



# **PATIENT PROFILES OF SERVICE USERS WITH COMPLEX MENTAL HEALTH NEEDS: AN INDEPTH CASENOTES ANALYSIS**

SEPTEMBER 2022

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NHS Foundation Trust

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## ACKNOWLEDGEMENTS

This report is the work of members of staff from the School of Psychology at Liverpool John Moores University, with the collaboration of Cheshire and Wirral Partnership NHS Foundation Trust. The aim was to examine patient profiles of service users with complex mental health needs through an in-depth casenotes analysis. We would like to thank everyone at Cheshire and Wirral Partnership NHS Foundation Trust, namely Dr Rebecca Cummings and Dr Phil Elliott for their time and effort in support of the development of our study protocol, and Michael Bourke, Daniel Carlson and Debbie Williams for their invaluable assistance with recruitment of participants for the study. We acknowledge the contribution of the following stakeholders involved in meetings for the development of the study design and tools: Dr Antony Martin, Darren Birks, Robert Oxley, Lisa Newman, Angela Davies, Gagandeep Singh, Sean Boyle, Susie Williams, Bridget Hollingsworth, Sarah Batty and Samantha Woodley. We would also like to thank the service users and carers from Cheshire and Wirral Partnership NHS Foundation Trust who were willing to take part in the qualitative interviews.

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# Executive Summary

## INTRODUCTION

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) provide a wide range of community and inpatient, physical, all-age disability, and mental health care services. The Trust also provide care to a specific cohort of patients who have been defined as having complex mental health needs. This is a broad term used to describe patients who currently receive a package of care commissioned by NHS Cheshire CCG either in an inpatient or community setting, as well as new referrals into the NHS continuing healthcare service who are eligible for NHS funding. This includes patients who are detained under Section 17 of the Mental Health Act or Section 117 aftercare, or who are out of scope, have learning disabilities, are children, those living with dementia who do not have complex, or specialist needs, those with acquired brain injuries and those with physical disabilities.

Mental health services for adults, as they are currently configured, have been designed to provide predominantly community-based interventions. It has long been recognised that patients with complex mental health needs cannot be adequately supported within standard service delivery models, resulting in a pressing need to consider the best models for this group of people. There is a paucity of information on the experiences of the service users themselves, particularly of those with complex presentations. The present study aimed to develop a profile of service users with complex mental health needs and provide a detailed exploration of their clinical histories.

## EVALUATION

A proforma was developed for extraction of data from clinical records, with input from relevant stakeholders comprising representatives of Cheshire and Wirral Partnership, patient engagement, the commissioners, the Local Authority, and housing. Metrics included were conventional records (e.g. demographics, diagnosis, placement), a wider range of data including that to undertake the economic analysis and data describing other relevant aspects of patients' experience (e.g. developmental history, housing difficulties, mental health and social care pathways). Stakeholder consultation was vital to creating a proforma for data extraction and involved discussion with staff across CWP. This allowed researchers to develop a document which could best represent this patient group and their needs based on knowledge and experience. Public advisors attended weekly research meetings and were involved in all stages of the project. Quantitative data was collected through data extraction from the case note files of 76 service users with complex mental health needs. Data extraction explored variables relative to service users personal, clinical, and forensic history.

## RESULTS

Service users were more likely to be younger, male, single, unemployed, have little or no formal qualifications, known to be on benefits, have social support, had an adult offense, be heterosexual and White British (although sexuality and ethnicity data was incomplete). Nearly one third were on out of area placements. Most of the service users living in hospital or alone had family involvement including visitation. One third of the services users had their

first contact with mental health services as children, 15% were looked after children and one in five were under the care of community adolescent mental health services (CAMHS). Majority of the service users had a family background including parental separation, parental violence or discord, parental criminality, parental mental health, or other family related issues. Childhood trauma including sexual, physical and emotional abuse, were recorded for 89% of services users. One third of the sample (34%) had a childhood mental health disorder or learning disability identified, a third had cognitive behavioural problems and 17% of service users had childhood involvement in criminal justice systems. Over 70% of service users had a history of self-harm, suicidal thoughts and 66% had a previous suicide attempt.

A diagnosis of schizotypal disorders was most common followed by mental health disorders due to psychoactive substance use. Changing diagnoses during the service users' clinical history was common for most service users with 46% having six or more diagnoses. Over two-thirds had a history of alcohol or substance misuse, however only 38% had received support for this. Most service users were prescribed multiple medications with 57% being prescribed six or more medications. One in five (22%) received psychological treatment. Four in ten service users had had more than six admissions to hospital, one third had failed placements or had placements that ended unexpectedly and one in five had failed mental health act detentions. Problems engaging with services were reported for 76% of service users. Covid-19 was not recorded for most service users, but the impact of covid on patient care (29%) and visitations (24%) was noted.

## RECOMMENDATIONS

Data highlights a lack of early, effective, and consistent interventions across multiple areas and the long-term consequences of this. These areas include adverse childhood events (ACEs), criminal behaviour, drug and alcohol use, and severe psychopathology. Services need to implement person centred interventions to address adverse childhood experiences at the earliest opportunity. Earlier intervention is needed to prevent maladaptive coping strategies and challenging behaviours, to provide support for mental health symptoms, and to minimise deterioration and admission to psychiatric services.

The complexity within this group suggests we need a different approach to assess, formulate and provide treatment, interventions, and support. The conventional approach is to identify the nature of problem based on diagnosis, and there may be different assessment and treatment services depending on diagnoses- this works well if patient has one major diagnosis. However, when complexity is at a level where there are multiple diagnoses that are changing, exploring models one might consider alternative approaches to understanding clinical issues such as dynamic methods which approach types and extent of problems without boundaries of diagnosis base.

The training for staff working in area needs to account for this complexity, training in how to provide effective services to people who have multiple diagnoses, ACEs, substance misuse and additional high suicide and self-harm risk. There is requirement for staff to be equipped to address problems over and beyond mental health symptoms.

## BACKGROUND:

It has long been recognised that some patients have such significant clinical and/or risk needs that those needs cannot be adequately met within standard service delivery models, resulting in a pressing need to consider the best models for this group of people. Recent recommendations for effective support from mental health services suggest that individuals presenting with complex behavioural and mental health needs are less likely to receive the provision of care they require due to their need for longer-term, highly specialised support (1). Many of these people may have a diagnosis of psychosis, severe negative symptoms, and/or cognitive impairments. Coexisting mental health problems and physical health concerns resulting from poor lifestyle conditions and side effects of psychotropic medication are also prevalent (2). Thus, there is a pressing need to inform an evidence-based service delivery model for mental health service users with complex needs.

Studies examining the profile of this group indicate that it is not just a matter of the extent of the need, but also the complexity of their clinical profile and history (2, 3). Whilst complexity appears to be a key factor common to these people (1), there is little understanding of why a person becomes identified as someone in this group. A delineation of the components of 'complexity' in this context will not only provide an evidence base to support the development of appropriate services, but also facilitate a 'prevention' approach in which the model of assessment and intervention at an earlier point may reduce the likelihood of the person becoming 'complex'.

Mental health services for adults, as they are currently configured, have been designed to provide predominantly community-based interventions. These community services are supplemented by additional provision that is accessed on the basis of acuity/risk (i.e. inpatient services) or of diagnostic specificity. Individuals presenting with complex needs are often accommodated in out-of-area placements that are a long distance from their loved ones and communities (4), due to the inability, or arguably the unwillingness (3), of local services to meet their needs. There are growing concerns about the impact of out-of-area placements on mental health service users, both clinically and financially (5). In addition to being costly to the NHS and local social care authorities, individuals placed out-of-area can become socially dislocated, achieve poorer outcomes (6), experience disruptions to their lives (7) and in some cases, be over-supported (5). The issue of distance can also cause complications for the 'home' services who made the referral, which are services generally provided in the locality of a patient's home, as it can be difficult to maintain contact regarding the suitability of the placement and the person's care, which can also hinder their rehabilitation and eventual reintegration into their home community (4, 8).

Service users with complex mental health needs were recognised as a priority group who meet the criteria for this study due to their earlier-discussed needs that currently cannot be adequately met within the standard mental health service model. This study aimed to gather the profile and history of service users described as having complex needs; this comprehensive evaluation aims to inform an evidence-based service delivery model for people with complex needs.

## METHODOLOGY:

### STUDY DESIGN

Quantitative data was collated through an in-depth analysis of patient medical records. A retrospective cohort design was employed to assess patients' pathways to current placement, along with their demographics, clinical profiles, and risk profiles.

Patient and Public Involvement (PPI) was extremely important to ensure the research met the needs of the target population. PPI members were actively involved in reviewing and interpreting findings, attending an average of two research meetings per week. Stakeholder consultation informed the co-design of a proforma for data extraction and involved discussion with staff across CWP; thus, allowing researchers to develop a document which could best represent the patient group and their needs based on knowledge and experience.

### PARTICIPANTS

One hundred and eighty-four service user data files were extracted, with 87 of those service users invited for in-depth case note analysis. Eleven service users were not included as they either declined (n=8) to take part or were unable to take part due to their current capacity to understand the study consent (n=3). Service users in out of area placements were identified using financial payment records and cross referencing these with clinical records held by staff monitoring the placements, to ensure all cases were identified. In respect to the suitability of the service users who were in out-of-area placements, two clinicians on the team assessed, based on a review of the service users' clinical records, who should be included for the study.

Out of the consenting 76 people, 36 were service users who were in inpatient placements at the time of recruitment (e.g., super-stranded [hospitalised for over twenty-one days (25)], out of area placements and rehabilitation) and 40 who met the criteria of being service users with complex mental health needs who were in community-based placements at the time of recruitment (e.g., home care treatment, supported accommodation). In terms of the inclusion criteria, participants were recognised by the Trust's clinicians as having complex and long-term recovery needs and longstanding mental health problems, who may have had out-of-area placements in the last five years. Participants were excluded from taking part in the study if they were under the age of 18 years. Post-hoc power calculations were conducted for quantitative inferential analysis, as the quantity and quality of extracted data was unknown. Moreover, the novelty of the research prevents the formulation of expected effect sizes for power calculations.

### MATERIALS

A proforma was developed for extraction of data from clinical records, with input from relevant stakeholders comprising representatives of CWP, patient engagement, the commissioners, the Local Authority, and housing. Metrics included were conventional records (e.g. demographics, diagnosis, placement), a wider range of data including that to undertake the economic analysis and data describing other relevant aspects of patients' experience (e.g. developmental history, housing difficulties, mental health and social care pathways). The proforma was piloted and any modifications were made prior to data collection. For service users in CWP, demographic, clinical and service utilisation data were gathered in situ by

experienced researchers (assistant/research psychologists) who received further training from onsite research and development managers.

## DATA MANAGEMENT

No identifiable patient data was extracted to the proforma templates. Data was transferred from the proforma templates to an Excel document and recoded for data analysis using SPSS and STATA software.

Participants contact details, and written consent forms for all aspects of the study were stored on a secure, password protected database and backed up on the Liverpool John Moores University (LJMU) server.

## DATA ANALYSIS

Information in medicals records were reviewed and a quantitative data base generated. Descriptive analyses were conducted to produce a clinical and demographic profile of the patient group. It should be noted that some patients had multiple diagnoses, even within one diagnostic category, e.g., schizotypal. We have recorded percentages of how many times a diagnosis was used across the whole sample, therefore the number of diagnoses may be higher than our total sample.

Tables below show a comparison between inpatient and community patients. It should be noted these are not two distinct groups, but rather patients who are not currently on the same care pathway. Whilst interpreting data, we acknowledge that these individuals are similar patients at a different point in time.

## FINDINGS:

### SECTION 1- DEMOGRAPHICS

TABLE 1A. DEMOGRAPHICS – AGE

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
18-24	15 (6)	11.1 (4)	13.2 (10)
25-34	35 (14)	11.1 (4)	23.7 (18)
35-44	30 (12)	22.2 (8)	26.3 (20)
45-54	12.5 (5)	25 (9)	18.4 (14)
55-64	7.5 (3)	22.2 (8)	14.5 (11)
65-74	0	8.3 (3)	3.9 (3)
75+	0	0	0

Many inpatients were under 45 years of age. Many community patients were over 35 years of age.

TABLE 1B. DEMOGRAPHICS – ETHNICITY

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<i>White- English/Welsh/Scottish/ Northern Irish/ British</i>	87.5 (35)	97.2 (35)	92.1 (7)
<i>White- Irish</i>	2.5 (1)	0	1.3 (1)
<i>White- Gypsy or Irish Traveller</i>	2.5 (1)	0	1.3 (1)
<i>Any other White</i>	0	0	0
<i>White and Black Caribbean</i>	0	0	0
<i>White and Black African</i>	0	0	0
<i>White and Asian</i>	2.5 (1)	0	1.3 (1)
<i>Any other mixed ethnic group</i>	0	2.5 (1)	1.3 (1)
<i>Indian</i>	0	0	0
<i>Pakistani</i>	0	0	0
<i>Bangladeshi</i>	2.5 (1)	0	1.3 (1)
<i>Chinese</i>	0	0	0
<i>Any other Asian background</i>	0	0	0
<i>African</i>	0	0	0
<i>Caribbean</i>	0	0	0
<i>Any other</i>	2.5 (1)	0	1.3(1)
<i>Black/African/Caribbean</i>			
<i>Arab</i>	0	0	0
<i>Any other ethnic group</i>	0	0	0

Across both groups most people were of White British ethnicity.

TABLE 1C. DEMOGRAPHICS – GENDER

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<i>Male</i>	72.5 (25)	63.9 (23)	63.2 (48)
<i>Female</i>	27.5 (15)	36.1 (13)	36.8 (28)
<i>Other</i>	0	0	0

Across both groups most participants were male.

TABLE 1D. DEMOGRAPHICS – CLINICAL COMMISSIONING GROUP (CCG)

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<i>NHS Cheshire</i>	22.5 (9)	2.8 (1)	13.2 (10)
<i>NHS Wirral</i>	27.5 (11)	63.9 (23)	44.7 (34)
<i>Cheshire Wirral Partnership</i>	2.5 (1)	19.4 (7)	10.5 (8)
<i>Out of Area</i>	47.5 (19)	13.9 (5)	31.6 (24)
<b>Local Authority</b>			
<i>Cheshire East Council</i>	17.5 (7)	0	9.2 (7)
<i>Cheshire West and Chester Council</i>	12.5 (5)	2.8 (1)	7.9 (6)
<i>Wirral Metropolitan Borough Council</i>	37.5 (15)	94.4 (34)	64.5 (49)
<i>Out of Area</i>	32.5 (13)	2.8 (1)	18.4 (14)

Many inpatients had an out of area Clinical Commissioning Group (47.5%). Community patients mostly had a local CCG (86.1%). A third (32.5%) of inpatients had an out of area local authority compared to a small number (2.8%) of community patients.

TABLE 1E. DEMOGRAPHICS – SEXUALITY

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<i>Heterosexual</i>	50.0 (20)	50.0 (18)	50.0 (38)
<i>Gay or Lesbian</i>	5.0 (2)	2.8 (1)	3.9 (3)
<i>Bisexual</i>	12.5 (5)	0	6.6 (5)
<i>Other</i>	0	0	0
<i>Unknown</i>	32.5 (13)	47.2 (17)	39.5 (30)

The majority of participants were heterosexual; however, for a large number of patients (47.2%), sexuality was not recorded.

TABLE 1F. DEMOGRAPHICS – EDUCATION

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<i>No formal qualifications</i>	20.0 (8)	11.1 (4)	15.8 (12)
<i>1 to 4 O levels/GCSE/CSE</i>	15.0 (6)	8.3 (3)	11.8 (9)
<i>5+ O levels/GCSE/CSE</i>	2.5 (1)	8.3 (3)	5.3 (4)
<i>NVQ</i>	5.0 (2)	0	2.6 (2)
<i>A levels/AS levels</i>	7.5 (3)	5.6 (2)	6.6 (5)
<i>Undergraduate degree</i>	10.0 (4)	5.6 (2)	7.9 (6)
<i>Master's degree</i>	0	0	0
<i>Doctoral degree</i>	0	0	0
<i>Other formal qualifications</i>	15.0 (6)	2.8 (1)	9.2 (7)
<i>Unknown</i>	25.0 (10)	58.3 (21)	40.8 (31)

Education levels varied across both groups, with many participants possessing no formal qualifications. It is notable that for 25% of inpatients and 58.3% community patients' education level was unknown.

TABLE 1G. DEMOGRAPHICS – RELIGION STATUS

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<i>Christian/Roman Catholic</i>	40.0(16)	44.4 (16)	42.1 (32)
<i>Muslim</i>	5 (2)	0	2.6 (2)
<i>Jewish</i>	0	0	0
<i>Buddhist</i>	0	2.8 (1)	1.3 (1)
<i>Hindu</i>	0	0	0
<i>Sikh</i>	0	0	0
<i>Atheist</i>	0	2.8 (1)	1.3 (1)
<i>Other</i>	2.5 (1)	0	1.3 (1)
<i>Unknown</i>	52.5 (21)	50 (18)	51.3 (39)

Similarly, religious background was unknown for 52.5% of inpatients and 50% of community patients. 40.0% of inpatients and 44.4% of community patients identified as Christian/Roman Catholic thus this was the majority religion identified.

TABLE 1H. DEMOGRAPHICS – MARITAL STATUS AND FAMILY INVOLVEMENT

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<i>Married</i>	2.5 (1)	8.3 (3)	5.3 (4)
<i>Single</i>	87.5 (35)	72.2 (26)	80.3 (61)
<i>Separated/Divorced</i>	2.5 (1)	13.9 (5)	7.9 (6)
<i>Widowed</i>	0	0	0
<i>Unknown</i>	2.5 (1)	2.8 (1)	2.6 (2)
<i>Other</i>	5 (2)	2.8 (1)	3.9 (3)
<b>Family Unit</b>			
<i>Lives with mother</i>	2.5 (1)	2.8 (1)	2.6 (2)
<i>Lives with father</i>	0	0	0
<i>Lives with siblings</i>	0	0	0
<i>Lives with other relative</i>	0	0	0
<i>Lives with non-relative</i>	0	0	0
<i>Lives alone</i>	10.0 (4)	91.7 (33)	48.7 (37)
<i>In hospital</i>	82.5 (33)	5.5 (2)	46.1 (35)
<i>Unknown</i>	2.5 (1)	0	1.3 (1)
<i>Other</i>	2.5 (1)	0	1.3 (1)
<b>Family Involvement</b>			
<i>Yes</i>	90.0 (36)	77.8 (28)	84.2 (64)
<i>No</i>	10.0 (4)	11.1 (4)	10.5 (8)
<i>Unknown</i>	0	11.1 (4)	5.3 (4)

Across both groups, many participants reported being single.

At the time of data collection, all inpatients were in hospital and all community patients were living in the community. At the time of data collection 82.5% of inpatients were in hospital and 10% living alone. At the time of data collection, 91.7% of community patients were living alone.

Many participants across both groups had family involvement, i.e., visitation and contact with family members (90% of inpatients and 77.8% community patients). The dynamics of family involvement varied. Case notes often reflected regular visits, sometimes by multiple family members. Family involvement was often found to be a protective factor and family being local was reported to be more positive. There was occasional notes about family support being so extensive that it prevented further development of independence in community settings. Case notes also reflected that some families could be a respondent or avoidant, and that family involvement could involve difficult family dynamics. Instances of difficult family dynamics were noted to have led to a decline in mental health following visits. There were also notes of patients requesting no contact or information sharing with families when experiencing paranoid symptoms.

TABLE 11. DEMOGRAPHICS – EMPLOYMENT STATUS

	% (N) Inpatients	% (N) Community Patients	% (N) Total
<i>Full-time employed</i>	0	0	0
<i>Part-time employed</i>	0	0	0
<i>Self-employed</i>	0	0	0
<i>Student</i>	0	2.8 (1)	1.3 (1)
<i>Retired</i>	0	0	0
<i>Unemployed</i>	92.5 (37)	94.4 (34)	93.4 (71)
<i>Homemaker</i>	0	0	0
<i>Physically unable to work due to DMD or related complications</i>	2.5 (1)	0	1.3 (1)
<i>Physically unable to work – other reason</i>	0	0	0
<i>Actively seeking employment</i>	0	0	0
<i>Other</i>	2.5 (1)	0	1.3 (1)
<i>Unknown</i>	2.5 (1)	2.8 (1)	2.6 (2)
<b>Benefits</b>			
<i>Yes</i>	57.5 (23)	86.1 (31)	71.1 (54)
<i>No</i>	7.5 (3)	0	3.9 (3)
<i>Unknown</i>	35 (14)	13.9 (5)	25.0 (19)

Many participants across both groups were unemployed (92.5% of inpatients and 94.4% of community patients). 57.5% of inpatients and 86.1% of community patients were known to be receiving benefits.

Regarding employment, qualitative data reflected that those who had never worked were unable to cope with the demands of employment. Employment histories across those previously employed highlighted periods prior to mental illness and employment ceasing due to mental illness. Roles were often multiple and varied and there were few periods of lengthy employment or employment meaningful to the individual. Employment was often temporary and sporadic due to mental health difficulties. There was a notable amount of job loss and being dismissed from employment due to implications of mental illness and associated behaviours and symptoms. Behaviours such as substance misuse often affected individual's ability to maintain work.

The stressors of employment sometimes exacerbated mental illness and the use of maladaptive coping strategies such as self-harm and substance misuse. Notes informed that many of the included service users were reported to be signed off due to being unable to cope with stress.

In terms of new employment, qualitative data reflected struggles to engage in plans to return to work due to mental health. Many people felt unable to return to work or were not in a position to work or actively seek employment.

## SECTION 2- CHILDHOOD AND FAMILY BACKGROUND

TABLE 2. CHILDHOOD AND FAMILY BACKGROUND

<b>Demographic</b>	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<b>Age of first contact</b>			
0-5	2.5 (1)	0	1.3 (1)
6-10	7.5 (3)	2.8 (1)	5.3 (4)
11-15	27.5 (11)	8.3 (3)	18.4 (14)
16-18	7.5 (3)	8.3 (3)	7.9 (6)
Unknown	55.0 (22)	80.6 (29)	67.1 (51)
<b>Looked after child</b>			
Yes	20.0 (8)	8.3 (3)	14.5 (11)
No	45.0 (18)	52.8 (19)	48.7 (37)
Not known	35.0 (14)	38.9 (14)	36.8 (28)
<b>CAMHS input</b>			
Yes	35.0 (14)	8.3 (3)	22.4 (17)
No	27.5 (11)	36.1 (13)	31.6 (24)
Not known	37.5 (15)	55.6 (20)	46.0 (35)
<b>Family background</b>			
Parental separation	37.5 (15)	27.8 (10)	32.9 (25)
Parental violence/Discord	22.5 (9)	16.7 (6)	19.7 (15)
Parental substance misuse	17.5 (7)	5.6 (2)	11.8 (9)
Parental criminality	2.5 (1)	0	1.3 (1)
Parental mental health problems	20.0 (8)	11.1 (4)	15.8 (12)
Other	16.7 (9)	22.5 (6)	19.7 (15)
<b>Childhood trauma</b>			
Sexual abuse	30.0 (12)	16.7 (6)	23.7 (18)
Physical abuse	35.0 (14)	22.2 (8)	28.9 (22)
Emotional abuse	20.0 (8)	16.7 (6)	18.4 (14)
Other	20.0 (8)	16.7 (6)	18.4 (14)
<b>Childhood mental health/Learning disability identified</b>			
Yes	45.0 (18)	22.2 (8)	34.2 (26)
No	55.0 (22)	77.8 (28)	65.8 (50)
<b>Childhood Behavioural Problems</b>			
Yes	47.5 (19)	13.9 (5)	31.6 (24)
No	52.5 (21)	86.1 (31)	68.4 (52)
<b>Childhood involvement in Criminal Justice systems</b>			
Yes	27.5 (11)	5.6 (2)	17.1 (13)
No	72.5 (29)	94.4 (34)	82.9 (63)

There was no notable majority within community patients in terms of known first assessment age. Many inpatients were reported to be first assessed aged 11-15 years. However, across

both groups this information was largely unknown as data prior to adult admissions was often not present in case notes. This is a notable lack of information and could be considered as having a potential impact on person centred care.

Many patients across both groups were found to have stayed within the family home during childhood. 35% of inpatients were known to have had CAMHS input versus 8.3% of community patients. Most participants did not have any recorded CAMHS input, this could reflect a lack of early input/involvement, or lack of notes from CAMHS services being shared. From the available data, the average age of initial contact with services was 14. The most prevalent CAMHS diagnosis was ADHD, the next most prevalent diagnosis was paranoid schizophrenia.

In terms of family background, staying within the family home did not necessarily reflect of a positive family or home environment. Across both groups, parental separation, violence and discord, substance misuse, criminality, and mental health problems reflected a home environment which was likely tumultuous and detrimental to psychological wellbeing. Childhood trauma was notable across both groups, including sexual, physical, and emotional abuse.

Those who were looked after children were taken into care due to poor parental mental health, the breakdown of family relationships, neglect and physical abuse, and parental inability to cope with the patient's challenging behaviours or mental health difficulties and the associated risks.

Sexual abuse was found to have occurred mostly from childhood to early teens, abusers were usually within the patient's family and of paternal association, whether biologically related or a step-parent. Similarly physical abuse was found to have occurred mostly from childhood to early teens. The abuser was usually identified as the biological father, or biological mother (often with the participation of a new male partner). Emotional abuse was also found to have occurred mostly from childhood to early teens and to take the form of bullying, either at school or at home. Most bullying within the home environment was perpetrated by the biological mother (often with the participation of a new male partner). Emotional abuse reflected invalidating experiences and a lack of unconditional positive regard from parents, caregivers, and peers.

With regards to learning disabilities and childhood mental health difficulties, 45% of inpatients were found to have issues identified in these areas, versus 22.2% of community patients. In some cases, patients had attended specialist schooling from additional learning and behavioural needs, presented with low IQ and showed delays in reaching developmental milestones. However, many presented with mild to moderate learning disability symptoms and there was a lack of formal assessment of these presentations. It was therefore difficult to differentiate to what extent high risk and challenging behaviours and struggling academically could be related to learning difficulties, or on the other hand, to what extent learning difficulties could be related to mental health problems, a challenging home environment, a lack of engagement in education and an erratic academic development.

Childhood behavioural difficulties were found to present from a young age and were frequently reflected in truancy, poor conduct within school environments and subsequent exclusions and expulsions. There was a notable level of underage drinking and drug use. There was also a prevalence of disruptive, volatile, and aggressive behaviour towards other children and adults. It is important to consider that these various behavioural difficulties were not necessarily mutually exclusive and often coincided with and exacerbated each other. Teenage pregnancy was also identified within female patients and reflected vulnerability to underage and non-consensual sexual contact. Behavioural difficulties were in many cases found to be too difficult to manage by parents, caregivers, and academic institutions. Patients were found to have been involved in the juvenile criminal justice system; 27.5% of inpatients were involved in the juvenile criminal justice system versus 5.6% of community patients. The extent of juvenile criminal behaviour across groups could reflect the notably higher level of inpatients with identified childhood behaviour problems (47.5%) versus community patients with identified childhood behaviour problems (13.9%).

### SECTION 3- CLINICAL HISTORY

TABLE 3A. DIAGNOSIS

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<b>Diagnoses</b>	<b>% (N) of diagnoses identified</b>	<b>% (N) of diagnoses identified</b>	<b>% (N) of diagnoses identified</b>
<i>Schizophrenia, schizotypal and delusional disorders F20-F29</i>	24.9 (52)	17.7 (37)	42.8 (89)
<i>Mood affective disorders F30-F39</i>	6.2 (13)	7.7 (16)	13.9 (29)
<i>Disorders of adult personality and behaviour F60-69</i>	10.1 (21)	3.4 (7)	13.5 (28)
<i>Mental and behavioural disorders due to psychoactive substance use F10-19</i>	20.6 (43)	14.8 (31)	35.6 (74)
<i>Neurotic, stress-related and somatoform disorders F40-F48</i>	4.3 (9)	4.3 (9)	8.7 (18)
<i>Behavioural syndromes associated with psychological disturbances F50-59</i>	1.4 (3)	0	1.4 (3)
<i>Disorders of psychological development F80-89</i>	0.5 (1)	1.4 (3)	1.9 (4)
<i>Mental retardation F70-79</i>	1.4 (3)	0.5 (1)	1.9 (4)
<i>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence F90-98</i>	2.9 (6)	0.5 (1)	3.4 (7)
<i>Unspecified mental disorder F99</i>	2.9 (6)	0	2.9 (6)
<i>Observation for disease or condition unspecified Z00</i>	12.0 (25)	11.5 (24)	23.6 (49)
<i>Organic, including symptomatic, mental disorders F00-F09</i>	0	0.96 (2)	0.96 (2)
<i>E</i>	4.3 (9)	7.2 (15)	31.6 (24)

TABLE 3B. NUMBER OF DIAGNOSES

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<b>Number of Diagnoses</b>			
0-5	52.5 (19)	52.8 (21)	52.6 (40)
6-10	32.5 (14)	38.9 (13)	35.5 (27)
11-15	12.5 (2)	5.5 (5)	9.2 (7)
16>	2.5 (1)	2.8 (1)	2.6 (2)

TABLE 3C. SUBSTANCE/ALCOHOL MISUSE

	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<b>History of Substance/Alcohol Misuse</b>			
Yes	72.5 (29)	63.9 (23)	68.4 (52)
No	15.0 (6)	33.3 (12)	23.7 (18)
Unknown	12.5 (5)	2.8 (1)	7.9 (6)
<b>Support received for Substance/Alcohol Misuse</b>			
Yes	40.0 (16)	36.1 (13)	38.2 (29)
No	42.5 (17)	50.0 (18)	46.0 (35)
Unknown	17.5 (7)	13.9 (5)	15.8 (12)

Many patients across both groups had a history of substance and alcohol misuse, and experiences varied as to whether they received support for this. Case notes reflected severe and enduring histories of alcohol and substance misuse with multiple substances used over a long period of time. Substance and alcohol misuse was often identified as a coping mechanism prior to mental health care and as the cause of deterioration in mental health, non-compliance with treatment, and relapse. Substance and alcohol misuse was identified and managed within patient care plans.

Substance and alcohol misuse usually began at a young age and became a pattern of excessive and continuous use in adulthood. It was frequently identified as a cause of aggressive and violent behaviour. Whilst some patients were now abstinent due to substance and alcohol misuse being managed within a mental health care plan, many declined or did not attend support services, treatments, and interventions. Support included Clinical Psychology, recovery services, liaison psychiatry, access teams, early intervention teams, CRHT teams, and abstinence pathway services. Inpatient recovery also included support staff such as substance misuse practitioners, nurse therapists, recovery programmes, and designated drugs and alcohol teams. Across both groups, referrals for support were often made by various professionals but not followed through by the patient; many declined due to reporting that they did not need support and could self-manage.

TABLE 3D. TREATMENT

	% (N) Inpatients	% (N) Community Patients	% (N) Total
<b>Number of Medications Prescribed</b>			
0-5	35.0 (14)	52.8 (19)	43.4 (33)
6-10	47.5 (19)	30.5 (11)	39.5 (30)
10-15	15.0 (6)	13.9 (5)	14.5 (11)
16>	2.5 (1)	2.8 (1)	2.6 (2)
<b>Psychological Treatment Received</b>			
Yes	35 (14)	8.3 (3)	22.4 (17)
No	65 (26)	91.7 (33)	77.6 (59)

Inpatients were identified as being prescribed more medication (the majority taking 6-10 medications) than community patients (the majority taking 0-5 medications). Across both groups, there was a sparsity of recent psychological treatment; in the past 12 months 35% of inpatients and 8.3% of community patients had received treatment. It is unclear as to why the number of community patients accessing psychological treatment was so low. However, it could be reflective of more difficulty accessing psychological treatment in the community, or less encouragement or necessity to do so.

TABLE 3E. ADMISSIONS

	% (N) Inpatients	% (N) Community Patients	% (N) Total
<b>Number of Admissions</b>			
0-5	47.5 (19)	72.2 (26)	59.2 (45)
6-10	30.0 (12)	22.2 (8)	26.3 (20)
11-15	20.0 (8)	5.6 (2)	13.2 (10)
16>	2.5 (1)	0	1.3 (1)
<b>Failed Placement/Placement ended unexpectedly</b>			
Yes	40.0 (16)	25.0 (9)	32.9 (25)
No	47.5 (19)	55.6 (20)	51.3 (39)
Unknown	12.5 (5)	19.4 (7)	15.8 (12)
<b>Failed MH Act Detention</b>			
Yes	2.8 (6)	15.0 (11)	22.4 (17)
No	72.2 (25)	62.5 (16)	53.9 (41)
Unknown	25 (9)	22.5 (9)	23.7 (18)
<b>Out of area placement/placements</b>			
Yes	22.5 (9)	5.6 (2)	14.5 (11)
No	77.5 (31)	94.4 (34)	85.5 (65)
<b>Problems engaging with services</b>			
Yes	87.5 (35)	63.9 (23)	76.3 (58)
No	12.5 (5)	36.1 (13)	23.7 (18)

There was a tendency for inpatients to have more admissions, failed placements, and out of area placements whereas community patients showed more failed mental health act detentions and endings. Both groups showed notable problems in engaging with services (87.5% of inpatients, 63.9% of community patients).

Readmission often occurred due to declining mental health and subsequently becoming high risk despite care procedures in place. This deterioration of mental health was often related to drug use and non-compliance with medication and ongoing therapeutic treatment. Independent living placements often failed due to struggles in living independently, for example difficulties managing money and food, living in unclean and poor conditions, and self-neglect. Placements also failed in many instances due to alcohol and drug misuse, absconding and going AWOL, aggression to staff and damage to property, attacks on staff, and the continuation of violent and aggressive behaviour despite treatment. Staff struggling to manage the deterioration of mental health, self-harming and unacceptable risks to physical health, and violent behaviour towards others frequently lead to admission to higher security placements.

Failure of mental health acts were reflected in patients moving from various sections to worsening mental health. In many instances Section 17 leave was withdrawn to going AWOL, substance misuse, and risky behaviours. In some instances, Community Treatment Orders were revoked due to hospital care needs. It is unclear as to why community patients had more instances of failed mental health act detentions, it could be speculated that as most failed detentions were related to Section 17 leave, that community patients in transition to independent living and discharge would have had more Section 17 leave opportunities, hence higher instances of compliance issues and breaking leave conditions.

Evidence of problems engaging in services was apparent across both groups. There was a prevalence of disengagement with services, struggles to engage with and rejection of support, noncompliance with medication. Physical, verbal, and racial abuse of staff and other patients was also prevalent, this included hostile and sexually inappropriate behaviour, threats of harm and acts of violence and assault. There was frequent mention of damage to accommodation and property.

#### SECTION 4- SOCIAL HISTORY

Table 4 highlights the social history for the sample. Nearly one in four service users had six or more changes of address and the most were due to being in hospital (66%), followed by homelessness (8%). Most of the service users had not had a change of address in the previous year (79%); however this may have been impacted by the pandemic. Community patients were more likely to be receiving social support (75%) compared to inpatients (53%).

TABLE 4. SOCIAL HISTORY

<i>Social History</i>	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<b><i>Frequency of address change</i></b>			
<i>No change</i>	5.0 (2)	5.6 (2)	5.3 (4)
1-2	22.5 (9)	36.1 (13)	28.9 (22)
3-5	45.0 (18)	33.3 (12)	39.5 (30)
6-10	17.5 (7)	11.1 (4)	14.5 (11)
10-15	7.5 (3)	8.3 (3)	7.9 (6)
16>	0	0	0
<i>Unknown</i>	2.5 (1)	5.6 (2)	3.9 (3)
<b><i>Reason for address change/s</i></b>			
<i>Homelessness</i>	12.5 (5)	2.8 (1)	7.9 (6)
<i>Eviction</i>	0	0	0
<i>Hostel stay/s</i>	0	2.8 (1)	1.3 (1)
<i>Mortgage repossessions</i>	0	0	0
<i>Repairs</i>	0	0	0
<i>In hospital</i>	72.5 (29)	58.3 (21)	65.8 (50)
<i>Private renting lease end</i>	0	0	0
<i>Council housing lease end</i>	0	0	0
<i>Other</i>	5.0 (2)	5.6 (2)	5.3 (4)
<i>Unknown</i>	10.0 (4)	27.8 (10)	18.4 (14)
<b><i>Freq address change in last 12m</i></b>			
<i>No change</i>	85.0 (34)	72.2 (26)	78.9 (60)
1-2	12.5 (5)	16.7 (6)	14.5 (11)
3-5	0	0	0
6-10	0	0	0
10-15	0	0	0
15>	0	0	0
<i>Unknown</i>	2.5 (1)	11.1 (4)	6.6 (5)
<b><i>Reason for address change/s</i></b>			
<i>Homelessness</i>	0	5.6 (2)	2.6 (2)
<i>Eviction</i>	0	0	0
<i>Hostel stay/s</i>	0	0	0
<i>Mortgage repossessions</i>	2.5 (1)	0	1.3 (1)
<i>Repairs</i>	0	0	0
<i>In hospital</i>	77.5 (31)	13.9 (5)	47.4 (36)
<i>Private renting lease end</i>	0	0	0
<i>Council housing lease end</i>	0	0	0
<i>Other</i>	0	0	0
<i>Unknown</i>	20.0 (8)	80.5 (29)	48.7 (37)
<b><i>Received social support</i></b>			
<i>Yes</i>	52.5 (21)	75 (27)	63.2 (48)
<i>No</i>	25.0 (10)	8.3 (3)	17.1 (13)
<i>Not known</i>	22.5 (9)	16.7 (6)	19.7 (15)

## SECTION 5- SUICIDE AND SELF-HARM

TABLE 5. SUICIDE AND SELF-HARM

**History of Self-Harm/Suicide**    **% (N) Inpatients**                      **% (N) Community Patients**                      **% (N) Total**

<b>History of self-harm</b>			
Yes	80.0 (32)	63.9 (23)	72.4 (55)
No	17.5 (7)	36.1 (13)	26.3 (20)
Unknown	2.5 (1)	0	1.3 (1)
<b>Planning of suicide</b>			
Yes	75.0 (30)	66.7 (24)	71.1 (54)
No	22.5 (9)	30.5 (11)	26.3 (20)
Unknown	2.8 (1)	2.8 (1)	2.6 (2)
<b>Patient still alive</b>			
Yes	100 (40)	100 (36)	100 (76)
No	0	0	0
<b>Has sought help during suicidal thoughts from:</b>			
<i>Intimate partner</i>	0	0	0
<i>Friend</i>	2.5 (1)	2.8 (1)	2.6 (2)
<i>Parent</i>	0	0	0
<i>Other relative/family member</i>	2.5 (1)	0	1.3 (1)
<i>Mental health professional</i>	7.5 (3)	8.3 (3)	7.9 (6)
<i>Phone helpline</i>	0	0	0
<i>Doctor/GP</i>	5.0 (2)	0	2.6 (2)
<i>Minister or religious leader</i>	0	0	0
<i>Not sought help from anyone</i>	2.5 (1)	8.3 (3)	5.3 (4)
<i>Sought help from another party</i>	5.0 (2)	2.8 (1)	3.9 (3)
<i>Unknown</i>	72.5 (29)	77.8 (28)	75.0 (57)
<b>History of suicide attempts</b>			
Yes	72.5 (29)	58.3 (21)	65.8 (50)
No	22.5 (9)	38.9 (14)	30.3 (23)
Unknown	5.0 (2)	2.8 (1)	3.9 (3)

Clinical histories reflected extensive thought and intent to self-harm, and often engagement in severe self-harming behaviours. Although inpatients showed a greater tendency to self-harm, plan, and attempt suicide and were generally more high risk, most individuals across both groups presented with these behaviours. Help seeking behaviours when experiencing suicidal thoughts were largely unknown and not apparent in clinical notes; it could be speculated that help seeking behaviours are limited prior to self-harm and suicide attempts. Some individuals frequently experienced suicidal thoughts which did not reflect suicidal intent.

Presentations ranged from thoughts of self-harm or suicide not acted upon, to extensive histories of self-harming and suicide attempts. Self-harming methods were varied and numerous and included: ligatures, overdosing, lacerations, starvation, purging, swallowing foreign objects, inserting foreign objects into wounds, self-poisoning, self-neglect, headbanging, burning, hanging attempts, wound picking and reopening, suffocation, pulling

our hair, female genital mutilation. Self-harm often required medical attention and immediate staff intervention to maintain safety. Self-harm was frequently impulsive. Risk to self often increased when experiencing relapse of mental health symptoms, drug and alcohol use, influence of psychosis, triggers of past trauma and abuse, and challenging life events. Many suicide attempts presented as planned or impulsive overdoses, lacerations, hanging, and jumping in front of incoming traffic or trains. Overdoses frequently involved overdosing on prescribed and over the counter medication. Many individuals presented at hospital following self-harm and suicide attempts, often requiring subsequent admission.

## SECTION 6- FORENSIC HISTORY

TABLE 6. FORENSIC HISTORY

<i>Forensic History</i>	<b>% (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<b><i>Juvenile offense/s</i></b>			
Yes	27.5 (11)	5.6 (2)	17.1 (13)
No	72.5 (29)	94.4 (34)	82.9 (63)
<b><i>Offense/s relating to:</i></b>			
<i>Possession of drugs/substance misuse</i>	3.1 (2)	3.6 (1)	3.3 (3)
<i>Assault/battery/affray</i>	14 (9)	32.1 (9)	19.6 (18)
<i>Grievous bodily harm</i>	4.7 (3)	7.1 (2)	5.4(5)
<i>Possession of a weapon</i>	6.3 (4)	3.6 (1)	5.4(5)
<i>Property damage/criminal damage</i>	10.9 (7)	10.7 (3)	10.9 (10)
<i>Harassment/abusive language</i>	3.1 (2)	10.7 (3)	5.4(5)
<i>Burglary/robbery/theft</i>	28.1 (18)	17.9 (5)	25(23)
<i>Murder/attempted murder/threats to murder</i>	1.6 (1)	0	1.1(1)
<i>Breach of order/license/suspended sentence</i>	12.5 (8)	3.6 (1)	9.8(9)
<i>Disorderly behaviour</i>	3.1 (2)	7.1 (2)	4.3(4)
<i>Rape/molestation/sexual assault</i>	3.1 (2)	0	2.2(2)
<i>Arson</i>	7.8 (5)	0	5.4(5)
<i>Vehicle related offences</i>	3.1 (1)	3.6 (1)	2.2(2)
<b><i>Adult offence/s</i></b>			
Yes	60.0 (24)	27.8 (10)	44.7 (34)
No	40.0 (16)	72.2 (26)	55.3 (42)
<b><i>Offense/s relating to:</i></b>			
<i>Possession of drugs/substance misuse</i>	5.2 (8)	10.9 (6)	6.7(14)
<i>Assault/battery/affray</i>	27.9 (43)	20.0 (11)	25.8 (54)
<i>Grievous bodily harm</i>	3.2 (5)	1.8 (1)	3.0 (6)
<i>Possession of a weapon</i>	4.6(7)	1.8 (1)	3.8(8)
<i>Property damage/criminal damage</i>	11.7 (18)	7.3 (4)	10.5 (22)
<i>Harassment/abusive language</i>	10.4 (16)	9.1 (5)	10.0 (21)
<i>Burglary/robbery/theft</i>	14.9 (23)	27.3 (15)	18.2 (38)
<i>Murder/attempted murder/threats to murder</i>	1.3 (2)	1.8 (1)	1.4 (3)
<i>Breach of order/license/suspended sentence</i>	11.0 (17)	14.5 (8)	12.0 (25)
<i>Disorderly behaviour</i>	7.8 (12)	5.5 (3)	7.2 (15)
<i>Rape/molestation/sexual assault</i>	2.0 (3)	0	1.4 (3)

Notably, more inpatients had juvenile offences (27.5%) versus community patients (5.6%). The most prevalent juvenile offences across both groups were assault/battery/affray, and burglary/robbery/theft. Similarly, notably more inpatients (60%) had adult offences versus community patients (27.8%). The most prevalent offences across both groups were assault/battery/affray, followed by burglary/robbery/theft, and breach of order/licence/suspended sentence. Inpatients also had a high instance of charges related to property and criminal damage, and harassment/abusive language.

## SECTION 7- COVID-19

TABLE 7. COVID-19

	<b>Covid-19 % (N) Inpatients</b>	<b>% (N) Community Patients</b>	<b>% (N) Total</b>
<b><i>Has patient ever been diagnosed with Covid?</i></b>			
Yes	15.0 (6)	8.3 (3)	11.8 (9)
Not known	85.0 (34)	91.7(33)	88.2 (67)
<b><i>Has patients care been affected by Covid?</i></b>			
Yes	27.5 (11)	30.6 (11)	28.9 (22)
No	72.5 (29)	69.4 (25)	71.1 (54)
<b><i>Has visitation been affected by Covid?</i></b>			
Yes	25.0 (10)	22.2 (8)	23.7 (18)
No	75.0 (30)	77.8 (28)	76.3 (58)

There was a low number of individuals found to have been diagnosed with Covid-19 across both inpatient and community patients. Care and visitation for the majority was not recorded as being affected by Covid-19; however, this could be reflective of what was recorded or unrecorded during this time. The extent of these restrictions and their success in preventing the spread of Covid-19 may be apparent in the low number diagnoses.

## CONCLUSION:

Whilst it was expected that ACE's, substance misuse, and co-morbidity were likely to be present within this population, this data captures the range and prevalence of these issues and highlights the extent to which these individuals are 'complex' in that many elements of their presentation extend beyond simply their mental health symptoms. These additional difficulties amalgamate to an increased and high risk within this group.

This study highlights that support intervention is needed at an earlier stage for individuals with complex mental health needs. This need for support includes challenges in employment, childhood abuse and neglect, drug use, alcohol use, and anti-social or criminal behaviour. Findings highlight that individuals in this population have many vulnerability factors, and

services must be mindful of how these can be interrelated and combine to increase risk and complexity.

The finding that ACEs are prevalent within this population group coincides with findings that childhood abuse and neglect can lead to serious adverse health and social consequences in adulthood (12). Adult survivors of childhood abuse are more likely to misuse substances and experience mental health problems and physical ill health (12). As aforementioned, this suggests a need for more effective early help intervention for vulnerable children, and effective intervention to recover following abuse and neglect.

The necessity of drug and alcohol services, and the contradictory lack of engagement in these also reflects a need for specialist intervention at a younger age. Alcohol and drug use was highlighted as a coping strategy; support services should therefore aim to provide alternative coping strategies before a behavioural pattern of or dependency on substance misuse develops. The data reflects a notably high level of mental disorders due to drug use, highlighting the significant and avoidable long-term consequences for these individuals due to maladaptive behaviours. Similarly, forensic data reflected a need for intervention and rehabilitation as soon as possible to prevent reoffending. The complex emotional and psychological impact of individual histories and experiences highlights the need to provide timely person-centred interventions to meet a spectrum of emotional and psychological needs. The high suicide and self-harm risk, alcohol and drug use, and criminal offences within this cohort could be related to a lack of development of emotional regulation and distress tolerance, suggesting these individuals would benefit from support in these developmental areas.

Co-morbidity is a significant issue within this group and diagnostic instability, whereby different diagnoses are made, and diagnoses change over time is another indicator of the difficulty mental services have in understanding this very complex population and their problems when they use a categorial diagnostic system.

A strength of this study is that it creates a dynamic and comprehensive profile of individuals with complex mental health needs accessing treatment and support; such profiles can inform adequate service delivery models tailored to this group. It could be noted that based on information that was unavailable for extraction, more thorough recording of demographics is needed, person centred care must consider elements of an individual's unique identity and background, which were largely unknown in many cases.

The findings also highlight potential issues with data capture insofar as there were large amounts of missing data related to sexuality, religion, and education. This is important given the well-established links between sexual identification and mental health (10) and socioeconomic status and mental health (11). It will be important to investigate further the mechanisms for collecting this data and how demographic data capture can be improved.

This report should be interpreted in the context of some methodological limitations. The results may not be representative of the rest of the UK (as data was only collected from North West England, where the service is situated), although many of the issues we identified are likely to apply across other areas. One limitation to consider is the lack of diversity in terms

of ethnic minority groups, as most service users included in the study dataset were White British (88% inpatients and 92% community patients). It is important to note, however, that our numbers are largely representative of the ethnic background of the local community, with only 3.19% of Cheshire West and Chester residents classified as ethnic minorities (Cheshire and Merseyside Health and Care Partnership, 2021). Nonetheless, it is important to ensure all views are captured moving forward and specific targeting of certain ethnic groups may aid future research and work. Furthermore, it must be noted that data collected and analysed was reflective of information which had been recorded by staff within patient files, naturally we could not collect or analyse any information which was not mentioned or was missing. It is important to note when viewing the data that it is reflective of only the information available to the research team.

## RECOMENDATIONS:

Data highlights a lack of early, effective, and consistent interventions across multiple areas and the long-term consequences of this. These areas include ACEs, criminal behaviour, drug and alcohol use, and severe psychopathology. Services must implement person centred interventions to address ACEs at the earliest opportunity. Earlier intervention is needed to prevent maladaptive coping strategies and challenging behaviours, to provide support for mental health symptoms, and to minimise deterioration and admission to psychiatric services.

The complexity within this group suggests we need a different approach to how we assess, formulate and provide treatment, interventions, and support. The conventional approach is to identify the nature of problem based on diagnosis, and there may be different assessment and treatment services depending on diagnoses- this works well if patient has one major diagnosis. However, when complexity is at a level where there are multiple diagnoses that are changing, exploring models one might consider alternative approaches to understanding clinical issues such as dynamic approaches which approach types and extent of problems without boundaries of diagnosis base.

The training for staff working in area needs to account for this complexity, they must be trained in how to provide effective services to people who have multiple diagnoses, and about ACES, substance misuse and additional high suicide and self-harm risk. Staff should be equipped to address problems over and beyond mental health symptoms.

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