



the care forum

Bristol Mental Health Network Meeting

The Vassall Centre

22 October 2009

Attended:

Sal Ball, Bristol Crisis Service for Women; Rosie Brandon, AWP; Mark Earl, Rethink; Diana Elliott, National Autistic Society; Gemma Mountford, Mental Health Matters; Claire Nichols, Bristol City Council; Dawn Osborne-Tiller, St Mungo's; Mark Owen, Bristol Active Life Project; Florence Owolabi, Salvation Army; Jenny Poppy, Missing Link; Liz Rogers, AWP; Paul Hazleden, Crisis Centre Ministries; Leon Quinn, The Care Forum, Katharine Gonzales, The Care Forum

Apologies:

Simon Allen, National Autistic Society; Kyra Bond, Womankind, Selina Postgate, South West Autistic Rights Movement; Douglas Gill, Studio Upstairs; Rhian Loughlin, Wellspring Healthy Living Centre; Geoff Loydon, Bristol Patients Forum; Anya Mulcahy-Bowman, CAAAD; Lorraine Munro, Action for Blind People/RNIB; Beverley Newman, Rethink; Christina Rees, Brunelcare; Isabel Simoes, Independent; Amanda Wheeler, Independent; Salena Williams, Bristol Royal Infirmary; Derek Dominey, Alzheimer's Society

1. Presentations: 'The Bristol Vision for Mental Health'

Catherine Wevill, Joint Mental Health Commissioning Manager, NHS Bristol/Bristol City Council

http://www.thecareforum.org/publication_uploads/Bristol%20Vision%20for%20Mental%20Health%20MH%20Network%20Oct%202009.pdf

Catherine introduced herself the rest of the mental health commissioning team: Grace Elias, employed by Bristol PCT and Ian Popperwell, employed by Bristol City Council. Catherine also chairs the Bristol Mental Health Local Implementation Team, and is leading on the implementation of the Bristol Vision for Mental Health. She also leads the Bristol Health Services Plan's mental health service development group.

Catherine's presentation provided an update on the working towards achieving the goals in the Vision. The Vision was collaboratively written by many different stakeholders, and is an aspiration for mental health services in the city for the period 2008-2013. It contains some specifics too, for example, calling for a crisis house for Bristol, which has now been commissioned and should open in January 2010.

The Vision is based on the key values of choice, wellbeing and service user involvement. Service user involvement is at the heart of the Vision and its development. The team is currently interviewing for someone with user experience of mental health services to join it, and the project is also recruiting mental health service user volunteers to monitor the Vision across

Bristol. Deciding on the Vision's three priorities of dual diagnosis, recovery and delivering racial equality in mental health was a careful and lengthy process.

Other important parts of the Vision include an emphasis on outcomes-focused commissioning as a way of addressing historical gaps, as well as a self-assessment process for all providers.

Grace Elias, Joint Mental Health Commissioning Manager, NHS Bristol

http://www.thecareforum.org/publication_uploads/Dual%20Diagnosis%20Presentation%20-%20Care%20Forum%20221009.pdf

Historically in LIT assessments, dual diagnosis always received a “red” rating, as there was no strategy or document to refer to as a single point of reference regarding how services were planned. A lot of good work was happening, but it needed coordinating and bringing together, as people with dual diagnosis were consistently falling into gaps between services. It was difficult at first to arrive at a local agreement about the definition of dual diagnosis. Following a literature review and a series of interviews, a working definition was nonetheless reached collectively, using a multiagency approach. This definition is not set in stone, however, and continues to be discussed at dual diagnosis steering group meetings (for example, the issue of whether prescription drugs should be included). The intention is for the strategy to be a fluid document.

So far, engagement with the new strategy has been very positive from the voluntary sector, carers and service users. The strategy has eleven key objectives, all of which are included in the action plan. The key now is to act on the clear need for resources to deliver that action plan. Disinvestment elsewhere might need to be considered in order to then reinvest in realising the dual diagnosis strategy.

Other potential challenges include ensuring sufficient provider engagement (the LIT assessment process is a good way of making sure the action plan is implemented by providers), personnel capacity and reaching the most marginalised people who are still in the gaps between services.

Q: Are there any solid examples of work practice that organisations are going to be asked to do?

A: One of the workstream areas is around joint protocols, and has already started work on improving communications and making information more available around dual diagnosis, as well as producing a resource pack for services. The key is for the strategy to be tangible and be seen to be producing solid results.

Q: During the consultation process, what did service users say they particularly wanted to see?

A: The main thing that came out when writing the strategy was access to services; in the focus groups specifically for women and BME communities, needless delays was the main user concern, together with the ‘Catch 22’ nature of with dual diagnosis. As well as the feedback received during the formal consultation, there is also really good service user representation on the steering group.

A: Indeed – there is a big issue here with people being told that the mental health problem can't be dealt with until the person is clean. There is an inability of services to work in tandem. In the action plan, there is a tiered approach to training: cycle of change; motivational skills and simple counselling skills are included.

Q: If someone is on the autistic spectrum and gets caught up in drugs, the fact that they are on the spectrum can be forgotten. Surely the autism should be dealt with first, or at the very least borne in mind all the way through.

A: That is a helpful prompt. I'll mention this to Ian Henderson and the Asperger's team.

A: It's also about complexity of needs as well.

Q: Will sufficient resources be made available to help strengthen the strategy's implementation?

A: There's a lot in the action plan that we could be doing now, for example, putting the person at the centre rather than the service. If there's an identified need for resources, it can be looked at. But we need to be realistic about the current financial situation.

A: "Dual diagnosis" is used in many different areas, but there still seems to be a preoccupation with specialist services in many areas. That's why there are so many gaps – the reality is that people are more complex than that.

Q: My organisation has just completed some research into people with learning difficulties who self injure. One of the main findings was that the reasons why are mostly the same as their counterparts without learning difficulties.

Q: To what extent are AWP engaged in the strategy?

A: We had excellent engagement from voluntary sector providers. With AWP it is more difficult, perhaps because of the size of the organisation. Individuals, such as Richard Edwards, specialist nurse for dual diagnosis, are totally engaged. We are working at ways to bring about better engagement.

A: Locally, the area manager is on maternity leave so personnel continuity isn't yet there. Also, managerially, it's a question of getting dual diagnosis seen as a fundamental part of its work rather than just a bolt-on. For example, Bristol's contract with AWP last year required AWP to have three dual diagnosis specialists.

Q: There are a lot of dual diagnosis people using all sorts of services, but who aren't identified as such.

A: The implementation group is looking at producing indicators. The Dual Diagnosis Handbook is a good basis for this. We are hoping to link in with others and bring this issue back to the LIT. It's an excellent time to have a strategic and LIT assessment on this.

Q: AWP are redesigning community services, so it's an ideal time for them to think about the dual diagnosis service too.

A: They are, but they wanted to get to the point where they are implementing it before considering that. They are looking at it within the redesign, but haven't got to the point of local consultation.

A: Catherine and I both sit on the steering group and we've both raised this as an issue.

Ian Popperwell, Mental Health Planning and Commissioning Manager, Bristol City Council

http://www.thecareforum.org/publication_uploads/Ian%20Popperwell%20-%20Recovery%20%20Inclusion%20Working%20Group.pdf

Ian has a background in equalities and leads the recovery and social inclusion group on the LIT. He is conscious of the mixed agendas surrounding social inclusion and recovery, and the lack of clarity as to what they mean. He aims to commission services that have tangible, positive results as an outcome, rather than just the indicator that a person used a service. Ways of measuring that social inclusion and recovery are happening therefore need to be found; services do need to promote social inclusion, and the working group of the LIT is trying to do some of that thinking. It will hopefully be able to share in the near future some of the progress around establishing that process of measurement. A clear range of measures and set of principles to measure recovery and social inclusion are certainly needed.

Q: Sometimes there's suspicion of the concept of recovery. Sometimes it's viewed a tick box exercise getting people into jobs. How will you deal with this?

Q: The system is complex and keeps changing and simplification is needed. I'd like to endorse what you're saying, but we possibly need to take it further. We need more measures for marking people's progress. We can't, for example, measure happiness. Getting someone into work is not the task.

A: It's a minefield and we need to avoid restricting the notion of recovery or social inclusion to one thing. Most mental health services teach people that they can't work. Employment does need to be core – there's a correlation between mental health and employment which is greater than employment and mental ill health. But recovery is also about balance in lives and embracing the complexity of life. We hope our definition will have a range of measures to check off against that reflects this

Q: Work can transform people's lives. Yet one of the organisations that seem to be working against recovery is the Department of Work and Pensions with their campaigns. Are they included in your plans?

Q: Sometimes being in employment can cause anxiety and onward support is necessary.

A: We're working increasingly with Jobcentre Plus, and there have been lots of improvements in benefits, although these are rarely recognised. There are a lot of elements of funding now supporting people into paid work. Of course, the benefit system could still be more flexible. We need the whole picture though, which is not just about the DWP, but about mental health workers being clear about the facts surrounding benefit traps – as well as being clear when they don't know them. Many myths are put out about benefits in the name of facts.

Catherine Wevill

http://www.thecareforum.org/publication_uploads/7%201a%20-%20Mental%20Health%20Report%20presentation.pdf

As well as dual diagnosis and recovery, the third priority in the Bristol is delivering race equality in mental health. I won't say too much about that as I know you've had Marvin Rees, the programme lead, and other DRE workers along to talk at previous meetings. But one other

element relating to the Vision is the work of the Bristol Health Services Plan's service design group for mental health.

The main focus of the plan is on enabling people to receive services closer to home. In the mental health group, we have focused on the interface between primary and secondary care. An audit was conducted last November and in which a number of South Bristol Consortium GP practices were contacted to look at access to secondary services. The report resulting from this research was presented at a meeting of the South Bristol Consortium, to which three AWP directors came, as well as NHS Bristol's Director of Commissioning. It is very positive that GPs continue to meet with directors to take this forward as AWP can then shift its focus and resource.

The service development group is also working at capacity building, so GPs can take on and hold more people with mental health issues. The aim is to make sure the pathway is transparent for service users, providers and people in different services.

2. Updates from Reps

Suzanne Pearson, Mental Health Network Representative on the Bristol Mental Health Local Implementation Team

Suzanne is Chair of Bristol Mind and was recently elected to the LIT. The most recent LIT meeting had been cancelled, so there was no specific update to give on this occasion, but LIT updates will continue to be a standing item at all Network meetings. Suzanne emphasised that LIT reps are there as individuals, not as a representative of their organisations, and seek to represent the views of voluntary sector as a whole. For example, any points Network members would like raised in relation to the Bristol Vision can be sent either to Suzanne at chair@bristolmind.co.uk (☎ 0117 980 0370), or to the Network's second LIT rep, Jim Conley, at jimc@aspectsandmilestones.org.uk (☎ 0117 970 9376).

3. Evaluations

Twelve evaluation forms were handed in for this meeting – thank you to all participants who returned one. All three of our speakers went down well, with lots of positive comments relating to the chance to learn more the dual diagnosis strategy and recovery and social inclusion work, as well as the broader overview of the vision more generally. This feeling was summed up by one comment on the most valuable thing gained from the session: 'Getting the bigger picture of the way forward for mental health services. Very thought provoking'.

The presence of representatives from AWP was also welcomed, as was the opportunity to meet Suzanne as one of the Network's LIT reps. As usual, the networking element of the meeting was a key outcome identified by many attendees, as one person put it, 'An opportunity to network with like-minded organisations'. Indeed, feedback on the whole session summed up by one comment in a nutshell: 'Useful update from commissioners. Useful networking opportunities'.

On the less positive side, one person commented on the room and the limited space it afforded. With the Vassall Centre's refurbishments now complete, network meetings from now on should be able to be held in one of its new rooms where more space and better facilities will be available.

The following table lists the average scores out of six for all of the various aspects of the meeting:

Content	Average mark (out of 6)
Interest	5.2
Usefulness	5.0
Facilitation	5.3
Sessions	
Speakers	5.2
Discussion	4.8
Other elements	4.8
Organisation	
Initial publicity	4.6
Pre-event information	4.3
Organisation on day	4.5
Venue	
Access	5.2
Refreshments	4.2
Standard of room	4.2