Bristol Mental Health Network Meeting

Monday 7 February 2011

Attended:
Lorraine Munro, Action For Blind People/RNIB; Marius Jennings, Age UK - Bristol; Derek Dominey, Alzheimers Society - Bristol Branch; Nikki Kehoe, AWP; Richard Bebb, Basf; Sal Ball, Bristol Crisis Service For Women; Erica Wildgoose, Bristol MDF The Bipolar Organistion; Paul Clarke, Bristol Mind; Salena Williams, Bristol Royal Infirmary; Nola Davis, Bristol Survivors Network; Roy Hackett, Bristol West Indian Parents & Friends Association; Suzanne Pearson, Chair of Bristol Mind and Freelance Trainer; Louise Dursley, Futures At Knightstone; Helen Gunson, Hartcliffe & Withywood Community Partnership; Nicole Andan, Mental Health Matters; Helen Curtis, Missing Link; Marvin Rees, NHS Bristol; Pat Rose, Nilaari; Jackie Boyce, Rethink; Emma Lawrence, Rethink; Dave Nichols, Rethink; Margaret Price, Rethink; and Michaela Fudge-Quinlen, Self Help Community Housing Association.

Apologies:
Jim Conley, Aspects And Milestones; Veronica Parker, B&NES Link; Marty Parish, Missing Link Housing Association; Dave Nichols, Rethink; Lynn Jones, UWE; and Piers Cardiff, Volunteering Bristol.

Presentation:
Nikki Kehoe, Team Coordinator, Bristol Early Intervention (EI)Team, AWP
http://careforum.pixillionserver.co.uk/assets/files/Volunatry%20Sector/Presentations/Bristol%20/AWP%20Early%20intervention%20Presentation.pdf

Nikki explained that their service is based on the evidence available. They see people between the ages of fourteen and thirty five, the possibility of their being no age limit is being looked into. The service has expanded since it began in 2007.

Q: When you talk about having a central point of referral for the Trust, do you mean an easy access point?
A: Yes, where we'll fit in from an early intervention point of view is still under discussion.

Q: What is the point of an easy access point?
A: It standardises everything. We are working a lot with hard to reach groups. We want the flexibility to do that and then route into an easy access point.

Q: Service users are very concerned about who is manning the phone.

Q: There is a rumour that in other parts of the locality, families could make direct contact with the early intervention (EI) team to get advice.
A: That is true. Friends, connexions workers etc could get in touch. Anyone can phone for advice.

EI work with people for up to three years, but there is rapid access back in to the service. We hope to get a consultant psychiatrist this year. At the moment, "previous treatment" refers to medication and we want it to include psychological therapy.

Q: What are vocational interventions?

A: In Bristol, we are using external agencies such as Mental Health Matters. We are looking at doing it in house in the EI team: visiting employers, reducing the stigma etc. There is emerging research on this and we are hoping to do a pilot.

Q: What percentage of the case load is at work?
A: Approximately 27%. A significant number are at school, college or university which is not considered to be employment. Part of the job of the steering group is to look at these issues.

Q: Do you know what is happening with redesign of AWP services and EI?
A: At the moment, EI is being left out of it. I think we'll be OK. My hope is that this expanded further in the next ten years.

Q: What about private nursing homes getting medication? One of my relatives is in a nursing home and there is no one there medically fit to give the medication to them. Someone needs to complain, I have raised the issue many times. A district nurse should spare a day to go into nursing homes.
A: That is a separate issue. There is no one in the case load of that age. If there is negligence, it needs to be taken forward.

They have hired a room at Co-exist and from April hope to run a weekly three hour session on different themes such as cannabis use, reiki, benefits.

Q: Is this for the existing case load?
A: Yes, to get a small grant a specific target population needs to benefit. We will open it up if there are less than 10 people.

We are looking for volunteers to join the steering group.

Q: How many patients are sectioned under the Mental Health Act?
A: Of a case load of approximately 160, approximately 7.

Q: A carer might go to a GP with a concern, but the person themselves might say they do not have a problem. Do your team get alerts from GPs and does the team do some outreach?
A: We try and link with GPs and speak to the families.

Q: Can you say more about the bumpy transition from CAMHS, if for example, a first episode happens for a person under sixteen.
A: There have been a lot of transition meetings and a clear pathway has been developed. If the first episode happens when someone is over 18, we will see them for three years. If they are 14, they will get five years.

Q: Does CAMHS have a similar process of EI?
A: It is patchy. Ultimately it is about commissioning. We are commissioned from sixteen plus.

Q: Can you say a bit about non medication therapy.
A: (i) Cognitive Behaviour Therapy (CBT) case management. (ii) Family intervention. This has the strongest evidence for preventing relapse, but we need to go carefully. (iii) dual diagnosis – vocational input. (iv) sports work. (v) psychotherapy, if appropriate. Everything with an evidence base.

Q: You mentioned receiving eight referrals and taking two.
A: Approximately that.
Q: What happens to the other six?

A: If they have had previous treatment and are not experiencing psychosis, there will be signposting and they will be handed back to the assessment team.

Selena Williams, Clinical Team Manager, Liaison Psychiatry, Bristol Royal Infirmary
Selena's team works with anyone with psychological or mental health difficulty or a physical illness, such as a broken leg and depression, terminal diagnosis of cancer etc. The core work in the emergency department is people who have harmed themselves in some way. There are 2000 such admissions a year in the BRI. An anonymous record is kept of all self harm cases coming to the BRI, so that there is an understanding of demographics. Suicide is intricately linked with self harm. Almost half of people committing suicide have a history of self harm. The suicide prevention group is part of a nationwide project whose aim is prevention. Bristol is a high risk area of suicide.

Risk assessment is done at triage. There is a crude traffic light system which dictates the service and is nationwide. Many people have been deemed as low risk although they have committed suicide. They are looking at how they assess risk.

Selena had come to this meeting to get people's views on Accident and Emergency (A and E) and self harm and suicide risk. She gave the following story as an illustration:

> Lisa, aged 34, was treated badly by her father who was an alcohol user. She has vivid memories from the past and is bitter and hateful of him. She has a diagnosis of borderline personality disorder and takes tablets. She comes to hospital for help. She doesn't want family and friends to know. She often takes alcohol. In hospital she feels separated from reality and finds it difficult to express herself. She is triaged by a nurse and is viewed as a regular attender with poor communication. She has to sit in a cold seating area and after an hour is asked the same questions as on arrival. If she says it is unlikely she will self harm again, she is deemed low risk and sent home with a leaflet.

The following comments were made:

- I hear this time and time again. A and E provides a poor service for our clients who are given a talking to for wasting people's time. It doesn't improve. It is dependent on the training and understanding of staff in A and E.

- It's similar in GP practices. There is little understanding of mental health, so the focus is on physical and it gets lower priority. There is little access to patient notes so they go on the word of the person in the present.

- Within the story, the Doctor is going against NICE guidelines. Practitioners are not working to guidelines.

A: Government targets on a four hour wait increases the stigma.

- The story seems familiar over a long period of time. A and E staff need training. Investment has to be made to give staff the basic understanding they need. A lot of them don't understand it. It raises the issue of diagnosis of borderline personality disorder. What is happening to that group of people? Services and responses are patchy. There is a big story behind that story. Traumatic abusive childhood is not acknowledged etc.

A: There is a big issue about treatment that is not medication.

- Recognition needs to happen for staff, not only once they are trained, to recognise and support their own mental health and wellbeing. For self preservation, they may de-sensitise themselves. Work around humanising their environment needs to be done as well as rotating staff. Training should include a reminder that they are a human being as well as the service user.

- In South Glos, we do a story like that and involve people who have experienced delivery of that. At the end, it will become clear that it was a member of staff.

- What is the thinking about having mental health nurses in A and E on a twenty four hour shift pattern.

A: Birmingham has just won an award for doing that.

- With EI, you attract people who want to work with people having a first episode of psychosis. Someone who really wants to work there could guide staff.

A: It is piecemeal. There is an alcohol specialist nurse working there. I'm particularly concerned that there are people who use self harm that we never see in A and E. The under estimation of suicide risk is my concern.

- There is unintentional suicide, too.

- It is a cry of distress and the only way to get help. Going to a medical environment isn't the relationship needed. It would be better to have someone to sit with you. How do you then keep yourself well?

- Separating out self harm and suicide risk is an age old question and is more complex at the moment of something happening. How you might feel a while after can be different. We shouldn't undermine the bit about how hard someone could be working at surviving.

- The idea of someone taking life is so abhorrent that their distress may not be heard. There is great skill in being able to hear that without our own resistance getting in the way. It is not unreasonable to ask how long they might like to be dead as it might just be the next month.

A: One of the key things is engendering hope. It is crucial that when a person comes in for help, we need to give them the best help.

- Sometimes there is a problem with training in hospitals. If someone is having training, they should meet with a service user who has had a positive experience of a nurse sitting down with them. The person impact is more important than the medical aspect. It is not just suicide and self harm, with dementia, for example, there is also a need for someone with mental health training.

- Carers talk about that. That person might have a repetitive thing. Training is complex. Your contact will make a massive impact on the situation. Extra honed communication skills are vital.

A: 25% of suicide deaths happen within a week of contact with NHS services.

- Recognised borderline post traumatic stress disorder. Very perceptive in relationships. Understanding impact of internal world. Service user experience.

- Many of our clients at Action for Blind People have been to eye hosp and had similar experience. Trauma from way they've been handled rather than the sight loss.

- Nurses understanding can be that suicide creates a work load.

- Leads into bigger problem people care enough about that part of that job feel important in job motivate and supported.

- If you have someone to advocate for you, you get better care in A and E.

A: We are developing systems that include advocacy support.

Comments will be passed back to suicide prevention group at the hospital.

Sally Ball, Helpline Coordinator, Bristol Crisis Service for Women
http://www.thecareforum.org/publication_uploads/MH%20network%20meeting%207%2002%2011.pdf

Sally stated that, due to lack of funding, the helpline is closing at the end of February. Their clients' ages range from 7 to 76. There are cases of over dosing, and self injuring as well as suicidal thoughts. Sally emphasised that, generally, if they really listen they can risk assess.

Q: Who are the callers being sign posted to now?
A: The self harm network; TESS is still running; South Glos Rethink; and there are a couple of national numbers. However, their helpline was quite unique in being non interventionist.

Rep's Report – Suzanne Pearson
Suzanne Pearson and Jim Conley are the Reps on the mental health LIT.
In the LIT there are a lot of updates from the many working groups linked to priority areas, such as: personality disorder; suicide prevention and employment. There have been a number of presentations over last few months from the housing subgroup, included in their thinking is an easy point of access by AWP. The health and wellbeing board will have a really important strategic function inside the local authority with public health sitting inside local authority. Suzanne thinks that the Voluntary sector will have representation on those boards. They will start shadowing other structures already there, from April this year. There has been a presentation from AWP about how they trying to monitor and evaluate the services they offer. The LIT is trying to think about its own future when PCTs go in 2013. There is a GP on the LIT. The LIT is getting positive feedback nationally about doing a good piece of work. Jim and Suzanne would really welcome questions that could go to the LIT.
A request was made that the following issue should be raised with the LIT: This group is sad and regrets that the women's crisis service is not functioning due to lack of money.

Information share
- A mental health awareness day is running on 1 March in Withywood Community Centre. From 10am approximately with workshops in the afternoon. It is for professionals and the general public and there will be stalls.
- Rethink has been one of the main assessors for the carers' breaks project and it has been widened out to any carers. The project will finish at the end of March. If anyone is

aware of any carers (not necessarily mental health), contact Margaret Price at Rethink by email.

- Bristol Mind is running Applied Suicide Intervention Skills Training (ASIST) on 10 and 11 May. For more information, visit http://www.bristolmind.org.uk/training-research/training/suicide-prevention. There are two free courses on children and young people's mental health first aid, one in March and one in April may which will be delivered by Mind. Contact Bristol Mind for details.
- On 24 March, The Care Forum is running a joint mental health network. Rachel Clark from AWP will be talking about collaborative working.
- There is a meeting at the council house about the future of VCS on 18 February. This workshop will look at recent government proposals for reforming health and social care and explore what they mean for Bristol. Issues to be addressed include patient and public involvement; local accountability; assessing the opportunities and challenges for different sectors and interests. Light refreshments will be available for a networking lunch at 12.30pm. Places are limited. To book a place please contact Suzanne Ogborne, ☎0117 922 2080, email suzanne.ogborne@bristol.gov.uk.

Evaluation:
What was the most significant outcome of the event for you?

- Updating and gaining greater knowledge of early intervention
- Holy moly - everything! Very info packed meeting
- EI and information about self harm/suicide
- Finding out about other services - feeling in touch with what is happening
- Information from Nikki Kehoe
- New information
- Learnt a lot about EI and BRI A and E
- Information about other services and networks
- Networking
- Networking within this community

Do you have any suggestions regarding topics/speakers for future meetings?

- 1st meeting for me - I'll probably suggest something when I have been more times
- Mental health and disability
- Redesign of community services - up to date info
- Personality disorder/mental health in general (2 people said this)
- Community signposting

Are there any other comments you would like to make?

- Excellent group of people
- Great to be involved
- Well chaired and friendly

Content	Average mark (out of 5)
Understanding of subject at start	2.7
Understanding of subject at end	4.2
Sessions	
Speakers	4.5
Other elements	4.6
Organisation	
Pre-event information	4.4
Facilitation	4.4
Organisation on day	4.4
Venue	
Access	4.6
Refreshments	4.5
Standard of room	4.6