Merton Mental Health Needs Assessment:

Supplementary Report

Merton Mental Health Review

Stakeholder Workshop 28.07.2014

“This is possibly the first time since I became an unpaid carer in 2009 that I felt comfortable enough to speak honestly about my experiences and overcoming my fear of health professionals.”

-Quotation from a participant at the event

CONTENTS

Word Cloud* from the feedback of the workshop

*A word cloud is a pictorial depiction of a collection of words. The bigger a word, the more frequently it was mentioned.

Summary

A workshop was held on 28th July 2014, with service users, carers, voluntary sector and community organisations, and statutory organisations including key providers, commissioners and mental health professionals in Merton. Hosted by the London Borough of Merton (LBM) and NHS Merton Clinical Commissioning Group (MCCG) and facilitated by Merton Healthwatch, this event obtained views and facilitated discussion about the Merton Adult Mental Health Needs Assessment (MMHNA) findings. In addition to the recommendations from the MMHNA, feedback in this report will support the future commissioning of mental health services in the Borough.

Detailed feedback is described in this report in themes corresponding with the MMHNA themes, plus there is additional feedback. There are some broad themes that emerged from the stakeholder workshop, which are key areas that commissioners must take into account in their plans:

Parity of esteem: It is vital to regard, talk about and address mental ill-health in the same way we do about physical ill-health.

Re-entry into the community: A critical juncture in the recovery and support of people with mental ill-health is when they are discharged from acute care into the community. It is crucial that there is a supportive and stable environment available to people with a mental health condition, especially around housing and countering the loneliness, isolation and alienating effects they may experience.

Community support and easy access to care: This is of paramount importance in sustaining patients once they are discharged from hospital, as well as for people with mental ill-health seen in the community. High quality, easily accessible and culturally competent services must be available to all groups of patients that need them.

Caring for carers: Formal and informal carers are often the back-bone of out of hospital care for people with mental health conditions. It is imperative that carers are provided good quality support for their own physical and mental health needs, have access to appropriate training, and are involved in the care plans of the person(s) they care for. Carers must be supported in order to sustain out of hospital care.

Commitment to on-going dialogue and regular workshops: This stakeholder event was very well received by service users and carers, who clearly expressed that this this needs to be a regular and on-going process. Therefore the key commissioners and planners in the borough must commit to regular workshops with users and carers regarding mental health services to ensure commissioners hear live messages, and progress on commissioning and service delivery is shared.

Introduction

A review of Merton's adult mental health services is currently underway. This work is in two stages, the first being an assessment of adult mental health need (completed) and the on-going second stage, which is the development of a commissioning plan. As part of this stage, a stakeholder engagement event was organised jointly by London Borough of Merton (LBM) and NHS Merton Clinical Commissioning Group (MCCG), supported by the Merton Mental Health Review Task and Finish Group and Healthwatch Merton.

Aims and objectives of the event

- Obtain feedback from members of public, service users, carers and local providers, voluntary sector, LBM and MCCG commissioners and key decision makers in Merton about the seven themed areas in the draft Merton Mental Health Needs Assessment (MMHNA).
- Provide recommendations for commissioners in the borough to consider as they formulate their commissioning intentions.
- Facilitate a sense check about the recommendations being considered in the draft MMHNA.

Overview of the day

The event was held from 9:30am to 4:00pm on the 28th of July 2014, at the Vestry Hall in Mitcham, Merton. Around 60 people attended the event, representing most of the major stakeholder groups in Merton including service users, carers, voluntary sector organisations, Merton Voluntary Service Council (MVSC), Healthwatch Merton, faith and community organisations, SW London and St. Georges Mental Health NHS Trust, LBM and MCCG.

The full programme is included in the appendix. The morning session was chaired by the Director of Public Health who also delivered the welcome address. This was followed by an opening speech by the Chief Officer of MCCG, who stayed the entire morning session and returned in the afternoon to make the closing remarks and thank participants for their contributions- something that was appreciated by the participants and recognised as MCCG's commitment to the review. After the opening speech a presentation on the key findings and recommendations of the draft MMHNA (a copy of which was made available to all participants prior to the event) was made. This was followed by table discussions about the MMHNA findings and recommendations, identifying three top questions to ask the panel during the panel discussion that followed. The panel discussion was chaired by the manager of Healthwatch Merton and had eight panel members (see programme in appendix for composition).

The afternoon session was chaired by the manager of Healthwatch Merton and consisted of themed table discussions on the seven themes under which the MMHNA recommendation are organised. Facilitators led the workshops and took notes of these discussions. After this a feedback carousel took place where all the facilitators moved from table to table presenting the main findings for three minutes and taking further comments for another five minutes at each table.

The seven themes for the workshops were:

1. *Mental Health and Wellbeing: Promoting Positive Mental Health, Prevention and Resilience*

This workshop explored the promotion of mental wellbeing of the whole population, lifestyle factors that influence mental health and the physical health of people with mental ill-health, prevention of mental ill-health through intervening early in life, and building resilience in children, young adults and older adults in our communities.

2. *Tackling Dementia*

This workshop explored how we could better support the newly inaugurated Dementia Hub, raise awareness of dementia in professionals and in the public, as well as steps that could be taken to prevent dementia.

3. *Community Mental Health Services, substance misuse and dual diagnosis (Substance misuse and mental ill-health)*

This workshop was around community mental health services (CMHS) and dual diagnosis, which is the term used to describe a person who has both a mental health and substance misuse problem. This looked at how we could improve CMHS and better address dual diagnosis, and the impact on the children of parents with dual diagnosis.

4. *Addressing mental health inequalities and inequity (access)*

Merton has marked mental health inequalities and potential barriers to access (inequity). For example people in East Merton and from poorer sections of our communities have higher rates of hospital admissions and community mental health services referrals. Certain ethnic groups have disproportionately high or low presence in our mental health services. This workshop explored what steps we could take to reduce these inequalities and inequity.

5. *Improving engagement with service users, carers and communities*

This workshop explored how the service users, carers, communities and health professionals could all work better together and design services that serve Merton's population the best.

6. *Primary care and IAPT services*

This workshop explored how we could improve the early detection and management of mental ill-health and the physical health of those with mental health concerns in our local GP practices and in the community.

7. *Hospital Care*

This workshop explored ways to improve care of mental health patients admitted to hospital, ensuring that they are provided the right care at the right place and at the right time, closer to home and in the least restrictive environment.

After this the Chief Officer of MCCG made the closing remarks, mentioning the next steps that would be taken and thanked the audience for their contributions.

In addition to direct feedback, the venue had an IDEAS WALL- participants were encouraged to use this to jot down any ideas/ feedback/ flashes of inspiration and stick these

on the ideas wall during the breaks. There was a comments sheet provided to each participant to capture further feedback and this also served as a form of informal evaluation of the event.

There was also an additional ten day post-event remote feedback period where participants and others who were not able to attend the event, could email their feedback to an email box specifically set-up for this purpose.

Feedback from stakeholders

A. Themed table discussions

1. Mental Health and Wellbeing: Promoting Positive Mental Health, Prevention and Resilience

What is working well in Merton?

- At an individual level, access to leisure facilities and being able to do what one likes doing (enabling environment and infra-structure).
- Merton has many Mental Health support groups for service users, and also for carers. Many of these groups allow people to talk about their own experiences and help people to develop [Imagine, Focus-4-1, Rethink, Positive Network (not a MH specific support group), SURGE (Sutton and Merton User Group), PROSPER].
- Employment specialists in secondary mental health teams- help MH patients in EET (Education, Employment and Training) and provide appropriate support, working independently of care coordinator in their own place of residence.
- Merton Adult Education (MAE) is viewed as a valuable resource.

What does good look like?

- Engaging different faith groups in Merton: different faith groups and places of worship have a potentially significant role to play in engaging and supporting Merton residents with MH problems. “Mental Health Wellbeing Hubs” could be created in vetted, trained and quality assured faith settings that residents could safely access. The risk is that some faith settings/ religious groups regard mental illness in an unhelpful and discriminatory manner that actually exacerbates stigma and taboos. Wandsworth has a model that could be considered.
- In order to support residents with mental ill-health to live independently and gain employment, retail banks could be engaged to provide small loans and/or support to start small business. Job centres could be engaged this way too.
- Provision of day centres that are linked with secondary mental health care and community services- to provide a base for social activities, enhancing life skills, and reducing loneliness and isolation. Similarly provision of lunch-clubs and befriending services (although remote/ telephonic befriending can be isolating).
- Providing avenues and supporting people with mental ill health to tap into/ express their creative side, for example using arts, drama. Could create a project where art work is created and loaned out for exhibition in public places, such as in Merton Council buildings including libraries. Sutton has a project like this.

- More investment in carers and supporting carers who are also in employment and young carers.
- Promoting work place wellbeing- mentors, counselling,

What should be kept?

- Crossroads
- Services users groups
- Carer support
- Sure Start centre programmes (five to thrive)
- Mental maternity nurses

What should be changed?

- Invest in a programme where the voluntary sector trains GP practices on tackling and addressing stigma and discrimination in mental health
- Invest in primary care in terms of carers and their needs
- Engage more faith groups and communities
- Create a time-bank type model for exchange of expertise and experience, and tackling loneliness and isolation.
- Improve prevention of mental illness and building resilience in schools by:
    - Addressing the MH wellbeing of teachers and children
    - Targeting early years in primary school, promoting mental resilience and ways to manage stress
    - PSHE should include mental health
    - Address low level substance misuse and impact on MH in schools
    - Promote positive lifestyles
    - Create a cadre of mental health champions (perhaps from educational psychologists)
- Broaden role of statutory services and include CAMHS

Feedback carousel (other tables)

- Effect of cannabis on mental health is not widely known
- Recovery college: very important in relation to MH wellbeing
- i-Merton: many people do not have access to internet and other ways to disseminate information need to be created
- Involve and inform parents, in partnership with teachers
- Services for post-natal depression
- Good parenting and links with health visiting
- Support for children of parents with MH problems
- Linking with anti-bullying work
- Create a network of practitioners to encourage mindfulness and mindfulness practice
- Being on benefits could reinforce and/or create a negative reality
- Promoting good nutrition in schools
- Using social media
- Problem with Free-dom pass and issues of access. Need better access to services to reduce isolation
- Many more places to hang-out for free

- Create facilities for community activities in residential areas
- Role of libraries
- Better use of Merton Centre for Independent Living
- Destigmatise services
- Promoting self-esteem in children in creating a vocabulary around mental health
- Craft classes
- Advocacy services for people with learning difficulties
- Young peoples substance misuse services and learning difficulties specialism in CAMHS being phased out
- Safe secure housing
- "How to stay well" courses in MAE
- Exercise on prescription

2. Tackling Dementia

What is working well in Merton at present?

- Merton Dementia Hub is a positive initiative especially for raising awareness about dementia - however it must be used; it is a focal point and not the only place services around dementia are available. Regular tours for health and social care professionals are ensuring that the referral process is accessible for all. However, these tours and the promotion of such need to be on-going as there are significant staff changes in these sectors and teams need to be kept up to date.
- London Borough of Merton is driving the Dementia Action Alliance forward. This will eventually impact upon mainstream provision, and make services more accessible for people with dementia.
- Dementia Hub tends to focus on early to mild dementia sufferers; severe dementia sufferers have been moved to Woodlands.
- An increasing number of third sector providers are making their specialist services more accessible to people with dementia and there are significantly more services available to people with dementia and their carers.
- Carers Support Merton- working well.
- The growing number of Dementia Champions.

What should good mental health services in Merton look like? How do we get there?

- Promote what to look out for in terms of the early signs of dementia; what can an individual do to help prevent/delay the onset of dementia? What can you do to keep the mind alive?
- Raise awareness of dementia right across the community; make dementia more 'ordinary'.
- Provision of practical support around the care pathway and planning for the future; how do you overcome the challenges around planning? How you get to the right mind-set to be able to plan your care?
- Co-location of services.
- Equity in access to services, so no matter where a diagnosis of dementia is given, people can access the same support across the borough at the point of diagnosis e.g.

the Dementia Adviser should be co-located with the Memory Service as this position will signpost to all organisation.

- Equitable access to services. Challenging dementias are often seen as a secondary diagnosis e.g. alcohol, drug and aids related dementias, so are not referred to the hub. Everyone with a dementia has the right to exercise choice and access the relevant information and support. CMHT to ensure all conditions are treated and supported in their own right.
- Improved Awareness Raising, particularly in BME communities. The Asian community do not have a word for dementia, and attach much stigma to this condition.
- In caring for someone with dementia, particularly if stigma is attached, it is recognised that up to 50% of carers of people with dementia will go on to develop their own psychosis, increasing the demand on the mental health service as a service user in their own right, and on social care as they become increasingly unable to remain the primary carer. The costs associated with this could be negated with a specific, strategic awareness raising campaign and targeted screening.
- More financial investment in dementia support services.
- An agreed diagnostic pathway that is visible on local health and social care websites so people understand the process and what to expect.
- Early evidence to support people with dementia need a prompt to 'remember' appointments – can be done by admin in GP practices and CMHT's. Increased attendance will increase capacity of Consultants etc.
- End of life care for people with dementia should be addressed.

<u>What are the things that should be kept? What are the things that need to change and how?</u>

- Enhance existing resources.
- Service users need to be aware of the services at the Hub so that they can access them.
- Ensure good partnership working across third sector organisations that provide similar services - there is currently a lack of co-ordination.
- There is a potential gap around the support available for 'Middle' level dementia sufferers.
- There is a gap around carer respite – this gap is not being addressed at the Hub.
- There is an issue around working carers, they can't leave the cared for at services and or they can't get them there – how do they access good quality carers for their loved ones?
- There is an issue around confidence levels in Care Provider Agencies – how can carers be practically supported to select good quality carers?
- The carer's voice needs to be heard; the carer's view needs to be acknowledged.
- There is an issue around travel support to get to the Hub (can existing travel schemes accommodate a Hub drop off?
- Run an on-going feedback system for carers.
- We need to understand the cultural issues surrounding dementia.
- Issue around GP's in terms of early diagnosis as well as knowledge of the dementia support services across the borough; provide dementia awareness training for GP's and create structured referral processes for GP's.
- Improve the experience of dementia for those who develop a dementia in a care home. This is now their home and they are less able to cope with another move.

By 2014 Dementia Quality Outcomes (DH) states that all people living with dementia in England should be able to say:

- I was diagnosed early
- I understand, so I make good decisions and provide for future decision making
- I get the treatment and support which are best for my dementia, and my life
- Those around me and looking after me are well supported
- I am treated with dignity and respect I know what I can do to help myself and who else can help me
- I can enjoy life
- I feel part of a community and I'm inspired to give something back
- I am confident my end of life wishes will be respected.
- I can expect a good death

3. Community Mental Health Services, substance misuse and dual diagnosis (Substance misuse and mental ill-health)

What is working well at present?

- What do we mean with regards to dual diagnosis? Does this include cannabis? Is probably should....?
- DART (Drugs and Alcohol Recovery Team) look at any king of addiction. From a commissioner's perspective, the focus is on Class A drugs. Also mental health tariff classifies it as addiction and psychosis
- Commissioning has worked well.
- In-patient service can be effective, but not geographically convenient
- HTT (Home Treatment Teams) in Merton do community alcohol detox
- Good recovery rates
    - Opiate detox (maintenance) Merton is the highest performing borough nationally
    - Good outcomes for cocaine
- Merton Adult Crack Service (MACS) provides good, long term care (recovery team Merton) - provides high levels of care / commitment to the service (recovering service users lead on engagement)

What should good look like?

- Prevention services ....
- Clear mechanism for referral
- Recognition in primary care
- GP's with a knowledge about addiction and skilled in motivational interviewing.
- Comprehensive, rapid assessment (including post release from jail)
    - Joint assessment
    - Single point of access
- Clear care pathway
- Good communication between services
- No gaps in the service provision
- Outreach service for people who struggle to engage with treatment
- Evidence-based effective care.
- Psychological therapy

- Effective transition between adolescent / younger adult and adult services

How do we get there?

What are the things that you most want to keep?
- DART Team (we need an effective treatment team)
- To continue with an inclusive commissioning process (we must avoid fragmentation)

What are there things that you most want to change, and how?
- More access to psychological treatment for people with dual diagnosis.
    - Particularly treatment for people with a comorbid personality disorder - preparatory work to get someone ready for DBT / MBT
    - Psychological treatment for people with comorbid anxiety and depression.
- Better joint working between agencies (including school / looked after children)
- More access to care coordination for complex people with dual diagnosis
- Early prevention services.
- Have agencies working together at a high level - particularly with regards to challenging families.
- Better strategy for prevention of addictions in children and young adults (what is the current strategy?)

Feedback carousel (other tables)
- Geography of the ward is a problem (located in Crawley)
- How do the police integrate into the service?
- Housing and benefits do not link in particularly well, and can be particularly challenging
- Are there services accessible for people with LD?
- Is there any screening for people with a LD?
- How are people enabled to hold on to a housing tenancy
- What support is given to carers of a patient with dual diagnosis?
- Self knowledge about addictions / the association between anxiety disorder and drinking
- Better access to support in the evening
- More investment in low level cannabis use - services that can respond in the evenings
- More educational about the best ways to maintenance
- Big problem with housing - people not able to maintain tenancies due to substance misuse
- Greater emphasis on carers. More could/should be done with this, to battle the stigma of addictions
- Probation services will have high numbers of patients with dual diagnosis.
- Have a better educational service in the school - more focus on early prevention.....
- How can you support children who are living with a parent with drug and alcohol problems
- This is a long term problem. We have a fragmented approach to dual diagnosis. We have to support people to begin to the stage that they are ready
- What is the evidence for residential placement - is there no other way
- More joined up services with Merton youth justice service ...

- Addressing alcohol use in society - particularly increase alcohol consumption in women.. The hidden problem associated with harmful use of alcohol
- Addiction in the home can be destructive...
- Improve the opportunity of early intervention in the faith communities .....

4. Addressing mental health inequalities and inequity (barriers to access)

What is Working Well in Merton?

- Once one has overcome the "access barriers" the services provided on the whole are good
- There are really good examples of Partnership working in Morden i.e. the Probationary Service work quite well with Springfield Hospital. They have Advance Case Discussions and a consultant rom Springfield Hospital who comes to tell give talks on Common Mental Heath Disorders
- In Merton the Mental Health Assessment Teams operate as a Single point of Access (SPOA) which is a best practice model and other boroughs aspire to have a SPOA
- The Voluntary Services provide invaluable services
- On the in-patient units the patients are treated equally, because there are many safeguards and systems in place to ensure equity. The staff are also from diverse backgrounds
- Early Intervention is good on the whole in Merton
- The concept of the Crisis management and Home Treatment team is good although there are issues with how the current service is run. The current service tends to concentrate on medication compliance and not holistic care, there are also concerns on whether the service is adequately resourced

What does good look like and how do we get there?

- Proportionate representation in terms of access, meaning that the service user demographics align with the borough demographics. This can be achieved through targeted outreach and educational programme to reduce stigma and increase awareness
- There will be an increased of common mental health disorders in order to reduce stigma and more education top enable the recognition of mental health issues particularly among underrepresented groups. This can be achieved through making use of religious groups i.e. churches and mosques
- There will be more people with mental health issues diverted from the Criminal Justice System by implementing scheme such as the Street Triage Scheme (adopted in Lambeth Midlands that ensures that people with mental health issues are kept out of police custody and receive the right treatment and care).The 'street triage' scheme, which sees mental health nurses and paramedics accompany police officers to incidents where it's believed people need immediate mental health support. This can be achieved by rolling out the pilot after evaluation.
- There will be better management of crisis situations through a review of the crisis and home treatment team
- There will be a discreet assessment suite for Mental health that is not A&E
- Merton GPs will be involved and interested in mental health. This can be achieved through finding out from the GPs how to better engage them

5. Improving engagement with service users, carers and communities

What is working well in Merton?

- Service user-led groups
- Service user engagement with MH Trust
- Various specific service areas and individual professionals
- Improvement in communication between carers and services
- Basic structure for carer involvement
- Recovery College
- IAPT

What should good MH Services look like?

- Joined up; integrated
- Effective
- Inclusive
- Transparent
- Triangle of Care embedded with more than token involvement by staff
- Carers' Strategy
- Support for carers (not just engagement/consultation)
- Young Carers-greater recognition, understanding, inclusion of their needs in service planning

How Do We Get There? *see below for notes on each area

- COMMUNICATION
- NETWORKING, FEEDBACK AND REVIEW
- BETTER CONTINUITY AND INTEGRATION OF PRIMARY AND SECONDARY HEALTHCARE
- ADDRESS SERVICE ISSUES
- CARER STRATEGY

Most want to keep?

- Triangle of Care
- Service user engagement
- IAPT

Most want to change and how?

- Improve networking and participation:
    - *access to easy, relevant venues and timing e.g. evenings not mornings*
    - *improved capacity to travel – Freedom Pass*
    - *meaningful service user and carer representation and involvement*
- Develop inclusive Carer Strategy
- Address gaps in communication between professionals, service users and carers

* COMMUNICATION

- Structure of regular networking opportunities

- **Evening 'Surgeries' for information sharing with reps from each organisation picking up information to disseminate to their groups**
- Website information – Pros: prolific capacity; cheap. Cons: whether people can access it – need to assess/train; information overload
- Paper information – Pros: visually stimulating; good point of reference; easy to keep info. Cons: people often don't read; expensive. **Posters across Merton public spaces.**
- Newsletters?
- Grapevine - **CMHTS having information and verbalising it – importance of communicating information and sources of support;** could be a hugely helpful resource but there needs to be consistency/continuity of service
- **Trust needs to show its telephone number so it doesn't come up as a private number**
- Transparency of planning, development and outcome with clear links

*NETWORKING, FEEDBACK AND REVIEW

- Time consuming nature of involvement – needs to be more effective
- Intelligent approach - consider timing of involvement. What are the specific needs of the groups? e.g.:

  Service Users
  - Mornings bad because of medication
  - Pick times when travel passes are valid
  - What are incentives? (No tokenism)

  Carers
  - Consider view of what a Carer is
  - Working?
  - Capacity to travel? (Localise events)
  - Has other family or caring responsibilities?
  - May need respite care in order to attend?
  - May be tired/stressed – what are incentives? (People want to see real change as a result of consultation, with quick feedback about what's happening)

- How do we make this an on-going conversation, not a one-off event? – **FEEDBACK on an ongoing basis so people feel things are taken on board e.g. YOU SAID/WE DID**
- **Planning ahead for each work stream or issue – future dates arranged/notified <u>in advance</u>**
- Longer notice of events not less than minimum of 3-4 weeks
- Widespread publicity to reach all groups

*CONTINUITY AND INTEGRATION

- Continuity of staff and high turnover – addressing this. Acknowledge can't necessarily stop the problem but want to know: what kinds of induction are there?
- Basic 'toolkit' for Agency Staff in relation to Triangle of Care and expected role/standard.
- Thought given to matching service users with appropriate worker where possible – may not be but – need to have **realistic assessments of how well the relationship is working – 3 and 6 month <u>reviews.</u>**

- IAPT Services – putting trust in them can be hard but mostly a positive experience. Recognise how they best meet needs (not as alternative to secondary services for people with severe/enduring conditions). Develop better communication pathways between CMHT and IAPT, not passing service users to IAPT to enable discharge from CMHT.

*ADDRESS SERVICE ISSUES

- Funding is OUTCOMES-focussed yet people are worried some outcomes aren't easily measurable e.g.: *time spent with someone might be effective in preventing suicide*. How to allow for outcomes involving quality time/interventions that are not as easily evidenced?
- Understanding impact of major changes that come about such as Welfare Reform, and helping people to understand them. E.g. trauma of 'fit to work' outcome of assessments, where there was no understanding or awareness shown.

*CARER STRATEGY

- Acknowledge hidden harms.
- Develop Risk Assessment procedure for carers and consider safeguarding procedure.
- Active support for carers
- Respond to new elements from Care Act and raise awareness/how will they be implemented?
- Young Carers:
  - Massive issues and overlooked
  - AYCES (Action for Young Carers Education and Support) is Big Lottery funded, not commissioned.
  - Half of Carer Support Merton's Young Carers look after someone with mental health issues
  - Young carers in families where there is drug/alcohol use are under-represented.
- For Young Carers there needs to be:
  - Central source of information
  - Educate around Mental Health. Drama – use in schools/colleges
  - Reduce stigma through campaigns
  - Time for Change initiative

<u>Feedback carousel (other tables)</u>

- **Work Assessments**
  - Regulation 29 and 35 at risk of suicide
  - Really need to hone down the **solutions** and **what** is good/bad
- Exploit **Time For Change** campaign
  - Social Media – make better use!
- **Hidden Harm**
  - Need to do something around Drugs/Alcohol. Talked about/not widely acted on.
- **Discharge planning –**
  - Look at the needs of the Young Carers/Children
  - How long to balance adult's needs and keeping case open because of children's needs.
  - Children's Services – don't know enough about Adult Mental Health Services

    - Much better understanding of what's needed **strategically.**
- Hear to **Carers' Strategy**!
    - Create pathway for **Anonymous Feedback** (RTF is anon but needs to be more widespread/accessible).
    - **Transparency** – to include political transparency – attendance by Councillors.
- Joining up of organisations – **Directory of community based services** – so that Carers and Service Users know about them and Health Professionals can access the information
    - **Tackling Stigma** – Staff in GP Practices.
    - **Surgeries** – under threat? Not immune to funding changes.
    - Long term investment from Health and Social Care
- **LTC – discharge plan** once under care of GP – structure for support and addressing needs when under Primary Care Services.

6. Primary care and IAPT services

What is working well in Merton at present?

- Availability of IAPT service the combination of people and process is very good
- Option by potential service users to self-refer
- GPs are aware of the service
- Commitment from CCG to improve current services

What should good look like?

- Increase awareness of IAPT services
- Leaflets (in GP practices including messages on Jayex board, sports centre, supermarkets, libraries, churches, mother and baby clinics etc.)
- Include pregnant women
- Accurate diagnosis of the condition so correct therapy is offered
- An optional service if IAPT doesn't work
- Signposting patients after the IAPT sessions to help them build confidence and independence (use 3rd sector possibly?)
- Increased number of people returning back to work, after being signed "fit" by the GP
- Reduced number of people returning back (repeat attenders) to access the service
- Offer IAPT as standard to people with co morbid conditions (cancer, diabetes, COPD, Falls etc.)
- Compatibility between therapist and service user

How do we get there?

- Ensure service is adequately funded
- Generate more resources by collaborating with private sector
- Other services to work in collaboration with IAPT. (for example the Addictions team, employment services, criminal justice system etc. should establish linkages)

What are the things you most want to keep?

- Retain the number of sessions offered up to 16 weeks
- One to one and group therapy.

What are the things you most want to change and how?

- Change the name of the service- (it's a mouthful, what does it mean to the general public). This view was shared by 4 of the 7 tables
- Reduce waiting times to access treatment following assessment; else the purpose of accessing the service and being assessed is lost leading to reduced productivity
- Introduce a way of proactively following up on service user who has recently been discharged from the service. That was re-entry can be delayed or even avoided

How change can be initiated?

- GP should be better informed
- Encourage more people to self-refer
- Improved and increased marketing
- Make available **one** directory of all services including health, social, 3rd sector etc. that is regularly updated (like a phone book or yellow pages)
- Teaching and encouraging service user to take responsibility for their own health

7. Hospital Care

This discussion highlighted the need for a spectrum of hospital/supported and independent accommodation to be available for the population of Merton, dependent on their mental health needs. Thus whilst people should be treated in the least restrictive environment required to enable their recovery, they should also be able to access higher dependency care (e.g. in-patient care) when required, dependent on their needs.

At the high end of the spectrum, this entailed hospital care provided from well- designed environments that equated to the Government's commitment on Parity of Esteem e.g. single rooms with en-suite facilities. Service users felt that the main stressor in inpatient environments was the behaviour of other patients, and that the ward needed to be designed in a manner which promoted privacy and dignity, but was also able to absorb noise/disturbance in contained areas of wards, without making the whole ward disturbed.

A study at Springfield Hospital had demonstrated the importance of design, where a rebuilt ward had only experienced 2 serious incidents over the previous 2 years, whereas a refurbished ward without the same scope to build from scratch had experienced 27 incidents over the same period. There was thus support for the redesign of the Springfield Hospital site such that all wards could be rebuilt to this level of design.

The availability of community based accommodation in Merton was perceived to be a particular problem – this ranged from step-down, crisis house, rehabilitation placements, supported accommodation and access to independent accommodation. There was felt to be a shortage of this, which resulted in bottlenecks where people were left in higher dependency accommodation than what they required, or that they were sometimes placed out of borough and the community and networks that they were familiar with.

This shortage meant that it was all the more important for existing resources to be aligned to need, and thus provide a cohesive spectrum of accommodation through which people can

move through, dependent on their needs and recovery. This was not felt to exist at present, and thus there is an urgent need to review the stock/levels of accommodation, both health and social care funded, and to re-profile this against need. There may be a need for imaginative interim solutions in this e.g. use of empty office space.

There was felt to be a particular shortage of supported accommodation for people perceived as high risk e.g. offenders, dual diagnosis.

B. Additional feedback from morning session

1. There is no up to date carer's strategy in Merton
2. Not enough information in the MMHNA on people with learning disabilities or young carers
3. The report does not have enough information on supported housing
4. Crisis points are not featured in the recommendations
5. No police statistics are featured in report
6. People have to pay for services (Law Centre)
7. Awareness of IAPT/ Secondary care interface- waiting time for IAPT treatment after phone assessment
8. BME residents need investment in services, not just voluntary sector "unregulated" organisations but statutory organisations as well. Voluntary sector groups may be well meaning but are not adequately joined up with mainstream organisations
9. Primary Care and secondary MH services need to be more joined up in their support for MH patients with long term conditions
10. The physical impact of taking medicines for mental illnesses is not adequately addressed
11. All other boroughs in the SWLStG MH NHS Trust have a client development worker to bridge the gaps and provide a more joined up service. Merton is the only borough that does not have one
12. Crisis intervention: "Living Room Experience" not A&E. (Examples of best practice: Chicago, USA http://www.gjcpp.org/pdfs/2013-007-final-20130930.pdf; http://informahealthcare.com/doi/abs/10.3109/01612840.2013.835012 and Southend, UK)
13. There are also concerns about bed occupancy management and people not being admitted when needed because of non-availability of beds
14. People fall through gaps are no seen by the Home Treatment Teams (HTT) and medication being missed. HTT does not work for people who live alone
15. There is a sense of lack of continuity between community mental health teams and in-patient/ HTT. People experience lack of communication between them and CMHS "disappears"
16. Personality disorders are a priority area but are not specifically mentioned in the report- there are 5 WTE workers in S&M for Personality Disorders
17. GPs lack knowledge of mental health and there is need for more expertise in primary care

C. Feedback on ideas wall

1. Regarding the Assessment suite other than A&E, can we use some of the new health centres in Merton?
2. Why do Merton GPs appear to lack interest in mental health issues?
3. Can we make mental health information available in GP surgeries
4. Can we require GPs to “up skill” or as a first step ask them to cluster a number of practices to offer expert help
5. Can the service providers use clear and easy to understand vocabulary
6. Leaflets in public areas would be useful to enable the public to identify their problems i.e. baby clinics, libraries, playgroups, sports facilities, chemists, GP surgeries etc.
7. How can anyone self refer to IAPT if they’ve never heard of the service?
8. For carers to access services for people they care for they have to organise transport and or a companion which is often impossible
9. Service users need empowerment with self-management techniques with early detection of relapses when discharged from hospital
10. There needs to be more recognition of health professionals of physical side-effects of drug treatments. I feel more training in this area is needed
11. Has anyone considered the effect of taking away freedom passes from service users on their mental well being?
12. What is unpaid caring and who are these people?
13. Commission an organization to put together an A-Z resource booklet of all services within the borough e.g. Local Authority, Private and voluntary services
14. The Home Treatment Team does not work for those who live alone
15. Why was there no GP representation from Merton in the Mental Health Stakeholder engagement event?
16. Are all the “grey” areas being fully identified? e.g. Are women expected to become unpaid carers without being asked if they want to? Are possible generalisations being made about minority ethnic groups? How much of the work of “community care” is falling on unpaid carers?
17. Circle housing is not responsible for mental health issues in their tenants .There is a tendency to create “ghettos” of people with drug, alcohol or mental health problems
18. More awareness of emotional health of service users is required for those who live in isolation
19. The average gap between onset and diagnosis of bipolar affective disorder is ten years. How can this be reduced?
20. IAPT offer fantastic services
21. The Smoking cessation services has been stopped. Service users want it back as people there understood their particular problems
22. How can the communication between inpatient , HTT , CMHT be improved as it is sorely lacking and impacts on Service users experiences of the services
23. Many service users experience bereavement of friends, can we have some bereavement counselling for them?

D. Remote post-event feedback

1. Crisis happens 24 hours per day 365 days per year - crisis support needs to be the same. As a carer, when I see my son relapsing outside of hours there is little help for me. I'm simply told to call police. I'm alone and distressed and get no support during the process and no follow up afterwards. A crisis plan must be part of the care plan.
2. Out of hours service should be compulsory element of training for trainee psychiatrists and practitioners.
3. Would it be possible to have a work experience programme for professionals linking them with service users/carers giving both professionals some work based practical learning and service users/carers an opportunity to influence professional development?,
4. GPs and psychiatrists need to consider the impact of long term medication on patients health and compliance and alternative treatments, when requested, should also be an option (including holistic, herbal, etc.)
5. Referrals for specialist clinical psychology should be available as an intervention
6. Patients were supposed to have the right to choose service and this should have been in place since April.
7. Communication between hospital, CMHT and carer is poor. I'm often left out of the loop and only learn of issues when things have gone wrong. As the primary carer and person with the most intimate knowledge of the situation I have a unique and valuable insight into how things are progressing, if recovery is working, if relapse is happening.
8. We (carers) need access to occupational therapy as part of a comprehensive care plan
9. Peer support from those that have the lived experience is invaluable and should be one of a menu of options made available to service users and their carers when agreeing a care and recovery plan

"I'm constantly told inadequate staffing and budget restrictions limit the service. This shouldn't be an excuse but should encourage service providers to come together to look at new ways of working and providing a service. Innovation and creativity should be encouraged and alternative providers commissioned for time-bound, targeted, specific outcomes."

10. Primary care patients with chronic biological diseases such as schizophrenia, bipolar and unipolar depression are not picked up at an early stage and do not receive consistent treatment throughout their lives.
11. For those already in treatment this has become even more relevant now that CMHTs are being encouraged to refer patients back to their GPs as soon as possible. And as with other serious illness, such as breast cancer, follow up and intervention are important. GPs may therefore be interested in specialist training to identify key markers at early diagnostic stages as well as on-going management and re-referrals.
12. One of the main points that I felt (service user) was not addressed at the workshop was increasing the contribution of primary and secondary health care professionals and carers, in the encouragement of users to self-manage their health conditions. Although in some cases, efforts are being made in this direction, it would be good if it could be rolled out across the board. This would include out-reach workers helping users identify

triggers, avoid stressful situations and , in conjunction with health professionals to act more immediately to alter medication levels or medication type to prevent the whole cycle of relapse. Carers should be involved at all stages where possible.

13. I (service user) am concerned about the lack of an intermediate environment for users who have just been discharged from hospital or who are in an intermediate situation but not ill enough to be admitted to hospital. Housing was mentioned at the workshop. This is obviously essential. There should also be a safe, understanding space for users to spend their days. The closure of drop-in/day centres is a backward step. I have often seen people with whom I have been in hospital, just walking the streets.
14. I (service user) believe that greater liaison is needed among Mental Health professionals, GP's and General Hospital staff. Physical health of users is often treated as secondary to Mental Health. In my opinion, there is a lack of acknowledgement from Mental Health professionals of the physical and mental side-effects of medications.
15. Recently my outpatient and care-in-the-community experiences have been very good. However, I understand from other people at the Workshop, that this is not the case for everyone. In many cases, users do not have family or friends to look out for them when needed. The Mental Health Teams are often not adequate and in some cases the out-reach workers are unreliable, frequently changing or cancelling appointments or not getting back to the user with information that has been requested. Often the user is not well enough to chase new appointments, and situations deteriorate until the situation reaches crisis point.
16. Appropriate housing stands out as being one of the key elements for leading a stable, healthy life. Issues range from:
    - The need for practical support upon discharge from hospital,
    - A guarantee of no discharge without an offer of appropriate accommodation and support
    - The need for short term high support accommodation as well as secure long term housing. This means no short term lettings in the private sector where tenancies can be ended at any point after the first six months, without reason
17. There is significant variation in the experiences of carers and people with mental health needs when visiting GP's. We have heard encouraging stories from people who say that their practice has improved its approach. It is sadly not a common tale. This applies across the spectrum of mental health, i.e. people with dementia as well as those with acute and long term mental health needs. It is difficult to understand why this variation exists – why are some practices/GP's supportive and knowledgeable about mental health issues and why do others fail at what are often critical and traumatic times for individuals? Some practices do not even offer the most basic information in their waiting areas, or fail to engage with voluntary organisations that are keen to offer information and/or support.

"The workshop appeared to be well received by carers, and users of services. The presence of key decision makers, such as Eleanor Brown, enhanced the sense that people might be listened to. We would support the development of a more regular forum, based on the workshop model to ensure that the implementation of the strategy has the support of local people with mental health needs, and their carers."

18. Leighton House was built not so long ago to act as a halfway house for people recovering from issues – mental health, drug abuse etc. and as supported accommodation. It has now been closed for some years and is gradually becoming more derelict. Can I suggest that Merton claw this back from the Housing Association?
19. Day care can be a life-saver for carers, and even enable them to work without worrying about their "patient". The removal of funding by the council and consequent closure of many of these is causing significant distress. Sending someone with e.g. learning difficulties to an adult education centre where they are not in a proper caring, safe environment is not the same.
20. The fact that the trust is apparently reducing the number of acute beds for five boroughs to only 126 seems very unwise, particularly as there are people being sent away early (and therefore coming back within a short time) or having to be transferred out of the area because of a lack of beds. It is suggested that extra stress on staff concerned with these patients is leading to a high turnover of staff, in itself a very expensive exercise, and not good for anyone. It is strongly urged that Merton re-think their policies in relation to relatively minor cost cutting in this area, and take into account the bigger picture. They really should look after the sector of society with mental health issues who cannot look after themselves, and often inadvertently cause extra costs due to their condition – e.g. in terms of violent or unsocial behaviour.
21. Merton does not have a client development worker for service users; all the neighbouring boroughs have a specifically employed worker for the good of their borough.

Evaluation of the day

Positive

1. Generally a helpful day, especially in the afternoon
2. Generally an engaging day
3. Feedback carousel, worked well, good use of time
4. Good venue, excellent catering
5. Glad to be a voice of the users, carers need more of that
6. Useful event in bringing people together
7. I believe there is a commitment to improve mental health services in the future whilst there is recognition that carers need support
8. Excellent organisation, facilitation and catering
9. Clear presentations, productive day
10. Please continue to include users and carers views in policy planning
11. Very relaxed atmosphere
12. Good central location apart from traffic noise
13. These days need to continue in the long term
14. A thoroughly enjoyable day, thank you
15. Good networking opportunity
16. This is possibly the first time since I became an unpaid carer in 2009 that I felt comfortable enough to speak honestly about my experiences and overcoming my fear of health professionals. The experience of unpaid cares should be incorporated in your report

Areas for Improvement

1. I would have liked to see the needs assessment earlier with more time to prepare
2. MHNA summary presentation had a lot of jargon
3. Why was the event held on Eid , this excludes practicing Muslims
4. The facilitator eight minutes feedback was good but towards the end my concentration levels were low, perhaps a short comfort break midway would have been good
5. Needs to be backed with some action, vision and strategic leadership
6. More consideration should be given to the timing of these events to ensure maximum service user involvement and access by working carers
7. Start these events with an overview of who is who e.g. LBM, Merton CCG, health watch etc.
8. Please address the needs of people with learning disabilities
9. GPs need to be part of the next workshop
10. The measure of this will be in the delivery, we need to see some early wins to build trust

Appendix 1: Workshop Programme

Merton Adult Mental Health Review
Stakeholder Workshop 1, 28th July 2014
Vestry Hall, Mitcham, Merton

PROGRAMME

Registration
You will need to sign in on the registration sheet and then choose and add your name to a workshop theme from the sheets on the table. There will be a pre-set limit of how many can sign-up for each workshop and once filled you will only be able to choose from the remainder. You will be asked to sit at the table in the hall labelled with the name of your workshop on it.

Ideas wall
There will be an IDEAS WALL and each table will have post-its on it. Participants are encouraged to use these (and/or the comments sheet) to jot down any ideas/ feedback/ flashes of inspiration and stick the post-its on the ideas wall during the breaks.

09:30-10:00 **Registration, tea and coffee**

10:00-10:10 **Welcome address and overview of the day by chair**
Kay Eilbert, Director of Public Health, Public Health Merton, London Borough of Merton

10:10-10:20 **Opening speech**
Eleanor Brown, Chief Officer, NHS Merton Clinical Commissioning Group (MCCG)

10:20-10:40 **Presentation: Key findings and recommendations from the Merton Adult Mental Health Needs Assessment**
Anjan Ghosh, Consultant in Public Health, Public Health Merton, London Borough of Merton

10:40-11:00 **Table discussion:**

- **What did you think about the findings and recommendations of the mental health needs assessment?**
- **Top three questions from each table for panel.**

11:00-11:20 Tea and Coffee break

11:20-12:20 **Panel Discussion**

- **Three questions from each table**
- **Other additional questions/ issues arising (if time permits)**

Panel members:

1. Dave Curtis, Healthwatch Merton (Chair)
2. Sue Batley, Carers Support Merton
3. Vanessa Anenden, Focus-4-1
4. Caroline Farrar, NHS Merton CCG
5. Laurence Mascarenhas, NHS Merton CCG
6. Rahat Ahmad-Man, London Borough of Merton
7. Anjan Ghosh, London Borough of Merton
8. Mark Clenaghan, SW London and St. George's Mental Health, NHS Trust

12:20-01:00 Lunch

01:00-01:10 **Welcome back and overview of afternoon session by chair**
Dave Curtis, Healthwatch Merton

01:10-02:10 **Themed discussions at tables**

- **For table theme, what is working well in Merton at present?**
- **What should good look like?**
- **How do we get there?**
  - **What are the things you most want to keep?**
  - **What are the things you most want to change and how?**

Table themes:

1. Mental Health and Wellbeing: Promoting Positive Mental Health, Prevention and Resilience
2. Tackling Dementia
3. Community Mental Health Services, substance misuse and dual diagnosis (Substance misuse and mental ill-health)
4. Addressing mental health inequalities and inequity (barriers to access)
5. Improving engagement with service users, carers and communities
6. Primary care and IAPT services
7. Hospital Care

02:10-02:30 Tea and Coffee break

02:30-03:30 **Feedback carousel**
Each table facilitator goes to the next table and presents for 3 minutes and takes feedback for 5 minutes, and then moves to next table till all tables are done.

03:30-03:45 **Q&A**

03:45- **Closing remarks and thanks**- Chair

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