Cumbria Mental Health Group

"speaking up for the mental health community"

REPORT OF PRE-CONSULTATION MEETINGS HELD ACROSS CUMBRIA BETWEEN 27 FEBRUARY AND 5 MARCH 2008

Prepared by Cumbria Mental Health Group on behalf of The Mental Health Community as input to the PCT Consultation

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1. Introduction

The Cumbria Mental Health Group was asked by Cumbria Primary Care Trust to organise a series of meetings across Cumbria to allow the Mental Health Community to have an input into the development of proposed changes to the mental health services. The following notes sum up the main points made by those attending the pre-consultation meetings as well as comments received subsequently.

The notes have been group as follows:

- Section 2. A summary from the point of view of the mental health community. A simple setting out of the common themes from the 5 meetings.

- Section 3 General Points for the consultation process emerging from the pre-consultation. This sets out the information that would be needed to understand the proposals to be set out in the formal consultation document.

- Section 4 Key specific points. This section sets out the key issues that were raised in the 5 meetings which give more detail of the expectations of the mental health community.

- Section 5 A review of the meetings process. This sets out the back ground to the meetings as a whole and how they worked including a table setting out who attended.

- Appendix A is the schedule of 'short term issues' which were raised during the process.

  This schedule lists the issues raised about the current operation of the mental health services and social care services in Cumbria. Those attending the meetings expect a response from the providers of mental health and social care services. The statutory sector organisations will be provided with the opportunity to put forward their views and then collaboratively Cumbria Mental Health Group along with representatives from the Trusts and Adult Social Care will develop and monitor an action and implementation plan to address the out standing concerns that have been raised via this process.

Appendices B through to F are the records of the individual local meetings (to ensure their authenticity we have not sought to reduce their presentation to a common form). Finally, at Appendix G there is a report of personal contributions received from individuals following the locality meetings.

2. Summary from the mental health community point of view

2.1. In each local area the mental health care and recovery of individuals should be considered as a whole. If this is to work effectively, GP, NHS, and Social Care teams are required to understand the full range of need and offer professional support at all levels. It is crucial that there is a network to support individuals needing help and to continue to support them as they return to normal life in the community. This necessitates planning, and the Care Programme Approach must work for all. Those organisations involved in the individuals Care Plan might include NHS services, Social Care, independent providers, charities and private firms as well as particular government departments, police and other local authority, community and faith organisations.

2.2. Quality of service is crucial for all.

2.3. Education and training to support this process is required for all staff working for the Foundation Trust, Social Care, GP practices, and community sector organisations, as well as for service Users and Carers. The training should include prevention, early intervention and detailed knowledge about each condition/diagnosis.

2.4. Clear expectations, as to what is provided and by which organisation, should be set out. This and all other aspects of the overall working of mental health services need to be clearly communicated.

2.5. Appropriate psychological therapies, including CBT and other specialist services should be available without waiting.

2.6. Special services for managing crises and supporting the individual's recovery are crucial. Local accommodation should be available to support this. In a few cases this may have to be further away. In all cases there must be "timely access as close to home as possible". The local communities are frightened that the pressure to reduce beds numbers will leave them without access to mental health beds at the time of need. There is an overwhelming call for an extended community service to be seen to be working before bed numbers are finally reduced

2.7. It must be recognised that in some cases individuals may not be able to live independently, and so alternatives must be available.

2.8. Carers need effective support, they should not be pressurised and overloaded, and they also require respite. If Carers cannot continue to support Service Users, alternative care must be available

2.9. The role of short term supported accommodation and specialist services needs to be clear, easy to understand and they need to be effective. The difficulties of actually travelling to them needs to be well recognised and supported.

2.10. The requirement for very specialised care needs to be recognised and fully provided. This in a few cases may require an 'out of area' treatment placement. The 'nightmare situation' is for people to have to go out of Cumbria unnecessarily for their treatment. When people go out of county, there must be effective monitoring directed to facilitating the return of the Service User at the earliest opportunity, as well as support for Carers.

2.11. At the present time it appears that the full use of resources available in the community is limited by gaps in availability of staff due in part, it is claimed, to 'staff stress' leading to sickness absence. This needs to be urgently addressed.

2.12. The whole process of Service User and Carer experience needs to be built on trusting relationships between all players and stake holders.

2.13. The approach set out here needs to be developed into a strategy which can be implemented within the resources available, and no element of it, including the changing of inpatient provision, should be decided without regard to the implications across all mental health services for those using or the people supporting those using, these services in Cumbria.

3. General points for the formal consultation

We recognise the policy context in which the proposed model for mental heath care has been developed and the pressures which have helped to shape it. However, the context needs to be presented clearly in the Consultation as well as the historical background. There have been previous PCT led Consultations regarding mental health in both North Cumbria and South Cumbria, but significant recommendations emerging from them have not been implemented. The consultation document should make clear what was and was not implemented and why this happened. Looking to the future, it is essential that the consultation document:

3.1. conveys a holistic approach, highlighting the relationships between the elements of care, and containing a commitment to care being tailored to local needs and managed locally so far as practicable, avoiding 'out of County' care unless essential.

3.2. reflects the geographical realities and constraints of Cumbria, and the location of the main areas of need, recognising that deprivation and related mental distress occur in proportion to population across all communities.

3.3. sets out what services are changing from and to, with proper details, numbers of service users and carers to be provided for, bed numbers, and costs etc.

3.4. makes clear the respective roles of the various organisations involved, highlights the basic distinction between commissioning and providing, and identifies which parts of which organisation do one or the other role.

3.5. contains a commitment to standardising and monitoring the quality of care whichever organisation is providing it

3.6. defines clear and effective roles for accommodation and specialist services, and recognises and caters for the difficulties of individuals and their Carers in accessing them

3.7. demonstrates service development from a Service User and Carer prospective, avoids jargon, and uses language and definitions which Service Users and Carers can understand (e.g. what is involved in Crisis Resolution, and who the service is targeted at, need explaining)

3.8. should provide explicit guidance as to the interlinked training required for individuals in the mental health community, and the full range of professional staff. Service Users and Carers should be included in the delivery of all specialist training and development as the 'expert'.

3.9. offers a commitment to prepare clear overall strategic direction with an associated implementation plan which reflects all these factors, and includes full costings, budgeting, timescales, and delivery, and saying what will be provided or delivered by which organisation.

4. Key Specific Points

4.1. **Acute Inpatient Wards**

It is recognised that a key element of the current proposals is the concentration of acute care in Cumbria, with only one location (Carlisle) for the very acutely ill. The reasoning behind this is understood but it has given rise to serious concerns regarding the need to ensure that:

- no-one requiring inpatient care is denied access to it
- inpatient care is properly integrated with care in the community and in particular with the work of CMHT's
- significant accessibility problems for patients, CMHT staff, Carers, family and friends are fully addressed – such access is vital to the recovery of all inpatients.

The recommendations for the consultation document are that:

4.1.1. there should be clear information which describes the existing bed based facilities in Cumbria together with the proposed number of beds including any reductions, with evidence to support the change

4.1.2. the evidence for and justification for the changes should be set out simply and clearly

4.1.3. in so doing the role of each type of inpatient facility should be clearly described and account should be taken of the following considerations:

- Specialist knowledge, safety and support for the very ill
- Patients' may need to have a period away from their home.
- Carers' need for respite
- The need in some cases for strong support over a long period in order to achieve the required degree of recovery
- The impracticality, in the case of dementia patients, of Carers continuing with long term support beyond a certain point in the development of the condition
- The more general concern of some Carers as to what will happen to the Service User when the Carer dies or when they are no longer able to carry on.

4.1.4. to ensure a proper balance between inpatient and other care, the document should specifically refer to the related commitment in the NSF, which indicates that each Service User who is assessed as requiring a period of care away from home should have "timely access to an appropriate hospital bed or alternative bed or place, which is:

-in the least restrictive environment consistent with the need to protect them and the public
-as close to home as possible"(how this is interpreted needs to be justified - all meetings recognised the crucial nature of this point for the success of care in the community)

4.1.5. the document should include information regarding how the premature discharge of patients from in-patient care will be prevented. There needs to be full support available for either the Service User's own home, or the home of the Carer. Carers need to be involved in the decision if possible and certainly for discharge to their home. Carers must not be pressurised.

4.1.6. it should be specified that a full range of multi-skilled staff will be available on the inpatient wards to provide psychological treatment, occupational therapy and meaningful activity as well as medicinal treatment as necessary

4.1.7. it should also make clear that as well as medical and nursing skills, the associated necessary "people skills" should be available, to aid recovery from the widest range of conditions practicable

4.1.8. provision should be made for local CMHT staff to keep in touch with inpatients and facilitate their return from hospital to their local area

4.1.9. provision of adequate support for facilitating visits to patients in hospital (It is particularly important for an Advocate who knows the Service User and/or the nearest relative and others close to the Service User to have ready access to represent the patient's interest and give more general support)

4.1.10. consideration should be given to offering accommodation on site, travel tokens etc (The Chief Executive of Cumbria Partnership NHS Foundation Trust gave an undertaking to make support available within a year from the last Partnership Trust AGM September 2007).

4.2. Crisis Beds

The importance of providing local beds as part of care in the community to cater for individuals in crisis and the need for respite is recognised. We recommend that the consultation document:

4.2.1. indicates what beds are available for people suffering from mental health problems now and what arrangements are contemplated to ensure an equitable distribution for the future across Cumbria

4.2.2. say what the local proposed crisis accommodation will be, and recognise the support needed in rural areas for accessibility as indicated above

4.2.3. specify clearly under what circumstances someone will be able to use these beds, and what support will be available, including issues such as the

level of 1 to 1 monitoring available in order to cope with someone who might be suicidal.

4.3. Crisis Resolution and Home Treatment (CRHT)

Our recommendations are that:

4.3.1. the specification of this service should set out how it will work for all Service Users of all ages with differing conditions and diagnosis. (The NSF specifies "being able to make contact round the clock with the local services necessary to meet their needs and receive adequate care").

4.3.2. the consultation document should refer clearly to what happens to those 'excluded' from Crisis Resolution & Home Treatment services; it should, in particular, provide clarity regarding those older people with dementia (The National Policy Implementation Guide for Crisis Resolution and Home Treatment limits the availability of crisis resolution, an aspect not discussed at the pre-consultation meetings).

4.3.3. the document should include information regarding accessing CRHT and the issue of suitability of supporting the Service User in their own home as envisaged. (Carers are particularly worried about being forced to continuing to support the Service User if there is not sufficient help from CRHT).

4.3.4. the document should include clear guidance on the content of home treatment and the level of risk the CRHT will be expected to manage which might be seen by some Service Users or Carers as being an 'unacceptable' level of risk. There needs to be discussion with all parties to agree what is to happen.

4.3.5. the specification must make it clear that home treatment should be available as a preventative service – available before the Service User's situation has developed into a full blown crisis.

4.3.6. the service needs to be accessible directly by those in need (self referral or referral by Carer).

4.3.7. accessibility should be available on a 24/7 basis to both Service Users and Carers, and provide a capability to direct the caller to specific services for action (there has been an understanding for a long time that a 24/7 help line would be available, and there remains a strong feeling that this is essential, as well as focused help)

4.3.8. out of hours GP services need significant mental health training to know what to do for Service Users and Carers.

4.3.9. the police should not, as on occasion, be seen as the only route for managing a mental health crisis. Appropriate procedures should be in

places which are communicated properly to all, and training should be given to the police for dealing with those cases where they do have to be involved.

4.4. **Community Services as a whole**.

At each of the meetings it was recognised that "at home or close to home" is a key principle guiding provision of care for someone with mental health need. However, there is serious concern over the adequacy of support in the community, in particular following discharge form specialist secondary services. There are reports of many people not getting 'full support' from mental health community services (see also schedule of short term issues). The problem goes way beyond what may or may not be expected from Crisis Resolution and Home Treatment services. As a result, there is a belief that significant numbers of people are left in a "yo yo" situation, trapped in isolation in the community, or with intolerable pressures on those close to and supporting a Service User, a situation which is at times unsustainable. It is not, moreover, practicable to expect all GP's to have full knowledge of mental health issues. It is clear in fact that some practices struggle to cope with them.

The efforts made by statutory services to address these difficulties are recognised but a lot more needs to be done. While we acknowledge in particular the value of the commitment of the Cumbria PCT/ Cumbria Partnership Foundation Trust now, and extra Government funding available shortly, to fund short term treatment sessions. One of the themes from all 5 pre-consultation meetings is that a much stronger holistic approach is essential and that this requirement is similar for:

- those with common mental health problems
- those recovering from much more disabling mental health situations
- those older people who are becoming frail
- people with dementia.

Our recommendations accordingly are that:

4.4.1. the document must emphasise that a full range of support for mental health recovery in the community is going to be put in place to allow for reduction in bed numbers,

4.4.2. it must also acknowledge that, following discharge from secondary care, a significant number of Service Users still have mental health needs which require support for the individuals recovery (there is concern over the number of Service Users left in isolation)

4.4.3. it should indicate that each local community will have access to professional staff with a full range of skills to support the majority of mental health problems and recognise quickly mental health needs which require expertise outside the local community

4.4.4. people should be given a clear view of what to expect from services. The roles of various staff members need to be clear. There is presently confusion in the community about the different roles of doctors, nurses, other qualified people and support staff with, in and outside the statutory sector.

4.4.5. the point of contact to initiate mental health care must be available 24/7 to those in the community.

4.4.6. the role of the GP Practice and its staff needs to be clear, with specific mental health training available for the whole team. (the GP's Receptionist is often a key player in the early care of someone with mental health needs)

4.4.7. the management of medication should be recognised as crucial (some feel there is too much dependence on medication, and there are issues on the appropriateness of some medications prescribed such as benzodiazepines; the review of dosage is critical and sometimes there are difficulties in knowing the relationship between the GP and the Mental Health Doctor)

4.4.8. the consultation document should outline the support available for those with what are referred to as "common mental health problems" - should include a range of services as well as short term talking therapy sessions

4.4.9. it should be recognised that care for 'recovery' is about much more than short term sessions of treatment (some one to talk to, and a range of activities are crucial). In particular, the staff involved with supporting a Service User should have the appropriate amount of time to work with the Service User and adequate time to build the trusting relationship necessary.

4.4.10. There needs to be training and education regarding mental health available for Service Users, Carers and the community as a whole.

4.4.11. the document should include the wider contribution which the community can make in relation to supporting those with mental health problems. Liaison with a whole range of supportive groups in the community including the 3rd sector, faith groups, schools, family, friends and others is crucial to support the mental health of the community.

4.4.12. the voluntary sector should be recognised and supported by Commissioners, financially and otherwise (a range of voluntary sector organisations can provide help and specialist support; it is essential that this contribution is not stifled by lack of funding from the statutory sector; 3rd sector funders are extra ordinarily resistant to fund that which should they consider should be paid for by the statutory sector)

4.4.13. there should be acceptance of and support for complementary therapies.

4.5. Specialist Services

Our recommendations are that:

4.5.1. there must be training for all professional staff becoming involved with mental health cases across the whole of the Cumbria so that they are aware of the needs of those with unusual conditions

4.5.2. where possible these needs should be met locally.

4.5.3. the specification of local services must ensure that inappropriate care in the local service does result in the deterioration of a Service Users condition with the result that they are then referred out of area (this has been described as the “nightmare situation”).

4.5.4. it should be recognised that access to independent second opinions is crucial to Service Users and their Carers so that there can be assurance that appropriate care is being provided.

4.5.5. there should be recognition that voluntary sector organisations can bring in specialist knowledge to contribute to an individuals care and treatment.

4.5.6. In exceptional circumstances, an out of area placement might be required. Where this happens, clear communication regarding what the local team has been working on with the Service User should be available. it should be clear that they are monitoring progress and working for a return to the local community as soon as possible.

4.5.7. given that existing services south of the Cumbria in Lancaster are seen to be more accessible than Carlisle, the case for *som*e use of these services needs to be reviewed as part of the consultation.

5. Review of process for meetings

5.1. The meetings were set up to ‘sound out’ the views of Cumbria mental health Service Users and Carers on the key elements of the proposed Consultation regarding changes to mental health services for people between teenage and old age.

5.2. The meetings were planned by Cumbria Mental Health Group after discussions with Social Care and PCT Managers from the commissioning prospective, GPs and the Foundation Trust leads. It was decided that the meetings should be lead by the Cumbria Mental Health Group and be of a simple format to allow the

maximum amount of time for participation. A senior clinician from the Foundation Trust would set out the key elements of the proposals, with the rationale and evidence base for the proposals, and the meeting would then be asked to consider a list of questions.

5.3. The meetings were set up in community meeting places. They were advertised by:

- Letter to all Cumbria Partnership NHS Foundation Trust members in the public and Service User and Carer constituencies
- Email circulation via Action for Health to relevant voluntary sector organisations
- Letter to members of South Cumbria Mental Health User and Carer Forum.

5.4. The meetings had an attendance as follows:

Classification of those present	**Barrow**	**Carlisle**	**Kendal**	**Penrith**	**Workington**	**Grand Total**
Service User	3	1	2	1	3	10
Carers	6	6	11	8	2	33
User or Carer	6	9	14	1	8	38
Public		1		1		1
Total of people with direct interest	15	17	27	11	13	82
Voluntary Sector	5	5	5	2	5	22
Faith					1	1
Total form Organisations	5	5	5	2	6	23
Total form Non Stat	20	22	32	13	19	105
GP practices		1				1
Job Centre					1	1
Local Authority Member					1	1
PCT staff		2		2		4
Partnership Trust staff	1				2	3
Total Statutory Staff	1	3	0	2	4	10
Total visitors to meeting	21	25	32	15	23	115
Those present to support						
CMHG	4	2	4	4	4	18
CPT	2	2	2	2	2	10
GP	1	1	1	1		4
PCT	1	1	1	1	1	5
Social Care	1	1	1	1	1	5
Grand Total	30	32	41	24	31	

5.5. The meetings worked well. They were successfully chaired to ensure an atmosphere of independence, combined with a spirit of cooperation and constructive criticism.

The character of each meeting differed considerably, partly due to the different composition of those attending and the differing nature of the relevant or important issues for each area. However, the key conclusions reached were

similar, and differences that did arise were more to do with the varying interests of the people attending.

The meetings were designed to allow joint working between those whose key interest was working age adults and those concerned with older persons' issues. This worked very well. The views of the two groups complemented each other and there were no obvious tensions.

5.6. The records of the meetings are set out by area/Locality in the following sections.

General Conclusion

5.7. Our general conclusion is that the process pursued proved itself highly appropriate and successful, providing a medium for valuable input to the Consultation, and a model for subsequent similar exercises.

Appendix A Schedule of short term issues to be resolved (keyed to area of individual meeting held)

This schedule lists the issues raised about the current operation of the mental health services and social care services in Cumbria. Those attending the meetings expect a response from the providers of mental health and social care services. The statutory sector organisations will be provided with the opportunity to put forward their views and then collaboratively Cumbria Mental Health Group along with representatives from the Trusts and Adult Social Care will develop and monitor an action and implementation plan to address the out standing concerns that have been raised via this process.

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No	Area	Issue	Review of issue	Org to act	Action by	Date proposed	Date complete
1	W	Provide contact + support for carers in cases of out of area hospitalisation. Work for return a.s.a.p					
2	W	Remedy current inequality of existing mental health service provision across county					
3.	W	Remedy gap in community support, esp. make sure someone to talk to/ turn to.					
4.	W	Provide more support in home (1 hour in a day is not enough)					
5	W	Provide better support for carers generally					
6	W	Ensure adequate after care is available now, after discharge from hospital					
7	W	Remedy current lack of support offered after initial consultation with GP and prescription (GPs should know of befriending possibilities, etc).					
8	W	Remedy current Service restriction					

No	Area	Issue	Review of issue	Org to act	Action by	Date proposed	Date complete
		when beds full in Lakeland Ward					
9	W	Cut waiting time for talking therapies					
10	K	Investigate why services are not available as contracted at Lancaster?					
11	K	Expedite necessary changes in medication					
12	K	Ensure GPs adequately informed for emergency situations					
13	K	Address inappropriate practice of Police arresting people and putting them in cells					
14	K	Ensure adequate respite for carers now					
15	K	Provide direct Access to Crisis Teams					
16	K	Provide for follow-up to discharge from hospital					
17	K	Provide clear info to voluntary sector on who does what (commissioning etc)					
18	K	Facilitate transport and support for carers visiting hospital					
19	K	Ensure that urgent appointments available from GPs for mental health issues					
20	K	Rectify lack of OT Support (existing services stepped down)					
21	B	Ensure that trained GP's available 24/7					
22	B	Address situation of care in community no longer being					

No	Area	Issue	Review of issue	Org to act	Action by	Date proposed	Date complete
		available from Cumbria Care					
23	B	Remedy lack of support from CMHT for Service Users who have been referred to them (Months between visits).					
24	B	Remedy existing shortage of dementia beds					
25	B	Arrange to fill gap when CPN not available due to sickness					
26	B	Address problem of Police being called to help because of lack of service					
27	B	Review generally working of CRHTs (alleged not to be working at present)					
28	P	Review in particular length of CRHT stays (stays of only 10 minutes alleged)					
29	P	Ensure consistency of support from CPNs and Consultants					
30	P	Review reasons why so many CPNs off sick					
31	P	Remedy lack of understanding of Mental Health issues by some GPs					
32	P	Address problems of CMHT services suffering because of time taken by CPN's to travel					
33	P	Ensure that Care Programmes followed through					
34	P	Provide support for Carers in crises					
35	P	Avoid Police intervention in crisis unless absolutely					

No	Area	Issue	Review of issue	Org to act	Action by	Date proposed	Date complete
		necessary					
36	P	Arrange for mental Health Specialist GP to be available out of hours					
37	P	Take action to cut waiting time for Psychological services					
38	C	Address problems of CRHT availability when more than one call out of hours					
39	C	Remedy lack of multi skilled staff on wards					
40	C	Indicate plans for assessment unit at Hadrian unit					
41	C	Provide 24 hour help line as promised					
42	C	Stop any use of receptionists for triage					
43	C	Provide for adequate respite for carers					
44	C	Provide more day services					
45	C	Review application of Section 136 service (7 hours wait for assessment; no statement of rights; Section 136 suite not working correctly)					
46	C	Communicate fully what services are available					
47	C	Involve users and carers in training					
48	C	Ensure Ward Staff recognisable and wearing badge as appropriate					
49	C	Limit out of area treatment as far as practicable					
50	C	Review facilities for Autistic Spectrum Patients					
51	C	Provide training for GPs and others on					

No	Area	Issue	Review of issue	Org to act	Action by	Date proposed	Date complete
		OCD					
52	C	Make available independent second opinions					
53	C	Address shortfall in psychological services					
54	K	Take due note of info provided by Carers					
55	B	Address problems of CPNs and others not being available because of stressed staff suffering from mental health problems					
56	C	Prepare care plans where still lacking					
57	C	Cut drastically wait for CBT					
58	C	Abolish use of Passive list for CMHT clients					

Appendix B Record of meeting in Workington Wednesday 27 FEBRAURY 2008

Harry Brown introduced himself and welcomed everyone to the meeting.

Jim Bradley explained the aims of the Cumbria Mental Health Group to the meeting. He then asked for names and addresses of attendees and said this was the first of a series of meetings.

He explained that David Le Mare and Vernon Watson were present and they just wanted to listen to the views of those present today.

The meeting wants to see what users/carers feel about the future of Mental Health care.

Chris Hallewell – Clinical Director/Consultant Psychiatrist for Cumbria Partnership NHS Foundation Trust stressed that people attending today should say anything that they want to say. 'The partnership trust is all about partnership'.

He explained that 3 primary objectives are currently being developed:

1. Crisis Resolution & Home Treatment Teams (CRHT)

Decreasing the number of inpatient beds will be possible if the CRHT becomes more effective and has the appropriate or necessary resources

2. Primary Mental Health Care

Delivered from GP surgeries, primary care will help people with problems such as anxiety and depression and there will be increasing access to psychological therapies developed over the next year.

He explained that it is not possible for the inpatient units to operate in 6 locations as has been the case in Whitehaven, Workington, Carlisle, Kendal, Ulverston, and Barrow.

It is crucial for the safety of both staff and patients to reduce to a smaller number of units. European Working Time Directives (EWTD) will be changing their rules in 2009 and this will mean the legal working hours of Dr's will reduce. In order to provide 24/7 psychiatric support, on call and working arrangements need to be changed.

Proposals for discussion not set in stone. But there are givens.

He divided the county into four - West Cumbria, Carlisle, Furness and South Lakes. All need Crisis Teams each area will have 'crisis beds'. It has not yet been decided where these beds will be. Only 24/7 beds will be in Carlisle (PICU). Acute wards in Carlisle and Furness. The situation in regard to EWTD is not just happening in Cumbria but countrywide.

Q What about patients sent out of county?

A. Should be small in number. Need to develop local services. The Cumbria Mental Health Services have the responsibility to maintain contact.

Q. How are the areas needs assessed?

A. Looking at a combination of factors including geography and needs of the locality will be used for the assessment.

Q. Will that happen?
A. It is happening.

Q. Is it reassessed yearly, how quickly would budgets change?

A. Can see how it should work, not got the sophisticated system.

Q. Allocation of resources, there is major deprivation in West and Furness, shouldn't the crisis wards be there?

A. Pragmatism about where the wards are. Access I accept. Will support this as best it can. Will try to manage folk locally as best we can.

Q. Community Support concerns, someone to talk to, somewhere to turn. NHS not prioritising this.

A. Agree totally. Commissioning becoming more local so GP's have the budget to help sort that out.

Q. Workington Impact things like that need support.

The next step needs to be now.

Q. Echoing what's been said. Voluntary Sector can fill gaps and should be involved.

Margaret Eccles: Good to see mental health services encouraging people to speak out together and meet.

Need support workers - 1 hr. per day is not enough. Vol Sector needs more money.

Q. What happens when you don't have friends or family? There needs to be somebody available for when someone needs to speak.

Harry directed people to work in small groups discussing concerns.

Back after groups. Key points from Groups

- **Should be more support in Community and it is not available. Better support for carers. Quality of service rather than quality of buildings.**

- **Can't discharge people from hospital to home if the services aren't there to support them. No aftercare.**

- **Before care and aftercare both essential. Need immediate help in each/every town. First time had chance to speak to NHS.**

- **Must look at whole picture funding not enough. Sharing and working together – needs to be more**.

VW. Very useful points raised at this meeting.

JB Thanks **to all for coming.**

Flipchart and Post it Notes from Workington Pre consultation Meeting

1) **Is it important that people can be treated in their own homes rather than in a hospital where possible? What are the advantages and disadvantages of receiving treatment in your own home?**

Advantages

Home is best.
Familiarity
Less Travel problems
Less stigma.

Disadvantages

Once initial consultation with GP is completed you are sent home with advice and medication, but you are now alone. Friends and family are probably at work. There is no one to talk to. The doctor ought to have a list of support groups, befriending schemes and be able to give you a telephone number and advice on somewhere you can actually go to.

Isolation
Lack of support
It is essential to have a practical, responsive support service.
Carers need support and respite too.
Backup from professionals when needed

Sending people home is not practical unless adequate resources and finance follows the patient.

2) **At the time of a crisis, are there advantages in expanding teams to assess and then if appropriate support a service user in their own home?**

For this to work there needs to be;

More community matrons.

Access to informed help at home

More crisis teams.

More day care.

More CPN's.

Disadvantages of home treatment;

What happens if a bed is needed and none are available? Lakeland ward is usually full.

General Notes and Comments. Workington cont'd.

West Cumberland should be the centre for services in the Workington area. NOT Carlisle.

More funding is needed for the voluntary sector so they can provide local services. E.g. Dementia Services within the community.

More Health promotion is needed. i.e. Preventative work.

Talking therapies are the flavour of the time, but why does it take 4 – 6 months to access such therapies.

24 hour helpline in Workington gets no support or recognition, yet is part of peoples' care plan.

24 hour Early Intervention and Psychosis

24 Hour C.P.N service

24 Hour Assertive Outreach Teams

Who will provide the crisis beds? Where will they be? Define Crisis Beds.

What happens to functional elderly patients who need beds?

There should be regular unannounced inspections of mental health hospitals.

Need for support from friends to help people to stay well.

24 hour helpline.

For community based care to work well, there needs to be a link person who knows what is going on in the NHS and in the community.

A need for a central contact who knows what is going on. GP surgeries should be the best communication point especially if community groups have picked up someone who needs more help.

Community groups should be willing to work together rather than safeguarding their turf.

Community support groups within each town to interlink with other organisations and offer each other support.

Transport issues. 47% of people in south Workington have no access to private transport.

Praise. 'I would like to say how much the CRHT help and how much better it was to stay at home'. 'Treatment on Yewdale ward was very good.'

Appendix C Record of Kendal meeting Thursday 28 February

Harry welcomed everyone to the meeting.

Jim B. explained the purpose of the meeting.

Today's talking process is about a review of the way mental health services are developed and how monies are allocated Cumbria wide. Involving Service Users/Carers in shaping services is important.

Chris Hallewell gave background on some of the changes already taking place.

1. Improvement in Primary Care Mental Health Services – more provided.
2. Improving access to psychological therapies
3. Health promotion. Healthy living/lifestyle.

These things are not what we are here to talk about today.

The Closer to Home consultations are about what will be happening with regard to the future of inpatient services.

There will be a formal consultation document produced in May.

Today is a general opportunity for people to say what they want. Health Care professionals are here to listen. There are however some givens.

Givens are:

County divided into four West, Carlisle, Furness and South Lakes.

All will have crisis resolution home treatment teams and crisis beds.

24/7 Psychiatric support, inpatient beds for acute and PICU will be in Carlisle.

Jim. Will this apply to older persons?

Chris. Yes

Age not a criteria. Chris said 'How you are treated depends on what is wrong with you, not how old you are'.

2009 things will change (European Work Time Directive?)

(Acuity) to do with complexity of illness.

In general medicine there is a trend towards out of county services? Will this be the case for mental health services?

Very unusual, only for people with specialist needs. This will be a very small number of people.

There was discussion as regards to South Lakes being much closer to Lancaster than Carlisle. So why not go to Lancaster? Closer to home?

Vernon Watson replied - In mental health, the relationship between agencies is critical – need integration between services and providers and community groups. Emphasis on community means that county boundaries are important in establishing good all round care for patients.

No implication that you would necessarily go to Carlisle if you are in S. Lakes.

R. Berry questioned S. Lakes beds. Chris stressed had to go through consultation.

DEMENTIA

South Lakes has a high and increasing proportion of older people so important to plan provision for dementia.

National strategy being written Cumbria is part of implementation.

Lancs Care Trust facing similar challenges to us. Reduction of services in Lancaster may mean relocation of Psychiatric Intensive Care Unit to Preston.

There is a need to keep within organisational boundaries.

Management introduced themselves to the meeting.

Split into groups; the following sets out key points raised on the return from groups:

Need for more training for carers and home care agency staff. Home carers ineffective as real support as they are unqualified in mental health.

Medication changes – time scales too long – once medication has changed the problems a patient has may be different. GP to consultant's communication needs to be more effective.

Holistic therapies – please consider more.

Some kind of funding for carers equally in crisis when comes with mental health problem. Respite in cases of dementia Carers.

Lack of confidence in GP's generally in urgent situations. There needs to be ongoing training for GP's in the area of mental health.

Importance of hospitals difficulty of access to hospital when felt it was needed.
Preparing for discharge
Holistic view of care for individual

Inappropriate imprisonment. Discussion about the Women's Institute Campaign.

Discussion about the relationship between the PCT and the Partnership Trust. Jim Bradley and Chris Hallewell explained this relationship.

Notes taken from working groups

Funding

Is funding that went toward older adults going there still now the dementia wards have closed at WGH?

Can we be certain that fundings are supplied across the age range.

Fund needed for carers in crisis.

Language and Jargon

Constantly changing jargon can confuse and stigmatise.

Training to support MH needs

Are all those interacting with people with MH problems adequately trained e.g. GP's, support, social workers and carers and prof carers, crisis team, Baycall.

Who will train the specialist care staff to work with people at home.

Standardising and monitoring the quality of care both in and out of hospital.

Inpatient services

Are there enough crisis beds in the area? Have we actually lost beds? Police arresting people and putting them in cell.

Hospital extremely important, how can users/carers access inpatient care? Emphasis on care in the community valuable but must be supported by hospital care when needed. Respite beds for mental health patients essential.

Direct access to Crisis Team essential – both carers and users need to be able to access CRHT immediately when necessary.

Must be better preparation for discharge, both for users and for carers, and follow up support **must** happen. This is currently variable.

Miscellaneous

Is carer support lost even if legally responsible?

Can people be asked to join 'voluntary help' bodies.

Respite for carers.

Look beyond the label!

Response from service users, carers, 3rd sector providers, and their input into commissioning/shaping of services, would be greatly facilitated if they could be provided with clear information about different professional bodies involved - e.g. who are the PCT, Foundation Trust, Adult Social Care, and what are the relationships between them? Where and when can people input into processes?

Institutional aspect of 'full range mental hospitals' usually negate therapeutic advantages.

Inappropriate prison use.

Research into causes of mental health problems needed, as well as treatment and responses.

Support Infrastructures

24/7 support for carers as well as users?

Transport and other elements of infrastructure needs to be in place if care spread countywide.

GPs and Hospitals

Medication adjustment often does not happen in time to meet immediate need – how can communication between these agencies be improved?

If GPs first point of contact, need to ensure that clients can get appointments immediately when needed.

Treatments

Need for ongoing critical reviews of medication regimes.

Complementary therapies

Need for a more holistic approach and a place for complementary therapies.

CBT now being promoted as talking therapy where when and how is this going to be put in place?

OT support in and out of hospital: Is there enough?

Home based treatment really important.

Need for whole person approach to factor in social circumstances and respond to all of a person's needs

Appendix D Record of Barrow meeting Monday 3 March

Harry Brown welcomed everyone to the meeting.

Jim Bradley then briefly described the intentions of the meetings taking place throughout Cumbria before handing over to Chris Hallewell.

Chris emphasised to the meeting that it was their opportunity today to speak and make their views felt.

Consultation somewhat limited. Most speak about inpatient services. Dev of 24/7 CRHT arrived in Furness very recently. Described the county in the familiar format.

Q. Where will the crisis beds be located.
A. not yet defined. PICU in Carlisle will have 10 beds.

Public: Not even coverage.

Chris: No, not what we would have chosen.

Public: Has The security, safety and confidence of patients been considered in this?

Chris: We need to make sure at discharge that links are safe and sound to your home.

Public: No 24/7 doctors what does that mean, none at all or no GPs.

Jim advised on questions to ask.

Public: Does it have to happen?

Chris: At any time there are any 80/90 Cumbrians . . . If in S. Cumbria you are more likely to have to travel greater distance for treatment.

Chris is saying if people are safe and secure then they system will work better.

Public: Quality of care is a concern

Today's technology should wipe out the distance issues.

Public: Is it the aim for acute beds in Carlisle and Barrow to cover all needs in Cumbria?

Chris: Not always – determining outside issues.

<u>Doctor situation</u>

9 – 5 team at Night. Local GP practice to cover ALWAYS A LOCAL GP ON CALL

Partnership Trust Manager: Important to see range of services complement each other in conjunction with proposals.

Split into Groups.

Jim B.: Report on each community feelings in Mental Health issues. Report influential on consultation document which will happen beginning May.

Vernon: What will happen in the next year or so.

Public: Till last year Trust had own carers. Split up last July can we have them back. Need to sort at base of triangle. Care in community not right therefore won't get top of triangle correct.

David LM: Services should be there and be available.

Lady: Home Care support Services lost. CPN's, psychiatrists, Carers all within three months. Want back what we had.

Jim Fraser: Will pick up personally, County Council contracts with private co's Need to get right at the base.

Group 2: Communication groups to work together in future.

Ged e: How much say will carer have in decision making in treatment?

Chris H: Decision will always consider carer. Carers will be heard.

How many crisis beds?

South Cumbria/Furness 30 beds acute/crisis.

PICU
Acute
Crisis – everywhere but may have to travel to next area of care.

Dementia – beds decreasing/numbers increasing.

Numbers Chris describes exclude dementia patients.

CPN/Social Worker roles – care co-ordinator.

Notes by Group One

- Safe and secure care
- Continuity of same care
- Health and social care
- Crisis teams are not working
- How much of the Carers voice is heard in the process?
- More explanation should be given to the patient
- Assessment – (no other comment to explain this)
- Mental Health worker needs to be attached to G.P's
- G.P's need to help with stage above low level anxiety /depression – moderate to severe
- Involvement of the voluntary sector – with the correct training

- Communication – between groups
- Carer involvement in decisions
- Improving access to group therapies – very good e.g. REACT
- Long term needs and loss of skills of those in inpatient care for a long time to help them to readjust into the community
- Smoother process of re integrating with the community and orientation

Notes by Group Two

- Every mental health patient needs a CPN – not only a Social Worker
- Won't accept either a CPN or Social Worker, must be a CPN – Social Worker is an extra
- If you want to stop people needing to go to hospital it is vital that care at the bottom layer (people with non-severe problems) is excellent
- More trained people
- Access to a different trained person if CPN is unavailable (off sick, etc)
- More support workers
- Too much money at the acute/crisis end of the triangle, and far too little at the lower end
- It should be simple and easy for both carers and users to access the appropriate help – it's complicated and difficult at the moment
- Mental health patients are all very different people – they're often lumped together in the system because they have got the same label – e.g. depression dementia, etc.
- Too much reliance on medication, other therapies should be tried particularly talking therapies
- The barriers to getting help often mean that Police have to be called because it's the only avenue left to access help – **Need better system**
- Carers need a support system which means access to respite care, etc. Family carers get older and exhausted and can become ill too
- Proper 'care in the community' should be in place. This will help prevent the yo-yo effect of people going in and out of hospital

- There needs to be resources in place to support users and carers in the period of transition from now to what is envisaged for the future

- In order to get support now, needs have to be greater than they used to be, therefore lots of people are left alone and become more ill

- If crisis and acute beds are in the same place and are all full of acute patients, what happens when there is a crisis which can't be dealt with in the community?

- Why do mental health service users have to have either a CPN or a Social Worker? Their skills are complementary but not the same, all need a CPN

- Concerned that acute beds and crisis beds are the same. What happens if crisis occurs which can't be managed in the community if the beds are full?

- CRHT's are not working at present – need to be referred and teams are too small – it's a long way to Carlisle in an emergency

Appendix E Record of Penrith Meeting Tuesday 4 March

Harry Brown welcomed everybody to the meeting.

Jim Bradley outlined the need for local forums countywide and explained how the Cumbria Mental Health Group would be taking this forward by creating local forums Cumbria wide.

This process of involvement has, he said, been accepted by the statutory sector.

Janice O'Hare introduced herself and explained her background in Mental Health.

She said that she was here today to convey the proposals that have been put forward for consultation concerning the future of inpatient mental health services in Cumbria. 'We are here today to listen; we really want you to get involved."

We want to make sure that local citizens have access to services that are as close to home as is possible. 'We know that it is not the right thing to take people into hospital if it can be avoided.' She explained that there is a wealth of research that supports this idea.

Care will be focused on the recovery of the individual. If patients need to be admitted it should only be for a very short time. However other needs, such as that of the Carer and of other complicating factors will of course be taken into consideration. This is really important. But the vast majority of cases will not need inpatient care.

24/7 access to Crisis Resolution & Home Treatment Teams has been successfully implemented in the north of Cumbria and is now available in the south as well.

Venetia Young at this point expressed her view that community based approaches are crucial in securing recovery for patients. She said that inpatient services can create a psychiatric version of MRSA, that is, loss of skills, alienation from society etc.

Janice continued to explain that inpatient services are not necessarily conducive to the recovery of patients. Hospital environments are often hostile and not best suited to mental health patients. For this reason the provision of crisis beds in each locality will be considered carefully.

Janice carefully explained the model of proposed inpatient care across Cumbria. She explained the legal requirements for things to be changed in light of the time that Dr's are allowed to work, she explained the European Working Time Directive. Safety and security of both Service Users and staff is crucial and for this reason it is impossible for services to continue as they have been.

24/7 access to CRHT will exist across Cumbria.

Acute wards will be in both Furness and Carlisle.

PICU unit will be in Carlisle only – this is for a very small number of patients.

At the moment people can be sent a distance away from home for treatment. The proposed changes are intended to reduce the need for this to happen and to ensure that people where possible will not have to go out of county for care.

Dementia - Organic Units exist to provide a period of assessment where the needs of individual Service Users can be assessed. Complicating physical and social factors will be taken into account before placement elsewhere

Time for questions and comments from the floor.

Comment from Carer;

The efficacy of the Crisis Resolution & Home Treatment Team is questionable. They [CRHT workers] may travel large distances and then only stay for10 minutes.

Comment from Carer;

Level of consistency of CPN's/Psychiatrists is an issue for Service Users' recovery.

R. In the case of Psychiatry the previous model of Psychiatrists having an enormous caseload [300] of routine checks proved to be ineffective and ultimately not targeting the expertise of the Psychiatrist. Therefore, a system that allows patients to be seen according to their need, is far preferable.

Comment about Dementia

There are a growing number of people with Dementia in Cumbria and due to the percentage of ageing people within Cumbria, the prediction is that by 2020 the amount will be significantly higher than present.

Daniel Scheffer, Deputy Director of Mental Health from Foundation Trust commented that the small number of assessment beds [Dementia] does not indicate that other services are not available.

Continuity of care is really important. It would be good if [Service Users] had someone who could see them through their mental health journey.

Continuity of CPN's. Why are so many off sick? Why is there no contingency for this event provided for? It can mean a huge delay and lack of consistency for Service Users.

There is a lack of understanding of mental health problems among G.P's.

R. Jim Hacking, Paul Wigmore and Venetia Young are G.P's who are concerned with this [mental health] area.

Transport issues for remote areas.

Training of G.P's on Mental Health to improve out of hour's service.

R: CueDoc/Baycall is available as out of hours G.P's

Workshop on Consultation.

Flipchart.

Flip Chart Notes from Penrith

Comments, ideas and questions concerning the Closer to Home proposals.

Continuity of care is really important for those with mental health problems.

Psychiatric units should be safe, with separate male and female areas.

The environment should be light and airy.

Dementia – More support for Carers and opportunity for respite.
Growth in number of people with dementia should be reflected in support available.

Closer to home support.

It would be good to have someone who travels through the journey with a service user. I.e. continuity, familiarity and understanding. Like Macmillan nursing.

CPN's based in GP practices.

Focus on GP practice as a community resource for support and information

More training for G.P's in mental health issues.

More support from GP's

Need to give hope.

Improve quality of life of Service Users

Care should be patient centred, everyone is different.

Reduced beds to balance with community services.

More resources should focus on community services.

Prevention before crisis

Could someone stay with Carer to support them in a crisis?

Could Carers have accommodation near to Psychiatric unit if far away from home?

- Issue of police involvement in crisis situations out of hours. Not suitable in cases where an individual may flee or feel scared/intimidated.

Availability of doctors with a mental health specialism out of hours. Not just the on call psychiatrist through CueDoc.

Accessibility to hospitals in remote areas. Transport issues specific to Cumbria.

Will there be enough beds for those who need them if beds are being reduced?

Carers and Service Users should be aware of what is reasonable to expect in terms of care and support.

Communication and continuity is key.

CPN's ought to call in advance to let their clients know that they are still coming.

Support in Community CBT
Family Therapy

Waiting time for CBT, talking therapy needed there and than.

Extra services what is actually happening now?
And in future
More funding coming?

Choices in care

Home - want to be in hospital
Therapies
Broader than psychology and medicine

Express things in language Service Users and Carers can understand

Travelling long distances to beds. Carer to be able to stay over night

Appendix F Record of Carlisle meeting Wednesday 5 March

Harry Brown welcomed everybody to the meeting.

Jim Bradley outlined the need for local forums countywide and explained how the Cumbria Mental Health Group would be taking this forward by creating local forums Cumbria wide.

This process of involvement has, he said, been accepted by the statutory sector.

Janice O'Hare introduced herself and explained her background in Mental Health.

She said that she was here today to convey the proposals that have been put forward for consultation concerning the future of inpatient mental health services in Cumbria. 'We are here today to listen; we really want you to get involved."

We want to make sure that local citizens have access to services that are as close to home as is possible. 'We know that it is not the right thing to take people into hospital if it can be avoided.' She explained that there is a wealth of research that supports this idea.

Care will be focused on the recovery of the individual. If patients need to be admitted it should only be for a very short time. However other needs, such as that of the Carer and of other complicating factors will of course be taken into consideration. This is really important. But the vast majority of cases will not need inpatient care.

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Janice continued to explain that inpatient services are not necessarily conducive to the recovery of patients. Hospital environments are often hostile and not best suited to mental health patients. For this reason the provision of crisis beds in each locality will be considered carefully.

Janice carefully explained the model of proposed inpatient care across Cumbria. She explained the legal requirements for things to be changed in light of the time that Dr's are allowed to work, she explained the European Working Time Directive. Safety and security of both Service Users and staff is crucial and for this reason it is impossible for services to continue as they have been.

Vast majority of people with mental health problems recover, get better and move on

Crisis beds who provides them? not necessarily NHS.

Older patients - issue of recovery. And support
24/7 access to CRHT will exist across Cumbria.
Safety

Acute wards will be in both Furness and Carlisle.

PICU unit will be in Carlisle only – this is for a very small number of patients.

South Cumbrian citizens that require access to PICU currently go to Lancaster, however a bed is not always available and so out of county services are required at times. Would be Carlisle in future.

At the moment people can be sent a distance away from home for treatment. The proposed changes are intended to reduce the need for this to happen and to ensure that people where possible will not have to go out of county for care.

Dementia - Organic Units will exist to provide a period of assessment where the needs of individual Service Users can be assessed. Complicating physical and social factors will be taken into account before placement elsewhere

Questions from the floor

At which units will it be possible to provide 1 to 1 nursing and observation?

JOH implied that this would only be possible at the 2 acute units for reasons of safety of Service Users and staff members.
Issue for people who are suicidal.

- **Dementia issues** **recovery not possible**
  Stress in home
  Respite needed
- **CRHT** **night time cover to be able to for several events at once**
- **In hospital mulit-skilled teams needed, there is a lack of this now**
  they are needed
- **Hadrian Unit at Carlton Clinic was going to have a 5 bedded assessment unit- what happened to those plans?**
- **There is a gulf between the theory of what is promised to happen and what actually happens. Impact of funding available.**
- **Neither hospital nor home the right place to support a Service User. "Half way house" needed. There has been a lot of work done on this issue in previous plans.**
- **No joined up thinking between health and social care**
- **Difference between what is said and what is done**
- **24 hour help line has been promised but not happened**
  - **Access to CRHT only available if recognised person. Difficult for Carers often do not get the number.**
  - **Help line should if necessary lead to action**
  - **Also able to signpost to right contact: not CueDoc**
  - **Able to contact CRHT team**
  - **24 help line should allow supportive discussion.**
  - **Be available for both Service User and Carer.**
  - **Receptionist doing "triage" of concern**
  - **Crisis prevention**
  - **Clarify what can happen at night.**
- **Not every one will fully recover. What support is there for them?**
- **What is happening to the number of beds?**

- **Respite needed**

- **Day services**
  - **Not enough**
  - **Service Users living isolated lives**
  - **What if no Carer (now or when Carers die)**

- **Section 136 (Service User brought in by police)**
  - **Held in interview room at Carlton Clinic of 7-9 hours without assessment**
  - **Need to know rights information**
  - **Section 136 suite not working in satisfactory manner**
  - **CHESS (Care Home education support service) across Cumbria. Support in actual home important.**

- **Communication about what is available**

- **Managers to demonstrate that they think things through from the Service User and Carer prospective**

- **Service User and Carer to be involved in training**

- **'Them and us' attitude**

- **Demonstrate that inter linking of all is working in partnership including Service Users and Carers**

- **Very frustrated that things have been said before but not dealt with**

- **Staff to wear badges (Service Users to know who are staff) uniform or other form of recognition**

- **Out of Area treatment, the biggest nightmare**

- **What facilities for autistic spectrum patients**
  - **Social care are building some units**

- **OCD explain to GP's. Carer had to bring knowledge to GP. Also had to go all over country to get help**

- **Second Opinions. Very important to get genuine second opinion outside of direct team involved.**

- **More money required for psychological services**

- **Partnership between GP's and Partnership Trust**

- **CBT should be available within GP practices**

Appendix G Contributions received after the meetings

G1) Carer from Ambleside

Suitable respite for younger people with dementia. My husband was diagnosed with Alzheimer's at the age of 51, he is now 62, because of the cost involved, no one will fund a 2 week respite. Do I have to have a break down first?

G2) From Ulverston

1. aim to provide a quality service, building on any proven good practice and ensuring any new or amended provision is embedded in a cohesive manner across the county.

2. Current gaps in provision must be accepted and addressed.

3. Co-ordinated education and development training programmes to be integrated throughout any changes across the count6y.

4. Co-ordination and real consultation (not to ???) in managing the provision with equal fair and corporate monitoring and reviewing at regular intervals.

Chris Hallewell's example triangle – bottom portion needs to support the rest.

G3) A CP Trust Member Windermere

Is this anything more than a cost-saving exercise? One feels that a pitifully small pot has been allocated and justifications are being sought.

Just as the group I was in barely, if at all, attempted to answer these questions – I'm afraid, I too have to ignore them because I think they are too broad: (there's no such thing as the mental health community). There are patients with vastly differing and complex needs and it's a great pity/shame that the NHS can't/won't allocate trained specialists to assess and treat them in sufficient numbers. It's not as if we live in a society where stress is diminishing after all. 'Care in the Community' pre-supposes that society is as cohesive and supportive as it once was.

What/if any/ attention has been paid (in the overall allocation of funcs) to the fact that south Lakes and Furness have large influxes of visitors? This was given as a reason why a particular patient should be transferred back to their own area from a Furness Psychiatric ward. (Reason prevailed in the end). Why is mental health such a poor relation?

It seems easily unsatisfactory to have the mental health community referred to as if it were one entity. Clearly there are enormous differences between congenital defects, mental disease or crisis affecting young and middle aged adults, and degenerative conditions affecting the elderly, Can it, should it, just be considered as a demographic or even geographic issue?

Just as the 'group' on Feb 28th questioned the general expertise of GP's in this field, surely 6 psychiatrists for 500,000 people cannot be expected to cover the range of specialism needed, or the volume of cases!

G4) A Carer from Kendal

I am a carer whose husband has MS and dementia.

Twice in the last few years he has been admitted to general wards, where, on admission, I have explained his care needs to the nurse but this information has not been heeded.

How can the mental health services influence and educate their general colleagues in how to care for people who cannot do for themselves what is needed or ask for help?

G5) From Troutbeck near Windermere

The following thoughts are gained from my own experiences.

A. Experience as a Carer for my aunt. Alzheimer's Disease

Care in her home was of utmost importance in the early stages. Co-ordination with GP, Consultant Psychiatrist and CPN at Kendal Hospital, Social Services (Care Manager) and Care workers very important.

- Care workers need to be trained to a higher level and paid accordingly.

The Alzheimer's Society (Benson Green Day Centre, Kendal) proved to be a valuable centre for appropriate stimulating activities. In some Care/Nursing homes, placing the patients in front of a very loud TV seems to be one of the few activities offered!

- More use of trained volunteers alongside better trained carers in Care Homes and Nursing Homes to stimulate patients e.g. reading, writing, jigsaw puzzles, crosswords, listening to music etc.
- As Alzheimer's disease is a medical condition why is it not recognised by the NHS as such until the condition deteriorates?

(My aunt had 18 months care in a locked ward in a care home paying full fees. It was not until she had strokes adding to her incapacity that she was transferred to a Nursing home and nursing fees are now covered by the NHS.)

G6) Experience of my son's Depressive illness. Age 30. San Francisco, USA

Psychiatric Consultations =

1. Drug treatment where necessary, with very regular reviews at first.
2. 2. Cognitive therapy (counselling, talking and listening etc.)
3. Exercise.

These were all used to help in his recovery.

- Chris Hallewell talked about this approach in his introduction but no one in my group seemed to relate to what I was saying when I mentioned the above. It is very important to provide or at lease encourage all three.
- Increased training in psychiatric care for GP's in the region.
- More localisation of services at Health Centres – G.P's, Social Services, Midwives, Health Visitors, Physio's, OT's and CPN etc.

G7) From Kendal

I did find the meeting very confusing at times.

1. The officials, apart from Dr. Hallewell, did not properly introduce themselves and their roles.

2. The questions to be considered were all geared towards keeping the Services User at home.

3. No provision or even mention of the Carer who had often been coping for long periods before asking for help.

4. The members of the crisis team have often insufficient training to help.

5. Short respite care on a regular basis important in longstanding illness (e.g. dementia)

6. GP should be first choice fore requesting help

7. Continuity of follow up is important by same provider who knows the case.

8. Too many chiefs and not enough braves!!!

G8) Anonymous

1. It is important for treatment to be from a home base.

2. Institutional aspect of Full range of mental hospitals usually negates therapeutic advantages.

G9) From Kendal

1. Prior to the Cumbria Mental Health Group meeting held at the Kendal Leisure Centre on 28 Feb I had not appreciated how closely the Mental Health and Dementia Groups were to be integrated. The two specialised areas are sufficiently complex and large enough to warrant their own specialists and staff. I feel sure that the proposed closer integration can only mean that both groups will suffer due to the clash of priorities and limited resources.

At the meeting the role of the care coordinators was described, if this role were expected to cover both Mental Health and Dementia cases then it would appear to bean almost impossible task.

2. The need for improved training of the 'paid for carers' was highlighted at the meeting . Unless the NHS and Social Services Groups decide to take greater responsibility for ensuring that adequate training is in place and that good conditions of employment are observed for Agency staff then the present situation will continue to apply.

3. There are many organisations and groups of people involved in the caring of Mental Health and Dementia patients in the community, e.g.

The NHS specialist Units
The NHS Day Care Units
The GP's practices
The District Nurses
The Intermediate Care Units

The Adult Social Care Organisation
The Local Authority Social Workers
The Paid for Carers, both Local Authority and Agency
The charitable organisations – Mental Health Forum, Alzheimer's Society, Age Concern, Help the Aged etc. etc.
The charitable Day Centres
The Volunteer organisation s
The users of the services
The home and family Carers.
Etc, etc.

There is a wealth of goodwill and experience in all of the above, but little co-ordination between many of the groups to harness these attributes. Additional efforts are required to enable learning to take place associated with good working practice.

G10) From Barrow in Furness

Sent: 04 March 2008 12:10 To: Jim Bradley

Subject: Ideas after yesterday meeting

Hi Jim,

Thelma and I were talking last night. It is imperative to get the base of the larger triangle right and as yet this hasn't been achieved. In fact the CPN's, social workers, support workers ,and care workers etc are really being effected by what is going on. They are suffering stress, depression etc, which are mental health problems. The outcome is that rather than reduce the numbers with mental health problems they are in fact increasing them. Many of these staff feel that they are unable to give the support to their patients that they deserve which leads to total frustration from both sides of the coin. This can only be stopped by(a) better in-house communication, (b) by ensuring that there are sufficient staff to cover for holidays, sickness etc without expecting people with full work loads to take on additional work. Failing to do this will mean that the existing problems of people not being properly cared for will continue. Please include this in your representative document.

G11) From Grange over Sands

N 11/03/2008

To Cumbria Mental Health Group,

Firstly, I welcome the approach of pre-consultation prior to submitting the report. It would have been helpful if more time could have been allowed for debate and response on the questions posed to the discussion group. However, I offer some thoughts for your consideration.

1. Abolish the word 'crisis' in mental health – it is offensive and an affront to those it is trying to describe. This melodramatic language is not used in general medicine so why is it used in mental health? Crisis teams could be renamed 'restoration teams' for instance (Oxford Dictionary definition of restoration – doctrine that all men will ultimately be restored to happiness in the future). That surely is what all concerned with mental health work are trying to achieve and it has a positive sounding approach. I am given to understand that the word crisis in mental health was adopted from 'the top'. We do not have to use it. Changing language and titles is a no cost exercise.

2. Establish a strong philosophy and working practice to keep service users in the community with care managers calling on whatever resources are necessary across all disciplines to support the users and their carers.

   Exporting and warehousing mental health problems to institutional care detaches their client from their family and community and institutionalises them. In many cases it creates a dependency which mitigates against independence. Also, it detaches clients from family, friends and community and this can create problems of reattachment.

   In order to implement such a philosophy will require commitments from all disciplines involved with care, not just mental health services. Once this is achieved a strong multi-disciplinary training package should be put in place to ensure staff attitudes and understanding encompasses the philosophy.

   A fundamental question should be – why can't the service user be maintained at home? A written multi-disciplinary statement outlining reasons why this cannot be achieved should be made.

   Do not remove people to institutional care to satisfy the demand of 'something's got to be done'.

   Peripatetic, specialist services is preferable to removing a Service User 90 miles to Carlisle - keep services local.

3. Establish a strong support service for Carers. They are often front line providers in mental health work and this needs full funding and recognition.

4. Work towards establishing a specialist mental health GP in every practice.

5. Establish a training team to assist Carers, staff and volunteers in gaining a greater understanding of mental health issues and possible outcomes.

6. Establish a public relations team to heighten awareness of mental health problems for Cumbrian communities. Fear of mental illness still exists because of the lack of understanding.

7. Ensure the Psychological services are brought under the control and management of mental health services. A stop is needed immediately to the game playing on contractual arrangements and creating long waiting lists.

8. Work towards establishing proactive services to help people in the early stages of illness rather than reactive services. Early detection and treatment may help avoid people becoming very ill and is likely to be more cost effective.

9. Monitor outcome of service delivery to ensure an effective service is being provided.

10. Appoint a worker to monitor and conduct research. Ensure this is well publicised and is available to all engaged in caring for people.

I trust these thoughts may be helpful even if a little provocative in moving the mental health service for people in Cumbria forward. I would welcome a copy of the report in response please.

G12) From an Attendee

1. Is it important that people can be treated in their own home rather than in a hospital when ever possible? What are the advantages and disadvantages of receiving treatment in your own home?

Advantages- familiarity of home, no distress at seeing other people ill, no inconvenience, safer and secure in your own home. Easier on family members (this can be advantage or disadvantage). All your own belongings around you, no need to be without things like home comforts. Not as much stigma, not marginalised as much as when given the stigma of a stay in a "mental ward". Staying at home may increase inclusion, not missing out on things and events because in hospital.

Disadvantages-when very anxious , people need a lot of attention-currently the CRHT do not provide intensive support. Can be very stressful for family members if person is at home-particularly if not a lot of support being offered from outside services. May still spend long periods alone. If visits form CRHT are limited, long periods may be spent alone, in bed, without eating etc with nobody to monitor.

2. At the time of a crisis, are there advantages in expanding teams to assess and then if appropriate support a service user in their own home? The objective being that if at all possible the service user does not need to go to hospital

Currently CRHT do not offer Home Treatment (in my opinion), they limit time spent wit h people, they rely on phone contact and they hide behind the Referral procedures and A&E. Especially when people are known to them it is not acceptable to ask people to go to A&E where they can sit in distress whilst waiting for the CRHT. The objective should not be just to stop hospital admissions but to ensure home treatment in place of hospital. It is not enough to tell somebody who is seriously ill or in crisis to go to A&E or to phone the Police (My recent experiences), neither is it acceptable to come out give a pill and go before the effects have taken place, still leaving a service user very distressed and placing extra burden on the family member. (Jim-these refer to recent personal experiences I am happy to expand on). Neither is it acceptable to tell a Service User they should not be on there own and to phone their daughter!!!

3. What are the advantages and disadvantages of mental hospitals which have the full range of expertise to enable someone very ill to start to recover?

They offer respite and intensive support when needed. They offer safety and security when people are so terrified by their thoughts and experiences nothing else will reassure them. They offer more one to one support for intensive periods.

4. Do you think that accommodation needed at a time of a mental health crisis is best provided within a hospital or would it be better within the community? What are the pros and cons of these options?

Hospitals still come with stigmas and discrimination and hold a lot of fear for people especially at times of paranoia and psychosis. Community support is much better where appropriate but would need to much improved on what currently is offered.

The CRHT does not step up to the mark and could work so much better if it did what it says in the title-Resolves Crisis and Treats at Home. The referral process between CMHT and A&E and CRHT needs to flow much better and they need to acknowledge they are all working towards the same goal. It's fractured and disjointed at the moment and this leads to poor responses for people at times of crisis.

5. What help is needed locally to support those with mental health needs?

   Would this be best available from a GP's surgery?

   Amongst others-GP's surgeries are hit and miss, like schools you might go to a good one or you might get a poor service-again there needs to be an across the board response from GP's if they are going to address MH problems in the community. There is a real need for greater awareness from GP surgeries as to the options available to them in the community. This includes a greater understanding of what 3rd sector groups can do. It's not enough for GP's to say-speak to the Crisis Team for the person in crisis to be told-you can't phone us you're not open to us! The whole system needs to work more to one goal rather than in their own little pockets.

6. In looking at services for all people from teenage years to old age what differences are needed depending on someone's age.

There needs to be some acknowledgement that people's needs are different depending on age and that vulnerabilities change with age. Reducing beds means that it is more likely if people are ill to the point of hospital admission they will be sharing wards with somebody of a very different age to themselves. Reduction in beds means it is less easy to have different hospital based services for different ages. This will be where community services must come into play. Services that acknowledge age as well as other difference and gear recovery to individuals.

Older adults may not have as much support at home, are more likely to live alone and are more likely to suffer from social isolation so treatment may be about increasing social links and offering home support. They may also be reliant on older Carers and need a lot more support to offer respite to Carers.

Young people may be working or hoping to work and may have different social networks-they may be less likely to want intensive support, wanting to keep their social networks up and avoid time off work etc. The support they need may have to be geared towards work and occupation.

Community Teams need to look beyond just medical interventions and look at the bigger picture, the holistic picture and be prepared to accept the help and input from other groups. I don't think they currently do that.

G13) From Carlisle

I still have concerns about care in the community and now into closer to home.

Both care in the community and closer to home seem to arise from a shortage of funds in the Dept. of Health. Budgets have been starved for many years now - begun with the Conservatives Governments abandonment of Public Ownership. This poured most funds into private companies, share holders etc. I realise that we have to live in the present, and cannot return to the original ideas. However health care, a basic tenet of Labour thinking, needs two or three times the current funding. Care outside Mental Health services involves putting the weight of care onto the shoulders of the public

On the questions

1. treatment in own home

   Why? Good for person, bad for community

2. Crisis care to avoid hospital

   What is "own home" to you, unlimited teams would be needed.

3. Advantages of mental hospitals

   Available psychiatric staff and source of medication may be impersonal.

4. accommodation in hospital or community
   In hospital all services can be applied to find psychosis. In community services may be too distant.

5. Help in community

   From CMHTs not best in GP surgery

6. differences in services for different ages

   Fix services to cover age groups. Even then a child can be old and an elderly person youthful.

G14) Case of obsessive compulsion disorder

No care plan for several years

CBT 4 years ago.

Long wait for psychological appointment. Psychologist did not understand case of OCD. Not empathetic, no understanding a brick wall

Person discharged

G15) From a Carlisle Carer

Develop concept of “half way houses” for people who need to feel safe and talk to staff – but not talk to Carers who maybe need a break and cannot cope. These houses need to be staffed 24/7 and are a type of respite.

Shorten waiting list DRASTICALLY for CBT

Definitely stop this Passive list and always involve service User and Carer if this is suggested, giving them the choice to go with it or not.

Develop much further the use of Service Users and Carers in staff training. Help staff to understand just what its like on the coal face.

1. treatment in own home

   Depends on whether or not they are living with their carers and if those carers can cope.

2. Crisis care to avoid hospital

   Hospital is an absolute necessity for Service Users and Carers at times of crisis. Space to recover for carers is a must, and feels that user is safe.

3. Advantages of mental hospitals

   Again a necessity, cannot see disadvantages

4. accommodation in hospital or community

   Hospital every time

5. Help in community

   Day services - not “just drop in” but company and things of interest to do, 7 days a week and bank holidays.

   Best in central location

6. differences in services for different ages

Thinking of day services, teenagers and young people need more action packed activities but they need to feel motivated to be involved in these. Isolation is such a major problem – if there were day services of quality the users would enjoy going and become more involved with others. Evening meals out, cinema trips, football matches, etc would involve people of all ages and help them

G16) From Carlisle Carer

I am concerned about the issue of placing Service User on a “passive” list. This means that they will no longer have a regular visit from a CPN. I see this as way of cutting costs, which may not be cost effective in the long term. The CPN visit is an important contact and support for carers as well as Service Users, when the Carer can raise any concerns with the CPN on an informal basis.

Also, regarding the partnerships emphasis on Recovery, whereas carers would applaud this, there should also be recognition , of the fact that in many cases, full and lasting total recovery is never achieved. Some service users will need to stay in the system to some degree for the rest of their lives.

Pressure should not be applied to discharge prematurely to meet targets.

The fact that Carlisle with by far the largest density of population, has no crisis beds should be rectified as a matter of urgency.

Carer of someone in remote forensic hospital

Concerned about major problems of visiting, and lack of interest and support of local Mental Health Services to work for return of patient to Cumbria.

G17) Resident from Barrow

1. treatment in own home

   Yes home environment can be reshaped for support.

2. Crisis care to avoid hospital

   Yes

3. Advantages of mental hospitals

   Disadvantages in Cumbria are Carlisle’s leadership role remote for majority of county.

4. accommodation in hospital or community

   Hospital best, but escalation of symptoms causes patients to move away from home base. Better if interest to exploit for current care needs with in localities.

5. Help in community

   GP’s least able to apply themselves to long term health needs of mental ill, it would be better if dedicated specialists could devote their efforts to mentally ill, allowing GP’s to put more effort into general medicine.

6. differences in services for different ages

Age always problematic in mental illness, as long as symptoms continue long term. Disabled Travel (Disabled Rail Card), Route 66 Coach cards, Now Cards - all impact age compared to youth, where stamina less. Tenancy regulations bear upon people of different ages, in a way that disadvantages age. Housing benefit not payable direct is needless.

G18) A contribution

There's an urgent need for a residential THERAPEUTIC centre for people in distress who are not a threat and not addicted to drink or drugs. A "low arousal" unit for intensive work which could prevent crisis and improve quality of life. Needs to be combined with out reach services.

From Kendal

CVT at Botton Village in Danby Dale North Yorkshire, a charity that has developed since the 1930's and offers a working environment on several farms and workshops of all kinds.

The mentally handicapped people who live there, male and female of all ages are allowed to try out work to suit them best. Nobody is paid, not even the tutors and mentors, they work to make money for the charity (themselves) to live in harmony.

It is a wonderful, prosperous happy venture that has spread country and now world wide. (See Brochure) It costs nothing to the county. (For the physically capable only)

G19) From Kendal

Number of crisis beds in South Lakes too few, so police have to arrest and put in cell, need respite beds for mental health patients.

Medication – value other therapies, look at what is on offer.

Inappropriate prison use.

Care in hospital needs to be near home

Why is Alzheimer's/ Dementia pot of money a small appendage – not part of general filter of funds. Funds needed for carers in Crisis.

G20) From Grange over Sands

I am concerned that CAUSES of depression and emotional turmoil is not really investigated.

Check out the 3 P's

Pollution (toxins/ chemicals/ mercury etc)

Parasites (steal O2, nutrients and pollute the body – can proliferate in many organs such as liver. Heart, brain etc. They love an acidic environment)

Ph (we should be alkaline at a cellular level and not acidic)

Self esteem issues are important. Watch the DVD called "The Secret" it is very empowering. We have all been disempowered in many ways.

Treatment obviously should be connected to de-toxing the body, correcting PH balances and zapping parasites. Rife Machine/ Dr Hilda Clark electrical sapper. Also full range of holistic therapies should be available from colour/small animal/ art/ massage/meditation/gardening/herbal treatments such as Kava – Kava and Sr John's Wort.

Toxins affect the endocrine system and immune system and yet all the 3 P's seem to be ignored by allopathic medics e.g. Ph test is simple – but it does not make money for the drug companies. (Sorry to be blunt but it is the truth)

We have been dumbed down and harmed and it is how the few control the many.

G21) Grange over Sands

Gill Rise shortage of beds. Admissions have been closed for long period. People referred to Carlisle

Lack of support in the community extreme strain on carers.

Social Work needed