Swale MHAG Task and Finish Group April 2017

1	**Introduction** The Swale MHAG initiated a task and finish group with the remit to: • establish a common understanding of the services available for the people of Swale and how organised into primary care and secondary care cluster pathways • understand what the services do to support people remain well and avoid crisis • Look at the numbers of people who used services during a set time period • Look at the numbers of people who required urgent help during that time period • Draw a conclusion • Identify any challenges for MHAG • Clarify unknowns • Report to MHAG in May 2017	
2	**Context** Swale CCG wants mental health care to be more personal and to be everyone's business. They want to help create a locality where everyone works together to encourage and support children, their parents, young people and adults, with a mental health problem or illness or at risk of developing one, live in their own community, with care closer to home, to stay out of hospital and lead a meaningful life. The CCG is committed to front line innovation, using new commissioning approaches in order to: • with partner agencies to tackle the cause of mental ill health and build resilience to drive prevention • to improve mental health crisis management and recovery • offer primary care mental health interventions with a skill mix to deliver modern evidence based treatments • for an equal response to physical and mental health and towards the two being treated together • for better care coordination and case management, close to home for early intervention evidence and value based care and outcomes	**Naomi Hamilton Swale CCG**
3	The following describes the services available in Swale to help people (aged 17+) remain well, and avoid mental health crisis; however when people are in crisis they are at their most vulnerable. It is essential that they receive the care and support they need as quickly as possible, in a place they can feel safe, and that they are supported by people who understand their needs.	

3 a	**Live well Kent Service** Live Well Kent is a wellbeing service offered by a range of providers coordinated by Porchlight. The service supports people to improve their mental health and promotes independence and recovery by connecting people to their local community. It is part of the primary care mental health service and works in partnership with a network of local services and organisations to provide choice and support in improving the wellbeing of Swale residents. Experienced members of staff help individuals to understand and manage their thoughts and emotions, achieve personal goals and access therapies and support groups. In addition they provide opportunities for people to receive support with employment through training and work, gaining new skills and help to find the right job. They can also assist with tasks of everyday living such as managing money, debt and benefits, offer housing support and guidance and help improve relationships with family and friends. Live well Kent also encourages people to keep active with dance clubs, walking groups and sporting activities and offers healthy living support such assistance with cutting down on smoking or alcohol. Live well Kent can help keep people in touch through volunteering, social enterprises and community projects, the arts, music and culture groups Under the Live Well Service, we offer support for people with housing needs that result from their mental health issues. Primary care mental health specialist nurses and mental health social workers, under Live well Kent, support people with a diagnosis of severe mental illness in recovery.	**Teresa Snowdon Live well Kent (Porchlight)**
	NHS Talking Therapies (Improved Access to Talking Therapies – IAPT) Is a primary care mental health service and provided in Swale by a number of organisations (Faversham Counselling Ltd, Insight and Thinkaction) Talking therapies can help all sorts of people in many different situations. Talking therapy is for anyone who's going through a bad time or who has emotional problems they can't sort out on their own. NHS Talking Therapies provide counselling and support for common mental health problems; anxiety, low mood, low self-esteem, stress, trauma, phobias and anger, as well as problems with regards to relationships, work or debt. People can contact the service direct and details for the Swale services are on www.liveitwell.org.uk They provide cluster pathways 1-3 evidenced based psychological interventions for people with common mental health disorders such as anxiety and depression delete and replace with diagram/narrative and link to national information on cluster pathways. (see Appendix 1) Individuals can make use of self-help materials, telephone advice, on-line, 1+1 service provision, counselling and group approaches depending on their need and choice. Service user outcomes and recovery rates are used.	**Jenny Solomon NHS Talking Therapies (Insight)**

	Promotion of recovery and positive mental health provides an opportunity for collaboration with the Live Well Kent Service and other community services and interventions as part of local service delivery (e.g. social care, housing, environmental services, education, criminal justice agencies, substance misuse services, physical activity and leisure services, black and minority ethnic focused services etc). This helps to build community resilience and opportunities for primary prevention of mental ill health and promotion of recovery. **Specialist Mental Health (secondary care)** KMPT provides more specialist mental health services then those described above to people who are more unwell. The secondary care service is provided by the Swale Community mental health team either in the clinic, individuals' home or in an inpatient unit. Teams are made up of nurses, social workers, social work assistants, Support Time Recovery workers, occupational therapists, psychiatrists and psychologists. They offer specialist mental health advice, information, assessment and treatment to the people of Swale who have complex needs and require the care interventions of cluster pathways 4-17. (See Appendix 1) All interventions are based on best practice, focused on recovery and quality of life to achieve transition of their care back to primary care. Care aims to achieve agreed outcomes and provide opportunities to optimise personalisation and social inclusion. Interventions include psychological interventions and medication. Active support may be given on other aspects of lifestyle and physical health to help with the individual's mental health needs. Vocational advisors who assist people on their caseload to retain work or gain employment. Social care needs are also assessed and individuals provided with packages of care. Urgent and crisis interventions are available 24/7 and individuals and their carers are able to access these when required.	**Sarah Rodger-Smith (KMPT)**
3b	**Service User Forum** Swale User Representative Forum (SURF) provides a space for people who need Mental health support to have a voice across services through: • actively engaging people who use services and people in need of mental health support via regular communications and meetings in community venues, • sharing information about local services and support, • challenging stigma and discrimination, • promoting the development of self-help and self-advocacy, • ensuring service user views are supported and considered by service providers and commissioners. SURF's approach ensures service user independence and confidentiality, whilst forming a non-intrusive bridge between service users and providers. In this way support to people is extended, with potential crisis being observed earlier and appropriate signposting.	**Paul Francis (SURF)**

	Membership is free and members meet fortnightly at 2pm on the 2nd Thursday of each month at the Healthy Living Centre, Sheppey, and 2pm on the last Thursday of each month at Phoenix house Sittingbourne. Regular contact is made with members by email, text and telephone, which also ensure those people unable to attend meetings are still engaged, and can still make an input. Rethink Mental Illness recommends that people with mental health needs are referred to, and encouraged to join SURF, as an important step in reducing local mental health crisis, and as part of all local providers' recovery processes.	
3c	**Carers Forum** The primary aim of the Forum is to support and promote, by providing timely and appropriate services; information, advice and guidance, practical and emotional help to carers from the age of 16 years, whether they care for a family member, neighbour or friend. Meet & Talk Groups provide carers with the opportunity to meet with others and share experiences in a friendly and supportive atmosphere. Getting together with like-minded people in an informal group, to talk about similar issues and hear other people's experiences and strategies can help to relieve some of their stress, improve confidence, build up self-esteem and help the person to keep on caring Through our telephone support or a face to face at a suitable venue of choice, the carer can talk with someone on an individual basis who understands the issues carers face. One of the main concerns carers have is what would happen if they themselves were taken ill or involved in an accident. The Kent Carers Emergency Card (KCEC) enables immediate access to pre-arranged planned care, giving the carer peace of mind in an emergency. Carers Support can help work out an emergency plan and issue a KCEC.	Lindsey Kennett (Carers Support)
4 **4a** **4b**	**Data information** (Appendix 2) Information has been collated from: • Porchlight Community Mental Health Wellbeing Service • IAPT • Supported Housing • KMPT community specialist mental health team This data identifies the number of people from Swale supported with a mental health problem for 6 month period (June to Dec 2016 broken down monthly) In addition data has been collated for the same period and identifies the number of people with mental health problem from Swale who: • Called NHS 111 • Attended A&E and referred to liaison psychiatry service • Assessed and accepted by crisis resolution home treatment team • Who had contact with street triage • Detained by police under section 136 MHA • Admitted to mental health inpatient bed	

5	**Conclusion** The available data shows that in Swale 1, 271 people used primary care mental health services during a six month period in 2016; 596 people on average were in receipt of secondary care services during the same period; total 1,867 people from Swale. Unfortunately primary care data did not include those being seen only by their GP for support and/or treatment. However the Kent Mental Health Needs Assessment 2014 states that there are approximately 10,306 people in Swale with a common mental health disorder which would mean there are approximately 8,439 people seeing only their GP for support and or treatment. **Based on this assumption there are more people with mental health problems being supported in primary care and which is what would be expected.** The number of urgent referrals made to the Single Point of Access (KMPT) was not collated due to the risk of double counting and is therefore not known. The number of urgent contacts made during the same period was 372 with 16 people receiving crisis home treatment, and 81 people requiring hospital admission during the same period. **One would expect more people being treated at home as an alternative to hospital admission.** The Kent Mental Health Needs Assessment 2014 estimated: • In Swale at any one time there are 10,306 people aged 18 and over, with a Common Mental Health Disorder and that 7.5% are likely to have symptoms severe enough to require treatment from secondary care mental health services • Swale has the highest rate of all Kent districts of generalised anxiety disorder and the second highest prevalence rate of all Kent CCGs for depression, which is also higher than England average. • Swale CCG has the highest burden of health need for people with mental illness in Kent, it is estimated that there are 288 adults with borderline personality disorder, 224 people with anti-social personality disorder and 268 people with a psychotic disorder (ages 18-64). Swale has areas of very high deprivation with a significant number of people living in temporary accommodation and the second highest percentage in Kent of children living in poverty. Mental health is associated with deprivation. (link to Kent MH Needs Assessment 2014 for Swale CCG) http://www.kpho.org.uk/__data/assets/pdf_file/0006/43926/MHNASwaleCCG2014.compressed.pdf	

	Children and Young People (CYP) Across Kent a new CYP Emotional Wellbeing and Mental Health Service is being procured with a go live date of 1 September 2017. For this reason the task and finish group have focused on adult mental health. However consider the same task should be completed for CYP in order to inform MHAG and engage with provider. **Carers' participation** The Task and finish group agreed that there appeared to be a difference in what is wanted/needed by and from carer representation at MHAG. This ranged from campaigning for change and improvement at a high level, to raising awareness within local carer group and representing their views back to Swale MHAG. This will continue to be a challenge to the business of the Swale MHAG if not resolved.	
6	**Recommendations:** Based on the information and data provided the task and finish group members recommend the following 4 actions: **6.1** Agree how to liaise with GPs to promote self-help resource such as live it well website and primary care services and support so to spread the work **6.2** Make enquiries as to what needs to happen to increase the number of people being treated at home and reduce the number being admitted to hospital **6.3** Undertake the same task for Children and Young People with support from CYP Swale CCG lead Caroline Potter-Edwards **6.4** Set up a task and finish group to look at how to engage positive carer participation at MHAG The task and finish group also agreed that for people to confidently approach and use services effectively **ALL** must both: • Work together to ensure a positive image and experience of the services available • Be familiar with services and take a no wrong door approach	

Task and Finish Group Members:		**Contributions to the report from:**
Sue August Sandra Bray Brian Clark Paul Francis Mrs J. Smith- Kearney	Sarah Sales Teresa Snowdon Kim Solly Jenny Solomon	Lindsey Kennett Sarah Roger- Smith

Appendix 1 Mental Health Cluster Pathways

Mental health pathways are organised into clusters of care, which set out who will provide the care and how long it will take. The care interventions are based on national guidelines and best practice. The table below sets out how the care is organised:

Cluster Name & Number		Description of need	Lead provider in Swale
1	**Common mental health conditions (mild)** Common Mental Health Problems (Low Severity)	Definite *minor problems* of depressed mood, anxiety or other disorder. No psychotic symptoms. *No disruption* to wider functioning (activities of daily living, work, socializing etc). Unlikely to be an issue with risk. Indicative duration of care: 8-12 weeks	**GP**
2	**Common mental health conditions (moderate)** Common Mental Health Problems (Low Severity with greater need)	Definite *minor problems* of depressed mood, anxiety or other disorder. No psychotic symptoms. *Minor problems* with everyday functioning. Risk unlikely to be an issue. May have already received care associated with cluster 1 and require more specific intervention or previously been successfully treated at a higher level but are re-presenting with low level symptoms. . Indicative duration of care: 12-15 weeks	**Primary Care NHS Talking Therapies or Live Well Kent**
3	**Common mental health conditions (severe)** Non Psychotic (Moderate Severity)	*Moderate problems* involving depressed mood, anxiety or other disorder. No psychotic symptoms. *Moderate problems* with everyday functioning. Risk unlikely to be a serious issue. Indicative duration of care: 4-6 months	
4	**Complex mood and anxiety conditions** Non-psychotic (severe)	*Severe* depression and/or anxiety *with increased complexity* of needs. *Significant disruption* in everyday functioning. *Moderate risk* to self through self-harm or suicidal thoughts or behaviours (for some). Individual is unlikely to improve without treatment and may deteriorate with longer term impact on functioning. Indicative duration of care: 6-12 months (with 6 month review)	**KMPT (planned care)**
5	**Acute mood or anxiety conditions** Non-psychotic Disorders (Very Severe)	*Severe* depression and/or anxiety and/or other. No distressing hallucinations or delusions. May have some *unreasonable beliefs*. May present safeguarding issues. *Severe disruption* to everyday living. Moderate or severe problems with relationships. Various problems in other areas of role functioning. *High risk* for non-accidental self-injury, other risks or safeguarding issues if responsible for young children or dependent adults. Indicative duration of care: 1-3 years (6 monthly review)	**KMPT (urgent care)**

6	**Enduring mood or anxiety conditions** Non-psychotic Disorder of Over-valued Ideas	*Moderate to very severe* disorders. *Limited treatment response* to date. Everyday activities and role functioning are *seriously affected* in many ways. Risk is unlikely to be a major feature. Safeguarding may be an issue if responsible for young children or vulnerable dependent adults. Indicative duration of care:3 years+ (6 monthly review) Annual tariff will apply.	**KMPT (planned care)**
7	**Stable mood or anxiety conditions (high disability)** Enduring Non-psychotic Disorders (High Disability)	*Moderate to severe* disorders. Received treatment over a number of years. Improvement in positive symptoms but considerable *disability in daily activity* and role functioning. Risk unlikely to be a major feature. Safeguarding may be an issue if any responsibility for young children or vulnerable dependent adults. Indicative duration of care: 3 years+ (annual review) Annual tariff will apply.	**Primary care (Mental health clinical specialist Live Well Kent)**
8	**Complex Personality Disorders** Non-Psychotic Chaotic and Challenging Disorders	Wide range of symptoms with *chaotic and challenging* lifestyles. Moderate to very severe repeat *deliberate self-harm* and/or other impulsive behaviours. Chaotic, over-dependent engagement accompanied by hostility towards services. Poor role functioning. Severe problems in relationships. Suicide *risk* likely to be present. Safeguarding may be an issue. Indicative duration of care: 3 years+ (annual review)	**KMPT (planned care)**
10	**First episode psychosis**	*First presentation with mild to severe psychotic* symptoms. May also have depressed mood and/or anxiety or other behaviours. Drinking or drug-taking may be present but *will not* be the only problem. *Mild to moderate* problems with activities of daily living and relationships. Poor role functioning. Indicative duration of care: 3 years (with minimum annual review).	**KMPT (planned care)**
11	**Stable psychotic conditions** Ongoing Recurrent Psychosis (Low Symptoms)	*History of psychotic symptoms* that are currently *controlled* and causing minor problems, if any at all. Currently experiencing a period of recovery. Capable of *full or near functioning*. May be impairment in self-esteem and vulnerability. Risk of relapse. Indicative duration of care: 2 years (with minimum annual review).	**Primary care (Mental health clinical specialist Live Well Kent)**
12	**Stable psychotic conditions (high disability)** Ongoing or recurrent Psychosis (High Disability)	History of psychotic symptoms. *Significant disability* and major impact on role functioning Possible *cognitive and physical problems* linked with long-term illness and medication. Limited survival skills and *lacking basic life skills*. Poor role functioning in all areas. Likely to be *vulnerable* to abuse or exploitation. Indicative duration of care: 3 years+ (with minimum annual review).	

13	**Enduring psychotic conditions** Ongoing or Recurrent Psychosis (High Symptom & Disability)	History of *poorly controlled severe to very severe psychotic symptoms*. Often co-morbid anxiety or depression. Significant level of disability with major impact on role functioning in all areas. *Lack of basic life skills*. Cognitive and physical problems linked with long-term illness and medication. Risk associated with *vulnerability to abuse* or exploitation. Indicative duration of care: 3 years+ (with minimum annual review).	**KMPT (planned care)**
14	**Acute psychotic crisis** Psychotic Crisis	Acute *psychotic episode with severe symptoms*. Severe disruption to role functioning. Cognitive problems may be present. Everyday activities and *role functioning severely disrupted* in most areas. *Risk* to self or others. Challenging behaviours and some vulnerability to abuse or exploitation. May be *poor engagement* with service. Safeguarding risk if parent/carer. Indicative duration of care: 8-12 weeks (with 4 weekly review)	**KMPT (urgent care)**
15	**Acute psychotic depression** Severe Psychotic Depression	Acute episode of *moderate to severe depressive symptoms* with *hallucinations and delusions*. *Severe disruption* to daily activities and role functioning. Cognitive problems may present. *Risk* of non-accidental self-injury, other risks and vulnerabilities. Safeguarding risks if parent or carer. Indicative duration of care: 8-12 weeks (with 4 weekly review)	KMPT (urgent care0
16	**Dual diagnosis** Dual Diagnosis (specialist care)	*Enduring, moderate to severe psychotic or affective symptoms* with *unstable, chaotic* lifestyles and co-existing *problem drinking or drug taking*. Role functioning often globally impaired. Physical illness or disability may be present from problem drinking or drug taking. May be cognitively impaired due to psychotic features, problem drinking or drug taking. *Risk* to self, including risk of accidental death. Moderate to severe risk to others due to violent and aggressive behaviours. *Poor engagement* with services. Indicative duration of care: 3 years+ (with minimum 6 monthly review)	KMPT + substance misuse service provider -shared care
17	**Psychosis and affective conditions (assertive engagement)** Psychosis and Affective Disorder – Difficult to Engage	*Moderate to severe* psychotic symptoms combined with an unstable, chaotic lifestyle. *Drug or alcohol misuse* not severe enough to warrant dual diagnosis care. May be cognitive impairments from psychotic illness, problem drinking or drug taking, or prescribed medication. *Severe problems* with relationships. Difficulty in one or more other area of functioning. *Moderate to severe risk* of harm to others due to aggressive or violent behaviour. *Risk* of non-accidental self-injury. *History* of non-concordance, vulnerable and *poor engagement* with	KMPT

		services. Indicative duration of care: 3 years+ (with minimum annual review).	

Key:	Planned primary care pathways 1,2,3,7,11 and 12	Planned secondary care pathways 4,6,8,10,13,16 and 17	Urgent and crisis care pathways (incl. admission) 5,14 and 15

Appendix 2 Swale Data

4 a Total number of people from Swale with mental health problems who between June and Dec 2016 were supported by:								
	Service	**June 2016**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Total**
Primary Care (cluster care pathways 1-3)	Live Well Kent Service	53	61	62	54	69	67	**366**
	NHS Talking Therapies (IAPT)	135	140	170	195	130	135	**905**
		188	201	236	249	199	202	**1,271**
Secondary Care (cluster care pathways 4-17)	Community Mental Health Team caseload (KMPT)	**566**	**583**	**564**	**582**	**636**	**648**	**596 average caseload per month**

4 b The number of people from Swale who between June and Dec 2016 had urgent need and:							
Service	**June 2016**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Total**
NHS 111	6	19	7	11	7	9	**59**
Referred to Swale CMHT	25	27	15	27	23	18	**135**
Attended A&E and referred to liaison psychiatry team	7	12	8	13	8	10	**58**
Assessed and accepted by crisis resolution home treatment team	0-5	8	0-5	0-5	0-5	0-5	**16**
Contact with Street Triage	4	4	2	0	8	2	**20**
Detained by police under Section 136 MHA	5	6	7	8	6	2	**34**
Admitted to inpatient unit	14	18	14	7	15	13	**81**
Total number of urgent contacts with services	**61**	**94**	**53**	**66**	**67**	**54**	**372**

Task and Finish Group members found this diagram helpful

The pyramid of psychological need (adapted)

LEVEL 5
Severe and complex mental Illness/disorder requiring specialist mental health intervention(s)

LEVEL 4

More severe psychological problems that are diagnosable and require biological treatments, medication and specialist psychological interventions

LEVEL 3
Psychological problems which are diagnosable/classifiable but can be treated solely through psychological interventions, E.g. mild and some moderate cases of depression, anxiety states, Obsessive/compulsive disorders

LEVEL 2
Some problems coping, causing anxiety Or lowered mood

LEVEL 1
Problems at a level common to most people and benefit from self-help resource