A guide to mental health services
for GPs and community services in the **Rochdale** borough

The Mental Health Stepped Care Model

1. **GP/Community Services/Voluntary Sector**
2. **Primary Mental Health Service (Mild-moderate)**
3. **Primary Mental Health Service (Moderate-severe)**
4. **Community Mental Health Services**
5. **Admission**

**Single access point for referrals into Pennine Care mental health services**

**Home Intervention Teams**

Pennine Care NHS Foundation Trust
About this manual

This manual has been developed specifically for GPs and community services, for ages 16 upwards, to explain the interface between primary and secondary care mental health services. The manual aims to support GPs and community services to access mental health services effectively.

The manual has been developed in four parts:

**Part 1 – The Stepped Care Model:** Explains what the Stepped Care model is and provides information on how to access front-line mental health services using Pennine Care’s single point of access for referrals.

**Part 2 and 3 – Primary and Secondary Mental Health Care:** Services for adults and older people are categorised and colour-coded according to each step of the model in this section.

**Part 3 – About mental health:** Offers detailed information about different levels of mental health problems. This is to provide a greater understanding of different mental health conditions from mild-to-moderate, to severe-to-complex. This would enable health professionals to make appropriate referrals in line with the Mental Health Stepped Care Model.

**Part 4:** Provides information about who are we and what the roles and responsibilities of our health and social care staff are.
About the Stepped Care Model
What is Pennine Care’s Mental Health Stepped Care Model?

The Stepped Care Model is a framework that underpins the different levels of support available within mental health services – please see the diagram overleaf. The Stepped Care Model illustrates which conditions are supported within mental health’s primary and secondary care. Patients can be referred into the most appropriate service in any of the steps.

How to make a referral

The Single Point of Entry (SPoE) is an integral part of mental health services in the Rochdale borough of Pennine Care NHS Foundation Trust. The service offers a single access point for referrals into mental health services from agreed primary care referrers for triage, assessment and sign-posting to the most appropriate service in the stepped care model.

Referrals to the SPoE are for service users who present with a complaint that cannot be managed in a Primary Care (non mental health) service and require a specialist assessment and/or interventions from mental health services. Referrals to the SPoE are for service users who require specialist mental health assessment and interventions at step 2, 3 and 4 of the stepped care model.

ADULT
Tel: 01706 676100
Fax: 01706 676160

OLDER PEOPLE
Tel: 01706 754491
Fax: 01706 754155

Pennine Care Direct

Pennine Care Direct provides referrers with a place to direct referrals to if you are unsure of how to access a service. The service operates seven days a week, 24 hours a day and is answered by a telephone operative who is able to send your referral onto the right service on your behalf. It applies to all services provided by Pennine Care. It does not replace existing referral points.

Tel: 0161 716 1716
Visit: www.penninecaredirect.nhs.uk
Email: pcn-tr.penninecaredirect@nhs.net

Pennine Care service directory

Should you need any further information about any of our services, please visit www.penninecare.nhs.uk and visit our service directory.
Figure 1: The Mental Health Stepped Care Model

Single access point for referrals
Single Point of Entry into Adult Mental Health Services

Access and Crisis Service

The Access and Crisis Service, also known as the Single Point of Entry Service, provides 24 hour response for people between the ages of 16-64 years old. The service has three key functions:

- A Referral Management Service for all new mental health referrals
- A Mental Health Assessment Service
- A Brief Intervention Service (providing two crisis follow-up appointments)

All new referrals are triaged appropriately on a daily basis by a multi-disciplinary team (MDT) of health and social care professionals. This includes:

- An Access Service Manager
- A qualified Mental Health Practitioner (Mental Health Nurse/ Social Worker)
- A Consultant Psychiatrist (when necessary)
- A qualified member of staff from Primary Care Mental Health Services

All referrals received would be logged onto Pennine Care’s IT system as a record and a letter response would be sent to the referrer providing information about the outcome of the referral. There are two main outcomes for the referral. These are:

- If the referral is not appropriate for mental health services an alternative suggestion would be offered where the referrer can then access other services.

- If the referral is appropriate a mental health assessment would be offered to the patient by letter for them to attend one of the following clinics depending on where the patient lives:
  - John Elliott Unit, Birch Hill Hospital – Rochdale
  - Hanson Corner Community Mental Health Team – Middleton
  - Sudden Resource Centre – Rochdale
  - Provide community home visits

The Access and Crisis Service will provide home visits for patients who are not able to get to the clinics. This information needs to be available at the time of referral. If you are not sure if the person is known (people that are open to Pennine Care services) or unknown
(people who are not open to Pennine Care services), then we encourage all health professionals to contact the Access and Crisis Service.

In addition to the Access and Crisis Service, a Brief Intervention Service has been developed for people who may fall into a mental health crisis and need additional support following an initial Mental Health Assessment. Two follow-up appointments can be offered by the Mental Health Practitioner or Consultant Psychiatrist.

Tel: 01706 676100
Fax: 01706 676160

Single Point of Entry into older peoples’ (65+) services for Rochdale and Heywood

Telephone: 01706 754491
Fax: 01706 754155
Office hours: Monday to Friday 9.00 am – 5.00 pm

In order to speed up entry to into older peoples’ secondary psychiatric services, all new referrals are screened and triaged by the SPoE nurses. This ensures that people are allocated to the correct team in a timely manner. SPoE can refer onto the following teams:

• Merit North and Merit South
• Intermediate Care
• Day services
• Psychological Therapies
• Outpatient Department
• Memory Assessment Service
• Adult Care Services
• Outreach Team

The nurses can see and assess people in their own home, a 24 hour care setting or in hospital to determine their needs and advise their referrers as to a plan of care. Hospital referrals must come through the Hospital Discharge Social Work Teams.

Referrals for Memory Clinic must be made by a GP, after a dementia screening has taken place. Patients under 65 years will not be seen in Memory Clinic unless they have been assessed by the Access and Crisis team who will then refer them via SPoE.

Urgent referrals will, whenever possible, be seen within 48 hours and routine referrals within five working days.

The team also offers a help and advice line for professionals which can be accessed on the above number. The nurses are happy to discuss cases even if a referral to SPoE is not required.

To access services via SPoE, the client must be over 65 years of age and reside in Rochdale or Heywood (Middleton residents are dealt with by Oldham SPoE 65.) They must not already be receiving psychiatric care at secondary level. Both the client and his/her GP must consent to the referral. GPs must have seen their patients immediately prior to them making a referral.

Referrals can be made via fax, telephone or letter. We do not have a dedicated referral form.

The team’s nurses have an advisory role only and cannot commission care, therefore it cannot respond to crises. If an inpatient admission is required, this must be discussed directly with the person in charge of the ward and not with SPoE.
The Stepped Care Model

Primary Care
The Primary Mental Health Service provides a range of psychological therapies for people from the age of 18 years old and over who present with a mild-to-moderate common mental health problem as described in Figure 2.

The treatment length can range from four-to-twenty sessions and can vary between thirty minutes or up to two hours.

Treatment offered include: Counselling, Facilitated Self-Help, Primary Care Liaison and Assessment, Stress Classes, Mood Matters Depression Group, Cognitive Behavioural Therapy, Being Heard Assertiveness Classes, Loss and Bereavement Workshop and Clinical Psychology.

The service has a skill mix of:

- Psychological well-being workers
- Cognitive Behavioural Therapists
- Counsellors
- Chartered Clinical Psychologist
- Psychological well-being workers
The service operates between 9.00 am and 5.00 pm, Monday to Friday and referrals are accepted from anyone in a helping capacity e.g. GP, Health Visitor, Speech and Language Therapist, Health Improvement Teams, Community Development Workers and the Voluntary Sector. All referral letters must go to the Access and Crisis Service for processing in line with the Mental Health Stepped Care Model.
ADULT SERVICES

Community Mental Health Services/Consultant Psychiatrist

The Community Mental Health Team (CMHT) is a multi-disciplinary service that consists of a team manager, community mental health nurses, mental health social workers, support workers, administrators and a Consultant Psychiatrist who are attached to the team. The CMHT can only accept referrals from the Access and Crisis Service who have been assessed as requiring Secondary Care Mental Health Services and meets the CMHT entrance criteria for CPA care co-ordination.

The service provides a specialist service for people aged 16 to 64 years old. Once a service user has been assessed as appropriate, they are allocated a Care Co-ordinator who can either be a Mental Health Nurse or a Mental Health Social Worker.

The CPA Care Co-ordinator’s role is to liaise with the appropriate Consultant Psychiatrist and other health and social care agencies in meeting the needs of the service user. They will assess and develop a care plan with the service user, identifying his/her needs and how these needs will be met. They will also review and then transfer/plan for discharge as illustrated below in Figure 3. Generally, the timescale of a service user requiring support from a CMHT would be up to two years.

Figure 3: The Role of the CPA Care Co-ordinator
Early Intervention Team (EIT)

The Early Intervention Team provides services for people between the ages of 14 to 35 years old. All referrals would be responded to and triaged appropriately by the EIT.

The EIT have an open referral system where any professional can make a referral if they suspect a person may be experiencing:

- First episode of psychosis
- Drug-induced psychosis present
- Suspected psychosis

All referrals received would be logged onto Pennine Care’s IT system as a record and would be responded to appropriately.

The EIT consists of:
- A Consultant Psychiatrist
- Mental health social workers
- Mental health nurses
- Support workers
- An admin worker

Services offered include:
- Assessment
- Specialist assessments
- Consultant Psychiatrist
- Care co-ordination
- Medication
- Access to the HUB (Psychological Therapies Service)
- Liaison with other health and social care agencies

Clinics are based at:
- Sudden Resource Centre, Rochdale
- Birch Hill Hospital, Rochdale
- Home/community visits

If you are not aware if the person is known to services (people that are open to Pennine Care services) or unknown (people who are not open to Pennine Care services) then you can contact the Access and Crisis Service who will advise you on this.

Mentally Disordered Offenders (MDO) Team

The Mentally Disordered Offenders Team have no age criteria in accepting referrals. The MDO Team operate between 8.00 am – 5.00 pm. Between 5.00 pm – 8.00 am, all emergency referrals/concerns go to the Emergency Duty Service (EDT).

All referrals are accepted for people who present with a mental health problem and are in the Criminal Justice System.

The MDO team consists of:
- A Mental Health Social Worker
- A Mental Health Nurse

The MDO team offer:
- A specialist assessment
- A Trust Approved Risk Assessment (TARA)
- Sign-posting to appropriate agencies
- Providing advice and guidance

The MDO team hold visits at the following areas:
- Probation service
- Police
- Courts
- In prisons
- In the community

Review and Recovery Team

The Review and Recovery Team is a service for people aged 18 to 65 years old that enables people to move away from mental health services, once they become stable in their mental health.

Referrals to the Review and Recovery Team are only accepted by care co-ordinators from a Community Mental Health Team(s) for people already receiving care from a Secondary Care Mental Health Service.

These include service users who meet the following criteria:
- Have stable housing/accommodation
- Have a stable care package
- Individuals who have a good insight into their mental health
- Individuals who are able to engage effectively with health and social care professionals
• Individuals who are able to self-manage their own care
• Individuals who do not have outstanding safeguarding issues

The aim of the Review and Recovery Team is to:
• Provide a daily duty system
• Undertake monthly or six-monthly reviews
• Risk management
• Depot and clozapine management
• Engage and liaise with other key health and social care agencies
• Apply the recovery model
• Plan care back to the GP

The service operates from 8.30 am to 5.00 pm, Monday to Friday.

OLDER PEOPLES’ SERVICES

Community Mental Health Services/ Consultant Psychiatrist

The Community Mental Health Team (CMHT) is a multi-disciplinary service consisting of a team manager, community mental health nurses, mental health social workers, support workers, administrators and two consultant psychiatrists attached to either the North or South CMHT. There are two Older Peoples’ Community Mental Health Teams operating in Middleton and Rochdale, Monday to Friday, from 9.00 am to 5.00 pm. These are the MERIT Team North in Rochdale and the MERIT Team South in Middleton.

The CMHT can only accept referrals from the SPoE, a Consultant Psychiatrist or from the Memory Clinic who have been assessed as requiring Secondary Care Mental Health Services and meet the CMHT entrance criteria for CPA Care Co-ordination. All Middleton residents are managed by a consultant psychiatrist based in the Oldham borough.

Both CMHT’s provide support for people aged 65 and over with long-term mental health problems and who have a diagnosis of dementia and other complex mental health problems such as depression, anxiety and bipolar. Once a service user has been assessed as appropriate, the service user is allocated a CPA Care Co-ordinator who can either be a Mental Health Nurse or a Mental Health Social Worker.

The CPA Care Co-ordinator’s role is to liaise with the appropriate Consultant Psychiatrist and other health and social care agencies in meeting the needs of the service user. They will assess and develop a care plan with the service user, identifying his/her needs and how these needs will be met. Services are commissioned via Rochdale Adult Care or through continued Health Care Funding.

Memory Clinic

The Memory Clinic operates Monday to Friday, from 9.00 am to 5.00 pm and is an assessment and diagnostic clinic for people who have a dementia type illness.

The Memory Clinic also provides long-term care management for people who require:
• Treatment
• Medication prescribing/monitoring
• Review – every 6 months

The staff skill mix includes:
• 1 x qualified Mental Health Nurse
• 1 x qualified Assistant Practitioner
• 2 x Consultant Psychiatrist providing two sessions

In the near future, all diagnostic clinics will be held in Primary Care/GP practices.

All Middleton residents will be managed by a consultant psychiatrist based in the Oldham borough.

Home Treatment Team/Intermediate Care Team

The Home Treatment Team and Intermediate Care Team have recently merged and are managed by one manager. Both services operate between 9.00 am and 5.00 pm, Monday to Friday.

Home Treatment Team

The service operates from 9.00 am to 5.00 pm Monday to Friday and provides an alternative to the hospital admission service for people requiring an acute mental health ward admission. There is a ‘fast-track system’ to the Home Treatment Team for people already on the ward as an inpatient. The team provides an outreach service for people in a nursing or residential home in the Heywood, Middleton and Rochdale area. The services include:
• Assessments
• Education to staff about risk management, advice, support and how to manage challenging people with a mental health problem
The skill mix of staff includes:
- 3 x Registered Mental Health Nurse

**Intermediate Care Team**

The service operates from 9.00 am to 5.00 pm, Monday to Friday and provides an intensive rehabilitation service for people who require support for:
- Coming out of acute mental health hospitals
- Crisis in the community with support in the individuals own home
- A bed-based service at Spring Hill

The bed-based service providing 12 beds is owned by the Local Authority. Access to this service is via the Intermediate Care Team.

The skill mix of staff includes:
- 1 x Manager
- 1 x Part-time Administrator
- 1 x Part-time Occupational Therapist
- 2 x Registered Mental Health Nurse

**ADULT SERVICES**

**Home Treatment Service**

The Home Treatment Service provides two main functions. These are:
- Home Treatment Service, as an alternative to hospital admission
- Supportive Discharge Service; a transition from inpatient care to community care

Referrals to the Home Treatment Service can only be made by the following professionals who work within mental health services. These include:
- A Mental Health Practitioner from the Access and Crisis Service
- A Consultant Psychiatrist
- A CPA Care Co-ordinator

The Home Treatment Service operates between 8.00 am and 10.00 pm, seven days a week, 365 days a year and provides the following services:
- Home treatment between two-to-six weeks
- Clozapine treatment
- Medication monitoring
- Risk management
- Physical health checks (bloods, BP, weight, smoking cessation)
- Talking therapy
- CPA mental health reviews
- Multi-disciplinary approach
- Multi-agency working
- Liaison with a Consultant Psychiatrist
- Liaison with community mental health teams
- Inpatient admission (where appropriate)

**Acute Mental Health Wards**

At Birch Hill Hospital there are two, mixed-sex adult mental health wards that provide inpatient services for people aged 18 to 65 years old. These are:
- Moorside Ward – 24 beds
- Hollingworth Ward – 16 beds

All admissions to the adult mental health wards can only be made by the Home Treatment Service who will decide whether or not admission is appropriate, or an alternative Home Treatment Service can be provided.

There is also a designated place of safety for people who have been brought to the ward on a Section 136 under the Mental Health Act 1983.

There are two inpatient consultant psychiatrist medical leads.

Both adult mental health wards also accept people that fall under the category of informal admission (of their own will) or formal admission (those who have been sectioned under the Mental Health Act 1983 for assessment or treatment).

The following services are provided on the mental health wards:
- Assessment
- Risk management
- Medication prescribing/monitoring
- Mental health reviews
- General nursing care
ALL AGES

Secondary Care Psychological Therapies Service

New referrals to the Secondary Care Psychological Therapies Service should be made to the Access and Crisis Service in-line with the Mental Health Stepped Care Model.

Referrals to the Secondary Care Psychological Therapies Service will only be accepted from the Multi-Disciplinary Teams (MDTs) and Community Mental Health Teams.

All referrals will be triaged and signposted to the most appropriate service within the Mental Health Stepped Care Model.

Referrals accepted by the Secondary Care Psychological Therapies Service will be offered the most appropriate intervention to meet the service user’s needs which may include:

- Consultation
- Assessment
- Formulation
- Treatment – individual and/or group

A broad choice of psychological modalities are also offered which include:

- Psychotherapeutic
- Psychodynamic
- Cognitive Behavioural Therapy (CBT)
- Cognitive Analytic Therapy (CAT)
- Dialectical Behaviour Therapy (DBT)
- Counselling
- Mindfulness
- Democratic Therapeutic Community
- Eye Movement Desensitisation and Reprocessing (EMDR)

The service has a skill mix of the following staff:

- Clinical Psychologist
- Cognitive Behavioural Therapist (CBT)
- Cognitive Analytic Therapist (CAT)
- Counsellors
- Art therapy

The service operates from 8.30 am to 5.00 am hours, Monday to Friday.

OLDER PEOPLES’ SERVICES

Acute Mental Health Wards for Older People

There is one Older Peoples’ Acute Mental Health ward consisting of 14 beds. The ward is divided and named:

- Beech Bay
- Hazel Bay

Beech Bay

Provides inpatient support for people with long-term mental health problems such as depression, for the assessment and treatment of their functional mental health illness and those detained under the Mental Health Act.

Hazel Bay

Provides inpatient support for people with dementia for the assessment and treatment of their organic mental health illness and those detained under the Mental Health Act. The gate-keeper (qualified Nurse-in-Charge) will accept and process all appropriate referrals to the wards from the following services:

- Single Point of Entry (SPOE)
- Consultant Psychiatrist/Home Treatment Team
- Emergency Mental Health Act admission
Adult Care Emergency Duty Team

The Emergency Duty Team (EDT) provides an emergency service only and it is not an out-of-hours service. The EDT operates from 5.00 pm to 8.30 am hours, Monday to Friday and 24 hours-a-day at weekends. Below are examples of the service areas the EDT will cover:

• Children services
• Adult services
• Older Peoples’ services
• Housing/homeless services
• Mental health
• Vulnerable adults
• Domestic violence

The EDT provides an emergency service only for people who are:

• In immediate danger of harm to themselves or harm to others
• People who pose an immediate risk/harm to the public
• People who are vulnerable and require immediate safeguarding
• People who require a Section 136 assessment under the Mental Health Act 1983
• People who require immediate care and treatment

The EDT also provides a responsive service for people with a low-level of risk to harm self or others, from all callers across the Rochdale Borough, providing advice and sign-posting.

The EDT has a skill mix of social workers who work on a roster basis, seven days-a-week. There are only two social workers on duty per shift. They specialise in:

• Child safeguarding
• Generic social work
• Provide an Approved Mental Health Practitioner (AMHP) to undertake assessments under the Mental Health Act 1983

Note: All referrals to the Adult Care Emergency Duty Team will be processed appropriately. Referrals that are deemed as an absolute emergency will be given priority.

Request for a Mental Health Act assessment

Adult Care Mental Health Act Request (9.00 am - 5.00 pm)

If a GP requires a person to be assessed under the Mental Health Act 1983 (as amended 2007) because the GP is concerned about the person’s mental health or the person’s mental health has deteriorated significantly and an urgent hospital admission is necessary, the following process applies:

• GP to check if person is known to Pennine Care Mental Health Services by checking their records. GP should contact the Consultant Psychiatrist attached to the relevant team to seek advice if required. If an assessment under the Mental Health Act is required, the duty AMHP should be contacted by the GP.

• If person is unknown to Pennine Care Mental Health Services, GP to contact the AMHP on-duty to discuss case. GP should contact the Psychiatrist on-call to seek advice if required.

The following information is required where possible for an AMHP referral to be processed in a timely manner. This includes:

• Demographic
• If person is known to other health and social care organisations
• Current mental health concerns
• Current legal status of person
• Any advance discussion
• Outcome of discussion with psychiatrist
• Nearest relative
• Consideration of alternative prior to AMHP request
• Useful contact/telephone numbers
• GPs availability to attend and undertake a Mental Health Act assessment

The following process applies:

• In immediate danger of harm to themselves or harm to others
• People who pose an immediate risk/harm to the public
• People who are vulnerable and require immediate safeguarding
• People who require a Section 136 assessment under the Mental Health Act 1983
• People who require immediate care and treatment

The EDT also provides a responsive service for people with a low-level of risk to harm self or others, from all callers across the Rochdale Borough, providing advice and sign-posting.

The EDT has a skill mix of social workers who work on a roster basis, seven days-a-week. There are only two social workers on duty per shift. They specialise in:

• Child safeguarding
• Generic social work
• Provide an Approved Mental Health Practitioner (AMHP) to undertake assessments under the Mental Health Act 1983

Note: All referrals to the Adult Care Emergency Duty Team will be processed appropriately. Referrals that are deemed as an absolute emergency will be given priority.
Rochdale Drug Service

Alcohol and/or drug problems occur in as many as 8% of patients in Primary Care and 20% and 56% of community and inpatient mental health settings respectively. GPs and community services should consider possible drug use or dependence when any patient presents with:

- Social problems which include marital or sexual problems, domestic violence, difficulties at work, legal or financial problems
- Mental health problems, such as irritability or rage states, anxiety, depression, hallucinations, insomnia, repeated accidents or trauma including repeated episodes of deliberate self-harm or a decline in usual standards of social concern and personal care
- Requests for anxiolytic, hypnotic, anti-depressant or analgesic medication, or a medical certificate
- History of frequent consultations with several different doctors which is generally known as doctor-shopping

Rochdale Drug Service offer assessment and a wide range of treatment and interventions to those with substance misuse issues within the Borough of Rochdale. The service’s ethos is on recovery and abstinence with a service model that is reflective of the various stages of a client’s journey through treatment. Rochdale Drug Service work in a multi-agency approach to reduce harm, achieve outcomes and to plan and provide a holistic package of care.

The Drug Service also provides:
- A range of services for people experiencing drug related problems
- Needle exchange scheme
- Substitute prescribing (opioids)
- Detoxification
- Individual therapeutic sessions and guidance to other agencies

Rochdale Drug Service operates Monday, Tuesday, Thursday and Friday at 9.00 am to 5.00 pm and Wednesday at 9.00 am to 7.00 pm and has an open referral system.
What is mental health?

Mental illness is very common. It is estimated from research studies that one-in-four people in the UK experience a diagnosable mental health problem at some point during their life. Depression and anxiety disorders are the most common forms of mental health problems and evidence suggests that around a third of people with depression and half with anxiety disorders, do not receive any support or treatment from health services.

A majority of people with mental health problems are supported solely by GP’s and other health and social care professionals working in Primary Care mental health services, for the treatment of common mental health problems.

According to the World Health Organisation:

“Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”
What are mental health problems?

There are many different conditions that are recognised as a common mental health problem. However, locally Figure 8 below describes the common type of mental health problems for mental health and Figure 9 describes Secondary Care mental health problems in line with the Stepped Care model.

What can cause a mental health problem?

There are many reasons why a person may begin to or experience a mental health problem during their lifetime. This could be because an individual may have inherited it from their family, it might be because of the individual’s lifestyle or it might be because of things that have happened to them in the past. Sometimes it’s a combination of all these.

There could also be different reasons for someone developing a mental health problem which could be linked to an individual:

- Physical
- Social
- Environmental
- Psychological problems

The bigger picture

For many people with mental health problems, it is not a single factor or type of factor that has led to the development of their problems. It is often the case that a series of life events have occurred, that have eventually triggered a mental health problem.

The difference between a working diagnosis and a diagnosis?

A Mental Health Practitioner or a Consultant Psychiatrist may recognise early signs of a specific mental health problem such as depression or anxiety during the assessment process with the patient, prior to a formal diagnosis of a mental health problem is made.

A formal diagnosis of a mental health problem can only be made by a Psychiatrist. However, mental health practitioners (Registered Mental Health Nurse/Social Worker) who are trained in mental health, are qualified to identify specific mental health problems through the assessment process which is often called a working diagnosis.

It could take up to several months before a formal diagnosis is made. A diagnosis can often change or a new diagnosis can be made. This depends on the patient’s mental health presentation. A Psychiatrist can only make the formal psychiatric diagnoses which are categorised by the International Classification of Diseases (ICD).
Mental health conditions

The following section contains information about a range of conditions to help you understand the types of mental health problems a person may present with.

These topics include:

- Anxiety
- Bipolar disorder
- Depression
- Dementia
- Eating disorders
- Long-term conditions and mental health
- Obsessive Compulsive Disorder (OCD)
- Psychosis
- Personality disorders
- Post-natal depression
- Schizophrenia
- ADHD with mental health problems
- Autism with mental health problems
- Asperger’s Syndrome with mental health problems
- Learning disability with mental health problems

### Anxiety

The symptoms of General Anxiety Disorder (GAD) often develop slowly and can vary in severity from person-to-person. Some people experience only one or two symptoms, while others experience many more. Anxiety can affect a person physically and psychologically.

If you suspect a person is anxious as a result of a phobia or because of panic disorder, generally you may know the cause of it. For example, if the person is claustrophobic (a fear of enclosed spaces), you know that being confined in a small space will trigger the anxiety.

However, if you suspect a person with GAD, what they are feeling anxious about may not always be clear. Not knowing what triggers the anxiety can intensify it and they may start to worry that there will be no solution.

<table>
<thead>
<tr>
<th>Psychological symptoms may include:</th>
<th>Physical symptoms may include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restlessness</td>
<td>Dizziness</td>
</tr>
<tr>
<td>A sense of dread</td>
<td>Drowsiness and tiredness</td>
</tr>
<tr>
<td>Feeling constantly ‘on edge’</td>
<td>Pins and needles</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>Irregular heartbeat (palpitations)</td>
</tr>
<tr>
<td>Irritability</td>
<td>Muscle aches and tension</td>
</tr>
<tr>
<td>Impatience</td>
<td>Dry mouth</td>
</tr>
<tr>
<td>Being easily distracted/</td>
<td>Excessive sweating</td>
</tr>
<tr>
<td>poor attention span</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Stomach ache</td>
<td>Stomach ache</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>Headache</td>
</tr>
<tr>
<td>Headache</td>
<td>Excessive thirst</td>
</tr>
<tr>
<td>Excessive thirst</td>
<td>Frequent urinating</td>
</tr>
<tr>
<td>Painful or missed periods</td>
<td>Frequent urinating</td>
</tr>
<tr>
<td>Difficulty falling or staying</td>
<td>Painful or missed periods</td>
</tr>
<tr>
<td>asleep (insomnia)</td>
<td></td>
</tr>
</tbody>
</table>
Bipolar disorder

Bipolar disorder (previously known as manic depression) is a condition that affects a person’s moods, which can swing from one extreme to another. If a person has a bipolar disorder he/she will have periods or ‘episodes’ of depression and mania.

The depression and mania that are associated with bipolar disorder are characterised as follows:

- **Depression** – During a period of depression (low phase) a person may experience the following symptoms as described below

- **Mania** – Where you feel very high, slightly less severe mania is known as hypomania. The manic (high) phase of bipolar disorder usually follows two-to-four episodes of depression and may include the following symptoms as described below

### Depression

- feeling sad and hopeless
- lacking in energy
- difficulty concentrating and remembering things
- a loss of interest in everyday activities
- feelings of emptiness or worthlessness
- feelings of guilt and despair
- feeling pessimistic about everything
- self-doubt
- being delusional, having hallucinations and disturbed or illogical thinking
- lack of appetite
- difficulty sleeping
- waking-up early
- suicidal thoughts

### Mania

- feeling very happy, elated or euphoric (overjoyed)
- talking very quickly
- feeling full of energy
- feeling full of self-importance
- feeling full of great new ideas and having important plans
- being easily distracted
- being easily irritated or agitated
- being delusional, having hallucinations and disturbed or illogical thinking
- not feeling like sleeping
- not eating
- doing pleasurable things that often have disastrous consequences, such as spending large sums of money on expensive and sometimes unaffordable items

### Psychological symptoms may include:

- Continuous low mood or sadness
- Feeling hopeless and helpless
- Having low self-esteem
- Feeling tearful, feeling guilt-ridden
- Feeling irritable and intolerant of others
- Having no motivation or interest in things
- Finding it difficult to make decisions
- Not getting any enjoyment out of life
- Having suicidal thoughts or thoughts of harming yourself
- Feeling anxious or worried

### Physical symptoms may include:

- Moving or speaking more slowly than usual
- Change in appetite or weight (usually decreased, but sometimes increased)
- Constipation
- Unexplained aches and pains
- Lack of energy or lack of interest in sex
- Changes to your menstrual cycle
- Disturbed sleep (for example, finding it hard to fall asleep at night or waking-up very early in the morning)

### Social symptoms may include:

- Not doing well at work
- Taking part in fewer social activities and avoiding contact with friends
- Neglecting your hobbies and interests
- Having difficulties in your home and family life
- Experiencing housing issues, homelessness
- Breakdown of relationship/marriage
- Using drugs and alcohol that impacts on mental health
- Financial issues

If you suspect a person who may be experiencing depression who is generally feeling sad, hopeless and has lost interest in the things they have previously enjoyed doing, then the person could be experiencing some form of depression. The symptoms can persist for weeks or months and are bad enough to interfere with their work, social and family life. A person with depression may experience a combination of **psychological**, **physical** and **social symptoms** which may impact on the person’s level of daily functioning.
Dementia

Dementia is a syndrome (a group of related symptoms) that is associated with an ongoing decline of the brain and its abilities. These include memory, thinking, language, understanding and judgment.

People with dementia may also become apathetic, have problems controlling their emotions or behaving inappropriately in social situations. Aspects of their personality may change or they may see or hear things that other people do not, or have false beliefs. Most cases of dementia are caused by damage to the structure of the brain. People with dementia usually need help from friends or relatives, including help in making decisions.

Alzheimer’s disease

Alzheimer’s disease is the most common form of dementia, which is a group of symptoms associated with a decline in mental abilities, such as memory and reasoning.

Alzheimer’s disease attacks nerves, brain cells and neurotransmitters (chemicals that carry messages to and from the brain). Although Alzheimer’s disease is often associated with increasing age, the exact cause is unknown.

This should not be confused with a delirium which presents with a sudden deterioration in memory, increased confusion and increased apathy. This is usually over a short-period of time (72 hours).

Delirium is commonly linked to physical health causes. The most common causes are Urinary Tract Infections (UTI) and chest infections.

Alzheimer’s disease is a progressive illness that affects memory, thinking and in most aspects of self-care. The cause of the illness can be rapid over a number of years or maybe slow over a decade or more.

Referral to the Memory Clinic enables a diagnosis and options for treatment which is usually medication.

Vascular Dementia

Vascular Dementia is caused when there is an interruption in the blood supply to the brain.

Like all organs, in order to work properly, the brain needs a constant supply of oxygen and nutrients, which is provided by your blood (vascular system). If the supply of blood is restricted or stopped, brain cells begin to die, resulting in brain damage.

This interruption to blood supply can develop gradually over time if the vessels inside the brain narrow and harden. This narrowing and hardening of the blood vessels is usually caused when fatty deposits build up on the blood vessel walls, restricting the flow of blood. This is called atherosclerosis.

Dementia with Lewy bodies

Lewy bodies are small, circular lumps of protein that develop inside the brain. It is not known what causes them. It is also unclear how they damage the brain and cause dementia. One theory is that they block the effects of two neurotransmitters called dopamine and acetylcholine.

Neurotransmitters are messenger chemicals that send information from one brain cell to another.

Both dopamine and acetylcholine are thought to play an important role in helping to regulate many brain functions such as memory, learning, mood and attention. Therefore by blocking their effects, Lewy bodies may trigger dementia.

Frontotemporal Dementia

Frontotemporal Dementia is caused by two parts of the brain (the temporal lobe and the frontal lobe) becoming increasingly damaged and then shrinking.

In an estimated 40-50% of cases, people who develop frontotemporal dementia have inherited a genetic mutation (an altered gene) from their parents. These genetic mutations are thought to have a negative effect on a protein called the tau protein.

All brain cells contain tau proteins that help to keep them stable. However if tau proteins stop working properly, they can damage brain cells.

Motor neurone disease is also known to cause frontotemporal dementia.
Eating disorders

Eating disorders are characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour. A person with an eating disorder may focus excessively on their weight and shape, leading them to make unhealthy choices about food with damaging results to their health.

Anorexia Nervosa

When a person tries to keep their weight as low as possible, for example by starving themselves or exercising excessively.

Bulimia

When a person tries to control their weight by binge eating and then deliberately being sick or using laxatives (medication to help empty their bowels).

Binge Eating

When someone feels compelled to overeat.

Spotting the signs

- Missing meals complaining of being fat, even though they have a normal weight or are underweight
- Repeatedly weighing themselves and looking at themselves in the mirror
- Making repeated claims that they have already eaten, or they will shortly be going out to eat somewhere else
- Cooking big or complicated meals for other people, but eating little or none of the food themselves
- Only eating certain low-calorie foods in your presence, such as lettuce or celery
- Feeling uncomfortable or refusing to eat in public places, such as a restaurant
- The use of ‘pro-anorexia’ websites

Causes

Eating disorders are often blamed on the social pressure to be thin, as young people in particular feel they should look a certain way. However, the causes are usually more complex.

There may be some biological or influencing factors, combined with an experience that may provoke the disorder, plus other factors that encourage the condition to continue.

Risk factors that can make someone more likely to have an eating disorder include:

- having a family history of eating disorders, depression or substance misuse
- being criticised for their eating habits, body shape or weight
- being overly concerned with being slim, particularly if combined with pressure to be slim from society or for a job (for example ballet dancers, models or athletes)
- certain characteristics, for example, having an obsessive personality, an anxiety disorder, low self-esteem, or being a perfectionist
- particular experiences, such as sexual or emotional abuse or the death of someone special
- difficult relationships with family members or friends
- stressful situations, for example problems at work, school or university

Long-term conditions and mental health

Many people with long-term physical health conditions also have mental health problems. These can lead to significant poorer health outcomes and reduced quality of life. Support for emotional, behavioural and mental aspects of physical health could play an important role for Health or Social Care professionals.
Obsessive Compulsive Disorder (OCD)

While Obsessive Compulsive Disorder (OCD) is a condition that can affect people differently, it usually manifests itself through a pattern of thought and behaviour. The pattern for most people with OCD generally falls into a set pattern or cycle of thought and behaviour. The pattern has four main cycles; Obsession, Anxiety, Compulsion and Temporary Relief.

The pattern of Obsessive Thoughts may include a person experiencing unwanted and unpleasant thoughts; such as if he/she does not act on their thoughts something bad is going to happen. If a person experiences a persistent, unwanted and unpleasant thought process that is overwhelming to the extent that it interrupts their processes and daily life, then he/she may have developed obsessional traits.

OCD Pattern

- Obsession – mind is overwhelmed by a constant obsessive fear or concern
- Anxiety – this obsession provokes a feeling of intense anxiety and distress
- Compulsion – a pattern of compulsive behaviour to reduce anxiety and distress is developed
- Temporary relief – the compulsive behaviour brings temporary relief from anxiety, but the obsession and anxiety soon return, causing the pattern cycle to begin again

OCD Behaviour

- Fear of causing harm to oneself or to others through deliberate action
- Fear of causing harm to oneself or to others through a mistake or accident
- Fear of contamination by disease, infection or other unpleasant substance
- A need for symmetry or orderliness (labels on tins in a cupboard must face the same way)
- Fear of committing an act that would seriously offend one’s religious beliefs

OCD Symptoms

- Cleaning
- Hand washing
- Counting
- Ordering and arranging
- Hoarding
- Asking for reassurance
- Needing to confess
- Repeating words silently
- Prolonged thoughts about the same subject
- ‘Neutralising’ thoughts (to counter the obsessional thoughts or images)
- Checking – such as checking that doors are locked, or that the gas or a tap is off

Psychosis

Psychosis is a condition that affects a person’s mind and causes changes to the way they think, feel and behave. A person who experiences psychosis may be unable to distinguish between reality and their imagination. People who are experiencing psychosis are sometimes referred to as psychotic. They may have hallucinations and/or delusions.

The length of time someone will experience a psychotic state of mind, known as a psychotic episode, will depend on the underlying causes. Drug or alcohol-induced psychosis may only last for a few days. However, psychosis that results from schizophrenia or bipolar disorder may last indefinitely unless it is treated. Psychosis is more common than most people realise. It is estimated that one in every two-hundred people in the UK has experienced psychosis. Some people will only experience one psychotic episode, while others may experience several throughout their life. Schizophrenia, which is one of the main causes of psychosis, will affect one person in every one-hundred in the population during their lifetime.
Hallucinations

Visual – a person seeing things which are not present to another person and can be distressing and uncomfortable

Auditory – a person hearing sounds such as voices, music, hissing, whistling and can be distressing and uncomfortable

Command hallucinations – Command hallucinations are hallucinations in the form of commands to cause harm to self or others – it can also be linked to a person who has schizophrenia

Delusions

Bizarre delusion: That is very strange and completely implausible; an example of a bizarre delusion would be that aliens have removed the affected person’s brain.

Non-bizarre delusion: A delusion that, though false, is at least possible, e.g. the affected person mistakenly believes that he is under constant police surveillance.

Mood-congruent delusion: Any delusion with content consistent with either a depressive or manic state, e.g. a depressed person believes that news anchors on television highly disapprove of him, or a person in a manic state might believe he is a powerful deity.

Mood-neutral delusion: A delusion that does not relate to the sufferer’s emotional state; for example, a belief that an extra limb is growing out of the back of one’s head is neutral to either depression or mania.

Personality disorders

Personality disorders are mental health conditions that affect how people manage their feelings and how they relate to other people.

Disturbances of feeling and distorted beliefs about other people can lead to odd behaviour, which can be distressing and which other people may find upsetting.

Cluster A

Personality Disorders

A person with a Cluster A personality disorder regards other people as alien and usually shows patterns of behaviour that most people would regard as odd and eccentric. Others may describe them as living in a fantasy world of their own.

An extreme example is paranoid personality disorder, where the person is extremely distrustful and suspicious.

Cluster B

Personality Disorders

A person with a Cluster B personality disorder struggles to regulate their feelings and often swings between positive and negative views of others. This can lead to patterns of behaviour that others describe as dramatic, unpredictable and disturbing.

An example is borderline personality disorder, where the person is emotionally unstable, has impulses to self-harm and has very intense and unstable relationships with others.

Cluster C

Personality Disorders

A person with a Cluster C personality disorder struggles with persistent and overwhelming feelings of anxiety and fear. They tend to show patterns of behaviour that most people would regard as anti-social and withdrawn.

An example is avoidant personality disorder, where the person appears painfully shy, socially inhibited, feels inadequate and is extremely sensitive to rejection. The person may want to be close to others, but lacks the confidence to form a close relationship.
A person with a paranoid personality disorder is extremely distrustful and suspicious. Other symptoms include:
- thinking other people are lying to them or trying to manipulate them
- feeling they cannot really trust their friends and associates
- worrying that any confidential information shared with others will be used against them
- often thinking there are hidden meanings in remarks most people would regard as innocent
- worrying that their spouse or partner is unfaithful, despite a lack of evidence

A person with a schizoid personality disorder may appear cold and detached and may avoid making close social contact with other people. Other symptoms include:
- preferring to take part in activities that do not require interaction with others
- having little desire to form close relationships, including sexual relationships
- being uninterested when receiving criticism or praise
- having a limited ability to experience pleasure or joy

A person with schizotypal personality disorder is likely to have poor social skills and delusional thoughts and behave in unusual ways. Other symptoms include:
- attaching undue and misguided significance to everyday events, such as thinking newspaper headlines are secret messages to them
- believing in special powers, such as telepathy or the ability to influence other people's emotions and actions
- having unusual ways of speaking, such as long, rambling vague sentences or going off on a tangent
- experiencing excessive anxiety in social situations, even if they have known a particular person or group of people for a long time

A person with an anti-social personality disorder sees other people as vulnerable and may enjoy intimidating or bullying others. They lack concern about the consequences that their actions may have.

Symptoms include:
- mistrust and deceit (including lying to people)
- feeling agitated, depressed and bored most of the time
- manipulating and exploiting other people
- lack of concern, regret or remorse about other people's distress
- blaming others for problems in their lives

A person with a borderline personality disorder is emotionally unstable, has impulses to self-harm and has very intense and unstable relationships with others.

A person with a histrionic personality disorder is anxious about being ignored. As a result, they feel a compulsion (overwhelming urge) to be noticed and to be the centre of everybody's attention.

Symptoms and behaviours include:
- displaying excessive emotion yet appearing to lack real emotional sincerity
- dressing provocatively and engaging in inappropriate flirting or sexually seductive behaviour
- moving quickly from one emotional state to another
- being self-centred and caring little about other people
- constantly seeking reassurance and approval from other people

Symptoms and signs may co-exist with borderline and narcissistic personality disorders.
Cluster B
Narcissistic Personality Disorder

A person with a narcissistic personality disorder swings between seeing themselves as special and fearing they are worthless. They may act as if they have an inflated sense of their own importance and show an intense need for other people to look up to them.

Other symptoms include:
- exaggerating their own achievements and abilities
- thinking they are entitled to be treated better than other people
- exploiting other people for their own personal gain
- lacking empathy for other people's weaknesses
- looking down on people they feel are 'beneath' them, while feeling deeply envious of people they see as being 'above' them

Cluster C
Avoidant Personality Disorder

A person with an avoidant personality disorder appears painfully shy, is socially inhibited, feels inadequate and is extremely sensitive to rejection.

Unlike people with schizoid personality disorders, they desire close relationships with others but lack the confidence and ability to form them.

Cluster C
Dependent Personality Disorder

A person with a dependent personality disorder feels they have no ability to be independent. They may show an excessive need for other people to look after them and are very 'clingy'. Other symptoms include:
- finding it difficult to make decisions without other people's guidance
- needing others to take responsibility over what should be their own important life choices
- not being able to express disagreement with other people
- finding it difficult to start new activities due to a lack of confidence
- going to extremes to obtain support and comfort
- feeling helpless and uncomfortable when alone
- urgently needing to start a new relationship once a previous relationship comes to an end
- having an unrealistic and constant fear they will be left alone to fend for themselves

Cluster C
OCD Personality Disorder

A person with an obsessive compulsive personality disorder is anxious about issues that seem out of control or 'messy'. They are preoccupied with orderliness and ways to control their environment and may come across to others as a 'control freak'.

Other symptoms include:
- having an excessive interest in lists, timetables and rules
- being so concerned with completing a task perfectly that they have problems completing it (perfectionism)
- being a workaholic
- having very rigid views about issues such as morality, ethics and how a person should behave in daily life
- hoarding items that seem to have no monetary or sentimental value
- being unable to delegate tasks to other people
- disliking spending money, as they think it is always better to save for a 'rainy day'
Post-natal depression

Post-natal depression (PND) is a type of depression some women experience after they have had a baby. It usually develops in the first four to six weeks after childbirth, although in some cases it may not develop for several months. There is often no reason for the depression. There are many symptoms of PND, such as low mood, feeling unable to cope and difficulty sleeping, but many women are not aware that they have the condition. It is important for partners, family, friends and healthcare professionals to recognise the signs of PND as early as possible so that appropriate treatment can be given.

It is very important to understand that having PND does not mean that a person does not love or care for her baby. Also, although post-natal depression is more common in women, men can be affected too. The birth of a new baby can be stressful for both parents and some fathers feel unable to cope, or feel they are not giving their partner the support she needs. They can also find it difficult to adjust to the big changes and demands made by a new baby. PND can be lonely, distressing and frightening, but you should be reassured that there are many treatments available. As long as PND is recognised and treated, it is a temporary condition that you can recover from.

PND can affect women in different ways. The symptoms can begin soon after birth and last for months, or in severe cases can last for over a year.

- Low mood for long periods of time (a week or more), feeling irritable for a lot of the time, tearfulness, panic attacks or sense of feeling trapped, difficulty concentrating, lack of motivation, lack of interest in one’s life or with the new baby, feeling lonely, feeling guilty, rejected or inadequate, feeling overwhelmed, feeling unable to cope, difficulty sleeping and feeling constantly tired
- Physical signs of tension, such as headaches, stomach pains or blurred vision, lack of appetite, reduced sex drive

Frightening thoughts

Some women who have PND have thoughts about harming their baby. This is quite common, affecting about half of all women with PND. A person may also have thoughts about harming or killing themselves. These thoughts are manifested to feeling bad as a mother, and it is very rare for either mother or baby to be harmed.

Schizophrenia

A person may experience a change in thinking and behaviour which are the most obvious symptoms of schizophrenia but people can experience schizophrenia symptoms in different ways. The earlier the symptoms are identified and treatment is started, the better the outlook. The symptoms of schizophrenia are usually classified into one of two categories: positive or negative.

- **Positive symptoms** represent a change in behaviour or thoughts, such as hallucinations or delusions.
- **Negative symptoms** represent a withdrawal or lack of function that you would usually expect to see in a healthy person. For example, people with schizophrenia often appear emotionless, flat and apathetic.

Positive symptoms may include:

- Hallucinations
- Confused thoughts (thought disorder)
- Delusions
- Changes in behaviour and thoughts

Negative symptoms may include:

- Can be many years before a person experiences first acute schizophrenic episode
- Can be part of the development of schizophrenia or caused by something else
- Usually begin gradually and then slowly get worse
- Relationship problems with friends and family
Positive symptoms may include: Hallucinations

- A hallucination occurs when a person experiences a sensation when there is nothing or nobody there to account for it. A hallucination can involve any of the senses, but the most common is hearing voices.
- Although other people cannot hear the voices or experience the sensations, they seem real to the person experiencing them. Research using brain-scanning equipment has shown that there are changes in the speech area of the brain in people with schizophrenia when they hear voices. These studies show that the experience of hearing voices is a real one, as if the brain mistakes thoughts for real voices.
- Some people describe the voices they hear as friendly and pleasant, but more often they are rude, critical, abusive or just annoying. The voices might describe activities taking place, discuss the hearer’s thoughts and behaviour, give instructions or talk directly to the person. Voices may come from different places or they may come from one place in particular, such as the television.

Positive symptoms may include: Delusions

- A delusion is a belief that is held with complete conviction, even though it is based on a mistaken, strange or unrealistic view. It may affect the way people behave. Delusions can begin suddenly or may develop over a period of weeks or months.
- Some people develop a delusional idea to explain a hallucination they are having. For example, if they have heard voices describing their actions, they may have a delusion that a secret agent is monitoring their actions. Someone experiencing a paranoid delusion may believe that they are being harassed or persecuted. They may believe they are being chased, followed, watched, plotted against or poisoned, often by a family member or friend
- Some people who experience delusions find different meanings in everyday events or occurrences. They may believe that people on TV or in newspaper articles are communicating messages to them alone, or that there are hidden messages in the colours of cars passing in the street.

Positive symptoms may include: Confused thoughts (thought disorder)

- People experiencing psychosis often have trouble keeping track of their thoughts and conversations. Some people find it hard to concentrate and will drift from one idea to another. They may have trouble reading newspaper articles or watching a TV programme. People sometimes describe their thoughts as ‘misty’ or ‘hazy’ when this is happening to them. Thoughts and speech may become jumbled or confused, making conversation difficult and hard for other people to understand.

Changes in behaviour and thoughts

- Behaviour may become more disorganised and unpredictable, and appearance or dress may seem unusual to other people. People with schizophrenia may behave inappropriately or become extremely agitated and shout or swear for no reason.
- Some people feel that their thoughts are being controlled by someone else, that their thoughts are not theirs, or that the thoughts have been planted in their mind by someone else. Another recognised feeling is that thoughts are disappearing, as though someone is removing them from their mind. Some people feel that their body is being taken over and someone else is directing their movements and action.

Negative symptoms may include:

- These initial negative symptoms are often referred to as the prodromal period of schizophrenia.
- Symptoms during the prodromal period usually begin gradually and then slowly get worse. They include becoming more socially withdrawn and experiencing an increasing lack of care about your appearance and personal hygiene.
- It can be difficult to tell whether the symptoms are part of the development of schizophrenia or caused by something else.
- Negative symptoms experienced by people living with schizophrenia include:
  - Losing interest and motivation in life and activities, including relationships and sex.
  - Lack of concentration, not wanting to leave the house and changes in sleeping patterns.
  - Being less likely to initiate conversations and feeling uncomfortable with people, or feeling that there is nothing to say.
  - The negative symptoms of schizophrenia can often lead to relationship problems with friends and family because they can sometimes be mistaken for deliberate laziness or rudeness.
ADHD, Autism, Asperger’s Syndrome with mental health problems and Learning Disabilities

ADHD with mental health problems
Pennine Care will only accept referrals for people who have Attention Deficit Hyperactivity Disorder (ADHD) who also present with a mental health problem.

Autism with mental health problems
Pennine Care will only accept referrals for people who have autism and present with a mental health problem.

Asperger’s Syndrome with mental health problems
Pennine Care will only accept referrals for people who have Asperger’s Syndrome and present with a mental health problem.

All referrals must be in line with the appropriate Mental Health Stepped Care Model. During the referral and assessment process the main focus will be on the person’s mental health problem and not the person’s ADHD, autism or Asperger’s Syndrome.

Learning Disability with mental health problems
Pennine Care will accept referrals for a person who displays with a learning disability and a mental health problem.

Services Pennine Care are not commissioned to provide for assessment, diagnosis and treatment
Pennine Care are not currently commissioned to provide an assessment, diagnosis or treatment specifically for a person who is suspected to have or has the following conditions:

- ADHD, autism, Asperger’s Syndrome, neuropsychology

All community services should firstly refer the person to their GP where the GP would explore the appropriate care pathways.

Fringe patients
The providers and commissioners have agreed arrangements for ‘fringe patients’; if you are unclear of the arrangements, please contact your local Mental Health Commissioner.

MENTAL HEALTH PROFESSIONALS

What is the role of a Mental Health Practitioner?
A Mental Health Practitioner can either be a registered qualified Mental Health Nurse or a registered qualified Mental Health Social Worker who are trained in mental health. They generally undertake the same role and responsibilities, and work at the Single Point of Entry Service (Access and Crisis Service) visiting people on the medical wards, Fairfield A&E Department and Rochdale Urgent Care Centre undertaking mental health assessments, risk assessments and formulating management plans.

A Mental Health Practitioner also engages with other key professionals such as a Consultant Psychiatrist for specialist psychiatric advice, medication advice, support and intervention where necessary.

A Mental Health Practitioner does not diagnose people but they do identify symptoms of a working mental health diagnosis – which is often called a working diagnosis. For example, a person may display symptoms of depression that may become a working diagnosis.

The role of a Mental Health Practitioner includes:
- Undertaking initial mental health assessments either in an acute setting or in the community and referring people to the right service at the right time with the right information.
- Undertaking risk assessments and formulating risk management plans.
- Working closely with a Consultant Psychiatrist in managing the care of the patient.
- Working closely with the Community Mental Health Teams in managing care and treatment.
- Working closely with GPs.
- Liaising closely with Primary Care Mental Health Trust.
- Managing risk and liaising with the right professionals and with other health and social care agencies across the Rochdale borough.
What is the role of the Consultant Psychiatrist?

The role of a Pennine Care Consultant Psychiatrist is to provide a specialist service which includes:

- An inpatient consultant attached to acute mental health wards
- A community Consultant Psychiatrist attached to a Community Mental Health Team
- Manage a caseload of complex people who are under Secondary Care Mental Health Services
- Formally diagnosing, treating and managing people
- Offer training and advice, undertake research and management roles
- To work in a multi-disciplinary approach with other health and social care agencies including the voluntary sector

What is the role of a CPA Care Co-ordinator?

The role of the Care Programme Approach (CPA) is to facilitate care for people with complex, severe and enduring mental health problems who are in Secondary Care Mental Health Services.

A Care Co-ordinator can be:
- A Mental Health Nurse
- A Mental Health Social Worker

A CPA Care Co-ordinator’s role is to:
- Undertake a comprehensive needs assessment
- Undertake a comprehensive risk assessment and management
- To prepare for crisis planning and management
- Assess and respond to carers needs
- Undertake care planning and review
- Transfer of care and discharge

A Care Co-ordinator can also be:
- A carer
- A service user facilitating their own care

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>AMHP</td>
<td>Approved Mental Health Practitioner</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CAT</td>
<td>Cognitive Analytic Therapy</td>
</tr>
<tr>
<td>CAU</td>
<td>Clinical Assessment Unit</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>DSM – IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>DV</td>
<td>Domiciliary Visit</td>
</tr>
<tr>
<td>EDT</td>
<td>Emergency Duty Team</td>
</tr>
<tr>
<td>EMDR</td>
<td>Eye Movement Desensitisation and Reprocessing</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GAD</td>
<td>Generalised Anxiety Disorder</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
</tr>
<tr>
<td>MDO</td>
<td>Mentally Disordered Offenders</td>
</tr>
<tr>
<td>OCD</td>
<td>Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>PAD</td>
<td>Pennine Assessment Document</td>
</tr>
<tr>
<td>PND</td>
<td>Post Natal Depression</td>
</tr>
<tr>
<td>PCMHT</td>
<td>Primary Care Mental Health Team</td>
</tr>
<tr>
<td>TARA</td>
<td>Trust Approved Risk Assessment</td>
</tr>
<tr>
<td>TAG</td>
<td>Treatment Advisory Group</td>
</tr>
<tr>
<td>UCC</td>
<td>Urgent Care Centre</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary Tract Infection</td>
</tr>
</tbody>
</table>