## Chapter 6: Severe and Enduring Mental Health

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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 lifetime. 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.

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/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). iii

**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.

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
caracterized by an inability to maintain an adequate, healthy body weight. Bulimia nervosa (BN) is
caracterized 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\textsuperscript{v}. Eating disorders are significant cause of mental health related ill health and mortality, particularly in young/adolescent women\textsuperscript{v}.

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\textsuperscript{v}.

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%).
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.

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

<table>
<thead>
<tr>
<th>Local Authority Area</th>
<th>Total Population 18 - 64</th>
<th>2+ Psychiatric disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herefordshire</td>
<td>108,500</td>
<td>109,900</td>
</tr>
<tr>
<td>Bath and North East Somerset</td>
<td>111,500</td>
<td>112,100</td>
</tr>
<tr>
<td>North Somerset</td>
<td>120,800</td>
<td>127,600</td>
</tr>
<tr>
<td>Solihull</td>
<td>121,800</td>
<td>123,600</td>
</tr>
<tr>
<td>North Lincolnshire</td>
<td>101,400</td>
<td>101,700</td>
</tr>
</tbody>
</table>

Source: PANSI, 2013

Figure 6.2 Prescribing of Medication for Psychoses and Related Disorders

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

<table>
<thead>
<tr>
<th>Local Authority Area</th>
<th>2014 Forecast</th>
<th>2020 Forecast</th>
<th>Predicted Increase between 2014 and 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herefordshire</td>
<td>379</td>
<td>386</td>
<td>1.9%</td>
</tr>
<tr>
<td>Bath and North East Somerset</td>
<td>391</td>
<td>396</td>
<td>1.3%</td>
</tr>
<tr>
<td>North Somerset</td>
<td>419</td>
<td>445</td>
<td>5.9%</td>
</tr>
<tr>
<td>Solihull</td>
<td>420</td>
<td>427</td>
<td>1.7%</td>
</tr>
<tr>
<td>North Lincolnshire</td>
<td>356</td>
<td>356</td>
<td>0%</td>
</tr>
</tbody>
</table>

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, 2007viii; Wade et al, 2006ix), and from 4 to 7% for full and partial bulimia nervosa (Favaro et al, 2003x). 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)

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)

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**

![Bar chart showing self-harm admissions by deprivation quartile](chart jpg)

- Q1 least deprived: 106.1
- Q2: 158.8
- Q3: 170.2
- Q4 most deprived: 275.7
- County: 180.1

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**

![Line chart showing self-harm admissions trend](chart jpg)

Source: SUS

Herefordshire Mental Health Needs Assessment 116
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).

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

Figure 6.7: Stepped Care Mental Health

<table>
<thead>
<tr>
<th>Step</th>
<th>Who is responsible for care?</th>
<th>What is the focus?</th>
<th>What do they do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 5</td>
<td>Inpatient care, crisis team</td>
<td>Risk to life, severe self-neglect</td>
<td>Medication, combined treatments, ECT</td>
</tr>
<tr>
<td>Step 4</td>
<td>Mental health specialists</td>
<td>Recurrent, atypical &amp; those at significant risk</td>
<td>Medication, complex psychological interventions, combined treatments</td>
</tr>
<tr>
<td>Step 3</td>
<td>Primary care, Primary mental health</td>
<td>Moderate or severe mental health</td>
<td>Medication, psychological intervention, social support</td>
</tr>
<tr>
<td>Step 2</td>
<td>Primary Care, Primary mental health</td>
<td>Mild mental health</td>
<td>Watchful waiting, guided self-help, exercise, brief psychological intervention, computerised CBT</td>
</tr>
<tr>
<td>Step 1</td>
<td>GP, Practice Nurse</td>
<td>Recognition</td>
<td>Assessment</td>
</tr>
</tbody>
</table>

**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
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”. 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
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\textsuperscript{xiii}. 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

\textsuperscript{xiii}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:

Herefordshire Mental Health Needs Assessment
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 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
Herefordshire Mental Health Needs Assessment
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 and 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, 2014xvi).

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, 1996xv). 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-effectivexvi, 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, 2014xvii) 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.
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\textsuperscript{xvii}). 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\textsuperscript{xx}).

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

![Graph showing Assertive Outreach Service caseload by month during 2013/14](image)

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

![Bar chart showing emergency admissions for self-harm from 2008/09 to 2012/13, with numbers in the legend: 300, 247, 295, 316, 291.]

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\textsuperscript{xx}, \textsuperscript{xxi} 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.

\textit{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

\textit{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**

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.
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**

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

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

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)

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

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 users 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.
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

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

*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

- 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\textsuperscript{xi}.

- 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.

<table>
<thead>
<tr>
<th></th>
<th>Jul-Sep 12</th>
<th>Oct-Dec 12</th>
<th>Jan-Mar 13</th>
<th>Apr-Jun 13</th>
<th>Jul-Sep 13</th>
<th>Oct-Dec 13</th>
<th>Jan-Mar 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>17</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Discharged</td>
<td>13</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Detained</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Informal admission</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Police custody</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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.

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

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

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.
References

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vi NICE (2011) NICE CG133; Self Harm-Longer term management NICE: London. URL: https://www.nice.org.uk/guidance/cg133/chapter/introduction (Last accessed 20/10/14)


xii JCPMH community services


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http://www.rcpsych.ac.uk/pdf/PS02_2013.pdf