Mental Health Service Transformation in Thurrock –

The Next Steps

A discussion Paper

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1 Introduction: the purpose of this paper.

This paper discusses the need for adult mental health systems transformation in the context of three key recent pieces of work; the Adult Mental Health Joint Strategic Needs Assessment Product; The Local Government Association Peer Review in Adult Mental Health and; consultation work undertaken by Thurrock Healthwatch and other local partners with local residents and users of mental health services. It aims to triangulate the findings of this work with other local intelligence and the published evidence base in order to continue a discussion with all stakeholders as to what needs to change.

There has been considerable effort undertaken within Thurrock to transform local health and care services over the last three years including plans to create four new Integrated Medical Centres, a *New Model of Care* for Tilbury and Chadwell, the *Stronger Together* programme of community development and asset-based approaches, a Thurrock *Integrated Care Alliance,* the joint *For Thurrock in Thurrock* CCG-Adult Social Care programme and considerable efforts to transform Primary Care services. However mental health systems transformation has not perhaps featured as strongly as it should within these programmes to date.

In discussing local mental health service provision, this paper highlights a series of concerns and areas of practice that need improvement, based on the findings of the MH JSNA, LGA Peer Review and Healthwatch *User Voice* work. In doing so, it seeks to criticise neither the hardworking front line professionals working with residents experiencing mental health difficulties, nor individual organisations that make up the mental health and care system, but the current configuration of the system itself, which it argues is not fit for purpose and needs urgent transformational reform. The paper proposes and discusses five key areas of transformation activity that emerge from the findings of the work to date around which this transformation should be concentrated. These are discussed in detail in section 3.

Public Health have committed to fund a new Strategic Lead post a key remit of working with all stakeholder organisations and local service users to develop a new Thurrock Mental Health Systems Transformation strategy and associated new models of care and commissioning arrangements. The paper makes a series of high level recommendations in each area, highlights current community and system assets related to the recommendations and poses a series of further questions that will hopefully guide development of this strategy, and which all stakeholders need to consider as part of our collective transformation journey.

2 Epidemiological Overview of Mental Health

Mental illness is the single largest cause of disability in the United Kingdom, contributing up to 22.8 per cent of the total burden, compared to 15.9 per cent for cancer and 16.2 per cent for cardiovascular disease[1]. Current figures suggest that one in four people will experience a mental health problem during their lifetime. No other set of health conditions match the combined extent of prevalence, persistence and breadth of impact of mental ill-health. [2]

Among people under 65, mental illness accounts for nearly half of all instances of ill health[3]. Mental illness often begins early in life and affects people over a long period.[4] Estimates suggest that between a quarter to a half of mental health issues experienced in adulthood could be averted with effective early interventions in childhood.[5] Depression and anxiety disorders are by far the most common mental illnesses, affecting 11.66% of the adult population of Thurrock aged 16-74 in 2016.[6] A further 0.7% of the adult population of Thurrock has been diagnosed with a serious mental health disorder. [7]

Mental illness has a huge impact on population health. There is a bi-directional relationship between poor mental health and poor physical health. People with mental health problems are at higher risk of experiencing significant physical health problems; they are more likely to develop preventable conditions such as diabetes, heart disease, bowel cancer and breast cancer, and do so at a younger age. People with serious mental ill health die on average 20 years before the general population.[8] . Conversely, rates of mental illness, particularly depression, are between two and three times more common in those with long-term conditions compared to the general population including coronary heart disease, cancer, diabetes, osteoporosis, multiple sclerosis, immunological problems and arthritis. Mental health co-morbidities in those with physical long term conditions contribute significantly to poor physical health outcomes and higher treatment costs; it is estimated that £1 in every £8 spent on treating a long-term condition is linked to a co-morbid mental illness.[9]

Mental illness further affects the way individuals manage their health and interact with services. People with mental health problems are more likely to misuse substances[10] and less likely to be physically active[11]. Furthermore, they are less likely to attend medical appointments[12] and less likely to adhere to treatment and self-care regimens[13] [14] [15]

The cost of mental ill-health in England has been estimated to be £105 billion of which £30 million is allocated to work related sickness. This is due to increase and double over the next 20 years. The costs to Social Care for people with mental health collates to £2 billion annually and is also likely to continue to increase if mental health services are not re-organised and managed more effectively.[4] This will put ever more pressure on an already overstretched NHS and Social Care system. Data held on Thurrock Council's LAS Adult Social Care record system suggests that the council spent £6.55M on social care packages due to mental ill health in 2015-16.

3 Background

Two major pieces of work on the Adults and Older People Mental Health agenda have recently been completed in Thurrock in response to anecdotal concerns raised by health and care professionals and *Thurrock Healthwatch* that the current system is not fit for purpose and is failing residents:

- Thurrock Joint Strategic Needs Assessment for Common Mental Health Disorders in Adults (recommendations agreed at the Joint Health and Wellbeing Board in March 2018)
- Local Government Association Peer Review into Mental Health (presented at the Joint Health and Wellbeing Board in July 2018)

The key findings of both of these reports are summarised below and overleaf and the findings/recommendations of both have been used in production of this paper.

3.1 Mental Health JSNA

Finding	Summary Recommendation
System Fragmentation The current mental healh prevention and treatment system is highly fragmented with a large number of services operating at different levels and commissioned in parallel	**Integration of commissioning** Pland for joing commissioning across health and social care in Thurrock should include integration of mental health commissioning between the local authority and CCG. Joint commissioning should be used as a platform to drive integration of services around the individual
	Integrated Service Delivery: The development of new models of care provides a huge opportunity to try doing thing differently. Mental health needs to be integrated into the delivery of new models of primary care and wellbeing teams delivering social care in the community. There are also important opportunities to integrate services addressing the social determinants of mental health such as housing and employment into these new models of care.
Under-diagnosis A large proportion of those with mental ill health are never diagnosed or treated. Depression is particularly poorly diagnosed and there is wide variation between GP practices in the extent of case finding.	**Reduce unwarranted variation between GP practices in case finding**. Building on the work of the GP practice profiles produced by the public health team there is an opportunity to reduce variation and find the 8000+ people estimated to have undiagnosed depression in Thurrock.
	Make better use of depression screening. There is a strong evidence base to support the use of depression screening amongst front-line staff working with high risk groups (e.g. use by social workers or health professionals in long term condition clinics). Current use of this tool appears to be minimal and is not consistently monitored. Joint work between the local authority and CCG is needed to promote this
Quality of Care Even when people are identified as having a mental illness they are often not referred for treatment or their treatment is not in line with the highest quality standards.	**Reducing unwarranted variation between GP practices.** Variation in referrals into IAPT services and reviews of newly diagnosed depression are examples of two quality standards which could be improved through joint working between GP practices and the public health team.
	Commissioners working to improve standards. Redesign of CCG-commissioned services of some existing services is underway and standards are expected to improve. This must be monitored closely by commissioners.
	Improve quality of service data. Commissioners in the local authority and CCG are working with providers to improve the quality of the service data they receive. New indicators need to be designed with are meaningful and focussed on patient outcomes, including wider social outcomes.
Risks Associated with Mental Health There are well-known wider health risks associated with mental health including high rates of smoking, obesity and long-term conditions (LTCs).	**Improve understanding of links between mental health and LTCs.** Feedback from residents with LTCs suggests that clinicians do not always appreciate these connections. Education of health professionals would be beneficial.
	Promote smoking cessation in those with serious mental illness. Work is ongoing between public health and mental health provider services to promote smoking cessation even in in-patient settings. This needs to be brought to completion and monitored.
	Promote referral of mental health patients into healthy lifestyles services commissioned by public health.

3.2 LGA Peer Review

	Area of investigation	Strengths	Areas for consideration
1	**THRESHOLDS** The extent to which he current servcie 'gate keeps' and the suitability of where 'thresholds' are set	· Thresholds are set and applied · Open referral for Local Area Coordinators · When high-level need is identified, the Grays Hall service received is perceived as good	· Crisis team perceived as gatekeepers and maintain high thresholds · GP referral system is seen as building delays; medical model · Opportunity to open up other referral routes but only as part of an holistic system change · Difference in perception of what "crisis" is and understanding of Threshold Criteria; for individual and service · Performance information not seen to evidence intervention impact on improvements in MH
2	**PERSON CENTRED-OUTCOME FOCUSSED** The extent that current arrangements and organisational culture delivers a person-centred, strengths based approach including a focus on delivering outcomes and a move away from "one size fits all"	· LACs person-centred approach widely acknowledged · MIND, Inclusion Thurrock (IAPT) and Recovery College services are well regarded · Once diagnosed, services are seen to be good · Cross-party political agreement for service improvement · Housing services reported that they worked well with Grays Hall on individual cases · Low numbers of rough sleepers	· Variable provision when thresholds are not met · Lack of a specialist housing plan for people with MH issues · Social workers should focus on the complex. Needs of the less complex should be met through other arrangements · Ensure that social work practice/values as a profession are asserted and owned within EPUT/Grays Hall team · Stretched but effective preventative provision for borderline homeless not consistent across the area, with rising demand from inner-London migration
3	**MARKET CAPACITY AND DEVELOPMENT** The extent that the current 'offer' needs to expand and the exent to which the market is robust enough to deliver against this	· Existing Market Position Statement and Joint Strategic Needs Assessment MH Product · Housing Investment and Regeneration Group recognises vulnerable people · Proactive in-house housing team deals with difficut supply issues · Innovation in terms of fragile social care market, e.g. Domicilary Care could be applied to MH · Community Hubs ad Strength Based conversations in ASC and 3rd sector; needs to be aligned and planned wih service model in nascent four IMCs	· Detailed analysis of MH market needs and specialist accommodation · Opportunity to Invest to Save to deliver accommodation, looking at external placements with the CCG · Build on personalisation approach and values in ASC and Housing
4	**A HOLISTIC SERVICE OFFER** The extent to which the current offer is holistic	· Thurrock First is seen as responsive and innovative · LACs development is sen as positive and well regarded · Joint commitment to development of IMCs · Joint funding of an Integrated Care Director · Opportunities to resolve operational housing issues through local housing group · Social prescribing in Primary Care	· Opportunity exists for EPUT to work jointly with NELFT, building on the NMC Pilot in Tilbury and Chadwell · Secondary MH care needs to benefit from a wider multi-disciplinary approach · IT incompatibilities between the council and EPUT · Ensure full engagement of seconded staff in all council initiatives · Grays Hall Crisis Line is not responsive · LACs have some inconsistency in approach, with skill variations
5	**PREVENTION** The extent to which the service is preventative	· LACs are responsive and can prevent crisis · Recovery College · Thurrock First · Improving out-reach reported in Purfleet and South Ockendon · MIND recognised as an asset · Thurrock Healthwatch providing useful feedback to prevent direct interventions	· Consider joint funding of prevention in MH with CCG as an invest to save initiative · Older People's MH service workload does not allow a focus on prevention · Thurrock First should consider interim measures to fill the gap in MH expertise and housing · Opportunities to agree a housing strategy and policy for people with MH issues - *"the same people float around the system "* · The Care Act is not well understood across partners
6	**WORKING WITH OTHER COMMUNITY PARTNERS** The interface between other key partners, e.g. housing and primary care	· Recent evidence of EPUT and Thurrock Coucnil wanting to improve their relationship · Robust evidence of good practice in the community, e.g. community enterprises, *Housing First, Shared Lives* · Shared care protocol · Positive relationships across partners witha 'can-do' attitude · Strong and valuable partnership with Thurrock coalition	· Recalibrate the relationship with EPUT and Thurrock Council, movnig on from legacy issues and past working · Make better use of resources across the Health and Social Care economy · Work in communities disparate and disjointed · Independent sector has expressed uncertainty about future funding, risking further integration
7	**SECTION 75** The extent to which the Section 75 is fit for purpose and possible areas of change	· Southend-on-Sea are open to working more closely on Performance Information · Thurrock Council is working more positively with EPUT post-reorganisation · Operations Group ready to take on a more engaged role; including provider and service user representation · BCF perceived as positive	· Need to develop and agree a single reporting and outcomes framework. · Assure that social care values and approaches are part of EPUT ways of working, including Executive Board level representation · Need to value social work practice including the availability of crisis team to support AMHPs and (for example), social workers being responsible for bed-finding, championed by Principle Social Worker. · No single point contact within Thurrock for Southend-on-Sea for developing commissioning issues · Section 75 staffing arrangements have a Health led culture that shapes practice
8	**COMMISSIONING ARRANGEMENTS** The extent to which current partnership arrangements are working both interms of providers and commissioning (CCG and Council)	· Public Health is an asset; has driven the Tilbury and Chadwell 'Case for Change' and through JSNA products and LTC management programme such as Stretched QOF · Opportunities to develop joint commissioning arrangements with CCG and others. · Council has recognised difficulties with EPUT and started to grip the situation · Council has a reputation for innovation and ability to deliver transformation - well regarded by partners.	· Consolidate new approach to management of EPUT; develop a plan that is set out and monitored · Need to commission for the *"Missing Middle"* e.g. with 24/7 crisis support, step-down, dual diagnosis. The current absence of services is seen as a clear gap by stakeholders · Consider how best to manage the development of the four IMCs in the context of NHS/STP · Ensure IMC development works to a realistic timeframe and service model · Joint commissioning with CCG-CCG currently focussed too narrowly on commissioning primary and secondary care. Need to develop a more holistic approach.

3.3 User Voice

Thurrock Healthwatch are currently undertaking a significant piece of research with service users of local mental health treatment services through both questionnaires and face to face engagement. Whilst this piece of work is not due to report until September 2018, the responses provided to *Thurrock Healthwatch* to date, together with intelligence gathered from workshops run by Th*urrock Coalition* with mental health service users have also been considered in the production of this paper.

4 Transforming Mental Health Services in Thurrock – Six Priority Areas

By triangulation of the intelligence, evidence and recommendations set out in the Mental Health JSNA, LGA Peer Review and User Voice, this paper proposes five *Key Themes* that warrant attention of local system leaders in order to improve and transform local mental health services for the benefit of Thurrock residents. These are summarised below and then discussed in turn in the context of the published evidence base, policy and other local intelligence.

1. Addressing Under-Diagnosis
2. Getting into the system
3. A new treatment offer for Common Mental Health Disorders
4. A new 'enhanced treatment' model including a greater focus on prevention and early intervention
5. Integrated Commissioning

These are discussed in detail in the proceeding sections

5 Addressing under-diagnosis

As with many other long-term conditions in Thurrock, there are a significant cohort of the population living with Common Mental Health Disorders who remain undiagnosed and are therefore not receiving support treatment. This has been repeatedly highlighted by the Thurrock Public Health Service in the Annual Public Health Report 2016[16], Tilbury and Chadwell New Model of Care *The Case for* Change[17], and Mental Health JSNA[7]. The latest modelled estimates from Public Health England (2016) found there are likely to be as many as 21,317 residents who have depression in Thurrock, of which 8,628 remain undiagnosed. The size of this cohort is a significant public health issue in itself and also will likely be compounding poorer health outcomes in patients with other co-morbid long term conditions.[8]

The Mental JSNA shows an approximate four-fold variation in GP Practice Depression QOF register completeness ranging from 24% through to fully complete. A number of programmes are already being implemented to *find the missing thousands* of residents with undiagnosed depression. These include:

- Including the PHQ-9 depression screening tool as part of the Thurrock NHS Health Check Programme

- Commissioning ICS to interrogate SystmOne in GP practices to identify patients' medical records that have entries that may suggest depression (for example prescription of an SSRI) but who are not on depression QOF registers
- Piloting proactive template prompts in SystmOne that highlight the need for a GP to undertake a PHQ-2/9 depression screen with patients being reviewed/newly diagnosed with physical long term conditions (starting with diabetes with a view to rolling out across all LTCs if successful).
- Piloting embedding electronic IAPT referral into SystmOne in response to a positive screen on a PHQ-9.

There are further opportunities to embed depression screening across the health and care system locally, particularly by front line professionals such as community nursing and social care staff working with older people (who are at significantly greater risk of having undiagnosed depression), other community workers for example Local Area Coordinators and Social Prescribers, and moving forward the new *Wellbeing Teams* about to be piloted in Tilbury and Chadwell. Future mental health transformation plans need to consider these and other opportunities for embedding depression screening into the role of the wider workforce, and for widening access to symptom checkers for the general population. For example, there may be further opportunities to embed depression screening tools into existing E-Consult/Web-GP and NHS Choices software.

Case Study – The Good Thinking Project

Public Health England interrogated the commercial datasets held by Google and Facebook to identify people in London who used social media to post about a mental health issue, including a 'look back' exercise to see what this cohort of residents were posting one, two and three years prior to their post about mental health. This allowed them to identify social media posts and internet searches that best predicted future mental health problems, and then build an algorithm that accurately predicted those in the population most likely to experience future depression or anxiety.

By forward running this algorithm, PHE identified a potential 1M people with undiagnosed depression or anxiety in London, many of whom were unlikely or unwilling to discuss their symptoms with their GP.

The Good Thinking Project is a web based intervention aimed at this cohort of residents. It includes an online symptom checker that acts as a screening tool for anxiety and depression and includes a range of different on-line treatment tools including peer support, mindfulness training and sign posting to local community resources and assets.

5.1 Next Steps: Addressing Under-diagnosis

High Level Recommendations	• Expedite roll out of PHQ2/9 depression screening tool prompt template in SystmOne for patients that are being reviewed for physical long-term health conditions • Improve uptake of the NHS Healthchecks programme to a minimum of 60% of those offered a healthcheck, as a systematic way to screen for undiagnosed depression • Embed depression screening into the practice of wider front line professionals and new models of care including front line housing, social care and community workers • Improve access to depression screening for the general population with the use of online screening tools linked to self-referral mechanisms
Key Questions for further Metal Health Transformation	• How can we best embed depression screening practice into the day job of a wider cohort of resident facing staff across the public sector? • Are there opportunities to embed depression screening into the work of community volunteers and at community hubs? • Can we capitalise on the proposed new models of care in Tilbury and Chadwell including Community Led Support Teams and Wellbeing Teams to systematise depression screening? • How can we use commercial datasets held by social media companies and search engines to better target depression screening at the general population at risk through on-line portals? • How can we better increase the up take of NHS Healthchecks in practice populations where this is currently low?
Existing Assets to build on	• *Better Care Together Thurrock* Long Term Conditions Working Group / Project Plan • Tilbury and Chadwell new models of care including Wellbeing Teams and Community Led Support Teams • Thurrock Council Public Health Social Marketing Research on Health checks • Local Area Coordinators • Community hubs • Analysis within the MH JSNA about other key 'at risk' groups that could benefit from a tailored approach.

6 Getting into the system

Difficulty in accessing current local mental health treatment services is a recurrent theme running through the JSNA, LGA Peer Review and 'User Voice' work undertaken by Healthwatch (featuring in 100% of all survey responses received to date) and The Thurrock Coalition. This is true of both services to treat Common Mental Health Disorders and more serious mental ill-health.

The issue encompasses variation in referral behaviour across different GP practices, unacceptably long waiting times following referral, complexity of referral pathways, current clinical thresholds for referral acceptance and inadequate coverage of the provision of crisis care services. These are discussed in turn.

"I have suffered for over 20 years with mental health problems, have been referred to MIND and a psychologist under Inclusion. I have been waiting months for an appointment, and would like to see a walk in centre"

The DH has stated a national ambition to have 25% of patients estimated to have depression or anxiety being treated by an IAPT service by 2020/21. The Mental Health Disorders JSNA highlighted significant variation in entry to IAPT services between different GP practice populations diagnosed with depression and anxiety in 2016/17, ranging from 8% to 46%. This could be partly a function of poorer levels of access to IAPT provision in certain localities across the borough (it is interesting to note that four of the seven practice populations with the lowest percentage of diagnosed patients with depression are in Tilbury), although is likely to also reflect variation in referral behaviour of GP surgeries and self-referral behaviour of their patients. Variation in knowledge and clinical practice of different GPs is highlighted in the user voice work, particularly in terms of serious mental ill health, with several responders highlighting the need for better training of GPs and other Primary Care clinicians in serious mental ill health.

Action to address this variation needs to be part of future Mental Health Service Transformation.

Waiting times for IAPT treatment also appears to be deteriorating and needs to be addressed. In March 2017, the Mental Health JSNA reported that 98.5% of patients waited fewer than six weeks for treatment by IAPT, however latest reports provided at the *Better Care Together Thurrock Long Term Conditions Programme Board* suggest that access has deteriorated to waiting times of typically 14 weeks. Waiting times for services provided by MIND have also been highlighted by some residents as too long. Further action (and possibly additional resource) needs to be considered to address this situation and reduce waiting times to 2016/17 levels.

Accessing secondary mental health treatment services is equally problematic and is highlighted in both the LGA Peer Review and User Voice work. EPUT currently only accept new referrals from a GP surgery. This causes an immediate problem to residents in mental health crisis who are unable to access a GP appointment quickly, leaving them without access to timely assessment and treatment and risking further deterioration in their mental health. The LGA Peer Review commented that "*GP referral is building unnecessary delays into the system.*"

Whilst Primary Care Transformation work including the mixed skill workforce that is being implemented in Tilbury and Chadwell as part of *Better Care Together Thurrock* should ameliorate Primary Care access issues, roll out borough wide is likely to take several years and urgent action is required now to provide timely access to mental health assessment and treatment for those with conditions too complex to be treated by IAPT. There may be opportunities to open up other referral routes into EPUT as part of holistic systems

A lack of 24/7 crisis care is repeatedly referenced in the user voice and LGA peer review. The current Grays Hall Crisis line is seen as not sufficiently responsive and doesn't operate out of hours or over the weekend leaving few choices of residents in crisis over and above attendance at A&E. *Thurrock First* is also seen by users as inadequate, reflecting the current lack of provision of 24-7 crisis services and simply signposting back to the limited access options of A&E or the GP surgery.

Front line clinicians have also highlighted difficulties in accessing assessment for patients experiencing mental health crisis, citing complexity and fragmentation within EPUT care pathways and the fact that Community Psychiatry won't take community referrals unless the patient is already known to EPUT and that new patients are only assessed as an emergency if they come via Acute Care. The quote opposite from a local Tilbury GP is an example of some of the current problems.

"One of my care home patients who has chronic schizophrenia was becoming aggressive and needed urgent assessment. I called the Crisis Team at EPUT and was told to contact First Response. I called them but was told they couldn't help and sign posted me to the Grays Hall Duty Team. They told me that they could only accept acute referrals and told me to take the patient to A&E. It was only when I lost my temper and refused to do this and eventually the Crisis Team undertook the assessment.

Thurrock GP

"My husband is suffering with severe anxiety and depression and was 'eventually' referred to Inclusion Thurrock by this GP but has been waiting for 20 weeks. This is not acceptable. He had a second breakdown this weekend and was so bad he ended up at A&E for the second time. Our GP surgery won't speak to me and my husband is finding it difficult to deal with. We now have to wait for a GP telephone appointment as we can't get a face to face appointment"

Thurrock resident telephone response to Healthwatch User Voice survey

A RAID (Rapid Access, Interface and Discharge) team is operating at Basildon Hospital. However anecdotal evidence provided by the hospital's Managing Director suggests that a lack of access to community mental assessment is driving patients in mental health crisis to A&E unnecessarily and causing avoidable system-wide treatment costs. The hospital operates a Clinical Decision Unit (CDU) where patients with high levels of need presenting at A&E can be seen and assessed/diagnosed with a view to preventing four hour A&E wait breeches and avoiding unnecessary hospital admissions. However the Hospital's Managing Director reports that capacity in the CDU is increasingly being monopolised by patients in mental health crisis, demand from whom is increasing at an unsustainable rate and now averages 10 per day. This in turn is resulting in inadequate assessment capacity within the CDU for patients with physical health needs and in turn,

avoidable hospital admissions to avoid A&E four-hour wait breeches, placing operational stress on the hospital and avoidable cost on the system.

The LGA Peer Review report a difference in perception of what "crisis" means between individuals and services. The LGA Peer Review and User Voice work also highlight that current 'thresholds' are currently set too high. This is resulting in what the LGA Review deem *The Missing Middle* – a cohort of patients with complex needs deemed too ill to be treated by IAPT but with a level of mental ill-health complexity below the threshold for treatment by EPUT without a service. This cohort of patients often ends up back in Primary Care who report having inadequate support or expertise to provide treatment, and/or is being picked up by Local Area Coordinators.

Work has already commenced at STP level to develop and commission a 24/7 Crisis Care model, and work has already begun as part of the Urgent and Emergency Mental Health Work Stream across the STP.

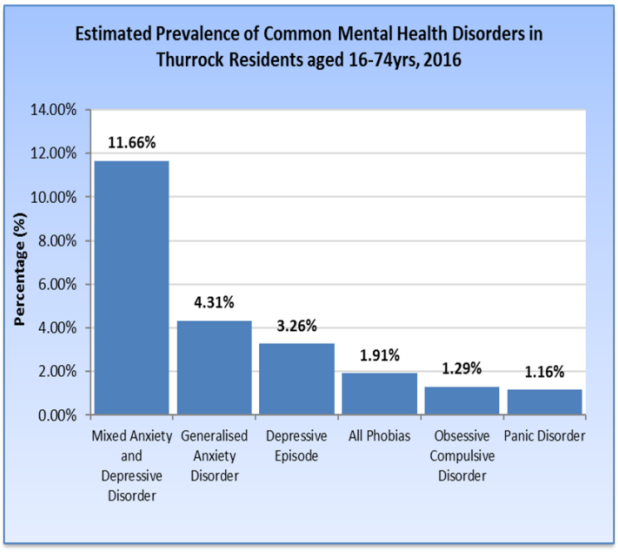
6.1 Next Steps: Getting into the System

High Level Recommendations	• Reduce waiting times to IAPT and MIND Services to an agreed maximum standard of no more than the six week national standard • Develop and implement a new model of 24-7 Rapid Direct Access Crisis Care Assessment within the community to reduce supply side demand on A&E and negates the need for a GP referral into secondary mental health care • Agree system wide *thresholds* for treatment into secondary mental healthcare services that are recognised by all stakeholders and ensure that all patients above the threshold for IAPT services receive prompt assessment and treatment
Key Questions for further Metal Health Transformation	• To what extent do we need to increase capacity of IAPT to meet demand and reduce waiting times, what will this cost, how do we fund it and what will be the Return on Investment and population health gain on avoided excess treatment costs in other parts of the system? • What does an effective model of 24-7 assessment/crisis care within the community look like, what will it cost, how do we fund it, and what will be the return on investment and population health gain in avoided excess healthcare costs elsewhere in the system (for example through releasing capacity in? • What changes need to be made to current treatment threshold levels across Primary, Community and Secondary Care to ensure that all residents with mental health needs receive a service, and how do we develop a single shared understanding of thresholds across all treatment providers? • How can work on a 24/7 Crisis response model commenced at STP level best be applied to Thurrock?
Existing Assets to build on	• Thurrock First • Local Area Coordinators • Community Hubs • Primary Care Locality Mixed Skill Workforce Team • IAPT • Thurrock MIND • Hospital based RAID Team • EPUT Assessment Services • Work already started at STP level of 24/7 Crisis Response

7 A New Model of Care for Common Mental Health Disorders

Figure 1

Common Mental Health Disorders (CMHDs) include depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). Figure 1 shows the estimated prevalence of CMHDs in Thurrock residents aged 16-74 in 2016.



CMHDs account for the vast majority of mental health problems in the population and moreover, the vast majority these cohorts of patients will be treated in Primary and Community Care.

Evidence in the Mental Health JSNA, LGA, Peer Review and other local intelligence suggests that the current offer is inadequate and subject to unwarranted levels of variation between different practice populations. Three key issues are identified which will be discussed in turn:

1) Unacceptable levels of variation of treatment between different GP practice populations and different population groups
2) The need to integrate mental health treatment services with physical health services
3) The need to broaden the treatment offer to encompass a strengths based approach, community assets and mentally protective factors such as employment and exercise.

7.1 Unacceptable variation in treatment between different GP practice populations and population groups.

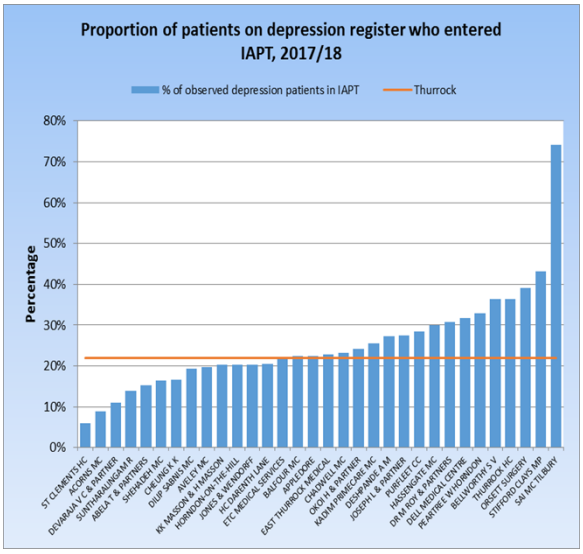
The most common treatment options for CMHDs in Thurrock are prescription of antidepressant medication (most typically Serotonin Selective Re-uptake Inhibitors [SSRIs]). Prescription of anti-depressant drugs has increased year on year between 2013/14 and 2016/17 for Thurrock patients, and there are 20% more anti-depressant items prescribed in 2016/17 compared to the 2013/14 baseline, although significant variation in growth of anti-depressant prescribing exists at GP practice level (from -18% to +70% between 2013/14 and 2016/17). This could partly be a function of variations in increase of need between different practice populations, but also suggests significantly different levels of prescribing behaviour between different surgeries.

Referral to talking therapies (IAPT provided by Inclusion Thurrock) is the second most common treatment option. Latest data from Inclusion, shown in figure 2 suggests that IAPT is treating approximately 20% of patients on QOF depression registers (assuming that all patients treated in IAPT are also diagnosed with depression and recorded on QOF registers). This figure has reduced from 25% in 2016/17.

However, the Mental Health JSNA also highlights that access to IAPT amongst residents with a diagnosis of depression is not uniform across different population groups.

Two thirds of those referred to IAPT are female, which is a greater proportion than would be expected from CMHD prevalence data even after adjusting for the higher prevalence of CMHDs in women compared to men. Only 7% of entrants are aged over 65, despite the fact that this age group makes up 18.4% of the Thurrock population aged 18+ and is at significantly greater risk than the general population of CMHDs. Furthermore, extreme variation exists (a 14-fold difference) between different practice populations which is likely to be (at least in part) due to variation in referral behaviour between surgeries.

Figure 2



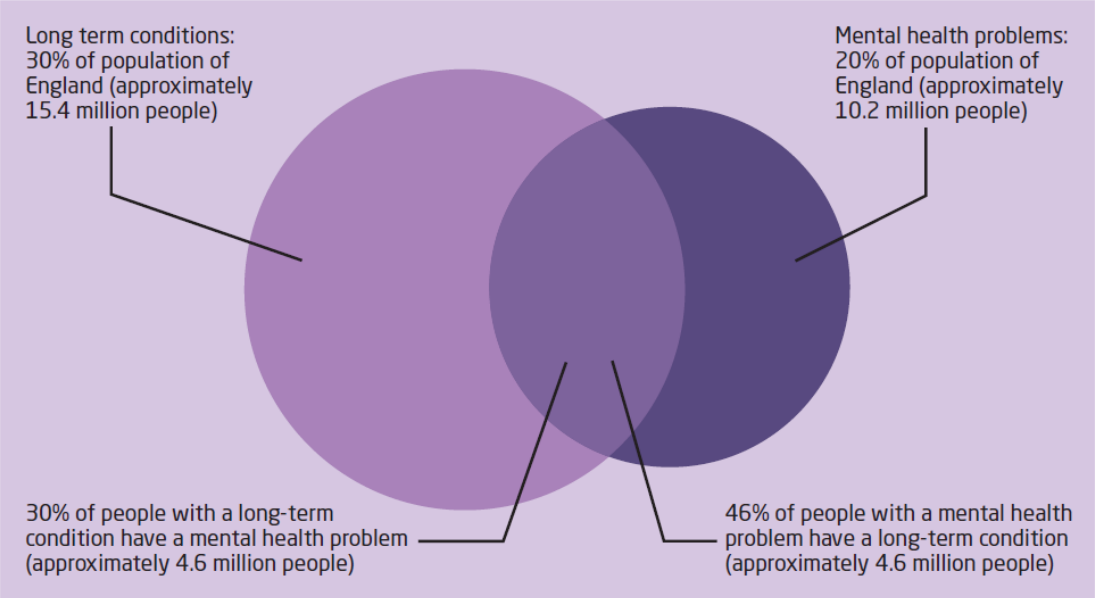
The Mental Health JSNA also highlights variation in management of patients on depression QOF registers between GP practices. The NICE clinical guideline on depression in adults states that patients with mild depression or sub-threshold symptoms be reviewed and re-assessed after initial presentation, normally within two weeks. CG90 recommends that patients with mild or moderate depression who start antidepressants are reviewed after one week if they are considered to present an increased risk of suicide or after two weeks if they are not considered at increased risk of suicide[18]. Patients are then re-assessed at regular intervals determined by their response to treatment and whether or not they are considered to be at an increased risk of suicide. As such QOF states that patients with a new diagnosis of depression should have a 'depression review' between 10 and 56 days after diagnosis. This review should encompass a review of depressive symptoms, social support, alternative treatment options, follow up on progress of external referrals, a medication review (where relevant) and an enquiry of suicidal ideation.

The Mental Health JSNA identified that only 60% number of patients with newly diagnosed depression in Thurrock who are not receiving this appropriate review 10-56 days after diagnosis. Once again there is unacceptable variation between different GP practice populations ranging from 6% to 90% of patients who receive this review.

7.2 The need to integrate CMHD treatment services with physical health services

The evidence base identifies an unequivocal link between CMHDs and long term physical health conditions. The DH estimates that long term health conditions account for 70% of all NHS spending and that between 12% and 18% of this expenditure is attributable to poor mental health. By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.[8] Putting this in terms of individual patient costs, the presence of poor mental health increases the average cost of NHS service use by each person with a long-term condition from approximately £3,910 to £5,670 a year.

Figure 3: The overlap between LTCs and MH problems in England, 2012.



Source: Naylor et al, 2012[9]

Co-morbid mental health problems are particularly common among people with multiple long-term conditions. Data from the World Health Surveys indicate that people with two or more long-term conditions are seven times more likely to have depression than people without a long-term condition.[19]A 2012 report by The King's Fund found that 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health problem.

Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively. A significant part of the explanation for poorer clinical outcomes is that co-morbid mental health problems can reduce a person's ability to manage their own physical condition actively, leading to poorer adherence to treatment plans and greater association with unhealthy behaviours such as smoking[20].

The strong relationship between mental health and LTCs suggests that care for large numbers of people with LTCs could be improved by the better integration of MH support with primary care LTC management programmes. The challenge is to integrate interventions for MH within physical health management protocols rather than merely overlaying MH interventions on top of existing protocols. Estimates in the Mental Health JSNA suggest that for Thurrock this would require integrating services for between 15,600 and 16,000 patients. Using the DH figures quoted earlier in terms of **average excess treatment costs attributable to untreated depression/anxiety with co-morbid physical long term health conditions**, **this would suggest a potential additional cost to the Thurrock local health economy of £28.16M**

The Tilbury and Chadwell *Case for Change* set out proposals to create a more integrated Long Term Conditions service within a locality network of GP surgeries that would be able to provide clinical management for multiple long term conditions and include IAPT services, providing a 'one-stop-shop' for residents. Implementation of this concept has been slow, hampered in part by fragmentation of current services for physical long term conditions between Primary and Community Care, and across different disease specialities. Further needs assessment work to

understand the scope for integration is on-going. Similarly IAPT have been resourced via an external funding stream obtained by Thurrock CCG to develop a programme of psychological support for patients with physical long term health conditions, although this is also in its early stages.

There is also an opportunity to embed case finding for physical long term health conditions, for example hypertension into IAPT and other mental health treatment service pathways, and conversely to screen for depression/anxiety within care pathways relating to physical long term health conditions. Work to embed this best practice has already commenced as part of the *Tilbury and Chadwell New Model of Care* Long Term Conditions Management Work Stream.

There is an urgent need to accelerate progress and integrate these two work streams to create a single long term conditions offer that addresses psychological and physical health needs of circa 16,000 Thurrock residents who are living with physical long term health conditions and co-morbid depression and anxiety.

In the medium term, there is further opportunity to provide significantly greater integration of long term physical and mental health condition treatment services through re-modelled workforce operating from the Integrated Medical Centres.

7.3 The need to broaden and integrate the current offer

Treatment options for those with CMHDs managed within Primary Care remain relatively narrow and almost exclusively clinical, with the offer for the vast majority of patients comprising of anti-depressant medication and/or talking therapy via IAPT. As such, the approach to date has been tailored at an individual level and almost exclusively deficit based.

However, there is clear evidence that CMHDs do not occur 'in a vacuum' and are strongly associated with socio-economic and psycho-social factors. As such, CMHDs are not evenly distributed amongst the population and are dependent at least in part by the environment in which the individual lives.

CMHDs are more likely to persist in people in lower socioeconomic groups such as people who are on low incomes, long-term sick or unemployed. The Marmot report*, Fair Society, healthy lives*[21] showed that, among other factors, poor housing and unemployment increase the likelihood that people will experience mental health disorders and affect the course of any subsequent recovery. Feelings of loneliness are worse and social network size is smaller among mental health service users than in the general population.[22,23] Conversely, there is a wide body of evidence that demonstrates the highly mentally health protective effect of having strong positive social connections and being employed.

7.3.1 Enhancing social capital – leveraging an assets based approach

A new model of care for treating CMHDs needs to 'join the dots', triangulating pharmaceutical interventions and the offer of talking therapies with action to connect residents with mentally protective community assets that improve social capital, and where appropriate interventions that help address wider determinants of help including access to employment and training.

> *"Working at Hardie Park as a volunteer has helped me manage my mental health due to being part of a community and not being isolated."*
>
> **67 year old female Thurrock resident**

Significant opportunity exists to design a new model of care for treatment of CMHD that broadens the offer to encompass a 'strengths based' approach to mental health, having a different 'strengths based' conversation with residents suffering from CMHDs, connecting them with community assets to increase social capital and helping them to address wider determinants of health where appropriate, particularly employment. Systematising of exercise on prescription as another valid treatment option also has to potential to improve population based mental health.

In the medium term, the new Integrated Medical Centres provide an opportunity to create new models of care that integrate mental health treatment provision with services that address wider determinants of health such as employment support and wider 'community wellbeing' approaches through flexible space for third sector groups and Local Area Coordination. In the short term, other potential mechanisms to achieve this could include standardising a referral template on SystmOne with a broader range of treatment options, systematising social prescribing into the CMHD care pathways and integrating employment support services with Primary Care and IAPT

Social Prescribing is one mechanism through which to achieve the above and is currently being piloted in Thurrock. The service, currently managed by CVS employs 3.0WTE social prescribers that aim to work as part of GP surgery teams and see patients who have issues in their lives that may not have an underlying clinical cause. CVS report that 60% of patients seen by social prescribers have some level of mental ill-health problem. By providing space for clients to work through problems with a social prescriber, empowers them to identify positive solutions. The social prescribers are also able to connect their clients with other assets within the community that may help them address their own problems.

The Social Prescribing Service is currently running as a pilot and is available to 21 of the 29 GP practices in Thurrock. As such there is currently insufficient capacity within the service to provide a systematic and uniform 'offer' to all patients with a CMHD being treated in primary care, and contact with this cohort is at present somewhat opportunistic. A new model of care for CMHD needs to expand and embed social prescribing into clinical practice of all GP surgeries in treating patients with depression or anxiety.

7.3.2 Work as a health outcome

Integrating employment support services with CMHD treatment services within a new model of care could also be a 'quick win'. Local intelligence suggests that 46% of Thurrock residents (2,160 people) claiming Employment and Support Allowance are doing so because of a mental health problem. Providing *Employment Advisors/Coaches* as part of an expanded offer within IAPT has been trialled successfully in other parts of the UK. Supporting this with an outcomes framework that promotes 'being in work' as a health outcome for treatment should also be considered in any new model of care.

Individual Placement Support (IPS) is a new programme of support offered to patients with SMI that seeks to enable them to get tailored employment support. Thurrock was unsuccessful in a bid for Wave 1 funding of IPS, but wishes to apply for IPS resource in the wave 2 funding round. There may be additional opportunities to embed employment support programmes as part of the Recovery College.

7.3.3 Physical Activity as a treatment option

There is a strong and growing evidence base demonstrating exercise to be an effective intervention for treatment of mild to moderate depression a valuable complementary therapy to the traditional

treatments for severe depression. A recent meta-analysis of the effects of exercise on depression/depressive symptoms in 58 randomized controlled trials (n = 2982) indicated that participants in the exercise treatment had significantly lower depression scores than those receiving the control treatment or no-treatment. The meta-analysis also showed that clinically depressed individuals receiving exercise as an intervention showed greater improvement that non-clinically depressed individuals, and that within the clinically depressed population exercise treatment was as at least equally effective to antidepressant medication and psychotherapy. Within clinically depressed populations, interventions lasting 10 – 16 weeks result in larger effects than interventions lasting 4 – 9 weeks; and exercise bouts of 45 – 59 minutes produce larger effects than bouts of 30 – 44 minutes and of ≥ 60 minutes. [24]

The same meta-analysis concluded similar positive results when considering the impact of exercise as a treatment for anxiety. 46 studies examined concluded a positive treatment effect of exercise on anxiety. Exercise was shown to be more effective than stress management education, slightly more effective than group therapy, stretching and yoga, relaxation and meditation, and as effective as cognitive behavioural therapy. Only psychopharmacotherapy produced a very small greater anxiety reducing effect than exercise.[23]

An *Exercise on Referral* intervention is currently commissioned by Public Health (partly via the Better Care Fund). This allows GP practices and Inclusion Thurrock to refer patients with a diagnosis of a range of long term health conditions (including depression and anxiety) to a structured exercise programme provided by Impulse Leisure. However, of the 111 referrals to the programme in Q1 of 2018/19, only five were placed into the mental health stream of which four from GPs and one directly from Inclusion. This would suggest that like social prescribing, prescribing exercise as a treatment intervention needs to be expanded.

7.4 A New Model of Care for CMHDs: Next Steps

High Level Recommendations	• Address the variation in referral to IAPT for CMHDs amongst GP practices such that a minimum of 25% of patients estimated to have a CMHD receive treatment each year, and age and sex variation is also reduced. • Address variation in clinical management of depression in Primary Care including inclusion of QOF indicators relating to depression review on the GP Practice Profile Card and future Stretched QOF interations. • Expedite integration of IAPT Services with other Long Term Physical Health conditions to create single integrated 'on-stop-shops' where all LTCs can be dealt with at the same time, as part of *Better Care Together Thurrock* transformation • Increase the capacity of the current Social Prescribing Service and embed it within clinical teams of all GP Practices, through the roll out of Locality Based Shared Mixed Skill Workfce Teams • Design and implement a *New Model of Care* for CMHDs that encompasses programmes that support residents to address worklessess, increase physical activity and increase social capital and community connectivness, building on existing community assets.
Key Questions for further Metal Health Transformation	• What are the key causes of variation in current referral patterns across local GP practice populations into IAPT and what needs to happen to reduce this variation? • What other actions need to occur to support individual practices and localities to reduce variation in clinical management of patients with CMHDs? • What does an integrated model of physical and mental long term conditions management look like, and how is this best delivered through Primary Care Transformation work at locality level? • What additional resource is required to expand the current Social Prescribing service to all GP surgeries and how can this be funded? • What does a new model of care for CMHDs look like that encompasses a broader strengths/asset based approach and how do we design, implement and resource this?
Existing Assets to build on	• Primary Care Locality Mixed Skill Workforce Team • Tilbury and Chadwell Long Term Conditions Working Group Programme • Primary Care/PH Development Team • Stretched QOF Programme and Practice Based Profile Card • Thurrock MIND • Existing Social Prescribing Programme • Community Hubs • Local Area Coordinators • Wider third sector community assets • Existing Employment Support Programmes • Exercise on referral programme • Recovery College

8 A New 'Enhanced Treatment' Model with a greater focus on prevention and early intervention

This paper defines *Enhanced Treatment* as any service aimed to assist the cohort of patients with mental ill-health that is more complex than Common Mental Health Disorders (as discussed in section 7). As such, *Enhanced Treatment* encompasses the needs of patients with disorders deemed too complex to be treated by IAPT or in Primary Care alone.

NHS England has defined a series of 12 *Mental Health Treatment Clusters;* groups of patients with similar clinical characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool.[25] A description the 12 clusters together with likely primary diagnoses relating to each is given in Appendix A. Inclusion Thurrock generally accept referrals from patients falling into clusters 1-3 (and possibly cluster 4). As such, this paper defines 'Enhanced Treatment' as interventions required for patients in clusters 4 and above. This would include a wide spectrum of patients from those with very severe non-psychotic disorders, personality disorders through to patients with severe and enduring psychotic illness including schizophrenia, schizotypal and delusional disorders and Bipolar Affective Disorders.

Evidence from the Mental Health JSNA, LGA Peer Review and User Voice suggests that the current health and care system is not adequately addressing the needs of this broad cohort of patients. The following issues have been identified and will be discussed in turn:

1) Inadequate provision of the current service offer to patients at the lower end of Enhanced Treatment spectrum of clusters *("The Missing Middle")*

2) A need to address fragmentation in current care pathways and broaden the focus of the current offer in terms of:
    a. Primary and Secondary Care
    b. Pathways within Secondary Care including continuity of care relationships
    c. Physical and Mental Health
    d. Social and community support
    e. Housing
    f. Employment

3) Inadequate focus on prevention and recovery

8.1 Inadequate provision of the current service offer to patients in lower end of the Enhanced Treatment spectrum - the *"Missing Middle"*

The LGA Peer Review concludes that when patients meet the EPUT crisis team criteria threshold and receive a service from EPUT, the service they receive is generally perceived as good. However the LGA Peer Review, user voice and other local intelligence suggest that there is a cohort of patients too mentally unwell to be treated by IAPT but who are not considered unwell enough to meet current EPUT thresholds for treatment. The Peer Review team referred to these as *The Missing Middle*. This suggests that the current threshold for accessing EPUT services is set too high.

EPUT referral criteria state that they accept all patients with needs that place them in Cluster 5 and above. Given that IAPT accept patients up to cluster four, the current referral criteria thresholds are

reported struggle to explain a lack of service provision for *The Missing Middle* unless they all fall into cluster 4 and are not accepted by IAPT. As such, this raises the question of whether stated referral thresholds are being applied correctly and warrants further investigation.

Anecdotal evidence on the characteristics of *The Missing Middle* suggests that they often return to Primary Care, Thurrock Healthwatch and Local Area Coordinators looking to access services from parts of the system that are not best skilled or equipped to provide it. Local GPs and Healthwatch report that many people within the *Missing Middle* have personality disorders, and often have chaotic lifestyles with multiple issues including housing and drug/alcohol problems. What they require is a coordinated response from multiple agencies.

The LGA Peer Review concluded that commissioning for *The Missing Middle* needs to include step-down, personality disorders and dual diagnosis and that it needs to integrate with Primary Care

8.2 The need to 'broaden' and integrate the current offer

Whilst the service provided by EPUT is perceived as positive in clinical terms, the LGA Peer Review, MH JSNA and user voice intelligence suggests that there is a need to broaden the current treatment offer to better integrated with other services that can assist in the recovery of mental ill health commenting that *"Secondary Mental Healthcare needs to benefit from a wider multi-disciplinary team approach".* This paper argues that a radically different approach to treating patients with serious mental ill-health is required locally that triangulates a clinical treatment offer with wider socio-environmental factors including family and community support, employment and housing.

Half of the current workforce at Grays Hall consist of Mental Health Social Workers seconded from Thurrock Council under current section 75 arrangements. This workforce should have a key role in addressing the wider determinants of health in clients with complex needs. The LGA Peer Review commented that "*social work values and practice as a profession were not adequately asserted and owned within the Grays Hall Team"*, and that there was a need for the current social work profession *to focus more on the most complex cases, leaving the needs of less complex cases to be met by other arrangements".*

Early Intervention in Psychosis has been shown to be highly effective in treating and preventing relapse of patients experiencing their first episode of psychosis (FEP). EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes. NICE states that from 1 April 2016 more than 50% of people experiencing first episode psychosis (FEP) should be treated with a NICE-approved care package within two weeks of referral and that 8 NICE Quality Standards shown in figure 3 should be followed as a measure of quality for EIP services:

Figure 3: NICE Quality Standards for Early Intervention in Psychosis (NICE QS80).

Quality Statements	Action (in adults)
Maximum waiting time from referral to treatment	Adults with FEP start treatment in EIP services within 2 weeks of referral
Psychological therapy	Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp)
Psychological therapy	Family members of adults with psychosis are offered family intervention
Medicines management	Adults with schizophrenia that has not responded adequately to treatment with at least two antipsychotic drugs are offered clozapine.
Education, Employment and Training	Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.
Physical health and healthy lifestyles	Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.
Physical health and healthy lifestyles	Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.
Support for Carers and families	Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

Source: NICE Psychosis and Schizophrenia in Adults, Feb 2015

The MH JSNA reported that as of February 2018 no patient with First Episode Psychosis (FEP) began treatment in an Early Intervention for Psychosis service provided by EPUT against a national target of 50% and that there was no evidence that the eight quality standards above were being adhered to as EPUT was not commissioned to collect or provide this data. This suggests that the current service offer is not as broad as it should be and may not be triangulating other key elements of wellbeing including the physical health and lifestyles of their patients, assistance with employment and support for carers and families. Since the MH JSNA was published, Public Health staff have met with EPUT, Inclusion and Social Care to discuss EIP going forward, and developed a new service specification which stipulates adherence and data recording against the NICE quality standards. EPUT are currently modifying their systems to enable this and supplying better monitoring data.

8.2.1 Fragmented healthcare pathways and a lack of continuity of care relationships

Local intelligence suggests fragmentation of current healthcare pathways for patients with serious mental ill-health. This includes a disconnect between Primary and Secondary Mental Healthcare, fragmented pathways within secondary mental healthcare including multiple teams being involved in a patient journey and a silo'd working in terms of the physical and mental healthcare needs of individuals.

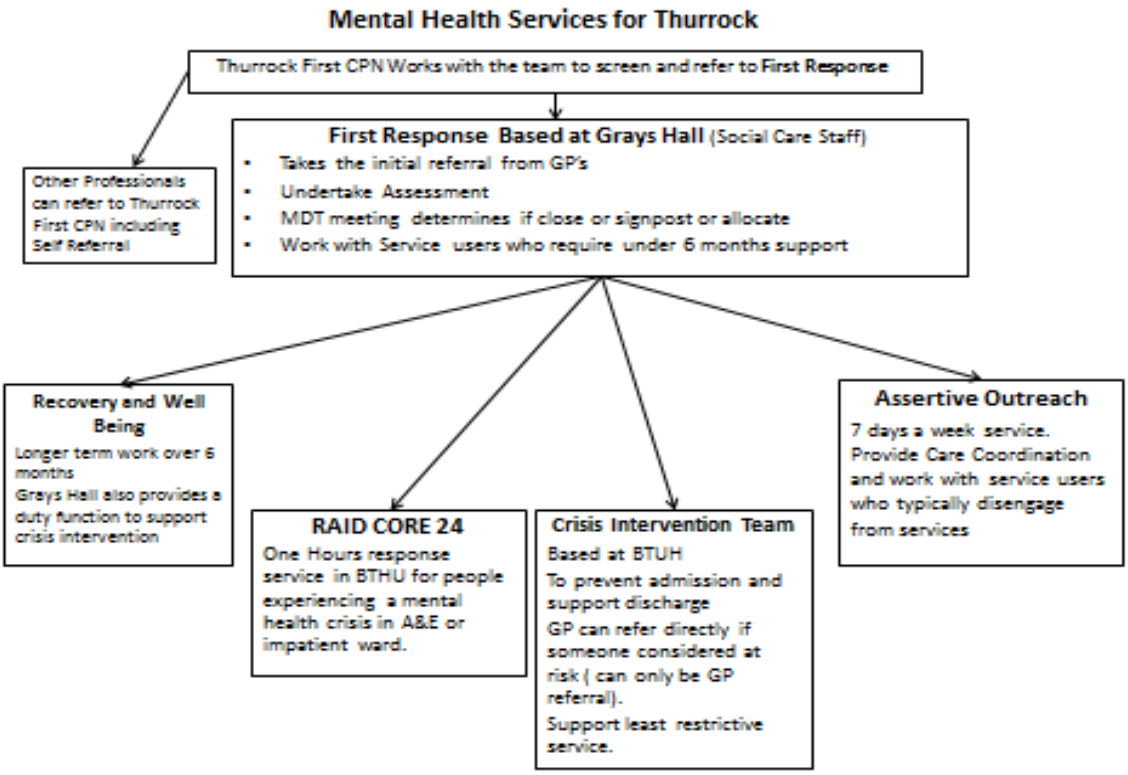
Provision of mental health care at Grays Hall is not adequately integrated within Primary Care and Thurrock Council has an ambition to move current provision at Grays Hall into the four Integrated Medical Centres when built to provide a more integrated treatment offer. However, given that it is unlikely that the first IMC will be open prior to 2020/21 there is a more urgent need to improve the

interface between Grays Hall and current Primary Care provision as part of new treatment models in *Thurrock Better Care Together* including provision of Psychiatric Nursing Support as part of the new Primary Care Mixed Skilled Workforce teams and within a wider offer of support to Community Wellbeing Teams.

EPUT provide the services outlined in figure 4 below. Thurrock Council delegate its statutory duty to provide adult social care assessment and care management services under the Care Act 2014 to EPUT through a Section 75 Agreement. A Community Psychiatric Nurse works within Thurrock First taking initial referrals and supporting the Thurrock First Advisors. The CPN can offer support information and advice and can also refer directly to the First Response Team. The First response team works with people who require six months of support or less. Within Grays Hall the Recovery and Well Being Team and the Assertive Outreach Team provide longer term support from both health and social care practitioners. The Crisis Intervention Team is based at BTUH and works with individuals to prevent admission and facilitate discharge. The RAID CORE 24 Team offers a one hour response to patients presenting with mental health challenges at BTUH accessing A&E or on inpatient wards.

Inpatient assessment and treatment across working age adults and older age adults is provided through a CCG block contract.

Figure 4: Secondary Mental Healthcare Services in Thurrock



"I'm fed up with the change of workers and high turn-over of staff within the Mental Health Service. Mental health workers are not informing people correctly that they are leaving and the patient will have to change worker. Grays Hall is not offering enough support"

The user voice work undertaken by Healthwatch and The Thurrock Coalition highlights concerns relating to lack of continuity of care relationships, and patients being passed from one individual to another.

8.2.2 Fragmentation between Physical and Mental Health Needs of Patients with SMI.

People with severe mental illnesses such as bipolar disorder or psychosis are at particularly high risk of physical ill health as a result of medication side effects, lifestyle-related risk factors and socioeconomic determinants[26] For example, smoking rates among people with a mental health condition are three times higher than among the general UK population (Public Health England 2015).

The high prevalence of co-morbid drug and alcohol addiction in people with mental health disorders has been well documented since the 1980s with data showing that people diagnosed with mood or anxiety disorders are twice as likely as the general population to also suffer from drug or alcohol misuse or dependence.[27]Despite this, evidence shows that people with SMI are less likely than the general population to receive health improvement interventions such as smoking cessation support, and most mental health professionals do not feel that reducing smoking is within their remit. [28]People with severe mental illnesses are also less likely to receive many other forms of preventive care, such as routine cancer screening[29]

Certain psychotropic medications are known to cause weight gain and obesity, leaving people at greater risk of developing diabetes or cardiovascular diseases, and contributing to low quality of life[30] The high prevalence of smoking, alcohol abuse and other lifestyle-related risk factors also contributes to this, and is one of the main factors responsible for the dramatic 15–20-year gap in life expectancy among people with severe mental illnesses.[31]

Contrary to some assumptions, people with severe mental illnesses who smoke are just as likely to want to quit as the general population, but are more likely to be heavily addicted and to anticipate difficulty quitting[32]. Smoking cessation in this group is associated with improved mental health and reduced levels of medication, illustrating that quality of life as well as longevity is affected [33]

The MH JSNA highlighted the need to address physical as well as mental health needs of patients in secondary mental health care and broaden the current narrow focus of treatment to include lifestyle assessment and improvement programmes. Lifestyle modification services are currently provided by the Thurrock Healthy Lifestyles Team within the council's Public Health Service either directly or through sub-contracted services provided by Impulse Leisure, Weightwatchers, Slimming World and some community providers.

Some good partnership working between Public Health's Healthy Lifestyle Service and EPUT and other providers treating patients with serious mental ill-health:

- All EPUT staff have been trained to Level 1 smoking cessation and two staff are 'level 2' smoking cessation trained and able to provide direct smoking cessation interventions to patients. Level 2 smoking cessation is also available within Inclusions Thurrock's drug and alcohol treatment services.

- NHS Health Checks are beginning to be offered at Grays Hall.
- Wellbeing clinics have recently commenced with Thurrock MIND offering mini NHS Health Checks and have generated referrals into stop smoking, weight management and hypertension treatment services.

There is a need to build upon this and systematise lifestyle assessment and referral into health improvement services as part of transformation work on care pathways.

Drug and Alcohol Treatment Services are currently commissioned by Public Health and provided by *Inclusion Thurrock.* There is also anecdotal evidence from the user voice work, that patients with dual diagnosis are being refused mental health treatment until they have addressed their drug and alcohol problem rather than being treated in parallel for issues that are likely to be strongly linked. There is an urgent need to investigate and address this.

There is some evidence in the Healthwatch user voice work that physical and mental health needs of EPUT patients are being silo'd due to the current system configuration. Some EPUT patients have reported being referred back to EPUT when they have contacted Thurrock First with non-mental health problems.

8.2.3 Interface with social support and community assets

Positive social networks have been linked to good mental health whilst social isolation and loneliness have been linked to poor mental health outcomes. Feelings of loneliness are worse and social network size is smaller among mental health service users than in the general population.[34,35]Previou s studies report loneliness to be related to personality disorders and psychoses[36 37], suicide[38], and more severe depressive symptoms.[39 40 41] Similarly, a systematic review[42] identified that poor social support and quality of relations, and lack of confidants were significantly associated with depression. In the context of severe mental illness, social isolation has been linked to higher levels of delusions[43], lack of insight[44], and higher hospital usage. [45]Conversely, people with stronger social networks were most likely to recover from psychotic symptoms[46]

Thurrock has a positive story to tell in terms of transformation of health and care services in the context of a 'strengths based, community assets approach', both in terms of the success of Local Area Coordination and more widely the *Stronger Together, For Thurrock In Thurrock,* and *Better Care Together Thurrock* programmes. Unfortunately mental health services have not been adequately reflected in strengths/community assets based transformation journey to date. Like housing, providing clinical treatment interventions in isolation to the social context that the patient finds themselves in is unlikely to result in optimum outcomes and recovery.

Opportunities exist in terms of the new Integrated Wellbeing Teams and *Better Care Together Thurrock* to begin to have radically different strength based conversations with mental health service users in terms of treatment and recovery plans set in the context of wider family and community support and social prescribing. However this work is currently in its infancy and certainly not mainstreamed into the EPUT clinical treatment offer. For example, the Social Prescribing Service reports inadequate collaboration between social prescribers and Grays Hall staff.

The User Voice work undertaken by Thurrock Coalition highlight the value of social and peer support from mental health service users. The need of a drop in centre where people with mental health difficulties can go when needing support, more coffee mornings, more peer support opportunities were all highlighted. There may be further opportunities to use the current capacity within the six Community Hubs in Thurrock as a base from which to build further peer support to this cohort.

8.2.4 Interface with housing

There is a significant body of evidence associating housing to mental health. Studies suggest that the overall quality of the housing environment including dampness, overcrowding, noise, poor neighbourhood and levels of infestations is positively correlated with poor mental health outcomes.[47] [48] [49] [50] Research has suggested that concepts of *personal identity* that housing provides[51]; *insecurity of tenure* [52]; *levels of social support* linked to housing design [53]; *parenting practices* in response to inadequate housing including ability for outdoor play [54]and; *perceptions of self-efficacy and life control* in terms of housing type and stress caused by having to deal with faceless bureaucracies [55] [56]ca n explain the interaction between housing and mental health outcome.

> *"My increase in banding level for housing based on medical priority has not been confirmed and I've had no response to my calls from the homelessness team".*
>
> **Thurrock Diversity Network member**

The link between homelessness and poor mental health is particularly strong. Up to 80% of homeless people report some form of mental health issue with 45% having a mental health disorder that has been diagnosed.[57] A considerable proportion of homeless people have a dual diagnosis, with both one or more mental health problems and a problem with drugs and/ or alcohol. Estimates of the prevalence of dual diagnosis among the homeless population vary from 10 to 50 per cent. [58] [59]R ecent research by the former National Mental Health Development Unit and the Department for Communities and Local Government, cited by Homeless Link, suggests that up to 60 per cent of individuals living in hostel accommodation and accessing homelessness services have experienced complex trauma or have an undiagnosed form of personality disorder.[60] [61]

Providing clinical treatment interventions for patients suffering from SMI in an environment where housing/homelessness issues remain unresolved are unlikely to deliver optimum outcomes for residents. As such, the treatment offer for serious mental ill-health needs to occur in the context of ensuring that patients' housing needs are also adequately addressed. Evidence from the LGA Peer Review, user voice work and other local intelligence suggests that this is not happening adequately in Thurrock, with stakeholders not working in a sufficiently integrated and holistic way. Whilst the Peer Review found evidence of *"Housing Services reporting working well with Grays Hall on individual cases",* there is evidence that this is not happening universally or part of a systematic and integrated offer. The Peer Review highlighted *a lack of specialist housing plans* for patients being treated by EPUT, the need for "*Thurrock First to consider interim measures to fill the gap in housing expertise",* and a *"Stretched but effective preventative provision for borderline homelessness is not consistent across the borough, with rising demand from inner-London Migration".*

> *"No, the organisations don't work well together. The Housing Department at the Council doesn't work with mental health services. Housing sees physical impairments but not mental health. Housing are really bad at assisting people with mental health conditions – providing inappropriate housing in the wrong areas and being away from carers/family pushes people back into crisis"*
>
> **Thurrock Diversity Network member**

Conversely, Thurrock Council Housing Team staff report issues with tenants with unmet mental health needs. In addition, the council's current housing allocation policy doesn't take into consideration mental health issues when assigning residents into priority bandings. The LGA Peer Review highlights "*Opportunities to agree a housing strategy and policy for people with Mental*

Health Issues – the same people float around the system". It also highlighted opportunities to *invest to* save to deliver an integrated supported accommodation offer for people with serious mental ill-health *'in*-borough' rather than relying on potentially more expensive out of areas placements. As such, there is considerable scope to provide a more integrated offer between housing and mental health services.
There is the opportunity to develop further work on housing as part of the Market Position Statement Specialist product on MH accommodation, and possibly through revision of the council's Housing Allocation Policies.

8.2.5 Interface with Employment

Being in employment has been shown to be one of the most mentally health protective factors. The workplace provides important opportunities for building resilience, self-esteem and development of social networks. Unemployed people may feel a lack of purpose as well a lack of social opportunities for development of self-esteem.

The Employment and Support Allowance (ESA) is a benefit for people who are unable to work due to illness or disability. The Mental Health JSNA highlighted the high proportion of claims for Employment Support Allowance for Mental Health problems in some wards, with almost 3.5% of the working age population of Tilbury St. Chads claiming ESA because of mental ill health.

Thurrock Council commission *Thurrock World of Work*, a third sector organisation to provide support to people with mental health difficulties to access employment including identification of goals and aspirations, training, work experience and volunteering opportunities. However it is unclear how well integrated this service is into the current EPUT treatment offer and what outcomes it is delivering as we do not currently collect outcome statistics on employment for patients with serious mental ill health. However, these metrics would form part of the IPS offer discussed in section 7.3.2.

Thurrock Council coordinates a Micro-Enterprises programme as part of *Stronger-Together. Micro-enterprises* are delivered by eight or fewer full time equivalent paid or unpaid workers and are completely independent of any larger organisation. They offer a diverse range of flexible and individually tailored community based services that aim to bring real choice to the local care and support market. There is considerable scope to better target and integrate support to people with mental health issues who may be interested in setting up new micro-enterprises and/or participating in/working/volunteering with existing programmes as part of a more holistic employment offer.

Future treatment models need to better integrate support to access employment within them.

Case Study – Open Dialogue, Western Lapland, Finland

'Open Dialogue' is a Finish holistic, strengths based approach to treating people with psychosis that is currently being piloted in the UK. Unlike traditional medical models treatment, it conceptualises psychosis as a problem occurring between individuals and in relationships rather than a problem that occurs in the brains of patients with SMI. It rejects traditional medical model paradigms of expert assessment and diagnosis plus pharmacological interventions and hospitalisation treatment with a community based approach that seeks to repair the relationships in the lives of patients and help them generate their own solutions.

The approach is humanistic and non-hierarchical. Patients are treated in their own homes where possible and therapy occurs between up to three therapists, the patient with psychosis and their family working together in the same session. The purpose of therapy sessions is to generate dialogue between therapists, patients and their families, and all parties reflect openly about their feelings towards one another and discuss ideas about the situation. The primary purpose of therapy is dialogue and "meaning making" and as a product of this dialogue solutions begin to emerge and relationships begin to be repaired.

Medication is kept to an absolute minimum and used for the shortest period of time possible, and only to help patients get over the worst symptoms. Sedatives to help patients sleep are favoured over neuroleptic medication which is seen as preventing "meaning making". Hospitalisation of patients is also avoided in all circumstances possible, with community nurses staying overnight in patients' own homes when they are very seriously unwell. Treatment is continued in terms of 'open dialogue' until medication is ceased.

Outcomes for patients using the approach have been highly positive in Finland. Two thirds of patients with psychosis never used anti-psychotic medication and of the third that did, 50% ceased using during treatment meaning only one in six patients with psychosis continued on long term anti-psychotic medication. In patient bed use has almost completely ceased. More impressively, the approach claims that 85% of patients with First Episode Psychosis (FEP) recover within six months meaning that schizophrenia prevalence has dropped in Western Lapland from one of the highest in the world to one of the lowest. (This compares to the gold standard target for NICE recommended Early Intervention in Psychosis interventions in the UK of 50% recovery. Furthermore, background unemployment rates of FEP patients who recover using Open Dialogue are lower than in the general population in Finland, suggesting the treatment produces productive individuals who integrate well back into general society.

8.3 Inadequate focus on recovery and relapse prevention

The LGA Peer Review and user voice work highlight the need to strengthen the offer around recovery and relapse prevention. The work of the Recovery College in supporting people to develop the capacity to cope with their mental health problems is seen as positive, and the diverse range of programmes provided by Thurrock MIND as a local asset. However, the user voice work highlight long waiting lists for both services which suggests that they is not operating as part of a single integrated pathway but as discrete services. The issue of clients being discharged from secondary care mental health services following treatment for a mental health crisis, but without adequate on-going care is also highlighted repeatedly in the user voice intelligence.

The Peer Review team also highlighted reports from front line staff and providers that there are a cohort of patients who although not presently in crisis, are at risk of escalating to require higher level support and who were unable to access a service until this happened. The need to invest in lower level mental health prevention services as part of an integrated offer was highlighted by the Peer Review, as was the need to shift the focus of the current service offer from one that deals only with complex patients and those in crisis to one aimed to prevent people reaching crisis in the first

place. The Peer Review highlighted opportunities for ‘invest to save’ if a more preventative programme of work could be commissioned jointly by Thurrock Council and CCG.

8.4 A new Enhanced Treatment Model of Care: Next Steps

High Level Recommendations

- Further investigate the needs and clinical characteristics of *The Missing*
- Review current referral criteria thresholds across IAPT and secondary care and agree new common standards to ensure service provision is available for *The Missing*
- Develop a new 'enhanced treatment' that model of care that:
  - Reduces fragmentation in current care pathways within EPUT and improves continuity of care
  - Reduces fragmentation between Primary and Secondary Care services
  - Seeks to reduce unnecessary in-patient stays and re-admissions
  - Embeds physical health assessment, health improvement and lifestyle modification into secondary care pathways
  - Provides an integrated treatment offer for patients will dual diagnosis including the ability to have mental ill-heath and drug/alcohol misuse problems being treated in paralell.
  - Better leverages the professional skill set of social care staff
  - Encompasses a 'strengths-based' community asset focus that promotes peer support and increases service users' social capital in the context of their families and community
  - Addresses housing and employment needs of service users as an integral part of their treatment and on-going recovery
  - Shifts the current balance of treatment from one of reactive intervention in crisis to one of proactive crisis and relapse prevention

Key Questions for further Metal Health Transformation

- What are the key needs characteristics of *The Missing Middle* and how does current service commissioning / delivery need to change to meet those needs
- How can we improve communication and shared care between Primary and Secondary healthcare providers?
- Why do current reported threshold criteria for IAPT and EPUT not match the lived experience of service users and how do they need to change to ensure that no service user 'falls between the gap' of IAPT and secondary care?
- How can we re-assert and leverage the professional skill-set of current social workers in transformed services?
- What does an enhanced, integrated and more holistic model of care look like and how do we bring together clinical treatment with community assets, third sector provision, housing and employment support in a single model that wraps around service users, rather than expecting them to access multiple single services?
- How do we best integrated the current service offer at Grays Hall into new clinical models being developed for the four Integrated Medical Centres
- How does commissioning/service delivery models need to change to move to a proactive preventative and relapse-prevention approach, and what will be the impact in terms of population health gain and system-wide return on investment?
- How can we leverage learning from the new *Wellbeing Team* approach about to be piloted in Tilbury and Chadwell and apply it to people with serious mental ill-health?

Existing Assets to build on

- Strong engagement of mental health service users and their voice through *Healthwatch* and Thurrock coalition, and the opportuity for co-design of services
- Primary Care Locality Mixed Skill Workforce Team
- Perceived quality within EPUT and Thurrock MIND
- Existing Social Prescribing Programme
- Community Hubs
- Proposed new models of care of *Community Liaison and Support Teams* and *Wellbeing Teams*
- Local Area Coordinators
- Wider third sector community assets
- Micro-enterprises programme
- Existing Employment Support Programmes
- Exercise on referral programme
- Inclusion Thurrock
- Thurrock Healthy Lifestyles Service

9 A new integrated commissioning and outcomes framework

Commissioning arrangements for the local mental health system in Thurrock as currently fragments, perhaps explaining in part why the provision of service models are also fragmented. NHS Thurrock CCG currently commissions IAPT and healthcare treatment elements of EPUT, although this is increasingly being done in collaboration with other local CCGs on a Mid and South-Essex STP footprint. Thurrock Council commissions social care elements of EPUT through a section 75 agreement.

Third sector provision in terms of mental health is commissioned by both Thurrock CCG and Council separately, and within the council services are commissioned from both Public Health and Adult Social Care and Communities divisions of the Adults Health and Housing Directorate. Supported Accommodation is commissioned by Adult Social Care with homeless and housing fieldwork services being provided directly by Thurrock Council.

GP provision is commissioned by NHS England with additional contracts for lifestyle improvement services and the mental health elements of Stretched QOF being commissioned independently by the Public Health Team. The CCG and Public Health also work together as part of a joint Primary Care Development Team to provide additional support and encourage transformation and service improvement within Primary Care. The Public Health Team also commissions Drug and Alcohol Treatment from *Inclusion Thurrock,* who also provide IAPT services, but through a different contractual route.

Reporting arrangements against these contracts happen at individual contract level and are inadequately focussed on outcomes, tending instead to concentrate on process inputs such as numbers of patients seen and interventions delivered. Furthermore, their focus almost completely clinical and many fail to capture wider wellbeing metrics and those focused on the wider determinants of health such as employment and housing. Primary Care performance is not triangulated with secondary performance, reinforcing the fragmentation of care between these two settings.

There is a clear need to rationalise and integrate the current disparate and fragmented commissioning arrangements relating to the local mental health service, and to agree a single systems wide performance framework focused on outcomes which underpins a transformed provider landscape and new integrated treatment models. The LGA Peer Review Team highlighted the lack of integrated commissioning and lack of evidence of a single reporting and outcomes framework as a *significant shortfall* in current arrangements and also suggested that the current section 75 agreement between the local authority and EPUT needed to be considered as part of a wider commissioning review. Future commissioning arrangements need to broaden the current focus and be more holistic and wider than current clinical services, encompassing the key issues of social support, housing and employment highlighted in sections 7 and 8. It is really important that new arrangements integrate with wider work on systems wide commissioning transformation as part of the new *Thurrock Integrated Care Alliance* including a shift from individual contract and provider process/input KPIs to single system wide outcome KPIs with agreed financial risk and reward mechanisms.

9.1 Improving Commissioning Intelligence

The Mental Health JSNA highlights a number of key areas where informatics intelligence to support commissioning is inadequate and need to be addressed. These include:

- The need to understand at patient level the issue of re-admission rates at Basildon Hospital and identify interventions to reduce the numbers of high intensity users accessing beds (the 'revolving door' patients).
- The need to better code patients who self-harm, particularly in A&E
- The need to collect and report Early Intervention in Psychosis outcome measures standardised against NICE Guidance.
- The extent of depression screening throughout the system and opportunities to improve it
- The need to develop predictive modelling and risk stratification tools to better describe the risk factors for the cohort of patients attending A&E with mental health crises in order to design interventions and look for opportunities for earlier intervention
- The need to work with adult social care commissioners to determine the cost of services per package as these are currently unavailable
- The need for all service providers, particularly emergency services to code and flag para-suicides so that these can be followed up promptly with appropriate interventions

The Integrated Dataset work being led by Public Health through MedeAnalytics has the potential to improve commissioning intelligence moving forward, and it is expected that IAPT data will be linked to SUS, Adult Social Care and about 25% of GP Practice SystmOne data by autumn 2018. There is a need to expedite linking of EPUT held data as part of this programme moving forward.

The Mental Health Service Data Set has been specified by Public Health in their contract with Arden Gem (the DESCRO that flows SUS data into Mede-analytics. As such, secondary mental healthcare data will form part of the integrated dataset moving forward.

9.2 Commissioning Arrangements: Next Steps

High Level Recommendations	• Create a single shared commissioning function between Thurrock Council and Thurrock Clinical Commissioning Group to undertake all Mental Health commissioning including all commissioning of third sector and public health provision related to mental health as part of the transformation journey • Agree a single strategic commissioning plan for mental health in Thurrock • Agree a single shared outcomes framework for mental health that encompasses Primary and Secondary Care outcomes, and wider determinants of health and wellbeing including prevention and recovery,physical health of the service users, housing, employment and social capital • Undertake further informatics work to support commissioing intelligence as set out in section 9.1
Key Questions for further Metal Health Transformation	• How do we bring together existing commissioning capacity across Thurrock Council and Thurrock CCG? • How do we manage the interface between what is commissioned at Thurrock level and what is commissioned by the CCG Joint Committee at Mid and South Essex STP level, and where do we need to involve STP partners? • What are the key shared outcomes that we want a newly transformed mental health system in Thurrock to be delivered and how do we agree and measure them? • How do we best involve user voice and the co-design of outcomes? • How can we quantify the impact of a newly transformed mental health service on system wide budgets in order to make the financial case for 'invest to save' initiatives? • How can we rationalise the number of process KPIs from existing contracts to free up front line provider staff to innovate? • How does a new outcomes framework and commissioning arrangements play into wider work in its infancy around the *Thurrock Integrated Care Alliance* and what does it mean for providers in terms of length of future contracts and financial risk-reward share? • What does the new outcomes framework and commissioning arrangements mean for the current section 75 agreement between EPUT and Thurrock Council and how do we best review this? • How can we better strengthen commissioning intelligence and how do we best expedite inclusion of EPUT data sets into the MedeAnalytics integrated patient data lake?
Existing Assets to build on	• Existing commissioning expertise held within the council, CCG and at STP level • Strong informatics expertise held within the Healthcare Public Health function • Mede-analytics integrated data set development • User voice engagement • Thurrock Integrated Care Alliance and work to develop an MoU and Alliance Agreement • Goodwill and strong partnership working commitment from all local partners

10 Conclusions and Next Steps

This paper has aimed to triangulate learning from the Peer Review, Mental Health JSNA Product and Healthwatch User Voice work with other local intelligence and the published evidence base around the five key themes that emerged from this work, as discussed in sections 5 to 9.

The issue of mental health and mental health service transformation is highly complex, and the no one person nor stakeholder organisation within Thurrock can have an adequate view of the system to know all the answers. As such, this paper perhaps highlights more problems than it proposes solutions, and has sought to set out a series of questions that the author hopes are a helpful starting point for further discussion from all stakeholders as to the next steps. The author encourages all stakeholders to review, comment and add to the proposals set out within this paper.

As stated in the introduction, Public Health have identified resource for a full time Strategic Lead for Mental Health Transformation to be recruited as a resource to coordinate and lead further work on mental health transformation in Thurrock, taking a 'whole systems' approach across all stakeholder organisations and working in partnership with respective commissioners and providers in both health and care to develop and agree a single, shared narrative for future mental health provision locally. It is proposed that the first key deliverable from this post will be an agreed Mental Health Transformation Strategy encompassing new models of care for CMHD and Serious Mental Ill-Health and associated outcomes framework and commissioning arrangements. Specific objectives of this work programme could include (but may not be limited to) the following:

- Map out Adult Mental Health as a whole system, incorporating relevant community and wider determinants services, to include referral mechanisms, patient flows, the specifics around the s75 etc.
- Undertake a comprehensive review of the literature to better understand best-practice models of delivering crisis care in Mental Health
- Maintain an influential presence within the existing Essex / Mid & South Essex STP work streams to ensure Thurrock transformational programmes are incorporated into the work agenda
- Review existing specialist accommodation for those with Serious Mental Health needs in Thurrock, and undertake a deep dive incorporating best practice from other areas, and model expected impacts for Thurrock if applied locally
- Work with relevant stakeholders to redesign the performance reporting requirements across all MH programmes (EIP, Crisis, Primary Care Mental Health, Dementia etc.), standardising against agreed Outcomes
- To unpick the true picture around demand on the Grays Hall Crisis line, and support redesign where required to ensure patients can receive quality care in a timely manner (in conjunction with literature review outcomes as mentioned above)
- Work with the third sector to better understand perceived barriers to accessing MH services and look at implementing solutions to address these
- Prioritise the identification of 'dual-diagnosis' in SMI patients, and working with stakeholders to streamline referral pathways where required
- Supporting implementation and establishing effectiveness of existing programmes such as Physical Health Checks for SMI patients in collaboration with EPUT staff
- To maximise opportunities to embed prevention within MH services

- To support monitoring of the reporting around the SALT return (in conjunction with Council PQBI team –
- To develop mechanisms to allow service user voice and co-design of future models of care
- To support the wider Communications around the transformation of mental health services, feeding into relevant stakeholder meetings, public events etc.

It is proposed that a Mental Health Transformation Steering Group be formed, containing appropriate representation from all key partner organisations to oversee the strategic work programme of this post. It may be possible to expand the existing membership and Terms of Reference of the Mental Health Operation Group to fulfil this function.

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Appendix A – Mental Health Care Clusters

	Care Cluster Name	Description	Likely Primary Diagnoses
1	**Common Mental Health Problems (Low Severity)**	This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms	F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F50 Eating Disorder.
2	**Common Mental Health Problems (Low Severity with Greater Need)**	This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms. They 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	As cluster 1
3	**Non-Psychotic (Moderate Severity)**	Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)	As cluster 1
4	**Non-Psychotic (Severe)**	The group is characterised by severe mood disturbance and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks	As cluster 1 plus F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders
5	**Non-Psychotic Disorders (Very Severe)**	This group will be experiencing severe mood disturbance and/or anxiety and/or other symptoms. They will not present with distressing hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk of non-accidental self-injury and they may present safeguarding issues and have severe disruption to everyday living	As cluster 1 plus F33 Recurrent Depressive Episode (non-psychotic), F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders
6	**Non-Psychotic Disorder of Over-Valued Ideas**	Moderate to very severe disorders that are difficult to treat. This may include mood disturbance treatment resistant eating disorder, OCD etc. where extreme beliefs are strongly held, some personality disorders and enduring depression	F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31.2&31.5 Bipolar Disorder with psychosis
7	**Enduring Non-Psychotic Disorders (High disability)**	This group suffers from moderate to severe disorders that are very disabling. They will have received treatment from a number of years and although they may have improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways	Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60.
8	**Non-Psychotic Chaotic and Challenging Disorders**	This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.	F60 Personality disorder.
9	**Blank Cluster**		
10	**First Episode Psychosis (with/without manic features)**	This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have mood disturbance and/or anxiety or other behaviours. Drinking or drug-taking may be present but will not be the only problem	(F20-F29) Schizophrenia, schizotypal and delusional disorders, F31 Bi-polar disorder.
11	**Ongoing Recurrent Psychosis (low symptoms)**	This group has a history of psychotic symptoms that are currently controlled and causing minor problems if at all. They are currently experiencing a sustained period of recovery where they are capable of full or near functioning. However there may be impairment in self-esteem and efficacy and vulnerability to life	Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.

12	**Ongoing or Recurrent Psychosis (High Disability)**	This group has a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation	(F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.