Southend, Essex and Thurrock Mental Health and Wellbeing Strategy

2017- 2021

MER SET V3a Draft (w/b 31 October)

MER V3a DRAFT

Contents

Glossary iv
1 Introduction 1
1.1 Our Vision 1
1.2 Our challenge – Setting the Context 3
1.2.1 Mental health matters: the evidence 3
1.2.2 Policy context – opportunities and challenges 7
1.2.3 Our approach 8
1.3 Our Outcomes 10
1.3.1 Health outcomes 10
1.3.2 Good places to live 12
1.3.3 Meaningful things to do 12
1.3.4 The means on which to live 13
1.3.5 Strong and sustainable support networks 13
1.3.6 Supporting delivery 13
2. Messages from Consultation 14
2.1 Adult mental health in SET – An independent review 14
2.2 The voice of experts by experience 15
2.3 The voice of clinicians 17
3. Getting the foundations right 19
3.1 Key challenges 19
3.2 Responding to financial challenges 21
3.3. Evidence, engagement and empowerment 22
3.3.1 Evidence – data and intelligence 22
3.3.2 Engagement and co-production 23
3.3.3. Empowerment – Personal Budgets 24
3.4 Making the connections 25
3.4.1 Drugs, alcohol and multiple needs 25
3.4.2 Domestic abuse 26
3.4.3 Childhood sexual abuse 27
3.4.4 Targeting inequalities 28
4. Children and young people's mental health 30
4.1 The bedrock for mental health and wellbeing 30

MER V3a DRAFT

4.2 Supporting transition with seamless services 32
5. Perinatal mental health 34
6. Adult mental health: common mental health problems and primary care mental health 39
6.1 Public Mental Health 39
6.2 Improving access to psychological therapies 40
6.3 Provision of mental health services in a primary care setting 42
7. Adult mental health: community, acute and crisis care 44
7.1 Crisis Care 45
7.1.1 Community mental health services 45
7.1.2 Crisis Care services 45
7.1.3 Personality Disorder and complex needs 48
7.1.3 Use of inpatient provision 50
7.2 Recovery and reintegration 51
7.2.1 Focusing on recovery 51
7.2.2 Families and carers 53
7.2.2 Developing the accommodation pathway 55
7.2.3 Supporting people into and in work 57
8 Health and Justice 59
8.1 Background 59
8.2 Reducing re-offending 61
8.3 The challenge for Southend, Essex and Thurrock 62
8.4 Improving outcomes 63
9. Suicide prevention 65
9.1 Southend, Essex and Thurrock Suicide Prevention strategy and 2014/15 suicide audit 65
9.2 Who is most at risk of suicide? 66
9.3 Strategic priorities for suicide prevention in Southend, Essex and Thurrock 68
9.3.1 Reduce the risk of suicide in key high-risk groups. 68
9.3.2 Tailor approaches to improve mental health and wellbeing 69
9.3.3 Reduce access to the means of suicide 70
9.3.4 Provide better information and support to those bereaved or affected by suicide 71

MER V3a DRAFT

9.3.5 Support the media on sensitive approaches to suicide and suicidal behaviour 71
9.3.6 Support research, data collection and monitoring 71
10. Sustaining transformation: testing new approaches 73
10.1 Making best use of research and innovation 73
10.1.1 Overview 73
10.1.2 New Models of Care 74
10.1.3 Expanding Access to Digital Services 76
10.1.4 A System-Wide Focus on Quality Improvement 77
10.2 A focus on outcomes 77
10.2.1 Use evidence based information to achieve outcomes 78
10.2.2. Use data to check that outcomes are being achieved 78
10.3 Local innovation 80
11. Sustaining transformation: a healthy NHS workforce 81
12. Sustaining transformation: infrastructure and hard-wiring 83
12.1 Background and issues 83
12.2 National response and Greater Essex actions 84
12.3 Local data concerns 85
References and Resources i

MER V3a DRAFT

Glossary

Accommodation Pathway. A structured approach to meeting accommodation needs for people with mental health issues in Essex, stepping down from inpatient provision to independent community based accommodation.

Acute Care. Treatment for acute or severe mental illness, which may include care as an inpatient in hospital or intensive support in the community.

Approved Mental Health Professional (AMHP). Professional trained to make assessments under the Mental Health Act 1983 to determine whether or not someone should be detained under the Act, and if so to apply for the 'section'.

Care Act 2014. Replaced most previous law regarding carers and people being cared for. It sets out the duties of local authorities, including carers and need assessments, eligibility for support and charging for residential and community care.

Care Pathways. Set out a process or best practice to be followed in providing treatment, care and support for a patient or client with a particular condition.

Clinical Commissioning Group (CCG). CCGs are the clinically-led statutory bodies with responsibility for planning and commissioning health and mental health services in their local area. There are seven CCGs in greater Essex.

Community mental health team (CMHT). Multidisciplinary team that provides specialist mental health support and outreach in the community. CMHTs can include psychiatrists, psychologists, community psychiatric nurses, social workers, occupational therapists and other specialists.

Comorbidity. Two or more medical conditions occurring simultaneously, for example learning difficulties and mental illness and substance abuse and mental illness (see also 'dual diagnosis').

Commissioning. The process of getting the best achievable health outcomes for the local population, based on assessing local needs, identifying priorities, purchasing services from providers (e.g. hospitals, clinics, community sector organisations) and

MER V3a DRAFT

monitoring performance. Commissioners are professionals with the responsibility for the commissioning process.

Community Psychiatric Nurse (CPN). Psychiatric nurse based in the community rather than a psychiatric hospital.

Co-production. The New Economics Foundation defines co-production as an approach to designing and delivering public services through 'an equal and reciprocal relationship between professionals, people using services, their families and neighbours'.

Core 24 Standard. Standard requiring NHS care to be available 24/7. At present only half of England offers a 24/7 community based mental health crisis services and only a minority of A&E departments have 24/7 community liaison services.

Crisis Care Concordat. National and local agreements between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis

Crisis Response Home Treatment Teams (CRHT). Teams of specialists who provide support in the community for people experiencing a mental health crisis, and try to prevent them from having to go into hospital.

Dual diagnosis. Used to describe a combination of mental health and drug and alcohol problems, which raises specific issues for the delivery of effective care and support.

Essex Safeguarding Adults Board (ESAB). Statutory Board responsible for oversight of safeguarding arrangements for adults in Essex, and protecting the right of adult's to live in safety and free from abuse and neglect.

Essex Safeguarding Children's Board (ESCB). Statutory Board responsible for oversight of safeguarding arrangements for children in Essex.

Essex Mental Health and Wellbeing Service (EMHWS), formerly CAMHS. New service for children and young people across Southend, Essex and Thurrock,

MER V3a DRAFT

launched on 1 November 2015, overseen by a joint commissioning group of three local authorities and seven CCGs and delivered by the NELFT foundation trust.

First episode of psychosis services. Multidisciplinary community mental health services that provide treatment and support to people experiencing a first episode of psychosis or at a high risk of developing psychosis.

Five Year Forward View for Mental Health. This report from the Independent Mental Health Taskforce to the NHS in England, published in February 2016, reviews current mental health provision and future challenges and sets out priority actions for the NHS and other partner to 2020-21 in 58 recommendations.

Implementing the Five Year Forward View for Mental Health. Sets out a blueprint for delivery of the Five Year Forward View, including year on year milestones for delivering the objectives by 2020-21 and funding, investment and savings figures.

Future in Mind. A report on promoting, protecting and improving children and young people's mental health and well-being published in 2015 and setting out the recommendations of a task force co-chaired by NHS England and the Department of Health. Funding has since been provided by government to support implementation. Essex has published its Future in Mind transition plan (Open Up, Reach Out), which will be reviewed annually.

Health and Social Care information centre. Based at NHS digital, providing data and analysis of health and social care issues, including mental health.

Individual Placement and Support (IPS). Employment support for people experiencing and/or in recovery from mental health problems. It aims to get people into competitive employment quickly, provides individualised support for the person and employer and brings employment experts into clinical teams.

Integration. NHSE – drawing on the work of the National Collaboration for Integrated Care and Support – explains that for health, care and support to be "integrated" it must be 'person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family … moving away from episodic care to a more holistic approach … that puts the needs and experience of people at the centre of how services are organised and delivered.'

MER V3a DRAFT

Integrated Support, Advice, Recovery and Mentoring Service (ISARMs). Service to be launched by ECC in 2016, which will support communities in Essex to develop and co-produce solutions to social inclusion and recovery for people with mental health and /or substance misuse problems.

Intensive enablement. Community based accommodation which people can receive for up to 18 months as an alternative to hospital or residential care, to prepare them for more independent community living, which can include help to manage medication and living skills, such as cooking and managing a budget.

Improving Access to Psychological Therapies (IAPT). Programme that has expanded access to psychological therapies (particularly cognitive behavioural therapy), with a particular focus on the treatment of anxiety and depression.

Joint Health and Wellbeing Strategy (JHWS). Produced by Health and Wellbeing Boards, these are strategies for meeting the needs identified in Joint Strategic Needs Assessments.

Joint Work and Health Unit. Set up by the 2015 Autumn Spending Review with a £115 million budget, the Joint Work and Health Unit was tasked with putting one million more disabled people into work, including people with mental health issues.

Joint Strategic Need Assessment (JSNA). Document setting out the needs within the local population, produced by Health and Wellbeing Boards.

Local Authority Mental Health Challenge. Challenge set up by seven mental health charities to encourage and support councils to prioritise mental health in their local areas, including through councillors acting as ‘mental health champions’.

Mental Health Act. The Mental Health Act 1983 sets out the conditions under which someone can be detained and treated in hospital against their wishes, also known as being ‘sectioned’.

Mental health ambassadors. Ambassadors recruited through HealthWatch Essex to help ensure that the voice and lived experience of service users, carers and the wider community inform the development and implementation of the mental health strategy.

MER V3a DRAFT

Mental health crisis. The mental health charity Mind describes a crisis as a point where someone's mind 'is at melting point', they 'can't carry on anymore' and where there may be an immediate risk of self harm or suicide, often involving extreme anxiety, having a panic attack or even a psychotic episode.

Mental health services data set (MHSDS). Provides comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with mental health services.

Multiple Needs/Complex Needs. Used to describe people with a combination of several problems at the same time, which may include mental ill health, drug and alcohol misuse, homelessness, offending and family breakdown. People with multiple and complex needs can find it difficult to access appropriate services.

NHS England. Leads the NHS in England, setting priorities and direction.

Mental Health Crisis Care Concordat. This is a national agreement between key organisations and agencies involved in the care and support of people experiencing a mental health crisis, with the aim of ensuring that a mental health crisis is treated with the same urgency as a physical health emergency.

Mental health social worker. Trained social worker who specialises in work with people experiencing or in recovery from mental illness, working in multi-disciplinary teams they may have a particular focus on supporting people with issues like debt, housing, relationships and unemployment.

Morbidity. A diseased state, disability, or poor health.

Parity of Esteem. A concept which emphasises equal status, and specifically that mental health should be regarded as equal to physical health in terms of importance, focus, funding, etc.

Peri-natal. Relating to the time immediately before and after birth, usually a number of weeks.

Personal Budget. An amount allocated to meet eligible care needs, intended to give the service user greater control over their care and support.

MER V3a DRAFT

Personal Health Budget. A personal budget for identified health and well-being needs.

Personality Disorders. The NHS defines personality disorders as conditions in which where an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

Police and Crime Plan. The Police and Crime Plan sets out the Police and Crime Commissioners vision and priorities for policing and safety.

Prevalence. Extent of a condition or disease within a given population; proportion who currently have that condition or disease.

Primary care. Health services in the community that provide people with a first point of contact and principal point of continuing care; treatment and care led by GPs.

Recovery College. A 'college' providing education and training to people experiencing and/or in recovery from mental health problems to manage their own conditions and live independently. Skills training is often peer-led.

Secondary care. Specialist health and mental health services (e.g. services provided by Community Mental Health Teams and inpatient hospitals).

Section 136. Under s.136 of the Mental Health Act police can take someone to a 'place of safety' for assessment for possible detention under the MHA, where the person is in a public place, and appears to have a mental illness and to be in need of care. The 'place of safety' can be a hospital or a police station.

Self-directed support. An approach giving service users more control over how their care needs are met, commonly involving personal budgets for care and support.

Success Regime. The success regime is supporting the NHS Five Year Forward View by concentrating on areas where there are deep rooted and systemic pressures, and where there are issues with management of financial deficits and/or service quality. The Essex Success Regime in Mid and South Essex is one of the three programmes across England.

Supported housing. Housing with additional support to help people with mental health problems to live independently. Supported housing can range from receiving

MER V3a DRAFT

help with things like budgeting and accessing services in your own home ('floating support') to a communal setting with resident support workers and/or therapists.

Sustainability and Transformation Plans (STPs). Every health and care system in England is required to produce a plan showing how local services will evolve and become sustainable over the next five years and deliver the Five Year Forward View for the NHS. The three Essex STP 'footprints' are: Mid and South Essex, North Essex and Suffolk and West Essex and Hertfordshire.

Transition support. Support where people move between services or leave services, often used to describe support for young adults moving from children and young people's to adult services.

Time to Change. Anti-stigma initiative led by Mind and Rethink and funded by the Department of Health, Comic Relief and Big Lottery Fund, it has created and supported a movement of people to change how we think about mental health.

DRAFT

Mental health services not covered by this Strategy

This strategy is concerned with mental health and related services where they are commissioned by Local Authorities, CCGs and other local partners (e.g. Police and Crime Commissioners). It does not cover:

Prison mental health and substance misuse services in so far as these are nationally commissioned by NHS England and the Ministry of Justice;

Secure psychiatric services commissioned by NHS England;

Other services nationally commissioned by NHS England, particularly:

- Services for serving members of the armed forces and their families;
- Mental health interventions under GP contract;
- Some specialised mental health services (e.g. some eating disorder services, treatment for deaf people and post-traumatic stress disorder services for armed forces veterans).

Difficulties may arise as individuals transfer both within such services and between services commissioned locally.

1 Introduction

1.1 Our Vision

This strategy is guided by a vision for mental health in Southend, Essex and Thurrock (Greater Essex); it is informed by the national prospectus set out in NHS England's Five Year Forward View for Mental Health, and explains how we will set about deliver the implementation plan in our county. It is primarily concerned with adult mental health. It sits alongside Greater Essex's Future in Mind strategy for children and young people's services, *Open up, Reach Out*, and Greater Essex's dementia strategy, which will be publishing later in 2017, to form a new and comprehensive, all—age ambition for mental health and emotional well-being in our county.

We will put mental health at the heart of all policy and services in Greater Essex, work with our communities to build resilience and emotional well-being, and ensure that anyone with a mental health need Southend, Essex and Thurrock can access the right service at the right time and delivered to the highest professional standards. We will have a strong focus on prevention, early intervention, resilience and recovery, as we believe a fundamental shift in focus is key to improving mental health and well-being in Southend, Essex and Thurrock while delivering a responsive, effective and sustainable mental health system. To develop and deliver our vision we will draw on the best available evidence, the latest innovations and the insights of people affected by mental health problems, empowering individuals and families to have more control of their lives, and supporting communities to support well-being and build resilience. We will also continue to play our part in ending mental health stigma and promoting social inclusion and social justice for all those whose lives are affected by mental illness.

There also needs to be greater recognition of the contribution made by families and carers, and the need – highlighted by the Care Act 2014 – to provide support for carers and families in their own right as well as to enable them to better support their loved ones.

MER V3 DRAFT

This strategy responds to and builds on the recommendations of an independent review of adult mental health services across Greater Essex, conducted by Boston Consulting Group in 2015. A key recommendation was that partners across Essex should come together to articulate a common vision and ambition for mental health and wellbeing, develop a shared language, agree shared outcomes and share data and information. It has also been informed by the first Essex Joint Strategic Needs Assessment (JSNA) for Mental Health, which was produced in 2016 and brings together data from different organisations to map need across the county and by the separate mental health JSNAs produced in Southend and Thurrock.[1] The mental health JSNAs are being developed as a live resource, with a commitment to produce an annual report that can inform discussion by partners at Essex's Health and Wellbeing Boards (i.e., the ECC, Southend and Thurrock Boards).

The other key recommendation of the independent Boston Consulting Group report was the need for all the commissioning organisations across Greater Essex to develop a shared language and approach.

Building on this recommendation, this strategy will be delivered by health and social care commissioners across Southend, Essex and Thurrock working jointly and create a pan- Essex Mental Health Commissioning focus.

This function will take an all-age approach to tailor commissioning and contracting activity based on needs and outcomes at a local level. This function will incorporate health and social care commissioning and contracting of all adult age and children's mental health (CAMHS). However, dementia will not be included in the mental health commissioning function and is to be kept separate and commissioned locally as part of frailty and end-of-life pathways. This aligns with the commissioning of dementia services in CCG's and Local Authorities.

The Greater Essex Vision for Mental Health

- We will put mental health at the heart of all policy and services in Southend, Essex and Thurrock as we work with communities to build their resilience and promote mental well-being for all.

[1] Insert link to the Mental Health JSNA.

MER V3a DRAFT

- We will ensure that everyone needing support in Southend, Essex and Thurrock – including families and carers –get the right service at the right time from the right people in the right way.
- We will continue to remodel our services to ensure people get support at the earliest opportunity, with support for recovery, promoting inclusion and empowerment.
- We will enable resilience in our communities, working in partnership with the third sector to transform the mental health and wellbeing of Essex residents.
- Our services will be based on best evidence and co-produced with people who use them.
- We will develop a seamless all-age approach, recognising that mental health is an issue throughout life and there are heightened points of vulnerability.
- We will play our part in challenging mental health stigma and promoting social inclusion and social justice for everyone affected by mental illness.
- We will have a resolute focus on delivering outcomes that matter to individuals, families and communities, and will not let bureaucracy or silo-ed thinking get in the way.

1.2 Our challenge – Setting the Context

1.2.1 Mental health matters: the evidence

Mental health and emotional well-being are profoundly important for us all.

First, everybody in Southend, Essex and Thurrock will be affected by mental health problems either directly or indirectly, and has a stake in emotional well-being and in resilience in our communities. One in four of us will experience a mental health problem each year, and the risks are higher at key stages of our lives – for example, for new mothers and older people.[2] There is also evidence that some parts of the community may be more likely to experience problems or less likely to get the help they need. Many people will need professional support to get better and keep well, with most of this being delivered in GP and other community services. Others need more specialist help, mainly in the community, sometimes in hospital.

[2] NHSE (2016), *The Five Year Forward View for Mental Health*, p. 4.

Second, mental health problems are linked to other health and social problems and poor outcomes. People with severe and prolonged mental illness will die 15 to 20 years earlier on average[3]; while, conversely, mental health problems can complicate and delay recovery from a physical illness. People with mental health problems may need time away from work, and they are more likely to be unemployed. Mental health needs can be related to other issues in someone's life, particularly alcohol or drug misuse, and sometimes issues like homelessness. A small minority of people with mental health problems find themselves in trouble with the law, with nine out of ten prisoners having a mental health issue.

Three, the costs to individuals, families and communities are substantial. Aside from the obvious impact on health and well-being, mental health problems can affect people's ability to work, their income, housing and relationships. The combined social and economic costs have been estimated at £105 billion annually (roughly equivalent to the cost of the entire NHS).[4] The cost of dedicated mental health support in England is £34 billion (including £14 billion of unpaid care), and that excludes spending on related problems like dementia and drug and alcohol misuse.

Finally, evidence based and co-produced approaches can both transform lives and save money. By building resilience, intervening early, supporting recovery and remodelling our services we can substantially reduce the high costs of providing more intensive support later on, freeing money to invest in further improvements and creating a virtuous circle.[5]

Essex completed a specific needs assessment for mental health during 2016. Below are key findings from the Essex and Southend needs assessments. Thurrock contributed to the Essex JSNA and is currently completing a local JSNA for mental health.

MER V3a DRAFT

[3] NHSE (2016), *The Five Year Forward View for Mental Health*, p. 6.
[4] *Ibid*, p. 4, p. 10.
[5] Rethink, LSE and Centre for Mental Health (2014), *Investing in recovery – Making the business case for effective interventions for people with schizophrenia and psychosis*.

Key findings from Essex's Needs Assessment for Mental Health

- **Essex is experiencing increased demand** for mental health services coupled with commissioning organisations with significant savings challenges to deliver, resulting in many challenges in delivery of services;
- **Comorbidity is common among individuals with mental illness** and results in further complexities in treatment, including for those with mental illness and substance misuse;
- **Early intervention and prevention is vital** to mental health well-being and its sustainability;
- **Personalised services and co-production are important to those with mental health issues** and essential for addressing specific needs and promoting recovery;
- **Over 150,000 Essex residents are known to be living with a mental illness,** which is roughly 16% of the population and is expected to increase gradually each year, with a three per cent increase in the next 10-15 years;
- Around **30% of those suffering from a long-term physical health condition also have a mental health problem**;
- **Common mental health problems are high among the over 65 age group**, with approximately 25,000 older people in Essex suffering from depression, and a further 8,000 with severe depression that can result in psychosis. Rates of depression and severe depression for this age group are expected to increase by over a third in the next 15 years (there is also a concern about the potential for an increase in alcohol-related problems among this age group);
- Within Essex, **60,683 people aged 18-64 are predicted to have two or more psychotic disorders**;
- In the past year in Essex there have been an estimated 62 suicides among people with a mental health disorder aged 18-64 years.

Key findings from Southend's Mental Health Needs Assessment

- Southend-on-Sea is experiencing **increased demand for mental health services coupled with commissioning organisations with significant savings challenges** to deliver, resulting in many challenges in delivery of services.
- Relatively high level of need in Southend-on-Sea with high estimated prevalence. However, **only a minority of people with mental health conditions (except psychosis) in Southend-on-Sea receive any treatment** while even fewer receive interventions to prevent mental health conditions or promote mental wellbeing.
- **Southend has a higher than average estimated proportion of adults with a common mental disorder:** 16.8% (21,131 people aged 16-74) – (England - 15.6%, east of England - 16.0%). Based on the prevalence remaining unchanged and 4% growth the projected number of people with common disorders in 2021 will be 24,775.
- 216.5 per 100,000 of emergency hospital admissions were for **intentional self-harm** in 2014-15.
- **8.4% of adults in the Southend population are in contact with specialist mental health services** (the highest proportion in the East of England).
- There is **a higher estimated proportion of the adult population in Southend with severe mental illness** (0.5% of the population or 702 people). This is the highest in the region (0.35%) and higher than the figure for England (0.4%). Based on the prevalence remaining unchanged, the projected number of people aged 16+ with a psychotic disorder in 2021 would be 743 based on 6% growth.
- **First episode of psychosis**: annual incidence (16-64yr) is higher in Southend than the rest of the region.
- **Admission rate** for mental health service users in Southend is higher than both the region and England
- An estimated **1400 - 2750 people are affected by hoarding disorder** in Southend
- The **suicide rate** in Southend-on-Sea was lower than regionally or nationally.

- The rate of **detention under the Mental Health Act** was higher than East of England or England.
- The proportion of people in contact with mental health services with a **crisis plan** in place in Southend CCG (0.8%) was very low compared to East of England (7.1%) or England (21.5%).
- The rate of mental health clients receiving *social care* in Southend-on-Sea was significantly lower than the eastern region or England.
- More than **6,300 parents in Southend-on-Sea were estimated to have a mental illness** while a further 255 parents were estimated to have a personality disorder and 2,525 an eating disorder.
- **Unemployment** in Southend-on-Sea was higher than regionally or nationally. Southend Job Centre Plus reported that 65% of people claiming Employment and Support Allowance had a mental health condition, with depression and anxiety accounting for the majority of people seen.

1.2.2 Policy context – opportunities and challenges

NATIONAL POLICY

Mental health has been moving up the national agenda for some time. Southend, Essex and Thurrock applauds the recognition of the importance of what has sometimes been treated as a 'Cinderella service' and is determined to remain at the forefront of the wider movement for the transformation of services and support. Key developments include:

- Changing attitudes to mental health, including the **Time for Change programme on mental health stigma**;
- Substantial and sustained **investment in talking therapies** via the Improving Access to Psychological Therapies (IAPT) programme;
- **'Parity of esteem'** for mental and physical health as a key principle for the NHS mandate;
- First mental health **access and waiting times standards** in the NHS, covering psychological therapies, first episode of psychosis and access to crisis support in acute hospitals;
- The **Crisis Care Concordat**, which is a national agreement between services and agencies involved in the care and support of people in crisis;

- The **Local Authority Mental Health Challenge**, which is supporting local councils to promote better mental health in their communities;
- The creation of a **joint health and work unit** as part of a wider programme to support people with health and mental health problems to find and stay in work;
- The **Five Year Forward View for Mental Health**, setting out a national vision, ambition and strategy for transforming mental health policy and services.

THE GREATER ESSEX POLICY CONTEXT

Our environment presents a number of challenges alongside these opportunities:

- All localities are experiencing an **increase in demand** for its mental health services, while having to deliver significant and on-going **financial savings**;
- All localities are addressing challenges in both health and social care, including developing **three Sustainability and Transformation Plans** setting the future direction for health and mental health services (including as part of the NHS Success Regime in Mid and South Essex);
- At the heart of this strategy, and key to the transformation envisaged in national policy, is a **shift in investment** from acute support to early intervention, prevention and recovery, but this 'invest to save' approach is challenging to deliver in practice alongside securing necessary improvements in access to and quality in acute and specialist services;
- There is a need to ensure a focus on mental health and 'parity of esteem' at a time of **significant change** for our health and social care services.

1.2.3 Our approach

OUR PRINCIPLES

Our Vision is underpinned by eight key principles as set out in the *Five Year Forward View for Mental Health*:

1. Decisions must be locally led;
2. Care must be based on the best available evidence;
3. Services must be designed in partnership with people who have mental health problems and with carers;
4. Inequalities must be reduced to ensure all needs are met across all ages;
5. Care must be integrated – spanning people's physical, mental and social needs;

MER V3a DRAFT

6. Prevention and early intervention must be prioritised;
7. Care must be safe, effective, and personal, and delivered in the least restrictive setting;
8. The right data must be collected and used to drive and evaluate progress.

In addition, and in line with our responsibilities under the Care Act 2014, the needs of families and carers must be taken into account and their health and wellbeing should be considered at all points in the care planning process.

We also recognise our role in addressing the challenge of reducing over-representation of British, Asian and Minority Ethnic (BAME) communities and other disadvantaged groups in our acute care services and those detained under the Mental Health Act, as well as the issues for Lesbian, Gay, Bisexual and Transgender (LGBT) people as highlighted in our mental health needs assessment.

A focus on prevention, early intervention and recovery is central to our approach, both as a way of improving the mental health and well-being of residents in Southend, Essex and Thurrock while ensuring the sustainability of the mental health system (see figure 1).

MER V3a DRAFT

Figure 1: Rebalancing the system in favour or prevention, early intervention, empowerment and recovery

1.3 Our Outcomes

A key theme for our vision is a resolute focus on achieving tangible outcomes for individuals, families and communities. The strategy identifies the broad framework of national outcomes that will set the direction of travel in Southend, Essex and Thurrock. Specific outcomes can be found in implementation plans that have been developed by Greater Essex partners and are concerned with the practical nuts and bolts that will enable us to deliver our broad strategic ambitions.

1.3.1 Health outcomes

Health services are committed to achieving the following outcomes nationally by 2020, in line with the priority areas identified in the *Five Year Forward View for Mental Health*:

- **Additional psychological therapies** so that at least 25% of people with anxiety and depression access treatment each year, the majority of which is integrated with physical healthcare with a focus on people living with long term conditions.
- **Better employment support** for people with mental health problems, with improved employment support in psychological therapies services and a **doubling of Individual Placement and Support** for people with severe mental illness in secondary care services.

MER V3a DR

- Commission additional **high-quality mental health services for children and young people**, so that at least an extra 70,000 people nationally are able to access services by 2020.
- Ensure all women can access evidence-based specialist **perinatal** mental health care locally through the development of specialist community perinatal services.
- Implement a **suicide reduction plan** together with local government and other local partners that reduce suicide rates by 10% against the 2016/17 baseline.
- Expand capacity so that more than 60% of people experiencing a **first episode of psychosis** receive treatment within two weeks of referral.
- Commission **community eating disorder teams**; 95% of children and young people to receive treatment within four weeks of referral for routine cases, and one week for urgent cases.
- Commission effective **24/7 mental health crisis response services** in all areas with **Crisis Response and Home Treatment Teams** as an alternative to acute admissions, supporting the elimination of out of area treatments for non-specialist acute care.
- Meet existing access and recovery standards for IAPT psychological therapies services so that 75% of people access treatment within six weeks, 95% within 18 weeks and at least 50% achieve recovery across the adult age group. We would also aim to exceed national standards for IAPT access.
- Eliminate inappropriate out of area placements for acute mental health care.
- To **meet the 'core 24' standard** for mental health liaison as a minimum.
- **Reduction in premature mortality** of people living with severe mental illness, so 280,000 more people have their physical health needs met by early detection, assessment and intervention.
- All NHS commissioned mental health providers have **armed forces champions** and a specific named clinician with expertise in military trauma.
- Evidenced **improvement in mental health care pathways across the secure and detained settings**, with access to liaison and diversion services increased to reach 100% of the relevant population.

Stakeholders in the Southend, Essex and Thurrock health and social care economies also strongly believe in a holistic approach to achieving better mental health. This recognises that in addition to good *clinical* performance, there is also a

MER V3a DRAFT

fundamental interdependency between better *social* outcomes and recovery from mental ill health.

To this end, there is a commitment In Greater Essex to the following outcomes:

1.3.2 Good places to live

- Commission effective **mental health accommodation pathway services**. All people in the pathway to have a plan covering their move-on aspirations, which also supports their wider goals such as employment and training, and recognises that parents of adults with mental health problems are not obliged to accommodate them and provides for move-on planning where appropriate;
- Settled accommodation: To become a best quartile performer[6] on the national Adult Social Care Outcomes Framework measure, **proportion of people known to secondary care in settled accommodation.**
- **Reduction in residential care use** to become a high quality performer against statistical neighbours. There is an over reliance on residential care provision which can have a disempowering and de-skilling effect on people who use it, preventing them from realising their potential and ambitions.

1.3.3 Meaningful things to do

- **Embed co-production** as the default model for commissioning solutions, providing people who use services with genuine opportunities to shape and deliver the support solutions for themselves and their peers:
  - Expand the **Recovery Course Programme and Recovery Colleges approach** to cover all areas of Essex.
- Employment:
  - To become a best quartile performer[7] on the national Adult Social Care Outcomes Framework measure, **proportion of people known to secondary care in employment**;
  - A year-on-year reduction in the gap in the employment rate between those in contact with mental health services and the general population;

[6] In comparison to CIPFA statistical 'nearest neighbour' authorities
[7] In comparison to CIPFA statistical 'nearest neighbour' authorities

MER V3a DRAFT

- Ensure people who are supported with their mental health needs through services outside of secondary care, have access to employment support and advice, so the national objective of doubling access to **Individual Placement and Support is extended to provide appropriate employment support from those with severe needs to those with moderate needs**.

1.3.4 The means on which to live

- Ensure access to debt management and financial advice for people who are aspiring to their own tenancy:
  - See also the measures around employment.

1.3.5 Strong and sustainable support networks

- Commission and/or develop specific services across Southend, Essex and Thurrock so that co-produced peer support and volunteering opportunities are available to people at all points in the mental health system, regardless of whether they are care coordinated in secondary care:
  - Through qualitative analysis, develop an evidence base that these co-produced solutions are supporting people's recovery from mental ill health.
- Improve the ways in which different organisations providing different parts of the care pathway work together so the parts of the system covering accommodation, assessment and care management, clinical services, peer mentoring, employment, advocacy and other recovery support can talk to one another and link together effectively to deliver shared goals around recovery:
  - Assessment via feedback from people who use service that their support needs are met holistically and in a coordinated way.

1.3.6 Supporting delivery

To support the delivery of our outcomes our strategy is also concerned with:

1. **Evidence, innovation and research** to drive change and service development;
2. **Monitoring and data** to track performance and provide accountability;
3. **Payment and incentive systems** that support services to deliver the outcomes and develop functioning markets;
4. **A supported, motivated and effective workforce**, including health, social care, the voluntary and community sector and mobilising volunteers and peer mentors.

MER V3a DRAFT

2. Messages from Consultation

2.1 Adult mental health in Southend, Essex and Thurrock – An independent review

All the statutory organisations responsible for mental health services in Southend, Essex and Thurrock have been engaged in on-going discussions about how they can best provide mental health care in the context of rising demand, financial and operational pressures. In May 2015, the NHS and local authorities in the county came together to commission an independent review of the current state of play from The Boston Consulting Group to advise us on the best way forward. The review was primarily focussed on specialist mental health services provided by the two main NHS providers in our county - the North Essex Partnership Trust (NEP) and the South Essex Partnership Trust (SEPT), and IAPT services in the north of Essex provided by Hertfordshire Partnership Trust (HPFT).[8]

The key findings and recommendations of the review are summarised below.

First, we need to simplify the commissioning landscape. The way mental health services are planned and developed in Greater Essex is complicated and confusing, with lots of different organisations in different parts of the county working to their own plans to deliver their own priorities to their own timetables. We need to simplify, harmonise and integrate so they can make connections, co-ordinate and synchronise their activity, use their resources more efficiently … and, by doing so, create a mental health system that makes sense to the people who need to access care and support.

Second, if these organisations are to come together in this way, they need to speak the same language – at the moment they are too often using different words for the same things and the same words for different things. This can be very confusing for service users trying to navigate the system. There also needs to be more clarity

[8] Boston Consultancy (September 2015), *Essex Mental Health Review – Final Report*.

MER V3a DRAFT

about what is expected of those who deliver mental health services, and how that is assessed and measured.

Third, there is a need for more information, and for information to be shared better. The more we know about mental health needs in different parts of the county, the better we can plan services and develop approaches that meet those needs. By agreeing a shared set of outcomes for what we want our mental health services to be achieving, we generate a common framework for assessing what we are doing and how well we are doing it.

Finally, the review concluded that we should be looking at options for creating a single mental health commissioning focus for Southend, Essex and Thurrock at a senior level, to co-ordinate services and provide a strong voice for mental health.

In addition the Boston Consulting Review highlights two challenges in particular: (1) the need to increase the number of Approved Mental Health Professionals (who are responsible for assessing people under the Mental Health Act, including for 'sectioning' decisions) – and to take another look at how we make the best use of the professional expertise of mental health social workers - and (2) to develop a seamless all-age system of support, particularly to ensure that young adults are not left stranded between young people's and adult services.

The review also highlighted the need to clarify the relationship between dementia and mental health services, and we are producing a new Southend, Essex and Thurrock Dementia Strategy to address this question in detail alongside this Mental Health Strategy.

2.2 The voice of experts by experience

Essex commissioned Healthwatch Essex Insights to work with us over a 12 month period to support the development of the strategy and the development of mental health services thereafter. Healthwatch Essex has recruited a number of volunteers as mental health ambassadors to work with commissioners as lived experience experts in mental health. The development of the strategy has been supported by the running of focus groups, a mental health survey made available to the public

MER V3a DRAFT

across Southend, Essex and Thurrock and the completion of a number of detailed case studies.

A number of key themes have emerged from the discussions in 11 focus groups involving over 70 mental health service users and carers in Southend, Essex and Thurrock, conducted by Healthwatch Essex in July 2016. To compliment this, Thurrock will be holding a number of consultation events regarding the strategy and the local implementation plan.

First, the complexity of the system highlighted in the independent review of adult mental health services was clearly reflected in the experiences of service users and carers. They talked about the difficulties of navigating the system, and the need for a 'map' of services available across the county, with the eligibility criteria for each. In particular, we heard that accessing support for crisis can be confusing, with too many attendees saying that they had been referred to A&E, where staff may not be trained or supported to work with someone in crisis. More generally, there was a need for 'signposting', so that people have better information about what services are available and where, when and how they are delivered.

Second, people at the focus groups wanted a greater focus on prevention, including suicide prevention. They highlighted the importance of clear and timely communication as a prevention tool, with participants saying that by keeping in touch with service users and carers, services could prevent crisis and therefore reduce the pressures on acute and inpatient services. The importance of putting the right support in place when people move out of hospital and other acute services was also highlighted, with a need for on-going support to prevent relapse and readmission. Many attendees stressed the impact of issues like homelessness and unemployment not only on recovery, but also on people's ability to maintain the contact with services that keep people well and prevent relapse (e.g., challenges in meeting the costs of travelling to appointments).

Third, a clear message was that 'one size doesn't fit all' and choice and control is a vital part of recovery, particularly where people are doing more to manage their own conditions. Despite investment in access to psychological therapies, it was reported

MER V3a DRAFT

that medication was still often the 'first line of treatment' and it was important to increase access to alternatives like Cognitive Behavioural Therapy, psychotherapy and other kinds of counselling.

Fourth, we heard that there was a lack of effective communication between services and with service users. Echoing the Mental Health Review's call for a 'common language', service users and carers complained that confusing 'language' and 'jargon' made it more difficult to navigate the system (for example, a lack of shared understanding of 'recovery'), and barriers to data and information sharing mean service users are providing the same information on several occasions, and having to repeating their stories. The concerns of families and carers may not be addressed, because workers are afraid to talk to them due to concerns about confidentiality.

Finally, the need for a national workforce strategy was reinforced by experts-by-experience, not only for specialist mental health staff, but also in specialist training for GPs, A&E staff, CPNs, ambulance staff and others – including those in employment support, debt and welfare advice, drug and alcohol treatment, learning disability and housing and homelessness services. Key competencies highlighted included empathy and active listening and mental health first aid.

2.3 The voice of clinicians

Clinicians working across Southend, Essex and Thurrock either in mental health services, or working closely with mental health services, including GPs, were asked about how mental health services were currently working in Greater Essex, what the gaps in provision were perceived to be, and how they felt services could work more effectively.

When asked about gaps and shortfalls in provision, clinicians told us that they were most concerned about:

- Gaps in provision between children and adult services;
- Gaps in provision between primary care and secondary care mental health services;
- The continuity of care given to service users;

MER V3a DRAFT

- The lack of evidenced based services available for people with personality disorders or complex needs including access to psychological therapies;
- The long waiting times for some treatments, particularly psychological therapies;
- Staffing shortages across the mental health workforce and the need to recruit and retain a skilled workforce;
- Shortages across the county in Approved Mental Health Professionals;
- The responsiveness of crisis services;
- The lack of resourcing in many of the current services; and
- The confusing pathways for some conditions.

Clinicians were concerned that a number of key barriers remained to prevent service users from accessing services in the right place at the right time. These included:

- Lack of specialist GP training in mental health issues;
- Stigma and anxiety about entering mental health services;
- Not knowing what services are on offer;
- Long waiting times for some treatments.

Clinicians felt that the following areas would help support mental health services to work more effectively:

- More opportunities for shared learning across different clinical groups;
- Joint mental health training with GPs and mental health clinicians;
- Improved working and reduced competition across different partners;
- The embedding of mental health support and provision into primary care;
- Availability of expert support to GPs to prevent unnecessary referrals into mental health services.

MER V3a DRAFT

3. Getting the foundations right

3.1 Key challenges

The NHSE *Five Year Forward View for Mental Health* highlights a number of key issues that commissioners will need to address in order to deliver its prospectus. Preventing problems, integrating services, making the most of the strengths and assets of individuals and communities and combining evidence based approaches with an openness to trying new things is not only the best way of improving mental health and well-being, but also of doing so in a financially sustainable way. The priority areas identified in the *Five Year Forward View for Mental Health* will require an additional £1 billion in investment by 2020-21 nationally. The expectation is that savings generated by prevention, early intervention and new models of care will be re-invested in mental health, creating a virtuous circle.[9]

Key areas where it is important to 'get the foundations right' are:

- Building partnership and integration to tackle the fragmentation of commissioning across NHS Clinical Commissioning Groups and local authorities, with a particular focus on closer integration of mental and physical health care.

- Engaging with experts-by-experience, carers, communities, clinicians, the voluntary and community sector and other stakeholders, with people affected by mental health issues seen as active participants in recovery, and not simply as passive recipients of services designed by others.

- Rebalancing the system in favour of prevention and early intervention, with a key role for public health and local prevention plans with a focus on place-based approaches to mental health promotion, tackling the social determinants of mental health problems, addressing stigma and targeting those most at risk. We recognise and will continue to support the vital role of local VCSE organisations in Southend, Essex and Thurrock to facilitate early engagement, peer support and recovery.

[9] See NHSE (2016), *Five Year Forward View for Mental Health*, p. 19.

MER V3a DRAFT

- Developing a seamless 'all age' approach across the life course, integrating this strategy with the Future in Mind transformation programme for children and young people's emotional wellbeing and mental health.

- Developing a Southend, Essex and Thurrock local suicide prevention strategy by 2017 as a matter of priority.

- Improving access to housing, employment and other meaningful activity, supporting families, challenging stigma, valuing relationships and drawing on the strengths and assets of communities.

- Getting it right for people with mental health issues who have 'multiple needs' such as substance misuse, homelessness and learning disability and ensuring that they get the help they need and do not slip through gaps between services.

- Recognising the support and information needs of the families and carers of people experiencing mental health problems, as well as their strengths and assets.

- Improving the continuity of care at points of transition, whether that is discharge from inpatient services into community based care or reconfiguring services to support young people with mental health needs in transition to adulthood as part of an all age approach to care and support.

All services must be provided with humanity, dignity and respect, and inequalities must be targeted and addressed, with evidence that BAME communities, children and young people, older people, LGBT people, survivors of child sex abuse and those with multiple needs can be poorly served by services.[10] Finally, getting it right means having the data and information to understand the mental health needs of people in Greater Essex and drawing on the best available evidence, quality standards and NICE (National Institute for Health and Care Excellence) guidelines.

[10] See *Five Year Forward View for Mental Health*, p. 7, p. 15 (Rec 22).

MER V3a DRAFT

Where work with people using services, carers and communities suggests new ways of doing things, we must also be prepared to develop and evaluate innovative approaches.

3.2 Responding to financial challenges

Delivering the *Five Year Forward View for Mental Health* nationally will require an additional £1 billion in investment by 2020-21, according to NHS England.[11] The scale of the financial challenges facing the health service and local authorities are no secret.[12]

The NHS across Greater Essex currently needs to make substantial savings, and is developing plans to do this through three Sustainability and Transformation Plans. Essex County Council has had to find savings of over £500 million in the last five years, and is expecting to need to save a further £300 million by 2020. In Thurrock, adult social care has had to make £13 million in savings in the last five years and is expecting to make further significant savings in the next four years.

It will be challenging to achieve our ambitions for mental health, and full realisation of the strategy and five year forward view ambitions, and will depend on the level of financial and other support from central government and NHS England.

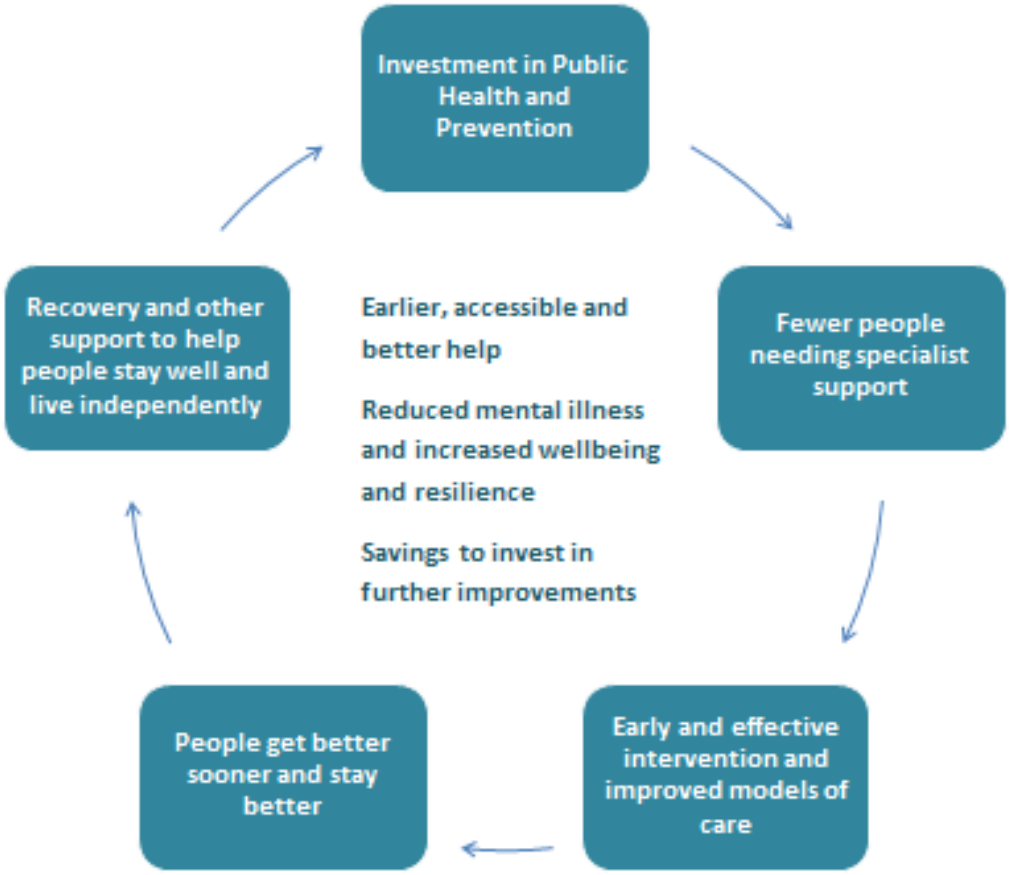
Over time the intention is that the *Five Year Forward View for Mental Health* will pay for itself by preventing problems developing, and dealing with them better when they do occur, creating a 'virtuous circle' combining better outcomes for individuals and communities and reduced cost to the taxpayer.[13]

As part of our strategy, we also want Southend, Essex and Thurrock to have a strong voice in national policy, and pro-actively supporting national initiatives, such as the Workforce Strategy, as well as being prepared to provide challenge where necessary.

MER V3a DRAFT

[11] NHSE (2016), Five Year Forward View for Mental Health, p. 19.
[12] Kings Fund (2015), Mental Health under Pressure.
[13] NHSE (2016), Five Year Forward View for Mental Health, p. 19.

Figure 2: The Southend, Essex and Thurrock Model: Better care drives system change and sustainability



3.3. Evidence, engagement and empowerment

3.3.1 Evidence – data and intelligence

Southend, Essex and Thurrock are actively monitoring mental health needs and trends across Greater Essex to build the evidence base for effective commissioning, care and support. In 2016, partners across Essex worked together to produce an Essex Mental Health Joint Strategic Needs Assessment.[14] It found that an estimated 136,053 adults aged 18-64 experienced a common mental illness in Essex, roughly 16 per cent of the population, and with an expectation of a three per cent increase over the next 10-15 years. It identified particular at risk groups in Essex as LGBT people, BAME groups, asylum seekers, refugees and migrants, the travelling community, new and expectant mothers, older people, armed forces and offenders.

[14] Insert references to Mental Health JSNA.

The Essex JSNA 2016 has particularly highlighted challenges around employment, housing and suicide (see below).

In Southend, the Mental Health Joint Strategic Needs Assessment found there is a higher estimated proportion of adults with a common mental disorder than elsewhere in the East of England at 16.8% (21,131 people aged 16-74) – this compares with 15.6% for England as a whole and 16.0% for the East of England region. Based on the prevalence remaining unchanged and 4% population growth the projected number of people in 2021 will be 24,775. It also showed that **Southend** is a relatively deprived area; the proportion living in the 20% most deprived areas of Southend-on-Sea (23.1%) is much higher than the East of England (7.7%) and England (20.4%).

3.3.2 Engagement and co-production

The redesign of children and young people's mental health services has been supported by extensive engagement and listening exercises including:

- Essex Healthwatch's countywide YEAH! and YEAH!2 projects, with YEAH!2 engaging with 865 young people involved in the National Citizen's Programme in Summer 2015 to explore their lived experience of mental health.[15]
- Consultation with children and young people to develop the Essex Child and Adolescent Mental Health Services Strategy 2012-14.
- Discussions with Young Essex Assembly, Southend Youth Council, Thurrock Youth Cabinet, Children in Care Council and other young people.
- Working with the charity Reprezent to develop systematic and built in engagement, with a focus on social media and on-line resources, building a campaign and getting young people involved as trained ambassadors.

Healthwatch Essex has a strong focus on engagement with mental health service users. The 555 mental health project captured the lived experience of mental health service users in Essex[16] and identified five key priorities for service users:

[15] Fletcher H (2015) YEAH! Report – Young Essex Attitudes on Health and Social Care 2014-2015, Healthwatch; Fletcher, H (2016), YEAH2! Report - Young Essex Attitudes on Health and Social Care 2015-2016, HealthWatch Essex

MER V3a DRAFT

- Continuity of care
- Trust and trustworthy practice
- 'Treating me as a whole person'
- Choice and control – not 'one size fits all'
- Communication and joined up services.

In 2015, ECC worked with the Public Office to produce *Hope for Better Mental Health: Exploring co-production and recovery*.[17] It identified six initiatives in which recovery and co-production were delivering radically improved outcomes for service users: Recovery College; Personal Budgets; Sociability (supporting people to run their own peer support initiatives); carer-led workforce training; Zero suicide; and intensive enablement to help people with complex needs move from residential or in-patient care to independent living. Similar initiatives were highlighted in Thurrock's consultation on the South East Mental Health Strategy.

3.3.3. Empowerment – Personal Budgets

Personalised budgets shift control from commissioners to service users, by giving people direct control over budgets available for their care, and enabling them to make active choices about the kind and nature of support they want, and who provides it to them.

Thurrock implemented personal budgets in 2008 and introduced personal health budgets in April 2015.

Innovation Case Study: Personal Budgets and Personal Health Budgets in Essex

Personal Budgets and Personal Health Budgets are sums of money to support a person's health and wellbeing needs, and move away from a 'one size fits all' approach to greater 'personalisation' of mental health and social care support.

Personal Budgets were first introduced in Essex in 2008 and Personal Health Budgets were initially launched in Basildon and Brentwood in May 2015.

[16] Healthwatch (2014), 555 – Capturing the lived experience of mental health services users in Essex.
[17] Ballantyne P and Temperley J (2015), Hope for Better Mental Health – Exploring Co-production and Recovery, The Public Office/Essex County Council.

Prior to the introduction of personalised budgets, people were restricted to the limited set of health and social care options that ECC or the CCG commissioned (regardless of how well these met needs or supported individual recovery plans). Personalised budgets aim to give people with social care needs and long-term health conditions greater choice and control over the support they access, and can be used to pay for a wide range of items and services, including therapies, personal care and equipment. They require people to make active choices about the support that will best help them maintain their health and wellbeing. There is further work to do to embed and develop personalisation, requiring both cultural and systemic changes.

3.4 Making the connections

3.4.1 Drugs, alcohol and multiple needs

Public health teams in local authorities have the primary responsibility for commissioning drug and alcohol services, including treatment and recovery services. The Essex needs assessments concluded that people with a history of mental illness are much more likely to experience drug and alcohol misuse problems. Conversely, national evidence shows that the majority of people in drug and alcohol treatment will have a co-morbid mental health issue.[18] The JSNA estimates that over 50,000 adults in Essex will be alcohol dependent, and around 28,500 dependent on drugs. [19]

Essex is developing innovative approaches for supporting people with 'dual diagnosis' and multiple needs (for example, offending and homelessness). A new Offenders with Complex Needs (OCAN) service, commissioned via the ECC Public Health Team, went live in April 2016, offering a care co-ordination approach for offenders in the criminal justice system with substance misuse, mental health, learning difficulties, housing and other problems. A new integrated support, advice, referral and mentoring services (ISARMs) is being launched for adults with mental health and/or substance misuse issues. This will be based on a co-production

[18] See, for example, Centre for Mental Health, DrugScope and UK Drug Policy Commission (2012), *Dual diagnosis: a challenge for the reformed NHS and Public Health England*. See also the Public Health England *Co-existing Substance Misuse and Mental Health Issues Profiling Tool*.
[19] Insert references to the Essex MH JSNA.

approach whereby recovery solutions are constantly being shaped and delivered through equal and reciprocal partnership with people who use services.

There are also thousands of individuals struggling with mental ill-health and substance misuse problems who are not in contact with the criminal justice system. Supporting these individuals with both their substance misuse and their mental health problems is essential for positive treatment outcomes and recovery, and may prevent them getting involved with the criminal justice system later on. This will remain a focus for service development, building on the creation of our new ISARMs service for people affected by mental illness and/or substance misuse.

The Southend JSNA highlighted drug use per 100,000 population in Southend-on-Sea at 165.7 was higher than the East of England (86.3) or England as a whole (121.7). Alcohol problems on the other hand were higher than the East of England but below England.

DRAFT

3.4.2 Domestic abuse

Over 26,000 domestic abuse incidents are reported in Southend, Essex and Thurrock each year, with 80 calls a day being reported to police, and the real picture estimated to be closer to 125,000 incidents a year.[20] Partners across Greater Essex have been working together to deliver appropriate joined up responses to those affected by domestic abuse. The current police and crime plan reports that Essex's Police and Crime Commissioner invested £580,000 in action to reduce domestic abuse in Essex in 2013-14 alone. The Living Well Essex website signposts both victims and perpetrators to support and resources, including mental health support. In February 2016, Essex, Southend and Thurrock joined together to launch a new campaign to tackle domestic abuse called TogetherWeCan.

The links between mental health, substance misuse and the domestic violence agenda have been highlighted in a *draft report by the Southend, Essex and Thurrock Domestic Homicide Review sub-group* focusing on recent Domestic Homicide cases. The report notes that 'Themes that ran throughout the case reviews relating to mental health and substance misuse included; depression, psychotic behaviour, personality disorders, self-harming, suicide attempts and overdosing.

[20] See '*TogetherWeCan campaign aims to tackle domestic abuse in Essex*' (22 February 2016)

Domestic Abuse – Next steps

A number of recommendations will emerge from this report. These are expected to include:

1) To build on the work underway around health engagement to develop a greater focus on training and upskilling health professionals to enable earlier identification and support.
2) To provide a renewed focus on early identification and work with children who have been affected by domestic abuse to consider gaps and new responses.
3) To develop further work around improving information sharing between agencies on domestic abuse cases.
4) To feed the findings regarding Multi Agency Risk Assessment Conference (MARAC) to the Multi Agency Referral and Assessment Team (MARAT) steering group who are currently implementing a new model with a focus on improved information sharing, action planning and accountability.
5) To provide a renewed focus looking at the mental health and substance misuse services responses to perpetrators and victims of domestic abuse and test new ways of working.

Consultation with experts by experience also highlighted:

- The need to improve awareness of and response to child to parent violence; and
- To improve information sharing protocols to ensure the voice of affected others is heard and appropriate action is taken.

We are committed to continually seek learning opportunities and closer collaboration across the mental health, substance misuse and domestic abuse agendas, including from domestic homicide case reviews, serious case reviews and adult safeguarding cases.

3.4.3 Childhood sexual abuse

One of the concerns raised by Essex Mental Health Ambassadors and more widely by people who access services was the need for greater recognition and understanding of the significance of childhood abuse – particularly sexual abuse - as

a cause of mental health problems, as well as in the development of personality disorder and vulnerability to 'multiple need' in adulthood.

There is a need for a more systemic recognition of the impact of childhood sexual abuse on mental health, reflected in staff training and workforce development. This will help to create a culture in which people are better supported to disclose sexual (and other) abuse where appropriate, which will often be contributing to mental health and other problems. Disclosure must, of course, be treated sensitively and appropriately, with clear referral pathways to support services, and a recognition of the role of the voluntary and community sector in supporting abuse survivors.

We know that personality disorder diagnosis is strongly linked to childhood abuse[21] with childhood sexual and physical abuse being predicators of antisocial and paranoid personality disorders, and emotional abuse and neglect linked to borderline personality disorder. Our strategy, alongside the North Essex personality disorder strategy seeks to ensure that we improve treatment and therapies for people with personality disorders, reducing the requirement for inpatient admission.

3.4.4 Targeting inequalities

Equality impact assessments are, and will continue to be, embedded in all commissioning activities. In terms of specific initiatives related to mental health, commissioners are fully supportive of the national direction for achieving parity of esteem with physical health and continue to promote these objectives in discussions around the wider health and social care economy. The co-production ethos also supports targeting inequalities, with people who use services integral to the shaping and delivery of provision.

Getting the foundations right – next steps and outcomes

In getting the foundations right for Southend, Essex and Thurrock, we will be guided by the Five *Year Forward View for Mental Health* which says that commissioners will:

- work in partnership with local stakeholders and voluntary organisations

[21] Bierer LM[1], Yehuda R, Schmeidler J, Mitropoulou V, New AS, Silverman JM, Siever LJ (2003), 'Abuse and neglect in childhood: relationship to personality disorder diagnoses', *CNS Spectrum*, 2003 Oct 8(10): 737-54.

MER V3a DRAFT

- co-produce with clinicians, experts-by-experience and carers
- consider mental and physical health needs
- plan for effective transitions between services
- enable integration
- draw on the best evidence, quality standards and NICE guidelines
- make use of financial incentives to improve quality
- emphasise early intervention, choice and personalisation and recovery
- ensure services are provided with humanity, dignity and respect.

MER V3a DRAFT

4. Children and young people's mental health

***Five Year Forward View for Mental Health* 2020-21 Objectives**

- At least 70,000 additional children and young people each year will receive evidence-based treatment, with access to NHS-funded community services.
- All local areas to have expanded, refreshed and republished their Local Transformation Plans for children and young people's mental health by 31 October 2016, with Plans including numerical targets.
- Transformation plans refreshed annually in line with business planning cycles.

4.1 The bedrock for mental health and wellbeing

Support for children and young people will provide the bedrock for improved mental health and emotional wellbeing across the life course. We know that around half of all mental illness has arisen by the age of 14 and as much as 80% by the age of 18. Our transformation plan estimates that 22,500 children aged 5 to 16 across greater Essex could have a mental health problem requiring specialist help.[22] We also know that these problems disproportionately affect some of our most vulnerable young people, and our transformation plan therefore has a particular focus on these groups.

These challenges are being recognised in our work with schools, including, for example, the award winning Risk Avert programme (Essex County Council and the Training Effect), which is being delivered in 30 Essex schools to support young people to build resilience, learn skills to manage risk and become more connected at school (see box).[23] The Children and Young People's Plan for Essex launched in 2016 includes a range of further actions to address risk and build resilience, with a particular focus on the most vulnerable. [24]

[22] See NHS, ECC, Thurrock Council and Southend Council (2015), *Open up, reach out – Tranformation Plan for the Emotional Wellbeing and Mental Health of Children and Young People in Southend, Essex and Thurrock*.
[23] The Risk Avert website is at http://www.risk-avert.org/
[24] ECC (2016), *Essex Children and Young People's Strategic Plan – 2016 Onwards*.

Innovation Case Study: Risk-Avert

Risk-Avert is an evidence-based, independently evaluated school based programme developed by ECC and The Training Effect. It identifies young people vulnerable to multiple risk-taking behaviours and offers both universal and targeted interventions, to help young people to:

- Build resilience;
- Improve their emotional health and well-being;
- Make better decisions and positively manage risk; and
- Become more connected to school.

A range of PSHE resources are provided to schools and social norm based interventions are delivered to whole year groups. A targeted programme for those most at risk offers a six session life skills intervention.

Risk-Avert won the Local Government Chronicle (LGC) Service Delivery Award 2016.

Until recently, the responsibility for commissioning targeted and specialist CAMHS services in the Southend, Essex and Thurrock areas were split across ten organisations: seven clinical commissioning groups and three local authorities (Southend, Essex and Thurrock).

A new emotional wellbeing and mental health service for children and young people was launched in 2015.[25] All targeted and specialist services in Essex are now delivered by one organisation (North East London NHS Foundation Trust) with locality-based teams managing local services, as well as working with schools, children centres and the voluntary, community and social enterprise sector (VCSE) on universal support and NHS England on acute services. The ten commissioning agencies are joined together in a collaborative commissioning forum, which is a legally binding partnership, and supports CCGs and local authorities to pool budgets and expertise. This strategy proposes building on these foundations to create an all-Essex all-age commissioning team to drive forward our strategic ambitions and deliver our vision.

[25] Details of the Essex Emotional Wellbeing and Mental Health Service fro Children and Young People can be found on the NELFT website at http://www.nelft.nhs.uk/services-ewmhs

In January 2016, the same partners launched Essex's Future in Mind Transformation Plan – *Open up, Reach out* – bringing an additional investment of around £3.3 million each year, and a focus on *Five Year Forward View for Mental Health* objectives, including enhanced crisis services working 9am to 9pm, 7 days a week and special training and support for prevention in schools and other universal settings.

4.2 Supporting transition with seamless services

One of the key challenges in delivering our ambition for a seamless life course approach to mental health is to address the historic problems with 'transition' support. Some young people with mental health needs fall below the threshold for adult services, even though they continue to need specialist help after the age of 18. In addition, services for vulnerable young adults with neurodevelopmental difficulties, including Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) have fallen outside the remit of adult mental health services and adult learning disability services.

One of the ten outcomes set out in *Open Up, Reach Out* is 'young people aged 14-25 to get the right support and, if necessary, a smooth transition to adult services', and our adult mental health strategy dovetails with our children and young people's transformation plan to prioritise and support delivery of this outcome.[26]

To support our ambition to improve transition between children and young people's and adult services and as part of our Future in Mind transformation plan in 2016-17 we are:

- Developing a single transition protocol across Southend, Essex and Thurrock;
- Implementing training for professionals;
- Ensuring young people and their families contribute their expertise and experience in the development of local transition processes;
- Considering the particular needs of young people with developmental disorders;
- Considering the needs of care leavers;
- Providing resources, information and choices;

[26] See See NHS, ECC, Thurrock Council and Southend Council (2015), *Open up, reach out – Tranformation Plan for the Emotional Wellbeing and Mental Health of Children and Young People in Southend, Essex and Thurrock*, p. 9 and p. 59.

MER V3a DRAFT

- Developing engagement with the Autism Partnership and Transforming Care Boards;
- Considering arrangements for follow up and monitoring and those leaving services.

We know that our commitment to transition planning and support is only half of the story if we are to get it right for young adults with emotional support and mental health needs. We also need to make sure that there are suitable services to transition young people to, and that appropriate support with issues like employment and housing is available. We have therefore 'proofed' the whole of this strategy to ensure it takes full account of the needs of young adults in transition, as part of our all age, life course approach. Our review and refresh of the *Open Up, Reach Out* transformation plan is considering how it can be integrated with our strategic approach to the reform of Greater Essex's adult mental health services.

DRAFT

Case study

'I value my daughter's safety and her needs being recognised'

I am the carer for my 17 year old daughter. She has recovered from anorexia but now suffers from anxiety and depression …

It is important that you can access help as soon as possible so the patient can recover quickly. Being able to get a doctor's appointment quickly and at a time that does not mean losing time at college. Carers need more support as the time between visits can seem long and daunting …

My daughter will soon be transferred to the adult services. i think there should be a bridging system so that the most vulnerable are still being cared for appropriately even though they are now adults.

Recovery means to me that my daughter can have a work, college and social life balance that she is not capable of sustaining at the moment and she will be able to go to university to continue her education safely.

5. Perinatal mental health

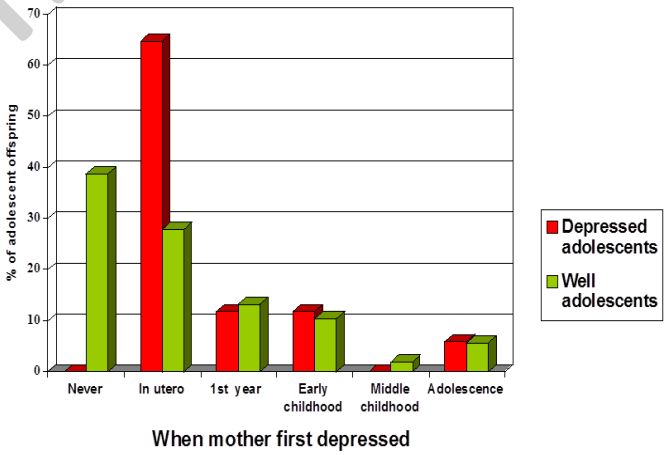
Five Year Forward View for Mental Health 2020/21 Objectives

- At least 30,000 women each year to receive evidence-based treatment, closer to home, when they need it.

The *Five Year Forward View for Mental Health* requires CCGs to ensure that there are specialist perinatal mental health services to meet the needs of women in all areas. This will require the development of specialist community services and their integration with inpatient mother and baby units.

Up to 20% of women experience mental health problems in pregnancy or the first 12 months after birth. The *Confidential Enquiry into Maternal Deaths* identified suicide as the leading cause of maternal death in the UK and depressive illness is the most common major complication of maternity.

Support for peri-natal mental health is also a critical component in giving everyone the best possible start for lifelong well-being and resilience. There is a strong familial association between maternal and adolescent depression. One recent study of children and young people in south London found that all of the 16 year olds who became depressed had been exposed to maternal depression at some point in their lives. Pregnancy was found to be the time period when the greatest number of offspring was initially exposed to maternal depression, and children who were exposed during pregnancy were almost four times as likely as those not exposed to become depressed at 16 years.



MER V3a DRAFT

Women who were depressed during pregnancy were almost 10 times as likely as those not depressed in pregnancy to have a recurrence.

The London School of Economics and the Centre for Mental Health have estimated the economic burden of the consequences of not adequately identifying and treating perinatal mental health problems as being £8.1 billion a year, 28% of these costs relating to the mother and 72% to the child. Almost three-quarters of this comes from the future impact on children and of impaired care in the first year of life. Around £1.2 billion of this additional annual cost falls directly on the NHS and local authority social services.

A key focus for addressing these problems must be improving the detection and treatment of perinatal mental health problems. As nearly all women will have contact with primary care (including health visiting) and maternity services antenatally and postnatally there is much scope to improve screening.

The *Five Year Forward View for Mental Health* requires CCGs to establish specialist community perinatal mental health teams based around areas with between 10,000 to 15,000 births a year, which would each provide care for 300 – 500 women.

WEB 3a DRAFT

	Annual birth rate (to nearest 100)	Expected morbidity: Mild/mod depression/anxiety (150/1000)	Expected morbidity: Severe depressive illness (30/1000)	Expected morbidity: PTSD (30/1000)	Expected morbidity: Postpartum Psychosis (2/1000)	Expected morbidity: Chronic serious mental illness (2/1000)
Basildon And Brentwood	3300	495	99	99	7	7
Castle Point And Rochford	1600	242	48	48	3	3
Mid Essex	4300	647	129	129	9	9
North East Essex	3570	536	107	107	7	7

Southend	2300	339	68	68	5	5
Thurrock	2400	357	71	71	5	5
West Essex	3700	555	111	111	7	7

Greater Essex as a whole has 21,170 annual births. The *Five Year Forward View for Mental Health* recommends that these teams should be configured around sustainability and transformation plan areas.

The development of a new, integrated 0-19 service led by public health in Essex provides an opportunity to review and develop the role of health visitors and other key professionals in identifying mothers who may be experiencing peri-natal mental health issues. A similar review by Public Health in Thurrock is looking at the 0-19 pathway and population.

In October 2016, Southend, Essex and Thurrock were successful in obtaining national funding for development of specialist community perinatal mental health services. These services will be developed in late 2016 and will ensure that women and their families across greater Essex will get the support they need at an early stage. These services will also form part of an improved pathway for peri-natal mental health care across the county.

V3a DRAFT

Case Study

'There seemed to be big gaps in provision for women who have suffered miscarriage or difficult pregnancies'

I was diagnosed with a post-natal mental illness after traumatic miscarriage, postpartum psychosis, anxiety and depression …

I contacted a number of agencies, Samaritans, mental health crisis team, Mind, even the NHS 111, but there seemed to be no clear pathway, referral when experiencing acute mental illness, like when a cancer referral is triggered. There seemed to be big gaps in provision for women who have suffered miscarriage or difficult pregnancies in terms of emotional aftercare from the hospital and primary care.

Once I reached crisis point, the GP, contacted the mental health crisis team, my referral was picked up quickly by the specialist community mental health team and I saw a community psychiatric nurse who together with my family supported me with treatment through medication and counselling in order that I was cared for at home. Once I was in specialist hands, who knew and diagnosed what I was suffering from then I have had very good support, but it should not take getting to crisis point i.e. suicidal for a referral to take place.

Case Study

"What have you got to be down about? You have a lovely little baby and it's beautifully sunny outside."

My son was born in April 2013 by emergency C-section. Looking back, I didn't feel right from the moment he was born. I had expected the rush of love and euphoria we are promised by the media and other mums, and instead I felt very unwell from the anaesthetic, emotionally numb and extremely anxious. Over the weeks that followed, as we stumbled through the minefield of caring for a new baby - sleep deprivation, feeding etc. - I felt less and less like myself … At my six week doctor's check-up she assessed me using the Edinburgh scale and said I scored a ten which was borderline …

… Insomnia led me to eventually break down after a baby group at my Children's Centre (approx. 9 weeks postnatal). The staff there were wonderful… they contacted my Health Visitor who came to see me that afternoon and kept in touch with me for the next few days. She referred me to the PEWS team who were very good also.

When the insomnia and anxiety hadn't improved after a couple more days I felt unable to be alone with my son … I broke down and told the locum GP everything and her incompetent reaction still haunts me to this day. Her exact words were "What have you got to be down about? You have a lovely little baby and it's beautifully sunny outside." She then turned to my husband and told him to take me

on holiday to "cheer me up". I felt like she'd punched me in the stomach. At the time I was already constantly beating myself up for not feeling happy and wondering why I didn't love my son and my new life, so to have it voiced in that way by a doctor no less was devastating.

She gave me prescriptions for Zopiclone for my sleep, diazepam and fluoxetine and told me to fill out a form to be referred to Therapy For You.

MER V3a DRAFT

6. Adult mental health: common mental health problems and primary care mental health

Five Year Forward View for Mental Health

2020/21 Objectives

- By 2020/21, there will be increased access to psychological therapies, so that at least 25% of people (or 1.5 million) with common mental health conditions access services each year. The majority of new services will be integrated with physical healthcare. As part of this expansion, 3,000 new mental health therapists will be co-located in primary care, as set out in the General Practice Forward View.
- In parallel, we will maintain and develop quality in services; including meeting existing access and recovery standards so that 75% of people access treatment within six weeks, 95% within 18 weeks; and at least 50% achieve recovery across the adult age group.

6.1 Public Mental Health

There is a clear recognition of the importance of parity of esteem in developing public health activity across Southend, Essex and Thurrock and of the impact of public health issues such as diet, physical activity and access to green space on emotional well-being, mental health and resilience, as well as the particular vulnerabilities of people with mental health problems to high risk behaviours, including smoking, alcohol and drug misuse. The Essex Health and Wellbeing Board is overseeing the development of a new public health strategy to be published in 2017, with mental health expertise feeding into this work. Similar initiatives are being developed by the Southend and Thurrock Health and Wellbeing Boards. We also note the *Five Year Forward View for Mental Health* recommendation that PHE should develop a national Prevention Concordat programme to support Health and Wellbeing Boards and to put in place updated Joint Strategic Needs Assessment

and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, by no later than 2017.[27]

The Essex public health team is further developing work with the mental health trusts in the county to reduce smoking prevalence among service users. Mental health and wellbeing is also picked up in a new Essex Lifestyle application launched in 2015 to offer advice for healthy living.[28]

In addition, Active Essex is working with District and Borough 'Active Networks' across the county to develop and deliver place-based approaches to increase participation in physical activity, and is engaging with Sport England's *Towards an Active Nation* strategy[29], This work is as important for mental as for physical health and wellbeing. Similarly, the work being done through the Health Checks programme in primary care to identify and engage with unhealthy alcohol consumption is an important tool in promoting mental health and wellbeing, given the links that can exist between mental illness and harmful drinking.

6.2 Improving access to psychological therapies

Local Authority and CCG commissioners across Southend, Essex and Thurrock had already identified the need to improve access to psychological therapies across the board for people with mental health problems. Better access to psychological therapies has been consistently highlighted as a key issue by people with mental health problems in the county.

We do not underestimate the challenges of continuing to improve access to psychological therapies for everyone who would benefit from them, but we are determined to address these challenges, and we know a lot about where blockages are and what we need to do to remove them.

The primary care psychological therapy services provided in many CCG areas across the county have not yet been able to consistently achieve current standards that they should be accessed by 15% of people with common mental health

[27] NHSE (2016), *Five Year Forward View for Mental Health*, p. 27 (Recommendation 2).
[28] The Essex Lifestyle Service website is at http://www.essexlifestyleservice.org.uk/ The App can be downloaded at https://itunes.apple.com/gb/app/lifestyle-essex/id967932040?mt=8
[29] Sport England (2016), *Towards an Active Nation Strategy 2016-2021*.

MER V3a DRAFT

problems in their local area each year and that at least 50% of the people treated should recover. Responding to concerns, Thurrock CCG re-procured its local service in 2015 and it is now provided by Inclusion Thurrock. Public and professional awareness of the local service and concerns about long waiting times for treatment have been identified as likely reasons why the numbers of people accessing these services is below this 15% target level.

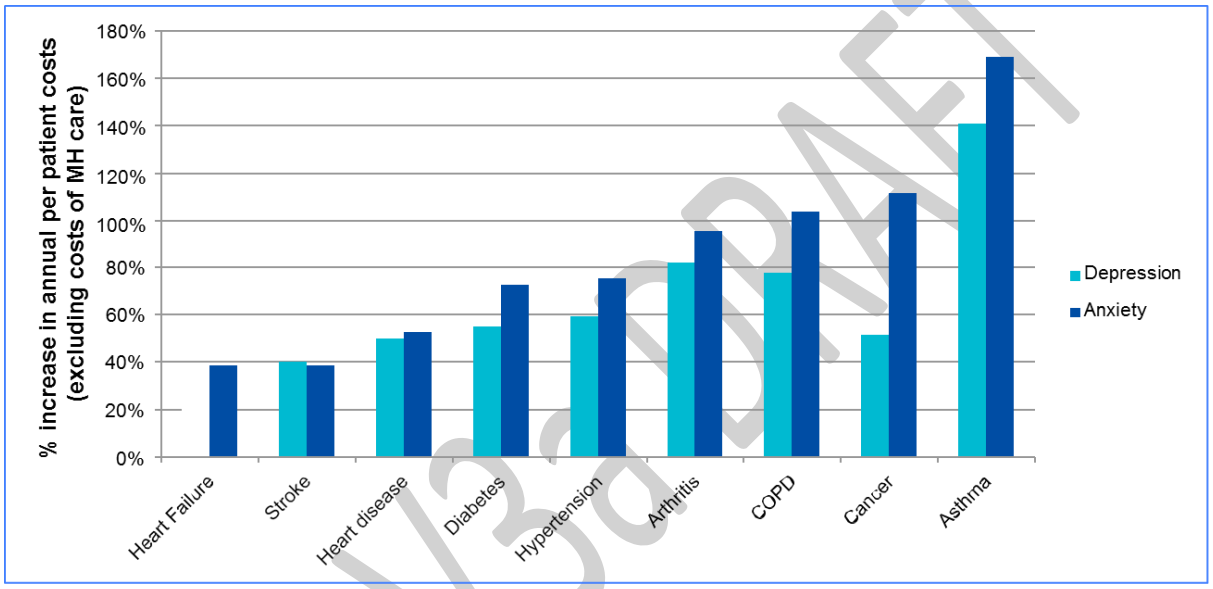
The *Five Year Forward View for Mental Health* says that primary care psychological therapies should be firmly embedded in primary care services. This is in line with the recommendation from the strategic review of mental health services in Southend, Essex and Thurrock which proposed that people with common mental health problems should receive the treatment and care they need from mental health services that are integrated with primary care (e.g. through the local GP surgery). As far as possible, we want therapeutic support to be available in local environments that are familiar to people and where they feel comfortable.

NHS England has said it will increase CCG's funding allocations to support the expansion of psychological therapy services for people with common mental health problems from 2018/19. West Essex CCG has been successful with Hertfordshire in obtaining "early implementer" funding to train the additional staff that will be needed to expand these services and pilot the development of integrated services. It is expected that these expanded services will deliver substantial savings, and will become self-sustaining, as there is evidence that a holistic, integrated approach that addresses the needs of people with long term physical health conditions and co-morbid mental health problems will reduce healthcare utilisation in terms of A&E attendances, short-stay admissions and prescribing costs.

Co-morbid mental health problems are associated with a 45-75% increase in service costs per patient (after controlling for the severity of physical illness). Between 12% and 18% of all expenditure on long-term conditions is linked to poor mental health and wellbeing, which is at least £1 in every £8 spent in the NHS on long-term conditions. Investment in both public health interventions and improving access to psychological therapies is critical if we are to create the 'virtuous circle' that will deliver the national ambition of the *Five Year Forward View for Mental Health* and

MER V3a DRAFT

the Greater Essex ambition that is articulated in this strategy. Investment in early interventions will deliver significant savings by preventing costs further down the line, which are then available to reinvest in further improvement to mental health services. There are a number of programmes of work across Essex which are embedding mental health services within physical health services and vice versa, including mental health liaison services within hospital emergency departments, as well as work to provide psychological support to people with long term conditions such as diabetes, cancer and COPD. We will learn from and build on these initiatives.



MER V3a DRAFT

6.3 Provision of mental health services in a primary care setting

The Boston Consulting Group Report (2015), highlighted the shift in activity required from the secondary care setting to the primary care setting to ensure that services are provided in the least restrictive environment.

Southend, Essex and Thurrock are seeking to move investment away from high cost inpatient interventions to evidence based primary care and community based mental health interventions and therapies.

Each CCG area will wish to integrate mental health services within their locality or neighbourhood models and provide these services as part of an offer of providing care closer to home.

Mental health services and IAPT psychological therapies will be provided within the primary care setting ensuring that individuals are able to access care outside of their specialist mental health trust setting. Mental health practitioners will form part of primary care multi-disciplinary teams, and mental health practitioners and community psychiatric nurses (CPNs) will be based within GP practices. Education, signposting to support services and social prescribing will be important aspects of this offer.

These services will provide an early intervention and preventative approach with a focus on mental wellbeing and maintaining good mental health.

MER V3a DRAFT

7. Adult mental health: community, acute and crisis care

Five Year Forward View for Mental Health 2020-21 Objectives

- By 2020/21, at least 60% of people with first episode psychosis will start treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral.
- By 2020/21 all areas will provide crisis resolution and home treatment teams (CRHTTs) resources to deliver a 24/7 community based response as an alternative to acute in-patient admissions in line with recognised best practice.
- Inappropriate out of area treatments (OATS) for acute mental health care should be eliminated by 2020/21. By 2016/17 all localities should have plans to ensure robust monitoring of OATs, with the aim of achieving a demonstrable reduction in acute OATs by March 2017.
- By 2020/21, all acute hospitals will have all-age mental health liaison teams in place and at least 50% of these will meet the 'Core 24' service standard as a minimum – during 2016/17, STPs should develop their approach to liaison mental health.
- By 2020/21, all NHS commissioned mental health providers will have armed forces champions and a specific named clinician with an expertise in military trauma and there will be a network of specialist collaborative providers co-commissioned with CCGs to provide care for the armed force community.
- Reduction in premature mortality of people living with severe mental illness (SMI); and 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
- A doubling in access to individual placement and support (IPS), enabling people with severe mental illness to find and retain employment.
- Increased access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

7.1 Crisis Care

7.1.1 Community mental health services

The *Five Year Forward View for Mental Health* sets CCGs and local authorities a clear challenge to invest in and develop community mental health services. The requirements with respect to services for people experiencing first episode psychosis are already explicit, and NHS England has set a target for CCGs to ensure that at least 50% of people experiencing a first episode of psychosis commence NICE compliant interventions within two weeks of referral. Further specific targets relating to employment for people with severe mental illness, their physical health and access to psychological therapies, and the levels of additional funding required to achieve these, have been promised.

Explicit aims of this additional investment and service development will be to improve access and reduce waiting times for evidence-based interventions; support the integration of community mental health services with primary care, social care and other services; and generate savings and efficiencies from other areas of mental health services (particularly inpatient services) as a result of earlier and more effective interventions.

7.1.2 Crisis Care services

The *Five Year Forward View for Mental Health* makes clear the importance of expanding and developing services that are able to offer a comprehensive and meaningful response to people who are experiencing a mental health crisis, and to their families, carers and the other professionals involved who may need support and advice. The key focus is the expansion of Crisis Response and Home Treatment Teams (CRHTs). Available evidence suggests that mental health admission rates in some parts of Greater Essex may be significantly higher than in other comparable areas in England. Expansion of CRHTs will provide community based crisis response and intensive home treatment as an alternative to admission to hospital and alleviate pressure on acute inpatient mental health care.

It will be important for CRHTs to involve family members and carers to ensure that they have the fullest possible picture of relevant risks, to the service user, family and the wider community, and that their views and needs are taken into account (for

MER V3a DRAFT

example, where they feel it is unsafe for them to continue to provide care). It will also be important for CRHTs to work effectively with drug and alcohol services.

This will be a necessary step in reducing the numbers of people who need to be admitted to acute mental health beds away from their home areas. This happens currently when local beds are full and there is no other alternative. NHS England has made clear that all CCGs will be expected to have eliminated these out of area admissions by 2020/21.

Changes to the Mental Health Act as a result of the Police and Crime Bill coming into force from April 2017 are also driving the need significantly to improve the capacity of the wider health, care and criminal justice system to respond to people who experience a mental health crisis. Critically, restrictions on the use of police cells as a “place of safety” will have significant impact on how specialist mental health services meet the needs of people in crisis who are being violent and aggressive, and also on the need for police officers to have access to mental health support and advice. Essex organisations secured additional capital funding in 2016 to improve the safety and environment within their section 136 suites.

The changes in legislation will require efficient system-wide working in Essex across a range of organisations including mental health trusts, social care and housing providers and the emergency services, including Essex Police. Essex County Council are focussing on increasing the number of Approved Mental Health Professionals (AMHP) available to undertake section 136 assessments, and health are focussed on improving the lengths of stay in inpatient provision and reducing admissions that could be seen within the community to ensure that beds are available should an individual require admission following a Mental Health Act assessment.

A centralised AMHP service will be operational in Essex County Council in the latter part of 2017. The service will operate 24/7 and deliver the local authority’s statutory responsibilities ensuring that there is a sufficient number of Approved Mental Health Professionals to meet the demands of the population. The centralised AMHP service will be supported by AMHPs within the wider workforce during working hours.

MER V3a DRAFT

Southend are considering the best approach to ensure the numbers of AMHPs meet the needs of the population and will be working closely with neighbouring authorities to find a solution that meets the needs of Southend. Thurrock will not be part of the centralised services but is committed to ensuring there are sufficient AMPHs to meet the demands of the local population.

Developing liaison mental health services in acute hospitals not only provides a speedier and more comprehensive response to people with mental health problems attending hospital emergency departments, but also supports improvements in the care of people admitted to hospital who may also have dementia or mental health problems, and for people referred for acute hospital investigations and treatment whose physical symptoms may be exacerbated by common mental health problems like anxiety and depression. NHS England will require CCGs to ensure that acute hospitals have these liaison mental health teams in place by 2020/21.Across Essex, we wish to have 24/7 mental health liaison available in all of our acute providers.

The Southend, Essex and Thurrock Mental Health Urgent Care Group has a significant role to play in ensuring that there is a continued focus on the development and improvement and joining up of crisis services across Greater Essex, including street triage and criminal justice provision, and that system-wide solutions are in place to ensure optimum support for service users.

Case Study

‘I feel that there is no preventative work with people that experience mental health, only reactive and crisis support’

I have diagnosis of bi-polar and recently at the start of this year diagnosis of anxiety, I first had trouble at the age of 17 where I took an overdose and was taken into hospital

… I feel that there is no preventative work with people that experience mental health, only reactive and crisis support. The process of the referral … takes too long … I can understand and relate to the limited resource that may be available, however what about a simple phone call to acknowledge that they have received it, communication is key so you do not feel that you are forgotten about.

V3a DRAFT

Case Study

'I tried to call the crisis line but they put me on hold'

Around two years ago, I suffered a break down and tried to hang myself, an ambulance was called and I was taken in to hospital and left in the waiting room with everyone in A &E. I felt everyone was looking at me judging me. I was then put to talk to a mental health professional.. I was transferred to the mental health unit, not knowing what was happening being left to sit in almost darkness alone not know what's going on. I was made to sleep on a mattress on the floor, no one tried to talk and help me I was just left.

In the morning things didn't improve, staff just seem busy you were given medication and just left to get on with nothing, occasionally certain staff would say I have 10 minutes if you want to talk, I didn't feel listened to it was just like they heard but didn't listen

I was released being told I was suffering reactive depression.....

A few weeks went by and things got worse for me I tried to call the crisis line but they put me on hold and told me there was no room for me.

7.1.3 Personality Disorder and complex needs

Across Greater Essex we are working to improve the provision of evidence based services for people with personality disorder.

At present, 30-40% of inpatient admissions into our specialist mental health trusts are personality disorder related, with a national estimate of this figure being 40-60%. North Essex CCGs developed a *Personality Disorder Strategy* in 2015, and this *Southend, Essex and Thurrock Mental Health and Wellbeing Strategy* adopts and endorses the principles and approach contained within that document.[30]

The core objectives of the North Essex guidance are summarised as follows:

[30] North Essex Clinical Commissioning Groups (2015), *Personality Disorder Strategy – 2015-2017*.

- To assist people with personality disorder, who experience significant distress or difficulty, to access appropriate clinical care and management from specialist mental health services; and
- To establish necessary education and training to equip mental health practitioners to provide effective assessment and management.

In January 2009 the National Institute for Health and Care Excellence (NICE) issued guidelines for treatment and management of personality disorder as part of their pathways programme that recommends how health and social care professionals can ensure that users of mental health services have the best possible experience of care from the NHS.

The guidelines on personality disorder have a strong emphasis on:

- Access to services;
- Using more than one type of intervention, and not using brief psychological interventions;
- Autonomy and choice – working in partnership with service users with clear boundaries;
- Developing an optimistic and trusting relationship;
- The use of care plans with goals and crisis plans;
- Professionals working together across the pathway.

These priorities are reflected and endorsed by the North Essex guidance, and will inform the approach to personality disorder and drive progress in Southend, Essex and Thurrock.

In particular, we intend to increase the availability of provision of specific evidence based therapies for people with personality disorder and complex needs by reducing reliance on inpatient beds across Greater Essex, and reinvesting these funds in skilled teams to provide outreach support and therapies. The outcomes we would expect to see from the change in the way that we support people with personality disorders are:

- A recovery model rather than a 'maintenance' model of care;
- Better and timelier discharge systems incorporating the use of technology;
- Reduction of PD prevalence and bed days on acute wards;
- Improved staff morale and a reduction in staff sickness;

MER V3a DRAFT

- Increase in knowledge of and attitude to PD;
- Improved service users /carers / families / satisfaction;
- Reduction in Section 136 usage;
- Reduction in suicide rate;
- More focus on physical health in order to improve healthy life expectancy;
- Increase in discharges to the GP;
- Reduction in admission to A&E and urgent care services;
- Increase in clarity about appropriate care pathways for PD;
- Better interface between primary, secondary & acute care;
- Better interface between children, adult and specialist commissioning;
- Increase in recovery based services; including self-care management.

Personality disorder: How prevalent?

Most service users diagnosed with a personality disorder fall into the borderline personality disorder (BPD) group. Prevalence of BPD in the general population ranges from 1.4% to 5.9%, and in psychiatric populations is around 20%.Personality disorders are more common in younger age groups (25-44yrs) and are equally distributed between males and females4 with an estimated occurrence rate for any personality disorder being 54 per 1,000 men and 34 per 1,000 women. It is also important to engage with the antecedents of personality disorder and multiple needs. For example, studies suggested that people diagnosed with Borderline Personality Disorder have a high prevalence of childhood sexual abuse.

7.1.3 Use of inpatient provision

We will seek to gradually reduce adult acute inpatient bed numbers across Greater Essex by increasing the amount of home treatment and crisis response available to service users to allow service users to be supported in the least restrictive setting. We intend to fully eliminate the use of inpatient beds outside of the Southend, Essex and Thurrock areas by the end of 2017 as we recognise that being placed away from family, friends and carers can have a detrimental effect on recovery. Funding currently utilised for high cost out of area placements will be used to increase capacity in community teams ensuring that intensive community support can be provided as an alternative to admission.

7.2 Recovery and reintegration

7.2.1 Focusing on recovery

The concept of recovery in mental health is about building a meaningful and satisfying life, whether or not there are recurring or ongoing symptoms or mental health problems. The key themes of recovery are:

- **Agency** - gaining a sense of control over one's life and one's illness. Finding personal meaning, an identity which incorporates illness, but retains a positive sense of self.
- **Opportunity** - building a life beyond illness. Using non-mental health agencies, informal supports and natural social networks to achieve integration and social inclusion.
- **Hope** - believing that one can still pursue one's own hopes and dreams, even with the continuing presence of illness. Not settling for less, including the reduced expectations of others.

To make recovery possible for people, mental health services need to be designed and operated differently. The objectives of a recovery-oriented mental health service are different from those of a traditional secondary care mental health service that tends to focus on treatment and the control of symptoms. The recovery approach also requires a different relationship between service users and professionals. This is a shift from staff who are seen as in a position of expertise and authority, to someone who behaves more like a personal coach or trainer. This change was reflected in the mental health strategy *No Health Without Mental Health* (Department of Health, 2011) for which key outcomes were enabling people to gain:

"a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live".

If services are to assist people in achieving these outcomes, significant cultural and organisational changes are required. These will involve:

MER V3a DRAFT

- A redefinition of the purpose of services from reducing symptoms to rebuilding lives;
- A change in the role of mental health professionals and professional expertise;
- A recognition of the equal importance of both “professional expertise” and “lived experience”;
- A different relationship between services and the communities that they serve.

Recovery colleges have become one of the principal vehicles for making these changes in the UK. They offer comprehensive peer-led education and training programmes within mental health services. They should be run like any other college, providing education as a route to recovery, not as a form of therapy. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals. Recovery college services should be offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus.

In a Greater Essex context, developing recovery colleges will represent a significant step in the process of shifting caseload and resources from secondary care to primary care mental health services in line with the recommendation in the Essex Mental Health Review.

Innovation Case Study: REACH (Recovery, Empower, Achieve, Community, Hope) - the South East Essex Recovery College

REACH is a recovery focused approach to service delivery in south east Essex. Rethink, The Richmond Fellowship, SEPT, Southend and Central Essex Mind and Trust Links are working together with service users so that people can manage their own mental health through learning, empowerment and co-production. It develops self-management skills for people with mental health challenges through:

- learning and developing skills;
- developing expertise in their mental health and their condition(s);
- developing personal skills;
- identifying and reaching goals and aspirations;
- reaching their own solutions through coaching.

V3a DRAFT

The primary purpose of REACH is to improve resilience and self-management, supporting people to achieve their aspirations. REACH aims to reduce dependence on mental health services by supporting self-management and increasing wellbeing and confidence.

A wellness navigator will support each student to develop a learning plan designed around their own needs and aspirations, this will be modelled around the 'recovery star' to provide a baseline and evaluation to model interventions.

REACH will provide a very broad range of interventions (courses) but include elements of class based activity, coaching, mentoring 1 to 1 to small group (3-5 people) and medium sized group (6-8 people) work. Mentoring, coaching, workshops and interventions will be developed and delivered with a wide range of people who are living with mental health issues.

7.2.2 Families and carers

There is plenty of evidence that recognises the positive role of family and other carers in support for treatment and recovery from mental health problems and addiction, as well as the importance of long-term relationships for health and well-being and, conversely, the risk of long-lasting harm as a result of family breakdown and poor relationships.

Families and carers in Southend, Essex and Thurrock make a vital and irreplaceable contribution to the care and support of people experiencing and recovering from mental health problems in Greater Essex. The Five Year Forward View concludes that, in England, unpaid carers (typically family members) contributed the equivalent of £14.2 billion to meeting the £32.4 billion cost of mental health support and services in England in 2013-14. Our approach will draw on the strengths and resources of families and carers to support our ambitions for recovery, while recognising the need to involve families, listen to them, provide appropriate support, manage risk and address safeguarding concerns.

Innovation Case Study: Carer-led workforce training

The Essex Social Care Leadership Team and North Essex Partnership NHS Foundation Trust have initiated a new programme of work to learn from carers about the experience of supporting someone with a mental health challenge. Prompted by the low numbers of people who are participating in the Carers' Assessment, the aim of this initiative is to empower a small cohort of carers to work with the Trust to deliver training to the Essex mental health workforce to enrich their understanding and appreciation of the pressures, realities and values of the caring role.

A particular issue highlighted in the engagement work for this strategy was the need for 'workforce development or training to develop skills for identifying, supporting and communicating with carers – for example, using language that the cared-for person can relate to such as "who helps you out?" or "who supports or looks after you?" rather than "do you have a carer?".

Our consultation with experts by experience highlighted a number of issues and concerns about the role of families, which will guide the development of services:

- Where carers and families believe there is significant risk to the patient/client or others they need support to manage this and a safety net where things become unmanageable.
- The need for a broad and inclusive understanding of 'crisis' that takes proper account of the views and experiences of families, and also recognises families ability to identify early warning signs, that can enable intervention before crisis point. Given the focus on supporting people to remain in the community, there is a need for clear structures, minimum standards of care and pathways to ensure that this does not place undue strain on carers and families, and that they receive support to play a positive role in their loved one's care and recovery.
- Where there is significant risk to the patient/client or others, families will be offered the support they need to know how to manage this and there will be a safety net for when things are unmanageable.

Essex's approach will be guided by the requirements of the Care Act 2014 and by our local carers' strategies. We are committed – in particular – to implementing a

'triangle of care' approach, where carers are equal partners alongside the cared for person and professionals.

Essex Carers Strategy

The Essex Carers Strategy sets out a high-level direction for all agencies working with carers:

1. **Choice and control** – carers know what their options are now and in the future and are supported to plan for all stages of their caring role;
2. **Respect and recognition** – carers are recognised, respected, valued and included as expert and knowledgeable partners by professionals, as part of the 'Triangle of Care' approach with the cared for person;
3. **Access to networks of support** – Carers are connected to local community support networks;
4. **Achieving full potential** – Carers are able to access education, employment and life opportunities;
5. **Good health and wellbeing** – Carers are able to maintain their health and wellbeing, both physically and emotionally, whilst managing their caring role; and
6. **Independence** – Carers are resilient and able to sustain a life of their own alongside their caring role.

7.2.2 Developing the accommodation pathway

Previous Southend, Essex and Thurrock strategies have highlighted that as funding arrangements and services change it is more important than ever to strengthen links between health and social care commissioners, health providers and local housing authorities to ensure that appropriate supported housing is available to support recovery.

District and Borough Councils have a duty to those who are at risk of becoming homeless and through this have built examples of good practice in partnership working such as supported housing and floating support with housing associations and pre-planning discharge with local hospitals. This has helped to improve not only access to accommodation, but also the opportunity to sustain recovery and live independently. Through this, many people have been able to break cycles of

readmission to hospital – as well as relapses into substance misuse in some cases – and to achieve better health and wellbeing.

Despite much good practice, the Essex JSNA 2016 reports that the proportion of adults in contact with secondary mental health services living in stable and appropriate accommodation in Essex at 49 per cent, is significantly below regional (56 per cent) and national (57 per cent) averages.[31] Most worryingly, it is reported that the figure for Essex represents a fall of almost a third in the proportion of people involved with mental health services in stable accommodation. Further research is looking into what lies behind this figure, but there is clearly more work to be done.

Southend JSNA reports the proportion of people on CPA in settled accommodation in Southend-on-Sea (70.2%) was higher than the East of England (65.5%) and England (58.5%).

The current Essex Accommodation Pathway is a progression model in which support should be offered at an appropriate level whilst people build the skills and the resilience needed to move on to more independent living options. A review of the current operating performance of the pathway is underway in Essex.

Southend is developing an accommodation pathway to enable people with mental health issues to enable their recovery. The Thurrock accommodation pathway is being developed to address the issues outlined above, progressing partnership working between health, adult social care and housing. The approach is aligned to the transformation agenda across all areas to be delivered through For Thurrock in Thurrock and Living Well in Thurrock.

Innovation Case Study: Intensive enablement

Intensive Enablement is an initiative from Essex County Council (ECC) that helps people with a history of mental health challenges to move from residential or in-patient care to independent living in the community. It provides short term high-intensity help within a supported housing setting, where the focus is to help people to stabilise their mental health and increase skills for living independently. The aim is to enable people to move into more independent settings within 18 months.

[31] Insert reference to the Mental Health JSNA.

MER V3a DRAFT

Historically, ECC spends a greater proportion of its budget for mental health services on residential and nursing care than other similar authorities. It has been seeking to change this as part of an approach to promoting recovery and self-management and increasing people's ability for independent living. It is also expected that Intensive Enablement will help to release significant savings in the system: people coming through this pathway leave residential care and have the opportunity to live independently, in a way that also helps to reduce the pressure on local budgets.

7.2.3 Supporting people into and in work

Around 60 to 70 per cent of people with common mental health problems are in work, but too often the support they need is not available. In addition, many people with depression and anxiety are not able to work and are managing on Employment and Support Allowance, at a significant cost to the welfare system.[32]

It is a different story for people in touch with specialist mental health services, where there is a 65% gap nationally between their employment rates and those of the general population. Further, where people are employed they are over-represented in high turnover and low paid work, and in part-time and temporary employment.[33]

In Essex, in 2013 only 16 per cent of people being treated for mental health problems by specialist services were in employment, presenting a barrier to recovery and independent living, as well as involving significant costs for the local economy. The Essex JSNA 2016 concludes that the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate was nearly 69 per cent in 2013-14, and with Essex's figure reported to be steadily rising against these average trends over the last three years.[34]

According to the Southend JSNA the unemployment rate in Southend-on-Sea is 6.8%; higher than the East of England and England (5.9%). The proportion claiming Employment Support Allowance and incapacity benefit in Southend (7%) was higher than the east of England (4.9%) and England (6.4%). The proportion of those on

[32] Centre for Economic Performance's Mental Health Policy Group (2008), *The Depression Report – A new deal for depression and anxiety disorders*.
[33] NHSE (2016), *The Five Year Forward View for Mental Health*, p. 6, p. 16-17 and p. 27 (Rec 5).
[34] Insert reference to the Mental Health JSNA.

MER V3a DRAFT

CPA in employment in Southend (8.6%) was lower than the east of England (12.4%) but similar to England (8.8%). However more recently, the proportion of people on CPA in employment fell from 6.9% Q1 13/14 to 3.1% Q2 14/15. It is not known what led to the fall in the most recent period - this was not seen at national level (HSCIC 2015).

The *Five Year Forward View for Mental Health* challenges us all to significantly improve employment rates, recommending that 'by 2020/21, each year up to 29,000 more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support.'

Employment Services across Essex have historically performed at a good level in comparison with statistical neighbours. Nevertheless, there is further work that can be done to broaden the coverage of employment support and to work with local employers to help foster a job market which is inclusive of people with mental health needs.

Innovation Case Study: Integrated Support, Advice, Recovery and Mentoring Service (ISARMs)

Ready to launch in 2016, ECC's new ISARMs service will support and empower service users, families and communities to draw on their insights, strengths and assets to support recovery and social inclusion. By supporting people who have mental health and/or drug and alcohol needs, ISARMs will also help us to meet the challenge of 'dual diagnosis'.

Recovery support will be designed by and for those who need to access it. Empowerment of service users, families and carers will ensure that support is responsive to need and sensitive to individual goals and circumstances, and people in recovery will be encouraged to play a key role in the co-production, design and delivery of mental health and other services. There will be a focus on designing interventions and services in a way that reduces social isolation and promotes full involvement in the local community, as well as on peer-to-peer support.

DRAFT

8 Health and Justice

Five Year Forward View for Mental Health 2020/21 Objectives

- By 2020/21, there will be evidenced improvement in mental health care pathways across the secure and detained settings.
- Access to liaison and diversion services will be increased to reach 100% of the population, whilst continuing to ensure close alignment with police custody healthcare services.

8.1 Background

Mental health problems are endemic within the criminal justice system, with some research suggesting that the majority of offenders have mental health issues, often alongside learning difficulties. Substance misuse is also prevalent and 'dual diagnosis' is common. The Greater Essex Police and Crime Plan says that 15% to 25% of all police time is spent on incidents where mental health is a factor[35].

Offenders with mental health problems have not always been able to access appropriate treatment within the criminal justice system or support for resettlement. A major programme of work led by the Department of Health has developed from Lord Bradley's 2009 report regarding people with mental health problems and learning difficulties in the criminal justice system, including an expansion of court liaison and diversion schemes and improvement of police custody healthcare.[36] The Transforming Rehabilitation agenda has resulted in significant changes to the prison and probation structures, and the Care Act 2014 has given local authorities a new statutory duty to provide social care services to prisoners in their area. However, more needs be done to integrate offender health, mental health and social care to provide seamless support in prisons, through the gate and back into the community.

In Greater Essex, the Police and Crime Commissioner has identified tackling drugs, alcohol and mental health issues as a priority, and has developed a pilot project in South Essex (encompassing Southend and Thurrock) involving specialist mental

[35] Police and Crime Commissioner for Essex, *Police and Crime Plan 2014*, p. 23.
[36] See *The Bradley Report – Lord Bradley's review of people with mental health problems and learning disabilities in the criminal justice system* (2009), Department of Health.

MER V3 DRAFT

health nurses working alongside police officers to provide early support, intervention and triage. The PCC and his office have monitored cases where Essex police have exercised their powers under section 136 of the Mental Health Act to take anyone thought to be experiencing a mental health crisis to a place of safety. Essex is also developing innovative approaches for supporting people with 'dual diagnosis' and multiple need (for example, offending and homelessness).[37] The new Offenders with Complex Needs service – Full Circle - is offering a care co-ordination approach for offenders with substance misuse, mental health, learning difficulties, housing and other problems.

Improving support for offenders with mental health problems has very significant benefits for the wider community, as it will:

a) Reduce re-offending and improve health – by developing and integrating support we will achieve improvements in the individual's health and social functioning - and where families are involved improved family functioning – along with reduced crime in our communities.

b) Better integration will improve our engagement with offenders at all points (including pre-offending crisis) and reduce the costs associated with multiple "touch points" and serial triage/assessment. By prioritising early engagement we will also be able to reduce demand for higher cost specialist provision.

Multiple and complex need

There is growing recognition of the complex interdependencies between mental health, substance misuse, learning disabilities and social exclusion (e.g. homelessness and lack of employment), and the need for systems of care and support that can work with these interdependencies.[38] Multiple and complex need is particularly pronounced in the offender population, and those with a number of inter-related problems in their lives have unequal access to the support options available to other offenders, are less likely to be rehabilitated and more likely to reoffend.

[37] Police and Crime Commissioner for Essex, *Police and Crime Plan 2014*, p. 23.
[38] See, for example, Bramley G and Fitzpatrick S (2015), *Hard Edges, Mapping Severe and Multiple Disadvantage in England*, Lankelly Chase and Heriot-Watt University. Programmes of work include the Big Lottery Fund's Fulfilling Lives programme for multiple and complex needs and the work of the Making Every Adult Matter coalition.

There will be a significant degree of overlap between those who have multiple or complex needs and those described as having a 'personality disorder' and some similar issues in developing and delivering appropriate packages of care.

8.2 Reducing re-offending

Southend, Essex and Thurrock are committed to transforming lives and reducing crime by taking a holistic approach to the mental health needs of offenders (including prisoners), guided by the 'seven pathways to reduce re-offending' as defined by the National Offender Management Service (NOMS). These are:

- accommodation and support
- education, training and employment
- health
- drugs and alcohol
- finance, benefits and debt
- children and families
- attitudes, thinking and behaviour.

A number of research projects have been commissioned by ECC's public health team (and previously the Drug and Alcohol Action Team) to support commissioners to address health and mental health inequalities within this group, address drug and alcohol misuse and reduce offending.[39] These studies have converged on a number of key findings which will inform Greater Essex's strategic approach to health and justice:

- Develop an integrated approach throughout the criminal justice system and across mental health, learning disability and substance misuse agencies.
- Terminology and criteria used to identify these needs should be specific and consistently applied across the whole system.
- Tools used to aid identification should be validated, comprehensive and used at the earliest opportunity and throughout the criminal justice system.

[39] In particular, see Scott M and Senker S (2014) *Rebalancing Rehabilitation – Making the case for change to ensure a level playing field for offenders with complex needs across Essex*, Tonic Consultants; Connor M (2014), *The Process and Treatment Outcomes Research Study* (PTORS); Senker S (2014), *Conceptualising recovery and addiction from the perspective of substance misusing offenders*.

MER V3a DRAFT

- Practitioners should feel skilled, confident and competent at identification of these needs and ensuing adaptation and referral.
- Agencies and policy makers should consult service users in the criminal justice system in improving the response to these needs.

8.3 The challenge for Southend, Essex and Thurrock

Where drugs and/or alcohol problems are identified there are effective services available in criminal justice settings. Equally there is a good level of mental health provision. The challenge now is to co-ordinated criminal justice and community services and, particularly, to develop pathways and referral routes from the criminal justice system and into community services and support.

There are still significant gaps in provision and co-ordination for people being released from prison or where problems have been identified in police custody, particularly for offenders with multiple needs. There is a need to continue to improve co-ordination of identification, assessment and triage across criminal justice and community services, particularly where people are returning to the community from custodial settings.

In addition, it is important to continue to improve criminal justice involvement in responding to crisis and supporting detention under the Mental Health Act. There is significant pressure on the availability of places of safety in Southend, Essex and Thurrock for assessment under s. 136 of the Mental Health Act, with the risk that individuals in crisis may not be appropriately managed and supported.

Essex police have new responsibilities under the Police and Crime Act 2016 from 1st April 2017, including:

- Police stations may never be used as ‘places of safety’ under s. 136 of the Mental Health Act for under 18s;
- A reduction in the maximum time period for which a person can be detained under s.135 and s. 136 of the Mental Health Act from 72 hours to 24 hours (with an extension to 36 hours in exceptional circumstances); and
- Requirement that the police consult a health professional (where practicable) before detaining a person under s. 136.

MER V3a DRAFT

Essex police have highlighted a number of challenges that partners will need to address. National data for 2015-16 shows that s. 136 detentions under the Mental Health Act are increasing year on year. Essex police had the twelfth highest number of detentions under s. 136 in this period, and the sixth highest use of police cells as places of safety as a result of significant capacity issues with health-based places of safety.

Essex police have identified key challenges that will need to be addressed by this strategy in order to implement the Police and Crime Act in Essex, specifically:

- Address lack of capacity in health based places of safety in Greater Essex;
- Ensure sufficient resources and capacity is made available to conduct assessments in reduced times, particularly availability of appropriate doctors and approved mental health professionals.

They point to a number of initiatives that are helping to meet these challenges and can be built on going forward, including the introduction of a new system which is placing responsibility on the health service to identify an available health-based place of safety, the further development of the pan Essex Mental Health Crisis Care 24/7 project, which is being led by Thurrock CCG and development of street triage. This strategy commits all partners to working together to end the use of police cells as 'places of safety'.

8.4 Improving outcomes

The *Five Year Forward View for Mental Health* has a particular focus on improving crisis care, which is reflected in our strategy for Greater Essex. This is a key issue for the criminal justice system, and we will build on work already happening across the county:

- The development of an Offenders with Complex and Additional Needs (OCAN) Service to work in HMP Chelmsford and the community in partnership with the Community Rehabilitation Company, National Probation Service and liaison and diversions services in police custody to support individuals with complex needs into and through appropriate specialist service provision.

MER V3a DRAFT

- Health, police and local authority partners are working together to explore options for developing the provision of crisis engagement such as street triage is further developed to engage offenders at the first opportunity and to divert them from the criminal justice system.

- There is a need to monitor and manage pressures on place of safety provision across Southend, Essex and Thurrock, and to eliminate the use of police cells as places of safety.

- Discussion is also underway to develop a local devolution/delegation of health and justice budgets and responsibilities from NHS England to Essex. This would bring significant new opportunities for Essex partners to integrate health and justice to meet local needs, improve outcomes for offenders and reduce crime.

DRAFT

Key priorities in developing our strategic approach to health and justice in Essex are identified below.

- A review and development of police custody and community crisis services to build more effective and efficient engagement and diversion services within the criminal justice system. This will include the Appropriate Adult Service, Street Triage, Liaison and Diversion and the Forensic Medical Examiner.

- Development of more effective pathways into and through services for those identified with mental health needs in the criminal justice system including:
  - Primary Care and low threshold support preventing escalation
  - Secondary care and community mental health provision
  - Specialist service provision incl. inpatient provision.

- Development of effective links to and provision within employability and accommodation support specifically targeting people with mental health problems in the criminal justice system.

9. Suicide prevention

Five Year Forward View for Mental Health 2020-21 Objectives

- By 2020/21, the *Five Year Forward View for Mental Health* set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. To support this, by 2017 all CCGs will fully contribute to the development and delivery of local multi-agency suicide prevention plans, together with their local partners.

Not everyone who has a mental illness will be suicidal, and not everyone who takes their own life will have been diagnosed with a mental illness. Therefore as well as ensuring that mental health services provide the best possible support to those they come in contact with, wider support to improve the mental health and well-being of other groups and the general population is needed.

In 2013 the *All Party Parliamentary Group on Suicide and Self-Harm Prevention* published its initial deliberations. This was followed by *The All-Party Parliamentary Group (APPG) on Suicide and Self-Harm Prevention Inquiry into Local Suicide Prevention Plans in England 2015*. The main recommendations from the latter were that all local authorities must have in place:

a) Suicide audit work to in order to understand local suicide risk.
b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.
c) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

9.1 Southend, Essex and Thurrock Suicide Prevention strategy and 2014/15 suicide audit

This chapter should be read in conjunction with the Suicide Prevention Strategy 2016 and the Southend, Essex and Thurrock Suicide Prevention Audit 2014/15 report which present more detail on the topic of suicide prevention and which are due to be published early 2017.

MER V3a DRAFT

The intent of the Suicide Prevention Strategy - in this first year iteration – is to collate and cross references the strategic intent and action plans of the various organisations and partnerships – many mentioned throughout this strategy – that have a role to play in suicide prevention across Essex.

The approach taken in the strategy is to recommend that the actions are owned by the responsible organisations and partnerships, with annual oversight by the Essex, Southend and Thurrock Health and Wellbeing Boards and an annual summit focused solely on suicide prevention. This recognises the complex geography of Southend, Essex and Thurrock with overlapping boundaries and jurisdictions which require both local and shared approaches to suicide prevention.

9.2 Who is most at risk of suicide?

Those who died were more likely to be male, white, and middle aged. Risk factors included drug and/or alcohol problem, previous suicide attempt and/or episodes of self-harm, mental or physical health problems, relationship stress, financial difficulties, involvement in criminal justice system or recent bereavement. Two thirds died in their own home; rail and coastline are small but significant locations with scope for intervention. Hanging and poisoning were the most common means of death; opiates being the most common cause of poisoning. About one third were known to be in contact with or had previous contact with mental health services.

NATIONAL CONFIDENTIAL INQUIRY

In October 2016 the National Confidential Inquiry into Suicide and Homicide by People with Mental Health Problems published its *Annual Report and 20 year review*. Key findings will guide prevention work in Greater Essex and include:

- in England. During 2004-14, 28% of suicides in the UK general population were by people within mental health care.
- Suicide by mental health inpatients continues to fall, most clearly in England where the decrease was around 60% during 2004-14.
- There are around three times as many suicides by CRHT as inpatients in England, over 200 per year. A third of CRHT patients who die by suicide have been under the service for less than one week, a third have been discharged

ER V3a DRAFT

from hospital in the previous two weeks and 43% live alone. It is concluded that the main setting for suicide prevention is now the crisis team.

- The first three months after discharge continue to be a period of high suicide risk. In England the number of deaths rose to 200 in 2014 after a fall in the previous year.
- The commonest method used by patients is hanging, followed by self-poisoning.
- Over half the patients who died by suicide in the UK had a history of drug and alcohol misuse.
- 13% of patients who died by suicide had experienced serious financial difficulties in the previous three months.
- 5% of patients who died by suicide were people who had been living in the UK for less than five years, 86 deaths per year.
- Certain risk factors have become more common as antecedents for suicide in the last 20 years, including isolation, economic adversity, alcohol and drug misuse and recent self harm.
- Non-adherence to medication in the period leading up to suicide has become less common and loss of contact is less frequent than 20 years ago but continues to be an antecedent.

The Southend Essex & Thurrock Strategic Child Death Overview Panel commissioned a review of the suicides in young people to explore what further actions SCDOP could take to reduce the risk of youth suicide in SET areas. Key findings included:

- Most of the young people were not previously known to services.
- Need to build resilience and problem solving strategies for young people
- Online support is key for children and young people.
- Youth champions within schools could be used as young people will often talk about their concerns to peers first, before teachers or professionals.
- The involvement in suicide prevention work by schools who have had experience of supporting staff, children and families following the suicide of a child would be useful.

Thurrock has produced its own locally specific suicide prevention strategy and has convened a prevention group.

9.3 Strategic priorities for suicide prevention in Southend, Essex and Thurrock

9.3.1 Reduce the risk of suicide in key high-risk groups.

The Government's *Preventing Suicide in England* (DH 2012) identified the following high-risk groups as priorities for prevention:

- young and middle-aged men (although recent trends are showing older men as a growing concern);
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

The National Confidential Inquiry highlights the risks to:

- CRHT patients, particularly those who have been under the service for less than a week and those discharged from hospital in the previous two weeks;
- Patients in the first three months after discharge;
- Patients who have experienced significant financial difficulties in the previous three months;
- Recent immigrants to the UK (living in the country less than five years).

Additional risk factors for suicide include physical health problems, drugs and alcohol misuse, and those with previous history of suicide attempt. *Preventing Suicide in England* (DH 2012) also make reference to the links between mental ill-health and social factors and life events such as unemployment, debt, social isolation, family breakdown and bereavement, and living alone. Public Health England has recognised the specific inequalities in self-harm and suicide affecting lesbian, gay, bisexual and transgender populations.

Chapters 4 to 8 of this strategy describe the efforts of the health and care system and wider partners to improve mental health services and outcomes .1; these actions will have a positive impact on suicide prevention as a key outcome of success.

MER V3a DRAFT

Essex Innovation Case Study: Zero Suicide

The Mid Essex Suicide Prevention Project is part of a group of pilots led by the East of England Strategic Clinical Network.

The aim is to raise awareness of mental health issues and ensure that professionals are equipped to respond to people who are suicidal, depressed or in mental distress. It also aims to support and empower carers and the wider community so that they too know how to respond to and support people in distress.

The Mid Essex pilot has focused on skilling-up primary care staff around suicide prevention. It has delivered training – SafeTALK and ASIST (Applied Suicide Intervention Skills Training) – to over 100 people across all disciplines and received positive feedback. It has explored the feasibility of training practice nurses and GPs as well as ensuring that medical receptionists are equipped to provide a basic mental health 'first aid'.

An independent evaluation of the East of England initiative published by the Centre for Mental Health in 2015 was 'very impressed' with the work, concluding that 'the projects showed creativity, vision and commitment to reducing suicide and proved their approaches to be very successful'.

9.3.2 Tailor approaches to improve mental health and wellbeing

Preventing suicide in England (DH 2012) recognised the following groups

- Children and young people;
- Survivors of abuse and violence;
- People living with long-term physical health conditions;
- People with untreated depression;
- People who are especially vulnerable due to social and economic circumstances;
- People who misuse drugs or alcohol;
- LGBT people;
- BAME people and asylum seekers

In addition to the actions noted in Chapter 4 for children and young people within children and young people's emotional health and wellbeing services and transition support, there are further suicide specific actions. The SCDOP commissioned a task and finish group to revise the current schools suicide prevention guidance and to develop complementary self-harm prevention guidance.

Suicide is also the second highest cause of maternal death. Chapter 5 of this strategy notes actions that will improve support for new and expectant mothers, including the opportunities in the new pre-birth to 19 pathway which will include emphasis on maternal depression.

As noted in 6.1, Essex County Council will be publishing its Public Health Strategic Approach in early 2017. In addition to the specific benefits of healthy lifestyles on mental health, this strategic approach recognises the importance of the wider determinants of health on mental health. It reinforces the message from national intelligence and the local audit that issues such as employment and financial worries are key risk factors for suicide, and as such prevention strategies need to be comprehensive and address all known risk factors.

Thurrock will be addressing similar issues though the work of the Public Health team to assess the needs and demands of the local population, with specific reference to a needs assessment for mental health.

9.3.3 Reduce access to the means of suicide

The main means of suicide include:

- Hanging/strangulation in psychiatric inpatient and criminal justice settings;
- self-poisoning;
- those in high risk locations;
- those on the rail and underground network.

The Greater Essex audit has identified changes in the means of suicide with hanging being the chosen method for most men and women; and similar findings were noted in the review of deaths in young people. Poisoning was the next most common means of death; where drugs were present at time of death (even if not explicitly the

MER V3a DRAFT

means of death) they were often prescribed medications. There is a limited amount that can be done to reduce access to these common means of suicide.

The local mental health trusts have made inroads into reducing the means of suicide in inpatient facilities. Network Rail has a national approach to monitoring incidents on track and at stations. The audit has further identified coastline and other bodies of water as a place of death by drowning or choice of location for other means of death (from personal communication, it is known that there are many more incidents involving bodies of water). The Coastguard and Maritime Agency (MCA) and local lifeboat services could be considered future partners in suicide prevention action.

9.3.4 Provide better information and support to those bereaved or affected by suicide

Voluntary sector charities and organisations can be particularly effective in supporting bereaved families. GPs, primary care professionals and other agencies need to be attentive to the vulnerability of family members and aware what support is available. Post-suicide interventions for schools are a key element of the existing schools suicide prevention guidance, and the review noted that schools are well supported during any periods of crisis.

9.3.5 Support the media on sensitive approaches to suicide and suicidal behaviour

We have found no local reference to the role of the media, including social media, in mental health and wellbeing promotion. There are additional elements for suicide prevention around reporting and the risks creating suicide clusters or known 'hot spots'. Further work is needed around communications and awareness of mental health issues in Southend, Essex and Thurrock and on tackling stigma.

9.3.6 Support research, data collection and monitoring

The Greater Essex audit report recommends that an audit is undertaken annually to monitor trends across time, using appropriate comparators. The audit has recommended – if not yet undertaken – that reviews of serious events in prison and under mental health care is undertaken, akin to the SCDOP commissioned review of child death reviews.

MER V3a DRAFT

Clinical recommendations from the National Confidential Inquiry

KEY ELEMENTS OF SAFER CARE IN MENTAL HEALTH SERVICES	
1. Safer wards: Removal of ligature points; Reduced absconding; Skilled in-patient observation 2. Care planning and early follow-up on discharge from hospital to community 3. No 'out of area' admissions for acutely ill patients 4. 24 hour crisis resolution/home treatment teams	5. Community outreach teams to support patients who may lose contact with conventional services 6. Specialised services for alcohol and drug misuse and "dual diagnosis" 7. Multidisciplinary review of patient suicides, with input from family 8. Implementing NICE guidance on depression and self-harm 9. Personalised risk management, without routine checklists 10. Low turnover of non-medical staff
KEY ELEMENTS OF SAFER CARE IN THE WIDER HEALTH SYSTEM	
1. Psychosocial assessment of self-harm patients 2. Safer prescribing of opiates and antidepressants	3. Diagnosis & treatment of mental health problems esp. depression in primary care 4. Additional measures for men with mental ill-health, including services online and in non-clinical settings

MER V3a DRAFT

10. Sustaining transformation: testing new approaches

From 2016/17, NHS England will lead a new programme which aims to put local clinicians and managers in charge of both managing tertiary budgets and providing high-quality secondary care treatment. Currently, secondary mental health providers and local CCGs have no responsibility or control over expenditure on tertiary services. This programme will give them the incentive and responsibility to put in place new approaches which strengthen care pathways to improve access to community support, prevent avoidable admissions, reduce.

10.1 Making best use of research and innovation

10.1.1 Overview

Mental health services in Southend, Essex and Thurrock share the same challenge as those in many other parts of England – how to improve the quality and productivity of services, and how to do this at a time when the desired level of investment in services may not be possible. In Greater Essex we believe that our approach to this challenge should be driven by a focus on two key areas:

- Identifying and exploring through co-production innovative models of care that have been developed in other places; and
- Ensuring that the services we commission use evidence based approaches to achieve clearly defined outcomes that improve the health and wellbeing of both the individuals who use those services and the population as a whole.

The *Five Year Forward View for Mental Health* identifies three priority areas where innovation is likely to have the greatest impact:

- **new models of care -** to stimulate effective collaboration between commissioners and providers to develop integrated, accessible services for all;
- **expanding access to digital services -** to enable more people to receive effective care and provide greater accessibility and choice;

MER V3a DRAFT

- **a system-wide focus on quality improvement -** to support staff and patients to improve care through effective use of data, with support from professional networks.

10.1.2 New Models of Care

There is an overwhelming case in support of the need for new models of care to meet the needs of people with mental health problems. This rests on the evidence that there is a significant disparity in the number of people with mental illness in contact with services, compared to physical health, yet it is a major cause of both premature death and of lives lived in distress and misery.

- Mental health problems are estimated to be the commonest cause of premature death;
- Mental illness constitutes the largest proportion of the disease burden in the UK (22.8%), larger than cardiovascular disease (16.2%) or cancer (15.9%);
- People with schizophrenia die 15-20 years earlier;
- Depression is associated with a 50% increased mortality from all disease;
- 26% of adults with mental illness receive care (by comparison 92% of people with diabetes receive care).

V3a DRAFT

	% in Treatment
Anxiety and depression	24
PTSD	28
Psychosis	80
ADHD	34
Eating disorders	25
Alcohol dependence	23
Drug dependence	14

Not enough people with mental health problems are getting the treatment and care they need and we need mental health services in Greater Essex that address this. Quite simply, we need a local system that is able to identify best practice in mental health and adopt it locally.

Innovation Case Study: Good lives

Good lives is a new approach to delivering adult social care support in Essex, which has been pioneered by ECC, partly in response to the requirements of the Care Act,. It moves Essex away from an 'assessment for services' approach to social care, with a much greater focus on wellbeing, prevention and independence.

We have created a number of innovation sites where we have coached staff in the art of having three different conversations with adults needing social care support:

1. How can I connect you to things that will help you get on with your life – based on assets, strengths and those of your family and neighbourhood? What do you want to do? What can I connect you with?
2. (Where people are at risk) what needs to change to make you safe? How do I help make that happen? What offers do I have at my disposal, including small amounts of money and using my knowledge of community, to support you? How can I pull them together in an emergency plan and stay with you to make sure it works?
3. What is a fair personal budget and where do the sources of funding come from? What does a good life look like? How can I help you use your resources to support your chosen life? Who do you want to be involved in good support planning?

These conversations should always start with the assets and strengths of people, their families and their communities, rather than with access to services.

Whilst Good Lives is an Essex initiative, the Southend Transformation Programme is looking at Social care in Southend, changing the way social workers approach their caseloads. These projects aim to transform the culture into one of prevention, delaying long term need and reducing dependency on the health and social care systems. This will give adults in Southend the best opportunity to stay in their own homes and have reablement services, where needed, to ensure that this is realised.

10.1.3 Expanding Access to Digital Services

The *Five Year Forward View for Mental Health* sees a pivotal role for digital technology in driving changes to mental health services over the next five years. In Southend, Essex and Thurrock this will be driven by the need to improve the accessibility and quality of mental health interventions and support so that more people get the help they need.

Some steps have already been taken locally to improve access through digital technology such as the on-line courses and therapy material for people with a range of problems available through the website for *Therapy For You*, the primary care psychological therapies service provided by SEPT in south Essex, and through their dedicated app.

But provision needs to be increased in a number of areas so that:

- people can access services conveniently, have greater choice, and can network with peers to provide mutual support and guidance;
- providers can deliver a more nuanced service, with contact through digital media backed up by face-to-face interventions;
- commissioners can improve outcomes through low-cost and easily scalable interventions;
- providers can work securely to share patient data on electronic health records, where appropriate, to benchmark their performance and to test new service models;
- people who use services, carers and the wider public can hold the system to account by using data across the entire pathway (from prevention and access through to productivity and outcomes) to scrutinise performance;
- The mental health system as a whole has a digital mind-set for a digital age. A key challenge is cultural. Thinking may be constrained by previous ways of working rather than instinctively looking to exploit digital solution;
- Mental health support solutions meet people's evolving needs and expectations in the internet age better. We consider how people build networks, learn and recover, and reshape our services and use of technology to respond;

MER V3a DRAFT

- Mental health and recovery services build and make use of peoples 'digital capital', equipping them to recover from mental ill-health, become independent and thrive.

Some of these areas will require work at a national level. Commissioners will also need all agencies in the local mental health system to adopt and develop their own approaches and to work together to produce the information that can be used to inform and refine local service provision.

10.1.4 A System-Wide Focus on Quality Improvement

Arrangements for commissioning and providing mental health services in Greater Essex have tended to make it difficult to develop a picture of how the different parts of the whole health and care system can work together to meet the needs of both individuals and the population as a whole. It will be important to find ways to move away from arrangements for commissioning and providing services that can lead to fragmentation towards approaches that support better co-ordination and collaboration. This will mean both more integrated approaches to commissioning services between NHS and local authorities, and to service delivery, between primary care and specialist mental health services, and between NHS and third sector organisations.

10.2 A focus on outcomes

An important part of developing this more collaborative approach between organisations will be to align their efforts to the achievement of shared outcomes. Defining clear outcomes – those desired for the population as a whole, for particular services through contracts and/or for individual service users through care planning - and ways of measuring those outcomes and progress towards them will be critical to achieving the ambitions outlined in the *Five Year Forward View for Mental Health* in Greater Essex. Adopting best practice to improve outcomes for people in Essex will require innovation and adaptability from local services and the people who work in them:

- all services should routinely collect and publish **outcomes data**. The information gathered should reflect **social as well as clinical outcomes** that matter to people with mental health problems;

MER V3a DRAFT

- **Providers should never be rewarded entirely for providing a number of days of care or level of activity**, but instead be rewarded for delivering whole pathways of care with achievement of defined outcomes or meeting local population need, as appropriate;
- **Outcomes should be holistic and reward collaborative working** across the system (e.g. stable housing, employment, social and physical health outcomes).

10.2.1 Use evidence based information to achieve outcomes

By 2020/21, a comprehensive set of care pathways will have been developed nationally and will need to be reflected in the services available to people across Southend, Essex and Thurrock (see *below diagram)*.

The aim will be to ensure that people are able to get the help they need more easily, that they are supported to achieve the outcomes relating to their health and wellbeing that are important to them, and that they are able to rely on acute mental health care services where they need them. Commissioners and providers have a shared responsibility to ensure that the resources available locally to meet people's mental health needs are used in the way that provides the greatest benefit to the greatest number of people. This means that there should be clear accountability for the allocation of resources at all levels and that they should be used to ensure that people are able to access interventions of proven effectiveness.

Types of care and therapies shown to lead to improved mental health outcomes and found to be cost-effective should be made available to people with mental health problems. The services provided locally and the types of interventions they deliver should have fidelity to the care pathways.

10.2.2. Use data to check that outcomes are being achieved

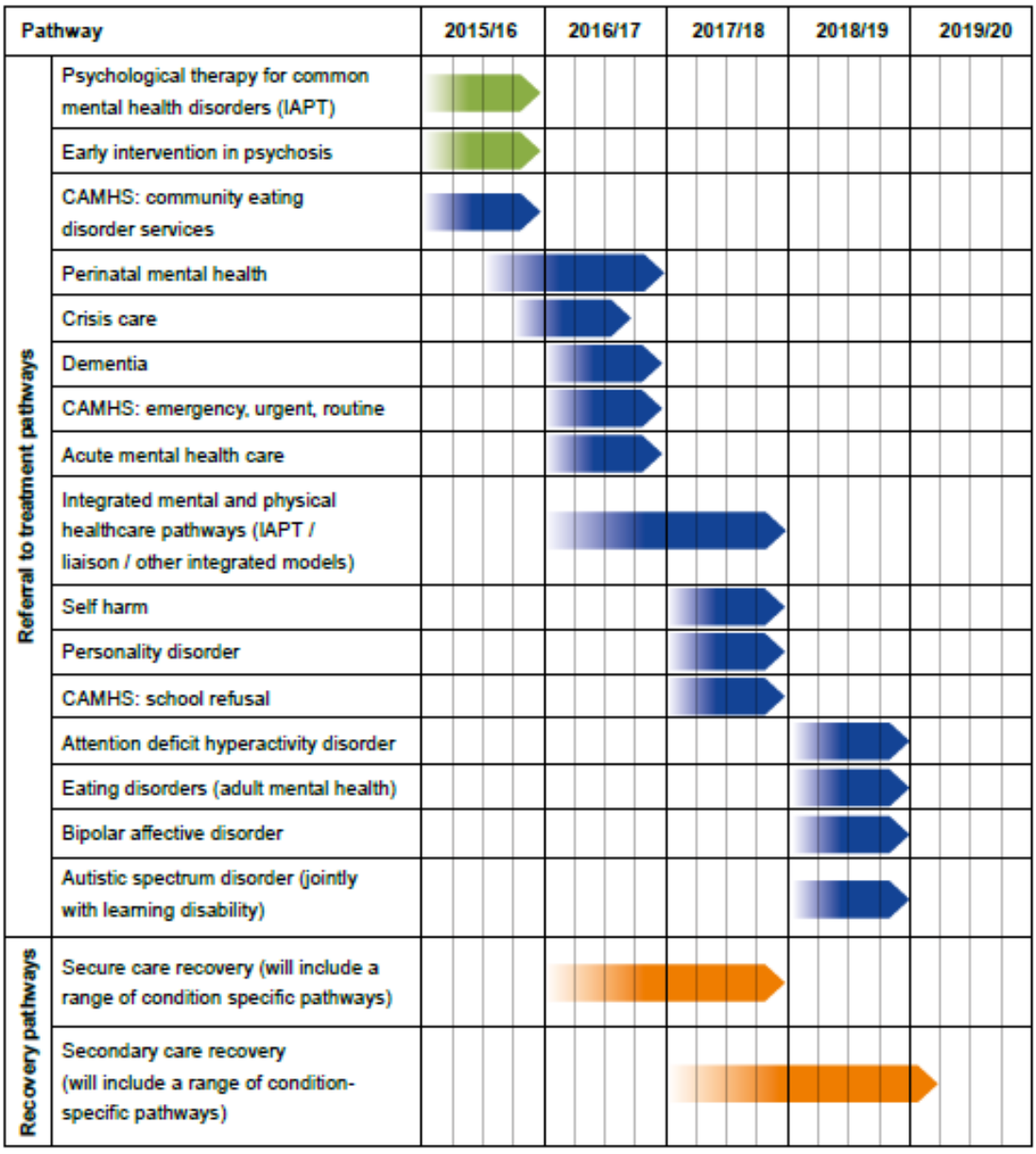
Moving the approach used across the local system towards a focus on outcomes will require substantial changes to the ways in which local services collect and use information. This will require changes in both practice and culture in local services. It will be important not to underestimate either the importance of making this change to the transformation of mental health services in Southend, Essex and Thurrock or the difficulties associated with this.

MER V3a DRAFT

The information gathered by the NHS should reflect social as well as clinical outcomes – e.g. education, employment and housing - that matter to people with mental health problems.

The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health.

Proposed mental health pathway and infrastructure development programme



10.3 Local innovation

In addition to the three priority areas for innovation identified in the *Five Year Forward View for Mental Health*, we believe there are also some specific areas that are priorities for innovation in Southend, Essex and Thurrock. These are:

- **The need for service providers to adopt co-production approaches to the re-design of care pathways.** Both for those elements of care pathways that are delivered within a particular organisation and pathways that mean people receive services from several different organisations within the same pathway.
- **For service providers to develop ways of using data from outcome measures as part of routine internal reporting and monitoring to improve service delivery**. This would involve using this data and reporting at all levels in an organisation, from discussion of outcomes for individual service users on a professionals caseload in supervision, to reports on overall performance in achieving good outcomes for all service users to an organisation's board.
- **The need for service providers to work together to find ways of developing the specialist mental health workforce** so that it has much greater capacity to deliver evidence based interventions in a way that maximises the use of the available resources.

MER V3a DRAFT

11. Sustaining transformation: a healthy NHS workforce

Ensuring that the NHS looks after its most important asset – its staff – and focuses on promoting their health and wellbeing to improve satisfaction, productivity and retention.

The workforce is critical to delivering the best possible mental health care and support in Southend, Essex and Thurrock and we are lucky to be able to draw on the expertise and passion of so many committed mental health professionals, as well as other professionals who understand the importance of mental health and make a huge contribution to delivering recovery – for example, in our schools, employment services, housing support, voluntary sector and substance misuse services. But we also face real challenges in recruiting and retaining all the people we need to deliver our vision – whether that is specialist CAMHS commissioners and providers in our health services or mental health social workers.

This is an issue that requires a strong lead at national level. The *Five Year Forward View for Mental Health* promises a national mental health workforce strategy and recommends that 'the Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health', including the expansion of Think Ahead to provide at least 300 additional places. We expect to work closely with national bodies in developing and implementing a workforce strategy to support us to deliver our vision.

We can also work to expand on some of the innovative best practice that already in place within parts of the County's workforce. Good Lives is an asset-based approach to social care assessment and care management being launched through 'Innovation Sites' in ECC's 'Adult Operations' directorate. This aims to make better use of the skills and commitment of all the organisations involved in the care landscape by shifting from a reactive 'eligibility and assessment' approach, to proactive 'prevention and independence', which focuses on what people can do for

MER V3a DRAFT

themselves and the totality of the resources available to them.. This way of working has the potential to transfer to adult mental health where there is evidence that asset-based approaches better support recovery.

Recognising issues of co-morbidity, and the need for a holistic approach, our strategy will also support the training and development of staff to be better skilled to work effectively with particular areas, including Asperger's, autism, personality disorder and substance misuse.

As part of the transformation project in Southend, social care staff are being provided with a comprehensive range of on-going training sessions, focusing broadly on Asset Based Community Development, the Care Act (2014), and the language and approach we use with vulnerable adults, especially the Single Point of Access, to make the 'front door' into social care robust. In doing so, Southend will reduce the dependency on Local Authority services and maximise self-help, advice and information, and ensure that the community and voluntary sector are fully utilised to support adults to become independent and maximise their well-being.

MER V3a DRAFT

12. Sustaining transformation: infrastructure and hard-wiring

Supporting activity, including workforce planning, data transparency and payment, outcomes and other system levers.

12.1 Background and issues

Concern about a "black hole" of data in Mental Health services has been expressed nationally, via the *Five Year Forward View for Mental Health* and locally in the *Greater Essex Strategic Review of Mental Health*. This concern extends from gaps around prevalence, condition and cost to lack of robust mechanisms for evaluating the outcomes and benefits from clinical and social interventions.

National data is collected through the Mental Health Services Data Set (MHSDS) by the Health and Social Care Information Centre (HSCIC) on behalf of the Department of Health. The MHSDS began operating on 1 February 2016 and its reporting capability is yet to be tested. Changes to the dataset can take more than 12 months and this will limit the immediate usefulness of the MHSDS for us. Social Care information is also collected annually by the HSCIC and again, these data sets are maturing following a 'zero-based' review in 2014.

For adults, clinical data is grouped together under 'clusters' which can inform how services are paid for but which do not align with diagnosis or NICE guidelines. It is therefore unclear whether people are getting recommended interventions.

The National Mental Health Intelligence Network (NMHIN), run by PHE, with support from NHS England and the Department of Health, presents data to help improve commissioning and service provision. The Fingertips tool released by PHE has provided the basis for much of the mental health needs assessments across Essex in 2016. However, a significant proportion of its content is old and focusses on traditional activity and output metrics.

Financial reporting is an important indicator for scrutinising commissioning and provision yet it is not consistently available in mental health. Likewise, qualitative

MER V3a DRAFT

data and 'service user voice' is rarely captured systematically or channelled in a targeted way to where it will get the most traction.

It is also important to recognise that a barrier to good care is the lack of appropriate data sharing to enable organisations to identify co-morbidities, anticipate problems and plan care in a holistic fashion. This barrier extends to the broader 'transparency' agenda – an important consideration in achieving a 'transparency revolution' will be appetite and mechanisms for reporting publically to Southend, Essex and Thurrock citizens so successes can be celebrated and decision-makers held to account.

12.2 National response and Greater Essex actions

The *Southend, Essex and Thurrock Mental Health and Wellbeing Strategy* is to support the recommendations outlined around data and transparency within the *Five Year Forward View for Mental Health*.

These include:

- The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services.
- National metrics to support improvement in children and young people's mental health outcomes.
- NHS England and the HSCIC should work to identify unnecessary data collection requirements.
- During 2016 NHS England and PHE should set a clear plan to develop and support the Mental Health Intelligence Network.
- By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies.
- Support for data-rich Summary Care Records.
- Department of Health to commission regular prevalence surveys.

In support of these objectives, the *Southend, Essex and Thurrock Mental Health and Wellbeing Strategy* commits partners to:

MER V3a DRAFT

- Engage with and offer leadership to the Eastern Region Mental Health Intelligence Network;
- Ensure that data reporting obligations set for providers are governed by the needs of the local mental health economy and not by the current recording and reporting limitations of case management software.
- Engage with national reporting developments, take opportunities to feed into these and offer leadership; transpose these to a local level through the reporting requirements set for providers.
- Commission benchmarking analysis based on the national collections to inform and monitor direction and ensure we can intelligently critique the data requests made on the system from the HSCIC.

12.3 Local data concerns

Research undertaken in 2015 has demonstrated how co-production can support with the recovery process. System leaders are therefore seeking to embed co-production as a default in designing, implementing and running services. A crucial part of this is ensuring 'service user voice' is continually heard in key forums and at the critical decision points. We will commit to ensuring the voice of lived experience is heard within all commissioning activities.

Southend, Essex and Thurrock also aspire to have a high quality mental health system. In order to demonstrate this to our citizens, our strategy is to publish as much data as possible and to volunteer for peer review activities as far as capacity will allow. There is also a commitment to undertake annual benchmarking work so we can understand system performance relative to our statistical neighbours.

There is a shortage of qualitative intelligence in the Southend, Essex and Thurrock Mental Health system. In addition to the earlier strategies around co-production and service user voice, we will embed opportunities for case review and audit within our commissioned services.

Lastly, previous engagement work has told us that people value 'joined-up' services. In order to foster strong working processes between providers of mental health (and other, physical health) support, our strategy is to ensure the mental health data sharing agenda is fully reflected in the ongoing work in this area being led nationally

MER V3a DRAFT

and via the ESR. This means we will ensure there is a legal basis for sharing information at the right level, at the right time and in the right way.

TO BE ADDED: Model of delivery

Where do we include our model diagram? Needs to ideally sit within a summary of above? Diagram to be inserted

The above diagram demonstrates how new services specified within this strategy document will fit together and inter-operate to ensure seamless pathways for people with mental health problems. The pathways ensure close links to physical health services and services provided outside of health and social care to ensure the best possible outcomes for service users.

An implementation plan has been developed alongside this strategy to show how the strategy and five year forward view ambitions will be realised over the next 5 years across Southend, Essex and Thurrock with a local emphasis on each locality area.

MER V3a DRAFT

References and Resources

Key resources

National

The Department of Health and Concordat Signatories published the *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis* in February 2014. It set out a vision, principles of effective commissioning and core principles and outcomes for crisis care.

The *Five Year View for Mental Health* (NHS England 2016) sets out the direction of travel for mental health in England to 2020-21, providing detailed analysis and setting out clear priorities for action. *Implementing the Five Year Forward View* for Mental Health (NHSE 2016b) sets out a blue print for delivery, including year on year milestones for delivering the objectives.

Essex

The *Essex Mental Health Review – Final Report* (Boston Consultancy 2015) was published in September 2015. Recommendations included creation of a pan-Essex mental health commissioning team to ensure all-age, cross-system care.

The *Essex Mental Health Joint Strategic Needs Assessment* (March 2016) provides intelligence on mental health across Essex, including prevalence information. Its purpose is to help inform local stakeholders and to provide evidential support for the Essex strategy, including information on prevalence.

Hope for Better Mental Health – Exploring Co-production and Recovery (The Public Office/Essex County Council, 2015) explores initiatives in Essex in which recovery and co-production are combined in innovative projects.

Topics

Messages from consultation

Healthwatch Essex produced *Capturing experiences of mental health services in Essex* (July 2016) to support the development of this strategy. This provides feedback from 11 focus groups across Essex that were convened to listen to the lived experience of mental health service users, families and carers across the county.

Other key resources developed by Healthwatch include *555 – Capturing the lived experience of mental health services users in Essex* (October 2014), which reports on an earlier series

MER V3a DRAFT

of focus groups, which particularly considered primary mental health services, secondary mental health services and peri-natal services.

Getting the Foundations Right

A number of reports provide analysis of the wider challenges for mental health services and make the case for investment in prevention, early intervention and recovery, which is a key component of the Greater Essex strategy.

The King's Fund report *Mental Health Under Pressure* (2015) considered pressures on mental health services. It is based on a review of the literature, national data sets and the King's Fund's quarterly monitoring survey.

The economic case for prevention and early intervention is assessed in *Health Promotion and Mental Illness Prevention* (LSE, 2011), and for recovery support in secondary care in *Investing in Recovery – Making the business case for effective interventions for people* (Rethink, LSE and Centre for Mental Health, 2014).

On the links between mental health and substance misuse see Centre for Mental Health, DrugScope and UK Drug Policy Commission (2012), *Dual diagnosis: a challenge for the reformed NHS and Public Health England* (Centre for Mental Health, DrugScope and UK Drug Policy Commission, 2012). See also the Public Health England *Co-existing Substance Misuse and Mental Health Issues Profiling Tool* (PHE, 2016).

See Bramley G & Fitzgerald S, *Hard edges – Mapping service and multiple disadvantage* (Lankelly Chase, 2015) on multiple and complex needs, and, for the views of people with direct experience on improving care and support, *Solutions from the Frontline* (Making Every Adult Matter, 2015).

On domestic violence, see, for example, Hegarty K, '*Domestic violence: the hidden epidemic associated with mental illness*' (British Journal of Psychiatry, Feb 2011, 198(3), 169-70). For Essex, see the *Report by the Southend, Essex and Thurrock Domestic Homicide Review sub-group* (2016).

Children and Young People's Mental Health

See Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing (Department of Health and NHSE, 2015). Essex's Future in Mind transformation plan was published at Open up, Reach out – Tranformation plan for the Emotional Wellbeing and Mental Health of Children and Young People in Southend, Essex and Thurrock 2015-20 (2015). See also *Essex Children and Young People's Strategic Plan – 2016 Onwards* ECC, 2016).

MER V3a DRAFT

For the views and experience of children and young people in Essex see Fletcher H *YEAH! Report – Young Essex Attitudes on Health and Social Care 2014-2015*, Healthwatch, 2015) and *YEAH2! Report - Young Essex Attitudes on Health and Social Care 2015-2016* (Healthwatch 2016).

Peri-natal mental health

On costs, see Bauer A et al, *The costs of peri-natal mental health problems* (LSE & Centre for Mental Health, 2014). For guidelines for the development of services, see *Peri-natal mental health services – recommendations for the provision of services for childbearing women* (Royal College of Psychiatricts, 2015).

Adult mental health: common mental health problems

For the seminal statement of the economic case for psychological therapies, see *The Depression report – A new deal for depression and anxiety disorders* (The 'Layard Report', LSE, 2006). On psychological interventions for people with long-term conditions (including examples of projects), see *Investing in emotional and psychological well-being for patients with long-term conditions and medically unexplained symptoms* (NHS Confederation 2012). See also Doming H et al *People with mental ill health and hospital use* (The Health Foundation & Nuffield Trust, 2015) and Naylor et al, *Bringing together physical and mental health* (Kings Fund, 2016).

Fossey M et al published an influential *Economic evaluation of a liaison psychiatry service in 2011* (NHS Conferation & LSE).

Adult mental health: community, acute and crisis care

The key resource is the *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis* (Department of Health, 2014).

On families and carers, see *Carers Count in Essex – the Essex Carers Strategy 2015-20*.

On employment support, see, for example, *Doing what works – Individual Placement and Support into Employment* (Centre for Mental Health, 2009), Carolan C, *Employment in Mind – The Poppy Factor employability service and veterans with mental health conditions* (Centre for Mental Health, 2016) and *Steps Towards Employment – How back-to-work support can be improved for people experiencing multiple need* (Making Every Adult Matter, 2016).

MER V3a DRAFT

On housing see, Boardman J, *More than shelter – supported accommodation and mental health* (Centre for Mental Health, 2016) and Buck D, Ross S and Simpson M, *The economics of housing and health – the role of housing associations* (Kings Fund 2016).

Health and Justice

The seminal report on diverting people with mental health problems is *The Bradley Report – Lord Bradley's review of people with mental health problems and learning disabilities in the criminal justice system* (Department of Health, 2009). See also Durcan G et al, *The Bradley Report five years on* (Centre for Mental Health, 2014).

For Essex, see Scott M and Senker S, *Rebalancing Rehabilitation – Making the case for change to ensure a level playing field for offenders with complex needs across Essex* (Tonic Consultants 2014); Connor M, *The Process and Treatment Outcomes Research Study* (PTORS) (2014); and Senker S, *Conceptualising recovery* (2014). See also the OPCC for Essex, *Police and Crime Plan 2014.*

Suicide prevention

See National Confidential Inquiry into Suicide and Homocide by People with Mental Illness, *Making Mental Health Care Safer, annual report and 20-year Review* (HQIP, 2016). See also the Public Health England suicide prevention tools and resources collected here. For Essex, see the *Southend, Essex and Thurrock Suicide Prevention Strategy* (2017).

Sustaining Transformation

On payment approaches, see NHS Improvement (2016), *New payment approachess for mental health services*. See also, *Improving Access to Psychological Therapies: a local payment case study* (Monitor and NHS England, 2014).

A suite of documents to support CCG improvement and assessment are available on the *NHS England website.*

See also Honeyman M et al, *A digital NHS? An introduction to the digital agenda and plans for implementation* (King's Fund 2016) and Collins B, *New care model – Emerging innovations in governance and organisational form* (King's Fund 2016).

MER V3a DRAFT

Do we need to onclude full north essex PD strategy as appendix-given comment son PD I think we should unless we move much more text from this into direct body of work.

Are we going to insert the feedback report from HW from the focus groups?

MER V3a DRAFT

MER V3a DRAFT