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Introduction

Mental illness will affect thousands of people in Suffolk at some point in their lives, as they either suffer from it themselves or care for someone else affected by it, and it has repeatedly been shown to be a major concern for the people of Suffolk. Mental ill health not only causes untold personal suffering and distress, but also affects people's relationships, their ability to work and their family life, and leads to a range of physical health problems.

There are two components to mental health – the care and treatment of those who have become ill, and the prevention of mental health problems before they arise.

Although local services for people who have mental health problems have improved over the last ten years, there are still areas where further improvements are needed, or where services are not meeting need.

As this report is published, the National Service Framework for Mental Health (DH 1999) comes to an end in 2009 and we anticipate a new national strategy ‘New Horizons’ – due to be published in October 2009 - that will set out the direction for how the Department of Health will improve the nation’s mental health.

‘New Horizons’ will not only focus on the need to continue to improve mental health services, but also on how the mental health of the whole population can be improved. In other words, those initiatives which are needed to encourage people to protect themselves against mental illnesses like depression and anxiety.

Many services already contribute to better mental health for the general public and include: mother and toddler groups, children’s centres, school health initiatives which promote self-respect or better relationships, older people’s lunch clubs, community arts projects, sports alliances and many more.

The purpose of this report is to highlight the major mental health issues for Suffolk, and to make some bold suggestions for service development. However, in view of the present financial situation, investments in service development will need to be evidence-based; concentrating on services which are known to improve users’ mental health or experience, are cost-efficient, meet the needs of those who are most vulnerable and promote links between existing services across agencies.

In this report, all of the data refers to Suffolk county, unless stated otherwise. In some instances, data for the NHS Suffolk area is presented and this is clearly indicated in the text.

I hope that you enjoy reading this report.

Dr Peter Bradley
Director of Public Health
Suffolk County Council and NHS Suffolk
Progress on the recommendations in previous Suffolk Annual Public Health Reports

2007

Children’s views about their health
The 2008 TellUS survey showed that Suffolk children and young people on the whole report very similar healthy behaviours and issues to those expressed nationally.

- 11% of children and young people feel unhealthy most of the time.
- 8% of children and young people reported themselves as not happy.
- 62% of children and young people said they can talk to their mum and dad when worried about something compared to 66% nationally.
- 50% of them said they can talk to an adult, other than their mum and dad, when worried about something compared to 52% nationally.
- 23% eat the recommended 5 portions or more of fruit and vegetables each day.
- 39% have had at least 30 minutes of exercise every day.
- 19% have never tried alcohol (compared to 25% nationally); but 19% had been drunk within the previous 4 weeks.
- 6% smoke cigarettes regularly.
- 12% have tried drugs.

The 2006/07 annual public health report covered the following topics:
- Health profile of children and young people in Suffolk.
- Services for children and young people.
- Health improvement initiatives for children.

In 2007, it was reported that children and young people in Suffolk are generally healthy, with 84% of children in school years 8-10 reporting themselves to be healthy or fairly healthy. However, the health of Suffolk children does not compare favourably with that of other European countries, and there is marked variation in health outcomes across the county.

The main findings were that:
- 10% of five year olds and over 18% of 11 year olds are obese, and 9% of 11-15 year olds are estimated to smoke.
- The accident rate for young people is higher than the national average, and educational attainment post 16 years is lower.
- Alcohol abuse, teenage pregnancy and homelessness are particular concerns, especially in Ipswich and Lowestoft.

The main recommendation was to organise a landmark event with Suffolk Children’s Trust, to build on current work. Urgent measures needed to be taken to:
• Improve vaccination rates for measles, mumps and rubella.
• Prevent unhealthy lifestyles in childhood, particularly childhood obesity, risky sexual behaviour and inappropriate alcohol consumption.
• Promote healthy lifestyles in school.
• Improve health, educational and social status of homeless children and children who are carers.

The following progress has been made:
The 2007 report focused on the health of children, and was influential in informing the selection of two high focus areas agreed by the Children’s Trust Partnership Board for 2007-08. A commitment to reducing childhood obesity and reducing teenage conceptions, reflect the Partnership’s ambition to focus on preventative strategies to improve health and wellbeing, and are featured in the current and forthcoming Local Area Agreement (LAA). In addition, the Joint Area Review (JAR) and Annual Performance Assessment (APA) inspections in 2007, made a number of recommendations regarding the improvement and development of child and adolescent mental health services, which were an additional focus of work in the last six months of 2007-08.

In 2008, the Children’s Trust Board commissioned a multi-agency needs assessment in order to find out the health, education and social needs of Suffolk’s children and young people, and to define future priorities for investment of our collective effort.

Based on results of the public consultation, the Children’s Trust has approved the Children and Young People’s Plan 2 (CYPP2) for 2009-11, focusing on 11 specific priorities which include issues that:
• Represent a significant challenge facing children and young people in Suffolk.
• Carry a high risk of getting worse without partnership intervention.
• Are based on evidence which includes the views of children and young people.

Vaccinations
There have been intensive public health campaigns to encourage parents to have their children immunised against measles, mumps and rubella (MMR) following concern about the safety of this vaccine.

• The rate for the first dose (given at 13 months) has been stable at 85%. However, rates for the booster are still low and there have been several outbreaks of measles across the country. Further campaigns are needed to ensure that enough children are protected by vaccination so that outbreaks are no longer possible. To achieve this, ideally 95% of children will need to be vaccinated.
• A new vaccine against invasive pneumococcal infection (IPC) which can cause serious illness, such as meningitis and pneumonia, was introduced for all children at 2 months of age with a booster at 13 months. The introduction of the vaccine has already decreased the number of children who have IPC.

Healthy lifestyle
A number of initiatives through Healthy Ambitions Suffolk have started to improve the diet and activity levels of our local children. It is hoped that these initiatives will allow Suffolk to find innovative approaches to secure a healthy weight for the majority of Suffolk children.

• In 2008, participation rates in the Child Measurement Programme were very good, with 97% of reception children and 84% of Year 6 children measured, compared to 57% and 42% nationally.
• The latest data shows that in reception classes, the rate of children who are overweight or obese has remained at 2005-06 levels. Latest figures show 14% of pupils as overweight in year 6, and 15% as obese in 2007-08. If current trends continue, it is anticipated that by 2050 about 25% of children could be overweight or obese.
• The previous LAA target for childhood obesity focused on an intensive support programme for children who were already
overweight or obese, called MEND (Mind, Exercise, Nutrition, Do It!). Although the LAA target was not met, the results for the 126 individuals who have completed the programme have been very positive, with measurable reductions in waist measurement and improved self-esteem.

- In autumn 2009, NHS Suffolk will invite applications for providers to develop healthy lifestyle services, including those encouraging healthy weight amongst children.
- Healthy Ambitions Suffolk Challenge has recently been launched and will encourage Suffolk’s 50,000 primary school children to become more active, by working with local schools.
- Some other approaches piloted in 2007-08 included:
  - Getting Suffolk Fit for the Future - a summer holiday campaign to weigh and measure children, working with local pharmacists based in supermarkets and other major stores throughout the county.
  - An innovative Healthier Lifestyle Project, working with children aged 12-19 years in a local Pupil Referral Unit (PRU) which has reported very positive outcomes for families and young people, with four out of five families changing lifestyles, and with improvement in behaviour, both in school and at home.
  - Healthy Ambitions Suffolk has piloted a mobile health promotion service on a bus, giving healthy living advice on diet and exercise for children aged 11-14 years in selected schools.
  - Healthy Ambitions Suffolk is developing plans for local hoteliers to work with primary schools to encourage healthy eating. This initiative will be commencing in 2010-11.

**Risky behaviour**

Approximately 45% (£500,000) of NHS Suffolk’s ‘Choosing Health’ funding was allocated to the children and young people’s agenda in 2008-09, and about 50% (£700,000) has been allocated for 2009-10. Specific areas include Chlamydia screening, 48-hour access to Genito-Urinary Medicine (GUM) services, improving sexual health, reducing teenage pregnancy and access to termination services, alcohol, smoking and childhood obesity.

**Sexual health**

- Services which encourage young people to avoid risky sexual behaviour are established and include; NORCAS (leading charity) which provides an alcohol and drug misuse prevention service in Ipswich and Lowestoft; TCN (Take Care Now) which provides sexual health and reproductive services for young people; a service at Lowestoft College, Otley College, West Suffolk College and Suffolk New College which offers interactive computer desktop messaging on a variety of health and welfare topics; the ‘No Borders’ condom distribution scheme run by the Teenage Pregnancy Strategic Board; the Virtual Baby programme targeting at-risk young people in schools, and the creation of the Young Parent Advocacy Workers.

- Between 1998 and 2007, the teenage conception rate in Suffolk reduced from 37.5 per 1,000 to 31.7 per 1,000 for women aged 15-17 years. The 2007 rate is below the England average and represents a greater reduction than reported nationally.

- Teenage conception rates for Suffolk in 2004-06 show that only five wards, Harbour, Kirkley and Whitton in Waveney, and Bridge and Gipping in Ipswich have significantly raised teenage conception rates compared to Suffolk as a whole.

- A further area of preventative work has been to review the effectiveness of school-based health services in the county, including reviewing the role of extended schools in delivering sexual health advice. The project started in February 2008 and is expected to report its findings in early 2009.

**Substance misuse**

Good progress has been made during the year on supporting young people affected by substance misuse issues. This has included delivering improvements in targeted support, e.g. screening...
and referral of young offenders and support for children whose parents misuse drugs or alcohol.

• The Drug and Alcohol Action Team (DAAT) completed a needs assessment in December 2008, and identified risk factors for substance misuse among children and young people, making recommendations to improve prevention, access to treatment and support for family/carers.

• Prevention of substance misuse among young people is undertaken by a range of multi-agency initiatives, such as the Healthy Schools Programme, training for staff to deliver substance misuse education within Personal, Social and Health Education (PHSE), and awareness raising campaigns, promoted through Community Safety Partnerships and local voluntary organisations.

Emotional wellbeing and mental health
There has been significant progress within all services contributing to the mental health and psychological wellbeing of children and young people. Further detail is given in this year’s report.

• A multi-agency child and adolescent mental health care needs assessment has been carried out to inform future service planning and design.

• A new Child and Adolescent Mental Health Strategy and Business Plan ‘Everybody’s Business’ for 2009-2011 has been developed, with the aim of establishing a comprehensive Child and Adolescent Mental Health Service (CAMHS) for Suffolk, through an integrated approach.

• The work with the ‘Investors in Children’ programme has commenced, which involves children and young people in the design of appropriate services. Staff training in CAMHS teams in Suffolk Mental Health Partnership NHS Trust (SMHPT) and in Waveney has taken place. The next steps are for the trained staff from Investors in Children to set up ‘agenda days’, with young people who have used CAMHS or related services.

• A number of new initiatives are underway, such as an infant mental health programme, Targeted Mental Health in Schools (TaMHS) work, Primary Mental Health Workers in the community, a specialist service to address the mental health of young people currently in Warren Hill Young Offenders Institution, an early intervention service to address psychosis among young people, and a Family Assessment and Support Team (FAST) to prevent family breakdown.

Accidents
Good progress has continued in reducing the numbers of children and young people killed or seriously injured in accidents, and in the target group for 2008 (young people aged 16-18 years) there has been a further reduction of 24%.

• Mortality rates from all types of accidents, for children under the age of 15 years, has shown a slight decrease between 2005 and 2007, from 3.90 to 3.35 per 100,000 residents.

• ‘Suffolk Young Carers’ help children and young people with care-giving responsibilities to fulfil their potential, and make informed choices about what they want to do, in partnership with young people, their families and other agencies.
2008

The Annual Public Health Report in 2008 concentrated on groups whose health was worse than average in our county. Since then a lot of progress has been made, although the health of many individuals in these groups remains much poorer than the health of an average Suffolk resident.

Prisoners
There has been a greater focus on the health of prisoners in the last year. Initiatives include:
• Awarding a new contract to develop primary care services for prisons in the west of the county.
• Establishing a health trainer programme in Hollesley Bay Prison, which will concentrate on healthy eating, dental health and reducing smoking. Prisoners will be trained to deliver health trainer interventions and will take the qualification with them when they go back into the community.
• The mental health of prisoners remains an issue, and plans to address this are covered in detail in this report.

Family carers
There has been a much greater focus on the health of carers in the last year. Initiatives include:
• The development of a multi-agency strategy overseen by The Family Carers Partnership Board, which was launched during national carers’ week (beginning 8th June).
• Funding by NHS Suffolk of a GP link worker, to work with Suffolk Family Carers and GP practices, and encourage the development of ‘carer champions’. Links have been established at all of the practices in Suffolk, and carer information packs developed.
• Several posts have been funded from the Carers Grant (a national grant to local authorities):
  - A 12 month post in Waveney to develop and promote good practice in carer assessments.
  - An employment and learning post specifically targeted at increasing the confidence of carers through learning.
  - A scheme to support employees who are carers.
  - Hospital-based staff who offer advice and information to carers when their relatives are using hospital services.
  - In 2008/9 SMHPT gave funding for workers to be employed by Suffolk Family Carers, to increase the number of carer reviews carried out and reduce the delays in assessment.
• The health and wellbeing of young carers is still a concern, and work has started to develop a strategic approach to supporting them.

Black and Minority Ethnic (BME) Groups
A much greater focus has been given to the needs of BME communities following last year’s report. Initiatives include:
• A year long project in partnership with the Bangladeshi Support Centre, NHS Suffolk and the National Social Marketing Centre, to find practical ways of reducing the risk of heart disease among the Bangladeshi community in Ipswich.
• Work to develop safe male circumcision services in Suffolk.
• A plan to develop tailored smoking cessation services for the Bangladeshi community in Ipswich.
• A project working with African Caribbean people in Suffolk.
to develop insight into their health needs.
• A successful project to reduce smoking amongst the Polish community, in partnership with the local Catholic churches during Lent 2009.
• A pilot scheme to give touch-screen multi-lingual access to local health information and information about NHS Suffolk.

Continuing concerns are that:
• Not all staff have sufficient knowledge of the diverse cultures of Suffolk, and care packages can be culturally inappropriate. This includes the provision of appropriate interpreting services.

**Gypsies and Travellers**
A much greater focus has been given to the needs of Gypsy and Traveller communities following last year’s report.

The Suffolk multi-agency Gypsy and Traveller Steering Group has developed plans to:
• Establish specialist health workers in an outreach programme, to build trust and links with Gypsies and Travellers in sites, houses and unauthorised encampments.
• Establish specialist health workers in community engagement and advocacy services to support communities so they can access local services.
• Raise cultural awareness and reduce prejudice towards Gypsies and Travellers, especially amongst frontline staff.
• Ensure information for Gypsies and Travellers is in an appropriate and accessible format.

Currently a link has been established between Gypsy and Traveller communities and health services, so that the health visitor working in the nearest children’s centre is responsible for promoting the health of Gypsy and Traveller families with young children. In addition, for unauthorised encampments, if there are young children present, the Traveller Liaison Officer can now directly contact the health visitor to ensure that the health visitor visits the camp within 5 days. Immunisations and doctor appointments can be made after the health visitor’s assessment.

The health of Gypsies and Travellers in our community however, remains poor, with a life expectancy estimated at as much as 10-12 years below the Suffolk average.

**Asylum seekers and refugees**
Suffolk Community Refugee Team (SCRT) continue to provide good medical care for asylum seekers and refugees in Suffolk.

There are continuing concerns about the lack of a dedicated sexual health service for asylum seekers and refugees, although a well women clinic is run by SCRT and can refer women to local GPs if necessary.

There are continuing concerns about the lack of a dedicated Improving Access to Psychological Therapies (IAPT) service for asylum seekers and refugees, although there is now a mental health link worker from CAMHS, linked to general medical services provided by SCRT.
2009 Annual Public Health Report - mental health

Key facts

- There are strong links between social deprivation and mental ill health.
- Evidence supports the beneficial effects of employment on mental health, by boosting people’s confidence and psychological wellbeing.
- People who are unemployed are twice as likely to have depression as people in work.
- Children from poor households are three times more likely to have mental health problems, than those in more affluent households.
- People who have been abused or who have been victims of domestic abuse are more likely to suffer from mental health problems.
- People with drug and alcohol problems are more likely to also have mental health problems.
- Between one quarter and one half of homeless people may have a serious mental disorder, and also be alcohol dependent.
- Black and minority ethnic groups are more often diagnosed with mental health problems than the general population.
- There is a high rate of mental health problems in the prison population.

Key figures

- Around one in four people will suffer from a form of mental illness at some point in their lives.
- At any time, one sixth of the population is suffering from a common mental health problem.
- 1 in 100 people suffers from a serious mental illness such as psychosis.
- More than 1.3 million older people suffer from depression or other mental illness.
- 6 million people in Britain have depression and/or anxiety disorders - few get effective treatment.
- One in ten mothers suffers from postnatal depression.
- Evidence shows a two fold excess in suicide attempts in lesbian, gay and bisexual people, the risk for depression and anxiety disorders are at least 1.5 times higher, and alcohol and other substance dependence is also 1.5 times higher.
- Young black men are 6 times more likely than their white contemporaries to be sectioned under the Mental Health Act for compulsory treatment.
- Suicide is higher than average among Indian-born people. People of south Asian origin under-use mental health services compared with the average.

Eastern Region Public Health Observatory (ERPHO)
Mental Health Profile: Suffolk PCT, 2009

Key recommendations

Recommendation 1:
Develop local strategies to promote better mental health across the population. These should take account of the diverse needs of the many different groups in our county. Local initiatives such as Healthy Ambitions Suffolk can play an important part in co-ordinating a broad response from the Suffolk community.

Factors which may influence mental health and wellbeing include; socio-economic conditions, race, ethnicity, sexual orientation, culture and disability.

Recommendation 2:
Develop local strategies to improve health for those who have been recently unemployed, in partnership with other agencies such as JobCentre Plus. Local initiatives such as Healthy Ambitions Suffolk can play an important part in ensuring a broad response from the Suffolk community.

Recommendation 3:
Develop a prioritised list for mental health service development for the next five years. The NHS is best placed to co-ordinate work with partner agencies, users of services and their family carers. As funds for investment will be limited in the next few years, it will be necessary to make quality improvements within a finite budget, but opportunities exist to improve mental health support and thus reduce the need for general health and social care.

Some of the services which are priorities for development are:

Children, young people and maternity services
- Links between services to support pregnant women with mental health problems.
- Services to prevent mental health disorders early in life, focusing on parenting support programmes and other national initiatives.
- Children’s mental health services – services to manage milder illness of Attention Deficit Hyperactivity Disorder (ADHD) and autism in a timely way.
- Links between mental health services and educational colleges, and between mental health services and custody services.

Adult services
- A clear assessment and treatment pathway for people with personality disorders.
- A clearer treatment pathway for people with mental health and substance misuse problems (dual diagnosis).
- A clearer treatment pathway for assessment and treatment of medically unexplained symptoms.
- Full development of Improving Access to Psychological Therapies (IAPT) programmes, so capacity is sufficient to meet demand, especially for groups at high risk of mental health problems.

Services for those at higher risk
- Services which are culturally appropriate and accommodate people whose first language is not English.
- Multiple services located in one place which meet users needs eg housing, social and health services.
- Prison mental health services, where capacity is currently low. This should include an expansion
of the Integrated Drug Treatment System (IDTS) so that prisoners with dual diagnosis can be effectively treated.

- Integrated, comprehensive services for refugees and asylum seekers, and refugee children. Currently mental health services from Suffolk Community Refugee Team are not fully integrated into general mental health service provision, and community provision is variable.
- Active support so people who are asylum seekers, refugees or from the Gypsy and Traveller community are able to register with their local GP.

**Older people**

- A clear assessment and treatment pathway for older people with mental health disorders. This should focus on how to recognise depression and hidden issues such as alcohol and drug misuse problems.
- Early diagnosis for people with dementia, so their needs and the needs of their family carers can be met.

**Recommendation 4:** Continue to develop the role of Community Development Workers who promote mental health services which are culturally sensitive, and which address the issue of race as a potential factor in the presentation of mental health problems.

**Recommendation 5:** Maintain progress in reducing suicide rates in Suffolk, especially in developing joint audit and learning between agencies. This should focus on assessing risk for those who have a history of attempted self-harm, and for those who have recently been discharged from specialist mental health services.

**Recommendation 6:** Develop educational opportunities for a wide range of clinical staff to increase their understanding of general mental health issues (‘mental health first aid’), and to give them the knowledge they need to develop culturally appropriate mental health care.

**Recommendation 7:** Ensure that contracts for supported housing services continue to offer an alternative to institutional care, using a variety of types of accommodation across the county, based on clearly identified need.

**Recommendation 8:** Monitor general mental health status and the impact of the recession on health, through the Joint Strategic Needs Assessment, so the future demand for health and social services can be predicted and planned for locally.

**Recommendation 9:** Support local employers to employ people with a mental health diagnosis, and also encourage them to sign up to schemes such as the Mindful Employer, to maintain and protect the mental health of all their employees.

**Recommendation 10:** Certain topics have not been addressed in this report. Future public health reports may need to investigate further the impact of alcohol, drugs and domestic abuse on mental health, and the needs of people with learning disability.
As individuals we may think that mental health issues do not affect us, but research shows that a quarter of us will have problems with our mental wellbeing at some time in our lives (NHS Choices 2009). We may also be affected as parents, children or carers. Mental health problems are a major cause of illness and have links to physical illness, social isolation and loss of economic status (RCP 2009; Osborn 2001; Shen et al 2008; Singleton 2001).

Mental ill health is equally common in men and women, but the types of problem differ. Women are more likely to be affected by anxiety and depression, while men suffer more from substance abuse (one in eight men is dependent on alcohol) and anti-social personality disorders (Singleton 2001). The Office for National Statistics (ONS) reports that the prevalence rate for personality disorder in the UK is around 5.4% for men and 3.4% for women. Men are also more prone to suicide: 75% of suicides are men, mostly young men (NCHOD 2008).

Mixed anxiety and depression, according to the ONS 2000 survey, is experienced by 9% of adults in Britain, followed by general anxiety at 4% and depression at 2%. Figures show an increase from 1993 to 2000 in the prevalence of mixed anxiety with depression (from 7.8% to 9.2%). The least common disorder in the ONS survey is panic disorder, affecting 0.7% of the population of Britain.

### Table 1: Prevalence of mental health problems - by gender among people aged between 16 to 64 years in 1993 and 2000 (percentages)

<table>
<thead>
<tr>
<th>Diagnosis and rate (past week)</th>
<th>Female 1993</th>
<th>Female 2000</th>
<th>Male 1993</th>
<th>Male 2000</th>
<th>All 1993</th>
<th>All 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety and depression</td>
<td>10.1</td>
<td>11.2</td>
<td>5.5</td>
<td>7.2</td>
<td>7.8</td>
<td>9.2</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>5.3</td>
<td>4.8</td>
<td>4.0</td>
<td>4.6</td>
<td>4.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>2.8</td>
<td>3.0</td>
<td>1.9</td>
<td>2.6</td>
<td>2.3</td>
<td>2.8</td>
</tr>
<tr>
<td>Phobias</td>
<td>2.6</td>
<td>2.4</td>
<td>1.3</td>
<td>1.5</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>2.1</td>
<td>1.5</td>
<td>1.2</td>
<td>1.0</td>
<td>1.7</td>
<td>1.2</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>1.0</td>
<td>0.7</td>
<td>0.9</td>
<td>0.8</td>
<td>1.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Any neurotic disorder</td>
<td>19.9</td>
<td>20.2</td>
<td>12.6</td>
<td>14.4</td>
<td>16.3</td>
<td>17.3</td>
</tr>
</tbody>
</table>


More serious and enduring mental illness is rarer, with 630,000 people in contact with specialist mental health services in England at any one time. ONS suggests a per year prevalence rate of around 5 per 1,000 of the population (0.5%) (Singleton 2001). While prevalence rates are the same for men and women, the incidence for men aged 15-24 years is twice that for women, whereas for those aged between 24-35 years, it is higher among women, reflecting late onset of the illness for women. Figures are based on people who have sought help for their mental health problems, but more could be living with undiagnosed mental health issues according to the mental health charity Mind. In much of this report, we will focus on more common mental health problems and the impact they have on the community.

The impact of mental health problems
Mental health is linked to physical health and wellbeing. People with mental disorders and disabilities have a higher risk of poor physical health and premature mortality than the general population (RCP 2009). Mortality from all causes, is higher in people with serious mental health problems, when compared with the general population, or indeed when compared with other patient groups. Much of this mortality relates to death from ‘unnatural causes’, namely suicides and accidents. However the standardised mortality ratios for other causes are also raised (Osborn 2001). In schizophrenia, standardised mortality ratios are increased 3-4 times compared with controls, with deaths mainly due to respiratory, circulatory, endocrine and digestive disorders (RCP 2009). In addition, high rates of preventable physical morbidity and premature mortality have been reported in people with learning disability (RCP 2009; DRC 2006). Older people with mental disorders and disabilities may also experience effects on their physical health from their mental health problems (RCP 2009; Druss et al 1999).

Life cycle
Mental health problems arise throughout life: in children and young people with behavioural difficulties and who self harm, in adults of working age with depression and anxiety, and in older people (Singleton 2001). There is evidence that discrimination and stigma continue to surround mental health problems and the individuals affected (Appleby 2007; Time to Change 2009). Carers who support those with mental health problems, may develop health problems themselves and require support (Singleton et al 2002; Mind 2009; Princess Royal Trust for Carers 2009).

Vulnerability
In last year’s Public Health Report, we considered vulnerability. Some groups within Suffolk may be particularly vulnerable to developing mental health problems and to the impact of these. These vulnerable groups include those exposed to particular stresses such as refugees, prisoners and indeed carers, or those with other health and social problems that have an impact, such as those with learning disability and older people (ERPHO 2009). Those with mental health problems have difficulty remaining in work and this affects their economic position and housing (Singleton 2001; Sainsbury et al 2008). In developing plans to promote mental wellbeing, we need to consider ways to reduce stresses and mitigate the impact of ill health and isolation (Appleby 2007).

The NSF ten years on
The National Service Framework (NSF) for Mental Health was published in 1999, setting out a comprehensive vision for mental health care in England (DH 1999). So ten years on, what has changed? How has health improved and are services more joined up? Have attitudes to mental illness changed? We need to consider access to care, co-ordination of care, equity of care, recovery and rehabilitation, and finally promotion of positive mental health. Professor Louis Appleby, the National Director for Mental Health, reviewed progress and illustrated improvements in
services, investment, workforce and in modernising services (Appleby 2007). Suicide rates and suicide in in-patient units have fallen since 1997, by 7.4%. Results from national patient surveys are positive. However, Professor Appleby states that we need to focus more on building social capital (community cohesion), reducing stigma, improving employment and training opportunities, improving care for ethnic minorities and improving access to psychological therapies (DH 2009). Later in 2009 the Department of Health will be introducing ‘New Horizons’, a strategy involving a wide range of organisations and individuals with an active interest in improving mental health, to replace the existing National Service Framework. Healthy Ambitions Suffolk aims to improve the health of the people of Suffolk with mental wellbeing as part of the agenda.

What next?
Undoubtedly we have the need for better quality information about mental health in Suffolk.

The recent mental health profiles from ERPHO fill in some important detail and compares NHS Suffolk and NHS Great Yarmouth and Waveney with other primary care trusts in the East of England and with England as a whole (ERPHO 2009). These cover a number of indicators. The values for NHS Suffolk are better than the national figures for all except one indicator, and for NHS Great Yarmouth and Waveney values are better than for England on all except four of the twenty four indicators. The one area where both NHS Suffolk and NHS Great Yarmouth and Waveney appear worse than England, is the relatively large number of people with dementia on GP practice registers. This could reflect either a higher prevalence of dementia in Suffolk, or that GPs here are better at recognising and registering the condition when it affects their patients.

This report attempts to address some of the knowledge gap and, where appropriate, makes recommendations for further work to identify the needs of the community and gaps in services.
Mental health promotion
As a community in Suffolk, we must aim to promote mental wellbeing, to prevent mental health problems, and to encourage rehabilitation and the full participation in society of those who have developed problems (NICE 2008). We need to focus efforts, and target those who are vulnerable or at risk.

Organisations promoting public health, including health services, local authorities and voluntary sector organisations, need to work together to address the factors affecting mental health and wellbeing. We also need to work closely with those in the community, individuals and carers affected by mental health issues, to promote all aspects of health.

Future services
In the future the shape of services will change, with an emphasis on promoting mental wellbeing in communities; services offered in primary care and the establishment of a Foundation Mental Health Trust in Suffolk. We need, as a Suffolk community, to consider areas where services should be developed. These may include areas nationally highlighted such as autism and ADHD in adults, eating disorders, and mental health promotion (NICE 2008; DH 2009; NICE 2004; NICE 2008).

Glossary

Standardised Mortality Ratios (SMR):
Standardised Mortality Ratios (SMR) are a way of being able to compare the death rates in different areas or in different populations, even though the areas may have different proportions of older or younger people, or different proportions of males and females.

Foundation Trust:
NHS foundation trusts are a new type of NHS trust in England and have been created to devolve decision-making from central government control to local organisations and communities, so they are more responsive to the needs and wishes of local people (Department of Health 2008).

References


http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_090011


**The Active Well Being Programme**

The Active Well Being Programme aims to deliver a programme of activities across Suffolk, specifically targeted at mid-life and older people, and also a selection of opportunities aimed specifically at family carers. It aims to support and promote increased participation in sporting and leisure activities, to promote health and wellbeing. During the year the project delivered 101 sessions of activity with almost 500 participants (130 family carers) involved in 11 activities including badminton, golf, dance, salsa, gentle aerobics, Tai Chi, Qi Qong, health walks, Pilates, yoga, and chair based exercise. User surveys have shown that:

- 85% of participants rated the activities they took part in as good or excellent.
- 89% of participants stated that the project had given them the opportunity to try new sports or activities.
- 80% of participants stated that taking part in the activities made them feel fitter and healthier.
- 82% of participants stated that they felt the project had helped to make local people more likely to take part in sport or physical activity.
- 96% of participants stated that they enjoyed the activities.
- 88% of participants stated that they felt motivated to do more exercise as a result of taking part in the project.
Chapter one
Recession and health

The UK officially entered recession in the 4th quarter of 2008 when Gross Domestic Product (GDP) contracted for two successive quarters. The recession will have a number of consequences including a generally negative impact on health. In January 2009, the World Health Organisation (WHO) announced that, ‘The challenge facing the world now is to prevent an economic crisis becoming a social and health crisis’ (WHO 2009).

What will be the impact on general health?
For many people, the reality of the recession will be a complex relationship of falling property prices, rising costs and in some cases, increasing personal debt. For some this will be accompanied by unemployment, fear of job loss, reduced incomes, and changed retirement plans. For those with lower income, which is more common amongst older people, disabled people or families with young children, the effect of the recession is likely to be more direct. As people on lower incomes are forced to economise, they may find that they have less to spend on food, heating and transport. If people were already living in a poorly heated home, had poor diet, mental health problems or were socially isolated, the recession will only make the issues more acute, and poorer health is likely to be a consequence.

According to Age Concern and Help the Aged, people aged 60 or over in the East of England are:
• skipping meals to save money on food (23%)
• struggling to afford essential items (42%)
• cutting back on socialising (48%)
• cutting back on electricity (38%) and gas (34%)
• reducing spending on food (25%).

Older people trying to cope with rising prices in this way will be putting their health at risk, and NHS Suffolk should consider further research as the recession continues.

Previous research on the impact of recession has largely concentrated on the effects of unemployment on men, where the health effects are most marked for middle working-aged men, especially those with dependent families (Hakim 1982). It is assumed that there are similar negative effects for women. Studies suggest that there is a time lag of about one to ten years before the health impacts of unemployment are fully realised. Of course individuals react differently to the impact of unemployment. Their health is also influenced by other factors including family status, age, educational status, social support, previous job satisfaction, reason for job loss, length of time out of work, expectancy and desire for re-employment.
It is possible for unemployment to improve health and wellbeing for some people, for example by increasing opportunities for social networking and physical activity (Warr and Payne 1983).

Research evidence shows:
• Increased rates of overall mortality, mortality from cardiovascular disease, lung cancer and suicide have been related to negative changes in GDP per capita and unemployment rates (Lin et al 1995; Mathers and Schofield 1998).
• In one UK study unemployed men aged 40-59 years, had a death rate about 47% higher in a 5 year period (Morris et al 1994).
• In another UK study unemployed men aged 16-64 years had higher overall death rates and higher death rates for ischaemic heart disease (Moser et al 1987).
• Death from heart disease increases for two to three years after unemployment and continues to increase for the next 10-15 years (Brenner 2002).
• Higher rates of smoking, alcohol use and poorer diet among unemployed people, although the evidence is not consistent, as personal circumstances and beliefs greatly influence people’s lifestyle choices (Morris et al 1992).
• There is not a consistently clear pattern of the impact of unemployment on alcohol consumption, but one important Finnish study showed increased alcohol consumption amongst poorly educated, single, unemployed men and highly educated, unemployed single women compared to those similar groups who were employed (Luoto et al 1998).

What will be the impact on mental health?
Several studies have consistently found poorer psychological health in unemployed compared to employed people (Smith 1987). The effects can be seen as poorer mental health and psychological wellbeing, more mental illness and increased rates of parasuicide. Several studies suggest suicide rates increase within the first year of job losses (Brenner 2002). For example, as Japan entered economic recession there was an increase in suicides from 18.8 per 100,000 population in 1997 to 25.2 per 100,000 in 1998 (Kondo et al 2008). The impact of unemployment on mental health can be mediated by general social conditions e.g. one study found lower levels of psychological distress among men from areas of chronically high unemployment, compared with men living in areas of low unemployment (Jackson and Warr 1987). A review of unemployment and suicidal behaviour concluded that unemployment and financial problems alone are not the most important triggers for parasuicide. The single most important trigger was interpersonal conflict, although the relationship between interpersonal conflict and unemployment was not assessed (Platt 1984). Poor mental health outcomes are also associated with less stable employment e.g. informal work, temporary contracts and part-time work.
Recession and health

How does this fit with the local picture?

A recent study of more than 20,000 people aged 45-79 years in Norfolk, who were followed up for 11 years, found that if people adopted four healthy behaviours, (non smoker, five servings of fruit and vegetables, sensible alcohol intake and physical activity) they would on average, live 14 years longer than those who adopted none (Khaw et al 2008).

In 2008, NHS East of England commissioned a Lifestyle Survey of East of England residents. The results can be used to estimate the proportion of the total adult population in the East of England who achieve these four healthy behaviours, and also to compare those unemployed and employed. Unemployed people within the East of England Lifestyle Survey had a lower prevalence of the four healthy behaviours with the exception of physical activity.

Table 2: Prevalence of four healthy behaviours according to working status

<table>
<thead>
<tr>
<th>Health behaviours</th>
<th>Working full time %</th>
<th>Working part time %</th>
<th>Unemployed %</th>
<th>Retired %</th>
<th>Not working – other %</th>
<th>ALL %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non smoker</td>
<td>79.4</td>
<td>83.3</td>
<td>66.4</td>
<td>88.6</td>
<td>79.1</td>
<td>81.5</td>
</tr>
<tr>
<td>Five servings of fruit and vegetables</td>
<td>40.4</td>
<td>42.8</td>
<td>30.3</td>
<td>47.3</td>
<td>38.8</td>
<td>41.7</td>
</tr>
<tr>
<td>Sensible alcohol intake</td>
<td>65.2</td>
<td>70.6</td>
<td>54.6</td>
<td>66.8</td>
<td>66.5</td>
<td>65.9</td>
</tr>
<tr>
<td>Physically active</td>
<td>47.8</td>
<td>47.0</td>
<td>43.3</td>
<td>30.3</td>
<td>45.2</td>
<td>42.8</td>
</tr>
<tr>
<td>Four healthy behaviours</td>
<td>11.4</td>
<td>11.9</td>
<td>8.1</td>
<td>10.8</td>
<td>10.8</td>
<td>11.2</td>
</tr>
</tbody>
</table>

Source: East of England Lifestyle Survey 2008

What will be the impact on the use of health and social services?

There is strong evidence from community level studies that economic recession leads to increased consultations and increased admissions to mental health services (Catalano 1991). There is likely to be an increased demand on Alcohol and Drug Services, but the association between the use of substance misuse services and economic recession has not been documented.

Several studies report increases in the rates of consultation with General Practitioners by those who are unemployed compared with those who are employed. One study reported a mean number of 3.4 annual visits by the unemployed, compared with 2.6 by those who were employed (D’Arcy and Siddique 1985). In another study in which unemployed people with a chronic illness were excluded, results showed that the unemployed were about 53% more likely to have consulted their GP in the past week than those in employment (Yuen and Balarajan 1989). A review of the impact of job insecurity on health found increased rates of GP consultations in workers with perceived or attributed job insecurity (Ferrie 2001).
Recession and health

Studies also suggest that the recession will lead to an increased use of hospital services. One study assessed the rate of hospital outpatient consultation in workers four years before and after they became unemployed, and found particularly marked increases in older male employees and in those who had previously been low consulters, consultation rates rising from a mean number of 3.9 to 9.6 consultations (Beale and Nethercott 1986).

Other adverse effects of unemployment upon family life may have an impact upon demand for social care services. These could include higher risk of separation and divorce, homelessness, domestic abuse, safeguarding children issues and unwanted pregnancy.

What will the impact be on health inequalities?
Intuitively the recession will have most effect upon the most deprived communities who are likely to have higher levels of unemployment and less financial resilience. However studies show that this is not necessarily the case if measures are put in place to limit the negative effects (Valkonen et al 2000). Where there was good access to primary and secondary prevention of coronary heart disease among manual workers, reduced alcohol consumption and a system of unemployment compensation, health among the unemployed did not deteriorate.

What can be done to improve health among the unemployed?
There are a number of initiatives which could be put in place to help mitigate the impact of the recession upon health. Specific initiatives could include:

• Ensuring that existing health improvement schemes such as smoking cessation, obesity management, healthy eating, health trainers, volunteering schemes and drug and alcohol services are targeted to those in greatest need, including the long-term unemployed.

Suffolk Economic Summit
Almost 100 leaders from public, private and voluntary sector organisations across Suffolk met on 4 December 2008, in a unique move to announce a series of actions designed to support Suffolk families and businesses struggling in the current economic recession. The key commitments from the summit were:

• Councils to pay invoices more quickly to help local businesses’ cash flows and help prevent bankruptcies.
• Councils to put extra money into Citizens’ Advice Bureaux and other advice agencies, to provide more money advisers to meet growing demand.
• Provide more money to credit unions for loans to local people, and to stop people using loan sharks.
• Create and strengthen support points across Suffolk for advice on how to apply for charitable funds for hardship cases.
• Maintain confidence in the Suffolk economy by marketing and promoting our strengths in education and employment, for example, University Campus Suffolk, the expansion of Felixstowe Port, and Suffolk involvement in the Olympics.
• Promote local tourism as an alternative to going abroad, encouraging people to take breaks and holidays in Suffolk to boost the local economy.
• Councils helping voluntary organisations to fill out application forms for funding to bring new money into Suffolk.
• Increase the advice and access to money available to people who are about to be made redundant, so that they can learn new skills for another job.
• Councils to accelerate investment in local building projects.

2009 Annual Public Health Report - Mental Health
Monitoring the impact of the recession with a focus on the local demand for health and social services, as part of the Joint Strategic Needs Assessment. Suitable measures would include; the number of people in employment and the employment rate, income level, early retirement rate, the number of people accessing further education courses, data on health and social service use and health data which reflects lifestyle choices.

Ensuring that necessary actions to cope with changes to demand for health and social services have been considered and implemented.

Glossary

Parasuicide:
Parasuicide refers to deliberate attempts to harm oneself. Often the attempts are superficial and repetitious. This occurs when people have difficulty coping with their psychosocial situations, usually as a result of deficiency in social skills. They tend to see self-harm as the only option when presented with a problem, and they generally have poor insight regarding the inappropriateness of this response (Royal College of Psychiatry 2009).

References

Age Concern and Help the Aged. (15th April 2009) Many older people in the East of England are going to extreme measures to cope with high prices, new research shows. Press release, retrieved on 28.04.09


Recession and health


Chapter two
Employment and mental ill health

The importance of employment in ensuring mental wellbeing is by now widely recognised. People with mental health difficulties often suffer stigma and discrimination in the workplace, and those who are unemployed, in an unsatisfactory job, or at risk of unemployment, experience much poorer mental health than those in stable employment. In 1999 the National Service Framework for Mental Health stated that; “unemployed people are twice as likely to have depression as those in work”, and this has been supported by further research described elsewhere in this report.

How does mental wellbeing affect the broader economy?
People who experience mental ill health remain one of the most disadvantaged groups in the job market. The Department of Work and Pensions highlighted that;
- Only 20% of people with severe mental health problems are employed compared to 65% of people with physical disabilities, and 75% for the whole adult population.
- In the case of people with more common conditions such as depression, only about half are employed.
- 90% of people with mental health problems want to work compared to 52% of disabled people generally (The Centre for Economic Performance’s Mental Health Policy Group 2006).

The result is that there are more mentally ill people on incapacity benefits than the total number of unemployed people on benefit, and 70 million days are lost each year because of mental health problems. The combined costs of sickness absence, non-employment, effects on unpaid work and output losses to the UK is £26 billion a year, which is equivalent to £1,035 for every employee in the UK workforce (Sainsbury Centre 2007).

What can employers do?
Creating the right environment
A healthy workplace can help prevent mental ill health. In particular;
- Programmes to combat stress, bullying and harassment are particularly valuable.
- In order to reduce unnecessary stress in the workplace, employers should review the workloads of their staff, their work patterns and the environment in which they work.
- A workplace that gives encouragement and support, promotes positive working and provides clear guidance on unacceptable behaviour, ensures a beneficial effect on its employees’ mental wellbeing (HSE 2005).

Measures to support people with mental health difficulties can include a range of initiatives to help people to remain in work, and reduce the risk of losing experienced employees. These can include;
- Opportunities for flexible working, for instance some medication means that people could be sleepy early in the morning.
• Arranging in the short term for another employee to undertake tasks for a while.
• Arranging support from a trusted colleague, even if it’s just someone to talk to.
• Ensuring that there is a place to take a break if needed.
• Raising awareness of mental health issues, including training for line managers, and the elimination of discrimination, in order to help promote a culture of respect.
• Maintaining regular contact with employees if they do need a period of time off, as this helps them to return to work.

Local support for employers
It can be difficult for employers to know how to support staff and to fulfil the requirements of legislation when employing people with mental ill health problems. However there are some local initiatives that can offer employers advice and support.

Employment support services

Support for people with severe mental illness
Individual Placement and Support (IPS) helps people to enter paid employment and to support them with training when in work. Specialist advisors work with individuals to target employment as a goal. It has seven key elements:
1. It aims to get people into competitive employment.
2. It is open to all those who want to work.
3. It tries to find jobs consistent with people’s preferences.
4. It works quickly.
5. It brings employment specialists into clinical teams.
6. It provides time unlimited, individualised support for the person and their employer.
7. Benefits counselling is included.

Mindful Employer

The Mindful Employer is a national, voluntary initiative which aims to increase understanding of mental health in the workplace, and helps businesses to support staff, thus keeping them in work, and also gives advice to businesses when they are recruiting new staff. It awards a charter for employers who are positive about mental health. This is a voluntary agreement to encourage employers to work towards a positive approach to mental health.

Many businesses in Suffolk are signing up to the charter which, in its own words:
• Makes yours a healthier workplace.
• Shows others and your own staff that you are a good employer.
• Expresses your corporate social responsibility.
• Reduces recruitment and training costs.
• Helps towards complying with legislation (e.g. Disability Discrimination Act (DDA) and Health and Safety Executive (HSE)).
• Reduces sickness levels.
• Enhances customer service.
• Improves productivity.
• Makes you more attractive to people with mental health issues and others.
• Helps you retain staff who have experienced discrimination in the past.

www.mindfulemployer.net
Support for people with mild to moderate ill health
People with less severe mental health problems may benefit from one to one employment advice to address the issues that may be affecting their work. This is provided by specialist employment advisors and adjusted to the level that an individual needs. Sometimes these individuals may need a period of short term support, such as cognitive behaviour therapy or counselling provided by the Improving Access to Psychological Therapies service.

Employment support organisations in Suffolk
There are a range of third sector employment services in Suffolk that support people with employment issues. Some work with people with severe mental health problems, some with people with milder conditions, to provide a range of individual support both to gain and retain paid employment, to undertake training and voluntary work, and to help them to be involved in the wider work place. They work with individuals, their mental health support workers, with Job Centre Plus and other agencies, and offer advice and assistance in relation to financial and welfare benefit matters relating to employment.

Suffolk Employment Care
Suffolk Employment Care is a jointly delivered service between health services, Job Centre Plus and the Suffolk Mind Partnership. Its aim is to support adults with mild or moderate mental health conditions to improve their prospects of retaining employment, or finding suitable new employment, by combining each organisation’s expertise. Support is given by teams of advisors based in Job Centre Plus or Suffolk Mind Partnership offices in Bury St Edmunds, Ipswich and Lowestoft.

Learning and skills
The benefits of furthering one’s education through adult education opportunities are greater than broadening an individual’s knowledge and experience. It also increases opportunities for earning, and helps to foster increased confidence and social involvement. Adult education includes any learning undertaken after compulsory schooling. It can include further education, higher education, local education authority provision, work-based learning and learning provided by the voluntary sector (DH and DWP 2006).

In England as a whole, it is recognised that people with low levels of educational achievement may be likely to have lower incomes and be less healthy overall. Just under one in three people with common mental health problems have no qualifications, and only one third have qualifications to GCSE level (Social Inclusion Unit 2004).
The service user’s story

This client was referred to the Ipswich Team of Suffolk Employment Care (SEC) in 2007, by a Support Worker. She was a single parent who had recently stopped Jobseeker’s Allowance because of mental health issues, but was keen to get work.

The SEC Adviser met with the client, drew up an action-plan and continued to provide support by telephone and e-mail. Support was given at a meeting with a JCP Adviser in the Jobcentre.

Meanwhile, an appointment was arranged with the Resourcing Officer from the County Council to discuss a work-placement. This resulted in an unpaid position within the “Community Learning Team” for 9 hours per week. After a few days, she told us how much better it felt to have a job to get up and go to in the morning.

The placement continued through until the summer, during which time we continued to send the client details of paid vacancies and she had access to information about opportunities with the Council. SEC helped her to claim her travelling expenses from the Jobcentre.

When the placement finished in July, the client’s manager thanked her; “all your help......has helped the team enormously”. In September, she obtained paid employment with her old team, providing maternity cover for 21 hours per week. On her “Evidence Form”, she added the note that at all times the Adviser had encouraged her and through perseverance had secured the job. In addition to her employment, the client was also assisted to volunteer with the CAB, training with them for two days per week.

It is clear that the contact this client had with SEC was positive in many respects. SEC have built up a supportive relationship with her, helping to lift her out of a depressive state, enabling her to access work and come off benefits, motivating her to re-engage with paid work and to become active in the community through volunteering.

Ipswich Borough Council and the Fit for Work Programme

As part of the ‘Healthy Ambitions Suffolk’ initiative, Ipswich Borough Council implemented the ‘Fit for Work’ programme designed to help employers improve the health and wellbeing of their workforce. In the first year, 20% of the Council’s workforce took part in the programme, and the number of staff taking part in regular physical activity rose by 5%, which is well above the Government’s target of an annual 1% increase. The Council offered its staff a number of different activities including a stair climbing challenge (for staff collectively to climb the height of Mount Everest!), running, kickboxing, Pilates and massage. One member of staff said: “It’s only half an hour but great fun and I have made new friends – plus it makes you feel good afterwards and ready to carry on working.”
Employment and mental health

Job Centre Plus

Jobcentre Plus (JCP) supports people of working age from welfare into work, and helps employers to fill their vacancies. It is part of the Department for Work and Pensions and plays a major role in supporting the Department’s aim to; ‘promote opportunity and independence for all through customer-focused services.’ Access to local services can be achieved by telephoning your local job centre or by logging on to the following websites; www.jobcentreplus.gov.uk or www.dwp.gov.uk. Its key objectives are to:

- Increase the effective supply of labour by promoting work as the best form of welfare, and helping unemployed and economically inactive people move into employment.
- Work towards equality of opportunity for ethnic minority customers, for instance providing interpreters when required.
- Pay customers the correct benefit at the right time, and protect the benefit system from fraud, error and abuse.
- Provide high quality and demand led services to employers, which help fill job vacancies quickly and effectively with well-prepared and motivated employees.
- Help people facing the greatest barriers to employment to compete effectively in the labour market, and move into and remain in work.
- Improve continuously the quality, accessibility and delivery of services to all customers.
- Ensure that people receiving working age benefits fulfil their responsibilities, while providing appropriate help and support for those without work.

Jobcentre Plus offers help and support to customers through a variety of programmes including Pathways to Work for people who are not working due to illness and disability.

Education providers need to be mindful that they should not have low expectations of people with mental health problems, but that they may need additional support, particularly when first accessing mainstream education. This could include one to one support, buddying and mentoring, as well as making adjustments for people, such as changing teaching and assessment methods, adapting expectations for attendance, or requirements for group work, or presentations.

Stigma and employees with mental health issues

Despite the fact that one in six people will currently be experiencing problems with their mental health, and that over half of us will have a mental health problem at some point in our lifetime, the stigma associated with mental ill health means that many people will not wish their condition to be known. The attitude of employers varies widely, and can affect a person’s mental health. Research indicates that fewer than 40% of employers say they would consider employing someone with a mental health problem (DH 2006).

This may be because they consider mental health problems to be rare. However, when employers have taken part in projects to increase awareness about mental health problems, they have reported improved staff retention and customer satisfaction, and reduced sickness rates (Shaw Trust 2006).

An Employment Commissioning Strategy for Suffolk

Work has begun between organisations to achieve a shared understanding of services and support in Suffolk, for people with mental health conditions who want to work. The next step is to draw together a commissioning strategy to ensure a comprehensive and consistent approach for people in the NHS Suffolk area.
East Suffolk Mind, established in 1973, is an independent, flexible, charity working collaboratively with service users and other partners. It provides a comprehensive range of services catering for a wide spectrum of mental health needs and wellbeing for people. This includes a range of residential services, community resource centres, primary care counselling services, advice and information services, and structured therapeutic group programmes in rural and urban areas of Suffolk. East Suffolk Mind promotes service user empowerment, linked to services that encourage self confidence, self determination, and building self esteem.

West Suffolk Mind, established in 1963, offers a range of services including advice and information, supported housing services and respite for carers. People are helped to help themselves via programmes and courses such as Anxiety Management and Anger Management. Recovery and creative activities such as walking groups and art groups are also provided. Counselling and a computer-based Cognitive Behavioural Therapy (CBT) programme help to alleviate anxiety and depression. Information and advice services are open to the public on every weekday.

Suffolk Mind Partnership was formed by West Suffolk Mind and East Suffolk Mind who have decided that by working closely together we can help people in the county better. We are working to ensure all our services are available across the county.
Employment and mental health

Suffolk Mind Partnership

**Advice & Information**
Direct access information, advice and support. These sessions provide an opportunity for people to access the service, to get information, seek advice, and be provided with support on mental health issues. Individual appointments can be offered for specific interventions including support planning, advice and information.

**Computerised Cognitive Behavioural Therapy**
This service offers an easy to use self-help computer delivered programme, which has been developed to help people cope with symptoms of anxiety and depression. No IT knowledge is necessary.

**Counselling**
Our Counsellors provide the opportunity for people to talk about their crises, anxieties and depression whilst helping them find ways to resolve their situations using their own insight and resources.

**Employment Advice and Support**
West Suffolk Mind developed this service as part of a Healthy Mind Centre, to provide support to people wanting to return to work, education or volunteering following a period of mental ill health.

**Programmes**
We offer a range of programmes to people who are experiencing mental ill health or are at risk of developing a mental health problem.

**Community Resources**
There are a range of services and activities available through Suffolk Mind’s Community Resources Services. The objectives are to continuously promote, develop, deliver and maintain a range of meaningful services and activities that build confidence and increase life choices, leading to improved quality of life and recovery from mental ill health.

**Self Help Groups**
These groups put people in contact with others experiencing the same kind of problems. By meeting together, people gain mutual support from each other. These groups are led by a trained facilitator.

**Supported Housing**
Our aim is to provide single supported accommodation to ensure a successful tenancy for those who have suffered mental illness. Our Housing Services embrace recovery approaches for mental health and well-being, a holistic, enabling, person centred approach to mental distress, disadvantage and social exclusion.
Employment and mental health

References


Chapter three
Homes and housing

Once people become mentally ill they often experience stigma and discrimination and generally live in poorer quality housing. Consequently, socially deprived areas with poorer housing contain more people with mental health problems (Page 2002). Research has shown links between overcrowded family housing and depression, anxiety, sleep problems and strained relationships, and that social housing is often associated with poor-quality buildings, high levels of unemployment, crime and poor access to local services. In addition, people with mental health problems are more likely to stay in homeless hostels or acute psychiatric wards because there is no suitable accommodation. This is an issue in both rural and urban areas. People living in rural areas may also have poorer access to other public services (Commission for Rural Communities 2006). People living in poor housing are more likely than others to experience poor mental health, and those with pre-existing mental ill health often find it difficult to find good quality homes. People with mental health problems often do not own their homes, and compared with the general population, are twice as likely to be unhappy with their housing and four times as likely to say that it makes their health worse. Many people who are admitted to in-patient care for their mental illness have experienced housing problems which have made their illness worse. However, those who work in the housing sector are often unaware of mental health issues (Mind 2007).

Why is housing important?
The housing charity Shelter has found links between overcrowded family housing and depression, anxiety, sleep problems and strained relationships, and that social housing is often associated with poor-quality buildings, high levels of unemployment, crime and poor access to local services.

What sort of housing do we need?
Good housing is associated with a number of key benefits including:
- Reduced re-offending.
- Increased employment.
- Improved physical and mental health, and reduced health inequalities.
- Increased individual choice if formal care is needed.
- Increased possibility of independent living (CSIP 2008).

The Department for Communities and Local Government guidance, ‘A decent home’ describes good housing that supports the wellbeing of people as:
- warm
- weatherproof
- equipped with modern facilities
- in a good state of repair.
Also that the immediate environment of a ‘decent home’ should provide:

• access to clean, safe, green spaces
• access to public services
• opportunities for social contact.

**What support is available for people with housing problems?**

Four out of five people with severe mental health problems live in mainstream housing, with the rest living in supported housing or other specialist accommodation. Half of those with their own home or tenancy live alone.

There is a range of support that people with mental health problems can access such as community mental health teams, community organisations, voluntary organisations, businesses or local authorities. Support might include financial assistance, legal advice, befriending schemes or practical support to live at home.

**Variable housing models – shared, individual**

Supported housing offers individuals with mental health problems both settled accommodation, and personalised care and support. The purpose of the service is to enable people with mental health problems to recover and sustain recovery, and to gain and maintain independent living skills. Individuals live in their own flat or room in a shared house. Each individual will have support from a dedicated staff team that is either based at the same location or who visit the property regularly (visiting support).

Support in supported housing can be provided at different levels according to need.

**Low Support**

Low support is provided by visiting staff mostly on weekdays. The providers offer a few hours of support by trained staff to each individual per week, but will also provide on call support including call out.

**Medium Support**

This is accommodation based support which may be provided by staff based at the scheme during the day or by visiting staff. The provider offers an increased level of support up to 24 hours per day as determined by the needs of the service user.

**Specialist Support**

The individual receives increased hours of support some of which may need to be provided late in the evening, early in the morning or at night. The service can be provided around the clock both waking and sleeping in, and provides access to trained or qualified staff at all times.

**Highest Support**

This is provided on a 24 hour basis and overnight cover is provided by waking staff. The provider works closely with statutory staff providing nursing input.

Supported housing and statutory services need to work together to achieve the best for individuals. This is often shown in a shared care protocol which includes activities such as developing shared training programmes, participating in feedback, review processes and shared team meetings.

**How can support advisors assist independent living?**

By working with tenants, supported housing providers ensure that tenants gain choice and control by involving them in decisions about the service they receive. Supported housing will help to prevent homelessness by supporting tenants to remain in their own accommodation whenever possible, agreeing a clear pathway that enables individuals to access services, helping them move between services, and helping them move on to their own accommodation, often with continuing but lower levels of support. With support, it will be easier for individuals to move between supported accommodation and independent (private) accommodation as their needs change.
Across Suffolk there are 254 flats and houses funded by NHS Suffolk, NHS Great Yarmouth and Waveney, and Suffolk County Council. These aim to offer an alternative to institutional care, and to provide a variety of types of accommodation from self contained to shared housing, for people with severe mental health problems. People living in these flats and houses have an ordinary tenancy agreement, but they are also offered support with managing their mental health, managing their money, jobs around the home such as cooking and cleaning, and taking part in community and social activities. The aim of the supported housing service is to enable people with mental health problems to recover and sustain recovery, and to gain and maintain independent living skills.

The staff providing the support may be based in the same block of flats or houses as the client, or they may make arrangements to visit regularly.

What service users want from supported housing in Suffolk

In order to get a better understanding of the requirements of people using supported housing services, the Suffolk County Council Accommodation Sub-Group which oversees housing provision, has recently undertaken a survey of need. The key messages are:

- There is a need to provide waking night support that does not currently appear to be fully met.
- There is high demand for services that offer low levels of support.
- Services should be flexible enough to respond in different ways as needs change.

Affordable housing and local government

The growth in households, particularly those occupied by single people, and the rise in house prices, has meant that for many people it is difficult to find a home of their own. Local authorities need to plan housing provision to take into account changes in future demand, and to ensure that affordable housing is developed so people have a decent home in a sustainable mixed community.

To meet the needs of those who cannot afford to buy homes, local authorities should work with affordable housing providers to ensure there is a mix of different types of housing, including social rented housing and shared equity housing, which will support people such as key workers and key tenants, to own their home. Affordable homes will therefore be offered at lower prices than the current market rate, with greater quality, flexibility and choice to those who rent (Communities and Local Government 2006).

Re-tendering supported housing services

Current contracts for supported housing services are coming to an end in 2009/2010 and will be re-tendered. This is an opportunity to ensure that services are commissioned that:

- Offer an alternative to institutional care.
- Provide a variety of types of accommodation, from self contained to shared.
- Provide a geographical spread across the county, according to clearly identified need.
- Respond to the issues raised in the housing survey.
Glossary

**Shared care protocol:**
A shared care agreement outlining ways in which the responsibilities for managing the service or care of a person can be shared between the specialists and service providers.

**References**


Chapter four

Mental health legislation

There are now two new Acts governing mental health care in England and Wales. These are the Mental Capacity Act 2005 and the Mental Health Act 2007.

These new Acts are accompanied by new codes of practice which directly affect the way people receive care.

What are the new Acts?
The Mental Capacity Act 2005 applies to people aged 18 years or over who have a mental disorder e.g. dementia or a learning disability. The Act is applied when it is considered that individuals lack the mental capacity to consent to decisions affecting their treatment and care.

Examples of when the Act would need to be used are:
- A person has been restrained to admit them to a hospital or care home.
- Medication was given forcibly, against the person’s will.
- Staff have exercised considerable control over the care and the movements of a person over a long period of time.
- Staff have taken decisions on a person’s behalf. This would typically have included choices relating to assessments, treatments, visitors and where the person can live.

From April 2009, primary care trusts and local authorities have to collaborate to ensure that systems are in place to justify any deprivations of liberty associated with the Act. All persons affected have a right to support from a representative, and a right to review and appeal.

The Mental Health Act 2007 is a refinement of the Mental Capacity Act 2005 and the Mental Health Act 1983 in the area of compulsory treatment. One of the major intentions of the Act is to give greater rights to patients, eg. strengthened rights to appeal through mental health tribunals, a new independent advocacy service for detained patients, rights to ‘displace’ their nearest relatives, and greater safeguards in using electroconvulsive therapy. The legislation also aims for a clearer, more timely process in assessing who needs compulsory treatment, and allows the assessment to be made by a broader range of professionals.

The Mental Health Act 2007 introduces Supervised Community Treatment Orders (CTOs), which give new opportunities to help and support patients in their own homes or in the community, rather than having to remain for lengthy periods of time in hospital. Supervised Community Treatment Orders may only be applied when a patient is already detained in hospital for treatment. In the event that patients become mentally unwell again, the Care Team (Responsible Clinician) has...
the power to return the person to hospital for fresh assessment and treatment.

Voices of Experience

In West Suffolk Hospital, people who are compulsorily detained because of a mental health issue are given the opportunity to give their views of the experience of being assessed and admitted under the Mental Health Act, so that both good and bad experiences can inform future practice. The interviews are held at a specific time each week on the in-patient ward, are carried out by a service user, and observed by an Approved Mental Health Professional. The experiences people have had of the whole admission process have led to lots of changes on the admission ward. This helps those in hospital to think about preparing crisis and contingency plans for how they want to be supported if they become unwell again.

Case study

Graham has a serious form of a longstanding mood condition known as ‘bipolar disorder’. Currently being treated in hospital, he is to be discharged on a Community Treatment Order (CTO). The Care Team consider Graham’s suitability for being placed on a CTO.

Graham’s Responsible Clinician and his Approved Mental Health Professional discuss the CTO with him. They secure both his agreement to the CTO and his input to the Care Plan devised for him. The Care Plan specifies Graham’s ongoing treatment and support, including his continuing usage of prescribed medication.

Graham leaves hospital as planned. He is able to settle back in at home, and within 7 months gets a part time job which he enjoys and seems to be handling well. Graham continues to see the Care Team specified in the conditions applying to the CTO. All appears to be going well for Graham. In the course of his first year on a CTO, Graham applies to the Mental Health Review Tribunal for the CTO to be discharged. However, the Tribunal is of the view that the need for the CTO continues. Graham understands that he may appeal again, and is relaxed about continuing with it, commenting that it doesn’t impose any real burdens on him in any case.

13 months after the application of the CTO, Graham’s Care Team quickly notice a change in his mood, his self-care and his general presentation. Their concern that Graham is again becoming mentally unwell is further reinforced by comments and opinions from Graham’s close friends and family members. It transpires that Graham has missed taking a significant amount of his prescribed medication.

Following an urgent meeting of the Care Team to review Graham’s situation, and taking all of the factors into careful consideration, Graham’s Responsible Clinician asks him to return to hospital. Graham agrees to this. Following a day’s further assessment, Graham’s medication is re-commenced. Graham quickly stabilises. Within the week he is well enough to return home, again on the CTO with the same Care Plan and conditions applying as before.

Whilst in hospital Graham met an Independent Mental Health Advocate to discuss his position and rights. He finds this helpful and reassuring. Graham knows that he can appeal again for his CTO to be discharged depending on how he feels.
Around one in ten children in the UK between the ages of 5 and 15 years have a mental health problem, and as many as 14.4% of boys and 7.6% of girls are affected (Meltzer et al 2000). The most common mental health conditions are emotional disorders (depression, anxiety and obsessions), hyperactivity (inattention and over-activity), and conduct disorders (awkward, troublesome, aggressive and antisocial behaviour). Rates increase with age and vary with ethnicity, the highest being 12% in black children and the lowest is 4% in Indian children (Barlow et al 2007).

**Introduction**

The long term consequences of mental health problems in childhood are considerable. By the time they are 33 years old, people who had a conduct disorder as a child are more likely to be on benefits, homeless, to have been a teenage parent, and to suffer poorer health than their peers (Collishaw et al 2004). Levels of unemployment are approximately 11% for people with a conduct disorder, compared to 3.7% for those without.

New research evidence supports the hypothesis that a person’s mental health at the age of twenty can be predicted by the time they are one year old (Collishaw et al 2004).

Both children and adults are strongly influenced by the factors that happen during pregnancy and the first two years of life – a period of rapid brain growth. Recent research suggests that this is a crucial period in developing the foundation for mental wellbeing. Although we have known this for a long time, new information looking at scans of how the brain develops shows this more clearly. In addition to genetic factors, brain growth has been shown to be influenced by the emotional and physical environment. Early interactions with a child’s main caregivers are especially important and directly affect the ‘wiring’ of the brain. Similarly these early relationships set the ‘thermostat’ for later control of the stress response, which in turn is linked to mental wellbeing (DH and DCSF 2008).

**Why is brain development so important?**

Early experiences determine whether a child’s developing brain architecture provides a strong or a weak foundation for all future learning, behaviour and health. The basic building blocks or architecture of the brain is constructed and developed through an ongoing process, which begins before birth and continues into early adulthood. It is rather like the construction of a home. The building process begins with the laying of the foundation, framing the rooms, and wiring the electrical system in a predictable
The brain is a very complex organ, with all of its multiple functions operating in a coordinated fashion. We know therefore that emotional wellbeing, social competence and cognitive abilities are all interlinked to one another, and as such form the bricks and mortar for human development (Centre on the Developing Child 2007).

**The effects of stress on a young child’s brain**

Stress in early childhood can have both positive and negative effects on the developing brain. A small amount of stress which briefly raises the heart rate and the stress hormone (cortisol) level, such as meeting new people, or dealing with frustrations seen in toddler tantrums, is a necessary part of healthy development, and children who are living in a supportive and stable environment are able to learn mastery and self control of their emotions.

Significant events however, such as the death or divorce of parents, or a natural disaster, have the ability to trigger physiological responses which are large enough to disrupt the architecture of the brain. We know that this can be relieved by supportive relationships which help the child adapt and cope, by reducing the sense of being overwhelmed.

It is important to recognise that most people’s childhood contains a mixture of positive and negative experiences. When a stressful situation occurs that overwhelms the family’s ability to cope, we know that professional intervention is proven to be very successful.

Some children suffer prolonged activation of the body’s stress response systems without a supportive adult relationship. These may be children who are suffering from physical abuse or neglect, or where the mother has severe postnatal depression, or there is parental substance misuse or family violence. Persistently raised stress levels and altered levels of cortisol produce an internal physiological state that affects the architecture of the brain. Children in this situation react in different ways to this severe form of what is termed ‘toxic stress’. Some of the likely outcomes are difficulties in learning and memory, health damaging behaviours in later life, greater susceptibility to cardiovascular disease, diabetes, obesity and stroke, as well as mental health problems such as depression, anxiety and substance misuse (Centre on the Developing Child 2007).

**What is the impact on children’s development?**

A baby’s brain becomes sensitised to cortisol somewhere between birth and three years, and as a result a child may react to stress in life with very little control, by being hyperactive, impulsive or anxious. They may, however, appear to be totally non-reactive to anything which may seem to be opposition – behaviour which is seen as defiance in the child.

Poverty is one of the biggest risk factors linked to poor health outcomes, and inequalities in learning and achievement become apparent very early in childhood, with the gap opening up between
the abilities of poor and prosperous children as early as two or three years of age. Many families with multiple risk factors such as unemployment, mental illness, substance misuse, debt, poor housing and domestic abuse are more likely to develop a range of poor health and social outcomes, and there is a clear relationship between some parent based disadvantages and adverse outcomes for children (Social Exclusion Task Force 2007). Other predictors of poor outcomes include young parenthood, unstable partner relationships, domestic abuse, parents with a history of anti-social behaviour, substance misuse and ambivalence about pregnancy.

It is estimated that around 2% of families in Britain experience five or more of these disadvantages, and this is likely to be replicated in Suffolk. Improving outcomes for these families will only be possible if the focus can be shifted from dealing with the consequences of difficulties, to preventing things going wrong in the first place.

**Postnatal depression**
The impact of a mother’s postnatal mental health can have a potential impact on the whole family: the infant, partner, other children and sometimes the mother’s parents (Pearson and Burn 2008). There is compelling evidence that postnatal mental health problems in a mother are strongly associated with adverse effects on her relationship with her baby, and on her children’s physical and social attachment, and cognitive development (Cartmell 2007). Postnatal depression covers a spectrum from mild to very severe depressive illness, which sometimes requires hospital admission. National studies suggest that 11% of women suffer mild to moderate postnatal depression, but in areas of deprivation this rises to 40% of women experiencing depressive symptoms (Cartmell 2007).

There is also evidence to show that 50% of partners of depressed mothers are also depressed themselves, increasing the chances of the couple being unable to care for and meet the emotional needs of their baby. Children of depressed parents are much more likely to present with childhood anxiety, disruptive or depressive conditions and have a higher rate of referral to children’s mental health services (Pearson and Burn 2008).

**What do we mean by infant mental health?**
A hundred years ago an eminent psychologist William James, considered the mental life of a baby to be a ‘booming, buzzing confusion’. We now understand that what might be seen on the surface as random and confused behaviour, is in fact highly organised, and that even in the first few weeks of life, a baby has the ability to be responsive to its carers.

Most families adapt successfully to the challenges of preparing for birth and caring for a new baby, and all parents do their best. One of the main protective factors in parenting is a strong bond of attachment being built between the child and the primary caregiver from infancy. We also know that pregnancy and the first years of life
The health visitor met Sue 16 days after the birth of her second baby, Mia, who had a spell in hospital at 9 days old because of bronchiolitis. Sue already had a four year old son, and sadly they had all been abandoned by the new baby’s father during pregnancy. Sue had help from her own parents and brother, but at that first visit, Sue appeared pale and exhausted with no interest in anything.

The health visitor contacted Sue by phone several times over the next few days, and she insisted that she was coping although she still sounded flat. When she visited her at home the next week, Sue was still very distant, and although she was meeting the baby’s needs, she nursed her constantly and was unable to interact with her. Sue had been to her GP because she was still worried about the baby’s breathing, and Mia had been admitted to hospital again overnight. The hospital staff had also noted Sue’s low mood. Sue was also finding it difficult to cope with her son, who was not surprisingly, confused by his mother’s behaviour.

The health visitor was very concerned, and with Sue’s permission, contacted her mother. She said that Sue had withdrawn from her family and friends, and although she was letting her parents take care of their grandson frequently, she wouldn’t let them look after the baby, leaving them feeling powerless.

The health visitor was even more concerned on her next visit, 2 days later. By now, Sue was totally flat and expressionless, not leaving her home or letting anyone in – not even her mother when she came to collect her son - and rejecting all other attempts to help her. She appeared very thin, and couldn’t remember when she’d last had anything to eat, or drunk anything but water. She was still nursing the baby constantly, but not interacting with her. Sue had self harmed and had suicidal thoughts, but said she wouldn’t carry them through for the sake of the children.

The health visitor explained to Sue that she wanted to get her extra support, and got Sue’s agreement for this. The health visitor contacted the GP, and then the Mental Health Crisis Team and Social Care. She also told Sue’s parents what was happening and asked them to be extra vigilant for Sue and the children.

Over the next 10 days, the Crisis Team visited daily, the GP visited and the health visitor visited Sue and called her by phone many times. Within 3 weeks there was a real improvement in Sue’s mood. She responded well to medication and agreed to have counselling, but as she is a quiet person, she didn’t want to join any sort of support group. She is more animated now, interacting with the baby and seeing her family and friends again.
are a time when parents are particularly receptive to learning and making changes.

When stress is experienced in pregnancy or the bond between a child and a main caregiver is broken, early intervention and prevention may have a significant impact on the child’s life outcomes, particularly in children who are born into disadvantaged backgrounds (Centre on the Developing Child 2007).

What do we mean by prevention and early intervention?

Our vision for Suffolk is: “to enable all children and young people in Suffolk to aspire to, and achieve their full potential, giving them the basis for a successful life as active members of the community” (Suffolk Children’s Trust Partnership 2009).

One of the five principles that underpin the National Children’s Plan, “Building Brighter Futures” is that “it is always better to prevent failure than to tackle a crisis later” (DCSF 2007). Early intervention and prevention are at the heart of what the Suffolk Children’s Trust Partnership is seeking to achieve for children, young people and families in Suffolk (Suffolk Children’s Trust Partnership 2009).

Improving outcomes will only be possible if the focus can be shifted from dealing with the consequences of difficulties in the lives of children and young people, to preventing things from going wrong in the first place. We need to recognise at a very early stage those families where the children have a high risk with low protective factors, and ensure that they receive personalised services, with targeted early interventions appropriate to their needs. Good early relationships between the caregiver and infant help to build resilience for life, and the most effective interventions are those which work on the relationship between caregiver and child (Crittendon 2005).

Every professional who works with children and families knows the importance of early parent-child relationships, which is fundamental to infant mental health. However, parents and professionals often still struggle to discuss this relationship in a meaningful way (Leerkes and Crockenberg 2006). In particular, health visitors are key to facilitating good infant mental health, but often lack training and tools for this work, despite the evidence for early recognition and intervention (Bakermans-Kranenburg et al 2005).

What is the situation in Suffolk?

To date there has been a lack of strategic planning and commissioning for a coordinated and cohesive approach to early intervention for very young children. Services have often been under resourced and monitoring and evaluation has lacked a robust approach.

There are however, numerous examples of excellent practice in Suffolk. Many of these revolve around the Sure Start Children’s Centres and are developed according to local need by health visiting and Children’s Centre’s teams. Activities include infant massage groups and breastfeeding cafes. Another example of good practice is the Teenage Parent Group run in a children’s centre (Keyside) in Ipswich, and other antenatal and post natal groups that use the PIPPIN (Parent In Partnership Parent Infant Network) model. The PIPPIN model aims to support parents during the period surrounding the birth, in order to maintain and improve their emotional health, and to raise confidence and self-esteem in people’s own parenting abilities. http://www.intute.ac.uk/healthandlifesciences/cgi-bin/fullrecord.pl?handle=2032885 (accessed 08.05.09)
**Glossary**

**Bronchiolitis:**
is a common respiratory infection that affects babies and young children. It occurs when the smallest airways in the lungs, called the bronchioles, become infected and inflamed, leading to a build-up of mucus. This makes it harder for the child to breathe because the amount of air entering the lungs is reduced.

**References**


Suffolk Children’s Trust Partnership 2009 http://www.suffolk.gov.uk/CouncilAndDemocracy/AboutSCC/ServiceOfficesAndDelivery/ChildrenAndYoungPeoplesServices/Partnerships/ChildrensTrustPartnership/ (accessed 22.05.09)
Growing up can be great. It can also be hard, confusing and upsetting. The way in which a child or young person approaches and tackles these opportunities and challenges is a good indicator of their mental health and psychological wellbeing.

Many of the children and young people with an established disorder (and some 2% have more than one) will continue to have difficulties well into adult life, and these may also have a lifelong impact on the health and social outcomes of that child. For example, conduct disorders in childhood reduce the chances of good educational attainment and therefore employment and income chances in later life. This means that prevention of mental health problems and early intervention are important (Wallace et al 1997).

What are mental disorders?
Mental disorders are defined as a clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress, and substantial interference with personal functions (WHO 1992).

What are the risk factors for developing mental disorders?
Mental disorders among children and adolescents are strongly associated with age, low socio-economic status, reconstituted families having stepchildren, and lone parenthood, (especially those who were previously married), mental health problems in parents, and low extended family support (ONS 2004). Nonetheless, most young people in these circumstances grow and develop without difficulties.

Poorer mental health is also linked to poorer educational attainment, absences from school, school exclusions, poorer friendship networks, physical health and offending behaviour (Wallace et al 1997). There are also protective factors which may prevent a child developing a mental health problem, such as a child’s own resilience, a positive family and education support, a good school and other social environments such as a supportive community (DCSF and DH 2008).

It is not possible to predict with certainty whether an individual will or will not develop a mental health problem, because of the interaction of risk factors with protective factors. However, there will be increased prevalence and increased need for health care interventions, in communities where there is a high prevalence of risk factors.

Overall, Suffolk is an affluent county with relatively few social problems, so we would expect to
have a lower number of people with mental disorders when compared with England and Wales. This same pattern should apply to children and adolescents. However, a significant number of children and young people in Suffolk experience poverty, with the greatest concentration in urban areas, particularly in Ipswich and Lowestoft, but with isolated patches in all of the county’s major settlements. Nearly a quarter of 0-15 year olds in Ipswich (23.4%) and Waveney (22.2%) are currently living in financial difficulties, which is much higher than in the East of England (15%).

In Ipswich and Waveney as a whole, it is expected that there will be higher rates of prevalence of mental health problems among children and adolescents. This is because these two areas have above East of England average rates of income deprivation, unemployment, adults with no qualifications, children living in poverty, and drug and alcohol misuse (ONS 2004; ONS 2007).

### Types of mental disorder common to children and adolescents (defined by WHO ICD 10 classification)

<table>
<thead>
<tr>
<th>Types of disorder</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conduct disorder</strong></td>
<td>Conduct disorders are characterised by a repetitive and persistent pattern of dis-social, aggressive, or defiant conduct. Conduct disorder is frequently associated with an adverse psychosocial environment, including unsatisfactory family relationships and failure at school, and is more commonly noted in boys.</td>
</tr>
<tr>
<td><strong>Emotional disorder</strong></td>
<td>Many emotional disorders in childhood seem to constitute exaggerations of normal developmental trends. This includes separation anxiety, specific phobias, social phobia, panic, agoraphobia, post traumatic stress disorder, obsessive compulsive disorder and depression.</td>
</tr>
<tr>
<td><strong>Hyperkinetic disorder</strong></td>
<td>Hyperkinetic disorders always arise early in development (usually in the first 5 years of life). Their chief characteristics are lack of persistence in activities that require cognitive involvement, and a tendency to move from one activity to another without completing any one, together with disorganised, ill-regulated and excessive activity. Hyperkinetic children are often reckless and impulsive, prone to accidents, and find themselves in disciplinary trouble because of unthinking (rather than deliberately defiant) breaches of rules. Their relationships with adults are often socially disinhibited with a lack of normal caution and reserve; they are unpopular with other children and may become isolated.</td>
</tr>
<tr>
<td><strong>Other disorders</strong></td>
<td>Disorders of social functioning with onset specific to childhood and adolescence, such as elective mutism, reactive attachment disorder and disinhibited attachment disorder. Tic disorder is an involuntary, rapid, recurrent, non-rhythmic motor movement (usually involving circumscribed muscle groups), or vocal production of sudden onset which serves no apparent purpose.</td>
</tr>
</tbody>
</table>

#### How many children and young people have mental disorders in Suffolk?

Application of national prevalence rates to the Suffolk population, shows that the total number of children aged 0-17 years with mental health disorders at any one time in Suffolk, is likely to range between 11,500 – 12,000 (ONS 2004). There are around 5,400 children with conduct disorders, 4,381 with emotional disorders and 1,426 children with hyperkinetic disorders, with slightly higher numbers of boys (Table 3). Any child may have more than one disorder.
Child and adolescent mental health

Rates of mental disorders among children increase as they reach adolescence, and boys have higher prevalence rates than girls.

The estimated prevalence of single disorders and the age-dependent variation in prevalence in 2008 and 2013 shows an increase of conduct disorders among children aged 5-10 in 2013.

At age 5 to 10 years girls have an estimated prevalence of mental disorders of 5.9% and 9.65% at age 11 to 16 years, and for boys the equivalent rates are 10.4% and 12.8%.

Some young people with learning disabilities, those who are looked after and young offenders have higher rates of mental health problems (Table 5). There are also approximately 1,670 children with autistic spectrum disorder (Kurtz et al 1995).

Children may have multiple problems and the numbers of individual problems should not be added together. This is particularly the case with problems such as autistic spectrum disorder, attention deficit hyperactivity order and learning disabilities.

Table 3: Prevalence of mental disorders among children and young people in Suffolk by age, sex and types of disorder, in 2007.

<table>
<thead>
<tr>
<th>Types of disorder</th>
<th>Prevalence rate</th>
<th>Boys aged 5-16</th>
<th>Girls aged 5-16</th>
<th>Total (aged 5-16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct disorders</td>
<td>5.3%</td>
<td>2,763</td>
<td>2,637</td>
<td>5,400</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>4.3%</td>
<td>2,241</td>
<td>2,140</td>
<td>4,381</td>
</tr>
<tr>
<td>Hyperkinetic disorders</td>
<td>1.4%</td>
<td>729</td>
<td>697</td>
<td>1,426</td>
</tr>
<tr>
<td>Less common disorders</td>
<td>1.3%</td>
<td>678</td>
<td>647</td>
<td>1,324</td>
</tr>
</tbody>
</table>

Source: Mental health in children and young people in Britain (ONS 2004)

Table 4: Population prevalence and projected numbers in 2008 and 2013 by mental disorders and age specific groups in Suffolk.

<table>
<thead>
<tr>
<th>Types of disorder</th>
<th>Prevalence (%)</th>
<th>Projected numbers in 2008</th>
<th>Projected numbers in 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>5-10 years 11-16 years</td>
<td>5-10 years 11-16 years</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td></td>
<td>2.2 4.4</td>
<td>1,057 2,326</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td></td>
<td>0.6 0.3</td>
<td>288 159</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td></td>
<td>0.2 0.2</td>
<td>96 106</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td></td>
<td>0.3 1.2</td>
<td>144 634</td>
</tr>
<tr>
<td>Depressive disorders</td>
<td></td>
<td>0.2 1.4</td>
<td>96 740</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td></td>
<td>4.9 6.6</td>
<td>2,353 3,489</td>
</tr>
<tr>
<td>Hyperkinetic/attention deficit disorder</td>
<td></td>
<td>1.6 1.4</td>
<td>768 740</td>
</tr>
<tr>
<td>Tic disorder</td>
<td></td>
<td>0.1 -</td>
<td>48 -</td>
</tr>
<tr>
<td>Eating disorder</td>
<td></td>
<td>0.3 0.4</td>
<td>144 211</td>
</tr>
<tr>
<td>Autistic spectrum disorder</td>
<td></td>
<td>1.3 1.4</td>
<td>624 740</td>
</tr>
<tr>
<td>Psychotic disorders eg schizophrenia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-17 year olds</td>
<td>0.1%</td>
<td>151</td>
<td>156</td>
</tr>
<tr>
<td>Likely range of all disorders 0-17 year olds</td>
<td></td>
<td>11,500-12,000</td>
<td>11,800-12,300</td>
</tr>
<tr>
<td>Total number aged 0-17 yrs</td>
<td>151,362</td>
<td>156,104</td>
<td></td>
</tr>
</tbody>
</table>

Source: Mental health in children and young people in Britain (ONS 2004) and Kurtz et al 1995.

Population projections based on ONS 2006-based sub-national population projections.

NB: Children may have multiple problems and the numbers of individual problems should not be added together.
What services are offered to children and young people in Suffolk?

Suffolk Mental Health Partnership NHS Trust is working very closely with statutory and voluntary sector agencies to meet the mental health needs of diverse groups of young people and their carers and families. Child and adolescent mental health services (CAMHS) are provided within 4 tiers. Children tend to move between tiers as their needs change, although many children use services from more than one tier concurrently.

**Tier 1** – covers primary professional groups such as teachers, GPs, social workers and health visitors. In Suffolk, over one third of the local CAMHS caseload (75%) is referred by primary health care, about 8% by social services, and the rest are referred by the education service, youth justice service and health visitors. The Suffolk Targeted Mental Health in Schools (TaMHS) pathfinder project was established in August 2008, to provide holistic mental health support in schools for children and young people and their families, (including those with mild to moderate learning disabilities) who are at risk of experiencing mental health problems. It operates in 11 schools in Felixstowe and 17 in Sudbury. The TaMHS project team is providing the ‘Everybody’s Business’ mental health awareness courses for school based staff, and other front line professionals working with children and young people.

**Tier 2** – covers individual professional groups such as psychologists, psychiatrists and primary child mental health professionals.

In Suffolk this level of service is provided only by primary mental health workers. They offer consultation to health professionals like GPs, health visitors, school nurses, and specialists within education, including special education needs co-ordinators, home start advisory teachers, learning support assistants, and social care and the voluntary sector.

### Table 5: Estimated prevalence rates and numbers of mental disorders in vulnerable groups of children and young people in Suffolk in 2007.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>741</td>
<td>2,600</td>
<td>320</td>
</tr>
<tr>
<td>Percent</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of children and young people</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number with mental disorders</td>
<td>289</td>
<td>43%</td>
</tr>
<tr>
<td>Conduct disorders</td>
<td>106</td>
<td>37%</td>
</tr>
<tr>
<td>Emotional disorders</td>
<td>34</td>
<td>12%</td>
</tr>
<tr>
<td>Hyperkinetic disorders</td>
<td>20</td>
<td>7%</td>
</tr>
<tr>
<td>Other disorders</td>
<td>160</td>
<td>55%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population</th>
<th>Prevalence rate</th>
<th>Estimated numbers with learning disabilities</th>
<th>Estimated numbers with learning disabilities and a mental disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9 years</td>
<td>39,600</td>
<td>0.96</td>
<td>380</td>
</tr>
<tr>
<td>10-14 years</td>
<td>44,000</td>
<td>2.26</td>
<td>994</td>
</tr>
<tr>
<td>15-19 years</td>
<td>44,200</td>
<td>2.67</td>
<td>1,180</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total aged</th>
<th>5-19 years</th>
<th>2.00</th>
<th>2,600</th>
</tr>
</thead>
</table>

Tier 3 – covers more complex cases and involves specialist multi-disciplinary working between mental health professionals, and includes child and adolescent psychiatric clinics with child guidance, child and family consultation. Locally, the range of services at this level is provided by specialist teams such as Suffolk East and Suffolk West Child and Adolescent Family Consultation Service, Suffolk Child Sexual Abuse Treatment Service, Connect (a countywide service for looked after children with mental disorders), the Early Intervention In Psychosis Service, East Suffolk Eating Disorder Service, Community Nursing Team for Children and Young People with Learning Disabilities, and the Mental Health In-Reach Service for Young Offenders.

Tier 4 – is highly specialised and includes in-patient services and clinics for rare problems. This service is provided by Norfolk and Waveney Mental Health
Partnership NHS Trust for Suffolk children and young people.

In the last two years, Suffolk CAMHS started using a Choice and Partnership Approach (CAPA) in both the west and east of the county. CAPA is a clinical system based on offering users choice, and by working in partnership with them over jointly agreed goals. It is led by users and guided by clinicians. This has led to an enormous reduction in waiting times for care.

“What are service users saying about the current services?”

Young people who had used the CAMH services were invited to the ‘Initial Agenda Day’ held on 10th May 2008 at the Malthouse project in Bury St Edmunds. They shared their experiences and suggested further improvements to the service.

The views of the young people who participated in this event are summarised:

**What is good about CAMHS?**
- Only a phone call away, ease you in
- Relatively quick referral and diagnoses, progress is well monitored
- Staff are patient, help take things a step at a time
- Listen to users’ opinions, staff are trustworthy, service is confidential
- Helps your family as well, keeps them involved
- Good connection with schools & specialised services
- Make things easier to comprehend and offer alternative ways of doing things
- It feels like the staff can empathise with you and connect with you
- CAMHS can help parents put things into perspective
- When discharged still stay in contact if you wish

**What changes could be made to improve the service?**
- Establish young people’s support group to promote good mental health especially in schools
- Counsellor should be well informed about the young person before the meeting/appointment
- Questionnaires need to be easy/quick to complete & if intrusive questions are asked an explanation as to why, should be provided
- Hospital staff need to be better equipped to deal with young people with mental health issues
- A dedicated professional should be assigned to the young person, to explain all steps & professionals involved, including discharge process & follow ups
- Parents need to be supported and informed about how to deal with their child’s condition
- The CAMHS building should look more welcoming, more things in the waiting area, maps should be given in a welcome pack as the CAMHS building is hard to find

**Suffolk Early Intervention In Psychosis Service (SEIPS)**

In order to promote the SEIPS service to GPs who are our primary referrers, a letter of introduction was sent to every GP Practice in Suffolk, one month prior to the countywide launch of the SEIPS service in 2007. This was followed by face to face visits where SEIPS staff also gave a screening tool to help GPs identify those clients who are appropriate for the service.

“I had always known who and where these young people were, but in the past did not have a service to refer them to, until the young person became so unwell that they either warranted admission to hospital, or in some instances had to be admitted ‘in crisis’ under the Mental Health Act”

General practitioner.
Gaps in current services
There are some challenges in improving mental health and psychological wellbeing of children and young people (Maidrag 2009).

- Looked after children, young offenders and children with learning disabilities have continued difficulties in accessing mental health services.
- There is unmet need for services for conduct disorders and autistic spectrum disorders.
- There is a need for integrated behaviour support services for a complex mix of young people with behaviour problems, and those with learning disabilities, looked after children and young offenders.
- Issues of stigma, communication difficulties and cultural differences need to be addressed.
- There is a lack of knowledge of service availability among families and staff.
- There are differences among professionals about whether specific services for particular groups are preferable to providing for them within generic services.
- There needs to be more collaboration between services for adults and children.
- Access to care and care pathways for vulnerable groups of young people with mental health needs can be difficult.
- There is a lack of capacity because of low numbers of clinical psychologists and primary mental health workers, given the high level of need.

What are the new developments?
Suffolk Children’s Trust Board is aiming to provide an easily accessible, evidence based service to meet the mental health needs of children and young people in Suffolk.

CAMHS Strategic Commissioning Board and CAMHS Partnership Advisory Group are in the process of developing a strategy for a comprehensive CAMHS, and a CAMHS Partners’ Day took place on the 26th January 2009 in Ipswich. During this event, a number of multi-agency ‘task and finish’ groups were set up to take forward seven priority areas.

These groups are working in partnership and are now focusing on initiating action plans to maximise the potential of current resources. This initiative should have a positive impact on the emotional and mental wellbeing of children and young people in Suffolk.

Suffolk should be proud of the examples of good work developed, such as those described below.

‘Everybody’s Business’
TaMHS project team is providing ‘Everybody’s Business’ mental health awareness courses for school based staff and other front line professionals working with children and young people. This training has been well received and has been a success. An in principle agreement has been reached with Suffolk County Council Workforce Development Team to host the roll out of ‘Everybody’s Business’ as a part of the Council’s workforce development strategy. The following feedback came after the delivery of a training workshop for a pathfinder school:

“Many thanks for your training session on attachment theory. I have received a number of very positive comments from staff who now say that they feel more confident about meeting the needs of children with attachment issues. Understanding the reasons why some of our children behave in a certain way, helps us to work out strategies that can help some of the most vulnerable children in the school. This approach fits in with our inclusion policy and will help us to further develop the way we work with children in our recently opened inclusion centre.”

Headteacher

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Case study – Joe

Joe was re-referred to the Community Nursing Team in July 2007. Joe was 14 years old and had a diagnosis of severe learning disability and autism. He displayed challenging behaviour. He had been in contact with services before, but now his behaviour was becoming worse, he was more anxious and had begun to harm himself. As a result he was unable to attend school on a full time basis, had to transfer to a new school and his family could not be offered respite care. A multi-disciplinary meeting was held and he was referred back in to the Community Nursing Team. It was not clear whether it was challenging behaviour as a result of his level of learning disability, or whether there could be another underlying cause.

After an initial home visit and assessment, it was clear that Joe was showing signs of acute mental ill health, and severely challenging behaviour which was resulting in injuries to his parents. Initially, it was thought that Joe’s needs were so severe that he might need to be treated in specialist facilities outside Suffolk. The local community psychiatric service is limited to office hours and is clinic based only. Joe’s needs were far too complex for this provision. So an application was made to buy private psychiatric care to meet Joe’s needs within the home setting. After an emergency assessment at home, with family members and the community nurse present, stress in the family began to reduce. Following the assessment, Joe was diagnosed as having mood disorder, impulsivity, over-activity and increased anxiety, for which a complex medication regime was needed.

Treatment was provided by the local GP, and monitored by a psychiatrist and the community nursing service. To begin with, Joe was able to stay at home, and also able to spend time in his school placement when he was well enough. Numerous changes in his medication were needed to ensure he got the most benefit. These changes were made by the psychiatrist and the community nurse, during regular visits to Joe’s home. Joe is now able to cope much better with the pressures of the every day world, and is being cared for by the local community psychiatric services. He is coping so well that he is now able to attend school for more of the school day. Joe has a community outreach package, jointly funded by health and social care services, which provides him with the opportunity to undertake activities with carers, in the community. Regular multi-disciplinary review meetings are held to ensure his continued progress, monitor risk factors and make sure that the family feel supported. We are using the care programme approach to deliver the services he needs. This approach involves agreeing future treatment and care with the client, parents and professionals, and regularly reviewing and monitoring the client’s needs and progress.
West Suffolk College students and mental health issues

In the academic year 2008/09 West Suffolk College has 1,951 16-19 year olds enrolled on full time courses. They travel from the satellite market towns within roughly a 28-mile radius, including Stowmarket, Haverhill and Thetford. By the end of February 2009, Student Welfare staff had seen 10% of these 16-19 year olds for a whole range of issues. There has been a noticeable change in the complexity of the needs and types of issues young people are discussing.

Over the last five years, the number of students discussing both general health and mental health issues has risen noticeably, year on year, with 29 students discussing mental health issues so far this year. In the first two terms of this year, staff have seen a rising trend in students who are injuring themselves seriously, becoming psychotic, or having suicidal thoughts leading to attempted suicide. Sadly one student died, and 10 others were admitted to hospital. For the first time we have several young people accessing support from both the Children and Adolescent Mental Health Service (CAMHS) and Adult Mental Health Services. The increase in the number of serious cases being referred to Student Welfare is partly attributable to the growth in students staying in further education, particularly the expansion of foundation level courses over recent years, although other students share these problems. This is a challenge for the College and we are taking steps to manage increased student diversity.

In the future, the College would like to be able to make a number of improvements to the care they are able to offer their students by, for example, giving College welfare staff more training in mental health issues, more access to mental health professionals for advice, and giving young people more direct access to mental health services within the College.

<table>
<thead>
<tr>
<th>Year</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
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<tbody>
<tr>
<td></td>
<td>Sept- Feb</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Welfare Clients</td>
<td>55</td>
<td>134</td>
<td>195</td>
<td>280</td>
<td>190</td>
</tr>
<tr>
<td>Finance</td>
<td>12%</td>
<td>17%</td>
<td>19%</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>Housing</td>
<td>12%</td>
<td>9%</td>
<td>6%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Transport</td>
<td>3%</td>
<td>2%</td>
<td>0%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Relationships</td>
<td>18%</td>
<td>14%</td>
<td>9%</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>Social Issues</td>
<td>12%</td>
<td>9%</td>
<td>6%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Personal Issues</td>
<td>40%</td>
<td>32%</td>
<td>28%</td>
<td>28%</td>
<td>5%</td>
</tr>
<tr>
<td>Child Protection</td>
<td>3%</td>
<td>4%</td>
<td>6%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Bullying</td>
<td>NA</td>
<td>5%</td>
<td>14%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Health</td>
<td>NA</td>
<td>5%</td>
<td>9%</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Drugs</td>
<td>NA</td>
<td>3%</td>
<td>8%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>College/Tutor issues</td>
<td>NA</td>
<td>NA</td>
<td>5%</td>
<td>16%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Glossary

**Looked After Child:**
A child or young person (less than 18 years old) who is in the care of a local authority under a care order by the courts, or accommodated under a voluntary arrangement. This may be as a result of there being no person who has parental responsibility, the child is lost or abandoned, or the person caring for them is unable to provide them with suitable accommodation or care.

**Special Educational Needs (SEN):**
Learning difficulties or disabilities that make it harder for children to learn or access education than most children of the same age.

**World Health Organisation International Classification of Diseases Revision 10 (WHO ICD 10):**
A coding system with standard definitions of illnesses and injuries.

References

Chapter seven
When physical illness is (partly) a mental disorder

Since the beginning of health care it has been known that some physical health problems are caused by the impact of mental disorder on the body. This can affect both the healthy and those who have physical illness. It is only in recent years that the extent of this, and its costs have been better understood, at roughly 16% of the total amount spent on health care (Barsky et al 2005).

The current estimate of the cost of what is termed medically unexplained symptoms (MUS) and somatisation, to the NHS in England is around £8.5 billion per year, in adults aged 16 to 75 years alone.

Applying that percentage figure of 16% to NHS Suffolk means a cost of £102.05 million per year, based on the amount that NHS Suffolk expects to spend on non-administrative services in 2009-10. Most of these mental health problems are every bit as treatable as everyday physical illnesses, provided they are diagnosed correctly and the best treatment is offered.

Definitions
Medically unexplained symptoms (MUS): physical symptoms and signs that cannot be explained by any physical illness that the patient has.

Pain amplification: when depression causes a change to the way the brain functions, physical symptoms such as pain can register in the brain as more severe or longer lasting than they would otherwise be.

Somatisation: a type of mental disorder that causes physical symptoms or signs, and can make people suffer more severe symptoms of a physical condition. The term psychosomatic used to be used.

What sorts of medically unexplained symptoms occur?
There are broadly two types of medically unexplained symptoms. The first is when mental disorder such as clinical depression, generalised anxiety or panic disorder causes physical symptoms. These can include pain, shortness of breath, fainting spells or a feeling of being generally unwell or run down. In more extreme cases it can cause loss of use of limbs, blindness, inability to swallow, major skin rashes and a wide variety of other problems. For example, 69% of people with depression first present with physical symptoms (Simon et al 1999).
Just as commonly, if not more so, a person who has a physical illness, such as diabetes, asthma or arthritis, can experience physical symptoms that are considerably more intense than would normally be the case for the type or level of illness they have. This is sometimes called symptom amplification, as it is similar to the body turning up the volume of the symptoms experienced.

Most medically unexplained symptoms occur because of a combination of physical effects and mental health problems, including depression and acute stress. However, stress itself can be one of the first signs of depression or an anxiety disorder. Alcohol and drug misuse can also mimic or worsen symptoms of physical illness.

**Overlap of mental and physical health problems in an acute hospital**

The table lists just some of the forms of mental disorder that commonly present in general hospital specialities. Medically unexplained symptoms occur in all cases.

### Table 8: Examples of clinical conditions where mental health input should improve outcomes.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Somatic presentation of mental disorder</th>
<th>Co-morbidity/ associated psychiatric problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiology</strong></td>
<td>• Unexplained chest pain</td>
<td>• Post-MI depression &amp; anxiety disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cardiac neurosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hypertension</td>
</tr>
<tr>
<td><strong>Gastro-enterology</strong></td>
<td>• Unexplained abdominal pain</td>
<td>• Chronic disorders (e.g. coeliac disease, Crohn’s disease, ulcerative colitis)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Irritable bowel syndrome (IBS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adjustment following resection &amp; stoma</td>
</tr>
<tr>
<td><strong>Neurology</strong></td>
<td>• Conversion states</td>
<td>• Psychiatric complications of organic brain disease (e.g. Parkinson’s and Multiple Sclerosis)</td>
</tr>
<tr>
<td></td>
<td>• Pseudo-seizures</td>
<td>• Brain injury (behaviour &amp; capacity issues)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Epilepsy-related mental illnesses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Migraine-related depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cognitive impairment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Post-stroke depression</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>• Diabetic control becoming “brittle”</td>
<td>• Adjustment to diagnosis (especially in children)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Destabilisation by depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Abnormal eating behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Needle phobia</td>
</tr>
<tr>
<td><strong>Endocrine (other)</strong></td>
<td></td>
<td>• Thyroid, parathyroid and adrenal disease causing mood disorders and psychosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complications of steroid treatment</td>
</tr>
<tr>
<td><strong>Accident &amp; Emergency</strong></td>
<td>• Self harm</td>
<td>• Acute confusional states</td>
</tr>
<tr>
<td></td>
<td>• Psychiatric presentations to A&amp;E</td>
<td>• Treatment refusal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Management of disturbed behaviour</td>
</tr>
<tr>
<td><strong>Orthopaedics &amp; Trauma</strong></td>
<td>• Chronic (e.g. back) pain</td>
<td>• Post Traumatic Stress Disorder (PTSD), anxiety disorders and depression after trauma</td>
</tr>
<tr>
<td></td>
<td>• Self-inflicted injury</td>
<td>• Depression after chronic pain</td>
</tr>
</tbody>
</table>
When physical illness is (partly) a mental disorder

| Plastic Surgery                | • Body dysmorphic disorder  
|                               | • Self-esteem issues        
|                               | • Delayed wound healing due to self-harm  
|                               | • Adjustment after major surgery  
|                               | • Pre-op assessment for procedures  

| ENT                        | • Globus hystericus  
|                           | • Tinnitus  
|                           | • Hyperacusis  

| Renal/Urology          | • Sexual dysfunction  
|                       | • Scrotal pain       
|                       | • Adjustment to dialysis  
|                       | • Renal failure causing depression  
|                       | • Organic brain disorder due to dialysis  
|                       | • Psychological impact of urological cancer  

| Rheumatology        | • Unexplained joint pain / swelling  
|                   | • Autoimmune disorders causing depression  
|                   | • Complications of corticosteroids  
|                   | • Immunosuppressant-related depression  

| Pain Clinic         | • Somatoform pain disorder  
|                    | • Pain amplification       
|                    | • Chronic pain causing depression  
|                    | • Some chronic pain syndromes  
|                    | • High dose painkillers causing depression  

| Respiratory         | • Panic disorder in asthma and COPD  
|                    | • Asthma / Chronic Obstructive Pulmonary Disease (COPD) leading to anxiety disorders and depression  
|                    | • Oxygen dependence due to anxiety symptoms  

| Oncology           | • Medically unexplained decline  
|                   | • Secondary depression / anxiety  
|                   | • Neuropsychiatric complications of cancer  
|                   | • Issues surrounding end of life  
|                   | • Adjustment disorders  

| General Medicine   | • General malaise or anergia  
|                   | • Medically unexplained symptoms  
|                   | • Multiple pains  
|                   | • Factitious disorders (e.g. Munchhausen’s syndrome)  
|                   | • Various forms of delirium  
|                   | • Pathological obesity  
|                   | • Numerous drug-induced causes of depression  

How much does it cost?
The costs caused by medically unexplained symptoms arise in many different ways. Investigating the causes of symptoms by the use of tests, can obviously cost a great deal of money. However, it also costs time for both the patient and their doctor. The longer the real cause of the symptoms go unrecognised, the more serious the underlying mental health problem can become.

It is estimated that around half of all hospital out-patients have some medically unexplained symptoms at the time of their discharge from the clinic (Nimnuan et al 2001). As many as a third of people admitted to hospital for physical illness have a significant psychological component to their condition. The understandable concern that some physical illness has been ‘missed’ and is going untreated, often leads to a situation in which the real underlying condition is missed and goes untreated. Sadly, we know that this is not unusual in mental health problems, and this too can be highly costly. People who have the most easily treatable types of
mental disorder, such as depression or anxiety, often do not receive treatment at all (Singleton et al 2001). Nationally it is estimated that among those who have been unable to work for over a year due to a serious mental health problem of this type, as few as a quarter have ever received useful treatment.

### When physical illness is (partly) a mental disorder

| Hepatology                        | • Hepatic failure causing depression  
|                                  | • Psychiatric precursors to alcoholic liver disease  
|                                  | • Psychiatric complications of antiviral medicines |
| Infectious Diseases              | • Chronic fatigue syndrome and myalgic encephalomyelitis (ME)  
|                                  | • Glandular fever  
|                                  | • HIV - adjustment to diagnosis, psychiatric complications, encephalopathy / dementia  
|                                  | • Psychiatric complications of treatment, eg antiretroviral agents |
| Geriatric Medicine               | • Pseudo-dementia  
|                                  | • Non-specific decline  
|                                  | • All the above with frailty issues  
|                                  | • Acute and chronic confusional states  
|                                  | • Dementias  
|                                  | • Age-related social problems (loss of partner, role change in society etc)  
|                                  | • Effects of polypharmacy  
|                                  | • Legal capacity issues |
| Paediatrics                      | • Recurrent abdominal pain  
|                                  | • Self-harm  
|                                  | • Enuresis and encopresis  
|                                  | • Neuro-developmental abnormalities  
|                                  | • Diabetes (adjustment, non-compliance)  
|                                  | • Chronic / enduring illness (eg cystic fibrosis, cancer – support for child & family)  
|                                  | • Child protection issues |
| Dermatology                      | • Obsessive washing  
|                                  | • Dermatitis artefacta  
|                                  | • Self-esteem issues and social phobia  
|                                  | • Complications of treatment (e.g. steroids and Roaccutane) |
| Obstetrics & Gynaecology         | • Unexplained abdominal pain  
|                                  | • Sexual dysfunction  
|                                  | • Antenatal advice re psychotropic medicines  
|                                  | • Antenatal screening for postnatal depression  
|                                  | • Postnatal psychiatric illness  
|                                  | • Affective disorders associated with menstrual cycle |

**Source:** Pieters and Webb, 2009
How the costs break down

Table 9: The estimated number of patients with MUS in NHS Suffolk 2008/09, by speciality

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Estimated no. of first appointments</th>
<th>Estimated no. with medically unexplained symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>9,194</td>
<td>3,402</td>
</tr>
<tr>
<td>Chest</td>
<td>4,060</td>
<td>1,665</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>5,342</td>
<td>2,404</td>
</tr>
<tr>
<td>Cardiology</td>
<td>7,417</td>
<td>3,931</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>3,254</td>
<td>1,887</td>
</tr>
<tr>
<td>Neurology</td>
<td>5,635</td>
<td>3,494</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>14,666</td>
<td>9,680</td>
</tr>
<tr>
<td>Totals</td>
<td>49,568</td>
<td>25,775</td>
</tr>
</tbody>
</table>

Source: NHS Suffolk data from SUS via Sollis 2008/09, and Nimnuan et al 2001

What can we do about it?
Most of the types of mental disorder that cause medically unexplained symptoms are every bit as treatable as the physical illnesses they imitate or complicate (Kroenke and Swindle 2000; O’Malley et al 1999). As with any form of illness, they need to be recognised and correctly diagnosed before the right treatment can be offered. Unlike most other forms of illness, many patients are reluctant to accept that they have this type of problem. While none of us likes the prospect of having to come to terms with the fact that a part of our body is not working properly, the idea that part of our brain may be letting us down is even less welcome. In reality though, most illnesses involve in part, an interaction between our bodies and our brains. It is just that in some cases the brain component is more important.

Dealing with medically unexplained symptoms is already a part of the daily working life of most doctors, nurses and other clinicians, both in hospital practice and in primary care. The question is whether or not these are dealt with effectively. Putting psychiatrists and psychologists in every ward and clinic is unlikely to work. There are not enough of these trained specialists, it would be extremely costly, and it would by-pass the experience other professionals already have to offer.

A more affordable and better approach, is to use these specialists to increase the skills of doctors and nurses who already deal with these problems, so that they are more comfortable and confident in spotting and dealing with the psychological component of the physical problems that people bring to their departments and surgeries.

Figure 1: The estimated total cost of MUS in NHS Suffolk, using figures from the NHS Suffolk budget for 2009–10 and Barsky et al 2005, in millions of pounds.

Estimated cost of MUS in Suffolk in 2009-10

- £18.58 acute non specialist
- £3.30 acute specialist
- £2.29 non acute
- £9.46 children
- £6.75 community
- £2.82 ambulance
- £2.78 primary care
- £0.58 dentistry
- £3.02 prescribing
- £55.50 total
When physical illness is (partly) a mental disorder

An example of this is the pilot in which all patients seen in the ‘rapid access chest pain clinics’ in East Suffolk will be screened for the form of anxiety called panic disorder. Those without heart disease, but with panic disorder, will have rapid access to treatment via the Improving Access to Psychological Therapies (IAPT) service. Those with heart disease, and panic disorder, will have both treated, it is hoped with a reduction in the distress caused by their heart disease.

The way forward
Changing the way we deal with medically unexplained symptoms will involve changing some of the ways in which we have traditionally looked at health care in Suffolk. It involves moving away from treating only particular illnesses, to treating the whole problem. It will represent a major challenge for the NHS in Suffolk but also a major step forward.

But aren’t you missing something, doctor?
The underlying fear for both doctor and patient where medically unexplained symptoms appear to be present, is that some underlying physical problem will be missed. The fear essentially is that the patient will suffer unnecessarily from a condition that needs to be treated. The ironic twist is that this is often usually occurring already. By not treating the psychological component of the patient’s problems, the health problem is continuing to cause unnecessary suffering.

References


Some people who have common mental disorders, such as depression or anxiety, recover with limited assistance. Others however, need professional help to aid recovery or improvement. Typically, GP’s have offered some help - usually in the form of medicines and/or limited counselling therapy.

There is a growing recognition that intervening early with psychological therapy, helps people suffering from these common mental disorders more quickly (and successfully). Psychological therapy is not the same as psychotherapy, but offers users a chance to learn skills to cope with stressful events. After an initial assessment an individual can still be offered traditional counselling, but increasingly psychological therapies are preferred.

How are mental health services developing in Suffolk?
NHS Suffolk has a clear aim to develop a mental health service which offers a full range of services, focused in the community. The Mental Health National Service Framework (NSF) (DH 1999) gave a framework for improving mental health care by calling for significant extra investment. The NSF outlined a 10 year strategy focusing mainly on hospital care and those people with more severe and complex mental health problems.

In October 2007, a new national initiative called IAPT – ‘Improving Access to Psychological Therapies’ (DH 2007) - was announced, with the aim of improving mental health services in primary care. NHS Suffolk was invited by the East of England Strategic Health Authority (SHA) to become one of the first areas to introduce IAPT.

What is IAPT?
The IAPT approach (or ‘talking therapies’), is about intervening early to maintain and improve the quality of people’s lives, and to stop the disabling effects of their mental health problems. All IAPT therapists must be accredited nationally.

The main component of IAPT is Cognitive Behavioural Therapy (CBT). The CBT approach is based on carefully selecting those who will benefit through assessment, and offers a real alternative to treatment with medication. The overriding principle is that users are
able to access services quickly when they need them. CBT is based on structured self-help and can be provided by a range of agencies. It also offers different levels of care according to need, so a particular therapist can advise more intensive therapy if required, including hospital treatments.

The aims of the IAPT service are that:
- Users improve their mental health and wellbeing.
- Users and carers have a better experience of services.
- People have a wider range of treatment options e.g. CBT and medicinal remedies.
- Users have more chance of being employed and socially active by focusing on:
  - Returning users to work or helping those already in work cope better.
  - Supporting users to carry out normal daily activities.

**What is the research evidence that shows IAPT works?**

There are different types of psychological therapies and different ways of offering the therapy eg face to face, in groups, or via a computerised programme, and they have all been applied to different clients for different mental health problems. Though there is a body of research evidence which shows that psychological therapies can benefit many, it does not follow that the approach will work for everyone in all circumstances. The research evidence has been reviewed by the National Institute for Health and Clinical Excellence who have provided guidelines for the treatment of anxiety and depression (NICE 2007; NICE 2007). NICE recommends that CBT should be available for all but the mildest forms of depression and anxiety, and recommends other forms of psychological therapy for selected conditions.
Improving Access to Psychological Therapies (IAPT)

How many people could benefit in Suffolk?
Because NHS Suffolk and Suffolk Mental Health Partnership NHS Trust were invited to be one of the first to implement IAPT nationally, the service described here does not apply to the residents of NHS Great Yarmouth and Waveney. However, needs assessment work has taken place in NHS Great Yarmouth and Waveney and an IAPT pilot project is currently running there. Full roll out of IAPT is anticipated in Great Yarmouth and Waveney towards the end of 2009.

Using figures from a nationally published survey of psychological illness (Singleton 2000), it is estimated that at any one time in Suffolk there are about 69,000 people who will be experiencing some form of common mental health problem. It is estimated by the Mental Health Observatory that approximately a fifth (about 14,000) people could benefit from psychological therapy. A further half of this total number will recover with no specific treatment. This first wave of IAPT services in NHS Suffolk will be able to offer therapy to about a third of this number, and will include liaison with employment coaches working with Employment Agencies (e.g. Job Centre Plus).

People offered the IAPT service may be experiencing any of the following mental health problems:
• Depression
• Panic disorder
• Generalised anxiety disorder
• Phobias
• Post traumatic stress disorder
• Obsessive compulsive disorder – including body dysmorphic disorder
• Medically unexplained symptoms (MUS) in addition to any of the problems above.

Mental health is still a taboo issue within many communities, and CBT and other types of therapies are not well understood by disadvantaged communities. Overcoming this, will be a challenge.

Table 10: Estimated prevalence of common mental health problems

<table>
<thead>
<tr>
<th>Mental Health Problems</th>
<th>NHS Suffolk Estimated Cases</th>
<th>Rate per 1,000 pop</th>
<th>Suffolk County Estimated Cases</th>
<th>Rate per 1,000 pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any neurotic disorder</td>
<td>64,874</td>
<td>155</td>
<td>78,197</td>
<td>156</td>
</tr>
<tr>
<td>All phobias</td>
<td>6,137</td>
<td>15</td>
<td>7,370</td>
<td>15</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>10,699</td>
<td>26</td>
<td>12,885</td>
<td>26</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>14,116</td>
<td>34</td>
<td>17,026</td>
<td>34</td>
</tr>
<tr>
<td>Mixed anxiety disorder</td>
<td>37,759</td>
<td>90</td>
<td>45,504</td>
<td>91</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>4,230</td>
<td>10</td>
<td>5,085</td>
<td>10</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>3,752</td>
<td>9</td>
<td>4,531</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Mental Health Observatory Brief No4; May 2008

How will IAPT be monitored?
IAPT is being monitored nationally, and NHS Suffolk will also evaluate the local service. Monitoring will look at key areas, to ensure that local services:
• Provide a range of psychological therapies approved by the National Institute for Health and Clinical Excellence (NICE).
• Promote case management using a range of specialists including Employment Advisors, where appropriate.
• Use a nationally specified minimum data set and a collection system to support formal evaluation.
• Result in more people using IAPT services over time.

What is stepped care?
IAPT works to a ‘stepped-care model’ which aims to match the needs of people with mental health problems to the most appropriate service. This takes account of their degree of illness and their personal circumstances and preferences. Each step introduces additional interventions, with clients moving up the steps according to their need for increased care.
The stepped care model

The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.

### Step 1: Assessment
Prior to the start of treatment, all patients receive a comprehensive ‘patient centred’ assessment that clearly identifies the extent and impact of their mental health problems, including identifying any employment, social or physical health issues. The risk of violence from users to themselves (e.g. suicide) or to others will also be assessed. Assessments will be made at each treatment session so that progress can be monitored.

### Step 2: Low-intensity service
A low-intensity service usually lasts for about 1-6 sessions and includes brief face-to-face contact and telephone support. It is delivered by specially trained low intensity mental health workers. The key elements are:

- **Education.**
- **Bibliotherapy** (book based guided self help).
- **Behavioural activation.**
- **Signposting to other services or self help arrangements, with follow up to ensure that the signposting has been effective.**
- **Guided cognitive-behavioural self-help for phobias and anxiety.**
- **Assisting with and encouraging patients to use for themselves, the problem-solving techniques and strategies learned through Cognitive Behavioural Therapy.**
- **Guided self-directed exposure therapy.**
- **Referral to various services, including social services and exercise referral.**
- **Introduction to a broader range of interventions and help from other agencies.**
- **Computerised CBT (8 sessions).**
- **Advice on medication for patients receiving antidepressants.**
- **Telephone support offered by therapists to patients on antidepressant medication.**
- **Individual CBT sessions with a therapist (6-8 face-to-face sessions).**

### Steps 3 & 4: Higher intensity services
Steps 3 and 4 offer high-intensity approaches from appropriately trained therapists and mental health specialists, which include the following components:

- **One to one CBT (8-20 sessions, average of 12 sessions over 6 months).**
• Group CBT (6-10 people, up to 12 x 2hr sessions).
• Therapy sessions, supplemented by guided self-help.
• Medication advice and support for patients receiving antidepressant medication.
• Telephone support for patients on antidepressant medication.

Step 5
This is mental health illness requiring hospital inpatient care and is not part of the IAPT programme.

Suffolk Information on Prescription
Suffolk Information on Prescription is a countywide service which supports better health information for patients and their carers on a wide range of conditions. In 2009, it has expanded to offer a mental health information service available from every Suffolk library, for people to ask for basic information about their mental health and wellbeing, and for accurate signposting to sources of more advanced help or expertise. The service will be accessible across Suffolk, seven days a week. The service is also working closely with the Improving Access to Psychological Therapies service.

Links with primary and secondary care
Suffolk Mental Health Partnership NHS Trust, working with Suffolk Mind Partnership as the service providers, are responsible for overall case management, including referral to more complex care (specialist services outside the IAPT service, Community Mental Health Teams and inpatient care) and for communicating with the service user’s general practitioner.

Currently services are being offered from specific centres in local towns, and general practices and community centres in rural areas are also offering services.
Service providers are required to establish links with other organisations that can help the user. For example:
• Primary care counselling services
• Citizens Advice Bureaux
• Debt and financial advice services
• Department of Health and Pensions
• Statutory and voluntary sector providers.

The future
It is still early days for IAPT but Suffolk has already been recognised by the Strategic Health Authority as being at the leading edge in introducing these therapies for its residents. It is hoped that by April 2010 the new IAPT service will expand so that it can be accessed by everyone who is eligible.

Lessons learned from the evaluation should help to improve the service.

**Glossary**

**Behavioural activation (BA):** This is a treatment in which the therapist helps the patient to work towards breaking the cycle of depression, by engaging in activities that are meaningful to them. This will not just increase activity, but will help to identify actions in life that the person has stopped engaging in since becoming depressed, but wishes to become involved in again. (Sheffield Health and Social Care NHS Foundation Trust)

**Bibliotherapy:** A form of supportive psychotherapy in which carefully selected reading materials are used to assist a subject in solving personal problems, or for other therapeutic purposes.

**Body dysmorphic disorder (BDD):** This is a body image problem. It is defined as an individual’s preoccupation with one or more perceived defects in his or her appearance. For the diagnosis to be BDD the preoccupation must also cause significant distress. (Mind)

**Cognitive behavioural therapy (CBT):** CBT is a form of psychotherapy which combines cognitive and behavioural therapy. Cognitive therapy looks at how our thoughts can create our feelings and mood. Behavioural therapy pays close attention to the relationship between our problems, our behaviour and our thoughts. CBT may focus on what is going on in the present rather than the past, but often the therapy will also look at how thinking patterns may have begun in early childhood and the impact patterns of thinking may have on how we interpret the world as adults. (Mind)

**Depression:** Health professionals use the terms depression, depressive illness, or clinical depression to refer to something very different from the common experience of feeling miserable or fed-up for a short period of time. When you’re depressed you may have feelings of extreme sadness that can last for a long time. These feelings are severe enough to interfere with your daily life, and can last for weeks or months, rather than days. (NHS Choices)

**Generalised anxiety disorder (GAD):** This is a condition where a person experiences excessive anxiety (feeling fearful, worried and tense) on most days. The condition persists long term. Anxiety tends to be about various stresses at home or work, often about quite minor things. A person may not know why they are anxious. Symptoms of GAD cause distress and affect day to day activities. (Patient UK)

**Guided cognitive behavioural self-help:** Self help books and materials that use CBT principles. (Royal College of Psychiatrists)
Guided self-directed exposure therapy:
This is a type of behaviour therapy where the person is gradually exposed more and more to feared situations. The therapist teaches the person how to control anxiety and to cope when facing feared situations. (Patient UK)

Medically unexplained symptoms (MUS):
These are symptoms that can’t be explained by a medical problem, rather they are usually the result of emotional distress. Symptoms can affect almost any part of the body, and may include muscle and joint pain, chronic fatigue and irritable bowels. Anyone can be affected at any age, but symptoms usually start before the age of 30 and can continue for many years. (BUPA)

Obsessive compulsive disorder (OCD):
This is a chronic mental health condition that is usually associated with both obsessive thoughts and compulsive behaviour. An obsession is defined as an unwanted thought, image or urge that repeatedly enters a person’s mind. A compulsion is defined as a repetitive behaviour or mental act that a person feels compelled to perform. A person with OCD gets no pleasure from their compulsive behaviour. OCD is one of the most common mental health conditions. It is estimated that about 1-3% of adults and 2% of children and teenagers have OCD. (NHS Choices)

Panic disorder:
For people with panic disorder, feelings of anxiety, stress and panic can occur at any time, usually for no obvious reason. A panic attack is when your body experiences a rush of intense psychological and physical symptoms. At least one person in 10 experiences occasional panic attacks, which are usually triggered by a stressful event or situation. However, people with panic disorder have recurring and regular attacks, often for no apparent reason. (NHS Choices)

Phobias:
A phobia is a type of anxiety disorder. It is a strong, irrational fear of something that poses little or no actual danger. There are many specific phobias. (Medline Plus)

Post traumatic stress disorder (PTSD):
This is a psychological and physical condition that can be caused by extremely frightening or distressing events. Many people develop PTSD because someone close to them died suddenly (around 40%). PTSD is common and affects around 5% of men and 10% of women at sometime in their life. (NHS Choices)

References


Improving Access to Psychological Therapies (IAPT)


Connected Care

Brandon is a small rural market town on the border with Norfolk. The town has relatively large numbers of people who feel isolated, or are on low incomes without many traditional academic qualifications.

The population of the town is getting older and more diverse with a high number of migrant workers moving to the area. All these issues affect mental wellbeing, as well as health.

Connected Care is an exciting joint project between NHS Suffolk and Suffolk County Council that aims to join up health and social care services in Brandon. Research carried out by Turning Point, which manages Connected Care, found that people with the most complex needs are often failed by traditional services, which tend to manage one problem at a time, instead of looking at the whole person.

Twelve community researchers were trained to lead a Connected Care audit. The audit gathered information and consulted with the community about the needs of local people. Ten percent of the population of Brandon were involved in the audit, and the final report makes recommendations for the redesign of services.

The research findings recommend that services need to be easy to find and access, and more joined up, to better meet the needs of the community. In terms of mental health, the audit found that there was a lack of support for those with low level mental health problems such as anxiety and depression. This was often linked to social isolation among older people. Many older people reported mental health needs but did not know where to go for help, and wanted general emotional support and assistance in engaging with services. In the coming months, the project will find innovative ways to ensure people receive the help that they need.
At present, many common mental health problems are treated in primary care with the use of medication. The range of drugs available to general practitioners has increased over the last few years, and as other therapies become more widely used, it will be important to understand how trends in drug treatment change in Suffolk.

Quarterly prescribing data from 2004/05 to 2008/09 was collected for the NHS Suffolk practices using an extract from the national electronic reporting system. This data indicates the number of prescriptions for mental health disorders issued by GP practices only. It covers the mental health disorders most commonly treated in primary care and does not include prescriptions outside primary care. The same data were obtained for England for comparison.

The British National Formulary (BNF) is a reference system to help doctors to select appropriate drug treatments for their patients. The number of prescriptions made each quarter was grouped by BNF code as follows:

- Drugs used to treat insomnia, anxiety and stress
  - Hypnotics
  - Anxiolytics
- Drugs used to treat psychoses and related disorders
  - Antipsychotic drugs
- Drugs used to treat depression
  - Tricyclic and related antidepressant drugs
  - Monoamine-oxidase inhibitors
  - Selective serotonin re-uptake inhibitors (SSRI)
  - Other antidepressant drugs

Since the available data only gives a count of the numbers of prescriptions made, it is not possible to make adjustments for differences in age, gender or sickness when comparing NHS Suffolk with England. For example, if proportionally there are more people living with illnesses in NHS Suffolk than in England, it might be expected that proportionally more prescriptions would be used in Suffolk. Nor is it possible to know how many of these prescriptions were actually collected and used by patients. Despite these limitations, it is possible to identify trends in the use of prescription drug groups.

The data have been expressed as a rate. This was calculated by dividing the number of prescriptions by the registered population for NHS Suffolk, and is expressed as the number of prescriptions per 1,000 registered patients. Rates for both NHS Suffolk and England are presented to enable comparison.
The prescription rate of hypnotics and anxiolytics is slightly lower in NHS Suffolk compared to England. There has been no significant change in the prescription rate of hypnotics. There has been a 14% increase in the use of anxiolytics in NHS Suffolk from 04/05 to 08/09, which has brought the NHS Suffolk rate closer to that of England (Figure 2).

Prescribing of antipsychotic drugs has increased in both NHS Suffolk and England in the four years from 04/05 to 08/09. In England there has been a 22% increase in their use and a 19% increase in NHS Suffolk (Figure 3).

**Figure 2**: Trend in prescribing of hypnotics and anxiolytics, 04/05 to 08/09 for NHS Suffolk and England.

**Figure 3**: Trend in prescribing of antipsychotics, 04/05 to 08/09 for NHS Suffolk and England.

Source: ePACT; NHS Business Services Authority
Depression is the most commonly treated mental health disorder in primary care. Of the drugs commonly used to treat this condition, selective serotonin re-uptake inhibitors (SSRIs) are the most commonly prescribed in primary care (Figure 4).

In the four years from 04/05 to 08/09 there has been a 30% increase in their use in NHS Suffolk. There has been very little increase in the use of tricyclic and related antidepressants, with their prescribing rate remaining at around 65 to 70 items per 1,000 persons per year.

There has been a 40% increase in the use of tricyclic and related antidepressants, with their prescribing rate remaining at around 65 to 70 items per 1,000 persons per year.

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Overall, from 04/05 to 08/09 there has been a 26% increase in antidepressant prescribing in NHS

**Figure 4:** Trend in prescribing of antidepressants, 04/05 to 08/09 for NHS Suffolk.

**Figure 5:** Trend in prescribing of selective serotonin re-uptake inhibitors, 04/05 to 08/09 for NHS Suffolk and England.

*Source: ePACT, NHS Business Services Authority*
Suffolk, from 408,000 to 515,000 items per year. This is slightly greater than the 25% increase seen in England. The rate of antidepressant prescribing (all types) is higher in NHS Suffolk than for England (Figures 5 and 6).

A large increase in the use of SSRIs can be seen in Figure 5 for both NHS Suffolk and England. In the four years from 04/05 to 08/09 there has been a 30% increase in their use in Suffolk. Throughout this time, their use in NHS Suffolk has remained about 27% higher than for England.

The prescribing of tricyclic and related antidepressants in NHS Suffolk has remained about 25% higher than the rate for England. Prescribing of other antidepressant drugs is about 37% higher in NHS Suffolk than in England.

We need to continue to monitor current trends in prescribing and use opportunities to offer alternative treatments such as IAPT when they are appropriate.

Figure 6: Trend in prescribing of tricyclic and related antidepressant drugs and other antidepressant drugs, 04/05 to 08/09 for NHS Suffolk and England.

Source: ePACT, NHS Business Services Authority
Personality disorder has a specific definition in psychiatry, and is characterised by extreme or disturbed behaviour, nearly always resulting in significant personal and/or social problems (WHO 1992). Personality disorder is distinct from other conditions because it is not directly caused by brain damage, disease, or other mental illness. Personality disorders usually appear in late childhood or adolescence, and then continue throughout adulthood. There are several types of personality disorder defined by the World Health Organisation International Classification of Diseases and Related Health Problems; tenth revision (ICD-10).

### Diagnostic clusters (WHO 1992)

<table>
<thead>
<tr>
<th>Types of disorder</th>
<th>Main characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoic personality disorder</td>
<td>Paranoia and a pervasive, long-standing suspiciousness and generalised mistrust of others.</td>
</tr>
<tr>
<td>Schizoid personality disorder</td>
<td>Lack of interest in social relationships, a tendency towards a solitary lifestyle, secretiveness, and emotional coldness.</td>
</tr>
<tr>
<td>Dissocial personality disorder</td>
<td>Pervasive disregard for the law and rights of others.</td>
</tr>
<tr>
<td>Emotionally unstable personality disorder</td>
<td>Marked tendency to act impulsively without consideration of the consequences, together with affective instability.</td>
</tr>
<tr>
<td>Histrionic personality disorder</td>
<td>Pattern of excessive emotionality and attention-seeking, including an excessive need for approval and inappropriate seductiveness, usually beginning in early adulthood.</td>
</tr>
<tr>
<td>Anankastic personality disorder</td>
<td>Rigid conformity to rules, moral codes, and excessive orderliness.</td>
</tr>
<tr>
<td>Anxious (avoidant) personality disorder</td>
<td>Pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation and avoidance of social interaction.</td>
</tr>
<tr>
<td>Dependent personality disorder</td>
<td>Pervasive psychological dependence on other people.</td>
</tr>
<tr>
<td>Other specific personality disorders</td>
<td>Fits none of the specific rubrics.</td>
</tr>
</tbody>
</table>
Personality disorder

Case study

Miss A is a 27 year old unemployed single woman who was admitted to the local acute psychiatric ward from the accident and emergency department, after she had cut both her wrists, following a fight with her boyfriend. Miss A was no stranger to the psychiatric services as she suffers from emotionally unstable personality disorder, and has been a service user for a number of years.

Miss A was sexually abused as a child by her mother’s late partner. It is not known whether her mother was aware of this at the time. Miss A was noted to be intelligent when at school, but she was expelled for violence towards a peer at secondary school. She was then already a regular user of alcohol and drugs, and on leaving school, Miss A advanced to using heroin, becoming addicted.

Miss A was interviewed on the psychiatric ward and it was noted that she had multiple scars on her arms, chest and legs. Miss A described herself as feeling “dead inside” which she temporarily relieved by self harming. In the ward she quickly settled into the routine, and did not appear to be excessively depressed. She regularly asked younger members of staff for favours, some of which were invasive and inappropriate. She left the ward on her fourth day, and returned with cannabis which she passed to other patients. After this was discovered Miss A was discharged. She has been referred for an outpatient assessment for psychotherapy.

What is the extent of the problem?

National figures indicate that personality disorder is a serious public health problem, not least because people with personality disorder tend to be high users of services.

The prevalence of personality disorder in the community varies between 10% to 13% of the adult population (NIMH(E) 2003). The most prevalent categories of ICD-10 personality disorder are anankastic (7.9%), impulsive (7.6%), anxious (7.6%) and paranoid (7.3%) (Moran et al 2000).

The prevalence of personality disorder in psychiatric hospital patients varies between 36 to 67%. In-patients with drug, alcohol and eating disorders also have higher prevalence of personality disorder (NIMH(E) 2003).

How many people have a personality disorder in Suffolk?

Due to a lack of local data, it is hard to know exactly how many people within Suffolk have a personality disorder. It is estimated that about 54,556 people (about 10.5%) between the ages of 16 to 74 years in Suffolk, have a personality disorder.

What services currently exist nationally?

In 2004, the National Institute for Mental Health in England (NIMH(E)) were asked to improve services for people...
Personality disorder

with personality disorder, by developing and delivering a series of workforce, training and direct service improvement initiatives. This was the first time the real issues of personality disorder were acknowledged. NIMH(E) published ‘Breaking the Cycle of Rejection: the Personality Disorder Capabilities Framework’, which set out a framework to support practitioners in new, dedicated personality disorder services.

The Department of Health commissioned eleven personality disorder service pilot projects in that same year. Their aim was to develop innovative psycho-social approaches to treatment, and interventions that promote personal recovery and social inclusion. The 11 pilots have been very important in increasing understanding of how people with personality disorders can be supported. At present, only a very few hospitals have dedicated personality disorder services.

There are a small number of specialist services for people diagnosed with personality disorders across the country, most of which provide in-patient services for people with more serious problems associated with personality disorder.

What services are currently available in Suffolk?
Suffolk reflects the national picture, as it does not have a dedicated or specialist service for people diagnosed with personality disorder. Currently, people with personality disorder get support and help from their general practitioners or from Community Mental Health Teams (CMHT) and other general adult mental health services.

Support is typically obtained from GPs, Accident and Emergency Services and the Criminal Justice System. Suffolk also has a number of voluntary services that provide support, such as the mental health charities Suffolk Mind Partnership and Together. Family support is provided through Family Action and Suffolk Respite who support the carers and families of people affected by mental illness.

Employment services including Meridian East, Suffolk Employment Care and the Shaw Trust provide support to individuals seeking employment. Drug and alcohol services in Suffolk include NORCAS, the Iceni Project and Focus 12, all of which provide services to people diagnosed with personality disorders.

What are the problems with services?
People with personality disorder often find it difficult to access the care and treatment they need from mental health services. GPs and other disciplines within primary care teams have very little specific training in the diagnosis, treatment and management of personality disorders (NIMH(E) 2003). However, they are often the first point of contact for many service users. People with personality disorder may experience similar difficulties when using voluntary sector and mental health services, as services are often targeted towards the mentally ill, with no specific service for this client group.

There is some national evidence that many health care practitioners are reluctant to work with people diagnosed with personality disorders (Crawford 2008). This is because many believe they have neither the skills, training nor resources to provide an adequate service. As a result, people diagnosed with personality disorder frequently become ‘revolving door’ patients (NIMH(E) 2003).

As well as this, the identification and classification of personality disorder can be difficult and controversial. There is a high level of stigma attached to the term ‘personality disorder’. Stigma is increased due to a commonly held false belief that all personality disorders are untreatable and unmanageable. The failure to identify the presence of a personality disorder can lead to a range of difficulties for the individual (Pidd et al 2007).
What would a good service look like?

Very few mental health providers have dedicated personality disorder services. The new Mental Health Act 2007 highlights the service gaps and suggests that appropriate treatment is likely to be relatively intense, long term and structured, and needs to be tailored to the individual circumstances of the person. National guidance has been produced to help commissioners and mental health trusts develop personality disorder services (NIMH(E) 2003).

Whilst there is a range of treatment interventions available for personality disorder, some sufferers find it difficult to access treatment because many clinicians are sceptical about its effectiveness. Research suggests that a combination of psychological treatments, reinforced by drug therapy at critical times, can be effective in treating personality disorder (Bateman et al 2002).

Some key principles that are attributed to the effectiveness of therapy for people with a personality disorder were determined to be:
- Defined structure.
- Devoted effort to achieving adherence.
- A clear focus.
- Relatively long-term.
- Well integrated with other mental health services available to the patient.
- A clear treatment alliance between therapist and patient.

The development of a local service model within an overall strategy is the key to the success of providing an effective service for people with personality disorder. The needs of people with more severe personality disorder may require additional specialist services.

Features of a good personality disorder service:

- Early intervention, before crisis point.
- Choice from a range of treatment options.
- Individually tailored care.
- Develops patients’ skills.
- Respects strengths and weaknesses.
- Good clear communication.
- Clear and negotiated treatment contracts.
- Good assessment and treatment links.
- Listens to feedback and has a strong voice from service users – patient experts.
- Supports peer networks.
- Shared understanding of boundaries.
- Appropriate follow up and continuing care.
- Atmosphere of “truth and trust”.

Service model for personality disorder - some key components:

- Develop a clear personality disorder pathway from the point of referral, to treatment, follow-up and ongoing support. This should include pathways between general mental health services and forensic (criminal justice) mental health services, and from child and adolescent to adult mental health services.
- Develop clear systems for communication with service users and within teams. Services should have a clear information sharing policy, communicated to the client during induction.
- Offer a range of interventions combining social, psychological and occupational approaches that are delivered by a multi-disciplinary team, across community and hospital-based mental health services.
- Offer choice, and foster a sense of personal responsibility among service users, including user online networks and support forums.
- Clarify arrangements for in-patient, specialist services, out of hours and crisis intervention services.
- Develop effective support arrangements for families and carers.
What is happening in Suffolk?

The Eastern Development Centre and NHS Suffolk have funded the appointment of a Personality Disorder Community Development Worker with Suffolk Mind Partnership, to review services in relation to personality disorder, including users’ experience of receiving care. This will include obtaining views from service users, carers, clinicians, service managers, commissioners and other stakeholders. Stakeholders are represented at regular Suffolk Personality Disorder Steering Group meetings which form the focal point for developing and improving mental health services for people with personality disorder.

This year, the steering group has a number of key targets to achieve:
- Identify areas of strength and weakness in our current mental health services in relation to the needs of people with personality disorder.
- Increase awareness of personality disorders.

Examples of service providers:
- Family Action is a charity that tackles issues facing families, including domestic abuse, mental health problems, learning disabilities and severe financial hardship. They also offer employment support.
- Focus12 is a charity located in Bury St Edmunds that deals with all aspects of addiction, offering counselling services and a day programme.
- The Iceni Project offers care and support to those members of the community of Ipswich and its surrounding area, whose lives have been affected by the misuse of drugs.
- Mind is a mental health charity in England and Wales which works to create a better life for everyone with experience of mental distress.
- NORCAS is an open access drug and alcohol charity, operating from teams based throughout Norfolk and Suffolk. They work with anyone experiencing problems with alcohol, drugs, tranquillisers or solvents, including families and carers.
- Richmond Fellowship, Workwise and Street Forge Workshops support people who want to work, but face disadvantage when it comes to entering the employment market.
- Shaw Trust is a national charity that supports disabled and disadvantaged people, helping them to turn their lives around by finding a job.
- Suffolk Employment Care (SEC) provides support and practical advice to help people who have suffered mental distress, to gain, regain or maintain paid or unpaid employment.
- Suffolk Mind Partnership: East and West Suffolk Mind provide a range of services including supported housing, community resource activities, therapeutic programmes and counselling across Suffolk.
- Suffolk Respite offers free support and practical help, in the form of regular respite breaks to the family carers of people who suffer from enduring mental health problems.
- Together is a mental health charity working to improve mental health and wellbeing and to promote hope.

If Only You Knew

Suffolk Mental Health Partnership NHS Trust led a highly successful local campaign ‘If Only You Knew’, to tackle stigma against people with mental ill health, drug problems and users of learning disability services. Service users were at the centre of the campaign and the six key messages reflected their experiences. They were involved in designing and setting up the campaign which involved posters, advertising on buses, and work with local schools. A full evaluation report is available.
**References**


Crawford, MJ. (2008) Services for people with personality disorder, Psychiatry 7(3): 124-8


Suicide is a rare event, but when it does occur it is tragic for everyone, the family and friends of the individual who took their own life, as well as the professionals concerned. Suicide generally occurs following a period of mental illness, particularly depression. It can however, also occur in those who have significant physical health problems, for example a life limiting or degenerative condition, and in those who have little or no contact with mainstream health services or support agencies.

Depression is a key cause of suicide, and the increase in rates of mental illness in the population has led to several major policy initiatives focusing on strategies to address mental ill health, both in the population as a whole and in those at increased risk.

The National Suicide Prevention Strategy for England (DH 2002) identified the following goals:

- To reduce risk in key high risk groups.
- To promote mental wellbeing in the wider population.
- To reduce the availability of suicide methods.
- To improve reporting of suicidal behaviour in the media.
- To promote research on suicide and suicide prevention.

An important element of these policies was the emphasis given to joint working across agencies including health, social care, education, the voluntary sector, and the media, to support those at risk of mental illness that might lead to suicide.

According to the World Health Organisation, approximately one million people died worldwide in 2000 from suicide, giving a global mortality rate of 16 deaths per 100,000 people (WHO 2009). The current estimated mortality from suicide in England is approximately 4,000 deaths per annum. It is estimated that up to 25% of individuals who take their own life are known to specialist mental health services during the year before their death.

During the period 2004 – 2006, eighty two people died from suicide in Suffolk. The death rate, even after taking into consideration population size, age, and sex was lower than in the East of England or nationally, for the same time period. Nationally the suicide rate is falling, although this decrease may not be uniform across the country.

It is important to note that the majority of people with mental illness make no attempt to take their own life. Many people with mental illness are supported by their families, health services, social care and voluntary organisations, and are able to hold down jobs, maintain homes and lead a normal life.
What may increase the risk?
There are some people who may, in the presence of a variety of risk factors, be at increased risk of suicide. These include:
• Current or former psychiatric patients (at least 10 times more likely to die by suicide than the general population).
• People who have made a previous attempt at taking their own life or who self harm (between 10 and 30 times more likely than the general population).
• People who misuse substances such as illicit drugs or who have an excessive alcohol intake (at least 20 times more likely than the general population).
• Privately renting.
• The individual does not have any religious belief.

There are social and environmental factors that may increase the risk of someone taking their own life, as described above. Where people have an existing mental health problem and are in crisis, other factors may heighten the risk of suicide. More research is needed to give us a clearer picture of all the factors involved in suicide.

The following, along with other risk factors, can increase the likelihood of someone taking their own life:
• The individual frequently changes address / moves house.
• They live alone.
• Unmarried, or divorced, or separated.
• Recently bereaved.
• The individual has a long-term or life limiting illness.

What information do we have on suicide locally?
An annual audit of suicides takes place within the Suffolk PCTs, using key information from the Office for National Statistics, Coroner’s reports and primary care case notes.

Local audit information tends to support the national picture, showing that more men than women take their own life. Data from the last 2 years is shown in Table 11.

<table>
<thead>
<tr>
<th>Year</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>33</td>
<td>12</td>
</tr>
<tr>
<td>2008</td>
<td>48</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: Suicide Audit NHS Suffolk 2009

The NHS Suffolk audit also showed that the most common methods of suicide are hanging and overdose which are the same as those found nationally. Although there are other methods of suicide or deliberate self harm such as drowning, the majority of deaths tend to involve hanging or overdose and sometimes involve alcohol.

Opportunities for sharing local audits should be encouraged. Currently both public health and specialist mental health services undertake an annual retrospective audit. Key findings should be shared at local and regional level, so that significant factors are noted and acted upon.

What can reduce the risk of suicide?
No single initiative or project has been shown to reduce the rate of suicide in all settings. However, there are some general strategies that may have success with those at most risk:
• Training on suicide risk factors for professionals working with those at greatest risk.
• Improve communications between primary care and specialist mental health services, for those considered to be at significant risk of suicide.
• Agree a crisis plan with the mental health service user who has been deemed at risk of suicide, flagging up ‘warning signs’ and identifying who should provide support to the individual if events escalate.

• Increase general mental health promotion to encourage people who use services and those who work in them, to value positive mental health as the equivalent of good physical health.

• Develop local strategies linking work on health and wellbeing at local authority level with the creativity and vibrancy of the mental health voluntary sector, and underpinned by the specialist expertise of health professionals. A local strategy that combines all three may have more success than individual agencies working alone.

People are particularly at risk when they are discharged from mental health services, and may feel isolated or vulnerable when back at home. It is important
that a person discharged from mental health services is followed-up within 7 days of their discharge, to make sure they are settling back at home, and that there are no immediate problems.

Links between general health and wellbeing and good mental health are important. National policy recognises that mental health promotion should be seen as part of an holistic approach that sees the importance for health and mental health of work, leisure, social support, diet and physical exercise. Local initiatives such as Healthy Ambitions Suffolk can play an important part, as it has multi-agency commitment, giving any local work on suicide prevention and mental health promotion a robust basis to work from.

References

Chapter twelve
Dual diagnosis

Dual diagnosis usually refers to people who have a mental health problem and also misuse substances. A national review conducted in 2007 concluded that although 90% of areas had a definition for dual diagnosis, there was wide variation on how it was defined (CSIP 2008). In NHS Suffolk, partner agencies have agreed a broad definition:

‘A co-existing mental health and substance use (alcohol and/or drugs) problem.’

There is an underlying acceptance that where problems co-exist they are complex and mutually dependent, and that services should address these needs together.

**Why is dual diagnosis a major problem and how common is it?**

Dual diagnosis is a challenging clinical problem for mental health services. Compared with people with a mental health problem alone, individuals with co-existing mental health and substance misuse problems, are likely to experience more severe mental health problems, be at increased risk of suicide, experience housing and financial difficulties, be less likely to engage with treatment interventions, and be more likely to fall between services (Banerjee et al 2002; Turning Point 2007). While concern for this group has increased in recent years, current service provision does not manage to address their needs adequately (CSIP 2008; Cooper 2009).

Studies show that up to half of people with severe mental illness also misuse substances (Cleary et al 2008; Afuwape 2003). Severely mentally ill patients who use drugs or drink alcohol can suffer from the associated detrimental effects, even when use is at low levels (Afuwape 2003). In a needs assessment completed by Suffolk Mental Health Partnership NHS Trust (SMHPT) local community mental health teams reported a prevalence of co-existing mental health and substance misuse problems in 20% of their clients. The study also found a prevalence rate of 34% in psychiatric inpatient areas, and 48% in assertive outreach teams, whose clients tend to be those with enduring severe mental illness (Cooper 2009).

In learning disability services, an overall prevalence of 4% was identified for people experiencing co-existing mental health and substance use problems, in addition to a learning disability. Estimates could not be made for substance misuse services, older people, and child and adolescent services because of the low response rates.

Local information also suggests an increased risk of suicide in this group. An audit in 2004 of suicide by people in contact with SMHPT services showed that 65% had
The relationship between cannabis and schizophrenia has been widely discussed in recent years, and there have been concerns about its psychoactive properties since 1928 (Rathbone et al 2008). Many suggest that high cannabis use is associated with an up to six-fold increased risk of developing schizophrenia (Rathbone et al 2008; Arendt et al 2005; Arseneault et al 2004; Smit et al 2004; Hall et al 2000), and that in those with schizophrenia, cannabis is felt to have a negative effect on the course of the illness (Arendt et al 2005; Arseneault et al 2004). However others suggest that cannabis is used by those with psychotic symptoms as a form of self medication, and that it may improve some of the negative symptoms of schizophrenia.

A recent thorough review of the published evidence concluded that the effects are still not clear, and there is not enough evidence to either support or refute the use of cannabis for those with schizophrenia (Rathbone et al 2008).

Dual diagnosis

co-existing substance issue problems (Cooper 2009). The 2007 inquiry into drug related deaths identified that 63% were being prescribed medication for mental health problems and would therefore be considered as having co-existing problems (Hoddell 2008).

It is not clear why individuals with severe mental illnesses are more likely to misuse substances. Suggestions that substances are misused as ‘self medication’ to alleviate problems associated with their illness or their medication, are not widely supported (Afuwape 2003). It may be that multiple risk factors for mental illness are the same risk factors that promote substance misuse. Such factors include social isolation, poverty or living near those who misuse drugs, genetic susceptibility and poor early environment. If there is a susceptibility for mental illness, this may increase if substances are abused (Mueser et al 1998).

What services are available in Suffolk?

Traditionally, the NHS has provided a serial or parallel service model of care for those with co-existing mental health and substance use problems. People are either treated for one condition before progressing to treatment for the second (serial), or treated for both conditions simultaneously but by different services (parallel). These models promote a culture where health problems are treated as separate entities with service users being passed between services. Currently services in Suffolk tend to follow the serial approach to care, and often people are expected to address their substance use problem prior to gaining support for a mental health problem (Cooper 2009). This type of care can mean that accessing a mental health assessment during crisis periods can be difficult.

When Suffolk Mental Health Partnership NHS Trust asked staff, partners, users and carers about their experiences, they suggested that in a crisis many mental health service workers believed that substance misuse was the primary problem, and access to mental health services during and after the crisis could be difficult (Cooper 2009). Although there were examples of clients with

Supporting People Enhanced Support Service

Initially funded in Lowestoft, this service provided intensive support for service users with drug misuse and/or mental health issues living in hostels, who were at risk of losing their accommodation. The key objective was to reduce the likelihood of eviction, by providing focused work delivered by an independent support worker. This allowed greater trust to be established, and people were much less likely to be evicted from their homes. The project will now be developed in Ipswich and Bury St Edmunds.
co-existing problems having a good experience of services, they seemed to be related to the knowledge, skills and attitudes of individual clinicians and teams rather than the system of care (Cooper 2009).

What are the gaps?
Nationally the importance of dedicated services for dual diagnosis and better collaboration between community drug and alcohol teams, and mental health teams is recognised. The need for training of the current mental health workforce, to enable them to adequately meet the needs of those with co-existing problems is paramount (CSIP 2008). Dedicated integrated services are not currently available to those with co-existing problems in Suffolk. The serial approach that is generally used exposes those with severe mental health problems and substance misuse to increased risk.

The information collected for the SMHPT needs assessment identified that a large majority of respondents felt there were gaps in current service provision, including a lack of resources, poor interagency working and communications, and a lack of dedicated dual diagnosis workers, which negatively affected service provision for people with co-existing problems. It suggested that the standard of care provided by mental health services was perceived as inconsistent, and dependent on individual workers’ views and attitudes. The non-statutory services, service users, and carers highlighted the difficulties they experienced in accessing support from mental health services, particularly during periods of crisis (Cooper 2009).

What do we need to do?
This overview confirms that those with co-existing mental health and substance misuse problems (or dual diagnosis) pose a challenge to mental health services. These individuals require an integrated approach to treatment, and good communication between services and agencies. Local evidence suggests that Suffolk, like much of the country, has a long way to go before those with co-existing problems receive appropriate services, and users and carers have a positive experience.

Some key requirements to improve services which have been highlighted by local stakeholders (Cooper 2009) and national reviews (CSIP 2008) are:
• The development of dedicated services for dual diagnosis which are client focused and have agreed care pathways.
• The need for better collaboration between mental health teams and community drug services and partner agencies.
• Training for staff, particularly mental health staff, in relation to the clinical management of substance misuse.

Locally the first steps towards ensuring services meet the needs of these clients have been taken (Cooper 2009). However further work is still needed between NHS Suffolk, Suffolk County Council, Suffolk Mental Health Partnership NHS Trust, the Drug and Alcohol Action Team (DAAT), users, carers and other partners, to ensure that local services improve for those with co-existing mental health and substance misuse problems.
Dual diagnosis

Glossary

**Assertive outreach team:**
A community based team that provides intensive support for severely mentally ill people who are difficult to engage in more traditional services.

**Negative symptoms of schizophrenia:**
Symptoms that involve loss from the person’s usual experiences or behaviour e.g. loss of energy, drive and motivation. Negative symptoms include: self neglect, poor dietary intake and poor self-care; social withdrawal - staying in bed, avoiding family, friends and social gatherings; depression - feeling sad and miserable; loss of motivation - loss of energy and drive to pursue activities; loss of feelings for others - blunting of emotions and not feeling anything; loss of insight into illness.

References


Cooper, P. (2009) Co-existing mental health and substance use:
Five year strategy 2009-2014. Ipswich, Suffolk Mental Health Partnership NHS Trust.


Chapter thirteen

Prison mental health

Offenders experience poorer health and poorer access to health and social care services than others in the community. Educating and empowering offenders to improve their health and wellbeing, whilst improving access to health and social care services is therefore a priority (DH 2007). There is currently a large amount of work being undertaken by all prison health care staff in Suffolk, to make this happen.

What are the mental health problems in this vulnerable group?

Prisoners have more mental health problems than people who live in the community. Some of these mental health problems are risk factors for, or associated with, criminal behaviour (e.g., personality disorders, functional psychoses and substance misuse), while other mental health problems are associated with imprisonment (e.g., neurotic disorders, self-harm, suicide) (Marshall et al. 2000).

NHS Suffolk, through prison health care services, aims to provide prisoners with access to the same quality and range of health care services as the general population. There is evidence that promoting physical and mental health of offenders can lead to better rehabilitation and less re-offending (Joint Prison Service and NHS Executive Working Group 1999).

Prisons within NHS Suffolk

<table>
<thead>
<tr>
<th>Category of prison</th>
<th>Highpoint</th>
<th>Edmunds Hill</th>
<th>Hollesley Bay</th>
<th>Warren Hill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category C</td>
<td>Category C</td>
<td>Category D</td>
<td>Category C</td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td>Training</td>
<td>Resettlement</td>
<td>Open</td>
<td>Training</td>
</tr>
<tr>
<td>Sex of prisoners</td>
<td>Male</td>
<td>Male</td>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>Capacity of prison</td>
<td>900</td>
<td>380</td>
<td>345</td>
<td>224</td>
</tr>
<tr>
<td>Type of health care services</td>
<td>Primary health care and in-reach services</td>
<td>Primary health care and in-reach services</td>
<td>Primary health care and in-reach services</td>
<td>Primary health care and CAMHS</td>
</tr>
</tbody>
</table>
What is the core structure of prison mental health services?

Each prison has a nurse-led health care facility, which consists of a core team including at least one mental health nurse. Primary care services identify and help those with general health and social problems, which in prison are mostly related to adjusting to prison life. This service is complemented by the secondary mental health care specialist in-reach service. Secondary care includes care for prisoners with moderate to severe mental health problems, or prisoners with personality disorders and an additional mental health problem, and also those with specific conditions like post traumatic stress disorder for which there is a specialist trauma therapist. Cognitive behavioural therapy is offered to eligible patients following assessment. General practitioners provide medical support, with specialist input from visiting consultant psychiatrists.

What mental health services are available in each prison in Suffolk?

<table>
<thead>
<tr>
<th>Service</th>
<th>Highpoint</th>
<th>Edmunds Hill</th>
<th>Hollesley Bay</th>
<th>Warren Hill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger management</td>
<td>Enhanced thinking skills. General prisoner education programme.</td>
<td>Not available.</td>
<td>Interfaith, a programme offered by the prison.</td>
<td>Provided by youth offender team. Funded jointly by health care and youth offender team.</td>
</tr>
<tr>
<td>Trauma counselling</td>
<td>Available through in-reach.</td>
<td>Not available.</td>
<td>Not available.</td>
<td>None specific offered.</td>
</tr>
<tr>
<td>Sexual abuse counselling</td>
<td>Not available.</td>
<td>Not available.</td>
<td>Not available.</td>
<td>None specific offered.</td>
</tr>
<tr>
<td>Examples of services offered externally</td>
<td>Bereavement counselling through chaplaincy.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
of self harm are seen among immigrant prisoners.

**Hollesley Bay**

Hollesley Bay is an open prison with around 345 male prisoners, of whom 27 are serving life sentences, and it is a re-settlement prison with some prisoners at the end of their sentence. If risk assessments are satisfactory, prisoners are able to work outside the prison on a voluntary or paid basis.

Alcohol and drug use is a problem at Hollesley Bay as it is an open prison. Although exact numbers are not known, it is very likely that, because of their offences, there are several prisoners with post traumatic stress disorder, such as prisoners with sentences related to dangerous driving.

As the capacity of the prison continues to grow, needs are increasing and constantly changing. Given the category status of this prison, the main issues are around re-integration into society. Most prisoners learn how to behave in custodial settings, sometimes altering their natural characteristics. When introduced back into freedom, the behaviour patterns change.

**Warren Hill**

Warren Hill is an institution for male youth offenders aged between 15 to 17 years, with some staying to age 18 years. There are 224 places, including a separate unit for section offenders serving sentences of at least five years. Warren Hill provides education and skills training using a 14-19 years vocational curriculum.

Mental health needs of young people in secure settings are high, severe and complex for several reasons, including substance misuse, learning difficulties, previous life experiences, and distress and anxiety on imprisonment and being away from home.

- One third of young offenders have a mental health need.
- Around half have problems with peer and family relationships.
- A third have significant problems with education or work.
- Two-thirds of young offenders
Prison mental health

come from backgrounds where the family structure has broken down.
• One third have been looked after by the local authority at some point (DH 2007).

Last year the primary mental health team, consisting of three mental health nurses, assessed 633 young people, of whom 216 were placed on their caseload. From April until December 2008, Child and Adolescent Mental Health Services (CAMHS) were involved with 25 young people.

Bereavement, attachment and anger issues are common. Many offenders suffer long-term consequences from losing regular contact with family and friends, having few social connections outside the prisons and difficulty in maintaining relationships. Although it does not necessarily mean that mental illness is present, this increases the risk. Alcohol and drug misuse is increasing in the prison and there is a high number of people with a past history of physical, psychological or sexual abuse, including neglect.

Overall, services at Warren Hill are expanding, and as a result more offenders are presenting with problems. It is challenging to provide services equivalent to those received in the community, because children in secure settings are more vulnerable, and have more complex needs.

What additional steps do we need to take?
Human resources, training and professional development and staffing levels need to be increased, particularly in primary mental health nursing, counselling and psychiatry. Continuing professional development for all staff must be encouraged. Management and administrative support need to be improved for primary mental health. Evidence shows that nearly half of all suicides take place within the first month of imprisonment. Although rare in Suffolk prisons, steps must be taken to prevent suicides by identifying those at risk, and improving staffing levels to increase contact time.

Wing-based services
In the community, some treatments take place in locations which are convenient to the patient, including in their own home. If prisoners were to have a service similar to that provided in the community, they could stay in their familiar environment thus reducing anxiety.

Dual diagnosis
Dual diagnosis applies to those who suffer from a mental health condition and also misuse illicit drugs or alcohol. The Integrated Drug Treatment System (IDTS) is being introduced across Suffolk’s prisons, which will expand the quality and quantity of drug treatment.

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**Glossary**

**Child and adolescent mental health services (CAMHS):**
Promote the mental health and psychological wellbeing of children and young people, and provide multidisciplinary mental health services to all children and young people with mental health problems and disorders, to ensure effective assessment, treatment and support, for them and their families. (Every Child Matters 2008)

**Detoxification:**
Process whereby toxic substances are removed or toxic effects neutralised. (Martin 1998)

**Enhanced thinking skills:**
A short programme which addresses thinking and behaviour associated with offending. This includes impulse control, flexible thinking, social perspective taking, values and moral reasoning, reasoning, and inter-personal problem solving. (HMPS 2009)

**In-reach team:**
Group offering mental health services for prisoners, especially those with severe and enduring mental illness. (Steel et al 2007)

**Motivational interviewing:**
A style of patient-centred counselling developed to facilitate change in health-related behaviours. The core principle of the approach is negotiation rather than conflict. (Treasure 2004)

**Primary mental health team:**
Group offering an individual approach to mental health with all interventions focused on empowerment, independence, comfort and quality of life. (DH and HMPS 2001)

**Psychosis:**
Mental health condition where an individual is unable to distinguish between reality and their imagination. (NHS Choices 2008)

**References**


Changing the outlook – a strategy for developing and modernising mental health service in prisons. London, DH and HMPS.

Department of Health. (2007)

Improving health, supporting justice – a consultation. London, DH.


HM Prison Service (2009)

CALM after the storm. http://www.hmprisonservice.gov.uk/prisoninformation/prisonservicemagazine/index.asp?id=5237,18,3,18,0,0. (accessed 28.04.09)

Refugees and asylum seekers are significantly more likely to experience poorer mental health than native populations as a result of ‘pre-migratory, migratory and post-migratory experiences and difficulties’ (Burnett and Fassill 2002).

Recent research carried out in the Great Yarmouth area identified a relatively high incidence of mental health problems among refugees and asylum seekers, despite the fact that they are often underrepresented among service users (Bowden et al 2006). Figures vary, with estimates that two thirds of refugees and asylum seekers have anxiety, depression, panic attacks, agoraphobia and/or sleep problems. Research in one city found that 35% of male Iraqi refugees had depression, other studies identified that 50% had been diagnosed with post traumatic stress disorder (PTSD), and between 11% and 20% with psychosis or severe mental illness (Joseph Rowntree Foundation 2007). This is compared to the local population where just over 10% are estimated to have these common mental health problems. The Suffolk Community Refugee Team saw 350 asylum seekers and refugees in the year 2008-09, and provided mental health care to 58 of these whose mental health needs were severely impacting upon their lives.

Why do refugees experience more mental ill health than the local population?
There are three main factors contributing to refugee mental ill health (Civis Trust 2004).

1. The trauma of the refugee experience: war, false imprisonment, torture, death threats, killings and disappearances of family members, witnessing brutality, persecution for reasons of political belief, faith, gender. The trauma of fleeing, leaving everything behind including home, family and friends, long arduous journeys, exploitation, sexual abuse, trafficking, starvation, cold and exposure. Five to thirty percent of asylum

‘I cannot do anything. I have no documents. I cannot work. I cannot look after my family. I have lots of psychological problems. Waiting and waiting for decision on my asylum claim is a trauma all over again. You don’t know what will happen to you’.  
(Iraqi asylum seeker)
Refugees and mental health

Seekers and refugees have been tortured (Burnett and Fassill 2002).

2 Despite such terrible trauma, evidence suggests that it is the experience of exile that often brings about mental distress (Crowley 2003). Uncertainty and fear over the outcome of a lengthy asylum application process, the threat of deportation (whether real or imagined), having to report weekly to the local police station, fearing detention, a sense of cultural bereavement upon leaving their country of origin, acclimatising to life in the UK, and adjusting to poor living conditions (such as low-quality, overcrowded or insecure accommodation), as well as the loss of control over their own lives, can be sources of considerable stress (Civis Trust 2004).

A project in Great Yarmouth identified a range of mental health problems experienced by refugees, which are summarised in the diagram on the left (Bowden et al 2006).

3 However, it must be remembered that refugees experience mental ill health for the same reasons as any person in any other settled community. Some refugees will have developed mental illness in their own communities before any trauma, and others settled in the UK may have mental health problems that are nothing to do with their refugee experiences.

What sort of mental health problems do refugees experience?

There is a basic, but incorrect assumption that refugees have specialist needs that cannot be met by mainstream services and that specialist services are necessary, but difficult to access. This assumption can often result in refugees receiving little or no care. It is also both difficult and dangerous to generalise about the mental health issues that asylum seekers and refugees might face. They are a varied group with a range of different immigration status, backgrounds and experiences, and they can also experience a range of mental health difficulties, and cope with them differently depending

‘Everything is lost and broken. So many were killed, beaten and shot. Women raped, beaten and shot. Men killed, missing, wives and children missing. I can’t think about it but do and cry all the time. It is the reason why we are here in UK, God willing. I am alone here now’

Somali Refugee (Bowden et al 2006)
Refugees and mental health

upon individual, cultural and contextual factors.

It is important to consider that:
• Refugees’ experiences are not necessarily pathological, and that mental health problems are ‘not an inevitable consequence of trauma’ and the migration process (Burnett and Peel 2001).
• Refugees experience a high level of psychological distress but only a minority experience a specific mental illness (Crowley 2003).
• Whilst there are a limited number of specialist needs (as a consequence of torture and sexual abuse) most refugees present with common symptoms of anxiety, depression, insomnia, inability to concentrate, lethargy, poor sleep patterns, reduced appetite and loss of self esteem (Civis Trust 2004).
• Many needs, especially for those newly arrived in the UK, are practical such as being able to find somewhere to live, access health care, getting children into school, learning a new language, finding work, and shopping for unfamiliar foods on a low budget.

• Refugees have considerable strengths, resilience and coping skills.

Some particular issues related to the refugee experience might include:
• Isolation, which is often the hardest problem to cope with; not having any family or friends in the country, not knowing anyone in the locality, not having any contact with anyone who speaks your language or shares your culture, not being allowed to work or go to college to meet new people.
• Bereavement, which can be particularly problematic if numbers of family members have been killed, the death was brutal and witnessed, or if there was no time to find the body, or to hold those religious and cultural ceremonies necessary to aid the bereavement process.
• Family problems, where children might have witnessed parents being abused or being powerless to help suffering children, or being able to find separated children. With different members of the family experiencing their trauma in different ways, it can be hard for each to support the other. Fundamental changes in roles, with women perhaps becoming more autonomous, men not being able to work, and children integrating and learning English more quickly, can place family dynamics under great pressure.
• Children may have particular needs. Their psychological distress may present with a number of behavioural issues including school refusal, phobias, bedwetting, night terrors, and self harm (Civis Trust 2004).
• Distress and anger where asylum seekers are powerless to choose to live with members of their own community or family, because of Home Office dispersal processes; where asylum decisions

Ipswich Befriending Group

The Friends Project has been running since late 2007 at the Ipswich Red Cross centre in Chevallier Street. Staffed by volunteer Project Managers and Befrienders, the project works in partnership with other members of the Forum for Refugees, Asylum Seekers and New and Emerging Communities (FRASNEC) to provide a safe, social space for vulnerable young refugees, asylum seekers and migrant workers to relax, chat, take part in games and activities, and get something good to eat!

During the course of 2008 we were able to spot a growing confidence among the young men who visited the scheme. This was particularly apparent when they began attending on their own, without being given a lift to the group by someone from Social Services. It is clear that, over time, and as they became more settled in Ipswich, Friends was having a genuinely positive impact on their state of mind, helping to make the young asylum seekers visiting us feel more confident in engaging with others, in addition to helping them settle and signposting other services available to them.
Case study

My name is Mani, I am from the Congo. I arrived in England in 2008 and what a journey! I lived in a village in North Kivu province with my family but we were not safe. Nkunda’s rebels were close by and often raided the villages killing men and women and taking away the children to fight in his armies: even in the day time, stealing them from school. At night we hid in the forest, fearing for our lives, fearing that we would be killed in our beds. Even now I cannot bear to be in a forest, surrounded by trees, the memories come flooding back. Such terrible killings, I saw with my own eyes, people split open. I cannot even say the words for what I have seen.

One evening it happened and the village was stormed, so many people were killed, the goats were killed, the houses were looted and burned to the ground. I hid amongst the dead, pretending to be dead, amongst the burning remnants of our homes until the militia had finished their drinking and partying. Then I crept out and fled. I was injured and the pain of it was terrible until I managed much later to find someone kind and antibiotics. I had malaria and got so sick. Oh what a journey, I was terrified, but always in my heart I held onto hope. Hope that I could find some peace somewhere.

I did not know where my family were, whether they were dead or alive, whether my little sister had been taken by the militia to be raped and forced to cook and clean for them. I knew about the refugee camps in Goma, but even there you were not safe, caught between the army and the militia and I heard about the burning. Many fled into Uganda. I was lucky I got out and far away. Thanks to God that I escaped, but how I wish I could see my family.

In England it is difficult. I was sent to Ipswich where I did not meet anyone else from Congo. Few people speak French and my English was poor and I knew no-one. I couldn’t even cook the food and eat properly. Sometimes I just wanted to die. I wandered round and round the streets with nowhere to go, no one to speak to. Sometimes I couldn’t sleep for days remembering what I had seen. Sometimes I felt so ashamed that I was here and I did not know where my family were and could not help them. Sometimes tears just streamed from my eyes when I thought about my sister.

I was lucky. I met people at the Refugee Council and they helped me to contact the Red Cross, who traced my mother and father to a refugee camp in Uganda. That made me so happy and I could feel hope again, but I still don’t know about my sister. The health team put me in contact with others from the Congo in Norwich and now I meet with them and we cook our favourite Congolese meals, though none of us talk about what happened to us. I joined an allotment group. People, refugees like me from different countries, and together we grow vegetables to help stretch out the little money we get. I joined a church here and now making new friends, and sometimes I can even feel joy, if I let myself. It is going to be a long hard journey but at least now I don’t feel the despair I once had and can feel that hope.

Mani’s name has been changed. He is 20 years old.
can take many years for cases presented prior to the new asylum processes introduced in 2007; where refused asylum seekers, unable to return to their own country are forced into destitution; where refugees cannot bring partners and children to the UK to live with them; where people experience racism and inhumanity.

- Some refugees may feel guilty that they have survived when others have not, or that they were unable to help family and friends who were killed. Some may feel ashamed that they are not coping, or are feeling suicidal. The stigma attached to mental health issues may prevent them revealing their need for help. Their experiences may make it difficult to trust anyone who tries to help, and feelings of shame may make silence a safer option.

- Refugees and asylum seekers did not leave their home willingly and often intend to return home as soon as it is safe, so adapting to a new country can feel overwhelming, especially without a close network of family and friends, where everything is done differently. People may not speak any English, and may experience hostility and sometimes racism. Difficulties adapting can often lead to isolation and despair.

The adverse effects of trauma may not become apparent until sometime after arrival, manifesting themselves through a wide range of symptoms including sleeping problems and nightmares, flashbacks, tearfulness, forgetfulness and loss of concentration, extreme anxiety and paranoia. The effects of such traumas can also be multiplied where asylum seekers have to retell their story to immigration officials, often on several separate occasions. It is important not to underestimate or misdiagnose specialist need, and whilst PTSD is often associated with refugees, caution is needed before making such a diagnosis (Burnett and Peel 2001). A diagnosis of PTSD can result in a neglect of social and cultural needs and a failure to acknowledge injustices and social inequalities (Patel 2003). It can result in a focus upon past rather than current traumas and prevent the giving of care in the present whilst waiting for access to rare specialist services.

What is Suffolk doing to help refugees with mental health issues?

Access to primary care services is fundamental to identifying and meeting mental health needs. The Local Medical Committee has agreed in principle that all asylum seekers and refugees will be fully registered with GPs. The Suffolk Community Refugee Team assists this registration process by seeing all newly arrived asylum seekers and refugees, and supporting GP registration with information, completion of forms, making appointments and supporting attendance. The team conducts an extended and holistic nurse assessment of needs, providing a summary health history for the GP practice, and signposts and refers to other services. Interpreters are provided for consultations in all the team’s work.

The assessment process involves a mental health symptom screening and risk screening, helping to identify victims of torture as early as possible, even if disclosure is difficult and painful for the person concerned, as this will have a significant bearing upon the asylum case and care required. A dedicated mental health worker will carry out a more in depth mental health assessment over a number of sessions, and works closely with other members of the team to provide a care pathway. Counselling and space to talk are provided, although the concept of counselling may not be well understood by clients. A flexible, client centred approach is used, which aims to allow the clients to tell their story in their own way, with the counsellor bearing witness to the reality of that story, providing a safe environment for their distress, and helping them to re-discover their own strengths and abilities to cope. The Medical Foundation for Care of Victims of Torture will take referrals of more
Refugees and mental health

complex cases, but more importantly offers supervision, support and training to help the team work effectively with clients.

Practical support and case work are offered either through the health advice worker or referral to other specialist refugee agencies. This highlights how essential it is to work collaboratively with a range of voluntary and statutory sector agencies to meet the wide range of needs, from contact tracing of family members through the Red Cross, to providing a meal or a winter coat from destitution funds. Refugee agency joint working has established an International Women’s Group and a Men’s Group (which will now receive further support from Suffolk Mind Partnership) which help to break down isolation, support the learning of English and establish valuable support networks. Bilingual support workers with SCRT work to empower individuals to adapt and use their strengths and coping skills, and the Social Care Services Asylum Team provide one to one care for some of the most vulnerable unaccompanied asylum seeking children, separated from family and friends.

Community engagement is essential to promotion of mental wellbeing and to addressing the mental health needs of refugees and asylum seekers. ‘Lets talk’ consultation events have contributed to service development, and SCRT works closely with the Patient Advice and Liaison Service to address difficulties in access to services and interpreting. The involvement of the new Community Development Workers in the refugee community is welcomed. Refugee communities in Ipswich are only just establishing fledgling Refugee Community Organisations, which are supported by the Refugee Council through the Basis Project. Suffolk wide inter-agency working groups on trafficking and domestic abuse will make important contributions to mental health care. However, much more needs to be done.

References


96 2009 Annual Public Health Report - Mental Health
Chapter fifteen
Older people

This section considers mental wellbeing and mental health problems, other than dementia, occurring in older people aged 65 and over. Mental health is as important in older age as at any other time of life. Estimates suggest 40% of older people seeing their GP, 50% of older people in hospitals and 60% of care home residents, have a mental health problem (SCIE 2006; Moriarty 2005).

As people live longer, and the population of older people increases in Suffolk, services will need to adapt. Health and social services, voluntary sector groups, individuals themselves and carers need to ensure people experience good mental health, and when problems arise, ensure equal access to care and support (DH 2008; PSSRU 2008).

How prevalent are (non-dementia) mental health problems in older people aged 65 and over in the UK and in Suffolk?
Over a third of older people (aged 65 and over) in the UK experience symptoms of mental health problems such as depression, anxiety, delirium (acute confusion), dementia, schizophrenia, bipolar disorder, and alcohol and drug (including prescription drug) misuse (Age Concern 2007). As the older population grows in size in Suffolk, these problems will increase.

Baldwin (1996) estimated that 10 to 15% of the population over the age of 65 years would be depressed, and that 3 to 5% would be severely depressed. This is the study used by the Projecting Older People Population Information System to produce national and local estimates, which suggest that in Suffolk, between 13 and

How do mental health issues affect health and wellbeing in older people?
Guidance from NICE uses the definition of mental wellbeing developed by NHS Health Scotland. This definition includes satisfaction with life, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support.

Culture Club
Culture Club provided a range of creative activities led by professional artists for older people living independently but who were often isolated and lonely. 569 participants attended 170 sessions. In some cases the participants formed their own self-sustaining networks. “Full of Life”, a collection of poetry and prose by Culture Club participants was published in a book, which is available in galleries and libraries all over Suffolk.
21,000 people aged 65 and over are likely to have depression at any time, and between 4,000 and 7,000 of these will be severely depressed, as shown in the table below.

The impact of mental health problems on older people is severe. Depression is a risk factor for suicide, along with physical pain or illness, living alone and feelings of hopelessness and guilt (MIND 2009). Estimates suggest that 10 to 20% of older people may be experiencing depression, but a smaller proportion are known to their GP or psychiatric services (DH 2007).

Most older people who die by suicide live at home, and most have had no contact with mental health services. One study found that these services were seeing fewer than 25 per cent of older people with depression who later went on to kill themselves, and most of these people had not seen their family doctor within the month before suicide (Cattell et al 1995). In the United States of America, although they comprise only 12% of the population, people aged 65 and older accounted for 16% of suicide deaths in 2004 (NIMH 2003).

Delirium, or acute confusion, can be a result of any illness in the elderly, and often affects older people admitted to hospital (Chonchubhair et al 1994; Bekker et al 2003; Inouye et al 1993). People aged between 55 and 74 years have the highest rates of alcohol-related deaths in the UK, and it is probable that rates of both prescription and illicit drug misuse in later life are under-estimated (Age Concern 2007).

‘The Second Report from the UK Inquiry into Mental Health and Wellbeing in Later Life’ considers the impact of mental health problems in older people (Age Concern 2007). The report outlines how individuals and their families, statutory service providers, businesses, voluntary organisations, government and wider society are affected, and considers the disabling effects including poor quality of life, isolation, exclusion, despair and even premature death. People who provide unpaid care for an older person with dementia are more likely to have depression (Livingston et al 1996).

Older people with mental health problems are more likely to end up in institutional care (SCIE 2006). Mental health problems are linked to physical problems and illness, and older people are more vulnerable to abuse (Bradley 1996). NIMHE (2005) states that the presence of a mental health problem is a strong and independent predictor of poor outcomes such as increased

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**Table 12: People in Suffolk aged 65 and over predicted to have depression to 2025**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
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<tr>
<td>Lowest predicted estimate</td>
<td>13,640</td>
<td>14,390</td>
<td>16,940</td>
<td>18,910</td>
<td>21,060</td>
</tr>
<tr>
<td>Highest predicted estimate</td>
<td>20,460</td>
<td>21,585</td>
<td>25,410</td>
<td>28,365</td>
<td>31,590</td>
</tr>
</tbody>
</table>

**Table 12: People in Suffolk aged 65 and over predicted to have severe depression to 2025**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest predicted estimate</td>
<td>4,092</td>
<td>4,317</td>
<td>5,082</td>
<td>5,673</td>
<td>6,318</td>
</tr>
<tr>
<td>Highest predicted estimate</td>
<td>6,820</td>
<td>7,195</td>
<td>8,470</td>
<td>9,455</td>
<td>10,530</td>
</tr>
</tbody>
</table>

Source: Projecting Older People Population Information System 2009 Crown Copyright
Older people

mortality, length of stay, institutionalisation and resource use.

There is evidence that older people are increasingly dissatisfied, more lonely and more depressed, many living with low levels of life satisfaction and wellbeing (Allen 2008). Forty percent of older people attending GP surgeries, and 60% of those living in residential institutions are reported to have poor mental health (UK Inquiry into Mental Health and Well-being in Later Life 2006). There may be a need to raise expectations for mental well-being in later life.

Is there an evidence base for care in older people?
The ‘National Service Framework for Older People’ was published in 2001 and set new evidence-based standards and models of care for health and social care services, including a standard on older people’s mental health care (DH 2001). ‘Better Health in Old Age’, published in 2004, provided a progress report on the NSF (Philp 2004). It indicated that more needed to be done with regard to older people with mental health needs. ‘Securing Better Mental Health for Older Adults’ (DH 2005) aimed to ensure that older people with mental illness did not miss out on the improved mental health services that younger adults would receive.

Evidence suggests both medication and cognitive behaviour therapy are effective in depression in older people (DH 2008; Lebowitz et al 1997; Reynolds III 2006; Reynolds III 1999; Bruce et al 2004).

Do older people have equality of access, or problems accessing services such as CBT?
National estimates suggest the prevalence of problems is high but that detection of problems could be improved (DH 2007; PSSRU 2008). Estimates suggest one in four older people living in the community have symptoms of depression that are severe enough to need treatment. However only a third of older people with depression ever discuss it with their GP, and only half of them are diagnosed and treated, primarily with anti-depressants (DH 2007). A report published in 2008, ‘Age Discrimination in Mental Health Services’ (PSSRU 2008) used available literature, interviews with management staff in key organisations and an analysis of epidemiological and activity data. The report concluded that use of mental health services is lower among older people, even after adjusting for factors such as

Homeshield

Homeshield is a multi-agency project that seeks to connect vulnerable people to a range of services both through the statutory and voluntary sectors. Front line visiting officers from over 50 partner agencies are empowered to carry out a common referral that looks at the safety and wellbeing of customers, in particular older and vulnerable people. This referral is then passed to a central coordinator who is able to signpost the service provider required directly to the customer. One aspect that Homeshield covers is social contact, and each referral form asks questions that will identify if a person is in need of more social contact and befriending. If this is the case the coordinator will pass details to one of the partner agencies who can provide this service directly.

The number of Homeshield referrals per month is typically between 100 and 150, and this number is steadily growing each month.

A new project called Homeshield Plus will be launched in the summer, and will enable specialist officers and advocates to proactively identify, and visit the homes of vulnerable and older people, where they will carry out the Homeshield process. This will include home fire safety checks, security checks and will also use the referral form to gauge if there are any further requirements that are needed in respect of health and wellbeing. It is anticipated that the Homeshield Plus scheme will be able to visit in the region of 6,000 households in the first year of operation.
“Whoever has been restored to health has almost always been restored to capacity for serenity and joy, and this may be an indemnity enough for having endured the despair beyond despair” (William Styron ‘Darkness Visible’)

Sitting alongside my mother in a small courtyard garden adjacent to the psychiatric ward where she was resident, we were both able to enjoy a bit of warm spring sunshine and a really ordinary conversation for the first time in five months.

Still unsteady, and very much a shadow of her former, (pre-illness) state, we delighted that afternoon in an easy relaxed chat about family, friends and life. I relished that afternoon, because it marked the start of a real recovery from the previous bleak months during which my mother’s suffering was palpable and acute.

The long months of anxiety, desperation and despair following her diagnosis for bowel cancer the previous year, felt like a bad nightmare from which we were now able to emerge and consider the real prospect of her reconnecting with her former independent and resilient self.

My mother’s physical ill-health and her heightened anxiety reaction to her diagnosis, resulted in her deep morbid depression.

I had seen my mother lying in bed vacant and confused with double incontinence, unable and unwilling to either eat or drink; being referred to as ‘playing up’ by ward staff, who, busy and distracted, appeared to have no understanding or tolerance of her mental illness. I had felt the emotional pressure and distress of being the only one able to spend hours at the bedside attempting to reassure her and persuade her to take just a few drops of liquid from a straw.

To be firmly informed that we needed to look for a nursing home placement for her, when clearly she had a treatable mental health condition, felt like a huge extra burden to deal with. She was in a surgical ward, with physical symptoms, but no-one seemed to want to see the rest of her needs.

We had to push for a review of her case and insist she be seen by a psychiatrist, who diagnosed the depression and prescribed the necessary medication. We were horrified to find a week later that the medication had not been obtained by the ward and yet another 2 weeks before ‘a bed’ became available on the psychiatric ward run by a separate hospital.

After a few slip backs and perilous episodes of severe dehydration and re-admission to the acute hospital, she eventually was fully admitted onto the psychiatric ward. After a course of Electro Convulsive Therapy, (12 treatments over a period of as many weeks,) gradually our mother returned to us.

We delighted in that warm spring sunshine.
symptoms and need. This is more marked for common mental disorders such as depression and anxiety. They also concluded that less money is spent on older people, and that to remove this age discrimination in mental health services ‘would require extra expenditure of around £2.0 billion’ (PSSRU 2008).

How can mental health and wellbeing be promoted in older people?
According to research five key factors affect the mental health and wellbeing of older people. These are discrimination (for example, by age or culture), participation in meaningful activity, relationships, physical health (including physical capability to undertake everyday tasks) and poverty (UK Inquiry into Mental Health and Well-being in Later Life 2006).

NICE public health guidance illustrates the importance of joined up working and targeting those at greatest need. The guidance is for NHS primary care and includes those working in local authorities and the wider public, private, voluntary and community sectors. It will also be relevant for carers and family members who support older people (NICE 2008). The guidance also says that: ‘If need exceeds the resources available, there should be a focus on the most disadvantaged older people, for example, those with physical or learning disabilities, those on very low incomes or living in social or rural isolation, including older people from minority ethnic groups.’ The interventions recommended include individual and group occupational therapy and physiotherapy, walking schemes and training for key staff and carers.

Conclusions
We need to raise awareness of mental health issues in older people, to ensure that there is better recognition of depression, concern over unconsidered issues such as older people with alcohol and drug misuse problems, and of an increasing number of people growing older with severe mental health problems.

Both the NHS and Suffolk County Council are working to make sure that mental health services in Suffolk are available to all adults, regardless of their age. For example, community based services purchased by NHS Suffolk, NHS Great Yarmouth and Waveney and Suffolk County Council now have new contracts in place that do not restrict access for those aged over 65 years. In the NHS Suffolk area the Older People’s Mental Health Teams are now located with the Community Mental Health Teams. This is helping the teams to work together and ensure that there is greater equality of access to services for those aged over 65 years.

We need better understanding of the level of need in Suffolk.

Befriending services
The Partnership with Older People scheme supports befriending services for older people across Suffolk as a way to improve mental health and emotional wellbeing. Volunteers working in the Age Concern befriending schemes provide friendship and support for older people who feel lonely or isolated. They visit people in their own homes, normally once a week for around an hour. Care is taken to match the interests of both volunteer and client as far as possible. The scheme is a free service, providing friendship to older people. The same volunteer will visit each week, so that in time a friendship may be built up. Age Concern also have a telephone befriending scheme in operation, where volunteers will ring each week where a personal visit is not possible or a telephone call is preferred.

A special service for the Bangladeshi community is run by the Bangladeshi Support Centre in Ipswich. With a particular focus on the needs of this community the project provides information, support and activities to alleviate social isolation and promote positive emotional wellbeing.
to ensure that specialist services for older people are properly resourced as the older population increases.

We must jointly ensure there is equity of access to services with no age barriers (CSIP 2005). The commissioning guidance for Improving Access to Psychological Therapies (IAPT), emphasised the importance of addressing the needs of harder to reach groups such as the elderly and ethnic minorities (DH 2008). The evaluation of IAPT will address equity of access.

Finally we must work in a joined up way, through Healthy Ambitions Suffolk, to promote mental wellbeing in all older people.

References


Key recommendations


Older people


Dementia is a progressive condition defined by widespread impairment of mental function (NICE 2006). As dementia progresses people can experience some or all of the following: memory loss, language impairment, disorientation, changes in personality, difficulties with activities of daily living, self-neglect, psychiatric symptoms (for example, apathy, depression or psychosis), and out-of-character behaviour (for example, aggression, sleep disturbances) (NICE 2006).

People with dementia have complex needs and, especially in the later stages, require high levels of support. This can be very challenging for family, carers and services. The issues faced can include restlessness and wandering, eating problems, incontinence, delusions and hallucinations, aggressive behaviour, and mobility difficulties that can lead to falls and fractures (NICE 2006). The impact of dementia, which can also more rarely, affect people at an unexpectedly young age, can include worsening in financial status and problems with accommodation (NICE 2006).

There is a common assumption, that dementia is a natural consequence of old age, and that nothing can be done. First, dementia can develop at any age, although becomes more common as age increases. Secondly, there is the potential to delay the onset and progression of the condition (NICE 2006; NICE 2008; NICE 2007).

What types of dementia are there? What are the causes?

There are many conditions that may cause the collection of symptoms described as dementia. The most common types of dementia are Alzheimer’s disease, affecting over half of people with dementia, vascular dementia and mixed dementia, (for example, Alzheimer’s disease and vascular dementia) which accounts for over a quarter of all cases, and dementia with Lewy Bodies (DLB), which affects 10 to 15% of people with dementia. Other, rarer causes of dementia include AIDS-related cognitive impairment,

Creative activity sessions

With new funding from the Alzheimer’s Society, creative activity sessions led by professional artists were delivered to a group of people with dementia and their family carers. A series of six workshops were delivered in three different locations across Suffolk to a total of 78 participants. Evaluation through Dementia Mapping showed an increase in wellbeing amongst all participants.
Creutzfeldt-Jakob disease, Down’s syndrome, Huntington’s disease, Niemann-Pick disease type C and Parkinson’s disease dementia. There are two types of vascular dementia. Stroke-related dementia is the result of damage to a specific part of the brain. This can be caused either by a single stroke or a series of smaller strokes (multi-infarct dementia). Secondly small-vessel disease-related dementia is caused by damage to small blood vessels deep inside the brain.

How can dementia be prevented and effects minimised?
The risk factors for dementia are complex and vary according to the type of dementia. However, there is a higher risk of dementia with age. Women are slightly more likely to develop dementia than men. Smokers, those who consume alcohol to excess and people with an unhealthy diet are at greater risk, as are people who are obese and who do little physical exercise. Finally, there is increasing evidence of increased risk if the mind is not kept active (NICE 2006). People who have been to college or university, or who keep mentally active, seem to be less likely to develop dementia as they get older. Activities that may reduce risk of dementia include reading, playing board games, playing musical instruments and exercise. There is currently no evidence from long-term studies showing that using ‘brain training’ computer games can reduce your risk of dementia (NICE 2006).

The risk factors are therefore similar to those for coronary heart disease, stroke, diabetes and cancer, and lifestyle changes can be made to reduce the risk of an individual developing dementia in the future. Recent NICE guidance recommends that middle-aged and older people should be assessed for vascular and other modifiable risk factors for dementia (for example, smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol) and, if appropriate, treated, in order to slow progression of dementia in an individual (NICE 2006).

Also NICE recommends that health care professionals working with people likely to have a genetic cause for their dementia (for example, familial autosomal dominant Alzheimer’s disease or Huntington’s disease) should offer to refer them and their unaffected relatives for genetic counselling.

Suffolk has already developed a joint strategy for dementia ‘Living well with dementia: transforming the quality and experience of dementia care for the people of Suffolk’. Early diagnosis is seen as crucial in improving life quality for people with dementia, as it makes it more likely that effective treatment and community services are available for the individual. Health and social care staff should aim to promote and maintain the independence, including mobility, of people with dementia. Evidence suggests the use of care plans that maximise independent activity, enhance function, adapt and develop skills, minimise the need for support, and provide the opportunity to participate in a structured group cognitive stimulation programme (NICE 2006).

What support is needed by carers of people with dementia?
There is increasing evidence of the impact of dementia on carers and the importance of the assessment of carers’ needs (SCIE 2005; NAO 2007; DH 2009) which was discussed in last year’s annual public health report. Suffolk’s
joint dementia strategy acknowledges this, and aims to ensure services make available effective support to carers. This should involve a range of options such as psychological therapy, including cognitive behavioural therapy, peer-support groups with other carers, information and training courses about dementia, services and benefits, and communication with and problem solving in the care of people with dementia (NICE 2006). In Suffolk, dementia support and advice services are to be developed for people with dementia and their carers.

**What is the health impact of dementia in Suffolk?**

Dementia of all types is estimated to affect approx 5% of the population in England and Wales aged 65 years and over, rising to 20% of those aged 80 years and over (NICE 2006). There are an estimated 700,000 people currently living with dementia in England and Wales and this is set to rise to one million people by 2025 (Alzheimer’s Society 2007). The number of people with dementia will increase. Estimates are given in the figures below for adults aged 65 years and over and for younger adults, over the next 16 years.

According to the Eastern Region Public Health Observatory Report (ERPHO 2008), approximately 16% of the region’s population are aged 65 years and over and 2% aged 85 years and over. In the Eastern region, admission rates for dementia, particularly in men, are significantly higher than the national average. Possible reasons given in the ERPHO report are high prevalence, variations in clinical practice, differences in the quality of care in the community and differences in how information about admissions is recorded (ERPHO 2008).

The figures in Tables 13 and 14 are taken from a study by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King’s College London, for the Alzheimer’s Society, 2007. The prevalence rates determined in the report have been applied to Office for National Statistics (ONS) population projections.

**How many people with dementia are seen by general practitioners?**

The Quality and Outcomes Framework for Primary Care (QOF) requires GPs to be aware of any patients with dementia and to

### Table 13: People in Suffolk aged 65 years and over predicted to have dementia to 2025

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males aged 65 to 84 years</td>
<td>2,265</td>
<td>2,395</td>
<td>2,802</td>
<td>3,261</td>
<td>3,709</td>
</tr>
<tr>
<td>Males aged 85 years &amp; over</td>
<td>1,261</td>
<td>1,359</td>
<td>1,734</td>
<td>2,226</td>
<td>2,876</td>
</tr>
<tr>
<td>Females aged 65 to 84 years</td>
<td>3,119</td>
<td>3,187</td>
<td>3,518</td>
<td>4,055</td>
<td>4,753</td>
</tr>
<tr>
<td>Females aged 85 years &amp; over</td>
<td>3,226</td>
<td>3,352</td>
<td>3,679</td>
<td>4,158</td>
<td>4,990</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,870</strong></td>
<td><strong>10,293</strong></td>
<td><strong>11,733</strong></td>
<td><strong>13,700</strong></td>
<td><strong>16,327</strong></td>
</tr>
</tbody>
</table>

*Source: Projecting Older People Population Information System 2009. Crown Copyright*

### Table 14: People in Suffolk aged 30 to 64 years predicted to have dementia to 2025

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males aged 30 to 49 years</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Males aged 50 to 64 years</td>
<td>102</td>
<td>103</td>
<td>103</td>
<td>115</td>
<td>121</td>
</tr>
<tr>
<td>Females aged 30 to 49 years</td>
<td>16</td>
<td>17</td>
<td>16</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Females aged 50 to 64 years</td>
<td>65</td>
<td>66</td>
<td>67</td>
<td>74</td>
<td>79</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>196</strong></td>
<td><strong>199</strong></td>
<td><strong>199</strong></td>
<td><strong>220</strong></td>
<td><strong>231</strong></td>
</tr>
</tbody>
</table>

*Source: Projecting Adults Needs and Service Information System 2008. Crown Copyright*
Dementia

The Psychiatrist’s view

I have been working as a consultant psychiatrist for older people’s mental health services in Bury St Edmunds since 2002.

Psychological disorders in older people are common, both the types of conditions that affect people of any age such as depression and schizophrenia, the so called “functional illness”, but also memory disorders such as dementia that much more commonly start in later life.

Sadly, older people with mental health problems have often faced a double whammy of discrimination, age-discrimination and the stigma of having a mental health problem.

In the last few years there have been significant developments in local mental health services for people with dementia. Our memory assessment and therapy service provides a multidisciplinary assessment of all patients referred with a memory problem. Patients have full access to anti-dementia medication and are provided with advice at the outset of their illness. In some parts of west Suffolk there is also a psychiatric intermediate care team that specifically helps support some vulnerable people with dementia living at home. Sadly this service is only available in Bury and Newmarket.

Services for older people with functional illness have faced more challenging times. Quite rightly the focus has been to try and treat more people at home with less need to be admitted to hospital. The number of in-patient beds has been halved, the dementia and functional wards were merged, and the day hospitals were closed. There has been the introduction of a crisis and home treatment team (CRHTT), but they have had relatively little experience of working with older people. The merging of the functional and dementia wards was detrimental to both patient groups, and within the last few months the wards have separated again. The CRHTT is gradually building up experience working with older people.

One final area to mention is the provision of mental health input to patients at the West Suffolk Hospital. These patients in particular have high levels of psychiatric morbidity which affects their clinical outcome, both in terms of length of stay in hospital, but also the proportion of patients that are able to return home. For a period of time from 2003 – 2005 we had a successful liaison service for older people, the backbone of which was a dedicated full-time liaison psychiatric nurse. Unfortunately this was a pilot study and funding was not continued. This is an important area for development over the next years.

The challenge for the next few years is to continue to improve the quality of mental health services, putting users and carers at the centre of services, and building a service that can respond to the increasing population of older people.
Dementia

offer at least an annual health check, which includes an assessment of carers’ needs (DH 2009). In 2007-2008 the Suffolk GP registered population was 605,335, with 2,688 people on the dementia registers, giving a prevalence of 0.4%. These are just the numbers of people that GPs are aware of. (QOF 07/08 NHS Health and Social Care Information Centre).

If the estimates above are considered, this appears to be an unexpectedly low figure. However the data is likely to be incomplete. Early diagnosis and intervention in dementia is cost-effective, yet only between a third and a half of people with dementia ever receive a formal diagnosis (NAO 2007). If a diagnosis is not made then, preventative advice and support cannot be given, nor appropriate health and social support.

People with symptoms may not present to their GP, and attitudes may mean that a diagnosis is never made, with many, including health and social care professionals, believing little can be done (Audit Commission 2002). Suffolk’s strategy for dementia acknowledges the need to address stigma, both within the wider public and amongst staff. The plans are to raise awareness, not only about the nature of dementia, but also the availability of services and how these may be accessed.

What is happening in Suffolk?

The ‘National Dementia Strategy’ has recently been published (DH 2009) and a joint Suffolk strategy has been developed in response, to meet national requirements (Suffolk Joint Dementia Board 2009). The Suffolk strategy will ensure raised awareness and understanding of dementia, early diagnosis and support. Currently there is joint work between NHS Suffolk, NHS Great Yarmouth and Waveney and Suffolk County Council, through initiatives such as Healthy Ambitions Suffolk, which will implement the dementia strategy and reduce the risks of people developing dementia, and ensure individuals are supported to slow the progression of symptoms. Information and support services are also being developed.
Glossary

**Vascular dementia:**
Vascular dementia is the second most common cause of dementia after Alzheimer’s disease, accounting for up to a third of all dementias. It is thought to be due to impaired blood supply to the brain, which may be caused by conditions such as stroke or mini strokes. (Personal Social Services Research Unit, 2005)

**Alzheimer’s disease:**
Alzheimer’s disease is a slowly progressing form of dementia. Over time, Alzheimer’s disease gradually damages the function and structure of the brain, which affects a person’s ability to remember, talk and carry out routine daily activities. (BUPA, 2009)

**Mixed dementia:**

**Dementia with Lewy Bodies:**
Dementia with Lewy Bodies (DLB) is a progressive dementia, the hallmarks of which are hallucinations and fluctuating levels of attention. Some rigidity and stiffness may be seen. There may also be a disturbed sleep pattern with nightmares and abnormal behaviour. DLB is thought to be due to a faulty production of a protein, which then builds up within the nerve cells of the brain. http://www.pdsg.org.uk/Factsheets/LewyBody.htm (accessed 06.05.09)

**Creutzfeldt-Jakob disease:**
Creutzfeldt-Jakob disease (CJD) is an illness of the nervous system that causes damage to the brain (the disease is named after two German scientists). CJD is fatal, and there is no known cure. CJD is caused by an abnormal protein (prion) that contaminates the nervous system. http://www.nhs.uk/Conditions/Creutzfeldt-Jakob-disease/Pages/Introduction.aspx (accessed 06.05.09)
**Electro Convulsive Therapy:**
ECT is usually given to people with severe depression which has not responded to other forms of treatment such as anti-depressants. During ECT, a brief electrical stimulus is given to the brain via electrodes placed on the temples. The electrical charge lasts between 1-4 seconds, and causes an epileptic-like seizure. Before treatment, the patient is anaesthetised and given an injection of muscle relaxant which depresses the breathing, and oxygen is given until the patient is able to breathe naturally again. (Mental Health Foundation, 2000)

**Down's syndrome:**
People with Down's syndrome have an extra chromosome in some or all of their body's cells, resulting in certain physical characteristics and some level of learning difficulty. Down's syndrome affects one in every 1,000 babies in the UK. (BUPA 2008)

**Huntington's disease:**
Huntington's disease is an inherited disorder that causes the degeneration of brain cells. This results in a progressive loss of the control of movement and mental ability, and changes in personality. Around 4,800 people in the UK are living with Huntington's disease. It used to be called Huntington's chorea. Chorea means jerky, involuntary movements - a main symptom of the condition. (BUPA 2008)

**Niemann-Pick disease type C:**
Niemann-Pick disease refers to a group of diseases passed down through families (inherited) in which fatty substances called lipids collect in the cells of the spleen, liver, and brain. Niemann-Pick Type C occurs when the body can not properly break down cholesterol and other lipids (fats). This leads to too much cholesterol in the liver and spleen and excessive amounts of other lipids in the brain. Type C usually affects school-aged children, but the disease may occur any time between early infancy to adulthood. Symptoms may include learning difficulties and progressive intellectual decline (dementia). (Medline Plus 2009)

**Parkinson's disease:**
Parkinson's disease is a movement disorder caused by a shortage of a chemical (dopamine) in the brain. People with Parkinson's disease develop stiffness, tremors and slow movement that can become worse over time. (BUPA 2009)

**References**


Acknowledgements

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