Health and Wellbeing Board
North Yorkshire

ITEM 5

NORTH YORKSHIRE SHADOW HEALTH AND WELLBEING BOARD

DATE: Fri 15th February 2013

Substance Misuse and Mental Health

1. Purpose:

This paper brings to the attention of the Health and Well-being Board the work done to date in the dialogue phases of two major projects to transform the way substance misuse services and mental health services supports people's health and well-being needs across North Yorkshire.

The Board is asked to give leadership to this work seen as highly important in the lives of those sections of our populations dependent on these services and to monitor progress as the joint approach to the transformation work progresses.

2. Background:

2.1 Users of mental health services and users of substances misuse services often share similar perspectives on these services. Some will be clients of both services. Some people with mental health problems also have issues with substance misuse and a proportion of people who access substance misuse services will have mental health problems. Mental health and substance misuse services tend to focus on treating the condition and this influences how these services have been commissioned in the past. This paper presents the first steps toward a client centred approach to these services.

2.2 The *Substance Misuse Partnership Board* is one element of North Yorkshire's Health and Well-being Network under the Health and Wellbeing Board. Another sub group is *North Yorkshire's Mental Health Strategic Partnership*. The *Substance Misuse Partnership Board* has representation from NYCC, Police, Probation, Prison Services, CCGs, National Treatment Agency (NTA), and National Health Service (NHS) North Yorkshire & York (NY&Y) and has a number of partnership groups supporting it. The *Mental Health Strategic Partnership* has membership from Three Mental Health Trusts, NYCC, NHS NY&Y, people needing support of Mental Health Services, Housing and a range of voluntary sector voices. With the PCT's role now being over-taken by the CCGs it now the expectation that there will also be CCG representation on this group.

2.3 The substance misuse service in North Yorkshire was historically shaped by National Treatment Agency (NTA) funding where the key measure of success in attracting funding was the number of people in treatment. So retaining people in treatment was, for many a key objective. There was insufficient emphasis nationally and therefore locally, on outcomes for people and recovery. The funding stream shaped a traditionally medicalised model of support based on treatment and not recovery. The funding approach also meant there was not enough emphasis on prevention. This, plus the under emphasis on recovery meant that opportunities to explore the role of housing, meaningful activity, family relationships and employment were never fully explored. Earlier discussions with stakeholders also indicated that the care pathways were often viewed by people needing support of the services to be complex.

2.4 In mental health there have been a number of national policy frameworks and the last one ***'No health without mental health: a cross-government mental health outcomes'*** for people of all ages sets out six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality services. These include:

1. More people will have good mental
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable *and*
6. Fewer people will experience stigma and discrimination

The interconnections between mental health, housing, employment and the criminal justice system are stressed. The county wide group, considered the state of mental health commissioning and provision. It recognised the landscape of services was provision was changing; across the county the partners had not yet collectively responded to the national policy and changed services accordingly though some have sought to within their organisations. From a commissioning perspective it was noted that NHS and Local Authority (LA) investment and commitment to mental health service provision was low in comparison to national comparators.

3. Dialogue with People

3.1 To start the transformation process the Substance Misuse Partnership Board initiated a dialogue with key stakeholders and in particular with people who receive services. This consisted of many face to face meetings in a variety of settings. People were met in groups and on a one to one basis or sometimes in couples. A full report on the outcome of this engagement is attached at **Appendix One**.

3.2 The time had also come to initiate a refresh of the approach to mental health commissioning and provision in North Yorkshire. It was likewise agreed to embark on a bottom up approach to the refresh. A series of face to face meetings were held with people who use mental health provision, carers and other stakeholders. The core questions to people who relied on mental health services were: 'What worked well for you in mental health services; what didn't work so well and in going forward what should services offer? This report of this work is attached at **Appendix Two** for the Board's information.

4. The Challenge

4.1 The reasons for bringing both topic areas to the attention of the Health ands Well-being Board and the partner agencies are numerous:

- Many people with mental health needs turn to substance misuse as a means of coping with their mental health condition;
- Many people with substance dependencies as well as having addictive personalities may also have mental health conditions or develop mental health conditions as a result of their misuse of substances known as dual diagnosis.
- In the two sets of dialogues the people who use services for support and assistance the key message, common to both, was that there must be a greater emphasis on recovery and reablement. People are seeking hope and want to be able to live life without services. There must be a shift in culture where the measure of success is not the number of people on case-loads or in services but how many people were able to be supported to be totally independent or need less input to do so in other words a shift to improved outcomes.
- Critical to recovery is the ability to feel valued and have a sense of self-worth by being able to work or give something back to society. People with these needs require the same supported pathways to employment as other vulnerable people and our support system should be geared accordingly.
- Another critical step on the path to recovery is the ability to access accommodation with

the appropriate support to be able to feel safe and secure and to maintain their accommodation.

- Discussions with people needing support because of substance misuse or mental health difficulties indicate that there is often a good appreciation of the specialist skills of people have who support them. However it was constantly underlined by those who spoke that what people value most is being treated as 'people first' and not a 'condition'. The link here is the need for person centred support solutions.

5. Ways Forward

5.1 As a result of the customer driven process in substance misuse services a set of design principles for a newly commissioned service will be launched on the 25 March 2013 in the Pavilions in Harrogate. This will be the start of a major consultation to shape services with a view to commencing a procurement exercise in June 2013 ready for newly reconfigured system commencing April 2014. At the heart of this is the need for a clear and personalised focus on recovery, specifically building on the strengths and recovery capital of each. individual.

5.2 While Public Health will drive and support this through the Substance Misuse Partnership Board it is hoped that all partners will see that the landscape of the future will require concerted efforts on the parts of many partners to transform the service landscape. The expectation is therefore that agencies will take this opportunity to engage in the consultation and help shape future service provision.

5.3 In mental health there is a need for a twin track approach. It is not the intention to go out to procurement as the NHS recently procured mental health services from its key three NHS Providers. The task here is to transform urgently the landscape in partnership with a range of agencies ensuring robust connections between the national objectives, the objective of this Board's Joint Health and Well-being Strategy and the aspirations of people who use services.

5.4 The proposal here is that Hambleton, Richmond and Whitby CCG will lead a partnership exercise with TEWV, Vale of York CCG, Scarborough CCG, and Harrogate CCG, HAS NYCC and Leeds to start the process of transforming and modernisation of mental health services.

5.5 A similar exercise is proposed in Craven led by Airedale, Wharfedale and Craven CCG and NYCC HAS. This may see some further partnership working with the neighbouring local authority in Bradford.

5.6 The oversight of the Health and Well-being Board is important in these two approaches as it is critical that the collective partnership delivers on national policy, addresses the aspirations of our communities as expressed in the dialogue exercises and takes forward the objectives of its own Joint Health and Well-being strategy. In the absence of an executive board beneath the H&W Board the board should task its *Substance Misuse Partnership Board* and its *Mental Health Strategic Partnership* to drive these agenda's forward and report on progress in a timely manner.

5.7 When the Board's decision to develop an executive Integrated Commissioning Board (ICB) is implemented then it will be appropriate for such a group to have oversight of the work of the two groups on behalf of the H&WB

6. Recommendations

6.1 The Board is:

6.1.1 Asked to note the results of the dialogues with people using substance misuse services

and mental health services;

6.1.2 Support the actions to transform services as outlined in paragraph 5 above;

6.1.3 Encourage all partner agencies to play their part in the transformation agendas;

6.1.4 Require its subgroups as outlined in paragraph 5.6 above to drive the agendas and report back on progress in a timely manner and

6.1.5 When the ICB is in place to task it with having an overview of the work in hand.

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APPENDIX 1

5 December 2012

North Yorkshire Substance Misuse Partnership

Treatment System Reconfiguration Project

Findings From Stakeholder Engagement Exercise September-December 2012

Compiled by Claire Cairns
on behalf of the
North Yorkshire Substance Misuse Commissioning Team

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Acknowledgements

The North Yorkshire Substance Misuse Partnership would like to thank all the stakeholders and service users who were involved in the engagement exercise for their valued contributions.

Section One – Introduction & Methodology

1.1 Overview

This report details a recent engagement process which was undertaken by the North Yorkshire Substance Misuse Commissioning Team between October and November 2012.

The findings, which are presented in the following chapter, are considered in two parts: Firstly from the perspectives of professional stakeholders and secondly from the perspectives of individuals accessing substance misuse services.

The final chapter then brings together the findings collectively and summarises the key common emerging themes.

1.2 Purpose of Engagement Exercise

The purpose of the engagement exercise was to consult with as wide a range of stakeholders from across the county as possible, in order to fully understand views and opinions about the current treatment system and to explore the concept of a recovery-orientated treatment system.

The North Yorkshire Substance Misuse Partnership Board was keen to undertake an engagement exercise prior to undertaking a full review and restructure of the current treatment system across North Yorkshire. It has been agreed, at board level, that any restructure of the treatment system will be a 'bottom up' approach, influenced by those with knowledge and experience of substance misuse services.

This engagement exercise therefore precedes any formal procurement process that may follow.

1.3 Methodology

The engagement exercise was conducted by means of a series of facilitated focus groups for professionals and service users/carers, alongside a small number of 1:1 individual meetings with service users who were unable to contribute by means of a group session.

- What is working well?
- What is not working so well?
- What improvements (if any) need to be made to achieve a recovery-focused treatment system?

In addition to the engagement events for service users, a series of events with a different group of service users was completed in 2011. The notes from these events were reviewed as part of the engagement exercise and have been merged into the summary in section three. The findings of the events in 2011 were largely consistent with the findings of the more recent engagement events.

Section Two – Findings

It should be noted that the views and opinions which are presented in the following section are of those who *attended* the engagement events. Whilst every effort was made to ensure a representative sample of stakeholders and service users was invited, the views can not necessarily be assumed to be fully representative and should rather be seen as a 'snapshot'.

3.1 Findings From Professional Stakeholders

The findings from professional stakeholders largely fall under the following categories, therefore this section of the report is divided as such:-

- Accessing the Treatment System
- The Treatment System
- Alcohol
- Perspectives on Recovery
- Personalisation
- Partnerships

3.1.1 Accessing the Treatment System – Where to Get Help

Professional stakeholders agreed that the system is very complex in some areas for people wanting to access support and there was general agreement that there needs to be a simpler method of accessing services. This was particularly evident in the Scarborough area but less evident in areas such as Craven (who operate using a single provider/integrated model).

Discussions took place in two of the three events around whether the reconfigured treatment system should comprise one-door (largely favored by referring professionals) or a choice of doors:-

> *"One roof is much better. Cases can go from prescribing to recovery if they are under one roof."*
>
> *"It works best if one organisation covers clinical governance"*
>
> *"If there was one easy referral we would get better take-up of services"*
>
> *"This is not about one door or one provider. It is about need. It is not a postcode lottery at the moment – it's simply a matter of responding to different needs. We can't have a single approach that meets the needs of the whole county"*

It was later agreed that a 'one-door' approach need not necessarily mean a single provider and that it could mean a single *access point* into treatment (managed by one provider) which then feeds an underpinning system comprising multiple providers.

Acknowledging the need for carers to understand the system and subsequently access it was cited by an individual carer in the Scarborough area:-

> *"You have got to knock on all doors and scream and shout to get noticed. The system was sending me mad"*

Strengthening the provision at primary care (GP) level was discussed with mixed views about this:-

> "*People don't want to go to their GP about stuff like they because they feel embarrassed"* (service user)
>
> "*GPs don't want to know. They don't want drug users in their clinics"*

However there was also a feeling that GP services for substance misusers need to be strengthened.

The issue of rurality was discussed at length in one event, with some professionals believing that solutions such as video conferencing, which is increasingly being used by the courts, being suggested.

Stakeholders from the courts and probation service were keen to express their concerns in relation to alcohol. They pointed out that, from their perspective, they deal with a much higher number of offenders who have alcohol problems than drug problems and they consistently find it difficult to access services.

3.1.2 The Treatment System

Carers were only represented at one stakeholder event and therefore the perspectives below need to be considered in the context of this locality. Interestingly, Scarborough is the only locality where there is specialist (substance misuse specific) carer support.

Support for carers was reported to be lacking in the Scarborough area. Although it was accepted that there are generic carer resources, these were not deemed to be specialist enough to support carers of substance misusers.

> *"Agencies don't tell you what is happening with the person you are caring for - we need more support"*

Transitional arrangements from young people's substance misuse services into adult services was reported as being critical:-

> *"10-18 year olds are still trying to find their identity. Accessing services for 18-year olds is very difficult. The transition between children and adult services really needs to be right."*

The Probation service also recognised the issue of transition arrangements for young offenders into probation services and described this as problematic.

The importance of making distinctions between mental health problems and addiction was cited by a nurse who commented that those with a drug addiction or other substance misuse addiction might have the need for physiological support to address a range of physiological issues but there might be a range of mental health issues that relate specifically to a psychiatric disorder or a functional disorder.

> *"Very often people experience a depression or some form of disorder which they then seek to self medicate or mask through the use of either drugs or alcohol. Remove the drug or alcohol and the depression or mental health issues return, so this becomes an interface issues that needs to be well managed through medical support and supervision"*

3.1.3 Perspectives on Recovery

A common theme across all three stakeholder events was the notion that 'recovery' is different for each individual.

Having a competent workforce was deemed important in terms of progressing the recovery agenda:-

> *"staff who have an appetite for working with chaos, staff who have the ability to be creative and staff who can find solutions and get people to internalise their own solution finding skills"*

The need for a system was cited where staff are able to work with people's motivational issues, what helps them to move forward in their journey to find that motivation, and to be able to elicit from them what is working and what is not working.

Providers in the Scarborough area welcomed the idea of being monitored based on outcomes rather than numbers through the door. It was perceived that this would lead to a more recovery-focused system.

Mutual aid networks and SMART Recovery were favorably reported, although there is significant inconsistency in coverage of these services across the area. There was a feeling that mutual aid networks are under-utilised and could potentially be a big help in the area.

> *"Peer mentors are available do to this work <engaging people with alcohol problems>. They are often better than professionals"*

> *"There are a lot of empty, partially-used resources in communities"*

Accessing affordable accommodation, including supported accommodation, was cited as being very difficult by stakeholders from Scarborough, despite service providers reported housing needs being a fundamental part of a care plan.

Employment was discussed as another cornerstone of the recovery agenda, however several challenges were raised in relation to this, mostly in relation to the 'benefits trap' but also in relation to the move from ESA to JSA:-

> *"It's scary that people in recovery now really need to get a job or they will lose their money. There doesn't seem to be any support to help these people move to this. They could easily relapse with the pressure"*

Visible recovery was discussed at two stakeholder events. In both Selby and Craven it was reported as being very positive that services are co-located, however there are limitations of this approach when trying to move towards recovery:-

> *"Space in Selby is quite limited and people in recovery don't want to be mixing with people that are 'bang at it'"*

> *"In Craven we have 'newbies' and 'oldbies'! Regardless of what you are you are all in the building together which is not so good."*

The aftercare system run by Ark House was reported to be excellent and something which could be mirrored in community services as they move towards a recovery focus.

> *"Transition from treatment to everyday life is the biggest issue for these people"*

One stakeholder felt that in-patient detox should, ideally be run separately from mental health provision:-

> *"Some people have major issues in trying to deal with their drug addiction … the last thing they want at this very low point is having to deal with or associate with people who are seriously who are seriously psychiatrically ill"*

3.1.5 Personalisation

The need to consider individual solutions for individual service users was a recurring theme in all three stakeholder events:-

> *"These people often have to re-learn independence. This involves managing money, taking responsibility and taking control of their lives."*

> *"We often just try and deal with the drug problem when so much else is wrong"*

Personal budgets were discussed as an aspirational element of a reconfigured treatment system. Specifically, the need to save on mainstream funds to allow personal budgets to happen was cited.

This concept was more fully explored in the service user events and is therefore described in section 3.2.

3.1.6 Alcohol

All events commented on the importance of alcohol services, despite the historical issues of budgets and weighted funding towards drugs rather than alcohol.

> *"There is no level playing field between drugs and alcohol"*

> *"In Harrogate we have one service for drugs and one for alcohol and these services don't work well together"*

It was noted that alcohol is a commissioning priority for the Clinical Commissioning Group in Scarborough.

Waiting times were reported as being too long in all areas for alcohol treatment by a broad range of stakeholders.

Professionals reported not being clear on how to manage individuals who were heavily intoxicated (i.e. acute stage) and pathways from A&E into community-based support being inconsistent.

The success of brief interventions for alcohol misuse was commonly cited. These brief interventions are occurring in a wide range of places in the county, although there appears to be a lack of consistency in approach and an overall lack of co-ordination of these activities.

3.1.7 Partnerships

Some services reported being hindered by the current commissioning system, suggesting that the focus has been too much about numbers and referrals in and not enough on quality of interventions:-

> *"Commissioning has restricted us"*

Stakeholders from Scarborough commented on the success of IOM (Integrated Offender Management) and felt that the reconfigured treatment system should learn from this:-

> *"IOM is not about a one size fits all. It is about a partnership that is locality based and they provide the right response for people in that locality"*

3.2 Findings From Service Users & Carers

3.2.1 Access to Services

Service users echoed the concerns raised in the professional stakeholder events about the treatment system being complex, with no clarity on where to go for what. However, service users in Craven and Selby were positive about having a single point of contact for treatment.

Most service users wanted services to be provided in one place or by one provider, transitions between services were seen as problematic. There was a perception that currently services were in competition with each other which impacts on treatment.

> *"None of the providers in Scarborough talk to each other and they don't want you to go to other services in case they lose funding"*

It was suggested the opening times for treatment services needs to be reconsidered, especially to accommodate those in recovery:-

> *"If we are trying to go back to work we can't come in during the day times. Evenings would be better"*

> *"Services should be open 11am-7pm"*

"I need a response when I am ready, not when services are ready"

"I needed help there and then. Nobody was answering the 'phone. My family tried too. I ended up trying to throw myself in front of a vehicle"

"Drugs and alcohol is available 24/7 therefore the challenges and risks are likewise for people trying to get clean"

It was acknowledged that not all services could be open in the evening and weekends, however service users suggested that 'hotlines' could be introduced as many national help lines (e.g. Frank) are not available 24/7. It was, however, stated that many people found online resources (such as 'Wired In' and 'Breaking Free') very useful.

Weekends were described as *"long and lonely"* by most service users.

Specific concerns were raised that people leaving prison did not have access to information about services prior to release and they felt they were not referred to the right services.

"You need to let people know what is out there before they leave prison"

Interestingly, some service users raised the issue of identity/image in the context of the CRI (Crime Reduction Initiative) service. Some felt that this labelled people as criminals, when in fact many individuals accessing services at CRI had never committed an offence.

Other service users were concerned about being labeled as 'smack heads' because of the service they were accessing and for this reasons, some stated they would prefer to see their GP:-

"You are there as any other patient seeing a nurse …"

"In the surgery it feels like I am more normal"

"I don't want to go to street agencies which are full of junkies when I am trying to recover"

3.2.2 Elements of a Good Service

Service users were asked what the elements of a good (ideal) treatment service would look like:-

"Being together in a group. It's like a little family of people you trust"

"Looking up to people who have got clean and seeing them do well"

"Having an indefinite group that are there for you even if you haven't been for a while – the doors stays open"

"A safe place where people don't judge you"

"Being helped by people who can empathise with you 'coz they've been through the same thing themselves"

"There should be just one or two services. Changing services leads you backwards. Change is too much"

"Having a combined unit for drugs and alcohol is a good idea"

There seemed to be general consensus that good treatment would involve a combination of 1:1 support and group work. One service user in Hambleton & Richmondshire described the support she had received from a psychotherapist to discuss specific personal issues and he had found this invaluable.

3.2.3 Barriers/Blockages

Alcohol treatment was reported as being inconsistent and difficult to access, with waiting times reported as being from 10 weeks to a year. The difficulties also included the clear demarcation of drug and alcohol services:-

"The drugs lot wouldn't treat me 'coz I had an alcohol problem"

Another recurrent theme was the difficulty in accessing treatment where mental health problems also exist alongside substance misuse (dual diagnosis). There were numerous examples cited by current and former service users of being "passed from pillar to post" which resulted in delays before any treatment was eventually commenced.

Service users reported multiple general barriers and blockages when asked about the current treatment system and a number of themes emerged ranging from alcohol provision, GP provision, employment and housing support:-

"The service wouldn't treat me because I had an alcohol problem"

""The service was not very welcoming"

"I had to wait a year to get 1:1 support for my alcohol problem" (Hambleton and Richmondshire area)

"There was never an acknowledgement of what was happening to me even though I had many visits to A&E. It just wasn't followed up"

"GPs don't have the experience. Some can be judgmental; others are more understanding and pick up health problems caused by drugs"

"as soon as GPs see your drug history they don't look at you - they say it's your own fault and just brush you off"

*"GPs look at you like a piece of s*** and so do hospitals"*

"More help from mental health services – they should join up better"

"You are isolated when you had addiction problems. That's why group work is so important. Social networking groups <facebook forums> are OK but this would isolate people at home"

"There aren't many options for rehab available"

"It's hard to get detox. <Anon> had to go to Halifax for a pre-detox course"

"There is a lot of ticking boxes going on in the service"

"Services in Scarborough are very backwards – drug users pay more for drugs in Scarborough than any other area. Provider services don't understand users and don't understand there is more than just a script" (comment made by service user in Selby)

"There's no aftercare support for alcohol in Harrogate"

"I didn't get any aftercare so made a decision that it was probably Ok to be a 'social drinker'… I relapsed after this. If I'd had aftercare I might have made a better decision"

"No-one ever told me about these groups they just give you a script"

Service users in Hambleton and Richmondshire reported barriers in commencing treatment where pharmacological interventions were required. Accessing prescriptions or changing prescriptions were reported as problematic, with long waiting times to see a doctor being cited.

In the same area, a service user commented on the difficulty in getting employment due to having a criminal record.

3.2.3 Perspectives on Recovery

There was recognition across all groups that recovery should start from the day people access treatment services and it is not just what happens at the end. It was described as an ongoing journey. Recovery should not be expected to be instant or quick and services need to be able to work to support people entering, during and after treatment.

"It took me 15 years to get here; don't expect me to recover in 6 months"

However it is interesting that those people who were not yet in contact with treatment services reported that 'recovery' was not really on their radar.

'Recovery is not on my mind"

All groups reported the critical importance of meeting others (usually in groups) and being able to support each other. This included peer support and mutual aid networks such as SMART recovery, AA and NA:-

"There's a difference between being lonely and loneliness. You might have family and friends so you're not lonely, but you suffer loneliness because they just don't understand what you're going through"

Furthermore, from those that attended the events, there appears a strong sense of commitment to help others into recovery, albeit the system currently doesn't recognise and capture this:-

"I would help anyone who wanted to go to their first few AA meetings"

One former service user was more cautious about the rapid development of support groups and stressed that many people find group settings daunting, hence the importance of other options:-

"Does the system understand the number of people who turn up for one group session but then don't come back as they found it scary?"

The same former service user also felt that treatment services are not readily able to deal with people from middle class backgrounds where wealth and lack of education is not a primary issue. In this instance 'recovery' has different implications

"The system was inflexible because I didn't fit the mould"

"I spend time out of the country and the system couldn't cope with that"

Better communication from services about expectations and what recovery means was welcomed. Service users felt the need to be reassured that certain services (specifically needs exchange and prescribing) would still be available/continued:-

"They need to sit down with you and explain all your options"

In some discussions the importance of having access to 'blockers' were seen as important in making a recovery. People emphasised the need for their script and their 'medication' and the stopping of this was a constant fear. Without it people felt they would have no alternative but to back on their drug of choice, hence their challenge to reduce their dosage over time.

When asked to consider what 'recovery' means the following comments were made:-

"More user-led services and peer support in work"

"We need more avenues for recovery like training for work"

"The transition from ESA to Job Seekers means you have to do jobs you don't like. We also have to choose between attending the group or going to work"

"Job seekers stuff is scary"

"Accommodation is a big issue – sharing a house is not very nice"

"There's no support from housing services in Harrogate"

"I was told not to reveal my addiction history as I wouldn't get interviews"

"Services should support you when you first start work. It's hard doing 9-5 when you've been out of work - Needs

a more phased work plan"

"Need bigger buildings with different rooms. When you're at different stages of recovery you don't want to get dragged back into what others are doing"

"It's a small building you can hear what is going on in other rooms, everyone knows what everyone is on"

"It would be better to travel and go further for rehab"

"No NA meetings in Selby"

"Would be good to get housing advice, debt advice and stuff all under one roof"

"The SMART meetings are good and I look forward to these"

"Need to let people know what is out there before they leave prison"

"Natural highs <service> is really good and empowering"

"A separate unit for aftercare would be a good idea"

"It would be good to have groups like NA in Harrogate"

"Services are more recovery focused now than they were a few years ago"

"Just because you're in recovery doesn't mean you don't need support"

"Important to have drop in available so I can get support"

"A good aftercare plan"

"Services that support you to build your recovery capital – access to NA, AA"

Fundamentally the importance of good aftercare for service users was deemed to be vital.

Discussions were held regarding the importance of 'identity' in the context that drug/alcohol use becomes people's identity. If they are to recover they need to find a new identity. This might, for some, be a professional identity by going to work, for others it might be more about building up inner strength and addressing issues such as low self-esteem and confidence:-

"Recovery isn't about filling your life with different things like work and stuff. It's about building yourself back up"

"People just swap from one addiction to another. Sometimes it's from one drug to another, other times it might be something more healthy like going to the gym"

"Drug and alcohol users have addictive personalities"

"Recovery helps you to trust other people"

Education and leisure were clearly important to service users, who described the benefits of these being exercising their brain and getting it to go through the gears.

Whilst employment was deemed as very important, service users consistently reported their difficulties in terms of accessing employment (i.e. Job Centres), but more importantly in terms of keeping employment. There were discussions that people may not always be "well" and therefore building a track record of being a good employee might take some time. There was a suggestion that support should not only be for the person entering employment, but also for the employer to raise their awareness and understanding of addiction recovery.

Addressing the stigma that is often associated with substance misuse was clearly important to many service users in Harrogate. It was felt that addressing this would be helpful in building local recovery capital and links with community resources.

Finally some former service users commented that a critical part of their successful recovery was down to having loved ones (having both parents and children were cited in this example). One

service users said (in the context of his Mum):-

"I feel good giving her something back"

The pressure on service users to *"get right"* because of having their own children was clearly evident and believed to be a really enabling factor with recovery.

3.2.4 Personalisation & Personal Budgets

Service users were enthusiastic about the concept of personalisation, including personal budgets. It is interesting to note that some service users reported not knowing what was on their care plan.

Whilst the term 'personalisation' was new to most service users, their comments and feedback clearly and consistently suggested their desire for personalised services:-

"*Providers need to recognise that not all people need the same treatment. We all got here by different methods and success in our journey will be about meeting our individual treatment needs"*

"A good service would have individualised treatment"

"There's too many guidelines; we just want to be listened to – each person is different"

Some service users felt that if personal budgets were to be introduced it would need to be done properly, focusing on those who are likely to spend the money well (i.e. well on their way to recovery) so that it isn't 'abused'.

When specifically questioned on this topic, service users agreed that the use of personal budgets would be a motivating factor for individuals and would be empowering, thus raising self-esteem and motivation.

It is really interesting to note that some service users were quite substance-misuse specific when considering how they would potentially spend their personal budgets:-

"It would help me get more counseling. At the moment I can only have 6 sessions"

"It would be good 'coz you can then get complimentary/alternative therapies"

Other service users expressed a desire to use an individual budget to fund wider things such as gym passes, training for work etc.

Because access to detox and rehab was cited as problematic by many services users one service user was particularly interested in the concept of a personal budget:-

"I would use my personal budget to get a detox and rehab"

Section Four – Summary

The following section collectively brings together all the findings from the engagement events and summarises them within the following three categories and sub categories. These are then explored briefly in the narrative that follows.

Key Messages/Principles:-

Accessing Treatment

- Clearer point of access, in a timely manner
- Driven by the needs of localities
- Communication with external professionals to ease referral pathways
- Reducing stigma associated with substance misusers

Treatment Provision

- Needs to be person-centered
- Greater availability out of hours (evenings/weekends)
- More consistent approach for people with alcohol problems
- Easier access to Tier 4 (residential) services
- Communication with services that can jointly support care planning

Recovery

- Recovery is about an *individual* jouney
- It starts as soon as people enter treatment
- it should be rooted in mutual aid, including 1:1 peer support and groups
- It should aim to utilise wider recovery capital (personal and social)
- Building social recovery capital is important - e.g. educating employers about addiction recovery
- Acommodation and employment are critical to recovery and more robust interfaces are needed with these services
- Greater focus on aftercare (indefinite)
- Visible recovery is important
- Commissioning based on outcomes will facilitate recovery- orientated system

4.1 Accessing Treatment

Service users, carers and professionals alike consistently reported difficulties in accessing treatment, mainly due to the complexity of the treatment system, particularly in the Scarborough area.

"The system was sending me mad!"

There was no consistent view in terms of the ideal future provision, although all were clear that a single point of access would be preferable (regardless of what arrangements were in place following access to treatment).

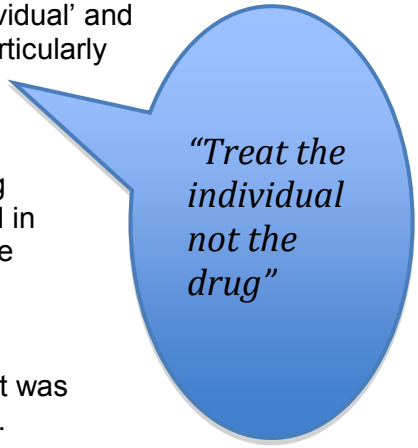
This said, there was a clear plea to ensure services are influenced by local characteristics and need and not overly controlled by any desire to 'centralise'.

It was requested that communication about what services exist, where and what they offer is made clear to external stakeholders (such as the courts and probation).

Reducing the stigma associated with substance misusers was deemed important in the context of service branding (Crime Reduction initiative) and also how service users are managed in GP/acute settings.

4.2 Treatment

There was a strong desire from service users to be seen as an 'individual' and for treatment services to address their whole spectrum of needs (particularly mental health) alongside self-esteem and confidence boosting.



Group work alongside 1:1 support was cited as very beneficial and there was a strong desire from service users to extend the operating hours of treatment services to allow more group work to be provided in the evenings/weekends. This is particularly relevant for those service users in recovery and starting work during the daytime.

Access to pharmacological interventions and alcohol treatment was reported as being patchy, with some areas reporting waiting times. It was implied that alcohol services in general, lacked overall co-ordination.

Access to in-patient treatment (detox and rehabilitation) was frequently discussed, particularly from a service user perspective. It was felt that greater consistency and clarity was needed.

Treatment services were seen, by service users, to be working in isolation. Professionals also agreed that treatment services alone cannot meet the multiple and often complex needs of their service users alone. Links, particularly with mental health services, were thought to be poor and opportunities for more creative linkages in localities (e.g. with leisure services) are often not fully utilised. Likewise transitional arrangements from the newly commissioned young people's substance misuse service needs to be properly considered.

4.3 Recovery

There was an acknowledgement (from both professionals and service users) that services do appear to be more recovery-focussed than they were a couple of years ago; however there is clearly some distance to travel. All service providers were committed to the recovery agenda.

Service users unanimously confirmed their desire to be free from *all* drugs (including methadone), clearly suggesting their vision for the future shape of treatment services is in line with the emerging direction of travel, both nationally, regionally and locally.

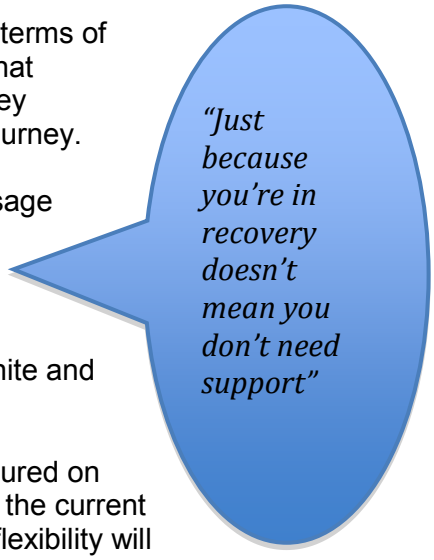
There was a clear message that recovery needs to be seen as an *individual* journey and that a more personalised approach needs to be taken to build on the recovery capital of each individual, linking with families where possible and where appropriate.

It was discussed that the tendency to see recovery as about 'things' results in the focus being on specific areas such as housing, education, employment and that the key to recovery is often achieved by means of raising an individual's confidence and self-esteem.

It was agreed that the recovery journey needs to start as soon as an individual enters treatment, and this will inevitably shift the way in which treatment services have historically operated. In the context of this, service users voiced some concerns that expectations, specifically relating to the meaning of recovery, need to be made explicit at the initial appointment (e.g. implications for needle exchange and substitute prescribing).

Service users consistently requested a greater presence of mutual aid, both in terms of groups (such as SMART recovery, NA and AA) but also in terms of the future potential of a peer mentoring or a 'buddy' system. They stressed the desire to have access to people who had been through the system and come out of the other end and to limit access to those still entrenched in substance misuse.

Accepting the point above that recovery needs to be seen firstly in terms of building up an individual's recovery capital, there was agreement that accommodation and education/employment services are the two key *practical* elements that need to be in place to support a recovery journey.



Aftercare for those in recovery was seen as vital, with a clear message that recovery in itself is not aftercare! The implications of being in recovery (which could entail starting employment, managing money, increasing independence) can be a daunting and stressful prospect and there is a propensity to relapse without adequate support. Service users were keen that aftercare is indefinite and that there is always an 'open door policy'.

Service providers were keen to have more autonomy and be measured on outcomes and not on referrals/processes. Many providers feel that the current style of commissioning has hampered innovation and that greater flexibility will allow a recovery-orientated treatment system to develop and thrive.

Health and Wellbeing Board
North Yorkshire

APPENDIX 2

Final

A step towards refreshing a mental health strategy for North Yorkshire

This document is the result of a series of dialogues with people in receipt of mental health services in Sept, Oct and Nov 2012 in North Yorkshire. It also captures some headlines from discussions with carers, social care staff and a number of volunteers supporting people with mental health needs. Some viewswere received from NHS staff

From the dialogue there are suggestions as to what might constitute the essential building blocks of a future mental service based primarily on the views of people who use services.

With this and other national frameworks commissionersneed an agreed action plan and investment strategy as one of the steps in addressing North Yorkshire's Health and Well-being Board Joint Strategy 2013.

Seamus Breen Jan 2013

With thanks to the many people who shared their thoughts, views and experiences about their lives and how services had or had not helped them.

Thanks to the staff who arranged the many little meetings across the county and then were big enough to step aside and let the voice of people who use services be heard where people wanted their own space but who also supported people to engage where required.

And a big thank you to Stacy Keeling who pulled together much of the research for me as part of the ground works for this report.

Seamus Breen 3 Jan 2013

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Developing a refreshed Mental Health Strategy across North Yorkshire

Background

The document tells of the feedback from a dialogue with users of services in the context of a transformed landscape where, under the Health and Well-being Board there is a new focus across all partnerships on the health and well-being of the people of North Yorkshire.

North Yorkshire's Mental Health Strategy Group, a subgroup of North Yorkshires Health and Well-being Board, agreed that the time was right in North Yorkshire to look afresh at developing a new mental health and well-being strategy across the County.

The Strategy Group understand:

- There is an increasing awareness of the issue of loneliness and isolation and the effects on people's mental health;
- Concerns exist around the numbers of people with depression and also the increasing use of alcohol
- The County is seeing a rise in the number of people with differing dementias
- There is increasing awareness of more people being stressed about the changes in the benefits system and the consequences of increasing debt;
- The consequences of the rising gap between the more affluent and those who suffer real deprivation and the increasing numbers who are dissatisfied about their lot are being high-lighted by national research in public health
- We have in our community people who are seriously ill who at the time of illness require a safe space and specialist support.
- Many people in recent dialogues see their substance misuse dependency as a 'mental illness' or personality disorder where their addictive behaviours could benefit more from the skills available in mental health services if these were more readily available.
- While there is some discussion about the integration of social care mental health and NHS mental health there is a bigger discussion about the integration of general social care and NHS community services and commissioning. The role of mental health within an integrated neighbourhood approach needs to be considered.
- The development of a new mental health strategy is closely interlinked with the development of the County's Joint Health and Well- being strategy where increasingly the focus is on mental –wellness as opposed to mental illness.

Having captured the feedback from various interest groups the report briefly looks at prevalence, national and other agency's policies before suggesting some building blocks for consideration in developing a County Wide mental health strategy.

Feedback from present users of services (excerpts)

It was not the intention to speak to all people needing support of services or their carers. Effort was made to access a cross – section of people from different parts of the County. There was a good balance of males and females and representation from different academic, social and financial backgrounds. Some choose to give their views in small groups and others in larger gatherings. Many were happy to speak and engage without the presence of support staff. Others felt the need to be accompanied. The intended outcome was to have a dialogue which would then help shape a set of strategic proposals which in time could become the subject of a wider consultation.

It is the experience of those who use service and the issues they have raised which should act as the primary driver of re-shaping North Yorkshire's new mental health strategy.

Summary Headlines from People needing support of Mental Health Services

- People acknowledge there are many good professionals and volunteers in the care systems who continue to make their lives better and this is clearly highly valued.
- Many of those who are ill recognise the importance of medication in helping them to cope and recover;
- People understand and expect there to be places which will keep them safe and secure during those critical periods when they are seriously unwell and not able to manage;
- Many value support staff who take an assertive approach and challenge them to build in routines which help and assist them to take more control of their lives;
- Likewise the availability of some form of day time occupation is not only seen as desirable but an essential ingredient in any future model.
- A great deal of support is found in having a safe place to share and receive peer support from others who are likewise suffering mental health issues.
- Those who have their own accommodation with support believe this has been a major factor in reducing their need for hospital care.
- Emphasis was placed by many on the importance of having some form of useful occupation while others were gaining a greater sense of self-worth as they collected credits or qualifications through further education.

However

- Many people feel they do not have enough information in the medication they are being prescribed and have insufficient say in what is being prescribed.

- There is a strongly held view that many of our mental health hospitals are outdated in style, have within them poor cultures and are often in the eyes of patient terrify places giving little sense of safety and security.

- The dominant theme from people is one where many professional people and many in society do not yet see people who suffer from a mental illness as individual people but as 'a condition to be managed'

- The above perception is sometimes re-enforced in the eyes of people who use services when they cannot access personal social care budgets and do not even have the possibility mentioned to them.

- Another theme is around the acceptance by many in the care that mental illness is a condition for life, that people might as well accept that fact and the present care/support system creates dependency on itself.

- Many people hope that we can change the system to one where 'helping people to recover' is the accepted approach from day one and that they as individuals are both challenged and assisted to make a full recovery.

- Some people spoke of being tired of living with their condition and of the need respite from it.

- For many there is a sense of loss that they did not receive intense input and assistance in the early stages of their illness. Others expressed very strong anger at the loss of wasted years.

- Some felt that issues around identity and their sexuality, around managing stress and pressures could be managed more effectively in schools during early adolescent years.

- Many spoke of the loneliness of those early years and others of the stress of being part of a home-life where domestic violence was present. Others made reference to sexual abuse being a factor.

- Others spoke of similar issues leading to both mental illness and substance misuse.

- Access to service in rural settings can be challenging and the system needs to think more about bringing services to people rather than people have to bus to services.

- As a sign of the times there are indications of very high levels of stress due the economic downturn, the changes in benefits and the new rules covering the cost of accommodation.

Feedback from Carers – Ripon/Harrogate/Scarborough

Relatively small numbers of carers have had the opportunity to date to share their views of services. From those who have a number of themes are emerging:

- There was a near over-whelming sense of despair and frustration by carers trying to get the care system to accept and understand that their young son or daughter needed urgent professional assistance. This often referred to the early times in the care pathway when the first signs of problems were emerging.
- There was a sense that if the system had been capable of investing time and effort and intense in-put back then people might have had a better chance to gain control of their lives and the cost to the system might have been less in the long run.
- Much could be done to improve sign-posting and information giving.

- Cares benefit from peer group support but not all commissioners invest in this area.
- Many cares felt they should be better treated as partner's in their loved ones recovery.
- Some felt totally excluded. Even in situations where sons, daughters or partners felt that they as carers might have been part of the problem then the system should recognise that they should then be part of the solution.
- Some cares spoke of their anger that their child had to come into a mental health system when clearly the proper diagnoses might have been some with autism or Aspergers.

Through Mind the following was received in respect of Carers:

Identifying Carers

* On average takes 5 years to identify a carer. Needs to be picked up at the earliest point of diagnosis

Consultation

* No time too tired. How do you engage this voice?

* No one ever speaks to carers

Carers

* Support of carers is preventing people from requiring secondary care. Cost saving for PCTs CCGs but for this to continue there needs to be more support

* Lack of support for carers will lead directly to increased costs in secondary Care

Better links between medical professionals and carers

* When Service User are over 18 professionals won't deal with carers. This leads to missed appointments. Carers need to be informed of appointments meetings etc. Carers need to be involved in planning the meetings etc.

* Users often not able to communicate their problems but carers can. No good if professionals won't listen. Some service users won't speak to anyone except their partner. Only way for professionals then to understand is through the carer.

GPs acting as blockage/not recognising carers

* Carers recognise the problems but GPs refusing to accept and refer on to CMHTs. One carer reported that it will have been 18 months from first telling GP her partner needed help to him receiving CBT.

* GPs failing to identify carers

Feedback from Social Care Professionals

Through-out the period of engagement with users of services and in a previous engagement with front line mental health staff a number of themes are developing:

- Social Care staff in mental health services often do not feel they are part of mainstream social care culture or support;
- There is a sense where NHS partners do not fully understand social care statutory requirement in mental health.
- While there is some improvement in parts of the County professional line management and development, lines of accountability and governances and case load management are not as robust as staff would wish for.

- There are calls for the on-going training and development of staff working in mental health services.
- Many see case-loads as far too high, not serving customers well and there is some strong evidence of personal stress and mental health issues developing among staff.
- Some staff accept there may be a legitimate challenge and a need to take a robust approach to case load management. While accepting that many people need on-going support this could possibly be better provided by external agencies in the voluntary sector and by a shift in culture which requires the measure of success to shift away from numbers of people in a service to one of numbers of people help out of the service or to a lower level of support.
- The perception is of social care community support budgets being ring fenced and therefore that mental health budgets are insufficient to support direct payment and personal budgets in social care. Often staff feel caught between a rock and a hard place knowing that they should be promoting personal budgets but because of perceptions around silo approaches feel there are not the resources to address matters.
- The bane of every social care mental health workers life is the duplication of effort required to feed the beasts of two IT systems which do not interconnect.
- There are strong concerns being expressed about the number of and the age profile of AMHPS in North Yorkshire.
- There is preference for restoring a role for mental health within older peoples services and a sense that the artificial line between adult mental health and older people's mental health issues does not serve people well. There is some call for a tighter alignment between all mental health services irrespective of age.
- The fragmentation of NHS Mental Health provision between three specialised provider each placing different emphasis within their approaches causes much debate and stress within the front line social care system

Feedback from NHS Professionals.

There has not been any structured dialogue with groups of NHS professional staff in mental health services. However occasional input from NHS staff suggests the following might come forward as issues:

- The perceived shortage in psychiatrist and psychology skills to allow nursing staff and out-reach support staff take a much more assertive approach to developing a recovery model;
- The workload challenge is seen within the NHS as well as social care.
- Some would wish to see a greater separation of intensive mental health accommodation based support and substance misuse accommodation based support.
- The call for ease of information and data flow and integrated IT systems.
- The call for access to recovery beds and specialist accommodation and support for those with high-end needs within North Yorkshire and the availability of skilled staff in these areas allowing for the development of a high quality service as opposed to a safe-keeping service.
- Some staff called for the development of Crisis Beds (ie usually a facility linked to respite where people can access a bed at short notice for a few days to prevent an acute admission; these are usually supported by IHTT). And suggested it might be better to look at the respite, supported accommodation & crisis facilities in nearby areas across our borders particularly where these function after 4pm on weekdays & at weekends.

(**Note:** there may be a need for NHS organisations to capture the thoughts and views of their own staff groups on their thoughts how services might be transformed)

Shared Health and Social care inter-agency themes

It is very clear from a number of discussions that both the NHS and Social Care in North Yorkshire must:

1. Address the issue of common and shared assessments in mental health services;
2. Must move quickly to a situation where the assessment belongs to the person who uses services and not any one organisation or professional group;
3. Must quickly address head on the issue of inter-connectivity of IT systems and shared information flows
4. Mental Health professionals and agencies must consider how they will play a part in the neighbourhood integrated team approach within the wider NHS/Social Care integration agenda.

Feedback from some Voluntary Organisations.

The primary focus of the discussions over the past two months has been with people who use services. People support them in most instances kindly step outside and let people speak freely. Pre and post these meeting a number of staff in voluntary organisations took the opportunity to share their views and thoughts. These included:

- Numerous comments about the changing profile of the population and level of need they are now supporting as agencies. All without exception spoke of themselves as agencies supporting people with high levels of need as a marked contrast to a different profile among their customers less than five- eight years ago.
- Some felt that the impact was one where they were now being asked to support people without a commensurate investment in their skill base. There was some concern expressed for client safety.
- If the was sufficient psychiatry and psychology capacity many would wish to see a new partnership and caring planning approach between voluntary organisation and providers meeting acute need. There was a sense the system was missing an opportunity to develop more whole system step up – step down approaches.
- Some voluntary organisations had or were developing working partnerships with local collages, housing and employment services in recognition of the fact that their customers needed a range of opportunities and not just traditional day care.
- One voluntary organisation was taking the leading step and assertive approach which required a contract with their customers. The requirement from the outset is that the person seeking support will be embarking on a road to recovery and the expectation that they will leave the service or need much less support in time.

Equalities and Excluded Communities.

The focus of this work was listening to people who came forward because they had a mental health condition and no other factor was addressed in an upfront manner. The approach was to allow an

open door and let people self select. However in a formal consultation phase the agencies will want to take proactive steps to reach out to some excluded or under represented communities.

Some National Research of Mental Health Strategies

The following were considered alongside the views and thoughts of stakeholders in North Yorkshire:

There's no Health without Mental health – Your guide to mental well-being	North Essex Partnership NHS Foundation Trust and Essex County Council
Better Mental Health in Oxfordshire 2012-2015. The Joint Mental Health Commissioning Strategy for Oxfordshire	Oxfordshire Clinical Commissioning Group, Oxfordshire County Council and Buckinghamshire and Oxfordshire NHS Cluster
Mental Health is Everyone's business – The Joint Strategic Framework for Public Mental Health	The City of Liverpool, Liverpool Primary Care Trust, Liverpool First and the Dept. of Public Health.
Joint Mental Health Commissioning Strategy – 2010 -2013 Doncaster	NHS Doncaster with Doncaster Metropolitan Borough Council
No Health without Mental Health: A Guide for Service Users	NSUN Network for mental Health March 2012
Mental Health Strategy for Scotland: 2012 -2015	The Scottish Government
The Joint Hampshire Adult Mental Health Commissioning Strategy 2012 -2017	Hampshire County Council and NHS Hampshire
Mental Health and Well-being Commissioning Strategy 2009-2014	Manchester City Council and NHS Manchester
Mental Health Commissioning Guide Section 6 World Class Intelligent Commissioning	2020 Commissioning Authors: Janet Crampton and Seamus Breen Commissioned by the DH
Healthy Ambitions	NHS Yorkshire and the Humber http://www.healthyambitions.co.uk/HealthyAmbitions/Mental-Health-Full.aspx
No Health without Mental Health – a cross government mental health outcomes strategy for people of all ages A Call to Action	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123991
MindNet Model of Mental Health	Mental Health Foundation of New Zealand http://www.mentalhealth.org.nz/page/353-MindNet+MindNet-Model
Live Well Good Practice Guide	**http://www.liveitwell.org.uk/**
North Yorkshire's Joint Health and Well-being Strategy 2013 -2018	North Yorkshire's Health and Well-being Board www.nypartnerships.org.uk

Prevalence of Mental Health Issues

Mental ill-health is common with a significant impact on individuals, their families and the whole population. 22.8% of burden of disease in UK is due to mental disorder and self reported injury compared to 15.9% for cancer and 16.2% for cardiovascular disease (WHO, 2008).

Depression and anxiety disorders are serious and debilitating conditions, associated with significant human and economic costs. The NICE Guidelines say that people diagnosed with these conditions should be offered evidence-based talking therapies as an effective treatment; this is also what most people with these problems want.

'Looked after Children' represent a particularly vulnerable group in our community. 62% of children looked after as a result of abuse or neglect.[1] Children of poorer households are three times more likely to experience mental health problems. People who have been abused or have been victims of domestic violence have higher rates of mental health problems.
25-50% of people who use night shelters or sleep rough have mental health problems.

[1] Dept for Children, Schools and families 2002

The number of young carers in the UK is estimated too be about 175,000 and nearly one third of these care for a parent with a mental health need.[2]
Severe mental health problems such as schizophrenia are relatively rare affecting one in 200 adults each year.
Just under a third of children with Autistic Spectrum Disorder (ASD) had another recognised disorder: - 16% with an emotional disorder (usually anxiety related) and 19% with a conduct disorder. Over 71% found it harder to make and keep friends compared to 5% of other children.
Three million older people in the UK experience symptoms of mental health problems and this number is set to grow.[3]

See appendix 5 for projections for North Yorkshire.

National Mental Health Policy Objectives

The National ***Strategy 'No health without mental health: a cross-government mental health outcomes'*** for people of all ages sets out six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality services. The interconnections between mental health, housing, employment and the criminal justice system are stressed.

SIX SHARED OBJECTIVES

1. **More people will have good mental health -** *more people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well;*
2. **More people with mental health problems will recover -** *more people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live;*
3. **More people with mental health problems will have good physical health -** *fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health;*
4. **More people will have a positive experience of care and support -** *care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure people's human rights are protected;*
5. **Fewer people will suffer avoidable harm -** *people receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service; and*
6. **Fewer people will experience stigma and discrimination -** *public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.* [4]

[2] SCIE Research Briefing 24

[3] Age Concern Aug 2007 Improving Services and Support for older people with mental health problems.

[4] ***No health without mental health: a cross-government mental health outcomes***

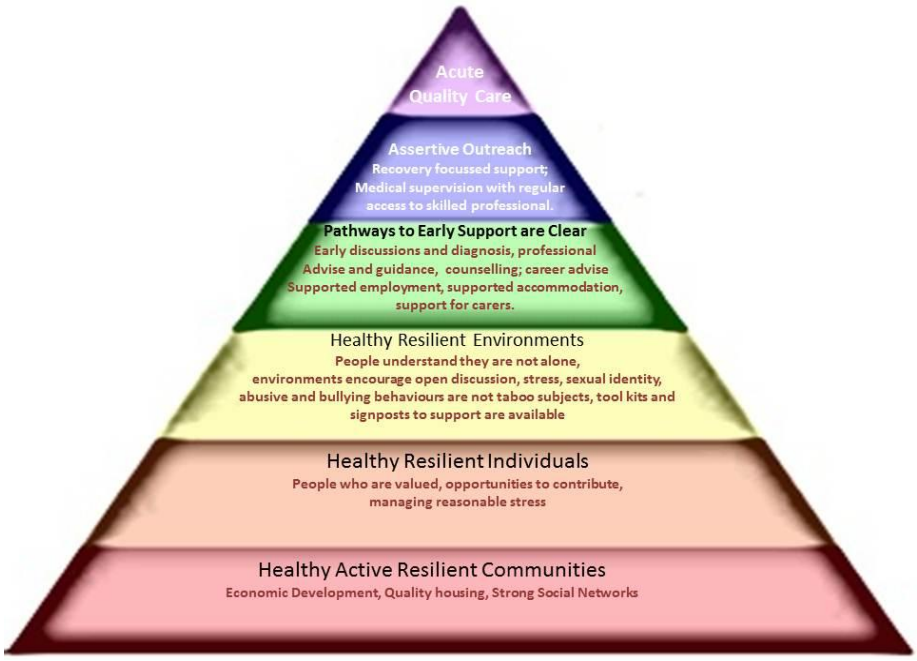
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

Sign-posting to the critical elements of a successful Mental Health Strategy for North Yorkshire

North Yorkshire's ***'Joint Health and Well-being Strategy 2013 -2018'*** recognises that emotional and mental well-being is important across all age groups. It states that 'mental health' is not just about the absence of mental disorder but is a state of well-being in which every individual realises his or her own potential, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community. (Page 12)

The approach of the partners in the Health and Well-being Board and of all who share in its vision is that as a community we should: work to improve the health of everyone; that there should be a focus on ill health prevention; those most at vulnerable and most at risk should targeted to ensure they too have the opportunity to improve their health and well-being and that these should include all people with long term condition together with children and young people. Emphasis is placed on developing healthy and sustainable community particularly in areas which are presently seen as most deprived.

The Building Blocks of a future mental health strategy in North Yorkshire



Taking the views of those using services as the starting point the following paragraphs sign-post to some of the ingredients which might go into a future mental health strategy. A joint commissioning board covering North Yorkshire might then considering the development of this strategy in partnership with key stake-holders and consult on this before drawing up their commissioning and implementation programmes. Clearly the expectation is that this will require an investment plan and a number of years to bring about a total transformation. However the expectations of people using services are that the direction of travel and transformation should be clear and the journey of change embarked upon as soon as possible.

The Prevention of ill-health and building resilience.

The foundation of good mental health in North Yorkshire and the starting point of a new strategy is one where there is a focus on building healthy sustainable communities with a focus on building up individual and community resilience.

Resilient Communities in North Yorkshire

Community resilience is … the existence, development and engagement of community resources to thrive in a dynamic environment characterised by change, uncertainty, unpredictability and surprise. Resilient communities intentionally develop personal and collective capacity to respond to and influence change, to sustain and renew the community and to develop new trajectories for the community's future.[5]

> Resiliency is like a muscle … that must be developed in advance and consistently exercised [to] be both strong enough to withstand severe challenges and flexible enough to handle a wide range of unpredictable forces.
> **http://www.globalresiliency.net**

Carnegie UK Trust and Fiery Spirits Community of Practice proposes four key characteristics (or dimensions) of communities that are becoming more resilient:

- Healthy and engaged people
- An inclusive culture creating a positive sense of place
- A localising economy – towards sustainable food, energy, housing etc.
- Strong links to other places and communities[6]

To achieve resilient communities we, according to the Risk and Regulatory Advisory Council (RRAC) need:

- To consider everyone, in all organisations, as a potential community activist. We shouldn't look for them only in certain sections of society;
- To focus on a community in a place and encourage all sectors of society in that place to work together. (Including businesses)
- To identify and remove barriers to individuals taking action – this requires us to see the situation from the point of view of an individual, not from the government's point of view (*or local authority, NHS, Local agency viewpoint –ed's insert);* and
- To encourage, support and help individuals to take positive action in their community – by ensuring they have access to the right information at the right time.[7]

[5]Community Resilience: literature and practice review (Magis 2007

[6]Exploring community resilience in times of rapid change by Carnegie UK Trust and Fiery Spirits Community of Practice @ http://www.carnegieuktrust.org.uk/carnegie/media/sitemedia/Publications/ExploringCommunityResiliencedownload.pdf

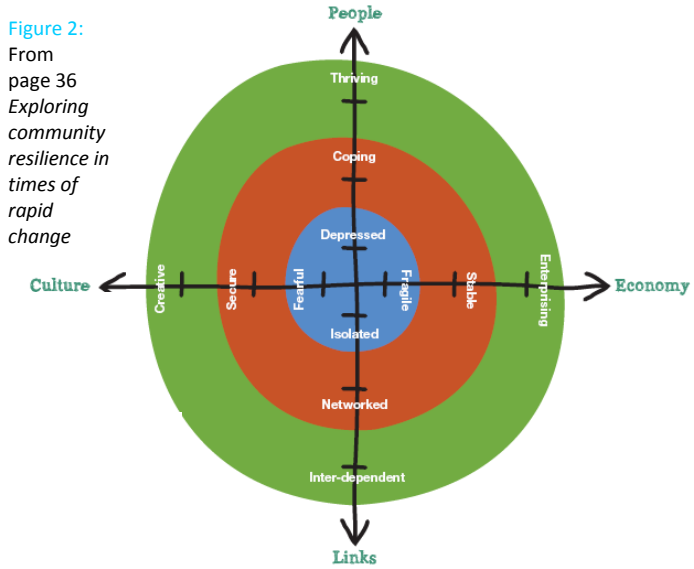
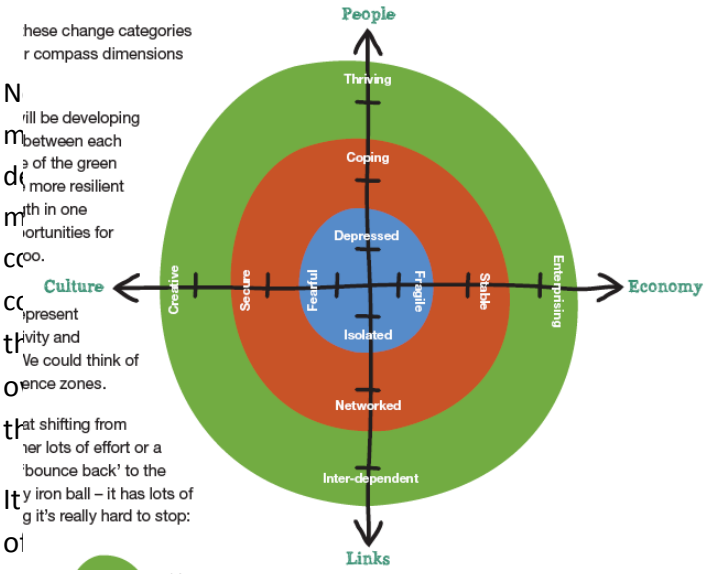


Figure 2: From page 36 *Exploring community resilience in times of rapid change*

The University College London Department of Epidemiology and Public Health, affirmed "the enormous capabilities and resilience that people already show in their everyday lives and under crisis conditions", and underlined that "it is social relationships that are most effective in maintaining resilience in the face of adversity". They concluded that resilience building needs to begin by making "best use of the many assets for well-being and social and economic development that already exist in communities".**http://www.ucl.ac.uk/capabilityandresilience/index.htm**



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about 17 % of people might be described as 'flourishing and they have good mental health, enthusiasm for life and are socially engaged. In contrast about 18% will have a diagnosed with a mental health problem but that an additional 11% are 'languishing'. By this we mean their life seems empty or stagnant and they live a life of 'quiet despair'. According to Keyes languishers are at increased risk of depression and physical disorders and drugs and alcohol are often seen as means of filling the void but only deepen the void and make lives more dysfunctional. People with drug and alcohol problems have higher rates of mental health problems.

It becomes clear then that North Yorkshire's mental health strategy is closely inter-twined with North Yorkshire's wider Joint Health and Well-being Strategy.[9]

[7]Risk and Regulation Advisory Council, September 2009, http://www.bis.gov.uk/files/file52720.pdf
[8] KEYES, CLM. 2002. Promoting a life worth living: in R.M. Lerner, F Jacobs and D. Wertlieb (Eds) Promoting Positive Child, Adolescent and Family Development. Sage

[9] North Yorkshire's Joint Health and Well-being strategy is available at http://nypartnerships.org.uk/index.aspx?articleid=20933

Resilient Individuals in North Yorkshire

Personal Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress -- such as family and relationship problems, serious health problems, or college, workplace and financial stressors. It means "bouncing back" from difficult experiences.

Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress.

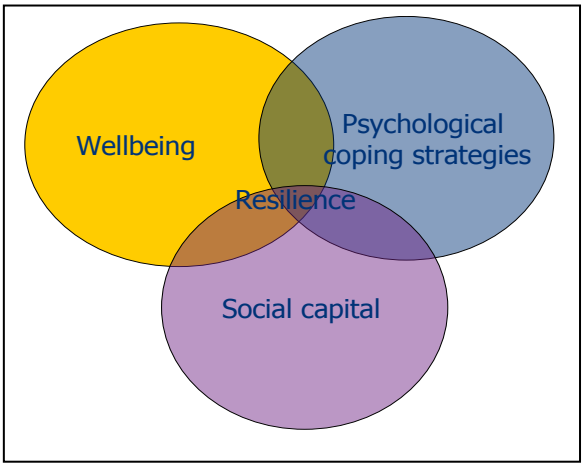
Resilience is not a trait that people either have or do not have. It involves behaviours, thoughts, and actions that can be learned and developed in anyone.

Many studies show that the primary factor in resilience is having caring and supportive relationships within and outside the family. Relationships that create love and trust, provide role models, and offer encouragement and reassurance help bolster a person's resilience.

Several additional factors are associated with resilience, including:

- The capacity to make realistic plans and take steps to carry them out
- A positive view of yourself and confidence in your strengths and abilities
- Skills in communication and problem solving
- The capacity to manage strong feelings and impulses[10]

Mind has reviewed the evidence base around prevention of mental health problems and drawn ideas from different disciplines, to develop their model of resilience building.[11]This model recognises the importance of three key elements in reducing the likelihood of mental health problems:



- positive activities, such as gardening and exercising outdoors, that are known to drive wellbeing, as a basis for good mental health
- building social networks and social capital - good quality human relationships are key to our capacity to respond to adversity and challenge
- education and developing psychological coping strategies, based around insight, awareness, and realistic optimism (using, for example, principles of CBT and mindfulness)

"We have discovered that there are human strengths that act as buffers against mental illness: courage, future-mindedness, optimism, interpersonal skill, faith, work ethic, hope, honesty,

[10] http://www.apa.org/helpcenter/road-resilience.aspx

[11] Scoping report on Mind's approach to resilience building – September 2012

perseverance, the capacity for flow and insight, to name several....Much of the task of prevention in this new century will be to create a science of human strength whose mission will be to understand and learn how to foster these virtues in young people."[12]

Families, schools and communities and support systems can help people to:

1. Build positive beliefs in their abilities

Research has demonstrated that self-esteem plays an important role in coping with stress and recovering from difficult events crises is a great way to build resilience for the future.

2. Find a sense of purpose in their life

In the face of crisis or tragedy, finding a sense of purpose can play an important role in recovery. This might involve becoming involved in one's community, cultivating one's spirituality, or participating in activities that are meaningful.

3. Develop a Strong Social Network

Again research supports the view that having caring, supportive people around acts as a protective factor during times of crisis.

4. Embrace Change

Flexibility is an essential part of resilience. By learning how to be more adaptable, people are better equipped to respond when faced with a life crisis.

5. Be Optimistic

Staying optimistic during dark periods can be difficult, but maintaining a hopeful outlook is an important part of resiliency. This mean helping people to learn and understand that setbacks are transient and that people have the opportunities to learn the skills and increase their abilities to combat the challenges.

6. Help people to understand that they must nurture and look after themselves

When stressed, it can be all too easy to neglect one's own needs. By taking care of one's own needs, people can boost their overall health and resilience and be in a better state to face life's challenges.

7. Develop Problem-Solving Skills

Research suggests that people who are able come up with solutions to a problem are better able to cope with problems than those who cannot.

8. Establish Goals

Resilient people are able to view crisis situations in a realistic way, and then set reasonable goals to deal with the problem.

9. Take Steps to Solve Problems

[12]Positive Psychology, Positive Prevention, and Positive Therapy, Martin E. P. Seligman, University of Pennsylvania, Chapter prepared for C.R. Snyder & S. Lopez (Eds.). Handbook of positive psychology.

Resilient People take steps toward making situations better and less stressful.

10. Help People to keep Working on Building their Skills

Resilience may take time to build and can be learned by most anyone.

A North Yorkshire Public Health programme might assist in this agenda.

This can be as simple as producing good guides to mental well-being for everyone including

- 'Stress Busting – taking action to reduce stress';
- 'Mental Fitness – What you can do to help yourself';
- Guide to living with dementia' – for people who suffer with early onset dementia and for carers'
- Simple pathways to finding early support in North Yorkshire' – sign-posting to early guidance and support. This should be easily accessible for carers and those needing low level advise and guidance. People are asking for access to written material but most of all someone with skills and competencies to listen and point them in the right direction

Supported programme might include:

- The development of school based programmes to help children and young people to stay emotionally healthy
- Projects aimed at increasing the uptake of exercise, walking, cycling, visits to our beautiful countryside and use of leisure centres by those.

Recovery Focussed Model

'Recovery' is a process that is unique to the individual. It moves away from traditional concepts of treatment of the symptoms of an illness in which mental health practitioners are seen as the experts. One approach identifies four key components to recovery (Anderson, Oades and Caputi[13]):

- Finding and maintaining hope – believing in oneself; optimistic about the future
- Re-establishment of a positive identity – finding a new identity which incorporates illness, but retains a core, positive sense of self
- Building a meaningful life – making sense of illness; finding a meaning in life, despite illness, engaged in life
- Taking responsibility and control – feeling in control of illness and in control of life

In our dialogue with people many spoke of 'managing the burden of their illnesses' in a way which allowed them to 'get on with their life'.

Essentially recovery means that the individual is supported to "recover" their life so that it feels worthwhile; so that they are working towards aspirations and goals that give value and meaning to their lives, although they may not "recover" fully from their illness. They find themselves living in and contributing to the community, not segregated from it in in-patient or residential care services for most of their lives. In practice this means that housing, employment, education and participation

[13]Andresen R, Oades LG, Caputi P: The experience of recovery from schizophrenia: towards an empirically validated stage model. Australian and New Zealand Journal of Psychiatry 37:586-594, 2003

in mainstream leisure and community activities become the focus of treatment and care. People are treated in familiar settings and in a manner that is sensitive to cultural needs. Inpatient admissions become less frequent and shorter as services are established that provide acute and/ or intensive treatment in the community.

To achieve recovery, the individual must be at the centre of their treatment and care planning process and have greater power in determining the supports and inputs that will assist their recovery.
In order to facilitate recovery, services have to be much more sensitive to the needs of the individual; the individual's uniqueness and culture has to be understood and acknowledged. This means that services have to focus to a much greater extent on the holistic needs that may arise from religious beliefs and diverse cultural norms, differences in gender and sexual orientation, age and needs arising from disability.
Commissioners and service providers in North Yorkshire are asked by people across the County to make a commitment to ensuring recovery as a whole system response all our CCGs and Districts.

A critical element of our future commissioning and service model has to be the establishment of recovery pathways from all services working with people with mental health problems. This is the desired approach of people who use mental health services.

The future approach includes helping people who are in employment to remain in employment, providing support for others to gain employment and become economically more stable, have access to settled and supported accommodation, supporting service users and carers in maintaining health and well-being return to education, and access opportunities for volunteering.
Commissioners will want to have commissioned partnerships involving third sector providers, Job Centre Plus, adult and higher education establishments, District Councils registered social landlords, homelessness teams and advocacy services and pathways to employment teams.

Assertive Outreach

Assertive outreach is a way of working with people with severe mentally illness who do not engage effectively with mental health services. Work is carried out with people in their own environment, rather than traditional building and office based approaches. In assertive outreach, the worker goes to see the person in need of support in his or her environment - be that home, a cafe, a park or in the street – wherever it is most needed and most effective.
Assertive outreach workers aim to establish a trusting relationship with each person in a flexible, creative and needs-focused person centred way that enables the delivery of a health and social care package that fits each person's own specific needs.

A full commentary on the role and necessity of assertive outreach as a key ingredient of service is available at the Sainsbury Centre for mental health.[14]

Stigma and attitudes within communities

'Time to Change' is England's most ambitious programme to end discrimination faced by people who experience mental health problems. The vision is to make lives better for everyone by ending mental health discrimination

[14] http://www.thurrock.gov.uk/socialcare/support/pdf/mental_health_sainsbury.pdf

The missionof the programme is to inspire people to work together to end the discrimination surrounding mental health The programme is backed by international evidence on what works, and has at its heart people with direct experience of mental health problems.

It includes: local community projects; national campaigns, participation in physical events, legal test cases, training professionals and a network of activists combating discrimination.

The aim is to work with all sectors and communities to tackle a lingering taboo and one of the greatest social injustices.

Other anti-discrimination programmes have measured their ability to change public attitudes around mental health, but Time to Change is the first to aim to change behaviour.

The project will measure success by evaluating the impact on the experience people actually have of discrimination.

The aims:

- To create a 5% positive shift in public attitudes towards mental health problems
- To achieve a 5% reduction in discrimination by 2012
- To increase the ability of 100,000 people with mental health problems to address discrimination
- To engage over 250,000 people in physical activity
- To produce a powerful evidence base of what works

All North Yorkshire's commissioners, services providers and community groups should be part of this agenda and sign up to this vision. See http://www.time-to-change.org.uk/ . Notice might also be taken of local projects where for example where it was shown that that in some rural environments people did not want to access services that were mental health related where they could be seen by their friends and neighbours, due to stigma.

Increasing Support for Self-management

There is now an evidence base for people taking a leading role in managing their own illness. Mental illnesses are among the most severe long term conditions amenable to this approach. Living Life Guided Self Help Services under which self help coaches guide individuals over the phone through a series of work books to help people understand some of the reasons why they are feeling low, depressed or anxious is available in NHS 24 in Scotland.[15] Among the comments one person states *"Without the help offered by Living Life I would have been unable to identify and deal with issues that needed to be dealt with. Living Life has aided my recovery."* This approach complements other programmes such as Steps for Stress.[16]I

It is suggested that Clinical Commissioning Groups and partners in North Yorkshire look at the case for investment in such approaches and in partnership with Public Health also consider the availability of easily accessible self-help materials, access to computerised cognitive behavioural therapy and guided self help.

[15] http://www.nhs24.com/UsefulResources/LivingLife

[16] See www.stepsforstress.org

Talking Therapies

Improving Access to Psychological Therapies (IAPT)

The IAPT programme was created to offer patients a realistic and routine first-line treatment for depression and anxiety disorders, combined where appropriate with medication – which had traditionally often been the only treatment available. The economic case on which it was based showed that providing therapy could benefit not only the individual but also the nation, by helping people come off sick pay and benefits and stay in or return to work.

A national shortage of cognitive behavioural therapy (CBT) practitioners, who are skilled in helping people recover from depression and anxiety disorders, was the core deficiency preventing routine NHS delivery of the NICE guidelines.

The evidence that proved CBT is as effective as medication in helping people with depression and anxiety disorders – and better at preventing relapse – led to the economic case that secured annual national funding to enhance this service. It is now time to review and where necessary enhance this service in North Yorkshire as this will better support people and assist in bringing the health economy into better balance.

Community, In-Patient and Crises Services

Many mental health conditions are episodic in nature with people experiencing stable periods with few symptoms and periods of crises with intense symptoms. In discussions with people who use services two aspects were mentioned frequently. People often spoke of the need for someone to be assertive with them to ensure they followed through in taking their medication, keeping to their exercises and maintaining some for of day time occupation. They also spoke of the preference for intensive home treatment where ever possible avoiding the need for an acute admission to hospital. The latter was a request for treatment in their homes during acute phases of severe mental illness.

There is a great deal of evidence of both the benefits to patients of assertive outreach and crises prevention approaches [78% of people reporting clinical improvement, 43% recovered at discharge and 96% feeling safe during their treatment] and to the economic benefits to the health economy [with occupied bed days being reduced and a 32% decrease in admissions and readmissions allowing for the closure of hospital beds] Likewise early intervention and intensive support to people who have had their first episode of psychosis is seen to be effective.

Within North Yorkshire's mental Health strategy it may be time to evaluate whether the balance of provision and investment in acute bed provision and assertive community outreach is the correct one.

Safe and Secure – Specialist Accommodation

People who use services stated there would clearly be times when someone might need to safe secure setting. Some might need these facilities for longer periods. Comments during conversations about traditional hospital settings suggest there should be a move away from hospital based rehabilitation to a range of community based reablement facilities that are more normative and that can still meet the needs of people with complex needs. A 'mental health hospital' does not need to look like a large institution.

Key features of specialist mental health accommodation might include:

- Up to 24 hour supported accommodation will be developed to cater for a broader range of mental health needs
- Multi-skilled input by staff that are experienced mental health providers
- Rehabilitation and recovery principles that will also includetherapeutic support based on best practice
- Emphasis on rehabilitation, symptom management, social and psycho-social support and physical health needs
- Design features to ensure a safe environment that does not compromise a homely atmosphere
- An active rehabilitation and recovery service for service users
- Flexibility – the service will be able to increase or decrease the level of staffing to meet the individual needs of theservice people needing support.
- The requirement for providers to involve family and friends where appropriate.

The refreshed Mental Health Strategy in North Yorkshire will wish to consider the need, demand and role of any specialist accommodation within the County in supporting people with acute mental health needs.

Ordinary Accommodation

The number of people who mentioned the importance of having a place of their own indicates that housing and accommodation has to be part of North Yorkshire's Mental Health Strategy. People however also acknowledged that sometimes having a place was not enough. Once again the need to 'feel safe' was an important factor in the recovery journey suggesting that affordable supported accommodation must be a key ingredient in the developing strategy.

The Mental Health Network NHS Confederation recognises housing organisations can:

- Help ensure housing is included in health needs assessment to inform commissioning plans.
- Identify tenants with risk factors for mental ill health and ensure access to appropriate prevention and early intervention services.
- Work with NHS organisations to provide integrated support for people with mental health problems, so improving outcomes and reducing overall costs.
- Ensure staff and contractors receive appropriate; evidence based mental health awareness training.
- Ensure debt and rent arrears collection processes are sensitive to people with a range of needs.[17]

[17] http://www.nhsconfed.org/Publications/briefings/Pages/mhn-briefing-247.aspx

There is a lack of affordable single person accommodation in some areas and with the financial restrictions for the under 35's and local housing allowance makes privately renting accommodation unaffordable. The current rate for a single under 35 yrs is £ 67 per week or £290.33 per month. The consequences of this are that clients are remaining in supported accommodation longer than need be and potential clients are ether on a waiting list or remaining in expensive hospital type accommodation for longer periods of time.

Of increasing concerns were the rising anxieties among those giving feedback on their concerns over the change in benefit and the costs associated with having a second vacant room in the house and the impact of the costs associated with this. This suggests single persons are not entitled to have visitors and that they are caught in a catch 22 as authorities provide very few one room apartments to rent.

A national audit carried out by ***homeless link*** asked homeless people whether they had experienced a mental health need:

72% of people using homelessness service reported that they had one or more mental health need. 61% of these people stated that this had been an issue for longer than 12 months. 44% stated that they used drugs and alcohol to alleviate the effects of their mental health issue. Only 10% received support from mental health services. 27% of homeless clients attending A&E did so due to a mental health problem, over five times that of the general population[18]. Practical Homeless Link's national audit found that over a third of homeless people with a mental health need would like more support with their mental health5 needs.[19]

There must then be close links between the mental health strategy and the local housing strategies.

Employment

In discussions with people experiencing mental health difficulties the role of employment was strongly emphasised. Many spoke with regret about their loss of status having had to leave work. Others spoke of their dilemmas in admitting they had mental health challenges as they struggled to fill in yet another job application

The economic impact of depression and anxiety among their workforce in terms of lost productivity is substantial. It is estimated that the average annual cost of lost employment in England, attributable to having depression as £7,230 and for anxiety £6,850 (both at 2005/6 prices). The Labour Force Survey suggests a figure equating to 27.5 days lost per ill worker were lost in Britain in 2008/2009 due to work-related stress, depression or anxiety. If depression and anxiety are not treated, additional costs are also likely to be incurred in treating co-morbid physical health problems. Also, in the longer term, many costs unrelated to the workplace may be incurred such as the cost of acute care, impacts on family members and premature death.

We have a number of arguments for furthering pathways to employment services:

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[18] COMMISSIONING FOR MENTAL HEALTH & HOMELESSNESS - OPPORTUNITIES IN THE NEW HEALTH LANDSCAPE Jan 2013

[19] See example case studies in http://www.homelessagency.ie/Research-and-Policy/Library/Mental-Health/Good-Practice-Guidelines-for-meeting-homeless-peop.aspx

- Employment assists people to be more socially included in the fabric of society;
- It helps people have a sense of self -worth and so it assists them emotionally and mentally
- Through employment people are invariably better off financially and with the changes in the welfare system this is the basis of the changes proposed by the Coalition Government
- Pathway to employments approaches are also a more effective way of using the public purse. Research illustrates savings can be made in local authority expenditure on traditional day care with the development of an alternative supported employment model

A social enterprise (SE) is: "a business or service with primarily social objectives whose surpluses are principally reinvested for that purpose in the community, rather than being driven by the need to maximise profit for shareholders and owners".

The key characteristics of a social enterprise are:

1. They trade i.e. sell goods and/or services and any profit or 'surplus' made as a result of their trading activities is either ploughed back into the business or distributed to the community they serve
2. They have a clear social purpose. This may include job creation or the provision of local facilities e.g. a nursery, community shop, or social care for the elderly.
3. They are owned and managed by the communities they serve

Why set up social enterprises involving people with Mental Health?

1. They utilises people's skills and life experience
2. They can provide tangible benefits to specific sectors of the community: ie people with Mental Health and the people they offer a service to;
3. They use business principles so that it is run in a professional way
4. It can help replace services withdrawn by central and local government

The development of more SEs might well form a role in North Yorkshire's Mental Health strategy.

'The MINDFUL EMPLOYER® initiative is aimed at increasing awareness of mental health at work and providing support for businesses in recruiting and retaining staff.

Stress, depression and anxiety are estimated to cause more lost working days than any other illness. The overall cost of mental ill health to employers in the UK through lost production and staff turnover is estimated at £30 billion per year. Positive steps to improve the management of mental health in the workplace should enable employers to save at least 30% of this cost – around £9 billion a year. Other research indicates spending 80p on health promotion and intervention saves £4 in costs due to absenteeism, temporary staff and absenteeism. With the right support, people with mental health issues can and do stay in work'[20].

Over 1¼ million people work for employers who have signed the Charter for Employers who are Positive About Mental Health.

'The Charter is just one part of the MINDFUL EMPLOYER® initiative and over 1,000 employers have signed it since the initiative began in 2004. The Charter is a voluntary agreement seeking to support employers in working within the spirit of its positive approach'. **The MH Strategy in North Yorkshire**

[20] http://www.mindfulemployer.net/

should seek to get all employers signed up to this Mindful Employer initiative starting with the larger statutory authorities.

First Aid in Mental Health

Many responsible organisations have worked well to ensure that when people are physically ill or have hurt themselves that they have to hand in the work place well trained first aid staff.

Internationally recognised the mental Health First Aid England (MHFA)course teaches delegates over two days how to recognise the signs and symptoms of common mental health issues, provide help on a first aid basis and effectively signpost towards support services. To date, there are over 650 instructors in England who have delivered the MHFA course to nearly 50,000 people[21]. We have these skills in North Yorkshire. It is recognised that more may need to be done to enhance awareness and take-up of this set of skills as part of the over all early intervention and prevention strategy in mental health.

A Practice Example

A case Study by the NHS Confederation in Sandwell suggested a very simple framework 5 step approach to mental healthcare. This approach developed by Sandwell commissioners is in line with national policy and the building blocks suggested above.

- The evidence base in the research was built through the GP profiling assessment highlighted: That there was correlation between people diagnosed depression and other long term conditions (Diabetes, Cardio vascular disease)
- One-third of people with mental health were attending GPs
- 15% of GP consultations and 50% hospital outpatient consultations arise from medically unexplained symptoms
- Significant number of people prescribed anti-depressants but not receiving therapy.

Figure 1. Stepped approach to mental healthcare in Sandwell

Wellbeing Emotional resilience Prevention	Promoting wellbeing Self-care, conditions management	Low-intensity service	High-intensity service		
Step 0	Step 1	Step 2	Step 3	Step 4	Step 5
Self-help Information Education Community settings	Guided self-help Education Advice Triage available in community and health settings	Range of 1:1 low-intensity supported interventions Pathways to work Improving access to psychological therapies (IAPT)	Primary care resource High-intensity psychological interventions Psychological interventions for people with long-term conditions	Access to psycho-therapeutic interventions from integrated child and adult mental health teams Early intervention, psychiatric liaison service within primary care	Centralised resources to provide specialist care and support – secondary care services

[21] http://www.mhfaengland.org/

Since the mental health and wellbeing services started in Sandwell, over 4,000 people have completed prevention, wellbeing and health improvement programmes. For commissioners, this equates to a saving of around £800,000 in prevention costs. In addition, over 3,000 people have accessed talking therapies, which suggests a saving of around £600,000." In terms of outcomes, initial results show reductions in lengths of stay and hospital episodes alongside clinical improvements and a rise in wellbeing.

The integrated primary care and well-being model and the stepped approach to mental healthcare within the paper also strongly appeals as a practical framework.[22]

[22] http://www.nhsconfed.org/Publications/reports/Pages/CaseStudyReportOnSandwell.aspx

Next Steps

North Yorkshire's Health and Well-being Board totask its subgroup the 'Mental Health Strategy Group'and partners to consider:

1. The views, expectations and aspirations of the people using mental health services as captured in this report;
2. Take accountof the building blocks and framework proposed as part of the mental health strategy across the County;
3. Agree that
    a. the views of people who use services and their carers together with
    b. the national policy framework 'No Health without Mental Health' and
    c. The outcomes framework for NHS, Social Care and Public Health

    Form the central plank of the County's mental health strategy.
4. Agree that these require the clinically ledCCGs, the proposed Joint Commissioning Board and the Council's Health and Adult Services and the Public Health Partnerships to demonstrate that these have been taken account of in their commissioning intentions and service planning
5. That in that journey account is taken of the views of their GP practices and Mental Health Providers and
6. That there is groundwork done to ensure a robust partnership with District Councils as Housing Authorities and their partners and with those who can support pathways to employment including the local enterprise partnership.
7. The timeframe and methodology for consulting on any service changes or development is made known to people who may use mental health services and that there isa financial and implementation framework behind the strategy.

It is suggested that points 1-3 are completed by the end of April 2013 and that work starts in April with behind the scenes discussions on investment, commissioning and implementations framework are negotiated during this period with a view to placing the completed work before the Health and Well-being Board in July/Aug 2013.

Meanwhile Agencies, Commissioners and Providers might wish to take an early opportunity to ask:

- Have they as agencies heard the voices of people needing support of services?
- What might be the possible implications for their delivery or commissioning approach?
- Is the culture and skill set within their organisation one where the focus is on aiding recovery?
- Has the collective got the right balance within its investment approach and is there sufficient emphasis on prevention?

- Is there a clear understanding of each agency's statutory duties and responsibilities as a minimum partnership foundation and a readiness to go beyond these where people risk falling between services?
- In building resilient individuals and communities has the approach allowed the development of a new and more mature relationship with the community and voluntary sectors?
- In terms of equity of provision and the health and well-being inequalities is there an appropriate level of investment in mental health services?
- Is the span of relationships across agencies sufficient to address an approach which is deemed to be everybody's business?

Appendices 1- 5

Appendix 1

Summary Notes from Meetings with people who use services.

Feedback from Northallerton, Catterick and Richmond Areas

'When first ill no one would listen to me and then it got to a stage where they prescribed me medication, I was forced to have it, in fact I was held down to ensure I had it.' This was the opening line in the discussion where there was sadness and anger around the difficulties in getting early support.

This theme was followed by a recognition that you arrive at a stage where you are known as a 'mental health patient'. You move into a parent /child role, you loose your adult identity and you know you are being treated patronisingly. . 'You are treated differently'. People treat you as if you were a child or like you were handicapped. The point was made if people had a physical illness they would still be treated as that same adult, acknowledged and recognised as intelligent people. But this is not so with mental illness.

As an adult I might assert my position, my principles in a debate or argument. As someone with a mental illness if I assert myself I am told 'there there don't get upset' you know it's not good for you!' If you gesticulate and raise an arm!! The label 'difficult' is very quickly tagged on.

Another person spoke of years as a respected and acknowledged professional in the NHS. But after return following a period of stress the attitude changed to one where she knew the attitude was 'watch out she's unstable'. What was most upsetting for this lady was that she felt she had lost her right to have a professional opinion.

Going to a centre where you can share and chat with others was described as 'a life line'. That plus the opportunities to do small tasks around the place, have a role in making the place run smoothly takes people 'out of themselves'. Some spoke of the importance of having opportunities to go out walking, swim some lengths at the local baths, pursue some hobbies or learn new skills in art and drawing or gain credits at the local college as part of their recovery. These seem to give not just satisfaction but allowed for positive re-enforcement and rebuilding of identities. People spoke of the need to get away from the burden of their illness and do 'normal things'.

Speaking about hospital care was very emotional for some. Some spoke of the state of the local hospital, having to share rooms, the loss of dignity. The expectation was that 'hospital would be a safe place', a 'haven' a place of recovery. People spoke of the staff and their approach and attitude being much more important than the building. The expectation was that all staff would treat you with a caring attitude, help you feel safe and respect you as a person.

On the issue of rurality those who lived away from the town spoke of an added sense of isolation. Some argued it was even more difficult for men living in a rural settings and spoke of men's inability to speak of a 'weakness'.

There was some discussion about the changes in the benefits system and the added stress this was causing. It was argued some people are more ill as a result.

On the issues of activities it was suggested that activities should take more account of the differing gender interests.

There was discussion on the need for and usage of a 'crises bed'. In the course of this one person spoke of deliberately taking an overdose in the past just to get away from the challenge of managing their home and their mental health condition. This suggested what people were referring to was the need for 'respite', a holiday, a break from the struggle of looking after themselves. But not all can afford a holiday.

Feedback from Bedale Area

This discussion involved four people and each described their lives and the challenge of living with schizophrenia. Some spoke of early adolescence and the traumas that surrounded this period. Others spoke of college and university pressures. References were made by some to identity crises and the support need but missing to help understand their sexuality.

Again there was a sense of loneliness and isolation and being alone in trying to manage what was happening to them with assistance only coming after a major breakdown or crises. One sought to get away from this a led a life on the roads and byways across England.

Entering into a mental health hospital when you are having a major crisis was, for all, a very frightening experience. Dealing with voices, meeting strangers, sharing accommodation was described as very stressful. The request was that those who run and manage hospital should do everything possible to lessen that stress and constantly offer assurance to help people feel safe.

The importance of living in a safe place be it provided by a housing association or a private landlord, was underlined as very important. The key ingredient was the housing and emotional support offered by an agency without which people felt they could not have got on with their lives.

One person brought home the sense of total fear and anxiety at the very thought of having a physical illness requiring them to be admitted into a general acute hospital. This particular part of the discussion under lined the importance of ensuring our hospital staff have the knowledge and skills to support people coming into general hospitals.

Note

The following information for Craven and Selby is drawn from a draft report by Nigel Ayre of Mind York who did a complementary piece of work and spoke to people who use services in these areas.[23] This report should be read in conjunction with this document.

Feedback from Craven Area

[23] Mind York. Service User - Project Report – January 2013 - No decision about us Without Us

The following information is drawn from a draft report by Nigel Ayre of York Mind who did a complementary piece of work and spoke to people in these areas.[24] This report should be read in conjunction with this document.

Craven Area

People spoke of the challenges of transport and rurality and getting to locations for services not locally based. The affordability issue was often a real barrier. Transport is limited and focussed on main population centres. Getting to and from outlying villagers is often impossible

It is also more challenging accessing information about services and service changes. Organisations are not good at keeping people with mental health needs up to date on an ever changing scene. Service Users and health professionals need more information about what services are available.

The importance of having a purpose to the day was emphasised and activities should be purposeful and give people a sense of achievement. Activities can also be social opportunities and reduce isolation.

The system needs to be much better at involving people, giving them the freedom to have a say, acting on feedback and communicating this change

The way organisations refer to adult and older people's services and the 65 age barrier makes no sense to people.

The issue of respect for people is seen in the food we serve to them, the behaviour of staff and whether people are listened to or not. People often report of very negative experiences in their hospital and other services.

. Providing services only to people who are "on the book" of CMHTs is counter-productive. People know their own condition well and often can say when more or less support is required. Again the theme of putting people in control is under-lined.

The whole system needs to be much better at sign posting to all the possible support opportunities and be less precious about whether a voluntary or statutory organisation offers the service. We are reminded that prevention is cheaper than cure.GPs as the gateway to services need better information on the range of offer.

There is a perceived need for community based support to aid the transition from secondary care. The preference would be for a local hub offering a variety of support/recovery based activities

GPs as the gateway to services need better information on the range of offer.

[24] Service User - Project Report – January 2013 - No decision about us Without Us

Provision of advocacy support is vital due to the negative impact issues can have on individual's mental health and the time taken up by professionals with other work than promoting recovery.

Feedback else where again underlined the issue of access services in a rural setting and how services place such great emphasis on the patient getting to the service rather than the other way about. Life stories clearly link rural isolation, transport, access to talking therapies and the unravelling of a life style when these rural support systems are not in place.

Professionals often feel neglected in these rural areas particularly when caught in what might seem like a twilight zone between commissioners and providers across geographical boundaries.

Feedback from Selby Area

Locating services away from the villages and rural areas requires people to over come the expensive challenges post by a poor transport system in rural areas and there was a call for services to be 'more mobile'. Having York based services doesn't help matters for some. Concerns around the possibility of developing Leeds based approaches by the new provider.

Again there was a call for good information on all available support options.

Assertive and encouraging approaches to day time activities are seen as important. Activities should be led by what service users want not by what staff are capable of doing. Two things to remember the option of gender specific groups should be within any offer and not everyone wants to do things in groups!

There is much disillusionment on the issue of people having a say in their own care

Organisations need to note and act upon the many comments by people who use services captured in the Mind Report about what people see as important 'quality issues'.

Community support in the form of drop in centres, peer group opportunities and support sometimes with support to access these are seen by many as an important ingredient in the local support scene. Such groups also provide much needed respite for carers

Again it was reiterated that GPs as the gateway to services need better information on the range of offer.

Again the provision of advocacy support was seen as vital.

Feedback from Harrogate Area

There were about 22 people present for this discussion. The group was made up of 10 females and 10 males with a range of ages present. A number of staff were present in the background but in the main did not engage in the discussion but acted as observers and saw this as a learning opportunity for them.

The discussion opened with a number of the younger participants speaking of the more modern ways that they get support. While the group they were attending at the Acorn Centre was very

important to them there was also recognition that they also received similar on-line support using Facebook and Social Network Groups such as the Depression Tribe[25].

In the early part of the discussion there was some criticism of our present approach to service access and of the skills within Community Mental Health Teams (CMHTs). A number spoke about the difficulty in accessing services and the absence of an 'open door' which encouraged people to come and speak about their difficulties and challenges.

Mention was made of the lack of investment and input in the early period of one's mental illness and how there seemed to be no great effort made in helping one to recover or prevent a further slide into mental illness. The suggestion was that professionals could use their skills in a better way to help people identify the early onset of their mental health problems and place a much greater focus on recovery. There was acknowledgement that people do not see the whole person but instead the mental illness and therefore fail to take into account the abilities and skills people often have.

There was much discussion about the benefits of peer support. There seemed to be an umber of issues or advantages in having peer support. These include the recognition that people undergoing similar issues have an understanding and empathy with one. There is a non judgemental approach and very often fellow sufferers recognise that an individual may becoming poorly again and see the early indicators and are therefore able to intervene more positively, for example, prompting and asking people if they are taking their medication, what's worrying them, do they need to speak to someone.

People in the group were also encouraged and find inspiration from others who have made progress or found themselves a job or occupation or are able to mange and cope better.

People described the group as "one big family", where you are accepted for what you are and where you find support.

In the course of discussion it became clear that people were wanting and needing a driver or motivation to get out of the house. The idea of keeping one's mind occupied, engaging with others, socialising, were very important. What people were saying was "I do not want to 'live' my mental health I want to get away from it, be distracted from it, do ordinary things".

Others spoke of the fact that "there is no joy in doing nothing" and went on to speak about doing jobs such as sweeping floors or other tasks which others might perceive as menial but were very important to them.

One individual spoke about their mind "being shot" and having great difficulty concentrating on a task. However the fact that they were able to do something to contribute to the group, to the centre, gave them a great sense of achievement and they were discovering that the path to recovery, although slow, did feel like a road to recovery.

The importance of peer group support was emphasised time and time again and people called for an open access approach and the need for flexibility in the system which responds to people's present state of health.

Returning to the topic of there being no joy in doing nothing, people gain spoke of the need to gain credits and recognition in education and the need for access to employment and employment type

[25] http://www.depressiontribe.com/

opportunities be it voluntary or paid. Others recognised the benefits of such an approach there was some concern on the part of a number of people that they may not be up to meeting their obligation. There was concern about letting down an employer.

As with other vulnerable groups on this topic there was discussion about how open people should be in terms of applying for a job. Should they admit on their CV that they have got a mental health issue? Once again we heard of a day time activity be it in the form of a job or attending a centre or doing something as critical to helping people to deal with and manage their mental health illness better.

A theme which had come up with other groups was also mentioned here. There was some discussion about Mental Health Hospitals and a number of individuals spoke about "feeling isolated" and "fighting for my survival". The sense was that some hospitals where individuals did not have their own room were not deemed to be "safe places" and while individuals recognise that they are going into hospital at a very time when they were most vulnerable and most at risk, there was a sense that hospitals and acute care situations could do much more to help them "feel safe". The idea of feeling safe arose time and time again.

People sometimes spoke of the need to have more say and control over how they are medicated and this was true of many aspects of the services they spoke about.

Some spoke with regret of reduction in respite care and the offer of respite care. People spoke about the need to get a break from trying to manage themselves and of the need for respite. Others expressed it as the need to have some form of holiday to look forward to, although for many, particularly those on benefits, this was something they would not be able to expect in their lives and therefore the role of respite was seen as very important to them. The context of respite referred to here was one of having a break, not having to deal with the daily difficulties of managing oneself in one's apartment, being well treated, having maybe a bit of luxury. The aspiration here was for something that contributed to the sense of being valued.

A number of the group lived in rural settings and spoke of the challenges and difficulties of accessing services which were urban based. There was also a recognition that sometimes in the rural community one experiences a much greater sense of isolation, or at least that's how it felt for individuals that were not only physically isolated but hadn't the presence of others within their community who understood and were able to support them in their situation.

There was some discussion around Personalised Services (PS) and Personalised Budgets (PB) and Direct Payments (DP). When PB were explained a number of individuals acknowledged it would be really good feeling they were in control and to be able to purchase things that would enable them to feel better. One or two acknowledged that making these choices would be very difficult for them and they might not like the responsibility of managing money.

Everyone spoke about the need for services that were designed around them and support that was designed around them. However, there was also recognition that actually the very things that help some individuals were also the very things that helped many in the group and again there was a return to the discussion around the benefit of having the group; having peer support.

Appendix 2

Summary of some Common Themes

In summarising the discussions again one is struck with the common themes including:-

1. A strong desire for people to have early engagement as they begin to develop a mental illness. People feel they would personally gain from an earlier diagnosis and early insight into their condition.
2. A number of benefits seemed to arise when they spoke about this – some referred to the fact that they go through periods of great loneliness and isolation because they feel that they are unique and alone and the only one having to address such problems. When they begin to understand that others have similar problems and challenges, while still difficult this offers some consolation. Secondly, people understand that a name or a label is given to their condition and there then maybe expert advise and guidance and even medication which would help them much earlier in their journey.
3. There is a strong sense within groups that there should be greater emphasis on the idea of recovery. People should be encouraged from the early onset to be helped to understand that there may be things that they may be able to do as individuals with support that would better help them manage their condition or reduce the effect of their condition.
4. There is a sense of anger that if people had other illnesses the system would automatically think about recovery and find ways and means of helping people to either overcome, address, or reduce their condition.
5. From many people from this group there was a sense that they are simply brought into a system that maintains them but doesn't work sufficiently or robustly enough or use all its skills to help people have better lives for themselves.
6. The importance of having access to a community which understands one's conditions, it non judgemental in its approach, and which seeks to support individuals is seen as being important. People get great comfort from engaging with others who are challenged to deal with similar issues to themselves. There are a number of themes within this including the theme of acceptance, respect, a non judgemental attitude, and seeing the person as an individual not just a mental health issue.
7. There was a strong sense from many within the group of the desire and wish to "get away from their mental illness". The importance of being occupied, having an occupation, doing something useful, gaining academic accreditation, respite, having a job, roles seen as essential along this pathway.
8. The idea of addressing loneliness and isolation and making individuals feel safe was a very strong theme within this discussion. One heard about the need for hospitals to be safe places, for the need for accommodation that felt safe and supports and the need for an environment where one felt supported and secure. This equally applied when one was in an urban or rural setting.
9. The group hoped to see their themes and issues reflected in any further involving mental health strategy.

Appendix 3

Carers supporting Family in Mental Health Services

In the course of the dialogue and discussion SB heard the following issues:-

1. Stigma – a number of the group, and K in particular, felt that stigma was still an issue in Mental Health. This was reflected in both the level of funding linked to Mental Health Services and the attitudes of organisations and people in the community.

2. Historical Spend – SB acknowledged that the level of investment in Mental Health was relatively low compared to other client groups across the County. This was part felt to be a historical pattern, developed over the years, where more groups and those who shout the loudest got the greatest level of investment. However this pattern is reflected across the Country, but North Yorkshire's level of investment in mental health is in the lower quartile of investments in comparison to other Authority areas.

3. The Medical Model of Service Delivery – A number of the group, but H in particular, felt that the Medical Model of Service Delivery was still very prevalent across North Yorkshire. We over medicalise Mental Health Services and pay insufficient attention to the support needs of people in the community.

4. Support and Community - in the course of the discussion it became very clear that a critical issue is the level of support available to people in the community. This was the need for a trusted friend, a trusted buddy, a trusted professional, who would listen and pay full attention to the individual with mental health needs, signposting them and giving them guidance on the way forward.

5. Direct Payments and Personal Budgets – there was a sense of anger at the denial of the rights of people with mental health needs to personal budgets and direct payments. The feeling from some carers was that staff were insufficiently trained and knew very little about the subject area. Another issue was the size of the big bundle of papers people needed to go through to access direct payments. There was a sense that staff and others should be better trained in personal budgets and in marketing personal budgets. and finally there was a recognition, and possibly the real reason why it was not fully promoted, was the lack of investment in community budgets, which meant that people did not want to market it very well.

6. Attitude – there was some very difficult and painful stories shared about the alleged abuse of people with mental health needs. This was both in institutional hospital settings and in community settings where vulnerable adults at risk where taken advantage of by others. There was a great sense of anger at the lack of rights experienced by some people with mental health needs and also by their carers who felt they were not being listened to. It was alleged that this lack of respect also reflected in the fact of how people were treated with medication and how mediation was changed which seemed to be more for the convenience of the sector rather than the individual themselves.

7. Supported Accommodation – there was a sense that a number of people with mental health needs were being left without adequate support in the community and that there was a particular need for support in maintaining and living well in people's own community settings. There were stories of people being taken advantage of by unscrupulous "friends" and neighbours.

8. Listen To Me – the sense again was that people were not being listened to either as patients or as carers. Carers very often have lived for long periods with a loved one with mental health needs and so have gained some insight to what works and what doesn't work. There was a sense that we were failing to include carers are part of the partnership that would create a solution and support network for people with mental health needs.

9. Advocacy and Voice – linked to the above one got a sense frequently of carers and individuals being unclear as to where they lay in the system and what the next steps were. There was a need for signposting, but also there was a need for advocacy, somebody to shout on their behalf when their voice was not being heard – as outlined above. The constant message from carers was listen, listen, listen.

10. Legal Support – Carers felt there were times where people were not being listened to and advocacy was not enough but then there should be access to some legal support, for example, when people need to access notes and records, which frequently seem to be denied to them.

11. Communication and Information Sharing – there was recognition that while carers had needs and rights the individual with mental health also has needs and rights. However, there were stories where people were being discharged from hospital without professionals advising the network of carers supporting this person that was being discharged. These gaps of information and lack of information sharing meant that the individual was more vulnerable and very often returned to an acute episode because there hadn't been sufficient support made available, which was on standby but the communication was such that it wasn't being made available.

12. Fight, Fight, Fight – one got the sense of carers having to constantly fight with the system and against the system, and you got a feel that this was a draining process undermining the carer's task of supporting the individual. The system seems to be in defensive mode, and we argue very well as to why something shouldn't happen. This may go back to the earlier point where staff are having to function in a system that is seriously underfunded.

13. Early Intervention - from the stories told one got a sense that early indications, particularly in teenage years, were not paid sufficient attention to. The consequence is that early intervention opportunities are missed and families suggest that acute episodes, and more costly care, could have avoided if there had been upfront investment much earlier. It wasn't just always about investment but actually we heard the stories of individuals themselves trying to refer themselves into the system when in need of support but being denied access.

14. Respite Breaks – the group highlighted the scenario of, in their mind, services slowly disappearing and the options for respite becoming less available. This was then linked into the discussion about choice and control and personal budgets but there was recognition that both carers and individuals very often needed respite from their present situation.

The question being asked throughout the meeting was 'Where is the caring?" The picture painted was one of a system that is struggling and stretched where some staff are working very hard to support individuals but that the jam is being spread too thin across the system. As a result the system appears to be less caring, pays less respect, and doesn't treat people with dignity.

The challenge over the next few months was for Senior Managers and Politicians to hear the voice of people using services to better understand their experience and explore how Mental Health could be given a greater focus and priority within the system, and how we could together collectively begin to shape the excellent Mental Health Services we need in future years.

Appendix 4

Social Care AMHP Staff Discussion - AMHP (Approved Mental Health Professional)

NYCC MEETING WITH AMHPS

The broader landscape of budgets, policy shifts, engagement with users and the broader integration agenda were outlined. The groups then looked at this environment and made the following comments:

1. Team around the child concept was mentioned as a model of good practice.
2. Call for integrated CMHT rather than a separation from NHS.
3. Discharge planning meeting approach around the person.
4. Different workers with different perspective. Some AMHPS are in CHMTs others are not. Need for a uniform approach. Some felt they were working the NHS agenda rather than user's agenda or even a social care agenda. Issue of night service: call for consistent model with power to make decisions. AMHP role is more than a rubber stamp role - looking at real alternatives to detention. Not understood well enough by our organisation or partners.Issue as perceived by some as there being a dilution of the AMHP role. There were linked issue of mental health role in older people's services. There is still a great sense of loss and regret within the organisation over historicaldecision which took mental health role out of older people's service teams.
5. Liked the idea of integration in its broadest sense and what the AMHP role might be in an integrated neighbourhood team. Highlighted concerns following massive increased need. Being clear about the focus of the work. Who makes the decision and the need for better understanding and marketing of the role. Supervision and professional support needs to be robust.
6. Also mentioned the expertise in working within the CMHT. Risk of losing teams expertise in a wider integration model. This was a reference to the wider LA/NHS integration agenda.
7. Concerns and about being clear about roles and reporting and accountability. This issue of roles and functions need clarifying. Big issue about trust and capacity. Compositions teams – the need for the right balance of skills.

IMMEDIATE ACTION REQUIRED: to clarify the roles and functions of AMHPS.

A strong message from this staff group was that their own organisation seems not to fully understand the role and function.

Very robust discussion on roles, workloads, strong views about accountability, complexity of roles, DOLS, SAFEGUARDING, and capacity manage demand. Group spoke of shared responsibilities of professional front line staff and management.

8. Staff: to ensure they are giving the best possible service to customers; sufficient to aid recovery and ensure people are safeguarded while avoid creating dependency. Measure of success is not the number on one's case load but the numbers of people assisted to be independent.
9. Management must be aware of gaps in service, capacity and skills shortfalls and continuity keeping an eye to age profile of staff group.

EARLY ACTION: In the wider context of social care address the immediate issues of capacity and continuity.

ACTIONS:

1. A series of actions internal to Health & Adult Service are underway as a result of this discussion but solutions may require engagement with a number of NHS partners.

Appendix 5

Mental Health Data – North Yorkshire

Overall Population by Age 18-64 North Yorkshire

Data for: North Yorkshire
Table produced on 07/01/13 10:58 from www.pansi.org.uk version 6.0
Population aged 18-64, projected to 2016

	2012	2013	2014	2015	2016
People aged 18-24	44,100	42,900	42,300	41,300	40,300
People aged 25-34	57,900	59,900	61,200	62,400	63,200
People aged 35-44	72,800	70,200	67,900	66,700	65,300
People aged 45-54	91,800	92,000	92,100	91,400	90,800
People aged 55-64	82,300	81,600	81,700	82,400	83,700
Total population aged 18-64	348,900	346,600	345,200	344,200	343,300
Total population - all ages	597,100	599,300	601,600	603,900	606,300

Figures may not sum due to rounding. Crown copyright 2010
Figures are taken from Office for National Statistics (ONS) sub-national population projections by sex and quinary age. The latest subnational population projections available for England, published 21 March 2012, are based on the 2010 mid year population
Long term population projections are an indication of the future trends in population by age and gender over a period of 25 years. They are trend based projections, which means assumptions for future levels of births, deaths and migration are based on ob

People aged 18-64 predicted to have a mental health problem, by gender, projected to 2016

Data for: North Yorkshire and districts

Table produced on 07/01/13 10:40 from www.pansi.org.uk version 6.0

People aged 18-64 predicted to have a mental health problem, by gender, projected to 2016

	2012	2013	2014	2015	2016
North Yorkshire: People aged 18-64 predicted to have a common mental disorder	56,142	55,776	55,558	55,382	55,266
North Yorkshire: People aged 18-64 predicted to have a borderline personality disorder	1,569	1,559	1,553	1,548	1,544
North Yorkshire: People aged 18-64 predicted to have an antisocial personality disorder	1,222	1,214	1,208	1,206	1,203
North Yorkshire: People aged 18-64 predicted to have psychotic disorder	1,395	1,386	1,380	1,376	1,373
North Yorkshire: People aged 18-64 predicted to have two or more psychiatric disorders	25,112	24,947	24,847	24,774	24,723

DISTRICTS

	2012	2013	2014	2015	2016
Craven: People aged 18-64 predicted to have a common mental disorder	5,050	4,934	4,948	4,941	4,857
Craven: People aged 18-64 predicted to have a borderline personality disorder	141	138	139	138	136
Craven: People aged 18-64 predicted to have an antisocial personality disorder	109	107	106	106	105
Craven: People aged 18-64 predicted to have psychotic disorder	126	123	123	123	121
Craven: People aged 18-64 predicted to have two or more psychiatric disorders	2,255	2,204	2,205	2,204	2,168
Hambleton: People aged 18-64 predicted to have a common mental disorder	8,138	8,093	8,028	8,003	7,944
Hambleton: People aged 18-64 predicted to have a borderline personality disorder	227	226	224	224	222
Hambleton: People aged 18-64 predicted to have an antisocial personality disorder	179	178	177	175	175
Hambleton: People aged 18-64 predicted to have psychotic disorder	202	201	199	199	197
Hambleton: People aged 18-64 predicted to have two or more psychiatric disorders	3,648	3,627	3,598	3,584	3,562
Harrogate: People aged 18-64 predicted to have a common mental disorder	14,946	14,869	14,810	14,798	14,778
Harrogate: People aged 18-64 predicted to have a borderline personality disorder	418	416	414	413	413
Harrogate: People aged 18-64 predicted to have an antisocial personality disorder	326	324	324	323	323
Harrogate: People aged 18-64 predicted to have psychotic disorder	371	369	368	368	367
Harrogate: People aged 18-64 predicted to have two or more psychiatric disorders	6,688	6,652	6,630	6,623	6,615
Richmondshire: People aged 18-64 predicted to have a common mental disorder	4,822	4,778	4,778	4,733	4,701
Richmondshire: People aged 18-64 predicted to have a borderline personality disorder	134	133	133	131	131
Richmondshire: People aged 18-64 predicted to have an antisocial personality disorder	111	110	110	109	108
Richmondshire: People aged 18-64 predicted to have psychotic disorder	120	119	119	117	117
Richmondshire: People aged 18-64 predicted to have two or more psychiatric disorders	2,183	2,162	2,162	2,140	2,126
Ryedale: People aged 18-64 predicted to have a common mental disorder	4,864	4,839	4,800	4,807	4,743
Ryedale: People aged 18-64 predicted to have a borderline personality disorder	136	136	134	135	133
Ryedale: People aged 18-64 predicted to have an antisocial personality disorder	104	103	103	102	101
Ryedale: People aged 18-64 predicted to have psychotic disorder	121	120	119	120	118
Ryedale: People aged 18-64 predicted to have two or more psychiatric disorders	2,169	2,155	2,140	2,141	2,112
Scarborough: People aged 18-64 predicted to have a common mental disorder	9,981	9,832	9,800	9,716	9,696
Scarborough: People aged 18-64 predicted to have a borderline personality disorder	280	275	275	272	272
Scarborough: People aged 18-64 predicted to have an antisocial personality disorder	213	210	209	208	208
Scarborough: People aged 18-64 predicted to have psychotic disorder	248	244	244	242	241
Scarborough: People aged 18-64 predicted to have two or more psychiatric disorders	4,446	4,381	4,367	4,331	4,323
Selby: People aged 18-64 predicted to have a common mental disorder	8,374	8,386	8,424	8,488	8,481
Selby: People aged 18-64 predicted to have a borderline personality disorder	234	235	236	237	237
Selby: People aged 18-64 predicted to have an antisocial personality disorder	180	181	183	184	185
Selby: People aged 18-64 predicted to have psychotic disorder	208	208	209	211	211
Selby: People aged 18-64 predicted to have two or more psychiatric disorders	3,738	3,745	3,766	3,795	3,794

This table is based on the report Adult psychiatric morbidity in England, 2007: Results of a household survey, published by the Health and Social Care Information Centre in 2009.
Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder. The report found that 19.7% of women and 12.5% of men surveyed met the diagnostic criteria for at least one CMD.
Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.
ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed. ASPD was present in 0.3% of adults aged 18 or over (0.6% of men and 0.1% of women).
BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour is common. The overall prevalence of BPD was similar to that of ASPD, at 0.4% of adults aged 16 or over (0.3% of men, 0.6% of women).
Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bi-polar disorder. The overall prevalence of psychotic disorder was found to be 0.4% (0.3% of men, 0.5% of women). In both men and women the highest prevalence was observed in those aged 35 to 44 years (0.7% and 1.1% respectively). The age standardised prevalence of psychotic disorder was significantly higher among black men (3.1%) than men from other ethnic groups (0.2%of white men, no cases observed among men in the South Asian or 'other' ethnic group). There was no significant variation by ethnicity among women.
Psychiatric comorbidity - or meeting the diagnostic criteria for two or more psychiatric disorders - is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. Disorders included the most common mental disorders (namely anxiety and depressive disorders) as well as: psychotic disorder; antisocial and borderline personality disorders; eating disorder; posttraumatic stress disorder (PTSD); attention deficit hyperactivity disorder (ADHD); alcohol and drug dependency; and problem behaviours such as problem gambling and suicide attempts. Just under a quarter of adults (23.0%) met the criteria or screened positive for at least one of the psychiatric conditions under study. Of those with at least one condition: 68.7% met the criteria for only one condition, 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions. Numbers of identified conditions were not significantly different for men and women.

Summary:

	% males	% females
Common mental disorder	12.5	19.7
Borderline personality disorder	0.3	0.6
Antisocial personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5
Two or more psychiatric disorders	6.9	7.5

The prevalence rates have been applied to ONS population projections
for the 18-64 population to give
estimated numbers predicted to have a mental health problem, projected to 2030.

People aged 30-64 predicted to have early onset dementia, by age and gender, projected to 2016

Data for: North Yorkshire
Table produced on 07/01/13 10:44 from www.pansi.org.uk version 6.0
People aged 30-64 predicted to have early onset dementia, by age and gender, projected to 2016

	2012	2013	2014	2015	2016
Males aged 30-39 predicted to have early onset dementia	2	2	2	2	2
Males aged 40-49 predicted to have early onset dementia	9	8	8	8	8
Males aged 50-59 predicted to have early onset dementia	49	50	51	52	53
Males aged 60-64 predicted to have early onset dementia	41	39	38	38	38
Total males aged 30-64 predicted to have early onset dementia	101	100	100	100	101
Females aged 30-39 predicted to have early onset dementia	3	3	3	3	3
Females aged 40-49 predicted to have early onset dementia	11	11	11	10	10
Females aged 50-59 predicted to have early onset dementia	33	34	34	35	36
Females aged 60-64 predicted to have early onset dementia	25	25	24	24	24
Total females aged 30-64 predicted to have early onset dementia	72	72	72	72	73

Figures may not sum due to rounding.

This table is based on the Alzheimer's Society report, Dementia UK - the full report. This 2007 report into the prevalence and cost of dementia was prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the I
The report gives rates for early onset dementia, in ten year age bands, from the age of 30, including numbers for males and females:

Age range	Per 100,000 males	Per 100,000 females
30-34	8.9	9.5
35-39	6.3	9.3
40-44	8.1	19.6
45-49	31.8	27.3
50-54	62.7	55.1
55-59	179.5	97.1
60-64	198.9	118

The prevalence rates have been applied to ONS population