Working with you to make Sheffield
HEALTHIER

NHS
Sheffield
Clinical Commissioning Group

Mental Health

Protected Learning Initiative: Delegate Pack

3rd September 2014

13:30 - 17:00

1867 Lounge, Sheffield Wednesday Football Club

Case Studies

The following case study highlighted in a recent Rethink publication outlines the story of Tracey who developed type 2 diabetes when she was just 22 years old after her antipsychotic medication and condition was not monitored adequately. She thinks medical professionals do not take her physical health concerns seriously because of her mental illness:

"I have schizoaffective disorder and borderline personality disorder, and was first prescribed antipsychotics in my early twenties. After I'd been taking them for around 18 months, I started to notice the impact it was having on my physical health. I felt completely exhausted all the time, thirsty and dehydrated and I constantly had to run to the toilet. I went to my GP because I was convinced something was wrong. But he dismissed my concerns, he wouldn't entertain the idea that there might be something serious going on.

About a year passed and the symptoms continued to get worse, before I was finally diagnosed with type 2 diabetes. My diabetes consultant told me that the symptoms I had gone to my GP about were clear early signs of the condition. He also said that it was the antipsychotics that had caused my diabetes. Seventeen years later, I still have to go regularly to the diabetes consultant.

When I'm unwell, I'm not great at looking after myself. It can be quite a big undertaking to go to see my GP, and I really do need them to take me seriously. As soon as a medical professional looks at my records, they see "borderline personality disorder" flashing up on the screen and it feels like they stop listening to me. They just think I'm neurotic or paranoid.

There also doesn't seem to be any communication between my GP and my psychiatrist. I think it would make a big difference if there was.

In my experience, GPs rarely know much about mental illness. One time, my GP called me after a routine blood test, saying that I might have a tumour in my brain because there was an unusually high level of prolactin in my blood. This sent me into a state of great distress and I had a panic attack. But when I called my community psychiatric nurse, he told me the prolactin level in my blood was probably caused by the antipsychotics. That turned out to be the case – there was no tumour, it was just a side-effect of my medication. A great deal of worry and anxiety could have been avoided if the GP had known more about the side-effects of the medication I was on." - CASE STUDY – *Tracey Butler (39). Hampshire*

"My son was a fit and active teenager who enjoyed many sports at school and would walk 15 miles easily. He was over 5ft 10in and weighed less than ten stone. AT 19, he was admitted to a psychiatric unit and given haloperidol which increased his appetite. He was then diagnosed with schizophrenia, and given olanzapine, after which the weight piled on. Now, at the age of 33 my son has diabetes and has been prescribed statins. We all wish we had known the potential side-effects of olanzapine and that another drug with less drastic drawbacks could have been available." - *Anonymous, Rethink Mental Illness supporter*

Articles taken from Rethink Mental Illness Publication Lethal Discrimination - September 2013 ©

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Introduction: 20 Years too Soon

Welcome to the Adult Mental Health PLI.

It has been nearly two years since the last mental Health PLI. The 'profile' of mental illness and wellbeing has thankfully continued to increase over this period both locally and nationally. The statistics remain stark and are reflected in some of the infographics (1) and other information (2) in this pack. There is extensive evidence outlining the burden of both morbidity and mortality that comes with mental ill health (3)

Among people under 65, nearly half of all ill health is mental illness.

In other words, nearly as much ill health is mental illness as all physical illnesses put together.

Mental illness is generally more debilitating than most chronic physical conditions. On average, a person with depression is at least 50% more disabled than someone with angina, arthritis, asthma or diabetes. Mental pain is as real as physical pain, and it is often more severe.

Yet only a quarter of all those with mental illness are in treatment, compared with the vast majority of those with physical conditions.

People with serious mental illness die on average 20 years earlier than the rest of the population – mostly from preventable causes. Whilst this event is predominantly about adult mental health, we cannot and should not ignore co-morbidity and mortality that occurs with diagnoses (4). Things have to change. Whilst this is not by any means the sole responsibility of General Practice, we do have a responsibility together with other mental health services providers, the Local Authority, Public Health and society as a whole.

If you have a serious mental illness e.g. schizophrenia then you have:

2 times the risk of diabetes
2-3 times the risk of hypertension
3 times the risk of dying from CHD
4.1 times risk of dying prematurely

There is much National Policy (5) - Whole-person care: from rhetoric to reality.

Achieving parity between mental and physical health, No Health Without Mental Health and evidence-based interventions that work to mitigate this situation. We will be hearing about the national perspective from Dr Geraldine Strathdee and despite the profound challenge of working in a 'cash-strapped' environment there are things that we can and are doing to address things locally. Today you will find out more about "Right First Time Work Stream 4", which has been working to develop a physical health strategy for people with serious mental illness and to work more collaboratively with Primary Care. You will be able to hear about some ground-breaking work that has led to the development of Practice Nurse (7)learning and up-skilling.

We asked you what your learning needs are via the survey monkey that came out a number of months ago and together with the evaluation of the last PLI and input from the PLI Steering group, we have developed this learning event. The workshops reflect your requests – there will be an overview of each workshop but we ask that you stick to your selected workshop and not change even if the sales pitch entices you! The overview of each workshop will give you the key messages you would have hopefully taken away from the workshops you are not able to attend and hopefully motivate you to go on and learn more after the event.

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Like many similar events the initial desire is to try to cram and compact as much as possible into the afternoon. However this is often detrimental and despite multiple competing and entirely legitimate needs, an event like this cannot be all things to all people. It can, however, be a continuation of things already in train and it can be a springboard to other important aspects of learning and changing and shaping and improving quality of the services we provide for people with mental ill health.

With that in mind we are considering the opportunity of developing GP and Practice Nurse expertise in mental health, neurodevelopmental conditions, dementia and learning disabilities. We are considering the possibility of establishing several GP Master Classes to run through the year which will be more in-depth than the PLI but still Primary Care oriented. These could be supported by online learning and may be an opportunity by which 'GP Associations' could develop as a provider. For outline information and to register an interest please click the button below:

MH Masterclass

This will not commit you to anything but will give us an indication of whether there is a desire to take this forward.

50% of lifelong mental illness has established by the time a child is 14 years of age and 75% by aged 20.

So what can we do and what could we potentially do? We need to consider our QOF/SMI registers and exception reporting, care-planning, access, early recognition and intervention. Diagnostic Overshadowing (10a) is well documented and can lead to physical conditions being untreated. The Inverse Care Law (10b) is well recognised. We need to consider how to The Quality Improvement Scheme may help by identifying barriers to care & access and helping to implement Reasonable Adjustments (10c) and the Equality act (10d). We need to consider Different Approaches to working (10e), particularly with each other ('associations'/federations) and with 3rd Sector colleagues and current mental health providers. The Sheffield Health & Social Care Trust, our main mental health provider, has asked to have more input from GPs – they want to know how they can better communicate and vice versa, click here to complete a short survey on your experiences (both good and bad) of the current services and how these might be improved:

SHSCT Survey

Please make every effort to see as much as you can in the market place. These are local organisations and services that can be accessed by our patients and their families. These services are often key in helping to break stigma related to mental ill health and in developing resilience for the future.

We have tried to make this delegate pack as interactive as possible and for it to be a useful resource alongside the relevant links to the CCG website and other local and national information.

Thank you for attending. More importantly, thank you for considering how we, as contributors to the health and wellbeing of our population, can continue to deliver and improve on the quality of mental health services that we provide.

The Mental Health, Learning Disabilities, and Dementia Portfolio Clinical Team

Working with you to make Sheffield HEALTHIER

Agenda

Protected Learning Initiative
Mental Health
13:30 – 17:00, Wednesday 3 September 2014
1867 Lounge, Sheffield Wednesday Football Club

13:30 – 14:00	Coffee/registration/video loop/market place
14:00 – 14:05	Welcome / Overview / Structure of the day
14:05 – 14:30	Overview of the six workshops - 3 Key points pertinent to Primary Care
14:40 – 15:10	Work Shop 1
15:10 – 15:45	Market Place / Refreshments
15:45 - 16:15	Work Shop 2
16:20 – 17:15	Key Note - Right First Time Work Stream 4: The Sheffield Story - Dr Geraldine Strathdee –National Clinical Director for Mental Health - Q&A / Challenges & opportunities for the future
17:15	Close

Speakers & Facilitators Biographies

Dr Geraldine Strathdee

Geraldine is the National Clinical Director for Mental Health. NHS England, a consultant psychiatrist in Oxleas NHS Foundation Trust, and Visiting Professor for the integrated mental health education programme at UCL Partners.
For over 20 years she has held senior roles in mental health policy, regulation and clinical management, at national and London regional levels, and advises internationally on mental health service design and quality improvement, while working as a practicing physician.

Dr Justin Garner

Justin's primary medical qualification is MB ChB Sheffield University 1995. He has worked in the mental health field since 1996 and held the post of Speciality Doctor In General Adult Psychiatry within the North CMHT at SHSC NHS Foundation Trust since 2004.
Justin is an approved by Secretary of State under Section 12(2) of Mental Health Act 1983 as having special experience in the assessment or treatment of mental disorder. Particular areas of interest include the mental health impact of trauma and personality disorder. Since 2013, he has also taken the lead in my CMHT on the assessment and management of young adults with ADHD. As well as his medical role, I have trained in Eye Movement Desensitisation and Reprocessing Therapy (EMDR) and has a working knowledge of Cognitive Behaviour Therapy (CBT) and Cognitive Analytic Therapy (CAT).

Dr Leigh Sorsbie

Leigh graduated from Sheffield Medical School in 1990 and has been a partner at Firth Park Surgery since 1997. This is in the North Locality. Her interests include Mental Health, Elderly Medicine, Minor Surgery and Diabetes.

Dr Sue Sibbald

Sue is a peer specialist in personality disorder and service user expert by experience working for SHSC.

Dr Jonathan Mitchell

Jonathan qualified in Medicine at the University of Sheffield and trained in psychiatry on the Mid and North Trent psychiatric training rotations. He has been a consultant psychiatrist working in south east of Sheffield CMHTs since August 2006. Since October 2013 he has been the Associate Medical Director for Quality and Governance in Sheffield Health and Social Care Trust. Jonathan has contributed to NICE guidance on management of Psychosis in adults, children and young people and people with coexisting substance misuse. He is a co-investigator in a multicentre randomised controlled trial investigating a lifestyle education programme aiming to reduce the consequences of antipsychotic related weight gain for people with schizophrenia.

Dr Zak McMurray

After qualifying in Sheffield in 1988 and completing the Sheffield GP vocational training scheme, Zak became a partner in his practice in Woodhouse. He was elected to the South East Sheffield Primary Care Group in 1999 as a Board member and acted as mental health and commissioning lead before taking over as PEC Chair. Zak became joint PEC chair , with Richard Oliver, on the creation of the Sheffield Primary Care Trust, moving to Joint Clinical Director within Sheffield Clinical Commissioning Group. He left his practice in June 2014 to take up his current substantive post as Clinical/ Medical Director. Zak is a member of the Quality Assurance Committee and the Sheffield Health and Wellbeing Board, as well as sitting on the CCG governing body and being an active member of the organisation's executive team.

Janet Southworth

Janet Southworth is a Health Improvement Principal within Public Health at Sheffield City Council. Her first post was as a nursing assistant at Middlewood hospital, she went on to work for Liverpool Mind and then in social housing and has qualified at a postgraduate level in both Housing Administration and in Public Health. She worked for Sheffield West PCT on the planning and commissioning of the NSF for Mental Health, and has worked in Public Health for 5 years covering a number of areas including mental health promotion and suicide prevention.

Dr Karen O'Connor

Karen graduated from Sheffield in 1984. She started GP training after house jobs but stayed for 4 years as a junior doctor in psychiatry covering adult, older age and children's mental health. When she returned to GP training she continued to work 2 sessions a week for 2 years as a GP clinical assistant in psychiatry managing the Lithium Clinic and providing medical cover to patients with SMI in community settings. Karen has been a partner at Heeley green surgery for 20 years and has an interest in complex problems, both mental health and physical health, including substance misuse. She works for the mental health, and children and maternity CCG portfolio teams, focussing on children and young people and the physical health of those with SMI. She has also worked for 11 years as a GP clinical assistant in the neurology movement disorder clinic. Karen is a member of Sheffield LMC. She has just said goodbye to her last GP registrar as a trainer but hopes to contribute to teaching and training in GP and hospital posts.

Dr Katy Kendall

Katy is a consultant psychiatrist in rehabilitation and clinical director for community services at SHSC.

Dr Angela Carradice

Angela is a consultant clinical psychologist leading on personality disorder across SHSC community mental health teams.

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Dr Alison James

Alison is a GP with 25 years' experience of working in student health during which time she has developed an interest in eating disorders. She is the mental health lead for the University Health Service and is a member of the NICE guidelines Eating Disorders group for Sheffield.

Helen Root

Helen has been a practice nurse for 17 years and has undertaken additional CBT training. In 2000, Helen and Dr Alison James established the Eating Disorders Outreach Clinic - a primary care based clinic with the aim of providing effective guided self-help for patients with mild to moderate eating disorders.

Kate Booth

Kate has been a practice nurse within student health for 16 years. For the last 9 years, she has been involved with the provision of care for university students with eating disorders, and has undertaken additional training in Counselling and CBT.

Helen Finner

Helen has worked within the Eating Disorder Service for just under 2 years and prior to this she worked extensively within the community with patients who have serious and enduring mental health problems and the department of Liaison Psychiatry. Working within a small specialist team, her key roles are assessments of clients, delivering therapeutic groups within the 3 day a week day service and liaison with both health and social care professionals.

Dr Amy Wicksteed

Amy is a Clinical Psychologist working for Sheffield Eating Disorders Service. She has worked in NHS Eating Disorders Services for the past 10 years & also has general adult mental health experience from CMHT work. She primarily uses Cognitive Analytic Therapy (CAT) and Cognitive Behavioural Therapy (CBT) approaches in her work.

Chris Hood

Chris has worked for SYEDA for 16 months and is responsible for all operational matters, strategy and organisational development. Prior to this post Chris was a regional manager for a supported housing provider. He has over 20 years experience of managing services in both the voluntary and public sector having worked for both Sheffield and Barnsley Borough Council's.

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Dr Sheila Hardy

Sheila is Education Fellow at UCLPartners, Honorary Senior Lecturer at UCL and Visiting Fellow, University of Northampton. She has twenty years of experience in primary care where her clinical work included caring for patients with physical and mental health problems. Sheila is keen to improve the care of people with mental health issues in primary care and has carried out in this area. Sheila is widely published and writes educational articles for practice nursing journals and has co-authored a book about mental illness in primary care. She has created training for practice nurses in various areas of mental health. She sits on a number of expert reference boards including NICE QOF Advisory, CQC GP co-production, NHS England (mental health), ministerial roundtable (mental health and premature mortality), and national mental health CCG leadership programme.

Dr Steve Thomas

Steve Thomas has been a GP in Sheffield for 15 years. He has always had an interest in mental health and was involved with developing the role of the Primary Care Mental Health Worker (now IAPT) both as a GP and a clinical academic. He has been involved in commissioning since the introduction of Practice Based Commissioning. He took up the role of clinical portfolio lead for the Mental Health, Learning Disabilities and Dementia Portfolio in 2012 and has been involved in service redesign, delivery of primary care education and contract negotiation for the portfolio. Steve is also involved in the wider work of the CCG, and he chairs the fortnightly Planning and Delivery group which is a key vehicle for scrutiny and decision making in the CCG.

Chris Neild

Chris works as Consultant in Public Health with Sheffield City Council. She has a strong personal commitment to addressing health inequalities and empowering communities. Chris began her career as a teacher in Sheffield at Chaucer School and subsequently held a Health Promotion post in the North Nottinghamshire's coalfields area.
After working as the Health Promotion manager in Nottingham she was appointed as Assistant Director of Public Health, leading Public Health work in communities, with children and young people and mental health, working closely with the Local Authority.
As Consultant in Public Health for NHS Sheffield Chris was responsible for work in communities and work with a Practice Based Commissioning Group. Following the transfer of Public Health into the Local Authority, Chris now leads the public health work in Sheffield City Council's Communities Portfolio where her responsibilities include public health programmes in local communities, the Public Health commissioning team and Mental Health.
Chris has recently been accepted to serve as a topic expert on the NICE Public Health Advisory Committee for Community Engagement.

Workshops – Aims and Objectives

The workshops will run twice, so you can attend two different ones. Please ensure that different members of your team attend different workshops with the intention of feeding back and disseminating relevant information and actions for change. Here is an overview of each workshop. A full brief can be found further on in this delegate pack

Workshop 1

Assessment and Mitigation of Suicide Risk in Primary Care

Aims - To obtain a better understanding suicide and the role of primary care in preventing suicide

Objectives - By the end of the session you should be able to:

- Recognise the incidence of suicide including demographics, risk factors and contact with primary care prior to suicide

- Have increased your knowledge about good practice when assessing suicide risk

- Have gained a better understanding of responding to suicide risk and services available for referral

- Have increased your understanding of universal approaches and the role of primary care in promoting wellbeing and preventing mental illness.

- Describe protective factors including support from family and friends

Workshop 2

Eating Disorder

Aims - To provide a clinical understanding of the symptoms, diagnosis and management of an adult Eating Disorder

Objectives - By the end of the session you should be able to:

- Recognise & diagnose an Eating Disorder in adults

- Undertake opportunistic case finding

- Understand your responsibilities for managing a patient with an Eating Disorder

- Be able to responsibly manage that patient

Workshop 3

Physical Health/MH for Practice Nurses

Aims - For attendees to hear about work carried out in London to deliver a module based health and wellbeing training package specifically aimed at practice nurses and how this might be applied to another area.

Objectives - By the end of the session you should be able to:

• Understand the results of a practice nurse mental health and wellbeing training needs analysis

• Describe the 10 module mental health and wellbeing training package designed specifically for practice nurses

• Explain how this was delivered in London and understand how it might be replicated in a cost effective sustainable manner

• Articulate the positive outcomes of the London project

Workshop 4

Common Mental Illness & Prescribing

Aims - To give an overview of treatment options, both pharmacological & psychotherapeutic, in the management of mental illness.

Objectives - By the end of this workshop you should be able to:

• Understand the rational for use of antidepressant drugs

• Understand the place of 2nd & 3rd line therapy, when to switch & what to use have an overview of psychotherapeutic treatments & understand their indications

• Understand the place of both pharmacological & psychotherapeutic treatments, or both, in the management of mental illness

Workshop 5

Personality Disorder

Aims - To have both a clinical and personal overview of Personality Disorder

Objectives - By the end of the session you should be able to:

- Recognise signs and symptoms of personality disorder
- Know when and how to refer to services
- Understand the impact of Personality Disorder on everyday life
- Know what help is available for people with Personality Disorder and what does and doesn't work
- Carry out prognosis – and understand why it is better than you might think
- Understand how to manage risk and frequent attenders

Workshop 6

Autistic Spectrum Disorder

Aims - To have both a clinical and personal overview of Autistic Spectrum Disorder

Objectives - By the end of the session you should be able to:

- Clearly identify key signs and symptoms of autism in adults
- Know when & how to refer for assessment
- Explain the local assessment process (diagnostic & post diagnostic)
- Be aware of the impact of ASD in daily life (education & employment)

The Market Place

We have invited local mental health organisations from a wide variety of backgrounds and perspectives to participate. You will be familiar with many, but certainly not all. Please take the opportunity to engage with these colleagues who have taken the time to come and who are doing much to support mental wellbeing and tackling mental ill health in our community.

Press to view the Market Place layout

Sheffield Health & Social Care NHS Foundation Trust

Sheffield Health and Social Care NHS Foundation Trust provides mental health, learning disability, substance misuse, community rehabilitation, and a range of primary care and specialist services to the people of Sheffield. We also provide some of our specialist services to people living outside of Sheffield. Our integrated approach to service delivery enables us to meet people's mental, physical, psychological and social care needs.

Download SHSCFT's market place programme by clicking the button below:

SeeAbility

SeeAbility is a specialist registered charity supporting people who have multiple disabilities, including visual impairment, learning and physical disabilities, mental health difficulties, acquired brain injury and life limiting conditions.
With specialisms acquired over 200 years, we are the leading experts in this field.
We believe that everyone has ability. We teach and empower people to develop and maintain their skills to lead meaningful and fulfilling lives.
Our approach takes experience, highly trained staff, dedication and patience.
We see this as an investment in a person's future.

Our expertise

We specialise in supporting people who have a diverse range of multiple needs including autism, brain injury, cerebral palsy, and epilepsy.
We take a holistic approach that addresses the psychological, physiological and emotional needs of each person.
Our highly skilled professional nurses, therapists and rehabilitation practitioners continually seek to broaden and deepen their specialist knowledge to support people more effectively and have developed outstanding awareness and understanding in their respective areas of expertise.
Together with support staff they work as an integrated team and reinforce a learning culture.
We offer this exceptional high quality support in either our own customised accommodation or in a person's home.
For more information please see: http://www.seeability.org

Contact details:

Vikki Kendall
v.kendall@seeability.org
07554 456 330

Sheffield Health Trainer Service

Health Trainers provide you with support to manage your long term conditions. They work with you, rather than issuing instructions for you to follow, and will help you to set your own goals and succeed in the changes you want to make.

Health Trainers can:
Support, encourage and motivate you to change or lead a healthy lifestyle
Support you to self-manage your long term conditions
Offer advice and information on healthy eating and increasing physical activity
Offer advice on losing weight and referral to stop smoking support
Help you to work out exactly what you want to change and how to go about it
Accompany you to first appointments (with other services)
Identify groups or activities in your area
Support you in setting your own health goals
Signpost you to other services.

Health Trainers are understanding and supportive. They will help and encourage individuals to achieve and maintain a healthier lifestyle.
https://www.sheffield.gov.uk/caresupport/health/healthy-communities.html

Contact details:
Aziz Muthana
aziz.muthana@sheffield.gcsx.gocv.uk
0114 293 0682

Miracle Cure

The scheme provides one direct route in order to refer all people that would benefit from more/some physical activity.
Anyone that is aged over 14 and a Sheffield resident can get involved
The aim of the scheme is to reduce the number of inactive individuals in Sheffield by motivating them to build sport and physical activity into their everyday lives.

Timescales will differ for customers depending on their needs however we will contact all customers within 3 days of receiving their referral form.
They will then be given guidance and information over the phone as well as an appointment being made, if appropriate within two weeks to suit them.
There will be a number of routes for them to access, including motivational interviewing, brand new experience sessions, local physical activity and sport sessions and access to some of the best facilities in Sheffield. Activities will range from walking, swimming and dancing to football, badminton, golf and many more. We will endeavour to find any activity a customer may want to try. All of the activities will be free or low cost, again dependent on what they would like to access and who is delivering it.

Each person attending an experience session will get a free life card.

Website:
www.movemoresheffield.com/miraclecure

Contact details:
Rebecca Trevor
Rebecca.trevor@sheffield.gov.uk
0114 273 4266

SOHAS

SOHAS is a registered charity (no.1085464) that was established 34 years ago and is based at Furnival House in the city centre.
We run the cities job retention service which is based in GP surgeries across the city.

The main objective of the service is to provide support and advice for the people whose health is affected by their work and to help and support them to keep their job. Our work is funded by Sheffield City Council, Sheffield IAPT and Macmillan Cancer Care. The help and support we provide is free and confidential and people can be seen at a GP surgery or at our offices and is accessible for anyone who works or lives in Sheffield. We have advisors in 32 GP surgeries and receive patients from all GP surgeries from across the city.

We work closely with GPs and other primary care practitioners and in the last financial year we gave advice to 1800 people of which a significant number of people suffer from mental health conditions, we also provide support on a wide range of issues physical and cancer issues, injuries at work and disability discrimination.

Website:
www.sohas.co.uk

Contact details:
Nick Pearson
Nick.pearson@sohas.co.uk
0114 27 55 760

St Wilfred's Centre

"St Wilfrid's Centre is a charity day centre supporting homeless, vulnerable and socially excluded people in Sheffield. The Centre provides practical support, a sense of belonging and a diverse range of activities to develop life skills. We are proud of our magnificent skills workshop where bespoke pieces are handcrafted to the highest quality and where our clients are offered opportunities to acquire skills which could assist them in finding future employment."

Please see attached link to the St Wilfrid's Centre website which is as follows:- http://www.stwilfridscentre.org/

Contact details:

Deb Leonard

Deb.leonard@stwilfridscentre.org

0114 2 555 720

IAPT

Improving Access to Psychological Therapies (IAPT) aims to provide psychological treatments to help people who are stressed, be that feeling low in mood (depressed) or very nervous (anxiety).

IAPT have three types of workers: Psychological Wellbeing Practitioners, Cognitive Behavioural Therapists and Counsellors. IAPT try to offer their service in different ways to suit different people, e.g. online treatments, large Stress Control evening classes, small workshops, telephone treatment, as well as more standard face to face treatment.

Website:
www.sheffieldiapt.shsc.nhs.uk

Contact details:
Steve Reaney
Steven.reaney2@shsc.nhs.uk
07854 594 071

Social Prescribing Service (SOAR / North Locality)

SOAR is a charitable social enterprise operating across North Sheffield.

SOAR delivers a range of services including:

Health
Training
Employment
Volunteering

SOAR aims to integrate service delivery by providing and coordinating access to a range of services provided internally and by its partner agencies via a single point of access.

The model has a 'no wrong door' policy which means that clients can access SOARs services through any of the individual services involved.

website: www.soarcommunity.co.uk

Contact details:
Guy Weston – *SOAR Health Services Manager*
Guy.weston@soarcommunity.org.uk
0114 213 4065

Share Psychotherapy

Share Psychotherapy aims to promote good mental health for the public benefit through the provision of psychotherapy at as low a cost as possible for those who are unable to afford it through lack of means or who are otherwise in need.

We currently offer brief and long-term individual psychotherapy in a range of modalities including, psychoanalytically informed psychotherapy, dynamic interpersonal therapy and person-centred psychotherapy, group psychotherapy and art therapy.

Further information about Share Psychotherapy and the services we provide can also be found on our website at http://www.sharepsychotherapy.org/

Contact details:
Pam Johnson – *Office Manager*
office@sharepsychotherapy.org
0114 273 0200 - Monday to Thursday 10am to 3pm

Sheffield Adult Autism and Neurodevelopmental Service (SAANS)

Recognising Strengths and Abilities

While people with an ASD experience significant difficulties in key areas of functioning, unique abilities and strengths associated with the condition are also increasingly recognised. Some people with an ASD have been outstanding achievers, usually because of their original and creative thinking style. With the right support and understanding, our team believe that adults with an ASD can succeed in higher education and the workplace, as well as enjoy meaningful relationships.

Psychometric Assessment

Our service also undertakes psychometric assessments in order to explore intellectual functioning, strengths and difficulties. This can provide important information for the purposes of diagnosis, as well as informing ongoing care and support needs.

Post-Diagnostic Support

In some cases where there are particularly high levels of need, we offer time-limited support after a diagnosis has been given. The nature of this support will be determined by the individual's specific needs.

Specialist Counselling Service

The team also offers specialist counselling, aimed at supporting individuals to address a broad range of emotional, social and behavioural difficulties that are commonly associated with Autism Spectrum Disorders. Trainee therapists can also contribute to this service while on specialist placements in the team.

Group Support

The service will also offer a range of groups to help people learn strategies and manage their condition. These will include groups for social and problem-solving skills, dealing with a new diagnosis of ASD and parent support. We recognise that some individuals with an ASD might have difficulty with group-based interventions so will aim to offer similar support on an individual basis.

Website:
shsc.nhs.uk/service/sheffield-adult-autism-and-neurodevelopmental-service/

Carers in Sheffield

Carers in Sheffield is a partnership of local voluntary organisations providing information and support to adult carers of adults in Sheffield. The organisations involved in delivering the Carers in Sheffield service are:

Sheffield Carers Centre
Sheffield Mencap and Gateway (The Sharing Caring Project)
Sheffield Mind
Roshni
Sheffield African Caribbean Mental Health Association
Pakistan Advice and Community Association
Maan (Somali Mental Health)

We offer:
Carer Support and Information, legal advice sessions, debt advice sessions, counselling service ,carer support groups ,telephone befriending, a monthly carers café, 'Time for Me' carers breaks grants, and a quarterly newsletter.

The careers Centre Website is www.sheffieldcarers.org.uk

Contact details:
Jan Outram
jan@sheffieldcarers.org.uk
0114 27 88 942

Sheffield Mind

Sheffield Mind is an independent charity, affiliated to Mind nationally (mind.org.uk).

We believe that good mental health is fundamental to living a healthy and fulfilling life and to having positive relationships with those around us. We recognise the close link between physical and mental health and offer a range of services and support to enable people to lead healthy and fulfilling lives. We also believe that everyone can do a lot to improve their mental health and we promote self help and empowerment as a route to prevention and recovery.

Sheffield Mind runs the Sheffield Mental Health Guide, an online resource for professionals and service users, offering comprehensive information on mental health services in Sheffield. www.sheffieldmentalhealth.org.uk

The Sheffield Mind Counselling & Therapy service offers individual and group therapy designed to suit the needs of each individual.

In addition, we run a wide variety of community-based activities and courses through our Mind & Body project, we are involved in 3 social cafes city-wide, we support carers through

Mental Health Street Triage

The Response to Mental Health Crisis

The importance of the response to those in mental crisis in difficult to overstate. Frequently, the police service and colleagues from the Ambulance service are among the first 'on scene'. As such it is vital that such a response is as well informed as possible, in order to make sure that any decisions made are in the best interests of the patient, with due regard to the law and codes of practice.

Within South Yorkshire, one of the measures introduced (January 2014) is what is known as a 'Street Triage' scheme.
In partnership with Sheffield Health and Social Care, this project puts a police officer and an appropriately qualified MH practitioner into a single resource, which can attend reports of a person in mental crisis.

Working together, SYP and SHSC can identify those in need at the earliest opportunity, signposting and referring to appropriate intervention, and using their joint skills to ensure that people are treated by the most appropriate person, first time, every time.

Visit our stall to meet some of the team, discuss what outcomes we have achieved already, and what the future holds for the project.

Sheffield Women's Counselling & Therapy Service

We are a specialist service providing free, confidential counselling and therapy services for women in Sheffield who have experienced abuse or trauma Our services are for women and girls in Sheffield aged 16 and over. At our discreet and welcoming centre we offer a safe, quiet, comfortable space to work with a counsellor or therapist to explore the impact that abuse and trauma has had on your life.

We know it can be hard to find help and you may have worries about coming for counselling. We particularly encourage women to use our service who, for whatever reason, find it difficult to access other services.

For more details of how we work please visit http://www.swcts.org.uk/

Sheffield Citizens Advice Mental Health Unit and Advocacy Service

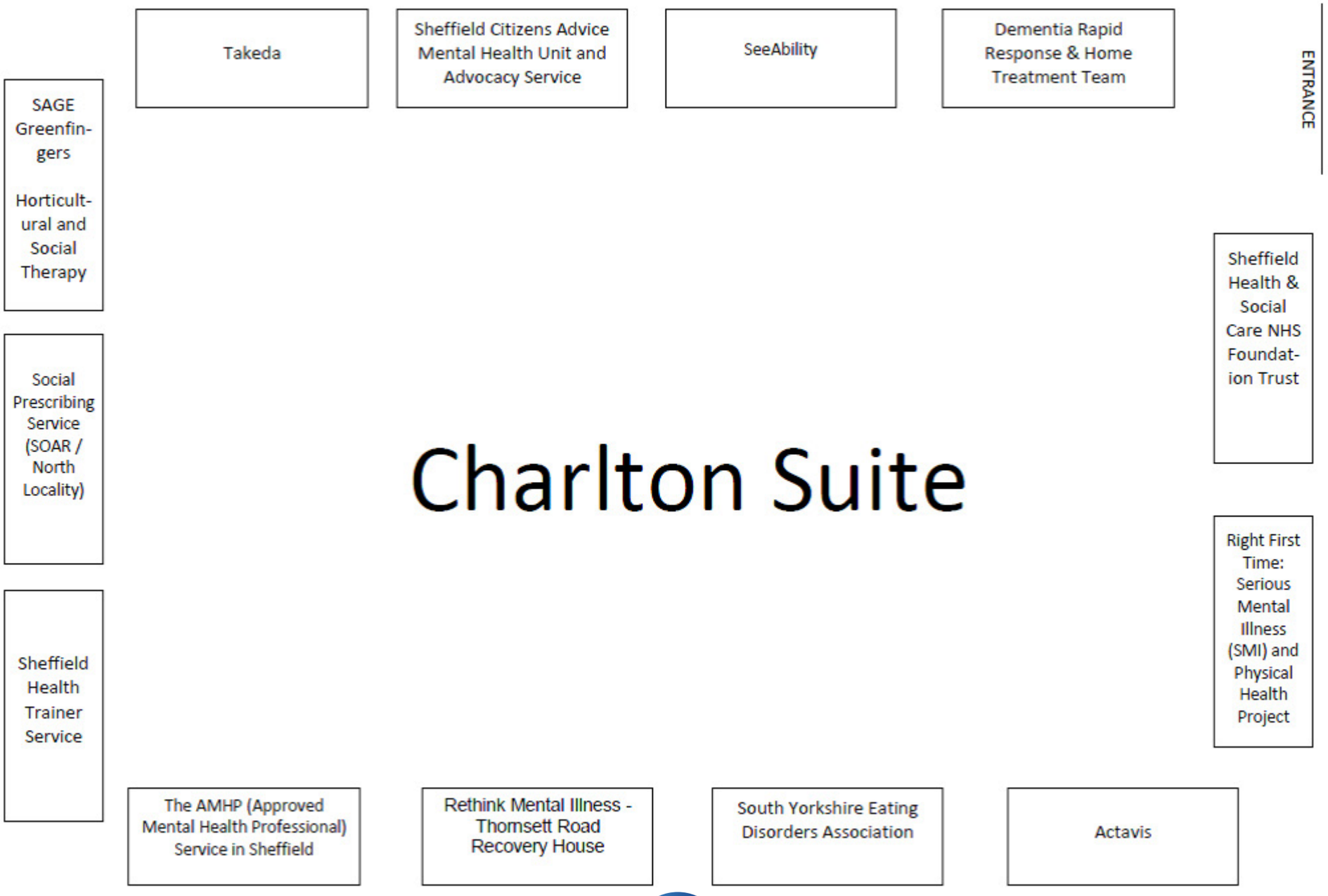
The Mental Health Unit is part of the Sheffield Citizens Advice Service. It provides welfare rights advice and independent advocacy for mental health service users in the city including IMHA, IMCA and DOLS paid representatives. The unit is based a the Michael Carlisle and Longley centres. Our phone numbers are, ***0114 271 8025*** for CAB answer machine and Freephone ***0800 035 0396*** for the Advocacy Service or via our website at www.smhcab.org.uk

Learning Disabilities Services SHSC

This stall will incorporate information from the following services:

Community Learning Disability Team
Respite Care Services
Community Nursing
Breast Awareness
Physiotherapy
MH and Wellbeing
ISS

The Market Place Floor Plan



Protected Learning Initiative: Mental Health

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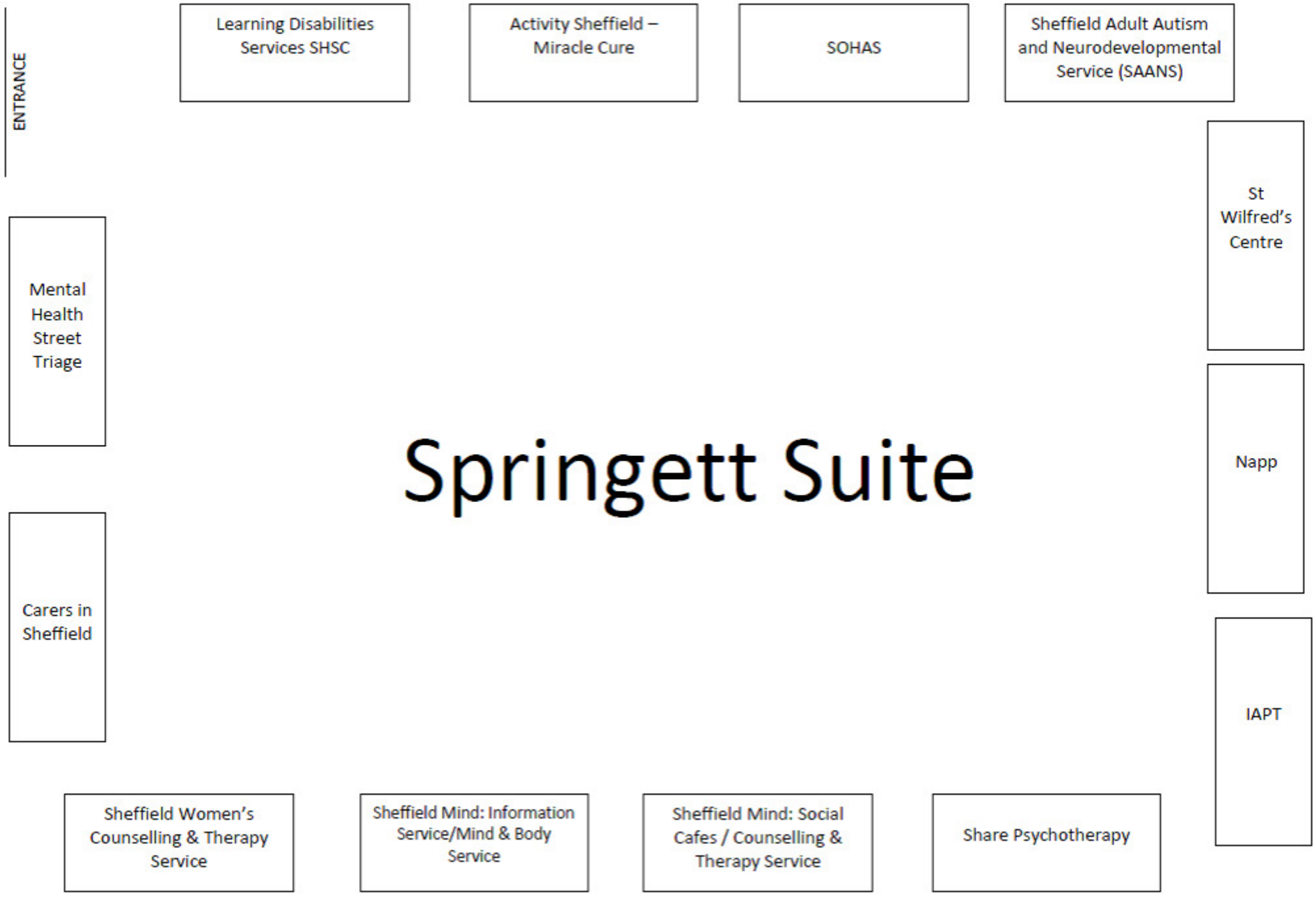


Working with you to make Sheffield HEALTHIER

Workshops and Presentations Menu

Welcome to the workshops and presentations menu.

Please select your desired presentation or workshop by pressing one of the following buttons.

Key Note Presentation

Workshop 1

Assessment and Mitigation of Suicide Risk in Primary Care

Workshop 2

Eating Disorders in Primary Care

Workshop 3

Physical Health/MH for Practice Nurses

Workshop 4

Common Mental Illness and Prescribing

Workshop 5

Personality Disorder Presentation

Workshop 6

Autism Spectrum Disorder

Key Note Presentation

Right First Time

Transforming the way Health and Social Care is delivered

Sheffield City Council

Sheffield Health and Social Care NHS Foundation Trust

NHS

Improving the Physical Health of people with SMI in Sheffield

Dr Jonathan Mitchell
Consultant Psychiatrist
East Glade
On behalf of RFT project 4 group

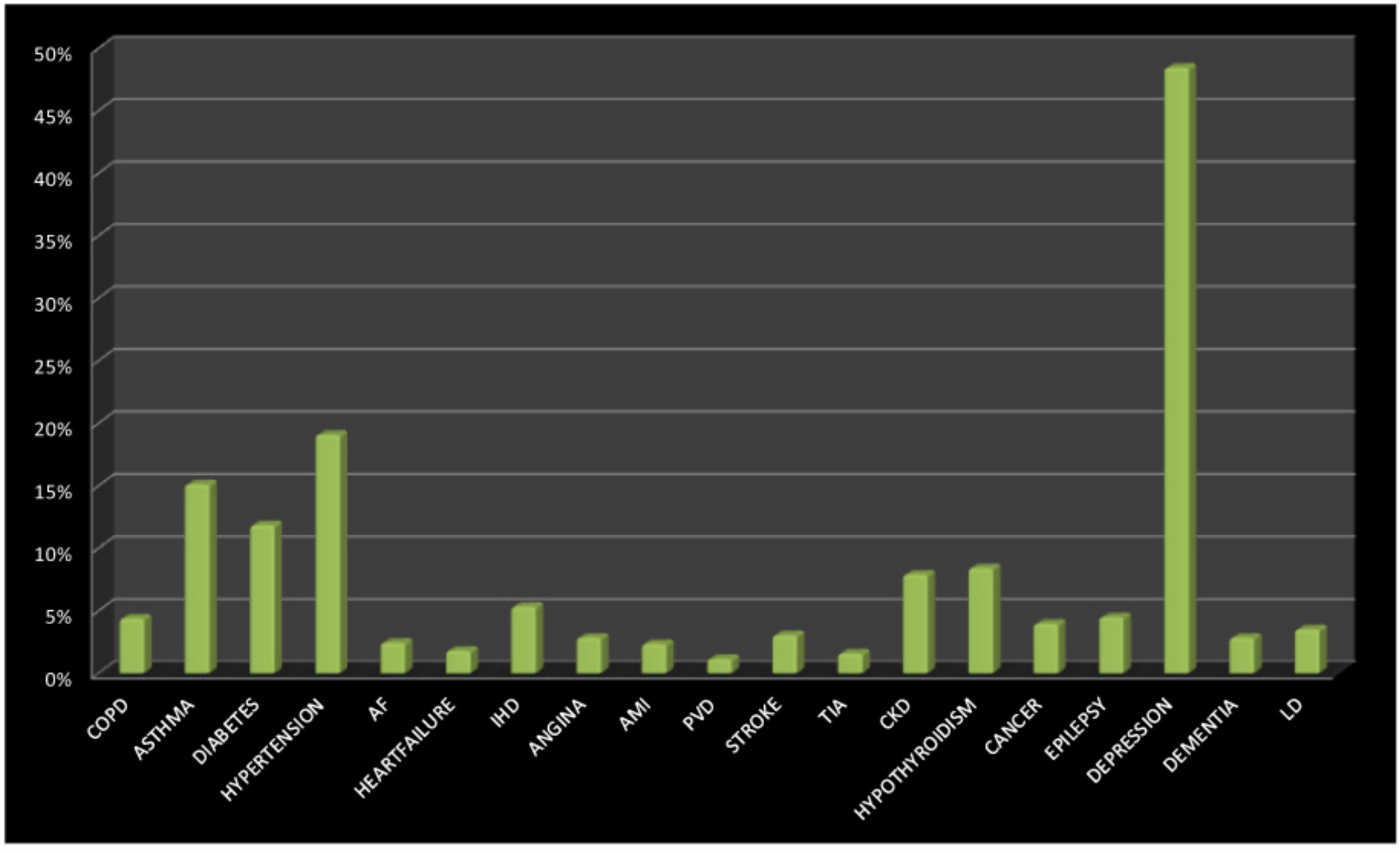
3rd September 2014

- What do we know about the physical health of people with SMI in Sheffield?
    - Statistics
    - What people say
- What have we been doing?
    - Annual physical health reviews
- What are we doing in Sheffield to improve?

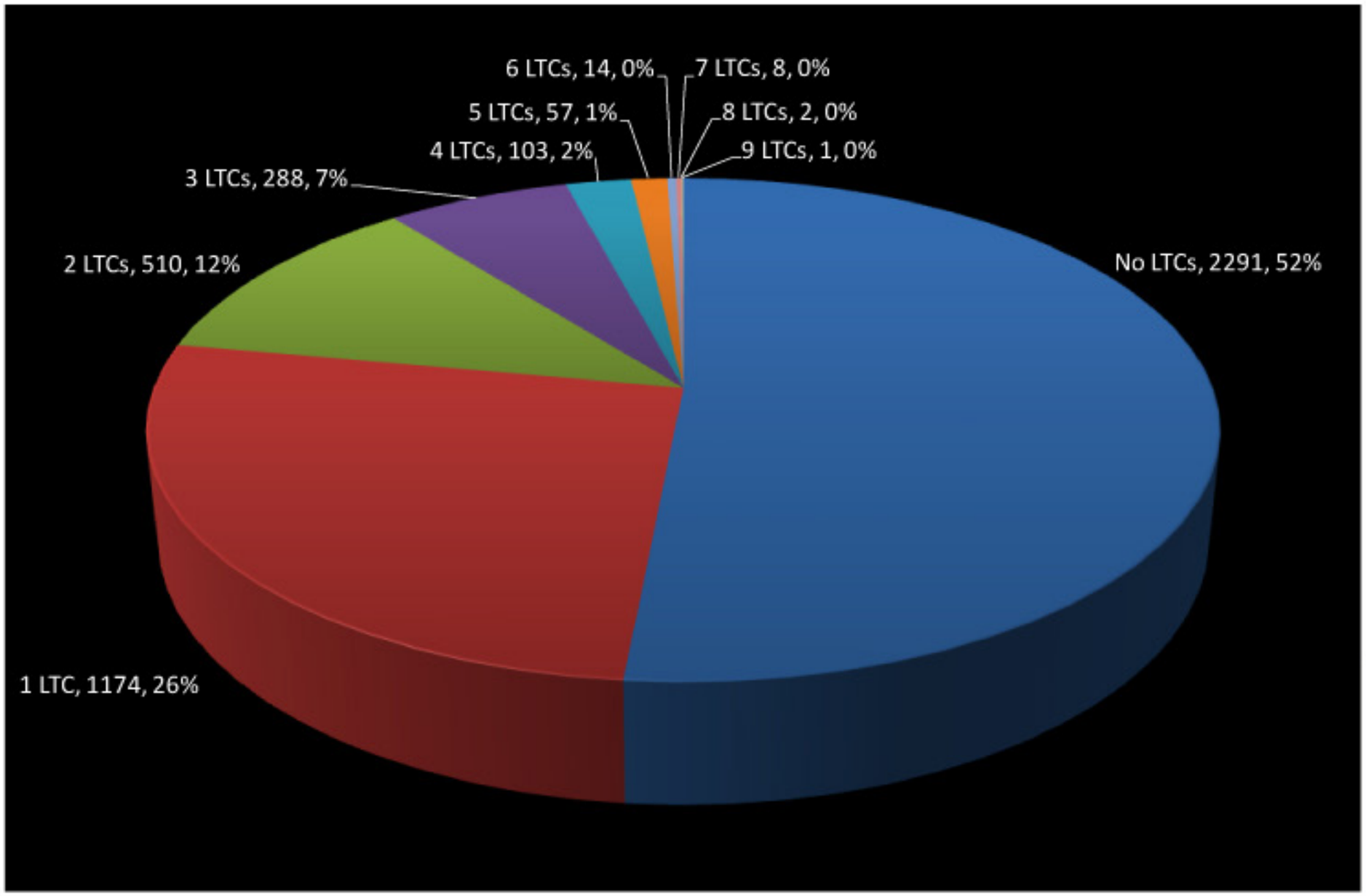
What do we know?

- Sheffield population – 582908
- 4683 on SMI registers
- Approx 2250 SHSC recovery teams (not all SMI)
- Relatively high premature mortality rate in Sheffield compared with other cities
  - Sheffield 988 per 100000
  - Manchester 498 per 100000
  - Birmingham 643 per 100000

Prevalence of co-morbid conditions in the Sheffield SMI cohort



Prevalence of multiple chronic conditions in the Sheffield SMI cohort



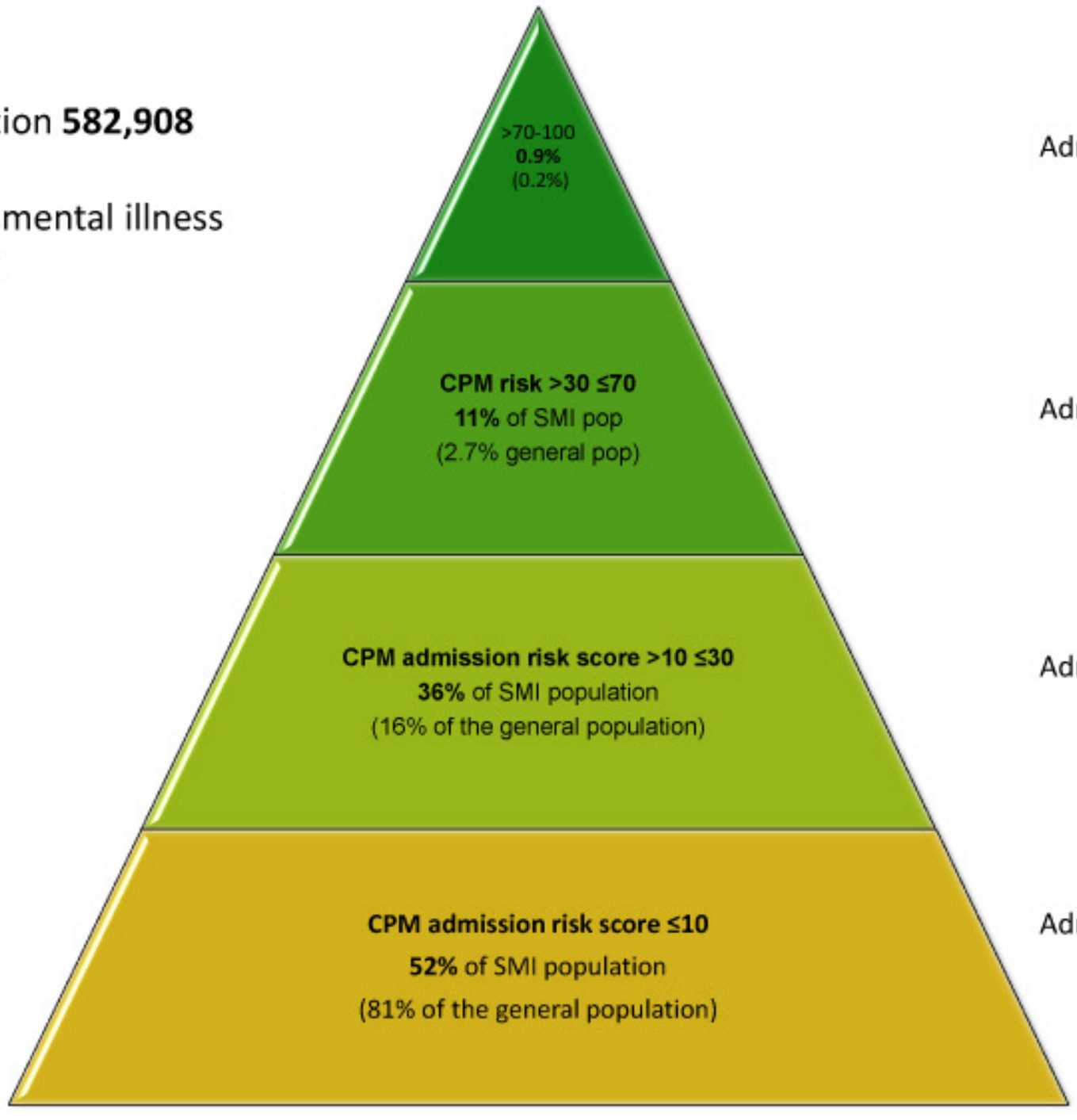
LTC = one or more of:
COPD
ASTHMA
DIABETES
HYPERTENSION
AF
HEARTFAILURE
IHD
PVD
STROKE
FH
CKD
HYPOTHYROIDISM
EPILEPSY
DEMENTIA

Sheffield SMI population stratified hospital admission risk

At March 2014

Sheffield total population **582,908**

People having serious mental illness on a GP register **4,683**



Admissions ~19 x pop average

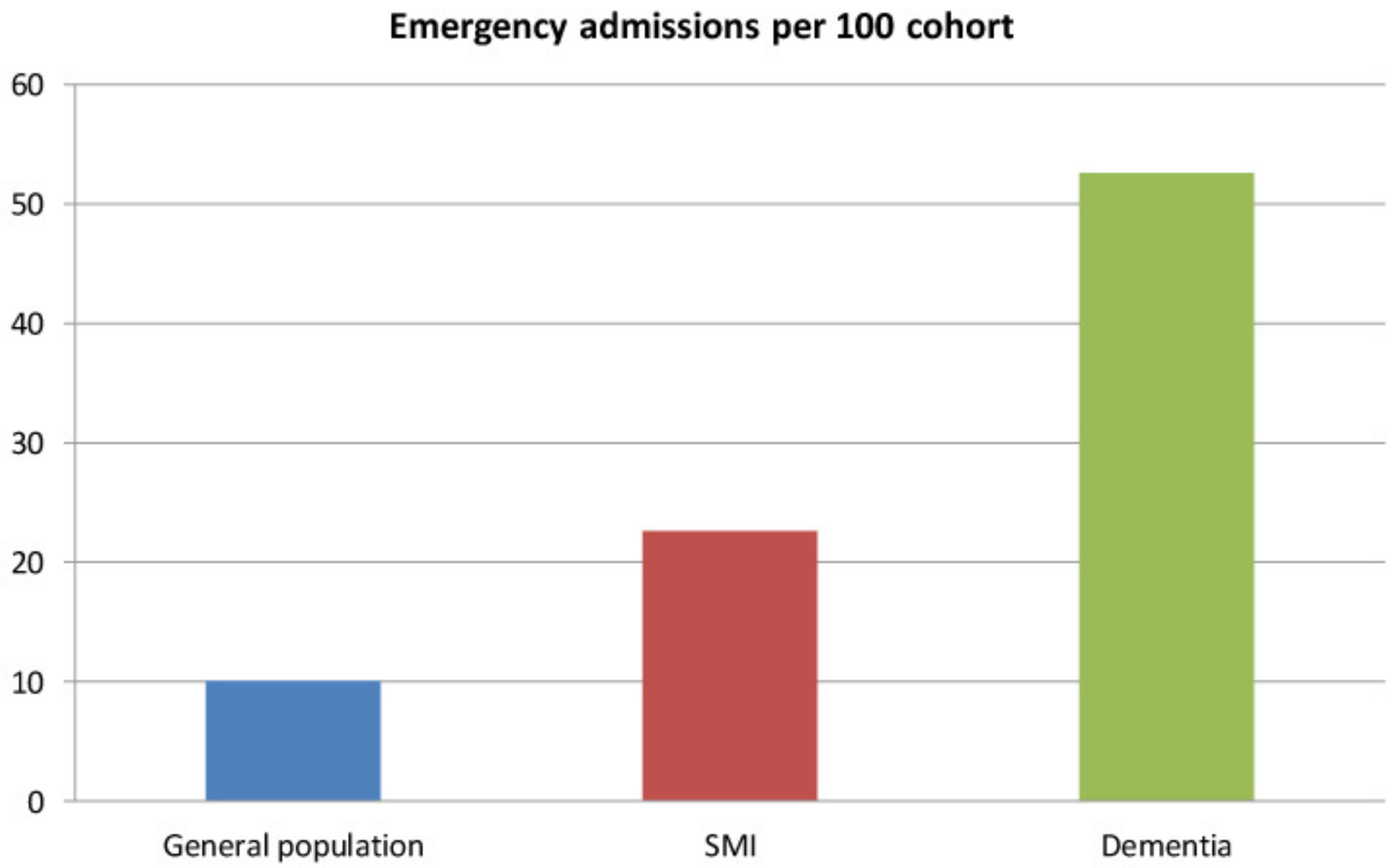
Admissions ~5.5 x pop average

Admissions ~1.7 x pop average

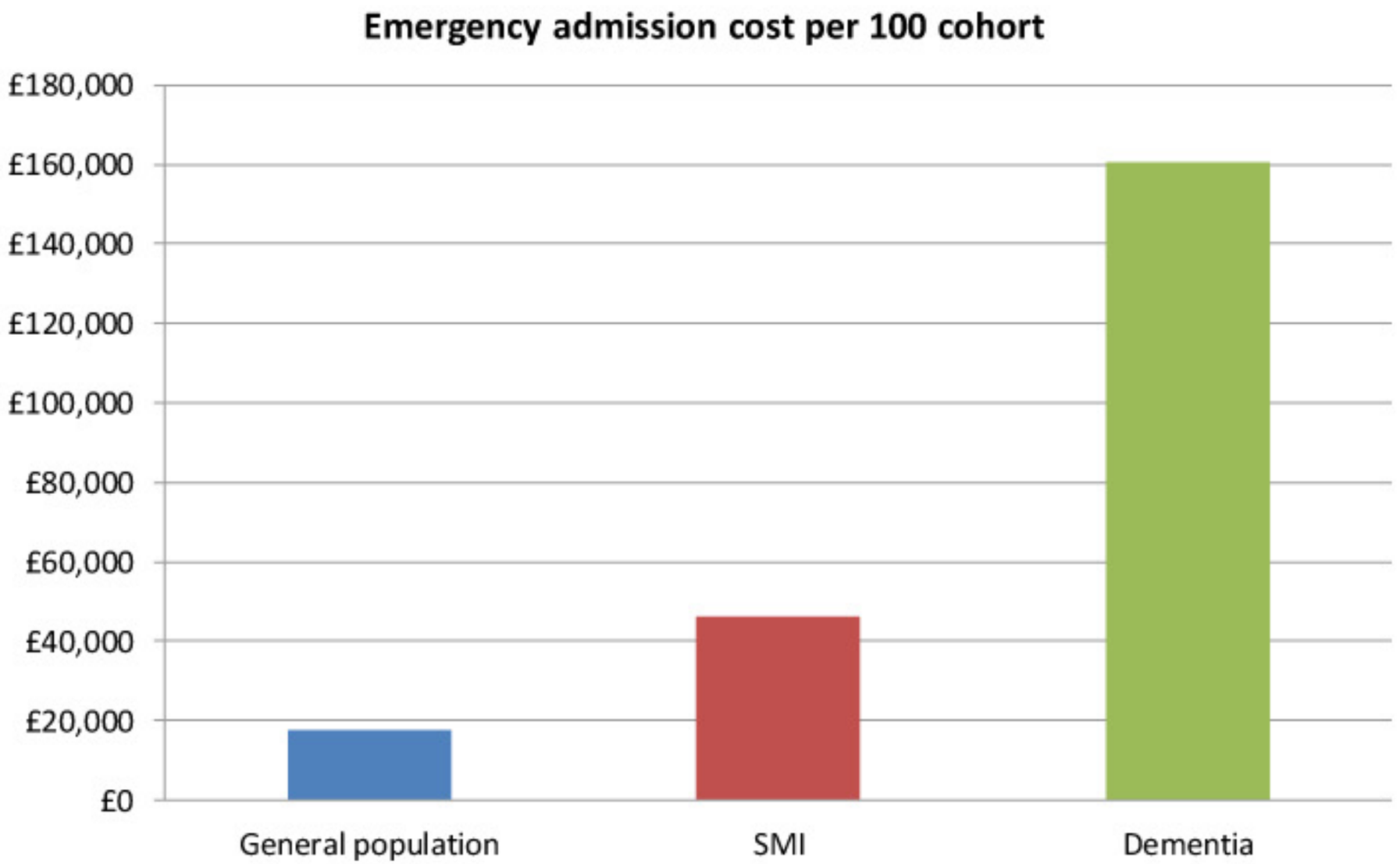
Admissions ~0.5 x pop average

CPM = Combined Predictive Model

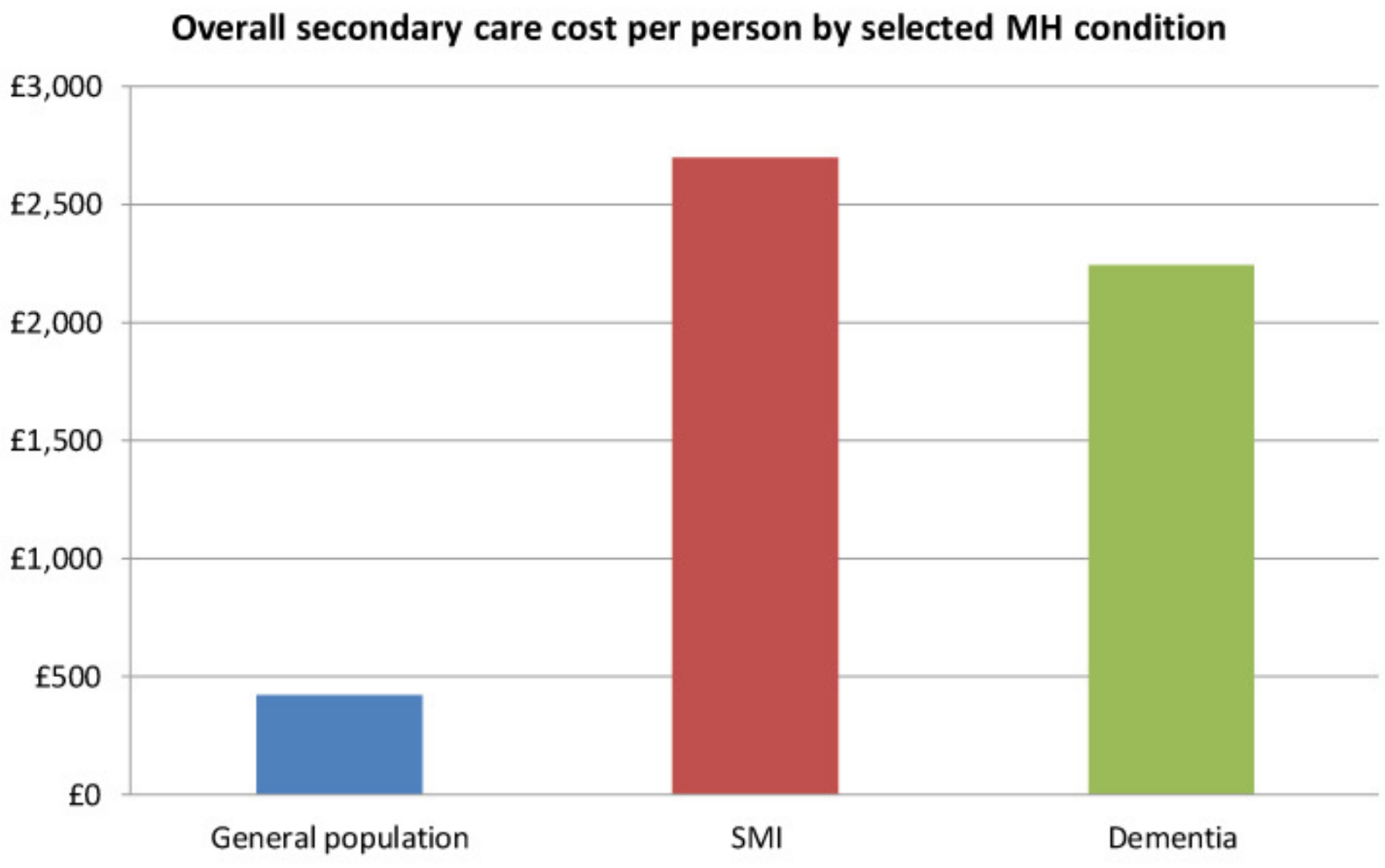
Comparative emergency admission rates 2013/14



Comparative emergency admission costs 2013/14



Comparative cost of secondary care in 2013/14



Secondary care costs includes all expenditure on elective inpatient spells, A&E attendance, emergency admission spells, outpatient attendance and psychiatric admissions.

What do people say?

- RFT survey - 48 people
  - Most felt exercise and diet important
  - Many reported barriers
  - Some felt weren't given enough info
  - Some people didn't know about annual health checks and feedback on them was mixed

Positive about health checks with GPs

- It’s good to get your results back and if you’re in the clear it gives you a boost- having the results is informative
- It’s a good opportunity to monitor my medication and side effects

Negative about health checks with GPs

- Time spent was too brief and once a year isn't enough to address issues
- Received poor guidance from GP even when results were bad
- Had a bad experience once at the GP's therefore avoid all appointments with them.
- Physical problems are not taken seriously as they know I have a mental health problem

National Audit of Schizophrenia Survey

- The people who give you physical health care should listen to you, show you respect and take your condition seriously

  - National 84% agreed

  - Sheffield 65% agreed

What have we been doing?

- Annual health review of cardiovascular and metabolic risks in primary care, share findings with CMHT
- CMHT review at CPA/care plan reviews
- If not done…
    - CMHT encourage to attend
    - CMHT support to attend
    - CMHT to do the health review

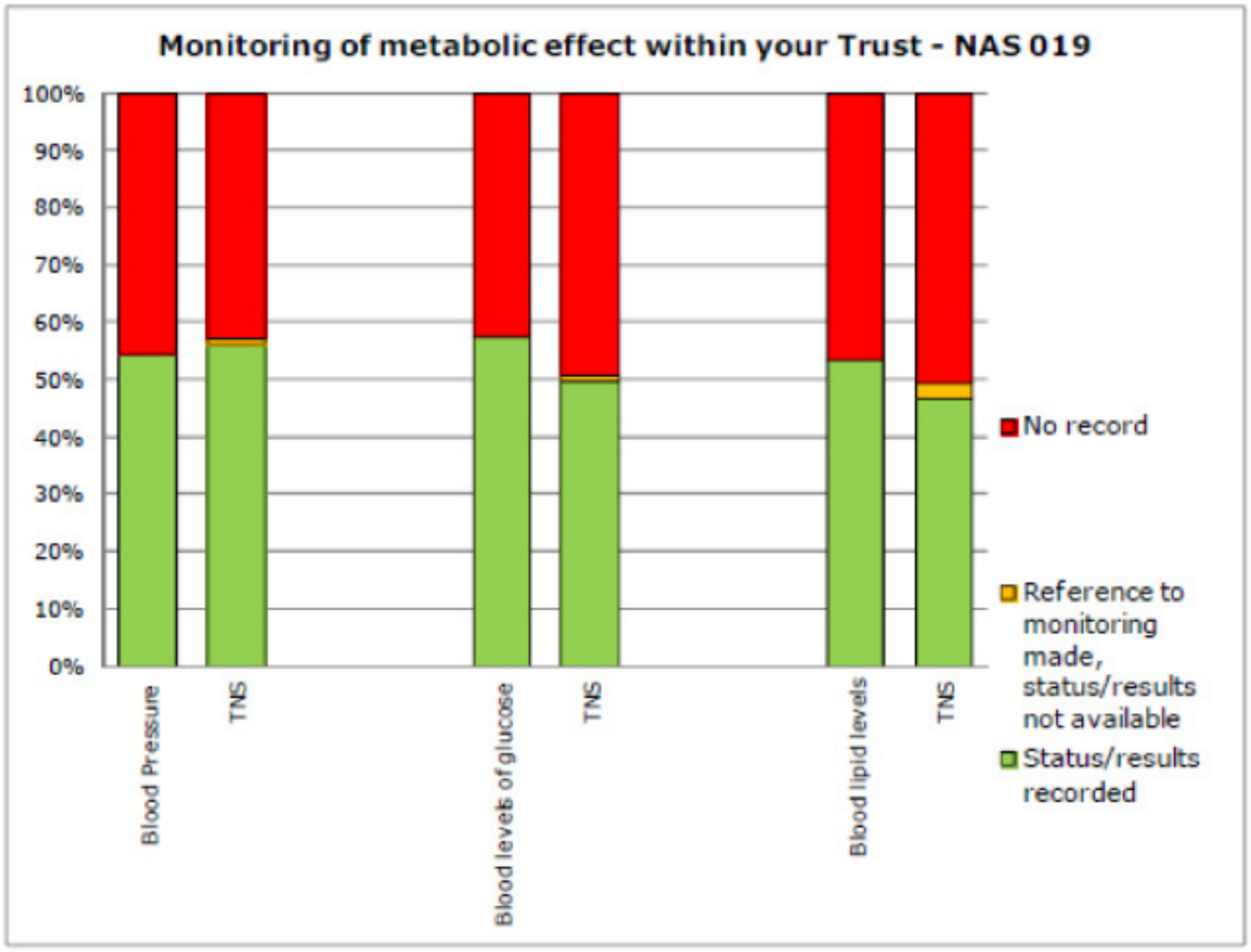
Is our approach working? – CMHT audit

- 218 people on CPA
- 150 had forms completed by GP
- 91 forms stated health check done in the last year, but didn't always include all relevant checks

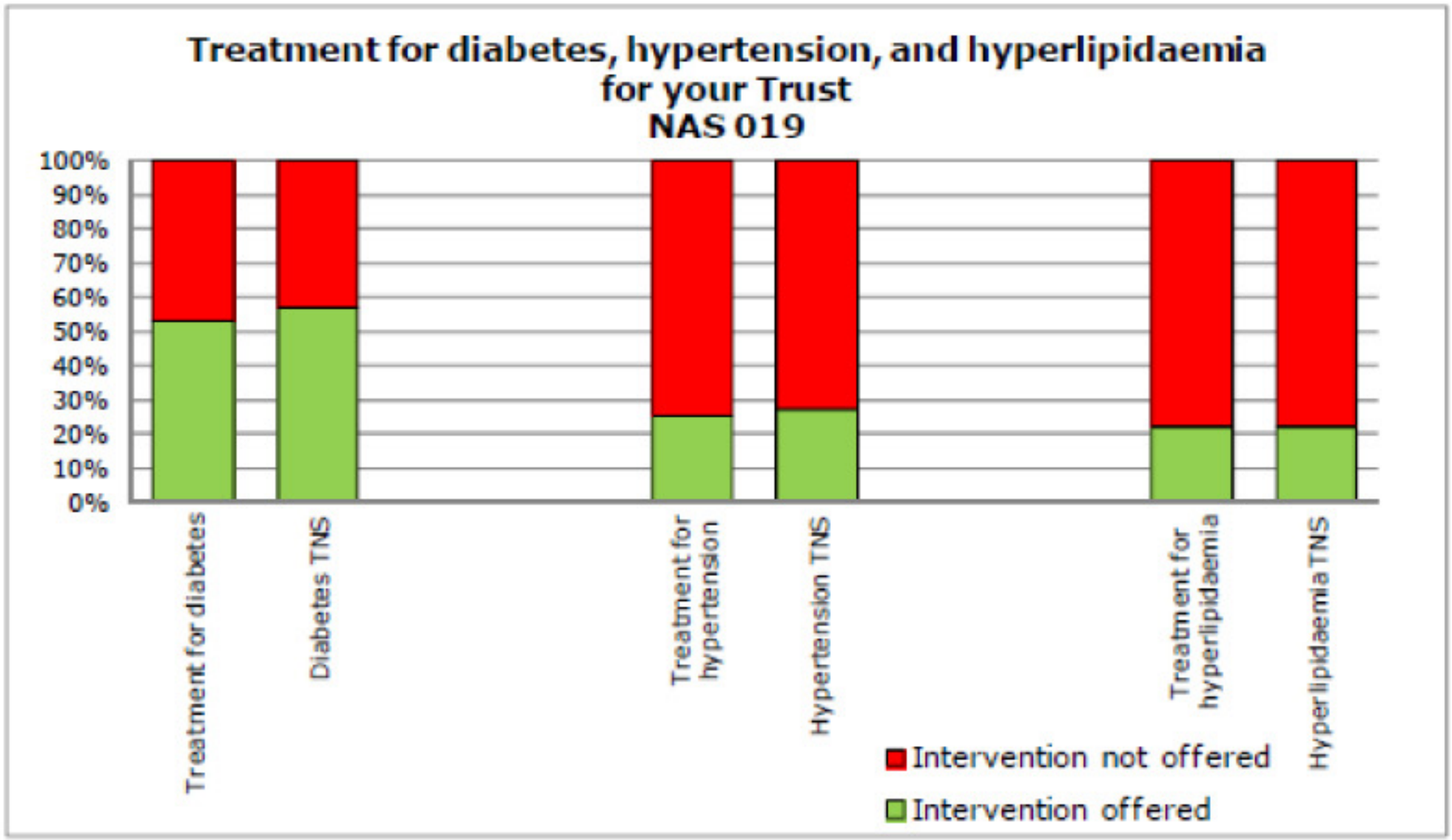
Is our approach working? – RFT audit

- 3 practices/2CMHTs, 51 people
- 6 cardiometabolic indicators
    - Smoking,BMI,BP,Lifestyle,Glucose,Lipids
- Variable rates for each indicator
- More info in primary care notes for most indicators
- BUT
    - Only 2 people had ALL 6 indicators
    - 8 people had none recorded

Is our approach working? - NAS



Is our approach working? - NAS



Is our approach working?

- Could do better
    - Information sharing
    - CMHTs need to take a bigger role
    - Collaborative working
    - Intervention

What are we doing to try to improve?

- SMI template for SystmOne & EMIS
  - Comprehensive physical health review
  - Simple report for care planning
- Updating letters/templates we send to you
  - To ask for the info we need
  - To let you know what you need
- Working with our CMHT and ward staff
  - To raise awareness & clarify responsibility
  - To promote action

What are we doing to try to improve?

- Piloting CDW working with people on SMI registers, not seen by CMHTs
  - *"Surgeries will offer a courtesy call to remind people about blood tests and medication checks but appointments still get missed on a regular basis. I have been doing some work with individuals to set up personal systems to encourage attendance, this may involve simply purchasing a diary, writing reminders on calendars or even escorting to surgery."*

What are we doing to try to improve?

- Developing eLearning package for health and social care staff
- Physical health clinic in assertive outreach team for those who won't attend their GP
- STEPWISE research project

Workshop 1

Assessment and Mitigation of Suicide Risk in Primary Care

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Assessment and Mitigation of Suicide Risk in Primary Care

Dr Zak McMurray
Clinical / Medical Director
NHS Sheffield Clinical Commissioning Group
Mental Health Lead – Woodhouse Health Centre (1995 – 2014)

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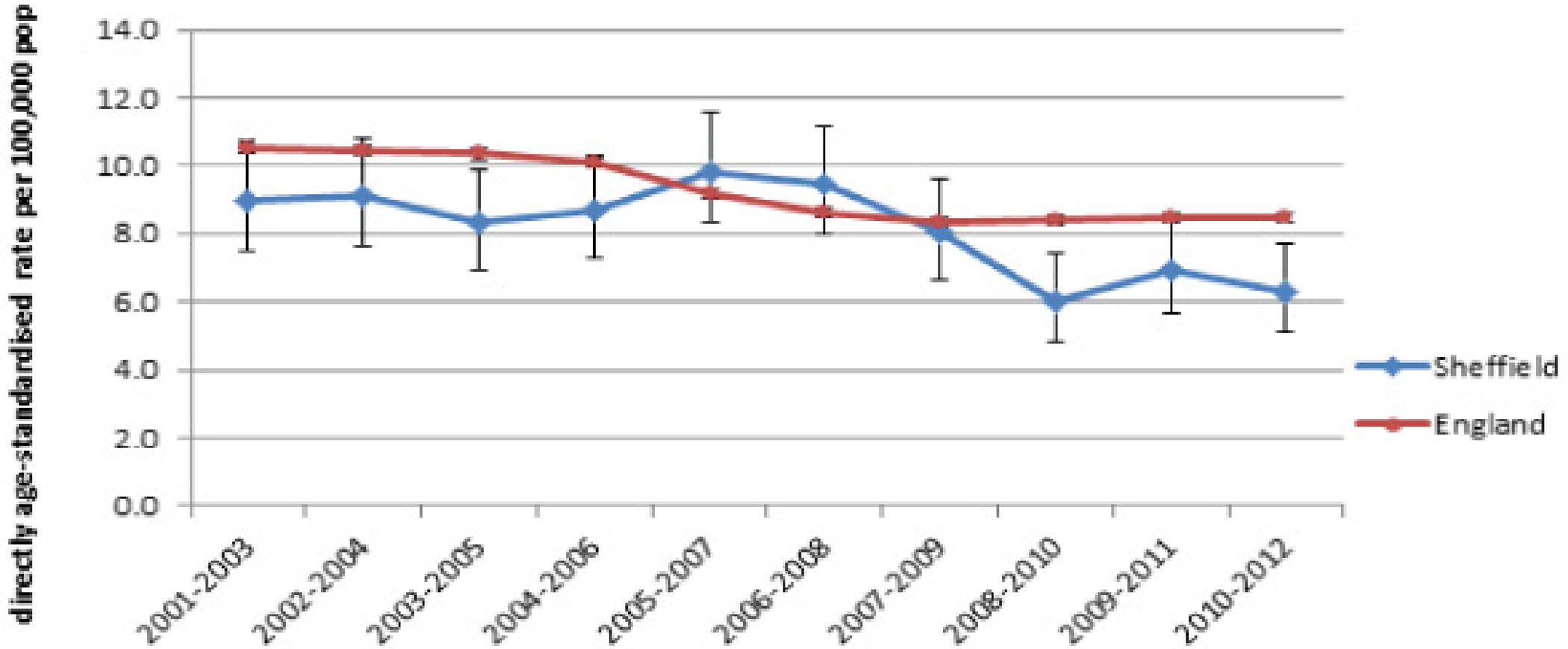
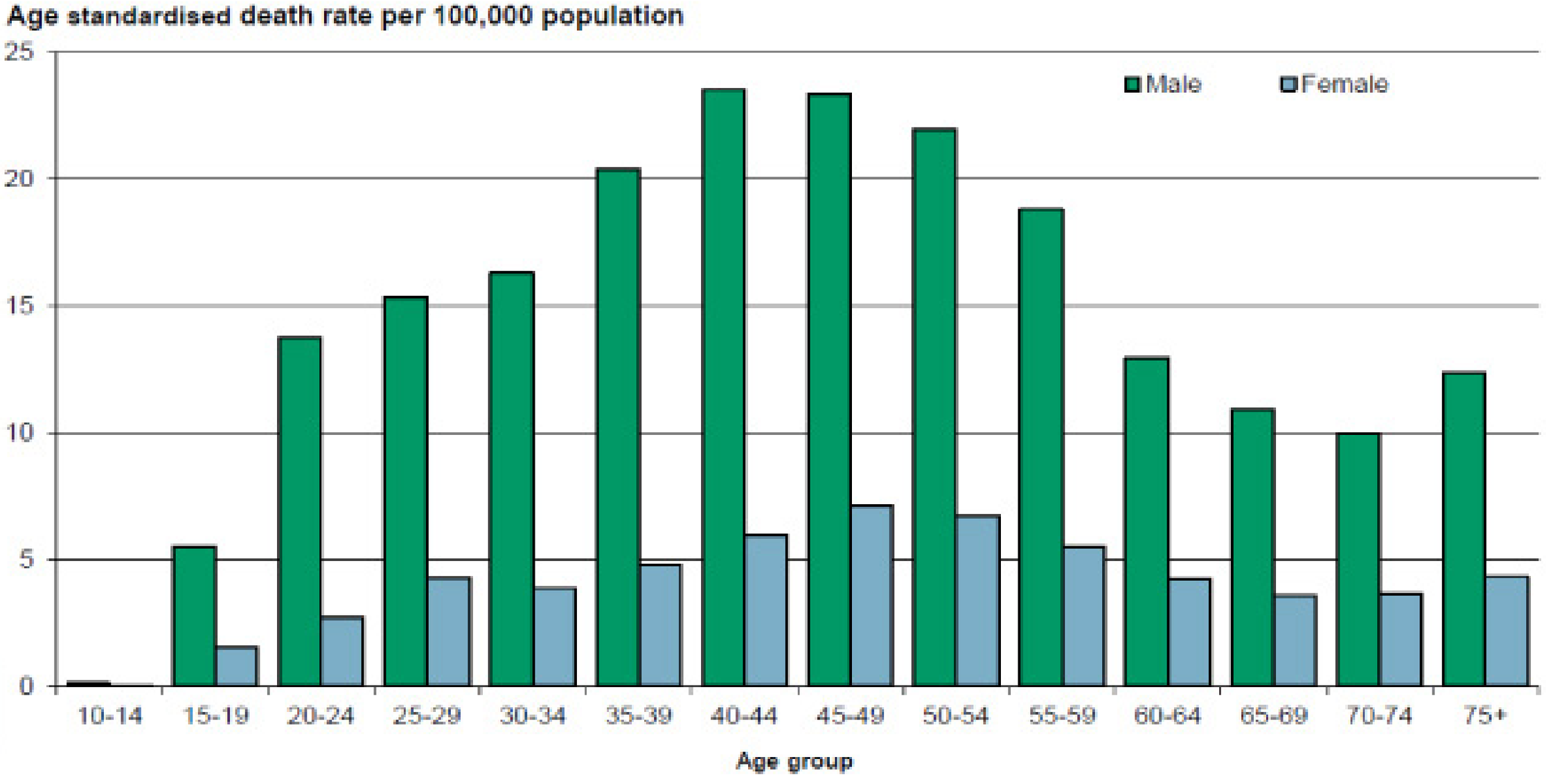
Sheffield and England
Suicides and Injury of Undetermined Intent
2001-2003 to 2010-2012



Source: PHOF Indicator portal

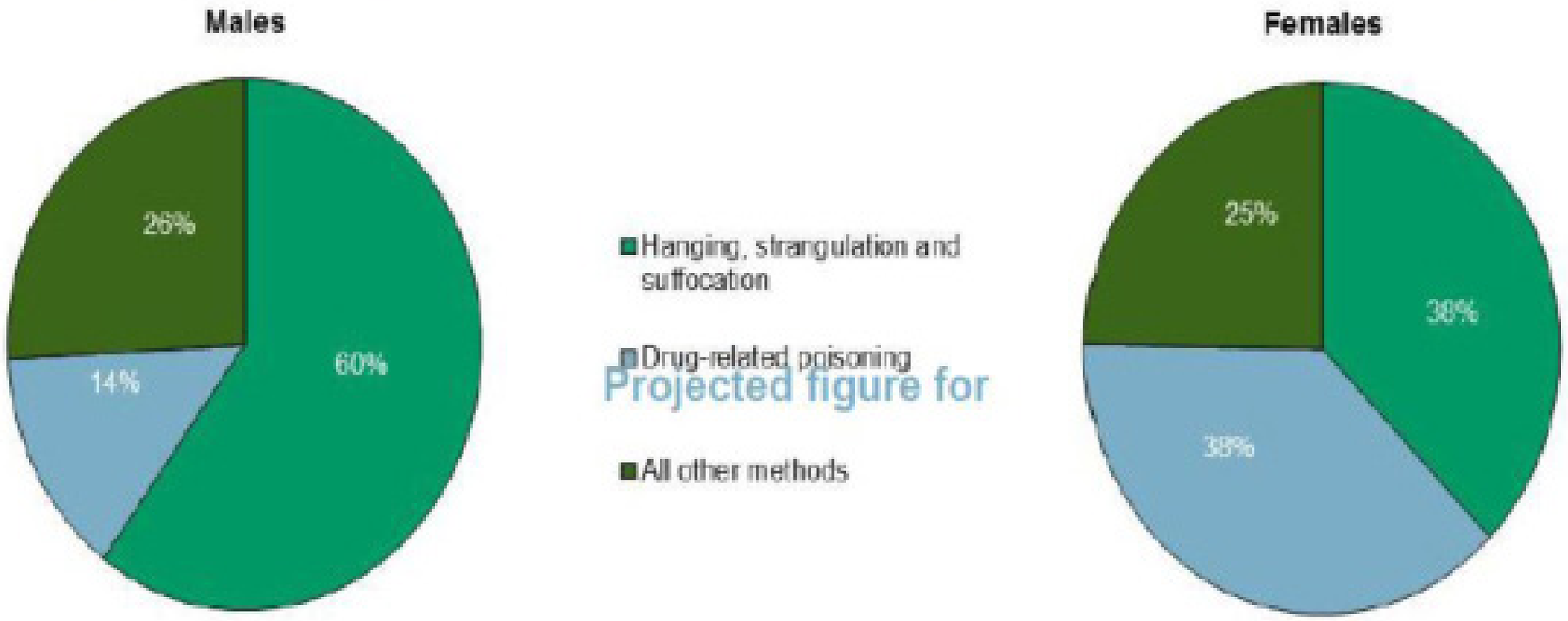
Public Health Intelligence Team, SCC, 19/8/14

Figure 2: Death rates from Intentional Self-harm and Injury of Undetermined Intent by five-year age band and sex, England 2012



Source: ONS (ICD10 X60-X84, Y10-Y34)

Figure 3 Deaths from Intentional Self-harm and Injury of Undetermined Intent by method and sex, England 2012



Source: ONS (ICD10 X60-X84, Y10-Y34)

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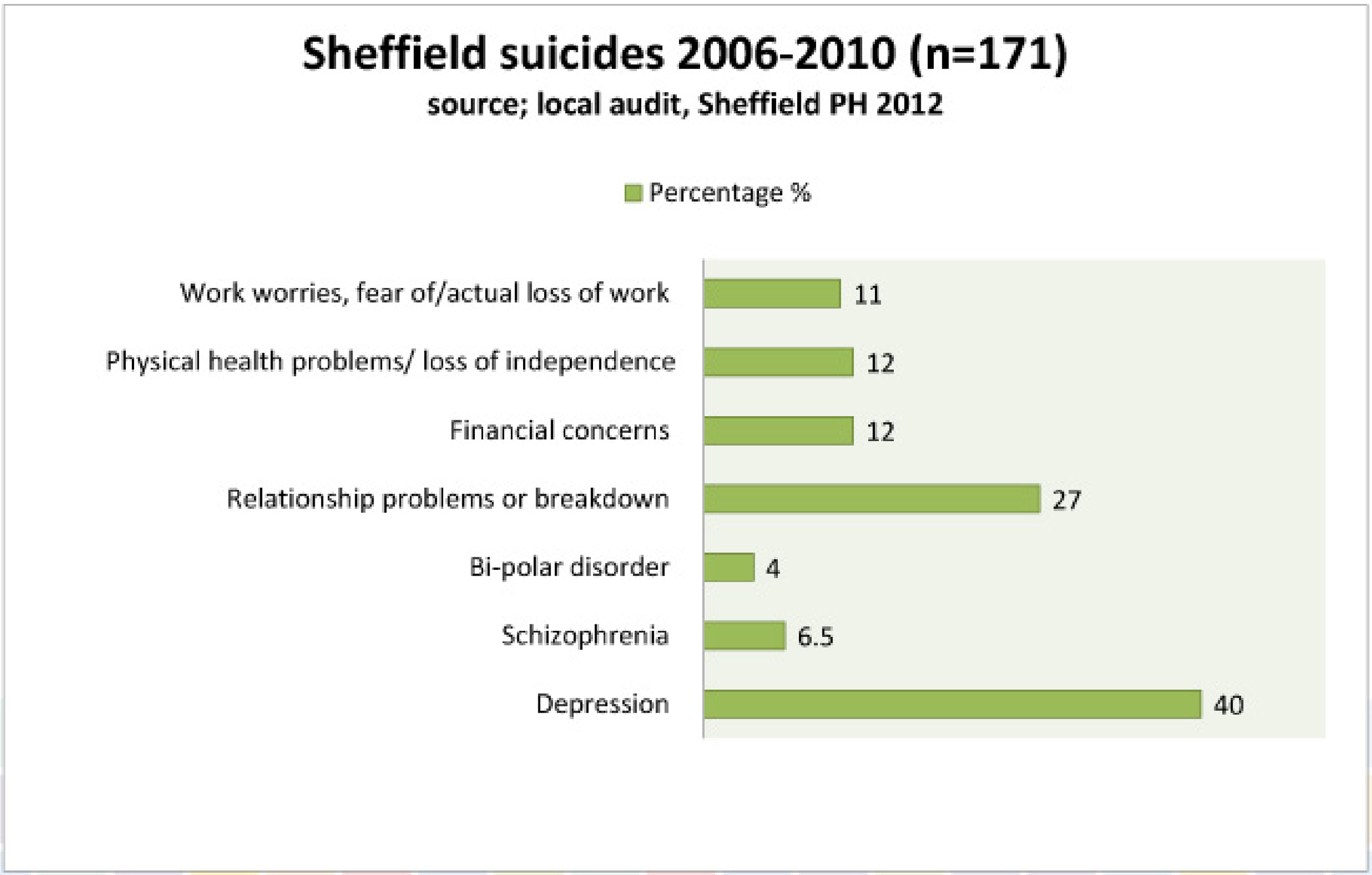
Sheffield suicides 2006-2010 (n=171)

source; local audit, Sheffield PH 2012



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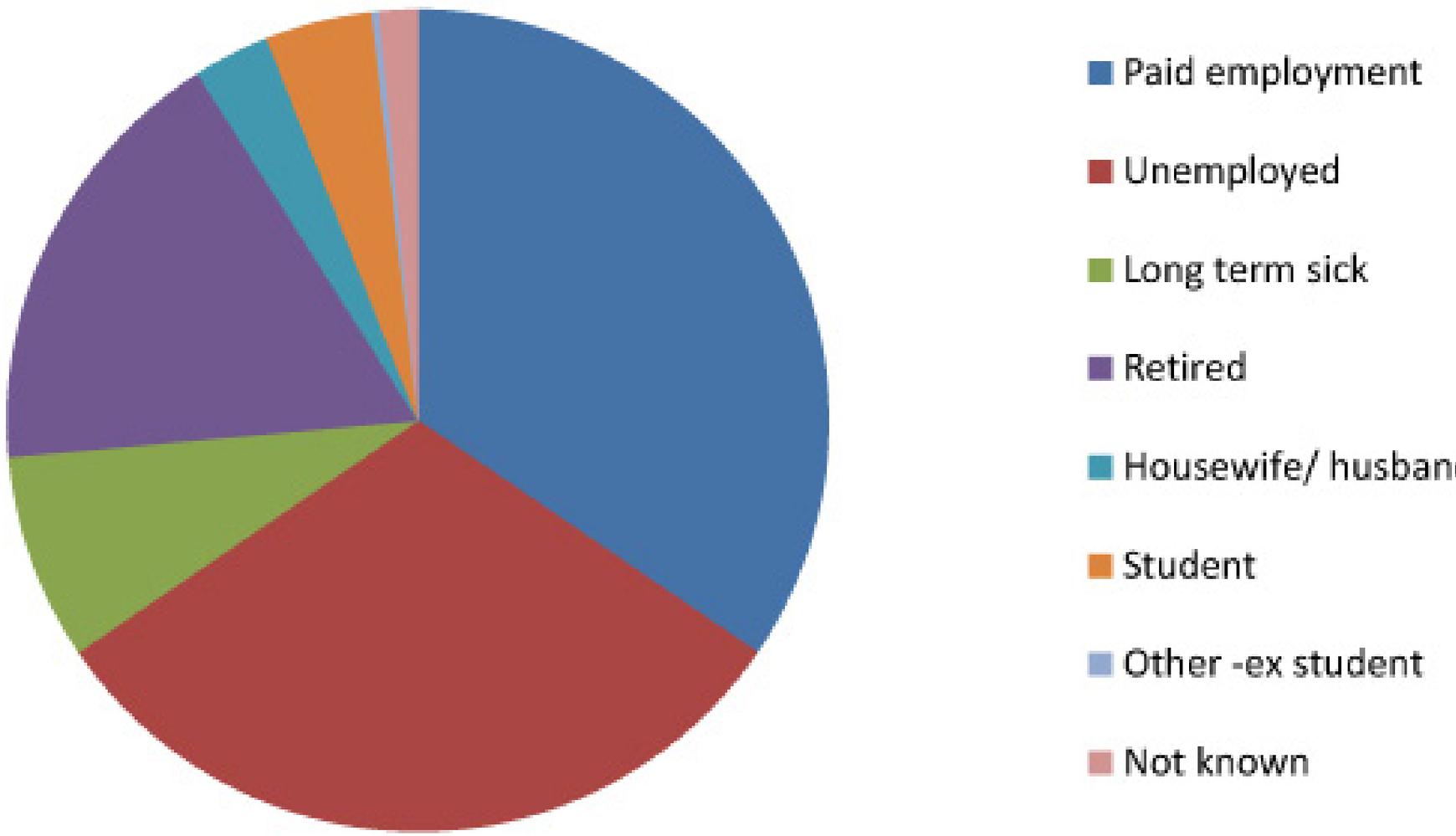
Sheffield suicides 2001-2010 (n=333)

Employment status



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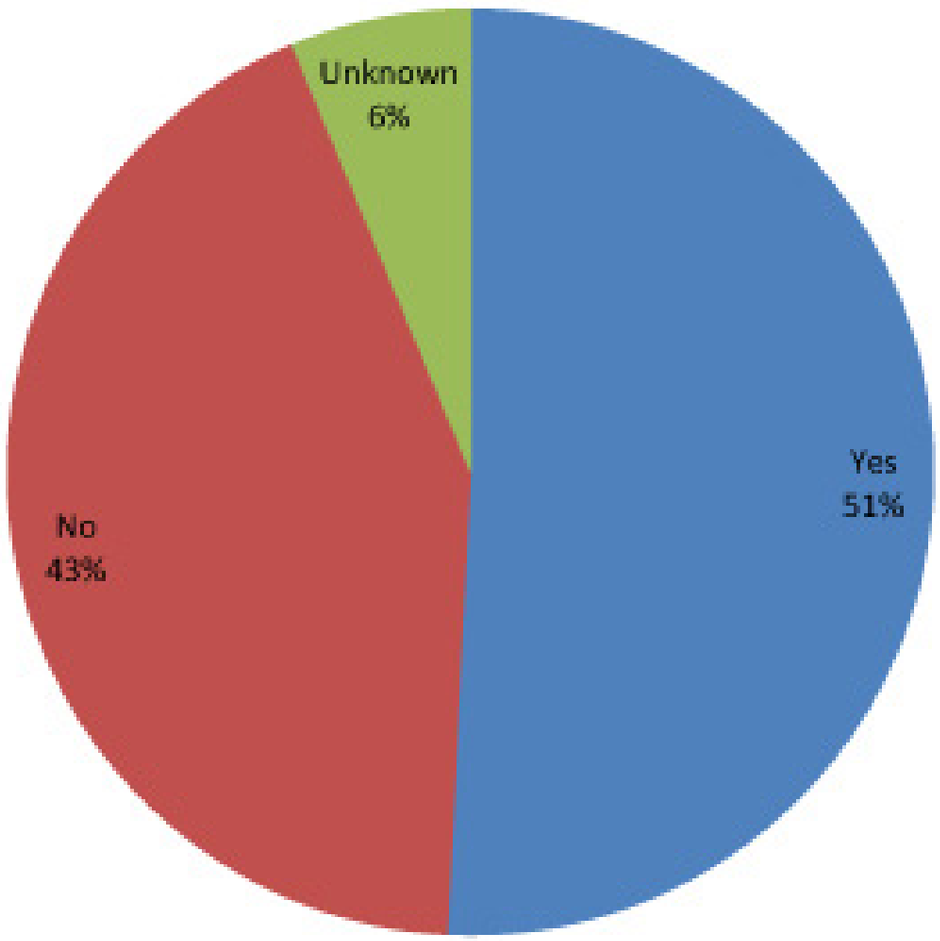
Sheffield suicides 2001-2010 (n=333)

History of self harm or attempted suicide



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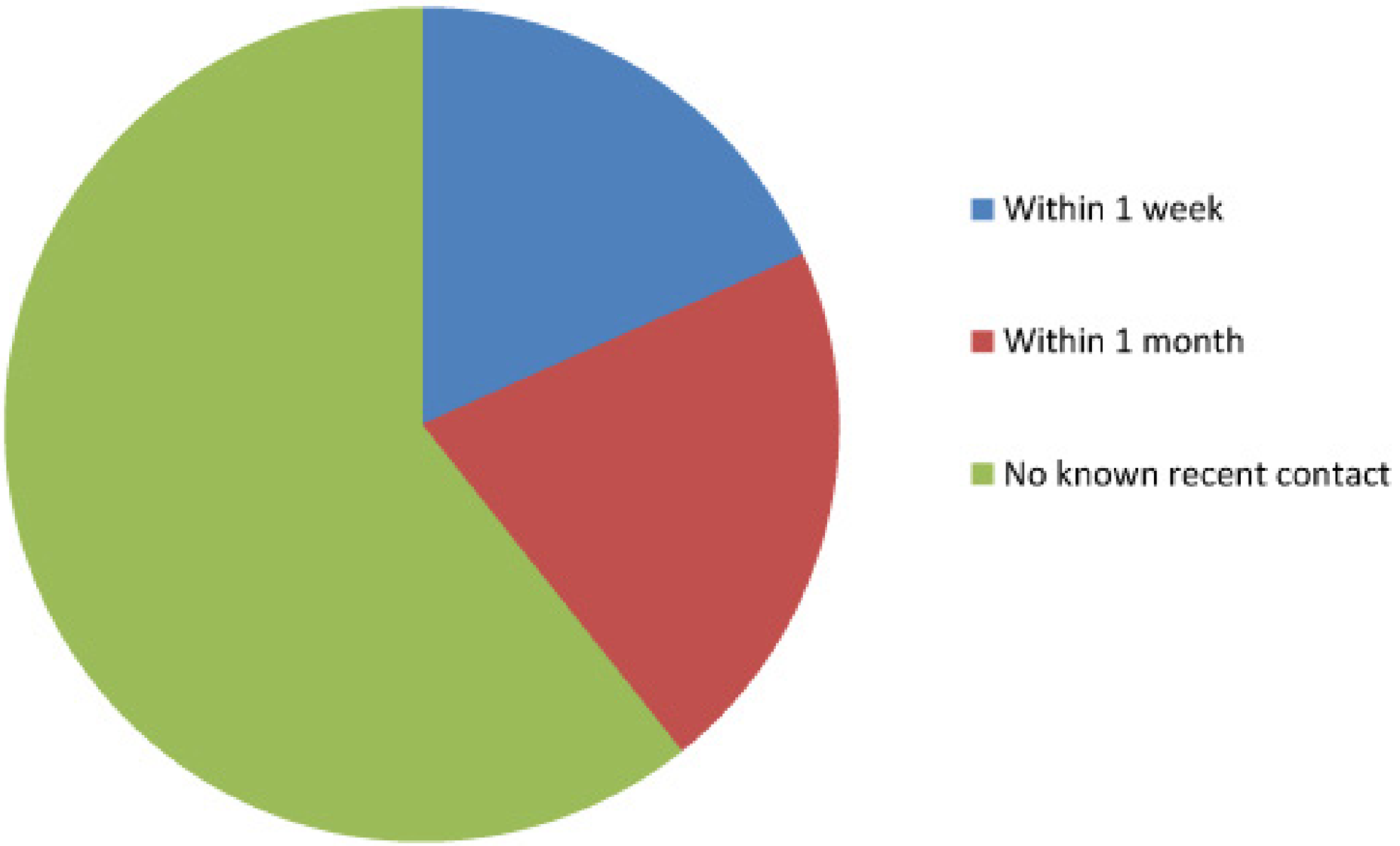
Sheffield suicides 2001-2010 (n=333)

Contact with GP prior to death



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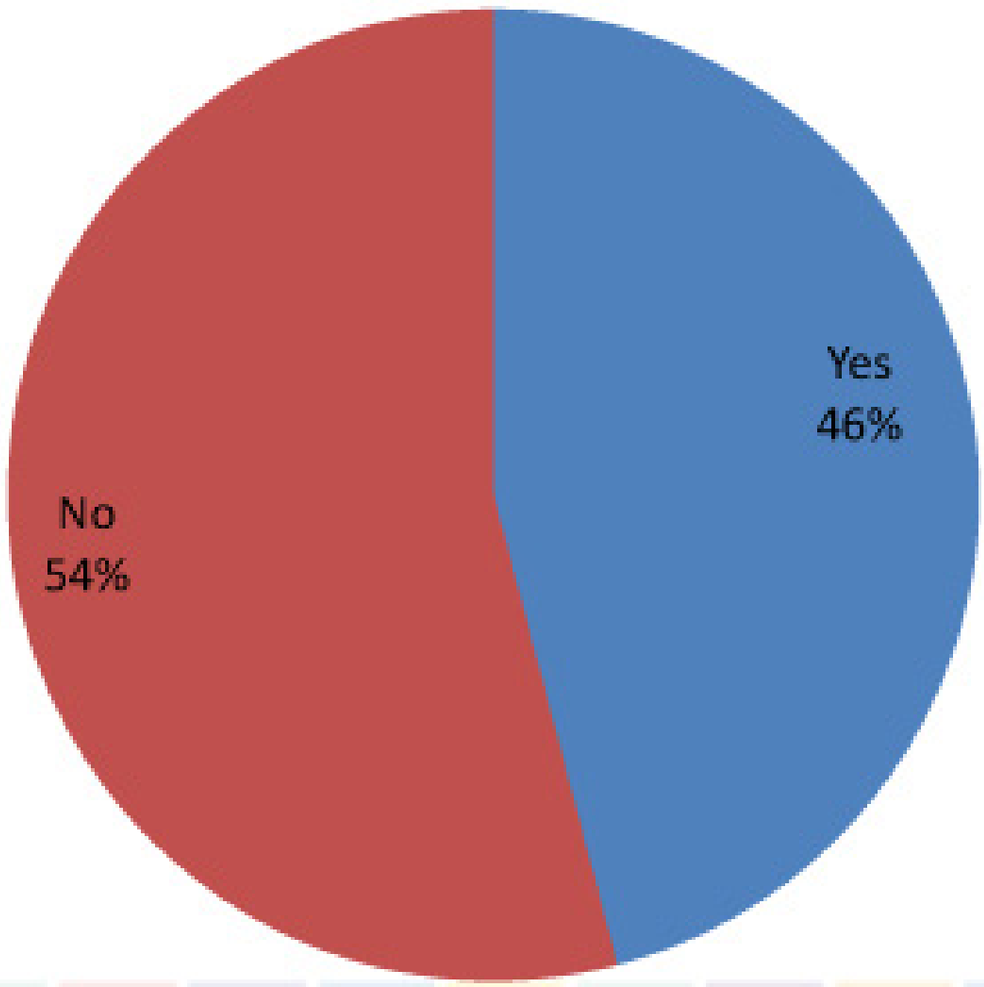
Sheffield suicides 2001-2010 (n=333)

Known physical health problem



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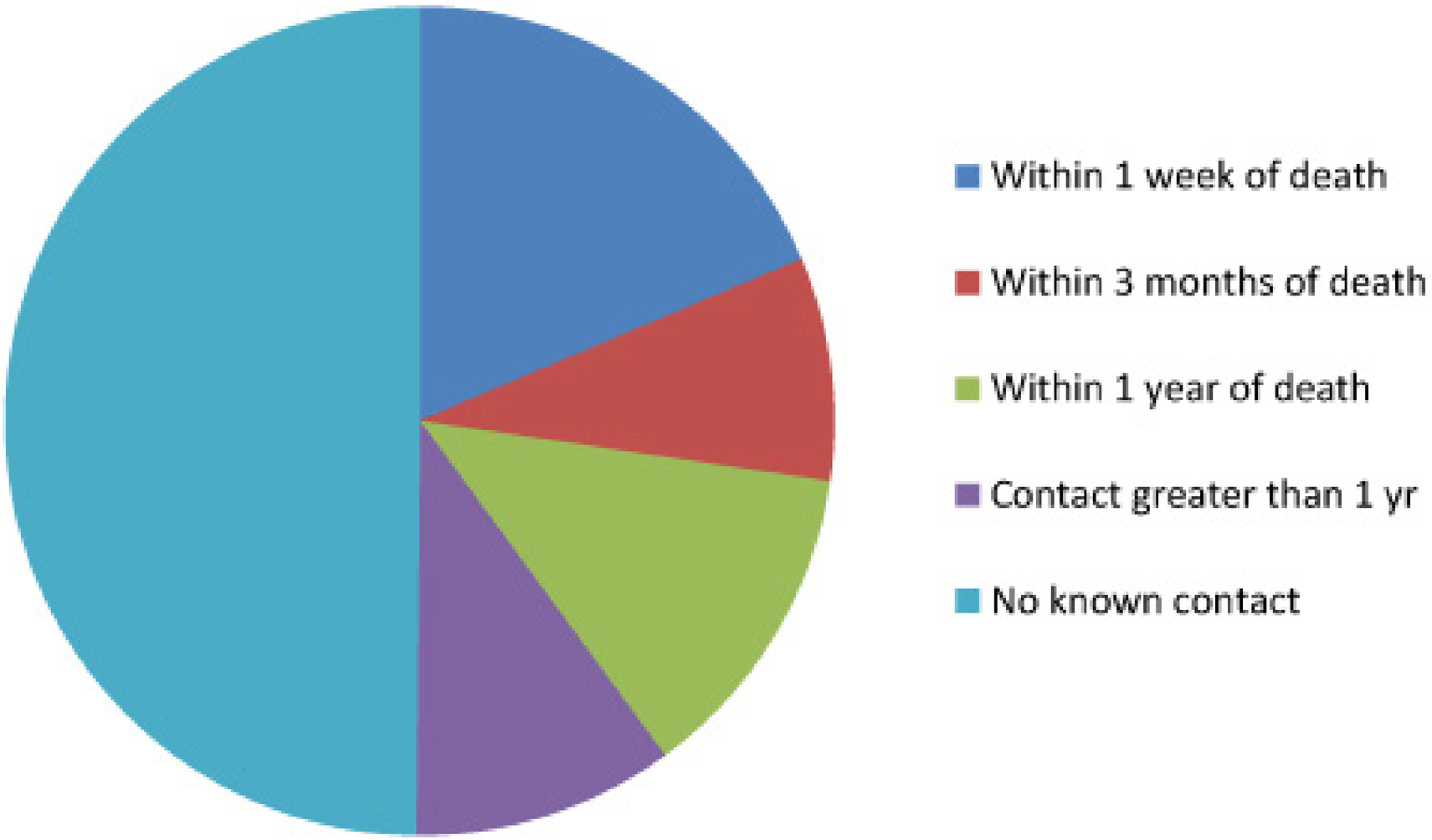
Sheffield suicides 2001-2010 (n=333)

Known contact with secondary MH



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Overall Approach

Suicide risk assessment should be routine

EVERYBODY'S BUSINESS!

MDT and BEYOND!

- Use of tools / training
- Safe but appropriate response
- Proportionate / realistic (own and extended system)
- Empathy / relationships / trust
- Collaboration – information / treatment
- 'Red Flag' response

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High Risk Group

- Psychiatric history – past / present
- Previous self harm / suicide attempt
- Recent discharge psychiatric hospital
- Alcohol / drug misuse
- Demographics
- ‘Balance scale of life’

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Red Flags

- Well formed suicide plans
- Hopelessness
- Distressing psychotic phenomena
- Sense of 'entrapment'
- Chronic medical conditions (including chronic pain)
- Perception / real lack of social support
- Clinician intuition / knowledge of patient
- Body language / presentation

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Management / Mitigation

- Bio-psychosocial assessment
  as full as practical / realistic
- 'Treat the treatable'
  psychiatric / chronic conditions
- Enhanced support
  - Follow up for support / further assessment
  - Consider other support
    - Family / friends
    - Voluntary sector
    - Statutory eg Social Services
    - Wider MDT
    - Crisis Team / Secondary Care
- Mitigation Plan
  - Co-production
  - Escalation
  - Support networks
- Communication
  - Patient / support network
  - Colleagues
- Escalation
  - Confidentiality issues
  - Risk to self / others priority

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Further Information

- RCGP / RCPsych Primary Care MH Forum- in your pack (includes list of support organisations)
- DoH Information sharing and suicide prevention- in your pack
- NHS Choices- information for those experiencing suicidal thoughts, and for concerned family and friends – link in your pack

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Thank you

Any Questions / Discussion

Workshop 1: Assessment and Mitigation of Suicide Risk in Primary Care

Resources

Factsheet – suicide mitigation in primary care (Royal College of General Practice and RC Psych)

Resource 1a: Suicide mit in primary care
http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf

Resource 1b: Information sharing and suicide prevention, consensus statement
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

Sheffield Health and Social Care Trust (SHSC), Referral for Crisis Assessment
'Crisis Assessment' and 'Home Treatment' are now integrated functions within each locality CMHT.

'Access Teams' provide a single point of access for all referrals to secondary care, including crisis assessments (which we respond to within 4 hours). There are 'duty' workers in each Access Team who triage referrals and undertake urgent assessments.

Crisis assessment outcomes could include a referral to Home Treatment (intensive, short-term treatment service), brief intervention within the Access Team or hospital admission.

Referrals should be directed to the locality CMHT between the hours of:

7.30am and 7.30pm and to the Out of Hours Team between 7.30pm and 7.30am.

Northlands 0114 2716217 or NorthCMHT.Duty@shsc.nhs.uk
Wardsend Road 0114 2716100 WestCMHT.Duty@shsc.nhs.uk
East Glade 0114 2716451 or SECMHT.Duty@shsc.nhs.uk
South West 0114 2718654 or SWCMHT.Duty@shsc.nhs.uk
Out of Hours Team (via SHSC Switchboard) - 0114 2716310

Preventing suicide one year on:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278119/Annual_Report_FINAL_revised.pdf
National statistical update:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278120/Suicide_update_Jan_2014_FINAL_revised.pdf
To find out more about Mental Health First Aid:
http://mhfaengland.org/
Local contact: janet.southworth@sheffield.gcsx.gov.uk
NHS choices for information for concerned families and friends:
http://www.nhs.uk/Conditions/Suicide/Pages/helping-others.aspx
Help for those bereaved by suicide:
Helpline and support groups at http://uk-sobs.org.uk/
Resource guide www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

Workshop 2

Eating Disorders in Primary Care

Eating Disorders in Primary Care

Realistic management and support in a Primary Care Setting!

What happens after Diagnosis:

Severe

- Referral to SEDS
- See regularly for physical Monitoring in Partnership with Specialist Service
- Signpost to resources including SYEDA.

Mild/moderate

- Baseline physical monitoring,(regular monitoring defined by clinical results and patient progress)
- Refer to SYEDA
- Signpost to other resources
- Consider supporting them through Guided Recovery with aid of resources listed below

Physical monitoring:

- Weight and BMI
- Regular blood tests: FBC U&E'S LFT TFT Mg and Calcium
- ECG
- Bone Density
- Note frequency of purging, laxative abuse and/or exercise and any other compensatory behaviour

Psychological Support for Mild to Moderate

- SYEDA (offer Treatment, Peer group support for Sufferers and carers, also Training for Professionals)
- On-line programmes: (access via B-eat)
- Self-Help Books
- B-eat
- BITEBACK (For students of Sheffield Uni and Sheffield Hallam)
- Anxiety Management

Useful Links

- *http://www.kcl.ac.uk/iop/depts/pm/research/eatingdisorders/resources/GUIDETOMEDICALRISKASSESSMENT.pdf*
- *http://www.get.gg/ (Get self help website for allsorts of downloads, info and useful resources)*
- *http://www.cci.health.wa.gov.au/ (Workbooks on Eating Disorders, Body Dysmorphia, Panic, Anxiety, Perfectionism etc.)*
- *http://www.syeda.org.uk/ (SYEDA)*
- *http://www.b-eat.co.uk/ (National Support Group)*
- *http://www.shef.ac.uk/union/advice/support-services/eating-disorders/biteback/ (Self –HELP support for Students of Sheffield Uni & Sheffield Hallam)*

Bibliography: Self-help and Guided Recovery.

- The Personal Notebook (A Self-Help Guide) Sheffield Eating Disorders Service)
- Overcoming Series, Bulimia and Binge Eating, Anorexia, Low Self Esteem, Anxiety etc.
- Getting better Bit(e) by Bit(e) Janet Treasure
- Anorexia (A survival Guide for Families Friends and Sufferers)
- Beating Your Eating Disorder: A Cognitive-Behavioural Self-Help Guide for Adult Sufferers and their Carers (Glen Waller)
- Body Image Workbook: An Eight-step Program for Learning to Like Your Looks (T Cash)
- Mind Over Mood: Change How You Feel By Changing the Way You Think (C Padesky)

Resources: (For Professionals)

- Nice Guidelines: Eating disorders: anorexia nervosa, bulimia nervosa and related eating disorders. National Institute for Clinical Excellence. 2004 *http://www.nice.org.uk/guidance/cg9/resources/cg9-eating-disorders-information-for-the-public-2*
- Sheffield Eating Disorders Toolkit for Primary Care and Adult Mental Health Services *http://www.sheffieldccgportal.co.uk/pressv2/index.php/clinical-guidance/item/eating-disorders-toolkit-for-primary-care-and-adult-mental-health-services?highlight=WyJlYXRpbmciLCJkaXNvcmRlcnMiLCJlYXRpbmcgZGlzb3JkZXJzIl0*

Resources: (For Professionals)

- Cognitive Behavioural Therapy for Eating Disorders: A Comprehensive Treatment Guide (Glenn Waller et al)
- Cognitive Behaviour Therapy and Eating Disorders (Christopher Fairburn)
- Clinician's Guide: Getting Better Bit(e) by Bit(e): A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders (Janet Treasure &Ulrike Schmidt
- Clinician's Guide to Mind Over Mood (C Padesky) Cognitive Behavioural Therapy for Eating Disorders: A Comprehensive Treatment Guide (Glenn Waller et al)

EATING DISORDERS IN PRIMARY CARE

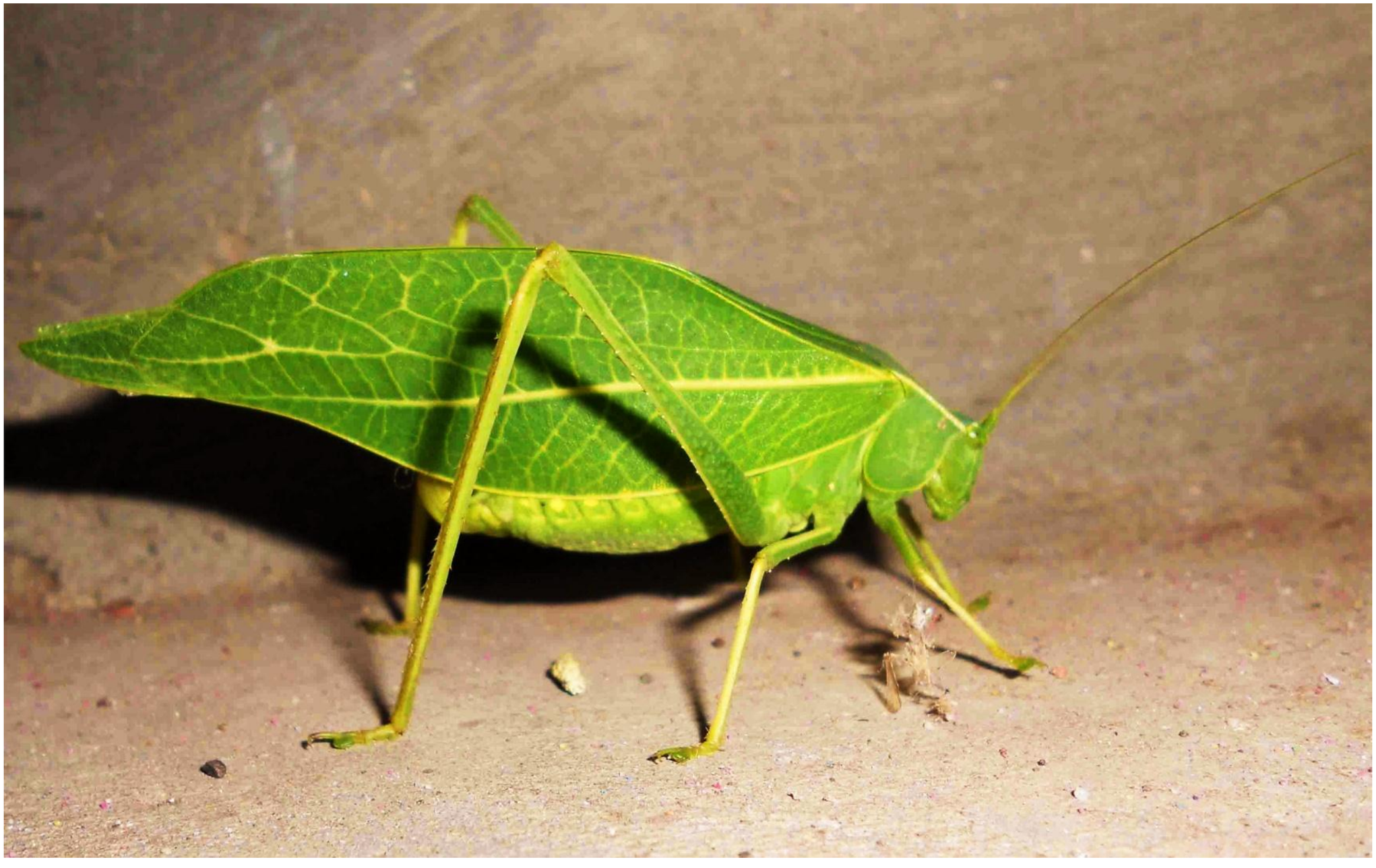
Detection and Diagnosis

Dr Alison James. GP, University Health Service

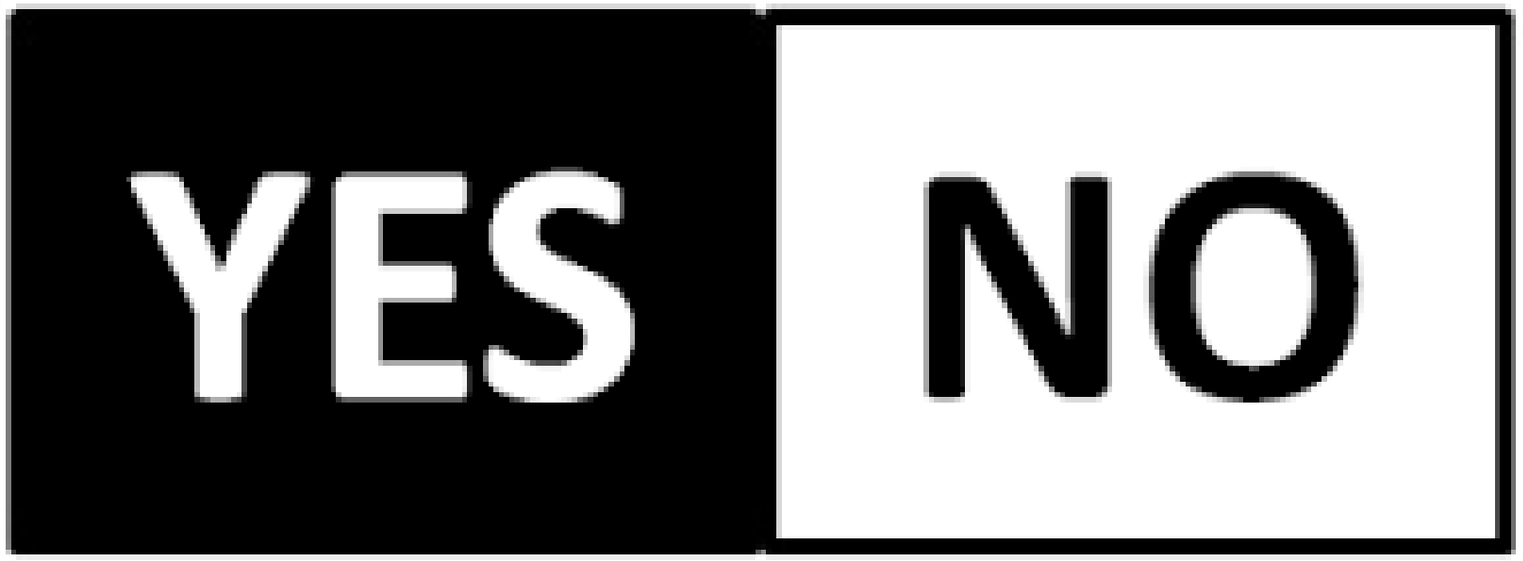
What are the challenges?

They may be hidden.

They may be disguised



They may be ambivalent



MAYBE

Why?

- No insight
- Not ready to disclose
- Ashamed
- Fear of impact:-job, course, relationship.
- No confidence in you, your skills, confidentiality

Barriers from the clinician's perspective

- Knowledge
- Confidence, risks
- Uncertainties about referral options
- Lack of environmental cues for the patient

Definitions

Anorexia Nervosa (AN) ICD-10

Food restriction, vomiting or other means leading to weight loss (85% less than expected weight or a body mass index of 17.5 or less.

Abnormal attitudes to food and weight. Body- image disturbance.

Endocrine disturbance. Loss of menstrual periods in females.

Loss of sexual function in males.

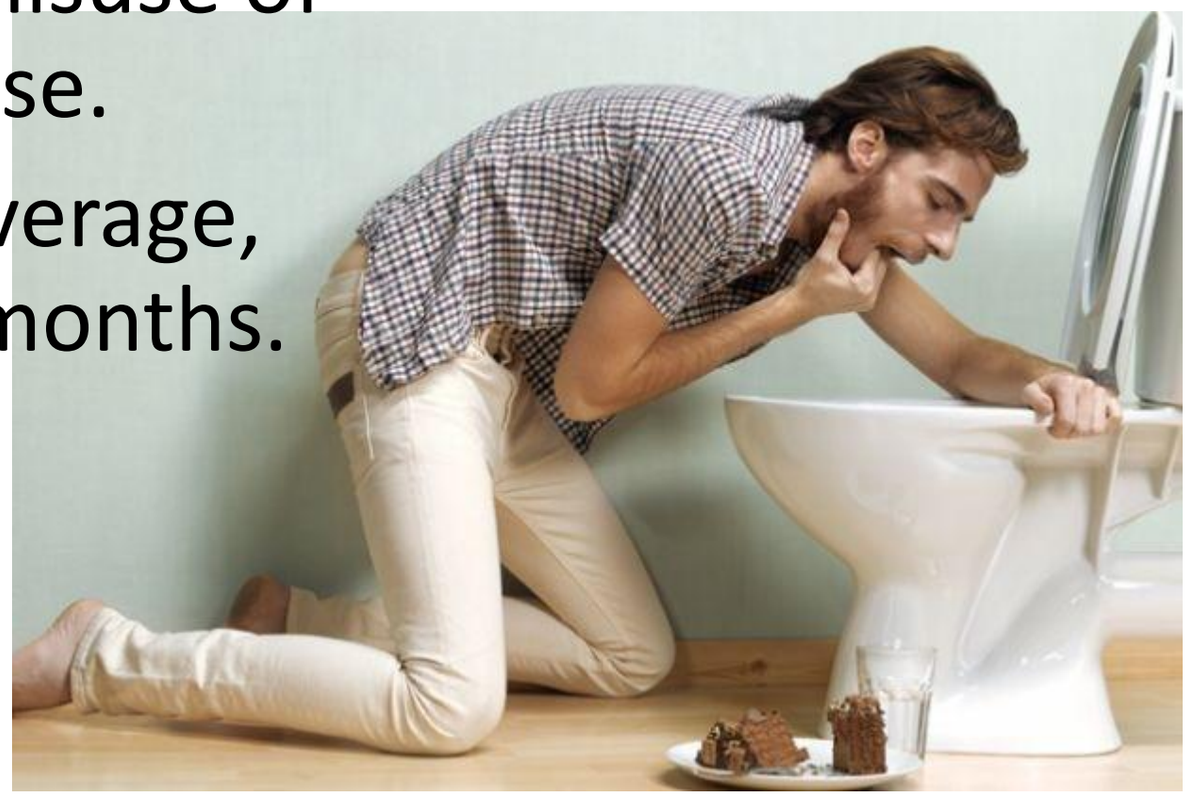
Definitions

Bulimia Nervosa (BN) DSM-IV

Recurrent episodes of binge eating.

Recurrent compensatory behaviours, eg. self induced vomiting; misuse of laxatives or excessive exercise.

Above behaviours occur, on average, at least twice a week for 3 months.



Definitions

Atypical Eating Disorder (EDNOS)

Fulfils some of the criteria for BN and / or AN.

(is the commonest)

Binge Eating Disorder (BED)

Binge eating in absence of compensatory behaviours.

Who should we screen?
What should we ask?

1.1.6 Identification and screening of eating disorders in primary care and non-mental health settings

1.1.6.1 Target groups for screening should include young women with low body mass index (BMI) compared with age norms, patients consulting with weight concerns who are not overweight, women with menstrual disturbances or amenorrhoea, patients with gastrointestinal symptoms, patients with physical signs of starvation or repeated vomiting, and children with poor growth.

1.1.6.2 When screening for eating disorders one or two simple questions should be considered for use with specific target groups (for example, "Do you think you have an eating problem?" and "Do you worry excessively about your weight?").

1.1.6.3 Young people with type 1 diabetes and poor treatment adherence should be screened and assessed for the presence of an eating disorder.

NICE Guidance 2004

SCOFF questionnaire

Do you make yourself **S**ick because you feel uncomfortably full?

Do you worry you have lost **C**ontrol over how much you eat?

Have you recently lost more than **O**ne stone in a three month period?

Do you believe you are too **F**at when others say you are too thin?

Would you say that **F**ood dominates your life?

Two or more ‘yes’ answers should prompt you to take a more detailed history.

Initial assessment

- History and duration
- Patterns: binging, purging
- Attitudes to weight and shape
- Menstrual history
- Mental state including self harm

Examination:

- BMI
- Emaciation?
- FBC, U+E, (Mg), LFT’s, TFT’s

How severe is it?
Can it be managed in primary care?

Severe

Meets **one or more** of the following criteria:

BMI is ≤ 16 – refer; BMI is ≤15 - refer **urgently**; BMI ≤13.5 refer to Acute Medicine for admission.

Laxative abuse / self induced vomiting on a daily basis > 5 days per week.

Rapid weight loss (25% body weight in 6 months).

Physical complications of eating disorder, eg. Electrolyte disturbance, amenorrhea.

Meets Moderate criteria and has additional health risks, eg. Diabetes, pregnancy or low potassium.

Aged between 16 – 18 years and BMI ≤17.5 / or under transitional protocol from CAMHS.

NO See referral guidelines (CCG PRESS PORTAL)

How severe is it?
Can it be managed in primary care?

Moderate

Meets **one or more** of the following criteria:

BMI is between 16 – 17.5.

Frequency of laxative abuse / self induced vomiting is between 3 – 5 times per week.

Recurrent episodes or duration of illness is more than 6 months.

YES

How severe is it?
Can it be managed in primary care?

Mild

Any eating disorder that meets **all** of the following criteria:

Frequency of laxative abuse / vomiting is less than x 3 per week.

BMI is above 17.5.

First episode of illness/ duration of illness less than 6 months

YES

Take home messages

- Make it easy for the patient
- Make it easy for yourself
- Be aware of Sheffield's Eating Disorders Pathway and NICE guidelines
- Work collaboratively with the patient and local external agencies (SYEDA)

Workshop 2: Eating Disorders in Primary Care

Resources

Eating disorders and physical health monitoring

Resource 2b – Eating disorders and physical health monitoring

http://www.sheffieldccgportal.co.uk/pressv2/index.php/clinical-guidance/item/eating-disorders-and-physical-health-monitoring?highlight=WyJlYXRpbmciLCJkaXNvcmRlciIsImVhdGluZyBkaXNvcmRlciJd

Local (Sheffield)

Sheffield Eating Disorders Toolkit for Primary Care and Adult Mental Health Services –
http://www.sheffieldccgportal.co.uk/pressv2/index.php/clinical-guidance/item/eating-disorders-toolkit-for-primary-care-and-adult-mental-health-services?highlight=WyJlYXRpbmciLCJkaXNvcmRlcnMiLCJlYXRpbmcgZGlzb3JkZXJzIl0=
The Sheffield Eating Disorders Pathway – http://www.sheffieldccgportal.co.uk/pressv2/index.php/clinical-pathways/item/mental-health-eating-disorders-referral-guidelines-clinical-pathway
Criteria for referral into the Sheffield Eating Disorder Service
http://www.sheffieldccgportal.co.uk/pressv2/index.php/clinical-guidance/item/mental-health-eating-disorders-referral-criteria
Form for Referrals to the Sheffield Eating Disorder Service
http://www.sheffieldccgportal.co.uk/pressv2/index.php/referral-forms/item/mental-health-eating-disorders-referral-form
Sheffield Health and Social Care Trust Sheffield Eating Disorders Service. Eating Disorders and Physical Health Monitoring
SYEDA http://www.syeda.org.uk/

For the professional

Eating disorders: anorexia nervosa, bulimia nervosa and related eating disorders. National Institute for Clinical Excellence. 2004
http://www.nice.org.uk/guidance/cg9/resources/cg9-eating-disorders-information-for-the-public-2
(Self –HELP support for Students of Sheffield Uni & Sheffield Hallam) http://www.shef.ac.uk/union/advice/support-services/eating-disorders/biteback/
Get self help website for all sorts of downloads, info and useful resources
http://www.get.gg/
Workbooks on Eating Disorders, Body Dysmorphia, Panic, Anxiety, Perfectionism etc. http://www.cci.health.wa.gov.au/
National Support Group http://www.b-eat.co.uk/
A guide to the medical risk assessment for eating disorders. Professor Janet Treasure http://www.kcl.ac.uk/iop/depts/pm/research/eatingdisorders/resources/GUIDETOMEDICALRISKASSESSMENT.pdf
The case for early intervention in anorexia nervosa: theoretical exploration of maintaining factors. Janet Treasure and Gerald Russell. –
http://bjp.rcpsych.org/content/199/1/5.long
MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa. October 2010. Royal College of Psychiatrists and Royal College of Physicians
http://www.rcpsych.ac.uk/files/pdfversion/cr162.pdf

Bibliography: Self Help and Recovery
The Personal Notebook (A Self-Help Guide) Sheffield Eating Disorders Service
Overcoming Series, Bulimia and Binge Eating, Anorexia, Low Self Esteem, Anxiety etc.
Getting better Bit(e) by Bit(e) Janet Treasure
Anorexia (A survival Guide for Families Friends and Sufferers)
Beating Your Eating Disorder: A Cognitive-Behavioural Self-Help Guide for Adult Sufferers and their Carers (Glen Waller)
Body Image Workbook: An Eight-step Program for Learning to Like Your Looks (T Cash)
Mind Over Mood: Change How You Feel By Changing the Way You Think (C Padesky)

Workshop 3

Mental Health in Primary Care: The Practice Nurse Project

UCLPartners
Academic Health Science Partnership

Mental health in primary care: the practice nurse project

Dr Sheila Hardy

3rd September 2014

Who was involved?

Health Education North Central and East London - HENCEL	
UCLPartners Academic Health Science Network	
Mental Health Trusts	•Barnet, Enfield and Haringey Mental Health NHS Trust •Camden and Islington NHS Foundation Trust •East London NHS Foundation Trust •North East London NHS Foundation Trust
GP practices	•Approximately 600

Aim

For patients seen in primary care to be treated by a health care professional who understands their mental, physical, emotional, spiritual and social needs and can respond appropriately and effectively

Objectives for patients

For patients in primary care to:

- Be offered assistance to maintain their personal wellbeing
- Have risk factors for stress recognized and/or symptoms of stress recognized and help to manage these
- Have their psychological distress and/or mental illness recognized and managed
- Be supported to change unhealthy behaviour
- Receive treatment in line with people with physical long term conditions if they have a mental health problem
- Be offered assistance to self-manage their conditions

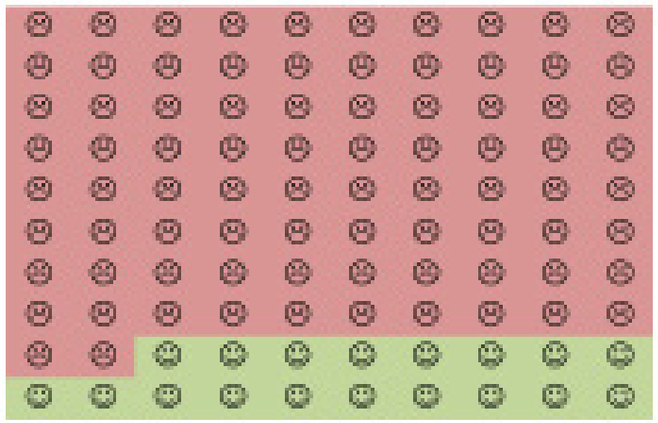
The project model

UCLPartners
Academic Health Science Partnership

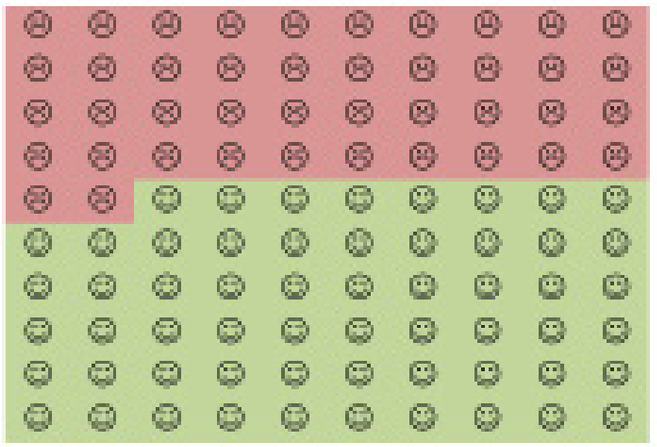
Understanding	•Gathering information about the problem •Learning from good practice across the partnership •Understanding the evidence base
Engagement & Involvement	•Formal & informal •Communication strategy •Recognising achievement
Developing the solution	•Co-creation with partners •Effective model for delivery •Evidence based materials •Interprofessional & cross boundary •Locally delivered to support local connectivity
Sustainability	•Model of delivery with partners •Developing communitites of interest/engagement/practice •System change
Evaluation	•Embedding a culture of evaluation •Understanding impact

Understanding

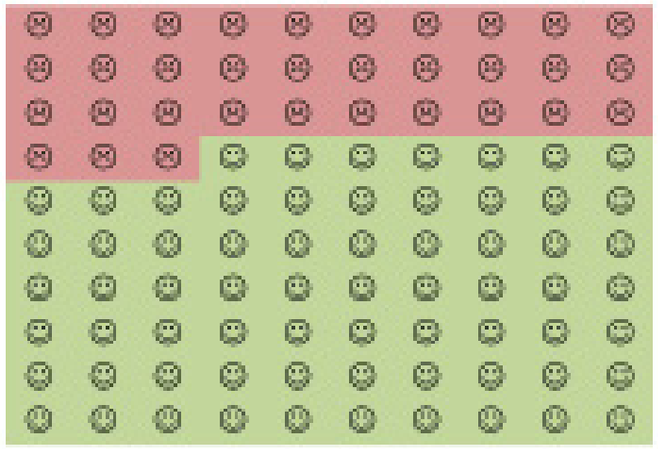
Key findings from our survey of practice nurses:



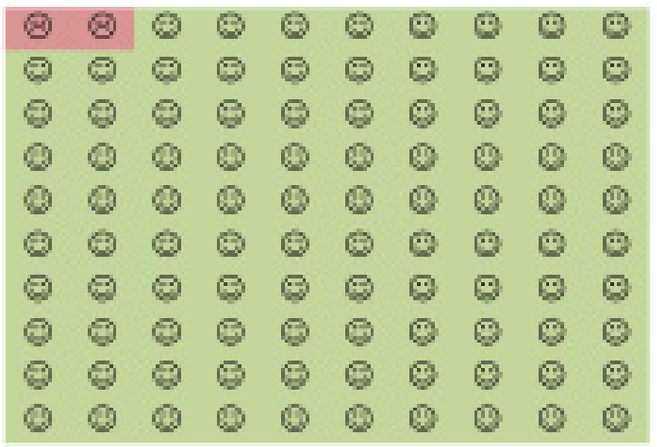
82% have responsibilities for aspects of mental health and wellbeing where they have not had training.



42% have had no training in mental health and wellbeing



A third would struggle to attend a course because gaining agreement from employers is difficult.

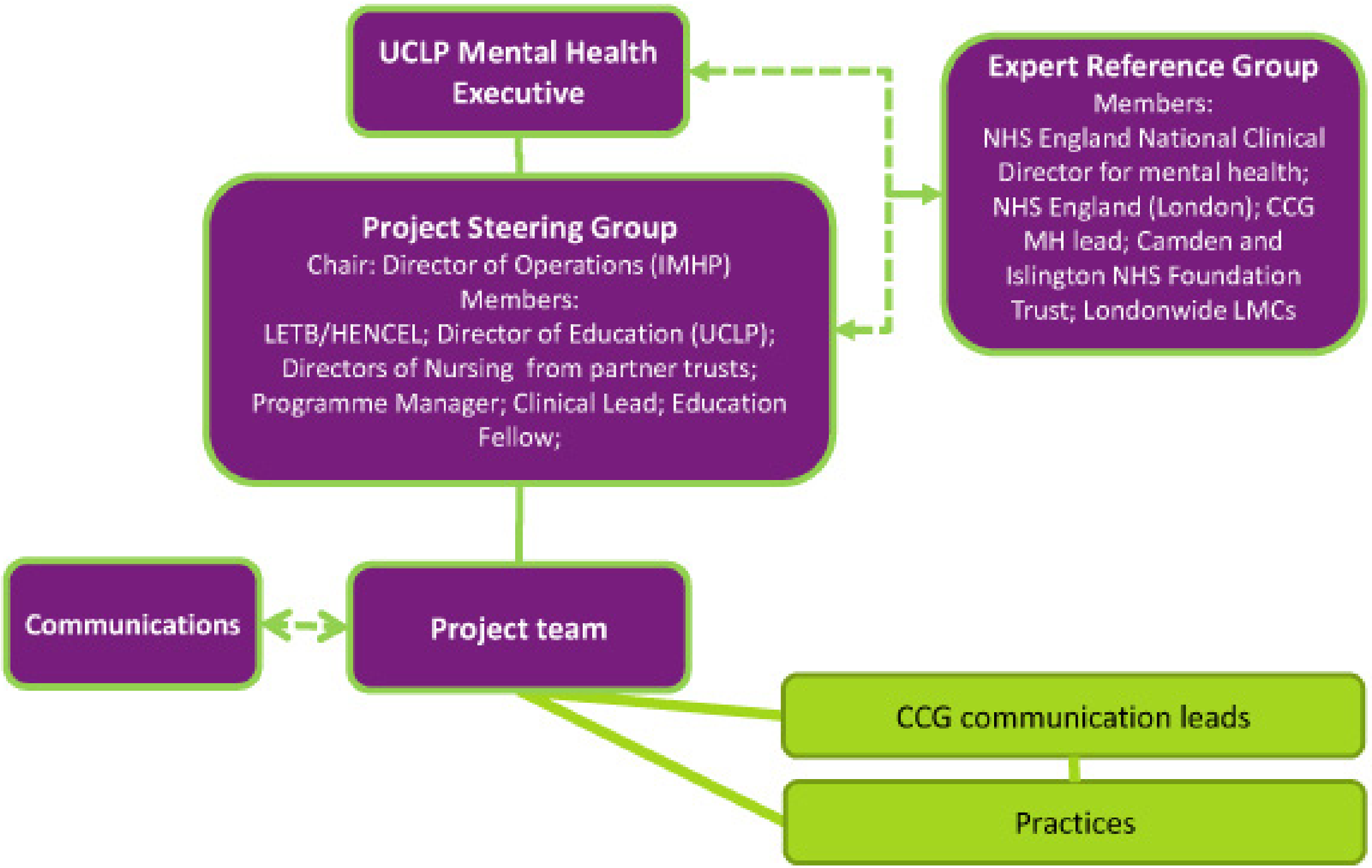


98% identified at least one area of mental health and wellbeing training that they would like to attend.

A mixture of face to face learning and e-learning are the preferred methods of education.

Hardy S. (2014) Mental health and wellbeing survey: A snapshot of practice nurses' views regarding responsibility and training.
http://uclpstorneuuat.blob.core.windows.net/cmsassets/Mental%20health%20and%20wellbeing%20survey%2020%20Jan%202014.pdf

Engagement and involvement



Developing a solution

- Co-creation with partners
- Effective model for delivery
- Evidence based materials
- Inter-professional & cross boundary
- Locally delivered to support local connectivity

Developing a solution 2

Modular programme:

- 5 face-to-face (RCGP accredited)
- 5 e-learning (BMJ learning)

Topics agreed with Expert Reference Group (ERG) at the outset

ERG comments on all course materials as developed.

Classroom modules	**Module 1: Mental Health Awareness**
	Module 2: Behaviour Change
	Module 3: Physical Health in Mental Illness
	Module 4: Wellbeing
	Module 5: Co-morbidities - using a psychological approach
E-learning modules	Module 6 - Alcohol and drug awareness
	Module 7 - Medications used in mental illness
	Module 8 - Your patient's journey
	Module 9 - Care planning
	Module 10 - Specific conditions

Sustainability

Creation of a Learning Community:

- Nurse Educator Action Learning sets
- Practice Nurse learning community (informed by focus groups).
- LinkedIn network
- Innovation Unit Critical Friend

Relevance of training to learning

Will you apply the learning to your practice?			
Module	Yes	Not sure	No
1	98%	2%	0%
2	93%	5%	2%
3	95%	5%	0%
4	98%	2%	0%
5	96%	2%	2%

Recommendations

Would you recommend this course to a colleague?			
Module	Yes	Yes, but with reservations	No
1 (n=178)	100%	0%	0%
2 (n=69)	91%	7%	2%
3 (n=68)	90%	8%	2%
4 (n=65)	93%	7%	0%
5 (n=58)	89%	11%	0%
All modules (n=438)	93%	6%	1%

Patient outcomes

Practice nurses provided:

- Case studies
- Perceived change in practice

Measuring patient impact requires an additional project

- Funding applied for to carry out a small service evaluation

Number of Educators trained

Number of modules trained to deliver	Number of nurses educators
Five modules	5
Four modules	3
Three modules	5
Two modules	6
One Module	25 (23)

Feedback about quality and organisation

Item evaluated (5=agree, 1=disagree)	Mean score from each module					
	One (n=178)	Two (n=69)	Three (n=68)	Four (n=65)	Five (n=58)	All (n=438)
The pre-course administration was good.	4.56	4.47	4.56	4.64	4.68	4.58
The pace of the training suited my needs.	4.49	4.48	4.52	4.77	4.56	4.56
The structure of the training was easy to follow.	4.68	4.64	4.64	4.83	4.62	4.68
The material presented was appropriate to my needs.	4.64	4.39	4.65	4.84	4.56	4.62
Adequate time was allocated for discussion.	4.55	4.67	4.58	4.86	4.60	4.65
Written materials were useful and easy to understand.	4.75	4.77	4.84	4.89	4.74	4.80
The trainer) listened and responded to questions.	4.77	4.75	4.68	4.94	4.76	4.78
Total	4.56	4.60	4.64	4.82	4.65	4.65

Practice Nurse pre and post self-evaluation scores

Item evaluated (5=agree, 1=disagree)	Mean score pre training (sd)	Mean score post training (sd)	95% CI Significance
Module 1 (n=178)	2.61 (0.74)	4.05 (0.60)	0.20 (1.34, 1.54)
Module 2 (n=69)	2.93 (0.83)	4.46 (0.51)	0.44 (1.31,1.75)
Module 3 (n=68)	3.06 (0.71)	4.52 (0.76)	0.32 (1.30, 1.66)
Module 4 (n=65)	3.21 (0.71)	4.68 (0.60)	0.40 (1.27, 1.67)
Module 5 (n=58)	3.31 (0.73)	4.61 (0.46)	0.46 (1.11, 1.47)
All modules (n=438)	3.02 (0.27)	4.46 (0.25)	0.22 (1.33, 1.55)

Next steps

- Creation of toolkit to aid replication (for trusts and CCGs)

Next steps

- Embed in trusts (funding applied for)
- Replicate in other areas – Northampton, North East Essex, Taunton (interest from others)
- Adapt for other professionals – custody suite nurses, Metropolitan Police, urgent and emergency care staff, physical health for mental health staff (funding applied for)

For more information please contact:

sheila.hardy@uclpartners.com

www.uclpartners.com
@uclpartners

Workshop 4

Common Mental Illness and Prescribing

Medicines Management for Depression

Dr Justin Gardner

GP PLI

3 Sept 2014

Objectives

"NICE" vs "real world"

1) Assessment and diagnosis
2) Principles of drug treatment in primary care
3) Prophylaxis and relapse
4) Treatment resistance (secondary care)

Diagnosis (ICD 10)

At least two of the following three symptoms must be present:

1) Low mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least 2 weeks

2) Loss of interest or pleasure in activities that are normally pleasurable

3) Decreased energy or increased fatigue

Major Depression Inventory (MDI) WHO

	How much of time	All of time	Most of time	More than half of time	Less than half of time	Some of time	At no time
1	Have you felt low in spirits or sad?	5	5	3	2	1	0
2	Have you lost interest in your daily activities?	5	4	3	2	1	0
3	Have you felt lacking in energy and strength?	5	4	3	2	1	0
4	Have you felt less self-confident?	5	4	3	2	1	0
5	Have you had a bad conscience or feelings of guilt?	5	4	3	2	1	0
6	Have you felt your life wasn't worth living?	5	4	3	2	1	0
7	Have you had difficulty in concentrating, e.g. when reading the newspaper or watching television?	5	4	3	2	1	0
8a	Have you felt very restless?	5	4	3	2	1	0
8b	Have you felt subdued?	5	4	3	2	1	0
9	Have you had trouble sleeping at night?	5	4	3	2	1	0
10a	Have you suffered from reduced appetite?	5	4	3	2	1	0
10b	Have you suffered increased appetite?	5	4	3	2	1	0

MDI Interpretation Severity(ICD-10)

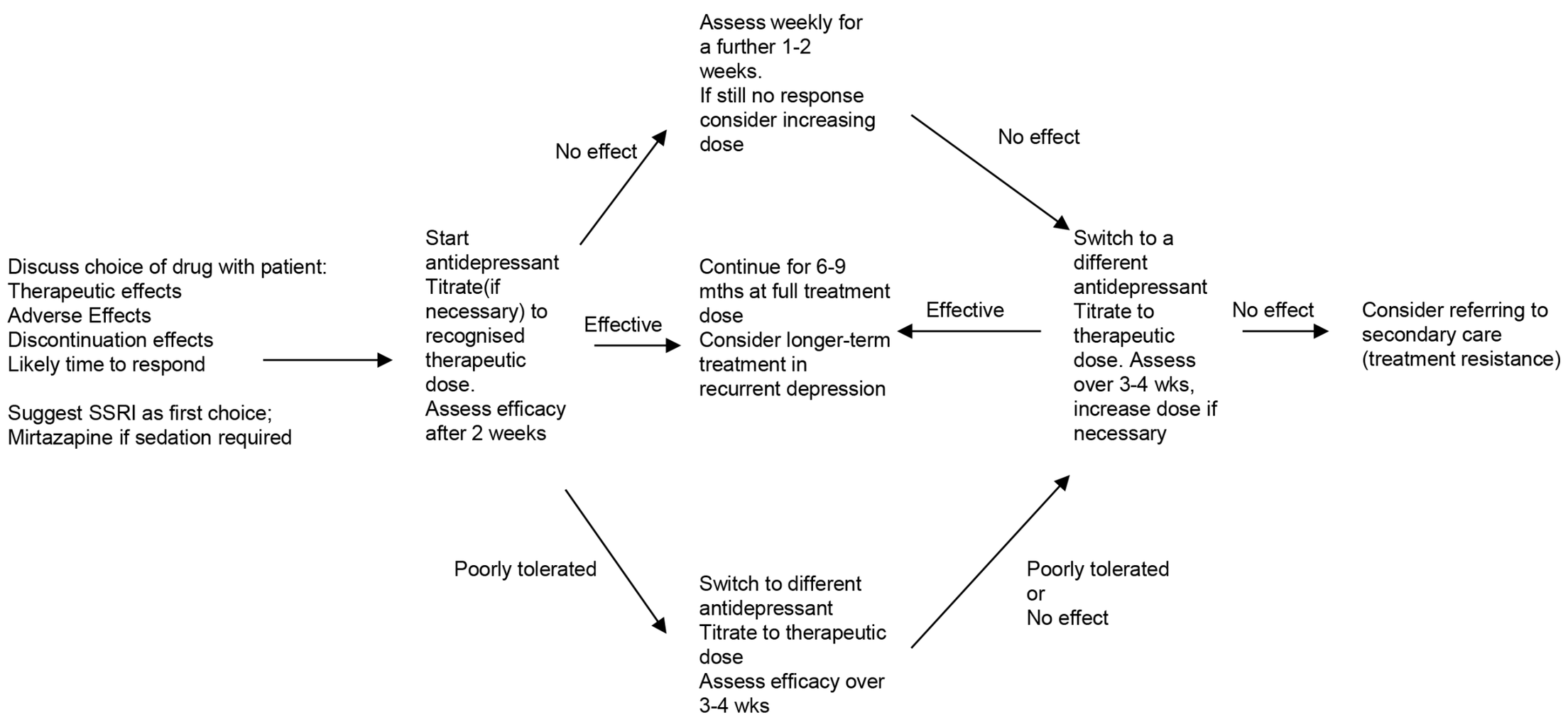
- Items 1-3 score 4 or more
- Items 4-10 score 3 or more

- 2 of the first 3 items+ at least 2 of the next 7 items = **Mild depression**
- 2 of the first 3 items+ at least 4 of the next 7 items = **Moderate depression**
- all of the first 3 items+ at least 5 of the next 7 items = **Severe depression**

Exclusion criteria (ICD 10)

- A hypomanic episode or manic episode at any time in the individual's life
- Attributable to psychoactive substance misuse
- Attributable to any organic mental disorder

Principles of prescribing in depression (Maudsley Guidelines)



Prophylaxis

- Single episode – 6-9 mths
- Two or more episodes – at least 2 years

Relapse rates

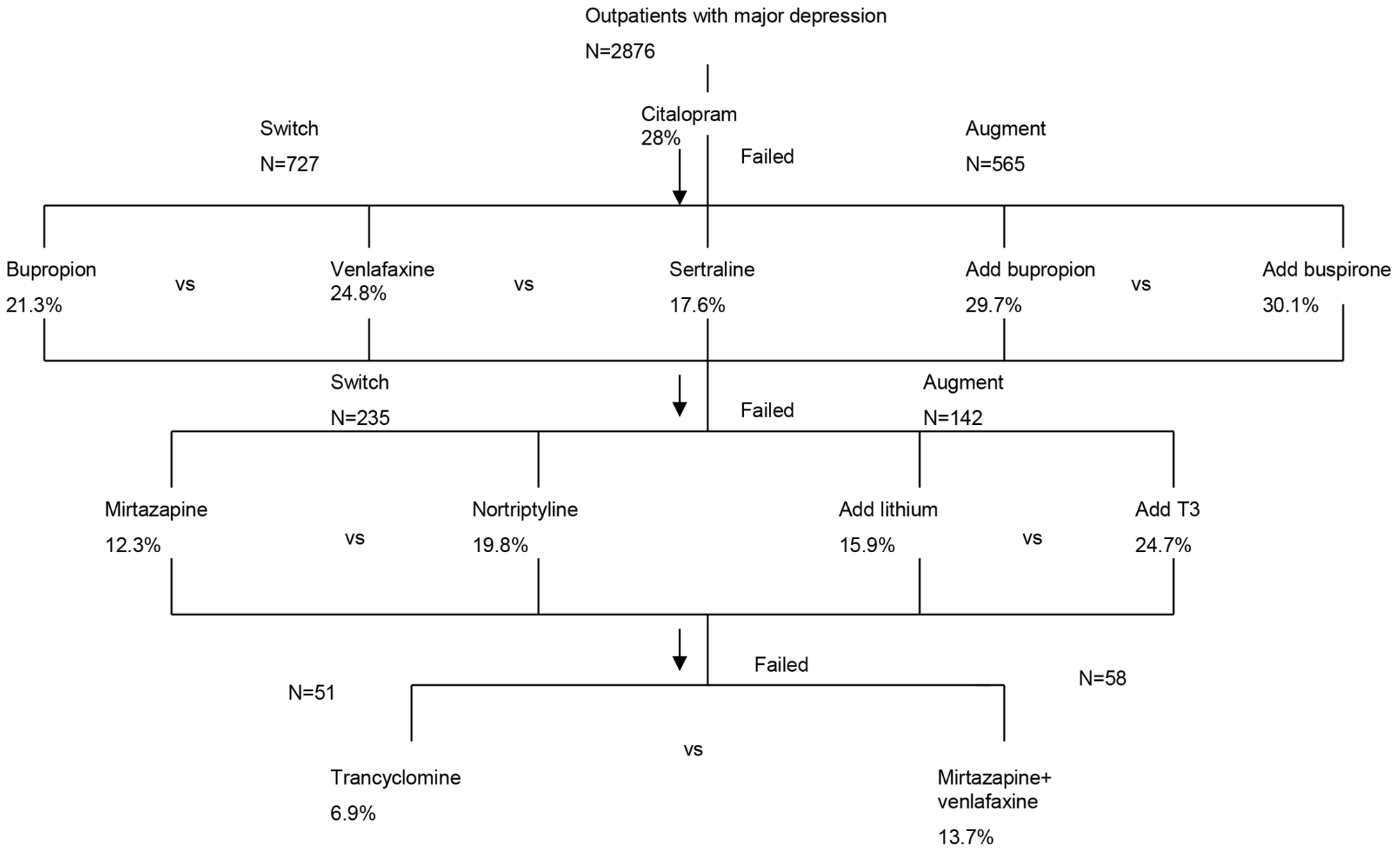
- 50 - 80% after first episode
- 80 – 90% after second episode

Treatment resistance

- Treatment adherence
- Correct diagnosis
  - Bipolar disorder
  - PTSD
  - Personality Disorder
  - Organic
- Alcohol/substance misuse
- Psychosocial factors

Star*D – Sequenced Treatment Alternatives to Relieve Depression

%=remission rate



Other options for TRD (in no preference order)

Good literature evidence:

- ECT
- Olanzapine +fluoxetine
- Add quetiapine
- Add risperidone
- Add aripiprazole

Other options for TRD cont.

Lesser evaluated evidence:

Add Lamotrigine

Add Pindolol

Summary

- Best efficacy for antidepressant treatment alone 35-50%
- High relapse rates
- 2nd and 3rd line treatment reducing efficacy with increasing potential adverse effects
- Multifactorial aetiology

All suggests importance of adjunctive psychosocial interventions

References

- NICE (Oct 2009).Depression in adults: The treatment and management in adults. www.nice.org.uk/CG90

- WHO (1992). The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic Guidelines.

- The Major (ICD-10) Depression Inventory (MDI). www.gp-training.net/protocol/psychiatry/who/mdi.doc

- Taylor D et al (2012). The Maudsley Prescribing Guidelines in Psychiatry. Eleventh Edition. Wiley-Blackwell.

- Sinyor M et al (2010). The Sequenced Treatment Alternatives to Relieve Depression (Star*D) Trial: A Review.The Canadian Journal of Psychiatry. **55**(3): 126-135

Workshop 5

Personality Disorder

Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

Personality Disorder Brief Headlines for GPs

Dr Katy Kendall, Consultant Psychiatrist,
Clinical Director, Community Services

Dr Angela Carradice, Consultant Clinical Psychologist and
Lead for PD across the CMHTs

and Sue Sibbald, PD Peer Specialist

Headlines for GPS

- Recognising signs/symptoms of personality disorder
- Impact on everyday life
- What helps? What doesn't?
- Prognosis
- When and how to refer to services
- Managing consultations – interpersonal difficulties, risk and frequent attenders
- Resources

Recognising signs and symptoms

Sensitivity to stress, as well as seemingly very small events can trigger overwhelming symptoms….

Lots of different diagnoses

- There are many different types of personality disorder
- 3 main types:
- 1. Suspicious e.g. paranoid or antisocial
- 2. Emotional and impulsive e.g. Borderline (or emotionally unstable), narcissistic
- 3. Anxious e.g. obsessive compulsive, dependent

Share common symptoms, but emphasis slightly different

Estimated 1 in 20 people in the UK have a personality disorder – many don't need specialist mental health services

5 main things for BPD:

- 1. Emotional instability – sensitivity (dysregulation)
- Extreme, rapid cycling – rage, misery, shame, panic, terror, emptiness, loneliness and so on – can mean others feel overwhelmed/anxious around them and struggle to know what to do

- 2. Disturbed thinking
- Transient psychotic symptoms, unstable sense of self and identity, may not have developed their sense of self

- 3. Impulsive behaviour
- Self harm and suicide attempts, alcohol and substance misuse, recklessness with money or sex
- 1 in 10 will complete suicide

- 4. Abandonment/rejection sensitivity
- Preoccupation with and extreme reactions to real or perceived abandonment – can unintentionally behave in ways that make it more likely

- 5. Unstable relationships
- often angry and anxious, idealisation vs devaluing, often related to abandonment issues, invitations that give others the urge to respond to the person in abusive or rejecting ways, or ‘idealised’ unrealistic ‘fixing for’ them

Can experience:

- Any other mental health symptom we know of
- Ways of coping that lead to self abuse and self neglect
- Instability and ‘state’ shifting – feeling and behaving very differently at different times
- Times of being ‘cut off’, numb, shut down or dissociated

Examples of what it can be like:

Service users' report

Each person is different for example:

- "Euphoria to devastation in minutes-cycling endlessly"
- Exhausting: Raging: Feeling out of control
- "Not believed, not taken seriously, mocked"
- Bored, feel a lack of purpose in life
- "Frightened, lonely, confused and anxious"

(Sue Sibbald, 2012)

Impact on everyday life

- Varies as everyone is different.
- Can affect every area of a person's life and ability to look after themselves
- The impact can vary depending on what a person is experiencing at any one time – periods when they cope better than others

- However, people can manage, recover and discover ways to cope and change
- The prognosis is better than you might think

- **The recovery model** is crucial – 'recovery' meaning everyone living the best life they can, despite their ongoing challenges and that there are many elements that lead to discovering the right recovery path for an individual

Sue Sibbald, PD Peer specialist

- Working with us on developing services for people with BPD
- Working on education for service users and their families, staff training and treatment
- Early days, scarce resources in mental health services, but developing
- Video to summarise Sue's views on BPD

- Insert video here

What helps?
Validation – what is it?

- Recognising and accepting the emotional response as valid for the person (even if it is different to your own) and trying to communicate this (it isn't lying about or necessarily agreeing with the response)

Examples: being present , listening and staying with it; authentic summary (reflection) reading their experience and having a go at guessing how it feels; understanding in terms of their context (e.g. history/biology etc) and normalising – 'that sounds really painful for you'

What helps?

- A sense of hope and positivity
- Learning about the recovery model – which promotes people self managing and discovering their recovery path – mental health services can either be part of the recovery journey for a period of time or not
- It helps to encourage people to help themselves – give them Sue's leaflet and other resources e.g. role models and the internet
- Recovery is possible and more likely for people who develop their own sense of agency and begin discovering what works for them

For those with complex needs

- Some people need help building sufficient stability day to day (practical stability and building positive coping skills)
- Some need specialist help to do this, including from the CMHT offering psychologically informed help
- For some, formal psychological therapy can help, but only once sufficient stability has been reached and the person is ready and willing to change

Pharmacological treatment

- **Don't** use medication for BPD itself or individual symptoms (e.g. emotional instability, risk – taking behaviour, self harm, transient psychosis)

- **Do** use medication for co morbidity (e.g. depression, psychosis) and follow NICE guidelines for treatment of that co morbid condition

- **Do** use sedatives (antihistamines better than benzos) *if necessary* in a crisis – but not for longer than a week

When and how to refer to services

When

- Increasing distress and risk to self
- Especially when the person hasn't responded to attempts to decrease anxiety and enhance coping sills
- If the person is asking for specialist help

How

- Check the care plan for advice re: managing a crisis
- If no care plan, refer to locality CMHT team who will respond with assessment and/or advice – either locality CMHT base (N, SE, SW, W) or switchboard 2716310
- If in Crisis – refer to locality CMHT team in hours, or out of hours team for advice and help – either locality CMHT base (N SE SW W) or switchboard 2716310

Managing consultations in helpful ways can be difficult

- Because the person has the difficulties we described, when they come to see you, you can think it is difficult to help them
- This can be because they are overwhelmed, in crisis, and/or struggling with their interpersonal skills
- They can show their difficulties to you in ways that can seem extreme sometimes
- They may come to see you frequently
- You can be left with strong reactions

Possible reactions to be expected

- Some people who experience PD can be difficult to be around when they are struggling
- You yourself can feel a little of what they are feeling e.g. confused, overwhelmed, unsure, driven, shut down, panicky

You can experience strong urges to do certain things that you think are right at the time such as

- ‘fix things’ or try to push others to do a great deal ‘for’ the person
- be too flexible, offer too much – creating a sense of dependency/disempowerment or think others should do this (give special care – look after them)
- Push them away or reject the person
- Be blaming or critical of them
- Believe in certain things that might provide a ‘cure’ and have unrealistic expectations

Risk

- Don’t ignore escalating symptoms and increasing frequency of crises
- Stay calm, try to understand, validate
- Check the care plan/ safety plan – what worked before?
- Try to make sure the person is safe till urges to self harm reduce
- Admission does not generally help; think about alternatives e.g. crisis line, home treatment team, crisis house
- Don’t make it worse by unintentionally rejecting, criticising/abusing and re- traumatising
- Remember there may be the strong urge to provide ‘special care’ or well meaning rescuing (to do too much for the person) which is disempowering – try to provide respectful, consistent, realistic responses

- Validate when in crisis, problem solve when less overwhelmed

Try to avoid unhelpful responses as these reinforce the person's difficulties

INSTEAD

- Validate their emotions and other experiences

- Respectful warmth
- Install hope, but realistic expectations
- If you yourself have strong urges, stop and reflect
- Try to stay balanced – flexible care with reasonable limits
- Encourage self help – link up with resources
- Remember recovery takes time, step by step

Workshop 5: Personality Disorders

Resources

This is a fantastic resource compiled by Sue Sibbald, Peer Specialist in Personality Disorder, available for all staff and service users in SHSC. It contains a personal take on life with BPD and many useful links to resource files including NICE guidelines, self help and training sites, books and Sheffield groups/services:
INSERT PDF: 5a – BDF information
http://www.sheffieldccgportal.co.uk/pressv2/index.php/component/finder/search?q=BDP+information&Itemid=101

Back From The Edge (BPD). Video material available at youtube.com
National Education Alliance for Borderline Personality Disorder (NEABPD) – selection of material available at youtube.com or twitter.com
http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/personalitydisorder.aspx
http://www.rethink.org/diagnosis-treatment/conditions/borderline-personality-disorder
http://www.mentalhealth.org.uk/help-information/mental-health-a-z/P/personality-disorders/
http://www.bmj.com/content/338/bmj.b93
http://www.nice.org.uk/guidance/CG78

Meeting the challenge
INSERT PDF 5b – Meeting the challenge
http://www.sheffieldccgportal.co.uk/pressv2/index.php/component/finder/search?q=meeting+the+challenge&Itemid=101

Workshop 6

Autism Spectrum Disorder

Sheffield Adult Autism and Neurodevelopmental Service

How many people are we talking about?

If you have a patient list of 5,000 you are likely to have between 18-24 people who have ASD with no additional learning disability

DSM V Diagnostic Criteria
Social Communication & Interaction

- Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

- Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

- Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

DSM V Diagnostic Criteria Restricted, Repetitive Patterns of Behaviour

- Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
- Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
- Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
- Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

DSM V Diagnostic Criteria
The Rest

- Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

- Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

- These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Recognising ASD – The Warning Signs 1

- May take all language very literally
- May be unable to use or maintain eye contact
- Mismatch between apparent cognitive ability and ability to perform everyday tasks.
- There may be a discrepancy between their academic achievement and the nature of the work they do.
- May make frequent requests for appointments and/or may frequently fail to attend, attend at the wrong time or wrong day etc. This due to difficulties with organisational abilities or anxiety due to having to talk to unfamiliar person.

Recognising ASD – The Warning Signs 2

- May present very frequently but be unable to clarify specific need – you will need to consider sensory issues relating to pain.
- May have reduced awareness of illness or injury or inability to describe symptoms
- May be highly anxious or apparently annoyed if appointment not at expected time

Recognising ASD

- May use very direct or pedantic language (this may cause offence)
- They may be stressed by having to break their routine to visit their GP or health visitor
- May become extremely distressed after waiting in noisy or crowded waiting room
- May have difficulty expressing self clearly but become upset at your lack of understanding.
- May be very repetitive
- May take time to process what is said to them

Important Considerations

- May have learned to cover up the problems so signs of the condition may be very subtle
- May use alcohol or other substances to manage anxiety
- Sensory difficulties may mean that they report pain differently to how you might expect.
- Sensory difficulties mean they might struggle with the lighting in the room or sounds in an ‘echoey’ room and be distracted by them.
- They may only present at times of crisis – which may be to seemingly minor life events or at times of change.

Impact on life chances Relationships

- Relationships – chances of a successful, rewarding family life are reduced.
- May experience severe isolation despite a desire to form relationships
- May experience depression due to inability to form fulfilling relationships

Impact on life chances Employment

- May not achieve professional potential due to difficulties with managing interactions within the workplace
- May take low paid work despite academic qualifications. May not progress to expected level.
- At risk of workplace bullying
- May get into trouble at work due to lack of understanding of others.
- May have trouble at work at times of organisational change.

Impact on life chances Education

- May achieve academic qualifications but struggle with social side of school/college.
- May suffer from stress due to high expectations of self.
- May focus on one aspect of study to the exclusion of others.
- May become very anxious at coursework deadlines or exams.
- Difficulties may become apparent (or significantly worsen) once in university/further education due to lack of structure and increased organisational demands

What can SAANS Offer ?

- Assessment and Diagnosis of ASD and associated conditions
- Post-diagnostic support to come to terms with diagnosis
- Specialist Psychiatric assessment and/or treatment
- Psychological Interventions
- Occupational Therapy
- Speech and Language therapy
- Group Interventions
- Carer support, advice, psychoeducation
- Training

How to Refer

- Contact SAANS on 2716968 to discuss
- Referral letter to: SAANS, Michael Carlisle Centre, 75 Osborne Road, S11 9BF

What you can do to help (in addition to all those things you already do!)

- Ensure reception staff are aware of potential difficulties
- Provide quieter/low stimulus waiting area if possible
- Offer first appointment of surgery session to reduce waiting time (longer appointment may be needed at times)

What you can do to help

- Welcome information from family/carers
- Use straightforward language
- Be clear on treatment options, timescales and any future plans
- Provide visual information where possible

Useful links

- www.shsc.nhs.uk/sass
- *www.autism.org.uk*
- elearning.rcgp.org.uk
- *www.sheffield-aspergers.org.uk*

GP "Master Class"

The aim of the series would be to:

- Provide GPs with updates on the current evidence-based treatments for common mental health conditions
- Share information on new assessment tools
- Share best practice care pathways
- Develop the skills of GPs & Nurses in mental ill health, Dementia & Learning Disability
- The master class programme could be an annual series of events focused on key topics of interest to local GPs and nurses. Possibly to be held quarterly, each event will include presentations on mental health issues delivered by relevant clinicians and with a primary care perspective. An appropriate & convenient venue and timing would need to be established.
- The evening could provide opportunities to raise issues and discuss cases with colleagues in a more in-depth way than can be done in a PLI.

Possible topics could include:

Depression and anxiety
Physical health of mentally ill people
Early intervention
Personality disorder
Recognising mental ill health in teenagers
Learning disabilities – common co-morbidities/dementia care/physical health
Mental capacity assessment
Depression in long term conditions
Perinatal mental health
Children's mental health issues
10 minute CBT

Complex cases with unexplained symptoms
Assessing and responding to auditory hallucinations
Therapeutic communication and engagement
Deliberate self-harm with suicidal intent
Advanced mental health assessment and risk formulation
Trauma and complex care for children and young people
Refugee and transcultural mental health
Aggression management and de-escalation techniques
Developments in dementia care
Managing ADHD
Eating disorders

Protected Learning Initiative: Mental Health

NHS
Sheffield
Clinical Commissioning Group

Up skilling is not 'taking on more', it actually can give you less to do and feel better about what you're doing. It can lead to less onward referrals, less consultations and more effective consultation time. GPs are constantly attending up skilling courses in diabetes, CHD etc etc, and it's not regarded as taking on more. It's important to break down the divide between physical and mental health. - Dr Alastair Dobbin GP

http://www.foundationforpositivementalhealth.com/

A typical event could consist of:

A typical event could consist of:
6.30pm onwards Arrival and refreshments
7.30pm Welcome
7.35pm Personality disorders – Consultant Psychiatrist / GP / psychologist
8.00pm Use / role of medication Chief Pharmacist
8.30pm Discussion and questions
The educational methodology would encourage more in-depth learning, stimulate thinking, 'doing' and innovation and should help to break down barriers between professional groups.

Are you interested? Please register your interest (with no obligations) on the below link:

https://www.surveymonkey.com/s/MHMasterclassexpressaninterest

Working with you to make Sheffield HEALTHIER

References

(1) Mental Health Infographic
(2) http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf

(3) http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf

(4) Confidential Inquiry into Premature Deaths of People with Learning Disabilities:
http://www.bris.ac.uk/cipold/

(5) National policies:
Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health
http://www.rcpsych.ac.uk/files/pdfversion/OP88xx.pdf
No Health Without Mental Health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
Crossing Boundaries
http://www.mentalhealth.org.uk/content/assets/PDF/publications/crossing-boundaries.pdf?view=Standard
A Primary Care Approach to Mental Health & Wellbeing http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Case-study-report-on-Sandwell.pdf

(7) Practice Nurse learning and up-skilling: http://www.uclpartners.com/our-work/academic-health-science-network/integrated-mental-health/practice-nurse-masterclasses/

(10)10a – Diagnostic Overshadowing:
http://www.gmc-uk.org/learningdisabilities/200.aspx
10b - Inverse Care Law:
http://ac.els-cdn.com/S014067367192410X/1-s2.0-S014067367192410X-main.pdf?_tid=24dfef44-1d6f-11e4-a7fd-00000aab0f27&acdnat=1407332572_0ab110822c3fdddbcb4a80b1ddbd4ada
10c – reasonable adjustments:
http://www.equalityhumanrights.com/private-and-public-sector-guidance/guidance-for-all/pre-equality-act-guidance/guidance-for-service-providers-pre-october-2010/areas-of-responsibility#reasonable
10d – Equality act:
http://www.equalityhumanrights.com/legal-and-policy/key-legislatures/equality-act-2010/what-is-the-equality-act
http://www.kingsfund.org.uk/blog/2013/10/achieving-equitable-outcomes-between-mental-and-physical-health-how-can-we-make-change
Making Mental Health Services More Effective & Accessible: https://www.gov.uk/government/policies/making-mental-health-services-more-effective-and-accessible--2
10e - Starting Today:
http://www.mentalhealth.org.uk/content/assets/PDF/publications/starting-today.pdf?view=Standard

Other links

Mental Health Commissioning Intentions: A Five Year Ambition

(Caution: large file download)

http://www.intranet.sheffieldccg.nhs.uk/Downloads/MH_LD_D/Mental_Health_Commissioning_Intentions_Interactive.zip

Sheffield Help Yourself:

http://www.sheffieldhelpyourself.org.uk/

Sheffield Mental Health Website:

http://www.sheffieldmentalhealth.org.uk/

Protected Learning Initiative: Mental Health

NHS
Sheffield
Clinical Commissioning Group

Evaluation & Feedback

As always, we would like to thank you for attending the Mental Health PLI event today. We would love to hear your feedback and ask that you take 5 minutes to complete the online questionnaire.

Evaluation Survey

You said; we did…

- ***"Can we hold PLI events at venues other than SWFC?"*** – We had feedback that there were drawbacks with SWFC and that this is at the wrong end of town for some of you. Given the constraints of venue size and layout, and parking, we are very limited with our choices across the city. But in 2013 we tried two new venues – Holiday Inn Royal Victoria and The Mega Centre. The majority of you gave us very strong feedback that these venues were NOT suitable for PLIs, so we have returned to SWFC for the time being. We do, however continue to investigate alternatives that meet the needs of the large numbers involved, have good transport links, are easy to get to, have sufficient parking and are able to accommodate workshops

- ***Case Studies*** – Many of you have told us that you find case studies a valuable learning aid; we have asked event organisers to incorporate these where appropriate – for example, the asthma case study in July's Respiratory event

- ***"It's better to be able to pre-book the workshops"*** – We have changed the way you sign up to all PLI events and where applicable, allow you to pick which workshop you wish to attend before the event

- ***Selecting Topics for the year's PLI programme*** – Some of our topics are driven by national priorities such as safeguarding, and local imperative to disseminate new pathways of care. Other topics have been chosen in response to your feedback, for example the Common Childhood Conditions event last autumn and the Mental Health PLI event held today. The feedback on the last two Infectious Diseases sessions have been so positive with many of you saying how useful these sessions have been, that this topic has become an annual fixture!

- ***"Ask us what we need before you kick off? How about a pre-PLI questionnaire?"*** – We invited you to let us know which topics you would most benefit from being in the Mental Health PLI and we created the programme based on your responses

- ***Content for Practice Nurses*** – We have had comments that some of our talks and workshop are aimed at GPs and miss the learning needs of practice nurses; we have been talking to practice nurses and finding out more about what would be useful to you. Forthcoming events will have workshops specifically aimed at practice nurses to update your skills and knowledge

As you can see, your feedback is very important to us and has helped us shape these events to meet your needs. We will continue to make improvements and appreciate your help in making these events a success. **Thank you – The Events Team**

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