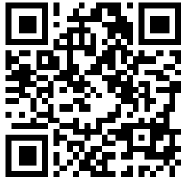

Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 11 June 2014 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Mrs. R. Palmer (0116 305 6098)**

Email: **rosemary.palmer@leics.gov.uk**

Membership

Mrs. J. A. Dickinson CC	Mr. J. Miah CC
Dr. T. Eynon CC	Mr. M. T. Mullaney CC
Dr. R. K. A. Feltham CC	Mr. J. P. O'Shea CC
Dr. S. Hill CC	Mr. A. E. Pearson CC
Mr. W. Liquorish JP CC	

A G E N D A SUPPLEMENT

The following additional appendix has now been published, agenda item 11 of the main agenda refers.

Item		Report by	
11.	Report of the Scrutiny Review Panel on the Referral Pathway for Older People with Anxiety and Depression.	Scrutiny Review Panel	(Pages 3 – 24)

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 11 JUNE 2014

FINAL REPORT OF THE SCRUTINY REVIEW PANEL ON THE REFERRAL PATHWAY FOR OLDER PEOPLE WITH ANXIETY AND DEPRESSION

Introduction

1. This report sets out the conclusions and recommendations arising from the Scrutiny Review Panel investigation into the referral pathway for older people with anxiety and depression.

Recommendations

2. The recommendations of the Panel are located within the body of the report. For ease of reference, they are also set out below:-

   (a) The Panel welcomes the arrangements already put in place to prevent older people from developing common mental health disorders and suggests that consideration be given to the following:-
   - Screening of people in residential care for common mental health problems and the development of a residential care based initiative to respond to any identified need;
   - Joining up community based initiatives with primary care services including the Improving Access to Psychological Therapies (IAPT) service;
   - Identifying a GP practice in Leicestershire to pilot the ‘community services desk’ in conjunction with VAL.

   (b) Recognising the barriers that exist, the Panel recommends that an awareness-raising campaign be undertaken using the following channels:-
   - Books on Prescription;
   - First Contact;
   - Libraries;
   - GP Surgeries;

   and that the success of this be measured through increased access to books on prescription and other community wellbeing services.

(c) That Patient Participation Groups (PPGs) be asked to undertake an audit of the accessibility of services provided by their GP surgery to older people with mental health problems and to support the surgery to act upon the findings of the audit accordingly.

(d) That Clinical Commissioning Groups be encouraged to work with the voluntary sector to identify community transport opportunities which would enable services to be more accessible and that wherever possible services are provided in accessible, local venues.

(e) The Panel recognises that the majority of common mental health disorders should be addressed in primary care and in order for this to happen on a successful and consistent basis, recommends the following:-

- That the Leicester, Leicestershire and Rutland Mental Health and Wellbeing Strategy Group be asked to consider ways of strengthening the role of primary care in treating mental health conditions and positioning primary care as the initial point of contact, early management and onward referral of patients as appropriate;
- That all organisations coming into contact with older people, in particular social workers, be encouraged to ask questions about their mental health and wellbeing and where appropriate refer them to their GP or the IAPT service;
- That voluntary sector organisations be encouraged to use outcome measures for wellbeing so that GPs can be confident in referring patients to them;
- That the use of online self-management programme for anxiety and depression be increased;
- That consideration be given to training volunteers to act as therapeutic friends and supplement the delivery of the IAPT service;
- That primary care practitioners be encouraged to consider social prescribing when treating older people suffering from anxiety or depression where appropriate;
- That GPs and IAPT therapists be asked to consider the aftercare of patients, specifically with regard to helping service users plan for the future and signposting them to community based services.

(f) That organisations providing specialist care for long term conditions be encouraged to take into account the potential mental health needs of patients and to ensure that there are appropriate links between their services and those provided in primary care.

(g) That all health and social care programmes intending to address mental health issues adopt an agreed set of patient-reported outcome measures.

Scope of the Review

3. The Joint Strategic Needs Assessment (JSNA) identified that depression is the most common mental health problem in older people and is associated with social isolation, long term physical health problems, caring roles and living in residential care. The JSNA found that access to relevant services for people aged over 65 was an issue which would merit further exploration. The Scrutiny Commissioners, when appointing the Panel, considered that scrutiny activity in this area was timely as it would address the JSNA recommendation and feed into the development of the delivery plan for the JHWS priority of improving mental health and wellbeing.

4. The following outcomes for the Review were identified by the Scrutiny Commissioners:-

   (i) To understand the referral pathways for older people with anxiety and depression and identify any areas where access or service provision could be improved;

   (ii) To understand the quality of services provided to older people and the outcomes for users regarding anxiety and depression;

   (iii) To examine the partnership arrangements currently in place and make recommendations for improved integration in the light of examples of best practice;

   (iv) To identify ways of increasing the potential for older people suffering from more than one medical condition to access appropriate support for anxiety and depression.

Membership of the Panel

5. The following members were appointed to serve on the Panel.

Mrs R Camamile CC	Dr T Eynon CC
Mr J Kaufman CC	Mr D Jennings CC
Mr W Liquorish CC	

Mrs R Camamile CC was appointed Chairman of the Panel.

Conduct of the Review

6. The Panel met on four occasions between 13 January and 6 March and over that period:-

   (i) Received detailed information on the findings of the Joint Strategic Needs Assessment, recommendations in the Joint Health and

Wellbeing and other appropriate evidence relating to anxiety and depression in older people;

(ii) Considered the pathways currently in place for older people suffering from anxiety and depression, including the Improving Access to Psychological Therapies (IAPT) service;

(iii) Considered case studies setting out the patient experience of the identification and diagnosis of anxiety and depression and the associated referral pathways;

(iv) Received details of the scope of current partnership arrangements.

7. The Panel was supported in its review by the following officers and is indebted to them for their contributions:-

Lorraine Austen	Head of Service, Leicestershire Partnership NHS Trust (LPT)
Dr Dave Briggs	Managing Director, East Leicestershire and Rutland Clinical Commissioning Group (CCG)
Jim Bosworth	Associate Director of Contracting, West Leicestershire CCG
Peter Caunt	Service Director, Good Thinking Therapy
Dr Samantha Hamer	Clinician, LPT
Ivan Liburd	Policy Officer, Healthwatch Leicestershire
Dr Mike McHugh	Medical Consultant in Public Health
Dr Noel O'Kelly	Clinical Director, LPT
Ian Redfern	Head of Service, Adult Mental Health, Leicestershire County Council
Ben Smith	Health Policy Officer, Voluntary Action LeicesterShire (VAL)
Jude Smith	Deputy Clinical Director, LPT
Dr Erik Van Diepen	Consultant Psychologist, LPT

8. The Panel is particularly grateful to VAL and Healthwatch Leicestershire for their investigation into service user experience. A copy of the report setting out their findings is appended to this report.

Background

9. Good mental health and emotional wellbeing are as important in older age as in any other time of life. Many people fear growing older, and assume that old age is depressing and distressing, characterised by loss and disability, offering little to look forward to. But the reality is that older people are as capable as younger people of enjoying life, taking on challenges and coping with life's difficulties.

10. The chief difference between older people and other age groups is that older people are more likely to have experienced events associated with poorer mental health, such as having to deal with a decline in physical health or bereavement. The term 'resilience' is often used to describe our ability to recover from difficult or stressful situations and it has been suggested that our resilience is also likely to influence our wellbeing in later life.

11. Although the majority of older people remain in good mental health, mental health problems in older adults are common; present in perhaps 40% of GP attendees, 50% of general hospital patients and 60% of care home residents.

Definition of common mental health disorder

12. The term 'common mental health disorder' Includes depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD).

13. *Depression* is characterised by low mood, emotional, cognitive, physical and behavioural symptoms. Symptoms typically include poor sleep, reduced appetite, tearfulness, irritability and social withdrawal. Marked anxiety can frequently co-exist with depression.

14. *Generalised anxiety disorder (GAD)* features excessive anxiety and worry, often accompanied by restlessness, fatigue, difficulty concentrating, irritability, muscle tension and disturbed sleep. GAD often occurs simultaneously with depression and this can make accurate diagnosis problematic.

15. *Panic disorder* results in either intermittent apprehension, and panic attacks in relation to particular situations or spontaneous panic attacks with no apparent cause. Patients often take action to avoid being in particular situations in order to prevent those feelings, which may develop into conditions such as agoraphobia which is anxiety about being in places or situations from which escape might be difficult.

16. *Obsessive-compulsive disorder (OCD)* involves the presence of either obsessions or compulsions, but commonly both fear of contamination from dirt, germs, viruses, body fluids etc., fear of harm, obsessions with religious, sacrilegious or blasphemous thoughts, sexual thoughts and repetitive behaviours or mental acts that the person feels driven to perform e.g. checking (for example, gas taps).

17. *Post-traumatic stress disorder (PTSD)* develops in response to one or more traumatic events e.g. acts of interpersonal violence, severe accidents, disasters or military action. The most characteristic symptoms of PTSD are

re-experiencing symptoms including flashbacks in which the person acts or feels as if the event is recurring.

18. *Social anxiety disorder* also referred to as social phobia, is characterised by an intense fear in social situations that results in considerable distress and in turn impacts on a person's ability to function effectively in aspects of their daily life.

Prevention

19. In order to prevent people from developing a common mental health disorder, such as anxiety or depression, they need to be supported to become more resilient. For older people, some particular risk factors have been identified which can make people more vulnerable to developing depression. These are as follows:-
    - Limited mobility, chronic pain, frailty or other mental/physical problems leading to loss of independence;
    - Physical illness;
    - Bereavement;
    - Social isolation;
    - Loneliness.

20. Another group of people at significant risk of developing anxiety or depression is older people who move into residential care. This is due to the scale of change in lifestyle. Although they are living with other people, it will not necessarily be a group of their choosing. They can also have difficulty coming to terms with the loss of their own home and independence.

21. There are a number of initiatives already in place in Leicestershire aimed at mitigating the risk factors and preventing older people from developing anxiety or depression. Organisations such as the County Council provide pre-retirement courses which advise people to keep active and form part of social groups to prevent feelings of social isolation and depression.

22. The Five Ways to Wellbeing are promoted across Leicestershire by the Culture, Health and Wellbeing Partnership; a partnership led by Leicestershire County Council and is supported by Leicester City Council and the Districts and Boroughs of Leicestershire County. The Five Ways to Wellbeing is a set of evidence-based public mental health messages aimed at improving the mental health and wellbeing of the whole population. They were developed by nef (the new economics foundation) in 2008 and are as follows:-
    - Connect with people around you;
    - Be active;
    - Take notice of your surroundings, people etc;
    - Keep learning;

- Give e.g. as a volunteer, share your knowledge and experiences etc.

23. A range of social activities aimed at promoting positive mental health are organised by libraries; these can help to reduce feelings of social isolation and depression. Libraries can also support people to self-manage their mental health, for example through the books on prescription service, which makes available cognitive behavioural therapy self-help books. These can provide very effective help and treatment for a range of common emotional and mental health problems. The main libraries in Leicestershire have wellbeing collections which include specific, evidence-based books.

24. The Panel feels that it is important that community-based initiatives, such as those in libraries, are linked to primary care services. The Panel was pleased to hear that Voluntary Action Leicestershire (VAL) is currently piloting a ‘community services desk’ at a GP surgery in Leicester. This has been developed with the Patient Participation Group and will be managed by volunteers who will be able to provide advice and guidance and direct people to the appropriate voluntary sector group for support. Further detail is included in the appended report which sets out the findings of Healthwatch and VAL’s investigation into patient experience.

25. More recently, the Better Care Fund Plan, a pooled budget aimed at improving the integration of health and social care in Leicestershire, has been developed. One of the workstreams in the Plan is the Unified Prevention Offer which will include specific work to raise awareness of mental health and target the most vulnerable. The Plan will also consider how to join up data systems to enable all health and social care services involved in the care of a patient to access the same records.

26. Within residential care homes, consideration is being given to whether residential homes should target known needs or whether there is a benefit to a general screening programme for services in residential care. Both Leicestershire Clinical Commissioning Groups have a care home project which aims to capture both the physical and mental health needs of patients. The Panel suggests that any screening activity would need to be linked to an effective intervention, such as providing basic Cognitive Behavioural Therapy training for some staff in residential care so that they were able to respond to identified need.

Recommendation

(a) The Panel welcomes the arrangements already put in place to prevent older people from developing common mental health disorders and suggests that consideration be given to the following:-
    - Screening of people in residential care for common mental health problems and the development of a residential care based initiative to respond to any identified need;

- Joining up community based initiatives with primary care services including the Improving Access to Psychological Therapies (IAPT) service;
- Identifying a GP practice in Leicestershire to pilot the 'community services desk' in conjunction with VAL.

Access to Services

27. A number of barriers have been identified which can prevent older people suffering with anxiety or depression from accessing services. These can be summarised as follows:-

Patient factors:

- feelings of shame
- stigma and fear
- distrust of healthcare services
- masking and normalising of symptoms (especially mental health symptoms)
- lack of knowledge about mental health symptoms or services
- lack of support or encouragement to access healthcare services from families and community
- a belief in spirituality and self-reliance as a means of overcoming healthcare problem
- somatisation (when mental and emotional problems present as physical ill-health)
- limited language and communication proficiency, resulting in communication problems (including hearing and speech problems)
- cultural factors, such as the lower levels of awareness of problems such as depression in black and minority ethnic communities

Practitioner-level factors:

- poor communication with patients and the wider community
- poor attitude to patients
- stereotyping of individuals by practitioners
- minimisation or poor recognition of mental health symptoms.
- have time constraints in their surgeries that prevent them from diagnosing mental health problems effectively
- consider that depression is an inevitable consequence of ageing and fail to see the value of treating it;
- recognise symptoms of depression or anxiety but fail to recognise that they can be treated with psychological therapies;
- attribute mental health problems to someone's reactions to physical health problems, such as diabetes, Parkinson's disease, arthritic pain, stroke, cardiac or thyroid disorders etc., and so do not consider them suitable for treatment;

- believe that treating physical health problems is a higher priority than treating mental health problems, and consequently do not refer patients to psychological therapy services;
- mistakenly believe that psychological therapies do not work for older people;
- prioritise referring younger people with depression and anxiety to services providing psychological therapies; and/or
- not have the skills to identify and manage mental health problems in older people.
- inadequate assessments arising from limited information about a range of issues (for example, cultural background)

System and service-level factors:

- poor allocation of services and poor quality of services
- poor communication between services
- lack of flexibility in healthcare systems and practices to take into account individuals' cultural beliefs
- use of standard procedures and practices that are unfamiliar or unexplained to vulnerable individuals
- transportation issues
- poor appointment systems

28. The stigma around mental health problems might create a barrier for some older people, particularly those in close-knit rural communities. These people are less likely to talk to other people about how they are feeling. In addition, older people may not have the words to enable them to identify their symptoms as the language of psychology is not common to older people.

Recommendation

(b) Recognising the barriers that exist, the Panel recommends that an awareness-raising campaign be undertaken using the following channels:-
  - Books on Prescription;
  - First Contact;
  - Libraries;
  - GP Surgeries;

  and that the success of this be measured through increased access to books on prescription and other community wellbeing services.

(c) That Patient Participation Groups (PPGs) be asked to undertake an audit of the accessibility of services provided by their GP surgery to older people with mental health problems and to support the surgery to act upon the findings of the audit accordingly.

(d) That Clinical Commissioning Groups be encouraged to work with the voluntary sector to identify community transport opportunities which would

enable services to be more accessible and that wherever possible services are provided in accessible, local venues.

Strengthening the Role of Primary Care

29. The majority of common mental health disorders should be treated in primary care. GPs can make an initial assessment of a mental health condition, provide good advice and initial support, arrange referrals to other treatments and services, such as psychological therapies and counselling and, if necessary, prescribe medication such as anti-depressants where appropriate. However, the Panel noted that there is some lack of consistency in the service offered by GPs. Those with a special interest in mental health were generally confident in identifying and diagnosing common mental health conditions. Where mental illness manifested itself through physical symptoms it was more difficult for a GP to make a correct diagnosis.

30. The correct diagnosis of mental health conditions is a particular issue for older people with long term conditions, who are more likely to suffer from anxiety and depression, but less likely to identify their symptoms correctly.

31. The GP appraisal process does not provide a way of ensuring consistency in the treatment of mental health conditions across primary care. It does not assess whether GPs are confident in dealing with mental health conditions unless the GP has been identified by the practice as a mental health lead. Under appraisal and revalidation requirements there are no specific requirements for GPs to attend training courses specifically for mental illness. The requirement is that they show evidence of keeping up to date in relation to their role as doctors. If they have a lead role, or identify mental health training as a learning need, this can be added to their personal development plan but it is not a requirement under any legislation.

32. The Panel is pleased to note the creation of a new Leicester, Leicestershire and Rutland Mental Health and Wellbeing Strategy Group. This group would have a significant part to play in strengthening the role of GPs in dealing with common mental health conditions through training and through facilitating development of clear pathways of care with the primary care team as the hub. However, it is not just GPs in primary care who should be able to help older people with anxiety or depression, help should be available from across the whole range of primary care services. In particular, practice nurses supporting patients with other chronic conditions ought to be checking their mental health regularly as well.

33. The Panel is pleased to note that East Leicestershire and Rutland Clinical Commissioning Group has developed a holistic care template which includes trigger questions that will result in a care co-ordinator referring patients to their GP for treatment of anxiety or depression. However, this was only in place for patients with specific long term conditions.

34. Self-management is an important aspect of treatment of anxiety and depression. This can be improved by access to online education sources, similar to the DESMOND (Diabetes Education and Self-Management for On-going and Newly Diagnosed) programme which supports people with type 2 diabetes to manage their own condition. Voluntary Sector organisations also have a key role to play, for example through forming partnerships with GP surgeries. It might be useful to develop a quality mark for voluntary sector groups so GPs feel confident when referring patients to them.

Improving Access to Psychological Therapies (IAPT) Service

35. The IAPT service provides psychological therapies for patients over the age of 16 years with depression and anxiety in a range of community venues, including GP surgeries. The service follows the recommendations set by the National Institute for Health and Care Excellence (NICE) providing evidence based psychological therapies. There are two types of practitioners:-
    - Psychological Wellbeing Practitioners (PWPs), offering assessments, guided self-help and psycho-educational groups;
    - High intensity therapists offering a range of psychological therapies including Cognitive Behavioural Therapy, Interpersonal Psychological Therapy, Dynamic Interpersonal Therapy and Counselling.

    The service was provided by Good Thinking Therapy until 31 March 2014, from 1 April 2014 Nottingham Healthcare NHS Trust are providing the service.

36. Many older people express a preference for talking therapies and there is a considerable body of research evidence that indicates that talking treatments are just as effective in addressing anxiety and depression in older people as other age groups. NICE guidance on the treatment of anxiety and depression makes no variation in its recommendations relating to age. The national data for IAPT indicates that there is no difference in recovery rates for those aged over 64 years and locally recovery rates for older people are better than average. There is also a trend towards older people being more likely to complete a full course of treatment than other age groups.

37. Despite IAPT services being open to all adults there is considerable under representation of older people amongst the population accessing IAPT. The following are nationally recognised barriers for older people accessing the IAPT service:-
    - Historically the IAPT service was primarily for working age adults which may lead care professionals to forget that IAPT is an all age service;
    - Perception that talking therapies are not relevant for older persons;
    - Physical barriers such as mobility or sensory impairment;

- Poor understanding of the issues relating to the treatment of the older person.

38. Locally, the following initiatives have been put in place to help older people access the service:-
    - All PWPs have been trained in the treatment of Long Term Conditions and Older Persons Feb to April 2013;
    - High Intensity Therapists are trained by experienced Older Persons Psychologists who are involved in adaptations to therapy to make therapy more accessible;
    - An Older Persons Champion has been appointed;
    - Cognitive Behaviour Therapy training across the county includes components addressing Long Term Conditions.

39. From mid-April 2014 ‘Mindfulness’ will also be available in Leicestershire. ‘Mindfulness’ is a way of paying attention to the present moment, using techniques like mediation, breathing and yoga. It helps people become more aware of their thoughts and feelings so they can manage them rather than being overwhelmed by them. GP surgeries not providing ‘Mindfulness’ will need to have arrangements in place to signpost service users to patient transport schemes. It was also felt that volunteers could be trained as ‘therapeutic friends’ to support ‘Mindfulness’ by working with the service user and helping them to think of things other than their illness, a type of distraction therapy.

40. Another area that needs developing is aftercare. There is a lack of structured aftercare for service users whose IAPT sessions had been completed. There was a role for therapists and GPs in helping the service user to plan for the future and signpost them to other services, such as those provided by the voluntary sector.

<u>Recommendations</u>

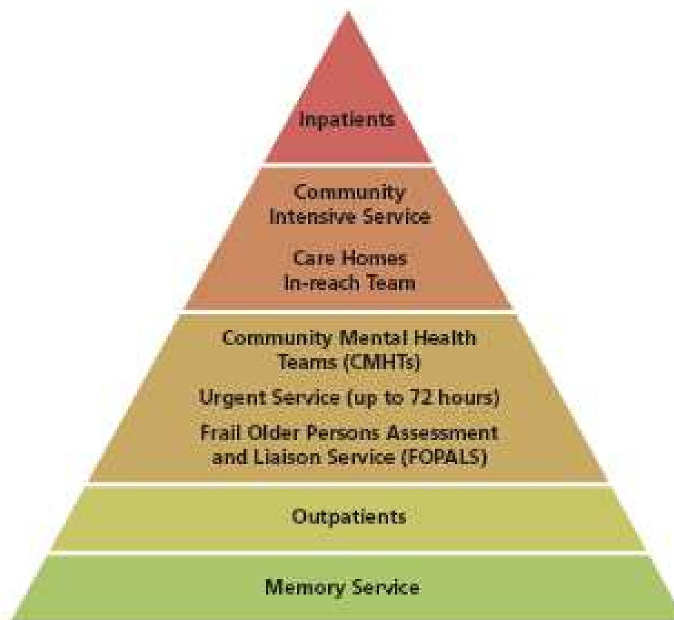
(e) The Panel recognises that the majority of common mental health disorders should be addressed in primary care and in order for this to happen on a successful and consistent basis, recommends the following:-
- That the Leicester, Leicestershire and Rutland Mental Health and Wellbeing Strategy Group be asked to consider ways of strengthening the role of primary care in treating mental health conditions and positioning primary care as the initial point of contact, early management and onward referral of patients as appropriate;
- That all organisations coming into contact with older people, in particular social workers, be encouraged to ask questions about their mental health and wellbeing and where appropriate refer them to their GP or the IAPT service;

- That voluntary sector organisations be encouraged to use outcome measures for wellbeing so that GPs can be confident in referring patients to them;
- That the use of online self-management programme for anxiety and depression be increased;
- That consideration be given to training volunteers to act as therapeutic friends and supplement the delivery of the IAPT service;
- That primary care practitioners be encouraged to consider social prescribing when treating older people suffering from anxiety or depression where appropriate;
- That GPs and IAPT therapists be asked to consider the aftercare of patients, specifically with regard to helping service users plan for the future and signposting them to community based services.

Secondary Care

41. Common mental health disorders should not be treated in secondary care except in rare circumstances. The Panel is pleased to note that, as with all age groups, only a very small proportion of older people suffering with anxiety or depression have a condition sufficiently serious to require secondary care intervention. Leicestershire Partnership NHS Trust (LPT) provides services for older people with severe anxiety or depression which cannot be treated elsewhere. It specialises in providing support for service users with complex conditions, such as having two or more chronic medical conditions.

42. LPT provide a stepped model of care in which the patients' needs are met by the service that provides the most appropriate intensity of care at that time. Patients can step up or step down into services as their needs change. The Panel emphasises the importance of ensuring patients are treated at the right level according to their needs, including being discharged to primary care when appropriate. Services are provided through outpatient clinics which patients are referred to by their GP. More serious conditions are referred to the Community Mental Health Team (CMHT) which provides on-going care through multi-disciplinary teams. The CHMT has a community intensive service which is between community services and hospitals, and a care home in-reach team. There is also an urgent service which can support patients for up to 72 hours whilst a care pathway is developed and a liaison service with UHL for patients with both physical and mental needs. The stepped model of care is illustrated as follows:-



43. One area where involvement is appropriate is in the rehabilitation programme for people with long term conditions. LPT has designed a pulmonary rehabilitation programme which focuses on education and exercise and also includes a session on recognising anxiety and depression. A heart failure rehabilitation programme is due to start soon using the same model.

44. The Panel supports LPT's intention to further develop the services it provides in the following ways:-

- increased access to physical health care in all clinical settings;
- increased integration of physical and mental health services for frail older people.

Recommendation

(f) That organisations providing specialist care for long term conditions be encouraged to take into account the potential mental health needs of patients and to ensure that there are appropriate links between their services and those provided in primary care.

(g) That all health and social care programmes intending to address mental health issues adopt an agreed set of patient-reported outcome measures.

Resources Implications

45. None specifically arising from this report.

Equal Opportunities

46. In the course of its investigation the Panel had focused particularly on the needs of socially excluded groups, including those identified as protected in the Equalities Act 2010.

Circulation under the Local Issues Alerts Procedure

47. None.

Background Papers

48. File containing the reports submitted to the Scrutiny Review Panel on the Referral Pathway for Older People with Anxiety or Depression.

Recommendations

49. ***The Health Overview and Scrutiny Committee is recommended to support the findings of the Panel and refer the conclusions to the Cabinet for its consideration;***

Mrs R Camamile CC
Chairman of the Panel

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healthwatch
Leicestershire

LEICESTERSHIRE COUNTY COUNCIL HEALTH OVERVIEW AND SCRUTINY COMMITTEE REVIEW PANEL ON THE REFERRAL PATHWAY FOR OLDER PEOPLE WITH ANXIETY AND DEPRESSION

Experiences of service users

Purpose

1. The purpose of this report is to present a summary of service user experiences as part of the Leicestershire County Council Health Overview and Scrutiny Committee (OSC) review of mental health pathways relating to anxiety and depression in older people.

Introduction

2. The Health and Overview Scrutiny Committee are working with partners including Healthwatch to understand and map the current pathways and to listen to users and carers to understand their issues and experiences.

3. Healthwatch Leicestershire in partnership with Voluntary Action Leicestershire has spoken to service users and voluntary groups to obtain real life experiences and concerns in regard to mental health services on the referral pathways for older people experiencing anxiety and depression.

Aim of the review

4. To understand the evidence base for the Review Panel and the areas which would merit further exploration, with a particular focus on the impact of health inequalities on access to services.

5. To provide a summary of the findings in the Leicestershire Joint Strategic Needs Assessment, recommendations in the Joint Health and Wellbeing Strategy and other appropriate evidence relating to anxiety and depression in older people.

6. To begin to identify ways of increasing the potential for older people suffering from more than one medical condition to access appropriate support for anxiety/depression.

7. To understand the referral pathways for older people (i.e. over the age of 65) with anxiety and depression and identify any areas where access or service provision could be improved.

8. To understand the quality of services provided to older people and the outcomes for users regarding anxiety and depression.

Methodology

9. The methodology for this research was developed jointly with Healthwatch Leicestershire and Voluntary Action LeicesterShire. The initial attempt to engage service users in a meeting with many people observing them was understandably difficult. This was due to:

   - People who have recovered from depression and anxiety finding it difficult and sometimes detrimental to discuss a difficult time in their lives when in recovery.
   - The thought of attending a meeting and providing evidence to County Councillors being too daunting.
   - Service Users not wishing to criticise the services that have helped them recover
   - Service users not being willing or having sufficient confidence to talk about their experiences in an unfamiliar environment.

10. Learning from the above, evidence was gathered through Voluntary and Community Sector (VCS) Groups to both obtain relevant information from a service user perspective and from the vast experience of their organisations.

11. VCS groups provided case studies and experiences of service users to demonstrate the impact of services on individuals.

12. One to one discussions were held with VCS groups, these include

   - Leicestershire Action for Mental Health Project (LAMP)
   - Good Thinking Therapy (Rethink)
   - Network for Change
   - Age UK
   - Voluntary Action South Leicestershire

13. Information and the offer for VCS groups to be involved with the review was sent out and promoted via various avenues, these include:

   - Voluntary Action LeicesterShire e-brief
   - Voluntary Action LeicesterShire Health & Social Care Newsletter
   - VCS Health and Social Care Forum
   - Market Harborough Mental Health Forum
   - VCS Adult Transformation of Social Care Group

- Healthwatch News Letter
- Healthwatch website

Access to services

14. This section provides experiences of service users relating to access to services and key points that were captured during various discussions with VCS groups.

15. A service user had been told that the Improving Access to Psychological Therapies (IAPT) service would not be able to help. They were not told why or advised about other services that may have been able to assist with their mental health issues. The perception of the user was that 'it's because I'm 65'. The voluntary and community group that this user had dialogue with has not heard from the service user since the initial conversation.

16. A service user wanted a Mindfulness model of counselling rather than Cognitive Behavioural Therapy (CBT). This appeared to cause confusion about whether or not the service was available. Following advocacy from a Voluntary and Community Sector (VCS) organisation the client was eventually referred for Mindfulness, however other difficulties in accessing services included a substantial waiting list. As this model is not as popular as others, the sessions are not run as frequently.

17. Following on from the point above, the issue of transport arose as the Mindfulness course took place in another area and client could not use public transport due to their social anxiety. The client had no family or friends to take them and could not afford to use a taxi. They eventually accessed a transport scheme through a local Citizens Advice Bureau (CAB) and are subsequently accessing Mindfulness therapy.

18. IAPT services are usually accessed through local GP surgeries and this can be a problem for some older people who are socially isolated or living in rural areas where local transport services are not very regular or accessible. Older people are more likely to have physical health problems, such as impaired mobility, which may prevent them from accessing IAPT services.

19. A report by Dr Mike McHugh touched on the access to healthcare from BME groups and the uptake of services compared to white groups. In addition to this some BME cultures especially those of south Asian decent, see the care of many older people to be the responsibility of a younger sibling/ family member. Often the older person continues to live with a son or daughter who provides care and support reducing isolation. The perceived social hierarchy system plays a key role in the stigma of accessing various mental health services within the community as it can often be wrongly seen to affect the family's reputation.

20. One client was unable to benefit from IAPT services as they could not get to their local surgery and the therapist would not visit them at home. This defeated the whole object as they were struggling with Agoraphobia. On this occasion there was no flexibility in the service and clients are reportedly sometimes being told that getting to the appointment

reflects their commitment to getting better, within the 'recovery model'.

Service Delivery

21. Several clients have suggested that the IAPT sessions were too short (one client said 20 minutes is usual) and do not give sufficient opportunity to work through issues.

22. One service user reported that they did not know what to do as they were not happy with the approach of their therapist and this was causing more anxiety. They eventually discussed the problem with their GP who said they would arrange for them to see another therapist, but several weeks later they were still waiting and unsure whether they had gone to the bottom of the list again.

23. Following advocacy from a voluntary and community sector organisation, this service user has now been allocated another therapist. Although the session is held in a different surgery the user has said that sessions with the new therapist are working well.

Maintenance of Good Mental Health

24. If clients require on-going support after the IAPT sessions have finished, therapists need to be aware of other services they can refer onto and be proactive in sharing this information or referring on. As outlined above, one client was not given any other advice or information when IAPT said they were not able to help.

Wider Considerations

25. There is an importance for services to work in partnership with Housing support groups that frequently engage with older people who display signs of anxiety and depression as well as being isolated. These individuals must be identified to fully understand the impact of anxiety and depression in the wider community, as often their environment can be a partial cause of their anxiety.

26. Many organisations support older people who suffer from anxiety and depression but have either not been diagnosed or do not access mental health services. This observation is very common with groups that run befriending services or support groups, social drop in services for older people. Some of the issues identified from this cohort of people can be seen below.

    - Through gathering information it is understood that getting doctors appointments is difficult for many older people, who have often given up trying as by the time they ring and get through in the morning, all the appointments are gone and they have to start all over again the next day.

    - Local groups had told us that befrienders have sat in people's houses and made the phone calls for them to ensure that they actually get an appointment. We were also told that some carers have made phone calls for patients who are struggling to successfully

secure an appointment. These patients are at risk of going without an appointment altogether, which is worrying considering they are some of the most vulnerable users of healthcare services and it is important to intervene as early as possible. There are concerns for people who have no one going in to support them and can be alone for weeks at a time.

- There is a recurring issue around access to information about services that can help.

- Statutory health and social care professionals require more information about availability of services to facilitate referrals to on-going VCS support services.

- Many people are do not meet the eligibility criteria for financial (social care) help so fall through the net, as travel and cost combined can often be an issue. Many people become isolated and depressed, as access to services becomes a problem.

- Some service users have stopped going to local clubs, as some organisations have implemented a charge and they don’t feel they can afford to go every week.

- One particular group had told us that some service users have also cut down on their carers because of cost, which is a concern.

- Over the years many Befriending Schemes have had statutory funding withdrawn and can no longer afford to deliver a service. .

Recommendations

27. Consider developing new ways to help BME sufferers of anxiety and depression access services more frequently than they do currently.

28. To better understand how well the Mindfulness services are promoted and offered by GP’s.

29. Consider some form of Information Advice & Guidance workers based in IAPT delivery offices or GP surgeries to help inform service users of alternative service provision (statutory and non-statutory).

30. Consider the establishment of structured referrals into specific services to address issues such as debt advice, housing support and bereavement counseling could be sourced by the worker to help identify and manage the root cause of the depression or anxiety.

Conclusion

31. Healthwatch Leicestershire and Voluntary Action LeicesterShire would like to thank the Leicestershire County Council Health Overview and Scrutiny Committee for allowing the voice of service users and VCS organisations to be heard during this review.

32. Whilst we have outlined concerns from some of the service users and groups we have spoken to, it is important to note that most users report a high level of satisfaction with statutory provision for older people experiencing anxiety and depression. Most VCS organisations we have spoken to are also complimentary about the IAPT model and have commented that it is much better than what went before.

33. As outlined above, there are some issues for the particular client group subject to the review and also some issues for BME residents of Leicestershire and their ability to access, and successfully engage with treatment. It is our opinion that the IAPT service is generally good, but with room for improvement.