii].

While there are a large variety of activities within Herefordshire which act to promote social cohesion, mainly within the voluntary or charity sectors, there does not exist a straightforward way for professionals, whether health, social care, other (police, clergy, etc.) to signpost patients towards these services. Provision of a web-based directory of services would help meet the duties of both Herefordshire Council and Herefordshire CCG to address wellbeing within the county.

4.7. Conclusion

Mental health is clearly about more than the simple absence of mental illness. It is linked to happiness, enjoyment of everyday experience, engagement in society and personal feelings of self-worth and safety. In a holistic sense, it is about people "being well". However, as outlined in chapter 1, measuring a person's wellbeing is difficult. There is a danger that the diversity of definitions of wellbeing render it nebulous, with interventions to support it impossible to evaluate.

Herefordshire CCG has a responsibility to invest its money where clear benefit can be demonstrated. The evidence in this chapter suggests that Herefordshire CCG should continue its focus on investing where there is a more robust evidence base on specific activities within the domains of mental illness prevention and mental health promotion. Such an approach is coherent with the evidence presented by the Chief Medical Officer and the World Health Organisation.

Many of the elements integral to mental illness prevention and mental health promotion require co-ordinated actions across the local system, such as promoting volunteering and accessing employment and housing support. In saying this Herefordshire CCG recognises that its commissioning of mental health provision sits within a wider strategic framework that integrates population approaches towards health and social care in conjunction with system partners that

include the local authority, the voluntary and community organisations, other parts of the NHS and statutory sector organisations, with the need for a system wide strategy.

The recommendations are:

Well-being

- For Herefordshire Clinical Commissioning Group to adopt low prioritisation of funding for mental well-being interventions without evidence of effectiveness.

All Agencies Response

- For Herefordshire to have an all-age mental health strategy with contributions from organisations across our economy to co-ordinate mental illness prevention and mental health promotion.

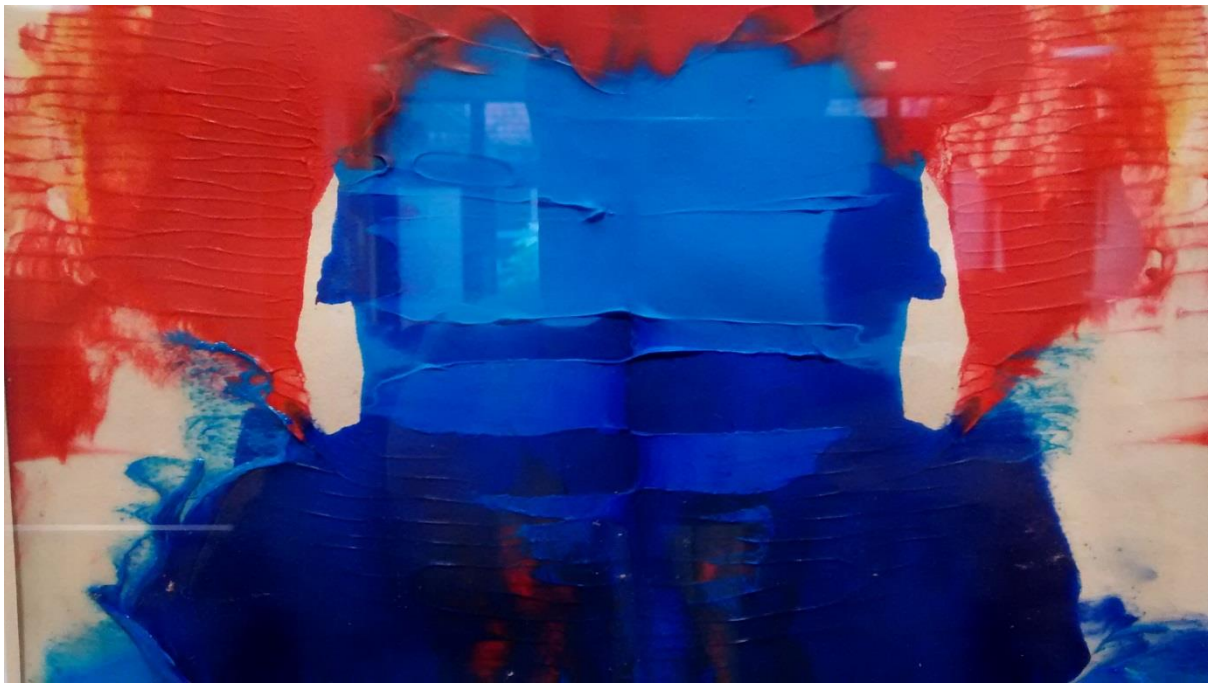
Stigma

- Herefordshire CCG and its partners to make an explicit commitment to tackling mental health stigma by pledging its support for “Time to Change” and raising awareness of mental health.

Sources of Advice and Information

- Consideration of a web-based directory of services to aid practitioners, the public and communities.

Chapter 5: Common Mental Health Conditions



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Contents

Chapter 5: Common Mental Health Conditions

5.1. Introduction

This chapter outlines common mental disorders. For the purposes of this needs assessment, and in line with NICE Guidance 123 (NICE, 2011[lix]), the term common mental health disorders encompasses depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder. These types of mental health illnesses cause emotional distress and interfere with the person's daily functioning.

This Chapter explores the prevalence for these conditions (subject to availability of information) before outlining models of care. The analysis is then presented in light of stakeholders' views and activity information before the recommendations are outlined for this area.

5.1.1. Depression

Depression is a broad and heterogeneous diagnosis. Central to it is depressed mood and/or loss of pleasure in most activities. Severity of the disorder is determined by both number and severity of symptoms, as well as the degree of functional impairment[lx].

5.1.2. Anxiety

Anxiety disorders include generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder. Generalised anxiety disorder is characterised by excessive worry about a number of different events, associated with heightened tension. A person with generalised anxiety disorder may also feel irritable and have physical symptoms such as restlessness, feeling easily tired, have tense muscles, trouble concentrating or sleeping. For the disorder to be diagnosed, symptoms should be present for at least 6 months and should cause clinically significant distress or impairment in social, occupational or other important areas of functioning[lxi].

5.1.3. Obsessive Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterised by the presence of either obsessions or compulsions, but commonly both. The symptoms can cause significant functional impairment and/or distress. An obsession is defined as an unwanted intrusive thought, image or urge that repeatedly enters the person's mind. Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. A compulsion can either be overt and observable by others, such as checking that a door is locked, or a covert mental act that cannot be observed, such as repeating a certain phrase in one's mind[lxii].

5.1.4. Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD does not therefore develop following those upsetting situations that are described as 'traumatic' in everyday language, for example, divorce, loss of job, or failing an exam. PTSD is a disorder that can affect people of all ages. Around 25–30% of people experiencing a traumatic event may go on to develop PTSD[lxiii].

5.2. Prevalence

The prevalence of the most common forms of mental health problems are given below.

- 2.6% of the population experience depression (McManus et al, 2009[lxiv])
- 4.7% have anxiety problems (McManus et al, 2009)
- 9.7% suffer mixed depression and anxiety, making it the most prevalent mental health problem in the population as a whole (McManus et al, 2009)
- About 1.2% of the UK population experience panic disorders (Goodwin et al., 2005[lxv]), rising to 1.7% for those experiencing it with or without agoraphobia (Skapinakis et al., 2011[lxvi]).
- Around 1.9% of British adults experience a phobia of some description, and women are twice as likely to be affected by this problem as men
- Post-Traumatic Stress Disorder (PTSD) affects 2.6% of men and 3.3% of women.
- Obsessive Compulsive Disorder (OCD) affects around 2–3% of the population.
- Generalised Anxiety Disorder affects between 2–5% of the population (Self et al., 2012[lxvii]), yet accounts for as much as 30% of the mental health problems in people seen by GPs (Martin-Merino et al., 2010[lxviii]).

5.2.1. Overview

The prevalence of individual common mental health disorders varies considerably. The prevalence rates gathered from the Office of National Statistics 2007 national survey[lxix] indicate:

- 4.4% of the population report generalised anxiety disorder,
- 3.0% of the population report PTSD,
- 2.3% of the population report depression,
- 1.4% of the population report phobias,
- 1.1% of the population report OCD,
- 1.1% of the population report panic disorder.

Applied to Herefordshire, the numbers can be extrapolated to approximately:

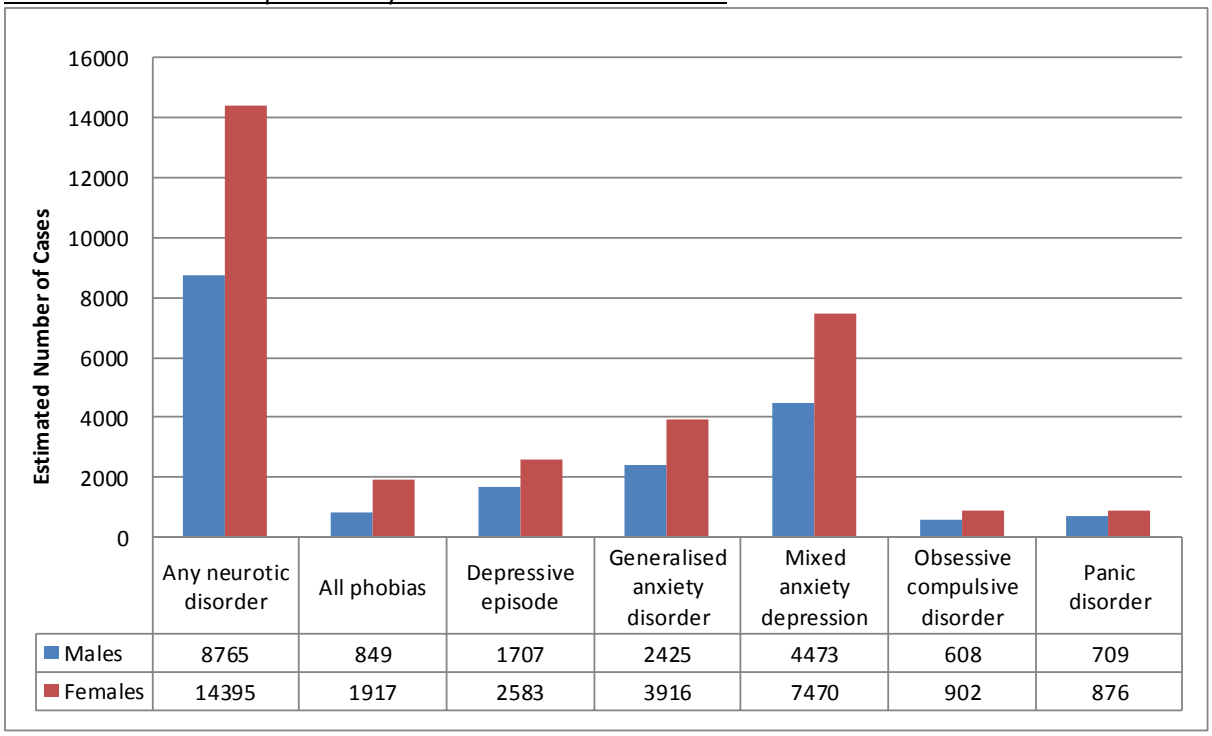
- 6341 people with generalised anxiety disorder
- 4290 people with depression

- 2766 people with phobias
- 1510 people with OCD
- 1585 people with panic disorder

The above figures will include some people with more than one mental health condition. Over a lifetime, more than half of people aged 16 to 64 years who meet the diagnostic criteria for at least one common mental health disorder experience comorbid anxiety and depressive disorders. Studies indicate that appropriately 16% of the population experience depression and anxiety over a lifetime (Kessler et al 2003[lxx]; Singleton et al, 2001[lxxi]). Based on census data the prevalence rate of common mental health problems for all ages in Herefordshire is estimated to be 15%. Overall, Herefordshire is estimated to have 14,520 adults with common mental health conditions.

Figure 5.1 shows the estimated prevalence of common health conditions in Herefordshire by gender as of October 2012.

Figure 5.1 Estimated Prevalence of Common Mental Health Conditions: Herefordshire CCG Population by Gender as at October 2012



	Any neurotic disorder	All phobias	Depressive episode	Generalised anxiety disorder	Mixed anxiety depression	Obsessive compulsive disorder	Panic disorder
Males	8765	849	1707	2425	4473	608	709
Females	14395	1917	2583	3916	7470	902	876

Source: PANSI

Prevalence is higher among females across all conditions at approximately 1.64 female cases to every 1 male. The ratio of cases varies from 1.24:1 for panic disorders to 2.26:1 for all phobias. Variation within the 'all phobias' group is 7:1 among young females aged 16-24 years compared to their male equivalents. People can have more than one common mental health condition so the number of people with common mental health conditions is will actually be lower than indicated by the numbers displayed within Figure 5.1.

5.2.2. Anxiety

Estimating the prevalence of anxiety is further complicated by the fact that, in diagnostic terms, anxiety is the common thread linking a range of disorders, from agoraphobia to obsessive compulsive disorder. Some disorders are linked (for example, agoraphobia and panic disorders), while each displays particular characteristics which themselves impact on people's lives.

Anxiety rates differ according to different groups of people:

- Although, on average, women rate their life satisfaction higher than men, their anxiety levels are significantly higher than men (Self et al., 2012[lxxii] the Office for National Statistics (ONS), 2013[lxxiii]).
- People in their middle years (35 to 59) report the highest levels of anxiety compared to other age groups (Self et al., 2012; ONS, 2013).
- The anxiety levels of people with a disability are higher, on average, than those of people without a disability (ONS, 2013).
- Unemployed people report significantly higher anxiety levels than those in employment (ONS, 2013).
- On average, all ethnic groups reported higher levels of anxiety than people describing themselves as White British (Hicks, 2013[lxxiv]).
- Young people aged 16–24 are more likely to report lower levels of anxiety compared with adults generally (Potter-Collins & Beaumont, 2012[lxxv]; ONS, 2014[lxxvi]).

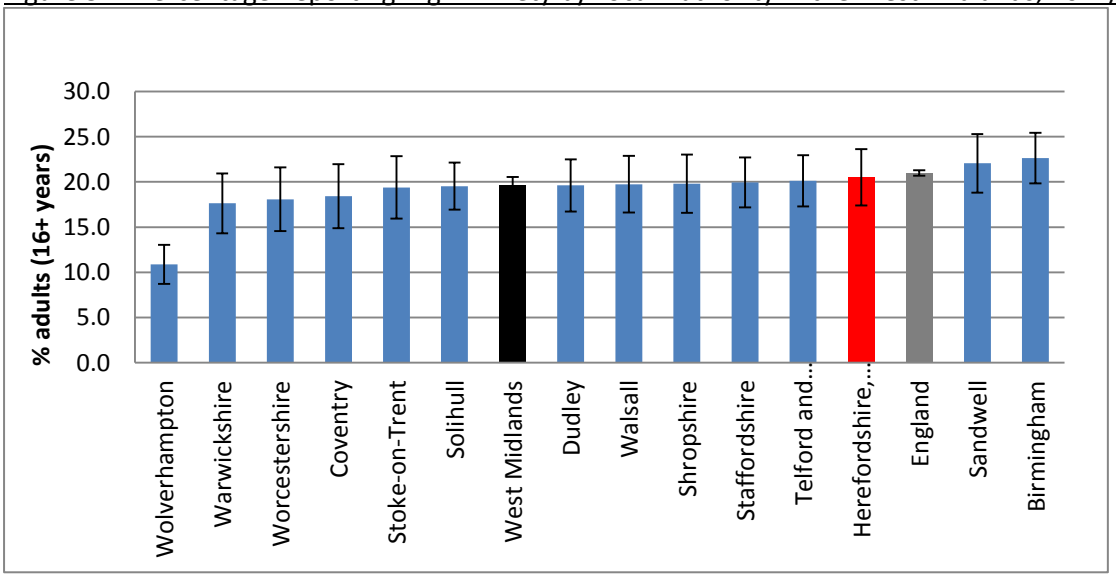
These findings are replicated by a recent survey by the Mental Health Foundation (2014)[lxxvii] of over 2,000 members of the public:

- Almost one in five people feel anxious all of the time or a lot of the time.
- Only one in twenty people never feel anxious.
- Women are more likely to feel anxious than men (Self et al., 2012; the Office for National Statistics, 2013).
- The likelihood of feeling anxious reduces with age.
- Students and people not in employment are more likely to feel anxious all of the time or a lot of the time.
- Financial issues are a cause of anxiety for half of people, but this is less likely to be so for older people.
- Women and older people are more likely to feel anxious about the welfare of loved ones.
- Four in every ten employed people experience anxiety about their work.
- Around a fifth of people who are anxious have a fear of unemployment.
- Younger people are much more likely to feel anxious about personal relationships.
- Older people are more likely to be anxious about growing old, the death of a loved one and their own death.
- The youngest people surveyed (aged 18–24) were twice as likely to be anxious about being alone than the oldest people (aged over 55 years).

- One-fifth of people who have experienced anxiety do nothing to cope with it.
- The most commonly used coping strategies are talking to a friend, going for a walk, and physical exercise.
- Comfort eating is used by a quarter of people to cope with feelings of anxiety, and women and young people are more likely to use this as a way of coping.
- A third of the students in the survey said they cope by 'hiding themselves away from the world'.
- People who are unemployed are more likely to use coping strategies that are potentially harmful, such as alcohol and cigarettes.
- Fewer than one in ten people have sought help from their GP to deal with anxiety, although those who feel anxious more frequently are much more likely to do this.
- People are believed to be more anxious now than they were five years ago.
- There is a tendency to reject the notion that having anxious feelings is stigmatising.
- People who experience anxiety most frequently tend to agree that it is stigmatising.
- Just under half of people get more anxious these days than they used to and believe that anxiety has stopped them from doing things in their life.
- Most people want to be less anxious in their day-to-day lives.
- Women and younger people are more likely to say that anxiety has impacted on their lives.

An annual population survey enables Herefordshire respondents perception to be compared to results from other parts of the West Midlands. Figure 5.2 illustrates the percentage of respondents scoring high (6-10) to the question "Overall, how anxious did you feel yesterday?" Herefordshire has 20.5% (17.4% - 23.6%) of respondents reporting high levels of anxiety with life (slightly down from 21.2% in 11/12), which is not significantly different from the national rate (21.0%).

Figure 5.2: Percentage Reporting High Anxiety by Local Authority in the West Midlands, 2012/13



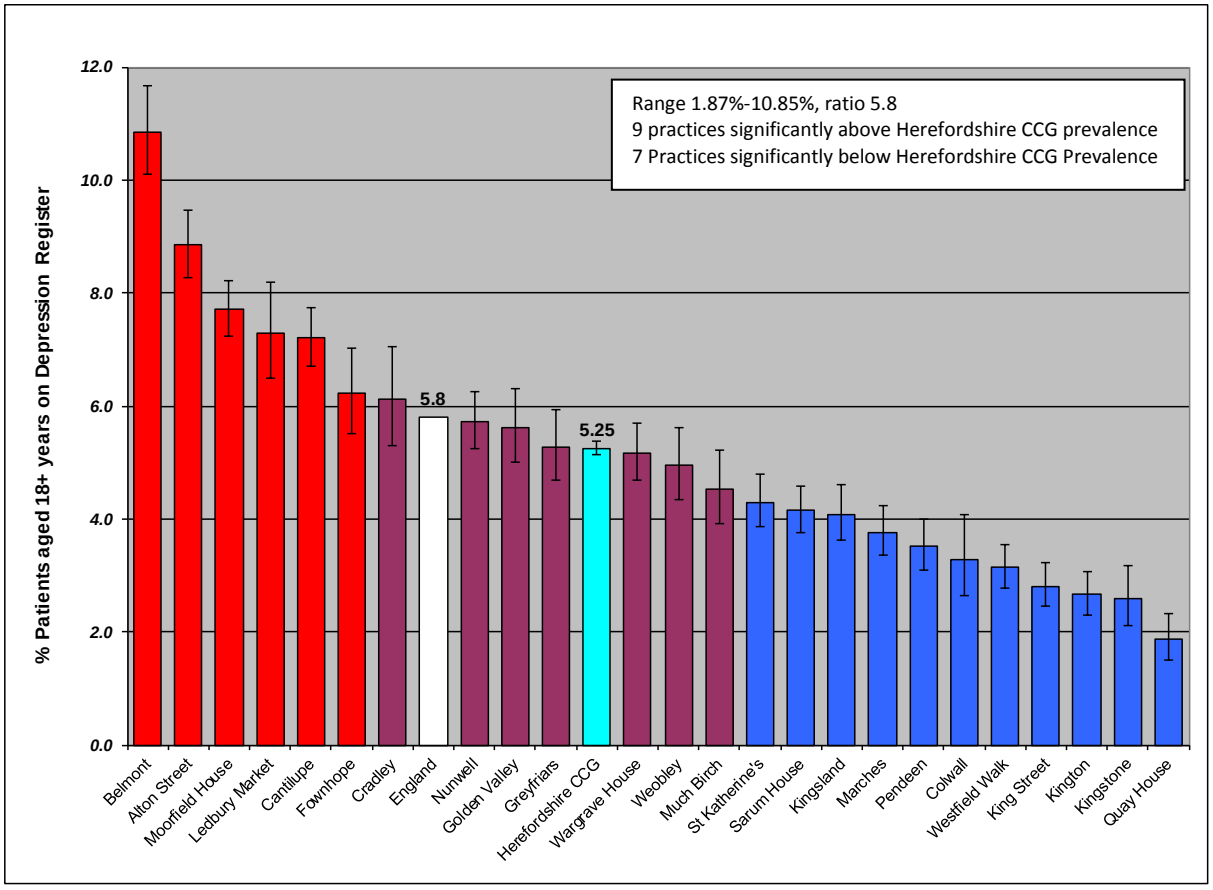
Source: Annual Population Survey, ONS, 2012/13

There is no evidence that Herefordshire has differing levels of anxiety to other counties.

5.2.3. Depression

Local information is available from GP surgeries on how many people present with a diagnosable depression. This is presented by Practice in figure 5.3 below.

Figure 5.3: Depression Prevalence Rate by Herefordshire Practice 2012/13



Source: QOF DEP6 Depression cases with severity assessment 12/13

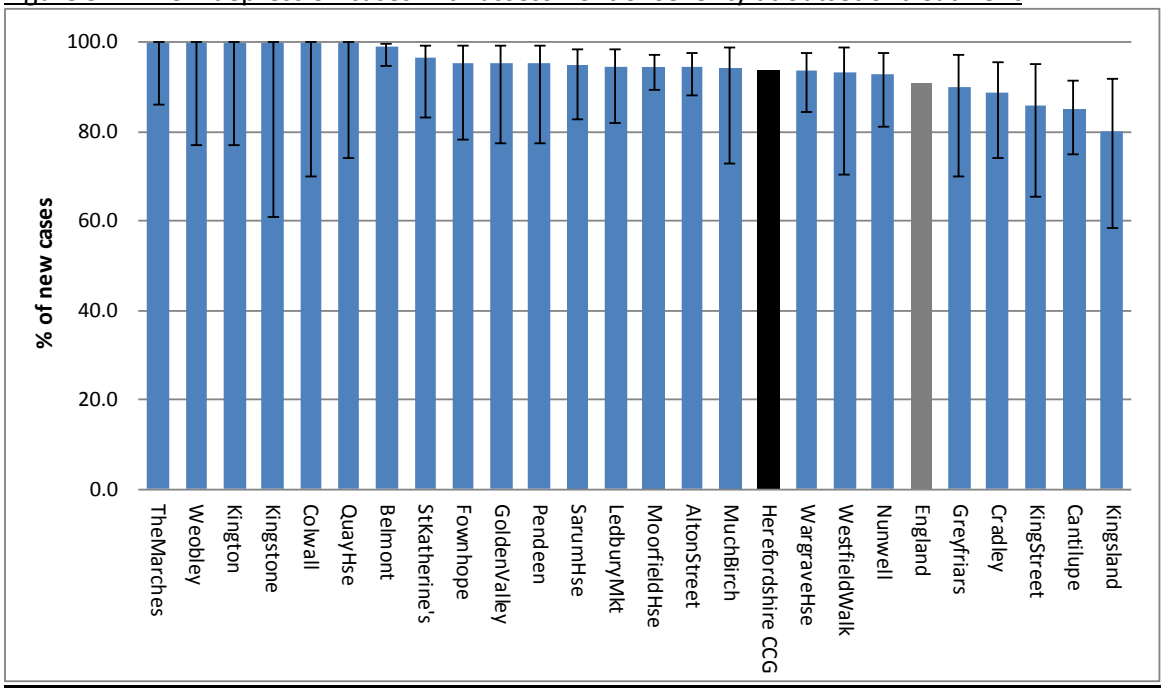
NB: This indicator applies to adults aged 18 years and over with a new diagnosis of depression in the preceding 1 April to 31 March. This indicator does not include women with postnatal depression.

A total of 7,790 patients were registered with depression across Herefordshire practices at the end of 2012/13. The CCG average prevalence is significantly low at 5.3% (5.1% - 5.4%), compared to 5.8% nationally. There are some differences between practices as some practices have a higher prevalence rate than the England or CCG prevalence rate. The average ratio of prevalence across practices is 5.8 i.e. between Belmont (10.9%) and Quay House (1.9%).

Case finding for depression in patients with diabetes and chronic heart disease was higher than the England average. Case finding was undertaken with 88.3% of patients with diabetes and/ or chronic heart disease within Herefordshire, compared to 85.9 nationally.

Figure 5.4 shows variation across Herefordshire practices of the proportion of new depression cases with an assessment of severity at outset of treatment. This varies from 80% at Kingsland surgery to 100% in several practices. As a whole Herefordshire CCG achieved an average of 93.8%, compared to 90.6% nationally. This suggests that, whilst people with depression in Herefordshire receive good assessment and care compared to peers elsewhere in the country, within the county the service is variable. Data coding could also explain this variance.

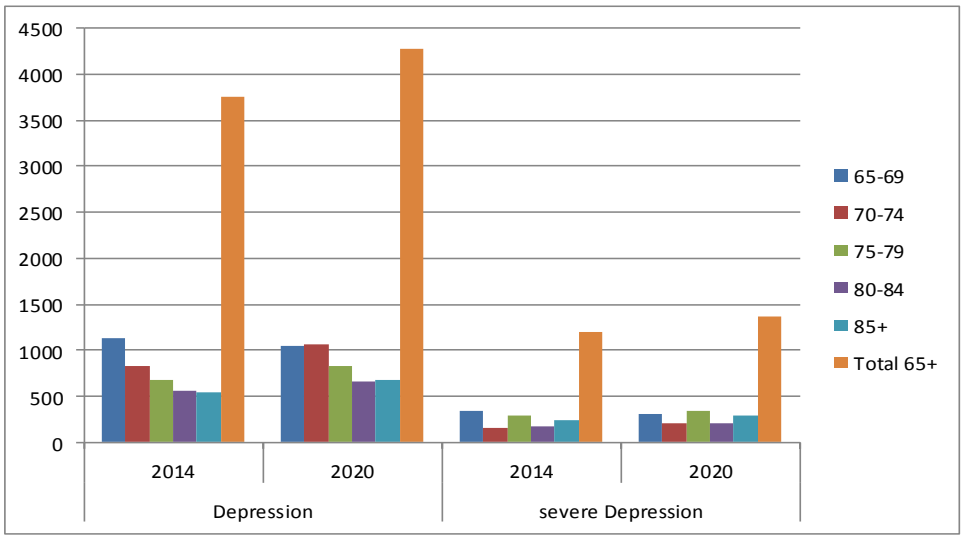
Figure 5.4: New depression cases with assessment of severity at outset of treatment



Source: QOF

Herefordshire has a higher than average proportion of elderly residents and that proportion is growing. Figure 5.5 shows that the total number of people with depression and severe depression is set to increase over the next 6 years, with a 14% increase in numbers of people aged 65+ with depression (from 3754 to 4285) and severe depression (from 1199 to 1371). Some of this growth is due to an increase in numbers of older people however the rate of depression is also increasing generally within the population. It should be noted that this increase has implications for the delivery of older people's services, with a need to acknowledge mental health comorbidity in older populations (including those patients with a primary dementia diagnosis). There may also be significant under-detection in these age groups, with low mood not investigated or treated as an inevitable consequence of ageing.

Figure 5.5: Prevalence of Depression 2014 – 2020, Projected Trends among the Elderly



Source: POPPI

5.2.4. Obsessive Compulsive Disorder and Phobias

Obsessive Compulsive Disorder (OCD) affects around 2–3% of the population and is characterised by unwanted, intrusive, persistent or repetitive thoughts, feelings, ideas, sensations (obsessions), or behaviours that makes the sufferer feel driven to do something (compulsions) to get rid of the obsessive thoughts. This only provides temporary relief and not performing the obsessive rituals can cause great anxiety. A person's level of OCD can be anywhere from mild to severe, but if severe and left untreated, it can destroy a person's capacity to function at work, at school or even to lead a comfortable existence in the home.

Reliable rates of OCD are not available.

5.2.5. Post-Traumatic Stress Disorder

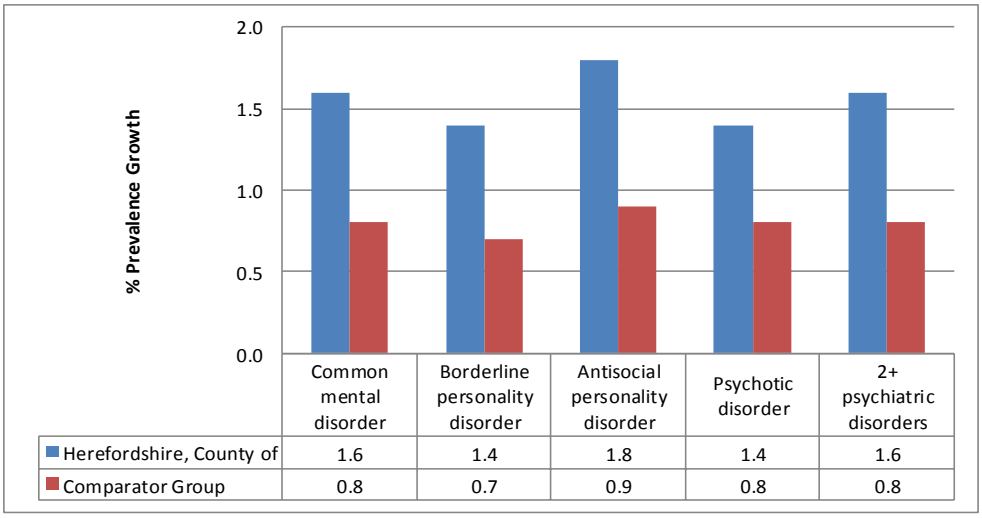
Post-Traumatic Stress Disorder (PTSD), or syndrome, is a psychological reaction to a highly stressful event outside the range of everyday experience, such as military combat, physical violence, or a natural disaster. The symptoms usually include depression, anxiety, flashbacks, recurrent nightmares, and avoidance of situations that might trigger memories of the event.

Reliable rates of PTSD are not available on a county level, with significant under reporting.

5.2.6. Common Mental Health Conditions 2014 – 2020: Projected Trends

The prevalence rates have been applied to the Office of National Statistics' population projections for the 18-64 population to give estimated numbers predicted to have a mental health problem, projected to 2020. All common mental health conditions are expected to increase by 1.4 – 1.8%.

Figure 5.6.Estimated Percentage Prevalence Growth for Common Mental Health Disorders by 2020



	Common mental disorder	Borderline personality disorder	Antisocial personality disorder	Psychotic disorder	2+ psychiatric disorders
Herefordshire, County of	1.6	1.4	1.8	1.4	1.6
Comparator Group	0.8	0.7	0.9	0.8	0.8

Source: PANSI

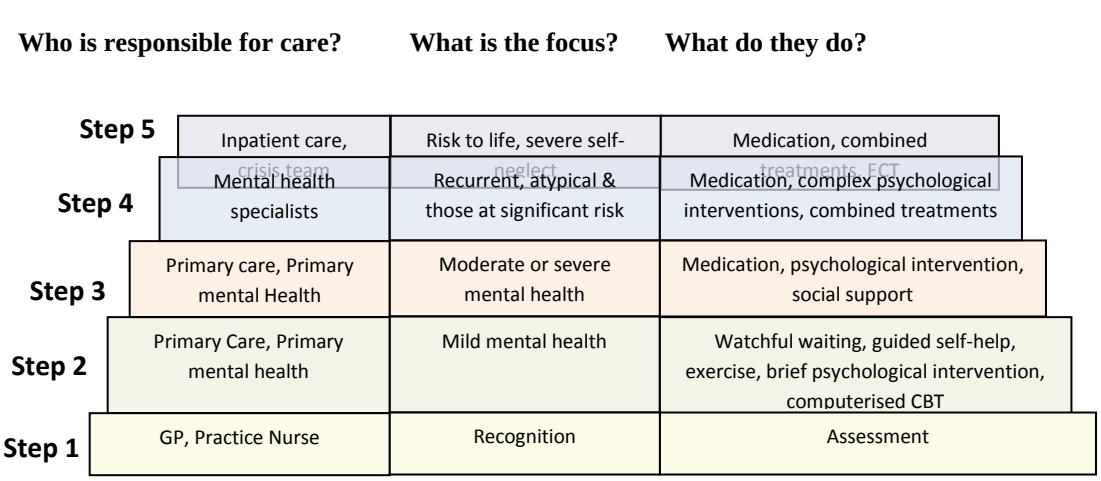
5.3. Models of Care

Mild and moderate mental health problems are usually addressed by services in the community. In recent years, primary mental health teams have developed as well as the national IAPT programme (Improving Access to Psychological Therapies).

5.3.1. Stepped Model of Care

National Institute for Health and Care Excellence (NICE) recommends a 'stepped care' approach to treatment, starting with interventions that are the least intrusive of those likely to be effective (NICE, 2012[lxxviii]). However, the evidence about the most effective ways of treating anxiety is mixed and we know little about the treatment preferences of those seeking help with anxiety. This requires integrated services using the stepped care model developed by the Joint Commissioning Panel for Mental Health. This should deliver evidence- based treatments that can be accessed via flexible referral routes, including self-referral, and offer a choice of psychological and non-psychological interventions, engaging with voluntary sector providers where appropriate.

Figure 5.7: Stepped Care Mental Health



Step One

Step one provides support for individuals with mild depression and anxiety. Such support will include:

- Supported self-management of psychological and emotional wellbeing (see chapter 11 for a discussion of supported self-management in relation to mental health)
- Social prescribing (to improve mental health outcomes, improve community wellbeing and reduce social exclusion[lxxix]).
- Peer experts and mentors, to coordinate and distribute information about self-management, co-ordinate mentorship programmes, and offer training and deployment of people with lived experience for specific purposes, such as advocacy.
- Health trainers, to help patients access computerised and internet therapies and support, teach techniques for enhancing psychological resilience, promote wellbeing skills, teach the principles of mental health first aid and introduce patient to relevant organisations in the community where they can get further help.
- Psychological wellbeing practitioners trained in cognitive behavioural treatments for people with mild to moderate anxiety and depression (such as group sessions)
- Access to e-mental health services such as on-line peer support groups.

Step Two

This is the provision of co-ordinated care involving the primary care team, including provision of low intensity therapies and links to employment support, carer support and other social support services. Patients may want their therapist at step two to act as a care coordinator in terms of signposting and navigating access to the various NICE-recommended options, such as structured exercise groups for depression. As needs increase and greater support is required for individuals, transitions to secondary mental health care services should be facilitated so that the patient's care is consistent (See Chapter 6).

5.3.2. Primary Mental Health Service

Primary mental health care teams may include the following:

- The core primary care team of the GP and the practice nurse
- Primary care mental health clinicians
- Primary care-based mental health specialists
- Third sector (not-for-profit) providers and social enterprises (e.g. community organisations and networks, including faith groups)
- Other community-based, non-specialist practitioners (for example, community pharmacists, school nurses and health visitors)
- Service user and carer experts by experience.

There are different models operating across England.

5.3.3. Improving Access to Psychological Therapies

Improving access to psychological therapies (IAPT) was developed to promote access to the National Institute for Health and Care Excellence (NICE) approved Cognitive Behavioural Therapy (CBT) based talking therapies as an appropriate evidence-based psychological intervention for depression and anxiety disorders (Clark et al, 2009[lxxx]). There are two tiers of IAPT therapy based on clinical severity – high and low intensity.

The function of IAPT is to deliver brief interventions at Step 2 and 3 of the Stepped Care model (figure 5.7). The service focuses on common mental health conditions or clusters 1-4, with monitoring of clinical outcomes achieved.

IAPT has been evaluated in regard to its clinical and cost effectiveness. Clarke et al (2009) indicated that at least 55% of patients who attended at least two sessions (including an assessment interview) recovered and 5% transitioned from unemployment into part or full-time employment.

An economic analysis of IAPT (Radhakrishnan et al, 2013)[lxxxi] showed that that costs of low and high intensity sessions are estimated at £99 and £177 respectively, broadly comparable with providing standard courses of CBT at £750 for 10 sessions (Layard et al, 2007[lxxxii]).

5.4. Findings

5.4.1. Primary Care

Seeing their GP is often the first step to recovery for patients with mild to moderate mental health problems. GPs also play a role in signposting patients and managing resources within the wider

system. With primary care offering support that is easily available but fixed length of appointments, there is tension between offering individuals sufficient levels of support whilst meeting the needs of a wider patient population. The majority of patients have good experience of their GP in relation to mental health support but it is acknowledged that variability exists across the county. There could be a number of reasons for this, including the confidence of the GP and the level of support that is possible from primary care.

I would say that GPs are vital as the first link. The GP was very informative and gave me correct information. My GP was amazing, so supportive and empathetic. However I know other people have not had the same experience.
Patient/ service user

GPs are unaware of what is available, or they didn't understand the process. There is no clear understanding about what the process is. There is a gap in terms of how GPS are informed. In one GP surgery, every GP gave a different opinion of what the lets talk service is. If you magnify that across Herefordshire, it is a very confused picture.
Parent Carer

There is variability in acceptance of risk on the part of GPs and as a result a huge variability of GP referrals. The answer is to reduce the variability by improving knowledge in GPs to recognize risk.
Primary Care Practitioner

GPs are good at identifying people, but there is still variability across the county.
Mental Health Practitioner

When I needed help, and worked up the courage to go, [my GP] pretty much dismissed me. He said "come back if you're feeling this way in a week" of course I didn't go back it was hard enough the first time and he made me feel like my problems were non-existent. He was wrong.
Patient/ Service User

The feedback from stakeholders revealed that their experience of primary care response to mental health concerns varied. To address that variability in patient experience, improvement measures could focus on further education for GPs and other staff in primary care; more resources in primary care to aid with signposting; and clearer care pathways and functions within it.

5.4.2. Medication

Among patients diagnosed with anxiety, approximately two-thirds are treated with medication, anti-depressants accounting for almost 80% of prescriptions made out to this group (Martin-Merino et al., 2010[lxxxiii]). Pharmacological interventions have been found to be effective at improving quality of life by reducing the symptoms of anxiety for some patients (Hofmann et al., 2013[lxxxiv]), although not for a significant number (Ravindran and Stein, 2010[lxxxv]). NICE suggests that for particular kinds of

anxiety, such as panic, social phobia and obsessions, GPs should prescribe anti-depressants, especially certain SSRIs (selective serotonin reuptake inhibitors). SSRIs appear effective in treating social phobia over the short term and the long term (Stein et al., 2004[lxxxvi]), while augmentative medications appear to be useful in the treatment of GAD (generalised anxiety disorder), which is a more chronic condition.

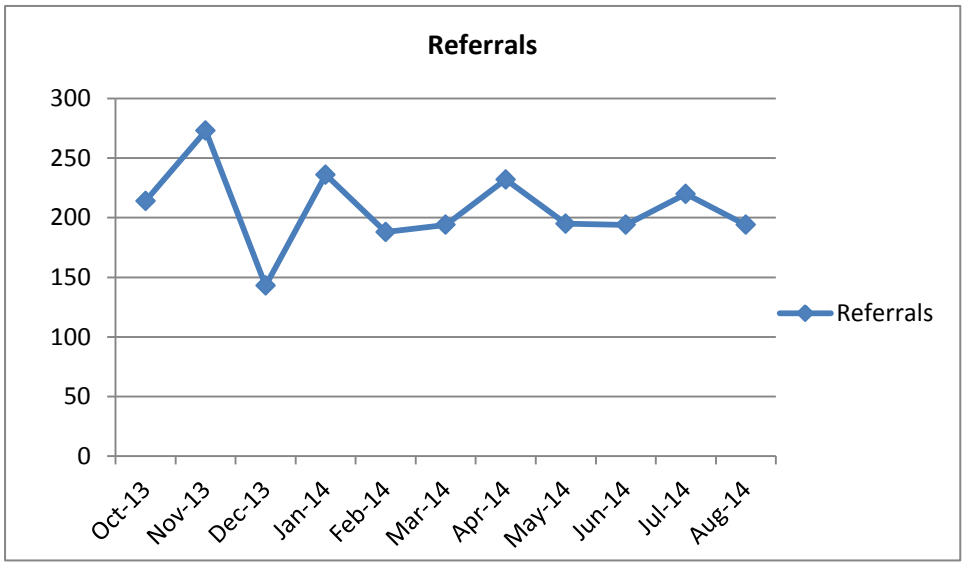
5.4.3. Non-Medical Activities

Studies on participation in leisure activities have shown improvements in self and life satisfaction, which helps in reducing depression and anxiety (Howarth, 2010[lxxxvii]), while the evidence about the effectiveness of exercise alone is mixed. The use of physical activities or engagement in activities to address social isolation and restore functioning is an attractive notion. Chapter 4 discusses social prescribing. The term *'social prescribing'* describes a range of mechanisms for linking patients to non-medical sources of support in the community[lxxxviii]. The service mapping showed that Herefordshire had a range of activities from art clubs to yoga sessions that people could access. Feedback from Primary Care highlights that GPs could be doing more signposting. To increase the level of signposting, GPs need to be better informed of the resources within their community. A directory of services would support knowledge and take-up of such activities.

5.4.4. Primary Care Mental Health

There are primary mental health nurses attached to each GP surgery in the county. The activity information shows that the number of referrals per month has averaged at 207 during the last year. As a relatively new service, there is not sufficient available data to present trends however 207 referrals per month suggest that this service is attracting demand.

Figure 5.8: Referrals to Primary Mental Health Service, October 2013- August 2014



Source: 2gether NHS Foundation Trust, 2014

The average caseload during the same period was 179 per month and 179 discharges per month. There is acceptance, particularly from GPs that the service is valued.

Implementation of the PCMHT has meant that people with mild to moderate problems are treated more appropriately in primary care, so preventing admission to secondary and preventing readmission through monitoring.
Mental Health Practitioner

Whilst it was recognised that primary care nurses provide good support for patients with mild to moderate mental health problems, there was a feeling among some professionals that the model provided could be modified to enable practitioners to meet the needs of a wider population.

Access through GPs is good…People may not want to be referred on. They may want to dip in and out through their GP.
Mental Health Practitioner

Spread out the work of the PCMHN. A GP gets ten minutes with a patient, some PCMHNs get an hour. By definition these patient are low risk. If we combine their expertise with how GPs manage in primary care, CMHN could see many more people and to meet the mental health needs of ALL patients in a locality. Adapting to a more primary care way of working would make the service more responsive.
General Practitioner

We need a proper PMH team with a wider range of treatments beyond CBT, such as counselling and interpersonal therapy. There is a need for quicker assessment with self-referral and communication between teams and GPs.
Mental Health Practitioner

The role of primary mental health workers is valued, however, further consideration of the function of the primary mental health team could improve access to brief or short-term interventions or form part of an effective triage role. Although the Service was conducting assessments, sometimes these assessments were carried out again in the community mental health service. This duplication indicates that the primary mental health team is not being considered as the gatekeeper to secondary mental health services or part of a stepped model of care. Further integration across teams is required to make better use of resources.

5.4.5. Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is one of a broad range of psychotherapies or 'talking therapies' that aims to change the way that you think and behave. Guided self-help has become an increasingly popular way of offering treatment because of its low cost, adaptability to different forms of digital and social media and its acceptability to people who might otherwise not receive treatment (Andrews et al., 2010[lxxxix]) either for reasons connected with their anxiety or because of time pressure from commitments such as caring. Most guided self-help is based on cognitive behavioural approaches and aims to help the person experiencing anxiety achieve a level of recovery whereby

they are able to understand the nature of their anxiety and what is happening physiologically to them. They are then helped to develop the necessary skills to tolerate and cope with it, by challenging unhelpful thinking, evaluating their bodily symptoms realistically and managing graded self-exposure to the source of their anxiety.

Computerised CBT can be supported by reminders from a non-clinical technician or practice nurse, or guided by a clinician via telephone, email, live links such as Skype, or posts on a private forum.

Many areas of the country also have self-help groups that offer peer support. Andrews et al. (2010) point out that a major advantage of this form of CBT is the level of treatment fidelity that can be achieved. Similarly, an evaluation of an online mindfulness course has shown promising results in terms of the acceptability of the means of delivering help to people who might otherwise not receive treatments and its ability to decrease the anxiety experienced by course participants (Krusche et al., 2013[xc]).

Research also suggests that skills acquired through mindfulness based cognitive therapy (MBCT) training enable patients to tolerate greater degrees of uncertainty and encourage acceptance (van Ravesteijn et al., 2014[xci]). These could be useful skills for distressed high-utilisers of healthcare services. Kurdyak and colleagues[xcii] compared the relative change in health service utilisation between high users in the MBCT and non-MBCT, found that the MBCT group had a significant reduction in mental health and non-mental health visits.

There was some evidence of self-help groups in Herefordshire, particularly for recognised mental health conditions. People reported that they valued the self-help groups however wanted / needed more groups across the market towns.

5.4.6. Increasing Access to Psychological Service (IAPT)/ Let's Talk

The IAPT provision in Herefordshire is delivered by one service called Let's Talk. The quarterly referral rate in quarter 4, 2013/14 showed that Herefordshire achieved a rate of 316 per 100,000 population aged 18+; compared to 700 per 100,000 for comparator CCGs and 708 per 100,000 for England.

The service received 1793 referrals in 2013/14. The table below shows the source of the referrals. People were referred for different reasons. The most common mental health conditions appear to be depression and anxiety (60.1%) with phobias making up a small proportion.

Table 5.1: Source of Referrals to IAPT 2013/14.

Referral Source	Number of Referrals	Percentage
GP surgeries	1127	62.85
Other NHS	529	29.5
Other	25	1.3
Self-referrals	111	6.35

Source: 2gether NHS Foundation Trust, 2014

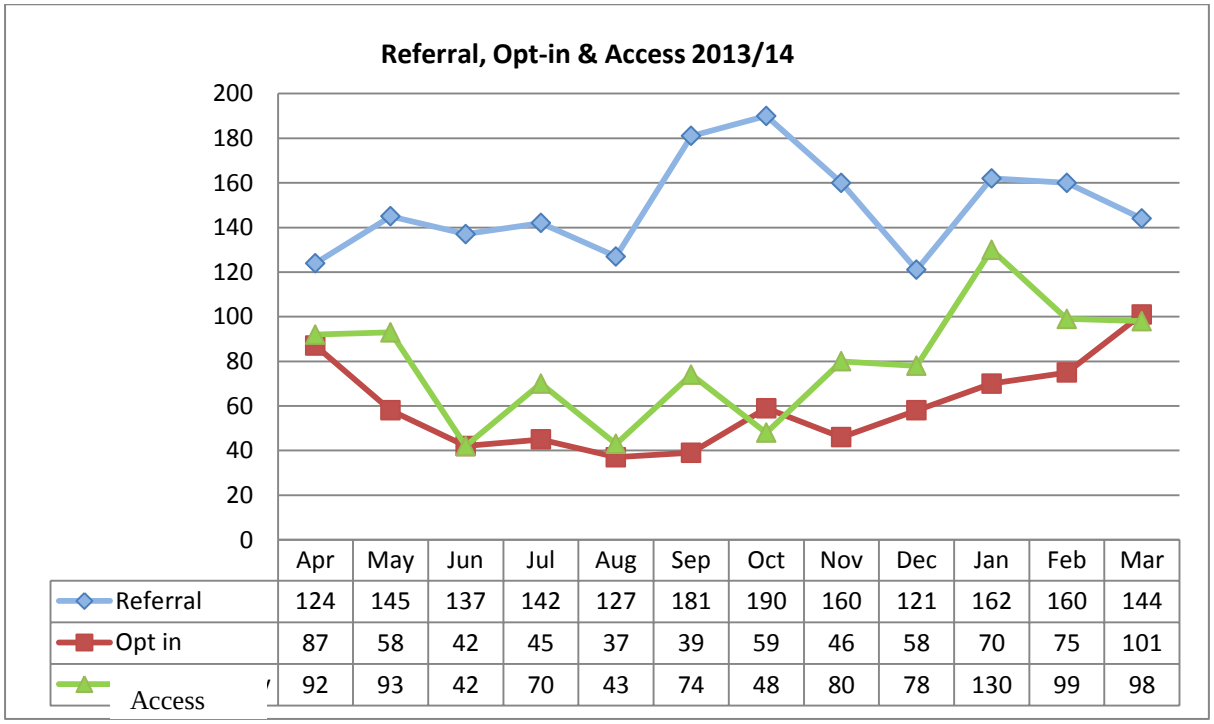
There is comparator CCG benchmarking information for the rate per 100,000 population entering treatment. Herefordshire is lower than the CCGs comparator cluster and England average (quarter 4, 2013/14).

- Herefordshire - 222 per 100,000
- CCGs Comparator Cluster average – 458 per 100,000
- England average – 469 per 100,000

Waiting times for IAPT (referral to first treatment) is monitored in terms of waiting more than 28 days. The percentage of referrals in March 2014 waiting more than 28 days was 57.9%.This is similar to the England average of 62.5%.

The conversion from referral to opt-in figures suggest that only 40% of referred clients take up the service. Figure 5.10 shows the trend over 12 months of the number of people who are referred, opt-in to treatment and then access the treatment. This shows that people drop out of the service despite agreeing to be referred. The Service has opened up to self-referrals in 2014. This might impact drop-out rate however it is too early to report on the impact of self-referrals.

Figure 5.10: Let's Talk Referral, Opt-in and Access Activity by Month (2013/14)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Referral	124	145	137	142	127	181	190	160	121	162	160	144
Opt in	87	58	42	45	37	39	59	46	58	70	75	101
Access	92	93	42	70	43	74	48	80	78	130	99	98

Source: 2gether NHS Foundation Trust, 2014

There is evidence that long waiting lists suppress referrals. Good practice suggests that first appointment takes place within 4 weeks for the majority of patients.

Benchmarking completion of treatment shows that Herefordshire as of quarter 4 2013/14 had a lower than average completion rate of both the CCGs comparator cluster group and England:

- Herefordshire – 151 per 100,000

- CCGs Comparator Cluster – 227 per 100,000
- England – 242 per 100,000

For people who completed the treatment, the recovery rate was 42.7% as of March 2014.

There is some evidence that Herefordshire Let's Talk is working with people that have greater severity than comparator IAPT services, with more patients in the moderate to severe range.

- National figures: mild = 36%; moderate = 43%; Severe = 21%
- Hereford depression: mild = 21%; moderate = 22%; Severe = 57%
- Hereford Anxiety: mild = 29%; moderate = 38%; Severe = 32%

This clearly indicates that Herefordshire Let's Talk are working with greater severity than anticipated, and in order to be more efficient, must see a greater proportion of clients in the mild – moderate range.

There is further work that the service can deliver to ensure equity of access for marginalised groups such as older people. The service run a targeted group for polish speaking patients however further promotion should focus on ensuring that provision is reaching marginalised groups.

Stakeholder feedback on IAPT service showed that whilst some patients value the service offered by IAPT, the programme is under-subscribed. Some professionals are not convinced by the service it offers and some patients stated that they did not welcome the telephone triage. The use of groups and telephone triage was not valued by all respondents and reconfiguration to allow a single referral pathway and more efficient use of resources were suggested. However, it is recognised that it meets the needs of a wider population to access psychological therapies in a cost effective way.

The Let's Talk CBT courses are very helpful, and should be more easily available
Patient / Service-User

The telephone interview for a first referral assessment is horrific. I could not do it, and luckily am old and wise enough to request a 1:1 interview. The call came through on my mobile when I was at work. Just the request to talk about my intimate mental health problems on the phone, to a stranger, made me shake with fear. 70% of communication is non-verbal and any assessment by phone will miss 3/4 of the information a face to face assessment would give.
Patient/ Service User

Some of my clients have complained about attending group therapy; there needs to be subsidised one-to- one counselling.
Voluntary Sector Practitioner

IAPT was developed to deliver CBT- that's where the evidence is. 1-1 is cost effective for the patients at the high end, but if we are going to meet the massive need for mild to moderate mental health support, groups are the only way forward.
Primary Care Practitioner

Some gaps were identified such as access to psychological therapies for people with a mental health condition other than depression or anxiety. Group work attendance and participation would be more difficult for some people, especially those with chaotic lifestyles. However this concern is also true of people with depression and anxiety that want more choice in where and how they access interventions. Online support is not available as a treatment option however this is an area of interest to the public, both patients and their families.

We need to be more effective for people who don't fall into criteria (Eating disorders, ASD, LD, PD, persons with controlled schizophrenia, bipolar.
Mental Health Practitioner

The principle of IAPT is fine, but patients don't engage. IAPT is fine for very low level need, but patients going through a difficult patch aren't really appropriate for groups. A lot of patients don't follow through on the referral and I ask them to self-refer now.
General Practitioner

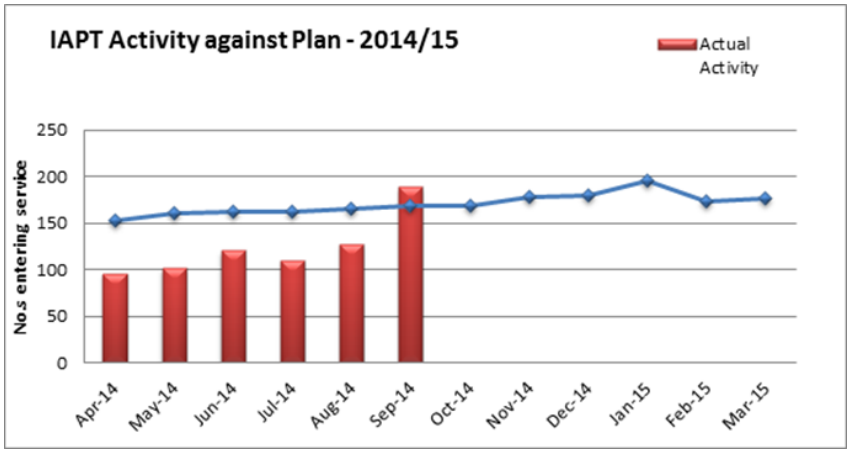
There is a need for online support so that people can access treatment in evenings and weekends from their own home.
Patient / Service-user

There are national targets for the IAPT adult service:

- 15% of mild-moderate anxiety and depression prevalence to be able to access psychological therapies
- 50% entering treatment will move to recovery

Figure 5.11 show that Herefordshire is increasing the number of people entering the service during 2014/2015. Latest performance shows that 5.14% of mild-moderate anxiety and depression prevalence to be able to access psychological therapies. This is a cumulative target with 15% expected by the end of March 2015.

Figure 5.11: IAPT Activity against Plan 2014/15



Source: Herefordshire Clinical Commissioning Group, October 2014.

The percentage of people who recover has a performance target of 50%. As of September performance was 49.45%. This shows that people who take-up the service and complete the interventions are benefiting.

5.4.7. Care Pathway

The existing NHS resources specifically for common mental health conditions run as two separate teams/ services. One serves the function of assessments and brief interventions, and the other delivers brief interventions either as one to one or in group sessions. Access to brief interventions has an evidence base that suggests self-referral and local delivery are important factors to take-up. Patients should be able to access help as early as possible with minimal waiting times. Consideration of care pathway for common mental health conditions (particularly clusters 1-4) would enable more effective delivery. Stakeholder views supported closer integration between the two services.

Primary care nurses could do the assessment and IAPT could do the treatment.
Mental Health Practitioner

The [functions of] Primary Mental Health Nurses overlap with IAPT. A single referral pathway would be more effective.
Mental Health Practitioner

Closer integration includes primary care, as seamless care will support identification of people and to ensure sustained benefit, particularly for people with recurrent and chronic conditions.

Currently the services are provided within the NHS however more choice for patients should be reviewed. Feedback found that patients with mild to moderate mental health issues who wished to access one to one therapies either had to wait for long periods or source support independently. The voluntary sector services could play a role in delivering lower level services to enable more patient choice within the county.

We need a supply of counselling and CBT services that do not require a long waiting list or a large purse.
Patient / Service-user

My counselling has been provided by my employer, NHS provision was either over the phone or group sessions. Neither of these were suitable for my needs.
Patient/ Service-user

I'd like to see third sector support services being used as a 'first aid' counselling/listening, with the ability then to access, signpost and refer to other support agencies.
Carer

IAPT courses could be delivered by a charity- There is still a stigma regarding mental health service and if it was less formal, people may be more willing.
Mental Health Practitioner

5.5. Conclusion

Herefordshire has a lower number of people receiving care and support as a result of their common mental health condition than the prevalence rates suggest. The NHS targeted services to address the needs of people with common mental health conditions are relatively new however this Needs Assessment indicates that further improvements are required to ensure people who require help receive timely and accessible assistance. It was not possible to identify the number of people receiving support for common mental health conditions in non-NHS Services.

The recommendations are:

Common Mental Health Care Pathway

- Create a single service that is primary facing service for common mental health conditions.
- Document and disseminate an agreed care pathway for people with common mental health conditions. A care pathway approach involving all organisations that operate in this field would eliminate duplication and ensure compliance with a stepped model of care.

Improve access to help

- Promote self-referrals and increase referrals by harnessing the reach of GPs & other existing health workers to identify unmet mental health need. This will include education and awareness raising for such practitioners.
- GP to be able to book people directly onto IAPT (rather than referral)
- Access to good quality self-help approaches should be made available including through a digital platform and the promotion of self-help groups.
- Further targeting of groups of people who are at highest risk of developing problematic anxiety and least likely to have their needs met by current service provision.
- IAPT to be audited to establish how well current referral processes are working, who is accessing these, and who is falling through the gaps.
- Voluntary sector organisations to deliver some provision for mild and moderate mental health conditions, particularly to address choice, stigma and a variety of need.
- Develop a directory of services to aid people in locating and accessing sources of help and support.

Chapter 6: Severe and Enduring Mental Health

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Contents

Chapter 6: Severe and Enduring Mental Health

6.1 Introduction and Definitions

Some people have a diagnosed mental health condition that will be ongoing throughout their life time. This Chapter explores the experience of people with severe and enduring mental health conditions (adults); the responses to those needs such as recognition of signs of exacerbation; and actions to stay well and rehabilitate after an episode of poor mental health.

This chapter considers psychosis, bi-polar, schizophrenia, self-harm, eating disorders and personality disorders. This Chapter explores the prevalence for these conditions (subject to availability of information) before outlining models of care. The analysis is then presented in light of stakeholders' views and activity information before the recommendations are outlined for this area.

6.1.1. Psychosis

Psychosis and the specific diagnosis of schizophrenia represent a major psychiatric disorder (or cluster of disorders) in which a person's perception, thoughts, mood and behaviour are significantly altered. The symptoms of psychosis and schizophrenia are usually divided into 'positive symptoms', including hallucinations (perception in the absence of any stimulus) and delusions (fixed or falsely held beliefs), and 'negative symptoms' (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect). Each person will have a unique combination of symptoms and experiences[xciii].

6.1.2. Bipolar

Bipolar disorder is characterised by episodes of mania (abnormally elevated mood or irritability and related symptoms with severe functional impairment or psychotic symptoms for 7 days or more) or hypomania (abnormally elevated mood or irritability and related symptoms with decreased or increased function for 4 days or more) and episodes of depressed mood. It is often comorbid with other disorders such as anxiety disorders, substance misuse, personality disorders and attention deficit hyperactivity disorder (ADHD).

6.1.3. Personality Disorders

Antisocial Personality Disorder

People with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This manifests in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others. The condition is associated with a wide range of interpersonal

and social disturbance, often as a result of growing up in fractured families in which parental conflict is typical and parenting was/ is harsh and inconsistent. Many people with antisocial personality disorder have a criminal conviction and are imprisoned or die prematurely as a result of reckless behaviour. Criminal behaviour is central to the definition of antisocial personality disorder, but there are people with no criminal history. Antisocial personality disorder is often comorbid with depression, anxiety, and alcohol and drug misuse.

Under current diagnostic systems, antisocial personality disorder is not formally diagnosed before the age of 18 but the features of the disorder can manifest earlier as conduct disorder. A history of conduct disorder before the age of 15 is a requirement for a diagnosis of antisocial personality disorder in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)[xciv].

Borderline Personality Disorder

Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. The extent of the emotional and behavioural problems experienced by people with borderline personality disorder varies considerably. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are particularly at risk of suicide. They also have high levels of comorbidity, including other personality disorders, and are frequent users of psychiatric and acute hospital emergency services.

People with psychopathy and people who meet criteria for dangerous and severe personality disorder (DSPD) represent a small proportion of people with antisocial personality disorder. However, they present a very high risk of harm to others and consume a significant proportion of the services for people with antisocial personality disorder[xcv].

6.1.4. Eating Disorder

Eating disorder is a collective term for a range of psychological illnesses defined by abnormal eating habits that may involve either insufficient or excessive food intake to the detriment of an individual's physical and mental health. Anorexia nervosa (AN) is a serious psychiatric illness characterized by an inability to maintain an adequate, healthy body weight. Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating in combination with some form of unhealthy compensatory behaviour such as vomiting (“purging”) and or exercise. Eating disorders not otherwise specified (EDNOS) is a catch all for eating disorders not meeting all of the ICD10 criteria for anorexia nervosa or bulimia nervosa. The lifetime risk of anorexia nervosa in women is estimated to be 0.3% to 1%, with a greater number of patients having bulimia nervosa[xcvi]. Eating disorders are significant cause of mental health related ill health and mortality, particularly in young/ adolescent women[xcvii].

6.15. Self-Harm

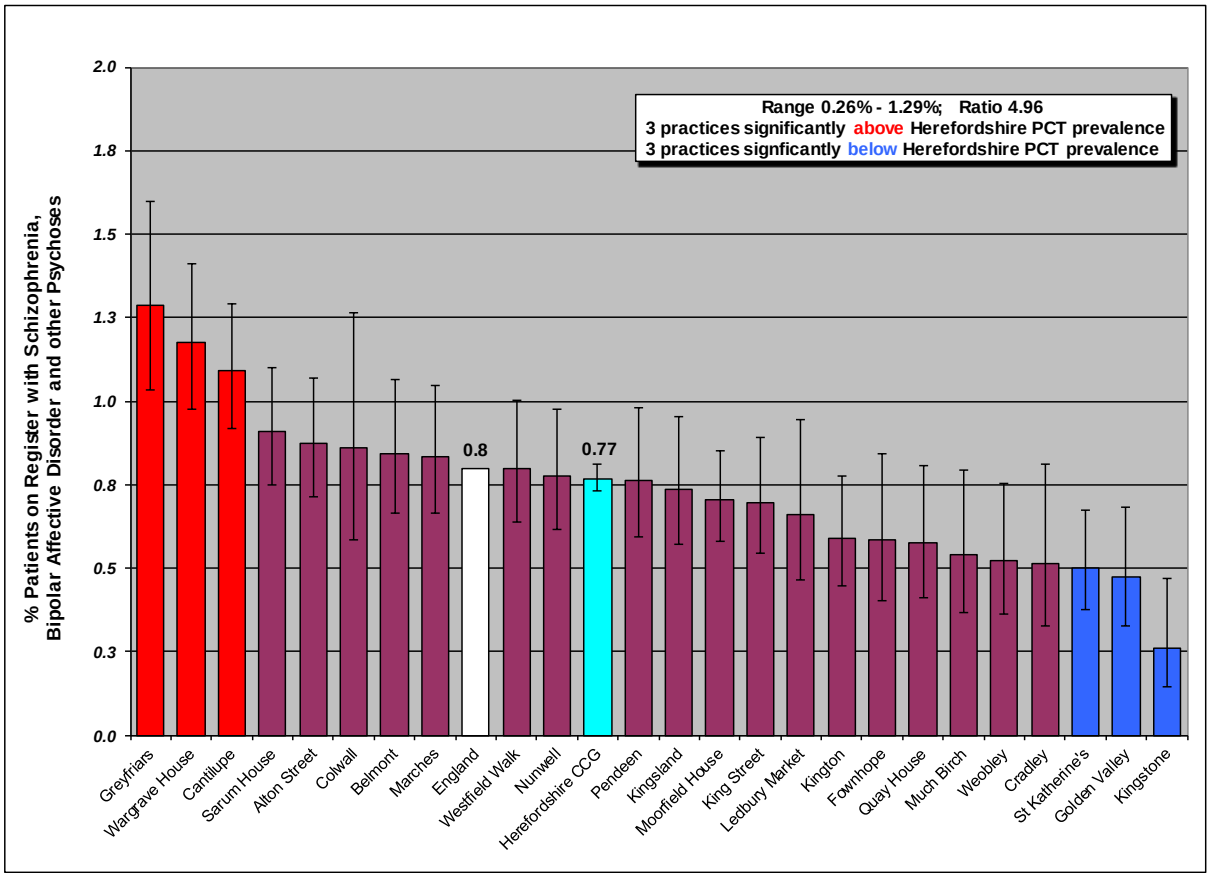
Self-harm may refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting. There are several important exclusions that this term is not intended to cover. These include harm arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself.

Self-harm is common, especially among younger people. A survey of young people aged 15–16 years estimated that more than 10% of girls and more than 3% of boys had self-harmed in the previous year. For all age groups, annual prevalence is approximately 0.5%. Self-harm increases the likelihood that the person will eventually die by suicide by between 50- and 100-fold above the rest of the population in a 12-month period. A wide range of psychiatric problems, such as borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol-use disorders, are associated with self-harm[xcviii].

6.2 Prevalence

There were a total of 1,403 patients on the mental health register across Herefordshire practices at end of 2012/13. This is likely due to an incomplete count, as records from mental health services indicate that 3,030 patients were seen in 2012/13. Part of the variance will be the range of patients with different diagnosis that are seen by secondary mental health services compared to the definition for inclusion on the primary care register. Comparisons between the primary care register and the national average shows that Herefordshire's average prevalence is not significantly different at 0.77% (0.73% - 0.81%), compared to 0.8% nationally. When differences from across practices are examined, then the ratio of prevalence varying across practices is 5.0 from Greyfriars (1.29%) to Kingstone (0.26%).

Figure 6.1: Mental Illness Prevalence Rate by Herefordshire Primary Care Practice 2012/13



Source: QOF, 2013

As can be seen in figure 6.1, there is a significant variance in the range of prevalence of enduring and severe mental health conditions across GP surgeries, with 1.3% of patients in Greyfriars being recognised, compared to 0.3% in Kingstone.

6.2.1 Psychosis, Schizophrenia and Bipolar

Half of adults with long-term mental health problems first experience symptoms by the age of 14 (Maughan et al 2004, DH 2010). The peak age of onset is 15–19 years, and there is often a substantial delay between onset and first contact with mental health services. The lifetime prevalence of bipolar I disorder (mania and depression) is estimated at 1% of the adult population, and bipolar II disorder (hypomania and depression) affects approximately 0.4% of adults. Bipolar disorder in children under 12 years is very rare[xcix].

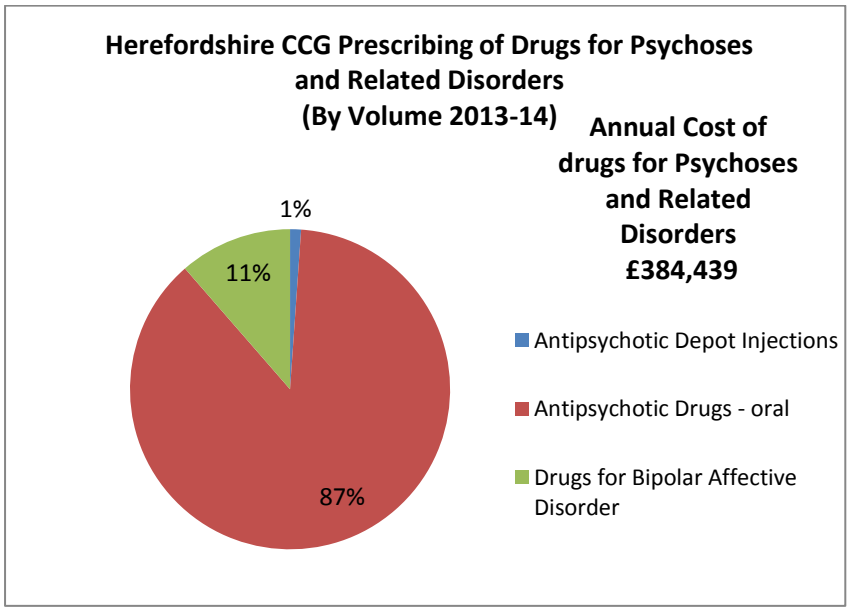
The published information on actual numbers of people with a diagnosis of psychosis, schizophrenia or bi-polar affective disorder is old (2007). This data was used to forecast prevalence by 2020. This shows no significant increase is expected. The table below illustrates Herefordshire information alongside its comparator local authorities.

Table 6.1: Estimates of people aged 18-64 predicted to have two or more psychiatric disorders by 2014 and 2020

Local Authority Area	Total Population 18 - 64			2+ Psychiatric disorders		
	2014 Forecast	2020 Forecast	Difference	2014 Forecast	2020 Forecast	Difference
Herefordshire	108,500	109,900	1.3%	7,805	7,927	1.6%
Bath and North East Somerset	111,500	112,100	0.6%	8,035	8,082	0.6%
North Somerset	120,800	127,600	5.4%	8,702	9,190	5.4%
Solihull	121,800	123,600	1.5%	8,770	8,929	1.8%
North Lincolnshire	101,400	101,700	0.3%	7,308	7,315	0.1%

Source: PANSI, 2013

Figure 6.2 Prescribing of Medication for Psychoses and Related Disorders



Source: Herefordshire Clinical Commissioning Group, 2014

Herefordshire's prescribing rate of drugs for psychoses is similar to other CCGs in the comparison group. Herefordshire issued 41.7 items per 100,000 population (2013/14 Quarter 4) compared to 43.8 for England and 44 for CCG comparator group average. (Source: HSCIC).

6.2.2. Personality Disorder

Table 6.2: Estimates of people aged 18-64 predicted to have an antisocial personality disorder by 2014 and 2020

Local Authority Area	2014 Forecast	2020 Forecast	Predicted Increase between 2014 and 2020
Herefordshire	379	386	1.9%
Bath and North East Somerset	391	396	1.3%
North Somerset	419	445	5.9%
Solihull	420	427	1.7%
North Lincolnshire	356	356	0%

Source: PANSI, 2013

According to national prevalence rates there were an estimated 4,650 residents with a personality disorder in 2005. Projections suggest a 3% increase by 2021, to 4,800 adults. In January 2007 around 60 adults receiving secondary specialist mental health care had a primary diagnosis of personality disorder – just 1.3% of all estimated cases. The large discrepancy between the number of clients and the estimate based on national prevalence rates may be explained by large numbers of people with a personality disorder not requiring specialist services, or who may be diagnosed with another mental health problem, e.g. anxiety.

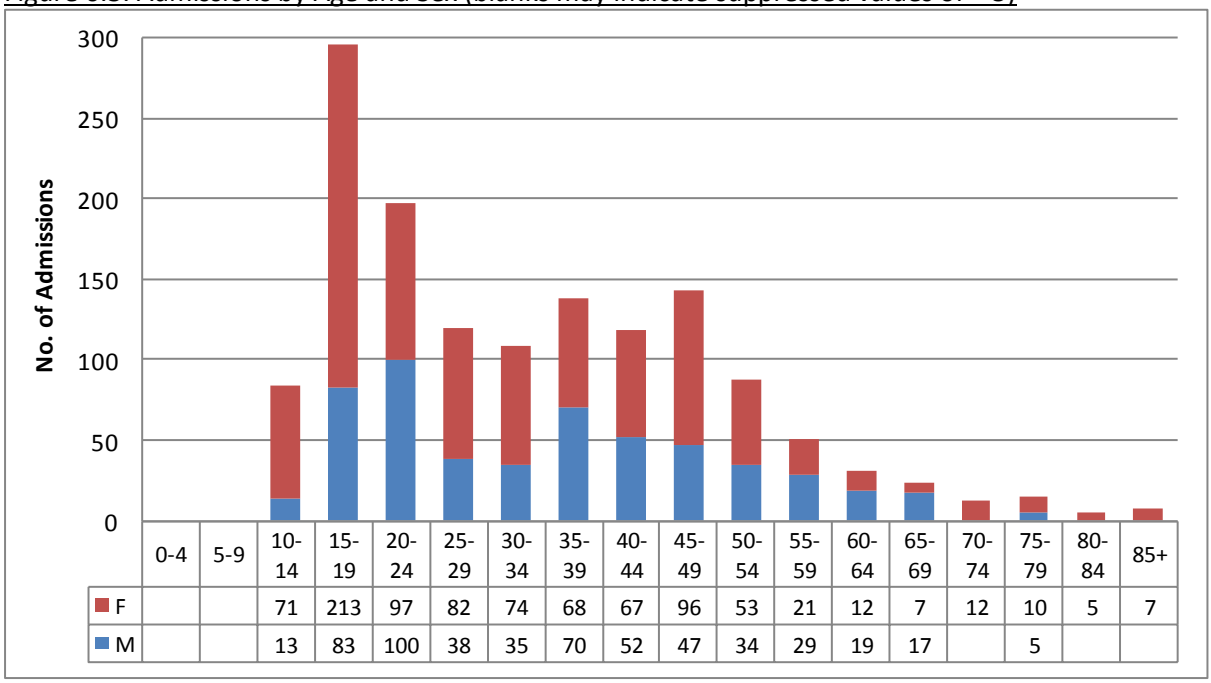
6.2.3. Eating Disorders

About 90% of those affected are female. Lifetime prevalence rates for full and partial anorexia nervosa in the general population range from 0.9 to 4.3% for females (Hudson et al, 2007[c]; Wade et al, 2006[ci]), and from 4 to 7% for full and partial bulimia nervosa (Favaro et al, 2003[cii]). The lifetime prevalence of binge eating disorder is 3.5% in women and 2.0% in men (Hudson et al, 2007).

6.2.4. Self-harm

Self-harm is typically only recorded when a patient seeks medical support. Therefore, records of self-harming behaviour are likely to understate true prevalence. Figure 6.3 shows admissions to hospital for Herefordshire residents who have self-harmed, broken down by age band and gender. Women outnumber men in all age groups, with a peak in incidence for women in the 15-19 age band and for males in the 20-24 age band. A secondary peak for women is seen at age 45-49 years. It should be noted that this does not indicate severity of self-harm.

Figure 6.3: Admissions by Age and Sex (blanks may indicate suppressed values of < 5)

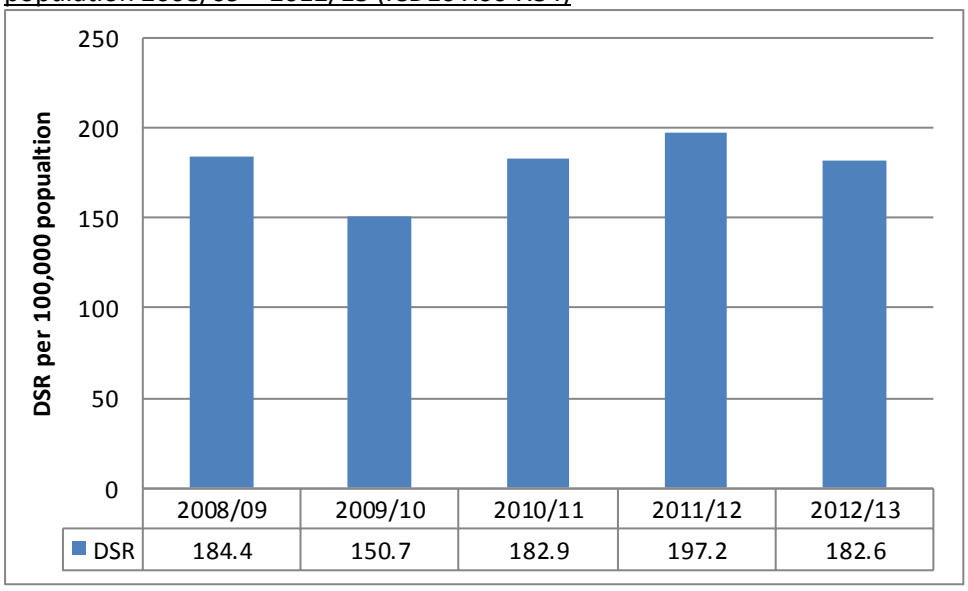


	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
F			71	213	97	82	74	68	67	96	53	21	12	7	12	10	5	7
M			13	83	100	38	35	70	52	47	34	29	19	17		5		

Source: HES

Figure 6.4 shows age and sex standardised admission for intentional self-harm between 2008 and 2014, broken down by five year age band. No discernible trend can be identified, with rates varying between 150 and 197 persons per 100,000 population.

Figure 6.4: Age-sex standardised emergency admission rate for intentional self-harm per 100,000 population 2008/09 – 2012/13 (ICD10 X60-X84)



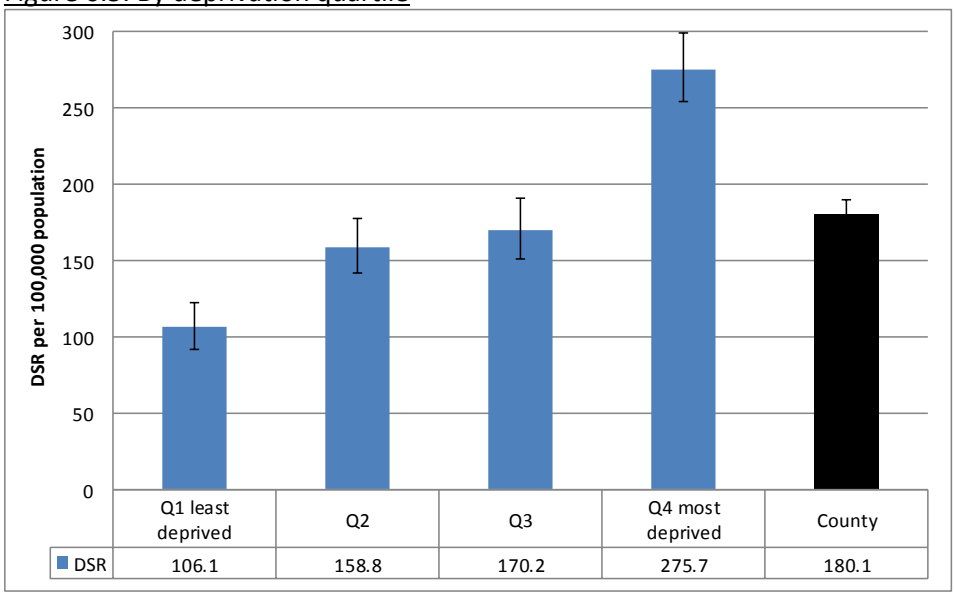
	2008/09	2009/10	2010/11	2011/12	2012/13
DSR	184.4	150.7	182.9	197.2	182.6

Source: HES

An examination of patients that self-harm by level of deprivation shows a link between an increase in deprivation and propensity to self-harm, suggesting a correlation. Figure 6.5 shows the rate of admission for intentional self-harm broken down by deprivation quartile, with quartile four being the most deprived. This shows that people in the least deprived areas are significantly less likely to

self-harm compared to the county average, with people in the most deprived areas significantly more likely to self-harm than peers elsewhere in the county.

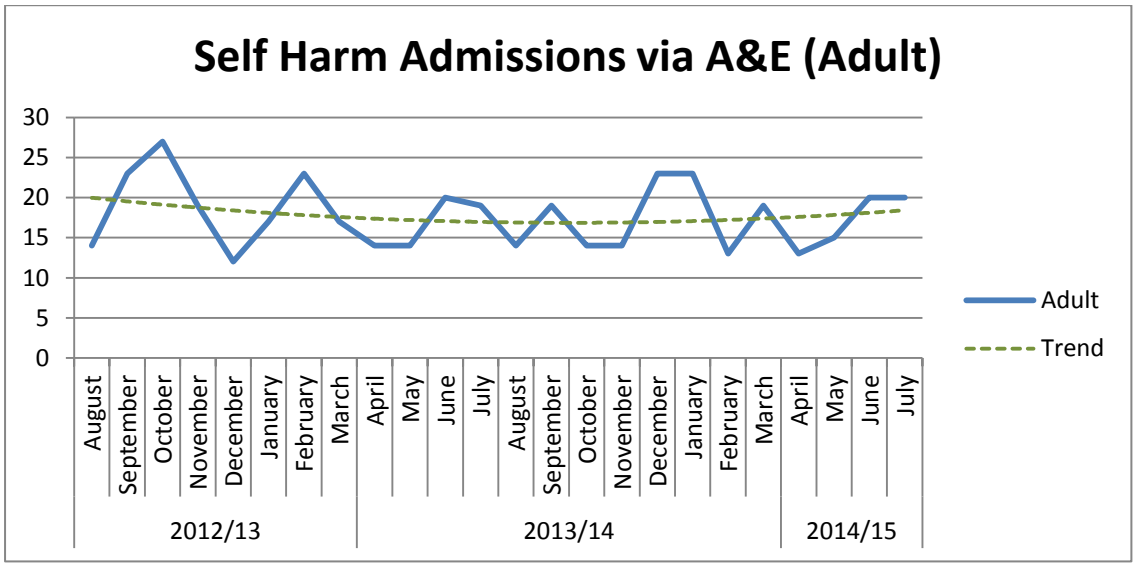
Figure 6.5: By deprivation quartile



Source: HES

Figure 6.6 shows the trends in self-harm admissions since 2012.

Figure 6.6: Self harm Admissions via A&E for People aged 18 August 2012-July 2014



Source: SUS

6.3. Service Model

6.3.1. Overview

There is evidence of both clinical and economic benefits of community mental health care:

- Crisis resolution and home treatment teams can reduce hospital admission rates and length of stay.
- Research on assertive outreach shows that the service can increase engagement and satisfaction but not reduce bed use.
- Community mental health teams can provide “as good” care as the assertive outreach team model.

NICE clinical guidelines relating to psychosis, schizophrenia and bipolar disorders make recommendations on use of early intervention, crisis resolution and home treatment and assertive outreach teams. However the evidence also shows that potential benefits of specialist teams are not always realised because of inappropriate skill mix, ineffective management arrangements, limited access to psychiatric expertise and inadequate capacity to provide 24/7 coverage.

Practice suggests ‘integrated acute care teams’ are part of a coherent acute care service, working with inpatients, day hospital and respite and other alternatives within a common management structure. Acute day hospitals should be considered alongside crisis resolution and home treatment teams instead of admissions to inpatient care to help early discharge from inpatient care.

Based on review of the evidence, NICE clinical guidelines for psychosis and schizophrenia recommend that crisis resolution and home treatment teams should:

- Be used to support people with schizophrenia during an acute episode in the community
- Pay particular attention of risk monitoring as a high priority routine activity
- Be considered for people with schizophrenia who may benefit from early hospital discharge.

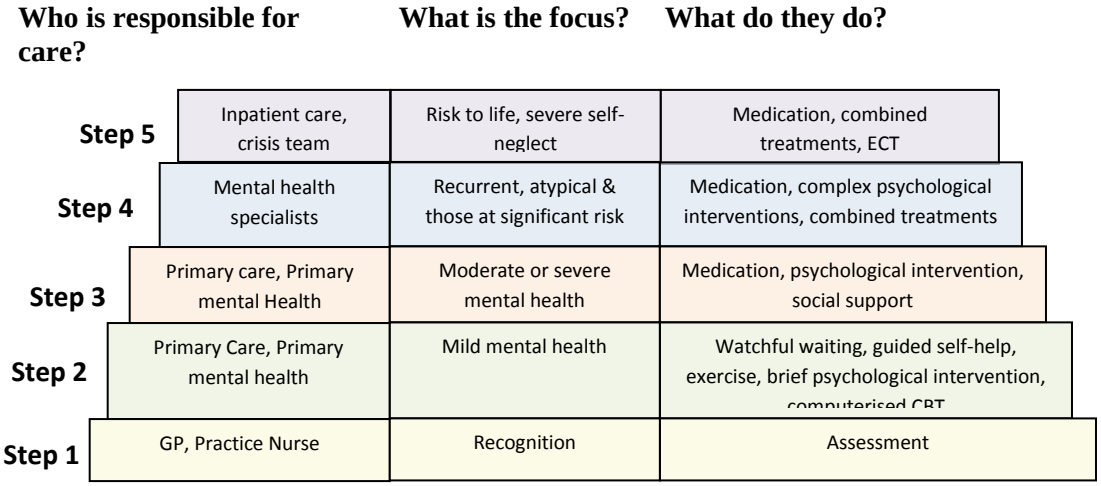
The method of care clusters is used as the basis of Payment by Results (DH guide 2010). This method of clustering is based care pathways for people grouped into needs-based clusters incorporating diagnostic groups but not based entirely on diagnosis. Each cluster defines a group of service users who are relatively similar in their care needs and therefore their resource requirements. Patients can move from cluster to cluster based on review / reassessment. Each cluster has associated typical interventions responses based on evidence-based care.

6.3.2. Stepped Model of Care

National Institute for Health and Care Excellence (NICE) recommends a 'stepped care' approach to treatment, starting with interventions that are the least intrusive of those likely to be effective (NICE, 2012[ciii]).

People with severe and enduring mental health will typically require step 3 -5.

Figure 6.7: Stepped Care Mental Health



Step 3

Step 3 comprises of high intensity psychological therapies and/or medication for people with moderate to severe depression or anxiety disorders, psychosis, and co-morbid physical health problems. For people with moderate to severe depression whose symptoms do not respond to these interventions, NICE recommends collaborative care.

The key components of collaborative care are:

- A multi-professional approach provided by practitioners from at least two different disciplines.
- A case manager (for example, a community psychiatric nurse, psychologist or graduate mental health worker), who works with the GP in primary care and receives weekly supervision from specialist mental health, medical or psychological therapy clinicians. Their role would include the delivery of (some) psychosocial interventions, care coordination and liaison with other providers to ensure smooth transition along care pathways, step up or down as required, regular and robust reviews of progress, and the delivery of systematic outcomes measures.
- Integrated communication between providers – for example, verbal/face- to-face contact between primary and mental health care providers, weekly team meetings, and shared records via the existing primary care electronic records system.
- Education and facilitation of providers to ensure rapid development of new roles within a collaborative care environment.

The GP, in liaison with whoever is providing the psychological care, will continue to review and manage the prescribing of psychotropic medication and oversee their physical health care. One GP or a team of GPs may take this on for their whole practice or, in some cases, for a group of practices, as a designated mental health liaison role in the delivery of collaborative care.

Step four

Step 4 comprises of specialist mental health care, including extended and intensive therapies, requiring clear, well understood pathways between the primary care mental health team, IAPT services and specialist mental health services.

In the 'stepped care' model, the role of specialist community mental health services begins within Step 3 (at a point sometimes referred to as 'Step 3.5'). Here, specialist services will expect to become involved with patients whose (a) social care needs or (b) needs for high intensity psychological therapy/complex medication regimes cannot be met in primary care.

Step five

Interventions at step 5 include crisis or urgent admissions to inpatient acute care.

6.4 Community Mental Health Care Findings

6.4.1. Recovery

The notion of recovery is widely accepted within mental health services, supported by key publications. The second objective of No Health without Mental Health (2011) is 'more people with mental health problems will recover'. Closing the Gap (DH, 2014) 'High quality mental health services with an emphasis on recovery should be commissioned in all areas.' Yet the evidence base is limited because the application of recovery to service design is relatively new, e.g. Recovery colleges (co-production of practitioners and service-users to develop and deliver courses).

Herefordshire's services and delivery of support has moved, in line with national best practice, to a recovery model of mental health. However, it was acknowledged by service-users, carers and practitioners that some people need permanent support with their mental health.

The recovery model is starting to happen, but cultural change takes a long time to occur.
Carer

There has been a move away from maintenance towards recovery- Although it should be recognised that maintenance is appropriate for some people

Mental Health Practitioner

We need to recognise that not everyone is going to 'get better'. Some people will be in the system forever and the progression may not be linear- People may experience periods of recovery and then relapse.

Voluntary sector Practitioner

Patients shouldn't have had the same CPN for 25 years, they shouldn't be in the system for that long. With the right support, once conditions are well managed people should be discharged to their GP.

Mental Health Practitioner

The JCPMH, whilst advocating a recovery model suggests that *"CCGs should recognise that entirely new, emerging, or evolving models in service delivery will offer both opportunities and risks. Any model should be sufficiently flexible to accommodate current thinking and evidence without requiring wholesale reorganisation"*[civ]. Commissioning an outcomes based model could introduce recognition that working with the person as a whole rather than problem by problem is more in line with patients' expectations.

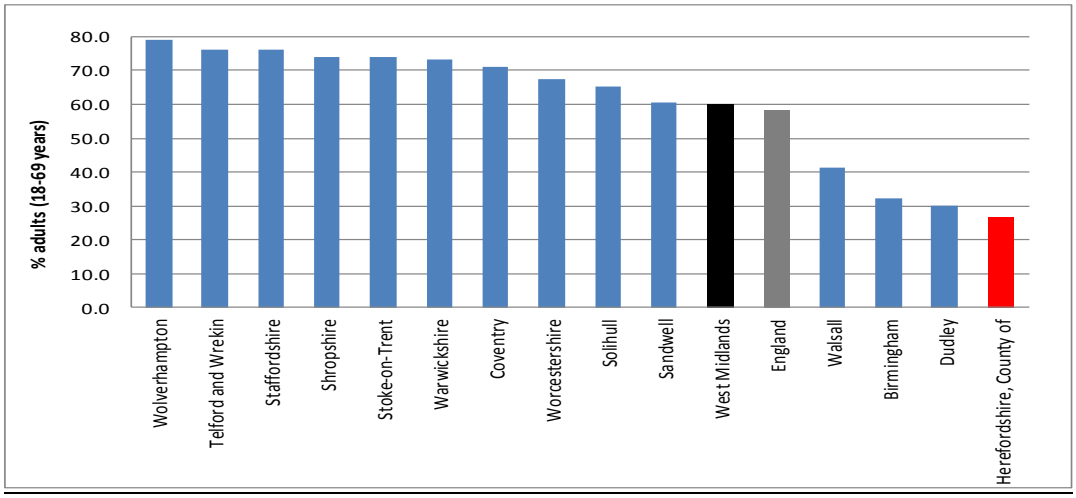
Crisis referrals are too rigid and too closely tied to whether they need IMMEDIATE admission. Prevention work would help prevent that person being admitted and the crisis team is in a position to deliver that far more readily than recovery

Mental Health Practitioner

We need integrated working that addresses housing, money, relationships. This needs to be addressed before the patient can approach recovery.

Mental Health Practitioner

Figure 6.8: % adults aged 18-69 years receiving secondary mental health services (CPA programme) living independently, with or without support 2012/13



Herefordshire has the lowest proportion of secondary mental health service users in settled accommodation (110 of 415 adults or 26.9% - down from 40.9% in 11/12) compared to 58.5% nationally. In terms of gender, this is 50 males and 60 females.

Maintaining stable and appropriate accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care.

As discussed in chapter 4, work is seen to have a positive impact of patients' mental health. Herefordshire has a relatively large gap between employment among those receiving secondary mental health services and general employment (66 percentage points in 12/13).

6.4.2. Care Co-ordination and Care Plans

About a third of people with serious and enduring mental illness are managed solely by GPs in primary care[cv]. This requires primary health care teams to work collaboratively with other services, supporting patients with access to specialist expertise and to a range of secondary care services as required. Two-thirds are managed by secondary mental health services, with the majority receiving support from community teams. Care co-ordination was frequently mentioned in feedback of patients and carers. Key issues were:

- Repeating assessments
- Limited knowledge of who or what a care co-ordinator did
- Poor cover arrangements / frequent changes to care co-ordinator
- Lack of knowledge about care plans
- Limited engagement in care planning

Medical staff need to know my history- not having to repeat myself all the time
Patient/ service user

Patients and staff recognised the benefits of consistency of service to support recovery and service provision. Some people had had a good experience and felt supported, others were disengaged from the process.

The last 10 years of my time with the Community Mental Health Services was positive. Luckily I saw the same doctor for this period (many do not have this continuity of care) and this is when I really became empowered to take charge of my illness.
Patient/ Service User

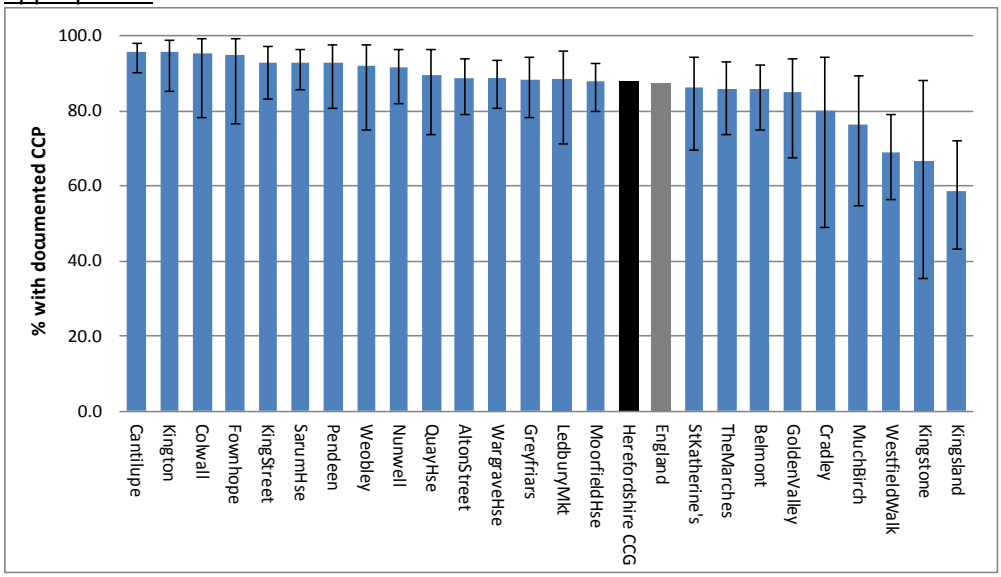
We would like stability rather than constant change. Change is draining and staff don't have time to read up the history.
Carer

The restructuring affects care coordinator continuity, leading to disruption to patients
Mental Health Practitioner

There needs to be better care planning of patients, with a care plan that is written out, given out and held by the patient, both in primary and secondary care.
General Practitioner

Information from primary and secondary care show high levels of compliance with care plans. Figure 6.9 shows the percentage of patients in primary care with care plans.

Figure 6.9: The percentage of patients on the mental health register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or careers as appropriate.



Source: QOF

There is variation across Herefordshire practices of approximately 40 percentage points between Cantilupe (95.7%) and Kingsland (58.5%). Herefordshire's average of 87.7% was not significantly different from nationally (87.3%).

There are possible explanations for the discrepancy between patients and carers views and the activity data:

- Patients and carers do not identify care plans as care plans
- Patients do not recall discussions on care planning due to severity of their illness
- Patients and carers are not engaged with care planning

Patients in secondary mental health care with severe mental health problems or a range of different needs will have their care co-ordinated under a Care Programme Approach (CPA). This is a particular way of assessing, planning and reviewing someone's mental health care needs. Herefordshire appears to have a low percentage of patients on CPA (9.3% as of Quarter 4, 2013/14). When a comparison is made to other areas as a rate per 100,000 of the population, then Herefordshire is one of the areas with the lowest rate. As of Quarter 4, 2013/14, Herefordshire had

191 people per 100,000 population compared to 550 per 100,000 for the average CCG comparison group and 544 for the England average. (Source HSCIC).

From practitioners' perspective, case co-ordination was a positive however further work on cultural change might be required to fully embed the benefits of case co-ordination.

The creation of a named care co-ordinator has been positive but the caseload becomes unmanageable because it is so difficult to pass on or discharge caseload
Mental Health Practitioner

Guidance on community mental health teams suggests that each full-time care coordinator will have a maximum caseload of 35 patients with adjustments based upon complexity, local demographics, and the availability of other functional teams to support the patient.

This examination of care co-ordination and care planning suggests that further work on the role of case co-ordinator is required. The findings question the effectiveness of care plans and ask whether the current application requires further improvement to become person-centred. It is also unclear whether all patients known to secondary mental health services with severe mental health are being co-ordinated using CPA.

6.4.3. Pass the Patient

A corollary of defined service boundaries and limited capacity within teams was the frustration of patients that they were being "passed" around the system. There was a feeling that individual services were resistant to taking responsibility for patients as their needs lay outside what could be provided by individual services.

Services have become more fragmented. Consultants formerly took care of both in-patient and community. Care is now divided between different teams ad this can lead to a "pass the patient". It can take time for a person to be found the most appropriate team. Often patients don't fit the criteria for other services and so remain in recovery.
Mental Health Practitioner

At the time I was referred, I was sent to one team and they then referred me to another as they didn't deal with two specific areas of my problems. This seemed like something that could have been prevented, if it was clearer which services deal with which conditions.
Patient/ Service User

There is a poor interface between teams. The boundaries/ criteria are not clear, nor are the pathways between services. This leads to patients being 'passed' between services.
Mental Health Practitioner

There is a feeling that every part of the pathway is resisting taking patients on. This is frustrating, because all of the teams are the same provider and they don't seem to talk to each other so we receive conflicting advice.
General Practitioner

The creation of specialist teams also increases likelihood of boundaries and growth in inter-team referrals (or passing the patient). On explanation could be that this perception reflects the different specialisms that are available or the complexity of people's needs. There may be good clinical reasons for this notion of passing the patient however from the perspective of the patient and carer, it feels dis-jointed.

Within this needs assessment, there is limited analysis of waiting times to verify the length of time that people spend in assessment rather than treatment. However the views of practitioners suggest that a number of areas require further investigation:

- The effectiveness of triage
- The effectiveness of care pathways and what aspects the specialisms deliver
- Improvement in communication across agencies delivering the care pathways.

6.4.4. Early Intervention in Psychosis

The largest gap between the rates of serious mental illness in the general population and services is 16-24 years old group (Lennox, 2014[cvi]).

The evidence suggests that:

- The longer the time between the onset of psychosis and the start of treatment (otherwise known as the duration of untreated psychosis) then the worse progress can be (McGorry et al, 1996[cvii]). Delay to receiving treatment can affect functioning, education, employment.
- Targeted services for young people to shorten the duration of untreated psychosis can comprise of low dose anti-psychotics, anti-depressants, Cognitive Behaviour Therapy, family intervention, assertive community treatment, GP education and vocational support**.**

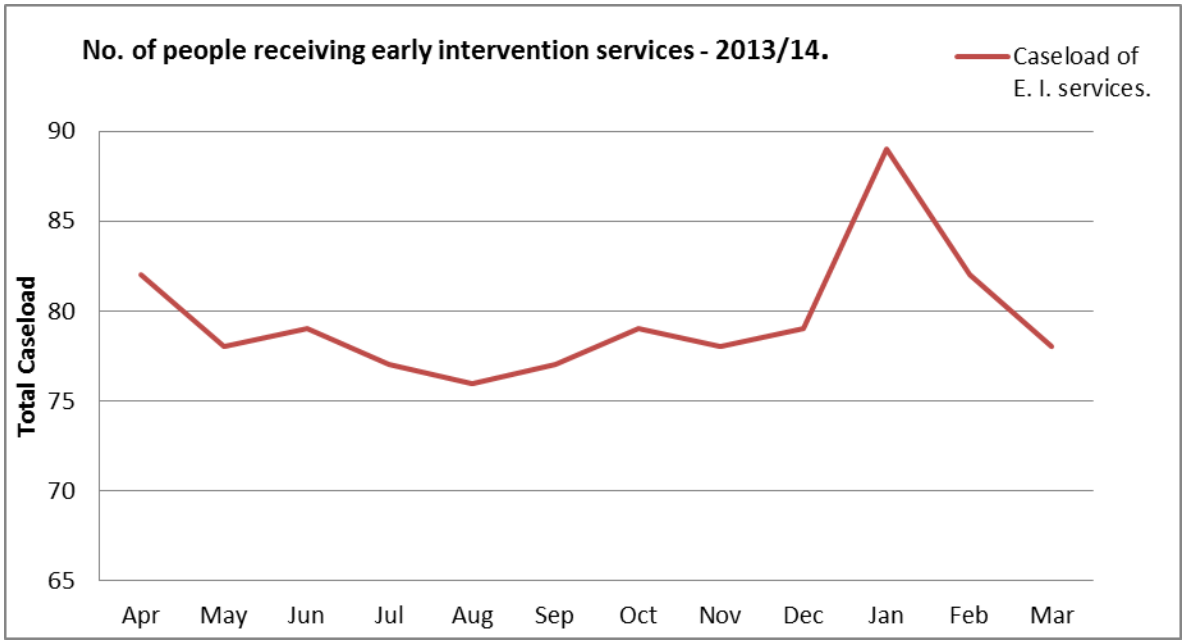
An Early Intervention Service focus on the early stages of schizophrenia, or on people with prodromal symptoms (early symptoms that might precede the onset of a mental illness) with the aim of reducing the duration of untreated psychosis and working with younger patients in their first episode of psychosis for up to 3 years. There is strong evidence that this form of intervention is cost-effective[cviii], and also much valued by patients and carers. Studies show that the net savings of £6780 per person is possible after 4 years. Over a ten year period, £15 in costs can be avoided for every £1 invested.

An economic analysis of interventions and care pathways for people with schizophrenia and psychosis (Knapp et al, 2014[cix]) highlighted that the high costs of impatient care (and over 50% of the

spending going on psychosis) confirmed the continuing importance of interventions which help to reduce bed use.

The early intervention service saw 26 new cases of psychoses in 2013/14. The total number of people receiving support within 2013/14 was 78. Figure 6.10 shows the caseload by month during 2013/14. There is limited data on the number of people with prodromal symptoms so not able to confirm if the capacity is sufficient.

Figure 6.10: Number of People receiving Early Intervention Services by Month (2013/14)



Source: 2gether NHS Foundation Trust

Information was not available on the duration of untreated psychosis, or the long-term impact of the Early Intervention Service on patient clinical outcomes. However if more attention is placed on identification and early intervention then it is doubtful that there is sufficient capacity to respond.

6.4.5. Assertive Outreach

There is good evidence for the effectiveness of AOT in the USA and Australia in terms of reducing the need for in-patient care and associated costs. However, however trials in the UK have not replicated these benefits. For example in the UK REACT (Randomized Evaluation of Assertive Community Treatment) study in North London found no advantage over usual care from community mental health teams in reducing the need for in-patient care and in other clinical outcomes, but participants found AOT more acceptable and engaged better with it (Killaspy 2006[cx]). The lack of additional benefits was attributed in part to the fact that both teams used intensive case management (primary clinical responsibility, based in the community, team leader doing clinical work, time-unlimited service) (Killaspy 2010[cxi]).

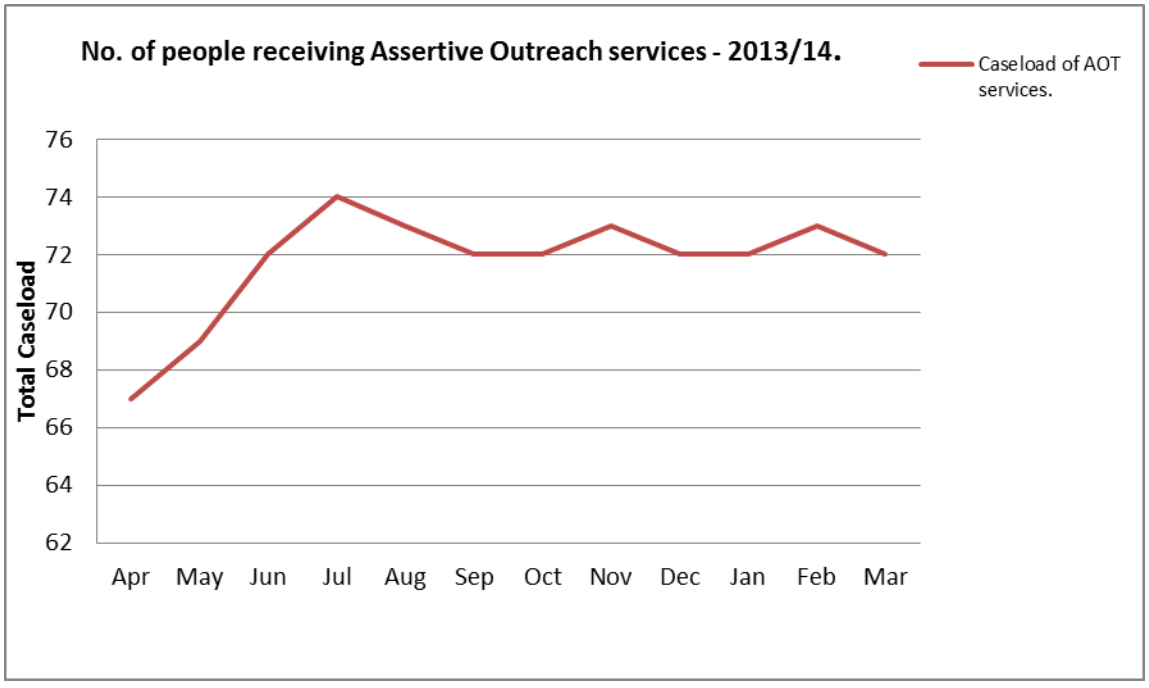
The NICE guidance clinical guideline for schizophrenia recommends that assertive outreach teams should be provided for people for people with schizophrenia who:

- Frequently use inpatient services, and
- Have a history of poor engagement with services leading to frequent relapse or social breakdown (homelessness or inadequate accommodation).

Assertive outreach teams provide intensive mental health and social care to patients with challenging, complex presentations who do not engage with CMHTs. Intensive contact improve engagement, reduce hospital admissions and improve social and clinical outcome.

The number of people receiving support from AOT in 2013/14 was 72 people (this is a rolling caseload figure). Caseloads are showing little variance from August to March 2014 which indicate either a steady demand, or gatekeeping of patients. There was a low level of discharge from the Service during this time.

Figure 6.11: Number of People receiving Assertive Outreach Service by month during 2013/14



Source: 2gether NHS Foundation Trust Activity Data

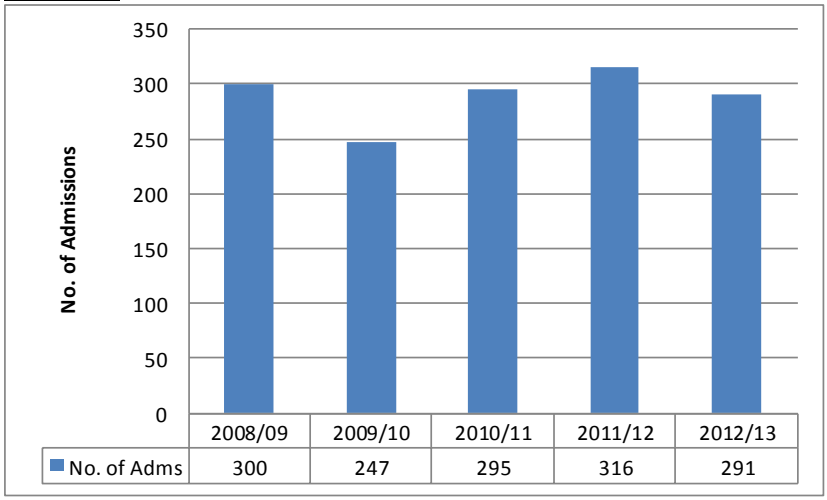
6.4.6. Self –Harm

Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year.

With the risk of death by suicide, rates of mental health problems, and alcohol and substance misuse being considerably higher among people who have self-harmed, it is essential that healthcare professionals address the experience of care by of people who self-harm.

The indicator based on hospital admissions published in the January 2012 Public Health Outcomes Framework is being redefined in order to find an indicator which better represents the prevalence of self-harm in the population. Hospital admissions are only the tip of the iceberg in relation to the health and well-being burden of self-harm, since inpatient hospital admissions represent a very small proportion of incidents of self-harm.

Figure 6.12. Emergency Admissions for Intentional Self-Harm 2008/9-2012/13 Trend: Herefordshire Residents



Source: HES

6.4.7. Personality Disorder

Individuals with personality disorder have historically received inconsistent care from specialist mental health services. Personality disorder comes with a variety of challenges that can be addressed at all levels of primary care and specialist services through evidence-based interventions[cxii], [cxiii] These generic services should be supported through the development of multidisciplinary teams with specialist knowledge so that a consistent clinical model can be offered and generic teams supported in engaging those people who can significantly challenge health and social care services. Yet there is limited evidence that treatments for people with personality disorders are effective.

There is no local commissioned specialist service although one-third of the mental health services caseload have personality disorders.

The acknowledgement of personality disorder (under the mental health act) means that these patients are consuming a lot of resource/ time and impacting on the care for other patients.
Mental Health Practitioner

We may need services for personality disorder where people have the skills and interest in working with that group.
Mental Health Practitioner

6.4.8. Forensic Mental Health Services

There is no dedicated community forensic mental health service available in the county. Forensic mental health services are provided for (a) individuals with a mental disorder (including neurodevelopmental disorders) who (b) pose, or have posed, risks to others and (c) where that risk is usually related to their mental disorder. Forensic mental health care services are part of a pathway that includes: liaison and diversion with police custody and courts; prison mental health services and mainstream mental health care.

An analysis of people placed out of county show that there are low numbers of people in secure hospitals but that the cost of care is high cost. The CCG is responsible for the commissioning of community forensic mental health services – to help individuals who no longer require secure care make the transition back to the community, including the provision of rehabilitation units ('locked rehabilitation units'); supported accommodation in the community, which may vary from 24-hour staffed support to "floating support" at various times during the week (commissioned by health and/or social care services).

Feedback from practitioners expressed a desire for a locked rehabilitation unit. However with such small numbers, the design of any rehabilitation provision needs to be such that a small element of locked unit is possible. Alternatively Herefordshire CCG could explore co-commissioning with other CCGs to achieve the same outcome. In addition, integrated care pathways should be commissioned so that transitions within or between services are seamless. Patients should have clear care plans addressing all their needs including those related to risk, mental and physical health and social care and delivered at the appropriate level of security to meet their needs.

6.5. Acute Care Findings

Separate inpatient consultants are not effective. There are often problems with discharge as what is agreed in hospital doesn't work in community.
Mental Health Practitioner

6.5.1. Admissions

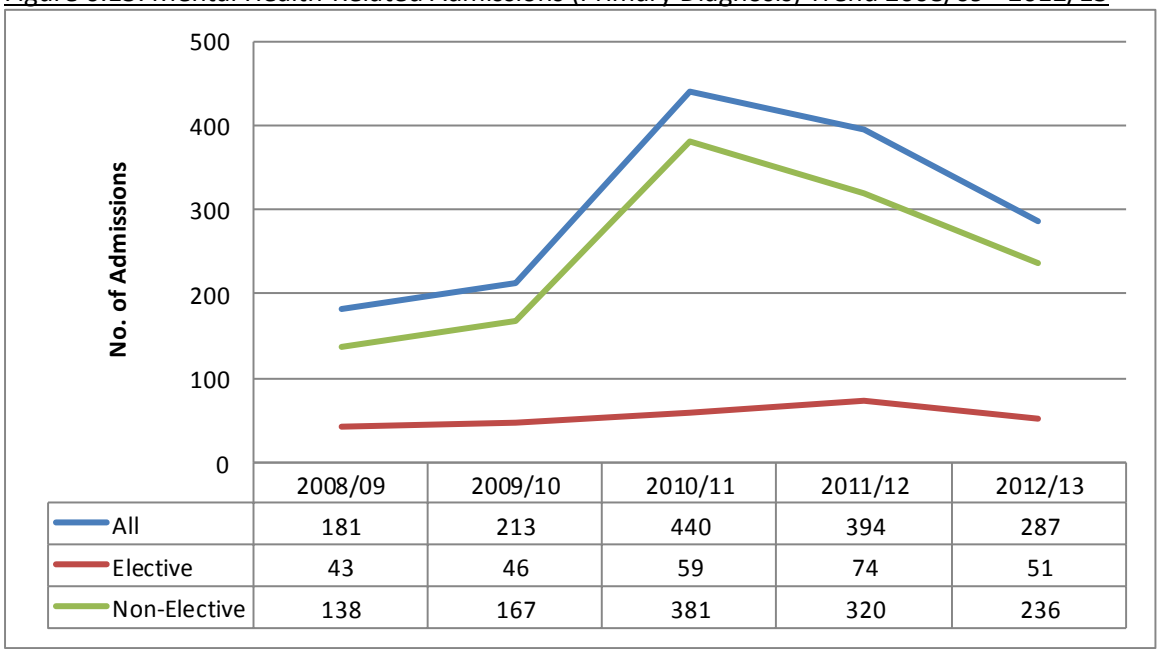
There is no national normative guidance provided for the number of inpatient beds that must be commissioned. The number of beds and their usage will be contingent on the service model adopted by the provider (e.g. a high level of planned readmissions may be appropriate if this is part of a coherent service model which uses inpatient care as a proactive choice; long lengths of stay may be appropriate if the local service model focuses on providing inpatient care only to those people with the most severe illness).

The CCG must be satisfied that there are sufficient beds (Acute inpatient, rehabilitation, acute community and place of safety) to meet the needs of the population (given population characteristics and the service model adopted by the provider)

- That beds are being used efficiently
- That interventions being undertaken are NICE compliant (via regular audit)
- That there are good outcomes of care and patient experience of in-patient care.

At any one time, the main mental health provider provides mental health and social care support to around 2,500 people across Herefordshire (3030 patients in 2012/13). Of these 2,500 people, circa 5% may require care and support from the acute inpatient services. For the majority of these people their length of stay within the inpatient services will be between 30-50 days before they are discharged into the care of a range of community support services to facilitate their discharge home.

Figure 6.13: Mental Health-Related Admissions (Primary Diagnosis) Trend 2008/09 - 2012/13



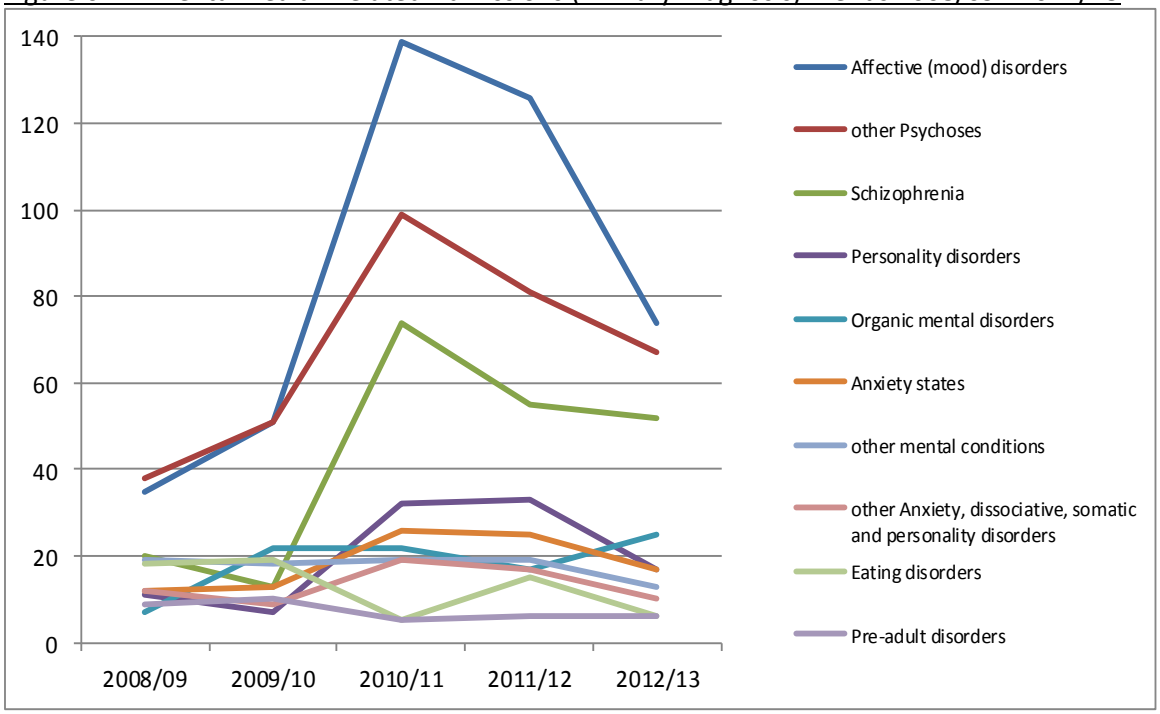
	2008/09	2009/10	2010/11	2011/12	2012/13
All	181	213	440	394	287
Elective	43	46	59	74	51
Non-Elective	138	167	381	320	236

Source: HES

There has been an average of approximately 300 admissions per annum across the five-year period among Herefordshire residents (over 80% non-elective i.e. emergency or transfer admissions). In terms of gender, around 55% were females. There was a spike in admissions in 2010, then the number of admissions dropped though not to 2008/9 levels. Availability of beds and alternatives to inpatient care would affect the number of admissions.

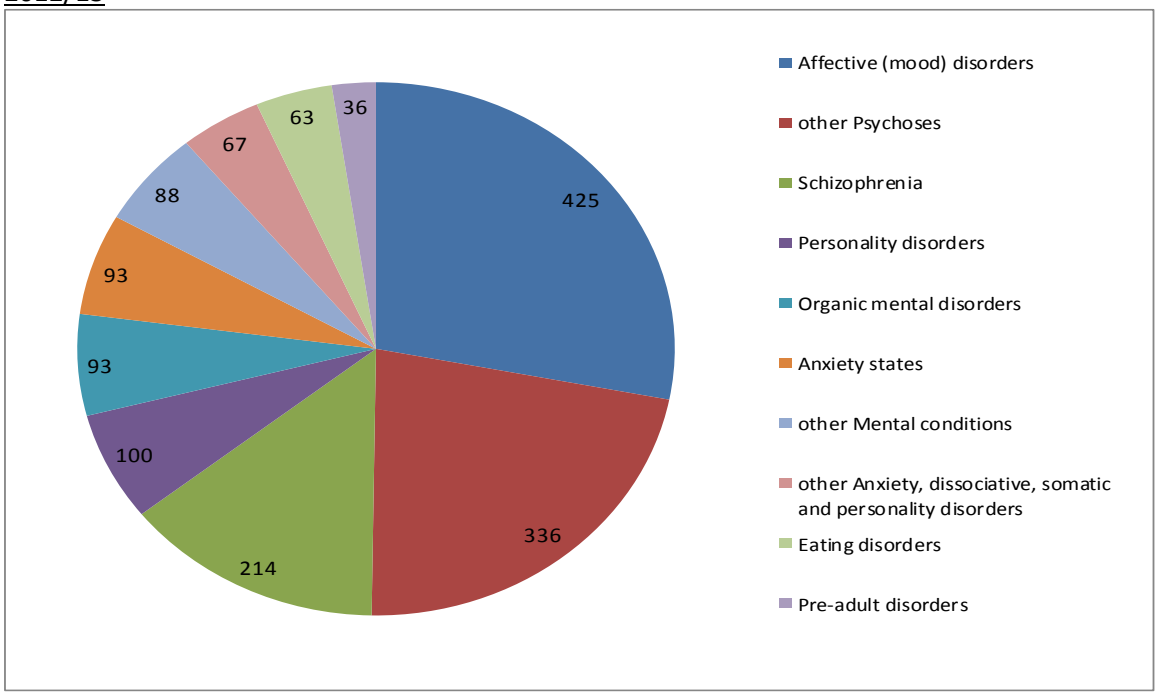
Bespoke ICD10 condition group coding is available below in figure 6.14.to show primary diagnosis.

Figure 6.14: Mental Health-Related Admissions (Primary Diagnosis) Trends 2008/09 - 2012/13



Source: HES

Figure 6.15. Mental Health-Related Admissions (Primary Diagnosis) by Condition Group 2008/09 – 2012/13

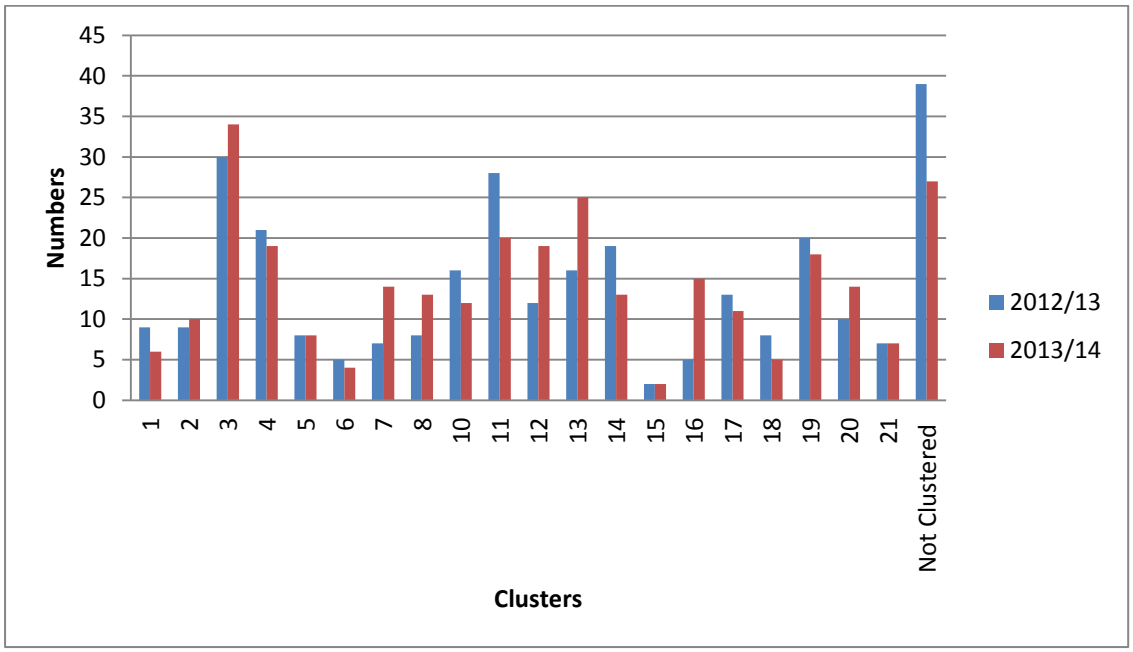


Source: HES

Affective (mood) disorders are the most common cause of hospital admission (28%) – half of these are depressive episodes and a further third are bipolar affective disorders. Other psychoses (e.g. delusional disorders, non-organic psychosis) and schizophrenia and related disorders account for a further 36% of admissions. Other 'mental conditions' refer principally to disorders of psychological development and hallucinations.

Information is available to analyse the assigned cluster at the point of admission (see figure 6.16). This shows that there were admissions across all clusters. Some of the clusters may have been appropriate yet recorded as incorrect cluster. Further work is required to understand why people were assessed as a low cluster and yet were admitted to an inpatient unit.

Figure 6.16: Count of Patients Admitted onto the Mental Health Wards by Cluster 2012/13 and 2013/14



Source: 2gether NHS Foundation Trust, 2014

Some patients were formally detained under the Mental Health Act. Information shows that the occupancy by detained patients had little variation from 40 to 49% per quarter (from July 2012 – March 2014).

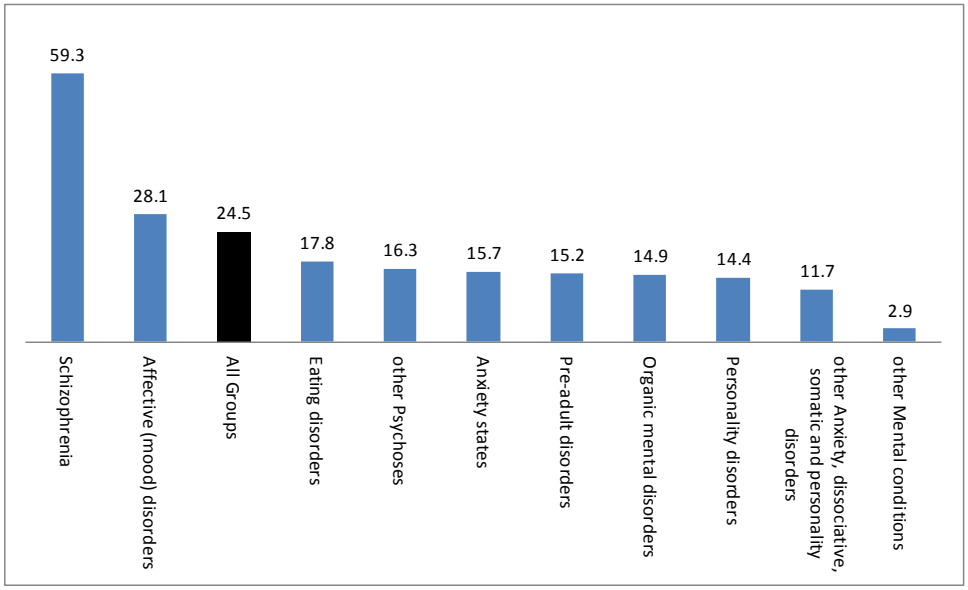
The number of patients formally detained under section 2 of the Mental Health Act for inpatient assessment varied from 18 people to 29 people per quarter (from July 2012 – March 2014). This is a rate of 16 per 100,000 of the population for 29 people per quarter.

The number of patients formally detained under Section 3 for admission for treatment under the Mental Health Act varied from 11 to 21 people per quarter (from July 2012 to March 2014). This is a rate of 11 per 100,000 population per quarter (based on 21 people).

Benchmarking data of comparator CCGs in England are available for detentions under the Mental Health Act. Herefordshire has a low rate per 100,000 population (37.6) compared to England (58.7).

Herefordshire also had lower rates of people subject to short-term orders under Mental Health Act during 2012/13. The rate per 100,000 population for Herefordshire was 6.0, compared to England of 31.5 and the CCGs comparator group of 21.2.

Figure 6.17: Mental Health-Related Admissions (Primary Diagnosis) Average Length of Stay (days)

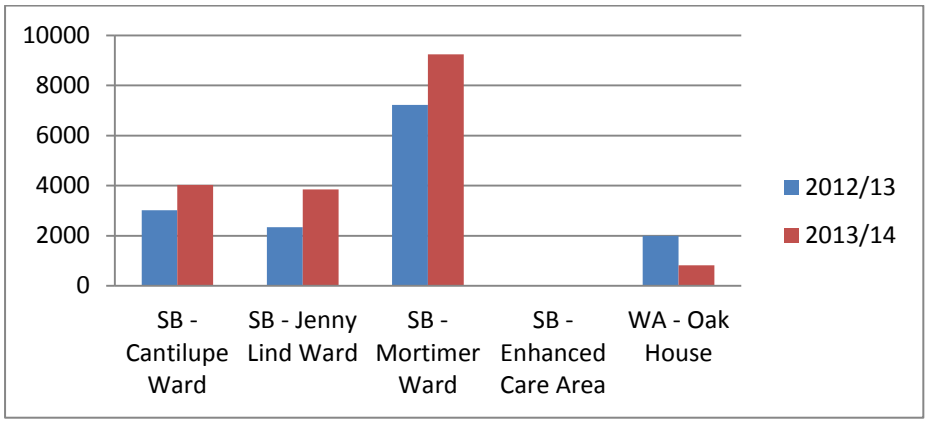


The average length of hospital stay following admission is almost 60 days for schizophrenia. Across all conditions the length of stay is 25 days. Although there are more people admitted for affective mood disorder, the length of stay is greater for schizophrenia.

There were differences in age profiles of admissions. 25-44 years old were the largest group in people with schizophrenia, while 45-64 years old group was the largest group of patients with affective (mood) disorders.

Information at ward level is available. From figure 6.18 it looks like the length of stay has increased however this is only two years worth of data therefore insufficient to explore trends.

Figure 6.18: Total Bed days for the Admissions by ward including leave days 2012/13 and 2013/14



Note: figures are given by ward of discharge. However, patients may have been moved wards during their stay.

The average length of stay by ward also suggests a difference between 2012 /13 and 2013/14, with the most marked increase on Cantilupe ward.

Table 6.3: Average length of stay including Leave days

Ward on Discharge	2012/13	2013/14	**Total**
SB - Cantilupe Ward	49	88	**65**
SB - Jenny Lind Ward	63	77	**71**
SB - Mortimer Ward	39	43	**42**
SB - Enhanced Care Area		x	**x**
WA - Oak House	285	207	**256**
Grand Total	50	57	**54**

A snapshot of bed days out-of-county showed that in a 36 week period during 2013, an additional 1.6 beds were required to avoid patients admitted to other units. This suggests that the number of beds is smaller than the population need.

6.5.2. Mental Health Pharmacist Input

National recommendations are for 0.5WTE specialist clinical pharmacist per acute adult inpatient ward with 20 beds plus a minimum 1 day a week for Community Teams. This would equate to 1.2 WTE minimum. Providing more strategic input into mental health services would be expected to deliver service user benefits, reduce risk associated with medicines use and provide cost savings for health economy prescribing budgets.

6.5.3. Discharge

The number of days as a result of delayed discharges is low. The rate per 100,000 population as of quarter 4, 2013/14 was 9.8 days compared to 34.8 England average.

Information is available on discharge destination. Table 6.4 shows the trends since 2008/09. The most popular place is usual place of residence.

Table 6.4. Place of Discharge from Hereford Mental Health Hospital by Year (2008/9 – 2012/13)

	2008/09	2009/10	2010/11	2011/12	2012/13	Total
Usual place of residence	241	217	249	265	254	1226
Temporary place of residence	5	4	5	8	6	28
Penal establishment or police station	0	0	3	2	2	7
NHS High security psych accom.	2	0	1	4	2	9
NHS medium secure unit	7	2	2	3	4	18
NHS general ward	6	5	7	0	4	22
NHS ward for mentally ill / learning disability	27	13	17	18	10	85
NHS run care home	0	0	0	1	0	1
LA residential care home	0	0	0	1	0	1
N/A - died	3	2	2	0	0	7
Non-NHS medium secure unit	1	0	2	1	2	6
Non – NHS run hospital	1	1	0	1	0	3
Not known	7	3	7	12	7	36
Total	59	247	295	316	291	1449

Source: MMHDS

It was not possible to analysis final destination following discharge.

It has not been possible to analyse the number of people discharged with a section 117 that entitles the patient to aftercare arrangements. Further work is underway to examine the number of section 117 orders given and the implications for the provision of services.

Information on Herefordshire rate of people with mental health conditions in residential or nursing care per 100,000 population (32.4) is similar to the England rate (32.7) in 2012/2013. (Source: RAP return, ONS).

6.6 Crisis Findings

Patients in crisis need rapid and effective support; whilst the crisis team is well regarded in Herefordshire, the small population means that adequate crisis provision has not been provided, with implications in terms of patient safety and staff resources, including police time. These issues are particularly stark at night, where low staff numbers and lack of shared notes mean that patients are more likely to be admitted.

6.6.1. Crisis and Home Treatment

Community acute mental health teams will have capacity to visit those receiving home- based treatment at least twice per day, but as often as necessary to keep out of hospital. The function of the service can be seen as gate-keeping access to mental health inpatients or a community alternative to acute care.

According to the original policy criteria (DH 2002), a fully functioning CRHT should:

- Be multidisciplinary (i.e. including nursing, psychiatry, psychology, social care and occupational therapy)
- Be available to respond to 24 hours a day 7 days a week
- Have frequent contact with service users, often seeing them at least once on each shift
- Provide intensive contact over a short period of time
- Stay involved with the service uses until the problem is resolved
- Have the capacity to offer intensive support at service users' homes.

There was recognition of the need to adequately support patients at the point of crisis. However, it was recognised that capacity to do this effectively was limited, with repercussions on other services. The service delivered 260 home treatments to people in 2013/14.

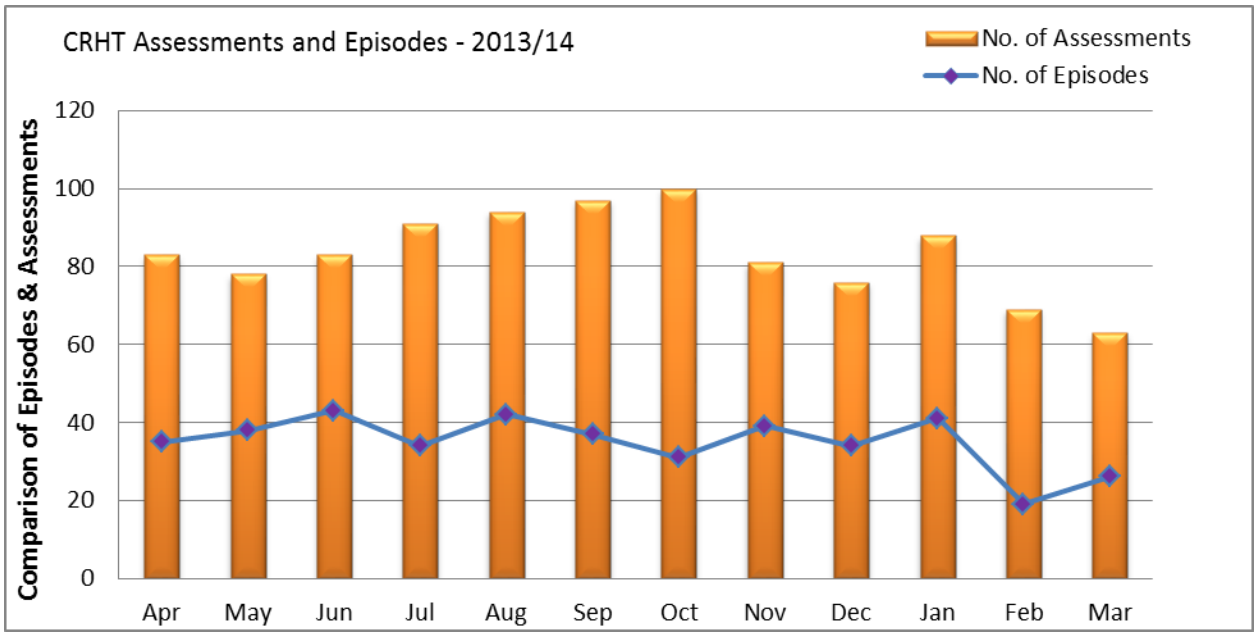
When I am in crisis I want to speak to someone who knows me
Patient/ Service user

QUICK and EASY access to the mental health professionals is essential for the individual who is in crisis
Patient/ Service User

The crisis team do their best, but one has to be very unwell to access them
Carer

The ratio of assessments to episodes of care appears to be high, indicating that the Service is responding to a greater need for assessment rather than home treatments. There are other explanations as to why the data from 2013/14 shows a ratio of 2.47 assessments to 1 episode including data quality, inappropriate assessments, availability of mental health services during weekends and evenings. This requires further investigation into the convergence rate. Figure 6.19 shows both the number of assessments compared to the number of episodes of care.

Figure 6.19: Number of Crisis Home Treatment Episodes and number of assessments by Month during 2013/14



Source: 2gether NHS Foundation Trust

The Service received 626 referrals in 2013/14.

It is a real challenge to get people seen by the crisis team. We don't fully understand the criteria, but the criteria is so narrow that people fall between the gaps.

Adult Social Care Practitioner

There are issues with night duty. Crisis do assessments as a two man team. We are now lone working, which leads to issues with risk and clinical appropriateness. It is an unsafe practice. The 'two AM' moments defy categorisation.

Mental Health Practitioner

An assumption from the admissions information is that the Crisis Team could keep more people out of a mental health bed. Allowing for the division between assessment / treatment and rehabilitation function of beds, there are people clustered to clusters 1-4 and 18 that could have been supported at home. There are a number of reasons that it may have been clinically appropriate for admission. These include resettlement, short-term step down, reaction to medication, intensive observation / assessment required or the data may be flawed, e.g. poor clustering coding. Figure 6.5 shows the number of patients by cluster that went into a mental health bed in 2012-2014.

Table 6.5: Number of Patients admitted to Acute Inpatient Care (and Rehabilitation Unit) by Cluster from 2012-2014

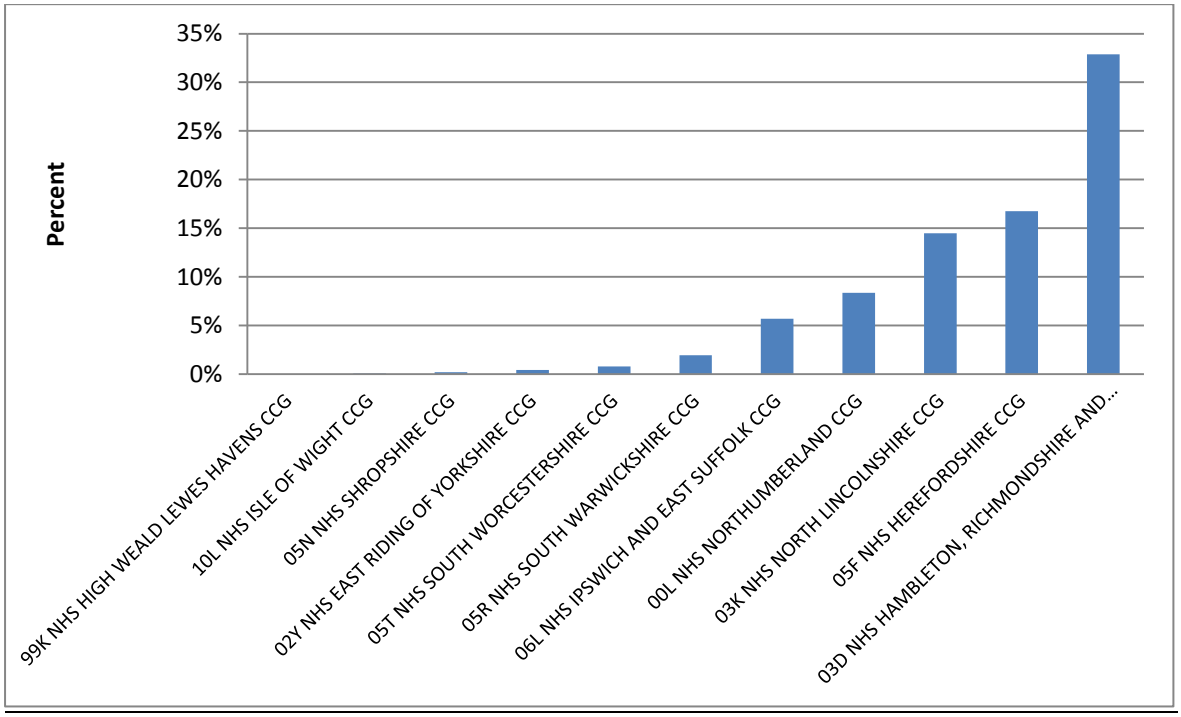
Cluster	2012/13	2013/14	Total
1 - Common Mental Health Problems (Low Severity) (12 weeks)	9	6	**15**
2 - Common Mental Health Problems (Low Severity with Greater Need) (15 weeks)	9	10	**19**
3 - Non-Psychotic (Moderate Severity) (6 months)	30	36	**66**
4 - Non-Psychotic (Severe) (6 months)	21	19	**40**
5 - Non-Psychotic Disorders (Very Severe) (6 months)	8	8	**16**
6 - Non-Psychotic Disorder of Over-Valued Ideas (6 months)	5	x	**9**
7 - Enduring Non-Psychotic Disorders (High Disability) (12 months)	7	14	**21**
8 - Non-Psychotic Chaotic and Challenging Disorders (12 months)	8	13	**21**
10 - First Episode Psychosis (12 months)	16	11	**27**
11 - Ongoing Recurrent Psychosis (Low Symptoms) (12 months)	28	20	**48**
12 - Ongoing or Recurrent Psychosis (High Disability) (12 months)	12	19	**31**
13 - Ongoing or Recurrent Psychosis (High Symptoms and Disability) (12 months)	16	25	**41**
14 - Psychotic Crisis (4 weeks)	19	13	**32**
15 - Severe Psychotic Depression (4 weeks)	x	x	**X**
16 - Dual Diagnosis (6 months)	5	15	**20**
17 - Psychosis and Affective Disorder (Difficult to Engage) (6 months)	13	11	**24**
18 - Cognitive Impairment (Low Need) (12 months)	8	5	**13**
19 - Cognitive Impairment or Dementia Complicated (Moderate Need) (6 months)	20	18	**38**
20 - Cognitive Impairment or Dementia (High Need) (6 months)	10	14	**24**
21 - Cognitive Impairment or Dementia (High Physical or Engagement) (6 months)	7	7	**14**
NULL	39	26	**65**
Grand Total	292	296	**588**

Data included admissions made to both Stonebow and Oak House

There is a possibility that the Crisis Team could have avoided some of the above admissions if the capacity of the teams allowed greater numbers of people to be managed at home.

6.6.2. Crisis Plans

Figure 6.20: Proportion of people in contact with the MH Services with a crisis plan in place at the end of April 2013



Source: Mental Health Minimum Datasets - : Annual MHMDS 2012-13, Health and Social Care Information Centre, ONS Census 2011

- There were 3030 people accessing Mental Health services at the end of April 2013 (Herefordshire CCG)
- Of these 30 were subject to a Mental Health act (1% of service users)
- Approximately 500 service users had a crisis plan in place

6.6.3. Place of Safety

Patients detained under section 136 of the Mental Health Act 1983 should be conveyed to a place of safety. The Royal College of Psychiatrists has outlined the key points regarding the commissioning of a dedicated 136 suite[cxiv].

- The place of safety should usually be within a mental health unit. The custody suite should be used in exceptional circumstances only.
- Patients who require emergency medical assessment or treatment should be taken to an emergency department and only those too disturbed to be safely accommodated in a healthcare-based place of safety should be taken to a custody suite.
- A vehicle supplied by the ambulance provider should be able to attend promptly so that it is used for conveyance unless the person is too disturbed.
- The AMHP and doctor approved under Section 12(2) of the Mental Health Act should attend within 3h in all cases where there are not good clinical grounds to delay assessment.

- The first doctor to perform a Mental Health Act assessment should be approved under Section 12(2) of the Act.
- A monitoring form should be agreed locally to meet all the national requirements and should be completed in all cases.
- There should be a minimum of two mental healthcare professionals immediately available to receive the individual from the police. If the unit is staffed by community staff, the local monitoring group must assure itself of their availability and of the required competences, including the ability to safely manage disturbed behaviour without police support.
- Consideration should be given to having dedicated Section 136 staff who can be assigned to other wards or teams when not required in the mental health place of safety (MHPoS). Extra staff should be available at short notice if required.
- In most cases the police should be free to leave within 30min, once the staff are satisfied they can safely manage the person.

In terms of activity data, this is an area with data recording issues. From the incomplete information, it appears that the number of people taken to a place of safety is very low (table 6.6).However, this data does not include Police data, only people who were taken to the section 136 suite.

Table 6.6: Number of Section 136 per quarter in Herefordshire from July 2012 to March 2014.

	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14
Total	17	7	8	10	18	14	18
Discharged	13	6	6	7	9	10	11
Detained	3	1	1	2	5	3	5
Informal admission	1	0	1	1	4	1	2
Police custody	0	0	0	0	0	0	0
Other hospital	0	0	0	0	0	0	0

Source: 2gether NHS Foundation Trust

Herefordshire has a locally agreed protocol however the working arrangements of the s136 require review.

Whilst we have a place of safety for patients detained under section 136, it needs to be reviewed as it is not really configured and commissioned in a manner that best meets needs. There are two rooms for which no staffing is commissioned and which present as an unsuitable environment for an emergency assessment, which has the potential to be risky to the patients, police and clinical staff involved.

Mental Health Practitioner

My officers being tied up for hours at the Stonebow safeguarding the unwell is completely unacceptable.

Police Officer

Often the people who present out of hours to A+E in a distressed state, feeling suicidal have been drinking. At present there is no nominated safe place for these people to sober up. Mental health services cannot assess someone while they are intoxicated, so they end up waiting in A&E.
Accident & Emergency Department Practitioner

A system-wide discussion on how we support people particularly those intoxicated, where all organisations cannot proceed with assessment / charging as well as addressing patient and staff safety at the section 136 suite is required. Particularly as the Section 136 suite is not staffed. Staff from the Crisis Resolution and Home Treatment Team respond to the demand.

6.7. Rehabilitation

There needs to be a reprovision of rehab services where there is a model of more to less support, where those with the more complex problems are supported to return to their own housing and maintain community tenure.
Mental Health Practitioner

Mental health rehabilitation services work with people whose long term and/or complex mental health needs cannot be met by general adult mental health services. They provide specialist assessment, treatment, interventions and support to assist people in managing debilitating symptoms, in order to both maximise their potential for recovery and improve their quality of life. This includes:

- **Reablement:** to help people recover from their mental health problems and regain the skills and confidence to live successfully in the community.
- **Enablement:** to prevent people losing further skills and confidence, enabling them to maintain their existing level of independence, despite on-going mental health problems.
- **Minimisation of deterioration:** to minimise the on-going loss of skills and confidence experienced by some people with on-going mental health problems.

Individuals who require support from such services are a "low volume, high needs" group. 80% have a diagnosis of a psychotic illness and many will have been repeatedly admitted to hospital prior to referral to rehabilitation services (Killaspy et al, 2012).

The Joint Commissioning Panel for Mental Health (2013) report *Guidance for commissioners of rehabilitation services for people with complex mental health needs* summarised the evidence and best practice for this client group. It identified a number of key messages for commissioners:

- There is good evidence that rehabilitation services are effective – around two thirds progress to successful community living within five years and 10% achieve independent living within this period.

- People receiving support from rehabilitation services are eight times more likely to achieve/sustain community living compared to those supported by generic community mental health services.

- Local provision of inpatient and community rehabilitation services ensures that service users with complex needs do not become "stuck" in acute mental health inpatient wards.

- Out of area placements cost around 65% more than local placements, are socially dislocating for service users and are of variable quality.

- Recent guidance for commissioners emphasises the importance local care pathways that minimise the use of out of area placements (National Mental Health Development Unit, 2011).

- An effective rehabilitation service requires a managed functional network of services across a wide spectrum of care. The exact components should be determined by local need, comprising:
    - Inpatient and community based rehabilitation services
    - Community rehabilitation teams
    - Supported accommodation services
    - Services that support service users occupation and work
    - Advocacy services
    - Peer support services

6.7.1. In-county Rehabilitation

Around 10% of service users presenting to mental health services for the first time with a psychotic illness will go on to require rehabilitation services due to the severity of their functional impairment and symptoms (Craig et al 2004). Within Herefordshire, this group of patients are often cared for by a mental health provider in the initial phases of their recovery at an inpatient rehabilitation unit - in the period January 2008 until 1st May 2013 there have been 48 admissions to the rehabilitative unit; 30 male and 18 female. During this time the average length of stay at the rehabilitative unit has been 288 days.

Patients welcomed a gradual reduction in support over time to enable them to build engagement in the community. However, it was acknowledged that provision for rehabilitation was hampered by a shortage of provision.

[Rehabilitative Unit] is a brilliant place. The staff here have really helped my mental health a lot. I'd like to say thank you and well done to the team.
Patient/ Service User

Because waiting times are so long, lots of patients are discharged home before coming to [rehabilitative unit], which is the wrong way around really.
Mental Health Practitioner

Based on guidelines, Herefordshire require:

- low secure unit (one unit/ 100,00 people)
- High Dependency Inpatient units (one unit/ 600,000- 1 million people)
- Community Rehabilitation Units (One unit/300,000 people)
- Longer term complex care units (one unit per 600,000 people)

Herefordshire is too small a population for many units, therefore commissioning should focus on a local inpatient and rehabilitation units, with other services commissioned on a larger footprint.

6.7.2. Resettlement

Patients welcomed a gradual reduction in support over time to enable them to build engagement in the community. However, it was acknowledged that provision for rehabilitation was hampered by a shortage of provision.

Good mental health services should provide phased "stepping stones" to greater independence via a range of placements.
Patient/ Service User

There is a shortage of suitable housing. Sometimes people are well but there is nowhere to discharge them to. The available placement [The shires] is good, but of limited capacity so patients may find themselves out of county or in a nursing home with much older people, which is inappropriate. Some patients are quite risky too, which limits their options. Intensive community input would reduce institutionalisation and so free up capacity in the acute/ residential setting.
Mental Health Practitioner

There needs to be support between discharge and patients going home- some intensive support over the first few weeks to prevent readmission. Their care co-ordinators should be involved both during admission and discharge.
Mental Health Practitioner

The lack of suitable housing, with adequate support, was raised as a key barrier to supporting people with mental health issues to remain in their homes and to support discharge when they were ready.

Ability to access appropriate housing is poor as people with mental health conditions are no longer a priority.
Mental Health Practitioner

There is a need for supported accommodation for people who experience mental health issues as a step-down from hospital placements.
Voluntary Sector Organisation

6.7.3. Out of County Rehabilitation

Rehab and recovery has gone, meaning people out of county remain out for longer. It's not clear how crisis and home care has caught up with the lack of beds, whether it has just resulted in more out of county placements.
Mental Health Practitioner

The 2009 Royal College of Psychiatrists Report *Enabling Recovery for People with Complex Mental Health Needs* states that "repatriating' people to local services and helping them live as independently as possible is likely to benefit the individual as well as saving money which could be used in more useful ways." Research shows that most people (67%) who require inpatient rehabilitation are able to move on to some sort of supported accommodation within five years (Killaspy et al, 2012). Therefore some of the people currently in out-of-county provision will require supported accommodation upon returning to Herefordshire.

Rehabilitation and related accommodation services are an important part in serving people with severe and enduring mental health needs to achieve good quality of life and well-being. The outcomes sought from such provision will be:

- Good patient experience of rehabilitation services
- Increased resettlement and independent living in the community 5 years after rehabilitation
- Minimal use of out of area placements
- Integrated care and support Reduction in use of Out of County Placements with both present and future potential.
- Reduction in use of residential/nursing home beds for service users aged 18-65.
- Reduction in average length of stay.
- Increase in service users with a severe and enduring mental health problem living independently.

Information on the current number of people in placements outside the county shows that a number could have potentially benefitted from care closer to home, specifically people with complex needs and medium support. The information below gives a brief summary of the provision being utilised by Herefordshire patients as of June 2013 for care commissioned by Herefordshire CCG. The information on care commissioned by West Midlands Specialist Commissioning was not available. Table 6.7 does not include information for placements where acquired brain injury is the primary diagnosis.

Table 6.7: Summary of out-of county placements for people with complex mental health as of June 2013

Level of care	Description	Location	Provider	Weekly cost
Complex needs, high support	Psychiatric intensive care unit (PICU)	Gloucestershire	2gether Foundation NHS Trust	£3815
	Male acute inpatient service for treatment resistant drug psychosis	Western super Mare	Cygnet Health Care	£2520
	Forensic secure services for men	Northampton	St Andrews	£2977
	Neuropsychiatry	Nottingham	Cambian Group	£2765
Complex needs, medium support	Rehabilitation For men with complex needs For women with complex needs	Wolverhampton	Cambian Group	£7259
	Short-term/ medium-term and long-term locked rehabilitation for men with mental illness / personality disorder	Malvern Wells	Partnerships in Care	£1960
	Rehabilitation hospital for women with primary diagnosis of mental health with complex needs	Birmingham	Choice Lifestyles	£2765
	Rehabilitation for adults with complex mental health or learning disabilities	Abergavenny	The Priory	£2345
Other	Residential care in a therapeutic community	Bristol	Camphill Community	£765 (NHS) JF
			Total	£27,171

6.8. Conclusions

There are a number of considerations to meet the needs of people with severe and enduring mental health conditions. This Chapter has explored some of the needs and the current manner in which services meet them, including community mental health services, crisis care and rehabilitation.

Community Mental Health

There is currently no standard model for the commissioning and provision of community specialist mental health care services. Instead there is broad agreement for the core principles of community specialist mental health care:

- Recovery: working alongside patients to enable them to follow their own recovery path
- Personalisation: meeting the needs of individuals in ways that work best for them
- Co-production and partnerships: delivering services with (rather than for) people with mental health problems
- Collaborative care: working with people as experts in their own mental health
- Promoting social inclusion
- Prevention through public health strategies and early interventions
- Promotion of mental health
- Pathway working: building on the stepped care approach from primary care and viewing mental health services as a system rather than a series of isolated services.

In Herefordshire, the current configuration of services has not been commissioned to meet the full complement of patients' needs, a situation exacerbated by raised thresholds and more defined boundaries between services. Far from being patient centred, patient needs are seen as having to "fit" services.

A repeated issue in relation to gaps in service provision was recognition of the increasing diagnosis of personality disorder. In the absence of an explicitly commissioned service, patients with personality were being maintained within services that did not meet their needs, reducing capacity within those teams to meet the needs of other patients. This is a deviation from the intended use of resources and limited evidence that the approach is effective.

Acute Care

There is evidence that we are making effective use of the resource available with good outcomes for patients such as short length of stays. There is a shortage of beds at times, suggesting that an additional 1.6 beds are required to avoid patients travelling out of county to other units.

Crisis Care

The care pathways to avoiding inpatient admission requires reconsideration, including what is the most effective function of the Crisis Response and Home Treatment Team. A key element of this is the re-commission of the place of safety.

Rehabilitation

Rehabilitation requires transformation to ensure that the following functions are available:

- Local specialist placements – to enable repatriation of current out of county placements for rehabilitation;
- Satellite recovery facilities – a step down from intensive support services, providing clinical supervision and observation (e.g. for titration for medication) in an "own front door" environment;
- A crisis house – to provide a managed alternative to hospital admission for those whose accommodation arrangements reach crisis; There is no Crisis House in Herefordshire, a facility recognised as able to prevent avoidable admissions to inpatient or higher acuity of care if managed appropriately to provide a secure temporary residence during times of acute crisis. This is a gap in the current services available in-county.
- Priority access to housing and accommodation services – to support resettlement and recovery in the community.

Recommendations

The recommendations are:

- Development of a single point of entry / effective triage to avoid duplication of assessment across mental health services, embedding a stepped approach and retaining a recovery ethos.
- Improvement in managing referrals across teams, e.g. reducing the gap in eligibility between teams.
- Improvements to person-centred care plans and crisis plans take-up to support self management and services' response.
- Review Place of Safety and its suitability for those with dual needs, e.g. mental health and substance misuse.
- Increase the capacity of crisis resolution and home treatment to continue preventing the deterioration of patients to the extent of requiring an inpatient admission.
- A coherent recovery and accommodation pathway for people requiring rehabilitation or step down, including a redesign of rehabilitation provision in-county to include a crisis house, access to housing and more rehabilitation provision.

Chapter 7: Living with Dementia

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Contents

Chapter 7: Living with Dementia

7.1. Introduction

Dementia is a term used to describe a range of neurological conditions, with the most common being Alzheimer's Disease (62% of all dementias in England[cxv]). NICE (2006) describes Dementia as "a disorder that affects how the brain works". Symptoms vary from person to person, but include a decline in memory, reasoning and communication skills with a gradual loss of the skills needed to carry out daily activities.

Historically, dementia was managed as a mental illness, however, in recent years there has been a shift towards its management as a long term condition. This presents an opportunity to diagnose and manage people in community settings, and to provide support to enable people and their carers to manage their own condition and maintain their independence.

A local needs assessment into Dementia was conducted in 2012. This chapter includes a summary of that work; the subsequent implementation plans and updates the gaps analysis around three locally defined outcomes:

1. Driving a Herefordshire wide culture change through raising awareness and understanding
2. Increase availability of early diagnosis of Dementia and support
3. Supporting people with dementia, carers and families to live well with dementia

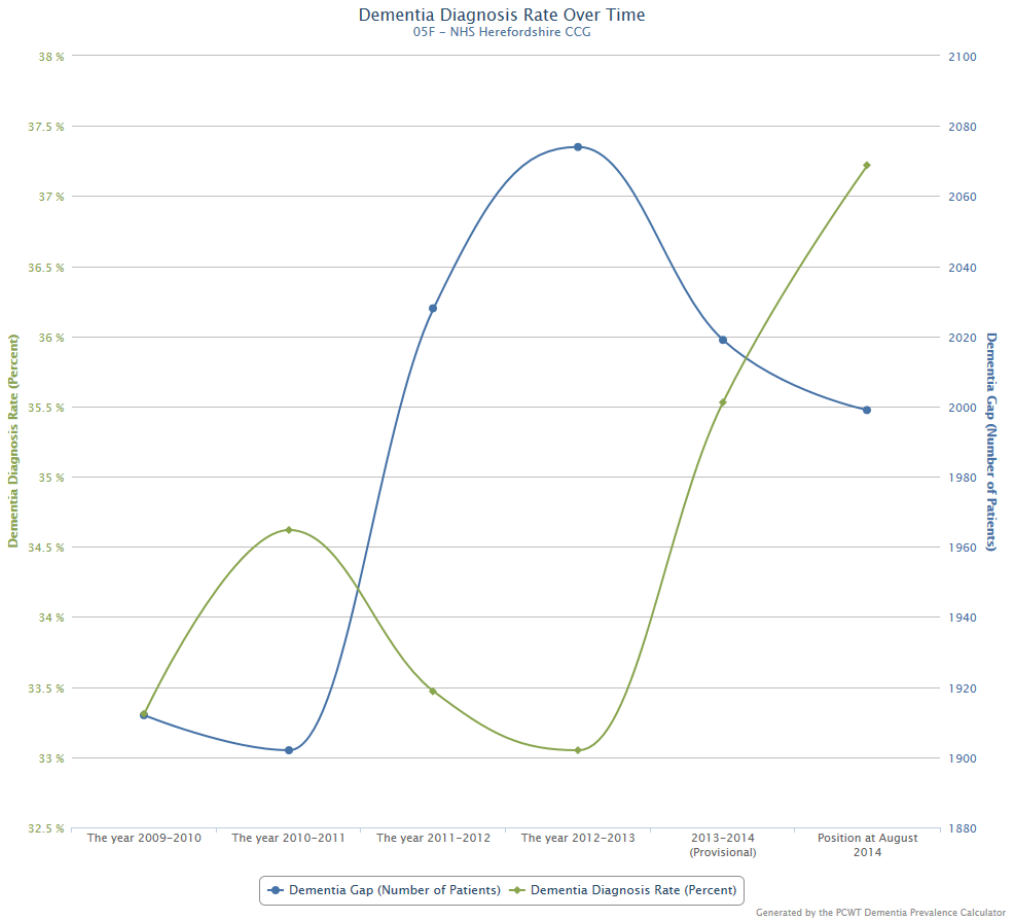
This Chapter explores the prevalence for these conditions (subject to availability of information) before outlining models of care. The analysis is then presented in light of stakeholders' views and activity information before the recommendations are outlined for this area.

7.2. Prevalence

The two most common forms of dementia are considered to be Alzheimer's Disease and Vascular Dementia. There are also a number of rarer forms of dementia[cxvi]; fronto-temporal degeneration and Lewy body disease being the most common[cxvii]. Alzheimer's disease is most common across all age groups; fronto-temporal and Lewy body dementia occurs more commonly in younger people (under age of 65). Dementia affects 800,000 people in the UK; with numbers expected to rise to 1,000,000 by 2021 and 1,700,000 by 2051[cxviii].

There are estimated to be approximately 3099 people in Herefordshire with Dementia[cxix], but only 35% of people were diagnosed in 2013.

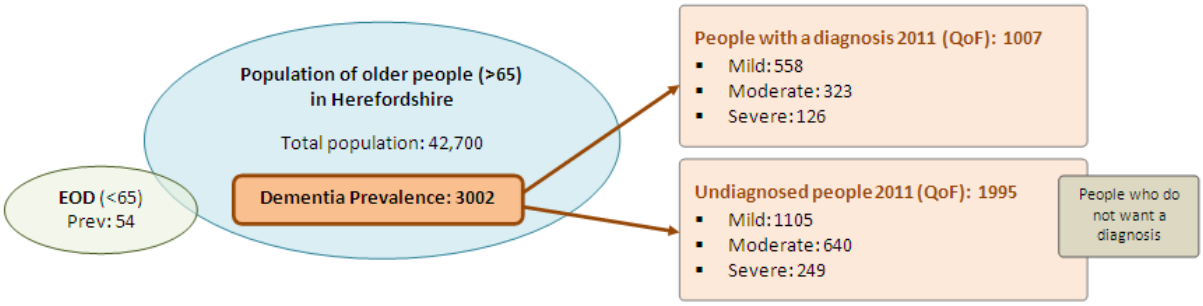
Figure 7.1 Dementia Diagnosis Rate over Time (2009-August 2014)



Current information shows that the trends in diagnosis rates have been slowly increasing. Information from September 2014 shows that the diagnosis rate is 40.95%. That is 1269 patients from 3099 expected number of people with dementia.

Since the severity of Dementia affects the level of support required, national data was used in the Dementia Needs Assessment to model expected severity levels in Herefordshire. This is shown in figure 7.2.

Figure 7.2. Prevalence of Dementia In Herefordshire



Source: Herefordshire Dementia Needs Assessment, 2012

Although the prevalence calculation has increased to 3099 in 2014, the increase is not statistically significant so figure 7.2 remains a valuable illustration of how the prevalence figure is broken down into severity.

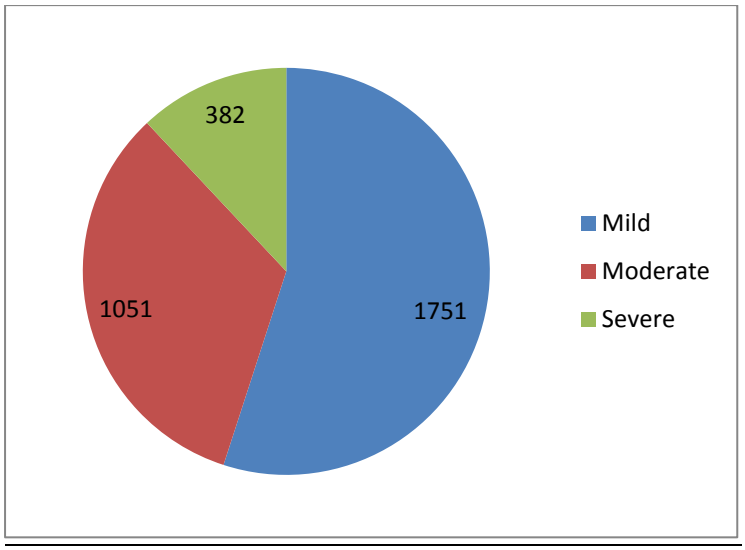
Early onset Dementia (EOD) affects people under 65 years. The expected prevalence of EOD is low at 54 cases. People with EOD have different needs. Individuals with Multiple Sclerosis, Motor Neurone disease, Parkinson's disease and Huntington's disease or those with a history of alcohol abuse are more likely to develop EOD.

People with Learning Disabilities (LD) are more likely to develop Dementia earlier in life and require a specialist approach to diagnosis and treatment. Data about Dementia prevalence for people with Learning Disability is not available in Herefordshire, however, there were approximately 500 adults with LD in 2013, and the number of people aged over 65 with LD is expected to increase by one third between 2011 and 2015.

Herefordshire has an older age profile than the average county in the UK; by 2015, the number of people aged over 65 is expected to rise to 46,900. Growth will be particularly high in the oldest age group of people aged over 80. There are older females than males in Herefordshire and this pattern is expected to continue in the future – this is relevant as there is a higher prevalence of Dementia in females. 20% prevalence is expected in people aged over 80 years old.

Using the national dementia prevalence calculator (2013) Herefordshire prevalence of 3099 people can be adjusted to take account of other factors such as number of care homes. The adjusted dementia prevalence is 3184 people. The figure 7.3 shows how the number of people is divided into mild, moderate and severe stages of dementia.

Figure 7.3: Estimated Proportion of People with Mild, Moderate and Severe Dementia living in Herefordshire.



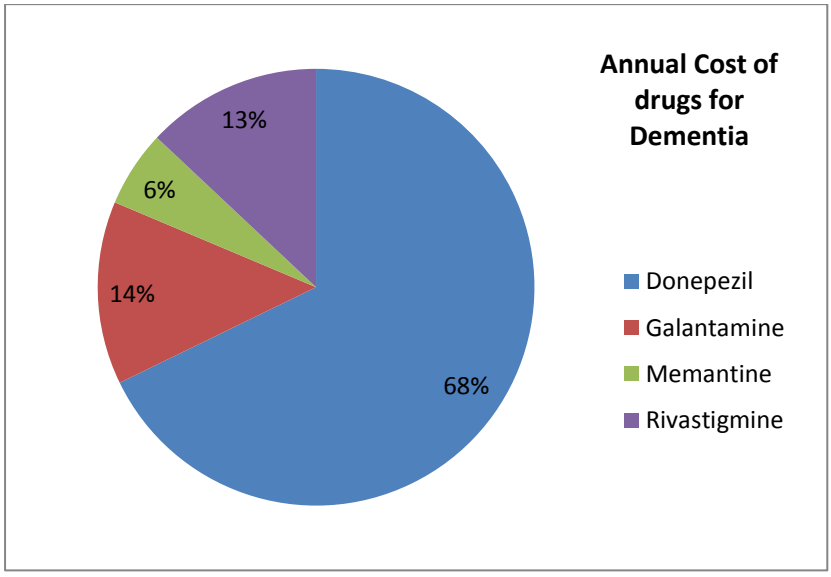
Source: The Dementia Prevalence Calculator, 2013

The prevalence of dementia can be divided into the number of people with dementia expected to live in the community and the number expected to live in a care home. As of August 2014:

- 445 people with dementia are expected to live in a care home
- 2739 people are expected to live in the community.

Local prescribing data shows that nearly £100,000 was spent on medication for people with dementia in 2013/14.

Figure 7.4: Herefordshire CCG Prescribing of Drugs for Dementia (By Volume 2013-14)



Source: Herefordshire Clinical Commissioning Group, 2014

7.3. Models of Care

7.3.1. Standards and Guidance

There has been many national strategy and guidance issued:

- National Dementia Strategy (February 2009)[cxxcxxi]
- Antipsychotics Report "Time for Action" (November 2009)[cxxii]
- National Clinical Director appointed (February 2010)
- Prime Minister's Challenge (March 2012) (Health and Care, Dementia friendly communities, research)
- Dementia State of the Nation Report (November 2013)
- Dementia G8 Summit (December 2013)

The National Institute for Health and Clinical Excellence, Social Care Institute for Excellence (2006) published guidelines in relation to dementia care. These can be used to compare against Herefordshire's provision and provide a foundation for developing the local model. In addition there are standards for memory clinics and dementia care standards for acute general hospitals.

7.3.2. Dementia Friendly Communities

Dementia friendly communities can be defined as:

"An integrated society where people with dementia live in 'normal' home-like situations throughout their lives with support to engage in everyday community activities." [cxxiii]

The Local Government Association has developed guidance for local authorities in developing Dementia friendly communities[cxxiv]. This identified that community could become more dementia-capable by:

- increasing its awareness of dementia
- supporting local groups for people with dementia and carers
- providing more information, and more accessible information about local services and facilities
- thinking about how local mainstream services and facilities can be made more accessible for people with dementia.

Organisations have been signing up to the Dementia Action Alliance and 'Dementia Friends' - an education programme for the public is available.

7.3.3. Person-Centred Care

The model of care has shifted from a medical model to a model based on person-centred care (Kitwood 1997)[cxxv]. Brooker (2007)[cxxvi] has suggested the acronym VIPS to encapsulate the broader meaning of person-centred care:

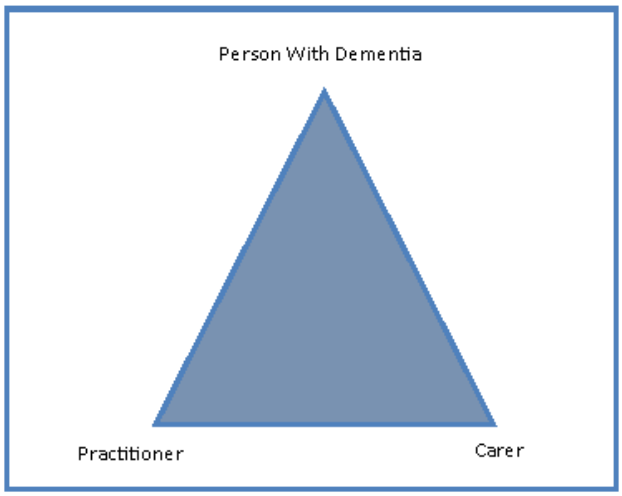
- **V**alues and promotes the rights of the person
- Provides **I**ndividualised care according to needs
- Understands care from the **P**erspective of the person with dementia
- **S**ocial environment enables the person to remain in a relationship.

Person-centred care is underpinned by a philosophy of personhood, which Kitwood characterized as follows: 'It is a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being' (Kitwood 1997: p.8).

7.3.4. Triangle of Care

The Triangle of Care for Dementia describes how meaningful involvement and inclusion of carers can lead to better care for people with dementia. By involving carers, staff and services can ensure they have a fuller picture of the person's needs and how their dementia affects their behaviour and general wellbeing. In addition, carers are reassured that the person they care for is receiving the best and appropriate treatment possible.

Figure 7.5: Dementia Triangle of Care



Developed by the Royal College of Nursing in conjunction with the Carers Trust, guidance for the triangle of care[cxxvii] suggests that the best outcomes for patients, carers and practitioners are achieved when:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.

2) Staff are 'carer aware' and trained in carer engagement strategies.

3) Policy and practice protocols regarding confidentiality and sharing information are in place.

4) Defined post(s) responsible for carers are in place.

5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.

6) A range of carer support services is available.

7.3.5. Community Dementia Services

Informed by NICE guidelines and quality standards, memory assessment services (which may be provided by a memory assessment clinic or by community mental health teams) are a single point of referral for all people with a possible diagnosis of dementia. It should be a responsive service to aid early identification and should include a full range of assessment, diagnostic, therapeutic, and rehabilitation services to accommodate the needs of people with different types and all severities of dementia and the needs of their carers and family.

The service model focuses on the organisation of diagnostic and community services, to provide flexible and individualised care plans. Specialised services should be developed only where traditional services are deficient.

7.3.6. Inpatient Care

The Royal of Psychiatrists (Faculty of Psychiatry of Old Age) (2011) guidance on inpatient care for older people within mental health services states:

- The purpose of inpatient care is to provide specialist expertise with intensive levels of assessment monitoring and treatment unable to be provided in other settings.

- There should be clear and robust arrangements for urgent medical interventions and regular expertise available from geriatric medicine services.

- Community services should provide alternatives to inpatient admission. This should include crisis intervention and home treatment that is focused on the needs of the elderly.

The guidance also states that the number of beds for acute care originally identified by the Faculty (1-2 beds per 1000 elderly persons) will need to be adjusted according to local resources and demands (e.g. availability of home treatment, day hospital, local authority provision, service age cut off). Consequently some areas have reduced acute beds to 0.8 -0.67 per 1000 elderly population. Optimal bed occupancy for safe and efficient in patient bed management is 85%.

7.4. Findings

7.4.1. Dementia Friendly Communities

There have been a number of events in Herefordshire to promote Dementia Friendly Communities. In addition, a number of organisations have signed up to the Dementia Action Alliance making pledges to improve their services for people with dementia. In Herefordshire, at least ten organisations have developed action plans, including Herefordshire CCG.

A number of events were held during Dementia Awareness Week (18-24 May 2014) illustrating a willingness by the public and organisations to participate.

The promotion of dementia friendly communities, dementia friends and dementia champions forms one of three strands of work by the inter-agency Dementia Partnership.

Promotion of the above schemes remains an on-going activity. It is recommended that awareness raising of dementia by all partners continues.

Several areas in Herefordshire have started to consider how to make their area a dementia-friendly community. These are at early stages but the lessons should be shared with other villages, parishes and towns.

7.4.2. Multi-Agency Partnership

The Health and Wellbeing Board recognizes dementia as one of the long-term conditions affecting Herefordshire that would benefit from a shared partnership approach to ensuring that people and their carers are supported during all stages of their illness or caring role. The Dementia Implementation Partnership was created in 2013 to oversee the implementation of the Dementia implementation Strategy as well as build strong partnership working across Herefordshire. Eleven organisations have supported this work.

There are the three locally agreed outcomes developed by the Herefordshire Dementia Partnership.

1. Driving a Herefordshire wide culture change through raising awareness and understanding

2. Increase availability of early diagnosis of Dementia and support

3. Supporting people with dementia, carers and families to live well with dementia

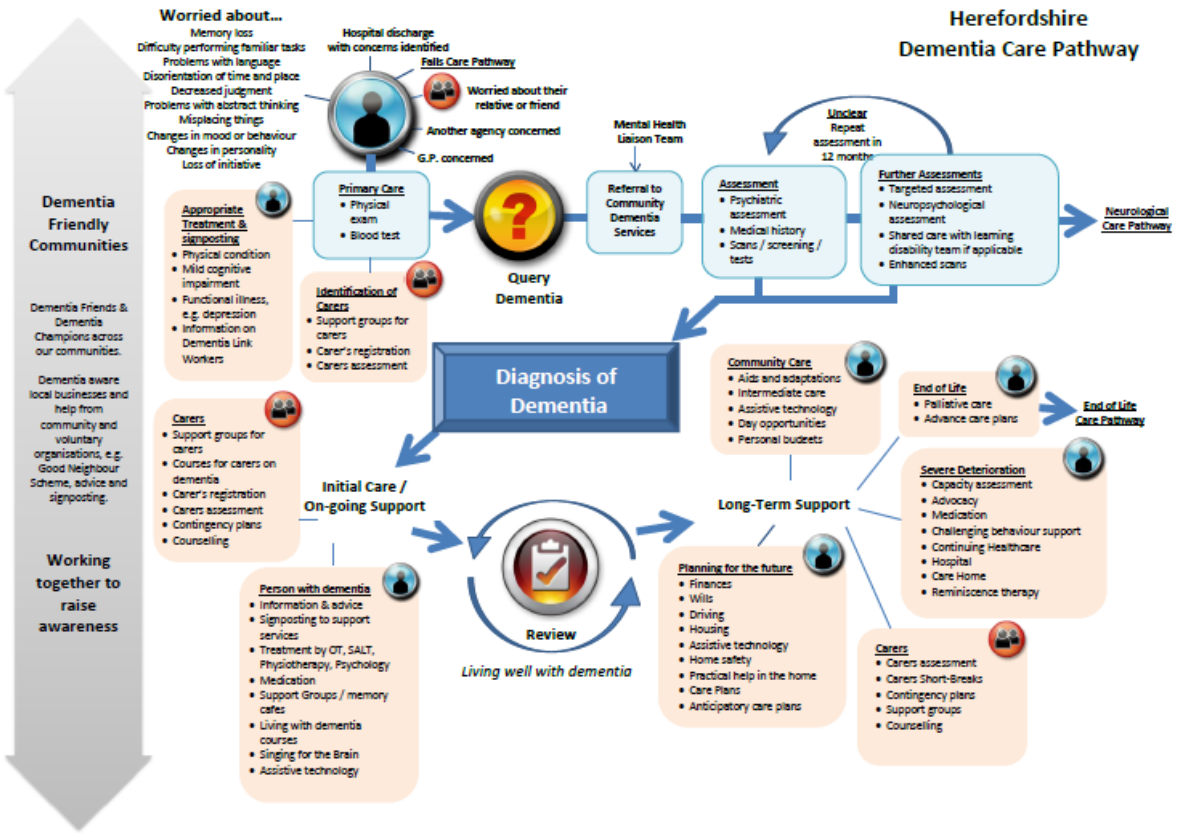
In addition to the action plan, the Partnership also developed an evaluation framework to monitor the impact of the activities on the lives of people with dementia and their carers. This is a good example of sharing a vision, activities and results with other agencies so that all elements can be monitored to see if outcomes are being achieved.

7.4.3. Care Pathway

We need integrated working that addresses housing, money, relationships. This needs to be addressed before the patient can approach recovery.
Mental Health Practitioner

During 2014, work commenced on a local dementia care pathway that recognised the needs of the person with dementia, the needs of carers and the role of the community, both pre and post diagnosis. Figure 7.6 is the agreed care pathway.

Figure 7.6: Herefordshire Dementia Care Pathway, 2014



Source: Herefordshire Dementia Implementation Partnership, May 2014.

Assistance is available pre-diagnosis and post diagnosis to both the person and their carer. This opens up access without the need for a diagnosis.

The design of the care pathway was consulted with the public through organisations and dementia events. People reported that they perceived the care pathway had the right elements that would

impact on their perception of feeling supportive and address keeping well when living with dementia.

It is recommended that Herefordshire CCG continues to promote and utilise this care pathway.

7.4.4. Access to Memory Assessments

The average waiting times for a diagnosis after referral range from 2 to 13 weeks in the West Midlands. The recommended standard from the Royal College of Psychiatry is 4-6 weeks[cxxviii] . The current average waiting time from referral to assessment is four weeks. This is a significant improvement in waiting times since 2012 levels when the Dementia Needs Assessment raised this as a concern.

The table below provides data for expected benchmark activity for new referrals against calculated Dementia incidence in Herefordshire in 2014 and 2015.

New Cases by Year	2014	2015
Estimated prevalence (cumulative)	3,099	3,285
Estimated incidence (by year)	573	575
Benchmark Activity: indicative new cases ±	351	353
Yearly new patient appointments at Memory Clinic*	302	303
Positivity rate: new positive diagnoses in year ±	190	191

± based on NICE commissioning and benchmarking tool[cxxix]

* based on 6 new patient appointments per week [cxxx]

Herefordshire CCG should continue to monitor the activity of the memory clinic to ensure that assessment is timely. With increasing referrals, the waiting times will grow.

7.4.5. Gaps in Services

There was recognition of the gaps in services by patients and practitioners.

a) The division of services between working age and older people meant that older people were poorly served for psychological support and patients were increasingly being "fitted" around existing services.

It is galling that certain psychological service only support people up to 65

Patient

Psychology support is poor for older people

Mental Health Practitioner

The Community Dementia Service has expanded the availability of psychology however there is insufficient information to ascertain whether there is a level of unmet need.

b) Younger people with dementia have special requirements, and specialist multidisciplinary services should be developed, allied to existing dementia services, to meet their needs for assessment, diagnosis and care. There is no dedicated provision for people with early on-set dementia particularly that addresses employment and other issues.

c) People with learning disabilities and those supporting them should have access to specialist advice and support regarding dementia. People with learning disabilities do not have sufficient support if they develop dementia. There is an innovative scheme in Herefordshire to develop a care environment dedicated for people with LD. Health and social care staff working in care environments where younger people are at risk of developing dementia, such as those catering for people with learning disabilities, should be trained in dementia awareness.

7.4.6. Inpatient Care and Discharge Planning

Delivering care in the right settings appears to be difficult at times. Stakeholder views raised the lack of inpatient beds and shortage of elderly mentally ill nursing beds in care homes. Mental Health practitioners identified a shortage of inpatient mental health beds, compounded by a lack of specialist nursing home placements. This resulted in local wards becoming mixed, with implications for management, as well as patients being moved out of county, with implications for care, support and expense. This was observed by carers too.

Beds have been cut at the stonebow unit, without beefing up the community care. This has led to more out of county placements and reduced flexibility, which is point of mental health- you never know when you'll need beds

Carer

We are short on beds. There is high demand, so we get working age adults in the older persons' beds. This causes problems with managing the mix of patients, ensuring everyone feels safe and we can't admit our own patients due to adult patients being in our beds.

Mental Health Practitioner

There are too few elderly mentally ill beds in the county, meaning that patients are placed out of county, which in turn impact on family visits and support. This leads to lengthy stays on the ward as there is nowhere to place them, which is upsetting for patients and families, who would like to be at home.

Mental Health Practitioner

There was felt to be a shortage of beds within the community into which to support people with dementia. The delay in discharges of patients from acute beds showed local incidents, however practitioners reported that the lack of beds was hindering admission for people requiring assessment and treatment. Some of the lengths of stay in a mental health bed suggest that a small number of people were not being supported in a timely manner to be discharged. Without an audit,

it is difficult to confirm that they could have been discharged if the planning was effective / or care beds available.

Practitioners commented on the delays and insufficient supply of residential and nursing care home beds.

Council and social care finances have impacted on availability of care homes and care at home. It causes bottle necks for discharge and means that people are being managed in the community with higher levels of risk, so admissions are only for those with the highest level of need.
Mental Health Practitioner

There are not enough beds in the community to meet need. There are too few placements for patients with dementia and challenging behaviour, which results in them being placed out of county. Placements are able to refuse patients whose needs are too high and there is a risk of upsetting families due to a lack of choice.
Mental Health Practitioner

One of the issues related to the engagement of Social Care in arranging care packages.

The delay in organising panel papers, or due to placements falling through lead to more bed days and delays in discharge, restricting beds further.
Mental Health Practitioner

Some people living in care homes and hospitals may not be able to make their own decisions. They may sometimes lack the capacity to consent to treatment or care they may need. Deprivation of liberty safeguards (DOLS) can be applied to people in care homes and hospitals who meet the following criteria:

•aged 18 or over

•have a mental health problem such as dementia or a learning disability

•lack the capacity to consent to where their treatment or care is given

•need to have their liberty taken away in their own best interests to protect them from harm

In 2013/14, Herefordshire had made a total of 73 applications under DOLS, of which 39 were granted. This is a low number considering the number of care homes and demography. It was not possible to determine how many people out of the 73 applications had dementia.

People in hospital for physical healthcare might experience improved recovery if their mental health needs were taken into account. Liaison psychiatry offers a model of health care that embeds mental health provision into physical healthcare settings. The benefit of identifying people impacts on discharge plans and adherence to treatment plans by treating the person as a whole rather than a focus on the presenting symptoms. Herefordshire has limited liaison psychiatry and further investment would enable this provision to be available across community hospitals and general hospital.

7.4.7 Capacity and Support in the Community

People with dementia, carers and practitioners all acknowledged that care in the community is vital if people with dementia were to live at home for longer and that support to carers was fundamental.

There is a need for better education and engagement with families to understand the aim of services and how they can contribute. Relatives are a huge resource for us in meeting patients' needs but they can be overwhelmed. Quite simple support would mean improved patient care and Carer wellbeing.
Mental Health Practitioner

Alternatives to hospital and home treatment are elements of the care pathway that are under developed. Alternatives to hospital generally focus on adults with psychosis or other mental health conditions. People with dementia that have severe or risky behaviours are often considered for hospitalisation, as limited community alternatives are available.

There needs to be more emphasis on visiting people in their homes so there is less need to be in hospital with more support from social workers and family support.
Patient/ Service User

We need more services to allow people to stay in their homes. Some GPs are not referring people early enough
Mental Health Practitioner

There is a need to strengthen skills in care homes/ community. Things like medication adjustments could be done in community to negate the need to admit patients.
Mental Health Practitioner

Feedback indicates that the work of the intermediate care service is valued in terms of aiding rehabilitation or resettlement in the community. There is little use of telecare or tele healthcare in Herefordshire for people with dementia. The main use is to contribute towards assessments in terms of wandering however technology could enhance the quality of life for some people with dementia and their carers. The greater use of telecare is an ambition of Herefordshire Council.

7.4.8. Education

Dementia Awareness sessions have been delivered in surgeries across both Herefordshire with further learning & development opportunities being offered to GP's and other medical practitioners. This includes Level 2 training, specialist training modules in specific areas such as; medicines management, good practice person centred care, special groups, i.e. learning disabilities, young onset, assessment tools and skills/early intervention, being delivered and additional learning at Level 3 training primary care liaison which also covers a wide range of areas is going to be delivered in 2015.

A multi-agency day - Living Well with Dementia in Herefordshire was held in June 2014. The purpose of the event was to engage with GP practices, Senior Clinicians, Practice Managers and other Health Professionals who are working with or supporting people with a diagnosis of Dementia. Nearly 100 practitioners attended the day and feedback showed that they valued the sharing of practice ideas.

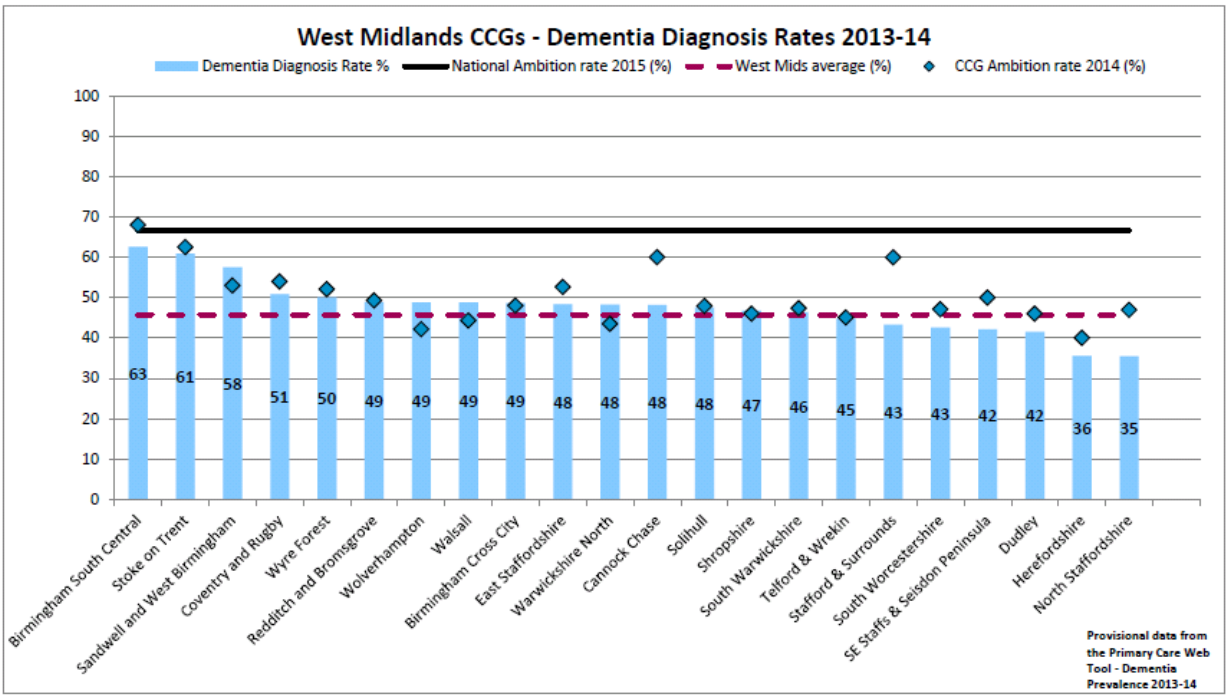
It is recommended that Herefordshire CCG supports the publicity of the dementia awareness sessions with GPs.

7.4.9. Diagnosis Rates

As of September 2014, Herefordshire had 1269 people diagnosed with dementia. This is the equivalent of 40.95% dementia diagnosis rate per 100,000 population.

The diagnosis rate across the West Midlands shows variation from 35% to 63% in 2013/14, with the England average as 46% as figure 7.7 shows:

Figure 7.7: Dementia Diagnosis Rates 2013-14 in the West Midlands.



Source: Primary Care Web Tool, 2014

Herefordshire is making progress as the diagnosis rate as of 2013/14 was up thirty-three per cent since 2012/13. However this is great variation between GP practices (between 19% to 62%) and further diagnoses are required by April 2015.

Explanations for the dementia diagnosis gap could be coding issues in primary or secondary care; poor case finding of vulnerable patients; lack of targeted screening and further education required

across practitioners to aid with recognition of cognition or memory impairments. Other community health staff are a vital part of recognising and identifying people that require assessment or support. To encourage practitioners to signpost to sources of support, information on the care pathway and referral routes should be cascaded, with specific training offered to other community teams.

Recommendation is to work with Primary Care to ensure that all people with dementia are recorded on the register and that the coding is standardised across Herefordshire. The CCG can offer support in reviewing the register.

7.5. Recommendations

Although there has been ongoing work to improve dementia awareness, the diagnosis rate and feedback from people with dementia indicate that there remains a lack of understanding in the county, affecting how supported people feel. Continued awareness raising of dementia within our communities and across all health services will enhance the number of people that come forward for an assessment and receive help with future planning and their quality of life. All parts of the NHS should form part of the greater workforce able to identify and enable patients to access an assessment. Voluntary and community organisations can equally identify people who may be in need of assistance, including assistance from a community dementia service.

This Needs Assessment reinforces the Dementia Needs Assessment (2012) that gaps still exist in provision for people with early onset dementia and people with learning disabilities. Some forms of support are restricted by capacity such as availability of nursing home beds within the community, making it difficult to discharge patients from hospitals. Other forms of support are restricted by capability of organisations to offer dementia care.

There has been positive change since the Dementia Needs Assessment (2012) with the introduction of the community dementia service and agreed care pathway. This offers a holistic approach to dementia care, in partnership with GPs, care homes and the voluntary sector. The creation of an interagency dementia action plan during 2014 demonstrates that organisations are actively working together to provide information, advice and support, including access to diagnosis, and assistance for carers. New developments such as community arts and early onset self-help groups are in recognition of the local needs that people have. And yet, although Herefordshire has a low rate of diagnosis, awareness of dementia by people living with dementia and their carers will drive the need and expectation for further services.

The recommendations are:

- To support the work of the Dementia Partnership and the development of dementia friendly communities across Herefordshire.
- To continue to raise awareness of dementia including a programme of education for practitioners to improve dementia care. This should result in earlier detection, allowing improved planning with the person and their family.

- To develop liaison psychiatry service that will identify people with dementia and improve clinical care.
- To improve support services for people with early onset dementia
- To improve support services for people with learning disabilities and dementia.
- To review availability of psychology for people with dementia against the level of need.

Chapter 8: Children and Young People

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Contents

Chapter 8: Children and Young People

8.1. Introduction

This chapter primarily focuses on children and young people up to the age of 18. However, in recognition that it is very unusual for very young children to require support for their mental health, and that transition for young people is flexible according to their individual needs (sometimes beyond the age of 18 years old), the chapter will take an inclusive approach to mental health needs of children and young people, from 0-24 years old.

This Chapter explores the prevalence for mental health conditions in this age group (subject to availability of information) before outlining models of care. Analysis is then presented in light of stakeholders' views and activity information before outlining recommendations.

There are 39,900 children and young people under the age of twenty living in Herefordshire, 21.6% of the total population (ONS Mid-Year estimates, 2013). Broken down further into age groups, the 0-4 age groups represents 5.3% of the total population (England & Wales 6.2%), 5-10 year olds 6.1% (England & Wales 5.7%), For 11-15 year olds 5.7% (England & Wales 5.9%) and 16-19 year olds 4.5% compared to the England &Wales average of 5.1%. This indicates that although Herefordshire has a lower than average percentage of children within its population, there is an above average number in the 5-10's age group.

The numbers of children living in the county have been increasing for the last two years but are still seven percent lower than in 2001. However, within this, the number of under-fives has been rising over the last eight years and the numbers of births has broadly been rising throughout the last decade. 8.1% of children aged 0-19 years old are from minority ethnic groups.

A total of 14.4% of children and young people (under 16 years old) are living in poverty (2011). This is better than the England average (20.6%). Further information on the demography and vulnerability of children and young people can be found from the Children's Integrated Needs Assessment (2014)[cxxxi].

8.2. Children and Young People with increased vulnerability for mental health illnesses

Although mental ill health may affect everyone, particular populations are at increased risk. The Department of Health (2004)[cxxxii] reported that:

"Looked after children are five times more likely than their peers to have a mental health disorder. Children and young people with significant leading disabilities are three to four times more likely to have a mental disorder and at least forty per cent of young offenders have been found to have a diagnosable mental health disorder." (p7)

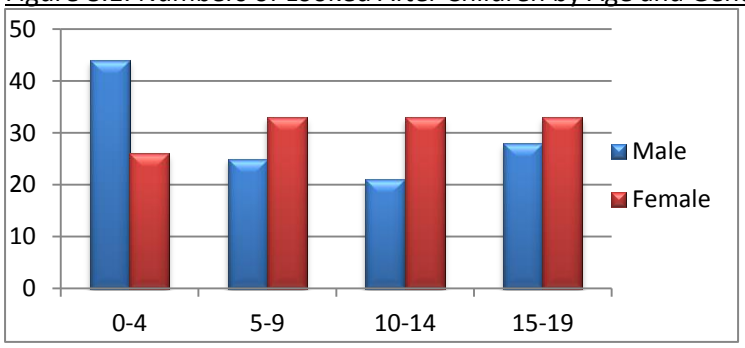
Herefordshire's integrated children's needs assessment of 2014 identified additional 'vulnerable' groups that may see an increased risk of poor mental health outcomes: those experiencing domestic violence, homelessness and Gypsy travellers.

It should be noted that a child may experience multiple vulnerability factors. As such, simply counting numbers in each category may not give an accurate picture of risk, yet it does give an indication of why some groups of children should receive further consideration to their possible mental health need.

8.2.1 Looked after Children

As of September 2013 Herefordshire had 243 children identified as 'looked after' (LAC), giving a rate of 61.7 per 10,000 people (aged under 19). This current rate is significantly higher than the averages for both statistical neighbours and national rates which are 47 per 10,000 children, and 59.0 per 10, 000 children respectively.

Figure 8.1: Numbers of Looked After Children by Age and Gender as of Sept 2013



Source: Herefordshire Children Services, MTFC trend data

Looked-after children are more likely to experience mental health problems (Ford, T. et al, 2007)[cxxxiii]. It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic (Meltzer, H. et al, 2003)[cxxxiv].

About two-thirds of children living in residential care (68%) were assessed as having a mental disorder and about four in ten of those placed with foster carers (39%) or with their birth parents (42 per cent).

For looked after children, there is

- 5 fold increased risk of any childhood mental disorder;
- 6 – 7 fold increased risk of conduct disorder; and
- 4 – 5 fold increased risk of suicide attempt as an adult.

Since April 2008, the government has required all local authorities to administer the Strength and Difficulties questionnaire (SDQ) annually to primary carers of all children aged 4-16 years defined as a Looked after Child for at least 1 year. This score is used as a screening device for mental disorders and an indicator to compare comparable Local Authorities. The questionnaire has 20 items relating to emotional symptoms, conduct problems, hyperactivity and peer problems which are summed up to create a 'total difficulty' symptoms score ranging from 0-40, where scores 17 and above are a cause for concern (Goodman & Goodman, 2012)[cxxxv].

For the period 2012/13, Herefordshire's mean SDQ score was 7.8. England's average SDQ score for Looked after Children is 13.8 and the 'norm' for British children is 8.8. 59% of SDQ forms were returned during the year 2012 – 2013 for Herefordshire LAC. 20 children (29%) had a score of 16 or more. Of these, half were girls, the majority of whom (seven) were accessing CAHMS. Herefordshire looked after children have better mental health than both England's average and British children who are not looked after.

8.2.2 Children with Disability

No definitive data source of the numbers of children with disability within Herefordshire is available. The Herefordshire Council-developed Understanding Herefordshire (2014) document suggests a number of between 1,000 and 1,800. Disability is suggested as the underlying reason for 5% of Herefordshire's 'children in need' population.

Over one third of children and young people with a learning disability in Britain (36%) have a diagnosable psychiatric disorder. They are thirty-three times more likely to have an autistic spectrum disorder; six times per likely to have a conduct disorder and four times more likely to have an emotional disorder. Some of the increased risk is attributed to the increased exposure to poverty and social exclusion, linked to social circumstances.[cxxxvi]

8.2.3 Young Offenders

In 2012 there were 275 youth justice sanctions (reprimands, final warnings or convictions) against 225 individual young people within Herefordshire (1.3% of the youth population). Of these 225 young people, 70% were male and the majority, 79%, were aged 15 to 17 years. The peak age of offending for both young males and females was 17 years. (Source: Youth Offending Service).

Research by Young Minds (2012)[cxxxvii] suggests that over 40% of young people involved in the Criminal Justice System have an emotional and/ or mental health need. If the national research is applied to the local youth offending sanctions, then approximately 90 young people involved in the criminal justice system will have an emotional/ mental health need.

Studies have shown that there is an eighteen fold increased risk of attempted suicide for men in custody age 15–17[cxxxviii] and a forty fold increased risk of suicide in women in custody under the age of 25[cxxxix].

8.2.4. Children and Young People experiencing Domestic Violence

The prevalence and impact of domestic violence on families is widely documented. For example, 69% of high risk adult victims of domestic violence have children, according to the Munro Review (2011)[cxl].

Children can experience cognitive, behavioural and emotional effects as a result of witnessing domestic abuse, both within the short and long term. Children are also often victims of abuse and national studies have highlighted that there is an increase in domestic abuse and violence present in teenage relationships[cxli]. Trevellion et al (2012)[cxlii] argues that of poor mental health is a 'symptom' of domestic violence.

The Crime Survey for England and Wales (CSEW) found that in 2011/12, 7% of females and 5% of males were victims of domestic violence or abuse in the previous year. The data does not allow us to see if this trend is similar to Herefordshire, however if applied to the local population that would equate to 3,600 females and 2,500 males.

A local Domestic Violence and Abuse Needs Assessment was conducted in 2013[cxliii]. It acknowledged the impact on children and young people on their mental health, but was unable to quantify the number of children and young people affected.

Table 8.1 shows the number of children per quarter recorded as being exposed to domestic violence within Herefordshire by West Mercia Police. These figures are likely to under-represent the number of children exposed, due to under reporting. There is also likely to be double counting of individuals across quarters.

Table 8.1: Number of children exposed to domestic Violence in Herefordshire 2013/14

	Q1 2013-14	Q2 2013-14	Q3 2013-14	Q4 2013-14
Number of children exposed to domestic abuse crimes and incidents	454	513	501	400
Children Exposed to domestic abuse three or more times	21	13	29	32

Source: West Mercia Police, 2014.

As part of the Domestic Violence Needs Assessment, CLD Trust counselling reviewed 913 open and closed cases referred for counselling during the period 1st April 2012 to 31st January 2013. 82 (9%) of clients had suffered the impact of domestic violence on their emotional well-being. A high proportion of people referred for help with the recovery from substance misuse reported domestic violence within the family.

One of the recommendations of the Domestic Violence Needs Assessment report was to work with Children's Services to identify resources to provide counselling for children and young people who are victims of domestic abuse.

8.2.5 Children and Young People experiencing Homelessness

Shelter (2010) stated that children that are homeless are more likely to suffer mental health problems[cxliv]. The Mental Health Foundation (2002) stated that there was an eight fold increased risk of mental health problems if children were living in hostels and bed and breakfast accommodation[cxlv]. The Department for Communities and Local Government Homelessness statistics for the first 3 quarters of 2013/14 indicate 56.5% of homeless households included children. In Herefordshire, there was a total of 201 children (including pre-birth) living within homeless households.

8.2.6 Young Carers

As of March 2014, Herefordshire's Carer's Support had 311 children and young people on their register. There are likely, however, to be many more who are providing care but are unidentified (The Children's Society, 2013)[cxlvi]. The majority of young carers on the register are aged between 10-15 years, which reflects the national profile on age of carer. 63% are female, just over half care for their mother and 8% provide over 100 hours of care per week. In addition to this 11% have a disabling condition themselves. A study into young carers offers some insight into the impact on their mental health. The research found that most children and young people experienced feelings of sadness, anxiety and difficulties with friendship and family relationships[cxlvii].

8.2.7 Lesbian, Gay, Bisexual and Transgender Young People

Data on sexuality is not collected locally in Herefordshire. The ONS national Integrated Household Survey (IHS) of 2012 presented data on young people aged 16 and over and showed that overall 2.6% of adults aged 16-24 compared to 0.4% of over 65's stated they were either Gay, Lesbian or Bisexual. This was a similar number compared to the previous year.

Published research indicates that there is a seven fold increased risk of suicide attempts in young lesbians, increasing to eighteen fold increased risk of suicide attempts in young gay men[cxlviii].

8.2.8 Gypsy Travellers

There is national evidence of the increased risk and incidence of suicide and also domestic violence within Gypsy Travelling communities (Cemlyn et al 2009)[cxlix]. There is limited information on the mental health needs of children and young people from Gypsy Travellers.

In terms of the size of the population, the most reliable data on this group is the school census and Local Authority attainment records. These showed that in October 2013, there were 255 under 19's known to the Gypsy Traveller Team in Herefordshire, however little is known of the extent of mental health illnesses.

8.2.9 Children with Long-Term Conditions

The risk of developing a mental illness is increased as a result of living with a long-term condition. Children and young people can experience depression or anxiety about managing a physical long-term condition, impacting on their mood and ability to self-manage their condition. Approximately 11% of children and young people experience significant chronic illness[cl], including chronic mental health, while 10-13% of young people report living with a chronic condition that substantially limits their daily functioning[cli]. Children with long-term conditions are twice as likely to suffer from emotional or conduct disorders[clii].

There is no register of children with long-term conditions, so it is difficult to state the number of children and young people affected, however this does highlight that children receiving support with their long-term conditions, should have support with their mental health too.

8.2.10. Sexually Exploited Children

Sexual exploitation of children and young people takes different forms, from young people being involved in sexually exploitative relationships and receiving money, drugs or accommodation in exchange for sex with one or more adults, to being exploited in more 'formal' prostitution. In all cases, those exploiting the young people have power over them by virtue of their age, gender, physical strength, or economic or other resources, such as access to drugs. While some element of coercion is common, the involvement in exploitative relationships is most significantly characterised by lack of choices, borne out of the social, emotional and economic vulnerability of the young person.

There are no locally commissioned services specifically for sexually exploited children and young people. Some support from CAMHS is available however the capacity is limited. Local information from Children's Social Care indicates that in the region of fifty children and young people are known to be affected.

8.3. Prevalence

The prevalence of mental health in children and young people has been presented in age bands commonly associated with stages of childhood development. These are 0-4 years, 5-10 years, 11-16 years and 17-19 years.

8.3.1. Children aged 0-4 years

There is a paucity of evidence of mental ill health in children younger than the age of 5 (CHIMAT, 2014), particularly in regard to more severe mental disorders.

Local referral data shows a 14.6% reduction in the numbers of referrals into CAMHS of children under the age of 4 (Table 8.2) over the 2012-2014 period. The decrease is more significant amongst females. Health Visitors and Community Paediatrics submitted the highest level of referrals. However general caution is required in interpreting these figures and their significance due to the small numbers involved.

Table 8.2: CAMHS referral activity in 0-4yr olds 2012/13 and 2013/14

	2012/13	2013/14	Trend
Total number of referrals	48	41	
Female	16	11	Down
Male	32 (67%)	30 (73%)	
Referral Sources			
Community Paediatrics	10	11	
G.P.s	4	6	
Health Visiting Service	7	12	Up
Hospital Paediatrics	5	1	Down
Social Care	2	6	Up
School Nursing Service	0	2	
LEA Education Service	2	0	
Non-LEA Education Service	1	0	
Other Clinical Speciality	1	0	
Other	0	3	
Internal Referrals			
CAMHS Learning Disability Team	7	5	
CAMHS Looked After Children Team	4	5	
CAMHS Team	37	31	Down

Source: 2gether NHS Foundation Trust 2014

8.3.2. Children aged 5-10 years

The most commonly recorded disorders within this age group are conduct disorders, emotional disorders and hyperkinetic disorders.

Conduct Disorders may be defined as “repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age–appropriate social expectations” (NICE, 2013)[cliii]. Conduct disorder has a very strong correlation with ADHD, a hyperkinetic disorder, with up to 40% of those diagnosed with conduct disorder also having an ADHD diagnosis.

Hyperkinetic Disorders are defined as “a heterogeneous behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention” (NICE, 2008)[cliv]. Children with ADHD frequently have coexisting conditions such as anxiety, communication and/or learning difficulty and disorders of mood. ADHD prevalence is between 3-9% of school age children although the severity of impact varies. Children and young people with ADHD are likely to continue to have difficulties into early adulthood and ongoing mental health services might be needed.

Table 8.3: Predicted prevalence of Mental disorders in 5-10 year olds in Herefordshire against referrals to CAMHS (2012).

	Males (2012)		Females (2012)	
	Estimated Number	Number referred to CAMHs and % of estimate	Estimated Number	Number referred to CAMHS and % of estimate
Total no of Mental Health Disorders	600	222 (37%)	280	125 (45%)
Conduct Disorder	405	*	155	*
Emotional Disorder	130	*	140	*
Hyperkinetic Disorder	160	*	25	*
Less Common Disorders	130	*	25	*

NB: numbers do not sum due to some children presenting with more than one disorder.
Source CHIMAT (2014) Office for National Statistics mid-year population estimates for 2012;
Green, H. et al (2004); 2gether NHS Foundation Trust (2014) * indicates no local data available.

The Child and Maternal Observatory (CHIMAT) estimates that 600 males aged 5-10 years in Herefordshire have a mental health disorder.

Actual data on prevalence, broken down to type of disorder, is unavailable locally as it is not currently recorded. CHIMAT shows that females have a much lower prevalence of mental disorder at this age, with 280 estimated compared to 600 males. Based on the CAMHS referral data it appears that females are better identified and referred at this age compared to males (45% and 37% respectively, against CHIMAT estimate data).

Table 8.4 shows an overall increased level of referral (8.52%) when comparing 2012/13 to 2013/14. This is particularly evident in males. In regard to referral source GP's show a significant increase (117 to 169) and hospital paediatrics have almost doubled their referrals (14 to 27). Education has reduced its referrals considerably from 90 to 68 (combining non and LEA education services). Most of the increase activity has been allocated to the core CAMHS team with a reduction in the level of Learning Disability Team allocation over the same time period.

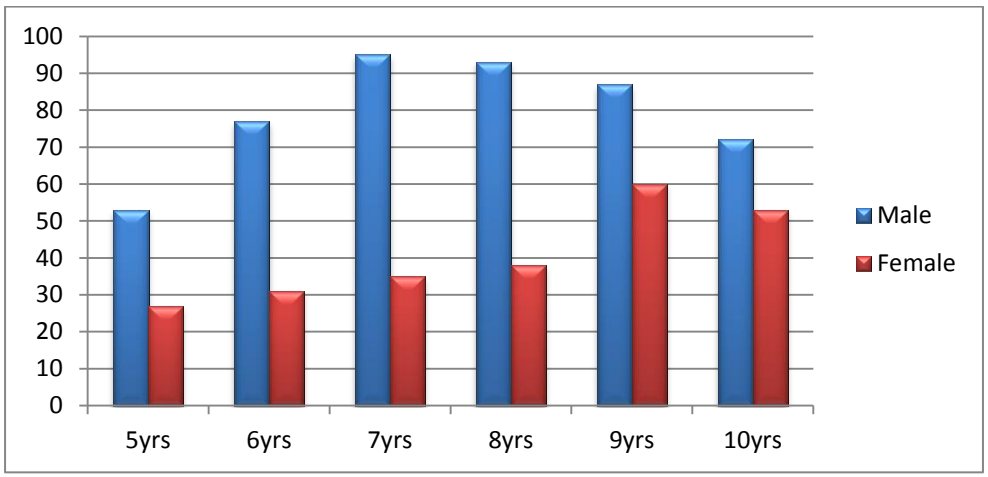
Table 8.4: CAMHS referral activity in 5-10 years old 2012/13 and 2013/14

	2012/13	2013/14	Trend
Total number of referrals	347	374	+8.5%
Female	125	119	-4.8%
Male	222 (64%)	255 (68%)	+14.9%
Referral Sources			
Community Paediatrics	53	49	
G.P.s	117	169	Up
Health Visiting Service	4	3	
Hospital Paediatrics	14	27	Up
Social Care	35	28	Down
School Nursing Service	15	12	
LEA Education Service	84	68	Down
Non-LEA Education Service	6	0	Down
Other Clinical Speciality	11	1	Down
Other	3	14	Up
Internal Referrals			
CAMHS Learning Disability Team	31	22	Down
CAMHS Looked After Children Team	23	25	
CAMHS Team	294	326	Up
Community Learning Disability Team	1	1	

Source: 2gether NHS Foundation Trust (2014)

With regard to age at point of referrals, during the 2012-2014 period, boys profiled significantly higher than girls at all ages (Figure 8.3).

Figure 8.3: Number of referrals to CAMHS broken down by age and gender 2012-14 (5-10yrs)



Source: 2gether NHS Foundation Trust (2014)

Whilst there has been an increased level of referral into CAMHS over the last 2 years there was a small reduction the number of referrals for females. Identification of mental health need presented significantly below estimate for both genders. Both CHIMAT and 2gether NHS Foundation Trust show increased mental health need, particularly amongst females in the 11-16 and 17-19 age groups which raises concern that female referrals in the 5-10 age group diminished. Early identification and

prevention work with this group should be a priority to assist a reduction in future mental health need.

8.3.3. Young People aged 11-16 years

In addition to the conditions outlined above, a number of additional mental health disorders begin to manifest in 11-16 year olds.

Early psychosis in children and young people is defined as "a major psychiatric disorder, or cluster of disorders that alters a person's perception, thoughts, mood and behavior" (NICE 2013)[clv].

The prevalence of early psychosis in early childhood is low but rises from the age of 15. Most young people present a 'prodromal' phase, where behavioural changes may occur and begin to present either positive or negative symptoms. This may last for up to 12 months.

Diagnosis of early psychosis does not assume that it will endure into adulthood; in many cases the psychosis is 'transient'. There does appear however to be an increased risk of long-term psychotic illness amongst those that have early onset during their teenage years.

Anxiety Disorder is the overarching name for a number of diagnostically more specific conditions: generalized anxiety disorder, social anxiety disorder (SAD), post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder.

The incidence of social anxiety disorder appears to peak during adolescence. Anxiety often presents as chronic, and this may be due to the fact that anxiety is often not diagnosed or recognised, or disclosed at an early stage. Anxiety can be linked to increased risk of depression and substance misuse and /or other mental health disorders. It is therefore imperative to identify early and provide treatment to reduce further risks / co-morbidities occurring (NICE 2014)[clvi].

Table 8.5: Predicted prevalence of Mental disorders in 11-16 year olds in Herefordshire against referrals to CAMHS (2012)

	Males (2012)		Females (2012)	
	Estimated Number	Number referred to CAMHs and % of estimate	Estimated Number	Number referred to CAMHS and % of estimate
Total no of Mental Health Disorders	820	227 (28%)	645	247 (38%)
Conduct Disorder	525	*	320	*
Emotional Disorder	260	*	140	*
Hyperkinetic Disorder	160	*	25	*
Less Common Disorders	105	*	70	*

NB: numbers do not sum due to some young people presenting with more than one disorder.
Source: CHIMAT (2014) Office for National Statistics mid-year population estimates for 2012. Green, H. et al (2004). And 2gether NHS Foundation Trust (2014) * indicates no local data available.

CHIMAT estimates that 820 males, aged 11-16 years have a mental health disorder in Herefordshire. Table 8.5 shows a breakdown for this age group by the type of disorder. It shows that females have a lower prevalence of mental disorder at this age, although it is less dramatic a difference compared to the younger age group, with 645 estimated. Based on the CAMHS referral data it appears that females are better identified and referred at this age compared to males (38.3% and 27.7% respectively against CHIMAT estimate data).

Both of these figures indicate a decreasing percentage of young people aged 11-15 being referred to CAMHS when compared to children aged 5-10.

Herefordshire saw a 15.4% increase in CAMHS referrals between 2012/13 and 2013/14 to this age group, with females profiling an uplift of 22.7%. GP's showed a 27.8% rise in the number of referrals they made into CAMHS (Table 8.6).

Table 8.6: CAMHS referral activity in 11-16yr olds 2012/13 and 2013/14

	2012/13	2013/14	Trend
Total number of referrals	474	547	+15.4%
Female	247	303	+ 6.9%
Male	227 (48%)	244 (45%)	+22.7%
Referral Sources			
Community Paediatrics	17	25	
G.P.s	223	285	Up
Health Visiting Service	1	1	
Accident & Emergency Department	4	4	
Hospital Paediatrics	50	59	Up
Social Care	36	37	
School Nursing Service	7	16	Up
LEA Education Service	60	66	Up
Non-LEA Education Service	8	2	Down
Other Clinical Speciality	12	5	Down
Other	42	39	
Internal Referrals			
CAMHS Learning Disability Team	28	26	
CAMHS Looked After Children Team	29	34	
CAMHS Team	408	482	Up
Crisis Resolution & Home Treatment	5	4	
Eating disorders (adults)	2	0	
Early Intervention	9	4	
Primary Mental Health Service	1	4	

Source: 2gether NHS Foundation Trust (2014)

CLD Trust provides some of the care in partnership with CAMHS. In 2013/14, there were 623 11-16 females and males.

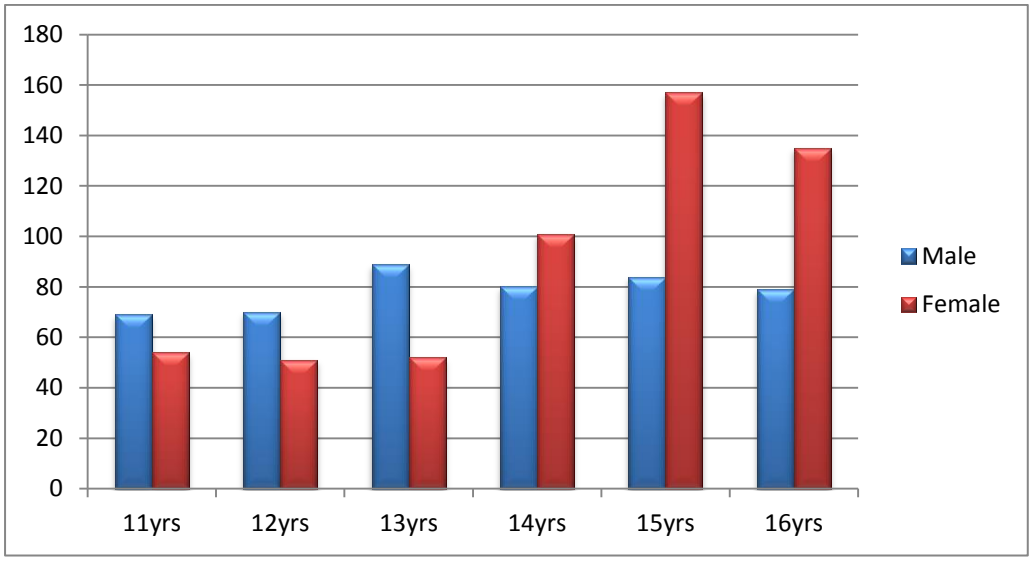
Table 8.7: CLD Trust referral activity in 2012/13-2013/14.

	Number	Percentage	Number	Percentage	Trend
Total	271	-	623	-	230%
Female	181	67%	392	63%	217%
Male	90	33%	231	37%	257%

Source: CLD Trust

Regarding age at point of referral, boys featured more highly between the ages of 11-13, although the gap was less dramatic than in other years (Figure 8.4). There was a substantial shift from age 14+ at which point females became more prevalent. At 15 years referrals for females were almost double the number of males.

Figure 8.3: Age and Gender breakdown of Referrals to CAMHS 2012-2014.



Source: 2gether NHS Foundation Trust (2014)

The 15.4% overall increase in CAMHS referrals masks the fact that females presented a 22.7% increase although identification of mental health need was significantly below CHIMAT estimate for both genders. With ADHD, conduct disorder and early psychosis more common in males it may suggest that anxiety/ depression are associated with the increased female referral. The lack of CAMHS diagnostic recording limits this suggestion however CLD data supports this view. It would further support the need to better identify females (and males) at an earlier age to prevent escalation of need during early adolescence.

8.3.4. Young People aged 17-19 years

In addition to the emergent conditions outlined above, further mental disorders begin to manifest in young people aged 17-19 years old.

Self–harm defined as '*self-poisoning or self-injury, irrespective of the apparent purpose of the act*' (NICE, 2004, p16)[clvii]. Factors associated with self-harm include life trauma such as being a victim of bullying, abuse (particularly sexual), family breakdown, existing physical or mental ill health, depression being the most common.

It has been found that young women have a 3-fold increased likelihood of self-harm compared to males. Although self-harm by injury is more common, self-harm by poisoning is more likely to come to the attention of medical services. Self-harm through injury is frequently not even known of by the young people's family. Cutting is the most common form of self-injury and analgesics the most common drug used in self-poisoning (Hawton et al, 2002)[clviii].

Eating Disorders become more evident during the mid to late teens with the average age for onset of Anorexia 16-17 and Bulimia 18-19. Evidence suggests a prevalence rate of 8 in 2000 females and 1 in 2000 males of Anorexia Nervosa. The incident rate of Bulimia Nervosa is five-fold that of Anorexia. There are additional eating disorders, which often go undiagnosed, often linked to physical health issues (NICE, 2004)[clix]. Anorexia, although less common than Bulimia, has the highest mortality rate when compared within any other children's mental health disorder. In adolescence few young people seek help for eating disorder independently, which suggests a 'denial' position. It is more usual for parents, GP's or school /college staff to raise concern (Deane, 2009)[clx].

Table 8.8: Predicted prevalence of Mental Disorders in 16-19 year olds in Herefordshire against referrals to CAMHS (2012)

Disorder	Males (2012)		Females (2012)	
	Estimated number	Number referred to CAMHS and % of estimate	Estimated number	Number referred to CAMHS and % of estimate
Any neurotic disorder	370	141 (38%)	780	177 (23%)
Mixed anxiety and depressive	220	-	505	-
Generalised anxiety disorder	70	-	45	-
Depressive episode	40	-	110	-
All phobias	30	-	90	-
Obsessive compulsive disorder	40	-	40	-
Panic Disorder	25	-	25	-

Source: CHIMAT (2014)
NB: numbers do not sum due to some young people presenting with more than one disorder.

CHIMAT has grouped data for 16-19 year olds therefore some of these young people will also feature in the 11-16's section and there is risk of double counting. CHIMAT estimates that 370 males aged 16-19 have a neurotic disorder in Herefordshire. Table 8.8 provides a breakdown for this age group by type of disorder. It shows that females have over double the prevalence to males in this age group with 780 estimated. It appears that males are better identified and referred at this age compared to females (38.1% and 22.7% respectively against CHIMAT estimate data). The gender profile of both estimate and also level of referral is in contrast to the earlier age group.

Overall Herefordshire has seen a 35.5% increase in CAMHS referrals between 2012/13 and 2013/14 amongst the 17-19 age group with both genders showing a significant uplift, males 24.1% increase, females 44.6% increase. GPs were the main referrers and presented a year increase of 48.9%. In regard to team allocation CAMHS saw a 42% increase and Primary Mental Health had a 146% increase (Table 8.9).

Table 8.9: CAMHS referral activity in 17-19yr olds 2012/13 and 2013/14

	2012/13	2013/14	Trend
Total number of referrals	318	431	+35.3%
Female	177	256	+ 24.1%
Male	141 (44%)	175 (41%)	+44.6%
Referral Sources			
Community Paediatrics	2	2	
G.P.s	182	271	Up
Accident & Emergency Department	45	46	
Hospital Paediatrics	6	10	
Social Care	8	7	
LEA Education Service	6	4	
Other Clinical Speciality	8	12	
Other	30	36	Up
Youth Offending Service / Probation	1	2	
Police / Courts	3	3	
Internal Referrals			
CAMHS Learning Disability Team	6	8	
CAMHS Looked After Children Team	11	10	
CAMHS Team	93	125	Up
Crisis Resolution & Home Treatment	78	76	
Eating disorders (adults)	12	18	Up
Early Intervention	15	24	Up
Primary Mental Health Service	46	113	Up
Community Learning Disability Team	8	10	
Recovery Teams	68	76	Up
Other	5	9	

Source: 2gether HNS Foundation Trust (2014)

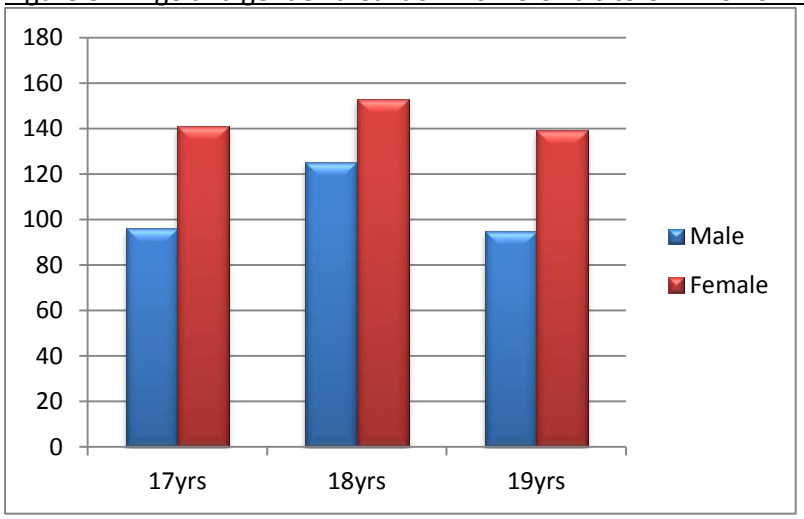
CLD Trust provides some of the care in partnership with CAMHS. In 2012/13, there were 129 17-19 females and males.

Figure 8.10: CLD Trust referral activity in 2012/13-2013/14.

	2012/13	2013/14	Trend
Total number of referrals	129	372	+63%
Female	76	247	+91%
Male	53 (41%)	125(34%)	+23%

In regard to age females featured more highly compared to males at point of referral. Referrals for both genders appear to peak at age 18 (Figure 8.5).

Figure 8.4: Age and gender breakdown of referrals to CAMHS 2012-2014



Source: 2gether NHS Foundation Trust (2014)

Whilst there continues an increase overall (35.5%) females feature more highly than males with a 44.6% increase in referrals between 2012/13 and 2013/14. Yet again identification of mental health presented significantly below CHIMAT estimate for both genders and although CHIMAT indicates that mental health disorder is more prevalent in females in this age group only 22.7% of the estimated number resulted in a referral to CAMHS in 2012/13. In addition to anxiety/depression self-harm is likely to be a major feature and often unidentified/undiagnosed. Self-harm has many pre-features, which could be identified during childhood to prevent onset. Current low female identification in under-13 year olds creates potential missed opportunity to prevent this increased mental health need in older girls.

8.4. Service Model

The tiered model of mental health services is often referred to when examining the arrangement of services to address the needs of children and young people.

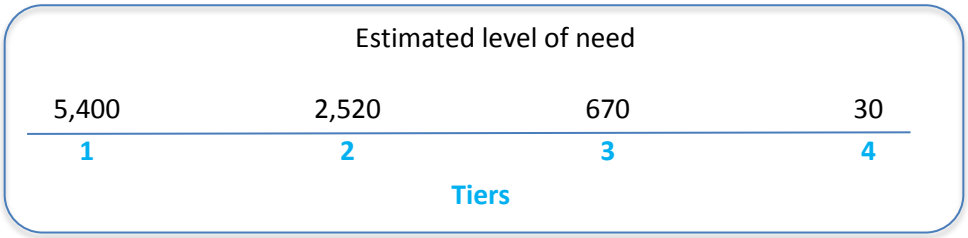
Figure 8.6: The four-tiered CAMHS framework

Tier 1	Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.
Tier 2	Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.
Tier 3	Services usually provided by a multi-disciplinary team of service working in a community mental health clinic, child psychiatry outpatient service of community setting. They offer a specialised service for those with more severe, complex and persistent disorders.
Tier 4	Services for children and young people with the most serious problems. These included day units, highly specialised outpatient teams and inpatient unit, which usually service more than one area.

Source: Department of Health (2008)[clxi].

CHIMAT, using a model developed by Kurtz (1996)[clxii] has estimated rates of need for mental health services by tier. The application of these rates against 2012 mid-year population estimates gives the predicted numbers of children and young people aged 18 years or below who would benefit from mental health intervention, by tier.

Figure 8.7: Estimated need for under 18 Mental Health Services by Tier



Source: CHIMAT/ ONS 2012 mid-year population estimate

As of 2013/14 a total of 119 females and 238 males are on medication prescribed by CAMHS, mainly for ADHD or Neurodevelopmental disorders. Other children/ young people may be receiving pharmacological treatment through their GP so this figure is not necessarily a true reflection of pharmacological use amongst this cohort.

Table 8.11: Number of children/ Young People receiving medication from CAMHs, 2013/14

	0-5	6-10	11-16	>16	Total
Female		16	67	36	119
Male	1	59	152	26	238
Total	1	75	219	62	357

Source: 2gether NHS Foundation Trust

8.5. Care Pathway Findings

8.5.1. All Tiers

Across all age groups there was a lower than expected number of children and young people identified as having a mental health disorder compared to the CHIMAT estimates. There was some evidence of partnership working between CAMHS and CLD Trust, which creates opportunity for more robust stepping up and down the Tiers to be developed however it was limited beyond these two agencies. CAMHS referrals came from a wide range of sources, which suggests good awareness of the service, but not necessarily what it provides. This perspective is strengthened by the fact that CAMHS rejects over 25% of its referrals but could also indicate a lack of capacity and a rising of the threshold bar. It emerges that children and young people are being referred to more than one agency simultaneously suggesting a lack of understanding of pathways and thresholds by referrers seeking support for children and young people or gaps in lower Tier provision. It would have been interesting to explore the rejected referrals to understand their profile better but this was unavailable.

Very few children are able to identify their own mental health needs or to self-refer, and most rely on their needs being identified and met by non-professionals and parents/ carers. Increased capacity to identify children and young people, especially early signs of mental health concerns could prevent severity of illness. Such identification should be a role across practitioners and engage families and communities. In conjunction with such an approach, is the need for identified responses to developmental delay and troubled children. Some of the referrals rejected by CAMHS will be related to the lack of mental health needs presenting by the child. Rather, the need is for support as a result of developmental delay or concerns about the behaviour of the child.

8.5.2. Technology

There is a greater potential for technology to be used more effectively to provide information and retain contact with children, young people and their families. Technology could be used more

effectively to meet the needs of service users in rural areas ad outside of core hours, especially to avoid crisis or deterioration in mental health.

Young people would like to see on-line facilities, including drop in and support, with comfortable environment, welcoming staff. There should be evening services and weekend sessions so that young people at work or training can access, with self-referral so we are able to go to services when we feel we have a need.
Young Person's Group

We don't use social media or even the telephone to provide information and early support. This could reduce higher end crises developing.
Mental Health Practitioner

We need a website containing information on conditions, strategies to try with children with behavioural issues, support groups, social media and links to local services; we need to run evening training sessions for parents.
Mental Health Practitioner

8.5.3. Transitions

Transition is a key factor in this age group, particularly for those young people experiencing longer-term mental disorder, and has received significant attention as an area requiring improvement nationally (DH 2008[clxiii], DH 2012[clxiv]). It is also apparent that CAMHS and Adults Mental health services are different with CAMHS including support for disorders such as ADHD and Autistic Spectrum which is not currently provided within adult services, affecting current transition arrangements. A further cohort of young people either get lost through the transition process or 'drop-out' once transferred to Adult Mental Health Service, as they perceive it as significantly different to their CAMHS experience (JCPMH 2013).

Good mental health services don't just stop when you turn 18
Young Person

Transition between CAMHS and adult mental health is problematic. Often these young people have difficult family relationships and may have no close support available therefore there is an even higher level of need at this difficult time.
Mental Health Practitioner

The Joint Commissioning Panel for Mental Health guidance (2013) stated that there should be:

- Clear processes in place for young people who will require intervention and support in adult life, and the young person should be involved in the decision making. This may take the form of one or more of:
    - A designated stand-alone transition service
    - A designated transitions team within an existing AMHS or CAMHS service.
    - Designated staff trained in working with young people seconded to AMHS teams
- Clear protocols in place for young people transitioning between CAMHS and AMHS. These should:
    - Promote person-centred planning

- Enable continuity of care
- Offer flexibility in decision-making
- Have sufficient detail in the operational procedures to ensure efficacy and consistency.

NICE guidance, both on specific mental health disorders and also transition, incorporates all of the above recommendations and specifically advocates the need for robust positive working relationships particularly between Adult Mental Health Services and CAMHS, bit also wider services if successful transition is to occur.

Transition is a huge issue- many of a young person's issues don't come out until they are 20-21 and by that time there is no-one to support them.
Social Care Practitioner

Transitions are tricky. There needs to be much more fluidity around boundaries. Moving a long term patient when they turn 18 makes no sense, nor does having a 17.75 year old new patient build a relationship, only to move them three months later. Transition should occur at any time even up to 25 for appropriate existing patients and to start with adult teams from 17 for new patients.
Primary Care Practitioner

There was no clear evidence of a robust partnership approach which suggests the relationship between CAMHS and Adult Mental Health Service needs further work to develop care pathways and monitor transition implementation.

8.6. Tier 1: Universal Provision Findings

8.6.1. Prevention

Stakeholders commented on the lack of support available from universal services. This was also reflected in the service mapping. There is a lack of preventative work being undertaken across the county (see chapter 3). A reduction in tier 1 and 2 services and support mean that children and young people are being referred to CAMHs as there are few other providers of support.

CAMHS is free for schools to refer to so schools would rather refer to CAMHS than other services.
Mental Health Practitioner

Local system strategies should examine how low level support and early help for children and young people with emotional well-being needs can be met. Supporting children, young people and their families earlier could avoid a mental health illness from developing or reduce the length of a recovery period. Practitioners questioned whether there was a universal understanding of emotional well-being and mental health.

Health visitors and early years provision could support young children. Within the 5-10 age group, the key areas are bullying / relationships, conduct and ADHD. There is a need to ensure schools are equipped and able to identify and provide appropriate interventions and support to reduce escalation of problems as they, in addition to parents, will be central to these children's daily lives. The use of Personal Social Health Education (PSHE) to equip and support young people's awareness and skills in reducing bullying and other harmful relationships has a strong evidence base, and can support young people with resilience and positive emotional well-being. The role of schools in supporting pupils would require in-reach from other agencies, information and resources being available to schools and training for school-based staff.

Primary Care is often a key provision in responding to the concerns or needs raised by families in relation to their child. However GPs do not receive specific mental health training that could support clinical decision-making in terms of referrals to tier 3 provision. In addition, Primary Care has little available to successfully signpost the child or young person to community sources of support. Referrals to CAMHS or CLD Trust have become the default position. Feedback from GPs showed that families are being asked to see their GP when schools have identified concerns, thereby asking GPs to refer young people for services that schools might be charged for. This can limit the information contained in the referral as schools usually have a much better understanding of the concerns identified.

8.7. Tier 2: Targeted Support Findings

8.7.1. Early Intervention

There is nothing to support children and young people with mild to moderate needs. If these children had had tier one and two support, they wouldn't need acute support.
Paediatric Consultant

There is a gap at the bottom end- there are children with behavioural and Emotional Difficulties where they cannot get CAMHs support-the threshold is set too high to meet the needs
Children's Well-being Practitioner

NICE in its evidence review of mental health and wellbeing of primary aged children identified that brief targeted interventions to reduce anxiety or avert its progression into full blown disorders appear to be successful in groups of children showing the early signs of anxiety disorders. They also highlighted the additional benefit of including parent training alongside group CBT as compounding the positive effect (NICE 2008)[clxv].

Deighton et al (2013)[clxvi], through the completion of a large randomised control trial of targeted mental health provision in UK primary schools found evidence of positive impact presenting that "Targeted Mental Health Service reduced levels of behavioural difficulties in those identified as having borderline-clinical behavioural problems at the outset (p44).

They went on to add that in agreement with Webster-Stratton and Taylor (2001)[clxvii] "These findings provide support for the argument that early mental health intervention is important, particularly for behavioural difficulties, which tend to increase as children move towards adolescence" p.44-45.

In Herefordshire, there is no targeted mental health provision available in schools. Some schools have counsellors available but this is not available at every school.

With CLD Trust only providing Tier 2 provision from the age of 10, there currently exists a gap in service for this age group until Tier 3 threshold is reached. This is in stark contrast to early intervention good practice / policy literature and significantly reduces opportunity to intervene early and reduce impact of mental health to both the child and its family. It also creates risk that services are inappropriately 'holding' a child or young person without the necessary skills/knowledge/ competency to meet their needs.

The number of referrals to The CLD Trusts young people's health contract rose by 63% during the year 2013/2014 with a total of 737 referrals compared to the previous year 2012/13 figure of 451 (this was also an increase on the previous year 11/12). Within these figures there was an increase in the number of referrals to the CLD Trust by 2gether NHS Foundation Trust CAMHS which accounted for 158 (21%) of referrals in 2013/14 compared to 30 (7%) in the previous year. Other observations to note, presenting issues of anxiety and depression rose during 2013/14 to 53% of presentations (389 clients) from 31% (139 clients) in the previous year. Presentations where self-harm was a feature rose to 16%, 117 clients in 2013/14 from 6%, 27 Clients in 2012/13. In terms of outcomes, clients identified an average of 5 impact / improvement statements each following their therapy with CLD Trust.

8.7.2. Parenting Support

Parenting training is available, both dedicated group courses and generic parenting support on a one-to-one basis. There are three types of parenting interventions in operation across the County:

- Triple P positive parenting programme
- The Solihull Approach
- The Incredible Years Webster Stratton

Multi-dimensional treatment foster care is expected to commence in Herefordshire by 2015.

The parenting programmes may be complimentary however greater co-ordination could realise a programme of consistent messages to families as well as good use of staff resources and capacity. There are a number of routes in to accessing parenting programmes however no clarity/assessment on why some go to a Children Centre and some go to CAMHS suggesting a lack of pathway. It would be advantageous to support families to access these rather than travel to CAMHS. This would create capacity in CAMHS to provide clinical support to professionals and if needed provide for families that, upon completion of a parenting programme, require a higher Tier intervention. The numbers of referrals from this age group, into CAMHS, reduced by 15.4% in the last year, which may indicate

that this is naturally happening due to raised awareness of the children centre offer or perhaps due to referrals being rejected - it is not clear.

Parental mental health is discussed in Chapter 9.

8.8. Tier 3: Community CAMHS Findings

The Joint Commissioning Panel for Mental Health has produced guidance for commissioners of child and adolescent Mental Health Services.

There should be an appropriate range of services, including 'sub-specialist' services for children with learning disabilities, acute hospital liaison services for children with serious and chronic physical illness, services for children and young people with ADHD and ASD (which may be provided jointly with community child health/community paediatrics), infant mental health services (which may be provided as part of multi-agency early years provision), eating disorder services, substance misuse services, and community adolescent forensic services (this is not an exhaustive list and there may be additional local needs)

There should be services which are able to offer more intensive interventions than standard care to children and young people who may otherwise require admission to hospital – these include acute crisis care, but could include services for young people requiring more intensive treatment over a longer period of time (e.g. young people who are housebound, young people with severe eating disorders, or young people who repeatedly self-harm).

8.8.1. Conduct Disorders

NICE (2013) also recommends robust collaboration between organisations and services in supporting children and young people with conduct disorder[clxviii]. Pharmacological interventions are not advised for routine management of childhood conduct disorder unless severe ADHD coexists. Risperidone can be used on a short-term basis to manage very aggressive behaviours (NICE 2013).NICE recommends that SDQ is used as an initial assessment and that alternative / coexisting problems be identified such as ADHD, Autistic Spectrum Disorder (ASD) and Learning disability (LD). Following a comprehensive assessment where conduct disorder is diagnosed then parent / carer training should be offered and group social and cognitive problem-solving intervention provided to the child.

NICE guidance (2008)[clxix] on diagnosis and management of ADHD in children and young people indicates the need to provide a comprehensive programme of intervention not only to the child but also the family. This includes assessment of parental mental health, provision of parental education / training, social skills training for the child. Further examination of ADHD is presented in Chapter 10.

8.8.2. Looked after Children

CAMHS received 1027 referrals in 2013/14, of which 62 were for children in care. In the previous year, 61 children and young people were recorded as looked after status.

In December 2013, Herefordshire Clinical Commissioning Group and Herefordshire Council conducted a review into CAMHS provision for looked after children[clxx]. The report made a number of recommendations based on the following findings:

- Poor communication and interagency working between social work teams and CAMHS.
- Low waiting times and good range of interventions available from CAMHS and CLD Trust.
- Long waiting list for The CLD Trust.
- Limited tier 1 and 2 provision
- Evidence that children could be prevented from needing an inpatient admission
- Early indications of CAMHS using an outcomes monitoring framework.
- No shared strategy for mental well-being in the county.

The recommendations were:

1. Develop a programme of improvements to communication and interagency working across Children's Social Care & CAMHS.
2. Develop a health, education and social care integrated care pathway children and young people with mental health needs in Herefordshire
3. Review early help offer in Herefordshire to ensure that sufficient support is available
4. Refresh service specifications for CAMHS based on a care pathway for mental health approach.
5. Produce a strategic plan for the mental health and emotional well-being of children and young people
6. Develop a CAMHS Service improvement plan 2014/15 to include transitions, voice of the child and monitoring of outcomes.

8.8.3. Early Psychosis

NICE (2013)[clxxi] draws attention to the need for swift referral from Primary Care into specialist CAMHS provision or Early Intervention Service for young people who experience early psychosis symptoms for 4 weeks or more. It promotes the need for pharmacological intervention alongside individual CBT and wider family intervention support. Marshall and Rathbones (2011)[clxxii] Cochrane review of early intervention for psychosis identified that many studies are small in size and therefore limited in their ability to provide robust statistical or clinical strength. They concluded that there is some emerging evidence of the benefit of early identification and intervention during 'prodromal' phase as without this there is increased risk of poorer outcomes / recovery.

The Department of Health (2014) Closing the gap: Priorities for essential change in mental health notes that early intervention can make a "massive difference" in addressing mental health problems among young people. The Government's mental health strategy highlights the impressive clinical outcomes achieved by EIP services, and the long term economic savings they offer[clxxiii].

A number of research studies have reported that the longer people go without having treatment, the harder it is to start the process of recovery. Quick and easy access to treatment when a person first becomes unwell have fewer relapses and less likely to be admitted into hospital, and have less severe symptoms.

1. When a young person receives Early Intervention support in the first 14 months of their illness, they are much more likely to make a full long term recovery. [clxxiv]

2. When an individual receives early intervention support within two months, their prospects of recovery are significantly improved, but a delay of longer than six months greatly reduces their chances.[clxxv]

3. When a young person receives Early Intervention support in the first 14 months of their illness, they are much more likely to make a full long term recovery.[clxxvi]

4. Fewer than 30% of people with schizophrenia receive recommended physical health checks [clxxvii]

5. The Schizophrenia Commission in 2012, acknowledged that In the context of health inequalities, the value of the holistic support offered by EIP services [support offered in terms of physical health, talking therapies, and employment support], are generally not available to young people with psychosis anywhere else in the health system. It recommended EIP services as one of the most effective models for supporting people with psychosis, and said that the holistic ethos of EIP services should underpin all mental health services for people affected by psychosis.[clxxviii]

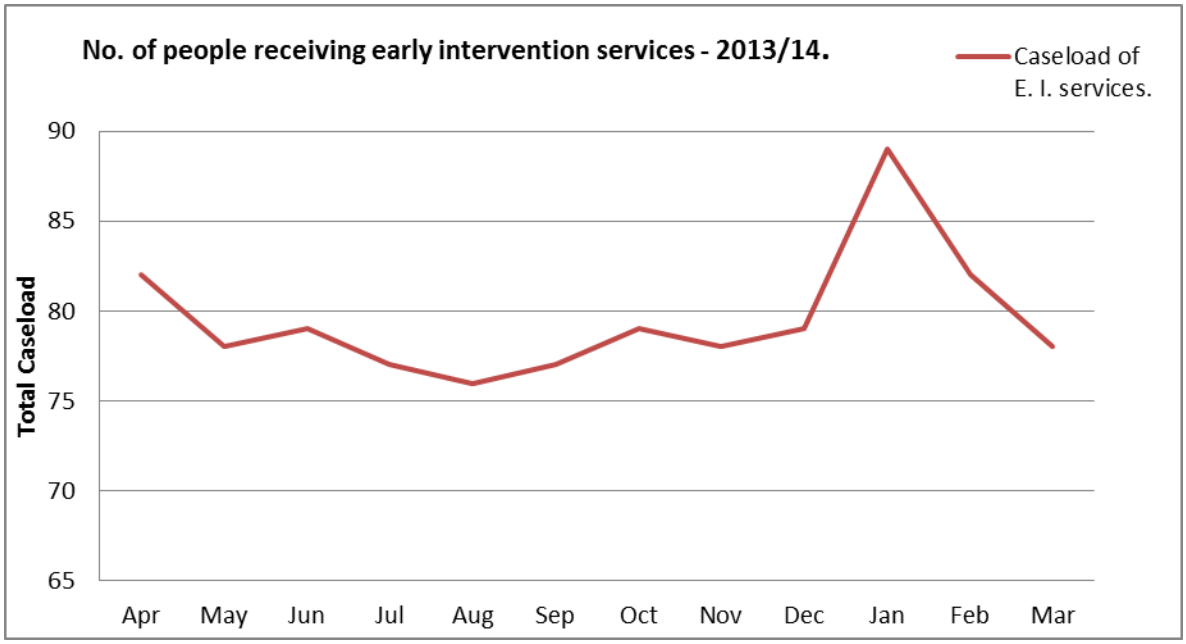
6. The success of early intervention services has led the National Institute for Health and Care Excellence (NICE) to recommend in its 2014 guideline[clxxix] about psychosis and schizophrenia that everyone who is experiencing a first episode of psychosis should be able to access them, regardless of their age.

7. The 2014 NICE guideline about psychosis and schizophrenia says that in some instances, people should be supported by early intervention teams for longer than three years.

8. Less than 50% of people with schizophrenia are offered recommended talking therapies.[clxxx]

The early intervention service saw 26 new cases of psychoses in 2013/14. The total number of people receiving support within 2013/14 was 78. Figure 8.7 shows the caseload by month during 2013/14. There is limited data on the number of people with prodromal symptoms so not able to confirm if the capacity is sufficient.

Figure 8.7: Number of People receiving Early Intervention Services by Month (2013/14)



Source: 2gether NHS Foundation Trust

The NICE guideline also suggests health professionals offer family intervention and cognitive behaviour therapy (CBT) to people who are experiencing psychosis for the first time. These talking therapies should be delivered by people who have had specialist training. Family therapy may sometimes be given with other families, if everyone involved agrees to that happening. NICE guideline stresses that CBT for psychosis and family therapy are proven to be more effective when given with medication. However, if someone wants to try family therapy and CBT without medication, NICE recommends a short trial (up to a month) of talking therapies only. During that time, mental health professionals should monitor their symptoms and when treatment is reviewed, antipsychotics should once again be considered.[clxxxi]

The Chief Medical Officer's report recommends the use of technology – mobile health applications to support early intervention[clxxxii]. With a young generation growing up with social media, use of mobile or digital applications could support recovery. The components are the ability for users to track their symptoms and staff alerted if symptoms suggest deterioration, allowing for preventative action. Medication management, social networking and other functionality can be included. This has the potential to enhance self-management, and improves children and young people's experience of collaborative care.

8.8.4. Self-Harm

Self-harm interventions according to NICE (2004, p29[clxxxiii]) should include:

- Rapid assessment of physical and psychological need (triage)
- Effective engagement of service user (and carers where appropriate)
- Effective measures to minimise pain and discomfort

- Timely initiation of treatment, irrespective of the cause of self-harm
- Harm reduction (from injury and treatment; short-term and longer-term)
- Rapid and supportive psychosocial assessment (including risk assessment and comorbidity)
- Prompt referral for further psychological, social and psychiatric assessment and treatment when necessary
- Prompt and effective psychological and psychiatric treatment when necessary
- An integrated and planned approach to the problems of people who self-harm, involving primary and secondary care, mental and physical healthcare personnel and services, and appropriate voluntary organisations
- Ensuring that the special issues applying to children and young people who have self-harmed are properly addressed, such as child protection issues, confidentiality, consent and competence.

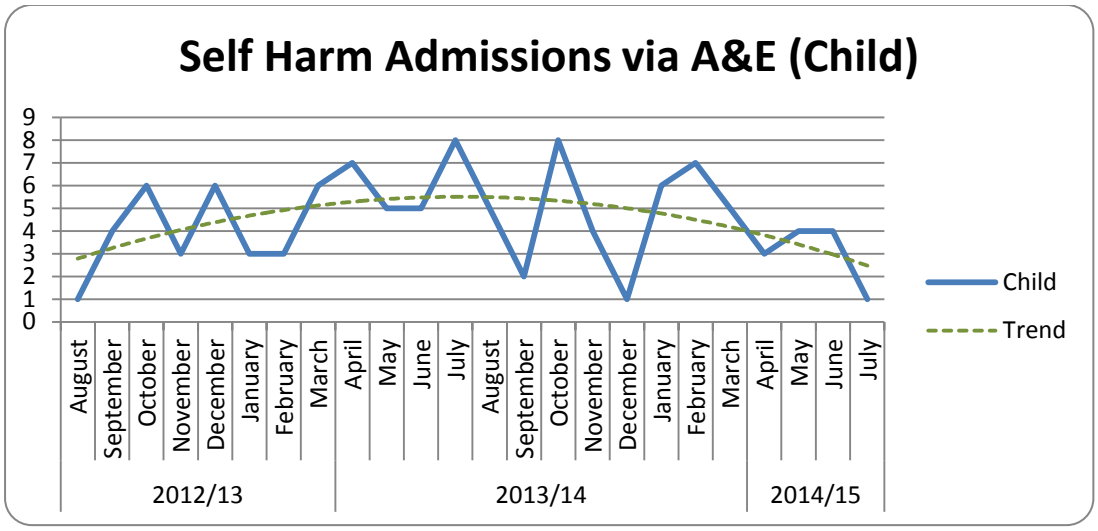
NICE also highlighted the need to ensure training is available for those likely to be in contact with YP who self-harm (wider than clinical 'health' staff) to equip them to support and care. In regard to self-poisoning, paracetamol is the most common. All cases of self-harm in children and young people an overnight admission to a paediatric ward and their mental health assessed by CAMHS prior to discharge should be provided.

Group therapy has been shown to be particularly effective in reducing repeat self-harm amongst teenagers (Wood, 2001[clxxxiv]) and NICE (2004) state group psychotherapy should be for at least 6 weeks and aimed at those that have repeatedly self-harmed.

School are asking young people to see a GP before returning to school. This results in a referral to CLD Trust/ CAMHS.

Activity information shows that hospital admission rates for self-harm have remained broadly similar since 2007. The rate of young people aged 10 to 24 years in 2010/11- 2012/13 period is similar to the England average. Figure 8.8 shows the trends in admission via accident and emergency for self-harm in Herefordshire since 2012.

Figure 8.8: Number of Patients admitted via A&E for Self-harm by month (August 2012 – July 2014)



Source: SUS as of Octover 2014.

The information shows that between August 2012 and July 2014, 35 children aged 10-14; 110 young people aged 15-19.

8.8.5. Eating Disorders

There is currently no eating disorder service commissioned. Hard management decisions need to be made that we don't do things we are not commissioned for.
Mental Health Practitioner

Young people with an eating disorder often go undiagnosed, even though they may have higher than average GP presentations (Ogg et a, 1997)[clxxxv] often with symptoms relating to the eating disorder. They are likely to require long-term support through primary, secondary and possibly tertiary care, and in addition between children and adolescent services and adults. This necessitates robust coordination, care pathways and protocols.

Psychological interventions are well evidenced, particularly CBT (CBT-BN for Bulimia Nervosa), Family Therapy and Systemic Therapy, recognising the age and wider family context of the young person. Information, advice and education on eating disorders should be provided to family members, including siblings, to assist them in their role to support the young person. Pharmacological interventions are not evidence based, unless wider psychological disorders and/or physical co-morbidities exist.

With consideration to whether Herefordshire should have a specialist service for children and adolescents with eating disorders, guidance suggests that[clxxxvi]:

- The service should treat a minimum of 25 new eating disorder referrals per year
- Comprise of a multi-disciplinary team, including medical and non-medical staff
- Requires more than one person with experience of treating eating disorders
- A team with the expertise to deliver recommended treatments (assessment of physical risk and psychological therapies including family therapy) and the resources to offer routine outpatient treatment.
- Rapid response to referrals, usually within 1-2 weeks, maximizing the chance of avoiding inpatient treatment.

8.8.6. Supported Self-Management

Children, young people and their families require tools and resources that facilitate support regardless whether the child is a patient of tier 3 provision. For some children, this might take the form of a person-centred crisis plan or complex care plan; for other children a simple guide to triggers and agreed steps to take would be useful. There was limited evidence of consistent person-centred care plans for all children and young people.

Feedback from young people revealed that open access to follow-up support was important to maintain recovery. This could take the form of online support, telephone follow-up or peer groups.

There should be a NHS direct type number you could call for advice.
Young Person

Young people want more peer to peer advice and to hear from professionals who have been through the process themselves.
Social Care Practitioner

Open access, check-ups during the waiting period, aftercare to prevent relapse.
Young Person

8.8.7. Therapies

A variety of therapeutic skills are needed, including behavioural, cognitive, interpersonal, psychodynamic, pharmacological and systemic approaches – there is a growing evidence-base of interventions that have a positive effect on mental health outcomes for children and young people. The challenge in Herefordshire is the availability of such therapies within the resources available.

There is a huge hole for children with chronic conditions (CFS, Chronic pain, CF, oncology, palliative)
Paediatric Consultant

The gap in availability of therapies also extends to children who have been sexually exploited as no intensive therapy is commissioned.

Herefordshire is participating in the Children and Young People's Improving Access to Psychological Therapies in 2015. CAMHs and CLD Trust are engaging in a programme of staff training and young people's engagement activities in order to deliver effective evidence-based therapies.

8.8.8. Thresholds

There was no mechanism identifying whether children and young people were being provided for at the appropriate Tier for their need and raises the question as to whether services are carrying additional risk burden through 'gatekeeping'. These unknowns substantially undermine commissioning / service planning on what needs to be provided and how much. Commissioning urgently needs to review service specification and monitoring adherence.

We are seeing children and young people at a more severe stage when they reach CAMHS. It's not clear if this is due to earlier referrals being rejected and they have reached crisis, or because other agencies are holding children and young people for longer.
Mental Health Practitioner

With increased demand, thresholds have increased and children and young people are presenting to CAMHS with higher level of need, with children accessing the service only when they have reached crisis. The reduction in support available elsewhere and the requirement to maintain quality services might be a partial explanation for why thresholds appear to have increased.

There is an unwritten pressure that tier three is more valid or justified

Mental Health Practitioner

There is an inequality: Children under 7 see a paediatrician and receive a diagnosis. Children over seven see a CAMHs clinician and get additional support with schooling, support groups etc. Parents have to wait until the child is seven to get the support they need
Mental Health Practitioner

CAMHS received 1027 referrals in 2013/14, of which 99 were through the 'duty' route as new cases. 8 referrals were already open.

Of the total 1027 referrals 296 (28.8%) were declined by CAMHS as not meeting the threshold, leaving a total of 731 referrals, 101 (16%) above the local estimate for tier 3 shown. A total of 1187 children and young people were discharged from CAMHS in 2013/14.

Staff recognised that children and young people in their care had social care needs that were not being met currently due to reduction in social care support.

Often the children and young people we see have massive social care needs. We get the sense that social care are overwhelmed and only pick up those with very severe need.
Mental Health Practitioner

We have a good multidisciplinary team that manages to hold people with risky behaviours (tier 3.5).
Mental Health Practitioner

Referrals that don't hit thresholds should be provided support by the referrer-there is a need for training to ensure this happens.
Mental Health Practitioner

Professionals don't understand CAMHS remit and think that as soon as the young person engages with CAMHS, their problems will be solved. CAMHS is about long term rather than a short fix.
Social Care Practitioner

One of the considerations is that practitioners refer because they cannot support or help the patient. Therefore rejecting referrals is not supportive to the practitioner or the patient. This indicates that the care pathways require further development.

8.8.9. Access to Community CAMHS

From the Joint Commissioning Panel for Mental Health guidance (2013)

- There should be clear care pathways with agreed referral processes and signposting.
- Staff within universal and targeted services should be able to discuss potential referrals, and receive advice and support through supervision/consultation
- There should be close working links between targeted and specialist services (including education and local authority children's services, as well as voluntary sector services) to facilitate easy, smooth transfer between the different service tiers, as well as joint-working
- There should be strategies to reach out to groups historically less likely to access CAMHS which are tailored to the particular needs of local populations

- There should be 24 hr services/on-call provision
- There should be agreement on emergency provision including assessment facilities in Accident and Emergency, place of safety during assessment, and access to emergency inpatient beds.

We were told that our practitioner was going away so we would have to wait 6 weeks before seeing them again. But who do we call if something happens?
Parent

The building is inappropriate and there is a need for a more flexible, 8 until 8 service to minimise disruption to education and parents work.
Mental Health Practitioner

Services are centralised in Hereford, causing issues of access to patients and families living in rural areas. Staff commented that the centralisation of services within Hereford and the social needs of children and their families sometimes impacts on access to services. Facilities were seen as inappropriate.

Young people would like services that are informal, accessible and available in the evenings and weekends.
Young Person

Rurality and poor public transport mean transport and travel is difficult and expensive for families
Mental Health Practitioner

There are no real outreach facilities to meet rural need.
Mental Health Practitioner

Young people in contact with MH and CJS typically have welfare issues and chaotic lifestyles- if they don't show 3 times, they are discharged-which means they don't get a service.
Youth Offending Practitioner

Young people most in need in terms of one of our vulnerable groups are discharged for failing to comply with attendance. The result is that their mental health goes unaddressed. Another gap is intervention and access to support for children with physical long-term conditions or medically unexplained symptoms. There is little information to quantify the scale of need however young people and practitioners have reported this unmet need. It is recommended that children and young people with physical health conditions should have their mental health needs addressed through liaison services.

8.8.10. Multi-Disciplinary Working

Staff reported that CAPA model (Choice and Partnership Approach where choice, care planning and evidence based practice is central) is now fully embedded in the CAMH service and is seen as a valued approach to practice. They report that the model:

- Focuses on engagement, therapeutic alliance, choice, strengths, goals and care planning;
- Improves access by ensuring timely appointments that are fully booked, i.e. no waiting lists;

- Ensures users are seen by a clinician with the right skills;
- Uses Outcome measures; and
- Facilitates commissioning and provision of CAMHS by transparency of capacity and services.

A system of routinely collecting patient outcomes used by clinicians to guide on-going interventions, and used by service managers to improve service provision. The Health of the Nation Outcomes measures will support regular feedback by children and young people. HoNOSCA (Health of the Nation Outcome Scales for Children and Adolescents which is an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning) is used to consider, by comparison of findings, the efficacy and quality of service delivery at transition to partnership, 6 monthly if the case is complex and again routinely at discharge. The outcomes from these reviews are then fed back into service redesign. It is recommended that the CAPA model is continued in Herefordshire.

8.9. Tier 4: Acute Care Findings

8.9.1. Urgent and Crisis Care

The crude rate per 100,000 of the population (0-17 years old) for hospitalisation related to mental health in 2012/13 was 97.2 (35 children and young people). This is not significantly worse than the England average of 87.6 per 100,000. (Source: Hospital Episode Statistics, Health and Social Care Information Centre).

If we admit a paeds overdose on a Friday, they won't get seen until Monday, so there is a gap in service. We wouldn't be able to get a CAMHS psych in the Emergency Department.
Accident & Emergency Department Practitioner

Due to the small numbers of children requiring inpatient support, no under 18s beds are available within county. This results in either inappropriate use of paediatric beds, limiting capacity there, or with a child/ young person being placed out of county. In 2013/14, there was one occasion of a young person placed in an adult ward. Local protocol states that this is the action of last resort or if the young person is 17 years old with a severe mental health condition that would be better placed for clinical care, rather than a children's ward. The absence of under 18 inpatient beds means that young people with higher need are not able to get an appropriate service within county.

There are no children's/ young people's beds in the county, which mean young people end up getting sent outside of the county which is disruptive to the client and means long travel times for staff.
Mental Health Practitioner

There is a shortage of beds. This is particularly the case for patients aged under 18. Patients under 18 are either placed in children's wards (which is not appropriate as there is no provision to detain individuals) or are sent out of county
Police Officer

During 2013/14 1 female and 5 male, aged 16-19 were admitted onto wards within Hereford Hospital, 5 on Mortimer ward and 1 to the enhanced care area. Tier 4 services are regionally commissioned and provided, an arrangement that is seen across England, with a national shortage of beds. 4 young people were provided with tier 4 mental health services out of county in 2013/14 (13% of CHIMAT's 2012 estimate). This was for specialist eating disorder care.

There is no commissioned assertive outreach to prevent children going into a tier 4 provision or supporting rehabilitation in the local area. In 2013, CAMHS had successfully worked with 10 young people (3 are Looked After Children) and avoided 2 readmissions. This outcome is supporting young people to retain their links with their education, community and families/ friends. For the local health and social care economy, this is a saving of approximately £500,000 per annum.

There is another group of young people who are in out of county residential placements due to their sexually harmful behaviour because local placements do not offer management/ treatment/ risk reduction programme to modify their cognitive perception/ distortion and behaviour. This is a gap in provision within the local area. The local CAMHS is not commissioned to offer intensive risk reduction programmes. This is not a traditional area of CAMHS activity; however a local intervention could be made available. This would be regarded as a specialist service and further investigation is required to ascertain whether this is feasible in the local area. The young people would also require a comprehensive team around the child response to support a local placement if such a management programme was available.

Long delays occur when a child is placed outside of the county and there is a need for therapeutic intervention to other CAMHS services from other counties. Herefordshire Clinical Commissioning Group is responsible for the cost of this additional service; however there is limited quality assurance of other CAMHs as they are the responsibility of other commissioners. This is a national issue and should be considered when making external placements to Herefordshire.

If the child becomes fostered or placed out of the county then CAMHS will maintain their treatment plan dependent on the location and duration that the child will be out of county. The expectation of what CAMHS can offer in not in line with the service specification. If the child is placed through an independent fostering agency or placed in a residential setting it is expected that the agency would source any therapeutic intervention needed as agreed in the terms of the contract for that placement.

It is recommended that further work on acute care pathways takes place to ensure safe and effective patient care.

8.10. Voice of the Child

There was evidence of engagement by children and young people in the running of the services. Young people both service users and the wider young people's population have been engaged in a number of ways with The CLD Trust participation staff.

A series of focus groups were conducted during 2014 and a wide range of young people consulted to hear their views about mental health and well-being, identify the things that cause them worry and concern and hear how they would like services to be developed.

Feedback from young people about service design included:

- More choice
- Less prescription in the way they access services
- More information about mental health and wellbeing and how to understand when things start to go wrong
- Venues which are appropriate for them and are non-clinical,
- The ability to self-refer and to be able to access services confidentially without this being disclosed to parents or carers .
- The need to be able to get to know staff before being asked to complete forms and other paperwork.

Young people unanimously agreed that it was important to discuss mental health and to have information. They were clear that anyone delivering training should be knowledgeable but also have the skills to work with young people and enable them to feel comfortable to engage in discussion.

Service users have been involved in evaluating service provision and in identifying the impact that therapy has had on their lives.

Life is good, I've never been so happy. I've gained a few exercises and strategies about the language I use and can also see how some people transfer their feelings onto others. I can now use these techniques to control my anger.

It was brilliant. I felt secure and it was just what I needed. I got to express my feelings and let go of my worries that were bottled up and talking about it.

Being able to talk to someone who always listens has been really good. I'm a lot happier and more confident in myself.

Engagement by children and young people contributes to an outcome of recovery but also assurance that services are responsive to the needs of their patients.

8.11. Conclusion

The provision of treatment for children and young people is not a comprehensive response to understanding and valuing prevention and early intervention. Children, young people and their families; services and the community all play a part. Against a tiered model of mental health, Herefordshire appears to have significant gaps causing children to deteriorate or become seriously ill before eligible to receive assessment and treatment. From this Needs Assessment, the following gaps or issues have been identified:

Tier 1 and 2

- Insufficient early advice, information and support;
- Lack of information on what mental well-being is and signs / symptoms that may present when well-being is not realised;
- Lack of information where children, young people and their families can go for help;
- Lack of information on what help they may be offered; and
- Greater engagement of organisations to identify and support children and young people and their families.

Tier 3

- There is no home treatment service available for children and young people;
- There is no acute hospital liaison services for people with serous and chronic physical illness;
- There is no multi-agency response for young people who self-harm;
- There is no access to a CAMHS assessment seven days a week; and
- Patients regard the clinic location as unsuitable.
- Patients desire online methods of support.

The recommendations for Herefordshire CCG are:

- Strengthen capacity of tier 2, through implementation and monitoring of CYP-IAPT to prevent escalation of issues to tier 3 need and introduction of using digital resources.
- Reconsider model of tier 3 support
- Improve prevention of tier 4 inpatient care and enhance provision of rehabilitation
- Provide education for GPs and primary care staff
- Improve CAMHS data recording of mental health diagnosis / working diagnosis to improve prevalence understanding and service planning.
- Explore and develop a robust transition process between CAMHS and AMHS that begins early, maintains the young person as central within the planning through effective communication, assessment of individual need, involves wider professionals to provide appropriate services.

- Develop an all-age mental health strategy with contributions from organisations across our economy to co-ordinate mental illness prevention and mental health promotion; including
    - Enhancement of tier 1 and 2 support
    - Information for young people and parents and carers
    - Education and awareness for professionals on what mental health is and signs / symptoms that may present; what tiers and thresholds are, what they mean in practice and referral routes; where to access professional support to enable them to better meet the needs of the CYP within their own service.

- Development of comprehensive referral care pathway using a tiered 'stepped' model rather than all referrals being directed to tier 3 CAMHS without consideration for appropriateness of tier 1 and 2.
- Improve cohesion / collaboration between CAMHS, Children Centres and Health Visiting so that families with children under 5 that need parenting programmes receive it via a children centre rather than a direct referral to CAMHS (in line with Healthy Child framework) CAMHS to provide clinical support to the early years workforce.

Chapter 9 Vulnerable People

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Contents

Chapter 9: Vulnerable Groups

9.1. Introduction

Commissioners have a legal duty – under public sector equality duties – to consider the mental health needs and care of ALL people, including those with a protected characteristic[clxxxvii].

Stakeholders within this needs assessment identified that some groups were either at more risk of mental illness, at more risk of exclusion from mental health services, or both.

A focus on "personal responsibility" will impact on vulnerable groups. Increased sanctions will impact on the access of patients with chaotic lifestyles
Benefits Officer

When money is short, sometimes the least vocal groups can lose out to the worried articulate people. There is an issue around advocacy.
Mental Health Practitioner

Victims of sexual abuse get a poor service and workers are unwilling to work with sexual abuse victims willingness to work with issue of SA due to the time limit. They address what they can but don't want to "open a can of worms". Not clear if that's a time issue or a training. There is very much a feeling that clients get 8 sessions and so people are being "closed down"
Voluntary Sector Practitioner

Unless criteria are met, there is nothing for certain groups (Adult ADHD, personality disorders, autistic spectrum, low level learning difficulties)
Mental Health Practitioner

This chapter will cover some of those groups for whom particular concern has been raised. Such groupings are internally heterogeneous- there is no suggestion that all service personnel will have similar needs, however, their explicit inclusion reflects a need for their needs to be reflected in the planning of mental health services. Consideration of children with increased vulnerability are described in Chapter 8. An in-depth examination of people with ADHD and people experiencing homelessness with dual-diagnosis is outlined.

9.2. People with Increased Vulnerability for Mental Health Conditions

9.2.1 Black and Minority Ethnic Communities

The 2011 census indicates that 6.3% (11600) of Herefordshire residents were not "white British". The Overwhelming majority of these individuals are from Eastern Europe. Of the 12,250 residents who were born outside the UK, 53 per cent have arrived since 2004, following expansion of EU membership. Over 5,000 residents were born in the new member states (Estonia, Czech Republic, Hungary, Lithuania, Latvia, Poland, Slovakia and Slovenia joined in 2004; Romania and Bulgaria in 2007).

Herefordshire also hosts many thousands of eastern European migrant agricultural workers each year, although it is not clear how many of these choose to settle.

The 2011 Census was also the first to include a Gypsy and Irish Traveller ethnic group category, and 360 Herefordshire identified with this category – this is just 0.2 per cent of the population, but just outside the highest ten per cent of authorities in England and Wales. It is estimated that the actual population is nearer to double this (between 550 and 800).

Important differences in health exist across ethnic groups, both in morbidity and mortality, have been repeatedly documented in the UK[clxxxviii], with significant differences in mental health and wellbeing existing between the majority white group and minority ethnic communities. Disadvantage and discrimination have an adverse impact on the mental wellbeing and mental health in all BME communities[clxxxix]

There is a need to ensure that mental health services and the wider system support BME communities[cxc].

The Joint Commissioning Panel on Mental Health[cxci] identifies significant and persistent ethnic inequalities in service experience and outcomes within mental health services with BME communities reporting higher levels of dissatisfaction with mental health service experience (compared to the white majority group).

Further, whilst some BME groups are overrepresented and others under-represented (in terms of their numbers in the general population, and in comparison to national average) within mental health services activity, these differences cannot be explained simply in terms of variation in clinical need or variable access to services – instead many mental health services and care pathways may be inappropriate for diverse communities.

The JCPMH does not believe that there should be specialist services for particular ethnic groups, because specialist expertise and skills should exist within all services. However, where the level of need, risk, or exclusion of generic services raises serious concerns about equity and equality, it is appropriate to provide specialist short-term or alternative care for particular marginalised groups.

9.2.2. Lesbian Gay Bisexual Trans Communities

Approximately 1.5% of adults in the United Kingdom identified themselves as Gay/Lesbian or Bisexual within the 2011 Integrated Household Survey[cxcii]. Figures for Herefordshire are not available as no census has ever been undertaken. However, were national rates to be applied, it would suggest that there are approximately 2775 gay, lesbian or bisexual people within the county.

The National Institute for Mental Health in England (NIMHE) carried out a review that showed that LGB people are at greater risk of suicidal behaviour and self-harm. The risk of suicide is four times more likely in gay and bisexual men, whilst the risk of depression and anxiety were one and half times higher in LGB people[cxciii]. Stonewall's "Prescription for Change" report found higher rates of suicidal thoughts and self-harm in lesbian and bisexual women compared to women in general[cxciv]. In addition, LGB people can face discrimination and poor experiences of care which can also impact on mental health.

Studies suggest that LGB people have higher rates of alcohol and/or drug abuse[cxcv] and eating disorder[cxcvi]. Gay and bisexual men are five and a half times more likely to have deliberately self-harmed, with lesbian and bisexual women twice as likely to self-harm as the general population.

9.2.3. Carers and Mental Health

A carer is someone who, unpaid, provides help and support to a relative, friend or neighbour who could not manage without that help due to frailty, long-term illness, disability or addiction. It is expected that the number of carers in Britain will increase by between 5 and 9 million over the next 30 years. In Herefordshire, it is estimated that there are currently 38,000 carers in the County[cxcvii].

Overall, there are 1.5 million people in the UK caring for a relative or friend with mental health problem[cxcviii]. There are also over 50,000 children and young people looking after someone with a mental health problem in the UK.

This means that:

- 1 in 4 carers are mental health carers; and
- 1 in every 40 people is a mental health carer.

Caring can also take its toll on carers. Half of the respondents to the 2011 Herefordshire Adult Carer Survey reported their health is fair or poor and 71 percent felt they had inadequate social contact. In a national survey conducted for Carers' Week in 2012[cxcix], more that 87 percent of carers reported caring had a negative impact on their mental health. 57 percent of carers reported having a mental health condition such as anxiety or depression; 39 percent had delayed their own necessary treatment due to caring responsibilities and 37 percent had needed to cease working to care.

Young carers are particularly at risk of poor health and development as a result of their caring. Young carers often assume practical and emotional responsibilities that would be demanding even of adults. Young carers therefore need specific support to engage with education, work and social development - to simply be young people.

Herefordshire Carers Support reported that from their work with carers, 921 people have told them that they are caring for a person with a mental health problem (which is approximately 25% of all registered carers with Herefordshire Carers Support). This is likely to be an under-reported. For example, not including people with another predominant condition and a mental health problem.

320 carers told Herefordshire Carers Support that they have a health issue and of those 55 said that they have a mental health problem, most commonly depression/anxiety. This is likely to be underreported too.

Herefordshire Council's People's Services have produced a Carer's strategy, providing a vision that:

"Carers will be recognised, valued and respected as Key Care Partners within Herefordshire and all agencies will work in partnership with Carers to provide reliable, flexible and appropriate provisions of care, support and guidance. Carers in Herefordshire will have access to flexible and innovative support services to meet their needs and have timely assessments to ensure support is provided at the appropriate point."

Recognising carers as part of the support available to the person with mental health condition is important. As equally critical is recognising the impact of caring on the carer's mental health.

9.2.4. Gypsy Travellers

Herefordshire Gypsy Travellers have been resident in the county for 500 years. Historically the nomadic backbone of the agricultural workforce, the majority of Herefordshire Gypsies and Travellers now live in conventional housing. Herefordshire's Gypsy population retains a distinct ethnic and cultural identity regardless of accommodation status (housed, sited, mobile).

The 2011 Census was the first to include Gypsy and Irish Traveller ethnic groups. 360 Herefordshire residents ticked this box –0.2 per cent of the population (ONS, 2013). However Herefordshire Council's Gypsy Traveller service estimates that the actual population is nearer to double this (between 550 and 800). This would include Showmen and New Travellers.

National data are not collected about the needs of Gypsies and Travellers, or the services they receive. As a result, evidence of the health of Gypsies and Travellers is relatively weak. Parry et al, (2004) in their review of the health needs of gypsies and travellers found a range of health inequalities compared to non-gypsy traveller communities, including high infant mortality rates, high maternal mortality rates, low child immunisation levels, substance misuse issues and high rates of diabetes[cc].

The same study found increased rates of mental ill health, with Gypsies and Travellers found to be nearly three times more likely to be anxious than others, and just over twice as likely to be depressed, with women twice as likely as men to experience mental health problems (ibid). A small scale study in Bristol found that specific cultural issues and stigma around mental health may prevent help seeking behaviour. Words such as 'nerves' were frequently used, whilst "mental" was avoided due to negative connotations (Bristol MIND, 2008)[cci]. Treise and Sheppard (2006)[ccii] identified that mental health issues were frequently "kept in the family" further limiting access to mental health services. Goward et al (2006)[cciii] identified the need for increased education, information and training on mental health needs for both health staff and community members, to reduce discrimination and increase support.

9.2.5. Service Personnel

In 2011, the MOD published the tri-Service Armed Forces Covenant (MOD 2011[cciv]). The principles underpinning this Covenant are that members of the Armed Forces Community should not be disadvantaged by their service and be provided special treatment where appropriate and based on clinical need.

Herefordshire has a long military history. The total strength of the UK Armed Forces in October 2012 was 180,000 people[ccv]. The ex-Service population has been estimated to be around 3.8 million[ccvi]and will grow over the next two years as a result of The Strategic Defence and Security Review (2010), which recommended a reduction in the size of the UK armed forces. Between 2011–2012, 21,370 military personnel left the Armed Forces; 3720 of whom were untrained in other occupations (DASA 2013).

It should be noted that "current and ex-service personnel" are a highly varied and heterogeneous population, with differing exposures to risk in terms of support, experience, training and background.

Serving personnel have medical care provided HM armed forces. The vast majority of current service men and women do not have mental health issues. However a study[ccvii] of 10,000 serving personnel (83% regulars; 27% reservists) found:

- 4% reported probable post-traumatic stress disorder
- 19.7% reported other common mental disorders
- 13% reported alcohol misuse
- Regulars deployed to Iraq or Afghanistan were significantly more likely to report alcohol misuse than those not deployed
- Reservists were more likely to report probable post-traumatic stress disorder than those not deployed
- Regular personnel in combat roles were more likely than were those in support roles to report probable post-traumatic stress disorder
- Experience of mental health problems was not linked with number of deployments.

The high rate of alcohol use in this study has been reflected elsewhere particularly in those deployed personnel having a combat role with a subset found to have psychiatric comorbidity[ccviii].

Whilst rates of suicide amongst serving personnel are lower than that for the general population, there is a notable anomaly amongst army males (serving between 1984 and 2007) under the age of 20 years[ccix].

Rates of help seeking amongst service personnel were found to be comparable to the general population. Reasons for not seeking help may be attributable to 'internal stigma'[ccx]not knowing where to go, or concern about being blamed for their problems by their employer[ccxi]. Current service personnel are half as likely to access treatment as the general population (13% compared to 26%)

Ex Service Personnel/ Veterans

When staff leave HM Forces, their healthcare transfers from the military to the NHS. Personell who leave the armed forces before the end of their contract ("Early Leavers") show high rates of heavy drinking, report suicidal thoughts or have self-harmed in the past compared to longer serving ex-Service personnel[ccxii], although self-harm is based on extremely small numbers. Emerging evidence confirms the existence of delayed-onset PTSD, with a prevalence of 3.5%[ccxiii].

There is emerging evidence for an increase in violent behaviour amongst those deployed in a combat role in Iraq in addition to self-reported aggressive behaviours, increased exposure to traumatic events, post-deployment alcohol misuse and symptoms of post-traumatic stress disorder (particularly hyper-arousal symptoms)[ccxiv].

Evaluation of specific services for ex-service personnel found a lack of robust evidence of effectiveness. Some evidence suggests Reservists experience difficulties with transition, finding it harder to resume social activities. Many of these experiences were associated with a common mental health problem, although some of the psychological and social consequences of deployment in Reservists appear transient[ccxv].

Service Families

There is very little UK evidence examining the impact of deployment on families. There is a body of evidence developed from the United States and Australia of adverse impacts on children's mental health as a result of parental deployment [ccxvi];[ccxvii].

9.2.6. Dual Diagnosis

The Department of Health (2011) strategy 'No Health without mental health' recognised dual diagnosis as an issue that needed integrated and flexible local responses.

'Dual diagnosis (co-existing mental health and drug and alcohol problems) covers a wide range of problems. It is important that the appropriate services are available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet the breadth of need'

Public Health England has reinforced the need for commissioners to develop effective services for dual diagnosis and that those services are central to the achievement of key policy objectives, including drug recovery[ccxviii].

The 2002 Co-Morbidity of Substance Misuse and Mental Illness Collaborative study (COSMIC) concluded that:

- 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems;
- 30% of the drug treatment population and over 50% of those in treatment for alcohol problems had 'multiple morbidity';
- 38% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem; and
- 44% of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year.

The term 'co-morbidity' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:

- A primary psychiatric illness precipitating or leading to substance misuse
- Substance misuse precipitating, worsening or altering the course of a psychiatric illness
- Intoxication and/or substance dependence leading to psychological symptoms
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.

The complexity of issues can make diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, readmission to hospital and suicide[ccxix]. Section 9.3. presents a local audit into people with dual needs, either substance misuse and / or mental health as well as experiencing homelessness.

9.3. Homeless People with Dual-Needs

[I] want to get better and get rid of methadone script but cannot do that whilst on street. Accommodation would make everything better.
Service-user

9.3.1. Introduction and Definitions

The term homelessness spans a continuum of housing needs, from insecurely housed to literally roof-less (so called "rough sleepers"). Many homeless people have co-existing mental health and substance misuse needs (drug or alcohol), with or without a formal diagnosis. Needs can often go unrecognised because people do not seek help; their mental health needs are masked by their substance misuse; or services are inaccessible and difficult to navigate for homeless people. The definitions used are:

- Dual needs: Any individual who has identified themselves as having both mental health and substance use needs (drug or alcohol) regardless of diagnosis.
- Homeless: rough sleepers, single homeless people in supported accommodation or rehabilitation; and those at imminent risk of homelessness.

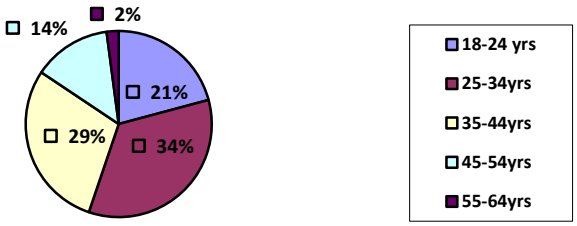
9.3.2. Prevalence

[There are] poor attitudes towards very vulnerable clients due to lack of understanding of dual diagnosis
Mental Health Practitioner

The Herefordshire audit in 2012 identified 96 individuals.

One in five of the people were under 25. This age profile is similar for homeless people with dual needs across England. The most common age was between 25 and 34, closely followed by 35-44. The downward trend beginning at the 25-34 age group is noteworthy, and could suggest that as people get older they either move into accommodation, continue treatment with other agencies who have not supplied information to us, or are no longer receiving treatment or support (this could include moving out of the area, death or disengaging).

Figure 9.1. Age Profile of People with dual-needs (Homeless and Mental Health / substance misuse)



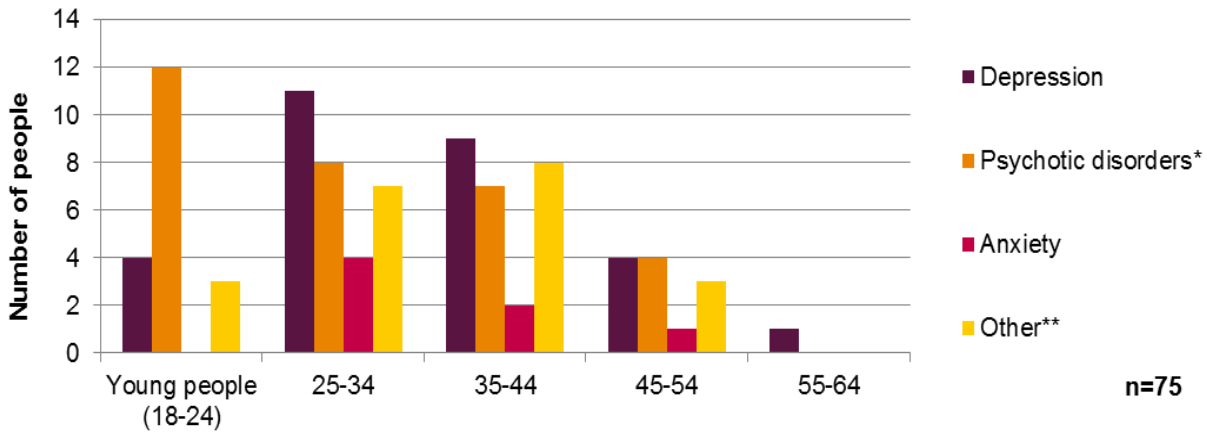
Most of these are male, across a range of ages with the common being between 25 and 34. Young people's presenting needs are significantly different to other age groups, with a higher prominence of psychotic disorders and wider range of drug use. Depression, opiates and alcohol use is more consistent among other age groups. There are significantly higher rates of anxiety, sleeping problems, and self-harm among this group of people compared to the general public.

9.3.3. Mental Health Needs

From Crisis team I have asked for help when suicidal or out of control but told there's nothing they can do. I used to receive support from mental health team but was discharged before I felt ready.
Patient / Service-user

From the audit, the most common mental health need of people that were homeless was depression, with 39% of agencies and 50% of people interviewed reporting this. Psychosis was 23% and schizophrenia 17%. The figure below illustrates the mental health diagnosis reported in the Audit by age.

Figure 9.2: Self-Reported Mental Health Condition by Age



The prevalence of mental health issues varied between age groups with notable observations:

• Psychotic disorders are much more prominent in young people than other ages (63% of young people compared to around 30% for others). Further work is necessary to understand why this level does not continue in to older age groups.

• Depression is underrepresented in young people, but stands out as the major issue in other age groups, evenly observed at around 45% within these groups.

• The incidence of other conditions remains similar proportionately across the remaining age groups.

In addition to diagnoses, the audit asked people about common mental health problems they experienced. These figures (table 9.1) paint a clear picture of anxiety, low mood, difficulty sleeping, paranoia and memory problems being very prevalent amongst this population.

Table 9.1: Self reported well being

	How often issue is experienced			
	Very often	Sometimes	Rarely	Never
Often feel stressed or anxious **(n=16)**	81%	19%	0%	0%
Low mood **(n=14)**	71%	29%	0%	0%
Difficulty sleeping **(n=16)**	63%	13%	13%	13%
Suicidal thoughts **(n=15)**	7%	20%	27%	47%
Self-harm **(n=15)**	7%	20%	13%	60%
Hear voices **(n=13)**	15%	23%	0%	62%
Memory problems **(n=15)**	40%	40%	7%	13%
Feel paranoid **(n=14)**	50%	21%	0%	29%

Results from the Audit give a picture in relation to mental health conditions (table 9.2).

Table 9.2: Mental Health Issues in Herefordshire Homeless and dual need population

Issue	General population[ccxx]	Homeless people[ccxxi]	Herefordshire homeless with dual needs*
Percentage of people who experience **depression**	10%	37% mild; 17% severe (49% with either severity).	39%-50%
Percentage of people who experience **anxiety**	General anxiety at 4.7%	41% reported 'often anxious'	9%-81%
Percentage **personality disorder**	4.4%(5.4 per cent for men and 3.4 for women) Estimates vary 3-13%	Not available	1%-13%
Percentage people with **schizophrenia**	0.2%	4%	17%-19%
Percentage people who **self harm**	4% (400 in 100,000) UK rate, 2002	14%	7% very often 20% sometimes
Percentage people who experience **sleep problems**	29%	50%	63% very often 13% sometimes

*Please note that this is a subset of all homeless people and therefore is not directly comparable. However it does give an indication of levels of need among this group. Percentages are expressed as ranges to show agency and client data sources.

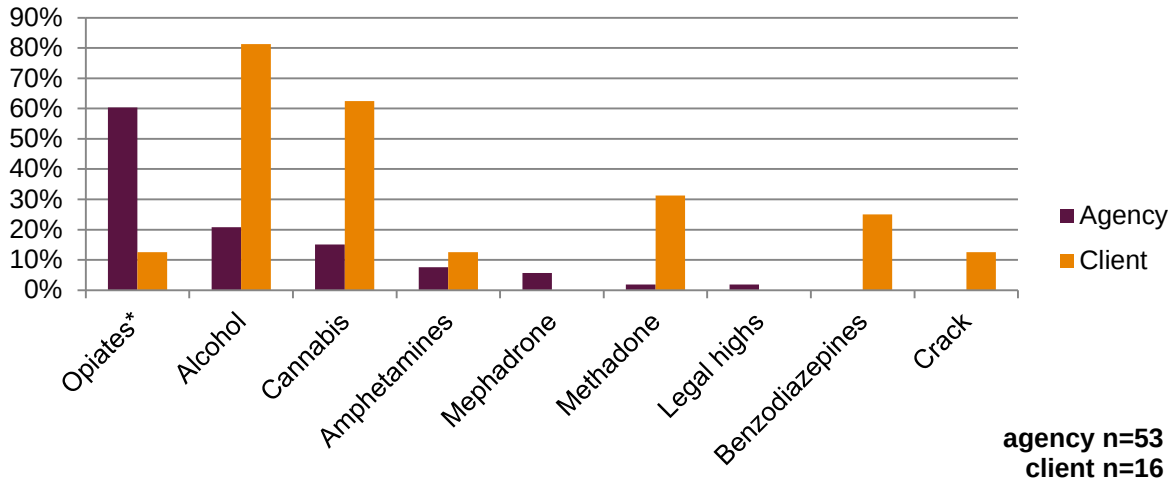
9.3.4. Substance Use Needs

[my situation is] doing the opposite of helping, I have to drink to get going and drink to keep warm.

Service-user

The Audit showed a high use of opiates (62%) followed by alcohol (21%) and cannabis (15%). People in the audit reported far higher rates of alcohol and cannabis use, as well as methadone and benzodiazepines. However, only five clients viewed their alcohol use as problematic and seven their drug use.

Figure 9.3: Self-reported Substance Use



Six people considered themselves to have had needs relating to drugs for more than 12 months. Of these, four smoke cannabis 'very often' or 'sometimes', two use crack 'sometimes', two use benzodiazepines 'very often' and one 'sometimes' and there were individual instances of people using all of the other drugs listed apart from 'cocaine' and 'legal highs'.

Table 9.3 Self-reported frequency of drug use

	How often drug is used			
	Very often	Sometimes	Rarely	Never
Cannabis **(n=15)**	33%	20%	13%	33%
Crack **(n=11)**	0%	18%	0%	82%
Cocaine **(n=9)**	0%	0%	0%	100%
Amphetamines **(n=9)**	0%	0%	22%	78%
Benzodiazepines **(n=11)**	27%	9%	0%	64%
Prescription drugs **(n=12)**	58%	0%	0%	42%
Heroin **(n=10)**	20%	0%	0%	80%
Methadone **(n=10)**	50%	0%	0%	50%
Legal highs **(n=10)**	0%	0%	0%	100%
Other **(n=7)**	0%	0%	14%	86%

The results from the audit can be summarised and compared against the national picture for substance misuse.

Table 9.4: Comparison of Drug use in settled, homeless and dual need populations

Issue	General population[ccxxii]	Homeless people[ccxxiii]	Herefordshire homeless with dual needs*
Percentage adults who are **drug users**	8.9 one or more illicit drug in last year (16-59 year olds) (2011/12)	Not available	87%-88%
Percentage adults who use **cannabis**	6.9%	29%	15%-63%
Percentage adults who use **crack/cocaine**	2.2%	13%	0%-18%
Percentage adults who use **amphetamines**	0.8%	5%	8%-22%
Percentage adults who use **heroin**	0.1%	13%	19%-20%
Percentage adults who use **methadone**	0.2	13%	2%-50%
Percentage of people who **drink more than 4 days each week**	20% (in last week)	20% (in typical week)	36% (in typical week)
People who **drink 2-3 times per week**	24%	16%	14%
People who **drink 2-4 times a month**	31%	19%	7%
People who drink **monthly or less**	13%	21%	36%
People who **never drink**	13%	23%	7%

9.3.5 National Evidence

There is a limited understanding of the problems faced by homeless people with dual diagnosis

Practitioner

DH (2011)[ccxxiv] recognised dual diagnosis as an issue which needed integrated and flexible local responses. 'Dual diagnosis (co-existing mental health and drug and alcohol problems) covers a wide range of problems. It is important that the appropriate services are available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet this breadth of need.' (2011).

The Housing Development Worker within the mental health services was seen as a vital expert in homelessness and housing issues for mental health teams, and this position was also identified as the only one with expertise or a particular specialism in working with people with dual needs. Throughout the research, it came across strongly that this worker is hugely important in linking services together and ensuring individuals receive appropriate services to meet their needs. This kind of role should be viewed as good practice and considered by other areas looking at this issue.

9.3.6. Service Provision

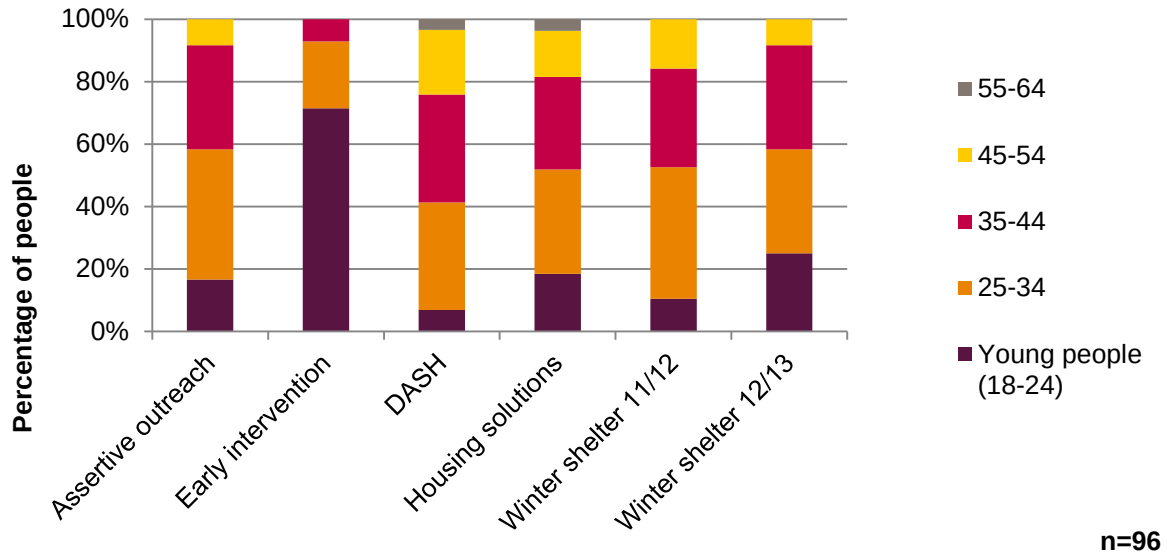
Service users (particularly those with a dual diagnosis) are often stigmatised and marginalised

Practitioner

The Audit showed that people had multiple needs, however only 17 of the 96 individuals were working with more than one agency. GPs were the most common route to seek help for mental health and substance misuse. Use of emergency services among this group was high, with people saying that they had used urgent care services within the last six months:

- 60% of people had used A&E, three of these over 5 times
- 40% of people had been admitted to hospital overnight, three of these over 5 times
- 57% of people had used an ambulance, three of these over 5 times.

Figure 9.4: Service Use by age band



The early Intervention Team worked with a higher proportion (and higher number of young people) than any other service.

Use of GP Services

Some GPs see that I've tried to kill myself twice and then don't want to deal with me regarding sleeping meds although I suffer with insomnia
Service-user

GP too rushed doesn't really work doesn't listen well to complex problems.
Service-user

Of clients who gave us this information, ten of 11 were registered with a GP. No-one was registered with a specialist GP for homeless people. Notably, nine clients reported that they receive support around mental health and substance use from their GP (or have done in the last six months). This is the most common source of support. GPs were also mentioned as key in referring people to other services, especially on to DASH.

Use of Hospital Services

I was previously receiving help from CMHT but all of a sudden stopped with no real explanation or follow up.
Service-user

Clients indicated the following use of hospital services over the last six months:

- 60% of clients had used A&E, three of these over five times
- 40% of clients had been admitted to hospital overnight, three of these over five times
- 57% of clients had used an ambulance, three of these over five times

There was a general underlying impression that the drugs and alcohol service (DASH) is catering well for the people in the audit (this may be due to the selection of people we spoke to) but that many feel their mental health needs are not being addressed. This is demonstrated in the numbers shown of the services people are accessing (only three have seen a Community Mental Health Team in the past six months but all have mental health problems).

9.3.7. Stakeholder Views

1 to 1 support motivates me and I like the person centred approach.
Service-user

People felt their mental health needs were not being addressed and accessing appropriate housing and mental health services was extremely difficult, especially in rural areas.

Table 9.5 shows whether people agreed or disagreed according to their experience of services. Largely, people agreed with a range of positive statements.

Table 9.5: Service User Views of services

Statement	Agree	Neither agree nor disagree	Disagree
It is easy to know where to go to access services or get support	67%	13%	20%
I feel staff respond well to my individual needs	80%	20%	0%
I feel staff treat me with respect	87%	13%	0%
I have the right information to make choices and decisions about the treatment/support I'm receiving	62%	31%	8%
The health services I use are comfortable and welcoming places to use	64%	21%	14%
I feel staff understand my current situation	75%	17%	8%
Overall, the services I am receiving are helping me to manage my mental health and substance misuse needs better	42%	33%	25%

Lots of people in waiting room, not very easy to talk.
Service-user

64% people agreed with the statement that 'the health services I use are comfortable and welcoming places to use'. A particular issue identified was crowdedness in the waiting room. This can be difficult for people with mental health problems and may correlate with the high incidence of paranoia.

9.3.8. Gaps and Issues

Care Pathways

Issues for agencies and clients in identifying exactly what the provision is locally and where.
Practitioner

One in five people did not believe it was easy to know where to go for support, with staff noting a lack of clarity around referral pathways and eligibility for different services. Accessing services is difficult. Staff raised a lack of clarity around referral pathways as a particular problem with integrating treatment and support for those who need multiple services. This includes knowing what services are out there and how to access them.

These include the length of time it takes, and referral processes and pathways not being clear or accessible for homeless people with multiple and complex needs, who require more flexible approaches to engaging with specialist services.

Inability to get direct access to mental health services without going through GP.
Patient / Service user

Fast track into mental health hostel would be useful.
Patient / Service user

Staff reported a number of services that they were unable to access at all for those who needed them. The most common were specialist services for people with either substance or mental health needs, with detox, IAPT services and residential rehab reported most commonly.

Housing Needs

Not enough housing and what is advertised is increasing hard to get with things such as age restriction applied and benefit entitlements imposed.
Practitioner

They are regularly banned from applying for social housing if their substance misuse leads to a criminal record or there have been ASB issues.
Practitioner

The most commonly identified of these was a shortage of accommodation, both general needs but also appropriate supported accommodation including for women, those with multiple needs, and those considered to be high risk. Several people also noted that there was nowhere within Herefordshire for people who were homeless to access basic services such as showers.

Information Sharing

DASH can be unwilling to share information regarding clients event though clients consent to this happening, there have been instances of information being withheld or not disclosed.
Mental Health Practitioner

There was an opportunity for DASH to be better involved with the winter shelter. However there was an impasse over what information could and couldn't be shared.
Voluntary Sector Practitioner

The lack of information exchange with drug services is affecting collaboratively working.

Staff Behaviour and Knowledge

Workers need to be able to work with people who are maintaining good mental health and not just use the services as crisis intervention that means all the good work previously done is destroyed because unsupported people have relapsed.
Practitioner

Workers lack knowledge to manage clients with severe and enduring mental health needs and substance misuse.
Practitioner

A significant issue highlighted throughout the audit was a lack of understanding of the needs of this client group and how to work with them.

9.3.9. Recommendations

There were several ideas for ways to improve this:

- A means of more easily coordinating support of clients between agencies. Suggestions were around case conferences and multi-agency actions plans for those with multiple needs, including representatives from mental health, on an ongoing basis.
- Using the existing dual diagnosis protocol.
- Having named people trained as champions or experts to build and maintain a level of understanding and expertise around working with this client group across services.
- Developing a hub style provision from which different agencies could offer services, to ensure an easy access point to multiple services. This could include the provision of basic facilities such as showers in order to engage people who are sleeping rough.
- A directory of services available including criteria for accessing these and the process, as well as training on different services.

The recommendations are:

a. A strategic system-wide approach to be taken to develop a dual diagnosis protocol.
b. Local champions to be identified within key services to build knowledge and skills around working with this client group. They should receive appropriate training and support.

c. A directory of services to be developed clarifying what is available and routes to accessing these.
d. An information sharing protocol to be agreed that all services can sign up and adhere to.
e. Given the shortage of specialist provision, explore accommodation options so that those who are homeless with dual needs can access existing supported accommodation while those with lower support needs can access other more appropriate housing options.
f. Ensure there is a means to identify and respond early to those with dual needs who are at risk of becoming homeless to avoid escalation of needs.

9.4. People with ADHD

9.4.1 Definition

ADHD is a heterogeneous behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. While these symptoms tend to cluster together, some people are predominantly hyperactive and impulsive, while others are principally inattentive. Symptoms of ADHD can overlap with symptoms of other related disorders. Common coexisting conditions in adults include personality disorders, bipolar disorder, obsessive–compulsive disorder and substance misuse.

There is evidence that ADHD symptoms can persist into adulthood and cause impairment, but there are no clear conclusions about the level of ADHD symptoms in adults that should be considered as grounds for intervention, or whether symptoms take a different form in adulthood.

9.4.2 Prevalence

The prevalence of ADHD in adults is based on the assumption that 65% of childhood cases of ADHD persist to adulthood, using the DSM-IV classification of ADHD (Faraone et al. 2006[ccxxv]). The Health and Social Care Information Centre's Adult Psychiatric Morbidity in England – 2007 survey estimated that 8% of adults in England have ADHD. Until recently, there was a view that ADHD was largely a childhood disorder however such studies such as one in the Netherlands showed that 3% of over 60s are affected (Michielsen et al, 2012) [ccxxvi].

It is now more widely recognised as a long-term condition. It is accepted that the prevalence for ADHD declines with age so the 4-8% in children alters to 0.6-1.2% of adults retaining full diagnosis by 25 years old, and a larger percentage 2-4% with ADHD in partial remission. The main impact of ADHD affects the person's ability to manage education, employment and relationships.

A meta-analysis of follow up studies of school aged children with confirmed ADHD indicates that by age 25 only 15% still met the criteria for full ADHD diagnosis. However, a much larger proportion (65%) fulfilled criteria for either ADHD or ADHD in partial remission, indicating the persistence of some symptoms associated with clinical impairments in the majority of cases (Faraone et al., 2006).

Assuming a population prevalence of ADHD in school aged children of between 4% and 8%, this would suggest that between 0.6% and 1.2% of adults retain full diagnosis by age 25 years and a larger percentage (2–4%) retain ADHD in partial remission. This is consistent with population surveys of adult that estimate prevalence of ADHD in adults to be between 3 and 4% (Faraone & Biederman, 2005; Kessler et al., 2006) and has been reinforced by subsequent longitudinal follow up (Biederman et al, 2010).

Were these rates applied to the Herefordshire 2013 Mid-Year population estimates (NOS, 2104), they would suggest that up to 1649 adults (between 820-1640) aged over 25 within Herefordshire

retain symptoms consistent with a full ADHD diagnosis, with up to 5468 (between 2734 and 5468) showing symptoms of ADHD in partial remission.

However, due to relatively short follow up and uncertain aetiology of ADHD, rates of persistence in adults over the age of 25 are uncertain and prevalence is likely to be far lower than this estimate.

Table 9.6: Estimated prevalence of Adult ADHD

				Lower full	Upper full	lower Partial	Upper partial
AGE				1%	1%	2%	4%
20-24	4,900	4,600	9,500	57.00	114	190	380
25-29	5,300	4,800	10,100	61	121	202	404
30-34	5,200	5,000	10,200	61	122	204	408
35-39	4,800	4,700	9,500	57	114	190	380
40-44	5,900	6,200	12,100	73	145	242	484
45-49	6,900	7,100	14,000	84	168	280	560
50-54	6,700	6,700	13,400	80	161	268	536
55-59	6,100	6,600	12,700	76	152	254	508
60-64	6,200	6,500	12,700	76	152	254	508
65-69	6,400	6,700	13,100	79	157	262	524
70-74	4,700	4,900	9,600	58	115	192	384
75-79	3,600	4,200	7,800	47	94	156	312
80-84	2,600	3,200	5,800	35	70	116	232
85-89	1,400	2,300	3,700	22	44	74	148
90+	500	1,500	2,000	12	24	40	80
		Total	136,700	820	1640	2734	5468

Currently the number of people with ADHD are significantly lower than the estimates suggest. An audit of Primary Care practices in 2013 (20/24 practices) gave a prevalence of diagnosed ADHD as 17 “graduates” (i.e. diagnosed as children and now grown into adulthood) and 9 new diagnoses as adults.

A similar audit was conducted by 2gether NHS Foundation Trust in 2013. This showed that they have 19 adults known to them (11 graduates, 8 new diagnoses) of who 4 are being prescribed ADHD drugs by their GP. This does not include children and young people with ADHD. These are likely to be overlapping groups.

9.4.3 National Evidence on Models of Care

NICE clinical guidelines encompass children and adults with ADHD (2008). Interventions are identified as:

- ADHD related education and self-help strategies
- Medications (atomexetine, methylphenidate, dexamphetamine)

- Psychological therapies such as behavioural therapy
- Occupational therapy.

9.4.4 Provision

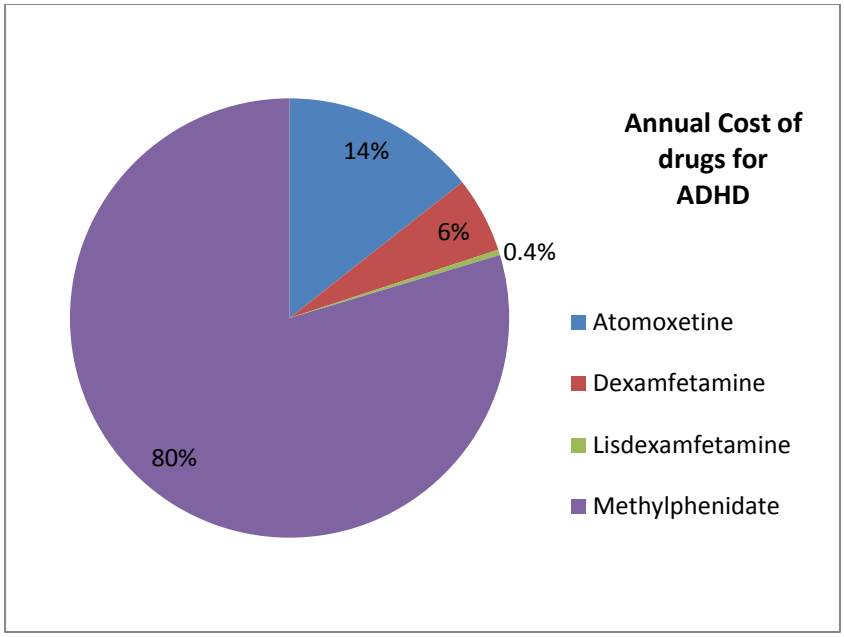
Many GPs feel they do not have the skills and resources to look after and prescribe for this small but increasing group of complex vulnerable patients.

General Practitioner

Accurate diagnosis is key to management so there does need to be a specialist service we can access.

General Practitioner

Figure 9.5: Herefordshire CCG Prescribing of Drugs for ADHD (By Volume 2013-14)



There are no dedicated NHS funded ADHD services in Herefordshire:

- Children are supported by CAMHs
- There are no formalised transition arrangements from CAMHs to adult services
- Adults are managed in primary care with a clinical guideline developed by 2G.
- Dual diagnosis patients access mental health services in the normal way for the second diagnosis; and
- Adults with challenging existing ADHD, or requiring investigation for adult diagnosis of ADHD, are considered through the Named Patient Panel for care outside of the County

This picture of service provision is common in other CCG areas. Part of the reason is that there are few adult ADHD specialists in the UK and the low prevalence in the adult population make specific or targeted services difficult to sustain. Yet waiting times for assessment are long. Currently, GPs are

making applications for Named Patient Panel to support one-off adult assessments and diagnosis because no local service exists.

The detail from 2gether NHS Foundation Trust information is presented below:

a. CAMHS Graduates (2013)

There were 11 patients in 2013.

- Three patients were managed in primary care alone (with methylphenidate).
- Eight patients were managed in secondary mental health services:
    - One was on no medication
    - One had their methylphenidate prescribed by the GP
    - Six patients had medication prescribed by secondary care consultant (methylphenidate, atomoxetine, equasym)
    - Six patients were managed by the Recovery Teams
    - Two patients were managed by the Early Intervention Service.
    - Three patients had other comorbid mental health disorders.

b. Adults First Diagnosis (2013)

There were 8 patients newly diagnosed in 2013.

- One patient was managed in primary care alone (with methylphenidate)
- One patient was managed in primary care with a shared care arrangement (with methylphenidate prescribed by GP)
- Seven patients were managed by the Recovery Teams (including one shared care arrangement).
    - Six patients had medication prescribed by secondary care consultant (methylphenidate, atomoxetine, combined methylphenidate)
    - Four patients had other comorbid mental health disorders.

Adults are more likely to be managed by mental health services because of other comorbid mental health disorders. 50% had substance misuse, and 50% had an emerging personality disorder. Some of the patients from both the Primary Care and 2gether NHS Foundation Trust audit are likely to be the same however it does give some indication of the scale of need.

9.4.5 Findings

Support for patients with ADHD remains a challenging area for patients, their families and primary care in Herefordshire. Unfortunately we do not know how many patients think they have ADHD, and need a specialist assessment to confirm a diagnosis. With limited information, it could be as many as a couple of patients per month. There is no specific diagnostic service within the county for adults where there is a suspicion of ADHD. If a service is created then the number for assessment might increase especially with an initial bulge of referrals of patients waiting for such a service. The suggested pathway is that patients are referred to mental health recovery teams who will assess for

comorbid conditions (there is lots of overlap with other conditions such as personality disorder, OCD, anxiety). If they can find no other treatable conditions then patients are referred out of county for assessment via Named Patient Panel.

The available information does not support the creation of a specialist service within county. The low level of demand and the need for specialist consultant sessions for the assessment, suggests that a local service would be unsustainable. Commissioning on a larger footprint may be an alternative.

Encouraging choice of provider can open up the options for patients regarding which provider undertakes their assessment and maintain clinical quality of assessment. A clear agreed care pathway would support the management of this process for the patient, primary care and secondary care.

Consultation with Primary Care practices revealed concern over such a service model. General Practitioners wanted a specialist service for the assessment and diagnosis of ADHD, with mental health services supporting the person long-term. If only 15% of children and young people experience ADHD symptoms by the age of 25, then HCCG could explore the feasibility of a transitions clinic.

Another of the gaps within the system raised was the lack of social care input following diagnosis. Improved management could support the person with social skills and social integration however there is no local provision to make this available.

9.4.6 Recommendations

- An agreed care pathway is required to assist the public, GPs and other practitioners in order that people are appropriately supported.
- The current low number of patients requiring assessment does not support the creation of a specialist service within the county. Commissioning on a larger footprint may be an alternative.
- Encouraging choice of provider can open up the options for patients regarding which provider undertakes their assessment.
- For CAMHS transition patients, a transition clinic should be explored.
- Ongoing management of ADHD adult patients should be commissioned to end the variety of arrangements and gap in provision.

9.5. Parental (including Perinatal) Mental Health

9.5.1. Introduction and Definitions

The needs of children and young people whose parents and carers have mental health needs can impact on the lives of children and their well-being. Parental mental health problems can have negative consequences for families, in particular on relationships and child development, and especially where problems are severe and complex and parents and children are unsupported.

The term 'parents with mental health problems' is used to denote parents and carers who are experiencing such emotional distress that they find it hard to function as well as they would wish, and they and/or others are concerned about the actual or likely impact this is having on their children. Parents and carers may or may not have a formal diagnosis from a GP or specialist mental health service, and they may or may not be in contact with statutory or voluntary agencies.

Within parental mental health, we have included Perinatal Mental Health. This definition is concerned with the prevention, detection and management of perinatal mental health problems that complicate pregnancy and the postpartum year. It can include both new onset of mental health illness, recurrences of previous mental health illnesses in women who have been well for some time, and those with mental health illnesses before they became pregnant.

9.5.2. Prevalence

The following insights from research highlight the issues:

- An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves
- Of the 175,000 young carers identified in the 2001 census, 29 per cent – or just over 50,000 – are estimated to care for a family member with mental health problems.
- Parental mental health is also a significant factor for children entering the care system. Childcare social workers estimate that 50–90 per cent of parents on their caseload have mental health problems, alcohol or substance misuse issues
- In a class of 26 primary school children, it is estimated that six or seven children are living with a mother with mental health difficulties

There are important implications of not addressing the needs of these families, as parental mental health problems can have an impact on parenting and on the child over time and across generations:

- Between one in four and one in five adults will experience a mental illness during their lifetime.

- At the time of their illness, at least a quarter to a half of these will be parents. Their children have an increased rate of mental health problems, indicating a strong link between adult and child mental health.
- Parental mental illness has an adverse effect on child mental health and development, while child psychological and psychiatric disorders and the stress of parenting can impinge on adult mental
- The mental health of children is a strong predictor of their mental health in adulthood.
- The two per cent of families who suffer the combined effect of parental illness, low income, educational attainment and poor housing are among the most vulnerable in society.

It is common for parents to have co-existing (or co-morbid) difficulties, where two or more problems are experienced at the same time, such as alcohol plus drug misuse or substance misuse plus mental health problems. The presence of any mental health problem – minor or major – was highest among parents (whether alone or in a couple) living with dependent children. There was a higher rate of mental health problems of all types among lone parents: they were three times more likely than other parents to have a major problem, and almost twice as likely to have a minor problem.

A quarter of adults referred for in-patient hospital psychiatric treatment are likely to have dependent children[ccxxvii]. A quarter of women diagnosed with schizophrenia live with children under 16[ccxxviii]. Between a third and a half of children in touch with 'young carer' projects are helping to care for a parent with mental health problems[ccxxix], [ccxxx].

The experience of mental health in pregnancy and after birth can be included within parental mental health considerations. Table 9.7 outlines the prevalence rates.

Table 9.7: Rates of Perinatal Psychiatric Disorder Per 1000 Maternities

Postpartum psychosis	2/1000
Chronic serious mental illness	2/1000
Severe depressive illness	30/1000
Mild-moderate depressive illness and anxiety	100-150/1000
Post-traumatic stress disorder	30/1000
Adjustment disorders and distress	150-300/1000

9.5.3. National Evidence

As stated in Working Together to Safeguard Children (DCSF March 2010):
... mental ill health in a parent or carer does not necessarily have an adverse impact on a child's development. Just as there is a range in severity of illness, so there is a range of potential impact on families. ..... The majority of parents with a history of mental ill health present no risk to their children.

Organisations adopting a “Think Family” approach, based on co-ordinating the support provided by adult and children’s services to a single family is widely recognised as good practice. This requires the use of targeted, specialised and whole family approaches to addressing family needs.

Fundamental to this approach is good inter-agency practice characterised by:

- Routine enquiry;
- Robust inter-agency communication and information sharing;
- Joint assessment of need;
- Joint planning; and
- Action in partnership with the family and, where necessary, child in need or child protection assessment and planning processes.

Promoting emotional and physical wellbeing and development of infants is central to perinatal mental health services. Perinatal mental health problems include a range of disorders and severities which present in a variety of health settings and are currently managed by many different services. Some of these services are specifically designed to meet the needs of pregnant and postpartum women and their infants e.g. specialised inpatient mother and baby units. Others care for them as part of a general service e.g. voluntary and self-help organisations.

Specialised perinatal mental health services which include mother and baby units and their linked specialised perinatal community mental health (outreach) teams are provided by Mental Health Trusts and commissioned by the NHS Commissioning Board under specialised commissioning arrangements. Other services that provide care for pregnant and postpartum women are the responsibility of Clinical Commissioning Groups.

9.5.4. Gaps and Issues

There is limited information available on the number of parents with mental health needs. Practitioners reported that it was common for children with a child protection plan to have at least one parent with mental health conditions. Other services also stated that parents were either not having their mental health needs addressed or patients with mental health conditions were not having their parenting capability supported.

Midwives need training to refer appropriately. 1 in 10 women will experience post-natal depression, only 1 in 100 will get support. In the long term, supporting women will have a huge impact on attachment and mental health.
Mental Health Practitioner

Care of pregnant women in Primary care is currently lacking, there is a lack of coordinated route.
Consultant Obstetrician

There is a nagging fear that a referral to primary care [about a pregnant woman's mental health needs] doesn't result in anything. There is a batting about of patients from service to service- there is a need to put patients at the centre of services.

Consultant Obstetrician

Commissioning of maternity care does not include specialist in-reach of mental health services to support people at risk or with mental health conditions. Although the numbers of patients are small, there should be parity of esteem for people to have their mental need addressed alongside their physical health needs. In this case, access to community mental health advice and support can assist patients with enduring mental health conditions to stay well / function during pregnancy and post-birth. This should include access to advice and information on the risks of pregnancy and childbirth on people's mental health and the health of the foetus/infant, including the risks and benefits of psychotropic medication.

Education of practitioners in Primary Care, Maternity, Health Visiting and Children's Centres can help create a workforce able to identify and support parents with their mental health needs. Inter-agency training should be considered within a parental mental health strategy. As part of the training, think family and safeguarding procedures should be outlined.

With the availability of Lets Talk / Improving access to psychological therapies, targeted group sessions or high intensity one-to-one interventions are evidence-based services that could be adapted for parents with common mental health conditions (see Chapter 5 for more information on IAPT). Combined or co-ordinated with a parenting programme, this would offer support with positive parenting and support people with recovery. This co-ordination of provision is currently not available in Herefordshire, however promotion of IAPT through children's centres, health visiting, and maternity services would facilitate access and broaden the support available to parents.

9.5.5 Recommendations

- Adult mental health services and children's services require effective information sharing and agreed operational practices to ensure that the needs of families are addressed.
- A Parental Mental Health Strategy is created, with the engagement of all partners. This need has been recognised by the Children's Safeguarding Board.
- Agreement of a clinical pathway that will assist in improving access by parents and children to support.
- The co-ordination of parenting programmes across organisations
- Perinatal care pathway agreed
- Inter-agency training to embed capability of organisations that work with children or with adults to consider the impact of mental health on parenting; ability to support parents and safeguard children.

9.6. Recommendations

People with Protected Characteristics

Herefordshire Clinical Commissioning Group should continue to commission high quality, accessible services for the whole population in Herefordshire, which identify and meet the specific needs of people with protected characteristics.

Service Personnel

Herefordshire CCG in all its activity should continue to meet their obligations under the Military Covenant, that members of the armed forces are not disadvantaged by dint of their membership.

Homeless People with Dual Needs

- A strategic system-wide approach to be taken to develop a dual diagnosis protocol.
- Local champions to be identified within key services to build knowledge and skills around working with this client group. They should receive appropriate training and support.
- A directory of services to be developed clarifying what is available and routes to accessing these.
- An information sharing protocol to be agreed that all services can sign up and adhere to.
- Given the shortage of specialist provision, explore accommodation options so that those who are homeless with dual needs can access existing supported accommodation while those with lower support needs can access other more appropriate housing options.
- Ensure there is a means to identify and respond early to those with dual needs who are at risk of becoming homeless to avoid escalation of needs.

People with ADHD

- An agreed care pathway is required to assist the public, GPs and other practitioners in order that people are appropriately supported.
- The current low number of patients requiring assessment does not support the creation of a specialist service within the county. Commissioning on a larger footprint may be an alternative.
- Encouraging choice of provider can open up the options for patients regarding which provider undertakes their assessment.
- For CAMHS transition patients, a transition clinic should be explored.
- Ongoing management of ADHD adult patients should be commissioned to end the variety of arrangements and gap in provision.

Parental Mental Health

- Adult mental health services and children's services require effective information sharing and agreed operational practices to ensure that the needs of families are addressed.
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- The co-ordination of parenting programmes across organisations
- Perinatal care pathway agreed
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NHS
Herefordshire
Clinical Commissioning Group

Chapter 10: Suicide

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Contents

Chapter 10: Suicide

10.1. Introduction and Definition

Suicide is a devastating event with far-reaching consequences. Each suicide represents both an individual tragedy and a loss to society. The factors associated with it are complex and varied.

Suicide can be described as a fatal act of self-harm initiated with the intention of ending one's own life. Although often seen as impulsive, it may be associated with years of suicidal behaviour including suicidal ideation or acts of deliberate self-harm[ccxxxi]. Suicide is the leading cause of years of life lost in England after accidents.

10.2. Risk Factors

In 2012, HM Government produced a cross Government Strategy on Preventing Suicide in England[ccxxxii]. This identified a number of interrelated factors as increasing risk of suicide:

- Previous suicide attempt or previous self-harm.
- Male gender
- Age Concurrent mental disorders or previous psychiatric treatment.
- Homelessness
- Alcohol and drug abuse
- Physically disabling or painful illness, including chronic pain
- Low social support/living alone
- Significant life events - bereavement, family breakdown
- Institutionalised – e.g. prisons, army
- Bullying

Certain professions have a higher than average rate of suicide, although unpicking this may be confounded by poor recording of occupation on death certificates and coroners reports. Historically, it was those occupations with the means/knowledge to kill themselves (vets, doctors, dentists, pharmacists, farmers) that had the highest rates of suicide[ccxxxiii]. More recently, rates in these professions have reduced significantly and higher numbers of suicides are seen amongst manual occupations such as construction workers and plant/machine operatives[ccxxxiv].

Individuals with existing mental health disorders are of particular risk of suicide. A review of 15 years of confidential enquiries into suicide in the UK, published in 2011[ccxxxv], found that the risk of suicide in patients with mental disorders is 5-15 times higher than that for patients without co-existent mental disorders. A quarter of people who commit suicide have been in contact with mental health services, with risk of suicide increasing following discharge from mental health wards.

10.3. Preventing Suicide

Whilst each suicide represents a personal tragedy, it also impacts individuals' families and communities.

In addition to the immense pain and grief that a completed suicide produces, there are also implications in terms of direct costs to police, funeral and healthcare services, amounting to some Euros 2million in European countries[ccxxxvi]. Suicide prevention therefore is both morally urgent and cost effective.

In addition to the National Suicide Prevention Strategy, a number of national activities have been shown as effective in reducing rates of suicide. These include the withdrawal of the analgesic co-proxamol[ccxxxvii], reduction in pack sizes of paracetamol and adoption of "safe by design" approaches for psychiatric wards[ccxxxviii] and structures such as bridges and car parks[ccxxxix].

On a local level, commissioners may contribute to the prevention of suicide through commissioning of mental health services that:

- support staff training around suicide and self harm
- are compliant with the National Confidential Review
- provide 24-hour crisis services;
- support patients with (and have a policy regarding) dual diagnosis
- undertake multidisciplinary reviews after suicide[ccxl]
- provide support (including CBT) for individuals who self harm[ccxli]
- provide support (including pharmacological support) for people (including the elderly) with depression[ccxlii]

McDaid et al (2010) indicate that a 20% reduction in the number of suicides, equating to an average of three per year in Herefordshire, would pay for the activity under the National Suicide Prevention Strategy in terms of deaths avoided and quality adjusted years of life gained.

10.4. Routine Suicide Data

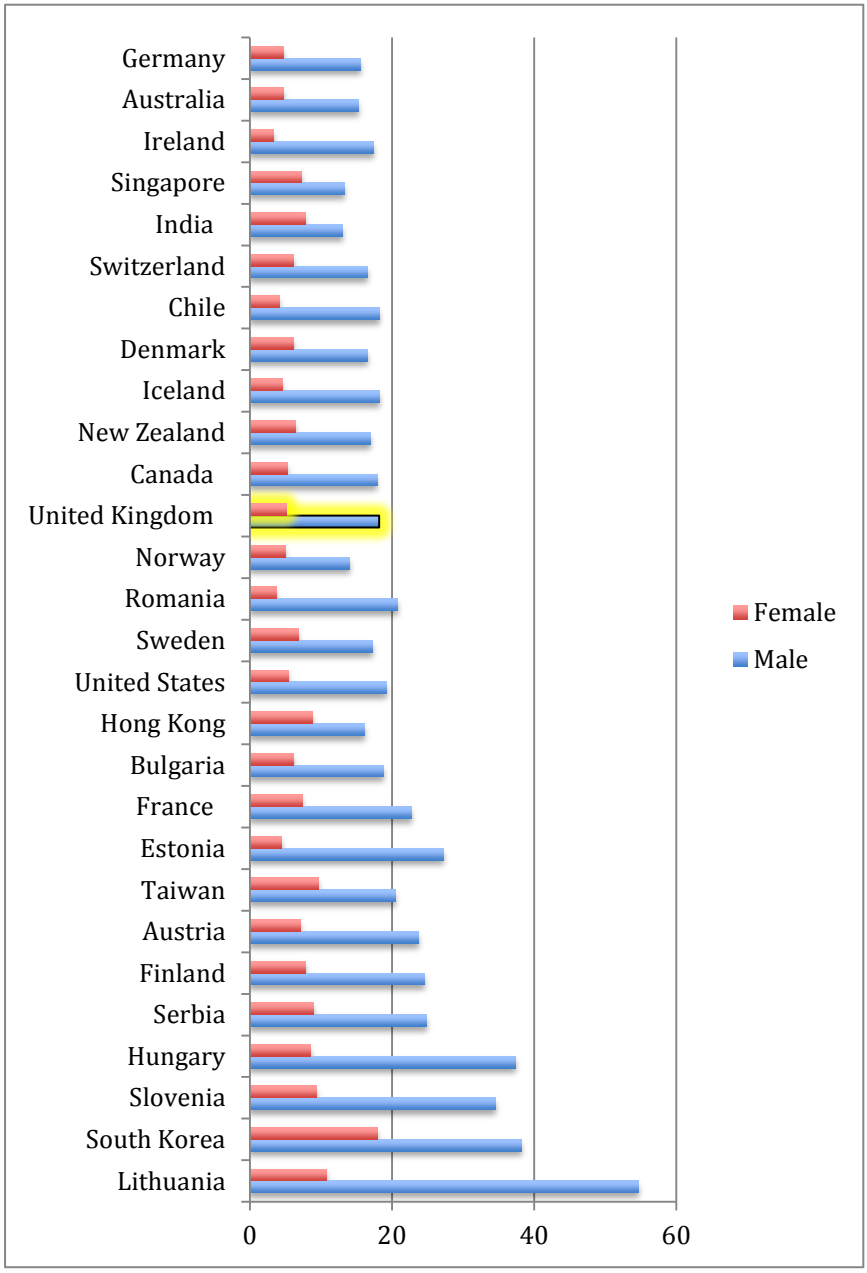
Data on suicide is collected nationally and internationally via coroner's records following an inquest. Due to cultural and economic reasons, such records are unreliable. In the UK all homicides and suicides committed by people in contact with mental health services (in the past 12 months) are investigated as part of the National Confidential Enquiry into Suicide and Homicide.

10.4.1. International Comparisons

The World Health Organisation has collated records on suicide notifications[ccxliii]. The UK is 33rd of 105 countries in terms of rates of recorded suicides per 100,000 people (See Figure 10.1). There are

likely to be significant issues in terms of recording between countries. Variation in rates of suicide between countries are most likely due to a combination of factors, including levels of alcohol misuse, the lethality of commonly used methods of suicide, economic prosperity, religious and cultural attitudes towards suicide, and access to treatment.

Figure 10.1: Rates of Suicide per 100,000 people



Source: WHO, Country reports on Suicide (2014)

10.4.2. National Comparisons

The latest national figures for suicide in the UK are for 2012, with a time series covering 1981 to 2011 to allow comparisons to be made.

In 2012, there were 4507 suicides in the UK in people over the age of 15. This equates to 10.4 deaths per 100,000 of the population.

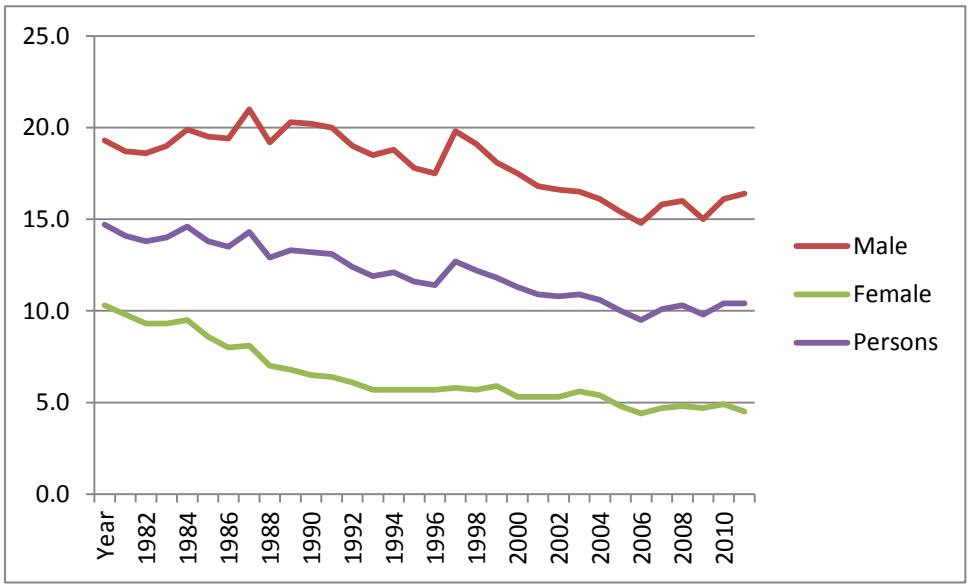
Men are three times more likely to commit suicide. In 2012 in the UK there were 18.2 male deaths per 100,000 population, and 5.2 female deaths per 100,000 in the UK. With the highest suicide rate is in men aged 40-44. In this group there were 25.9 deaths per 100,000 population.

Suicide rates have fallen since the 1980s, although this decline has not been consistent, with significant increases in 1989-90, 1997-98 and 2010-11.

The most common methods of suicide in the UK in 2012 were hanging, strangulation and suffocation (58% of male suicides and 36% of female suicides) and poisoning (43% of female suicides and 20% of male suicides). There has been a year-on-year rise in suicides by helium gas inhalation over the last 5 years[ccxliv].

High-risk groups for suicide include men aged 35-54 years and people who have self-harmed, have depression, misuse alcohol, are facing economic difficulties, are going through divorce or separation, or have long-term physical illnesses[ccxlv].

Figure 10.2: Age Standardised Rates of Suicide per 100,000 persons in England (1981-2012)

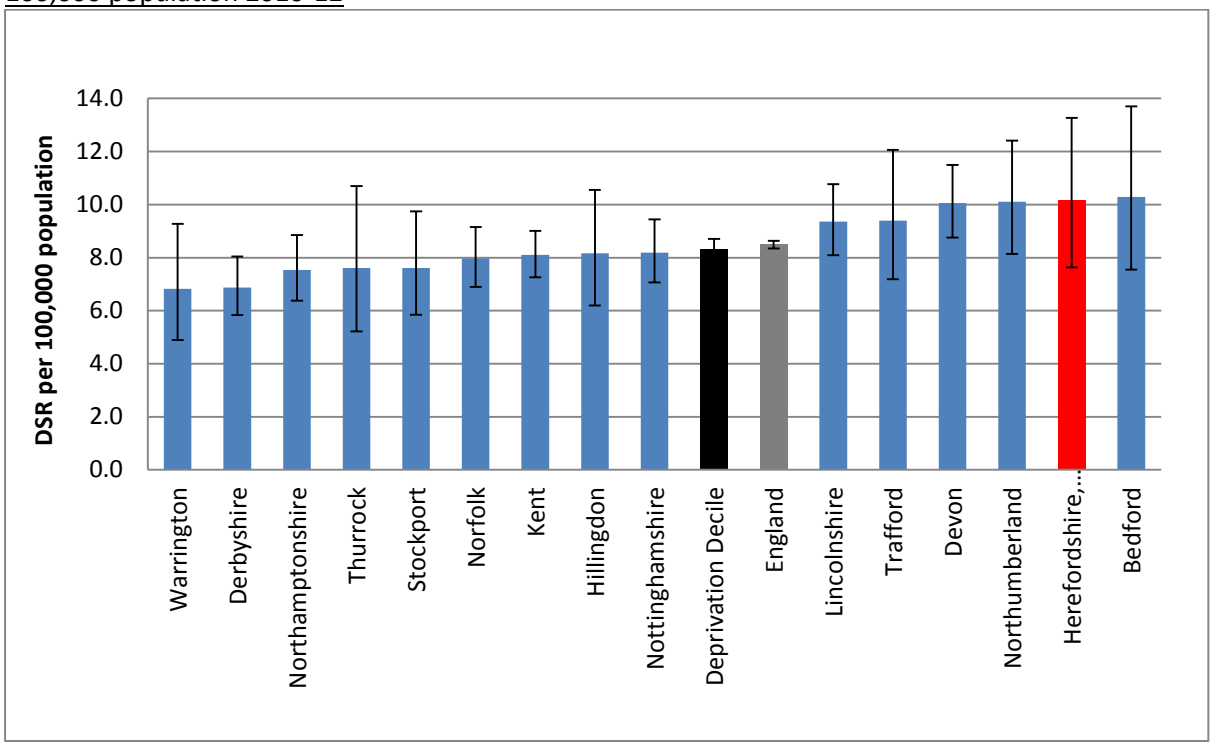


Source: ONS (2013)

10.4.3. Local Incidence

National comparable data for Herefordshire can viewed via the Public Health Outcomes Framework[ccxlvi], pooling data from 2010 to 2013. These figures combine both suicide and deaths from injury of undetermined intent.

Figure 10.3: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population 2010-12



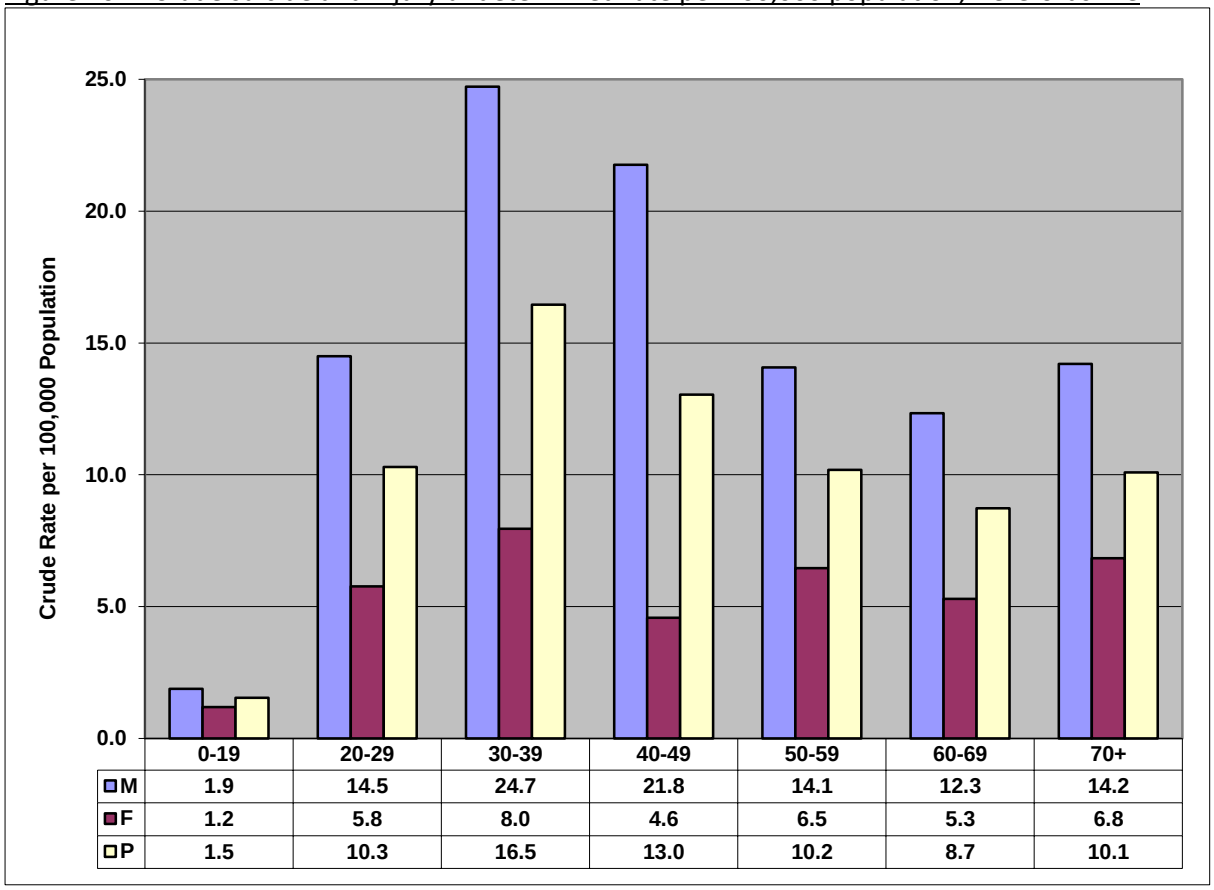
Source: Public Health Outcomes Framework (2013)

Within this data set, England has an age standardised mortality rate from suicide and injury of undetermined intent of 8.5 per 100,000. Herefordshire has a rate of 10.2 per 100,000 population. However, due to the low numbers of events and Herefordshire's relatively small population size, this is not significantly different from national or average deprivation decile rates.

Reflecting national rates outlined above, men in Herefordshire have higher rates of death from suicide and injury of unknown intent in compared to women, with men comprising over 70% of related deaths.

In contrast to the figures above, deaths by suicide and injury of unknown intent in Herefordshire peak for both men and women in the age band 30-39 years.

Figure 10.4: Crude suicide and injury undetermined rate per 100,000 population, Herefordshire

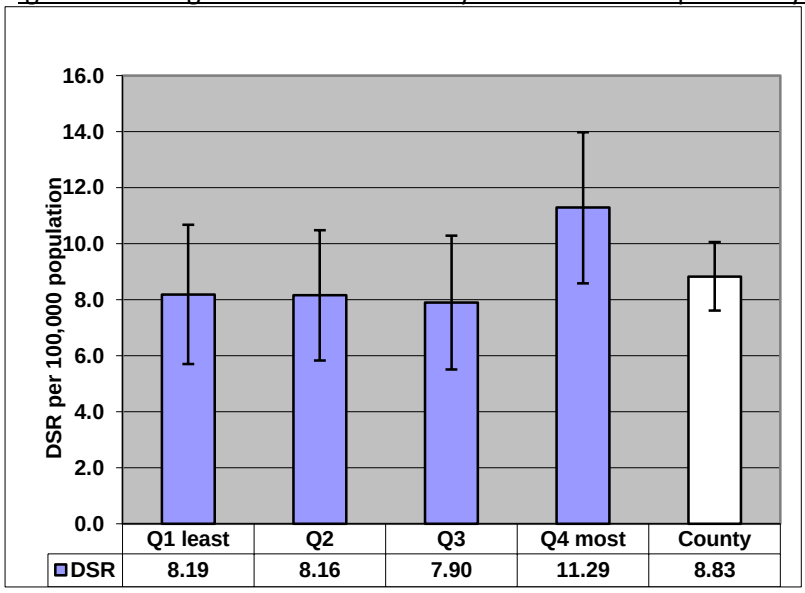


	0-19	20-29	30-39	40-49	50-59	60-69	70+
M	1.9	14.5	24.7	21.8	14.1	12.3	14.2
F	1.2	5.8	8.0	4.6	6.5	5.3	6.8
P	1.5	10.3	16.5	13.0	10.2	8.7	10.1

Source: ONS (2013)

The distribution of death by suicide and injury of unknown intent within Herefordshire is also seen to be influenced by deprivation, with the highest rates occurring in the most deprived quartile, although this is not statistically different to the county average (figure 10.5)

Figure 10.5: Figure: Suicide Mortality Rates 2001-13 pooled by Deprivation Quartile (IMD2010)



	Q1 least	Q2	Q3	Q4 most	County
DSR	8.19	8.16	7.90	11.29	8.83

Source: ONS (2013)

10.5. Local Suicide Audit

Given the lack of detailed data reported on a national level for local suicides, a local suicide audit was undertaken in August and September 2014. Coroners reports were obtained and reviewed for the period 1994-2014, giving a 20-year data set of all deaths confirmed by inquest as resulting from suicide.

Data was extracted for sex, address, place, date and mode of death occupation and marital status to identify trends over time. A second phase is planned following October 2014, reviewing patient medical records (GP and mental health secondary care) and national confidential enquiry records for the period 2008-13, to identify if cases had contact with GP and/or mental health services prior to their deaths.

10.5.1. Results Summary

- There were a total of 300 recorded suicides in Herefordshire between 1994 and 2004, an average of 15 suicides per year.
- Peaks in suicide incidence occurred in 2006 (22 suicides), 2001 (20 suicides) and 1995 (16 suicides).
- The lowest number of suicides was recorded in 2003 (11 suicides)
- The variability in rate may reflect a number of interconnected issues relating to the economy, employment and service provision such as the availability of psychiatric and social services.
- As with national data, men in Herefordshire are nearly 3 times more likely to take their own lives as women.
- The peak in recorded suicides in the 70+ age group demands further investigation. It should be noted that these figures are not age standardised and some of the increase in this age group may reflect Herefordshire's age profile, which is older than the national average.
- The proportion of persons recorded as "single" may be a coding issue and may not reflect current or historical levels of cohabitation. However, social isolation is a contributory factor in mental health and a taken as a group, the categories "Divorced" "Separated", Widowed" and "Single", representing two thirds of suicides, are suggestive of individuals living alone. This may guide future targeting of preventative work.
- The predominance of agricultural professions is not unexpected given the high profile of rural suicides and the importance of farming and allied industries to Herefordshire's economy. It does however suggest that further targeted work is required in meeting the mental health needs of Herefordshire residents in rural areas.
- The frequency of suicide in the construction industry may also reflect employment profiles within the county, but likewise points towards opportunities for targeting mental health interventions at men employed in construction.

- The data suggests heightened risk of suicide in persons who are unemployed and/or housewives.
- The most frequent means of suicide was death by hanging or asphyxiation. That men choose more violent methods of suicide and women are more likely to use poison or overdose is well documented, although may support future programming.
- The paucity of recording of means of poisoning prevents conclusions being drawn regarding medicines management etc. and should be addressed in future reporting.
- Men aged over seventy are more than 2.4 times more likely to commit suicide using a firearm than younger men. This figure is statistically significant at the 95% level.
- Contact with clinical services is poorly recorded and should be addressed.

10.5.2. Total Number

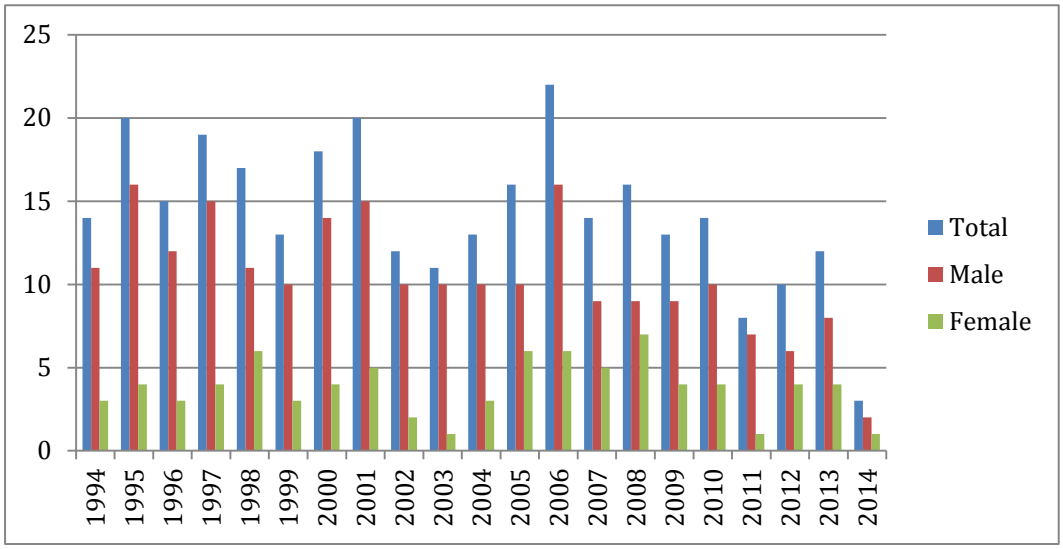
There were total of 306 suicide record found and noted, out of which 5 were deleted because of no other records apart from names. In addition, one record was deleted because of error in the year of death (was recorded as 2017), leaving a total of 300 recorded suicides between 1994 and 2013-2014. It should be noted that due to the lag in receiving notifications of inquest, the year 2014 was incomplete.

10.5.3. Number of Suicides by Year

From the above figure of 300 suicides between 1994 and 2014, Herefordshire experienced approximately 15 suicides per year over the preceding twenty years. However, as can be seen in figure 10.6 below, the number of suicides varied markedly over time, with notable peaks in 2006 (22 suicides), 2001 (20 suicides) and 1995 (16 suicides).

Small numbers in 2014 can be explained by incompleteness of the data record and delay in suicide notifications, however, the low figures for 2011 (8 suicides) and 2012 (10 suicides) may be suggestive that national and local efforts to reduce suicide are showing results.

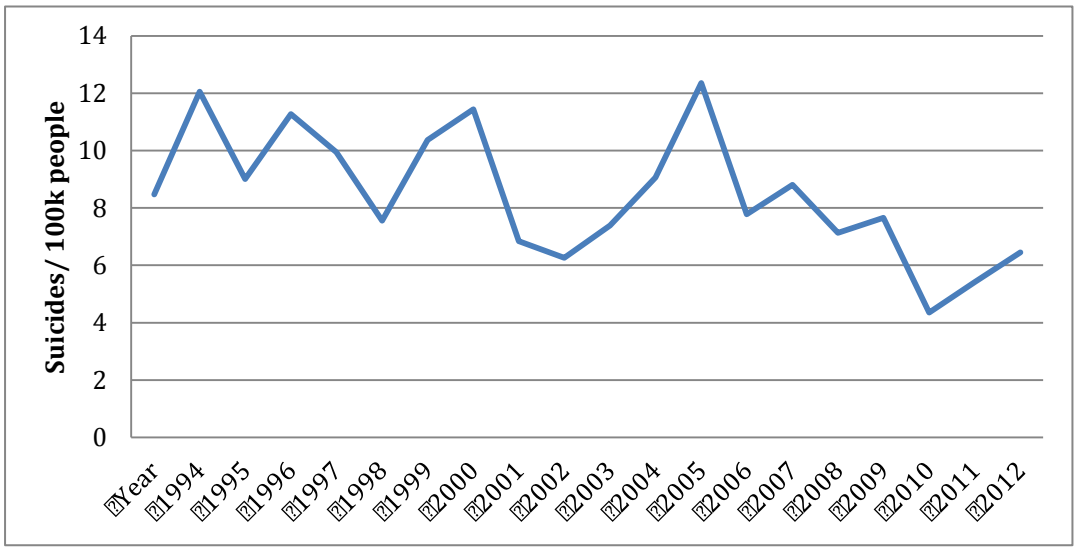
Figure 10.6: Numbers of Suicide Per year in Herefordshire by Sex



10.5.4. Suicide Rates

Figure 10.7 shows the rate of suicides per 100, 1000 people in Herefordshire between 1994 and 2013. This graph shows an overall decreasing trend in rates of suicide in the county, reflecting the national trend shown in Figure 10.2. A notable reduction in rate is seen in the data around 2002/3 to approximately 6.8 suicides/100,000 people, with a peak in 2006 of approximately 12.3 suicides / 100,000 people.

Figure 10.7: Rates of Suicide per 100,000 people in Herefordshire, 1994-2014



The reduction in rate between 2002 and 2003 does not match that shown nationally and recording error cannot be discounted.

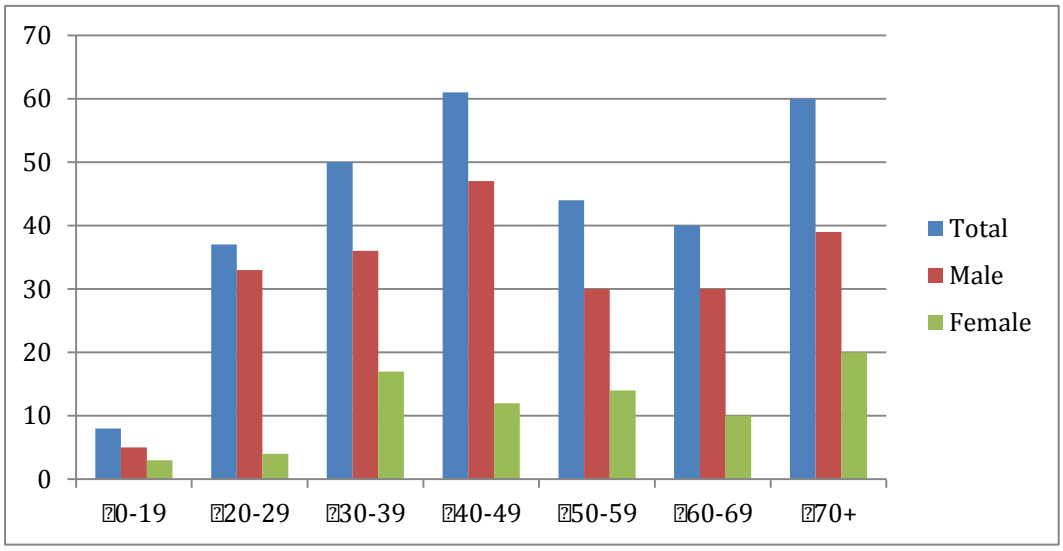
It should be noted that the rate of suicide per 100,000 people during the period of 2008-2010 is 7.86, below the 7.9 national average used as a benchmark under the National Suicide Prevention strategy.

10.5.5. Suicides by Age and Sex

Reflecting national data, men were 2.75 times more likely to be recorded as having committed suicide than women (men=220 suicides, women=80 suicides). However, in contrast to national data, the highest number of suicides in men occurred in the age band 40-49 years (compared to 30-39 years in the national data), with the highest number of suicides in women occurring in the 70+ category (compared to 30-39 years nationally).

Figure 10.8 shows that the 70+ age category has the second highest frequency of suicides with 60 suicides recorded in this age group between 1994 and 2014 (39 men and 21 women). This is not reflected in the national data and suggests that persons in Herefordshire aged over 70 years are more at risk of suicide (or more likely to have cause of death recorded as suicide) than their peers nationally. People aged over 70 represent (55/300=) 18% of the suicides in Herefordshire between 1994 and 2014. For reference, people aged 70 or older represent (27600/183500=) 15% of Herefordshire's population. It is not possible to compare to the national figures to identify if this increase is statistically significant.

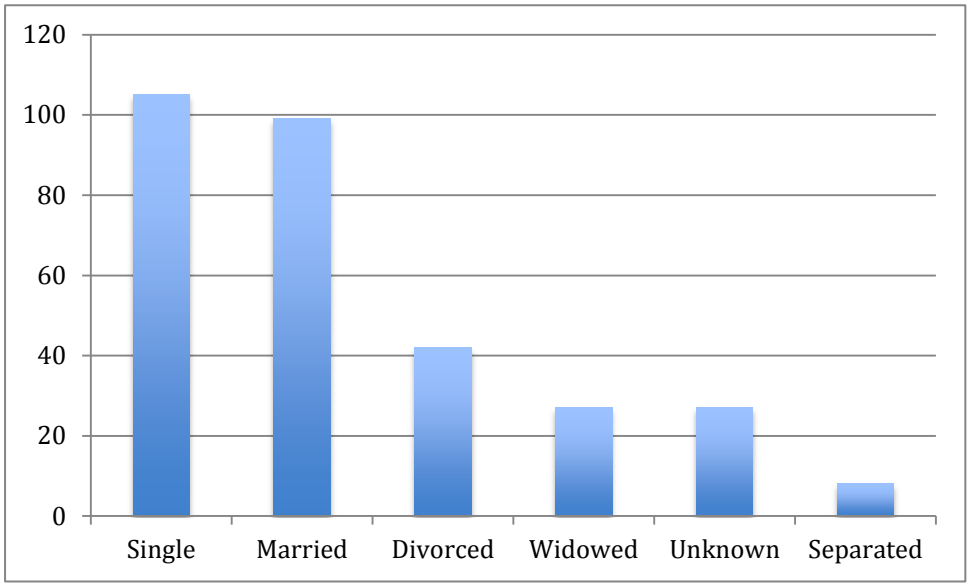
Figure 10.8: Number of Suicides in Herefordshire, 1994-2014, by age and sex



10.5.6. Marital Status

Figure 10.9 shows the number of suicides broken down by marital status. Approximately one third of people who committed suicide in Herefordshire during 1994-2014 were married and another third were single. The remainder were divorced, widowed or unknown. It is notable that the number of "single" individuals predominate, although this may be a coding issue, with divorced, and widowed individuals recorded as being single.

Figure 10.9: Number of Suicides by Marital Status



10.5.7. Means of Death

The data shows a striking disparity in means of death, when broken down by sex.. Whilst the most frequent means of suicide for the population was asphyxiation (56% of deaths in men and 43% of deaths in women), women were more likely to take poison or an overdose (49% of women compared to 23% of men). Men were more likely to shoot themselves (12% of men compared to no women) and use other 'violent' means of death (self-injury, traffic collision, burning, jumping/ falling from heights) women were more likely to commit suicide on railway tracks.

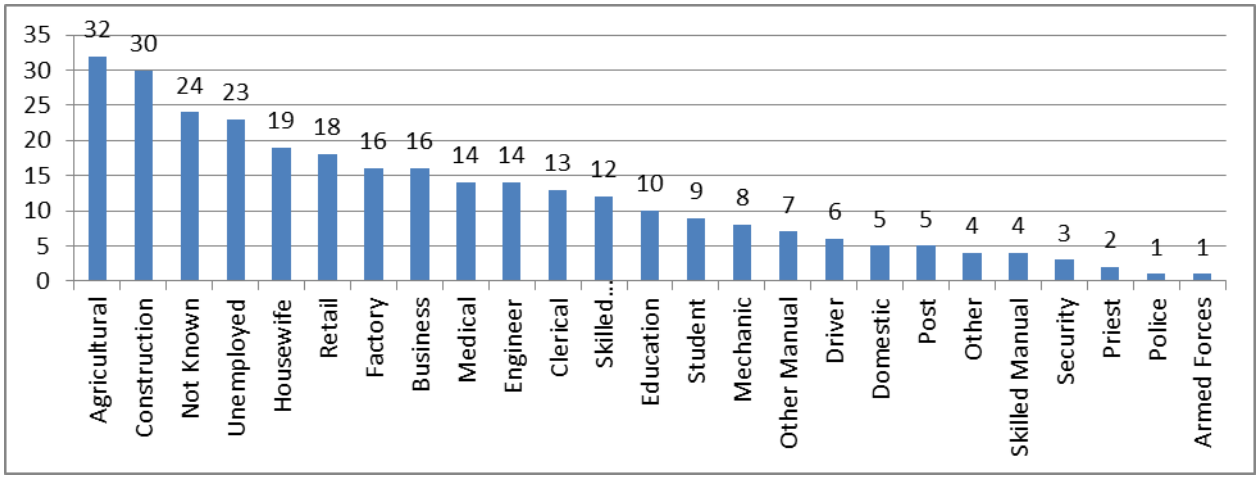
The most frequent form of asphyxiation was via hanging/ self-strangulation (81 men, 22 women), followed by drowning (9 men, 3 women), with three men killing themselves via plastic bag suffocation. There were 55 cases of asphyxiation where the means was unknown or unrecorded.

Means of poisoning was not sufficiently well recorded to enable breakdown by poisoning type.

People over 70 are recorded as using fewer means of suicide (either asphyxiation, self-poisoning or shooting). In the 70+ age band, 9 men (22.5%) committed suicide via self-shooting, compared to 9.4% of men aged 69 or younger. Men aged over 70 were therefore 2.4 times more likely to commit suicide via shooting than men aged under 70 (CI 1.1775 to 5.0706, p=0.165).

10.5.8. Occupation

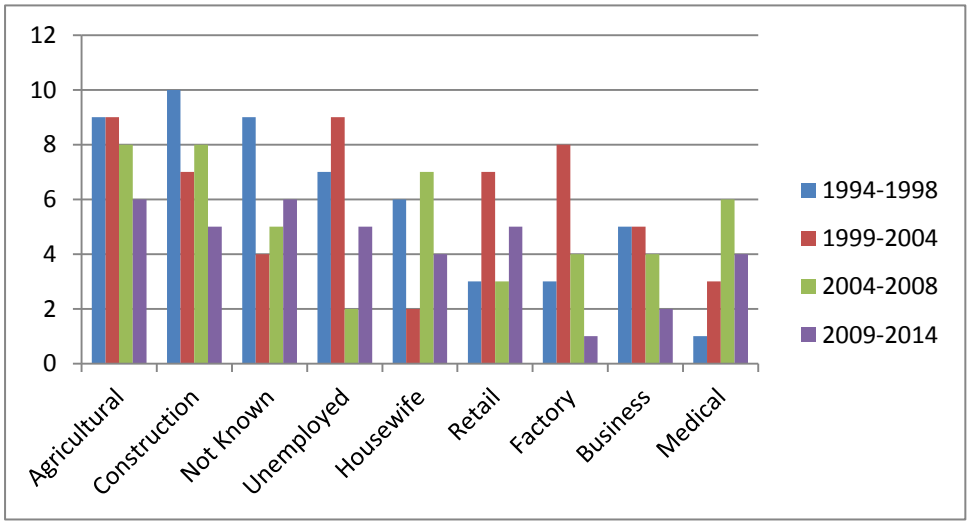
Figure 10.10: Frequency of Suicide by Occupational Group 1994-2004



Breaking down suicides by occupational grouping (Figure 10.10), it becomes clear that particular occupations predominate. Of known occupations, people employed in agriculture, construction, people who are unemployed, Housewives and people employed in retail have greatest frequency of suicide. In addition, 52 people (17.5% of those with recorded occupation) are recorded as being retired.

All persons recorded as "housewife" were female, whilst 17 of the 23 people recorded as "unemployed" were male, which may suggest that "housewife" may be a proxy for women not in paid employment. It was not possible to cross reference with Department of Work and Pensions data to identify if those recorded as housewives were in receipt of unemployment benefits.

figure 10.11: Frequency of suicide by occupational group by five year bands



When suicide by occupational grouping are analysed by five year bands (Figure 10.11), notable variation becomes apparent. Whilst overall suicide rates have decreased over time, this is not borne out in all occupation groupings.

In 1994-1998, the highest numbers of suicide were identified for people employed in construction occupations, followed by agricultural workers and the unemployed. In the period 1999-2004, the unemployed and those employed in agricultural work had highest rates, with notable peaks in numbers of suicides by persons employed in factory and retail settings. In 2004-2008, construction and agricultural workers were most highly represented, with notable peaks amongst housewives and medical staff. For the most recent period, 2009-14, reflecting overall decreases in rates of suicide both locally and nationally, rates are highest in agricultural workers, construction workers the unemployed and retail workers. However, whilst rates had fallen in agricultural and construction workers relative to the previous five years, they had risen for the unemployed and those employed in retail.

It is difficult to draw any firm conclusion regarding trend by occupational group due to small numbers, although it may be suggested that there is a declining trend in suicides amongst people in agricultural occupations.

10.5.9. Contact with Services

Contact with services was poorly recorded in the coroner's records. A total of 46 people were recorded as having had recent contact with their GP, with 22 recorded as not having had recent contact and 232 (77%) not recorded or recorded as 'not known'.

Contact with mental health services is somewhat better recorded, with nearly one third (93 or 31%) of cases recorded as having received recent contact with a mental health team, half (149 or 49%) recorded as not having had contact and the remainder (58 or 19%) not recorded or recorded as 'not known'.

10.6. Discussion

The audit of suicide has highlighted a number of issues. On average, there are 15 suicides per year, ranging from 11 recorded suicides in 2003 to 22 in 2006. Changing patterns in rates of suicide do not conform to patterns seen nationally although there may be an element of lag, reflecting local changes in the economy and services within county. It is notable that for the period 2008-10 the rate locally (7.86/100,000 people) was below the national average (7.9/100,000 people) used as a benchmark within the national suicide prevention strategy.

Reflecting the national picture, men were nearly three times more likely to be recorded as having committed suicide than women. The highest number of suicides in men occurred in the age band

40-49 years (compared to 30-39 years in the national data), with the highest number of suicides in women occurring in the 70+ category (compared to 30-39 years nationally). Rates of suicide in the over 70s were markedly higher than seen nationally.

Suicide rates were highest in persons living alone (single, divorced, widowed) and so suggest that isolation is a factor in suicide locally.

Means of death showed a marked disparity in terms of sex, with men most likely to use asphyxiation (typically hanging) whilst women showed highest rates of poisoning or overdose. Men were far more likely to use "violent" means (Self shooting, self-injury, traffic collision, burning, jumping/ falling from heights), with men aged 70 and older being statistically more likely to shoot themselves than younger men in the county.

Agricultural and construction were the most represented occupational groupings for suicide in 1994-2014 although there were notable recording issues for persons recorded as unemployed, retired and "housewives".

Overall, contact with services was poorly recorded.

10.7. Recommendations

In addition to national and local recommendations contained within the national strategy, specific recommendations may be identified as a result of the intelligence contained in this audit:

10.7.1. Reduce the Risk of Suicide in Key High-risk Groups

The national strategy identified that those at the highest risk of suicide were:

- Young and middle-aged men;
- People in the care of mental health services, including inpatients;
- People with a history of self-harm;
- People in contact with the criminal justice system; and
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

Given the variety of groups highlighted both within the national strategy and within the audit, multi-agency partnership across multiple locations delivered by staff aware of and trained in reduction of suicide will be key to reducing risks of suicides in Herefordshire.

Specific recommendations that can be identified from this audit are to:

- Ensure that suicide prevention is included in the Joint Strategic Needs Assessments and the future Health and Wellbeing Strategy.
- Undertake a review of the medical records relating historical cases of suicide in the county to identify contact with medical services and ensure nationally recommended protocols and pathways are in place.

10.7.2. Tailor approaches to improve mental health in specific groups

As part of a whole population approach to improving mental health within Herefordshire (See chapter 4- "Feeling Good") there is a need for interventions to support good mental health across the county. Specific groups have been identified particularly benefitting from targeted programmes. These include:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the Youth Justice System;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;

Given the intelligence contained in this audit, local measures should also be targeted at men, particularly those employed in agricultural, construction and low pay occupations; socially isolated individuals including unemployed and housewives, persons living alone and the elderly).

10.7.3. Reduce Access to the Means of Suicide

Suicide methods most amenable to intervention are:

• Hanging and strangulation in psychiatric inpatient and criminal justice settings;
• Self-poisoning;
• Those at high-risk locations; and
• Those on the rail and underground networks.

Given the information contained within this audit, it is recommended that the location of suicides are mapped, both historically and going forward, to identify opportunities for 'safe by design' interventions.

Given the significantly high risk of suicide by self-shooting in men aged over 70, there is a need for awareness amongst professionals, particularly GPs, of the potential for suicide by older men who own firearms.

There is a need to recognise the risk of suicide from prescribed medication for people with long term conditions.

10.7.4. Provide Better Information and Support to those Bereaved or affected by Suicide

Individuals and communities can be devastated by suicide, increasing the potential for increased risk in poor mental health and subsequent suicide events. As a result, it is vital to have in place effective local responses to the aftermath of a suicide and provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

In the context of Herefordshire, it is necessary to review suicides prospectively via Herefordshire Clinical Commissioning Group Mental Health Steering Group and ensure that effective protocols are in place to support family neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, and faith leaders to the incident.

10.7.5. Support the Media in delivering sensitive Approaches to Suicide and Suicidal Behaviour

Local services and agencies may wish to work with local and regional newspapers and other media outlets to encourage them to provide information about sources of support and helplines when reporting suicide and suicidal behaviour. Working with local media is particularly important where there is a specific location for suicide causing concern.

10.7.6. Support Research, Data Collection and Monitoring

To support research, data collection and monitoring we need to:

- build on the existing research evidence and other relevant sources of data on suicide and suicide prevention;
- expand and improve the systematic collection of and access to data on suicides; and
- monitor progress against the objectives of the national suicide prevention strategy.

In addition to the ongoing, prospective review of suicides outlined above, the Herefordshire CCG Mental Health Steering Group should support the Herefordshire Coroner's Office to improve recording of suicides via the use of available best practice proformas, in particular focussing on the recording of contact with services.

Chapter 11: Systems Discussion

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Contents

Chapter 11 Systems Discussion

11.1. Background

The National Mental Health Outcomes Strategy, "No Health without Mental Health", has outlined the principles of good quality mental health care (See box 10.1). Despite this, mental health services remain lacking across England, with poor outcomes for users, lack of choice in terms of services and a lack of parity between physical and mental health services.

Mental health care accounts for only 13% of NHS spending while being responsible for 28% of all morbidity in England[ccxlvii]. People with psychotic, affective personality or drug and alcohol related disorders die on average about 15–20 years earlier than people without mental illness[ccxlviii], [ccxlix].

The Chief Medical Officer has identified a number of significant issues relating to the delivery of mental health Services across England[ccl]:

- Mental health services are not currently achieving appropriate availability coverage, as evidenced by the treatment gap.
- There is evidence that the services that do exist are being strained further, reducing effective coverage.
- There is a lack of systematic, appropriate and mandated use of activity and outcome measures to enable evaluation of the effectiveness of services at both local and national levels. Significant variation in practice, activity and outcome is suspected, but no datasets exist to allow appropriate comparison of spending and outcomes between trusts.
- Systems are not currently embedded to collect meaningful quality and effectiveness data (meaningful to people with mental illness as well as to clinical staff).

Reflecting this national picture, there are local issues regarding provision of mental health services that cut across clinical groups, age groups and services. These issues are pervasive and may not show up in routinely collected quantitative data. The following chapter outlines concerns (and solutions) to these systems issues highlighted by service users, carers and professional in the course of interviews and workshops in Herefordshire.

The issues considered are:

- Ease of Access to care and support
- Supported self-management
- Community mental Health Services
- Liaison Psychiatry services.

Box 10.1: Principles and Objectives underpinning Mental Health Services- No Health Without Mental Health (2011)

The principles of high-quality care to apply at all stages of care and support:

- Putting the person at the centre and sharing decision-making – 'No decision about me without me' should be a governing principle in service design and delivery;
- Early recognition of and intervention in problems in workplaces, places of work and education, primary care, acute health and social care settings and the criminal justice system, as well as anywhere else care and support is taking place;
- Where appropriate, adopting a whole-family approach;
- Equal and timely access to appropriate services and evidence-based interventions;
- Proactive, assertive engagement, particularly with people at higher risk (e.g. people at risk of offending/offenders/other risky behaviour);
- Single assessments that underpin continuity of care – using the principle of 'ask once';
- Co-ordinated interventions planned around outcomes agreed by the user of the service, tailored to their individual needs, choices and preferences, with a recovery-based focus on building individual strengths and improving quality of life, including improvements in employment, accommodation and social relationships;
- Co-ordination of care and support – using tools such as the Care Programme Approach;

11.2. The Current Picture

Service users/ carers and professionals were asked "What is most important in keeping people mentally and emotionally well?" Both groups ranked the components in the same order, with "access to care and support" and "ability to self-manage" identified as the most important components.

Figure 11.1: Professionals responses to "What is most important in keeping people mentally and emotionally well? " (n=84)

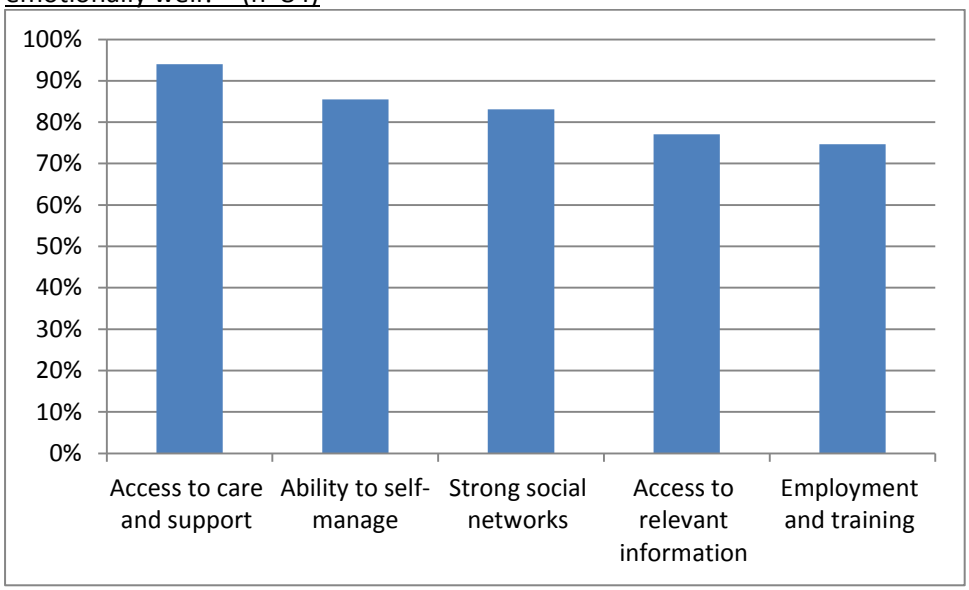
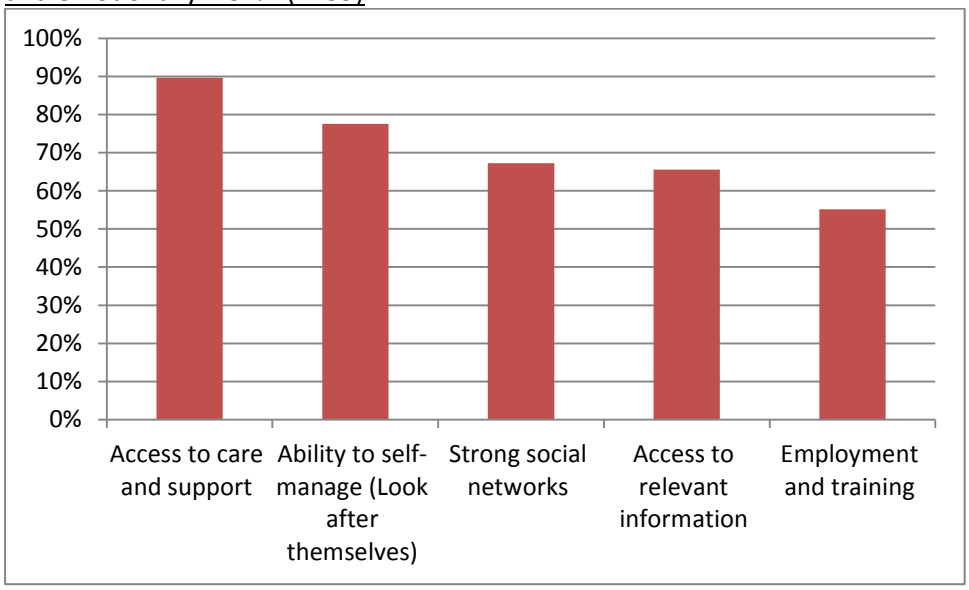


Figure 11.2: Patient and carers responses to ""What is most important in keeping people mentally and emotionally well?" (n=59)



Patients and carers with experience of mental health services in Herefordshire were also asked to rate local mental health services in terms of their effectiveness and supportiveness. As can be seen from figures 11.3 and 11.4 below, where 1 is poor and 6 is excellent, the majority of respondents answered that services were poor or quite poor.

Figure 11.3: Responses to the question "How effective were services?" (n=50)

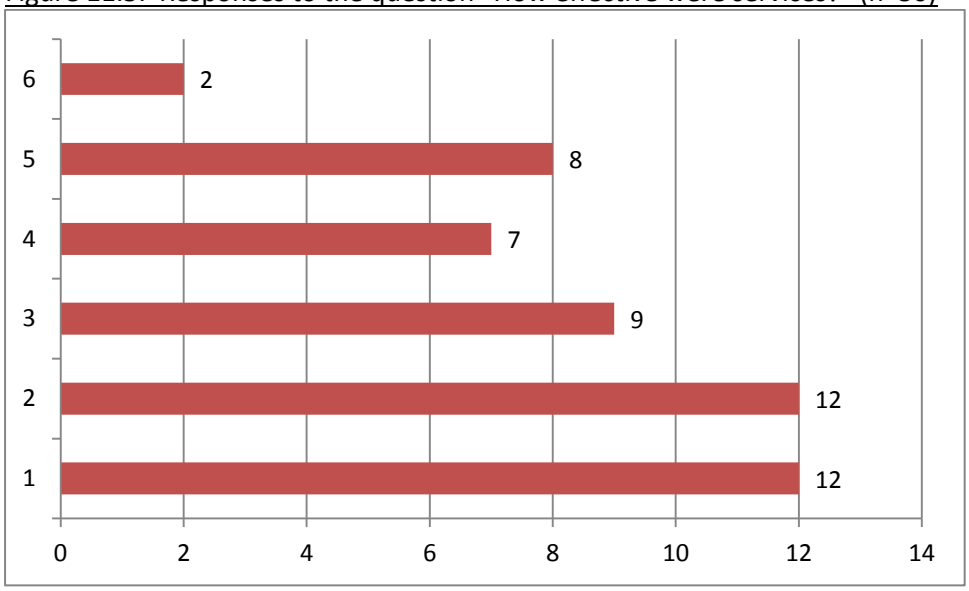
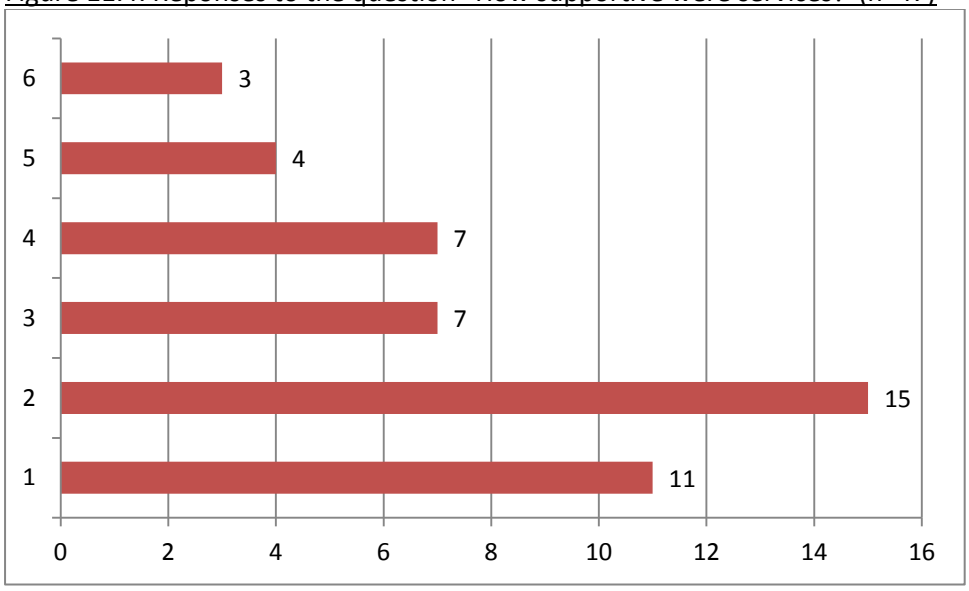


Figure 11.4: Reponses to the question "How supportive were services?"(n=47)



Service users (n=32) at a workshop run by MIND, were asked to plot their responses with reference to Herefordshire Mental Health Services against the NICE Quality Standards for Mental Health Services, where 1= strongly disagree and 6 is strongly agree. Weighted averages were calculated for responses. These responses indicate that patients using services feel they are treated well and that services received will be effective but do not feel confident that they will have an effective care plan or that they will understand the process and supported emotionally.

Box 11.2: Weighted Averages of Service User ratings for Herefordshire Mental Health Services

Statement	Weighted average
People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect	3.97
People using mental health services, and their families or carers, feel optimistic that care will be effective.	2.65
People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.	2.48
People using mental health services are actively involved in shared decision-making and supported in self-management.	2.46
People using community mental health services are normally supported by staff from a single, multi-disciplinary community team, familiar to them and with whom they have a continuous relationship	2.41
People using mental health services feel confident that the views of service-users are used to monitor and improve the performance of services.	2.41
People can access mental health services when they need them.	2.27
People using mental health services who may be at risk of crisis are offered a crisis plan.	1.95
People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.	1.84

Overall therefore, service users, carers and professionals were agreed that the most important things in keeping people mentally well were access to services and support for self-management. However, the service users and carers who responded to a public questionnaire felt that services in Herefordshire were lacking in most areas, with the exception of being treated with dignity and respect by staff. These issues, of access to care and services and support to self-manage will be discussed below.

11.2.1. Ease of Access to Care and Support

A number of 'system issues' were identified in the course of interviews and workshops with service users, carers and professionals. These describe a picture of decreasing or static funding, with a system attempting to deliver high quality services at the point of need.

The impact of the change of government meant that we have to make savings and that is felt on the front line.
Mental Health Practitioner

2g is providing a good quality resource for the funding it has, but the decision on what services are delivered is dependent on funding. [Commissioners] are not paying for more than they have and there is more need than is being paid for.
Mental Health Practitioner

This shortage of funding has a number of interconnected implications:

a) Staff teams are small, with limited resilience.

My psychiatrist went off ill, so my appointment was cancelled and then delayed by 3 weeks. When you are in a bad state yourself that is pretty hard to deal with. The staff with whom I had contact were caring and professional, but there is simply no resilience in the system.
Patient / Service user

There are committed, flexible staff who are willing to work in and across teams and organisational boundaries to help clients….There is a reliance on generic specialisms as there aren't many staff.
Mental Health Practitioner

People work hard and the problems are not due to inefficiencies.
Voluntary Sector Practitioner

There is limited spare capacity within services. As a result, there are knock on effects. Band 5 nurses end up doing intermediate care for example. Whilst commissioners are already paying for a band 5's time, so it is an absorbed cost, it's not a great use of resources. In turn, a lack of community nursing can lead to hospital admission, which has clear cost implications.
Mental Health Practitioner

The size of the provision means that we have single handed specialism. There is no backfill if one person is off. Apart from the very generic specialties, it is difficult to see how some services can continue autonomously.
Mental Health Practitioner

There is not enough slack in the system to allow for training and improvement- The urgent is overtaking the important.
Mental Health Practitioner

b) Services have become more defined, enabling teams to more appropriately manage their workloads. Despite this, practitioners still voice a lack of understanding regarding service criteria, which hinders referral.

Things have been improved by [The current provider] by helping to make services more uniform in terms of presentation and thresholds for entry… Client group is more defined. For crisis, this is people at the point of admission.
Mental Health Practitioner

Boundaries between services mean that it can sometimes be difficult to get patients seen.
Mental Health Practitioner

Services tend to be split and divided. Skills that are in the adult mental health and are not pushed over to DMHOP for example
Mental Health Practitioner

There is a need for clear/ robust referral criteria and a commitment to stick to them (with some flexibility).
Mental Health Practitioner

We need to provide smooth transition across services. Wherever you put a boundary or criteria in place, you can cause problems. Teams are under pressure due to thin resources and teams can default to a "no" response. Services should be open and accessible/ flexible
Mental Health Practitioner

Services have a focus on diagnosed illness rather than mental health.
Mental health Practitioner

c) A combination of defined criteria and insufficient resourcing has led to gaps developing within provision.

It appears to me, as a lay-observer, that the various threads of mental health support just aren't joined up. There needs to be far better communication between people supporting an individual; and support needs to be delivered holistically - shaped to the individual's needs, not driven by systems and process silo working.
Patient/ Service User

There will be some people who don't meet the recovery threshold but are outside IAPT. There may be a group that slip between clusters.
Mental Health Practitioner

d) A further corollary of rising demand and limited resources is the acknowledgment that thresholds to access specialist care had risen. This in turn has meant that patients are remaining outside of specialist care with significant levels of need.

There's talk of "parity of esteem"- with other conditions you would be tested and treated as soon as possible. With mental health, you pretty much have to be falling over before you get a service.
Patient/ Service User

Most of the services are when problems have got so severe, so reactionary rather than being proactive
Carer

People know when they need help, but services have become so difficult to get into that they are getting iller before they get help.
Voluntary Sector Practitioner

Threshold for crisis have been increased, leaving clinical staff at the acute to carry risk
Mental Health Practitioner

As criteria for all teams get tighter and thresholds higher, people are being managed at a lower level than before.
Mental Health Practitioner

e) This "lower level" typically includes voluntary sector organisations. However, staff within such organisations highlight that their capacity to provide support was affected by cuts in their funding.

Sadly it appears that individuals have to be very badly ill with mental health issues before they get any support from within the health community. Many people rely on assistance, but given the reduction in charitable support, they cannot get the support they need.
Voluntary Sector Practitioner

Significant amounts of third sector floating support has been removed and nothing put in its place. £1m has been removed from low level and social mental health support and changes in access to support via change in eligibility criteria; The removal of support organisations mean that we are finding people moving into crisis.
Voluntary Sector Practitioner

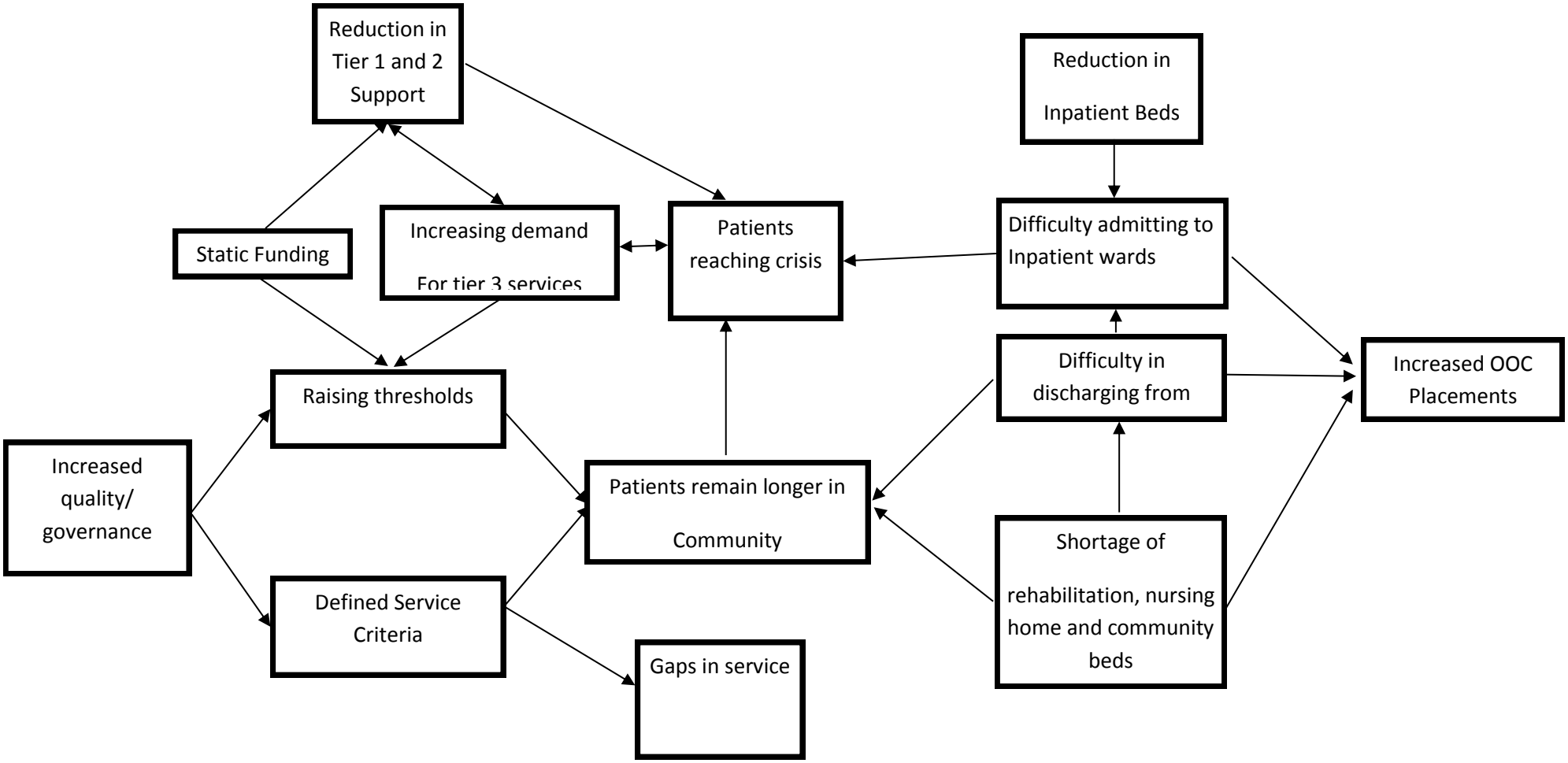
f) As a result, patients may remain without specialist support unless their GP is persistent, meaning that the service a patient receives is likely influenced by how well the GP can "work the system".

We make an assessment to move a patient on, but it gets batted back.
Mental Health Practitioner

GPs may 'play up' the seriousness of a patient's condition to get a more urgent referral.
Mental Health Practitioner

Collectively, such pressures result in patients being delayed access to appropriate services. Whilst the services provided are of a good standard, the size of mental health provision, in addition to system wide issues affecting admission of patients and discharge back into homes and/or community mean that people with mental health needs in Herefordshire are reaching crisis before they can access required specialist mental health services. See figure 11.5 below for a summary of the issues.

Figure 11.5: System issues within Herefordshire



11.2.2. Supported Self-Management

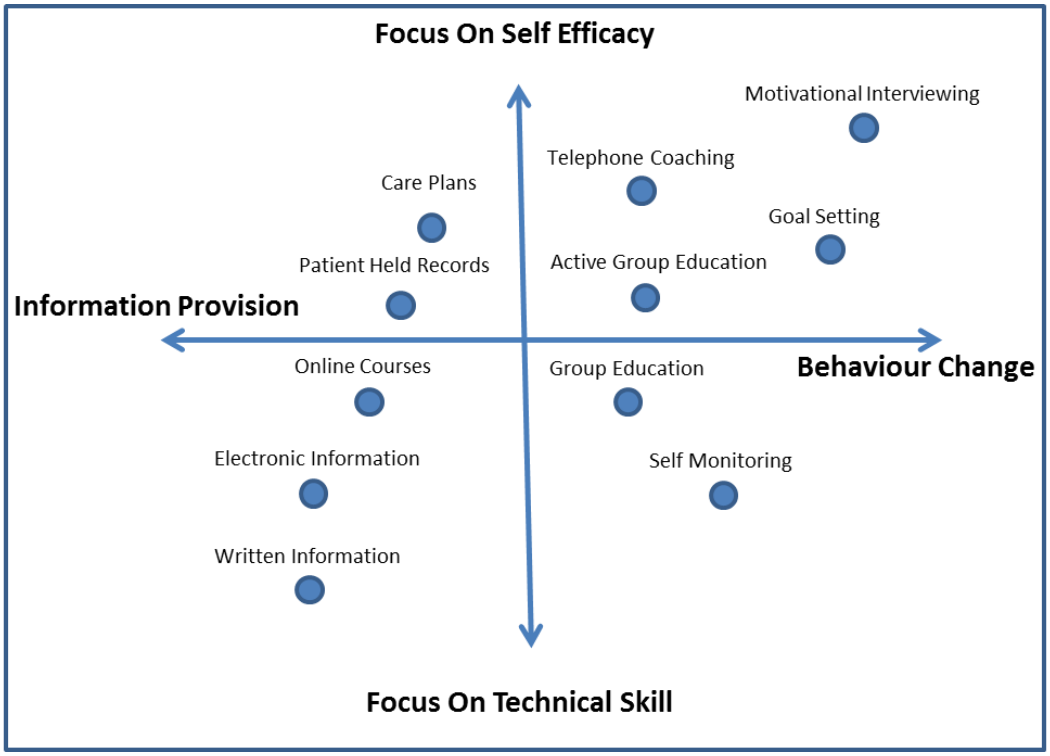
Treatment and support of people with long term conditions accounts for over two thirds of primary and acute care spend and half of all GP appointments[ccli]. However the vast majority of care is undertaken by people affected with long term conditions themselves, or via informal care.

Patients and service users within Herefordshire were keen to be supported to take charge of their own mental health; carers were identified as a key resource. However, it was identified that for self-care to be achieved, support and education would have to be provided to ensure it was reality.

Empowering people to take charge and take the lead in being responsible for their wellbeing is a strong force for staying well. So 'training' people to manage their illness is a good idea. Furthermore we should be assisted by the professionals and work alongside each other. We are tired of being 'done to'. Help us to take control of our own lives again.
Patient/ Service User

De Silva (2011) defined self-management as supporting a continuum of activities, from provision of a portfolio of techniques and tools to help patients choose healthy behaviours, through to fundamental transformation of the patient-caregiver relationship into a collaborative partnership (de Silva 2011).

Figure 11.6: Continuum of Strategies to Support Self-Management (after De Silva, 2011)



A review of collaborative care and self-management support for individuals with mental health diagnoses indicated the use of small group teaching, online education and support, smartphone technologies, text messages, electronic memory aids and psychosocial interventions to reduce anxiety, depression and stress[cclii].

This evidence review suggests that, whilst specific conditions may benefit from individually tailored programmes, some general principles may apply, including:

- Involving people in decision making;
- Developing care plans as a partnership between service users and professionals;
- Setting goals and following up on the extent to which these are achieved over time;
- Helping people manage the social, emotional and physical impacts of their conditions;
- Motivating people to self-manage using targeted approaches and structured support;
- Helping people to monitor their symptoms and know when to take appropriate action;
- Promoting healthy lifestyles and educating people about their conditions and how to self-manage;
- Proactive follow up, including providing opportunities to share with and learn from other service users.

However, the diversity of "interventions to support self-management" poses a barrier to the development of definitive evidence statements, with small study sizes and diverse intervention types precluding reliable conclusion of clinical and cost effectiveness.

Supported self-management shows some promise in regulating symptoms and preventing relapse in persons with depression[ccliii], anxiety[ccliv] and OCD[cclv]. Supported self-help also shows some benefit in terms of medication adherence for psychiatric patients[cclvi].

Service users and carers in Herefordshire were vocal in their wish to be better supported to provide (self) care, but also explicit that such approach would require meaningful input from professional service providers.

There needs to be more support for Carers
Patient/ Service user

There needs to be support for people pre diagnosis of mental health problems. Signposting should be improved so families know where to go, with more self-help groups in the market towns, not just in Hereford at good times.
Patient/ Service user

We need more education with relatives to help them understand the services provided and how they can contribute. Relatives can get overwhelmed, but simple support could improve patient care and carer wellbeing.
Mental Health Practitioner

As such, when taken as a suite of tools and integrated into a wider strategic approach to improving mental health support, there is potential for interventions to support self-management to improve mental and physical outcomes for individuals with mental disorders across primary, secondary and community settings and contribute to a clinical and policy framework for care integration[cclvii]. The National Voices review also highlights the need for cultural change in terms of service delivery, ensuring patients themselves are willing to change (and integrating stages of change models into programmes) and training clinicians and other practitioners to work collaboratively and proactively with service users.

11.2.3. Community Mental Health Services

In speaking with service users, carers and practitioners engaged with mental health services in Herefordshire, it becomes clear the needs of mental health service users are too extensive and complex for specialist mental health services to meet in isolation.

Just as mental health need is multi-causal (See chapter 4), multiple partners are required to respond adequately to the needs of mental health service users in Herefordshire.

The need for multiple approaches for meeting service users' needs is apparent both within and between services:

There needs to be greater understanding of the links between physical and mental health
Patient/ service user

We are treating more physical health issues as well as mental health issues. There has been an increase in physical needs.
Mental Health Practitioner

We are good at managing their mental illness, but not their other issues. Things like their family and friends, their care needs, their occupational therapy, budgeting and employment... The chaos in their lives.
Mental Health Practitioner

In particular, the interface between specialist mental health services, primary care and social services was seen as critical in supporting patients' needs over time.

GPs were seen as a crucial "first step" for patients in accessing mental health services.

I would like to go to my GP surgery to access more mental health services. It is a comfortable place that I trust. I don't want to always be passed on to 'mental health' services.
Patient/ Service user

GPs need to play a key role in liaising with their patients identified to have mental health problems when they are at home, including more regular proactive check-ups or a phone call by the GP, and when at crisis point, proactive regular contact with the patient, in addition to the crisis team.
Patient/ Service User

However, opportunities for people with low-level or stable conditions to receive support in primary care are confounded by a lack of support to meet their non-mental health needs and a failure of communication between services

I was disappointed to have to go over the same questions, because they didn't have my notes
Patient/ Service User

There are still people being managed by mental health services when they could be managed by primary care, but practices are reluctant to take them back.
Mental Health Practitioner

Patients with stable MH problems have been discharged from MH services and they are turning up very frequently instead in general practice because they have social needs & isolation. This is not an efficient use of GP time. The idea was that community services would be developed, but that hasn't happened.
Primary Care Practitioner

The crisis team and consultants should give feedback on referrals, particularly if there was a more appropriate referral route.
Primary Care Practitioner

We need a single point of access from general practice into acute mental health services. It is difficult to decide on the appropriate person to refer to.
Primary Care Practitioner

Social care was seen as a key partner whose membership of multidisciplinary teams was seen as crucial to meet patients' needs. However the current arrangements were seen as inadequate by some respondents, highlighting the need for improved communication and increased co-ordination of care and support, whilst recognising the skills that different specialists provide.

We need more of a social care presence, there is a need to address finances, housing, packages of care. The delay in organising panel papers, or due to placements falling through lead to more bed days and delays in discharge, restricting beds further.
Mental Health Practitioner

The processes needs to simplify as it takes too long to get packages of care and they are becoming more and more difficult to get, with more hoops to jump through due to the funding situation. The problem with delays in care packages is that services stop working when they don't get paid.
Mental Health Practitioner

If I have a client, we won't know if they have MH contact. We use personal contacts, but it would be enhanced if we knew each other.
Adult Social Care Practitioner

Multidisciplinary team working brings different ideas and skills. We try to work to our different strengths; we do assessment clinics and decide who would be the best person to give the best service to the patient.
Mental Health Practitioner

Separation of teams is not good. We need multidisciplinary teams. There needs to be a balance between generic workers and separate specialist teams.

Mental Health Practitioner

We are duplicating work with social care. It should be a joint assessment and then start to focus on individual skills and specialities
Mental Health Practitioner

There needs to be improved communication between health and social care services, with defined responsibilities and more "flow" between services.
Mental Health Practitioner

These complex needs, each served by multiple agencies, highlight a requirement for effective liaison between specialist mental health practitioners, other health staff, social care and voluntary and community organisations, in addition to support for self-care and informal care as outlined above. As a result, there is highly evident need for effective mental health liaison and care co-ordination that follows service users throughout their journey.

11.3. Mental Health Liaison Psychiatry Services

Reflecting the links between physical and mental health and the multiple needs of patients, there was a call from professionals for improved liaison psychiatry to work across specialities, educate practitioners and reduce demand.

We know that there are huge numbers of patients with physical manifestations of mental health issues and vice versa. Psych liaison needs to be much wider, encompassing community hospitals and out patients. It would pay for itself
General Practitioner

We are missing a proper psychiatric liaison within WVT. A proper multidisciplinary team could deal with delayed discharge, medically unexplained symptoms and primary care issues.
Mental Health Practitioner

A lot of what Psych liaison is about is education. Currently minor self-harm and OD is sent to crisis. Psych liaison would enable clinical staff operate improved clinical judgment.
General Practitioner

We have an RMN but not on duty at all times. Ideally we would have one on every shift. Additional RMNs in the A&E team would reduce the demand on crisis.
Acute Hospital Consultant

There are still situation where individuals are discharged from ED to wait for MH assessment- risk of potential massive patient harm- This is a Francis report issue. There is a situation where the A&E

have the choice of either not meeting the 4hour wait target or discharging the Patient to wait for mental health support. That is how breaches are being kept down for mental health.
Mental Health Practitioner

Enhancing management in mental health improves outcomes in physical health and vice versa[cclviii]. There is evidence that liaison services are both clinically and cost effective[cclix].

A liaison service should be an integral part of the services provided by acute hospital trusts. In addition, there is a clear role for liaison to support primary mental health care to manage people with LTCs and MUS, in order to avoid unnecessary admissions to secondary care.

An acute liaison service is designed to provide services for:

- People in acute settings (inpatient or outpatient) who have, or are at risk of, mental disorder
- People presenting at A&E with urgent mental health care needs
- People being treated in acute settings with co-morbid physical disorders such as long-term conditions (LTCs) and mental disorder
- People being treated in acute hospital settings for physical disorders caused by alcohol or substance misuse
- People whose physical health care is causing mental health problems
- People in acute settings with medically unexplained symptoms (MUS).

The service aims to increase the detection, recognition and early treatment of impaired mental wellbeing and mental disorder to:

- Reduce excess morbidity and mortality associated with co-morbid mental and physical disorder
- Reduce excess lengths of stay in acute settings associated with co-morbid mental and physical disorder
- Reduce risk of harm to the individual and others in the acute hospital by adequate risk assessment and management
- Reduce overall costs of care by reducing time spent in A&E departments and general hospital beds, and minimising medical investigations and use of medical and surgical outpatient facilities
- Ensure that care is delivered in the least restrictive and disruptive manner possible.

Effective mental health liaison requires a full spectrum of activity, from prevention and treatment of mental illness in patients with long term conditions (e.g. coronary heart disease[cclx]; diabetes[cclxi]; cancer[cclxii] ; chronic pain[cclxiii]and COPD[cclxiv]) through to improving the physical health of people with mental illness, via such interventions as smoking cessation[cclxv].

There is a need within Herefordshire for clear, well understood pathways between primary care teams (including IAPT practitioners and primary care mental health nurses) and specialist mental health services.

There is an equally pressing need for acute liaison services to provide specialist mental health input to acute hospitals and oversee acute inpatient and community-based interventions for comorbid

long-term conditions and medically unexplained symptoms. Appropriate management of medically unexplained symptoms should lead to a significant reduction in the inappropriate use of acute inpatient resources as these patients often have many assessments and outpatient appointments.

There is currently no single, uniform model for liaison services across the country. However there is a body of evidence, reflected in JCPMH guidance[cclxvi] indicating what liaison services should look like.

Principles

- Staff members sole (or main) responsibility is to the liaison team
- The team includes adequate skill mix
- The team has strong links with specialist mental health services and good general knowledge of local resources
- There is one set of integrated multi-professional healthcare notes
- Consultant medical staff are fully integrated.

11.4. Recommendations

Parity of Esteem

Mental health must achieve parity of esteem with physical health. This will have a number of implications:

- The system will treat people as a whole, appreciating the links between mental and physical health, housing, employment and training, deprivation and social isolation.
- The mental health impacts of long term conditions and the physical impacts of mental health conditions will be explicitly recognised.
- The functions of psychiatric liaison will be reinforced and extended to cover primary care and community hospitals, with a strong presence within the acute hospital.

All agencies have a role in promoting mental health and supporting people with mental health conditions. Identification of people's mental health needs should occur across the NHS system, reinforced by extension of psychiatric liaison services across acute and community hospitals, with communication and training links to primary care.

Supported Self-Management

Meeting people's care needs will require support to informal carers and to individuals to manage their own conditions. Supporting people to identify risk or trigger factors, and agreeing steps that they can undertake, can enable more people to take in charge of their mental health. There is a need for an active market place with choice for the person in terms of where and how they choose to access assistance. This will include support to voluntary sector, service user and carer groups.

Employers and other organisations can also encourage people to consider these personal care plans as a resource to increase resilience. Raising awareness of mental health with family, friends, employers and communities can help foster an environment for good mental health to develop.

Ease of Access to Care and Support

There remains significant unmet need for common mental health conditions. Insufficient numbers of people are being diagnosed and people appear to be receiving support too late. Many recognised that some of their experiences could have been avoided if early intervention had been available. Part of this issue is that the current system is complex for patients and professionals to navigate. People do not understand where to go and how to ask for help, with the exception of seeing a GP. This is further complicated by the need of carers and families requiring a route to ask for assistance with a concern of a loved one.

For this reason, the mental health "front door" needs to be within primary care, specifically within GP practices. This would tackle stigma and encourage more people to treat their mental health in line with their physical health. People will be able to access assessment, treatment and appropriate triage to further mental health support if and when required.

Recognising primary care's role as the front door of mental health services, there is a need to enhance and strengthen primary care mental health capacity and function.

The assessment of mental health within a primary within primary care will negate the "passing" of patients and duplication of assessment, meaning that service users do not have to repeat their story. Waiting times should reduce as people can receive early support closer to home. This is in line with the recovery model and the evidence base round early intervention.

Group therapies represent a cost effective model of delivering low level psychological support. There is a need to extend provision and make it more accessible and accepted. Other agencies have a role in promoting its availability and supporting people to attend.

Community Mental Health Services

The model of secondary mental health services must reflect the demography, geography and the financial resources available within Herefordshire, as well as issues of workforce recruitment and retention. Given its context, Herefordshire would most benefit from a model that is flexible and risk based, removing the gulfs between the existing teams with specialist workers for some specific functions. This is not removing specialisations, but gaps between teams. Multidisciplinary team working remains a critical way of managing people, with continuity of care critical.

A key consideration is whether a service configuration of separate teams for working age and older people is sustainable Removal of older people care in favour of all age team. Other areas have moved to a separation of all-age organic and functional teams.

All patients engaged with secondary mental health services should receive a care/ crisis plan.

Within this model, day care; crisis and home treatment form part of the acute care pathway, alongside inpatients. No service model changes are recommended here however, criteria for access to support must be explicit and made available to practitioners and the public. Equally, when people

are discharged, they should be equipped with strategies to maintain their health at home, to include signposting to appropriate community support.

The recommendations for the service model require financial modelling and clinical consideration as part of Herefordshire Clinical Commissioning Group commissioning for outcomes. This should be reflected in the next steps arising from this Needs Assessment.

Chapter 12: Conclusion

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Contents

Chapter 12 Conclusion

12.1. Summary of Findings

Herefordshire CCG's responsibility to provide effective secondary and community mental health services is located within a wider context of provision by multiple partners across the county. Herefordshire CCG is committed to working with our partners to ensure the best possible outcomes for people in Herefordshire.

Prevention of mental ill health means recognising and improving those factors in our society which impact upon mental health, as well as recognising the links between mental health, physical health and social engagement. We can only address these issues engaging effectively with our partners working between different groups, all of whom have a role to play.

Communities can help by addressing stigma and promoting healthy environments. Embracing initiatives such as dementia friendly communities help support the vulnerable and increase understanding of a condition that still carries a significant stigma. We know that loneliness and isolation are potent contributors to mental ill health, and that promoting community cohesion can reverse these effects. Signposting people towards sources of community support is the best way to encourage these protective social bonds.

Housing, employment, education and the environment all impact impact on individuals opportunities and outcomes, Employment support may be needed to overcome lack of confidence in returning to the workplace, while appropriate housing allows earlier opportunities for independent living. Close working is needed particularly between education and health, to identify and support those children and young people at risk of problems. We know that early intervention prevents problems later in life, and that parenting support is hugely cost effective in the longer term. The challenge is to overcome the current financial constraints, and look forward to prevent problems in future generations.

The voluntary sector has a huge role to play in supporting, informing, providing advocacy, challenging, ensuring choice and healthy clinical discussion. Voluntary and community organisations are already providing advice and support to patients throughout the county, and as commissioners, we need to reach out and build these relationships, tapping into this expertise for the benefit of our patients.

For health services, embedding crisis plans within the clinical record and patient held documentation will ensure continuity of care and respect patient autonomy. Many patients are now treated entirely within primary care, and GPs need to ensure that these patients still receive expert levels of care, are routinely offered talking therapies, and have sufficient signposting to other forms of support within the community. Specialists need to support this process and provide timely access to those patients needing more help. Anxiety and mood disorders underlie many presentations to health care, and treating these will help to reduce demand on overstretched services throughout the

system. Recognition of dementia and mental ill health in hospital patients allows the acute trust to manage patients more appropriately, using the shared expertise of specialists from all disciplines.

This needs assessment is a report into factors that will affect future health provision for people with mental health conditions.

As outlined in chapter 4 “Feeling Good (Public Mental Health)”, Herefordshire CCG should continue investing where there is a robust evidence base. As one of many commissioners of services to meet public mental health needs, specific activities within the domains of mental illness prevention mental health promotion and early intervention should form part of the overall programme of services. Employers, schools, practitioners, services and community organisations all have a role in ensuring people are aware and able to access sources of support, remain socially engaged and keep well.

As outlined in Chapter 5 “Common Mental Health Conditions”, the Increasing Access to Psychological Therapies (IAPT) provision was deemed to be the most cost effective approach to meeting the needs of people with mild to moderate mental health problems. However, there were issues in terms of access. We know that many patients with mental ill health do not seek help, and that milder symptoms can often go undetected or be hidden behind physical complaints.

Effort is required to ensure that people who require help receive it in a timely and accessible manner. To achieve this, the functions of a common mental health service could be situated in primary care so that more people might engage. To understand the current position, IAPT services should be audited to assess the effectiveness of referral pathways and self-referrals.

Access to good quality self-help approaches should be made available, to include digital platforms and there is strong potential for voluntary sector organisations to deliver some provision for mild and moderate mental health issues, particularly to address choice and a variety of need.

Chapter 6 outlines issues surround severe and enduring mental health conditions. It is recommended that a single point of entry is developed alongside effective triage to ensure that patients are not passed between services. To achieve this, there is a need to better manage referrals across teams, with clear, patient held, crisis and care plans to facilitate effective treatment and negate the need for patients to repeat their story or experience repetitive assessments.

There remains a need to review the place of safety in the county, as this is currently unstaffed and results in clinical and police staff being drawn away from essential duties when the suite is occupied. There is a need to address rehabilitation provision within the county to ensure people have access to phased “stepping stones” to recovery. A coherent recovery and accommodation pathway would maximise maximises the potential for excellent outcomes.

Chapter 7 revisited the dementia needs assessment undertaken in 2012. Whilst this has resulted in more strategic awareness of dementia, gaps still exist in provision for people with dementia such as support for people with early onset and people with learning disabilities. Further work is required to raise awareness of dementia and the support that is now available. Acknowledging that people should live well with dementia, continued effort to improve dementia care remains a priority. This

includes support for carers, families and care homes, as well as other settings in the community, such as voluntary and community activities.

Children and Young Peoples' Mental Health was covered in chapter 8. This highlighted a lack of information and support to service users and their families.

It is recommended that HCCG and its partners strengthen capacity at tier 2 (including via CAMHS IAPT) and the model of provision at tier 3 to prevent progression of need and provide a stepped model of care. Education of GPs and other health workers is highlighted as a priority, as well as recording of data to improve understanding of prevalence and support service planning.

There is remains a need to improve young people's experience of transition to Adult Mental Health services, retaining the patient at the centre of services and based on need rather than age.

Vulnerable groups are considered in chapter 9. This recommends that services pay due regard to the needs of populations with a protected characteristic, ensuring high quality service for all.
In addition to the development and maintenance of a service directory, there is a need for a dual diagnosis and information sharing protocol be agreed to meet the needs of homeless people with dual needs.

Herefordshire CCG will continue to be mindful of its obligations under the Military Covenant to ensure that members of the armed forces (and their families) are not disadvantaged as a result of their membership.

Parental mental health needs could be improved through greater information sharing between practitioners to recognise the needs of people with mental health conditions as parents and to recognise children as young carers. The creation of a parental mental health strategy, a need recognised by the Children's Safeguarding Board, would be the vehicle for outlining a Think Family approach and the development of effective parental and perinatal mental health care pathways.

Chapter 10 outlines the results of a suicide audit. Herefordshire has experienced an average of 15 suicides per year over the past 20 year. The suicide figures describe individual tragedies, with each having widespread repercussions throughout community, family and friends. The chapter makes recommendations congruent with the National Suicide Prevention Strategy outlining how suicides may be prevented and, where they do occur, responded to ensure that family and community members, as well as professionals, are adequately supported.

Throughout the needs assessment, key themes have been repeated around availability of resources, access to and sufficiency of services and appropriateness of existing model(s) of service to meet the mental health needs of people in Herefordshire. These "System Issues" are explicitly raised in chapter 11 including an outline of how existing blockages and barriers may be overcome via re-provisioning of mental health services. Such services would be situated within a context of interagency working across the county, with specific support for people to better self-manage their

own mental health needs, in conjunction with effective and flexible services. Mental health services could streamline referrals through a "single front door", making access easier.

One area to establish is effective liaison psychiatry, identifying co-morbidity with physical health conditions and enabling improved progression of patients through the mental health pathway, via training of professionals and improved referral processes.

Herefordshire CCG will continue with a recovery based model, however it recognises that some people will continue to live with long term mental health conditions. Reflecting what is offered to patients living with other LTCs (such as diabetes or arthritis) provision should be flexible enough that people can access support when they need it. This will include support to self-manage.

In recognising these recommendations, it is clear that HCCG cannot operate independently. It is important that the development of mental health support within Herefordshire is co-produced by service users, carers, mental health professionals and other practitioners across the county.

12.2. Outcomes

Our shared vision is to develop Herefordshire as a "centre of excellence" for mental health recovery, providing local services for people with severe mental health needs and/or compatible complex care needs. This is line with the vision of *No Health without Mental Health: implementation framework (2012)* for health and care services to be focused on recovery, rehabilitation and personalisation. Community services will affect the achievement of good recovery outcomes for patients and support carers.

In addition to the recommendations on addressing the gaps and striving for improvement, the qualitative engagement enabled conversations about what outcomes people said were important.

Table 12.1: Service User Identified Outcome Measures

I am supported to have the best possible mental AND physical health
I am able to function in my daily life
I can get assessment and support where and when I need it

Transitions are seamless and teams work together to meet my needs
Services support me to recover and remain well
Services support me at the end of my life if needed
I am listened to and my views taken into account
I am treated as a person, not a diagnosis or collection of symptoms
I am able to be open about my mental health condition if I choose to be
Carers are supported in their caring role

12.3. Next Steps

Herefordshire CCG will continue to commission high quality, patient centred mental health support that meets the unique needs of the people of Herefordshire, as part of a wider strategic approach to ensure adequate resources and support are secured.

There are three key next steps:

1. The findings of the Herefordshire Mental Health Needs Assessment will inform Herefordshire CCG considerations in the forthcoming system-wide discussions into how Herefordshire as an economy will address the needs of people with mental health conditions and their families. It has been agreed that an all-age system-wide mental health strategy will be developed. Herefordshire CCG will play an active role in the development of an overarching mental health strategy.

2. The outcomes for people with mental health conditions and the wider Herefordshire population developed through the course of the engagement work will be used by Herefordshire CCG in its future commissioning of services. Further engagement, clinically

and publicly will be undertaken to refine the outcomes and ascertain local priorities. This is in the recognition that not all care and support will be achievable within available resources.

3. To reflect the Mental Health Needs Assessment in the forthcoming considerations in contracting for mental health services including the implementation of the recommendations.

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