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Foreword

This needs assessment has been produced to support the commissioning of mental health and wellbeing services across Kirklees and forms part of the wider Mental Health Programme Review. The purpose of this wider review is to ensure Kirklees commissioners, namely the Council, Greater Huddersfield Clinical Commissioning Group and North Kirklees Clinical Commissioning Group are working collaboratively to deliver the best possible services for the residents of Kirklees in relation to mental health. The focus of this review is to ensure all-age provision is in place, including high quality preventative services that ensure people don't reach crisis, and if any person does reach crisis, they receive the best possible care from within existing resources, physical, human and financial.

The findings of the wider review will help to shape the future service model to improve effectiveness, quality, performance, efficiency, and value for money across the Kirklees footprint. This will be driven by local need, the evidence base, best practice, policy and legislation so that local commissioning decisions deliver the best possible outcomes to the people of Kirklees. It will also deliver outcomes based on the principles of good commissioning of mental health services and public mental health. [1]

The aim of this Mental Health and Wellbeing Needs assessment is to:

- Understand the mental health and wellbeing needs of the Kirklees population, with specific reference to high risk groups and;
- Establish whether the content and configuration of existing services meets this and future projected demand.

None of the issues described in this report are mutually exclusive; it aims to provide a coherent picture of mental health need. Recommendations are made for specific vulnerable groups as well as at the end of the report.

Dementia is not included in this needs assessment; however a Kirklees Dementia Needs Assessment has recently been written and can be accessed here.

The recommendations in this document should be considered alongside other related needs assessments to ensure a full picture of need so all the wider determinants, including those related to social economic deprivation are also considered in the decision making process.

Acknowledgements
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[1] Joint Commissioning Panel for Mental Health (2013) Guidance for Commissioning Public Mental Health Services

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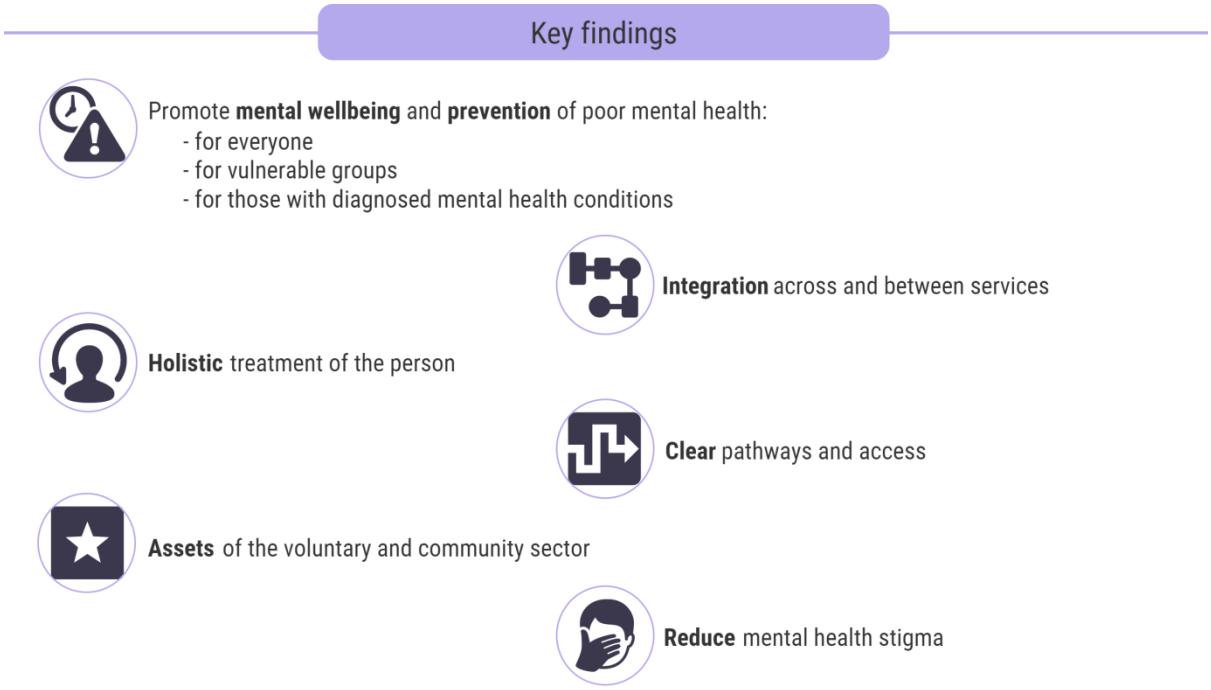
Executive Summary

This Mental Health Needs Assessment has found the following elements need to be in place in order to improve the mental health of people in Kirklees:



- Ensuring good mental health within the population and throughout the life course is about more than just the absence of mental disorder, and is a major contributor to wellbeing within the population.

- Mental health impacts on all aspects of people's lives and it is therefore the responsibility of not only the individual, but also families, friends, employers and the wider community to enable people to develop and maintain good mental health.

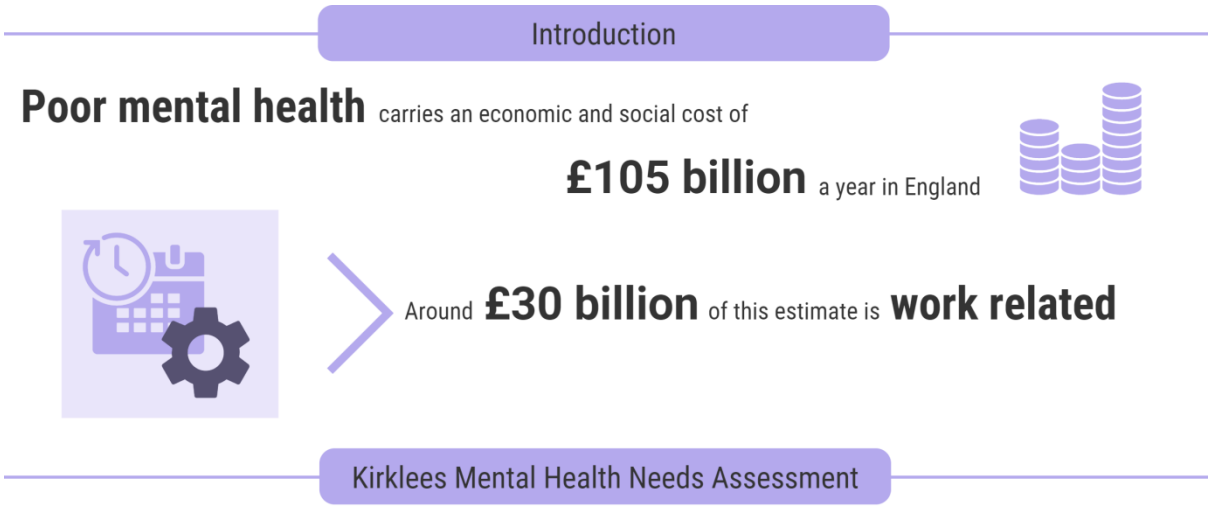
- There is a collective need to move resource further upstream, both in terms of raising awareness of mental health and supporting people to access help earlier.

- Individuals should be treated holistically, recognising the link between mental and physical health, which requires all services to work collaboratively.

- There needs to be a shift in focus from services, to communities and how people can live emotionally well.

- No one service can reduce the health inequalities associated with mental health; it has to be a core element of all our work.

1. Introduction



In the UK and across the world, advances in technology and health and social care have led to many people living longer and physically healthier lives. However, these advances have not been matched by corresponding improvements in our mental health. The World Health Organisation (WHO) has identified the scale of the mental health challenge by stating that if we do not act urgently, by 2030 depression will be the leading cause of the disease burden globally. [2]

Ensuring our population experiences good mental health is important for a wide range of reasons. Good mental health is vital to ensuring good physical health. It is also important for ensuring the development and maintenance of family relationships and friendships, our education, training and ability to fulfil our potential in employment. The WHO defines mental health as:

'Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his family.'[3]

This definition demonstrates the pivotal role that mental health has on an individual's functioning. Although mental health has always been an important priority, the way in which it is now being considered is different. Although prevention and treatment of people with mental health disorders are still important and necessary, it is acknowledged that promoting good mental health and wellbeing is wider than this and includes ensuring that all people, not just those with a defined condition are experiencing positive mental health. If we are to reduce the prevalence of mental health problems, we will need to relook at where this issue is owned. To ensure good mental health for all, the responsibility needs to lie

[2] McManus, S., Bebbington, P., Jenkins, R., and Brugha, T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.
[3] WHO. Mental Health: a state of well-being. http://www.who.int/features/factfiles/mental_health/en/ (accessed on 16th May 2017)

across all systems with individuals and communities at the centre. Managing ill health through specialist services can no longer be the central component to our approach. It is also vital to expand to community and settings in order to consider wider factors that impact on a person's mental health. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism; ensuring high quality services for those that need them, while also intervening early to reduce the need for specialist provision and to give individuals, families and communities, the tools to protect and manage their own mental health and create supportive environments.

Evidence shows that the risk of developing poor mental health is influenced by a range of complex factors including socio-economic status, gender, genetic traits, age and ethnicity. The interplay between genetic factors and the environment is complex and it is difficult to attribute causality but there is body of evidence on the effect of socio economic adversity 'activating' genetic susceptibility.[4][5] Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the risk of poor mental health.[6] Recognising the impact of both risk and protective factors relating to the circumstances of peoples' lives is imperative when designing health improvement interventions.

1.1 Why undertake a health needs assessment?

The requirement for this needs assessment was identified as part of the Kirklees Mental Health Strategic Review, led by North Kirklees Clinical Commissioning Group (NKCCG) and supported by GHCCG and Kirklees Council. The strategic review (undertaken jointly by Children's, Adults and Public Health commissioners) is required to decide future commissioning intentions alongside other community mental health and wellbeing services.

A multi-agency working group was established in order to develop and direct the needs assessment. The working group members have signposted and liaised with appropriate partners to inform the development of the mental health needs assessment (MHNA). The working group consisted of, NKCCG, Public Health Improvement and Public Health Intelligence specialists. Regular feedback was provided to the Programme Board throughout the development of the assessment.

The purpose of the health needs assessment was to identify the underlying factors and needs of those with mental health conditions in Kirklees and to put forward proposals for the development and delivery of improvement programmes and services. The methodology to carry out the health needs assessment included:

[4] McGowan et al The epigenetics of social adversity in early life: Implications for mental health outcomes Neurobiology of Disease 39 (2010) 66 72https://www.utsc.utoronto.ca/~pmcgowan/documents/McGowanNeuroDisease10reprint.pdf

[5] Ptal, C. Epigenetic approaches to psychiatric disorders Dialogues Clin Neurosci. 2010: 12(1): 25–35 accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181944/

[6] WHO (2014). Social Determinants of Mental Health.

- Evidence from both local and national data
- Evidence from service providers and professionals from within the field
- Data from local self-reported surveys

Pressures and challenges to positive mental health vary throughout the life course. Therefore, this report aims to examine needs and activity including:

- Population overview
- Key factors influencing mental health across the life course
- Children and young people (through reference to the Transformation Plan)
- Adults
- Older People
- Vulnerable groups
- Service Mapping

Mental ill health represents one of the main causes of the overall disease burden worldwide. [7] People with severe mental health problems die 15-20 years prematurely compared with people who do not have severe mental health problems.[8] Due to medication and lifestyle factors, those with severe mental health problems are two to three times more likely to suffer from cardiovascular disease.[9] We have a local economic need to prevent mental ill health arising and worsening and this needs assessment aims to be the starting point for this to happen.

1.2 Economic Context

Mental health accounts for 23 per cent of NHS activity but NHS spending on secondary mental health services is equivalent to just half of this. Poor mental health carries an economic and social cost of £105 billion a year in England and around £30 billion of this estimate is work related. Analysis commissioned by NHS England found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance use.[10] Additionally, 70 million days are lost from work each year because of poor mental health and this is likely to be under reported.[11] One of the largest areas of cost is the benefit system. The most common reason for incapacity benefit claims is mental health; 43% of the 2.6 million people currently on long-term health-related benefits have a mental or behavioural disorder as their primary condition.

[7] Vos, T., et al. (2013) Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study. The Lancet. 386 (9995). pp. 743-800.

[8] DH (2014). Annual report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence. London: DH. Retrieved from: http://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mentalhealth

[9] British Heart Foundation (2017) Heart and Mental Health. Accessed here: https://www.bhf.org.uk/heart-health/preventing-heart-disease/heart-and-mental-health

[10] NHS England internal analysis (2016)

[11] DH (2014). Annual report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence. London: DH. Retrieved from: http://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mentalhealth

Mental ill health also impacts on the economy of the wider society. This includes educational attainment, employment, housing and family relationships. Psychosocial pathways help explain how exposure to social, environmental, economic, political and cultural factors (known as social determinants) shape health outcomes.

1.3 Mental Health throughout the life-course

By taking a life course approach, it is possible to intervene early to address developmental factors and neglected determinants that can increase risk (primary prevention), while working to identify those at heightened exposure to adversity to prevent mental health problems from resulting and reducing the impact of these when they do (secondary and tertiary prevention). This approach helps to identify systems and services that have a role to play at each stage of the life course and how they integrate with other to have the greatest impact.

In 2008, The Government Office for Science produced a report based on the project Mental Capital and Wellbeing: Making the most of ourselves in the 21st century. The report examined how our population is changing and what the expected impact will be on wellbeing and mental health. The report uses a diagram to illustrate the factors impacting upon mental capital across the life course. This is shown in figure 1.1 [12]

[12] The Government Office for Science, London (2008). Foresight Mental Capital and Wellbeing Project Final Project Report- Executive Summary

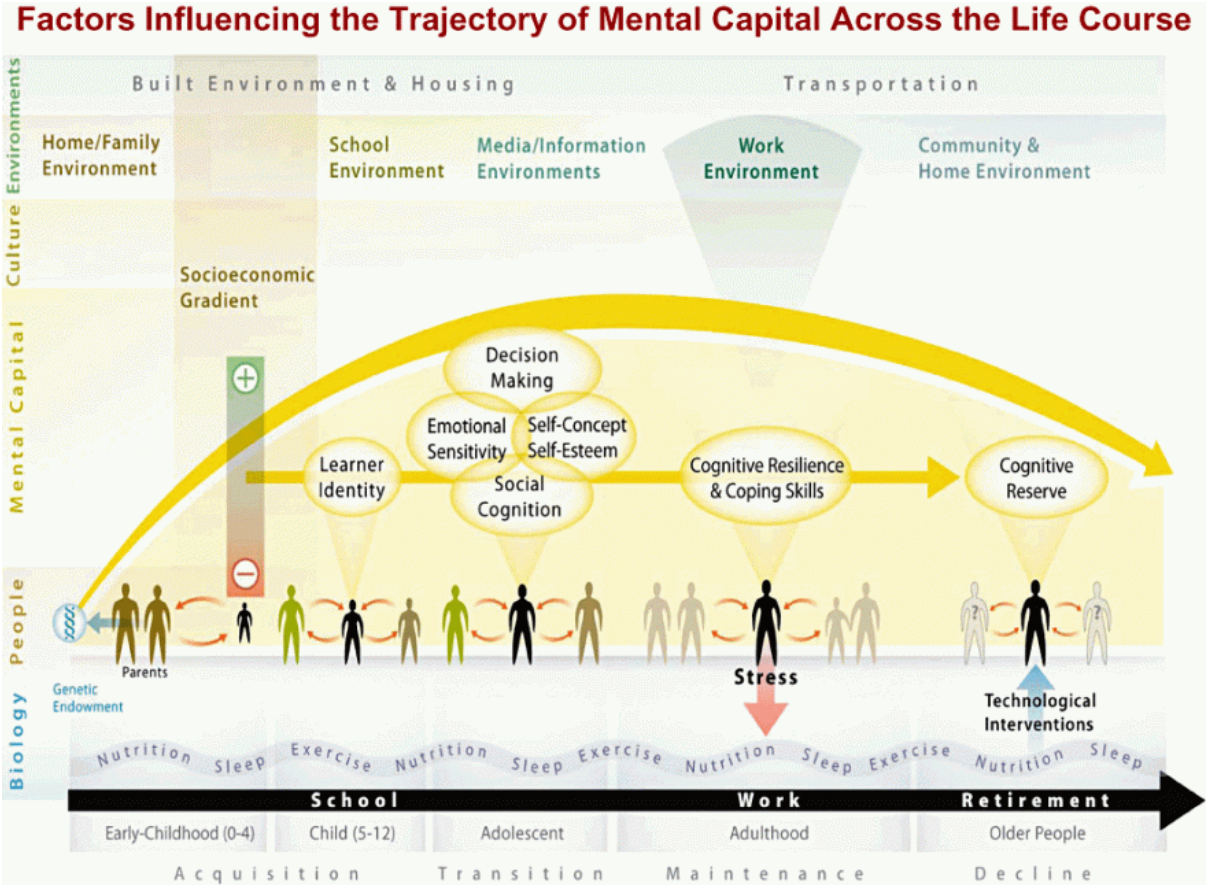


Figure 1.1: Mental Capital through life

Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances. Taking a life course perspective recognizes that the influences that operate at each stage of life can affect mental health. Social arrangements and institutions, such as education, social care, and work also have a huge impact on the opportunities that empower people to choose their own course in life.

1.4 National Policy and Context

In February 2011 the Department of Health published the national public health strategy '[No Health without Mental Health: A cross government mental health strategy for people of all ages].'[13] The strategy identified six outcomes:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a good experience of care and support
5. Fewer people will suffer avoidable harm

[13] Department of Health. (2011). No Health without Mental Health: A cross Government mental health outcomes strategy for people of all ages.

6. Fewer people will experience stigma and discrimination

NHS England and the Department of Health published Future in Mind in 2015[14], which articulated a clear consensus about the way in which services can make it easier for children and young people to access high quality mental health care when they need it. The NHS Five Year Forward View (FYFV) (2016)[15] builds on the foundations of this paper, by setting 6 priority actions for the NHS and the wider system:

1. A 7 day NHS – right care, right time, right quality
2. An integrated mental and physical health approach
3. Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens
4. Prevention at key moments in life
5. Creating mentally healthy communities
6. Building a better future

Throughout this taskforce public consultation, prevention emerged as a priority. Priority areas identified included: mental health promotion within workplaces and schools, being able to self-manage mental health, ensuring good overall physical and mental health and wellbeing and getting help early to stop mental health problems from escalating.

Public Health England (PHE) has led on establishing a Prevention Concordat for Better Mental Health Programme for Better Mental Health, as set out in the Five Year Forward View for Mental Health recommendation two. The aim is to galvanise cross-sector action to deliver an increase and escalation in the adoption of effective prevention planning arrangements in all local areas. This is part of a wider drive to secure an increase in the implementation of public mental health approaches across the whole system. The focus is on the prevention of mental health problems and the promotion of good mental health. To read more about the Prevention Concordat, click here.

A key principle behind this needs assessment comes from, The Marmot Review, 'Fair Society, Healthy Lives', that proposes a new way to reduce health inequalities in England post-2010. It argues that, traditionally, government policies have focused resources only on some segments of society. To improve health for all of us and to reduce unfair and unjust inequalities in health, action is needed across the social gradient. Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life. This is reflected in the 6 policy objectives, with the highest priority given to the first objective:

1. Giving every child the best start in life
2. Enabling all children, young people and adults to maximize their capabilities and have control over their lives
3. Creating fair employment and good work for all
4. Ensuring a healthy standard of living for all

[14] Department of Health (2015). Future in Mind: Promoting, protecting and improving our children's and young people's mental health and wellbeing.
[15] Mental Health Taskforce (2016). The Five Year Forward View for Mental Health. NHS.

5. Creating and developing sustainable places and communities
6. Strengthening the role and impact of ill-health prevention

A final national driver for this needs assessment comes from the Five Ways to Well-being developed by the New Economics Foundation (NEF)[16]. It was developed using evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing and include a set of evidence based actions which promote people's wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give. These activities are simple things individuals can do in their everyday lives. The Five Ways to Wellbeing interact to generate an overall sense of wellness for individuals, families and communities.

The scope includes Health and Wellbeing Boards, local authorities, the NHS, public, private and voluntary sector organisations and employers. The development phase has been guided by an expert steering of key national partners (including Faculty of Public Health, Local Government Association, and NHS England) and wider support through members of the National Prevention Alliance for Mental Health. The programme is underpinned by an evidence base which demonstrates that adopting prevention focused approaches to improving the public's mental health makes a valuable contribution to achieving a fairer and more equitable society. This prevention focused transformation will be delivered by increasing impact through evidence based planning and commissioning decisions.

The suite of resources and subsequent programme activity are intended to:

- Facilitate every local area to put in place effective prevention planning arrangements.
- Enable every area to use the best data and intelligence available to plan and commission the right mix of provision to meet local needs.

The West Yorkshire and Harrogate Health and Care Partnership and CAMHS Transformation Plans are emerging as significant opportunities for local areas to take action to improve and protect the public's mental health.

1.5 Local Policy

This needs assessment will contribute to the production of a Kirklees Mental Health Strategy and inform the priorities set out within CCG's and Local Authority commissioning plans as well as integrated social care plans. It will also support the Kirklees Joint Strategic Assessment as well as inform developments around Wellness service design, (see appendix B).

There are two strategic frameworks in Kirklees Council which this work supports. These are the Joint Health and Wellbeing Strategy (JHWS)[17] and the Kirklees Economic Strategy[18].

[16] New Economics Foundation (2008). The Five Ways to Wellbeing. NHS Confederation. Accessible here: http://b.3cdn.net/nefoundation/d80eba95560c09605d_uzm6b1n6a.pdf
[17] Kirklees Council (2014-2020). Kirklees Joint Health and Wellbeing Strategy. Accessed here: http://www.kirklees.gov.uk/beta/delivering-services/pdf/health-strategy.pdf

Neither strategy can be seen in isolation as both seek to improve the health, wellbeing and life chances of local people during times of change, reduced public spending and difficult economic circumstances. Strong connections have been built in to developing the two strategies and both share the same aim, which is that:

Kirklees is a district combining great quality of life and a strong and sustainable economy – leading to thriving communities, growing businesses, high prosperity and low inequality and where people enjoy better health throughout their lives.

Delivering the JHWS vision means that:

- People in Kirklees are as well as possible, for as long as possible, both physically and psychologically.
- Local people can control and manage life challenges.
- People have a safe, warm, affordable home in a decent environment within a support community.
- People take up opportunities that have a positive impact on their health and wellbeing.

Without good mental health and wellbeing at its core, neither strategy will be able to achieve its outcomes.

[18] Kirklees Council (2014). Kirklees Economic Strategy. Accessed here: http://www.kirklees.gov.uk/involve/publisheddoc.aspx?ref=0tpbko6i&e=661

2. What factors/ conditions impact on good or bad mental health?

Kirklees Council, Public Health, have developed an Oyster Model (figure 2.1) to demonstrate its approach to Health Promotion. It has been developed using the Ottawa Charter (1986)[19] principles and it visualises that health promotion is a comprehensive, multi-faceted approach. At the centre are the individuals, families and communities living in Kirklees, with the upper circles drawing attention to the four main action areas which enable health improvement. The lower circles highlight the social determinants of health which influence outcomes for individuals, families and communities. Commissioners and service providers should use this model to consider areas which they contribute to and where they might be able to have greater impact by collaborating more effectively with other parts of the system.

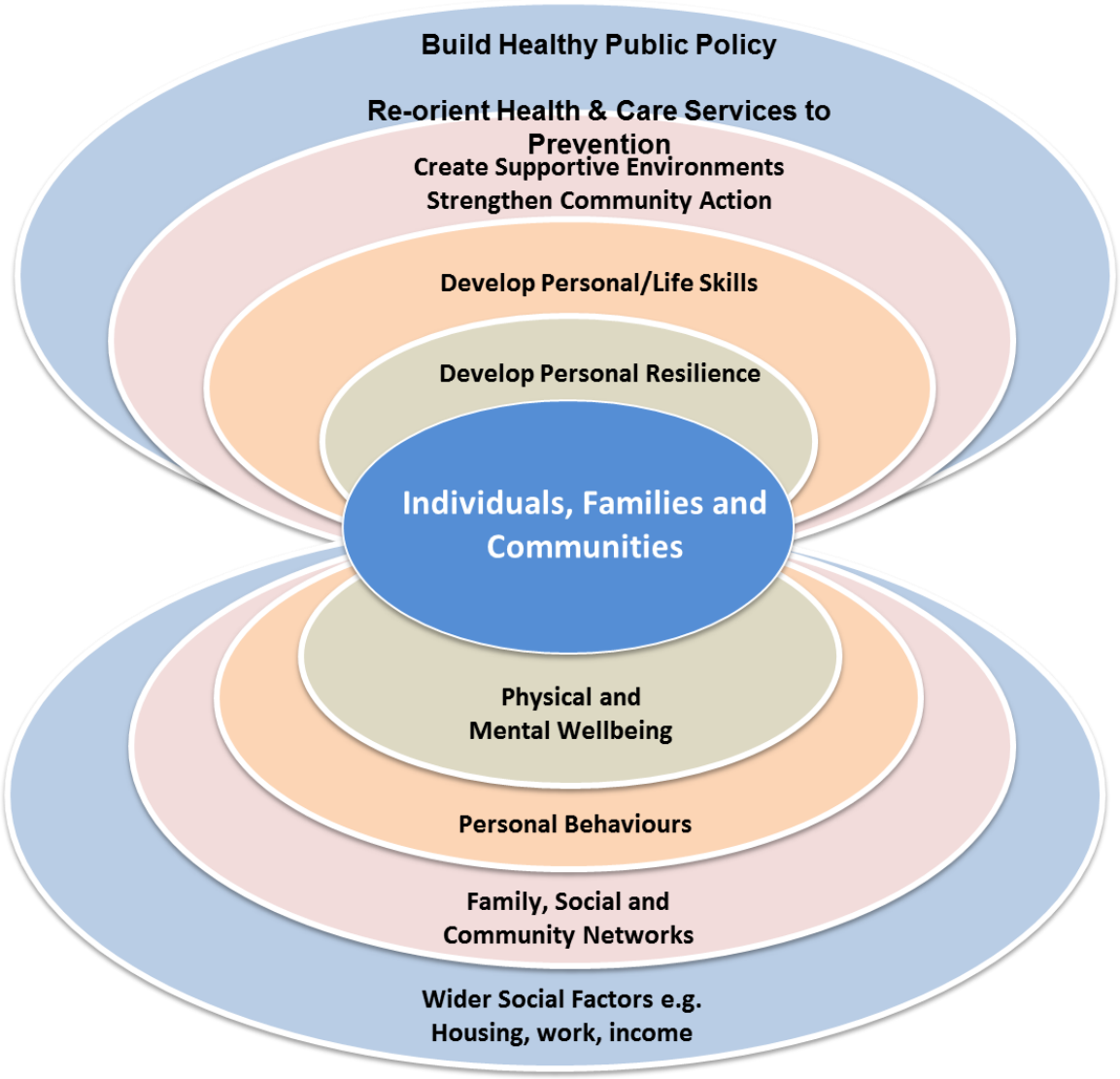


Figure 2.1: Oyster Model

[19] Ottawa Charter (1986) The Ottawa Charter for Health Promotion. Accessed here: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/ on 12th June 2017

Public mental health aims to improve mental health and wellbeing for the whole population. It includes promotion and prevention, as well as working to achieve greater equity, quality of life and better outcomes for people experiencing mental ill health. Communities matter for health. A community where people are well connected, are inclusive and respectful of all and involved in local decision making are healthy communities. Improving population health requires us to address these community factors and work with and alongside community members to improve the things that matter for their health.

The Oyster model refers to creating supportive environments for mental health. There is a growing understanding that connected communities, supported through interventions designed to promote social inclusion and strengthen social networks, have the potential to make an important contribution to mental wellbeing within the community.[20] Our relationship with place (including the community, our home, our educational settings, our work settings, the built environment and the natural environment); can define experiences in many ways across the life course.

Communities

Communities have many assets that can support mental wellbeing. Actions intended to achieve good mental wellbeing for all need to be embedded at multiple levels so that protecting and promoting mental wellbeing becomes a shared and central aspiration in ensuring that communities reach their potential. The Marmot Review made clear that strengthening communities, through empowerment and asset based approaches, is essential to reducing health inequalities. The Five Year Forward View also prioritises working with communities and releasing their capabilities for health and wellbeing.

Home

A mentally healthy home enables children to grow up resilient and can prevent some mental health crises, promote recovery and reduce the burden on health services.[21] Quality of housing impacts on people's wellbeing with poor standards adversely affecting both physical and mental health.

Educational Settings

Schools are an ideal setting for allowing young people to learn more about how to support their mental wellbeing.[22] School ethos, bullying and teacher wellbeing all have an influence on children's current and future mental health.

Work settings

Positive employment is one of the most strongly evidenced determinants of mental health.[23] With appropriate support and terms and conditions, the workplace can be key to

[20] Goldie, I., Elliott, I., Regan, M., and Bernal, L. (2016). Mental health and Prevention: taking local action. London. Mental Health Foundation.
[21] Mental Health Network NHS Confederation in partnership with National Housing Federation. (2011). Briefing: Housing and Mental Health. London: NHS Confederation Mental Health Network.
[22] Ofsted. (2013). Not yet good enough: personal, social, health and economic education in schools. London: Ofsted.
[23] Gordon Waddell, A Kim Burton. (2006). Is work good for your health and wellbeing? Available at: https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

promoting mental wellbeing. It can enable people to contribute to society, be financially independent, afford decent food and clothing and participate in leisure activities. The Department of Health 'No Health without Mental Health' recognised that the workplace provides an important opportunity for people to build resilience, develop social networks and develop their own social capital.

The built environment

Living in densely built up areas with limited access to facilities or areas that allow for connecting or playing can have an impact on individuals' and communities' mental health. Often, these spaces are not equally distributed in communities and where they do exist in deprived areas, they are not always safe or accessible.[24]

The natural environment

Living in an area with significant access or exposure to green spaces has a lasting and positive effect on mental wellbeing for all ages and socio-economic groups.[25]

2.1 Family and early years (see also section 4)

Evidence is now emerging about the process that takes place during pregnancy related to brain development, and during the first 2 years of life, which are essentially the building blocks for life. Positive and secure attachment between parent and child results in positive emotional and social development. Children are more resilient, able to cope with stress, have a higher perception of self-worth and can adjust better to adversity and change.[26] Parental mental health problems can have a significant impact on children's growth and development throughout childhood and children may assume a caring role in order to maintain a relationship with their parent. This can affect their educational performance as well as contributing to social isolation for the child. It is important to note that whilst the first few years of life have an enormous influence on mental and emotional development, environmental factors can affect neurological, behavioural and social development at any stage of our life.[27]

Family breakdown, through separation or divorce, can create considerable upheaval for children and young people. 2011 census data for Kirklees plotted against the Index of Multiple Deprivation (IMD) (figure 2.2), shows that marital status is correlated with deprivation. Less deprived areas have a higher proportion of people married or in a registered partnership and more deprived areas have higher proportions of single and separated or divorced people. Being in a stable relationship is also a protective factor for

[24] Silke, A. (2010). Place and Space in Goldie, I. Public Mental Health Today: A Handbook. London: Mental Health Foundation.

[25] Barton, J., Pretty, J. (2010). What is the best dose of nature and green exercise for improving mental health? A multi-study analysis: Environmental Science and Technology, vol 4, no 10, pp 3947-55

[26] Kenny, M.E and Sirin, S. (2006). Parental attachment, Self-worth, and Depressive symptoms among Emerging Adults. Journal of Counselling and Development, 84, 61-71

[27] Kolb et al J Can Acad Child Adolesc Psychiatry. 2011 20(4): 265–276. Brain Plasticity and Behavior in the Developing Brain https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222570/

adult emotional health and wellbeing. It is also strongly associated with lower levels of smoking and drinking and greater life satisfaction than being single. [28]

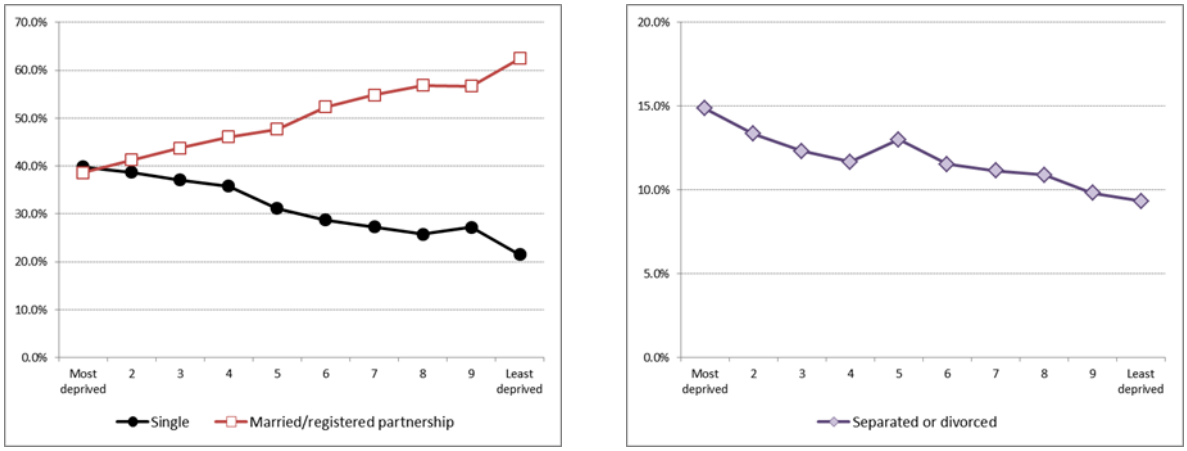


Figure 2.2: Marital status (2011 census) plotted against IMD decile for Kirklees

All children and young people may experience adverse life events at some time in their lives, but some are more likely to develop mental health disorders, for example: following multiple losses and/or trauma in their lives, as a result of parental vulnerability or due to disability, deprivation or neglect and abuse. More information on Adverse Childhood Experiences (ACE's) can be found in section 4.

The most powerful childhood predictor of adult life-satisfaction is a child's emotional health. [29] The majority of mental health problems emerge in childhood, with 75% of issues present by the age of twenty-four. Therefore, the most modifiable risk factors for mental health problems and the most important determinants of mental wellbeing lie in the family, the environment, the community and the society into which a child is born and raised.

2.2 Adulthood

Experiencing two or more adverse life events (serious illness, job loss, bereavement or other unpleasant event) in adulthood is associated with mental health problems and for some this can have a cumulative effect following on from adverse life experiences in childhood. Importantly, work, or lack of it has a strong impact on mental health and being in work is a strong protective factor for positive mental health. However, The Work Foundation makes the distinction between 'good work' characterised by fair treatment, autonomy, security and reward and 'bad work,' in which individuals do not feel supported, valued or

[28] Robles, T. F., Slatcher, R. B., Tronbello, J. M,. and McGinn, M. M. (2014). Marital quality and health: A meta-analytic review. Psychological bulletin, 140 (1), 140-187. 126 Mental Health Foundation. (2016). Relationships in the 21st Century. London: MHF

[29] Layard, R., Clark, A. E., Cornaglia, F., Powdthavee, N., and Vernoit, J. (2013). What Predicts a Successful Life? A Life-course Model of Wellbeing. CEP. Available at: http://cep.lse.ac.uk/pubs/download/dp1245.pdf.

stimulated.[30] This is supported by NICE who have recently developed 4 Quality Standards for Healthy Workplaces[31]:

1) Making health and wellbeing an organisational priority
2) Role of line managers
3) Identifying and managing stress
4) Employee involvement in decision making

According to the 2011 census, 68% of those aged 16-74 in Kirklees were economically active, including more than half (51%) in full- or part-time employment, with a further 9% being self-employed, 5% unemployed, and 3% studying full-time. Of those that were economically inactive (32%), the largest proportions were those that were retired (14%), students (6%), or looking after the home or family (5%).

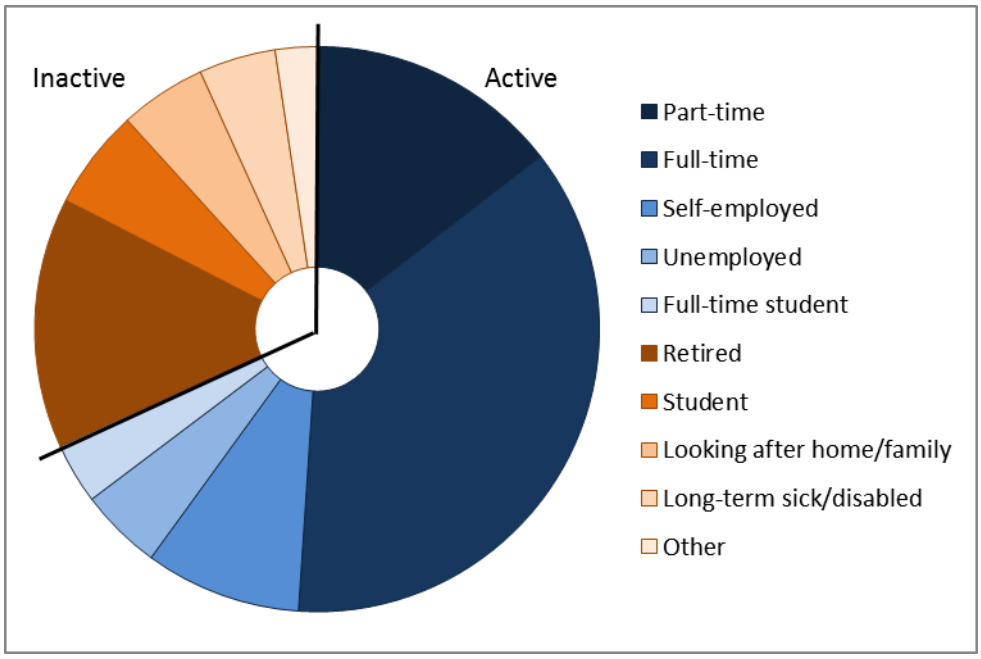


Figure 2.3: Economic activity for Kirklees (2011 census)

The number of unemployment benefit claimants in April 2017 (Jobseekers Allowance and out of work Universal Credit claimants) for Kirklees was 6,095 (2.2% of those aged 16-64). At ward level, the highest claimant rates were in Greenhead (3.6%), Ashbrow (3.4%), Dewsbury West (3.3%), and Crosland Moor and Netherton (3.3%). The lowest rates were in Denby Dale (0.7%), Kirkburton (0.7%), Holme Valley South (0.9%), and Holme Valley North (1.0%). (Source: DWP, Nomis, ONS, via Kirklees Observatory)

Claimant rates in Kirklees are higher than those for England, but lower than the rates for West Yorkshire:

[30] Coats, D., and Max, C. (2005). Healthy work: productive workplaces- why the UK needs more 'good jobs.' Lancaster: The Work Foundation.
[31] NICE (2017). Healthy workplaces: improving employee mental and physical health and wellbeing. Accessible here: www.nice.org.uk/guidance/qs147

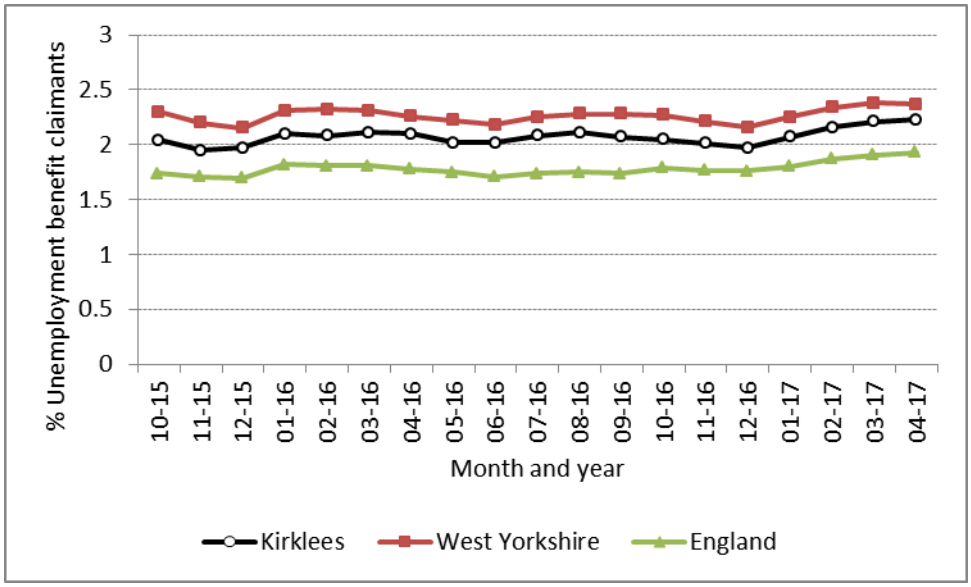


Figure 2.4: Unemployment benefit claimants (proportion of those aged 16-64), Oct 2015 to Apr 2017 (Source: DWP, Nomis, ONS, via Kirklees Observatory)

In quarter 3 2016, there were 19,515 Disability Living Allowance claimants (4.5% of the total population in Kirklees, compared with rates of 4.6% for West Yorkshire and 4.1% for England). In addition, there were 505 Incapacity Benefit claimants (0.2% of the Kirklees working age population, a similar rate to West Yorkshire and England). [32]

People who are unemployed are between four and ten times more likely to develop anxiety and depression.[33] Being in work is a key part of recovery for many people with a mental health condition. More than half of those out of work with a mental health condition would like to work. The Individual Placement and Support (IPS) service is internationally recognised as one of the most effective ways to support people with mental health conditions to gain and maintain paid employment and is currently offered in about half of all mental health trusts in England. Other protective factors in adulthood include access to community resources, facilities for children and the quality of the environment, including opportunities for physical activity. According to the 2016 Current Living in Kirklees (CLiK) adult population survey, 11% of adults never do 30 minutes or more of moderate physical activity in an average week. Those of Asian ethnicity are significantly more likely to never do 30+ minutes of moderate physical activity in a week (16% compared with a Kirklees average of 11%). Those with a physical/mental health condition lasting or expected to last 12+ months are also significantly more likely to never do 30+ mins (17%), as are those with a self-reported long-term condition (13%).

People with a self-reported mental health condition are more likely to do no physical activity; 16% of those with a mental health condition are inactive, versus 9% of those without.

[32] DWP, ONS, via Kirklees Observatory

[33] Lelliott, P., Tulloch, S., Boardman, J., Harvey, S., Henderson, H. (2008). Mental Health and Work. Royal College of Psychiatrists.

People with a mental health condition are also less likely to achieve the recommended minimum level of physical activity (5 x 30 minutes of moderate physical activity in a week); 30% of those with a mental health condition will achieve this level, versus 40% of those without a mental health condition.

Across the whole survey sample, those aged 65 or above and those from the most deprived areas are more likely never to do any physical activity. The variation with deprivation is more pronounced for those without a mental health condition than for those with a mental health condition.

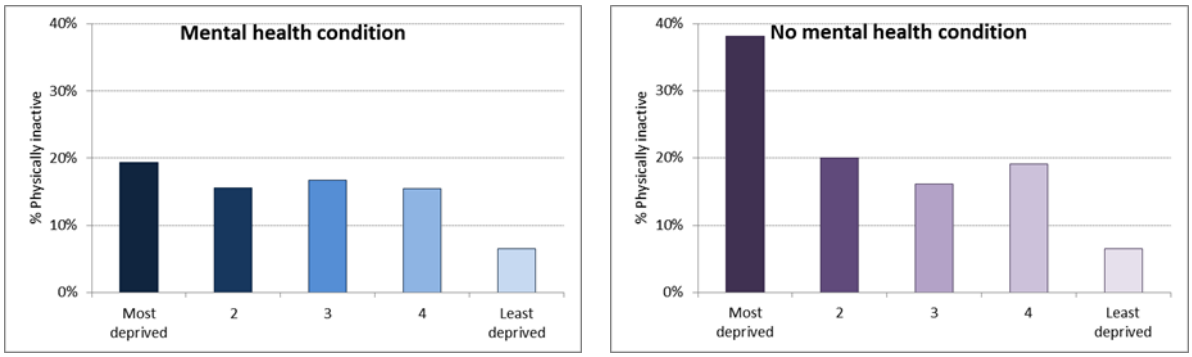


Figure 2.5: Percentage of people that are physically inactive by deprivation quintile, for those with and without a self-reported mental health condition (Source: CLiK 2016)

2.2.1 Physical Wellbeing

Many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. The causal relationship is likely to be two-way (see figure 2.6 below); people developing a mental health condition because of their long term physical health condition but also the fact that having a mental health condition increases the risk for onset of a range of physical illnesses. For example, chronic stress has a direct impact on the cardiovascular, nervous and immune system, leading to increased susceptibility of a range of diseases.[34] As a result of these associations, people with mental health conditions are two to four times more likely to die prematurely, from natural causes such as cardiovascular disease. [35]

[34] Contrada, R. J., and Baum, A. (2010). The Handbook of Stress Science: Biology, psychology and health. New York: Springer

[35] Eaton, W, W., Martin, S, S., Nestadt, G., Bienvenu, O, J., Clarke, D., Alexander, P. (2008). The burden of mental disorders. Epidemiological Reviews, vol 30, no 1, pp. 1-14

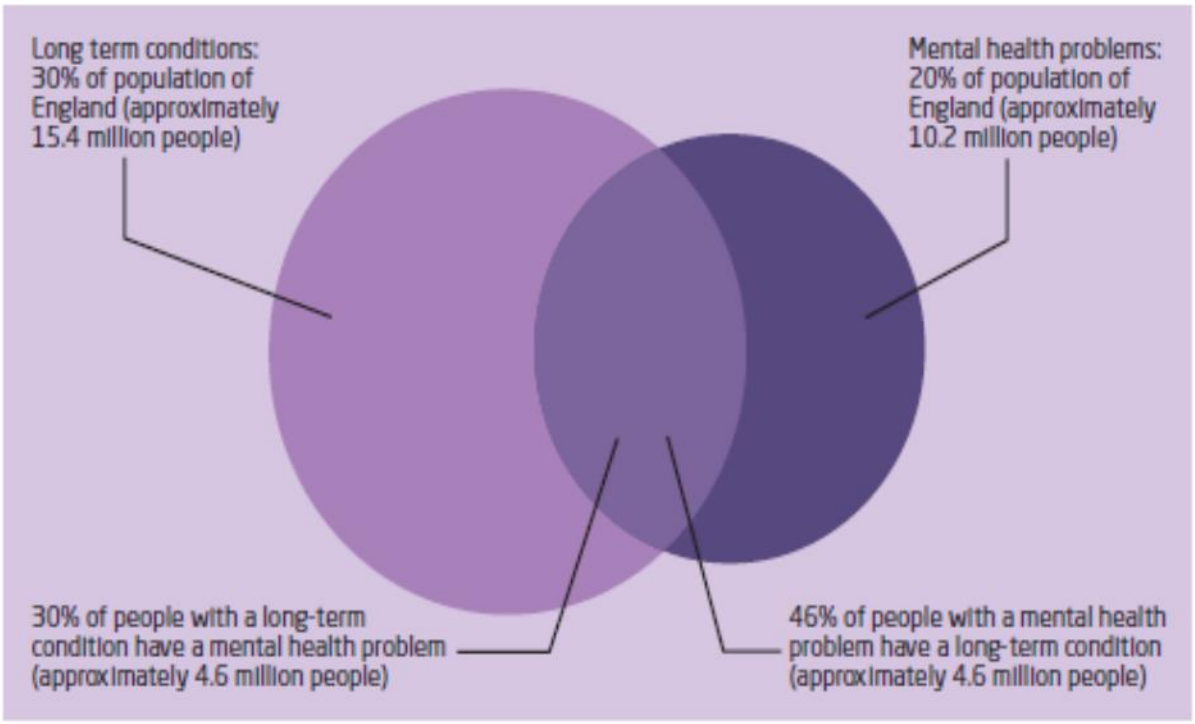


Figure 2.6: The overlap between long-term conditions and mental health problems, The Kings Fund and Centre for Mental Health, 2012

There is growing evidence that supporting the psychological and mental health needs of people with a long-term physical health condition more effectively can lead to improvements in their overall wellbeing. For example, addressing the psychological needs of someone with diabetes can improve clinical outcomes, quality of life, relationships with health care professionals and carers, dietary control and overall prognosis. Additionally, being diagnosed with a life-threatening illness, experiencing a sudden physical trauma or undergoing painful or complex medical and surgical procedures are associated with very high levels of distress[36]. Research estimates that 35-50% of cancer patients will experience clinically significant psychological distress[37] and these figures suggest that many of these patients require specialist support. Patients frequently report unmet needs and desire to access psychological support.[38]

Through our commissioning, providers should be encouraged to grow more integrated forms of care for people with long-term conditions. Commissioners should consider how the emotional, behavioural and mental health aspects of physical illness can be supported as a standard component of that care. This will have an impact on health outcomes and satisfaction with care, which are improved by addressing patients' psychological and emotional needs. Neglecting these aspects of care is likely to result in longer hospital stays,

[36] Johnston, M. (1998). Hospitalization in adults. In A. Baum, S. Newman, J.Weinman, R. West and C. McManus (Eds.) Cambridge Handbook of Psychology, Health and Medicine. Cambridge: Cambridge University Press, pp. 121–123.

[37] Zabora J, BrintzenhofeSzoc K, Curbow B, Hooker C, Piantadosi S. The prevalence of psychological distress by cancer site. Psycho-Oncology. 2001;10:19–28.

[38] Absolom K, Holch P, Pini S, et al. The detection and management ofemotional distress in cancer patients: the views of health-care professionals.Psycho-Oncology. 2011; 20(6): 601-608. PMID:21308857. http://dx.doi.org/10.1002/pon.1916

poorer life expectancy, poorer adherence to medical treatment, increased demand on health care resources, and unnecessary distress and dissatisfaction with care.[39] [40][41] Mental health support could also be further enhanced in primary care, chronic disease management programmes and social care to build a comprehensive collaborative model.

2.2.2 Smoking

Stopping smoking is a protective factor for those with mental health problems. People with mental health conditions are more likely to smoke than the general population and smoking related diseases such as cardiovascular disease, lung disease and cancer are among the most common causes of death among adults with mental health conditions.[42] A common misconception is that smokers with mental health conditions either cannot or will not give up smoking. However, research has shown that adult smokers with mental health conditions—like other smokers—want to quit, can quit and benefit from evidence based smoking cessation treatments. People with mental health conditions may face unique challenges in quitting smoking and may benefit from additional services, such as more intensive counselling and/or longer use or a combination of cessation medications. But with support, they can and do quit smoking successfully.[43] Another common misconception is that smoking has mental health benefits and helps patients cope with their psychiatric symptoms.[44] However, smoking is associated with poor outcomes, such as greater depressive symptoms, greater likelihood of psychiatric hospitalisation and increased suicidal behaviour.[45] Furthermore, smoking can complicate treatment by accelerating the metabolism of certain psychiatric medications, resulting in the need for higher doses to get the same therapeutic benefit.

A large body of clinical research has shown that patients can quit without worsening their psychiatric symptoms, if they are given the appropriate support.[46] Evidence also suggests that quitting smoking is associated with mental health benefits, including reductions in

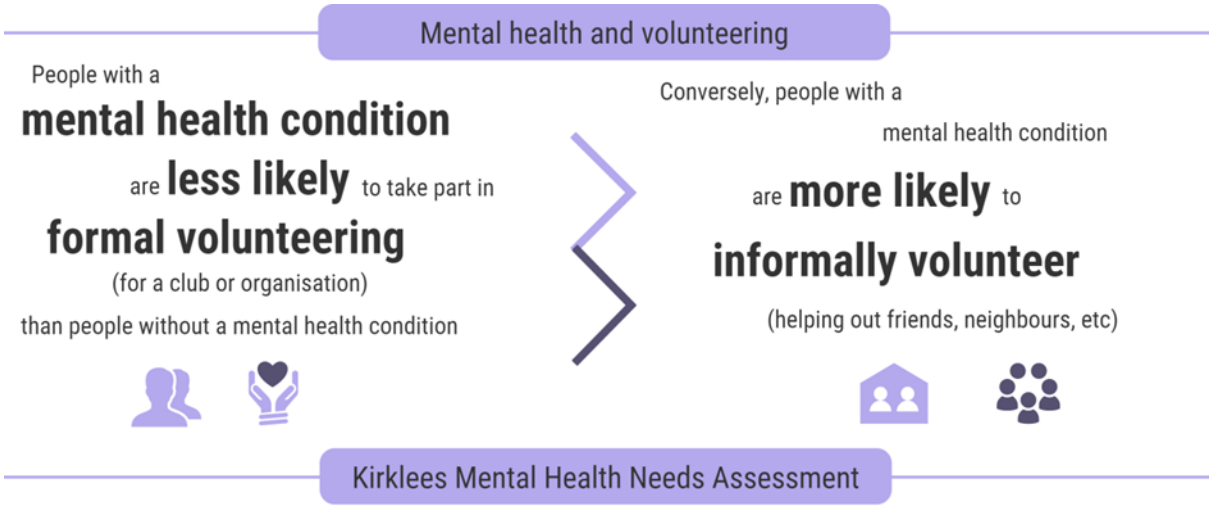
[39] Friedman, R. et al. (1996). Behavioural medicine, clinical health psychology and cost offset. Health Psychology, 14(6), 509–516.
[40] Saxby, B. & Svanberg, P. (1998). The Added Value of Psychology to Physical Health Care. British Psychological Society, Division of Clinical Psychology.
[41] Chiles, J., Lambert, M. & Hatch, A. (1999). The impact of psychological interventions on medical cost offset: A meta-analytic review. Clinical Psychology: Science and Practice, 6, 204–220.
[42] Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-Year follow up of a nationally representative US survey. Medical Care, 49(6), 599-604.
[43] Tidey, J. W. & Miller, M. E. (2015). Smoking cessation and reduction in people with chronic mental illness. British Medical Journal, 351: h4065.
[44] Prochaska, J. J. (2011). Smoking and mental illness — Breaking the link. New England Journal of Medicine,365(3), 196-198.
[45] Khaled, S. M., Bulloch, A. G., Williams, J. V., Hill, J. C., Lavorato, D. H., & Patten, S. B. (2012). Persistent heavy smoking as risk factor for Major Depression (MD) incidence: Evidence from a longitudinal Canadian cohort of the National Population Health Survey. Journal of Psychiatric Research 46(4), 436-443
[46] Tidey, J. W. & Miller, M. E. (2015). Smoking cessation and reduction in people with chronic mental illness. British Medical Journal, 351: h4065.

depression and anxiety and lower rates of re-hospitalisation and suicide.[47] People with mental health conditions have an equal right to be asked whether they smoke. They need to be offered effective methods to quit smoking or reduce harm as part of their care plan and there is an urgent clinical need to improve the support people with mental health conditions receive.[48]

2.3 Later life

Retirement can be associated with high well-being and can be an opportunity to pursue leisure activities and volunteering, which can have as many benefits as paid employment. However, for some, a lack of choice such as enforced retirement, or redundancy can result in poor wellbeing with people feeling unengaged in meaningful activity.

According to the 2016 CLiK survey, those with a mental health condition are less likely to take part in formal volunteering for a club or organisation compared to those without a mental health condition (27% of those with a mental health condition versus 29% without). Conversely, people with a mental health condition are more likely to informally volunteer (34% of those with a mental health condition informally volunteer versus 30% without).



The lowest formal volunteering rates are found in more deprived areas. The variation with deprivation is more pronounced for those without a mental health condition than for those with a mental health condition. CLiK showed that 65-74 year olds were the age group most likely to volunteer (formal volunteering at least once a month, significantly higher than the Kirklees average). The three factors which would encourage those aged fifty-five and above to do more volunteering (according to CLiK 2016) were:

1) If the hours were flexible
2) If more information about the things that could be done was available

[47] Cavazos-Rehg, P. A., Breslau, N., Hatsukami, D., Krauss, M. J., Spitznagel, E. L., Grucza, R. A., Salyer, P., et al. (2014). Smoking cessation is associated with lower rates of mood/anxiety and alcohol use disorders. Psychological Medicine, 44(12), 2523-2535.
[48] DH (2017). Towards a Smokefree Generation. A Tobacco Plan for England.

3) If it didn't involve a big time commitment

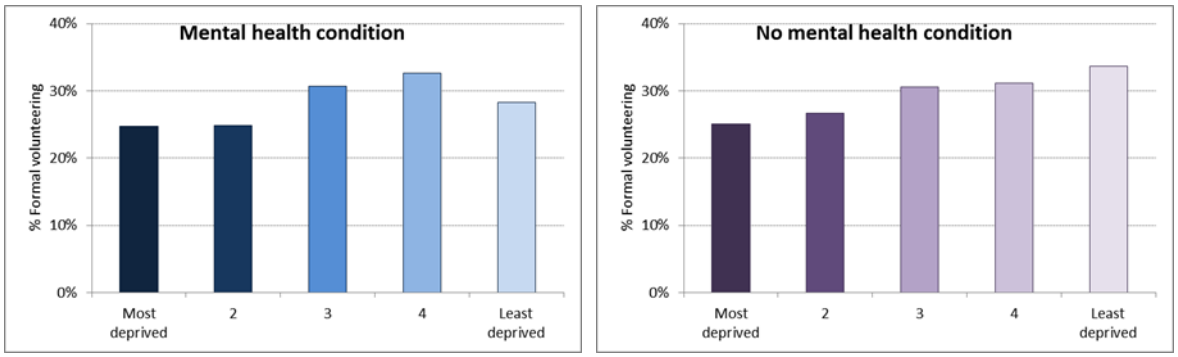


Figure 2.7: Percentage of people that formally volunteer by deprivation quintile, for those with and without a self-reported mental health condition (Source: CLiK 2016)

Relationships and connecting with others is a key protective area for a mentally healthy later life. In 2008, Age Concern found that 1.2 million people over fifty were severely socially excluded and had little engagement in their communities. Communities have many assets that can support mental wellbeing. Actions to achieve good mental wellbeing for all need to be embedded at multiple levels across communities: within family homes; streets and neighbourhoods; settings such as workplaces and schools; and systems like local NHS provision and community policing. Protecting and promoting mental wellbeing needs to become a shared and central aspiration in ensuring communities reach their potential. [49] As the proportion of older people in the UK is expected to grow significantly over the next few decades, a life course approach will become ever more important to the promotion of good mental and physical health, as well as to the prevention of mental disorders during old age.

2.4 Social isolation

People with a mental health condition are much more likely to feel lonely or isolated than those without a mental health condition. In Kirklees, 17% of those with a mental health condition feel lonely or isolated most or all of the time, compared with 3% of those without a mental health condition (2016 CLiK survey). People with a mental health condition are also less likely to be socially connected (based on questions about having people to comfort them when upset or help them in a crisis): 81% of those with a mental health condition are socially connected, compared with 89% of those without a mental health condition.

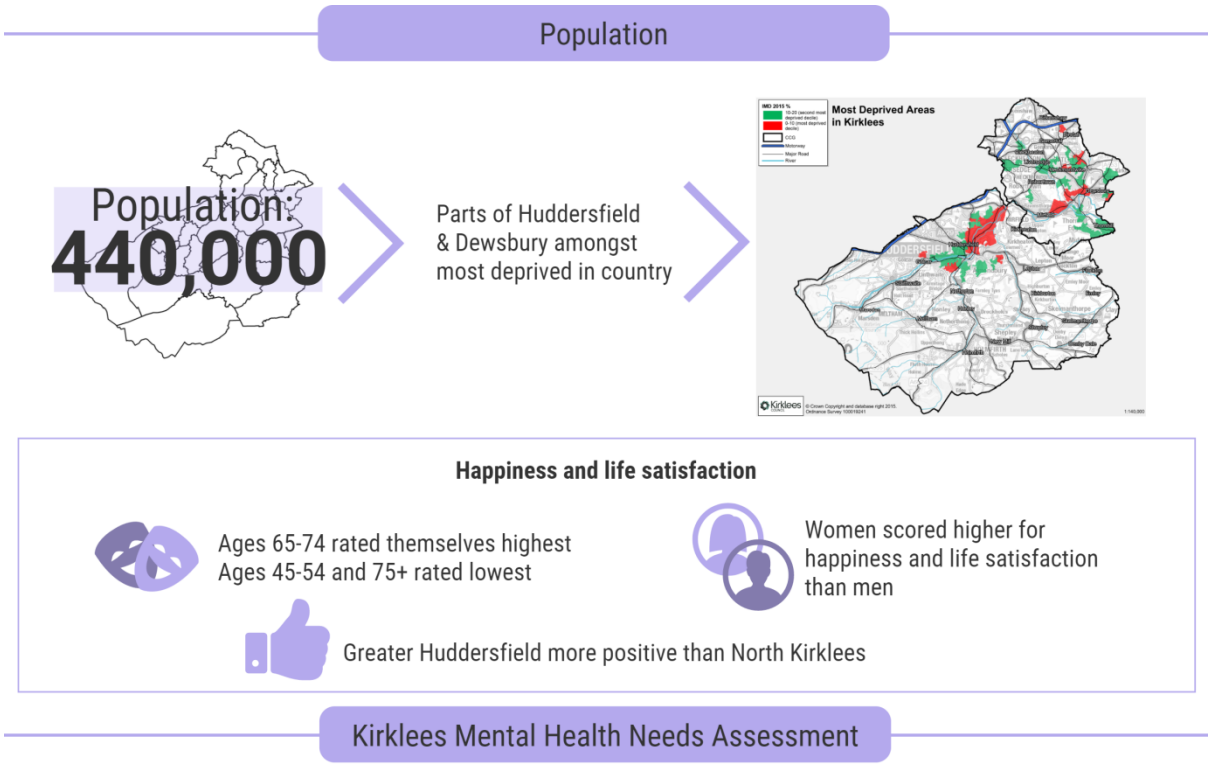
Those living in the least deprived areas are most likely to never feel lonely or isolated and are most likely to be socially connected. A similar pattern is seen in those with and without a mental health condition.

According to research by the University of Exeter, published in 2013, individuals have both lower mental distress and higher wellbeing when living in urban areas with more green space. The potential cumulative benefit at a community level highlights the importance of

[49] Goldie, I., Edwards, J., O'Sullivan, C., Regan, M., Elliott, I. (2016). A Whole community approach to Prevention in Mental Health. London: MHF

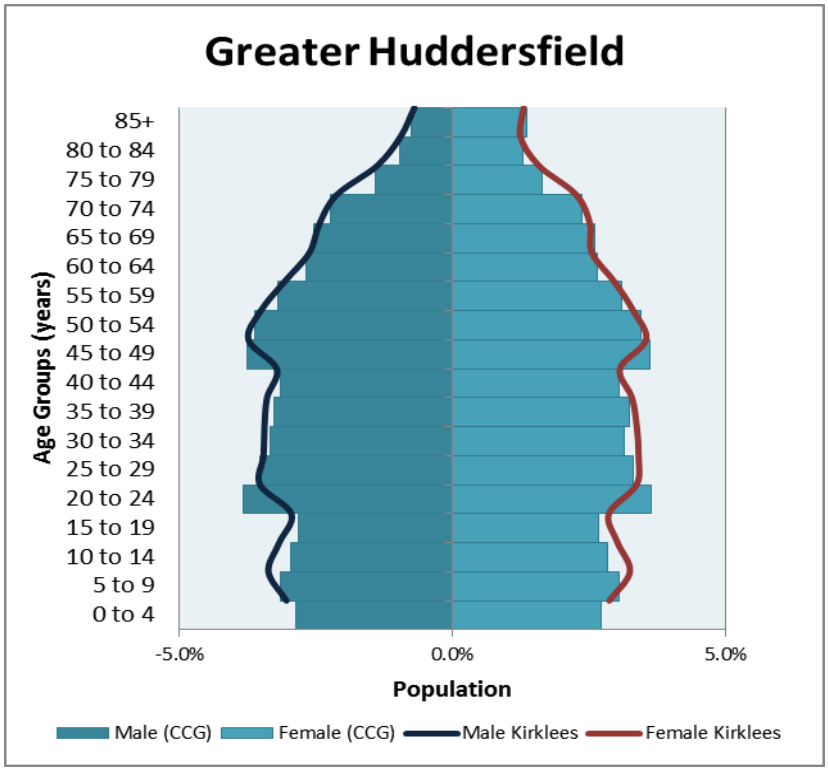
policies to protect and promote urban green spaces. Green spaces facilitate interaction and therefore reduce social isolation. A key role of councils is the planning, provision and maintenance of green and open spaces for all the community to use and enjoy. This is one example of an early intervention approach to positive wellbeing.

3. Population, Profile of Happiness and General Wellbeing and Quality of Life in Kirklees

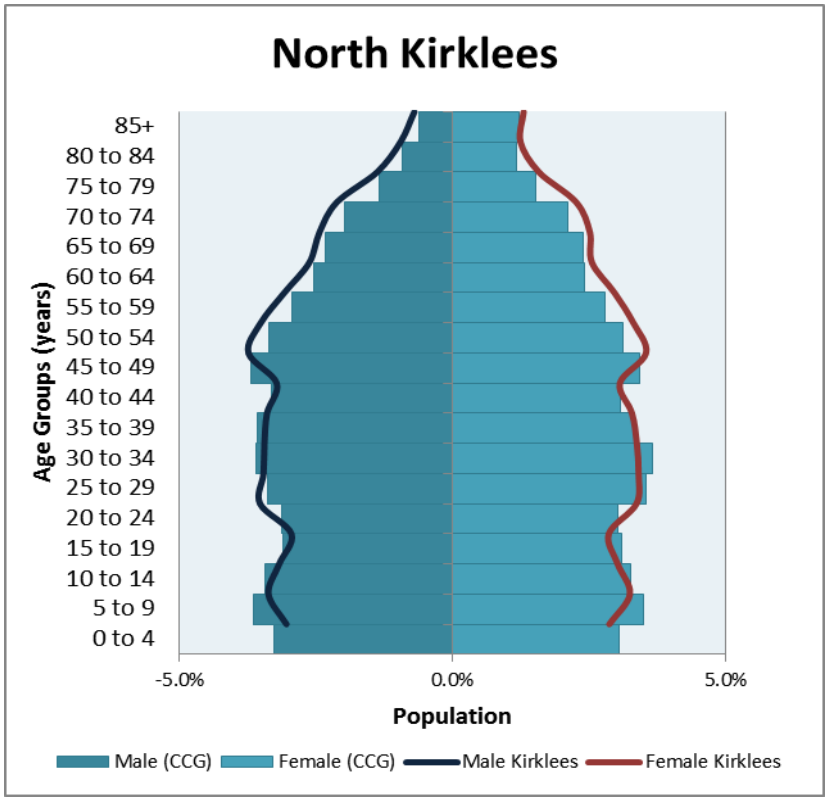


3.1 Population

Around 440,000 people live in Kirklees (GP registrations January 2015), with around 44% (191,562) living in the North Kirklees CCG area and 56% (248,488) living in the Greater Huddersfield CCG area. The population in both CCGs is split evenly between males and females, but there are some differences in the age profiles, with North Kirklees having a younger population (Figure 3.1).



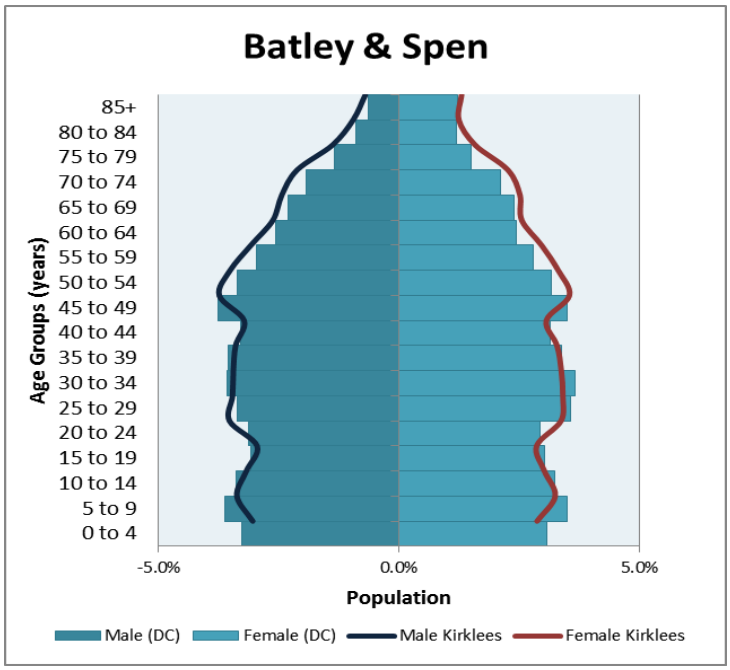
Under 20 years: 23.1%; 65+ years: 17.2%



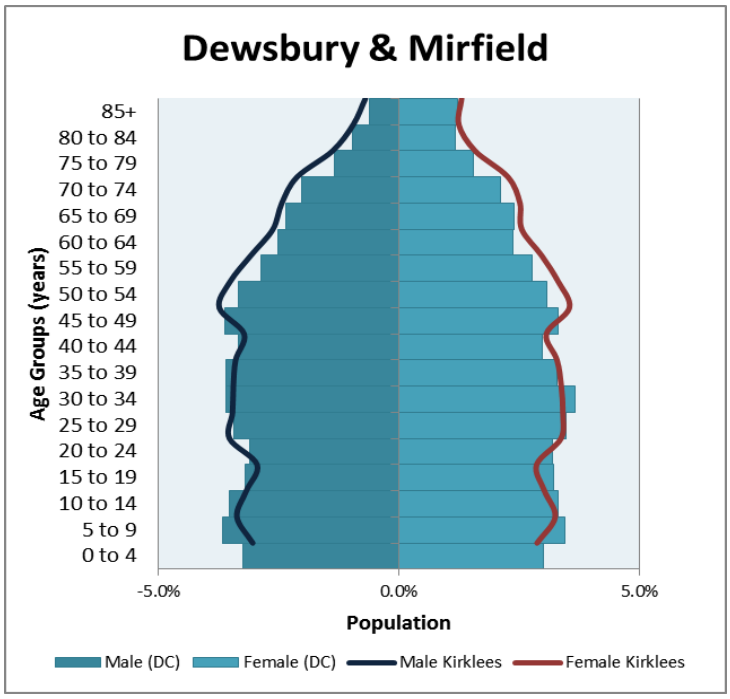
Under 20 years: 26.4%; 65+ years: 15.6%

Figure 3.1: Age distribution across both CCG's in Kirklees. GP registered population for Kirklees practices, September 2017 (NHS Digital).

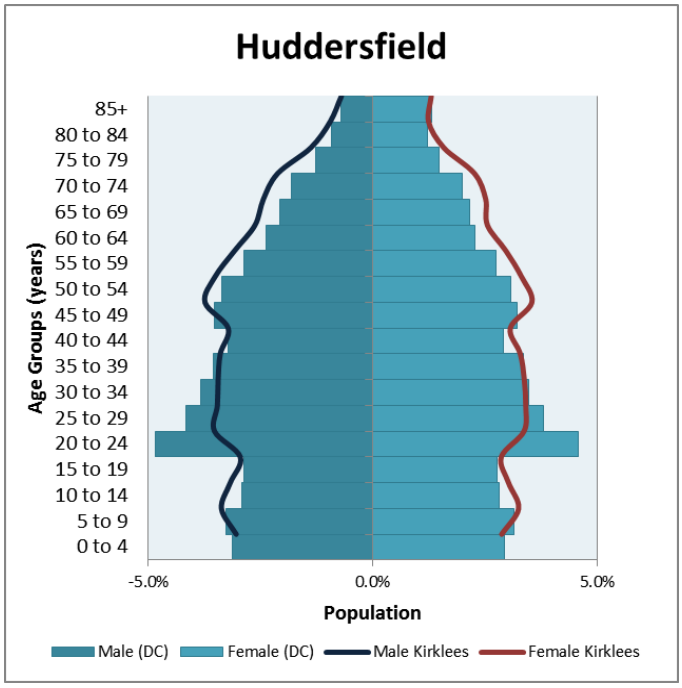
Figure 3.2 shows these population distributions at District Committee level. Batley & Spen and Dewsbury & Mirfield have relatively large proportions of young children, Huddersfield has a large proportion of young adults (reflecting the University student population living in this area), and Kirklees Rural has a larger proportion of older people.



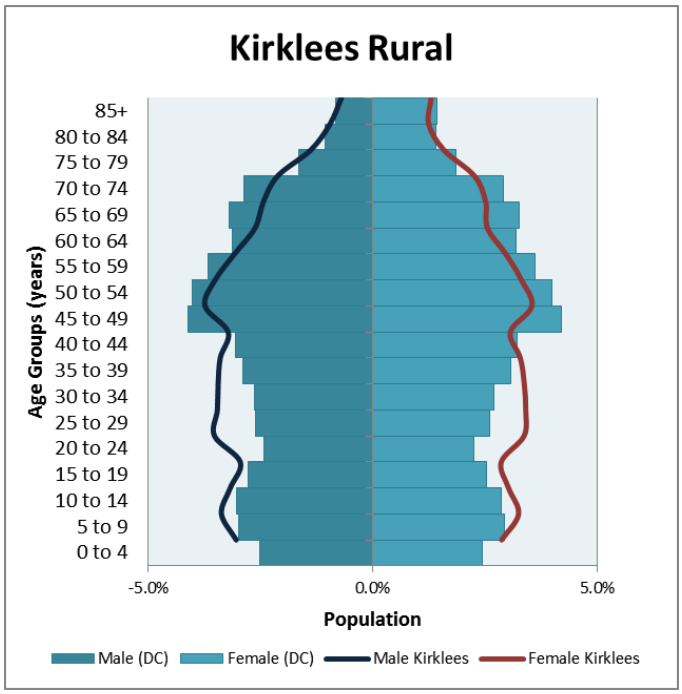
Under 20 years: 26.2%; 65+ years: 15.6%



Under 20 years: 26.7%; 65+ years: 15.7%



Under 20 years: 23.9%; 65+ years: 14.9%



Under 20 years: 22.1%; 65+ years: 20.5%

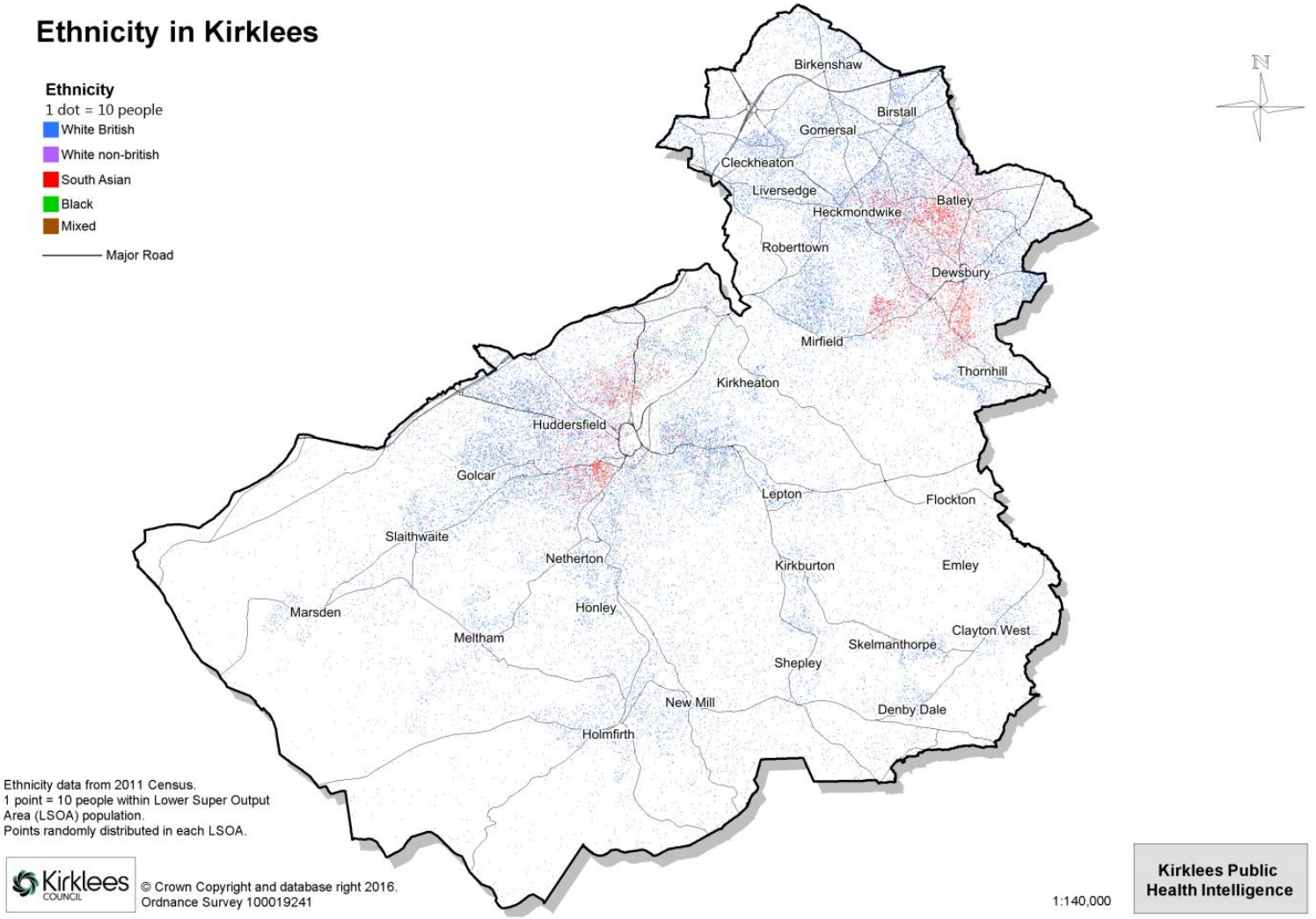
Figure 3.2: Age distribution across the four Kirklees District committee areas, with a comparison to Kirklees overall. GP registered population for Kirklees practices, September 2017 (NHS Digital).

3.2 Ethnicity (see also section 6.6)

Ethnicity figures from the 2011 census show that more than three quarters (77%) of the Kirklees population are White British. However, some parts of Kirklees have much higher

proportions of minority ethnicities (Figure 3.3), and ethnic minority groups tend to live in areas defined as more deprived (Figure 3.4).

Figure 3.3: Ethnicity distribution for largest ethnic groups in Kirklees (2011 Census)



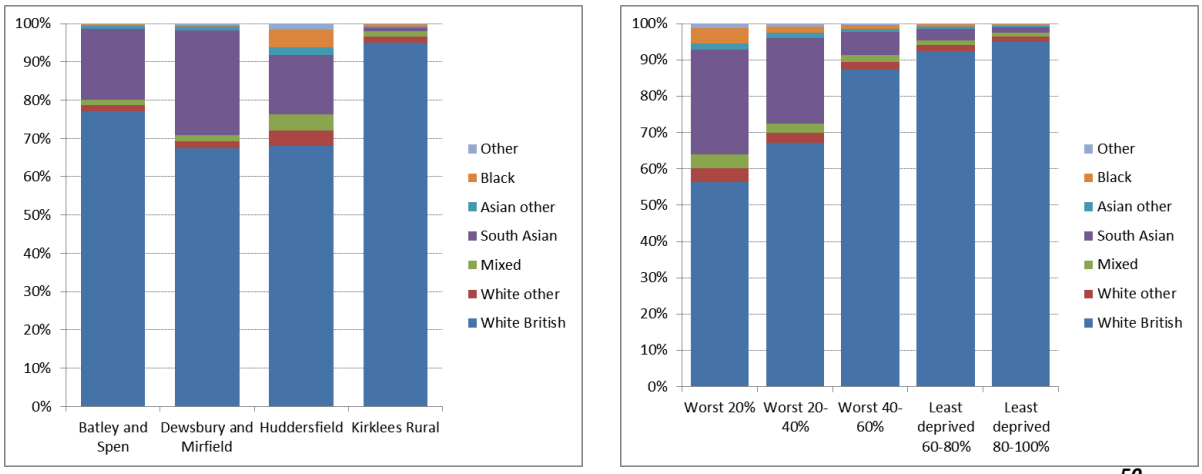
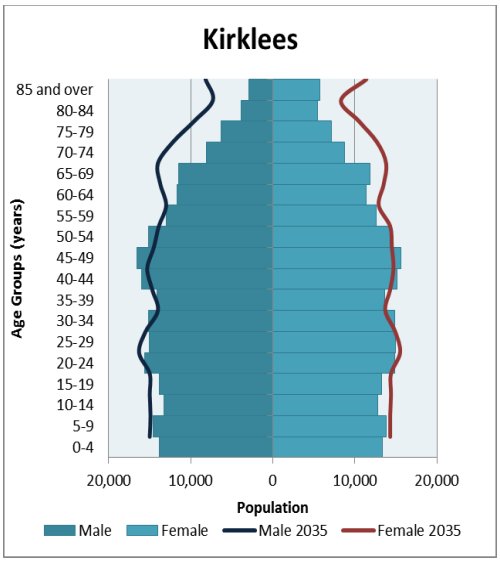


Figure 3.4: Population by ethnicity for District Committees and deprivation quintiles [50]

3.3 Population projections

The population of Kirklees is projected to increase to 484,500 by 2035, with the largest increases expected for older age groups (Figure 3.5).



Under 20 years: 24.7% (2015); 24.2% (2035); 65+ years: 16.3% (2015); 22.3% (2035)

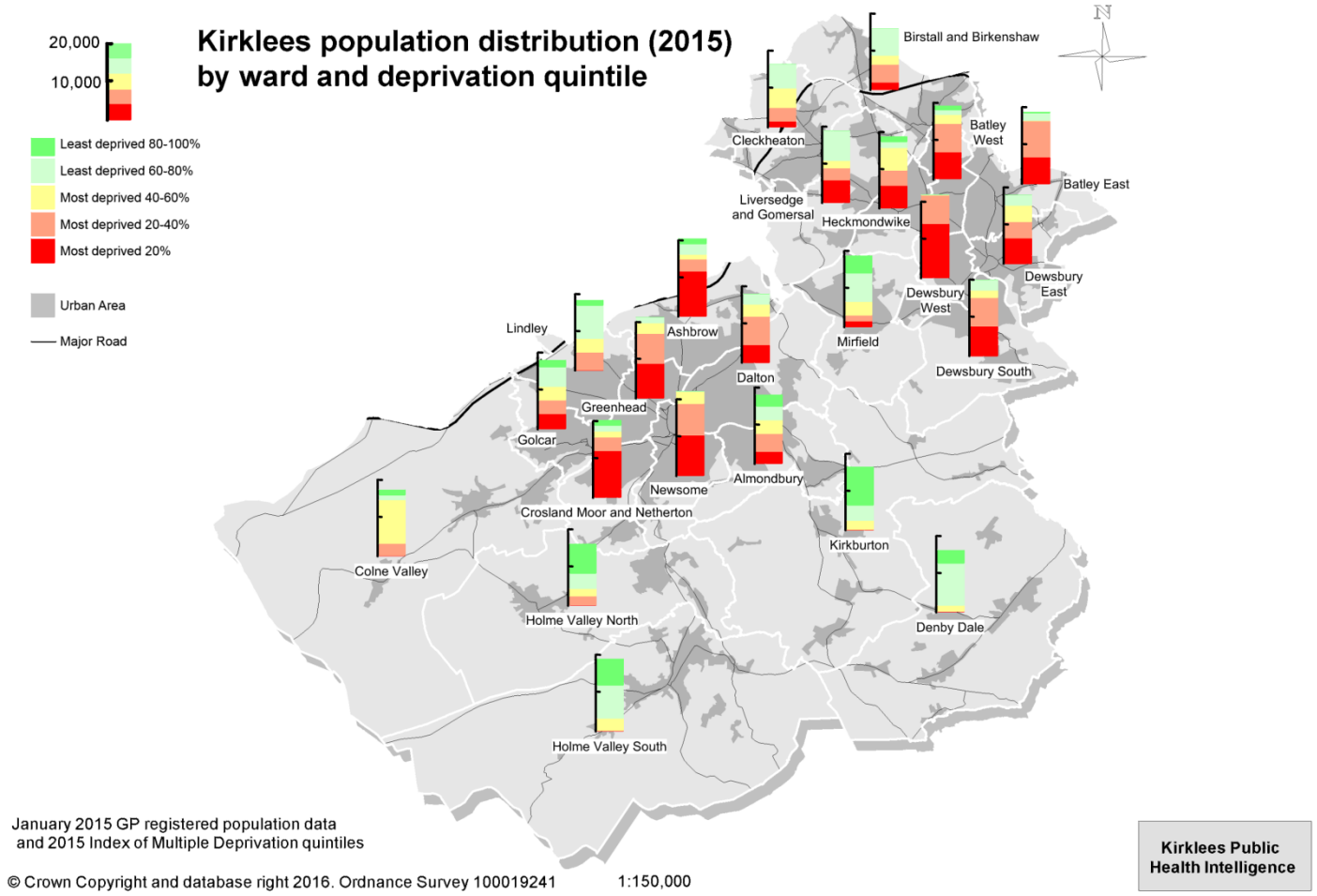
Figure 3.5: Comparison between current population (Source: GP registrations, Jan 2015) and projected population in 2035 [51]

[50] ***ONS, 2011 Census***
[51] ONS projections, 2014

3.4 Deprivation

Levels of deprivation, measured by the Department for Communities and Local Government Index of Multiple Deprivation, vary considerably across the region. Figure 3.6 shows the numbers of people living in each deprivation quintile for all 23 Kirklees wards. Rural areas of South Kirklees (the Holme Valley, Colne Valley, Kirkburton and Denby Dale) have very few people living in more deprived areas, in contrast to some of the urban areas around Huddersfield and Dewsbury where more than half the population live in areas defined as amongst the most deprived in England (Ashbrow, Crosland Moor & Netherton, and Dewsbury West).

Figure 3.6: Deprivation distribution across Kirklees



3.5 Happiness and life satisfaction

The Current Living in Kirklees (CLiK) adult population survey (see appendix C) was sent to one in five randomly selected households in July 2016. In total, 8,500 responses were received, with responses reweighted to reflect the demographic profile of the area. Respondents were asked to provide a score between 0 (Not at all) and 10 (Completely) to the following three questions:

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

Mean average scores to each of these three questions are presented by age, gender and area in Figure 3.7, with a higher mean score reflecting a more positive response.

This shows the following:

Age

The age group which responded more positively than the Kirklees average across all 3 questions was 65-74 year olds. The age group which was significantly worse than Kirklees average across all 3 questions was 45-54 year old and 75+ year olds.

Gender

Women responded more positively than men across all 3 questions. These findings are in line with national findings – which found that a higher proportion of women than men rated their satisfaction/extent of their life being worthwhile and happiness as very high.[52]

District Committee

The Kirklees Rural area responded significantly more positively than the Kirklees average across all 3 questions. Dewsbury and Mirfield responded the lowest for feeling worthwhile, while Batley and Spenborough responded the lowest for feeling happy.

Clinical Commissioning Groups

Residents from Greater Huddersfield CCG responded more positively than North Kirklees CCG across all 3 questions.

Ethnicity

People of White British ethnicity had a significantly higher mean score than the Kirklees average for the 'satisfied', 'worthwhile' and 'happy' questions (CLiK 2016). People of Indian ethnicity had a significantly higher mean score (than Kirklees average) for the 'worthwhile' question. Although the mean scores for the other two questions were also high for those of

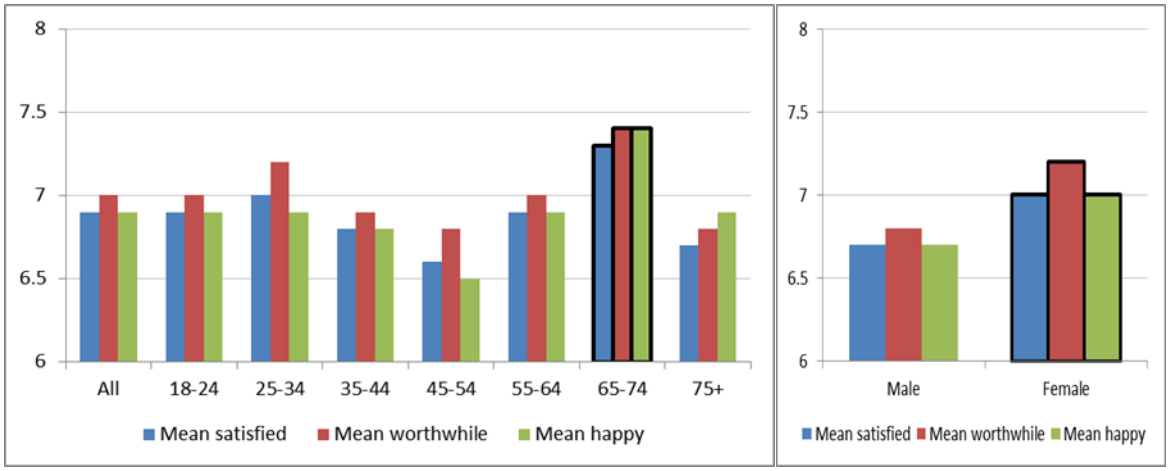
52 https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/datasets/measuringnationalwellbeingdomainsandmeasures

Indian ethnicity, the sample size was not sufficiently large to say that these scores are significantly higher than average.

Long term condition

People who do not have a physical or mental health condition which has lasted or is expected to last 12 months or more (Q5 in the CLiK 2016 survey) and people who do not have a long-term health condition (Q8 in CLiK) have significantly higher mean scores than the Kirklees average for the 'satisfied', 'worthwhile' and 'happy' questions.

Age **Gender**



Geographic Area: District Committee and CCG

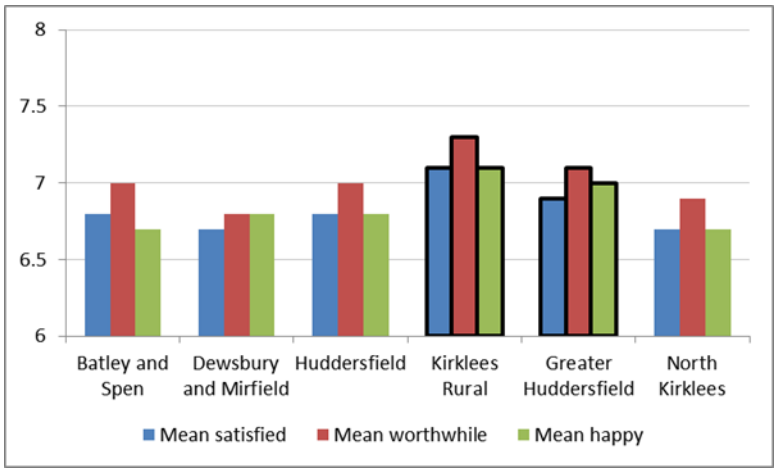


Figure 3.7: Mean scores by age, gender and area *('Overall how satisfied are you with your life nowadays?'; 'Overall to what extent do you feel the things you do in your life are worthwhile?'; 'Overall how happy did you feel yesterday?'; Bars with black outline are significantly higher than Kirklees average.* [53]

[53] *CLiK 2016*

4. Children and Young People

The mental health and wellbeing of children and young people is of paramount importance to the future health and prosperity of our society. In order to improve the mental wellbeing of children and families in Kirklees, both the factors that increase the risk of poor mental health and those that protect mental wellbeing need to be taken into account.

Children and young people are not in the scope of this needs assessment due to a substantial amount of work having been completed to date. Future in Mind (2015)[54] had a number of far reaching recommendations to improve and transform Children and Adolescent Mental Health Services (CAMHS) provision. There was a requirement for local areas to respond to the recommendations by producing and publishing a CAMHS Local Transformation Plan (LTP). Kirklees' transformation plan was regarded as an example of good practice by NHS England and it provides a comprehensive picture of needs, which flows into outcomes and commissioning priorities. This can be accessed here.

Following on from this, an ambitious programme of work was undertaken to develop the Healthy Child Programme, now known as 'Thriving Kirklees.' Throughout the specification development, in depth consultation and insight work was undertaken with children young people and families to inform the specification along with the appropriate evidence based interventions and associated CAMHS LTP priorities. It means a move away from a tiered system of provision to one focused on functions; getting advice, getting help, getting more help, and getting risk support. The delivery of 'Thriving Kirklees' will meet the majority of the transformation plan priorities and will also meet the recommendations from a commissioned report into our local child experiences of CAMHS provision called the 'Child's journey,' and there is an annual requirement to refresh the CAHMS LTP in October each year, so the needs assessment will be ongoing.

4.1 Transition between CAMHS and Adult Mental Health Services

Transition between services can be a difficult time for vulnerable young people and therefore it is important to ensure it is a well-managed process. The transition can be difficult for a number of reasons, one of which is the age thresholds and severity thresholds for different services and identifying and preparing for transition to ensure that young people do not get lost in this transition due to their age or severity of condition. Some young people may transition to services other than adult mental health services, which may offer a different type and level of service which may take some adjusting to. Good life-course models of care, communication and planning are needed to ensure continuity of appropriate care is provided.

[54] Future in Mind (2015). Accessible here: https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

5. Adult Population

During adulthood, mental health can impact upon people's ability to maintain employment, housing and secure family relationships. Some people and groups are more at risk of common mental health problems often as a result of the social, economic or environmental circumstances in which they find themselves. Early identification and supportive intervention, across a range of services and initiatives, will help provide stability and negate the need for further more intensive health care and treatment.

5.1 Prevalence

The PANSI web tool (Projecting Adult Needs and Service Information, www.pansi.org.uk) uses national prevalence rates and local population projections (Office for National Statistics, ONS) to estimate the number of people aged 18-64 likely to have various conditions. Services that work with these population groups should consider the increase in population projections and think about how they could re-orient their services toward more upstream ways of working.

5.1.1 Common mental disorder

Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder.

Results of a household survey[55] found that 19.7% of women and 12.5% of men surveyed met the diagnostic criteria for at least one CMD. Applying these prevalence rates to ONS population projections gives the following estimated number of people predicted to have a common mental disorder in Kirklees:

Table 5.1: Estimated number of people predicted to have a common mental disorder in Kirklees

	Year				
	2014	2015	2020	2025	2030
Males aged 18-64	16,388	16,425	16,600	16,738	16,850
Females aged 18-64	25,669	25,728	26,083	26,260	26,378
Total aged 18-64	42,057	42,153	42,683	42,998	43,228

[55] Adult psychiatric morbidity in England (2007). Results of a household survey. Accessible via: https://sp.ukdataservice.ac.uk/doc/6379/mrdoc/pdf/6379research_report.pdf

5.1.2 Borderline personality disorder (see section 6.6)

Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Borderline personality disorder (BPD) is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour is common. The overall prevalence of BPD was 0.3% for men and 0.6% for women. Applying these prevalence rates to ONS population projections gives the following estimated number of people predicted to have BDP in Kirklees:

Table 5.2: Estimated number of people predicted to have a borderline personality disorder in Kirklees

	Year				
	2014	2015	2020	2025	2030
Males aged 18-64	393	394	398	402	404
Females aged 18-64	782	784	794	800	803
Total aged 18-64	1,175	1,178	1,192	1,202	1,207

5.1.3 Antisocial personality disorder

Antisocial personality disorder (ASPD) is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed. ASPD was present in 0.6% of men and 0.1% of women. Applying these prevalence rates to ONS population projections gives the following estimated number of people predicted to have ASPD in Kirklees:

Table 5.3: Estimated number of people predicted to have antisocial personality disorder in Kirklees

	Year				
	2014	2015	2020	2025	2030
Males aged 18-64	787	788	797	803	809
Females aged 18-64	130	131	132	133	134
Total aged 18-64	917	919	929	936	943

5.1.4 Psychotic disorder

Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder. The overall prevalence of psychotic disorder was found to be 0.4% (0.3% of men, 0.5% of women). In both men and women the highest prevalence

was observed in those aged 35 to 44 years (0.7% and 1.1% respectively). The age standardised prevalence of psychotic disorder was significantly higher among black men (3.1%) than men from other ethnic groups (0.2% of white men, no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women. Applying these prevalence rates to ONS population projections gives the following estimated number of people predicted to have psychotic disorder in Kirklees:

Table 5.4: Estimated number of people predicted to have a psychotic disorder in Kirklees

	Year				
	2014	2015	2020	2025	2030
Males aged 18-64	393	394	398	402	404
Females aged 18-64	652	653	662	667	670
Total aged 18-64	1045	1047	1060	1069	1074

There is evidence to suggest that adverse experiences in childhood are associated with psychosis and that exposure to adverse childhood events should be regarded as an important determinant of psychotic disorders.[56] Clinicians should routinely inquire about adverse events in childhood in order to develop comprehensive formulations and treatment plans when working with patients with schizophrenia or similar diagnoses. Psychosocial interventions which have been used for patients affected by trauma might be considered among the treatment options for patients with psychosis.

5.1.5 Two or more psychiatric disorders

Psychiatric comorbidity - or meeting the diagnostic criteria for two or more psychiatric disorders - is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. Disorders included the most common mental disorders (namely anxiety and depressive disorders) as well as: psychotic disorder; antisocial and borderline personality disorders; eating disorder; posttraumatic stress disorder (PTSD); attention deficit hyperactivity disorder (ADHD); alcohol and drug dependency; and problem behaviours such as problem gambling and suicide attempts. Just under a quarter of adults (23.0%) met the criteria or screened positive for at least one of the psychiatric conditions under study. Of those with at least one condition: 68.7% met the criteria for only one condition, 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions. Numbers of identified conditions were not significantly different for men and women. Applying these prevalence rates to ONS population projections gives the following estimated number of people predicted to have two or more psychiatric disorders in Kirklees:

Table 5.5: Estimated number of people predicted to have two or more psychiatric disorders in Kirklees

[56] Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., Os, J., and Bentall, R. P. (2012). Childhood Adversities Increase the Risk of Psychosis: A Meta –Analysis of Patient- Control, Prospective- and Cross-Sectional Cohort Studies. Schizophrenia Bulletin, volume 38, Issue 4, 661-671

	Year				
	2014	2015	2020	2025	2030
Males aged 18-64	9046	9067	9163	9239	9301
Females aged 18-64	9773	9795	9930	9998	10043
Total aged 18-64	18,819	18,862	19,093	19,237	19,344

Data accessed via PANSI (www.pansi.org.uk version 8.0), 07/06/17

5.2 Primary Care and Mental Health

Of those who need treatment for their mental health, the majority are treated in primary care.[57] Mental health is a core business for primary care; GP's and other primary care staff have a clear understanding of just how much our mental health and physical health are related. For example, those with diabetes or chronic pain will often struggle with their mental health and will have better outcomes if our physical health and mental health is addressed. Primary care can provide the holistic 'whole-person' care.

5.2.1 Impact of Mental Health on Primary Care

On average, GP's spend nearly a fifth of their appointment time on social issues[58] and around one in three GP appointments will involve a mental health component.[59] This demand on primary care is putting the workforce under a lot of strain and having an impact on many primary care professionals' own mental health and wellbeing. We cannot work to improve the mental health support provided by primary care services, unless we support the healthcare staff providing those services.

Primary care mental health services include two elements[60]:
1) Ensuring the primary care workforce has the knowledge, confidence and capacity to provide mental health support. For this to be achieved, primary care professionals need to have the necessary training and time to provide an adequate level of support for people's mental health.
2) Mental healthcare which is provided by primary care professionals who are additionally skilled in mental health and who are able and supported to provide mental health services. This element is about providing more specialised mental health support in primary care. For example, a primary care mental health worker based in a GP practice.

These services can provide more specialised mental health support for those that require more support, but who don't need or are unable to access secondary care, or who have been discharged from secondary care because their mental health is stable. This approach is

[57] Gask, L., et al. (2009). Primary Care Mental Health. RCPsych Publications.
[58] Citizens Advice (2015). A very general practice: How much time do GP's spend on issues other than health? Available from www.citizensadvice.org.uk
[59] London Strategic Clinical Network for Mental Health. (2014). A commissioner's guide to primary care mental health. Available from www.sicsn.nhs.uk
[60] Funk, M., and Ivbijaro, G. (2008). Integrating mental health into primary care: A global perspective. Geneva: WHO

supported by the NHS England 'General Practice: Forward View' which states that the primary care workforce would be expanded, including through investment in an extra 3,000 mental health therapists to work in primary care by 2020, which is an average of a full time therapist for every 2-3 typical sized GP practices.[61]

5.2.2 Mental Health in Primary Care - Kirklees

The following indicators (percentage of GP practice population) were plotted against the relative deprivation rank (from 1- most deprived to 72 -least deprived) of each GP practice in Kirklees:

- anxiety, neuroses
- personality disorder
- substance use
- QOF depression register
- QOF mental health register

Out of all of these indicators, only the QOF mental health indicator showed a weak positive correlation (i.e. more deprived, higher prevalence). As the evidence tells us that mental health is associated with socio-economic deprivation, this might suggest that records are not accurate and/or people are not able to recognise they have signs and symptoms of a mental health condition. This is something for primary care to consider both in terms of raising awareness with their registered population, but also amongst the primary care staff.

Each of these indicators is plotted against the relative rank of each GP practice,

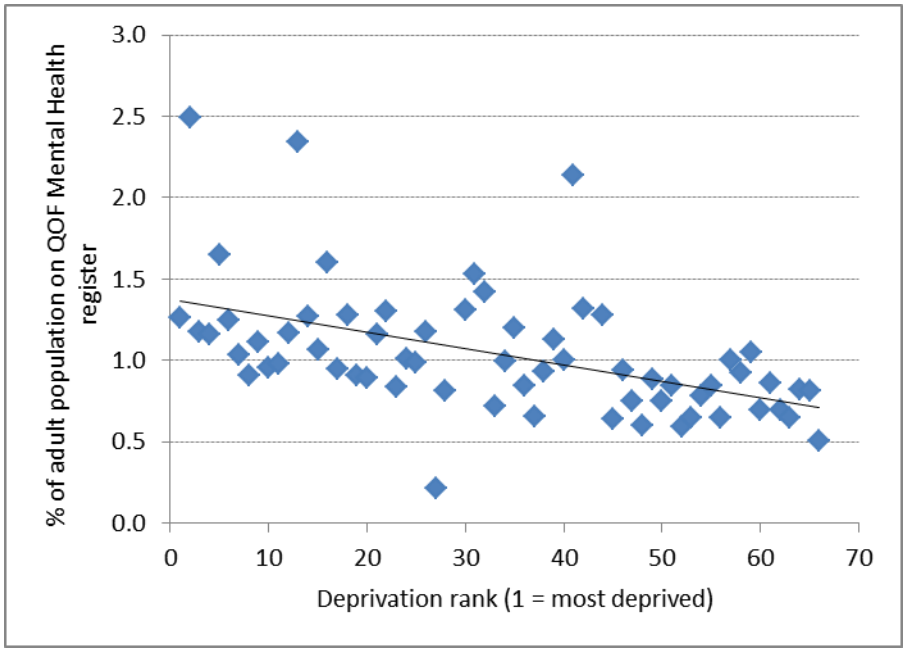


Figure 5.1: % of GP practice population on QOF mental health register against GP deprivation rank

[61] NHS England (2016). General Practice Forward View. Available from www.england.nhs.uk

We should interpret this data with caution as relative ranks of GP practice deprivation have been plotted rather than an actual measured value, (a value of 1 between a practice and the next highest/lowest ranked practice).

5.2.3 QOF - Depression

This chapter should be read in conjunction with section 5.4 – Prescribing data.

The Quality and Outcomes Framework (QOF) is an annual reward and incentive programme for GP practices. It looks at a range of achievement measures or indicators in many different areas of practice. The QOF indicators below look at the overall prevalence of depression in the practice population (by CCG) in Kirklees.

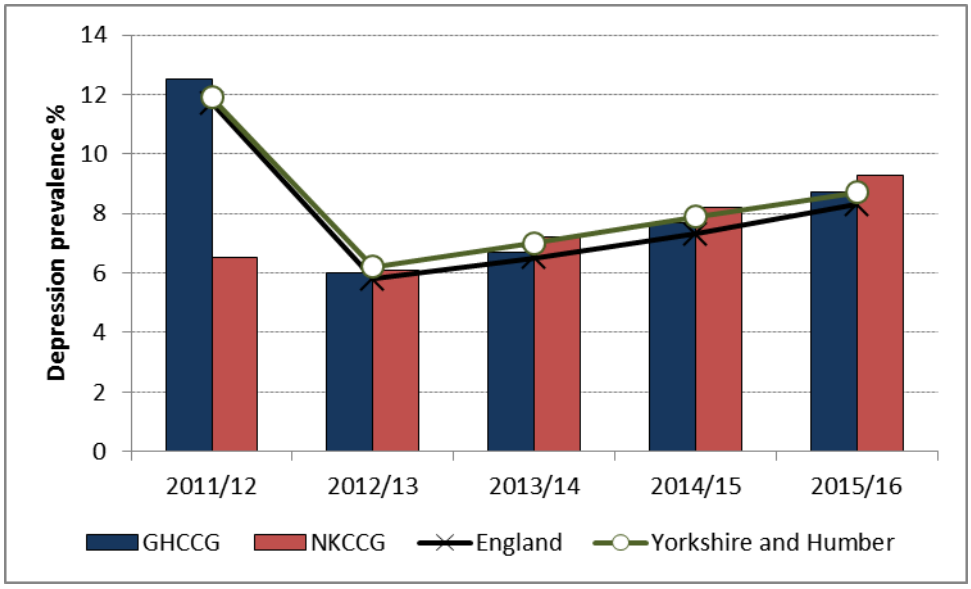


Figure 5.2: Depression recorded prevalence (% of practice register age 18+) For Greater Huddersfield and North Kirklees CCGs [62]

Since 2012/13, NKCCG shows higher levels of depression recorded prevalence.

[62] *Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof*
Note: Yorkshire and Humber values are aggregated from all known lower geography values

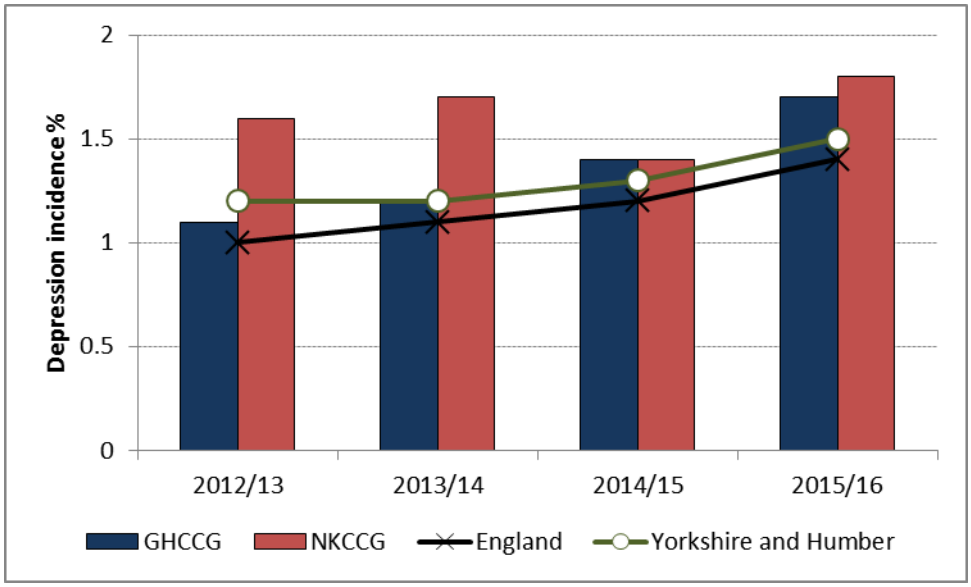


Figure 5.3: Depression recorded incidence (% of practice register age 18+) for Greater Huddersfield and North Kirklees CCGs [63]

Depression recorded incidence is higher in NKCCG and is considerably higher in Kirklees (2015/16) than in Yorkshire and Humber and England. This could be because our incidence is higher, or because recording has improved in Kirklees. However, incidence rates are at their highest since 2012/13.

5.3 Self-reported wellbeing

Question 8 of the CLiK survey asked: Which, if any, of the following health conditions or illnesses do you have or have you had in the last 12 months? Please tick all that apply. This was followed by 17 named conditions including 'Depression', 'Anxiety' and 'Other mental health condition', along with options for 'Other' and 'None of the above'.

In total, 29% of the sample reported having at least one of the three mental health condition options. This proportion was highest amongst younger adults (43% of those aged 18-24 and 34% of those aged 25-34, compared with 19% of those aged 65-74 and 17% of those aged 75 and above). The rate in females was also significantly higher (32%, compared with 26% in males), as was the rate for those of mixed ethnicity (44%, compared with 24% for those of Asian ethnicity and 30% for those of White ethnicity).

People living in more deprived areas are significantly more likely to report having a mental health condition – in 2016, 35% of those in the most deprived quintile (defined by the Index of Multiple Deprivation) compared with 21% of those in the least deprived quintile. Although the same pattern was seen in the previous CLiK survey (2012) the figures are

[63] Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof
Note: Yorkshire and Humber values are aggregated from all known lower geography values

significantly higher in 2016, with the largest increase seen in the most deprived quintile (up from 25% in 2012).

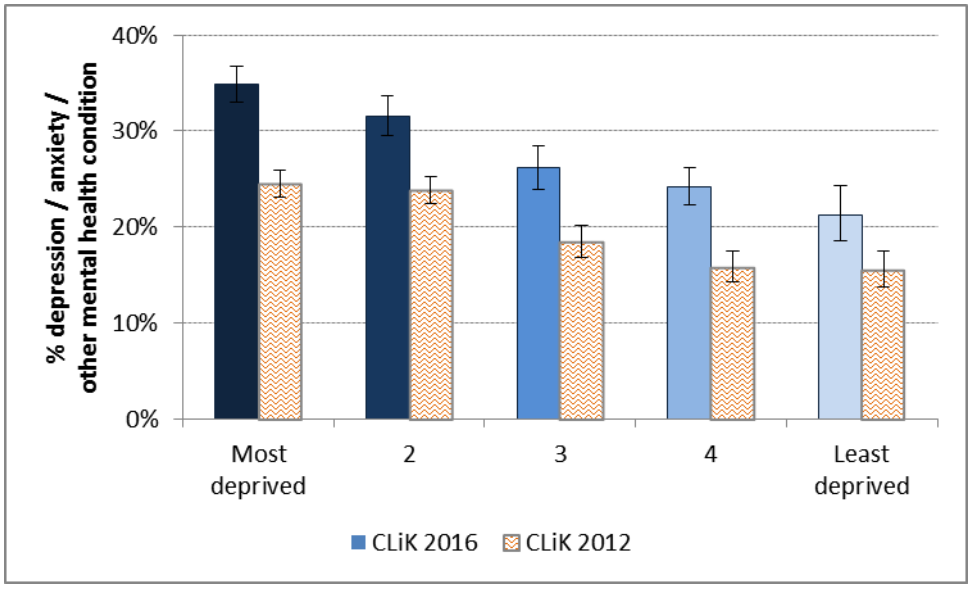


Figure 5.4: Self-reported mental health conditions by deprivation in Kirklees [64]

Higher levels of self-reported mental health condition compared to recorded incidence could indicate that there are more people living with these conditions that have not been to their GP to seek help or receive a formal diagnosis.

5.4 Prescribing data

This chapter examines the prescribing of some medicines used to treat common mental health conditions within Kirklees. The prescribing is presented as rates and is weighted to allow comparison between England, North Kirklees Clinical Commissioning Group and Greater Huddersfield Clinical Commissioning Group. Prescribing data has also been provided to the CCG's at practice level. This data is sourced from ePACT (the prescribing database developed and maintained by NHS Business Services Authority).

Prescribing is presented as ADQs per weighted denominator. ADQ (Average Daily Quantity) is a measure of the volume of the drug prescribed. There are 2 weighted denominators used - STAR PUs and ASTRO PUs. Both use nationally agreed weightings to enable the comparison of prescribing between organisations of different sizes. They calculate the demand in Prescribing Units (PUs) for particular drug groups, and are calculated from the organisation's patient lists sizes and their age sex demographics.

5.4.1 Antidepressants

[64] CLiK adult population surveys, 2012 and 2016

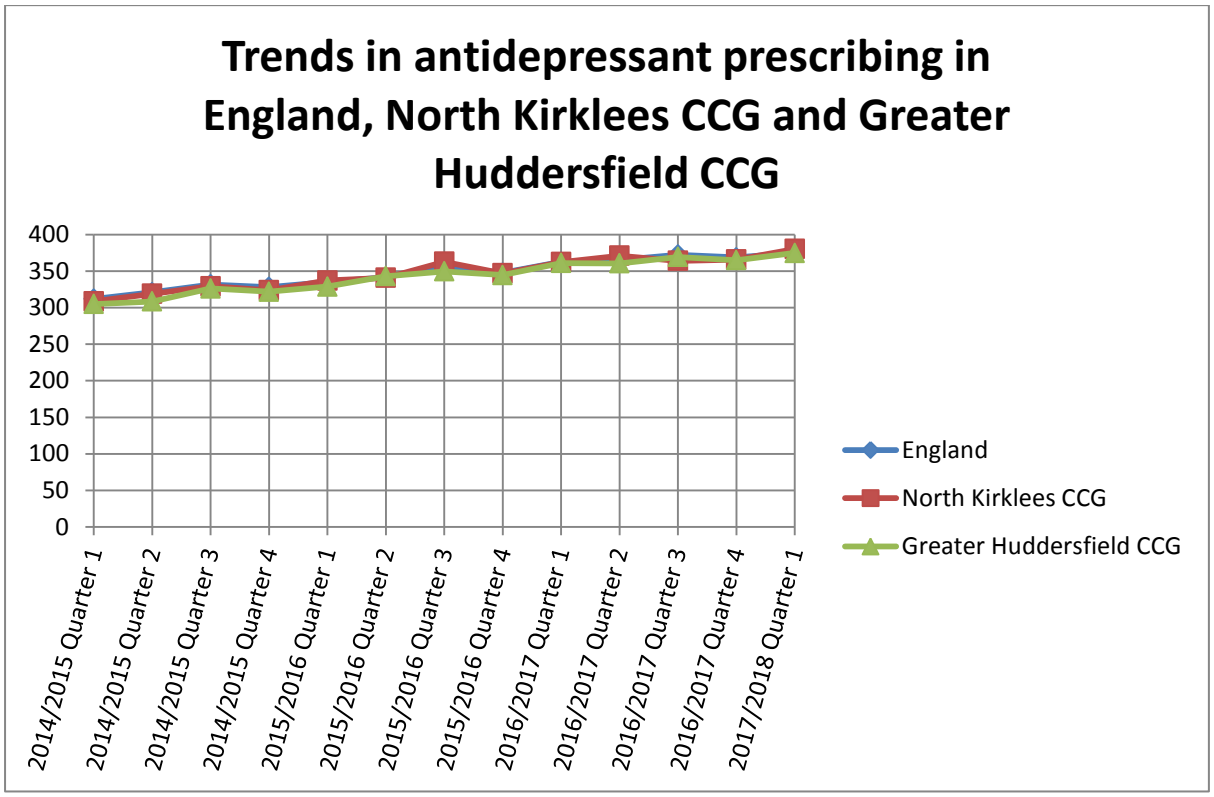


Figure 5.5: Trends in Antidepressant prescribing in England, North Kirklees CCG and Greater Huddersfield CCG; 2014-2015, 2015-2016 and 2016-2017.

Antidepressant drugs are used to treat clinical depression as well as anxiety disorder, obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), bulimia and serious phobias (e.g. agoraphobia & social phobia). They are also prescribed for chronic nerve (neuropathic) pain. This data does not differentiate between prescribing for depression and related conditions or chronic pain. Figure 5.5 shows that the prescribing of antidepressants is increasing at a national level as well as within Greater Huddersfield CCG and North Kirklees CCG. Both North Kirklees CCG and Greater Huddersfield CCG broadly follow the national trend and are now similar to national volumes.

5.4.2 Anxiolytics

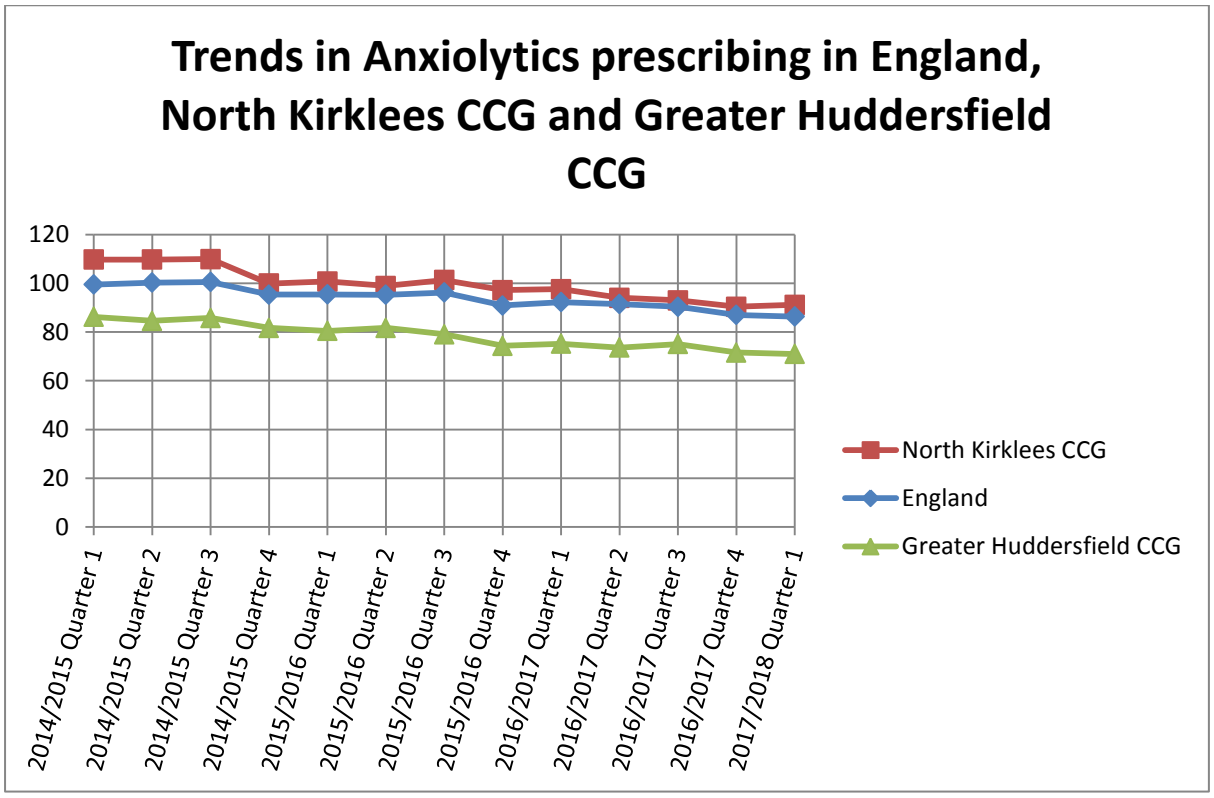


Figure 5.6: Trends in Anxiolytics prescribing in England, North Kirklees CCG and Greater Huddersfield CCG; 2014-2015, 2015-2016 and 2016-2017.

Anxiolytics are tranquillisers which are used to treat the symptoms of anxiety and agitation in other mental health conditions. They may also be used in patients experiencing severe acute stress. The interpretation of data on benzodiazepine prescribing can be difficult to as these drugs may often be prescribed appropriately as stand by medication for people prone to prolonged epileptic seizures or for short term problems such fear of flying, claustrophobia in MRI scanners or relief of muscle spasm. They are intended for short term use only as there is a high risk of dependence and potential for abuse. Figure 5.6 shows that Anxiolytic prescribing rates are reducing across England. Both CCG's are following the national trend of declining rates. Rates for Greater Huddersfield CCG are lower than both England and North Kirklees CCG, whilst North Kirklees CCG rates are slightly above England's rates.

5.4.3 Anti-psychotics

Anti-psychotics are major tranquillisers primarily used to treat the symptoms of serious mental health conditions such as schizophrenia and bipolar disorder. They can also be used for the treatment of other mental health conditions such as depression, anxiety and dementia. Treatment for psychosis involves a combination of antipsychotic medicines,

psychological therapies, and social support. Prescribing of antipsychotics is usually initiated by a team of mental health professionals, who review patients regularly and then advise GP's on which medication to issue to patients. Anti-psychotic Depot injections are the same medication as Anti-psychotics but are provided in a slow release and slow acting form. Figure 5.7 shows that Anti-psychotic medication rates are fairly stable across England, with North Kirklees CCG and Greater Huddersfield CCG rates higher than England and increasing slightly. Figure 5.8 shows Anti-psychotic Depot injection rates are decreasing in England, with rates for North Kirklees CCG and Greater Huddersfield CCG both lower than England. North Kirklees rates are varied but currently lower than the rates in England. Greater Huddersfield CCG prescribing rates are lower than England and North Kirklees CCG.

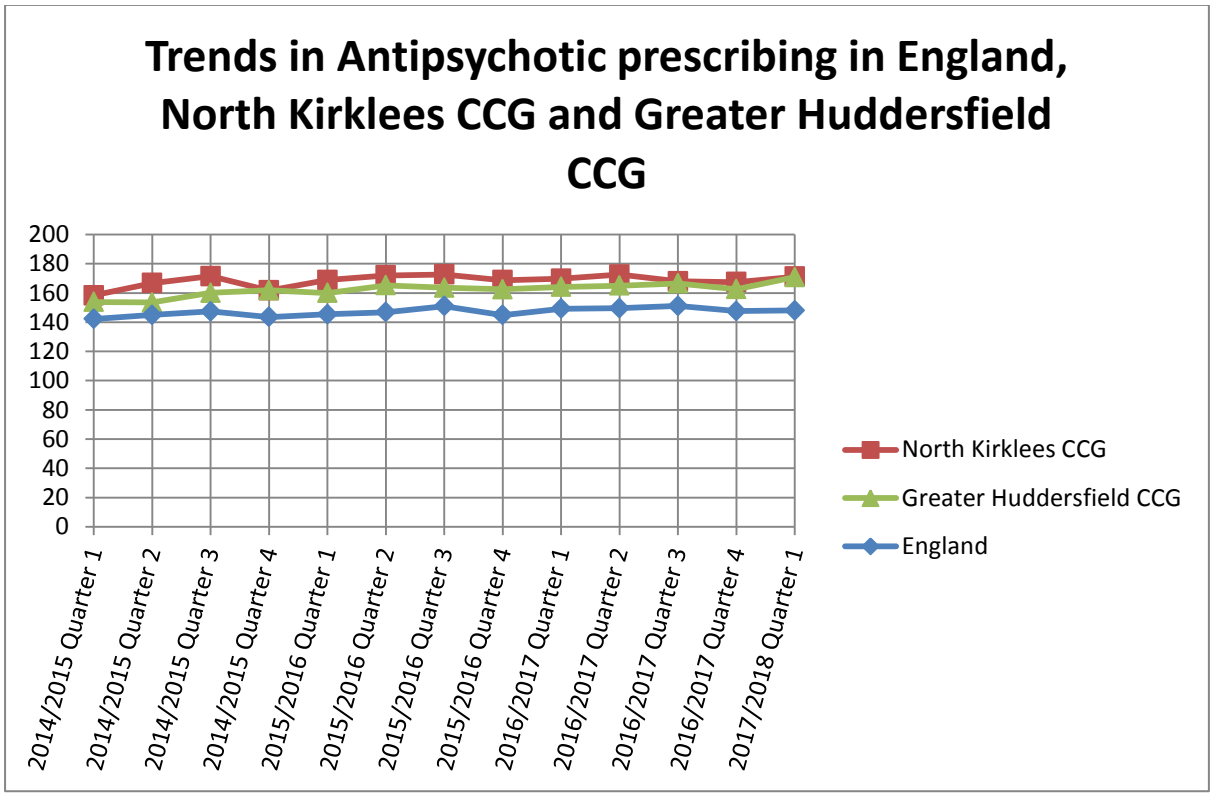


Figure 5.7: Trends in Anti-psychotic drugs prescribing in England, North Kirklees CCG and Greater Huddersfield; 2014-2015, 2015-2016 and 2016-2017

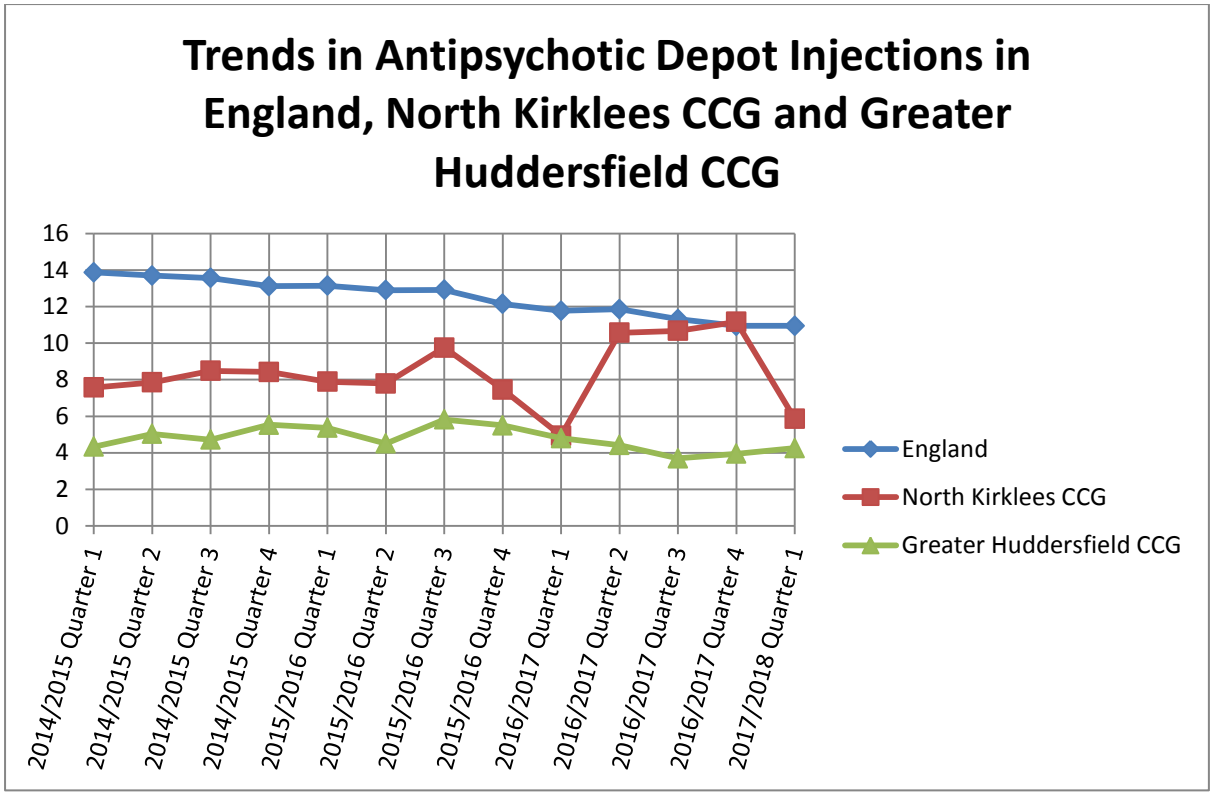


Figure 5.8: Trends in Anti-psychotic Depot injections for England, North Kirklees CCG and Greater Huddersfield CCG; 2014-2015, 2015-2016 and 2016-17

5.4.4 Hypnotics

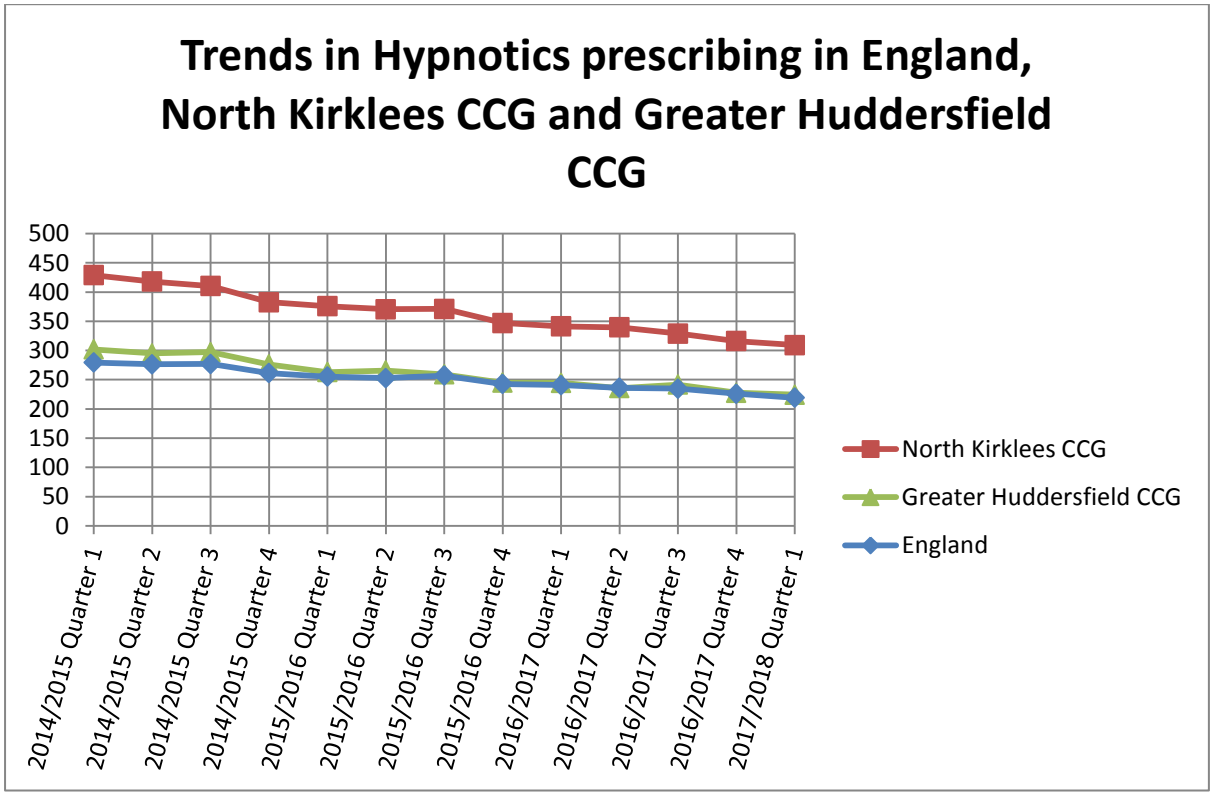


Figure 5.9: Trends in Hypnotics prescribing in England, North Kirklees CCG and Greater Huddersfield CCG; 2014-2015, 2015-2016 and 2016-2017.

Hypnotics are short-acting tranquillisers primarily used to treat the symptoms of insomnia. Prior to prescribing hypnotic medication the underlying cause of insomnia should be investigated and treated. Hypnotics are also used for the relief of agitation, particularly in patients suffering from dementia. They are intended for short-term or intermittent use only, as there is a high risk of dependence and potential for abuse. Figure 5.9 shows that Hypnotics prescribing has reduced across England, Greater Huddersfield CCG and North Kirklees CCG. Hypnotics prescribing rates for North Kirklees CCG are higher than Greater Huddersfield CCG and England, and Greater Huddersfield CCG rates are broadly similar to England.

5.5 Patient contacts with Mental Health services

This section examines recorded patient contacts with mental health services. This covers 2 areas of provision:

- South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).
- Kirklees Council commissioned mental health services which provide a range of community based services.

As these are separately commissioned services, it is possible that a patient can access both services at any one time. Therefore the numbers provided below may include some double counting of individual patients.

5.5.1 Patient contacts with South West Yorkshire Partnership NHS Foundation Trust

Figure 5.10 shows the number of patient contacts with SWYPFT for Greater Huddersfield CCG over the course of 2016-2017.

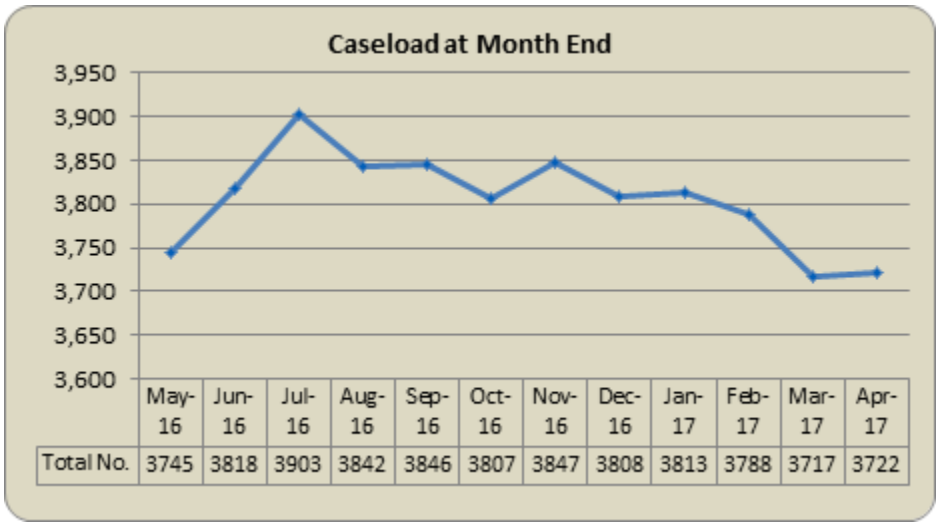


Figure 5.10: Patient contacts with SWYPFT – Greater Huddersfield CCG; 2016-2017

Figure 5.11 shows the number of patient contacts with SWYPFT for North Kirklees CCG over the course of 2016-2017.

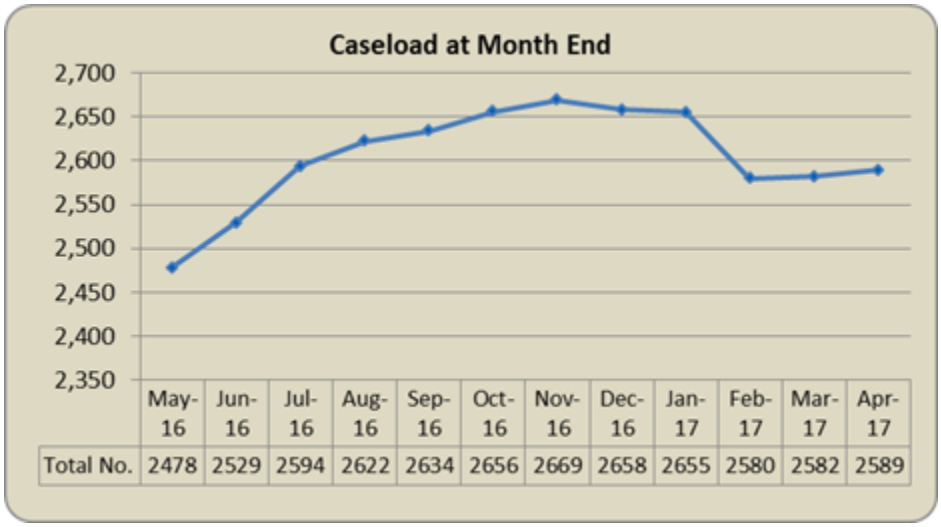


Figure 5.11: Patient contacts with SWYPFT – North Kirklees CCG; 2016-2017

Table 5.6 shows SWYPFT contacts by cluster for both GHCCG and NKCCG. Mental health clustering is a method of categorising patients by their level of need and the types of interventions they might require. There are 22 clusters in total, including clusters 18-21 for organic mental health conditions which are not in scope.

In addition, there will be a number of people receiving mental health services who have not yet been clustered or who have a mental health condition which sits outside clustering, e.g. ADHD. These people will be assigned to cluster 99 or cluster 0 respectively.

Table 5.6 shows that 61.5% of total SWYPFT contacts are with residents of Greater Huddersfield CCG and 38.5% are with residents of North Kirklees CCG. When taking overall population into account, Greater Huddersfield has disproportionately slightly more SWYPFT contacts than North Kirklees (56% of the Kirklees registered population lives in Greater Huddersfield, with 44% in North Kirklees).

The clusters for functional mental health conditions can be viewed in Appendix A.

Table 5.6: Patient contacts by SWYPFT cluster and CCG for May 2017

	GHCCG	NKCCG	Total
Primary Care Psychology Services (Cluster 1-3)	243	90	333
Serious Mental Illness - Non-Psychotic (Cluster 4-8)	1639	1011	2650
First Episode Psychosis (Cluster 10)	129	72	201
Serious Mental Illness – Psychosis (Cluster 11-17)	890	687	890
Not assigned to cluster (Cluster 99)	234	119	353
Variance – ADHD (Cluster 0)	65	27	92
Grand Total	3200	2006	5206

5.5.2 Patient contacts with Kirklees Council commissioned services

Table 5.7 shows the number of people accessing Kirklees Council mental health services, with a description of what each service provides and the % accessed by men and women. The most common age range to access this support is age 45-54, followed by age 25-34. It is important to note that some people may be accessing more than 1 of these services and therefore may be double counted.

Table 5.7 - Patient contacts for Kirklees Council services

	Ave no. of participants for 2016-2017	Male	Female
Active for Life, Physical Activity Service Improving mental health through physical activity	**205**	**55%**	**45%**
Self help, Welbeing, Recovery To promote recovery, social inclusion and self-determination, decreasing social isolation.	**532**	**60%**	**40%**
Creative Arts Improving mental health through involvement in creative arts	**365**	**48%**	**52%**
Employment Support Support into employment, vocational training and volunteering	**170**	**71%**	**29%**
Volunteering in the Outdoors Supporting people with mental ill health to engage with the outdoors	**528**	**50%**	**50%**
Mental Health Advocacy Advocacy service for people with mental ill health	**200**	**49%**	**51%**
Carers Support Support for carers of people with mental ill health	**278**	**36%**	**64%**
Womens Support Supporting women with ill health on their road to recovery	**407**	**0%**	**100%**

Feedback on Kirklees' Mental Health Act Assessment Numbers, (from Allied Mental Health Practitioners) where people are in crisis, is that these numbers are increasing. This is because they are not accessing services earlier and are not acknowledging that their mental health is deteriorating. The commissioned services listed above go some way to tackling this, but often these services are seeing people who are referred, so have raised their

concerns about their mental health already. The gap here is raising awareness amongst the general population of how to recognise deteriorating levels of emotional health and wellbeing and how to help improve this as soon as possible.

5.6 Emergency admissions where MH was part of the diagnosis

5.6.1 Mental health condition (primary and secondary diagnosis) – by age

The following graphs show the age specific rates per 1,000 population of emergency hospital admissions where mental health was (a) part of the primary diagnosis and (b) part of the secondary diagnosis. Dementia has been excluded from the mental health diagnosis (ICD-10 codes F00, F01, F02 and F03).

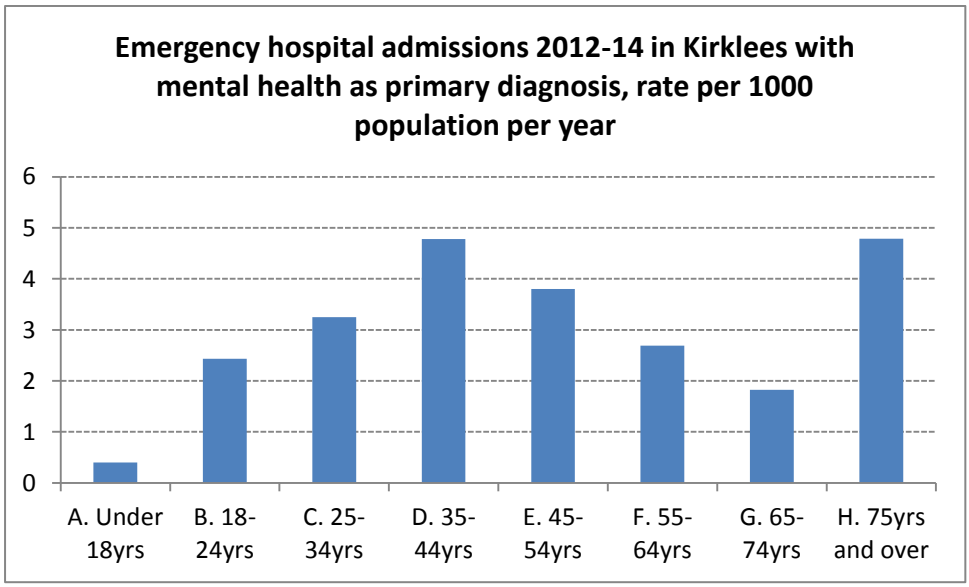


Figure 5.12: Emergency hospital admissions with mental health as a primary diagnosis

Figure 5.12 shows that the rate of admissions where mental health is a primary diagnosis is highest amongst 35-45 year olds and 75 years and over.

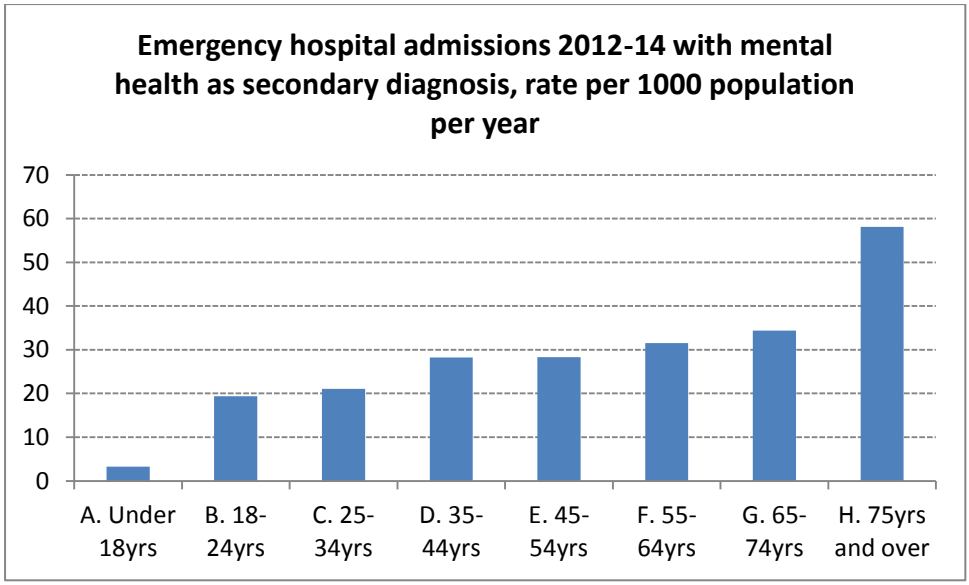
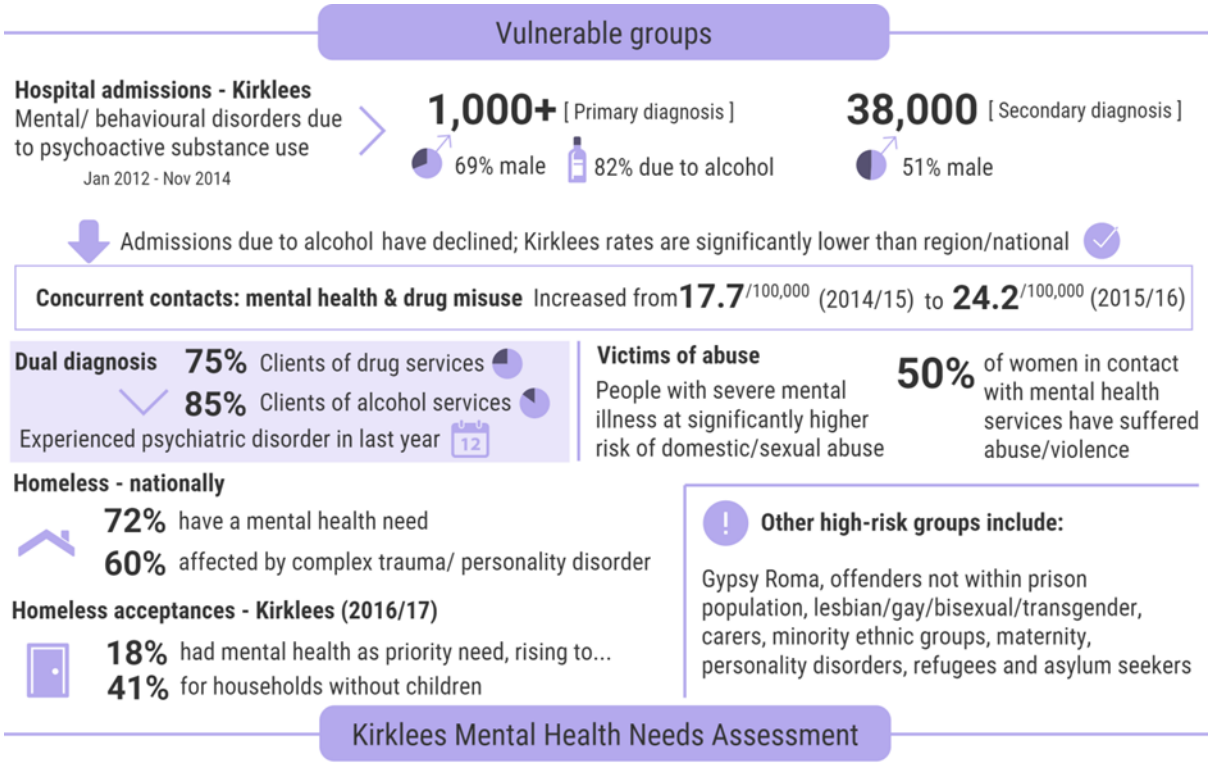


Figure 5.13: Emergency hospital admissions with mental health as a secondary diagnosis

Figure 5.13 shows that the rate of admissions increases slightly with age, with 65-74 year olds and 75 years and older having the highest rates of admissions with a secondary diagnosis of mental health. The rate for ages 75+ is double the rate for adults aged 35-74 and three times the rate for adults aged 18-34

6. Vulnerable Groups



Evidence shows that a number of adult population groups are at a greater risk of developing poor mental health. Their mental health issues may co-exist with other challenging factors such as substance misuse, offending, homelessness, physical ill health and caring responsibilities. This chapter examines the evidence around these specific population groups, what local intelligence exists, what qualitative insight we have and considerations for commissioners and providers moving forward.

It is important to consider that whilst mental health need and other co-existing issues may be greater and more complex in these groups, this should be viewed alongside the need to improve the mental health of the broader population in Kirklees. Taking an early intervention and prevention approach, focusing on the determinants of health which can impact on and promote good mental health, will result in more people living with good mental health throughout their lives. Solely focusing on the most vulnerable people will fail to achieve the required reduction in health inequalities necessary to reduce the steepness of the social gradient in mental health outlined in earlier sections.

6.1 Substance misuse and Mental Health – Dual Diagnosis

This section should be viewed in conjunction with the Offenders and Homelessness sections.

6.1.2 Hospital admissions, drug related mental health and behavioural disorder

Between January 2012 and November 2014 there were 1,093 hospital admissions for Kirklees residents with an ICD-10 primary diagnosis code of F10-F19 (Mental and behavioural disorders due to psychoactive substance use). The majority of these admissions were males (69%); of the overall number of admissions in this category, 82% were for mental and behavioural disorders due to alcohol, 4% due to cannabinoids, and 8% due to multiple drug use and other psychoactive substances.

There were 37,902 hospital admissions for Kirklees residents with either a primary or secondary diagnosis codes of F10-F19, between January 2012 and November 2014. Of these, just over half (51%) were males.[65]

6.1.3 Hospital admissions due to alcohol

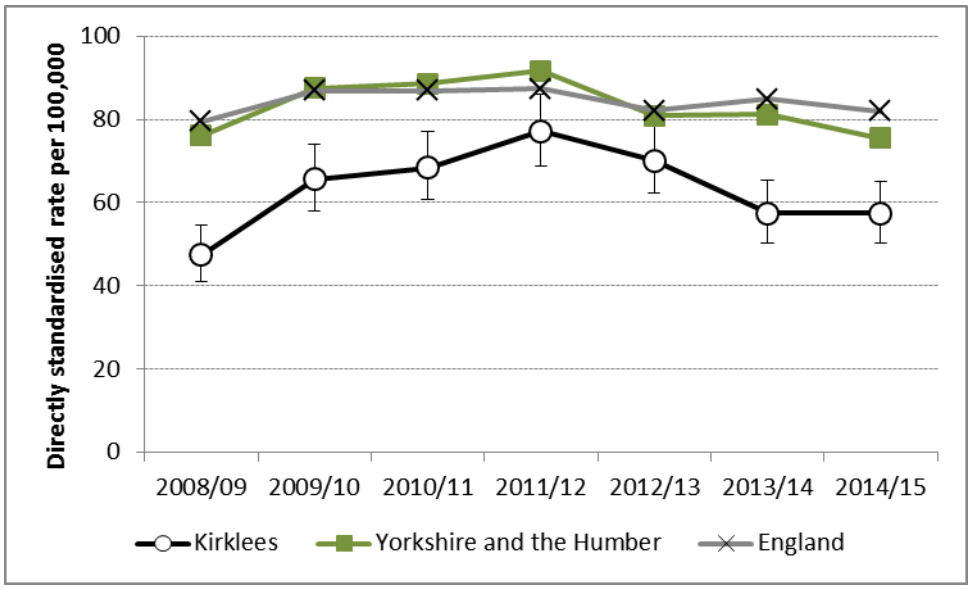


Figure 6.1: Admissions to hospital for mental and behavioural disorders due to alcohol, Kirklees: Directly standardised rate per 100,000 population [66]

Figure 6.1 shows the trend of hospital admissions due to alcohol between 2008 through to 2015. The rate for Kirklees has reduced from 77.1 per 100,000 in 2011/2012 to 57.4 per 100,000 in 2014/2015; the figure for 2014/15 is significantly lower than both Yorkshire and Humber and England.

[65] Secondary Uses Service dataset, inpatients

[66] : Calculated by Public Health England: Risk Factors Intelligence team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates. Data accessed via PHE Fingertips (https://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth), 07/06/17

6.1.4 Concurrent contact

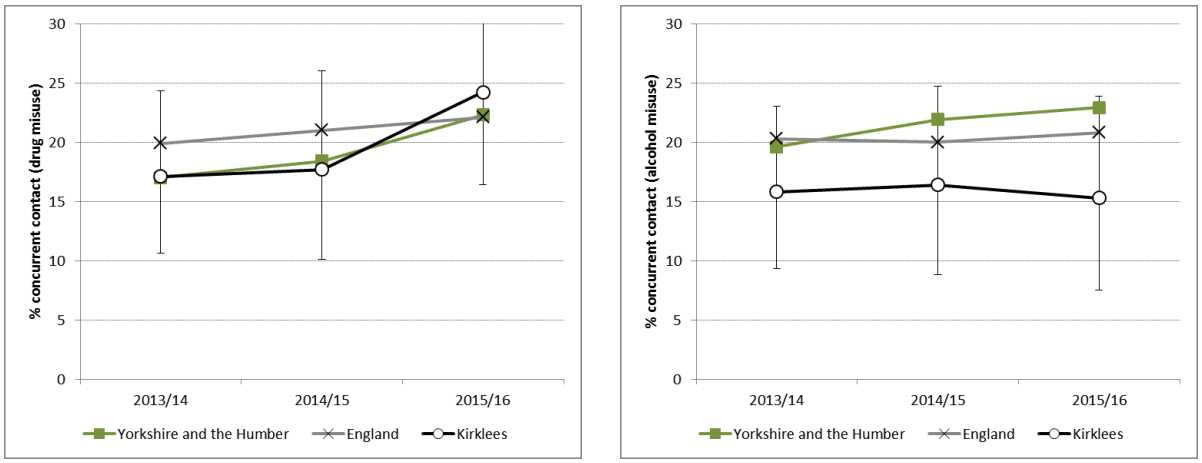


Figure 6.2: Concurrent contact with mental health services and substance misuse services for drug misuse (left) and alcohol misuse (right), % of users of substance misuse service[67]

Figure 6.2 shows the number of patients in Kirklees who are receiving support from a mental health service and treatment for either drug misuse or alcohol misuse. This shows that the number of concurrent contacts for mental health and drug misuse has increased from 17.7 per 100,000 in 2014/2015 to 24.2 per 100,000 in 2015/2016 and is now higher than both Yorkshire and Humber and England (although not significantly higher). The number of concurrent contacts for mental health and alcohol misuse has remained relatively stable across the 3 year period and is lower than both Yorkshire and Humber and England.

6.1.5 Dual diagnosis -the impact

'Dual diagnosis' is a term which is often used to describe co-existing mental health and alcohol or drug misuse problems. A national report by DrugScope[68] found that:

- For clients of drug services, 75% had experienced a psychiatric disorder in the last year.
- For clients of alcohol services, 85% had experienced a psychiatric disorder in the last year.
- For clients of Community Mental Health Trusts, 44% had experienced problem drug use and/or harmful alcohol use in the past year.
- Of clients of drug and alcohol services with comorbidity, 22.4% reported contact with psychiatric services.

Anecdotal evidence at a local level has shown that dual diagnosis is an issue for service users; they are experiencing a disconnect in the service they receive because their

[67] National Drug Treatment Monitoring System, Data accessed via PHE Fingertips (https://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth), 07/06/17
[68] Mental Health and Substance Misuse; DrugScope; On behalf of the Recovery Partnership; 2015

substance misuse issue has to be treated before the mental health problems and vice versa. This is impacting on service users who aren't necessarily getting the right support or treatment to help them, when both issues often need to be treated at the same time in order for the service user's health to improve.

Further intelligence on drugs and alcohol can be found in the Kirklees Joint Strategic Assessment.

There is a Dual Diagnosis Psychiatrist and an Advanced Nurse, commissioned by South West Yorkshire Partnership Foundation Trust. The Mental Health nurse is the initial point of contact to Dual Diagnosis services and these are discussed with him. If it is felt appropriate then service users can then access the consultant psychiatrist. The Nurse will also offer assessment and treatment options dependant on the needs when discussed. The service then sees all accepted referrals in 8 weeks.

The dual diagnosis service has strong links with the wider health and social care system locally to ensure each individual receives the most appropriate support and does not enter secondary mental health systems unnecessarily. Service users will often be diverted from Single Point of Access (SPA) directly to the dual diagnosis service when involved with local drug and alcohol services (CHART). The staff also reach into SWYPFT mental health services and care teams to enable other parts of the system to benefit from specialist interventions, treatment options and advice.

Table 6.1 provides some data around the numbers of CHART users who were recorded as having mental health issues for Q3 and Q4 for 2016/2017 as well as numbers of clients who were referred to specialist mental health services. 'Mental Health issues' in this instance will include both diagnosed and undiagnosed conditions.

Table 6.1: CHART users with recorded mental health issues and numbers referred to specialist mental health services

2016/17	Quarter 3		Quarter 4	
	Drug Services	Alcohol Services	Drug Services	Alcohol Services
Number referred to mental health services	64	34	84	43
Total active clients (snapshot as at end of quarter)	1160	305	1201	342
Number with mental health issues recorded in quarter	430	120	541	165
% with mental health issues recorded against total service users	37%	39%	45%	48%

Other dual diagnosis challenges include:

- At present there is significantly higher demand for the Dual Diagnosis service than can be managed by the number of staff. The mental health nurse spends significant amounts of time working with front line referring organisations in order to assess the

appropriateness of referrals and the expectations of what the service can and cannot provide.

- Accessibility to Dual Diagnosis service can be perceived as challenging and can vary dependent on the needs of the service user. Many clients are asked to reduce the use of substances before referring to Dual Diagnosis services as this enables a more comprehensive assessment.

- Psychoactive substances interfere and hinder all pharmacological and psychological psychiatric interventions and it is not always possible to access treatment options for psychiatric disorder/symptoms with active ongoing substance misuse.

- When clients present having experienced significant trauma through life events and are exhibiting the associated mental health needs, whilst misusing substances as a way of coping on a daily basis, it is very challenging to enable full access to psychological therapy services and is a restriction to what Dual Diagnosis offer.

6.1.6 Dual diagnosis – Considerations

Public Health England has recently produced some guidance for commissioners and service providers of mental health and substance misuse services[69], which can be accessed here. It is recommended that commissioners read and consider this report fully as part of any future working.

The guidance suggests 2 principal ways of working in order to improve the support for people with dual diagnosis. These are:

1. ***Everyone's job.*** *Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.*

2. ***No wrong*** **door.** *Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.*[70]

Other points to consider are:

- Ensuring that pathways for patients experiencing dual diagnosis are clear, understandable and easy to access for both service users and frontline staff.

- Working to ensure that approaches between mental health and substance misuse are holistic and integrated.

[69] Public Health England; Better care for people with co-occurring mental health and alcohol/drug use conditions; A guide for commissioners and service providers; 2017

[70] Public Health England; Better care for people with co-occurring mental health and alcohol/drug use conditions; A guide for commissioners and service providers; 2017; pp.9

6.2 Unemployed – see Section 2.2

6.3 Gypsy Roma Traveller community

According to the 2011 Census there were 158 people of Gypsy or Irish Traveller ethnicity in Kirklees[71] at that time. Apart from this, there is little specific quantitative or qualitative data available around this population group at a local level. It is therefore not possible to make any assumptions or conclusions about the Gypsy Roma population within this assessment. That is not to say that there isn't a need for this group, but further intelligence is needed at a local level to understand what the picture is.

The Roma Support Group[72] has produced an information leaflet for healthcare professionals who work with people from the Gypsy Roma community. This includes valuable information, which could be applied at a local level. The main points for consideration are:

Communication about mental health

- Health is considered an 'unclean' subject, often not to be discussed even with closest family members.
- Roma may talk about being sad or feeling down in relation to specific problems in their lives. In these cases it is acceptable to say that someone is depressed.
- Some may talk about 'problems with the head' or 'being crazy' instead of naming specific mental health conditions.

The Social context about mental health

- There is a strong belief that mental health problems can be passed on genetically without taking into account environmental factors. This can jeopardise the prospect of marriage, affecting relations within the family unit and Roma community.
- Drug addiction is a controversial subject and Roma community members often deny its existence within their clan, tribe or family.
- Alcohol abuse is often viewed as a social activity and not treated as an addiction.
- Victims of rape and domestic violence are often stigmatised; they rarely discuss their traumas.

Barriers to accessing mental health support

- Roma often try to hide the fact that they are suffering from mental health problems, even from close family members.
- Language and Interpreters.
- Discrimination, distrust and low self-esteem.
- Lack of knowledge.

[71] Kirklees Observatory; accessed https://observatory.kirklees.gov.uk/Kirklees_Census/
[72] Roma Support Group; Roma information leaflet; The Roma Community; 2016.

The full leaflet can be read here.

A report by The Roma Support Group[73] evaluated a 3 year Roma mental health advocacy project. The purpose of the project was to (a) improve Gypsy Roma access to mental health services (b) to improve the wellbeing and empowerment of Gypsy Roma with mental health needs and (c) to raise awareness of Roma culture and Roma patients specific needs among mental health providers. The evaluation report recommended the following for services working with the Gypsy Roma community:

- Improving communication strategies with Roma mental health service users.
- Person-centred care.
- A holistic approach that combines individual and social empowerment.
- A holistic approach that supports individuals to improve other aspects of their lives that improve mental health such as housing, welfare etc.
- Research to explore the impact of racism and discrimination on the mental health of the Roma.

6.3.1 Gypsy Roma - Considerations

- If deemed necessary, conduct a more thorough investigation into needs of the Gypsy Roma population at a local level.
- Consider using other national research and evidence to better understand the Gypsy Roma community and their experience and understanding of health, including mental health.

6.4 Lesbian, Gay, Bisexual and Transgender (LGBT) groups

There is evidence to suggest that minority sexual orientation groups can experience high prevalence of poor mental health and low wellbeing. In order to assess health outcomes by sexual orientation, there is a need for a widely accepted national estimate of the size of the lesbian, gay and bisexual (LGB) population in England.[74] This does not currently exist. Although attitudes towards gay people are improving, most lesbian, gay and bisexual people have experienced difficulties in their lives. Homophobic bullying, rejection from family, harassment at work and poor responses from healthcare professionals are still commonplace for many lesbian, gay and bisexual people.

According to the 2016 CLiK survey a significantly higher proportion of lesbian/gay/bisexual people have a self-reported mental health condition (46% versus 28% for heterosexuals). Some of the issues faced by lesbian, gay, bisexual and transgender (LGBT) people in Kirklees are highlighted in a 2010 qualitative research report.

[73] Roma Support Group; Roma Mental Health Advocacy Project; Evaluation Report; April 2012
[74] Public Health England (2017). Producing modelled estimates of the size of the lesbian, gay and bisexual (LGB) population of England. Final Report

6.4.1 Lesbian, Gay, Bisexual and Transgender (LGBT) groups considerations:

- All commissioners and service providers to monitor sexual orientation among their staff and service users.[75]

- Monitoring should be preceded by desensitisation around the topic, including communication about legislation and benefits of recording this equality characteristic.

- Consultation, explanation and communication with service users should take place before successful monitoring can take place.[76]

- Train staff on the specific mental health needs of lesbian, gay and bisexual people.

- Services that employ nurses should refer to the following toolkits: LGB Suicide Prevention Toolkit and Trans Suicide Prevention Toolkit to support LGB groups and the Trans suicide prevention toolkit to support trans groups.

- More awareness raising and education about LGBT and/or diversity in schools.

6.5 Adult Carers

In the context of this health needs assessment, it is the impact of being a carer on mental health that is being described.

Around 56,000 people aged 18 and over in Kirklees are carers, which is 1 in 6 (17%) adults with 12% providing 1-19 hours of care per week, 2% providing 20-49 hours per week, and 2% providing round-the-clock care. People aged 55-64 are most likely to be carers, with 26% of this age group providing care. Females are slightly more likely to be carers than males (18% females, 16% males). Adult carers are significantly more likely to have a self-reported mental health condition: 33% of carers have a mental health condition versus 28% of non-carers.[77]

Due to advances in healthcare and more support being provided outside of hospitals, Carers UK estimate the number of carers will increase by 40% over the next 20 years.[78] This will mean Kirklees will have almost 80,000 adult carers by 2037.

[75] Hunt, R., and Cowan, K. (2012). Monitoring sexual orientation in the health sector. Stonewall.
[76] Creegan, C., and Keatingm M. (2010). Improving sexual orientation monitoring. Manchester: Equality and Human Rights commission. ISBN 978 1 84206 333 0
[77] Kirklees Council. (2016) Current Living in Kirklees Survey 2016.
[78] Carers Trust. Facts About Carers (2014. 2015). Available from: http://www.carersuk.org/for-professionals/policy/policy-library

There are 10,000 carers in Kirklees who provide more than 50 hours of care each week[79]. Of these, many care around the clock, for example those who care for someone with dementia are often 24/7 carers. More than 70 per cent of those caring round the clock have suffered mental ill health at some time.[80]

6.5.1 Adult Carers - considerations

- Prioritise and support carers to maintain their physical health and emotional wellbeing through a variety of means such as improving breaks, 'Looking after Me' courses, access to leisure services and enhanced support from GPs.

- GPs must be included in the identification of future gaps, as they are a key first point of contact for many carers and are often involved in their ongoing support.

- Provide more flexible, creative support to people being cared for, to enable carers to return/remain in employment and to support carers into education, training and employment.

- Encourage organisations in Kirklees to sign up to the Kirklees Carers Charter.

- Provide more awareness around what a Carer is to try and find the 'hidden carers' in Kirklees.

- Professionals working within health and social care have a crucial role in identifying carers and so these staff must be aware of carers, understand the impacts caring can have, and know where the carer can turn to get more information and help.

- Utilise the results of the Survey of Adult Carers 2016/17 when they are released in 2017.

- Services should listen to the felt and expressed needs of carers to help alleviate some of their concerns that impact on their own mental health.

- Read Kirklees Joint Strategic Assessment for more information.

6.6 Black, Asian and Minority Ethnic Groups (BAME)

According to the 2016 CLiK survey 30% of people of White British ethnicity have a self-reported mental health condition, which is significantly higher than the rate for South Asians (25%). People of mixed ethnicity reported the highest prevalence of mental health problems

[79] Kirklees Council. (2016) Current Living in Kirklees Survey 2016.
[80] NHS England. Commitment to Carers - Improving carer health and wellbeing. (2016). Available from: https://www.england.nhs.uk/2016/05/commitment-to-carers/

(44%, significantly higher than the rate for White British people), although the sample sizes for ethnic groups other than White British and South Asian were relatively small.

Discrimination can play a part in why BAME groups in our society are likely to experience poor mental health compared to others. Direct experiences of prejudice and harassment impact negatively on our mental wellbeing, while indirect factors such as deprivation and exclusion also contribute to poor mental health. It is likely that mental health problems go unreported (reflected in the CLiK statistics which shower lower self-reported mental health conditions for the South Asian population), and untreated because people in some ethnic minority groups are reluctant to engage with mainstream health services. Some Black and Ethnic Minority groups are less likely to have their mental health problems detected by their GP. Some Asian communities view the individual holistically - as a physical, emotional, mental and spiritual being.[81] In addition, BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems.[82]

6.6.1 BAME considerations:

- More research is needed within this group, to understand the meaning attached to mental health and the structural factors that impact on help-seeking behaviour and access to support.

- Specialist mental health services should review their uptake in relation to ethnicity to see if this is proportionate to the Kirklees population.

- Further work/community engagement should be done to understand the stigma associated with mental health and how more prevention work could be implemented effectively with this high risk group.

- Explore co-produced therapeutic interventions and recovery approaches with this community. There is a role for spiritual healers to come together with mental health services to help encourage earlier engagement with this population group.

6.7 Homelessness

This section should be viewed in conjunction with the Offenders and Substance misuse sections.

Poor health (including mental ill health) can be both a cause and a consequence of homelessness, although it is not always clearly specified or identified. For example, ill health can be a contributory factor in relationship breakdown or job loss, which can then result in homelessness. Homelessness has a significant impact on both physical and mental

[81] Mental Health Foundation (2017). Black, Asian and Minority Ethnic groups. Available from: https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities
[82] NHS (2016), the NHS Five Year Forward View for Mental health, www.england.nhs.uk/wpcontent/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

health, with life expectancy for homeless people 30 years lower than the general population at 47 years old[83].

Homeless Link[84] conducted a Health Needs Audit of the health needs of homeless people in 2011. This found the following:

- 72% of clients said they had one or more mental health needs.
- 45% said they had one or more long-term mental health needs (61% of all those with a mental health need).
- 35% of those with a mental health need said that they would like more support with their mental health.
- Other research also found that 60% of people in homelessness services have been found to be affected by complex trauma or personality disorder.
- 44% of those with a mental health problem said they self-medicate with drugs or alcohol.
- 14% of clients stated that they self-harm, compared with 4% of the population.
- One fifth of clients who had recently attended A&E had done so because of either mental health or self-harm.
- 10% of clients have additional support from mental health services.

The definition of homelessness is complex. It can include rooflessness (sleeping rough), houselessness (living in temporary accommodation such as a shelter), living in insecure housing (for example under threat of eviction) or living in unsuitable housing (for example extreme overcrowding or very poor housing)[85]

In order for a person or household to be deemed 'statutorily homeless' by the local authority they must have been made unintentionally homeless and considered to be in priority need[86]. One accepted priority need is mental health issues. Kirklees Council uses the following sub-categories to define mental health as a priority need:

- Severe depression being treated by a mental health service where professional opinion to the severity and impact will have a significant effect on the applicant if rendered homeless or were to remain homeless.
- Recent Psychiatric hospital admission;.
- Verified history of self-harm from GP or other health professional
- On anti-psychotic medication
- Evidence of current psychosis
- On injected depot therapy

[83] Department of Health; Homelessness: applying All Our Health; 2016; accessed https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

[84] Homeless Link; Homeless, Mental Health and Wellbeing Guide; 2011.

[85] Department of Health; Homelessness: applying All Our Health; 2016; accessed https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

[86] Public Health England; Public Health Outcomes Framework; accessed 2017 http://www.phoutcomes.info/search/homelessness#page/6/gid/1/pat/15/par/E92000001/ati/6/are/E12000004/iid/11502/age/1/sex/4

- Diagnosed condition of bipolar.

Local data from Kirklees Council can provide some evidence of the number of people who are accepted as statutorily homeless with mental health as a priority need. However, it is important to note that mental health issues are likely to be underreported in these figures. This is because homeless applications only consider 1 priority need per application. Staff report that the recording system is not a good indicator of how many cases they are seeing with mental health issues. Often customers may have multiple priority need reasons and they will typically only record 1 of them - usually the most obvious one, e.g. dependent children, pregnant, care leavers.

The way the council reports homeless statistics to Government is changing from April 2018 with the introduction of the Homelessness Reduction Act. There will be more opportunities to record support needs, including mental health needs, for all customers who are homeless or threatened with homelessness – not just statutorily homeless.

Table 6.2: Kirklees Council, Statutorily Homeless Acceptances with mental health as a priority need.

	2015/2016		**2016/2017**	
Total h/less acceptances	**404**		**462**	
Priority need: mental health	**109**	**27%**	**85**	**18%**

Table 6.2 shows that in 2015/2016, 27% of homeless acceptances have mental health as a priority need and in 2016/2017, 18% of homeless acceptances have mental health as a priority need.

Given the fact that this data is likely to underreport mental health need, it is also useful to examine data concerning households without children (single people or couples).

Table 6.3: Kirklees Council, Statutorily Homeless Acceptances with mental health as a priority need – households without children.

	2015/2016		**2016/2017**	
Total h/less acceptances (households without children only)	**219**		**198**	
Priority need: mental health (households without children only)	**103**	**47%**	**82**	**41%**

Table 6.3 shows that in 2015/2016, 47% of homeless acceptances of households without children had mental health as a priority need. In 2016/2017, 41% of households without children had mental health as a priority need.

Anecdotal evidence from Housing staff at Kirklees Council has highlighted the following points:

- Staff feel that the numbers of clients presenting with mental health issues are increasing.

- If a client has an official mental health diagnosis then this can help them to access the appropriate support. However, staff report that there are increasing numbers of people with undiagnosed mental health issues. It is difficult to access support for this group as they often are not accepted for an assessment through SPA.

- Homeless people will often have a number of co-existing issues such as offending behaviour and substance misuse issues. Staff report that the more holistic and integrated the support provided, the more positive the outcome.

- Early intervention and prevention is vital in order to prevent clients reaching crisis point. Staff find that early intervention often does not happen and it can take a crisis (i.e an arrest) for someone to access mental health services.

- The support provided by Clare House hostel is greatly valued. It is felt that staff at the hostel go above and beyond expectations for their residents and do all they can to connect clients to appropriate services.

- Housing staff also value the benefits of the West Yorkshire Finding Independence project. The added value of this work is the holistic and integrated approach to service users and the positive outcomes it produces. This is explored further in this chapter.

- Staff report that it would improve their work if they could have access and advice from a 'link worker' within mental health service.

- A multi-agency, formalised and person centred approach is the most effective.

The Whitehouse is a specialist GP practice which works with homeless patients (as well as asylum seekers and refugees). The Whitehouse is based in Huddersfield, managed by Locala Community Partnerships and commissioned by Greater Huddersfield Clinical Commissioning Group. In 2016, a Care Quality Commission inspection[87] found the quality of care provided by the Whitehouse to be Outstanding. There is currently no similar service within North Kirklees. Staff from the Whitehouse have identified the following needs/issues/opportunities for the homeless population:

- **Mental health need.** Homeless patients often present with 'complex trauma' (also often referred to as complex post- traumatic stress disorder and personality disorder). The underlying cause is often due to severe adverse events in childhood. It impacts on trust and behaviour in a way which usually means patients do not always behave in a predictable manner which is expected by mainstream services.

[87] Care Quality Commission, Whitehouse Centre GP Practice; Quality Report; 2016 accessed http://www.cqc.org.uk/sites/default/files/new_reports/AAAF1593.pdf

- **Access to mental health services.** The complex needs of homeless patients often means that their mental health issues are too difficult to be managed through Improving Access to Psychological Therapies (IAPT) and are often too chaotic and unstable for clinical psychology services. Psychological services are currently expected to be able to demonstrate an improvement in mental health, following their discrete intervention which is challenging with this client group. Furthermore homeless individuals are often not appropriate for acute services (i.e. they are chronic rather than acute and/or using substances), unless they are considered at an unusually high risk of self-harm or harm to others. This means that homeless patients fall between the branches of traditionally configured secondary care mental health services and will not be able to access the mental health support which is needed;

- **Funding.** The Whitehouse is a primary care service where the doctors and nurses provide a limited mental health service by default which has evolved because most patients have mental health needs and cannot access or retain contact with secondary care mental health services. GPs and nurses currently deliver this in frequent short and practical appointments but there is no funding for therapies and the result is an over-reliance on medication. There is currently limited integrated working with mental health services and there is no presence from South West Yorkshire Foundation Trust at the site. The Whitehouse supports their patients as much as they can by "being there", providing flexible drop in sessions and a safe place to come. There are close links with substance misuse services. They are also committed to new ways of working and developing links with partners. Due to limited resource, there are no opportunities for new ways of working;

- **Lifestyle.** Patients often lead chaotic lifestyles so fixed appointments offered by many other services are not appropriate. Homelessness and mental health issues will often co-exist with other needs such as substance misuse - meaning that a holistic approach to need is better suited to patients. Homeless patients are by their nature often transient and move between services. Opportunities to work with a service when they ask for it or need it are to be seized upon and this does not fit well with traditional models of healthcare, which usually involve waiting times etc.;

- **Hospital Discharge.** Patients will often self-discharge from hospital without the Whitehouse Centre being informed. Some may present at the centre but many do not and the service is reliant on picking up the precarious discharge when the paperwork comes through some days later. There are also instances of patients not having an effective planned discharge pathway within the hospital, with little communication between hospital staff and community services such as the Whitehouse staff and housing staff. Staff at the Whitehouse Centre cannot recall any calls from the hospital to register a homeless patient;

- **Prison Release.** Similarly, patients will arrive after prison release with no communication or notice. This can also present risk issues not being communicated to GP's or Community Mental Health Services.

- **Community/voluntary organisations.** Support, advice and guidance for the homeless is often provided by local community and voluntary organisations. These relationships are recognized, valued and needed in order to provide a more holistic approach to supporting the homeless towards recovery. These services are often carrying a lot of risk and need access to health professionals when they ask for it.

West Yorkshire Finding Independence (WY-FI) Project is a 5 year funded programme which works with people who are experiencing ineffective contact with services and 3 of the 4 following needs: homelessness, addiction, re-offending and mental ill health. Out of the 58 people on the current WY-FI Kirklees caseload there were 54 identified as having mental health needs. All of these people had at least two co-existing issues with their mental health - homelessness, addiction or offending.

Evidence from the project[88] has shown that service users have had the most difficulty in accessing mental health services, compared with other services. This is partly because service users were unused, unwilling or unable to talk about their mental health and wellbeing. Additionally there were very few service users who described mental ill health as their primary issue, despite the fact that research has shown that the majority of people with multiple needs are likely to experience mental ill health, whether it is formally recognised or not.

The full report, WY-FI and Mental Health Services, 15 months on can be read here.

An integrated and holistic approach to tackling homelessness and mental health is needed. The 2017 Homelessness Reduction Act[89] makes it a duty for public authorities to refer cases of concern to the local housing authority. Called the "Duty to Refer", it is expected that public authorities notify the housing authority of service users they think may be homeless or at risk of becoming homeless (with consent). Whilst the Act has only just received Royal Assent and there is no implementation date as yet, the aim of the measure is to ensure that services work together to prevent homelessness.

6.7.1 Statutory homelessness

In Kirklees in 2015/16, 0.4 in every 1,000 households (69 households) were in temporary accommodation and the proportion of eligible homeless people not in priority need was 0.3 per 1,000 households (57 people). [90]

6.7.2 Local strategy

[88] WY-FI and Mental Health Services, 15 months on; 2015
[89] Homelessness Reduction Act; 2017; accessed http://www.legislation.gov.uk/ukpga/2017/13/pdfs/ukpga_20170013_en.pdf
[90] Department for Communities and Local Government, accessed via PHE Fingertips: https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna, 07/06/17

Kirklees Council is currently refreshing its Housing Strategy. One arm of the strategy is **Housing Need**, which is described as:

"To meet the housing needs of the most vulnerable groups by maintaining and strengthening our focus on prevention and early intervention, to enable people to access a suitable home of their own and to live there as independently as possible."

The relationship between good housing and mental health has also been recognized at a local level, with the joint commissioning strategy for people who experience mental health problems[91]. This highlights the need of early intervention and prevention and the need for people with mental health needs being housed in the most appropriate accommodation.

Kirklees also has a Preventing Homelessness Strategy[92]which is in the process of being refreshed. The strategy also makes the links between good housing and good health as well as the need to take an early intervention and prevention approach to preventing homelessness. The strategy makes reference to the importance of partnership working in order to achieve improved outcomes for homeless people and the need to tackle the root causes of homelessness.

6.7.3 Homelessness - Considerations

- A holistic, timely and flexible approach to working with homeless population groups is needed, given the complex nature of need and the relationships between homelessness, mental health and substance misuse.

- Commissioners to consider bringing together key partners, working around homelessness and mental health, to explore how partnerships can be strengthened and the opportunities for a more holistic and integrated approach to care.

- Explore opportunities to improve homeless discharge from hospital and prison.

- Use data from the Whitehouse Centre to understand this client group more effectively.

- Examine if there is a need to provide a similar service to The Whitehouse Centre within North Kirklees.

6.8 Adult victims of abuse

[91] Good Housing Good Health; A Joint Commissioning Strategy; Accommodation for People Who Experience Mental Health Problems in Kirklees; 2016 – 2018; Kirklees Council, Greater Huddersfield Clinical Commissioning Group, North Kirklees Clinical Commissioning Group.
[92] Preventing Homelessness Strategy; 2013-2016; Kirklees Council.

A study by University College and Kings College London[93] has found that men and women with severe mental illness (SMI) are at a significantly increased risk of domestic abuse and sexual abuse when compared to the general population. The study also found that:

- People with diagnosed SMI in contact with psychiatric services had 2 to 4 fold elevated odds of all subtypes of domestic violence (emotional, physical and sexual) compared with the general population.

- People with SMI are known to have elevated risks of childhood maltreatment and abuse by family members.

- Men and women with SMI who are under the on-going care of psychiatric services are 2–8 times more likely to experience sexual and domestic violence than the general population, with a high relative burden of family violence.

- Women with SMI are more likely than women in the general population to suffer psychological ill health and attempt suicide following sexual assaults.

- Most victims do not disclose violence to healthcare professionals.

6.8.1 Survivors of sexual abuse (age 18-64)

The PANSI web tool (Projecting Adult Needs and Service Information, www.pansi.org.uk) uses national prevalence rates and local population projections (Office for National Statistics, ONS) to estimate the number of people aged 18-64 likely to have various conditions.

Applying prevalence rates of 7% for males and 16% for females (based on the report by Cawson, P., Wattam, C., Brooker, S. and Kelly, G., Child Maltreatment in the United Kingdom, 2000, NSPCC) to local population estimates gives figures for 2015 of 9,198 male and 20,896 female survivors of childhood sexual abuse aged 18-64.

Table 6.4: Kirklees estimation of male and female prevalence rates and local projections for survivors of sexual abuse, age 18-64.

	Year			
	2015	2020	2025	2030
Males aged 18-64	9198	9296	9373	9436
Females aged 18-64	20896	21184	21328	21424
Total population aged 18-64	30094	30480	30701	30860

[93] H. Khalifeh, P. Moran, R. Borschmann, K. Dean, C. Hart, J. Hogg, D. Osborn, S. Johnson and L. M. Howard; Domestic and sexual violence against patients with severe mental illness; Psychological Medicine (2015), 45, 875–886; Cambridge University Press 2014.

[94]

Anecdotal feedback from staff at Kirklees and Calderdale Rape and Sexual Abuse Counselling Centre (KCRASACC), an independent charity provided the following local context:

- KCRASACC is predominantly Big Lottery Funded, with some additional funds provided by the Rape Support Fund and the Police and Crime Commissioner for West Yorkshire. The Big Lottery funding is due to end in April 2018, which will mean a significant reduction in the core offer, if additional funding cannot be found.

- There are currently 75 people waiting to see a councillor, with an additional 20 people waiting to be assessed. This has resulted in a 7 month waiting list for counselling. There is a current caseload of 110 people for the ISVA (Independent Sexual Violence Advisory) part of the service. The counselling caseload between counselling staff is 56 people each week.

- Out of KCRASACC's counselling clients seen for 2016-2017, 57% had official mental health diagnoses. There are also significant proportions of clients they work with who do not have diagnoses of mental ill health but do present with symptoms.

- People accessing KCRASACC experience a wide range of complex mental health issues as a result of the trauma of sexual violence (either historical or current). This can include depression and anxiety, anger, post-traumatic stress, personality disorders, dissociative disorders, self-harm, risk taking and addiction issues, attachment issues and suicidality.

- Staff report that the mental health needs of their clients are increasing in their complexity. They are working increasingly with homeless clients, refugees and asylum seekers and clients with substance misuse needs. The needs of these clients are broad and complex and go beyond issues of mental health.

- Staff at KCRASACC report that their experiences of accessing specialist mental health support via SPA can be difficult. Clients may 'slip through the net' of the system as their needs can be too difficult for Improving Access to Psychological Therapies yet not severe enough for clinical psychology services.

- There are challenges with dual diagnosis clients as while KCRASACC do not require people to be stabilised in their substance misuse before they work with them, Psychological services and Improving Access to Psychological Therapies do. KCRASACC work with people with dual diagnoses because they recognise the addictions are very often symptoms. By tackling underlying causes, there is a likelihood of the addiction reducing or stopping.

[94] Data accessed via PANSI (www.pansi.org.uk version 8.0), 07/06/17.

- KCRASACC provide support across the whole of Kirklees and Calderdale but only work out of a Huddersfield base. They do not have the resource to provide outreach and therefore their service is inequitable.

- A number of clients require interpreter services as they do not speak English. KCRASACC do not have the resource to provide these services and again this creates an inequity in access and support.

- Staff feel that early intervention and prevention is key to the welfare of their clients in order to prevent clients being stuck in a crisis cycle.

6.8.2 Domestic abuse incidents

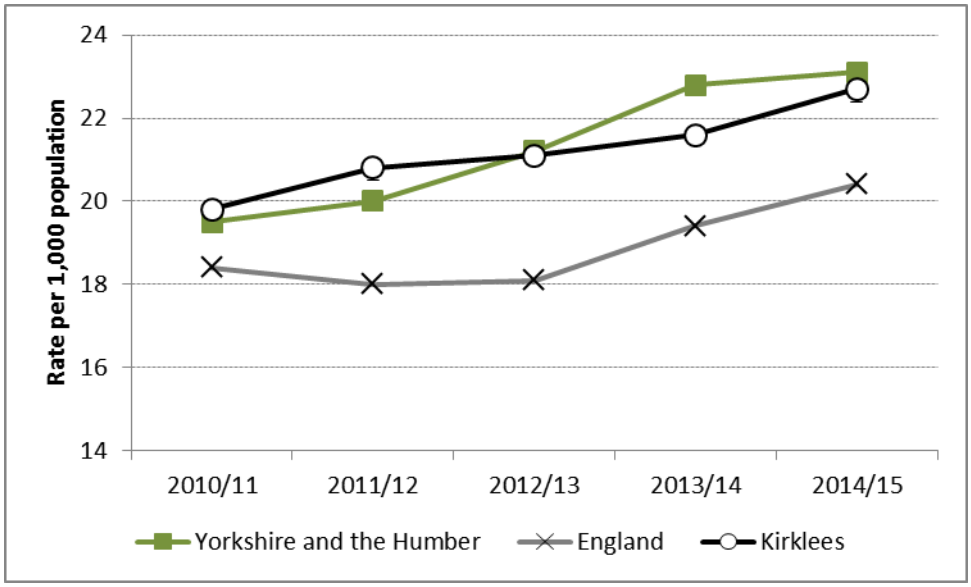


Figure 6.3: Domestic abuse incidents recorded by the police, Kirklees (rate per 1,000 population) [95]

The Home Office[96] defines Domestic Abuse as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial

[95] Office for National Statistics, Data accessed via PHE Fingertips (https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna), 07/06/17

[96] The Home Office; Domestic Violence and Abuse Guidance; 2013. Accessed https://www.gov.uk/guidance/domestic-violence-and-abuse

- Emotional

Controlling behavior 'is a range of acts designed to make a person subordinate and / or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape, and regulating their everyday behaviour.'

Coercive behavior 'is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group'

Domestic abuse is also now a category of Safeguarding under the Care Act 2014. The new Adult Safeguarding definition of domestic abuse incorporates all of the previous types of abuse and adds the following:

- Discriminatory abuse
- Modern slavery
- Neglect and acts of omission
- Organisational abuse
- Self-neglect

In 2012, Kirklees Council produced a Domestic Abuse Needs Assessment[97].

This reviewed national and local evidence and found that there are clear and significant links between mental health and victims of domestic abuse. The assessment found that national data shows that:

- 50% of women in contact with mental health services have suffered abuse/violence.
- 64% of abused women suffer post-traumatic stress disorder against 1-2% of non-abused women.
- Domestic violence is a factor in 49% of suicide attempts by BME women, and 22% of attempts from White communities.
- One third of women attending A&E for self-harming have experiences of domestic violence.

The Crime Survey for England and Wales[98] has found the following mental health effects of partner abuse:

- Mental or emotional problems (30% of male victims and 47% of female victims).
- Stopped trusting people or difficulty in other relationships (19% of male and 22% of female victims).
- 28% of victims had gone to a specialist mental health or psychiatric service.

[97] Kirklees Council; Domestic Abuse Needs Assessment; March 2015.
[98] Office for national statistics; Crime Survey for England and Wales; 2015; accessed https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2015/chapter4intimatepersonalviolenceandpartnerabuse#main-points

- 3.3% of men and 3.9% of women had tried to kill self.

Anecdotal feedback from Pennine Domestic Violence Group, an independent charity, provided some local context. Staff from the service reported the following:

- The majority of service users identify as having feelings of anxiety and depression, with other users suffering from post-traumatic stress and other personality disorders (diagnosed and undiagnosed).

- Victims at crisis point receive timely crisis intervention support via Single Point of Access. However, staff felt that it was harder to access longer term support once a victim is removed from crisis point.

- For victims who aren't at crisis point and are referred to specialist counselling, there is currently a 6 month waiting list. Once victims are able to access counselling, they may be out of service or no longer wishing to access the support. Staff felt that opportunities are often missed for victims to access mental health support and that support does not always coincide with the impact of domestic abuse. Translation services are not available through this counselling, which excludes some victims.

- Victims can also access Improving Access to Psychological Therapies (IAPT) and are currently waiting 6-8 weeks for an initial telephone conversation.

- Transferring mental health support from one GP to another can be really difficult when a woman is fleeing abuse from another area and moves to stay in refuge Kirklees. For example, it can result in a delay in accessing medication and on-going psychological therapy and having to make new referrals to local services.

- Victims' mental health issues will often co-exist with other physical or social needs such as substance/alcohol misuse or housing.

Further intelligence on domestic abuse can be found in the Kirklees Joint Strategic Assessment.

6.8.3 Adult Victims of Abuse – Considerations

- Early intervention and prevention is fundamental in supporting adult victims of abuse. This will enable timely access to mental health support and prevent crisis.

- Voluntary organisations are a clear asset in terms of the support they provide to adult victims of abuse. Commissioners should ensure they work closely with these organisations in order to understand need and plan effectively.

- Ensure that pathways and access to timely mental health support are clear and easy to navigate.

6.9 Personality Disorder (PD)

Throughout our childhood we all develop patterns of thinking, feeling, and behaviour and these patterns make up what we refer to as our 'personality'. These personality traits shape the way we view ourselves, the world and the way we interact with it. Whilst we all develop personality 'traits', for some people, especially if they have had a difficult or traumatic childhood, these traits can become problematic and have a major impact on the way they live. When these personality traits have such a significant impact, people may receive a diagnosis of a 'Personality Disorder'.

There are several different types of personality disorder but all have an impact on how people cope with life, manage relationships, and their emotions. This can be distressing for them and others and people with personality disorders may find that they develop other mental health problems e.g. depression or anxiety. Within the ICD-10 classifications there are nine categories of personality disorder and ten categories within the DSM-IV. Clinicians find these classifications difficult to use as patients often fall in to more than one category. People with personality disorder may develop coping strategies such as drinking heavily, using drugs, harming others or harming themselves. These in turn can exacerbate their condition causing further difficulties in the person's life and their interaction with others. Personality Disorders are a long-term pervasive problem but can often be helped by input from mental health services.

Psychotherapy is the basis of care for personality disorders. People with personality disorders have poor or limited coping skills and psychotherapy aims to improve perceptions of and responses to social and environmental triggers to help reduce the risk associated with this.

Based on Kirklees' population size, there are estimated to be approximately 19,127 people living with a PD (4.4% of the population are estimated to have a PD)[99]. Rates are higher among men, separated and unemployed people in urban locations. By definition, personality disorders are associated with a significant burden on the individuals with the disorder, those around them and on society in general. Fewer individuals with a PD make contact with psychiatric services compared with other conditions such as schizophrenia and depression[100] and their probability of withdrawing from treatment is considerably higher.[101]

The mainstay of treatment for people with PD should, therefore, initially be provided within secondary care Mental Health services because of the significant risk they present to themselves or others and the frequent need for a multi-disciplinary, inter-agency approach to their care.

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[99] Office for National Statistics, http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/MentalHealthPrevalence.aspx

[100] Andrews,G., Issakidis,C. & Carter,G. (2001). Shortfall inmental health service utilisation. British Journal of Psychiatry, 179, 417-425.

[101] Percudani,M., Belloni,G.,Contini, A., et al (2002) Monitoring community psychiatric services in Italy: differences between patients who leave care and those who stay in treatment. British Journal of Psychiatry, 180, 254-259.

The figures for SWYFT (see Table 6.5) show that as of the end of July 2017, there were 355 service users in Kirklees on a cluster 8 (see appendix A) and, therefore, highly likely to have been diagnosed with a PD. The definition of Cluster 8 is 'Enduring non-psychotic Chaotic and Challenging Disorders'. This cluster is characterised by moderate to very severe repeat and deliberate self-harm and/or other impulsive behaviour and chaotic, over dependant engagement and often hostile with services.

Table 6.5: Breakdown of cluster 8 by CCG

Greater Huddersfield	206
North Kirklees	189
Total	**355**

Table 6.6: Breakdown of Cluster 8 by Age and Gender

Age Group	Female	Male
16-25	41	20
26-35	68	29
36-45	68	21
46-55	63	24
56-65	7	7
65+	6	1
Total	**253**	**102**

These figures are likely to be under-reported for a number of reasons. Firstly, many people with PD will not seek help; due to fear and shame, lack of insight, distrust and hopelessness. Secondly, the process of diagnosis for PD is complicated – only Psychiatrists 'diagnose' whereas Clinical Psychologists and other health professionals do not. Some psychiatrists are reluctant to diagnose PD and almost always, people with PD have co-morbidities, meaning some service users with a PD may be misdiagnosed or not diagnosed at all. Thirdly, clusters are not the most accurate way to estimate the incidence of PD as apart from cluster 8, the others are not diagnosis specific, meaning there will be people with a diagnosis of PD but no way to separate them out from other clusters.

Table 6.7 from SWYFT indicate that the numbers of people with PD are slightly increasing year on year. This may be due to increasing awareness and/or access e.g. self-referral through IAPT who then refer on to Secondary Care and also increasing referrals from GP's where perceptions might be changing about the treatability of PD.

Table 6.7: Rates of cluster 8's between 2015 and 2017

CCG	Apr - 15	Sep - 15	Apr- 16	Sep - 16	Apr -17
Greater Huddersfield	201	214	225	240	230
North Kirklees	123	160	132	157	148

6.9.1 Personality disorder – considerations:

- People living with severe mental health problems, such as personality disorder, should not be held in restrictive settings for longer than they need to be;

- Proven community-based services for people of all ages with severe mental health problems should be expanded so that they can live safely as close to home as possible;

- Investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

- Further work needs to be scoped within the community to develop community services to minimise the need for expensive out of area placements

- Improve work with Primary care to try and improve referrals to appropriate services for people with PD

6.10 Refugees and Asylum Seekers

The mental health needs of asylum seekers and refugees can be significant. The mental health charity Mind[102] has found a number of issues for this population group, which include:

- The trauma of war, torture and persecution which can result in anxiety, stress and depression.

- Obstacles accessing mental health services, including the language barrier, cultural differences, stigma, racism and confusion.

- Confusion around the complex policies concerning access to free healthcare for foreign nationals. As a consequence, many migrants are wrongly denied primary and secondary mental health services, and their mental health deteriorates to the point of crisis.

A detailed definition of refugees and asylum seekers can be accessed here. [103]

Within Kirklees, there are three formal schemes which work with refugees and asylum seekers:

[102] Mind; Improving Mental Health Services for Vulnerable Migrants; accessed 2017 https://www.mind.org.uk/about-us/our-policy-work/equality-human-rights/supporting-vulnerable-migrants/
[103] Medical Protection; Healthcare for All?; accessed https://www.medicalprotection.org/uk/casebook/casebook-september-2014/healthcare-for-all

Kirklees is part of the Home Office Syrian resettlement programme, which aims to support UNHCR (United Nations High Commissioner for Refugees) selected refugees direct from the Middle East into safe and suitable housing as well as provide access to various support services including health, social care, education and financial. This programme has funding for all aspects of support required, including healthcare. The health needs of these newly arrived refugees are managed by the Whitehouse Centre. Patients will receive a full health assessment, including mental health screening and a torture check if appropriate. There is follow up as needed. In October 2015, Kirklees Cabinet agreed to resettle 131 individuals in to Kirklees over a two year period. There are currently 81 individuals in Kirklees. For the initial years they have good access to all services because of funding.

Kirklees Council is also part of the Home Office Vulnerable Children's Resettlement Programme. Kirklees Cabinet in October 2016 approved the resettlement of 20 individual children and their family unit, starting in late 2017. This will run along the same lines as the Syrian resettlement programme but those arriving will be from the Middle East and North Africa

Kirklees Council is an asylum dispersal area. This is a Home Office programme that is contracted out to regional providers. For the Yorkshire and Humber the provider is G4S. Kirklees Council has no control over the programme and only has a consultative role on where asylum seekers are housed. A proportion of asylum seekers who arrive in England are moved to the Yorkshire and Humber dispersal centre in Wakefield, where a proportion are then moved and re-housed within Kirklees. This is all managed by G4, who have the responsibility to orientate new households to their local area.

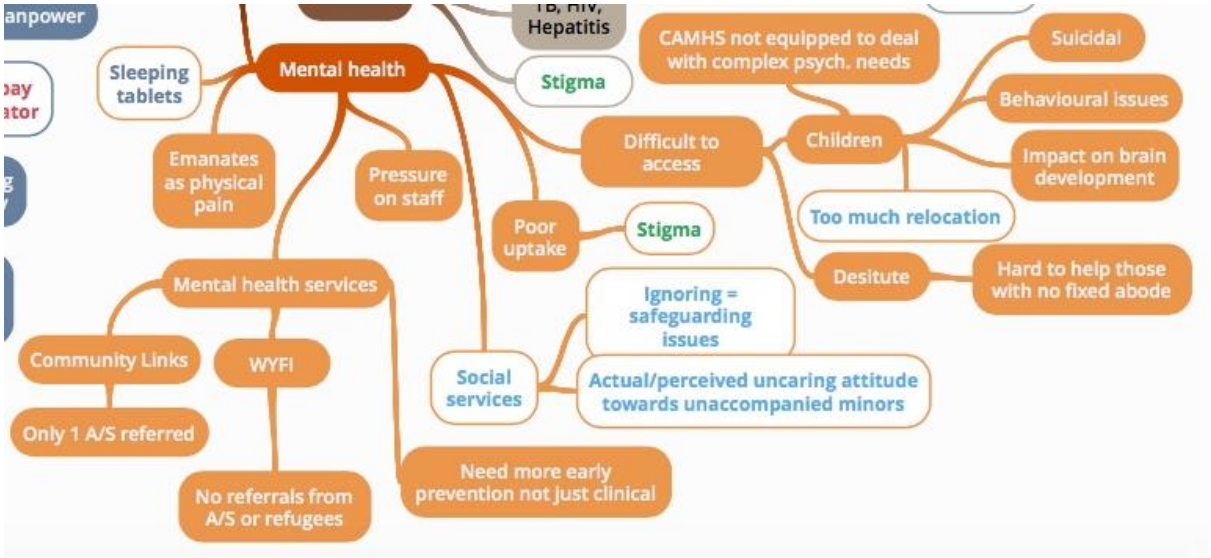
The health needs of the majority of these asylum seekers is managed by the Whitehouse Centre. However, not all asylum seekers will register at the Whitehouse – some will register with the GP practice within their locality. These patients are unlikely to receive the same specialist support which is provided by the Whitehouse. Patients registered at the Whitehouse will receive a full health assessment, including mental health screening and a torture check if appropriate. There are currently 690 asylum seekers in Kirklees. Asylum seekers arriving in Kirklees via the dispersal scheme do not have any additional financial resource attached to them for the support services they may need. This means that while they have full entitlement to NHS primary and secondary care they are often resource intensive patients with needs for longer appointments, interpreters, management of cultural expectations, high mental health load and advocacy and medico-legal support. In Huddersfield, asylum seekers do have good access to primary care because of the Whitehouse Centre. Access to secondary care is good except for mental health services who do not have any extra resources to manage the new challenges of this patient group.

It is worth noting that there are likely to be undocumented refused asylum seekers and/or people with no documentation from abroad, as well as people with refugee status who move into Kirklees. These population groups will not be accessing the formal pathways identified above and therefore face barriers in accessing support.

In 2017, Healthwatch Kirklees[104] produced a report focusing on the health issues and health barriers for emerging communities in Kirklees. This included the feedback from the Kirklees Multi Agency meeting where a mental health session was held with groups and some services working with the asylum and refugee community in Kirklees. The report from Healthwatch covered a broad range of communities and was not specifically focused on asylum seekers and refugees. However, the findings do provide some useful insight into the issues surrounding mental health for refugees and asylum seekers, which is detailed below:

- There was a felt need for early intervention and prevention services as well as just clinical mental health services;
- GP's may be struggling to cope due to demands on resources and increased needs and demands by immigrants/refugees and asylum seekers;
- It is important to consider the cultural background of asylum seekers and refugees. For example, the uptake of mental health services can be poor due to the stigma associated with mental health.

Figure 6.4 details the mental health issues which were reported to Healthwatch by emerging communities as part of their report.



105

Figure 6.4: Mental health issues which were reported to Healthwatch by emerging communities.

Staff from the Whitehouse Centre, South West Yorkshire Foundation Trust and Solace (a charity which provides psychotherapy, complementary therapies and advocacy support to the survivors of persecution and exile) have identified the following needs/issues/opportunities for asylum seekers and refugees in Kirklees:

[104] Healthwatch Kirklees; Emerging Communities: Health Issues and Inequalities; 2017
[105] Healthwatch Kirklees; Emerging Communities: Health Issues and Inequalities; 2017

- Access to services – Syrian refugees and vulnerable children's programme. Patients who are part of the Syrian resettlement scheme are relatively well resourced and able to access services they may need more easily. Greater Huddersfield Clinical Commissioning group have recently commissioned Solace to deliver mental health support to the Syrian Refugee Resettlement Families. The numbers of refugees receiving this specialist support are small when compared with the numbers of asylum seekers in Kirklees.

- Access to services – Dispersal Scheme Asylum seekers. Patients who are asylum seekers do not have any additional resource attached to them and it is, therefore harder for this population group to navigate and access the healthcare system. Asylum seekers will often have complex trauma issues, compounded with the stress of waiting for the result of their asylum claim. In terms of mental health services, the needs of asylum seekers are often too complex for Improving Access to Psychological Therapies, they are 'not stable enough' to engage in clinical psychology and they are chronic, rather than acute, so community mental health teams are rarely involved.

- Funding. The Whitehouse are not funded to provide specialist mental health provision within their service. However, they do support their patients as much as they can by "being there", providing drop in sessions and a safe place to come. They are also committed to new ways of working and developing links with partners;

- Community/voluntary organisations. Support, advice and guidance for asylum seekers and refugees is often provided by local community and voluntary organisations. These relationships are recognized, valued and needed in order to support asylum seekers navigate complex systems.

- Opportunities. Partners recognize the difficulties in the complex system which asylum seekers and refugees have to navigate. They welcome opportunities for more collaborative and joined up approaches to working.

6.10.1 Asylum Seekers and Refugees – Considerations

- The needs of asylum seekers and refugees could be largely met through an early intervention and prevention model, for example via a primary care service which works together with secondary care. This would require a shift from secondary care to primary care. The potential benefits of this would be that patients could quickly access support when it is most needed – and referrals to secondary care would not be necessary unless there were other factors e.g. a suicide risk.

- There is a genuine willingness amongst key partner organisations in Kirklees to explore opportunities for a more integrated approach to the support which is provided for asylum seekers and refugees in Kirklees. Commissioners could consider bringing together key partners working with asylum seekers and refugees/mental

health services to explore how partnerships can be strengthened/opportunities for integrated support/care.

- There may be a lack of knowledge and understanding amongst front line staff around the needs of asylum seekers and refugees. It may benefit the system to identify interested staff who are able to access specialist training on the needs of asylum seekers and refugees and advise colleagues accordingly. There are plans in place in Kirklees to develop this, so commissioners and providers will benefit from linking in with what is developed and provided.

- The needs of asylum seekers and refugees are complex and go beyond mental health. There is work undergoing in Kirklees to strengthen and integrate the support which asylum seekers and refugees receive. The focal point of this work will be highlighted in the Asylum Seekers and Refugees chapter of the Joint Strategic Assessment, which is currently being written. Healthcare commissioners and frontline organisations should work collaboratively in order to develop the Joint Strategic Assessment and planned next steps (based on opportunities and need).

- Access and use data from the Whitehouse Centre to understand this client group more effectively.

6.11 Maternity

Mental health problems affect more than one in ten women during pregnancy and the first year after childbirth.[106]

Pregnancy and the period after childbirth can bring a range of emotional changes for the mother, her partner and other members of the family. Many mothers find these changes are a positive experience, but for some this significant life event can result in mental health conditions developing. Some women who experience mental illness in the perinatal period may have no history of mental illness and experience it for the first time in relation to their pregnancy or childbirth. Other women may have a pre-existing mental illness which persists, deteriorates or reoccurs during the perinatal period as a result of the intense social, psychological and physical changes, because of a change of medication, or as a result of the events of childbirth. Socio-economic factors increase the risk of perinatal mental ill health or exacerbate its effects. The risk of depression is higher for teenage mothers[107] and for women living in poverty, experiencing domestic abuse, poor housing or homelessness.[108]

[106] Joint Commissioning Panel for Mental Health. (2012). Guidance for commissioners of perinatal mental health services.
[107] Deal, L. W., & Holt, V. L. (1998). Young maternal age and depressive symptoms: Results from the 1988 National Maternal and Infant Health Survey. American Journal of Public Health, 88, 266–270.
[108] Hogg, S. (2013). Prevention in Mind. All babies count: Spotlight on Perinatal Mental health. NSPCC

Perinatal mental health can affect all women and some negative outcomes are more prevalent amongst advantaged women.[109]

Women who have a history of mental health problems before becoming pregnant are at increased risk of certain mental health conditions during pregnancy and the year after childbirth. Therefore, if there is a higher than average rate of mental health problems in your local general population, there may be a higher level of maternal mental health problems as well. In Kirklees (2015/16), 8.9% of patients aged 18 and over had depression, as recorded on practice disease registers. This is higher than the England value of 8.3%.

Anxiety is more prevalent during pregnancy than depression and is an important predictor for postpartum depression, highlighting the need to incorporate ongoing screening.[110] Anxiety in the antenatal period is also regarded as a predictor of childhood behavioural and emotional problems at 47 to 81 months, especially in boys.[111] Better antenatal detection of depression offers an opportunity for earlier intervention to address the illness and reduce the risk that it will cause longer term problems for the mother and her baby. Supporting mothers with mental health conditions may have a direct impact on young children's development and well-being and could enhance children's early school experiences.

6.11.1 Summary of Perinatal Mental Health Incidence by Type

Table 6.5:Perinatal Mental Health Incidence by Type

Disorder	**Frequency (per 1000 births)**
Mild to moderate depressive illness & anxiety states	100-150[1]
Severe depressive illness	30-50[1]
Post-traumatic stress disorder	20[2]
Obsessive Compulsive disorders	20[3]
Postpartum psychosis	2[4]
Chronic serious mental illness	2[5]

1. *Heron et al., (2004); Bennett et al.; (2004); Gavin et al., (2005)*
2. *Ayers (2004); Olde et al. (2006); Alcorn et al. (2010)*
3. *Russell et al. (2013)*
4. *Kendell et al. (1987); Oates (2003); Blackmore et al. (2013)*
5. *Munk-Olson et al. (2006); Kendell et al. (1987); Terp and Mortenson, (1998)*

[109] Galloway, S and Hogg, S. (2015). Getting it Right. Getting it Right for Mothers and Babies. Closing the Gaps in community perinatal mental health services. NSPCC Scotland

[110] Ross L.E and McLean L.M (2006) Anxiety disorders during pregnancy and the postpartum period: a systematic review. Journal of Clinical Psychiatry, 67: 1285-1298.

[111] O'Connor, T.G, Heron, J. and Glover, V (2002). Antenatal anxiety predicts child behavioural/emotional problems independently of postnatal depression. Journal of the American Academy of Child & Adolescent Psychiatry, 41:569-573,

6.11.2 Kirklees Context

Table 6.6: Kirklees Context

1. Number of recorded Births in 2015 (ONS, July 2016)

	Live births	**Stillbirths**
Kirklees	5,375	17

2. Age of Mother at Birth (ONS, Nov 2015)

	Under 18	**Under 20**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45+**
Kirklees	58	244	994	1,681	1,668	707	171	7

3. Projected Figures for Numbers of Births per Year (based on UK-Principal fertility figures)

	2021	**2026**	**2031**
Kirklees	5,413	5,508	5,508

4. The expected incidence of perinatal mental health problems by type:

KIRKLEES		**2015**	**2021**	**2026**	**2031**
Number of Live Birth		5375	5,413	5,508	5,508
	Disorder				
	Mild to moderate depressive illness & anxiety states	538 - 806	541 – 812	551 - 826	551 - 826
	Severe depressive illness	161 - 269	162 – 271	165 - 275	165 - 275
	Post-traumatic stress disorder	108	108	110	110
	Obsessive Compulsive disorders	108	108	110	110
	Postpartum psychosis	11	11	11	11
	Chronic serious mental illness	11	11	11	11

Public Health England has released a perinatal mental health profile at Local Authority/CCG level. The prevalence figures in table 6.7 are modelled estimates but provide some consistency in identifying need in Kirklees.

Table 6.7: Kirklees Perinatal Mental Health Profile

Compared with benchmark: Lower, Similar, Higher, Not Compared

Benchmark Value: Lowest | 25th Percentile | 75th Percentile | Highest

Indicator	Period	Kirklees		Region England	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Postpartum psychosis: Estimated number of women	2013/14	15	15*	-	*	-	-	-
Chronic SMI in perinatal period: Estimated number of women	2013/14	15	15*	-	*	-	-	-
Severe depressive illness in perinatal period: Estimated number of women	2013/14	165	165*	-	*	-	-	-
Mild-moderate depressive illness and anxiety in perinatal period (lower estimate): Estimated number of women	2013/14	550	550*	-	*	-	-	-
Mild-moderate depressive illness and anxiety in perinatal period (upper estimate): Estimated number of women	2013/14	820	820*	-	*	-	-	-
PTSD in perinatal period: Estimated number of women	2013/14	165	165*	-	*	-	-	-
Adjustment disorders and distress in perinatal period (lower estimate): Estimated number of women	2013/14	820	820*	-	*	-	-	-
Adjustment disorders and distress in perinatal period (upper estimate): Estimated number of women	2013/14	1,640	1,640*	-	*	-	-	-

Source: Public Health England (2013/14)[112]

Compared to England, the profile in Table 6.8 shows that Kirklees has a higher rate of births to mothers 20 years old or younger, which might suggest that we should see proportionately more mothers in this age group within perinatal mental health services.

Table 6.8: Kirklees Fertility and Birth data

Compared with benchmark: Lower, Similar, Higher, Not Compared

Benchmark Value: Lowest | 25th Percentile | 75th Percentile | Highest

Indicator	Period	Kirklees		Region England	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
General fertility rate: Birth rate per 1,000 females aged 15-44	2015	5,375	64.2	61.9	62.5	43.7		84.8
Women of childbearing age (15-44): % of total population	2015	83,756	19.3%	19.1%	19.4%	14.3%		28.7%
Births to non-UK parents: % of live births	2015	1,698	31.6%	25.8%	34.0%	6.1%		84.2%
Births to mothers aged <20: % of live births	2015	213	4.0%	4.5%	3.4%	0.8%		7.6%
Births to mothers aged 40+: % of live births	2015	187	3.5%	3.2%	4.2%	1.9%		10.2%

Source: Public Health England (2015)[113]

[112] Public Health England (2013/14). Accessed via: http://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health

[113] Public Health England (2015). Accessed via: http://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health

Funding has been secured through NHS England to establish a specialist perinatal community mental health team working through a 'hub and spoke' model. A multi-disciplinary team brings together specialist expertise and local service delivery, supported by technology and peer support to engage local communities. The service covers the four districts of Kirklees, Barnsley, Wakefield and Calderdale.

The Specialist Perinatal team:

- Provides education and advice to local communities and the voluntary sector. This includes the development of a 'learning network' of perinatal mental health peer supporters who have lived experience of the issues. This will lead to earlier identification and treatment and care.

- Provides specialist support and co-working with existing local mental health and maternity pathways. Greater specialist capacity in every locality will promote recovery and help people access care closer to their home.

- Directly manages care for the most complex cases including gatekeeping the patient journey into and out of specialist Mother and Baby inpatient units.

It is estimated that this service will make a difference to 2920 women a year with 730 requiring direct support from the specialist team. This will support recommendation 15 of the 5YFV which states that by 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies.

At the 6-8 week check, GP's are encouraged to enquire about the mother's emotional wellbeing and this is an ideal opportunity to spot any mental health problems that are developing. Given many new mothers' reluctance to actively seek help for mental health problems, if they are not picked up at this appointment, there is a significant chance of them remaining undiagnosed. Encouraging a mother to talk about how she feels and is coping is not something that can be done briefly. Open, supportive questioning and taking the time to listen and read between the lines is vital to spotting the signs of a developing mental health problem. The Royal College of General Practitioners (RCGP) and Royal College of Psychiatrists have recently made great strides in improving the resources available to doctors and are developing imaginative training tools.[114]

Within the new Healthy Child Programme Specification, which started in April 2017, there are new indicators related to maternal mood which should help to build a greater understanding of the local need and impact of interventions. The performance indicators are:

- % of mothers who received a Maternal Mood assessment in a timely manner
- % of reviews identifying concern for Maternal Mood

[114] http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

- % of people where a concern for maternal mood is identified who are supported by the KIHCP workforce
- % of mothers where concern for Maternal Mood are identified who report positive outcomes following the intervention of the KIHCP workforce

6.11.3 Maternity - considerations:

- Where a woman has a pre-existing mental health condition at booking, make a prompt and early notification to health visiting teams.

- Ensure that the perinatal commissioning and delivery of comprehensive perinatal and infant mental health pathways complies with NICE guidance and is focused on securing sustainable arrangements to meet the needs of women and their families before and during pregnancy and the year following childbirth.[115]

- Invest in health visiting, home and family based interventions and peer support, to support maternal mental health improvement.

- Where appropriate implement national improvement initiatives locally, including: developing local health visitor champions, implementing the Family Nurse Partnership Programme, ensuring that Midwives have access to perinatal mental health training and implement guidelines for GP's and primary care from NICE.[116]

- Peer support for young mums and/or young fathers should be considered where local insight shows this is needed.

- Allow more time for the 6-8 week maternal check to help conversations around mental health of the mother.

- Improved recording/data collection within primary care of postnatal depression to enable areas to understand local need more effectively and to benchmark.

- The Royal College of Midwives' report: *Every mother must get the help they need* provides invaluable insight from those who have direct or indirect experience of maternal mental health problems and should be referred to alongside bespoke local engagement when identifying local need.

- Within any local action plan, consideration of the father's/partner's mental health should be given.

[115] NICE (2014). Antenatal and postnatal mental health: clinical management and service guidance. (CG192). London: NICE. Accessible via: http://www.nice.org.uk/guidance/cg192
[116] NICE (2007). Antenatal and postnatal mental health: Clinical management and service guidance. NICE clinical guidance 45. London: NICE. Accessible via: https://www.nice.org.uk/guidance/cg45?unlid=501393348201621214243

- Families should be provided high quality advice on how to access housing, finance and benefit support

6.12 Frequent Attenders at A and E

'Frequent attenders' have been defined as patients who attend a health care facility repeatedly. The frequency of attendance has been variously defined between 3 and 12 attendances per annum.[117] The burden of work for 'frequent attenders' is difficult to define, however most estimates are that between 1 and 2% of attendances to U.K. Emergency Departments are made by 'frequent attenders'. Consistent findings from cohort studies reveal that 'frequent attenders' to Emergency Departments tend also to be frequent users of other health and social care facilities (for example, primary care).[118],[119] Additionally, they tend to have a higher triage category, greater rates of admission, and a greater burden of chronic disease, when compared to matched groups. Frequent users of Emergency Departments are also vulnerable patients, with a higher mortality (including death by violent means and suicide)[120], and greater prevalence of alcohol and psychiatric disorders.
There is also consistent evidence that 'frequent attenders' for a department do not constitute a stable cohort; that is, most patients do not persist in this pattern of attendance.

Table 6.9 below shows the number of frequent attenders at A and E for Kirklees in 2015/16 and 2016/17 who had attended A and E twelve or more times in these year groups. It shows that there has been an increase in the number of frequent attendees from 2015/16 to 2016/17 who have been diagnosed on one or more attendances with a Mental Health condition, which has also increased the number of visits by this cohort. Interestingly the total price/cost of these attendances has remained similar. The average number of attendances per patient in each year has been 21 with the average price/cost of each patient appears to have dropped slightly. The cost of an A&E attendance will depend on how many treatments and investigations are done during the attendances, and these are grouped into Healthcare Resource Group (HRG) codes. The costs being lower in 2016/17 is most likely due to the fact that the attendances came in the lower priced HRG.

There are 24 patients that have been identified from 2016/17 financial year that were also frequent attendees in 2015/16 financial year, over the two years the price/cost of their attendances is £124,557 with 1261 attendances over the two years. In fact, the number of people in this cohort is likely to be higher as there will be many ambulance call outs that do not result in an A and E attendance.

[117] Moore, L., Deehan, A., Seed, P., Jones, R. (2009). Characteristics of frequent attenders in an emergency department: analysis of 1 year attendance data. Emergency Medicine Journal; 26: 263-7
[118] Byrne, M., Murphy, A. W., Plunkett, P. K et al. (1999). Frequent attenders to an emergency department: a study of rimary health care use, medical profile and psychosocial characteristics. Journal of Accident and Emergency Medicine; 16, 425-7
[119] Williams, E. R. L., Guthrie, E., Mackway-Jones, K. et al. (2001). Psychiatric status, somatisation, and health care utilisation of frequent attenders at the emergency department: a comparison with routine attenders. Journal of Psychosomatic Res; 50(3): 161-7
[120] Hansagi, H., Alleback, P., Edhag, O., Magnusson, G. (1990). Frequency of emergency department attendances as a predictor of mortality: nine-year follow up of a population based cohort. Journal of Public Health Medicine; 12:39-44

Table 6.9:Frequent Attenders at A and E

Frequent Attendees attendances at A&E where one or more diagnoses was for "Psychiatric conditions" or "Social Problems (includes chronic alcoholism and homelessness)"

Data Source: SUS_A&E Attends

		Number of Patients	Total Visits	Total Price of visits	Average visits per patient	Average Price per patients	Frequent Attendees From previous year	Price of the Frequent Attendees in both years	Attendances's of the Frequent Attendees in both years
North Kirklees CCG	1516	31	664	£72,976	21.4	£2,354			219
	1617	33	695	£65,304	21.1	£1,979	10	£45,912	286
Greater Huddersfield CCG	1516	43	886	£103,869	20.6	£2,416			374
	1617	50	1044	£110,279	20.9	£2,206	14	£78,646	382
Kirklees Council (NK and GH combined figure)	1516	74	1550	£176,846	20.9	£2,390			593
	1617	83	1739	£175,584	21.0	£2,115	24	£124,557	668

NHS England has recently developed a national CQUIN: Improving services for people with mental health needs who present at A and E for the period 2017 – 2019. The rationale for this indicator is that people with mental health problems are three times more likely to present to A and E than the general population. A Quality Watch study also found that people with mental ill health had 3.6 times more potentially preventable emergency admissions than those without mental ill health in 2013/14, and that the 'high levels of emergency care use by people with mental ill health indicate that they are not having their care well managed and suggest that there are opportunities for planned care (inside and outside hospital) to do more.[121] Many frequent attenders will attend A and E with a primary physical health need but may in fact have an underlying mental health need that may go undetected.

The first year of this CQUIN will focus on improving understanding of the complex needs of a small cohort of people who use A and E most intensively. There will be a particular focus on identifying those people within this cohort who may benefit from integrated mental and physical health assessment, care planning and interventions. Year 2 will seek to maintain the progress of year 1 for the selected cohort of frequent attenders, but the focus will broaden to deliver a reduction in the number of attendances to A and E for all people with primary mental health needs. The cohorts of people, who could benefit from case management, advance care planning and community interventions might typically include:

- People with dual diagnosis

[121] http://www.qualitywatch.org.uk/focus-on/physical-and-mental-health

- People with long term conditions which have a mental health component that has previously gone undetected
- Older people with a combination of multiple and deteriorating physical health problems, frailty and increasing social need
- People with primarily complex mental health needs including self-harming behaviour, personality disorder, substance misuse
- People with medically unexplained symptoms (MUS) (see section 6.12.1)
- People with complex social needs, e.g. housing, domestic violence, loneliness/social isolation or financial difficulties

6.12.1 Frequent Attenders – Considerations

- Acute and mental health providers should aim to improve the quality of data in terms of coding, to demonstrate the true prevalence of mental ill health in A and E, and make the case for improved services.

- Improvement is needed in coding of primary and secondary mental health needs in A and E.

- Improve information sharing practices within the NHS and beyond in order to improve care and outcomes and to avoid missed opportunities in relation to patient safety.

- Improve the understanding of the needs of those 24 frequent attenders in Kirklees.

6.12.2 Medically Unexplained Symptoms (MUS)

The terms MUS refers to persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology.[122] Patients with a combination of symptoms will often present to primary care or A and E departments seeking appropriate treatment, which usually results in a referral to a relevant medical or surgical outpatient department for further investigation. Table 6.10 below describes some of the symptoms that can present, the associated syndromes and the speciality that the patient is usually referred to. [123]

Many people with MUS have complex presentations caused or exacerbated by co-morbid mental health problems such as anxiety, depression or personality disorders. MUS accounts for approximately 10% of total NHS expenditure on services for the working age population

[122] Chitnis, A., Dowrick, C., Byng, R., Tuner, P., and Shiers,. D. (2014). Guidance for health professionals on medically unexplained symptoms- 2011; Royal College of General Practitioners and Royal College of Psychiatrists

[123] Nimnuan, T., Hotopf, M., and Wessely, S. (2001). Medically unexplained symptoms: an epidemiological study in seven specialities. Journal of Psychosomatic Res; 51: 361-367

in England.[124] MUS also account for 20-25% of all frequent attenders at specialist medical clinics,[125] and an estimated 25% of people attending their GP. Sickness absence and decreased quality of life for people with MUS costs the UK economy over £14 billion per annum.[126]

Table 6.10: MUS –symptoms that present

Symptoms (combination of)	Syndrome	Specialty
Bloating, constipation, loose stools, abdominal pain	Irritable Bowel Syndrome	Gastroenterology
Fatigue (particularly post-exertional and long recovery) pain, sensitivity to smell	Chronic Fatigue Syndrome/ Myalgic Encephalomyelitis	Infectious Diseases, Endocrinology, Rheumatology, Pain Clinics
Headache, vomiting, dizziness	Post Concussion Syndrome	Neurology
Pelvic pain, painful sex, painful periods	Chronic Pelvic Pain	Gynaecology
Pain and tender points, fatigue	Fibromyalgia/Chronic Widespread Pain	Rheumatology
Chest pain, palpitations, shortness of breath	Non-cardiac chest pain	Cardiology
Shortness of breath	Hyperventilation	Respiratory Medicine
Jaw pain, teeth grinding	Temporo-mandibular Joint Dysfunction	Dentist, Oral Medicine
Reaction to smells, light	Multiple Chemical Sensitivity	Allergy clinic

Source: Guidance for commissioners of services for people with MUS[127]

MUS should be considered if someone has had a physical symptom for longer than 3 months, which is affecting their functioning but cannot be readily explained. It is more common in women and risk factors include those with a long term condition and anxiety or depression. Doctors often manage the symptoms by normalising and treating accordingly, whereas patients usually want explanations and emotional support – for their symptoms to make sense. Most people with MUS who see their GP will improve without any specific treatment, particularly when their GP gives an explanation for symptoms that makes sense, removes any blame from the patient and generates ideas about how to manage their symptoms.[128][129]

Sufficient service provision in local areas should exist to meet local needs. To estimate MUS prevalence, primary care records would need to be examined. However, the most recent estimates assume that 20% of primary care patients have somatoform disorders.[130] Locally, South West Yorkshire Foundation Trust is in the process of developing a MUS pathway

[124] Bermingham, S. L., Cohen, A., Hague, J., and Parsonage, M. (2010). The cost of somatisation among the working-age population in England for the year 2008-2009. Mental health in Family Medicine; 7(2): pp71-84
[125] Burton, C., McGorm, K., Richardson, G., Weller, D., and Sharpe, M. (2012). Healthcare costs incurred by patient repeatedly referred to secondary medical care with medically unexplained symptoms: a cost of illness study. Journal of Psychosomatic Research; 72:3: pp 242-47
[126] Bermingham, S. L., Cohen, A., Hague, J., and Parsonage, M. (2010). The cost of somatisation among the working-age population in England for the year 2008-2009. Mental Health in Family Medicine; 7(2): pp71-84
[127] www.jcpmh.info
[128] Salmon, P., Peters, S., Stanley, I. (1999). Patients' perceptions of medical explanations for somatisation disorders: qualitative analysis. BMJ; 318: 372-6
[129] Hatcher, S., Arroll, B. (2008). Assessment and management of MUS. BMJ; 336: 1124-1128
[130] Schaefert R, Hausteiner-Wiehle C, Häuser W, Ronel J, Herrmann M, Henningsen P. (2012). Clinical Practice Guideline: Non-specific, functional and somatoform bodily complaints. Dtsch Arztebl Int;109:803–813

within primary care, with GP's from North Kirklees. The pathway will consist of a MUS clinic based in GP's surgeries. GP's will directly book into a clinic where the patient will receive an IAPT assessment and either a long term condition specific group or individual treatment.

Examples of best practice from other areas in tackling MUS can be accessed here and here.

6.12.3 MUS – Considerations:

- Appropriate services for people with MUS should be commissioned in primary care, community, day services, A and E and inpatient facilities. This would enable patients to access services that are appropriate for the severity and complexity of their problems.

- Local areas should bring together professionals with skills in general practice, medicine, nursing, psychology, psychiatry, occupational therapy and physiotherapy.

- Educate and train all healthcare professionals to develop and maintain the skills to work effectively with patients experiencing MUS.

- Pathways of care should support alternatives to hospital referral e.g. health trainers, peer supporters, social prescribing and links to IAPT.

- Services that come into contact with MUS patients should: validate their suffering, remove blame, offer explanations that make sense, focus on the patient's words, ideas, concerns and expectations and jointly explore ways of improving function.

- Local areas should determine the prevalence of MUS

6.13 Suicide and Self-harm

Although not a statutory duty, there has been increasing recognition of the key role of councils in leading the development of local suicide prevention plans. This depends on effective partnerships across all sectors including health, social care, education, the environment, housing, employment, the police and criminal justice system, transport and the voluntary sector. Sustainability and Transformation Partnerships (STPs) also have a "must do" target to reduce suicide rates by 10% by 2020/21 against the 2016/17 baseline, as outlined in the Five Year Forward View for Mental Health (NHS England 2016, Mental Health Taskforce 2016).

There is no single reason why people take their own lives. Suicide is a complex and multi-faceted behaviour, resulting from a wide range of psychological, social, economic and cultural risk factors which interact and increase an individual's level of risk. Men in the lowest social class, living in the most deprived areas, are up to ten times more at risk of suicide than those in the highest social class, living in the most affluent areas.

In Kirklees, the death rate due to suicide is slightly lower than the national rate (see Figure 6.5 below). In 2001-3 Kirklees had a rate of 11.4 per 100,000 compared to the England rate of 10.3. More recently, in 2013-15 the rate in Kirklees has dropped to 9.7 per 100,000 compared to the England rate of 10.7. The Yorkshire and Humber rate in 2013-15 was 10.7 per 100,000.

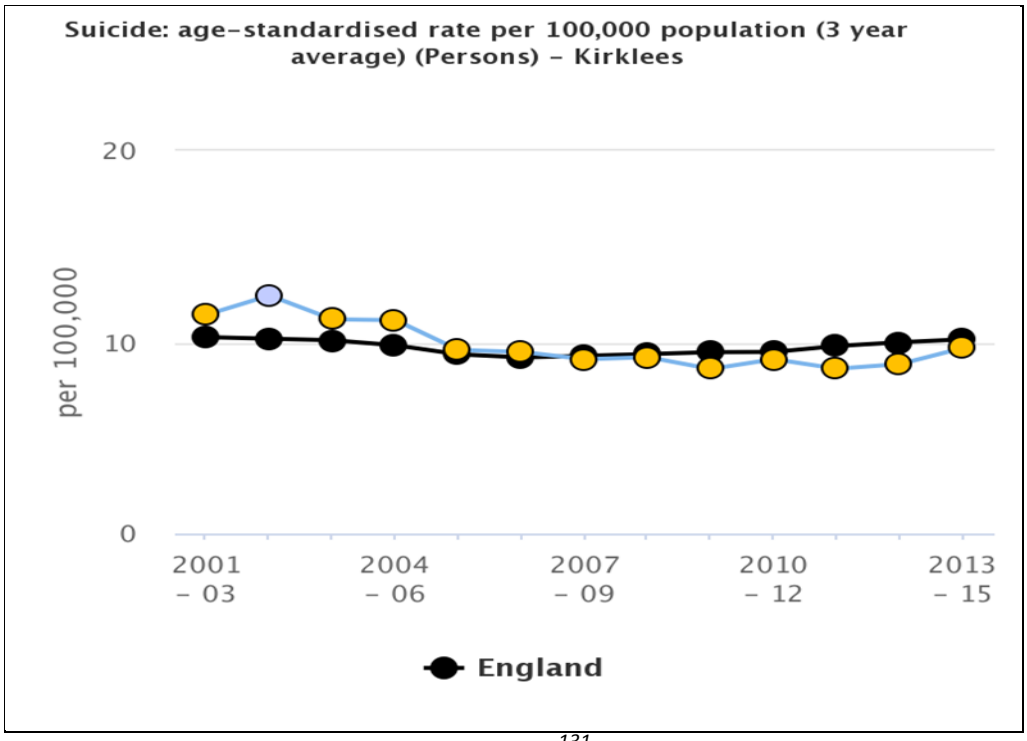


Figure 6.5: taken from PHE Fingertips tool[131]

(Please note that between 2006-8 and 2009-10, the value for female suicides in Kirklees could not be calculated as the numbers were too small). Figure 6.6 shows the difference in rates between male and female suicide and shows how Kirklees is very similar to the England rates. It highlights where efforts should be focused in terms of gender, but whilst being aware of changes in trends in female suicide rates. Many of the clinical and social risk factors for suicide are more common in men. Cultural expectations that men will be decisive and strong can make them more vulnerable to psychological factors associated with suicide, such as impulsiveness and humiliation. Men are more likely to be reluctant to seek help from friends and services. Linked with this, providing services appropriate for men requires a move away from traditional health settings.

[131]Public Health England: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/4/gid/1938132828/pat/6/par/E12000003/ati/102/are/E08000034/iid/41001/age/285/sex/4

Suicide: age-standardised rate per 100,000 males and females in Kirklees against England (3 year average)

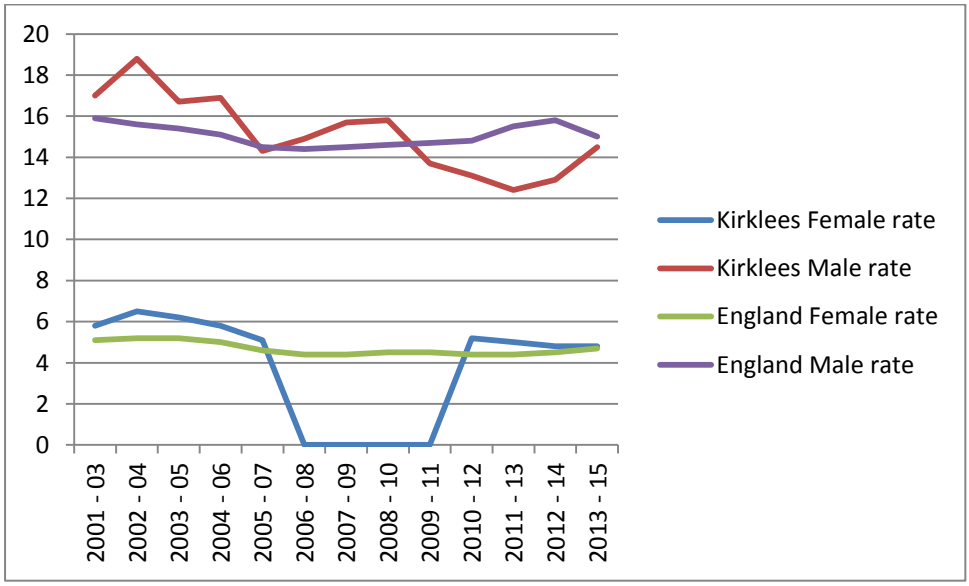


Figure 6.6: analysed from PHE fingertips data[132]

The most recent Kirklees suicide audit was completed for the years 2011-2013. A total of 121 deaths occurred during this period that met the inclusion criteria for the audit. Although the rates of mortality and numbers of deaths from suicide are generally low compared to other causes of death, the numbers of years lost when people die can be considerably higher than other causes and the impact on surviving family and friends is also considerable. There is a Kirklees Suicide Prevention Action Group (SPAG) that meets quarterly to use local intelligence and coordinate local actions accordingly. The key findings from the 2011-2013 audit included:

- Suicide rates in Kirklees appear stable.
- Men taking their own lives (74%) was similar to the national average.
- In 45% of deaths, hanging was the method used.
- 45% of those taking their own lives lived alone.
- Multiple stresses were evident in many instances and relationship problems were most common, being identified as a factor in 23% of those taking their own lives.
- 54% of suicides had been seen by their GP on one or more occasions in the three months prior to their death.
- 32% had attempted suicide at least once in the 12 month period before their death.
- 46% of persons committing suicide had a history of alcohol and/or drug misuse.
- 47% had past or current contact with specialist mental health services.

[132] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/4/gid/1938132828/pat/6/par/E12000003/ati/102/are/E08000034/iid/41001/age/285/sex/1

The typical profile of a person committing suicide locally is a white British male, aged between 40-49 years, facing significant recent life stresses. National findings[133] suggest that men:

- Have measurably lower access to the social support of friends, relatives and the community.
- Demonstrate poorer symptom awareness and reporting than their female counterparts.
- Are less likely to access psychological talking therapies.

Around 81% of working age adults in England comes into contact with a GP at least once a year[134], and there is evidence that suicide prevention education for GPs can have an impact as a population-level intervention to prevent suicide. This has the potential to be cost-effective if it leads to adequate subsequent treatment.[135] With greater identification of those at risk of suicide, individuals can receive cognitive behavioural therapy (CBT), followed by ongoing pharmaceutical and psychological support to help manage underlying depressive disorders.

Mental health services prevent many suicides, but it is difficult to accurately measure how many deaths are actually prevented because it is impossible to know who would and who wouldn't have eventually died by suicide had services intervened. For example, it is of note that in South West Yorkshire Foundation Trust in 2016-17 (April to March), out of 35,617 initial risk assessments, it was identified that 7973 service users had suicidal ideation, plans for suicide or both. In the same time period 28 service users died by suicide (0.35%).

6.13.1 Self-harm

Men are more likely than women to choose more dangerous methods of self-harm, meaning that a suicide attempt is more likely to result in death. According to the refreshed National Suicide Prevention Strategy,[136] local areas should place greater emphasis on self-harm and support for those bereaved of suicide. New research has shown that alcohol-related deaths are more frequent than expected among both males and females presenting at emergency departments with self-harm. Hospital-presenting patients should receive assessment following self-harm in line with NICE guidelines[137] to enable early identification and treatment of alcohol problems. Suicide risk is raised 49-fold in the year after self-harm, and the risk is higher with increasing age at initial self-harm.[138] Figure 6.7 below shows the level of emergency hospital admissions for intentional self-harm in Kirklees, compared with

[133] Engaging with men to improve their health: A toolkit for the voluntary sector (2016). Accessible via: http://www.menshealthforum.org.uk/sites/defualt/files/pdf/mhf_vcs_toolit.pdf

[134] Bermingham S, Cohen A, Hague J, Parsonage M (2011) The cost of somatisation among the working-age population in England for the year 2008/09. Mental Health in Family Medicine forthcoming.

[135] Appleby L, Morriss R, Gask L et al (2000) An educational intervention for front-line health professionals in the assessment and management of suicidal patients (The STORM Project). Psychological Medicine 30:805–12.

[136] Preventing Suicide in England: two years on (2015). Second Annual Report on the cross-government outcomes strategy to save lives. Department of Health.

[137] NICE (2013). Self-harm, Quality Standard QS34. Accessible via: https://www.nice.org.uk/guidance/qs34

[138] Hawton K et al. Suicide following self-harm: Findings from the Multicentre Study of self-harm in England: 2000-2012. Journal of Affective Disorders, Vol 175, 147-151

England and Yorkshire and Humber. Whilst Kirklees levels appear lower, it is important to recognise that not all self-harm will result in an attendance at A and E, highlighting the importance of raising awareness of the issue, more broadly in the community and within families.

Examples of self-harming behaviour include:

- Cutting
- Taking an overdose of tablets
- Swallowing hazardous materials or substances
- Burning, either physically or chemically
- Over/under medicating, e.g. misuse of insulin
- Punching/hitting/bruising
- Hair-pulling/skin-picking/head-banging
- Episodes of alcohol/drug abuse or over/under eating
- Risky sexual behaviour

Emergency hospital admissions for intentional self-harm, Kirklees
Directly standardised rate per 100,000

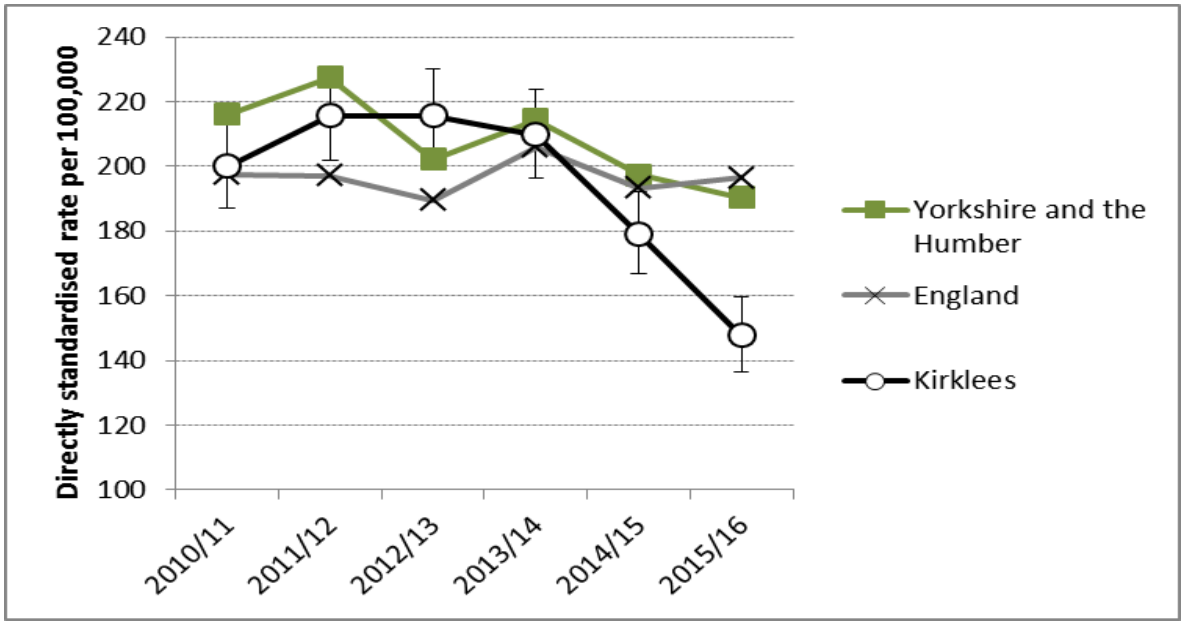


Figure 6.7: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England.[139]

Figure 6.8 shows that for females there seems to be a peak at age 18-24; for males, the peak is less pronounced and comes later (age 35-44). The ICD-10 codes for self-harm (X60-X84) are only used in the secondary diagnosis field positions, with the primary diagnosis code being used to indicate what is wrong with the person.

[139] Public Health Outcomes Framwork (2017). Accessed via: http://www.phoutcomes.info/

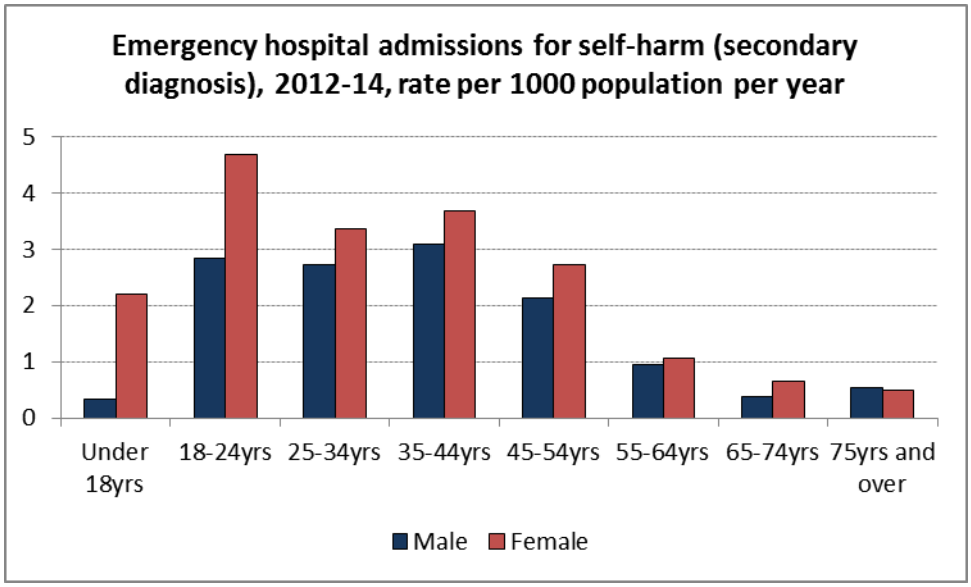


Figure 6.8

6.13.2 Suicide Bereavement

A postvention is an intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). Research shows that bereavement by suicide is linked to a number of negative health and social outcomes. This includes depression and an increased risk of suicide and suicide attempts.[140][141] Friends, as well as family members and colleagues may be affected. Postvention is one way of limiting these consequences. The current national suicide prevention strategy published in 2012[142] identifies those bereaved by suicide as a vulnerable group and recognises how weak and limited the evidence base is in this area.

6.13.3 Suicide Prevention and self-harm – Considerations:

- There needs to be greater awareness among welfare, housing and employment agencies of the impact of economic hardship on suicidal behaviour and self-harm.

- Staff and volunteers at services accessed by individuals who are experiencing socio-economic disadvantage, including food banks and job centres, should receive specialist training in recognising signs of emotional distress.

- People bereaved or affected by suicide should be offered psychological and material support in with the guidance set out by the National Suicide Prevention Alliance.

[140] Pitman A, Osborn D, King M, & Erlangsen A. Effects of suicide bereavement on mental health and suicide risk. The Lancet Psychiatry. June 2014;1(1):86-94

[141] Pitman A, Osborn D, Rantell K & King M. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ Open. 2016 Jan1;6(1)

[142] HM Government. Preventing Suicide in England: A cross government strategy to save lives. London: Department of Health; 2012

Additionally, 'Help is at Hand' should be given out by all primary, secondary and third sector organisations when they come into contact with anyone bereaved by suicide. Commissioners should consider how postvention support could work in Kirklees in order to support this vulnerable group.

- Ensure information about depression and services are available in 'male settings' and male activity-based interventions can provide a 'hook' to encourage engagement into services and provide a group context which promotes social inclusion and enjoyment.

- For professionals working with people who have self-harmed they should know the limits of their role and be aware of local resources and services where they can access further support for the person they are helping. Follow up after someone has self-harmed is key in terms of preventing further self-harm and suicide prevention.

- Increase investment in GP training for suicide prevention awareness.

- Currently, councils receive no specific funding for suicide prevention, so any review of distribution of available funding that recognises the role of councils and the resource implications is welcomed.

- Recommendation 3 of the 5YFV, states that the DH, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017.

6.14 Offenders not within the prison population

This section should be viewed in conjunction with the Substance Misuse and Homelessness sections.

Many offenders will experience complex and multiple needs beyond their offending behaviour. This includes mental health, substance misuse and homelessness but is compounded by other broader factors such as poverty, unemployment and debt.[143]

There is also evidence that the 'average' local authority has around 1,470 people in contact over the course of a year with two or more out of substance misuse services, homelessness services and/or the criminal justice system.[144] Evidence[145] also suggests the following inequalities for offenders:

[143] Rebalancing Act; A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users; Home Office and Public Health England; 2017

[144] Hard Edges; Mapping severe and multiple disadvantage; England; Lankelly Chase Foundation; 2015

[145] Rebalancing Act; A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users; Home Office and Public Health England; 2017

- Released prisoners and offenders in the community, such as probationers, have over two to over three times the population mortality rate;

- Prevalence of mental ill health and/or personality disorder also tends to be higher among the probation caseload, or offenders in the community, than among the general population;

- People in contact with the criminal justice system are recognised as a priority group within the current cross-government suicide prevention strategy, and have substantially more risk factors for suicide, including increased prevalence of mental illness, substance misuse and socioeconomic deprivation.

Anecdotal evidence from Kirklees Community Rehabilitation Company (CRCs) has highlighted the following issues around offenders and mental health:

- Kirklees CRC manage medium and low-risk of serious harm offenders. Kirklees CRC works with people sentenced to custodial Sentences, Community Orders and Suspended Sentence Orders to deliver the sentence of the Court, to address areas of criminogenic need and harm and to reduce the likelihood of further offending.

- Mental health is described as a 'huge' issue for this population group. Mental health issues often cover the wide range of issues in the spectrum of Mental Health, with most prevalence around stress, anxiety, depression and paranoia.

- Two student councillors from University provide lower level support to appropriate service users.

- Kirklees CRC have received 2 years of funding from the Police and Crime Commissioner, via Kirklees Community Safety Partnership to pay for a mental health nurse who is seconded from SWYFT. The mental health nurse is co-located with staff from Kirklees CRC and is considered a vital asset. The nurse assists magistrate and the National Probation Service with mental health assessments as well as advising and supporting CRC staff with their clients and helping to navigate further mental health services and support. This funding is due to end in February 2018.

- It is strongly felt that without the added value of this early intervention and prevention approach, the outcomes for service users would be greatly reduced. Kirklees CRC recognise the need for a shared and equitable commitment to partnership working and would welcome the opportunity to work more closely with health commissioners in order to provide a more sustainable and integrated approach to offender health.

- Kirklees CRC also report other issues for their service users accessing healthcare. For example, if they do not have an address they are often told they cannot register with a GP.

6.14.1 Offenders not within the prison population – considerations

- There is a genuine commitment from Kirklees CRC to work more closely with healthcare partners and commissioners. Commissioners could consider opportunities to develop relationships with Kirklees CRC and to use the evaluation and learning from the mental health nurse pilot;

- More generally, a holistic and integrated approach would work best with this group, given their complexity of needs – which go beyond mental health.

- Once offenders leave prison and return to the community to rebuild their lives, councils have an active role to play in their support, particularly if they have a mental health condition or substance misuse issue.

- Further intelligence on Offenders can be found in the Kirklees Joint Strategic Assessment**.**

7. Older People

Supporting people to age well involves local action to: reduce social and emotional isolation; prevent depression, and support mental health and physical health in later life. There has been growing concern about the prevalence of depression in older people; depression affects one in five older people living in a care home.[146] Depression has been linked to dementia and it is estimated that 40% of people living with dementia may have a co-morbid depression.[147] Depression can compound isolation and speed up cognitive decline and it can often go undiagnosed despite the risk exposure to risk factors (bereavement, retirement, loneliness and deteriorating physical health). The identification and treatment of depression amongst older people is important to help older people live with good mental health for as long as possible. Depression should not just be seen as part of the ageing process.

7.1 Prevalence of depression

The POPPI web tool (Projecting Older People Population Information, www.poppi.org.uk) uses national prevalence rates and local population projections (Office for National Statistics, ONS) to estimate the number of people aged 65 and over likely to have various conditions.

Table 7.1: National prevalence rates, split by age and gender, are taken from: McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787-1795.

Age range	% males	% females
65-69	5.8	10.9
70-74	6.9	9.5
75-79	5.9	10.7
80-84	9.7	9.2
85+	5.1	11.1

Applying these prevalence rates to ONS population projections gives the following estimated number of people aged 65 and over predicted to have depression in Kirklees:

[146] Halliwell, E., Main, L., Richardson, C. (2007). Fundamental Facts. Mental Health Foundation: London.
[147] Alzheimer's Society (2015). Depression and anxiety briefing. London: Alzheimer's Society

Table 7.2: Estimated number of people aged 65 and over predicted to have depression in Kirklees

	Year			
	2015	2020	2025	2030
Males aged 65-69	679	626	667	742
Males aged 70-74	559	731	676	731
Males aged 75-79	372	413	543	513
Males aged 80-84	378	475	543	728
Males aged 85 and over	153	189	250	321
Total Males aged 65 and over	2,141	2,435	2,679	3,036
Females aged 65-69	1,341	1,188	1,297	1,450
Females aged 70-74	865	1,093	979	1,074
Females aged 75-79	792	877	1,124	1,006
Females aged 80-84	506	570	644	828
Females aged 85 and over	655	722	866	1,032
Total Females aged 65 and over	4,158	4,450	4,909	5,389
Total aged 65-69	2,020	1,814	1,964	2,192
Total aged 70-74	1,424	1,824	1,655	1,805
Total aged 75-79	1,164	1,290	1,667	1,519
Total aged 80-84	884	1,045	1,187	1,556
Total aged 85 and over	808	911	1,116	1,353
Total aged 65 and over	6,299	6,885	7,588	8,425

The data shows the numbers appear to be increasing as the population increases, whilst Figure 7.1 shows that females are more likely to be living with depression in older age compared with males. There is a downward trend in depression as people age, but this rises again for women aged 85 and over.

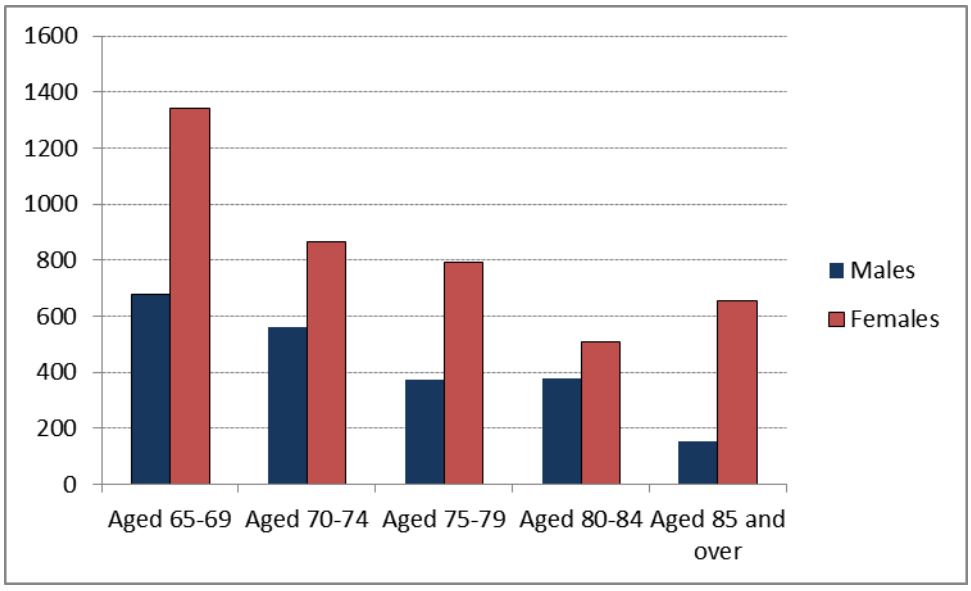


Figure 7.1 Number of older people estimated to have depression in Kirklees, by age and sex (2015)

7.2 Severe Depression

Table 7.3: National prevalence rates, split by age, are taken from: McDougall et al, Prevalence of depression in older people in England and Wales: the MRC CFA Study in Psychological Medicine, 2007, 37, 1787-1795.

Age range	% people
65-69	2.5
70-74	1.6
75-79	3.5
80-84	3
85+	3.9

Applying these prevalence rates to ONS population projections gives the following estimated number of people aged 65 and over predicted to have depression in Kirklees:

Table 7.4: Estimated number of people aged 65 and over predicted to have depression in Kirklees:

	Year			
	2015	2020	2025	2030
Total aged 65-69	600	543	585	653
Total aged 70-74	275	355	322	350
Total aged 75-79	480	532	690	634
Total aged 80-84	282	330	378	495
Total aged 85 and over	343	402	495	608
Total aged 65 and over	1,980	2,161	2,469	2,740

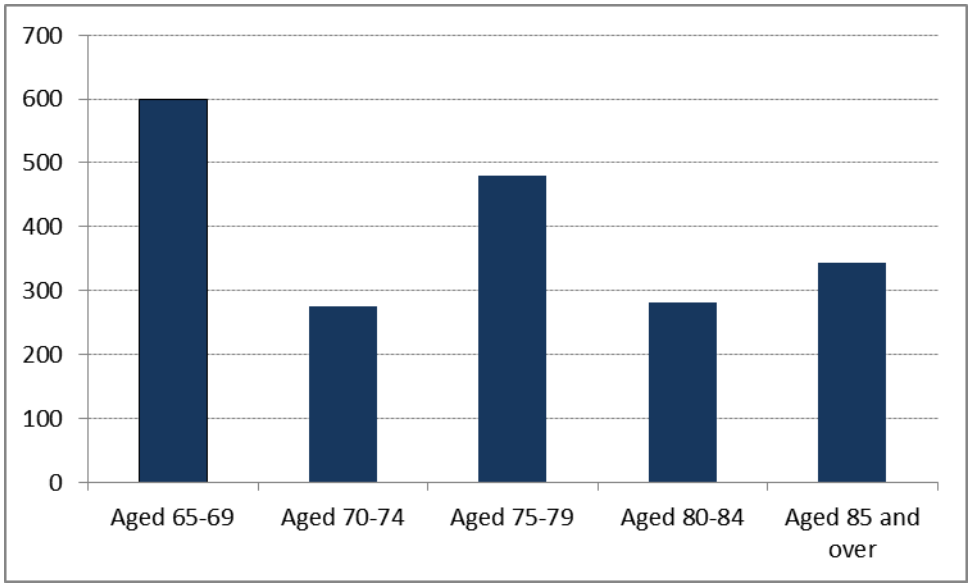


Figure 7.2: Number of older people estimated to have severe depression in Kirklees, by age (2015)

The patterns of those living with severe depression are similar to those living with depression, but there is less of a downward trend with more people aged 75-79 living with severe depression than those aged 70-74.

7.3 Older People - considerations

- Utilise the findings in the Healthy Ageing Director of Public Health 2017 annual report.
- Reduce the stigma associated with mental health conditions in older people to encourage discussion with GPs.
- Involve young people in working with older people to help with valuing and respect of older people, but also to harness a wealth of knowledge and experience.
- Make it easier for older people to volunteer to alleviate mental health conditions and to enable older people to feel valued after retirement (see page 14 of this report).
- Provide Mental Health first Aid Training to enable services in contact with older people to respond to distress.
- Identify older people who are less visible within communities and may be at risk of developing depression.
- Develop peer support programmes for older people as a cost-effective tool for addressing the difficult and widespread challenge of social isolation.

- Make sure that local pathways exist for older people to access stepped care approaches such as Cognitive Behavioural Therapy and Psychotherapy, where data indicates higher recovery rates than those under 65.[148]

- Sign up to the 'Campaign to End Loneliness'

[148] Mental Health Foundation (2011). An Evidence Review of the impact of Participatory Arts on older people. London: MHF

8. Existing Provision of Mental Health Services in Kirklees

8.1 Mapping

The Five Year Forward View for Mental Health recommended a performance framework for all localities to assess the impact of commissioned services against, based on the core elements of the mental health programme:

1. Children and young people's mental health;
2. Perinatal mental health;
3. Adult mental health: common mental health problems;
4. Adult mental health: (i) community, (ii) acute and crisis care;
5. Secure care pathway;
6. Health and justice;
7. Suicide prevention.

Outlined below is an overview of current services commissioned against the 7 key core elements of the mental health programme area:

1. Children and Young People

- Healthy Child Programme including;
    - HCP 12 Month Development Review
    - HCP Integrated 2 – 2 ½ Year Review
    - Early Years Parenting Courses
    - Safety in the Home (SiTH)
    - Peer Educators
    - Family Volunteers
    - HCP 4-5 Year Health and Wellbeing Check-in including National Height, Weight and Measurement Programme (NCMP)
    - Safety Rangers
    - HCP 10-11 Year Health and Well-being Check-In (inc NCMP)
    - HCP 12-13 Year Health and Well-being Check-In
    - HCP 15-16 Health and Wellbeing Check-in
    - Children's Emotional Wellbeing Service (ChEWS) Tiers 2
    - Children and adolescent mental health service (CAMHS) Tiers 3
    - Home-Start Kirklees

2. Perinatal

- Healthy Child Programme (as above)
- General Practice
- Health Centres
- Antenatal units at Mid-Yorkshire Hospital Trust and Calderdale and Huddersfield Foundation Trust

3. Adult mental health: common mental health problems

- Common mental health problems are covered within the Adult community and Adult acute and crisis care services.

4. (i) Adult – Community

- General Practice
- Expert Patient Programme and Looking after me
- Practice activity and leisure scheme (PALS)
- Whitehouse OT
- Cognitive Behavioural Therapy
- Older People Community Mental Health Team
- Adult Community Mental Health Team
- Intensive Home Based Treatment Team
- Health Advocacy
- Mental Health Employment Service
- Social Prescribing
- Safe Places
- Women's Mental Health
- Great Outdoors
- Health Trainers
- Self-help, wellbeing and Recovery
- Creative Arts
- Physical Activity and Mental Health Service
- Carers Options Service
- Changes
- Community Links Alcohol Support Service (CLASS)
- West Yorkshire Finding Independence (WYFI)
- Community Links Engagement and Recovery (CLEAR)
- Community Alarm
- Kirklees Rape and Sexual Abuse Counselling Centre

(ii) Adult - Acute and Crisis Care

- Crisis Service
- Adult acute inpatients
- Psychiatric Intensive Care
- OPS ward 19 (Priestley Unit)
- Assertive Outreach
- Older People Service Assertive Outreach Team
- Older People Service Memory Monitoring
- Admiral Nursing
- Older People Service – Acute Liaison and Care Home Liaison
- Older People Service – Psychology

- Learning Disability
- Mental Health Liaison Team
- Mid-Yorkshire Psychiatric Liaison Service
- Improving Access to Psychological Therapies
- Early Intervention Psychosis
- Attention Deficit and Hyperactivity Disorder
- Adult Psychology
- Eating Disorders
- Single Point of Access Team (includes crisis team)
- Pathways Adult Day Treatment

5. Adult – secure care pathway

- Section 136
- Enfield Down – Rehab

6. Health & Justice

- West Yorkshire Finding Independence (WYFI)
- Mental Health Nurse for Kirklees Community Rehabilitation Company (CRC)
- Richmond Fellowship
- Community Links Engagement and Recovery Service (CLEAR)
- Community Links
- S2R (Support to Recovery)
- Mental Health nurses who work with the police predominantly on evenings and weekends

7. Suicide prevention

- There are currently no services commissioned against suicide prevention.

It is clear from the above service mapping undertaken against the key core elements of the mental health programme in Kirklees that there needs to be a greater emphasis on early intervention and prevention as a key priority.

The above 7 key themes are also incorporated into a public dashboard so that localities and NHS England can monitor progress on its commitments to transform mental health services. Additionally, by making the data publically available, it ensures commissioners, providers, service users, families and carers can use the tool to assess how local services are performing and understand where to look to make informed choices about their care.

8.2 IAPT analysis

Improving Access to Psychological Therapies (IAPT) is an NHS programme that has rolled out services nationally, offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders. In Kirklees, patients can either self-refer to the depression and anxiety service or referred by their GP or a range of other services.

8.2.1 IAPT Kirklees Early implementer pilot - Long Term conditions Care Pathways

By 2020/21 over 1.5 million people with common mental health problems each year will access psychological therapies. People with common mental health problems often also have physical long term conditions such as diabetes or cardiovascular disease. When mental and physical health problems are treated in an integrated way people can achieve better outcomes. Greater Huddersfield and North Kirklees Clinical Commissioning Groups are part of the twenty two Early Implementer projects across the country to lead the way in integrating psychological therapies with physical health care.

Integrated care pathways are being developed with chronic obstructive pulmonary disease, dementia care, cardio vascular disease, diabetes and pain management. Existing links with the providers of support for people with long term conditions will be used to further develop pathways so that the extended service is an integral part of them. The service will be co-located within GP practices and the acute trusts. To support physical health professionals in identifying and referring people who would benefit from the integrated service the team are developing a screening tool.

As part of the IAPT LTC expansion South West Yorkshire Foundation Trust committed to recruiting six trainee Psychological Wellness Practitioners (PWPs) for 2017/18, to be integrated with the pathways outlined above.

Data for the following charts have been taken from the PHE profile for common mental disorders: https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

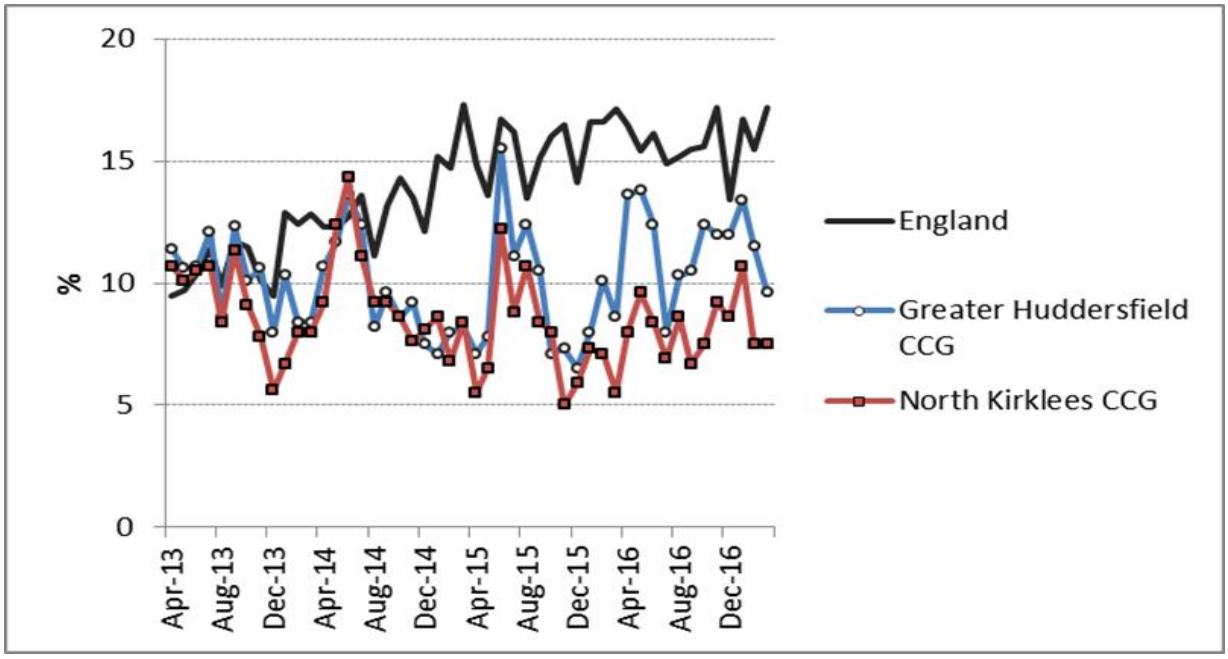


Figure 8.1: Access to IAPT services: people entering IAPT (in month) as % of those estimated to have anxiety/depression
March 2017: Greater Huddersfield = 9.6%; North Kirklees = 7.5%; England = 17.2%

It is noted that in Kirklees the proportion of patient with a diagnosis of anxiety and depression referred to IAPT is lower than the national average. There may be a number of reasons for this including clinician awareness or confidence in the service, local cultural preferences associated with a reluctant to engage with IAPT or data veracity.

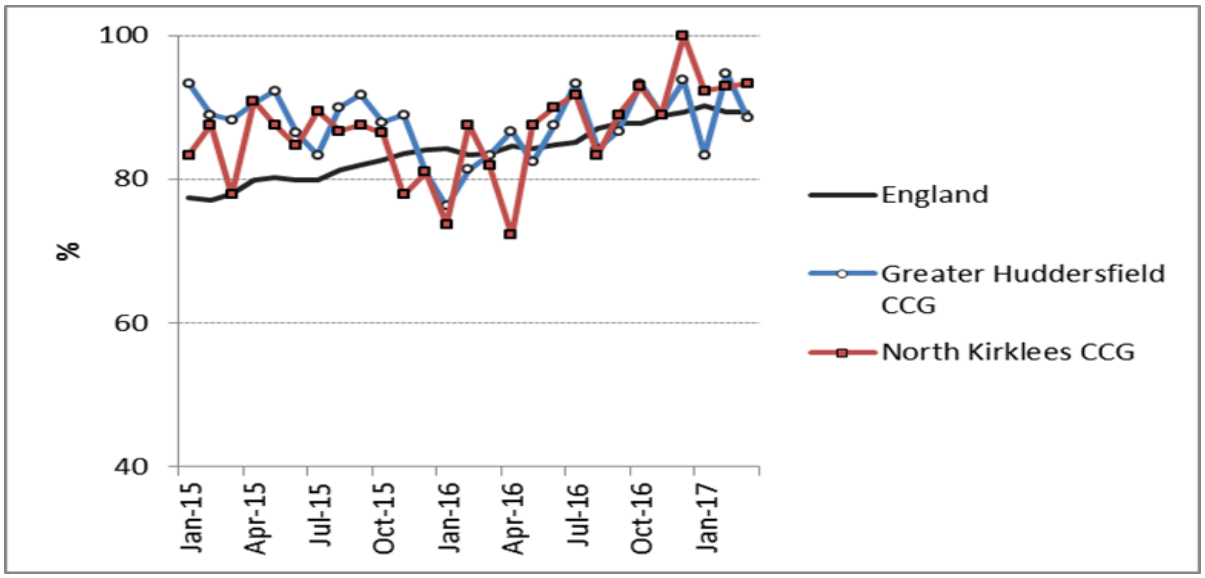


Figure 8.2: Waiting < 6 weeks for IAPT treatment (standard measure): % of referrals that have finished course of treatment waiting <6 weeks for first treatment
March 2017: Greater Huddersfield = 88.5%; North Kirklees = 93.3%; England = 89.4%

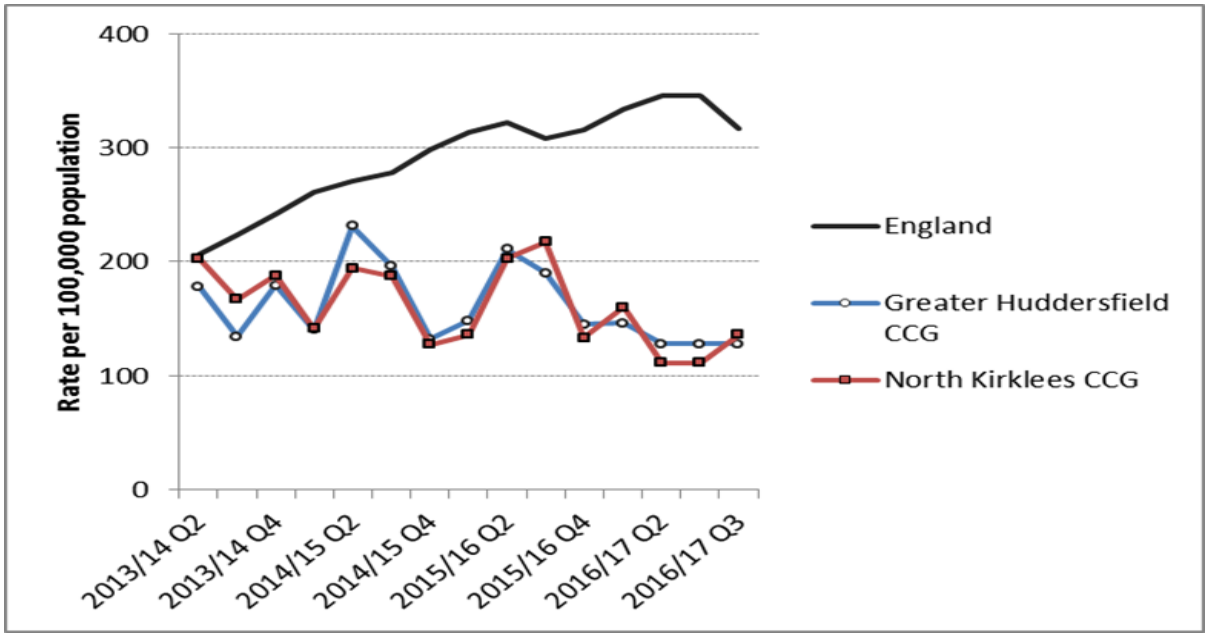


Figure 8.3: Completion of IAPT treatment: rate (quarterly) per 100,000 population aged 18+Proportion of people who complete treatment who are moving to recovery Q3 2016/17: Greater Huddersfield = 128; North Kirklees = 136; England = 317 per 100,000 population

The number of people completing IAPT in terms of per 100 000 population seems to be less than half the national rate. This is concerning but for further interpretation it would be useful to see the completion rates as a percentage of those referred. There may be a number of possible reasons including expectations formed during consultations with clinical, content and style of the service and factors peculiar to the local population.

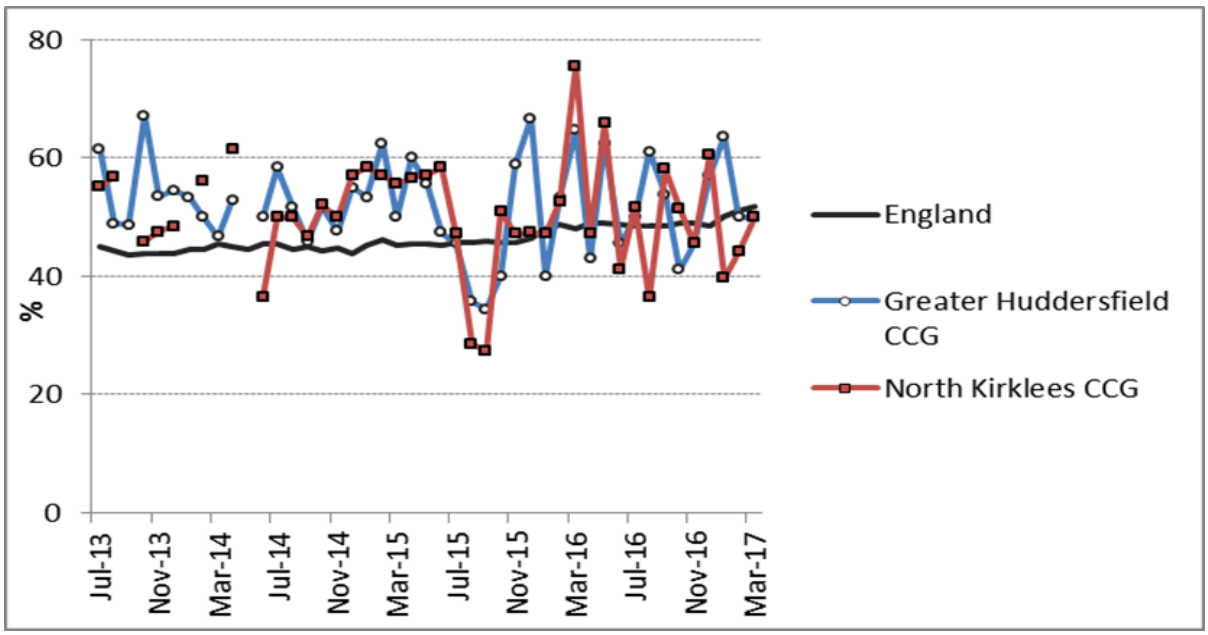


Figure 8.4: IAPT recovery: % of people (in month) who have completed IAPT treatment who are "moving to recovery"
March 2017: Greater Huddersfield = 50.0%; North Kirklees = 50.0%; England = 51.7%

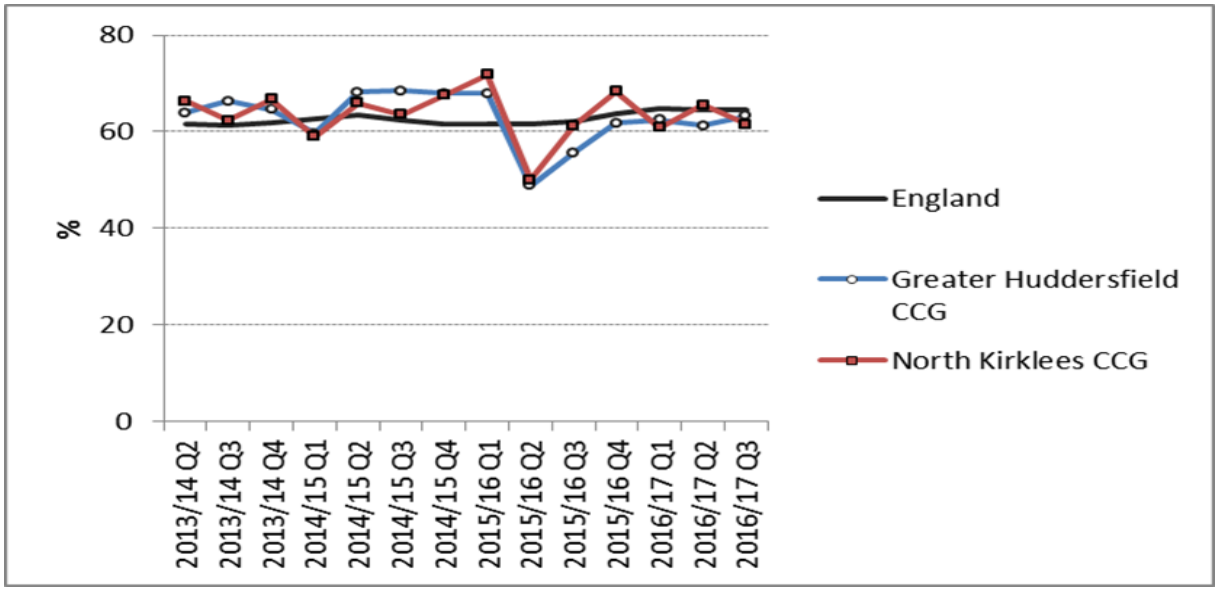


Figure 8.4: IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement"
Q3 2016/17: Greater Huddersfield = 63.3%; North Kirklees = 61.5%; England = 64.6%

8.2.3 IAPT – considerations:

- The early implementer LTC pilot is working with acute trusts and a small number of GP practices within Kirklees. Explore opportunities to widen the service to more GP practices.

- Review data from the long term conditions teams within the acute trusts to see if there is a possibility to strengthen the integrated approach.

- Ensure that pathways and access to Psychological therapy is timely

9. Conclusion

This mental health needs assessment outlines the main factors impacting on and protecting mental health in Kirklees. It provides the evidence base behind a life course approach to improving our emotional health and wellbeing as well as the behaviours and actions that can improve how we feel.

It is clear that mental health and approaches to tackling mental ill health is complex. Our response to improving mental health across Kirklees should reflect the complexities of mental health need across the life course and take a holistic and person led approach.

Mental health needs to be improved by increasing the resilience of our families and communities. Social arrangements and institutions such as education, social care and work have a huge impact and should be used as settings to improve the mental health and wellbeing of the general population.

Risk factors for many common mental health conditions are heavily associated with social inequalities. The report highlights vulnerable groups who are more at risk of developing mental health conditions and what should be done to improve their mental health outcomes.

Services should ensure there are clear access and pathways in place and that there is as much integration and partnership working as possible between organisations.

A partnership group should be established to take forward the actions and implications highlighted in this report including a systemic sign up across partners.

10. What works/recommendations

For all:

- Create supportive environments that support the five ways to wellbeing. This requires targeting outwards from the home and where people live, to education and work settings, to the physical environment and finally to the overarching socio-economic conditions. Engagement with community members should be central to this, which empowers them in decision making and has been shown to increase resilience.[149]

- Increase access to positive activities such as social prescribing, learning and skills and social networks. These activities help to build social support and connections and improve resilience.

- Early intervention and prevention. Anecdotal feedback shows that many providers felt that access to mental health support came too late or as a result of a crisis. As identified in the 5 year forward view, prevention is vital to achieving lasting change. [150] Ensuring that people are able to access appropriate support at the earliest opportunity will help to avoid escalation, personal distress and crisis management. Every commissioner or provider should do more to help people access mental health support earlier, throughout the life course and in a range of settings including school, housing, work and communities.

- Felt and expressed needs. There appear to be some gaps in the collection and application of the felt and expressed needs of people with lived experience. Whilst this may be gathered by individual services, it is unclear if this is being collected centrally and shared more broadly and formally across Kirklees partners. The felt and expressed needs of people with lived experience of mental health should be gathered centrally, regularly and shared with partners.

- Intelligence based decision making. Decision making should be informed using the qualitative and quantitative local data in this report and national intelligence, accessible here.

- Pathways and access. Pathways and access to current and future mental health support need to be clear for organisations and service users in Kirklees. Anecdotal feedback on accessing mental health services is that access to support is often perceived as complex and confusing. Commissioners and providers should work together with service users to establish and clarify clear access and pathways. There are also geographical discrepancies across Kirklees in relation to certain services so

[149] Wallerstein, N. (2006). What is the evidence on effectiveness of empowerment to improve health? Copenhagen: WHO Regional Office for Europe.
[150] The Five Year Forward View for Mental Health; A report from the independent Mental Health Taskforce to the NHS in England; February 2016.

onward support and positive recovery should be encouraged when care has not been close to home.

- Communication. It should be made easier for the general population to see what is available locally to help them stay emotionally well. This could be through the development of a mental health website for Kirklees for example.

- Third sector organisations and community development. The voluntary and community sector in Kirklees is an asset and anecdotal feedback shows that the voluntary and community sector is a vital source of mental health support. Commissioners and statutory organisations should ensure that they work closely with the third sector as well as community groups and alliances of people in order to provide co-ordinated and clear support.

- Holistic practice and support. This review shows that mental health will often co-exist with other physical, social or environmental issues. It is vital that mental health is not treated as a separate issue to other co-existing challenges and that practice and support takes into account the psycho-social determinants of health.

- Outcomes. Commissioners and providers of mental health services should work collaboratively to develop holistic person centred outcomes, rather than treatment or issue specific outcomes.

- Reduce mental health stigma and breaking down barriers. Support organisations within Kirklees to sign up to Time to Change and establish Mental Health Champions or informal networks of support in each community. This supports recommendation 12 of the five year forward view. All employers should address the physical, environmental and psychosocial factors influencing mental health. Employers should refer to https://www.nice.org.uk/guidance/qs147 for more information.

- Workforce development – mental health first aid. As a minimum, anyone that comes into contact with the public should be trained in mental health first aid in order to improve parity of esteem and to ensure holistic working.

- Support for all. Anecdotal evidence has shown that there are cohorts of people whose mental health needs are too complex for IAPT but not severe enough for acute mental health services. This means that there appear to be gaps in provision which is leading to people 'falling through the net'. Commissioners and providers should work together with service users to identify systems and approaches which meet the needs of all those with mental health needs.

- Integration and Partnerships. A multidisciplinary and inter-sectoral approach must be adopted as no one discipline has all the knowledge or power to affect the required level of change. Partnership working should be initiated and embedded between organisations. Anecdotal evidence from Kirklees shows that mental health interventions work well through a 'hub and spoke' model, whereby specialist mental

health support is integrated within the organisations and the communities where it is most needed.

- To tackle health inequalities, all service providers and commissioners should consider the promotion of mental health within their business planning processes and subsequent actions plans/specifications. This should include assessing whether service specifications are considering the social determinants of mental health. Equality impact assessments should be considered to help with this.

- Practitioners should support patients to help themselves and reinforce the message that recovery is possible, and that they can regain employment and social networks. This is particularly important for people who have been out of work for some time. Recovery is not simply about a reduction in, or removal of, symptoms; it is about communicating hope and restoring opportunity to patients.

- Workforce development. Investing in the workforce so it can help improve health and wellbeing across the whole population as well as for those with mental illness is a key priority. The ability of the broader public health workforce to recognise and address mental health and physical health equally and holistically is key to stopping this, and to achieving 'parity of esteem'. See here for the Public Mental Health Leadership and Workforce Development Framework.

For commissioners:

- Commissioners should ensure that people with lived experience of mental health are involved throughout the entire process of any programme of change. Refer to recent guidance Progress through partnership: involvement of people with lived experience of mental illness in CCG commissioning.

- Commission mental health across the life course and not just for those who are already accessing services. Commissioners should focus on upstream interventions in order to prevent crisis and escalation.

- For any service that supports people with their physical health, integrate support for emotional health and wellbeing within the pathway of care. By allowing psychological and physical needs to be fully addressed, services are more able to respond to a patient's needs.

- Consider an integrated hub and spoke model for commissioned services to help prevent people 'falling through the net' between organisations and to ensure an integrated and holistic approach to support and recovery.

- Commission models of primary care that address poor access amongst particular groups who have increased need for mental health support.

- Services should be commissioned and provided on the basis of need and the estimated prevalence of mental health problems.

- When commissioning or reviewing services, commissioners should use the RightCare Commissioning for Value Dementia and Mental Health Pack to understand how their CCG compares to other similar CCG's and the England average. This might help to understand where there are gaps in access or provision or where service uptake is poor. Interpreting this data should be done alongside local intelligence and awareness of local issues.

For Local Government:

- There should be opportunities for older people in their community to meet and interact. The local transport structure should support this connectivity to reduce social isolation in this group.

- People experiencing mental health issues are supported to retain employment, where they can, by their employer and local public services. The local authority should work to support local business to achieve this through their commissioning, influencing and promotion of national services.

- Work towards supporting communities to have access to and use safe local green space of good quality where people can socialise, exercise, walk and reflect.

- The local authority should work with developers to ensure that new developments create an environment which supports healthy, active and safe communities. New developments should take into account mental wellness and suicide prevention. This should be done by considering issues such as access to daylight, street lighting, green and blue spaces and building design.

- Enable people in public and high profile appointments to share stories of mental health experiences. Recruit a Member of the local council to act as a Mental Health Champion, who will use their role to regularly support and promote mental wellbeing in Kirklees.

For voluntary sector:

- The wider community and the voluntary sector are key community assets. They should be enabled to work closely with Local Government and to incorporate their work into local mental health strategies and wellbeing plans.

For Secondary Care/ Community Rehabilitation

- Support in the community after discharge from hospital/mental health care/prison/IAPT. Service users should be supported during their transition into the community and transitions should be planned, timely and person centred. Positive recovery should be an integral part of discharge

For service providers:

- Front line providers to offer an equitable service, with proportionate access based on intelligence of population needs.

- Ensure that equalities monitoring is improved to allow for greater transparency about access, quality and outcomes for various vulnerable groups - particularly those people that share protected characteristics as per the Equality Act 2010.

- Any service provider working with people with mental health conditions should have their staff trained in Smoking Cessation: Very Brief Advice and Core Competencies in helping people stop smoking. They should identify key staff to be trained to become an Intermediate Advisor. There are additional training courses available through National Centre for Smoking Cessation and Training (NCSCT) focused on smoking cessation for mental health. http://www.ncsct.co.uk/

Appendices

Appendix A – adapted from 2017/18 and 2018/19 National Tariff Payment System, Annex C: Technical Guidance for mental health clusters.
https://improvement.nhs.uk/uploads/documents/Annex_C_-_Mental_Health_Clustering_bookletl.pdf

Primary Care Psychology Services

People in clusters 1 - 3 have a common mental health problem such as anxiety and depression or post-traumatic stress disorder which is assessed as being low to moderate.

A person in Cluster 1 might receive low intensity psychological interventions such as group therapy or self-guided materials, along with lifestyle and physical health advice. People in Clusters 2 and 3 might receive similar interventions to people in Cluster 1, but in addition they might also receive individual therapy sessions depending on their level of need. In Cluster 3 the interventions could include counselling and Cognitive Behavioural Therapy (CBT) therapy. There might also be a requirement for medication for a person in Cluster 3.

The services for people in Cluster 1 would probably be provided by GPs or by voluntary sector organisations without a formal GP referral. The services for people in Clusters 2 and 3 would normally be provided by Improving Access to Psychology Treatment (IAPT) services which could be accessed by self- referral or a GP referral to the Single Point of Access. Medication would be prescribed by the person's GP.

Serious Mental Illness - Non-Psychotic

People in clusters 4 – 8 have more complex and severe needs with significant risks. People in these clusters do not suffer from psychosis.

A person in cluster 4 might have severe depression and anxiety and may experience disruption to functioning in everyday life. A person in this cluster would receive care coordination, high intensity psychological interventions as well as lifestyle and physical health support.

People in clusters 5, 6, 7 and 8 have more complex difficulties, including very severe and/or enduring anxiety and depression, over valued ideas, personality disorders and chaotic and challenging behaviour. People in these clusters would receive similar types of intervention to people in Cluster 4; however, people in these clusters would also require the Intensive Home Based Treatment Team (IHBTT) and inpatient services.

The services for people in clusters 4-8 are provided in secondary care mental health services following a referral to the Single Point of Access.

First Episode Psychosis

A person in Cluster 10 will have experienced a first episode of psychosis and would be in the age range of 14 to 65.

A person in Cluster 10 would receive treatment from the Early Intervention in Psychosis (EIP) team. For children and young people under the age of 18 the Child and Adolescent Mental Health team would work with the EIP team to provide holistic care.

The treatment is multi-disciplinary and provided for a period of 3 years. Treatment includes CBT for psychosis therapy, family interventions, support to work or attend college and support to maintain or improve physical health. A person in Cluster 10 would also be offered medication.

The EIP team also provides services for people who are classified as having an "at risk mental state" (ARMS). People who are referred for ARMS services receive 12 sessions of treatment including CBT therapy and are monitored following treatment for up to 2 years. The aim of the treatment is to prevent escalation to psychosis.

The EIP service is a secondary care mental health service. Access to the service is by referral to the Single Point of Access or directly to the EIP team.

Serious Mental Illness - Psychosis

People in clusters 11-17 have recurrent psychosis, psychotic depression or have a dual diagnosis of psychosis and substance misuse. People in these clusters may have low symptoms or may suffer with high symptoms/disability and have high risks.

A person in cluster 11 has recurrent psychosis with low symptoms. Support is provided by the Community Mental Health team.

People in clusters 12-17 have high symptoms and/or disability. People in these clusters would be supported by the community mental health team, but might also benefit from rehabilitation and recovery services, IHBTT and inpatient services. People who have a dual diagnosis may also receive substance misuse and psychology services. People with affective disorder psychosis will also receive psychology services.

The services for people in clusters 11-17 are provided in secondary care mental health services following a referral to the Single Point of Access.

Appendix B

Factsheet No 1 - May 2017

1. What is the Integrated Wellness Model?

The context for the work is set by Professor Sir Michael Marmot's review, *Fair Society, Healthy Lives* (2010). The review emphasised that individual health behaviour is increasingly understood within the context of social, economic, cultural and environmental influences.

Integrated Wellness models aim to develop an integrated Health Improvement approach for adults; to help people build their capacity to maintain good health and be independent. Wellness is defined as a proactive, preventive approach that emphasises the whole person and which works to achieve optimum levels of physical, mental, social and emotional health. Integrated Wellness models are increasingly being commissioned in other areas of the country and aim to integrate a range of systems, interventions and services in order to improve health and wellbeing.

2. How does this fit with both Kirklees Council Early Intervention and Prevention and the Sustainability and Transformation Plan?

The Wellness Model will support the aims of New Council to empower people to live their lives to the fullest possible potential by enabling people to increase control over their lives. It will work systemically with the EIP programme, especially Community Plus to create supportive environments.
It will support the aims of the West Yorkshire and Harrogate STP and our local Kirklees Health and Wellbeing Plan by reducing demand on health and social care services.

3. Our vision

People in Kirklees will live longer, healthier, happier lives and feel more able to look after themselves and others.

4. What do we want to achieve?

We want to bring together organisations, people and services to develop a shared approach, using a 'strengths based' mind-set that acknowledges and builds upon the strengths, skills and capacities of people to live healthy lives alongside the assets within the local community. The aims are:

- Improved health and wellbeing
- Early access to preventative interventions
- People feel more able to do more for themselves and each other
- Increased healthy behaviours; more people active, improved diets, and reduced smoking
- Strengthened resilience and emotional well-being

- People feel supported to manage their health conditions
- Early intervention and prevention of ill health, long term conditions, disability, early death
- Reduced demand on the health and social care system

5. Commissioning services

Good nutrition, healthy weight, exercise, increased resilience, active social networks and avoiding risk factors such as tobacco use and alcohol misuse, all play a role in wellness. Many of the current services focus on single issues, e.g. weight management, smoking cessation etc. Increasingly, evidence shows the relationship between physical activity, emotional health and wellbeing and long term conditions. Our Wellness Model will go beyond looking at single-issue healthy lifestyle services and a focus on illness, instead taking a whole-person and community approach to improving health. In particular, it will support individuals to find solutions to things which determine their health.

6. The commissioning plan

To design and commission a Wellness Model to improve outcomes for adults in Kirklees. The services that are currently delivering elements of adult wellness include:

- Smoking cessation support from primary care
- NHS Health Checks
- Kirklees Health Trainers
- Kirklees Practice Activity and Leisure Scheme (PALS)
- The Expert Patients Programme (EPP) and Looking After Me (LAM)
- Weight Management service

7. Key design focus

The Kirklees Integrated Wellness Model will focus on:

- Promoting positive health that can empower individuals, enabling them to maintain and improve their own health
- Promoting relationship-based approaches
- Facilitating access to a supportive environment, information, life skills and opportunities for making healthy choices
- Enabling people to have more control of those things which determine their health
- Providing, safe, enjoyable means to boost physical and mental health
- Working in conjunction with traditional medical services
- Where necessary, facilitating lifestyle adjustments to enable individuals to gain wellness
- Promoting quality of life, not just length of life
- Embedding behaviour change approaches that utilise the most effective behaviour change techniques tailored to each individual – person-centred, motivational, enabling

- Considering the whole person: mind, body and spirit and the wider determinants of health including social, economic, environment, and cultural factors
- Providing easy access to advice and help from a range of sources
- Reducing inequalities – proportionate help according to need and available assets. Also actively seeking out those individuals that do not usually benefit from mainstream health services

8. Timescales

- Stakeholder engagement event Feb 2017
- Generation of public insight via research company - completed June 2017
- Commissioning model/route to market finalised by Aug 2017
- Stakeholder engagement ongoing throughout development and implementation
- Service specification complete Aug - Dec 2017
- Service implementation 2018

9. Need more information?

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Appendix C

The CLiK Survey 2016 - www.kirklees.gov.uk/clik2016