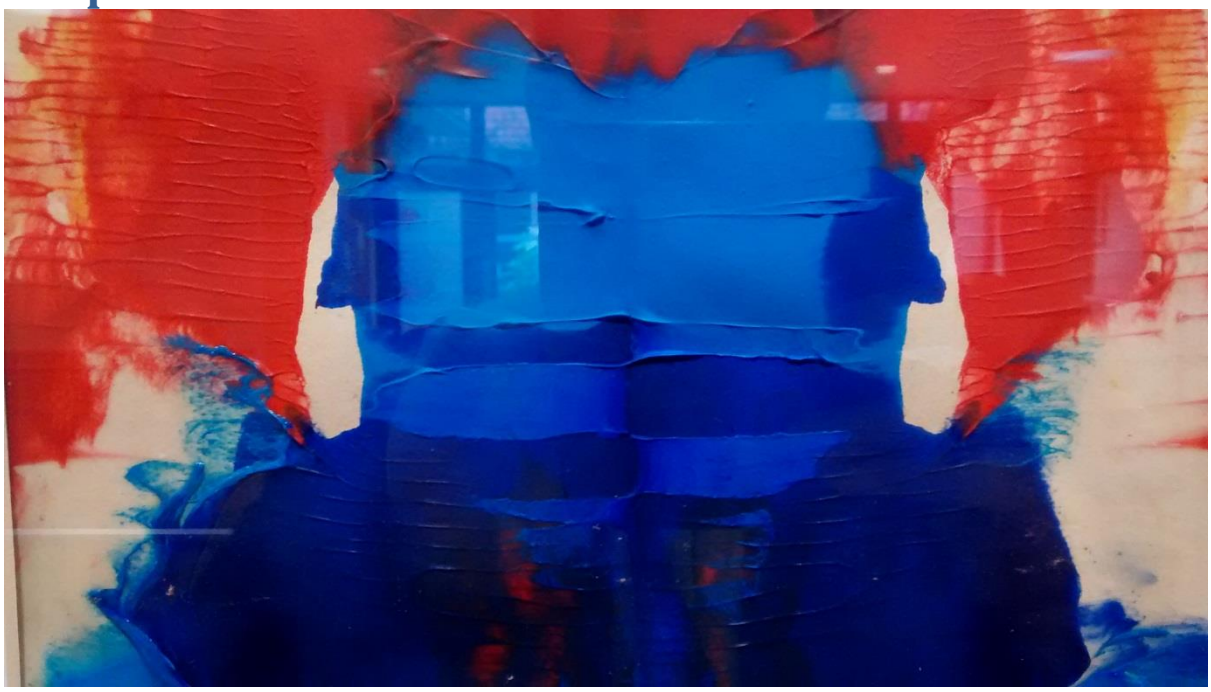
Chapter 5: Common Mental Health Conditions



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Contents

5.1 Introduction and Definitions p 82

5.1.1 Depression p 82
5.1.2 Anxiety p 82
5.1.3 Obsessive Compulsive Disorder p 82
5.1.4 Post-traumatic stress disorder p 83

5.2 Prevalence and Projections p 83

5.2.1 Overview p 83
5.2.2 Anxiety p 85
5.2.3 Depression p 87
5.2.4 Obsessive Compulsive Disorders p 90
5.2.5 Post-Traumatic Stress Disorder p 91
5.2.6 Common Mental Health Conditions Projections p 91

5.3 Models of Care **p 91**

5.3.1 Stepped Model of Care p 91
5.3.2 Primary Mental Health Service p 93
5.3.3 Improving Access to Psychological Therapies p 93

5.4 Findings **p94**

5.4.1 Primary Care p 94
5.4.2 Medication p 95
5.4.3 Non-Medical Activities p 95
5.4.4 Primary Care Mental Health p 95
5.4.5 Cognitive Behavioural Therapy p 97
5.4.6 IAPT / Let's Talk p 98
5.4.7 Care Pathway p102

5.6 Conclusion **p103**

References **p104**

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[i]), 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[ii].

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[iii].

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[iv].

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[v].

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[vi])
- 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[vii]), rising to 1.7% for those experiencing it with or without agoraphobia (Skapinakis et al., 2011[viii]).
- 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[ix]), yet accounts for as much as 30% of the mental health problems in people seen by GPs (Martin-Merino et al., 2010[x]).

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[xi] 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.

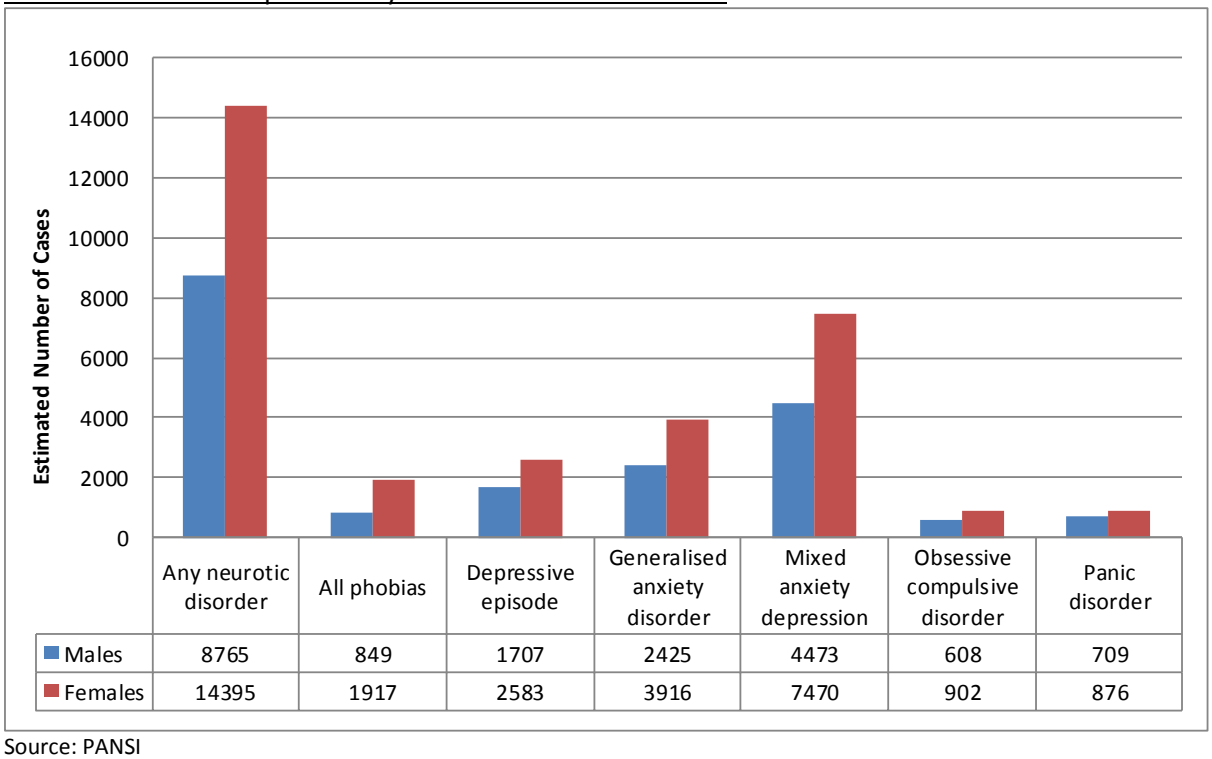
Applied to Herefordshire, the numbers can be extrapolated to approximately:

- 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[xii]; Singleton et al, 2001[xiii]). 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[xiv] the Office for National Statistics (ONS), 2013[xv]).
- 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[xvi]).
- Young people aged 16–24 are more likely to report lower levels of anxiety compared with adults generally (Potter-Collins & Beaumont, 2012[xvii]; ONS, 2014[xviii]).

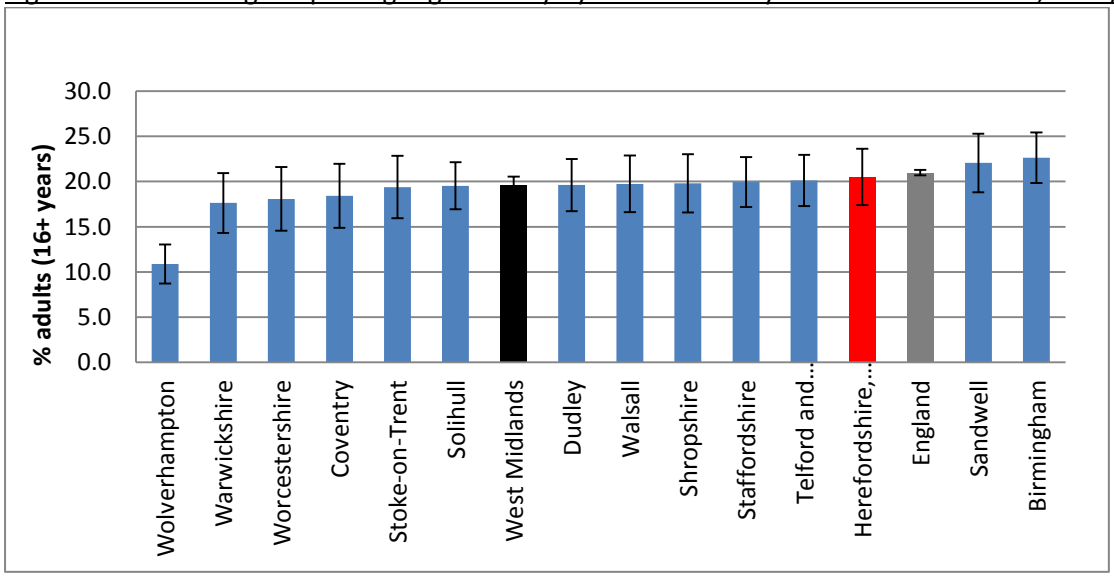
These findings are replicated by a recent survey by the Mental Health Foundation (2014)[xix] of over 2,000 members of the public:

- 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



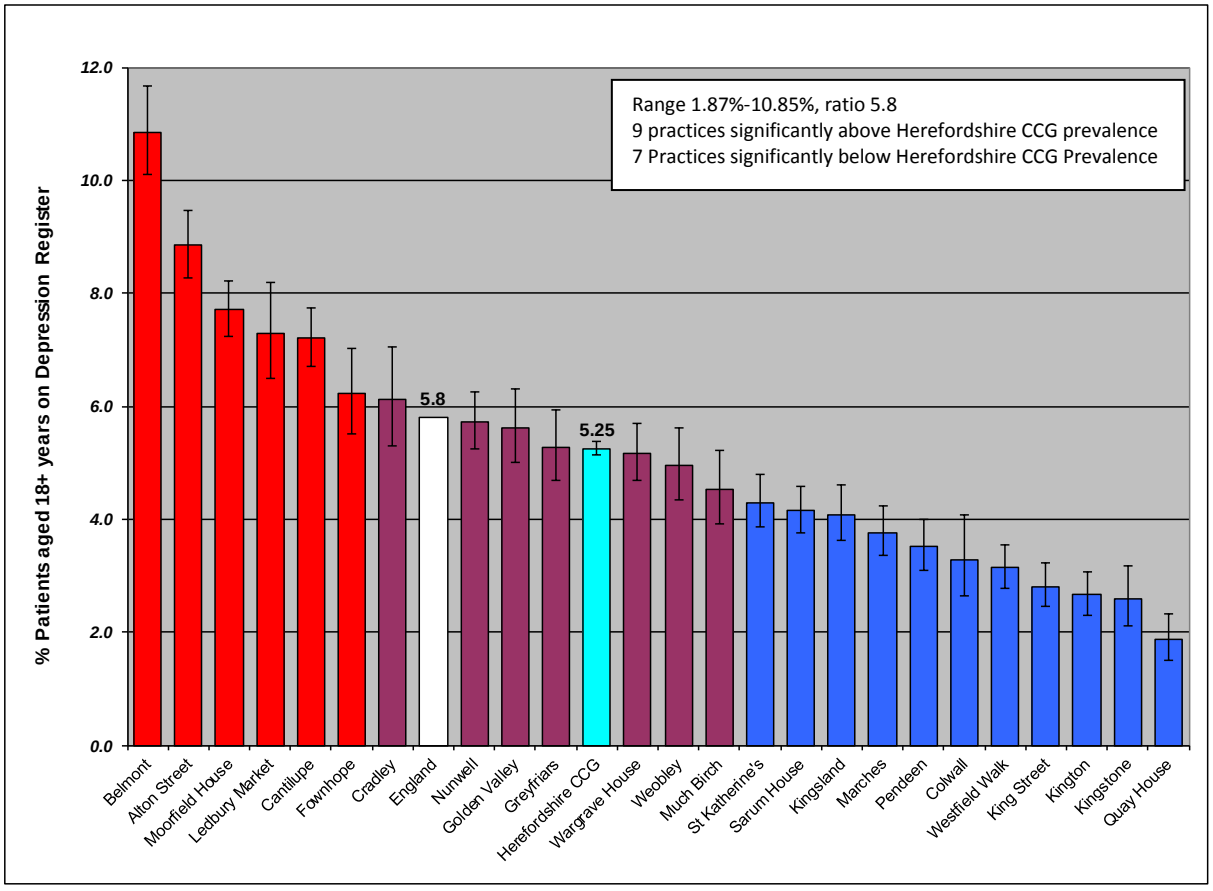
Source: Annual Population Survey, ONS, 2012/13

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

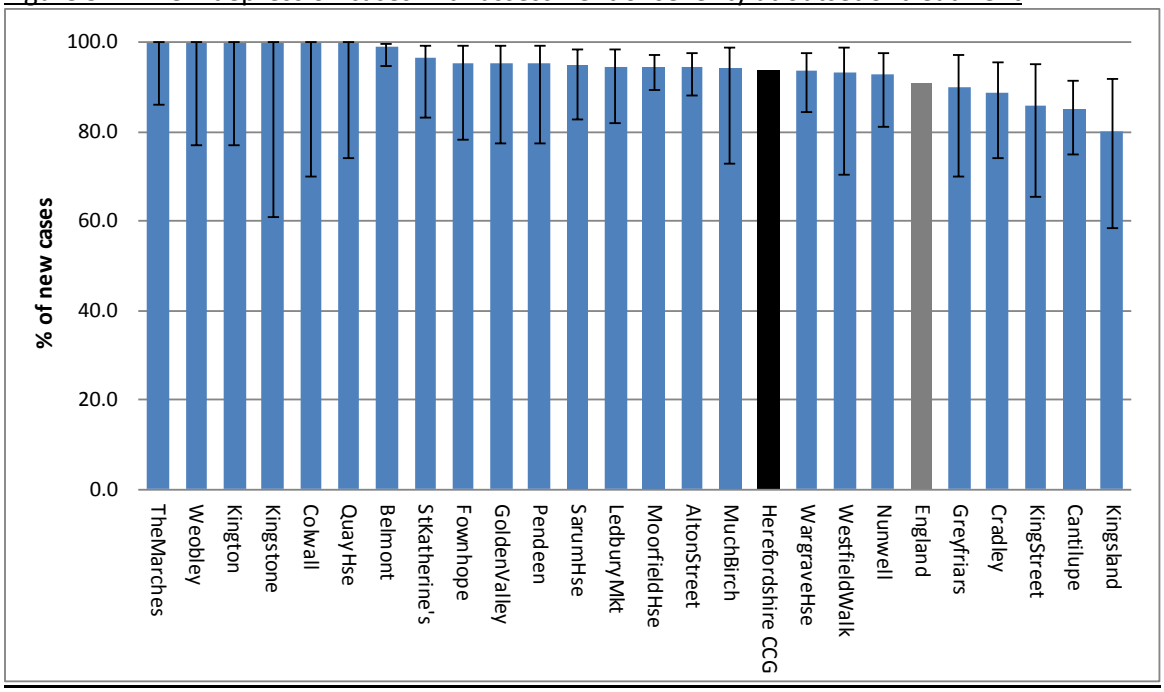
NB: This indicator applies to adults aged 18 years and over with a new diagnosis of depression in the preceding 1 April to 31 March. This indicator does not include women with postnatal depression.

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.

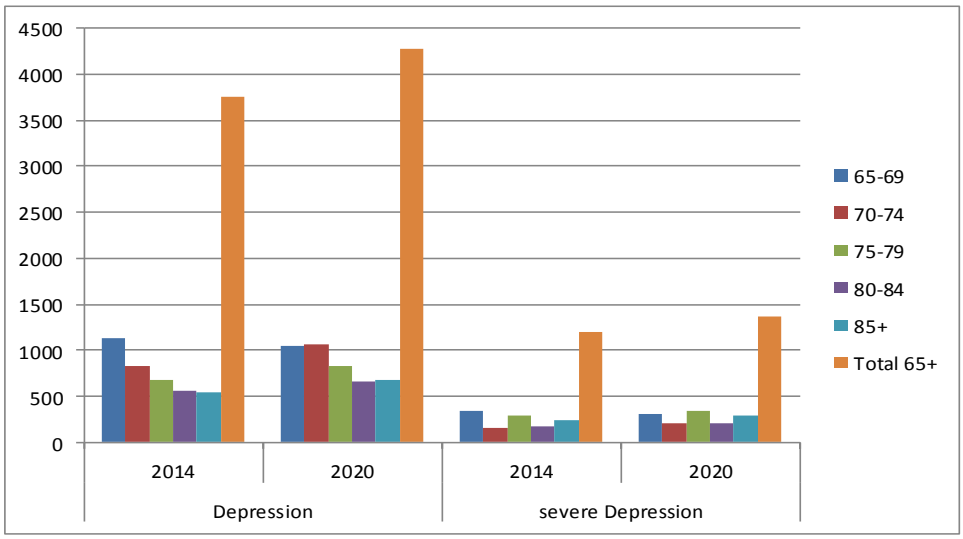
Figure 5.4: New depression cases with assessment of severity at outset of treatment



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

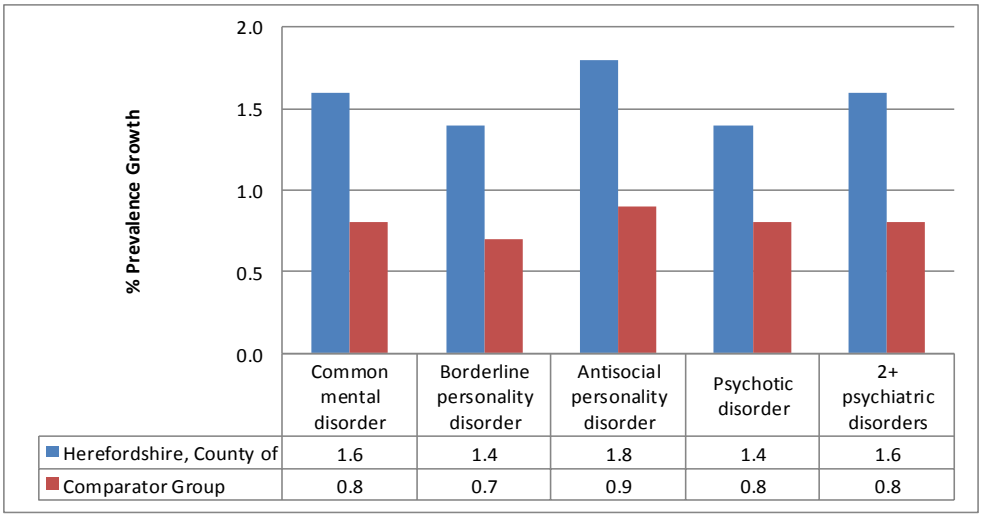
Post-Traumatic Stress Disorder (PTSD), or syndrome, is a psychological reaction to a highly stressful event outside the range of everyday experience, such as military combat, physical violence, or a natural disaster. The symptoms usually include depression, anxiety, flashbacks, recurrent nightmares,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

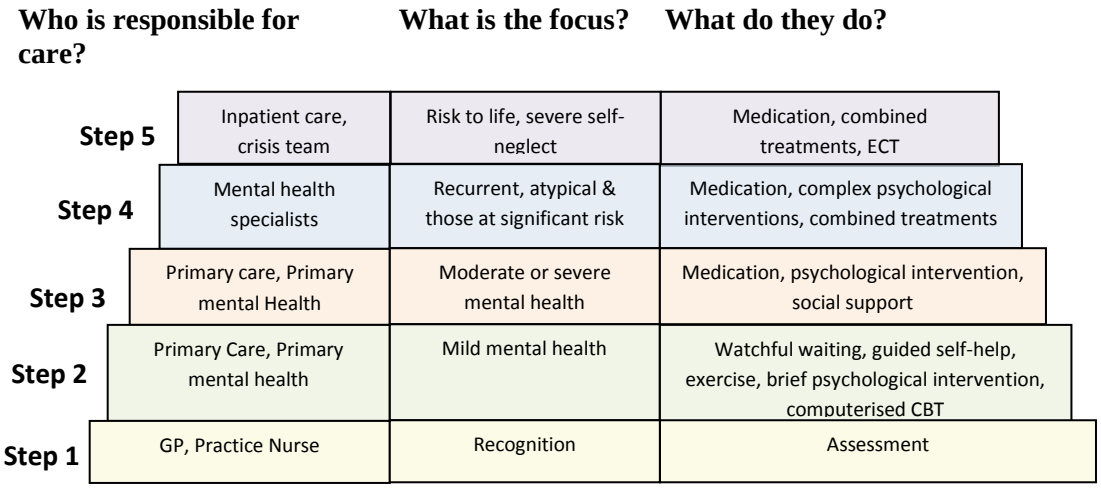
5.3. Models of Care

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[xx]). 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[xxi]).
- 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[xxii]). 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)[xxiii] 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[xxiv]).

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[xxv]). 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[xxvi]), although not for a significant number (Ravindran and Stein, 2010[xxvii]). 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[xxviii]), while augmentative medications appear to be useful in the treatment of GAD (generalised anxiety disorder), which is a more chronic condition.

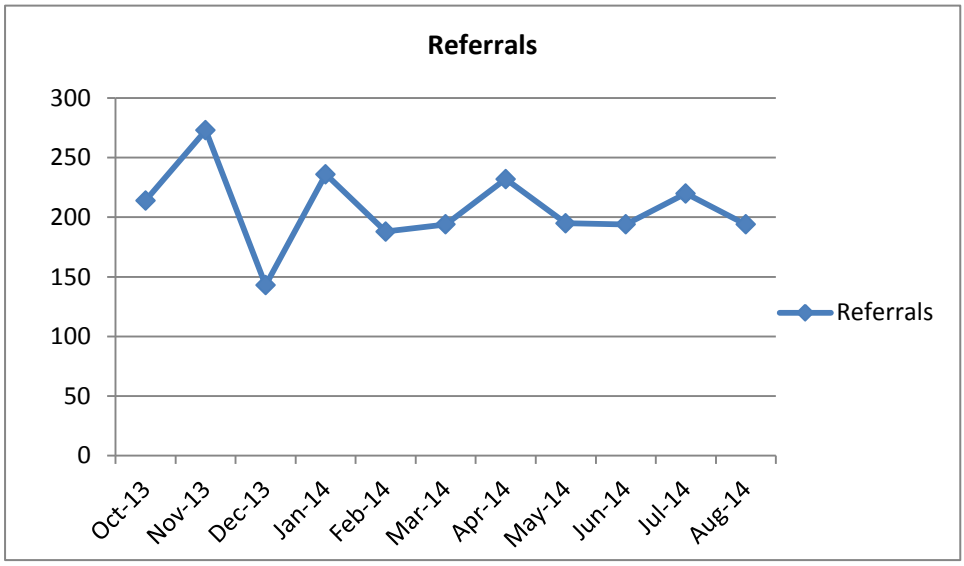
5.4.3. Non-Medical Activities

Studies on participation in leisure activities have shown improvements in self and life satisfaction, which helps in reducing depression and anxiety (Howarth, 2010[xxix]), 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[xxx]. 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[xxxi]) 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[xxxii]).

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[xxxiii]). These could be useful skills for distressed high-utilisers of healthcare services. Kurdyak and colleagues[xxxiv] 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

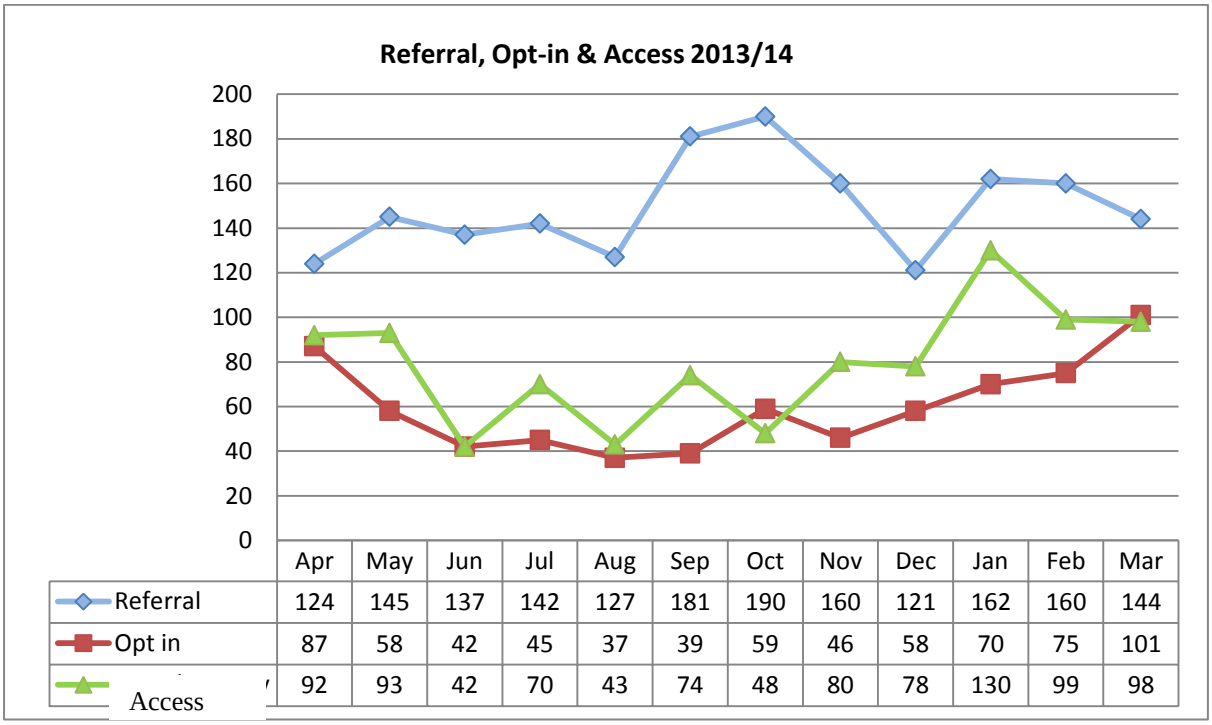
There is comparator CCG benchmarking information for the rate per 100,000 population entering treatment. Herefordshire is lower than the CCGs comparator cluster and England average (quarter 4, 2013/14).

- 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

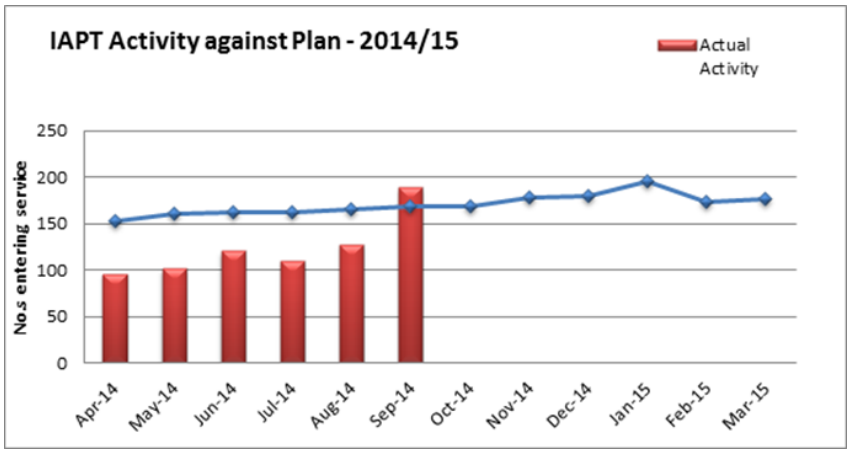
There is a need for online support so that people can access treatment in evenings and weekends from their own home.
Patient / Service-user

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.

References

[i] http://www.nice.org.uk/guidance/CG123/

[ii] NICE (2009) *CG90- Depression in adults: The treatment and management of depression in adults*. NICE: London

[iii] NICE (2014*) QS53: Anxiety Disorders*. NICE: London

[iv] NICE (2014) *Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder*. NICE: London

[v] NICE (2005) *CG26- Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care*. NICE: London

[vi] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (2009) *Adult psychiatric morbidity in England, 2007: Results of a household survey.,* Leeds: The NHS Information Centre for health and social care.

[vii] Goodwin, R., Faravelli, C., Rosi, S., Cosci, F., Truglia, E., de Graaf, R. and Wittchen, H. (2005) The epidemiology of panic disorder and agoraphobia in Europe European, *Neuropsychopharmacology 15, 435–43.*

[viii] Skapinakis, P., Lewis, G., Davies, S., Brugha, T., Prince, M. and Singleton, N. (2011) Panic disorder and sub-threshold panic in the UK general population: epidemiology, comorbidity and functional limitation, *European Psychiatry 26 (6), 354–62*.

[ix] Self, A., Thomas, J. and Randall, C. (2012) *Measuring National Well-being: Life in the UK,* London: Office for National Statistics.

[x] Martín-Merino, E., Ruigómez, A., Wallander, M.A., Johansson, S., García-Rodríguez, L.A. (2010) Prevalence, incidence, morbidity and treatment patterns in a cohort of patients diagnosed with anxiety in UK primary care, *Family Practice 27 (1), 9–16*.

[xi] [xi] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (2009) *Adult psychiatric morbidity in England, 2007: Results of a household survey*, Leeds: The NHS Information Centre for health and social care.

[xii] Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, (2003) The epidemiology of major depressive disorder: Results from the National comorbidity survey replication (NCS-R). *Journal of the American Medical Association; 289:3095–3105*

[xiii] Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H,(2001) *Psychiatric morbidity among adults living in private households, 2000*. London: The Stationary Office.

[xiv] Self, A., Thomas, J. and Randall, C. (2012) *Measuring National Well-being: Life in the UK,* London: Office for National Statistics.

[xv] Office for National Statistics (2013) *Personal Well-being in the UK, 2012/13* ONS Statistical Bulletin, 30th July.

[xvi] Hicks, S. (2013) *Differences in well-being by ethnicity*, London: Office for National Statistics.

[xvii] Potter-Collins, A., Beaumont, J. (2012) *Measuring National Well-being - Measuring Young People's Wellbeing*,2012, London: Office for National Statistics.

[xviii] Office for National Statistics (2014) *Measuring National Well-being – Young People's Well-being*, 2014, downloaded from the ONS website 20th March 2014.

[xix] Mental Health Foundation (2014) *Living with Anxiety: Understanding the role and impact of anxiety*. London: Mental Health Foundation.

[xx xx] National Institute for Clinical Excellence (2012) *Depression: Evidence Update April 2012. A summary of selected new evidence relevant to NICE clinical guideline 90 'The treatment and management of depression in adults' (2009),* London: NICE.

[xxi xxi] Friedli, L., Watson, S. (2004). *Social prescribing for mental health*. Durham: Northern Centre for Mental Health.

[xxii] Clarke, D., Layard, R., Smithies, R., Richards, D., Suckling, R. & Wright, B. (2009) Improving access to psychological therapies: initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy, 47:910-920.*

[xxiii] Radhakrishnan, M., Hammond, G., Jones, P., Watson, A., McMillan-Shields, F. and Lafortune, L. (2013) Cost of Improving Access to Psychological therapies (IAPT) programme: An analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the east of England Region. *Behaviour Research and therapy 51: 37-45*.

[xxiv xxiv] Layard, R., Clark, D., Knapp, M. & Mayraz, G. (2007). Cost benefit analysis of psychological therapy. *National Institute Economic Review 202:90-98.*

[xxv] Martín-Merino, E., Ruigómez, A., Wallander, M.A., Johansson, S., García-Rodríguez, L.A. (2010) Prevalence, incidence, morbidity and treatment patterns in a cohort of patients diagnosed with anxiety in UK primary care, *Family Practice 27 (1), 9–16.*

[xxvi xxvi] Hofmann, S., Wu, J., Boettcher, H. and Sturm, J. (2013) Effect of pharmacotherapy for anxiety disorders on quality of life: a meta-analysis, *Quality Of Life Research: An International Journal of Quality Of Life Aspects Of Treatment, Care And Rehabilitation Nov 16*.

[xxvii] Ravindran, L. and Stein, M. (2010) The pharmacologic treatment of anxiety disorders: a review of progress, *The Journal Of Clinical Psychiatry 71 (7), 839–54.*

[xxviii] Stein, D., Ipser, J. and van Balkom, A. (2004) Pharmacotherapy for social anxiety disorder, *Cochrane Database of Systematic Reviews 2004, 4.*

[xxix] [xxix] Howarth, J. (2010) *Life, Work, Leisure and Enjoyment: the role of social institutions*. Working Paper presented during the ESRC/Manchester Metropolitan University Well-being Seminar Series.

[xxx] Friedli, L (2009) *Social prescribing for mental health a guide to commissioning and delivery*. CSIP: London. http://www.centreforwelfarereform.org/uploads/attachment/339/socialprescribingformentalhealth.Pdf

[xxxi] Andrews, G., Cuijers, P., Craske, M., McEvoy, P. & Titov, N. (2010) Computer Therapy for the Anxiety and Depressive Disorders is Effective, Acceptable and Practical Health Care: A meta-analysis. *PLoS ONE 5:e13196.doi:10.1371/journal.pone.0013196.*

[xxxii] [xxxii] Krusche, A., Chylarova, E. and Williams, J. (2013) Mindfulness online: an evaluation of the feasibility of a web-based mindfulness course for stress, anxiety and depression, *BMJ Open 3: e003498 Downloaded from bmjopen.bmj.com 1st March 2014.*

[xxxiii] Ravesteijn H.J, et al(2014) Mindfulness-based cognitive therapy (MBCT) for patients with medically unexplained symptoms: Process of change. *Journal of Psychosomatic Research. Volume 77, Issue 1, July 2014, Pages 27–33*

[xxxiv] Kurdyak P, et al(2014) Impact of mindfulness-based cognitive therapy on health care utilization: A population-based controlled comparison, *J Psychosom Res, 25 Jun 2014. [Abstract*]