

Healthy Communities Scrutiny Sub-Committee

Wednesday 2 March 2016

7.00 pm

Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1
2QH

Supplemental Agenda

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Item No.	Title	Page No.
5.	Review : Joint Mental Health Strategy: A joined up approach? The review will consider the following questions: <ul style="list-style-type: none">• Does the mental health strategy set out a convincing enough case for a joined-up approach to mental health in Southwark?• What more do we need to do to ensure a joined up approach to mental health?• What recommendations can we make to the Council and CCG as they develop the mental health strategy? A report from the council and Southwark Clinical Commissioning Group is enclosed updating progress in relation to taking forward the development of a Joint Mental Health Strategy.	1 - 5
6.	Roundtable on the Joint Mental Health Strategy Jan Hutchinson - Centre for Mental Health, will do a presentation , followed by a roundtable with :	6 - 22

Contact

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Date: 26 February 2016

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- Susan Underhill – Blackfriars Settlement
- Marcela Vielman – Copleston Centre
- Stephanie Correia – Southside Rehab
- Graham Collins – Community Action Southwark
- Zoë Reed & Matthew Patrick - South London and Maudsley NHS Foundation Trust
- King's College Hospital Foundation Trust
- Healthwatch

Healthwatch Southwark & Community Action Southwark have produced papers to support the review. Please find enclosed.

Item No. 5	Classification: Open	Date: 2 March 2016	Meeting Name: Healthy Communities Scrutiny Sub-Committee
Report title:		Joint Southwark Mental Health Strategy: update on progress	
Ward(s) or groups affected:		All Electoral wards	

BACKGROUND INFORMATION

1. In December 2015 Cabinet considered the findings of the Southwark Mental Health Social Care Review. It accepted the recommendation that the Council bring into place with NHS Southwark Clinical Commissioning Group (CCG) a Joint Mental Health Strategy.
2. The Chair of the Healthy Communities Sub-Committee requested information about progress made in relation to establishing this Joint Mental Health Strategy, to inform a joint review being undertaken by Education & Children's Services sub-committee and the Healthy Communities Scrutiny Sub-Committee.
3. On 23 February 2016, the Education & Children's Services Scrutiny Sub-Committee considered the Southwark Children and Young People's Mental Health and Well-being Transformation Plan 2015-2020.
4. NHS England required CCGs to submit these transformation plans in relation to local children and young people mental health services. Within these plans the local strategy in relation to children and young people and mental health is expected to be set out, taking into account the national mental health strategy, No Health Without Mental Health (2011) and also Future in Mind (2015).
5. Southwark NHS CCG worked in partnership with Southwark Council to prepare this local Transformation Plan, with input from South London & Maudsley NHS Mental Health Foundation Trust and other key stakeholders, including education, youth offending and children's social care. It also took into account the key messages from consultation with young people on mental health and wellbeing. The final version of this Transformation Plan was approved by NHS England on 18 December 2015. It contains the basis of the mental health strategy in relation to children and young people's mental health and well-being and it is intended to link strongly with the overall joint strategy.
6. This report is intended to brief the Healthy Communities Sub-Committee of progress to date on establishing terms for the development the Joint Mental Health Strategy and contribute to setting the scene for a roundtable discussion at the Sub-Committee meeting, so this can inform the Joint Mental Health Strategy development.
7. Council and Southwark CCG officers have scoped out key areas to be addressed in the joint mental health strategy, so that a set of priorities can be tested through the process of consultation. This scoping has been informed by the work of

Southwark & Lambeth Public Health Department's work on the Mental Health Joint Strategic Needs Analysis (JSNA) and the Children & Young people's JSNA, the work of the Mental Health & Parity of Esteem Board, and the findings of the Southwark Mental Health Social Care Review. The proposed strategic priorities to test are:

- **Protection, promotion and prevention**
The delivery of effective, evidence-based, targeted mental health promotion through Public Health programmes, including mental health and emotional wellbeing in schools and colleges, community-based resilience programmes and peer/self-management programmes to more vulnerable citizens in the general population. The focus here is on prevention and self care;
- **Primary mental health care**
The local development of mental health primary care integrated to social care, with secondary care so that step down and step up to secondary care mental health services is achieved. Mental health and social care service delivery through Local Care Networks will require stronger shared care arrangements with primary care. The focus here is community-based service delivered in local neighbourhoods with less reliance on acute hospital care;
- **Better delivery of care for long-term conditions**
Delivering more effective community crisis resolution, home treatment and peer support so that those who experience longer term mental health conditions maintain their tenure in the community. The focus here is on increasing quality of life and reducing demand for hospital and intermediate care;
- **Further development of the Southwark Dementia Strategy**
To continue to improve dementia care pathway for individuals and families in Southwark and drive forward work to make Southwark a Dementia Friendly Borough. The focus here is on increasing understanding of dementia and care at home;
- **Further develop a Children and Young People's Emotional Wellbeing Strategy**, with a specific focus on key vulnerable groups of children and young people, including looked after children (children in care); children and young people with neurological conditions; and children and young people in contact with the criminal justice system. Schools to be at the centre of this development. Focus here on resilience and safety, including understanding and responding to self-harming behaviours.
- **Focus on better responses to complex needs** related to presence of mental health needs and substance misuse.

8. There are a number of important perspectives to consider to ensure the strategy is developed comprehensively, including:

- Mental health promotion;
- Mental illness primary and secondary prevention;
- Treatment, recovery and intervention;

- User experiences of treatment and support, including peer support, personalisation and self-management;
 - Carer and family perspectives;
 - Anti-stigma;
 - Parity of Esteem and addressing health inequalities;
 - Service capacity and access;
 - Safety and crisis care;
 - Community support models and their role in delaying or avoiding hospital admission.
 - Impact of austerity on mental and physical health to what extent this can be mitigated through mental health service design.
9. An invitation to tender (ITT) has been developed to invite expressions of interest from suitably experienced and qualified provider organisations to assist Southwark CCG and Council with the development of this joint mental health strategy. This will enable Southwark CCG and Council to have dedicated resources to engage and consult key stakeholders; to collate already existing information sources; assess the impact of national, regional and local priorities and other strategies, including the Southwark Five Year Forward View; and draft a joint strategy with an implementation programme to bring about required changes. Shortlisted providers will be interviewed about the methodology to be deployed to deliver a comprehensive mental health strategy to bring about improvement in mental health and wellbeing in the borough and how this will be measured.
10. Work is currently being undertaken to establish sufficient governance arrangements around the development of this strategy, to ensure that there are clear accountability and reporting lines to Council and CCG, and representation in a Reference Group to ensure that the strategy is comprehensive and addresses key areas to bring about improvement of mental health and wellbeing across Southwark.

Background Papers	Held At	Contact
Southwark Mental Health Social Care Review http://moderngov.southwark.gov.uk/mgChooseDocPack.aspx?ID=5142 (Look at Public reports pack - Item 11)	Southwark Council	Dick Frak, Interim Director of Commissioning

<p>Southwark Children & Young People Mental Health Strategy and Wellbeing Transformation Plan 2015-2020</p> <p>http://www.southwark.gov.uk/site/scripts/google_results.php?q=Southwark+Children+%26+Young+People+Mental (Look at 3rd Link down - Southwark Children's and Young People)</p>	<p>NHS Southwark CCG</p>	<p>Carol- Ann Murray Senior Commissioning Manager</p>
<p>NHS Southwark CCG (2015) AMH Transformation: Adult Mental Health Services 2015-2018.</p>	<p>NHS Southwark CCG</p>	<p>Rabia Alexander, Head of Mental Health</p>
<p>Southwark Five Year Forward View 2016/17 to 2020/21 http://moderngov.southwark.gov.uk/ie/ListDocuments.aspx?CId=365&MId=5219&Ver=4 (Look at Agenda reports pack then Public Reports Pack – Item 11)</p>	<p>NHS Southwark CCG</p>	<p>Mark Kewley, Director of Transformation,</p>

REFERENCES

1. HM Government (2011) No health without mental health: A cross government mental health outcomes strategy for people of all ages
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
2. Department of Health/NHS England (2015) Future in mind: Promoting, protecting and improving our children and young people's mental health and well being
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
3. HM Government (2014) Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

AUDIT TRAIL

Cabinet Member	Councillor Stephanie Cryan, Adult Care and Financial Inclusion	
Lead Officers	David Quirke-Thornton, Strategic Director Children's and Adults' Services Andrew Bland, Chief Operating Officer, NHS Southwark CCG	
Report Authors	Dick Frak, Interim Director of Commissioning, Southwark Council Caroline Gilmartin, Director of Integrated Commissioning NHS Southwark CCG	
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Dated	26 February 2016	
Key Decision	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	Comments Sought	Comments Included
Director of Legal Services		No
Strategic Director of Finance and Corporate Services		No
Cabinet Member	No	No
Date final report sent to Scrutiny Team	26 November 2015	



Themes emerging from Healthwatch Southwark’s engagement on mental health

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Mental health was identified as a priority area for Healthwatch Southwark (HWS) through public and stakeholder consultation. Our evidence on this topic is collated here from the many engagement activities where people have told us about their experiences, between HWS's beginning on 1st April 2013, and 25th February 2016. It is arranged thematically, roughly following a pathway through services from access to discharge. Whilst we do hear of some very positive experiences, we naturally receive more contacts from those who are unhappy. We believe that every voice counts and even one person's negative experience needs to be addressed.



Our engagement activities

Public forums

Healthwatch holds **quarterly public forums** on different themes. At some forums, members of the public have raised mental health services spontaneously or discussed them in a more directed way:

- [December 2013](#): Directed tabletop discussion on each of our priorities, including mental health, amongst people with experience of relevant services.
- [July 2014 forum on social care](#): Questions and anecdotes were raised about the role of care coordinators for people with mental health difficulties.
- [November 2014 update on our priorities](#): Several people raised the topic of discharge, including for mental health patients.
- [June 2015 updates on health and social care integration](#): Discussions touched on mental health topics.
- [September 2015 forum focused on equalities](#): Questions raised by the public.

Focus groups

Healthwatch runs **focus groups** with members of seldom-heard communities. Again, participants may discuss mental health issues spontaneously or after prompting:

- In discussions with [Somali women](#) and [Bengali women](#) (June 2014), both groups raised mental health spontaneously amongst more general consideration of primary and secondary care, cultural needs, and long-term conditions.
- Discussion with people aged 16-25 at a mental health support group (February 2015) focused on sexual health but also we also asked about mental wellbeing.
- Our focus group with [Vietnamese and Vietnamese-Chinese mental health service users](#) attending the Vietnamese Mental Health Services (VMHS) community organisation (October 2015) focused on different levels of mental health care.
- A [carers' focus group](#) (January 2015) touched on the impact of caring on people's own mental health.

Information and signposting service

We run an **information and signposting service**. Many queries also highlight problems with services and we receive other contacts from people who simply want to share their experiences. All contacts are logged so that we can identify themes emerging. During this period 46 contacts have mentioned mental health issues and services. Where not otherwise referenced, evidence collated below is from our signposting function.

As well as the themes discussed in detail below, we have provided assistance regarding:

- Information on where to go for mental health support, how to register with a GP in order to get help, or access mental health advocacy and legal advice
- How to access records for a mental health patient whose surgery had closed
- How to follow up on an IAPT referral into secondary care
- Contact details for CAMHS supported housing.

Engagement prior to Care Quality Commission (CQC) inspection of the South London and Maudsley Trust

Prior to the CQC's inspection of the local mental health trust, South London and Maudsley (SLaM), in September 2015, HWS collaborated with Healthwatches in other affected boroughs to **actively seek feedback from the public and patients about SLaM's services**. This included call-outs for comment via email, website and e-newsletter, and visits to groups such as the Cuckoo Club (Southwark and Lambeth Mind) and the Dragon Café. The feedback was submitted to the CQC to inform inspectors' investigations.

Enter and View

HWS has the statutory right to visit publicly funded health and social care services, observe the environment and activities and talk to patients. We have conducted these 'Enter and View' visits at two mental health facilities - Aubrey Lewis 1 (March 2014) and the Snowsfield Unit (March 2015), both provided by SLaM. Reports on these visits can be found at our website here: <http://healthwatchsouthwark.co.uk/reports>. As they refer to very specific services, the findings of these visits are not incorporated into this report.



Timely access to appropriate services

Education, preventative and community support

People are worried that **preventative and community support** for those with mental health problems is inadequate and threatened. Some forum participants argued that cuts to services such as Mental Health Day Centres leave people vulnerable and undermine the prevention agenda.¹ An email contact agreed, saying that *"mental health and other invisible disabilities are being unfairly and disproportionately targeted"*, and that not everyone feels able to go to a statutory service. Another was concerned about support for minorities, saying funding for an advocacy project had been withdrawn 'because there is no concept of advocacy in Vietnamese culture/language.'

In a focus group with young people, 12 of the 13 participants said that young people can access mental health services without fear of judgement. However, they felt that in sex education there was an emphasis on physical health rather than 'emotional support'.²

Waiting times

¹ HWS public forum, June 2015

² Focus group with young people aged 16-25, February 2015

Concerns have often been raised about **people with mental health problems having to ‘jump through a lot of hoops’ and wait a long time to get support.**³ During our engagement prior to the CQC inspection of SLaM, people raised long waiting lists to get onto developmental courses like mindfulness which were themselves seen as excellent (and the need for a good GP who could push for the patient), and long waiting times following referral to a Community Mental Health Team (CMHT). People cannot access Improving Access to Psychological Therapies (IAPT) treatment or be on its waiting list until their CMHT referral is accepted or rejected, so they may have no support and face two separate waiting periods.⁴ One contact referred from practice-based counselling to Southwark Psychological Therapies Services (SPTS) had not heard anything in six months, despite his counselling being discontinued. It is felt that often people do not get support until someone gets hurt.⁵

There have also been some problems with **referrals getting ‘lost’ or people being unable to contact a service** about referral, and being discharged without care.⁶ Patients would like to be involved and updated throughout the referral period.

Triage has been described as a ‘lottery’ which can miss some people with real needs.⁷ Some people are **refused particular treatments** which professionals feel will not be successful, or because they are ‘not sick enough’ (the person reporting this later presented at A&E).⁸

Access to the right kind of talking therapies

People are particularly concerned with being **offered the right type of support, including talking therapies.** Bengali women told us they were concerned about the abundant use of medication to treat illnesses like anxiety. They felt that medication tends to make people tired, which can interfere with their responsibilities, and that talking therapy would be better.⁹ Somali women with long-term conditions told us that they are keen to be offered psychological therapies to manage pain, and it would be good to have counselling provided at the GP surgery.¹⁰ We had contact with a patient on lithium who was unhappy about not having a Community Psychiatric Nurse (CPN) - they were told by the CMHT that this was not available due to the change in government.

Even when talking therapy is offered, it is not always the right kind. Participants at one forum felt that while programmes such as IAPT were helping more people access therapy, access to more specialist help might be getting worse. They said patients were often offered short-term Cognitive Behavioural Therapy (CBT), which was described as a ‘sticking plaster’, and that when this was not the right approach for the individual it could be damaging.¹¹ Another person contacted us for help as he had been referred to group therapy at IAPT and felt this was not suitable for the issues he needed to discuss.

³ Focus group with Somali women, June 2014

⁴ Callout for evidence prior to CQC inspection of SLaM mental health trust in September 2015

⁵ HWS public forum, June 2015

⁶ Callout for evidence prior to CQC inspection of SLaM mental health trust in September 2015

⁷ HWS public forum, December 2013

⁸ Callout for evidence prior to CQC inspection of SLaM mental health trust in September 2015

⁹ Focus group with Bengali women, June 2014

¹⁰ Focus group with Somali women, June 2014

¹¹ HWS public forum, December 2013

Many people spoke to us with high praise for the psychologists and therapists who have helped them, but it is also important that people feel able to speak up if they do not get on well with an **individual therapist**, as those who cannot engage with their practitioner will have poorer outcomes.¹²

Language barriers

Language is a particular barrier to accessing good mental health support. A Deaf forum participant told us about the impact of this: *“High numbers of Deaf people have poor mental health because of barriers they face with communication - they can’t access services to talk about their problems. When their physical health gets worse, their mental health gets worse too.”*¹³

At our focus group with Vietnamese/Vietnamese-Chinese mental health service users, participants agreed that language is the main barrier for them in accessing services. Even some who normally or previously spoke good English may struggle to do so when unwell or may lose the ability due to their illness.

Most of the Vietnamese-speakers we talked to had not accessed mainstream **health information**. Some had not received help until in a crisis because of this - *“no idea, no help, no contact”*; *“By the time you [get] it is when you’re sectioned”*.¹⁴ Two people said that if the VMHS voluntary organisation was not there, they would rely on friends and word of mouth for information. Two said that it would be very difficult and that they did not know where they would be able to get information. Two said it would lead to crisis for them, *“I’m in hospital, definitely”*, *“Hospital for an emergency”*.¹⁵

Some **GP surgeries** are not meeting the need for interpretation. Making GP appointments was agreed to be a problem for many in the group, largely in connection with the language barrier - this has been reported in more detail in our **GP access report**. Interpreters were sometimes also required for **talking therapy** (as also discussed at a previous forum¹⁶); we did hear a couple of examples of this being provided.¹⁷

Pressure on care coordinators

There is some indication of mental health **care coordinators being overstretched** - one forum commentor said that coordinators do not have the time to do what they need to for people being assessed for personal budgets; another that one care coordinator failed to respond to emails and calls from a person whose mental health was deteriorating.¹⁸



Attitudes in primary care

Being listened to and taken seriously

¹² SLaM CQC callout

¹³ HWS public forum, September 2015

¹⁴ Focus group with Vietnamese and Vietnamese-Chinese patients, October 2015

¹⁵ Focus group with Vietnamese and Vietnamese-Chinese patients, October 2015

¹⁶ HWS public forum, December 2013

¹⁷ Focus group with Vietnamese and Vietnamese-Chinese patients, October 2015

¹⁸ HWS public forum, July 2014

People with mental health conditions do not always feel that primary care staff support them well. Whilst some people at our Vietnamese focus group felt understood by their GP, one participant told us, *“The GP doesn’t have enough time to listen to our problems. I feel like they don’t want people with mental health [problems]. They think we talk too much silly things, and say ‘quickly, quickly’. They give medications and that’s it. I feel like I don’t have enough time to explain my problem...No, they don’t understand.”*¹⁹

In one discussion, 6 of 8 participants were unsure whether their GP took their emotional wellbeing seriously and 2 disagreed that they did - people said this very much depends on the individual GP.²⁰ One caller with mental health issues felt her GP was 'sarcastic'.

Beyond attitudes, the **set-up of GP practice** can pose challenges for those struggling with their mental health - some feel that ten-minute appointments are not enough to discuss these problems, and that the need for a long-term relationship with a named GP is not always fulfilled.²¹

All primary (and secondary) health care staff need to be aware of the impact of people’s mental [ill] health - one person who waited a very long time at the foot clinic felt that staff there were unsympathetic to the impact on his anxiety and agoraphobia.

Tension between mental and physical health needs

We have had two calls from people worried about physical symptoms who felt **dismissed by their GP’s focus on their mental health** and anxiety. One of these people said that she thought racial stigma was playing a role.



Medications

Discussions at one forum revealed that many **patients do not feel aware of how to manage their conditions well with medication, and about possible side effects** - the one out of eight participants who said patients *were* aware was referring only to children. People were not sure what counted as ‘a good result’ from psychiatric medication. The participants all felt **GPs needed more training about the drugs** and their side effects, and more communication with CMHTs about how people are getting on with their prescriptions.²² It was suggested that pharmacists could run sessions at GP practices about this, as they do in mental health inpatient wards.

HWS has received a few contacts about **psychiatric medication errors and mistakes** - one psychiatrist prescribing the wrong medication, one medication change being missed due to the patient’s GP surgery closing, and one person feeling that the GP had given her the ‘wrong’ medication - a foreign brand. Presumably the drug is generic but this may indicate a need for patient education.

¹⁹ Focus group with Vietnamese and Vietnamese-Chinese patients, October 2015

²⁰ HWS public forum, December 2013

²¹ HWS public forum, December 2013

²² HWS public forum, December 2013



Crisis care

Crisis care was much discussed during our engagement around the CQC inspection of SLaM. The clinical care provided by the psychiatric liaison team at King's A&E was described as very good and helpful by four people who had presented there. One patient said the two doctors were *“very good and very sure of themselves”* which she needed when she was unsure herself. They also explained the process well.

However, significant unhappiness was raised around the use of A&E for mental health crisis. Common across the accounts were the long waits to be seen. Two people found it hard to sit among those who did not have a mental health crisis, and said the environment could be confusing. One person said *“the ambulance just dropped me off at the entrance hallway, nothing else”* which was daunting. A father disliked the use of police vans to escort his daughter to A&E, and the waits there, *‘I was in tears the other day, watching her being escorted out of her house into the cage of a police van - the ambulance service being too busy... I didn't realize she would still be sitting in A&E ten hours later, still waiting for a bed.*

Suggestions for improving the experience of going to A&E for mental health problems included:

- Written information to be provided after A&E presentations outlining patient details, the process and next steps. Patients may not remember the detail of what happened.
- Light refreshments of food/water as people will arrive at A&E having not taken care of themselves [and this will only increase their unwellness].
- A separate space away from other patients.
- Option of a volunteer or professional advocate to sit with or talk to patients.
- All mental health patients to have clear discharge plans and crisis plans (circulated to family members as well), to help avoid A&E where possible.



Quality of inpatient care

Many people have highlighted **positive traits in staff** at Maudsley Hospital, such as empathy, attentiveness, appropriate introductions, calmness and confidence. Some families feel well-involved in their relative's care and people appreciate help with practical social matters like paying bills during their stay.

However, we have heard of problems with both **staff capacity and the personalisation and coordination of care in inpatient services.**

One person very unhappy with her care in the Maudsley Hospital (EC1) told us that staff had too little time to help - she was given only five minutes to talk to a doctor, who was not a good listener. She had no care coordinator, and felt there was no collaboration between staff. A separate caller who had been sectioned at the Maudsley said she had been given medication but had not seen a doctor in her several days there.

Reports from a voluntary organisation about the experiences of other Maudsley patients tell us that it seems often generic care plans are used, and they are not clear to patients. Also, a lack of staff capacity means people cannot always take full advantage of their leave, causing loss of contact with family and friends. (In another hospital this impacted on people's ability to exercise which may also be a problem here).

Appropriateness and safety of inpatient and supported accommodation environments

Being admitted to hospital is obviously stressful and some people find the **ward environment** can make the experience frightening and possibly harmful. A former Maudsley inpatient recounted her experience where she felt *“frightened”* on the ward and alleged she had been attacked many times by other patients.²³ We have heard from a person who found Maudsley EC1 a scary environment with verbal abuse and door slamming from other patients. Another said that the Maudsley Intensive Care Unit was an ‘inappropriate environment’ for her daughter, due to constant loud reggae music making her daughter feeling isolated as the only white person present. Another mother informed us of her son being given illegal drugs by other patients in Maudsley AL3.

Relatives of patients in Maudsley AL3 said that the inside garden was *“neglected, with dead plants and rubbish”* which was interpreted this as implying the inpatients’ *“life was less valued”*. However, the activity room at this ward was praised as helping take the pressure off relatives and giving families a place to spend time together.²⁴

We also heard from a previously homeless person with mental health difficulties who found the environment in his **supported accommodation** (for people with mental health or substance misuse problems) very distressing. He said he was surrounded by drugs and alcohol and felt it was bad for him.

The Mental Health Act, Deprivation of Liberty, and restraint

Fears as an inpatient can be exacerbated by the actions of staff, who may need to use **restraint**. One contact was upset at nurses allegedly shouting, throwing her on the bed, twisting her arms and holding her wrists tightly enough to leave bruises for two weeks.

A voluntary organisation has also told us that there is inconsistent practice on hospital wards with not all staff aware of patients’ rights under the **Mental Health Act**. As mentioned above, a patient who had been sectioned was unhappy at being prescribed medication and not having seen a doctor. The patient unhappy with the use of restraint said that her sectioning kept being extended, but that she and her family didn’t know why. Communication with patients on this matter is very important.

Discharge and ongoing support

²³ Callout for evidence prior to CQC inspection of SLAM mental health trust in September 2015

²⁴ Callout for evidence prior to CQC inspection of SLAM mental health trust in September 2015

In one forum discussion, discharge was recognised as an crucial period. It is important to look at how **carers are involved** at the point of discharge.²⁵ We have heard cases which indicate possible failings in **risk assessments** and in **aftercare**.

Discharge from hospital

During engagement around CQC inspection, a family told us that their relative with schizophrenia was inappropriately discharged from Maudsley Hospital in 2012 without them being informed. Another family said that when their son was transferred from the Maudsley to Ladywell Unit, there was little information or willingness to involve relatives.²⁶ Three individuals also contacted us independently about issues around their discharge from Maudsley Hospital AL3. One had not had their records sent to their GP and so could not be prescribed medication; one had had a discharge meeting without an advocate/friend present; another implied that if discharged he intended to kill himself as he was not ready to leave but was not being listened to (it appears his stay was extended).

Discharge from the Community Mental Health Team (CMHT)

A distressed and possibly suicidal person contacted us about his discharge from the CMHT in Camberwell as he had missed an appointment for which he had not had the invitation in time. He felt 'I am crying for help and no one is helping me'. We confirmed that he had been discharged but the team agreed to contact him for further support.

Support after discharge from hospital or the CMHT

We have heard from a voluntary organisation that many service users do not have enough support after discharge from hospital, and return on a regular basis. Some people have complained of abrupt discharge from the CMHT, lack of clarity about post-discharge support (and long waits) and time-limited interventions without any follow up.²⁷ One person told us that after discharge from the CMHT she had been waiting a month so far for contact from the Wellbeing Hub.²⁸ Support needs to be in place before discharge and stepped down gradually to ensure patients can remain stable. Those who have received support from community care nurses and the Home Treatment Team often say this is very helpful, with staff listening to them and helping with social issues.



Integration and coordination across services

Our engagement work prior to the CQC inspection of SLaM highlighted that patients find it stressful and frustrating to have to **repeat information and assessments** when accessing different services. More coordination across local services would help with this issue. One father told us his daughter had presented to services from St Thomas' A&E to triage wards in Lambeth, Bethlem and Bromley, to inpatient wards in Lambeth and Maudsley, to the local home treatment team - each involving a new assessment. It was confusing in terms of who to call, and highlighted **fragmented and siloed working**

²⁵ HWS public forum, November 2014

²⁶ Callout for evidence prior to CQC inspection of SLaM mental health trust in September 2015

²⁷ Callout for evidence prior to CQC inspection of SLaM mental health trust in September 2015

²⁸ Focus group with Vietnamese and Vietnamese-Chinese people with mental health difficulties, October 2015

structures. We raised in our response to SLaM's Quality Accounts 2015 the lack of consistency of service across the four boroughs where SLaM operates.



Transitions from children's to adults' services

During our engagement work prior to the CQC inspection, transitions between child and adult services were consistently raised as an issue. The treatment and environment for children and adults is significantly different and there is a lot of understanding and trust to be rebuilt after transition. Relatives and patients highlighted a lack of robust handovers and became less confident in the care received as an adult.²⁹



Privacy and confidentiality

Given the stigma that still surrounds mental illness, **privacy and confidentiality** for patients is particularly important. We have been informed of two concerns about this, with one visitor to King's College Hospital having overheard someone's mental health assessment taking place at ward level, and one woman's GP having passed information about her mental health to housing officers.



Cultural understandings of mental illness

Understanding and interpretations of mental ill-health vary across Southwark's diverse cultural groups and this needs to be recognised in order to provide appropriate help.³⁰

Stigma around mental illness

Participants at some of our focus groups recognised that their cultures traditionally placed stigma on mental illness: *"In Vietnam there is bad talk about people with mental health [problems]. They don't want to believe what you say. They laugh behind you"; "We don't like to talk to strangers about our problems such as marriage problems"*³¹

Stigma can take many dimensions - for example Somali women told us that mental illness may cause someone's faith to be questioned, and that they are expected to suppress postnatal depression due to a cultural image of the 'strong Somali woman.'³²

Impact of culture on mental health treatment outcomes

People's cultural background also influences their approach to self-help and their experiences of treatment. One Somali woman told us that she considered reading the Qur'an to be 'psychological therapy'.³³ At our focus group with Vietnamese/Vietnamese-Chinese service users, many said that they felt understood and some appreciated the

²⁹ Callout for evidence prior to CQC inspection of SLaM mental health trust in September 2015

³⁰ HWS public forum, December 2013

³¹ Focus group with Vietnamese and Vietnamese-Chinese people with mental health difficulties, October 2015

³² Focus group with Somali women, June 2014

³³ Focus group with Somali women, June 2014

regular support provided by their CMHT.³⁴ However another participant in the same group felt strongly that they were not understood by white British professionals: *“I don’t think they understand our religious background and problems... They give medication that doesn’t work; I need Vietnamese medication...They are understanding, yes, but not for mental health. They can’t just section us for months when they don’t understand our beliefs...I don’t want to be sectioned, I want to be among Vietnamese people. They know a Muslim needs a prayer mat and to pray [but]...they don’t understand my religious needs.”*³⁵ This person said that people’s experiences as refugees impacted on the way they needed to be treated. He wanted more people from ethnic minorities to be trained as mental health staff in order to help their communities.



Consultation and complaints

Healthwatch aims to promote the public voice, and sometimes people do not feel they have been **listened to**. There has been recent widespread concern about the closure of voluntary-sector-run mental health services and day centres and their replacement with a Wellbeing Hub, as described above. Some feel that the changes were made too rapidly and without consultation, and announced in a way that would shock many vulnerable people relying on the services. We have also heard from a person who complained to SLaM but the complaint was not accepted as it did not contain the word ‘formal’; after being resent no response had been received within 28 days.



Social causes and exacerbators of poor mental health

Whilst we are not able to delve deeply into the social and root causes of mental ill health, members of the public are concerned that these are addressed - we have heard particularly about the impact of housing problems, difficulties with finances and benefits, the experiences of refugees, and digital exclusion.³⁶

Some root causes of mental ill health can be addressed within the health and social care system itself. A forum attendee questioned how much **education about mental health and drugs was provided in schools**.³⁷ Discussion at a focus group highlighted that carers’ health and wellbeing can suffer greatly due to the overwhelming **pressure of caring and lack of time**.³⁸ We have received three contacts from people whose **poor experiences in maternity and obstetric care** had led to mental health deterioration. This is a pertinent issue especially given the increased focus on perinatal mental health.

³⁴ Focus group with Vietnamese and Vietnamese-Chinese people with mental health difficulties, October 2015

³⁵ Focus group with Vietnamese and Vietnamese-Chinese people with mental health difficulties, October 2015

³⁶ Focus group with Vietnamese and Vietnamese-Chinese people with mental health difficulties, October 2015

³⁷ HWS public forum, September 2015

³⁸ Focus group with carers, January 2015



Voluntary Sector Discussion on Southwark's Mental Health Strategy: Improving Support for Children & Young People

June/July 2014

1. Introduction

[Southwark Council](#) and Southwark [NHS Clinical Commissioning Group](#) (CCG) are developing an overarching mental health strategy for the borough. [Community Action Southwark](#) (CAS) brought together a group of local voluntary & community sector (VCS) organisations working with children and young people on 11th June to hear the plans for the strategy and give an insight into the needs of the people they work with ('service users').

This short paper highlights the key points from the discussion. It is intended to support CCG/council officers drafting the strategy. It argues that a full understanding of voluntary sector organisations (VCOs), and ongoing partnership working and support of the sector, are vital to improving mental health in Southwark.

See a full list of attendee organisations in Appendix 1.

2. What happened on the day?

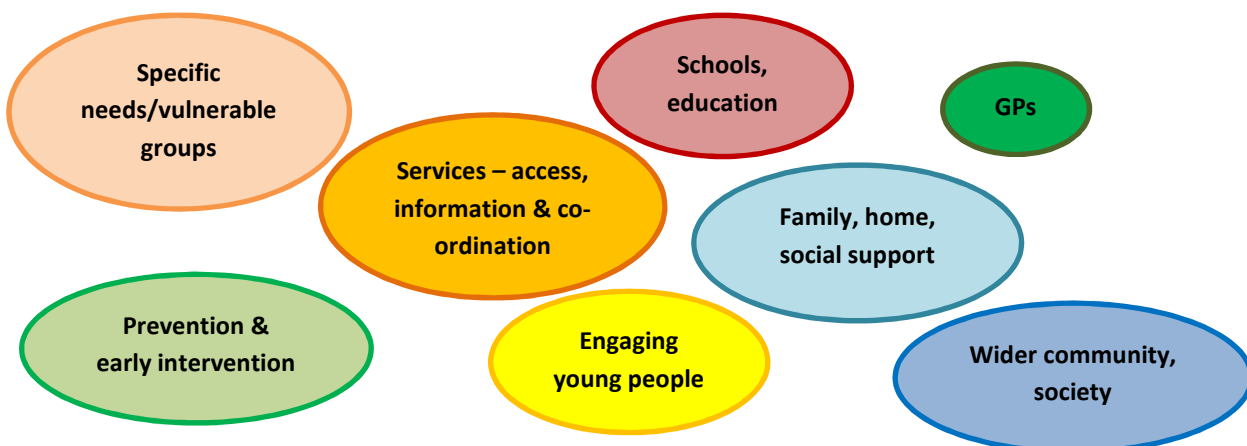
Jodie Adkin, Senior Mental Health Commissioning Manager at the CCG, gave a short presentation outlining the national priorities for change in mental health from the [Department of Health](#), and the local context for change, including:

- Increasing demand from a growing population.
- The dominance of a single service provider, and need for a wider range of commissioned services.

Sharon Wellington, Pathway & Project Service Manager for Mental Health at [South London & Maudsley NHS Foundation Trust](#), gave a short presentation on the need to improve support for 14-25 year olds. Key points included:

- Ending the 'cliff-edge' in support as young people reach 18.
- Supporting schools to identify mental health problems earlier.
- Improved access to psychological therapies.

This was followed by group discussions, where participants discussed **unmet needs**, how to better **engage young people** and offer support, and how to provide better **preventative support**. The discussion can be summarised according to the key themes below.



3. Key points from group discussions

3.1 What specific needs or vulnerable groups do we need to consider?

Participants highlighted a number of specific needs and vulnerable groups that the mental health strategy should acknowledge and address:

- Do schools and GPs currently identify **self-harm** in young people and know how to support them?
- How can we raise awareness of the abuse of **marijuana** by young people, which can lead to social isolation and mental health issues?
- How can we better support people with **complex** and **multiple** health and social care needs?
- How can we provide early intervention or 'sub-threshold support' for key groups such as **LGBT people, care leavers** and **unaccompanied minors**?
- How can we improve support for young people with **physical** and **learning disabilities** and associated mental health issues?
- Services should be **LGBT-** and **disability-**friendly. **LGBT young people** need support around self-harm and suicide, need to be more confident about coming out, need LGBT-appropriate services, which will result in lower risk of family breakdown and homelessness.
- How can we reduce the prevalence of **eating disorders**, which can result from self-esteem and confidence issues?

3.2 How can we successfully engage young people who might otherwise fall through the gaps?

Because young people sometimes refuse statutory services which are offered to them, VCOs can step in to engage the most excluded young people. Prevention is difficult when working with these young people; interventions all too often will come at the crisis point. For example, services working in Peckham have reported difficulty in engaging young people who are out of education and work, and have a weak social support network and do not take an active role in society.

Various methods could be used to engage with these excluded groups, such as:

- **Building strong relationships over time**, and ideally enabling support staff to come back to young people with extreme needs later on and review their progress. We acknowledge that this is potentially **resource-intensive**, but is the most effective way to reach people with extreme needs.
- **Using peer supporters** to connect with young people, such as other young people from within the same community, who are linked to mental health professionals.
- **Engaging young people through music**, for example providing facilities such as a recording studio, in order to captivate young people in a way that one-to-one meetings often cannot.
- **Providing opportunities for volunteering, education and training** which give young people a stake in society, but making sure these are optional rather than compulsory, and chosen by the young people.
- **Providing support at convenient locations** where young people frequently visit, and using similar **language** to successfully connect with young people.
- Services should engage with young people in a **holistic way**, seeing mental health as linked to other parts of their lives, e.g. employment, housing. Support should be **timely**, offered at key points in their lives.
- There could be a **buddying** service between young people and older people, for mutual support.

3.3 How can we improve access to services, information on services, and better co-ordinate different services?

Some voluntary sector staff are frustrated because they do not know where to go for support for children they work with. Many do not know what services are available outside statutory CAMHS¹. Information on support available and referral routes needs to be **clearer**. Participants suggested the following actions as ways to tackle service-related issues:

- Forging **stronger links** between mental health professionals and **youth workers** through 1) upskilling youth workers and 2) developing **closer links** between youth workers and mental health professionals.
- **Offering support through ‘non-stigmatised professionals’** such as youth workers to broaden support and ensure issues are picked up earlier.
- Using **different, non-stigmatising language** to describe services – for example, using ‘reasoning’ rather than ‘counselling’ has increased demand for a local service markedly.
- Providing a **variety of ways** for people to **receive information**, and tailoring information to people’s needs and preferences.
- Enabling **broad and simple access** to support – providing a single ‘gateway’ through which young people can find support and making it easier for people to self-refer.
- Taking a **holistic, whole-family approach** and not isolating mental health issues from other factors.
- Providing **support planners** through local peers.
- **Avoiding causing further stress** to people, for example by ensuring that people are not overloaded with confusing, conflicting information.
- Ensuring **100% follow-up to referrals** in five years’ time; this could be done by VCS staff and peer supporters, as well as mental health professionals.
- Focusing on **integration** between different services, pooled funding, and shared benefits.
- Developing a **dedicated ‘transition service’** to support young people moving from CAMHS to adult services – this could include a ‘passport’, like the new Education Health & Care Plans, although this risks stigmatising people
- Increasing access to **talking therapies** to build resilience and confidence.
- Allowing young people to find and access the support they need in a **convenient location**.
- Ensuring **co-ordination with the SEND² policy agenda**; how does mental health support for young people link with support for young people aged 0-25 with SEND, including the new Education, Health & Care Plans?

3.4 How can we embed prevention and early intervention into mental health services?

Prevention and early intervention are crucial for delivering effective mental health services. Without them, more resources are necessary further down the line to tackle a problem which has worsened. An example was given of a young person demonstrating signs of abuse and distress was not being given support because their needs were below the CAMHS criteria. Five years down the line, they had developed much more advanced and extreme needs.

Discussion around early intervention covered the following points:

- **Acting as early as possible** can prevent predictable life courses, e.g. young children (5-7) who are sexually abused or suffer ADHD and enter the criminal justice system later in life.
- Clarifying support for young people with **sub-threshold needs**, including those not eligible for CAMHS support. How can we re-design the system from the bottom-up so it supports the youngest children with low-level needs before those needs escalate?

¹ Child & Adolescent Mental Health Services

² Special educational needs & disabilities

- Providing **clearer and better access points into support**. If people have to wait for support or don't know where to get it, it leads to crises.
- **Acting early with key groups with sub-threshold needs**, such as LGBT young people, care leavers and unaccompanied minors.
- **Funding more preventative work**; and providing support to help VCOs and professionals demonstrate the preventative impact of how their services.

3.5 How can we address mental health issues through our schools and education system?

Participants were concerned about the need to flag up **potential mental health issues** as early as possible. Low level mental health needs can often be spotted in the playground, but it is difficult for school staff to know what action to take if needs are below CAMHS thresholds. Participants made the following suggestions for addressing mental health issues through education:

- **Identifying mental health needs** – teachers and other school staff need to more consistently be able to identify these needs and know what action to take.
- Providing mental health support in the **school setting**.
- **Equipping teachers to recognise signs of distress** when children of single parents misbehave in school, and giving them the knowledge and resources to access the appropriate support.
- **Integrating mental health services with schools** to address issues such as bullying
- Providing **emotional education** in schools to help young people express and manage their emotions.
- Some participants wanted to see **philosophy** on the school curriculum for younger children.
- **Embedding mental health into schools** similar to how safeguarding is embedded.

3.6 How can GPs work towards improving mental health in Southwark?

GPs can play a key role in improving mental health across the borough, but there are things that need to change. Participants wanted to see the following:

- **GPs having a better awareness** of mental health issues generally, including what questions to ask patients. Some GPs have a poor understanding and are out of touch, using inappropriate language, e.g. 'psycho'.
- **GPs identifying mental health needs earlier**, i.e. under-14s. For example, can they currently identify post-traumatic stress disorder?
- An **increase in referrals from GPs to VCS providers**. VCOs find it difficult to engage with GPs and make them aware of their services.

3.7 How can we address mental health issues in family, home and social network settings?

Young adults sometimes don't want their social circle or family to know about their mental health issues, due to **embarrassment** or an **unsupportive home environment**. They consequently **lack the social support network** that others do have. Some young people have **mental issues that result from their home environment**. They avoid home as it is unsafe, and sleep on the streets.

Certain changes and improvements would lead to better outcomes for those with mental health issues:

- Improving young people (and their families') **communication skills** would lead to improved family relationships and reduced homelessness.

- Services need to reflect the **instability of modern family life**, i.e. divorce is more common, people re-marry, different family structures. These can have an effect on people's mental health and certain events act as **trigger points** for crises.
- **A whole-family approach** would be most beneficial for improving mental health.
- One success in five years' time would be more people having **stronger relationships and connectedness** within and beyond their family.

3.8 How can we improve mental health across the community and in wider society?

Raising **public awareness** of mental health issues is of paramount importance in order to ensure that young people **understand** mental health issues, can **self-diagnose**, and are more open about mental health problems in the future. This could include mental health **'first aid'**.

Mental health issues need to be addressed alongside **underlying social problems**, for example housing, employment, finance, and food poverty.

Other ways in which mental health issues can be addressed include:

- Support for the most socially excluded children and young people to **contribute to society** and be more sociable.
- **Making time** for both parents and professionals to listen to and **understand the mental health needs** of young people. This is a societal challenge as people have less time for each other.

3.9 What else can be done to improve mental health across Southwark?

Participants voiced that they felt that **£4m funding** for children and young people's mental health support out of £60m (7%) for all mental health support is **too little**. This is not enough to provide adequate support for young people. They also felt that a higher proportion of mental health funding should be dedicated to children and young people, especially given that Southwark has a **young population**.

While the window for developing the mental health strategy is short, participants felt it is vital that young people in general, and disadvantaged groups (LGBT young people, disabled people), are **directly consulted**.

4. Summary and next steps

Voluntary & community sector organisations and groups work with many children and young people in Southwark of all ages and levels of need. The mental health strategy should aim to improve identification of **low-level** mental health needs **early on** and to reach the most excluded young people with **severe needs**. To do this, it must have a **clear and meaningful vision for the VCS**.

It should also see VCS provision as part of a **continuum** of different kinds and levels of support, ranging from medical interventions to counselling (or 'reasoning') to building people's confidence and resilience to engaging the most excluded and hard-to-reach young people. Some VCS services are unique in their ability to provide some of these services and reach some young people, so they should be seen explicitly as **key partners** in meeting mental health needs.

CAS is eager that the mental health strategy reflect the expertise, ideas and concerns of the VCS. We know that the process of strategy development is complex, lengthy and iterative. However, **we ask officers writing the strategy to be explicit about if and how these contributions are used in the final strategy**. We also offer ongoing support in the process and are very happy to try and expand on the points made.

5. Contact

To discuss any of the points raised in this paper, please contact:

Phil Mawhinney, Senior Policy Officer, Community Action Southwark

[E] phil@casouthwark.org.uk [T] 0207 358 7018

Appendix 1: Attendee organisations

Blackfriars Settlement
Cambridge House
CoolTan Arts
Copleston Centre
Faces in Focus
Healthwatch Southwark
Kairos Community Trust, SIPP
MAC UK
NHS Southwark Clinical Commissioning Group, Engagement & Patient Experience Committee, patient representative
Southwark & Lambeth MIND
Southwark Carers
The Well Centre
Three Wantz
Westminster MIND

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**HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE
MUNICIPAL YEAR 2015-16**

AGENDA DISTRIBUTION LIST (OPEN)

NOTE: Original held by Scrutiny Team; all amendments/queries to Julie Timbrell Tel: 020 7525 0514

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Councillor Rebecca Lury (Chair)	1	David Quirke-Thornton, Strategic Director of Children's & Adults Services	1
Councillor David Noakes (Vice-Chair)	1	Andrew Bland, Chief Officer, Southwark CCG	1
Councillor Jasmine Ali	1	Malcolm Hines, Southwark CCG	1
Councillor Paul Fleming	1	Dr Ruth Wallis, Public Health Director	1
Councillor Maria Linforth-Hall	1	Jin Lim , Public Health Assistant Director	1
Councillor Lucas Green	1	Jay Stickland , Director Adult Social Care	1
Councillor Bill Williams	1	Rachel Flagg, Principal Strategy Officer	1
		Shelley Burke, Head of Overview & Scrutiny	1
Health Partners		Sarah Feasey, Legal	1
Matthew Patrick, CEO, SLaM NHS Trust	1	Chris Page, Principal Cabinet Assistant	1
Jo Kent, SLAM, Locality Manager, SLaM	1	Niko Baar, Liberal Democrat Political Assistant	1
Zoe Reed, Director of Organisation & Community, SLaM	1	Julie Timbrell, Scrutiny Team SPARES	10
Steve Davidson, Service Director, SLam	1	External	
Marian Ridley & Jackie Parrott Guy's & St Thomas' NHS FT	1	Rick Henderson, Independent Advocacy Service	1
Professor Sir George Alberti, Chair, KCH Hospital NHS Trust	1	Tom White, Southwark Pensioners' Action Group	1
Julie Gifford, Prog. Manager External Partnerships, GSTT	1	Fiona Subotsky, Healthwatch Southwark	1
Geraldine Malone, Guy's & St Thomas's	1	Sec-Chan Hoong, Healthwatch Southwark	1
Sarah Willoughby, Stakeholder Relations Manager, KCH FT	1	Kenneth Hoole, East Dulwich Society	1
		Elizabeth Rylance-Watson	1
Electronic agenda (no hard copy)		Total:44	
Reserves		Dated: December 2015	
Councillor Maisie Anderson			
Councillor Helen Dennis			
Councillor Jon Hartley			
Councillor Eliza Mann			
Councillor Johnson Situ			