◼ HARINGEY COUNCIL ◼

Scrutiny Review - Mental Health

TUESDAY, 6TH DECEMBER, 2005 at 18:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Jean Brown (Chair), Edge, E Prescott, Patel, Robertson and Santry

AGENDA

1.   **APOLOGIES FOR ABSENCE (IF ANY)**

2.   **URGENT BUSINESS:**

The Chair will consider the admission of any late items of urgent business. Where the item is already included on the agenda, it will be dealt with under that item but new items of urgent business will be dealt with at item

3.   **DECLARATIONS OF INTEREST, IF ANY, IN RESPECT OF ITEMS ON THIS AGENDA**

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public, with knowledge of the relevant facts, would reasonably regard as so significant that it is likely to prejudice the member's judgement of the public interest.

4.   **MINUTES: (PAGES 1 - 12)**

To receive and confirm the minutes of the meetings of 4 and 25 October 2005 (attached).

5.   MENTAL HEALTH SERVICES - RESPONSE FROM THE VOLUNTARY SECTOR (PAGES 13 - 14)

To receive a response on behalf of the voluntary sector service providers that has been co-ordinated by Haringey Association of Voluntary and Community Organisations. A list of the key issues that they have been asked to respond to is attached.

6.   DATES OF FUTURE MEETINGS:

To note the following dates of future meetings of the Review Panel:

- 12 December at 4:00 p.m.
- 10 January at 10:00 a.m.
- 23 January at 4:00 p.m.

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❋ HARINGEY COUNCIL ❋

OVERVIEW AND SCRUTINY COMMITTEE - SCRUTINY REVIEW OF MENTAL HEALTH

NOTES OF MEETING OF 4 OCTOBER 2005

Members:

Councillors *Jean Brown (in the Chair), Edge, *Erline Prescott, Patel, Santry and *Robertson

*Member present

Also present: Mr. N. Bishop (Manager – Mental Health Carers Support Association), Mr. D. Hindle (Barnet, Enfield and Haringey PPI Forum/Haringey PCT PPI Forum), Ms. D. Burkens (Barnet, Enfield and Haringey PPI Forum), Ms. E. Kwaja (Haringey PCT PPI Forum) and Mr. P. Sartori (The Campaign Group). In addition, seven members of the Mental Health Carers Support Association also attended the meeting.

1. **APOLOGIES FOR ABSENCE:** Councillors Edge, Patel and Santry.

2. **URGENT BUSINESS:** None.

3. **DECLARATIONS OF INTEREST:** None.

4. **PROGRESS OF REVIEW:** We noted that visits were being arranged to consult with a wide range of groups and users. In particular, Members would be visiting:

    - The Selby Centre to speak to refugee and asylum seeker organisations
    - Various mental health day centres
    - A meeting of the Patients Council at St. Ann's Hospital

5. **MINUTES OF MEETING OF 15 SEPTEMBER 2005:** Agreed.

6. **MENTAL HEALTH SERVICES – USER AND CARER REPRESENTATIVE PERSPECTIVE:**

    Mental Health Carers Support Association

    6.1 This was a voluntary association with limited resources based in Tottenham with 2.5 staff. They carried out casework and advocacy, including advising carers at assessment meetings. They also provided:

    - A respite service funded by the local authority
    - Counselling

    - Training for carers

    6.2 Their views were as follows:

- The 250 carers the association has contact with wished to be viewed as a valuable resource and, in particular, "partners in care" and involved in care planning, information sharing, symptom monitoring etc.

- Their contact with carers was particularly valuable as neither the Council nor the Mental Health Trust yet had IT software systems in place that would enable them to identify clients with a carer.

- There were two specific booklets to assist carers, plus NHS information and strategy groups. However the association felt there was a need for more comprehensive information and training for carers.

- There were a range of factors that influenced mental health including socio-economics, depravation, exclusion, illicit drugs, drug and alcohol abuse and crime. Promoting economic and commercial regeneration, neighbourhood renewal and education initiatives and public information campaigns to alert people of risks to their mental health and de-stigmatise major and minor mental illness were approaches that had the potential to promote good mental health.

- The best approach to care was multi-disciplinary. Purposeful and well defined care packages offered a greater chance of treatment leading to rehabilitation, particularly if intervention was made at the earliest stage. Services typically came into play when an individual was experiencing a breakdown rather than displaying the early symptoms of illness or breakdown.

- Additional choice in the provision of services would be welcome. The lack of capacity and waiting lists for the provision of "talking therapies" was an acknowledged national problem that the Department of Health was currently seeking to rectify.

- The association felt that the location of some day care provision was not ideal for some users,

- Appropriate community services were needed to address the needs of young people.

- The Council had adapted well to the fact that the local population was multi ethnic and had resources in place to help it respond to ethnic communities who were resident. The local NHS services needed to draw on this experience and expertise.

- Rehabilitation needed to be part of the mainstream ethos of services. Provision was currently committed principally to symptom stabilization and medication monitoring - mainly through the use of anti psychotic medication – and care coordination.

The Campaign Group

6.3 The Panel noted that the Campaign Group had been formed in response to changes to day hospital services. Their views were as follows:

- An accessible overview of services would improve the overall knowledge of the functions of organisations and groups.

- The perception of users was that services needed to be even more responsive. Crises often came on very suddenly and most users therefore went to whichever service was the most readily available.

- Services were currently inconveniently located for some users. It was important that they were equally accessible to all.

- Users often had children and the effect that this had on them needed to be considered. The Mental Health Trust, who were currently planning services for the future, needed to especially consider the needs of children.

- Fears about the future of St. Ann's Hospital arose from the way Friern Barnet Hospital had been closed. Reassurance was needed that services would not be lost.

- The experience of users and front line staff needed to be fed into the reconfiguration process.

6.4 Although it was suggested that a purpose built carers resource centre was needed to enable carers to provide support and reassurance, carers felt that current accommodation was adequate and that the money would be better spent on services. What they wanted was an infrastructure to support carers.

Patient and Public Involvement Forum Barnet, Enfield & Haringey Mental Health Trust and Patient and Public involvement Forum Haringey Teaching Primary Care Trust

6.5 The views of the PPI Forum representatives were as follows:

- Public bodies should take into consideration the impact on mental health when drawing up policies. Positive media stories and working through schools would also be a means of promoting good mental health.

- Issues that could have a negative effect on mental health included matters such as unemployment, racism, family breakdown, drugs and alcohol. Someone with mental health problems could be easily overwhelmed and unable to solve problems.

- Employment was particularly important and it was often very difficult to get back into work after mental illness. The Council, as a large employer, could possibly play a role. It was possible that ex patients might not be consistent so work placements might be a more appropriate initial response in order to get people back into the jobs market.

- The accessibility of services depended at what point of the process people were at. In major crises, help was quick. For cases which required an initial GP referral where it was not a crisis or on re-admittance into the secondary sector, access was less timely.

- The waiting list for "talking therapies" was currently long. There needed to be a way whereby access to 'low level services' could be provided, in a holding operation, while waiting.

- The majority of people got their help from their GP. However, not all GPs were equally well versed in mental health. Access to secondary services could also be delayed as admission criteria could require the GP to try other interventions first.

- Services needed to be 'culturally accessible' and the Council and health services needed to consult and learn from community organisations and especially those of newer communities, such as refugee groups, which were not yet participating fully in the shaping of services.

- Waiting times for services were a limiting factor on choice. There were some very good services, such as the Haringey Therapeutic Network, and their capacity needed to be increased.

- Day services needed to provide meaningful structured activities in a supportive environment, and provide encouragement for people to move into mainstream activities. It was important to recognise that, as there was a move to reduce inpatient facilities, there would be a greater demand on services within the community.

- It was important to work together with informal carers and community organisations, who might be the 'first point of call' for those in pre-crisis situations. Voluntary agencies, which were being used to provide part of care plans, needed to be made sufficiently aware of the mental health of their clients in order to help. Some voluntary organisations in the course of their work catered for people with mental health problems, but did not work exclusively on the issue.

- The location of day services needed to be reflected in the location of community based facilities. Day services generally catered for the needs of people with a Care Plan. Ideally access needed to be made available to anyone with a mental illness who felt that they needed it which would require more provision.

- People with mental illness could be discouraged from going to community-based facilities if they had to travel far or had awkward journeys. Only those with a serious and permanent condition could receive the type of benefits which are a passport to free travel.

- Having good benefits advice was important.

- Appropriate public education on mental health was vital. Schools should be encouraged to talk about the issue and those who have had mental illness encouraged to use mainstream opportunities.

- For many people, help was needed to manage conditions as they were likely to always be there. Provision needed to make people equipped to manage their illness through investing in skills

- Services could be improved by the following:

  ⇒ Services acting quickly and appropriately by providing early intervention for the young and vulnerable

⇒ A reduction in waiting lists and waiting time for what would currently be described as non-urgent cases and the provision of early opportunities for talking therapies

⇒ More intensive support when someone was showing significant signs of developing a mental Illness both at the outset, and at times when symptoms reoccurred.

6.6 The Panel noted that there could be a disincentive for people to get better if they lost access to services. Systems for collecting feedback from users were felt to need improvement. .

6.7 We thanked all of those who had given evidence for their kind assistance.

7. DATE OF NEXT MEETING: 25 October at 18:30 p.m.

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OVERVIEW AND SCRUTINY COMMITTEE - SCRUTINY REVIEW OF MENTAL HEALTH

NOTES OF MEETING OF 25 OCTOBER 2005

Members:

Councillors *Jean Brown (in the Chair), *Edge, *Erline Prescott, Patel, *Santry and Robertson

*Member present

Also present: Ms D. Cohen and Ms. J. Shaw – Barnet, Enfield and Haringey Mental Health Trust and Mr. B. Slade – Welfare to Work Co-ordinator, Haringey Council

1.   **APOLOGIES FOR ABSENCE:** Councillor Robertson.

2.   **URGENT BUSINESS:** None.

3.   **DECLARATIONS OF INTEREST:** None.

4.   **MENTAL HEALTH SERVICES**

     Barnet, Enfield and Haringey Mental Health Trust

   4.1   We received evidence from Deborah Cohen and Jackie Shaw from Barnet, Enfield and Haringey Mental Health Trust in response to our questions as follows:

   • The only service that the Trust specifically provided that was aimed at early intervention was Antennae, which addressed the specific needs of African Caribbean young people between the ages of 18 and 25 and could cater for 50 patients at a time. This compared with the caseload of the Community Mental Health Teams (CMHTs), which was around 300. They were therefore able to provide a high level of input to their patients. They worked with a range of external services and followed an assertive outreach model. Children and Adolescent Mental Health Services (CAMHs) had an outreach service that was aimed at young people suffering a first episode of illness. In addition, there was a specific service that worked with older people in the first stages of dementia.

   • Consideration was being given by the Trust, in consultation with commissioners, to the setting up of a specific early intervention in psychosis service for Haringey as recommended by NSF guidelines. The original guidance specified that there should be one such team per half million of population, which would entail one team for the whole of Barnet Enfield and Haringey. Whilst this was unlikely to be sufficient for the needs of all three Boroughs, there was not enough funding for one team per Borough. One

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option that was being looked at was the development of a "hub and spoke" model whereby CMHTs would seek advice and guidance from the central team.

- There were mixed views on the effectiveness of early intervention teams for people aged between 15 and 35. Those who worked within them tended to be convinced but this was not always shared by those who did not. The service that they could provide was well resourced and of the type that all mental health services should ideally be able to provide. However, this could only be provided during the first instance of illness and the care of patients provided when they transferred to CMHTs was not comparable, due to fewer available resources. Whilst early intervention could help prevent illnesses becoming worse, there was a lack of evidence to support the proposition that having a discreet team made a significant difference.

- Improved liaison with the North Middlesex Hospital was possibly a higher priority then the setting up of a discreet early intervention service, were sufficient funding to become available. Such a service could provide a link with A&E and the medical wards. Amongst other benefits, it would enable post natal depression to be detected and addressed at an earlier stage.

- Better detection would be the most significant improvement that could be made to the ability of services to respond at an early stage. Many people only came to the attention of services when having their second or third episode. GPs were probably best placed to address this issue. The ability of primary care facilities to detect within Haringey needed to be developed and the PCT were currently addressing this issue. In particular, GPs needed to know when to refer onwards and who to approach in the first instance. The ability of GPs to respond effectively was hampered by a lack of time and their knowledge base needed to be expanded.

- GP practices in the Borough were characterised by long lists, inflated by the transient nature of the population, and were often single practices. A large number of GPs were due to retire within the next 5 years. This could provide the opportunity to develop new facilities providing a wide range of services, such as the Laurels Health Centre and build close working relationships with a new cohort of GPs.

- There were no specific waiting lists as such for mental health services. It was an emergency service and not elective. If people need help from a Care Co-ordinator or the Community Mental Health Teams, this was allocated. There could be waiting lists for out patient appointments but this particular model of treatment was now becoming out moded. Those waiting for such appointments were likely to have a Care Co-ordinator. There were waiting lists for psychological therapies and these could be up to a year. Efforts were being made to increase CBT provision.

- Nationally, there had been huge investment in therapists. Mental health teams would need re-focussing to ensure that they made best use of these facilities and to develop recovery based service. It was proposed that each community mental health team would have access to two psychologists. There would initially be cuts in waiting times for those people who were more severely ill. Cognitive Behavioural Therapy (CBT) helped patients to develop

coping strategies and could help them manage their illness better and stay healthier.

- In respect of other mental health teams, most places (including Haringey) now had crisis teams. There had been a mixed response to assertive outreach teams in terms of their effectiveness. Users were appreciative of them as they were able to give more time to them. CMHTs were under pressure. In particular, accommodation was inadequate, with not enough space for staff or rooms for group work. Space within neighbourhood offices or health centres would be very welcome.

- There was no specific team that dealt with the needs of refugee and asylum seekers although the Halliwick Centre had the capacity to deal with post traumatic stress disorder. Effective engagement would be facilitated best by better liaison with primary care and a proactive approach by GPs. Mental health staff would benefit from improved training in this area and could be constrained by difficulties in accessing interpreters. There was some anxiety on what might happen after the closure of the asylum team in April.

- There were particular concerns about the comparatively large numbers of Turkish and Kurdish young people who were coming into contact with the CAMHS team and appeared likely to graduate onwards into adult services.

- There was an over representation of African Caribbean young men in acute care, particularly amongst forensics (services for patients who had committed criminal offences whilst ill). An academic piece of research on the issue would be useful, particularly as it might have relevance for the Turkish/Kurdish communities.

- Improving joint working was a major priority. A shared vision of holistic care that catered for a whole range of needs was being developed but a different mind set would be required to take this forward. Multi disciplinary working could be facilitated by having the right structures in place. The draft mental health strategy addressed the issue and there was currently a skills mix review. 80% of the staff in mental health were from the NHS and it could be dominated by the medical model of care. The links with local authorities were very important and, in particular, those with adults and children's services. Annual commissioning planning and reviews would be of assistance and this was an area where the local authority could have a key role.

- There was a national lack of supported housing for people with mental health problems and there were issues with some providers being choosey about who they accepted as tenants.

- There was a gap in the provision of advocacy services. An independent person was probably best placed to undertake this. Brent, Camden and Islington were Boroughs that had particularly good advocacy services.

- Improved IT was a major priority and was a national issue. NHS and local authority systems were not compatible. The majority of expenditure currently goes on acute care. Approximately £1 million needed to be spent on the infrastructure within Haringey.

- Key ongoing issues for mental health health services were;

  - Improving joint working and bringing Haringey up to the same level as other authorities;
  - Agreeing the mental health strategy and the vision for the way forward; and
  - Disaggregating children's services

4.2 The Panel received evidence from Bill Slade, the Welfare to Work for the Disabled Co-ordinator. The Panel noted that he had also worked for MIND, managed the Clarendon Centre and was currently involved in drafting the Day Care strategy for mental health. His views in response to the questions of the Panel were as follows:

- The day care strategy would be aimed at providing opportunities rather than care. The previous emphasis had been more on containment. A particular difficulty was that CMHT assessments were often limited in scope as they concentrated on medical issues and did not look at the wider needs of the person. In the absence of necessary detail, it could be difficult to know how to address a persons particular needs. There was also a problem with not having an aggregation of recorded need over a significant period of time on which to base future commissioning decisions. The strategy was being based on the hope that in the future the necessary information would be forthcoming.

- It was possible that the whole issue of assessments would have to be looked at anyway. It was unlikely that CMHTs would have the scope to do the kind of assessments that would provide day services with all the information that they needed. There was not a lot of assessment of aspirations in social care and it would be useful to look at practice elsewhere. Care plans from Boroughs like Camden and Islington could be long but arrived quickly. This showed that the issues were resolvable as others were achieving in this area.

- The day care review would look at how needs were being responded to within all current provision and beyond. It would be guided by the principles contained within the ODPM's report "Mental Health and Social Exclusion" and "Redesigning Mental Health Day Services" (the London Development Centre for Mental Health and the Care Services Improvement Partnership, September 2005)

- Around 1.2 million disabled people nationally were economically inactive. A large proportion of these wished to work but had given up trying to find employment. People who had suffered mental illness had the lowest employment rate of any disability group and equated to around 900,000 nationally and around 8,500 to 10,000 locally. It was difficult to know how many of these would like to work. Nationally, the problem was getting worse.

- There were a number of barriers to people gaining employment. Negative attitudes of employers and within workplaces were a factor. The benefit gap was a disincentive although rules were in the process of being changed so that people could regain their benefits more easily if they relapsed. This was particularly important for mental health as people often suffered recurrences. There was also often a lack of flexibility and support in the workplace. Employment advisers and occupational health departments could both

benefit from an enhanced awareness and sensitivity towards mental health issues.

- Haringey Council had a number of disabled employees and a positive attitude to taking on such staff. There was currently a pilot scheme for placements for people with disabilities but nothing specific in respect of mental health. He understood the reservations that managers might have and they needed to be convinced of the benefits. There needed to be structured support in place, such as support from a mentor for the beneficiary. The role of human resources was important and developing. It needed to be borne in mind that the Council received a lot of requests for placements but resources to support these were finite.

- One option for improving levels of employment would be to place employment advisers into the community in locations such as health centres. This had been done successfully in other Boroughs such as Barnet and Enfield, where advice was commissioned from voluntary sector organisations.

- There was a lot of research that showed the benefits to people with mental health problems of being in work. If resources were put in and allocated effectively, it was possible that there would be less need to spend money elsewhere. Meaningless jobs could, however, be counterproductive as they demotivated people. Local efforts had so far yielded limited levels of success although the PCT now had a robust scheme for taking people on. Employers were often concerned at the additional responsibility that it could entail.

- In respect of day services, he felt that it was understandable that access was dependent on the patient having a CPA. Day centres were not equipped to deal with all eventualities and there needed to be a support network that they could turn to if required.

- There were a lot of people who did not receive services, such as people with obsessive compulsive disorder and people suffering from anxiety and depression. The gap needed to be filled at primary care level and consideration was being given to who GPs could refer people to in such circumstances. Such support might have the additional benefit of ensuring that they stayed well enough to stay outside of the system.

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SCRUTINY REVIEW OF MENTAL HEALTH

6 DECEMBER 2005

QUESTIONS FOR VOLUNTARY SECTOR SERVICE PROVIDERS

1. How easy do think that it is to access help when people start to show early signs of mental illness;
   - How quickly can people gain access to services?
   - How responsive are they?
   - How easily can they be accessed?

2. Are there any specific services that are provided within the voluntary sector that are aimed at addressing the needs of people who are experiencing early symptoms of mental illness and which aim, through early intervention, to prevent their severity worsening?

3. Are there any specific gaps in overall service provision for people are experiencing early symptoms of mental illness?

4. How do you think that services could be made more accessible to people from all communities (i.e. ethnic minority communities/people with disabilities) within the Borough?

5. Do you think that there is sufficient choice for patients and carers in the kind of therapies and treatments that are offered?

6. Are there any specific services provided for people without a CPA and how easily can they be accessed?

7. What do you think are the main barriers to successful rehabilitation?

8. What do you think could be done to counter stigma and discrimination against people who have been mentally ill?

9. What do you think would improve services aimed at early intervention?

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