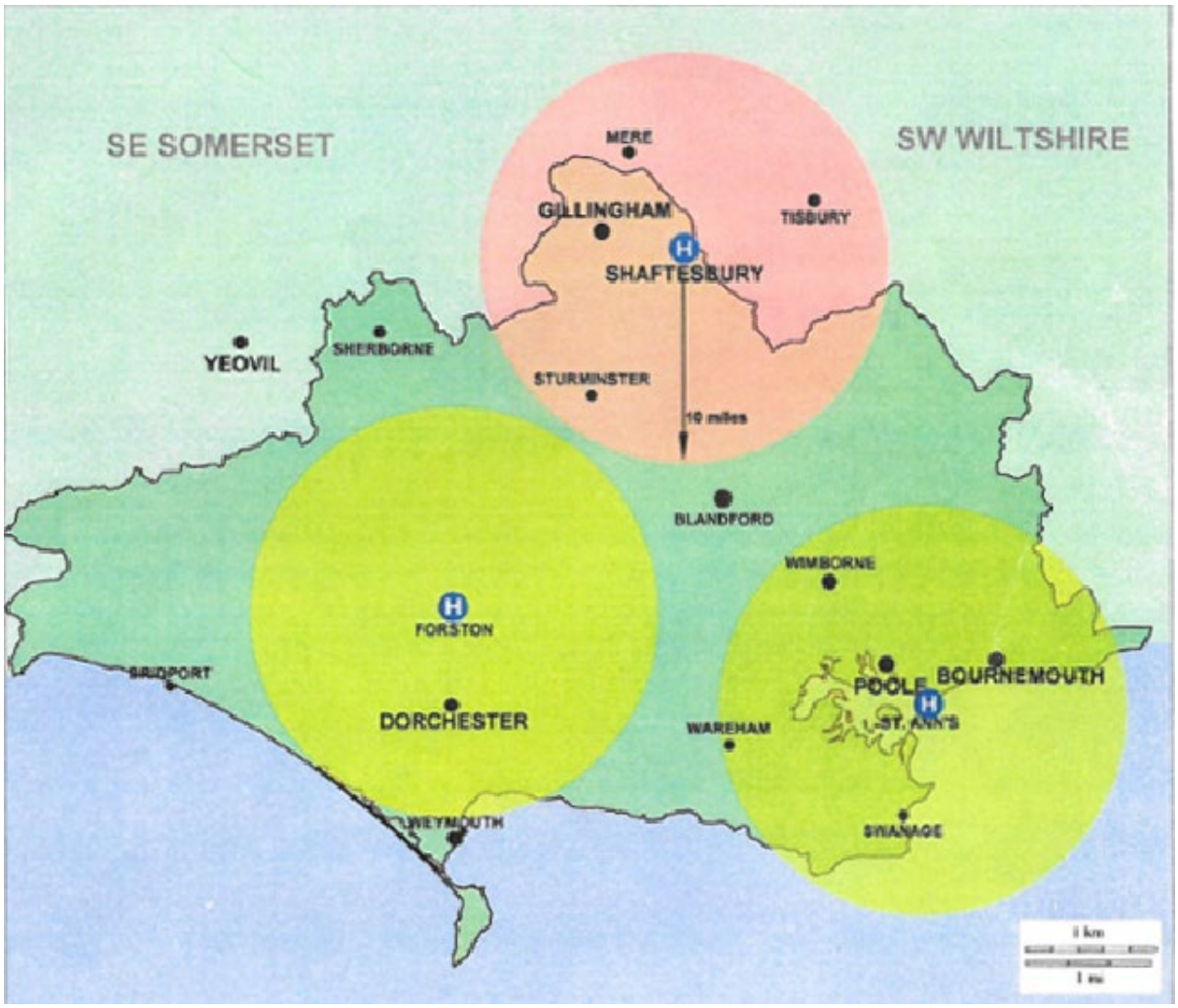
REPORT

Commissioned by Shaftesbury and District Task Force

Improving Mental Health Services



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> *"People have a right and duty to participate individually and collectively in the planning and implementation of their health care."*
> Alma Ata WHO 1978

Save our Mental Health Services SOMH!

Reply to Dorset CCG Proposal for Mental Health Acute Care Pathway

Contents:

Introduction

The Dorset CCG Proposal for Mental Health Acute Care Pathway has many aspects which are welcomed by service users and carers. These include early intervention and alternative care provisions intended to reduce the incident of MH crises and in-patient admissions. The Proposal focusses on redesigning services to benefit people in Dorset who may experience serious mental illness. This is an admirable goal, but we note that a significant proportion of the Proposals will tend to benefit people with mild to moderate MH issues. However, there are some very serious gaps in the Proposal, and it is upon these that we intend to focus. The main points include:

a. Parity of esteem between mental health and general health services
b. Area bias in favour of the south and east of the County
c. Transport problems and access to services

We will follow the structure of the report and look in detail at its proposals, adding some issues that have come up in response to it.

Connection:

The expansion of a phone, email and Skype service is welcome, as is the extended staffing for peak hours. However, we note that not all MH service users are able to use the internet, and internet/mobile services are not always equally available

within rural areas. This means that not everyone will be able to access this service equally.

Community Front Rooms:

We applaud the principle that CFRs will be located in community facilities such as libraries and cafes, in a way that is non-stigmatising; although the use of supported housing services and day centres as a location flies against this. However, it was not clear exactly what the role of the CFRs is intended to be. Specifically, what services are they intended to provide? We were not clear why there was no involvement with CMHTs.

The Proposal states that these CFRs will make it easier for people to get to services in rural parts of the county where transport is poor; yet we are not told where these CFRs will be located and what will need to happen to allow appropriate facilities in the community to be identified. Are the proposed opening times of the CFRs seen as a challenge for libraries or cafes which do not currently have these opening times? Opening hours from Thursday –Sunday from 15:00-23:00 means that public transport will not be available during those times.

The Proposal tells us that CFRs would be staffed by peer support workers. It is not clear from the document whether peer support workers are already employed in the service, or whether this is a new arrangement for Dorset. Are these existing NHS staff, or will extra such staff need to be recruited? What level of staff will be available, and where will these staff be recruited? How will these peer support workers be trained, managed and appropriately supervised? Although the Proposal mentions a Band 6, it is not clear what background and training this post will have. And we are concerned by the implication that there will be few or no mental health professionals involved in the CFRs. Whilst the value for money of peer support workers is a good thing, as is the 'peer' aspect of their role, the attached report *[Centre for Mental Health "Peer support in mental health care: is it good value for money?" Marija Trachtenberg, Michael Parsonage, Geoff Shepherd & Jed Boardman 2013]* makes no mention of training, support and supervision of peer support workers. It is clear that these staff will require a high level of support and a high level of personal development and awareness in order to make then safe and effective workers with MH service users.

In spite of the reference to similar services in Aldershot, there is no clear projection of the expected uptake and usage of this service, so therefore there are questions about the staffing levels needed by them.

There is no mention of the need to evaluate this new service, and the criteria for success.

Although the total number of CFRs is not yet clear, the Proposal suggest that the best locations for the CFRs is Bridport, Sturminster Newton and Wareham.

Retreats

There is a confusion of the roles of the three residential services: Retreats, Recovery beds and in-patient beds. It is unclear the exact differences between them and what they are trying to achieve. We are told that the Retreats will be staffed by a combination of qualified professionals and peer support workers, but no mention is made of projected staffing levels. The total number of beds is dependent on the configuration of other services such as the number of CFRs. It is unclear where these beds would be situated. Would they be in existing hospitals or residential care facilities; or be newly built? We are told that they include both early intervention beds and pre-discharge beds; but how would this difference be manifested in areas such as staffing and community liaison? Mention is made of the involvement of the Police and A&E Depts, which seems to be suggesting that acute admission could be a feature of the Retreats.

Recovery beds

These are currently provided in the West of the county and whilst they do not meet the demand, and the intention is to commission the same number of recovery beds across the east and west of the county, it is clear that the north is missed out. It may be that Westminster Memorial Hospital in Shaftesbury could accommodate a small number of recovery beds, for early intervention and local pre-discharge.

In-Patient Beds

The proposed increase in in-patient beds is welcome, but we note the huge increase in St Ann's, Poole. This is going towards a more centralised mental illness hospital instead of creating smaller, more accessible and less stigmatising local units. We note that there are no beds proposed in the north of Dorset, even though there are considerable general health in-patient facilities in this area. We would suggest looking at ways in which existing NHS facilities, such as Westminster Memorial Hospital, Shaftesbury, could accommodate a small number of in-patient beds. This has been done in other areas of the country in rural areas and could be incorporated into the work of the CMHT and CRHT.

Integrated working

The consultation also proposes to have integrated working between the Community Mental Health Teams (CMHT) and the 2 Crisis Resolution Home Teams (CHRT), and we broadly welcome this, in particular the focus of attention of early intervention and ease of access to services. However, it is hoped that this does not extend to co-location, and that the CMHT will continue to be based at the Westminster Memorial Hospital serving Shaftesbury and District. The CCG also state that the CMHT's will merge with the Crisis Teams, but do not say where or if they will be moved.

Care Pathway.

It was unclear what the proposed care pathways are, and there is a need for further clarification as to what we can expect from the care pathway overall. It would be helpful to understand the proposals in the context of the range of services and interventions within the care pathway This would make it easier to assess the proposals in their context.

Stages of the care pathway appear to include elements of services that support prevention, early intervention, planned care, crisis care, recovery and on-going support. But there is little reference to the services in GP surgeries, CMHTs or the work of associated agencies. The CCG mention more involvement 'in-reach' with G.P's, but fail to elaborate on what that actually means.

Rural Access

The Proposal notes its vision to value mental health equally with physical health to achieve 'parity of esteem' and to provide equitable services across Dorset for people with mental health conditions. However, the provision of services for people with MH problems is not at all as comprehensive, especially in the north of Dorset, as the provision for general health, taken as a proportion of the population. Partnership Working will be particularly important for those in areas which have least ready access to services such as north Dorset. This has implications in particular for Shaftesbury and District, and thought should be given to locating services, such as one of the CFRs or Retreats, in North Dorset, serving a mainly rural population in the north of the County.

"Rural proofing" policies are important. Rural areas face particular challenges around distance, sparsity and demography. Policies should take these into account these challenges at all stages of development. "Rural proofing should start at an early stage of policy development and continue beyond policy evaluation…this does not need to be complicated and can be built into any consultation and policy development process."

https://www.gov.uk/government/publications/rural-proofing

Rural access is seen to be a huge gap in the provision of current and proposed MH services. The Proposal seems to have completely ignored the north of Dorset (except for a suggestion of a CFR in Sturminster Newton). It is of concern that rural areas will not be well served by the proposals, which will centralise services in Poole and in Dorchester. The proposal needs to identify provision for those living in rural areas, and evaluate current and proposed provision.

The Crisis Care Concordat, referred to in the consultation document, is at odds with the Proposals; the CCC refers to "enabling access to timely and appropriate care for both mental and physical health needs". It seems clear that the Proposal does not make provision for service users and carers to have easy and timely

access to MH services, and does not address the inequity between MH and general health provision.

There is a legal requirement on commissioners to consider the equality impact of changes to services with regard to disability, gender, race, ethnicity, age, gender re-assignment, sexual orientation, religion/belief, pregnancy/maternity, carers and other groups. There is also an overarching requirement that "People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds." CCGs should provide accessible and equitable services to the whole population of the area, yet there is an inequality of service provision throughout the county, and accessibility issues within rural areas, due to services being located too far away

Taking this into account, it is very important to know what steps the CCG plans to take to mitigate the negative effects of centralising some of the services such as to inpatient beds in urban centres, especially with regard to transport and access for service users and carers.

In fact, far from being small and insignificant, the north of Dorset is home to the second largest population of any area in Dorset. The Shaftesbury and Gillingham area is home to around 20,000 people, on a par with Dorchester. Gillingham is also the fastest growing town with rail links to London, and is expecting to increase its population considerably in the coming years.

Travel, Transport links and accessibility

Dr Andrew Mayers' research on rural mental health *[Dr Andrew Mayers, Bournemouth University http://www.andrewmayers.info/rural-mental-health-research.html]* concluded that there was evidence that *"access to mental health services was perceived to be poorer in rural settings."* The CCG have seemingly neglected 34% of potential service users in non-urban areas. This means that it more attention should to be given to the needs of people living in rural areas, with consideration to access and transport.

Page 17 in the consultation states that the respondents 'would be willing to travel 25 minutes using their own car'. For people living in Shaftesbury and surrounding towns/villages it would not be possible to get to a Retreat or an inpatient acute bed in 25 minutes, using a car. In fact even travelling to Sturminster Newton may take at least 30 minutes by car. Relatively few service users have access to a car, and public transport would be either much longer or non-existent. We could also question if people in a crisis, or nearing a crisis, or were taking medicines, could or should be expected to drive.

There is no public transport for the weekends from Shaftesbury to Sturminster Newton. Roads in north Dorset are very different to those in the urban areas, factoring in narrow roads, farm traffic etc.

Questionnaire:

There are some flaws in the questionnaire process. There is an assumption built in that the current proposal is the only one available, and questions are framed in this way, e.g. we are told that one retreat will be in Bournemouth and there is a choice of location for the other retreat in either Weymouth or Dorchester – but no option for anywhere in the north of Dorset. Dorset residents are being asked their opinions on the mental health proposals, but how much response was there from people living in Shaftesbury, Gillingham and other rural areas?

Conclusions:

SOMH! Is broadly in favour of the proposals by the CCG to expend services in Dorset. However, we do have some very serious concerns.

1. **Parity of Esteem**. Our main concern is in the inequity of services provided throughout the County. Whilst it is accepted that greater population centres are in the south and east of Dorset, we do believe that there is an area bias against the north. The proposal focused on the 66% urban population of Dorset, and felt that left the 34% rural areas, in particular north Dorset, with an inequality in terms of service provision and facilities re mental health. Parity of esteem between MH services and general health service is of paramount importance, especially as many people are users of both services.
2. **Rural Issues**. Provision of public services, NHS services and MH services are all challenges for a mixed urban and rural area, but rural arears are often the losers. Due to the close-knit nature of the rural community, Mental health problems are often hidden and go unreported. In particular there is a serious issues of suicide within farming families and communities. Alcohol misuse is common, and there is an often underestimated use of illegal drugs in rural areas, especially in young people and early adults. Unemployment and de-agricultralisation has often hit very hard in traditional farming families..
    a. http://yas.co.uk/uploads/files/YRSN_Annual_Report_2015_-_Print.pdf
    b. http://www.rsnonline.org.uk/analysis/breaking-the-silence-on-rural-mental-health
    c. http://www.fwi.co.uk/farm-life/suicide-investigating-a-farming-taboo.htm
    d. https://www.bassetlaw.gov.uk/media/162020/RuralConferenceReport.pdf
    e. http://www.eastbourneherald.co.uk/news/call-to-improve-vital-services-in-rural-areas-1-6699914
3. **Transport.** This is a huge challenge for MH service users and their carers, and services need to be located within easy reach of people in rural areas.

Car ownership is lower and public transport is at best patchy. It is clear that the proposed services would not be accessible to service users within a reasonable time limit.

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SoMH!
Save Our Mental Health

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Appendix A: Mental Health Care Within General Hospitals

There is much in the literature about the value of basing small mental health units in general hospital settings.
"Mental health beds should be based on the same site as a **general hospital."**
https://www.rcpsych.ac.uk/pdf/FR_OA_1_forweb.pdf

The World Health Organisation says: "In-patient treatment of mental disorders should preferably take place in general hospitals"
http://www.who.int/gho/mental_health/care_delivery/beds_hospitals/en/

a US study on bed shortages refers to mental health 'scatter beds' within general hospital settings: "if hospitals can adjust scatter bed use or length-of-stay, the number of psychiatric beds needed in a population may change dynamically over time. Thus, a decrease in the number of psychiatric beds would result in adjustment to a new equilibrium between length-of-stay, scatter bed use, and inpatient volume. This dynamic model of hospital adjustment would imply that "shortages" are transitory disequilibrium phenomena whose existence and resolution depends on local area factors, such as local population growth and local bed capacity, as well as on hospital-specific adjustments to changes in bed needs.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4207711/

In any case, there is no hard-and-fast difference between people suffering with mental health or general health problems: "Over one-quarter of patients in a general hospital bed have a mental health problem. The number is even greater in those aged 65 and over."
https://www.myhealth.london.nhs.uk/mental-health/improving-care

This is by no means a new phenomenon, as Dr Alex Langford says: "Having mental health wards as part of general hospitals is something that already happens in other countries." He states the benefits to both services in being based on the same site. However, he does warn against the danger of increasing medicalisation of mental health problems within a general health environment.
https://psychiatrysho.wordpress.com/2014/07/12/shouldnt-mental-health-units-be-part-of-general-hospitals/

another example of MH care within a general health care setting is Bodmin Community Hospital:
http://www.cornwallft.nhs.uk/hospitals/bodmin/

Appendix B: Distances from the main population and hospital centres