



Bristol Mental Health Network Meeting

The Vassall Centre

14 July 2009

Attended:

Sue Bateman, Action for Blind People/RNIB; Marius Jennings, Age Concern Bristol; Jim Conley, Aspects and Milestones; Duncan Garner, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP); Catherine Wevill, Bristol City Council - Health & Social Care; Adam Cutler, Bristol City Council Libraries; Sal Ball, Bristol Crisis Service for Women; Salena Williams, Bristol Royal Infirmary; Suzanne Pearson, Chair of Bristol Mind and Freelance Trainer; Rebecca May, Cruse Bereavement Care - Bristol; Dianne Pitt, Greenaway Community Practice; Helen Gunson, Hartcliffe & Withywood Community Partnership; Paul Davey, Mental Health Matters; Marty Parish, Missing Link Housing Association; Susan Everett, National Autistic Society, The; Jude Carey, NHS Bristol; Sarah Hancock, NOVAS; Kerrie Ford, Raphael House; Paul Conyers, Rethink; Karen Allen, Rethink Carers Service; Michaela Fudge-Quinlen, Self Help Community Housing Association; Selina Postgate, South West Autistic Rights Movement; Lyn Mitchell, CCM Carer; Nick Moore, Studio Upstairs; Debbie Howitt, The Care Forum; Anna Sansom, The Care Forum; Lysa Pierce, Victim Support - Bristol; Mandy Cox, Wellspring Healthy Living Centre; Rhian Loughlin, Wellspring Healthy Living Centre; Larry Harvey, Bristol City Council

Apologies:

Geoff Loydon; Susanna Hoare, Addiction Recovery Agency; Ella Hydes, Aspects and Milestones; Richard Ashby, Avon and North Somerset Probation Service; Jacky Humphreys, Avon Sexual Abuse Centre; Marcel Osborne, Barton Hill Settlement; Claire Nichols, Bristol City Council; Ruth Williams, Bristol City Council - Health & Social Care; Simon Greaves, Bristol Drugs Project; David Elson, Bristol Tenants' Resource Centre; Gill Burton-Davies, Care and Repair - Bristol; Vanessa Parmenter, City of Bristol College; Paul Hazelden, Crisis Centre Ministries; Tina Dibble, Dimensions (UK) Ltd; Wendy Parker, NHS Bristol; Madeleine Vaughan, NHS Bristol; Sue Jackson, NHS South Glos; Sally Morrissey, Novas Scarman; Florence Owolabi, Salvation Army; Rachel Barclay, The Two Way Street; Diana Elliott, Avon Adult Asperger Group

1. Presentation: 'Improving Access to Psychological Therapies in Bristol'

Dr. Lisa Frankland, Right Steps Bristol

http://www.thecareforum.org/publication_uploads/Bristol%20IAPT%20Presentation.pdf

The argument for the Improving Access to Psychological Therapies (IAPT) programme is based helping the greatest possible number of people, not just economics; 1% of people have psychosis, 15% have depression/anxiety disorders.

IAPT's evidence-based practice is based on NICE guidelines, and the programme is being very heavily scrutinised in terms of what it is providing and the outcomes of that provision. The economic argument for IAPT arises, however, because it has been demonstrated that if investment is made in psychological therapies, money will be saved; at present only 4% of

people have access. Increased provision in psychotherapy services pays for itself in the long term, as more people enter employment and less medication is required.

Sizeable pilot projects were set up to look at some of the issues involved in using different service models, and these pilots achieved a recovery of 50%. Service users tend to split about 2:1 in favour therapeutic rather than medical treatments.

The rolling out of the IAPT programme in the South West has started already, based on a two-year timetable (in other places the norm is for the service to be provided in full within three years). The programme is suitable for outpatient psychological therapy; GPs retain all medication duties. The accredited training of therapists started in April this year at the first site in Bristol. There is currently a 1/3 to 2/3 ratio of qualified staff to trainees.

Wellbeing coordinators are already doing telephone assessments and offering a whole range of interventions. Both high-intensity and low-intensity therapies are available. Treatment can be also stepped up to 1:1 therapy where necessary. People with non-mild OCD go straight to intensive therapy.

One of the key aspects is the pathway to care. At the moment, people are being referred by GPs, but one of the aims of the Department of Health's national implementation plan for IAPT is that, by 2010, people will be self referring by email or telephone, and arranging their own times for assessments.

Service users are given a contact in the service within 48 hours; at present there is no waiting list, though they do then have to wait for the actual assessment to take place. Self-referring should reduce the time between assessment and treatment. Nonetheless, there still need to be strong links in Bristol so that non-self referring people are referred to the right services, and to ensure that equal access will be offered across the community.

Phil Harrison, Right Steps Bristol

Phil joined Turning Point in January of this year. Prior to that, he had worked for many years in the NHS and managed Inner Care in Bristol. When Right Steps was set up, Turning Point was identified as the preferred bidder. Existing staff from Inner Care who already had knowledge and experience of working in Bristol were transferred into the new service.

There are three stages of service delivery and recruitment in the rolling out of IAPT in Bristol. The start of referrals in April of this year was the first. Recruitment is now taking place for the second stage of training due in September. The third and final stage in terms of recruitment and will take place in April 2010.

This three stage process is mirrored in the widening of the area where the service is delivered. At present, it is limited to 1/3 of the area covered by Bristol's GPs/PCTs. This will increase to 2/3 in October, before full coverage of the local authority area is achieved next April. GP practices which will fall into stages 2 and 3 are being identified at present.

Q: What is the background of Turning Point?

A: Turning Point has been around for 45 years. It is a national organisation, and was established as a service for people with alcohol problems in London. Its core business is around taking a whole person approach to substance misuse, but since the 1980s it has also worked with people with learning difficulties, and now has a flourishing mental health sector. It was the first non statutory service to be awarded a complete IAPT contract for an area (there is now a second in Oxford).

Q: What is the exact area being covered?

A: The area covered by Bristol's PCTs.

Q: The pilot project demonstrated a 50% recovery rate; how was this audited in Bristol? Also, how do the links with employment coaches work? What about suicide prevention?

Lisa: Recovery is measured by outcomes. There are anxiety measures, disorder specific measures, phobia measures. A minimum data set looks at whether the person is in employment at each session and receiving benefits, and the work and social adjustment scale measures the effect of their difficulties on their current functioning.

Phil: In terms of links with employment coaches and suicide prevention, this is a work in progress – a discussion that needs to be had. We are having meetings with agencies that are supporting people back into work, service user organisations such as Mental Health Matters, and others.

Q: What is GAD?

A: The Generalised Anxiety Scale. This is used in IAPT because it's free (together with the Phobia Scale); it gives an overall measure and is not disorder specific.

Q: With issues around self injury, what will you measure as success?

A: That is part of the whole person approach, and our approach is very person centred. Our view is that we're looking at the function of behaviour for that person. We would get them to identify their own goals, and this might include a goal around self injury if that is what they would like – but it is up to them; we will not be standing over them in judgement.

Q: What is the length of the therapy service offered through IAPT?

A: Based on research, we offer up to twenty sessions of Cognitive Behaviour Therapy (CBT).

Q: Can people come back after a gap?

A: Yes – I think that is a good model. They may have a low intensity intervention, then come back to do some more sessions. It depends what their goals are.

Q: Is CBT a replacement for longer-term psychological therapies that look at the deeper, underlying things that often need to be addressed?

A: You might have to ask some of the patients! But it is one of the myths about CBT that it ignores these things. Some of a patient's core early experiences might be targeted in those twenty sessions and that might include trauma and abuse.

Q: What awareness is there of autistic spectrum conditions? What training do people get in this?

A: Knowledge in general is limited; it is an ongoing issue to maintain awareness. It may be covered in core training. The connection with Turning Point will help in this regard, and experience is topped up with training days, but more training is needed. There is a review looking at autism in Bristol at the moment which will focus on the unmet needs of service users.

Q: My organisation is based in an area with a high Somali population. What is the programme doing to address their specific needs?

A: I have talked to Marvin Rees [Programme Manager - Black and Minority Ethnic Community Health Development (Mental Health)]. We are thinking about being creative in taking the service out. Part of the issue is about providing a service which is culturally specific.

Q: What about language?

Lisa: This has been an issue. We went on local community radio to try to attract people from different groups, but nobody has yet come forward who speaks an ethnic minority language. Phil has a meeting set up with the local contact for the Somali community in Barton Hill.

Q: I work with a hidden disability group: deaf-blind people. There are huge mental stress issues which are often missed as they are hidden away. Often many of the people in the profession do not have enough knowledge about how such impairments affect people. This is another sector where needs are very high.

A: Can we link with you? We don't know a lot about what's out there. We get guidance on how to work with deaf-blind people and our IAPT model is flexible (for example, telephone assessment). But it doesn't know everything. We are thinking carefully about what to do make it an inclusive service.

Q: Everyone is excited that the service has arrived. Has a list of which third of GPs can currently provide the service been published? What is the current waiting time to assessment?

A: The PCT will be publishing the list. A realistic assessment timeframe at present is within a month, although there may be greater pressures in holiday times.

Q: With the holistic approach, is there expertise around people who have problems with drugs and alcohol?

Phil: I have a long history of this and have worked in dual diagnosis. We encourage people to look at the relationship between drug and alcohol use and their mental health. I am also involved in a city wide dual diagnosis improvement group.

Q: Where are you located?

A: The team is based in Victoria Street [in the centre of Bristol]. We are in the process of talking to GP practices about the availability of rooms and are also in consultation with community centres too.

2. Updates from Reps

Following election, Jim Conley and Suzanne Pearson are now the network's representatives on the Bristol Mental Health LIT. They can be contacted with any issues or information you would like taken to the LIT on jimc@aspectsandmilestones.org.uk (0117 970 9376) and chair@bristolmind.co.uk (0117 980 0370).

3. Presentation: 'The Care Programme Approach and Social Inclusion'

Anne-Laure Donskoy, Bristol Mind User-Focused Monitoring Network

http://www.thecareforum.org/publication_uploads/UFM%20CPA%20Report%20Presentation%20July%202009%20-%20Care%20Forum.pdf

(Anne-Laure was the research coordinator for the project, and gave the presentation above outlining its findings):

The research focused on the relationship between care planning and social inclusion and the findings were made possible through the access won by the team of user researchers that carried it out. Service user researchers were involved from the beginning to the end of the process.

The research made use of a Life Domains system to look at how inclusive care plans were, for example in relation to areas such as housing, shopping or other aspects of daily living.

The research process itself is a process that promotes social inclusion, and has helped move some of its service user researchers into employment.

A piece of software was used to select participants randomly. Amongst the people interviewed were matrons and service users on wards and interviews were conducted in pairs. Specific training was arranged, for example, in prisons, and interview training undertaken with experienced UFM researchers.

Sophie Robinson, Bristol Mind UFM Network

(Sophie was a service user researcher and described the actual process of gathering the data for the project:)

We didn't draw up the questionnaire, but a lot of thought was put into the questions. A lot of the questions came from personal experience. The interviews were approximately an hour long and people said that they found them really useful.

Mental health services are not proactive about asking about basic needs, such as shopping. Care planning is potentially a very good tool for dealing with many issues like this.

Q: One of the many interesting findings emerging from this research is the evidence regarding direct payments. What does it say about direct payments if, as the research shows, two thirds of people on care plans have not heard of them?

A: Personalisation and mental health were not linked together as an issue when this research was carried out. Even now, there isn't yet emphasis on personalisation and mental health. In the mental health world, people hear a lot of things from other service users or advocacy services, so more emphasis will increase awareness.

Q: With the personalisation agenda, a lot of people are responsible for delivery, but don't know how to implement it. Is it that there's not enough awareness training?

A: There's an issue with selection criteria. Fair Access to Care Services (FACS – the system used to assess need in relation to direct payments) doesn't work for mental health service users as it is such a fluctuating condition.

Q: When interviewing people about direct payments, was there lack of knowledge across the board?

A: The interviews were undertaken over a year ago and the lack of information about whether people were even on a care plan or not was striking. The exception was the forensic sample which was very well informed.

Q: Direct payments are changing continuously. They seem to have worked fairly well with people who have learning difficulties or physical disabilities. But success has been patchy for people with mental health issues. Supporting someone through the process is a massive piece of work and people don't understand the detail of it.

A: The Government has set a target by 2011 that everyone will have individual budgets. That doesn't mean that they will have direct payments or be an employer. The spending of the budget can be done through a social worker or third party agency. It's important to differentiate as direct payments are working in older people's services in mental health, partly because carers are involved.

4. Evaluations

Sixteen evaluation forms were handed in for this meeting – thank you to all participants who returned one. Thank you also to our speakers, whose presentations were very well-received. There were too many positive comments to list in full, but the following give a flavour:

- My first visit – I thought the choice of speakers were both excellent.
- Great for me as a non-specific mental health worker to get very valuable information specific to Bristol service delivery within statutory services.
- Excellent update on IAPT. The presentation on user focused monitoring was also very interesting, and the method can be replicated across sectors.
- The forensic side that came through the UFM data was very interesting to me.
- The mental health network is always a very useful meeting to attend with various issues and areas covered, and good opportunities to network.
- As an occasional attendee I found it very interesting and will attend more regularly.

In terms of the most specific outcomes, the most valuable were seen as the information gleaned from the session, along with networking opportunities. One person summed it up, saying they had 'learnt an enormous amount and made many new contacts'. Also interesting was one person's observation that the most valuable thing of all for them in the session was 'hearing various other uncertainties around personalisation, individual budgets and direct payments' - even though this was not specifically intended as an outcome of the session.

The table below lists the average scores out of six for all of the various elements of the meeting:

| Content | Average mark (out of 6) |
|------------------------------|----------------------------|
| Interest | 5.2 |
| Usefulness | 5.4 |
| Facilitation | 5.3 |
| Speakers | 5.4 |
| Updates | 5.2 |
| The event overall | 5.3 |
| Organisation of event | |
| Initial publicity | 4.6 |
| Pre-event information | 4.5 |
| The programme | 5.3 |

| | |
|-----------------------------|-----|
| Overall organisation | 5.0 |
| Venue | |
| Access | 5.6 |
| Standard of refreshment | 4.4 |
| Standard of room | 4.3 |
| Overall assessment of venue | 4.7 |

5. Next Meeting

The date of the next meeting is Thursday 22 October, 10am-12 noon, at the Vassall Centre. Please note this is a change of date from that originally advertised in the April edition of The Care Forum's ebulletin. The meeting will look at, among other things, at the Bristol Vision for Mental Health and the work of the Bristol Health Services' Plan's Mental Health Service Design Group. You should already have received a full invitation and booking form. For further information contact leonquinn@thecareforum.org.uk or ☎ 0117 958 9307.