	HEALTH SCRUTINY PANEL 31ST JANUARY 2005	Ref No.
Title of report **ACCESS TO MENTAL HEALTH SERVICES**		

1. **BACKGROUND**

1.1 On 30th September 2003 the Health Scrutiny Panel agreed that the question of the accessibility of mental health services in Walsall would be considered for scrutiny.

1.2 Following discussions with organisations suitably qualified to assist with this work, the Sainsbury Centre for Mental Health (SCMH) was appointed as research partner and has undertaken the project with a steering group comprising a service user and officers from social care and the tPCT.

2. **FINDINGS**

2.1 A copy of the report produced by the Sainsbury Centre for Mental Health is attached as appendix 1.

2.2 The lead researcher will make a verbal presentation to the Panel on her key findings.

3. **RECOMMENDATIONS**

3.1 Scrutiny Panel is recommended to:

- Receive the report "Review of Accessibility of Mental Health Services in Walsall" produced by the Sainsbury Centre for Mental Health
- Note the findings presented by the lead researcher
- Refer the Sainsbury Centre report to the Joint Director of Mental Health, requesting a report to Health Scrutiny Panel responding to the findings and recommendations contained in the Sainsbury Centre report.

David Martin
Executive Director
19th January 2005

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Review of Accessibility of Mental Health Services in Walsall

Prepared by Karen Knowles
January 2005

About SCMH

The SCMH is the leading mental health charitable organisation, involved in national policy determination, practice development and training, service development and research and evaluation.

The SCMH is a nationally respected organisation with a wealth of knowledge, expertise and well-established contacts and partnerships with clients, providers and commissioners across the country. SCMH is the leading organisation providing support to those organisations delivering mental health care. It is an independent charity committed to delivering improved mental health services. SCMH has established a formidable reputation for influencing national policy, producing valued operational research, delivering practice development and training programmes nationally and locally and for providing service development support to commissioners and providers of mental health services.

Acknowledgements

We are grateful to the clients and staff who kindly agreed to be interviewed for this report. Also, we would like to thank Pat Nye at the Service User Council for all her efforts.

Contents

Glossary

Community Mental Health Team (CMHT)

A Community Mental Health Team is a multidisciplinary team offering specialist assessment, treatment and care to adults with mental health problems in their own homes and the community. Staff in a CMHT will include community psychiatric nurses (CPNs) and social workers (Social Workers) as well as other professional disciplines.

Primary Care CPNs

Primary Care CPNs work in primary care settings such as GP practices to provide assessment of individuals identified as having mental health problems as well as support for people with less complex mental health problems.

Assertive Outreach Team (AOT)

Assertive Outreach Teams, known also as assertive community treatment teams, provide intensive support for the severely mentally ill people who are difficult to engage in more traditional services.

Crisis Resolution / Home Treatment Team

A crisis resolution team (sometimes called home treatment) provides intensive support for people in mental health crisis in their own home, or other suitable alternative such as a crisis house

Early Intervention Service

Early intervention in psychosis services provide assessment and care for individuals experiencing a first onset of psychosis, usually under the age of 35.

Service user

An individual in receipt of mental health services

Care Programme Approach

The CPA process has four stages including assessment of an individual's health and social care needs; the development of a care plan which is agreed by the service user; identification of a key worker and regular review of progress.

Service User Network (SUN)

The Service User Network promotes support and involvement of service users within Mental Health Services.

Service User Council (SUC)

The Service User Council (SUC) provides support and representation for service users in Walsall across a range of disabilities (not just mental health).

Executive Summary

Introduction

The Sainsbury Centre for Mental Health was commissioned by Walsall Council's Health Scrutiny Panel to consider the accessibility of mental health services within the borough of Walsall. This involved investigation of the initial access routes to mental health services experienced by current service users of working age (18-64). This report summarises the findings, conclusions and recommendations that have emerged from this review.

Background

The impetus for this review is in part a result of Walsall Council's Health and Social Care Scrutiny and Performance Panel being established to scrutinise NHS services in the borough. Furthermore, equitable access to services for individuals is a government priority; standards two and three of the *National Service Framework for Mental Health* (1999) (NSF) deal specifically with primary care and access to services. It is well documented that the majority of mental health problems are dealt with in primary care and therefore is crucial in determining how individuals with mental health problems will be managed.

Methodology

Have Your Say Day

SCMH were invited to attend the Service User Network run *Have Your Say Day* event. These are regular events which provide an opportunity for service users to voice their opinions about the services they receive. Approximately forty people attended; a mix of men and women. The majority were white and middle aged or older. People who attend these events tend to be long term service users and therefore may hold specific opinions about mental health services which would differ from new referrals. Nevertheless, their experience of the mental health system is valuable for finding out whether services are able to meet people's needs.

SCMH was present at a workshop during the event at which service users and carers discussed issues of accessibility. Information was recorded and from this key themes were identified.

Stakeholder interviews

The steering group agreed a list of stakeholders to be consulted as part of this review. A range of professionals were suggested from primary and secondary care as well as the voluntary sector. SCMH were provided with names and contact details of the stakeholders and arranged, where possible, to carry out interviews with them. Letters were sent to the identified stakeholders to inform them about the project. Twenty-one interviews were conducted in total from a list of thirty six stakeholders. Primary care professionals and consultant psychiatrists were particularly difficult to engage which from SCMH experience is often the case.

SCMH interviewed stakeholders for approximately one hour. The majority of interviews were recorded onto a minidisk player and subsequently transcribed. Hand written notes were also taken to supplement the recorded data. Interviewees were asked for their consent for the interview to be recorded and reassured that only the interviewer would be able to access them. In addition they were informed that the comments they made would be confidential. Following the interviews, the data was analysed for emerging themes and issues.

A total of 30 service users contributed to the report (including 15 interviewees and 15 who responded to the questionnaire (see below).

Service user questionnaire
The questionnaire was designed and agreed by the steering group (see appendix). It was decided that it should be concise so that people would be more willing to complete it. Two hundred existing service users were sent the questionnaires and given three weeks to complete and return it in a free post envelope. In addition, contact details for two of the steering group members were given in case respondents had any queries or concerns. Targeting service users who were already using the service was deemed to be a pragmatic way of discovering any problems they had accessing mental health services.

Response rate
As may be expected from a postal survey of this nature, the number of returns was low. A total of 15 questionnaires were returned and the results of these (in terms of qualitative information) have been incorporated into the findings.

Key Findings

Environment

- Some service users experience long journeys to attend mental health services which can be frustrating (or frightening if a person is unwell).
- The Assertive Outreach base was thought to be problematic in terms of its physical accessibility and safety.
- The design of the Dorothy Pattison building has led to problems in terms of lack of single sex accommodation and also in terms of the lack of access to outside space for individuals requiring intensive care. Both these issues are being addressed.
- Service users who had experienced admission to inpatient care reported that wards were also used for people with problems of substance misuse.
- Complaints made to ward staff were not thought to have been taken seriously.

Pathways to care

- Problems were identified in terms of referrers having the appropriate knowledge about when and who to contact when dealing with mental health problems.
- Lack of knowledge in primary care about how to recognise and respond to individuals presenting with mental health problems.
- There are myriad reasons which impact on an individuals own help seeking behaviour. A greater understanding of these issues and how they impact on when and how they access services as a result should be investigated.
- There should be increased opportunities for self referral and a single access point to services would ensure that service users get the right service first time.
- Access to psychology is limited due to extensive waiting lists and there is limited psychology input to community services.
- A number of interviewees felt that Dorothy Pattison Hospital was being inappropriately used for detoxification and that there was a gap for people requiring this type of support.
- Work is underway to address issues of people who are diagnosed as having either a Personality or Borderline Personality Disorder who have traditionally experienced difficulties accessing services.
- Protocols between services are being developed which aim to improve joint working. It is envisaged that this will help to provide a seamless service for people who traditionally 'fall through the gaps' in services.
- There is concern that Broadway North isn't accessible to some service users due to its remit to provide training courses. Service users want to be able to access services which are geared towards socialising and relaxation.
- Black Sisters have a reduced role in providing mental health support to Black people with mental health problems due to funding problems which could potentially mean a gap in services for this community.

Assessment and care planning

- Mental health services reported meeting the needs of clients using holistic assessments which take into account health and social care factors as well as cultural needs.
- A number of service users reported that they weren't in receipt of a care plan (or didn't know what a care plan is). This is worrying as it in the means by which service users can be involved in planning their care as well as a means of documenting how mental health services are meeting specific individual needs.

Relationships and communication

- Mental health services report good relationships but evidence suggests that these need to be formalised. Relationships and communication with agencies outside of mental health need to be developed.
- There is no strategy for self harm in A & E services and at the time of interviewing no A & E liaison service (although this is being looked into). This suggests that mental health problems are not well managed if someone presents to A & E. In addition people with physical illness or problems may be at risk of developing emotional or mental health problems. Staff in the Manor Hospital should be able to respond to this appropriately.
- Structures are in place to support people who have a dual diagnosis of mental health problems and substance misuse. However, currently there is no co-ordinated strategy to manage them which means that they are not being supported appropriately. The Department of Health has produced guidance on managing people with dual diagnosis which the PCT is looking at.

Culture

- Barriers to services for specific communities such as Black and Minority Ethnic communities; women and people with disabilities were not identified by service providers.
- Mental health services have worked well with organisations such as Black Sisters; however, it was felt that more robust partnership working was needed with the voluntary sector service providers.
- The role of the Asian mental health support worker is an example of good practice although it has highlighted issues for example, that service users from different communities may find services less accessible due to cultural barriers (i.e. that mental health services have a Eurocentric foundation) and that carers who are from BME communities maybe unaware of their rights to certain benefits and support.
- Organisations providing services to BME communities require sustainable funding.
- Black and minority ethnic communities and mental health is part of Strategic Health Authority themed review which Walsall is involved with which should begin to address concerns about the accessibility and provision of services to this group.
- Day services lack crèche facilities or are unable to cater for children.

- There is an issue around perinatal mental health. How are mothers with mental health problems supported?
- Women's mental health issues are being taken forward by Walsall mental health services and a women's lead has been identified.
- Service users who are Deaf or hard of hearing have more difficulty accessing services. The needs of this group need to be explored more fully. An audit of the accessibility of buildings for Deaf people would clarify the extent which issues such as clear signage; Mincom and loop facilities are available.
- The difficulty of asylum seekers and refugees in accessing mental health services has been highlighted in this report.
- The issue of stigma needs to be addressed as this is preventing people from accessing services at an early stage. Better outcomes are associated with early detection of mental health problems.

Public Information
- Service users want to have more information about their mental health problems including about medication and side effects.
- Service users and service providers lack information about what services are available and also about mental health issues.
- There is a gap in information aimed at people from BME (and other) communities about mental health and mental health services.
- Mental health services should make greater use of self help materials.
- Information needs to be targeted at carers so they are aware of the support they are entitled too.

Management Information
- New information systems were being developed when this research was carried out. This should enable information to be collected about service usage (who is accessing the service and who isn't) and also provide a means of monitoring and measuring the outcomes of services and interventions.
- Various audits are conducted within mental health services but there is evidence that some teams, such as Assertive Outreach need a strategy for the management of information as they currently only collect 'crude' data. There needs to be consistency in the provision of information in mental health services and the new system should facilitate this.

Conclusion

The aim of this research was to review the accessibility of mental health services in Walsall. When compared to the Mental Health First report published in 1994 it is clear that some of the issues that have arisen are not new to Walsall. Nevertheless, the report also highlights that mental health services have tried to address these concerns and there are numerous areas of good practice which can be built upon.

There are still concerns that there is lack of knowledge amongst professionals in terms of identifying mental health problems and directing clients to appropriate services. However, most service users were positive about their experience of GPs. The development of the primary care team should enable a more comprehensive service to be provided. They will enhance the capacity of primary care to respond to and manage mental health problems and they will also have a specific remit around BME communities and women which is encouraging.

At the time of this review, Walsall mental health services were (and still are) going through a period of considerable change which on the whole is perceived to be positive. However, when responding to the government agenda it is important to ensure that local needs are not overlooked. In particular the redevelopment of the Crisis Team as a Crisis Resolution / Home Treatment team which means that open access to this service will cease. Limiting options for self referral is the opposite of what service users want and even if the benefits outweigh the costs, services should ensure that service users feel that they have someone to turn to, should they need support.

A significant issue to be addressed in order to improve the accessibility of mental health services is that of social inequalities and their impact on mental health. Mental health services need to have a clear understanding of how gender, race, socio-economic status, disability and so on can contribute to mental health problems as well as determine the type of response provided by mental health services. Walsall mental health services have acknowledged that there is much work to be done with regards to this issue.

SCMH are pleased to hear that Black and minority ethnic communities' mental health is being reviewed but thinking about *all* social inequalities should be part of the main fabric of providing services to meet the needs of individuals. This may include thinking about more flexible referral procedures as formal referrals by GPs or professional letter may exclude certain groups or at least make access problematic.

The need to improve communication across service boundaries was also acknowledged. Relationships need to be established with services outside of mental health such as housing and education to ensure that they are aware of what is available and where to refer people. One useful suggestion was that there should be collaboration with a range of stakeholders comprising both mental health and non mental health services. It was felt that mental health services needed to be more 'outward looking'.

Stigma was identified as an important issue which creates a barrier to mental health services. People's fear of being 'locked up' or 'mad' is a serious deterrent to seeking help for mental health problems. Mental health services need to dispel these myths using campaign and information strategies. We know that the outcomes are better for people who access services at an earlier stage and people must be encouraged to do this.

It was reported that various protocols are in the process of being developed, for example, between learning disability and mental health services. In addition the crisis team; the homeless team and inpatient services have been working to develop procedures and protocols between their services. One interviewee described the importance of having protocols as they helped to consolidate informal relationships and so that people know what their roles and responsibilities are.

Certainly evidence from the interviews suggests that this comment is accurate,

'*At the point of delivery services are good but getting there is a problem.*'

A number of interviewees accessed the service in crisis due to their needs not being met at an earlier stage. However, SCMH would argue that accessibility and service delivery could be improved if staff are more aware of the reasons that people come in to contact with mental health services as well as their mode of access.

Recommendations

Environment

- Conduct a needs assessment exercise to determine the profile of the client group served by the CMHT to identify their needs and care pathways to services.

- Adaptations to the Assertive Outreach base could be made to increase the safety and physical accessibility. Service users and staff should be involved in deciding the most appropriate methods of doing this.

- Government guidance states that there should be separate wards for men and women on acute inpatient units. This is being addressed in Walsall but must include consultation with service users (both men and women).

- Patient and Public Involvement Forums to investigate complaints procedure in Dorothy Pattison hospital. Inpatients should be aware of how to complain or to contact advocacy services.

Pathways to care

- Information to promote mental health; raise awareness about mental health problems and services available should be produced in collaboration with relevant stakeholders (e.g. voluntary sector organisations). This could take the form of leaflets; web based information; training in the community to raise awareness and combat stigma. Mental health services could make links with local media agencies and the Employment Retention Scheme could 'reward' employers who they successfully work with.

- Research into the help seeking behaviours of different communities could be a useful method of establishing patterns of how people access and use services (see Morgan et al, 2004).

- There should be increased opportunities for self referral and a single access point to services. This may be a single phone number or an intake team which assesses an individuals needs and signposts them to the appropriate service.

- Primary care CPNs should monitor the use of 'opt in' letters to ensure that they are not preventing people accessing the service have literacy problems or who may be 'put off' by having to respond to them.

- Establish a local mental health help line which is available 24 hours and which provides single point of access to mental health services.

- It is recommended that CMHT training is extended to include other evidence based interventions such as cognitive behavioural therapy (CBT). The training could be led by the psychology service and they could also provide on going support.

- A 'visiting psychiatrist' is available at Brace Street Health Centre once a week. This is a good model of practice which should be extended to other areas.

- The care pathway which is being developed for (Borderline) Personality Disorder should ensure that issues of violence and abuse are acknowledged by service providers. Community and inpatient mental health staff will require training in dealing with this area and with regards to women; guidance is available in the Department of Health document, *Mainstreaming Gender* (2003).

Assessment and care planning
- Service users should a) have a care plan and b) be involved in the care planning process. Care plans should be reviewed at the team level and gaps in care planning addressed through supervision.

- The new policy, Delivering Race Equality in Mental Health Services (DH, 2005) states that the ethnicity and cultural needs of clients should also be recorded in care plans.

- Care plans should be monitored as they can provide useful feedback as to where needs have not been met and how they can be addressed in the future. For example, the outcomes of various interventions could be measured to see what is effective for different individuals.

Relationships & communication
- Protocols between services are being developed which aim to improve joint working and clarify roles and responsibilities. It is important that these protocols are monitored and evaluated to ensure that they are being adhered to (and indeed, working) in practice.

- Non mental health staff, e.g. general nurses should be trained in identifying people who are at risk of developing mental health problems, such as those with serious physical illness.

- There needs to be a strategy to manage people with dual diagnosis. The Department of Health has produced guidance on managing people with dual diagnosis which the PCT is looking at.

- Mental health services need to look at increasing the participation (and engagement) of people from BME and other relevant communities (Deaf people; people with physical disabilities) in strategic planning processes.

- Systems for liaison across teams and agencies need to be improved. We recommend that any link worker have their caseload reduced in proportion to the level of liaison activity. A written agreement about the role of link workers may clarify their remit.

Cultural issues

- Targets related to the review of BME services in Walsall will be agreed with and overseen by the Strategic Health Authority. This area of service development should have designated organisational leadership at a senior level and be a priority for commissioning in mental health.

- A training strategy should be developed, in partnership with key stakeholders (including service users and the voluntary sector) in relation to people from BME communities.

- It is vital that Walsall Mental Health Services work in partnership with organisations that provide culturally sensitive services to the community.

- The commitment to improving services for people from culturally diverse backgrounds should be in the form of sustainable funding for voluntary sector organisations.

- SCMH would recommend that the needs of women who are mothers are taken into consideration and that where possible crèche facilities or options for home visits are made available so that they can attend appointments. More specifically, this should be investigated as part of the review of day services to determine what the options are for this client group.

- There should be an audit of health and social care buildings to clarify the extent which clear signage; Mincom and loop facilities are available.

- A member of the CMHT should be nominated to liaise with Deaf and Hard of Hearing Team to improve care for this group. This could inform the development of a training strategy for the management of people who are Deaf or hard of hearing.

- Mental health services need to address the needs of asylum seekers / refugees at a strategic level and in collaboration with partner agencies.

- Mental health services should look at anti-stigma and discrimination campaigns as a way of overcoming preconceptions of mental health problems.

Public information

- Mental health services should promote good mental health and highlight the benefits of accessing services at an early stage. Offering services outside of traditional health care settings is one approach.

- Non-stigmatising self help information for people with mild or 'common' mental health problems in the form of books, leaflets, tapes, CD-ROMs or

web based, and derived from evidence based interventions, should be made available to service users at places where a health care professional is available to monitor their usage.

- Details about medication and its potential side effects should always be explained to service users.

- Any information which is provided should be appropriate to the needs of the community, in different languages or formats (such as Braille or signed video).

- Minority communities and appropriate voluntary sector organisations should be involved in developing methods of raising awareness about mental health in a way which is culturally relevant.

- BME community development workers should have a specific responsibility to facilitate communication and the exchange of information between service providers and service users.

Management Information
- All mental health services need to produce regular information to enable strategic planning and development of their organisation.

- Basic information about clients such as gender and ethnicity can inform who is accessing services but data also needs to be collected to monitor outcomes of service provision (including who is using the service and who is not).

- Staff should be trained to collect and record accurate data, with a consistent approach to training staff in different teams and agencies and ensuring necessary access to computers.

- All services should monitor waiting lists for services – including waiting time for an assessment and waiting time for an appointment.

- If a client is refused a service, they should be given the reason why, and this should be recorded.

- Workforce data should be collected and monitored within and across agencies, and targets set to achieve a workforce that is representative of the communities it serves.

Introduction

The Sainsbury Centre for Mental Health was commissioned by Walsall Council's Health Scrutiny Panel to consider the accessibility of mental health services within the borough of Walsall. This involved investigation of the initial access routes to mental health services experienced by current service users of working age (18-64). This report summarises the findings, conclusions and recommendations that have emerged from this review.

Background

The impetus for this review is in part a result of Walsall Council's Health and Social Care Scrutiny and Performance Panel being established to scrutinise NHS services in the borough. Furthermore, equitable access to services for individuals is a government priority; standards two and three of the *National Service Framework for Mental Health* (1999) (NSF) deal specifically with primary care and access to services. It is well documented that the majority of mental health problems are dealt with in primary care and therefore is crucial in determining how individuals with mental health problems will be managed. However, as the guidance states, primary care is not the only means of access:

'…there are a number of points of access to mental health services, and local health and social care communities need to ensure that advice and help is consistent…'

Having more than one access point to a service can be useful as not everyone may interpret or understand their mental health problem in the same way, however, too many access points where there is no consistency or clearly defined pathway may create a barrier to accessing services and receiving timely care (or duplication of services).

The NSF also emphasises the need to ensure that cultural needs are taken into consideration, including the needs of people from Black and minority ethnic communities. A number of reports have highlighted the difficulties faced by particular communities in accessing mental health services which are caused by many factors. *Breaking the Circles of Fear* (2002) highlighted the specific issues faced by members of African Caribbean communities, particularly men, in terms of their experiences of mental health services. The study found that African Caribbean men are more likely to: receive a diagnosis of schizophrenia; be given higher doses of medication; be detained under the Mental Health Act and receive coercive care. Consequently there is a (not unjustified) level of fear amongst this community which may deter them from seeking help for their mental health problems.

The *David Bennett Inquiry* has also made specific recommendations as to how services can be more culturally competent. In the consultation document *Delivering Race Equality: A Framework for Action* (2003), the Department of Health (DH) has pledged to take on board the recommendations from the Bennett enquiry and indeed this document; the David Bennett inquiry and Inside Outside (DH, 2003) have informed Delivering Race Equality in Mental

Health Care: An Action Plan for Reform Inside and Outside Services and the Government's Response to the Independent Inquiry of the Death of David Bennett (DH, 2005). The document also sets out a five year action plan for reducing inequalities in Black and minority ethnic patients' access to, experience of, and outcomes from mental health services; and the Government response to the recommendations made by the inquiry into the death of David Bennett. It draws on the three 'building blocks' which were set out in Delivering Race Equality: A Framework for Action which includes: more appropriate and more responsive services; community engagement and better information.

The need to urgently address the high suicide rates among particular ethnic groups such as East African and Indian women and Irish born men has also been recognised by the report, as has the need to understand the social context of an individual's distress. By meeting the actions identified within these three building blocks, services will also be meeting their obligations under the Race Relations (Amendments) Act 2000, which places emphasis on actively encouraging equality and equity in provision. This includes ensuring that the diversity of the community served is reflected in the staffing at all levels of service and specific programmes have been developed to address this.

The Department of Health has also acknowledged that mental health services have tended to overlook the needs of women and has produced two reports aimed at addressing this. *Women's Mental Health: Into the Mainstream* (DH, 2002) and *Mainstreaming Gender and Women's Mental Health* (DH, 2003) provide an insight into the gender differences in the diagnosis, development and duration of mental health problems and guidance as to how services can become gender sensitive. They also highlight the specific issues women face regarding access to services, which include, amongst other things, lack of private transport; lack of child care facilities; fear about safety in mixed sex services and social stigma of substance misuse as a barrier to seeking help. In addition, it was announced in May 2004 that the government plans to introduce a duty on public authorities to promote equality and eliminate discrimination between women and men.

Mental health services have also been failing to meet the needs of people who have sensory and / or physical impairments. *A Sign of the Times* (DH, 2002) states that people who are Deaf are disadvantaged when trying to access mental health services. In fact people who are Deaf are at high risk of social exclusion as a result of communication difficulties which can subsequently impact negatively on their mental health. *A Sign of the Times* sets out a vision for mental health services; that Deaf people are able to access communicatively and therapeutically appropriate services to meet their needs.

In order to make mental health services accessible the government is saying that services need to take account of the factors that may make us vulnerable to mental health problems and which ironically may also impede our ability to access the appropriate care and support.

Work Identified

A process for undertaking this review was identified and included:

- Attendance at a large group feedback event, which is planned as part of an annual user led consultation day and provide analysis on the findings from the day.
- Stakeholder interviews and analysis of findings
- Developing a questionnaire for existing service users and devising and undertaking the methodology for the selection, analysis and dissemination procedures.

Methodology

Have Your Say Day

SCMH were invited to attend the Service User Network run *Have Your Say Day* event. These are regular events which provide an opportunity for service users to voice their opinions about the services they receive. Approximately forty people attended; a mix of men and women (with little representation from Black and Minority Ethnic service users). The majority were white and middle aged or older. People who attend these events tend to be long term service users and therefore may hold specific opinions about mental health services which would differ from new referrals. Nevertheless, their experience of the mental health system is valuable for finding out whether services are able to meet people's needs.

SCMH was present at a workshop during the event at which service users and carers discussed issues of accessibility. Information was recorded and from this key themes were identified which have been reported in the main body of this report.

Stakeholder interviews

The steering group agreed a list of stakeholders to be consulted as part of this review. A range of professionals were suggested from primary and secondary care as well as the voluntary sector. SCMH were provided with names and contact details of the stakeholders and arranged, where possible, to carry out interviews with them. Letters were sent to the identified stakeholders to inform them about the project. Twenty-one interviews were conducted in total from a list of thirty six stakeholders. Primary care professionals and consultant psychiatrists were particularly difficult to contact which means that in the case of GPs their views are not represented.

SCMH interviewed stakeholders for approximately one hour. The majority of interviews were recorded onto a minidisk player and subsequently transcribed. Hand written notes were also taken to supplement the recorded data. Interviewees were asked for their consent for the interview to be recorded and reassured that only the interviewer would be able to access them. In addition they were informed that the comments they made would be confidential. Following the interviews, the data was analysed for themes and issues.

Service user interviews

In order to obtain a picture of current access issues, the steering group agreed that interviews with service users should target individuals who had accessed mental health services in the last twelve months. A number of approaches to 'recruiting' participants have been employed which are detailed below:

- SCMH designed a flyer advertising the project to service users, with details of who to contact if they were interested in participating. Community team managers were asked to distribute them.
- Letters were sent to people who had used the Crisis Residential Unit at Broadway North (and had stated that they were happy to be contacted in the future).
- Some service users have been identified via the Patient and Public Involvement Initiative.
- Access to service users via day centres has been explored.
- Primary care CPNs will be asked to distribute flyers to their service users.

A total of 30 service users contributed to the report (including 15 interviewees and 15 who responded to the questionnaire (see below).

Service user questionnaire

The questionnaire was designed and agreed by the steering group (see appendix). It was decided that it should be concise so that people would be more willing to complete it. Two hundred existing service users were sent the questionnaires and given three weeks to complete and return it in a free post envelope. In addition, contact details for two of the steering group members were given in case respondents had any queries or concerns. Targeting service users who were already using the service was deemed to be a pragmatic way of discovering any problems they had accessing mental health services.

Response rate

As may be expected from a postal survey of this nature, the number of returns was low. A total of 15 questionnaires were returned and the results of these (in terms of qualitative information) have been incorporated into the findings.

Interview findings

This section reports on the findings that emerged from the interviews with stakeholders. In total 37 staff and service users participated in the interviews. Staff from a range of disciplines were interviewed (including voluntary sector staff) in order to obtain a broad range of perspectives. Steering group members in conjunction with advice from SCMH compiled the list of stakeholders to be interviewed. All stakeholders were contacted by SCMH staff and given written information as to the purpose of the interview before an interview appointment was arranged. Unfortunately it was not possible to arrange interviews with all those who were identified. In particular, GPs (who have little free time during working hours) have had no input to the findings and it is important to recognise that their voice is missing from the report.

In addition the findings of the service user questionnaire have been incorporated into the interview findings in view of the low response rate. Fifteen service users responded to this and made additional comments which are of interest to this report. However, a total of 30 service users contributed either by interview or questionnaire which has been helpful in understanding the user perspective.

The purpose of the interviews was to explore people's views on mental health services in Walsall looking at examples of good practice and also areas in which there are gaps or where improvements are needed. More specifically people were asked to consider the barriers that prevented people accessing mental health services and how these could be overcome.

The interviews were by their nature concerned with people's views and these views may not be held or shared by others. **Some views may be influenced by circumstances that were true of the past, even though the circumstances in the present are changed**. Therefore the reader must exercise caution. Every attempt has been made to ensure that the reporting of these interviews is balanced and the reporting largely concentrates on perceptions and views that were commonly held and recurrent themes.

N. B. The Crisis Team is going through a period of reorganisation so by the time this report is produced the structure of the service will be quite different from how it was when the interviews were carried out. Currently the service has open access, which means that individuals are able to self refer, however, the service is being restructured to adhere to the service specification for Crisis Resolution / Home Treatment Teams described in the Policy Implementation Guide, which means that direct access will cease. This report acknowledges that the findings reported here are not necessarily representative of how the service will be when it is re-established; the focus is on the Crisis Team as it is now but also some key questions shall be raised about potential service gaps that could result in the future.

Environment

This section focuses on the issues raised which were associated with environment with particular reference to transport, location and physical and 'cultural' environment of services based on stakeholder perspectives. Their relevance to the access is related to the extent to which services are physically accessible and create an accessible 'environment'. It is related to the patient journey in that the range of services available will influence what services can be accessed (Morgan, 2004).

Discussion about the location of services is quite difficult as essentially your point of view is dependent on where you live. For some people centrally located services, such as Archway, are preferable whereas others may find them inaccessible. However, potential problems of accessibility were identified for people living in certain areas in Walsall. More specifically, the east of the borough which is a reasonably affluent area may be less well resourced for those who do have high levels of need. Individuals from the Brownhills area were identified as potentially having problems in accessing mental health services; although a Rethink day centre is available in this area.

Service users, particularly if they are feeling unwell, may be fearful of using public transport which could create a barrier to accessing services. It can also be frustrating when using a service such as Ring and Ride as if you are the first to be picked up you have to endure a long journey before reaching your destination. Mental health support workers are available to help service users increase their confidence on public transport where this has been identified as a problem however, there are no easy answers to the latter problem. It may be that services need to be more creative in the provision of services, for example, making use of community buildings such as churches or community centres. This should be based on a sound needs assessment.

A point raised by one interviewee was the rationale for dividing the borough into four CMHT areas. It was thought that there may be better ways of reflecting the needs of the population than a geographical basis. A needs assessment, profiling the population and the needs of clients may help to inform this.

The building in which the AOT are based was thought to be impractical in terms of both safety and access. It was thought that it would be difficult to manage a crisis situation in that building and it would be unsuitable for clients with physical disabilities. No clients are allowed in to the building unless there are at least two members of staff on duty. Given the nature of AO work this could prove problematic. Nevertheless, the location of the building is thought to be good (and next to Archway Day Centre) so the team would be reluctant to move. Are there opportunities for making adjustments to the current building to increase its safety?

Both service users and staff commented upon the environment of the inpatient ward at Dorothy Pattison. It was perceived by staff and service users that there were a lot of people with substance misuse problems using the service and so the location of an off licence just outside was perceived to be

particularly inappropriate. Interviews with staff also highlighted problems with the environment of DPH, including its propensity to attract 'unsavoury' individuals as well as problems with the environment in general. In addition as mentioned earlier, the location of the PICU on the first floor of the building has contributed to aggressive instances due to the frustration of not being able to access out door space. It was recognised that for the therapeutic integrity of the service, these issues need to be addressed.

SCMH were informed that some progress was being made in this area. The Service User Network (SUN) are working with Dorothy Pattison Hospital (DPH) to develop a therapeutic garden for inpatients and the PCT have put in a bid to the Strategic Health Authority to move their Intensive Care Unit to the ground floor of the building.

Service users who had accessed the inpatient service described their experiences of staying there and a number of key issues emerged. Lack of separate wards for men and women was highlighted as problematic and to illustrate, an example was given of a situation in which a woman inpatient 'stripped off' whilst she was ill in front of men and women inpatients. It was felt that this would be particularly embarrassing to this woman once she was feeling better and may even impact on her recovery time.

DPH was built in 1997 and therefore is relatively new. However, it was designed in advance of guidelines for single sex wards and has been unable to meet this requirement so far. It was reported that work is currently underway to address this.

Two interviewees reported being harassed by other inpatients and that staff did not treat it seriously. One service user felt unable to leave her room and the other tried to discharge himself as a result. According to the interviewees untoward incidents have occurred when ICU inpatients have mixed with other inpatients. In spite of this staff were excused from being responsible as 'they can't be here, there and everywhere.'

Pathways to care

Primary care

Communication between primary and secondary care is a nationally recognised problem and is caused by a number of factors. A study by Slade (2000) found that general practitioners (GPs) are often criticised by community mental health teams (CMHTs) for making referrals they deem to be inappropriate or for providing insufficient information within a referral letter. Conversely, GPs feel that CMHTs do not respond to their needs and they are expected to manage individuals with mental health problems with little support (Slade et al, 2000).

Unfortunately, the GP perspective in Walsall has not been investigated and therefore it is unfair to draw conclusions about their opinions. From a CMHT perspective, few problems were identified with GPs although there can be issues about the amount of information they provide about referrals. Further,

variation in terms of referral rates between GPs was thought to indicate that there is a lack of consistency in the knowledge available in primary care about mental health and mental health services. In spite of this, relationships were thought to be good and were being enhanced due to have primary care CPNs.

The majority of service users who participated in this research reported that their first point of contact for help with their mental health problem was the GP. This means it is vital that GPs have the knowledge and skills to identify and deal appropriately with people experiencing these problems. However, their ability to do this was thought to be variable. Some service users reported that GPs were helpful and supportive and others felt that their problems were not taken seriously.

From a mental health service perspective there was thought to be a lack of knowledge about when, whom and how to contact appropriate services amongst service providers and the general public. As a consequence it was felt that it can take time for people to get the right service. It was perceived that more awareness was needed amongst professionals and clients about what mental health services can offer and who they are available too. Service users would like more self referral opportunities (as they did eleven years ago in the 1994 Mental Health First report).

One explanation was that this was more of a problem for GPs in single handed practices that do not necessarily have the same access to resources such as training, (the comment does also relate to other services that may come into contact with individuals who have mental health problems). Although there are single handed practices in the borough, there is a shift away from this as those GPs retire. It would be useful to know how soon this will be and what impact this will have on the community and the delivery of primary care services. Secondary care staff were positive about the impact that Primary Care CPNs would have in GP practices. Research is currently underway to establish their impact on secondary care.

This criticism regarding mental health awareness was also levelled, particularly at GPs, in the Mental Health First report produced in 1994. Feedback from this report indicated that there was dissatisfaction with GPs knowledge of mental health issues and services available and also that they were too 'eager' to prescribe medication. The findings reported here still show evidence of this, although it should also be noted that from a service user perspective, most GPs were thought to have been helpful and supportive to people with mental health problems. Nevertheless, it was felt that GPs should receive mental health awareness training and support to provide short term interventions to clients.

Primary care CPNs have been located with CMHTs for several years and their work in primary care settings has enabled them to establish links with GPs. However, it was reported that GP access to primary care CPNs has not been equitable. Walsall mental health services are now developing a separate, borough wide primary care team consisting of primary care CPNs and

graduate workers which it is envisaged will provide a more co-ordinated and accessible service. This is important as they will be able to support GPs in terms of education about mental health and advice on clients as well as providing a gate keeping role to the CMHTs. Unfortunately as GPs were not interviewed it is not possible to provide feedback on their perspectives about these developments or existing circumstances.

One interviewee perspective was that for new referrals the process of being referred could be 'unduly protracted'. SCMH were informed that this was because primary care CPNs are not available to all GPs which means that there are limited referral options. In addition, if a GP does not give the CMHT enough information,

'…the GPs expectation is that the CMHT will accept them and no-one does anything so the patient is left waiting.'

This viewpoint was not reflected within the CMHT who reportedly can accept referrals on the basis of little information (this was particularly mentioned in relation to primary care CPNs who are in a better position to ask GPs for more information about referrals), although it was acknowledged that sometimes individuals can be directed to inappropriate services before being referred to the CMHT. One interviewee commented that the CMHT is 'quite liberal' in terms of the referrals it receives. It was thought that this could mean that resources were being spread too thinly at the expense of those with more severe and enduring mental health problems.

As well as primary care CPNs, it was reported that psychiatrists are keen to develop stronger links with GPs. This would establish a dialogue which could help GPs addresses any problems or concerns they have. In particular there are issues about co-ordinating care for people with severe and enduring mental health problems and how information is communicated so that the relevant people are kept informed. SCMH were informed that these links are already being established in one community health centre.

The South CMHT is based at Brace Street practice (where there is also a dentist and a GP surgery) and a psychiatrist attends once a week to see patients. This has been enabled as CMHTs now have more access to psychiatrists. This is a positive development particularly as it enables service users to have their appointments in a community based and thus less 'stigmatising' setting. However, a focus on a medical model of care as provided by psychiatry should be avoided. There is little psychological input into the CMHTs which means they are less accessible within the community. Government guidance on CMHTs (Policy Implementation Guidance: Community Mental Health Teams) states that clinical psychologists are not necessarily required to sit within CMHTs and rather, staff should be trained in the range of therapies which are available. SCMH were informed that staff have received training in brief solution focussed therapy. What about other techniques such as cognitive behavioural therapy?

Identification and management of mental health problems ideally requires individuals and professionals to have insight and an ability to recognise mental health problems. One interviewee, having had problems in the past was aware of what to do when she felt herself becoming ill again and took steps to deal with the problem at an early stage. However, another interviewee felt that without the support of friends and his GP he would never have sought help. This highlights the importance of professionals being able to identify mental health problems and for individuals to have an insight into their own illness in order that they can do something about it.

In addition to understanding and recognising mental health problems it is important that people are given information about what is available to help them and a choice. The latter is particularly important as interviewees using primary care services were reluctant to take medication. They saw this as treating the symptoms and wanted a form of treatment that would help to address the underlying issues. GPs are often criticised for handing out medication to people with even the mildest forms of depression and anxiety and it was clear that interviewees were wary of this as a sole form of treatment (some were prescribed medication alongside therapy which was seen to be more acceptable).

How and at what level an individual accesses mental health services will depend upon a number of factors. In particular a person's own understanding of their distress / illness will have an impact as an interview with one particular service user highlighted. Following the death of his wife he suffered a breakdown. Thanks to good support networks, however (including a particularly tenacious GP who visited him at home regularly), he was admitted to Dorothy Pattison. He states that he

'… *wouldn't have accessed mental health services without the help of my friend and my GP. I probably would have killed myself.*'

He further explains that this was due to his own lack of insight into his situation,

'…*you're convinced you're ok – I'll just have another drink, that'll sort it...you don't realise that you need that help. You need it taking out of your hands because you're not in a situation where you can make decisions.*'

This raises an important issue for mental health services in general, as to how they can make their service available to individuals who are unaware of the severity of their problems and emphasises the importance of all primary care professionals (and arguably staff in non mental health services) to recognise the signs and symptoms of mental distress.

Interviewees using primary care mental health services had found them easy to access and helpful. It was reported that they were able to see the primary care CPN very quickly, usually in the space of a week. A further advantage of receiving support from a primary care CPN is that they visit clients in their home. For clients suffering from agoraphobia or for those who have child care

commitments this is ideal as it removes the pressure of having to find additional support to attend appointments. Being able to access a service which is discreet was therefore viewed as important. One interviewee commented that in one practice there is a sign on a door which says 'mental health consultation room. It was thought that this would be off putting to people as they would feel stigmatised.

In order to avoid the problem of clients not attending appointments primary care CPNs send out 'opt in' letters explaining about the service and providing people with the option to accept or decline the service (it also provides information about other local services). If clients want an appointment they are asked to contact the service to confirm. This has reduced the number of non-attendees, enabling them to offer people appointments more quickly. According to a primary care CPN approximately three quarters of people opt in to the service. Whilst this is positive, it should also be recognised that it may not be the most appropriate way of encouraging people to access the service for example if people are unwell and unable to respond to a letter or if they have literacy problems (which may exclude particular groups).

CMHT

In terms of discussing pathways to health and social care services it is unfortunate that this research has been unable to obtain the perspective of the main referrers: GPs. Undoubtedly, their input to this section would have been valuable. Referrals to the CMHT are on the whole thought to be appropriate but there are some in which information is lacking or 'misleading', as one interviewee described it (for example, they may refer someone who is experiencing a normal grief reaction following the death of a relative or friend which doesn't need the involvement of secondary care).

Situations also arise whereby people contact the CMHT directly which they feel is not appropriate. However, the possibility of self referral should be explored as those with insight into their mental health problem are aware of the services they need. It is viewed as the role of Primary Care CPNs to bridge this gap between the services as they can offer education and advice to GPs about patients, including what an appropriate referral for a particular client would be, as well as provide help for 'common mental health problems' such as anxiety or depression which do not necessarily require intervention from secondary care. The added benefit of this is that clients are cared for in a non-stigmatising primary care setting, Brace Street Health Centre is a good example of this.

One CMHT manager acknowledged difficulties when referrals to a service such as psychology were required. However, they try to avoid holding on to cases as this is seen to take up staff time and create a false burden upon the team. To do this, clients can either be referred to day services which provide courses in anger management; anxiety management and so on (as long as the day services agree that clients are suitable) or be skilled in short term coping strategies to help manage their immediate distress. In the case of the former, courses run for eight weeks and so this is the maximum a client would have to wait for the service. However, this option will not be appropriate for all

service users and in this case CMHT staff provide a 'sticking plaster service' to clients requiring longer term therapy. Is there a danger that this does create a burden on their service and clients are in fact held on to if there is nowhere appropriate to refer them too? If some people require a more intensive intervention but have to wait does this impact on other services (e.g. the Crisis Team or A & E?)

Primary care CPNs were viewed positively in terms of their role in providing a link between primary and secondary care services and in increasing the accessibility of mental health services. In addition, the CMHT perspective was that they had helped to reduce inappropriate referrals from coming to the CMHT. At the time of interviewing there were no reported waiting lists for either primary care mental health services or CMHTs which was also thought to be a key factor in relation to access,

'...if it was me accessing the service, the longer I had to wait, the more I would be…thinking, do I really want to access this service?'

However this was not the experience of service users who reported long waits before referral to the CMHT. It would be interesting to find out whether the fact that there are no waiting lists reflects the efficiency of the service or whether there are issues about the criteria used by the team which prevents some people from accessing the service.

A perception held by some service users (those who were interviewed and those who attended the Have Your Say Day) was that CPNs were 'like gold dust.' CPNs were seen to have a particularly important role in terms of maintaining people in the community, essentially because service users feel more secure in the knowledge that they have someone to turn to if they are feeling unwell. Several service users talked about the importance of having someone to talk to. Having access to a local helpline for example may provide an alternative to needing the support of a CPN. Setting up a helpline was originally suggested in the 1994 Mental Health First Report. SCMH were informed that this was also being considered currently.

Another possibility is to establish a befriending service. SCMH did not determine whether this service is offered in Walsall but it may be another option to consider.

The issue of access to CPNs contributed to a feeling of not being listened to by mental health services. It should be borne in mind at this point that attendees of the Have Your Say Day are long term users of mental health problems which may mean that access issues although pertinent are slightly different from what this report was trying to discern[1]. Nevertheless it does highlight the need for mental health services to maintain a dialogue with

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[1] People who have had mental health problems for many years may not always require support from mental health services, however, if they relapse or once again require support there may be issues about how accessible they find services. The main focus of this report is initial access by new service users and the issues that arise.

service users, especially when they are told that they are not eligible for a service (if they are told at all, as in the case of one interviewee).

It was also felt that CPNs and social workers should provide more information about mental health problems and other services which are available to enable service users (and their carers or relatives) to make informed choices about their care.

Interviews with staff indicated that CPNs have large caseloads and are overstretched. This requires further investigation. Do CPNs have to meet the needs of people with more complex mental health problems? It was reported that the Assertive Outreach team have not met their targets on the number of service users they should be seeing. Is their capacity there? One service provider commented that it is not necessarily desirable for some service users to be allocated a CPN. How is this decided?

Assertive Outreach

The Assertive Outreach Team (AOT) is a specialist mental health service with a specific remit. This includes clients who do not traditionally engage with mental health services and who tend to have the most complex needs. Thus, it is a service which is not and necessarily should not be available to all but a very specific group of people (for more information see the Department of Health Policy Implementation Guide). Nevertheless it is useful to understand their perspective on accessibility of mental health services in terms of how they relate to other teams. In particular the development of specialist teams such as Assertive Outreach and Crisis Resolution / Home Treatment has led to criticisms that they create more defined service boundaries resulting in service users not meeting the necessary criteria to be eligible for a service; service users having multiple assessments and restricted access for more complex cases (Sainsbury Centre for Mental Health, 2003).

There were concerns that the remit of the AOT is poorly understood by other services. The appropriateness of the service for some of the clients they were asked to take care of was questioned. In particular, it was felt that they were expected to take on the role of a home treatment service; the example given was that of services wanting to send a person on section three of the mental health act on home leave and want AOT to go with them to supervise medication. The purpose of the AOT is to work with clients who are difficult to engage with services and who have severe and enduring mental health problems. If a client has already engaged with a particular service, it is arguably not within the remit of the AOT to intervene.

Another problem that the AOT experienced was also related to other services not being aware of their remit. For example, they found that inpatient staff will contact the AOT if a patient is distressed and ask them to take the individual out for a while to go shopping and so on. This was perceived to be an inappropriate use of their time which SCMH would argue depends upon whether the client does meet the criteria for the AOT. If so, then shopping is an activity that it would be in the remit of AOT to support a client with; however, as previously mentioned, if they are being asked to take someone

shopping who is already engaged with a service then this could be considered an inappropriate use of their service.

In spite of their perceived problems, the AOT feel that as a team they are motivated, have good relationships and provide a quality service to their clients and managed to prevent hospital admissions. They have also begun to work with carers, in spite of reporting limited resources (however, it was also stated at the time of interviewing that they hadn't reached their targets yet). If the number of referrals to the service increases, how will this impact on their ability to collaborate with carers?

More generally, the AOT felt that limited resources impacted on the accessibility of services. For example, mental health act assessments can require a number of staff to be present who at certain times may not be available. SCMH were told that in this case, clients weren't turned away but that assessments may take longer. The AOT have established relationships with agencies such as the police and ambulance services in order that there is a forum on which they can discuss particular issues. It provides an opportunity for the AOT to educate them in how to manage someone with mental health problems and for other concerns to be raised. This has resulted in the AOT having a named contact within the police which has helped enormously and is an example of good joint and cross boundary working.

Community Drug and Alcohol Services

The Community Drug and Alcohol Service (CDAS) provide a multi disciplinary service within Walsall PCT. Their role is to facilitate access to structured treatment for people with drug and alcohol problems within the waiting times and performance targets set out by the National Treatment Agency. If it is identified that an individual has a mental health problem the CDAS and CMHT will work together to provide support to them. As the CDAS is currently not subject to Care Programme Approach arrangements the CMHT usually takes the lead on such cases.

It was thought that accessing mental health services was relatively straightforward unless you were classified as having a personality disorder in which case the care tended to become the responsibility of the CDAS (if they were also identified as having a substance misuse problem). An organisational approach is being taken to address this issue and an appropriate care pathway is being developed for people with personality disorder.

Other interviewees identified issues with people who have problems with substance misuse. There are specific services for detoxification including Broadway North Crisis Residential Unit which provides short term support for people requiring detoxification. Longer term support tends to require out of borough placements which are funded by Walsall MBC. Although under review, there is also a contract with Birmingham to provide inpatient detoxification. One interviewee felt that services were unclear about the management of people who want to detox from drugs and alcohol. More specifically, the problem was identified as a lack of a care pathway through

community services for people with problems of substance misuse which has resulted in people coming into Dorothy Pattison Hospital for detoxification (even though there are no specific beds for detox).

As these individuals often present in a crisis this was thought to be inappropriate as people are less likely to respond to treatments and interventions such as motivational interviewing which, as the name suggest, requires the individual to be motivated to change their behaviour (Rollnick and Miller, 1995).

The perception that people with problems of substance misuse were accessing the inpatient service was evident in comments made by service users at the *Have Your Say Day* event at which it was stated that the inpatient service is 'full of people with drug and alcohol problems'. It was reiterated further in interviews with other service users. Another interviewee suggested there were lots of pathways to services and a lack of clear criteria to define their remit and also cited the use of inpatient beds for drug and alcohol detox as an example. One interviewee acknowledged that more people were being seen for detox and a care pathway was being developed to address this.

Care pathways are being developed for individuals with personality disorder and joint working between drug and alcohol and mental health services is facilitating this. In addition, links with NHS Direct have been established and are being formalised in relation to their walk in service so that there is a specific and easily accessible route for an individual presenting at this service. Walsall mental health services are aware of the importance of these pathways and there is a post dedicated to managing care pathways. Where difficulties arise, for example, for one service referring to another service it is their role to work towards improving those pathways using Integrated Care Pathways (ICP).

Walsall Local Authority

Walsall Council is taking steps to improve access to services following criticism in the Joint Review report (2002). The report found that there were too many access points and that signposting was poor which resulted in people getting 'passed from pillar to post'. It was reported that this is still an area in need of improvement so that people receive the right service, regardless of the point at which they access it.

Single access points through council services are being developed using a One Stop Shop model and specialist services are aiming to provide a single route to their services. Linking in with health to provide a single point of access was thought to be difficult as people with mental health problems are more likely to go through a health route as opposed to a social services route. However, a mental health 'presence' at this point of the service may also help to provide a less 'stigmatising' route to the service.

There was still a gap to be bridged in relation to signposting people to the appropriate service although protocols are being developed to facilitate joint working arrangements and criteria for referring or transferring cases between

services. This was thought to be particularly important in order to improve accessibility for people who traditionally 'fall through the gaps' between services.

It was highlighted that there are issues for vulnerable individuals who don't fit neatly into, as one interviewee described, 'the labels we put on them'. The example given was of young adults with mild learning disabilities and who may also have a mental health problem. If they only have a mild learning disability, they may not meet the criteria of the Learning Disability team. However, if they require support for mental health problems, mental health professionals may not necessarily have the skills to help with their learning difficulties.

People diagnosed as having Borderline Personality Disorder (BPD) was also cited as an example. It is hoped that by establishing robust links between adult services they will be better equipped to manage these individuals thus enabling services to work together e.g. to provide advice and support on issues where they have expertise.

Psychology

The Psychology service is based in Dorothy Pattison Hospital. The focus of the service was described as caring for people in terms of their medical, social and psychological care. As stated earlier, waiting times for the service are approximately 18 months making accessibility an issue, particularly for the CMHTs who have no psychological input of their own. (Although other services also highlighted that access to psychology was an issue). Inpatient services are slightly better off as they have input from a 0.5 WTE clinical psychologist and are able to make referrals which is thought to be working well. It would be interesting to explore this further to determine which inpatients gain access to them and also whether a 0.5 WTE is sufficient to meet demand.

In order to manage their waiting list the psychology team have adopted a pragmatic approach of working 'at both ends' of the list with more 'straightforward' cases being taken on by either less experienced psychologists or those with more difficult cases to help prevent burnout. However, this is still likely to cause delays for individuals who do not meet those criteria. How are they managed? Will having to wait months for a service exacerbate their problem? Walsall mental health services have taken the step of providing training for around eighty members of staff in brief solution focused therapy; the aim being that the techniques can be employed in areas of their own work. It is hoped to extend this training to provide staff with the opportunity to do post graduate training. Does this overcome the problem of not having access to psychologists in the CMHTs?

Crisis Services

At the time of data collection, the crisis team was an open access service i.e. service users were able to refer themselves directly. However, reorganisation of the service so that it will adhere to the Policy Implementation Guidance (Department of Health, 1999) to become a crisis resolution / home treatment

team will fundamentally alter this and other aspects of the service. Open access for referrals will be replaced and referrals will be made by other professionals such as GPs, Social Workers and CPNs. It is envisaged that as a crisis resolution / home treatment team they will be more structured and have a clearer remit.

This was positive in that currently the team felt that their remit was too broad and they end up providing a service to people who use emergency services for support. Re-establishing themselves as a crisis resolution / home treatment team provides the opportunity to (re-)define what they offer and what people should expect from them. However, it was also highlighted that a clearer remit is adequate as long as there are other services that people can be referred to. As one interviewee stated, the crisis team definition of 'crisis' was not necessarily the same as that of individuals wishing to access their service. If the crisis team do not feel that an individual meets their criteria what options do they have? It was acknowledged that there was a gap in terms of support for people who are in distress but just need someone to talk to, for example, following a relationship break up. A possible solution being investigated is that of a mental health helpline.

Another issue is who will provide out of hours services (and mental health act assessments) if following reorganisation this is not the remit of the crisis team. SCMH were informed that an Approved Social Worker (ASW) will provide an out of hour's service as part of the Crisis Resolution / Home Treatment team. (In addition, Broadway North Crisis Residential Unit is able to respond on a 24 hour basis.) However, the fact that it will no longer be an open access service is likely to viewed negatively by service users; particularly as it was agreed at the Have Your Say Day that improved access should correspond with more opportunities for self referral.

Overall, from a crisis team perspective it was thought that there no problems in accessing services, other than psychology due to long waiting lists. This response is somewhat disappointing (and was shared by other service providers) as it fails to go beyond the notion of waiting lists as causing barriers to access. Factors such as gender and ethnicity were not viewed as problematic, however, there is a wealth of evidence (and policy) highlighting that they are barriers to accessing services. The lack of appreciation of these issues does not necessarily reflect a deliberate unwillingness to understand these issues rather it emphasises that services are geared to a Eurocentric worldview.

Service user interviewees were aware of how to contact the Crisis Team in an emergency although they were not always considered to be accessible. From discussions with services users at the Have Your Say Day and also in interviews it appeared that there is a disparity between the remit of the service and the needs of service users. This is supported somewhat by comments made by staff that definitions of crisis may vary from one person to the next. The findings do indicate that what a service user and a service provider view as a crisis situation can be different.

One interviewee recalled her experience of being in a crisis situation and felt that she received an inadequate response. She was feeling suicidal and was on the verge of taking an overdose. When she called the Crisis Team they told her that it would be two hours before they could see her. She said,

'…they were telling me I had to wait two hours and I couldn't…I was frightened and I just needed somebody there…'

The Crisis Team arrived after forty minutes and she felt that once they arrived they were supportive and provided a good service.

Another interviewee commented that you feel as though you have to threaten extreme behaviour just so you will be taken seriously. It was commented by the Crisis Team that definitions of what is a crisis can vary between one person and another. Will the remit of the team become clearer following its review? Where should people go if they feel distressed but are perhaps not at the point where they are suicidal? From the comments made by this group of service users, having someone available to talk to is their priority as it gives them the security of knowing they have someone to turn too.

Employment Retention Project
The Employment Retention Project in Walsall is a unique service which aims to help people return to work following a period of illness. There are a variety of ways to access the service including self; GP; CMHT or psychiatrist referral. Inpatients at Dorothy Pattison are asked about their employment status and then automatically referred to the service if they are employed.

The project offers service users support for anxiety and depression using short term interventions; self help materials and complementary therapies. In addition, they work with employers to build up relationships with their employees and involve them in the recovery process. It was thought that this had helped address the stigma of mental health amongst employers. Reduced recovery time for service users was also reported as the stress about their employment was being addressed; this enables service users to focus on getting better. Support for service users continues when they return to work.

Good cross working relationships were reported with the Employment Retention Service. The service keeps the clients GP informed about progress and psychiatrists are accessible to discuss issues around medication. In addition SCMH were shown a number of documents written by other professionals (including GPs and psychiatrists) who praised the service.

SCMH were concerned that the service could be used to 'fill gaps' in other parts of the system, for example, to overcome the problem of waiting lists for other support services (e.g. anxiety management courses run at the day hospitals). It was reported that the Employment Retention Service were aware of this issue and it would not be tolerated. However, it was also commented that their service does relieve pressure on other services such as counselling and psychology services as it manages clients in the mean time.

The Employment Retention Service monitors equal opportunities but reports no problems in terms of people from minority or oppressed groups accessing the service. However, even though there is a self referral option to the service, the level of access for people from, for example, BMEC will partly depend on their ability to access the service at a different level e.g. via their GP.

Black Sisters

Black Sisters began providing mental health support as social services saw an opportunity for them to meet the cultural needs of people experiencing mental health problems. Initially, the mental health service was provided alongside the elderly project but funding from Joint Finance (Social Services and Health monies) allowed a separate project to develop. This enabled them to employ one co-ordinator and one outreach worker and so were able to provide outreach; therapeutic care; conferences and trips. Unfortunately, the funding was not sustained and the mental health project has diminished. It was and still is the only service catering for people from the African Caribbean community with mental health problems and is a service, which is needed. There was some money available from Health which enabled a group to meet on a Friday but that has now finished as well. They have tried to get mainstream funding from the Health Authority but were told that nothing was available due to cut backs.

Some funding however has been secured from the Lan Kelly foundation which has enabled an outreach worker to be employed. Ideally, two workers are required for this project as there are safety issues for an outreach worker working alone but the funding has only been enough to employ one worker for three years. In addition the funding is not enough to secure a qualified worker which is what the service really needs.

Day Services

Archway and Brownhills are day centres provided by Rethink in Walsall. Both are partly funded by Walsall Social Services. The Archway Centre is located near to the town and so is relatively easy for people to access. It is currently situated in a prefabricated building behind the base of the AOT and is very basic in terms of the physical environment. However, a considerable amount of funding is being provided by Social Services to rebuild it.

These day services are valued by service users who see them as opportunity to relax and socialise. They are provided for people with severe and enduring mental health problems and in addition to being places where people can 'drop-in' they try to gear activities towards recovery. IT sessions and other courses; employment advice; outings and a horticultural project (at Archway) are some of the things available to people (or can be accessed via links with local colleges). At Brownhills there is also acupuncture and aromatherapy. A meal is provided at the services and any additional money from this goes towards funding outings and other activities.

Referrals are made to the service by either GPs; Social Workers or CPNs and there are opportunities for self referral (something which is very important to service users). They have their own referral form and risk assessment form

that they send out or they will accept CMHT assessment forms. If it is a self referral they will require details of an individuals GP once this has been received they will invite people to look around their service in order that they can decide whether it is appropriate for them. This is felt to be an easily accessible service with a high profile within the CMHT as they receive a 'constant flow' of referrals from them. Furthermore, they note an increase in referrals since changing their name to Rethink from the National Schizophrenia Fellowship which for some people was off putting.

Most service users who were interviewed particularly valued services where there was a focus on relaxation and socialising. Staff in both Archways and Broadway North were praised for the time they spent with service users and their willingness to listen, which service users felt to be a therapeutic activity in itself. With regards to Broadway North, there were concerns that there is a shift in focus from therapeutic to educational activities and it was reported that this is causing anxiety amongst regular attendees.

It was reported that a fundamental review of day services is planned which will aim to develop an integrated day care strategy including partner agencies and service user / carer groups and which will also address service users concerns.

Broadway North Crisis Residential Unit

Broadway North Crisis Residential Unit has been running for ten years and provides an alternative to inpatient care. It has six 'crisis' beds and two respite beds. They are a unique service in the West Midlands and the only specific respite service in Walsall. SCMH were told that emergency accommodation tends to be used for this purpose. They receive referrals from the CMHTs, the crisis team and the out of hour's social work team.

Broadway North perceive their access to be fairly flexible; they provide tours of the service; publish leaflets about the services they provide and some staff (social workers) were thought to be good at promoting the service. However, it was acknowledged that any service which has particular criteria for access may create problems for some individuals who will end up being pushed from pillar to post.

Assessment

CMHT

Walsall has a diverse population in terms of ethnicity and assessments need to be able to take this into consideration as well as other factors for example, gender; socio-economic group; sexuality and faith to ensure that services are responsive to people's needs. The importance of being able to understand the context of people's lives is now widely recognised and is reinforced by government policy. People with mental health problems are more likely to be socially excluded and this is often compounded by additional discrimination on the basis of race, culture, gender, disability and sexuality (SEU, 2004). Service providers need to consider how these issues can underlie mental

health problems and also how their own values and beliefs can affect how they respond to a person experiencing mental distress.

Community Mental Health Teams use integrated health and social care assessments which aim to take a holistic approach to individuals, using the Care Programme Approach. It was emphasised that although there are specific headings to be addressed in the assessment, such as risk, psychological, physical and welfare needs, it is ultimately the needs of the individual which determine the care they receive. For example, if the client has particular welfare needs he or she will receive help from a social worker. A person requiring psychological input however is likely to fare less well given the waiting list for the service. Opportunities for referral to 'culturally sensitive' services are limited; according to interviewees there are gaps in this area. Similarly, how skilled are mental health professionals in understanding and managing the specific issues affecting Deaf people who have mental health problems?

The Care Programme Approach was developed as a means of identifying and meeting people's needs and ensuring a straightforward pathway through services. Feedback about this revealed that although perceived to be an effective tool in principle, there are problems in terms of its implementation and usage (discussed later). CMHTs are required to have a plan in place to manage risk, particularly if a person has been identified as being at risk of self-harm or suicide. Risk assessments monitor past and current risk including whether they are or have been vulnerable to abuse from others. The latter point is particularly relevant for women whose mental distress is often linked to experience of violence or abuse (Williams et al, 1993). One respondent recognised that these are issues which take time to talk about and felt that the teams were well-equipped to deal with this.

'*Staff are aware of how to deal with the needs of people, for example, who have been abused and there is a good voluntary sector to support then in Walsall for domestic violence and abuse…*'

Care Programme Approach data, if recorded and managed effectively, has the potential to provide useful information on clients which can establish patterns of behaviour in terms of how mental health services are accessed and used.

The CMHTs try to do joint assessments i.e. with a CPN and a SW or OT to ensure that they are holistic. SCMH were informed that assessments enabled the team to meet individual needs and when asked to elaborate on this mainly focused on matching service users with staff in terms of gender or ethnicity. Where communication needs were highlighted, respondents reported that they had access to interpreters, including sign language. In addition, links are established between the CMHT and local churches and community leaders (although they would not be contacted without the patient's permission). Although laudable, services also need to ensure that they are proactive in engaging different communities and are aware of how to target information about mental health and mental health services.

Interpreters do not have mental health training although it was considered that they could gain 'on the job' experience. In spite of this the service was thought to be good and clients are informed that what they say is confidential. Access to interpreters could be problematic however, especially for 'rarer' languages. This could result in a delay to getting an appropriate service during which time a relative may be used to 'fill the gap'. As was stated by one respondent, this is not ideal as family members may be reluctant to give all the information or may present a different version of events. Evidently, the ability to communicate is crucial to enable swift, timely access to services. The current situation would indicate that individuals whose first language is not English are likely to find accessing services difficult.

Interviewees with access to CPNs or social workers described them as being helpful and supportive. However, few service users knew whether they had a care plan (or even what a care plan is). The aim of care plans is to enable service users and carers to collaborate in deciding what the problems are; what the best course of action is and what the outcomes should be. The new policy, Delivering Race Equality in Mental Health Services (DH, 2005) states that the ethnicity and cultural needs of clients should also be recorded in care plans. Therefore it is imperative that all service users are aware of and involved in their care planning if services are to show that they are meeting individual needs.

Crisis Services

As previously stated, the Crisis Team is going through a period of reorganisation and as a result of this key policies and procedures are currently being reviewed and updated. The current manager aims to develop new systems which comply with the service specification detailed in the Policy Implementation Guide (PIG). Similarly, it was thought that current assessment procedures required considerable updating to be more solution focussed and also to take account of the needs of people with specific needs such as women or people from Black and minority ethnic communities. It was thought that the latter areas in particular were lacking from the assessment process but as part of the review of the Crisis Team this are will be looked at.

The assessment process was thought to be fairly comprehensive in terms of people's social care needs, i.e. identifying where there are issues with housing or benefits and that where such needs were identified the client would be transferred to the CMHT. However, as the service is redeveloped to become a Home Treatment Service they will be able to take on more of this work themselves. They will also be monitored as to how well they are carrying out these aspects of their work. In spite of this the same questions asked of CMHT apply.

Relationships & communication

Integration between services is key to providing a seamless pathway into care. Overall, relationships between services in Walsall were viewed positively although there was agreement that there were areas for improvement. In

particular this was around sharing information and developing protocols between services. Staff have gone through a period of significant change: after a drought of consultant psychiatrists five new consultants were appointed as well as a new director of adult mental health services. Integration of teams from health and social care disciplines has resulted in some difficulties and in some cases it has felt as though competing priorities have inhibited the development of formal working relationships. One interviewee felt that the government agenda for mental health services was to blame:

'*[You] end up with a lot of very…committed people who don't always pull together in the same direction not...because people have been too busy…focused on the latest political imperative.*'

Primary care mental health workers

In Walsall, primary care CPNs are part of the CMHT but work in primary care settings, which provides a link between primary and secondary care. As stated earlier, significant advantage of primary care CPNs is their location in GP practices which can help to reduce the feelings of stigma associated with mental health. Stigma was identified by most interviewees as a barrier to accessing services and it was felt that resources such as primary care CPNs could help to overcome this. The development of a separate, primary care team should ensure that it becomes a robust service.

Again it would have been helpful to have had GPs views of their relationships with the primary care CPNs. The feedback from other staff and service users, however, indicates that they are valued professionals and an asset to the service.

CMHT

The CMHTs perceive themselves as being at the core of mental health services and therefore have vital relationships to establish and maintain with other teams and services. The multi disciplinary nature of the team facilitates closer working relationships with other services such as psychology. They have regular, compulsory multi disciplinary team meetings which other services are invited to attend. In addition, there are monthly managers meetings which have representation from the CMHT, Assertive Outreach, the Crisis Team, Rehabilitation services and Housing. How often do they actually attend and is it realistic to expect people to attend?

Staff in the CMHT also attend weekly ward reviews at Dorothy Pattison. They have also established other important links, for example, at Brace Street Health Centre a Citizens Advice Bureau clinic is available one afternoon per week for clients and carers (the CAB also provides a drop in service at Dorothy Pattison). The service provides information and advice about a range of issues including benefits and debt advice. In addition there is a 'visiting psychiatrist' once a week which service users can book an appointment for. There are currently plans to extend this to include an emergency appointment clinic to respond to clients in crisis. This is a good example of liaison work that should be extended to other practices.

The CMHT do liaison work with inpatient services to facilitate information exchange as well as a means of monitoring people who are being admitted and discharged from the service. The inpatient service however reported having little knowledge about who is accessing their service which suggests that liaison processes could be improved.

The interviews revealed mixed perceptions about the relationships between different disciplines and services. One interviewee reported that there is lots of multi agency working with different clinical colleagues and service users in health and social services. The integration between social services and adult mental health was perceived as robust with long standing relationships being in place. This was thought to be in need of formalising however, to ensure that different professionals and services are clear about their boundaries and responsibilities.

However, integration can also result in a clash of working cultures and a number of issues emerged from the interviews which suggest that health and social services has some way to go. These include issues regarding clinical grading, equity of pay and caseload size. In terms of caseload size, a disparity is perceived between social workers and community psychiatric nurses. This was a perception held by those within and without the service. Differences in caseload size do not necessarily equate to differences in workload however and other differences also need to be considered, such as the type of intervention used and the time that Approved Social Workers have to spend on Mental Health Act assessment duties. There is an educational element to this to ensure that individuals have a clear understanding of each others roles and responsibilities to avoid conflict (and wider stakeholders should be clear about this remit). This would also enable the CMHT to be clearer about its own remit as the structure of mental health services changes and develops.

The need to focus on the internal workings and processes of the team has been exemplified by the issues discussed above. One interviewee stated that there would be emphasis on developing the CMHT by concentrating on team building and leadership. This will include a review of the Care Programme Approach, to address concerns that it is not being used to its full potential. In particular, the link between inpatient care and community teams was highlighted as an area needing improvement, as currently people tend to work in isolation. However, there was recognition that instability within the teams may have contributed to existing problems and there is optimism that things will improve due to the commitment of senior management and staff. A key priority for the future is educating primary care professionals about mental health.

Another interviewee had a different opinion on the usage of the Care Programme Approach. They felt that the strength of it was in its ability to enhance links between community and inpatient teams. From their perspective, the Care Programme Approach was particularly beneficial to new service users whose first access to mental health services was via inpatient care,

'…*the* [Care Programme Approach] *ensures that they have a well-coordinated package of care which starts at admission…*'

From the perspective of the inpatient service and supported by other perspectives there should be more links with the general hospital. There is no cohesive strategy for self-harm and there are also barriers for people who have both mental and physical health problems (in terms of people receiving treatment for physical health problems and vice versa). Liaison services were perceived to be lacking capacity and clear service provision. These issues are being addressed as part of the review of the Crisis team; there is consideration about developing a liaison service with A & E to improve relationships between the general and psychiatric hospitals. Similarly, the new guidance on self-harm will be a means of forging relationships with agencies beyond the mental health service.

Crisis Team

From the perspective of the crisis team, problems occur due to poor information. It was reported that they have a significant number of referrals, a result in part, of inpatient services requesting that the crisis team sees service users before a decision is made whether to admit them. SCMH were told that the Manor Hospital (the general hospital) often leave out information when trying to refer a client to mental health services (such as whether a client is drunk or violent).

Again, liaison with A & E is important and it is expected that the Crisis Team when redeveloped as a Crisis Resolution / Home Treatment team will adopt this role.

Assertive Outreach

The Assertive Outreach team also emphasised the importance of having links with other services. In addition to close links with the CMHT who are their main source of referrals, they liaise regularly with inpatient services; psychology; primary care as well as non mental health services such as housing and benefits services (the latter were viewed as particularly important). In spite of this, as mentioned earlier, they felt that other services were not clear about the remit of the AOT which causes frustration for the team.

Community Drug and Alcohol Service

The CDAS has a nominated liaison worker for each of the CMHTs to ensure that if someone presents with dual diagnosis, there is a named person available to make the necessary arrangements. Currently there are no specific dual diagnosis workers but a number of staff in the CDAS are RMN trained (although they don't have access to other parts of the mental health service in the way that CMHT staff do) and the Policy Implementation Guidance on Dual Diagnosis is being looked at in the PCT.

There was a general consensus between representatives of services that working relationships between mental health and other services needed to be formalised with protocols. Relationships with the CMHTs were thought to be

inconsistent, with some good relationships and some that needed to be developed. One interviewee described consultants as being 'very dismissive' of people with dual diagnosis.

Another issue was highlighted in relation to accessing crisis services. One interviewee described a tendency on the part of mental health services to focus on the substance misuse element of an individual presenting in crisis as opposed to their mental health need. This is interesting in view of other perspectives that viewed the situation differently. They perceive many crisis referrals to be the result of individuals having had too much to drink as opposed to as a result of a mental health need.

Whatever the case, these findings do indicate a problematic relationship between mental health and drug and alcohol services. From the Drug and Alcohol team perspective, clients with problems of dual diagnosis are managed 'reasonably well' on a one to one basis but that a formal strategy was required to ensure that there is consistency in the treatment and care of this client group.

From a mental health services perspective it was reported that there are no specific services for people with problems of dual diagnosis and that 'the sector consultants deal with it as best they can'. This suggests that access to appropriate care and support is difficult for people who present with problems of dual diagnosis.
To improve this relationship and thus the accessibility of services for people who have mental health and substance misuse problems it is advisable to establish a forum involving key stakeholders. This may include representatives from the CMHT, the Drug and Alcohol Team and other agencies such as the police and probation. The focus of these meetings would be the discussions of cases, providing support and exchanging information.

A number of interviewees (including service users) were concerned that inpatient beds are often provided to people who have substance misuse problems. Appropriate services for people with problems of substance misuse or dual diagnosis seem to be lacking in Walsall. Currently, if an individual requires detoxification they have to be referred out of area to a service in Birmingham. However, this contract with this service is under review and it is possible that this situation will change.

Psychology
Psychology services reported good relationships with other mental health services. They are involved in mental health management team meetings and view themselves as an integral part of mental health services who work with other parts of the service on a daily basis. The CMHT also reported close links and regular networking with the psychology service in spite of the difficulties in referring to the service. Currently, psychology is involved in a multi disciplinary project to redesign the intensive care service which also has involvement from service users. In addition, they provide training in psychological therapies to other teams and services. The nature and extent of training needs clarification

although one interviewee reported that lots of staff are trained in Brief Solution Focused Therapy (this was carried out by an external agency).

The psychology service reported a close working relationship with Borderline UK with whom they are developing care pathways for people with personality disorder (and they already provide treatment for individuals with BPD which SCMH were informed is the first one of its kind in the Midlands and possibly the country). It was acknowledged that more links could be established with local voluntary sector organisations as generally those relationships are on an ad hoc basis.

Crisis Team

The crisis team informed SCMH that they do have protocols with CMHT and good working relationships with them. Protocols with other services will be developed following reorganisation of the service.

Early intervention

At the time of interviewing, Walsall mental health services were in the process of establishing an Early Intervention and First Episode Psychosis Service. The team is not fully operation although there are Early Intervention link workers in CMHTs and the inpatient service. There is also an Integrated Care Pathway (ICP) for Early Intervention enabling link workers to work with clients who present with a first episode of psychosis.

It was reported that the link workers facilitate good networks between the community and inpatient services as well as other agencies. Early Intervention steering groups are open to voluntary sector services, Child and Adolescent Mental Health Services (CAMHS), drug and alcohol services and transition and leaving care services. In addition both Early Intervention workers and primary care CPNs have established relationships with young peoples' services such as Walkways. Part of the philosophy of Early Intervention is to develop ways of encouraging people to seek help at an early stage. Working with organisations which are targeted at young people (but not about health per se) is a proactive way of trying to engage people who may be at risk of developing mental health problems.

A potential problem for Early Intervention Services is that of transition between services. Specialist services have clear remits which can make boundaries more instead of less defined. Transition between services can be problematic for this reason. There was concern that this would be an issue for the Early Intervention Service where clients may be a young as fourteen. This would be a barrier to accessing a service such as the Crisis Team. There is scope to discuss these issues before the Crisis Team is relaunched and the PIG has acknowledged this as an area to be examined.

Broadway North Crisis Residential Unit

Relationships with other services are on the whole good although some issues do arise about risk management. This is the result of different practices being used in different services. Related to this, and another source of tension is that the Crisis Residential Unit staff, though highly experienced do not

necessarily have the qualifications that other mental health staff. A consequence of this is the feeling that their knowledge and experience is not valued and from their perspective, they are not given an equal voice within the service. It was felt that social workers needed to be properly inducted into the service so they had greater knowledge and understanding about it. In fact, all referring agencies were thought to be in need of a clearer understanding of what Broadway North services can offer to service users.

Rethink

Rethink report positive relationships with mental health and social services in Walsall and feel that their service is valued and supported by the statutory sector at a strategic level. However, it was also felt that once people had been referred to their service that CPNs or Social Workers tend to withdraw support for that individual. Furthermore it was thought that the CMHT could be more proactive in working with them to manage clients, for example, informing them if one of their clients has been admitted and involving them in ward reviews.

Service user representation

There are two main service user groups in Walsall: the Service User Network (SUN) and the Service User Council (SUC). SUN is run by and for people with mental health problems whereas the SUC is a generic service, although many of the members are mental health service users. In addition, Walsall mental health services involve service users and carers in the strategic development of the service in a number of ways including partnership boards which are currently being established; audits of the service and public and patient involvement initiatives.

This is very positive; however, the extent to which these Fora and initiatives represent the views of BMEC needs to be questioned.

For carers there is a carer's network, Carer Education Support Programme (CESP) which was established to facilitate carer involvement and also the Standard Six Group (which relates to standard six in the National Service Framework for Mental Health, Caring for Carers) which carer representatives are involved in.

Problems were cited with regards to the attendance of service users from these forums at various meetings. It was felt to be more appropriate for one particular service user representative to attend meetings about a certain topic than for different representatives to attend each time. Where the latter occurs, there is a lack of consistency and people attend meetings who aren't necessarily familiar with all the relevant issues which could impact on their ability to influence the proceedings. A further problem was raised that service users who are less able to articulate what they want than others have less of a 'voice' than their more confident counterparts. A challenge for services is to ensure that they engage with those whose voice isn't always listened too. A way of partially addressing this could be to train service users in how meetings operate; negotiation skills and so forth so that they can feel more confident about attending meetings with professionals.

A partnership board is being established with representation from all service areas and service users, which is beginning to address this issue. At the time of interviewing a protocol between learning disability and mental health services was awaiting approval.

Cultural issues

This section focuses on the particular access issues which arise for people from Black and minority ethnic communities (BMEC) including asylum seekers and women. These issues were highlighted in the 1994 Mental Health First report and findings reported here indicate that there is still progress to be made in this area. Evidence has shown that it is these groups in particular who have negative experiences of accessing and using mental health services. Government policy (Delivering Race Equality, 2005; Mainstreaming Gender, 2003) is trying to respond to these issues and mental health services have specific obligations under the Race Relations (Amendments) Act 2000 amongst other things to ensure that they provide culturally appropriate services. Furthermore, it has just been announced that mental health services have to monitor the ethnicity of people using their service in light of the David Bennett Inquiry which deemed the NHS to be 'institutionally racist'. Walsall mental health services acknowledge that there is a lot of work to be done in this area but that it is being given a high profile and will be monitored by the Strategic Health Authority.

A themed review is underway focusing on BME services which comprises a number of areas including: the strategic context; service user and carer involvement; planning and care processes; accountability and clinical governance; commissioning; partnership working and training and education. Within the section on accountability and clinical governance there is a specific remit to complete an audit relating to the David Bennett Inquiry. A group has been established to look at implementation of the findings from this and the Daksha Emson inquiry. These initiatives will take time to have an impact but ultimately should address some of the issues identified in this report.

All services were said to have equality action plans to 'try and keep in line with the Race Relations (Amendments) Act', although they are reportedly at different stages of development. It was acknowledged that there is a lot of work to be done in this area; there is a requirement to do equality impact assessments but mental health services are not at this stage yet. SCMH were informed that there is a lack of leadership in this area at the moment but the director of mental health services and the social care lead will have responsibility for issues of equality and diversity. Should there be a separate lead? Is there a danger of this being seen as an 'add-on'?

Interviewees were unable to agree on whether the mental health workforce is representative of the population it serves. It would be advisable for mental health services to monitor staff and service users in terms of ethnicity in order to determine for the former: which communities are represented within which services and at what level and in the case of the latter issues such as proportions of individuals from particular ethnic backgrounds are under section or who are given a diagnosis of schizophrenia. As stated above

monitoring of patients' ethnicity is about to become a government requirement.

It was felt that stronger and more consistent links need to be made with voluntary sector services aimed at Black and minority ethnic communities. Interviewees representing Black Sisters, an organisation aimed at meeting the cultural needs of the Black community, have provide some of this support but are under resourced at present. From their perspective, services need to do more to understand and engage Black people in mainstream services. One interviewee suggested that BMEC may not want to receive services from the statutory sector and that there should be consideration of who is best to provide services to these communities. However, statutory services have a duty to provide mainstream services to all individuals and communities who may be perceived as 'difficult to engage' should not simply be viewed as the responsibility of the voluntary sector.

In addition, there should be a focus on the workforce and their own understanding of culture and mental health. How much do their own values and beliefs about mental health problems impact on their ability to identify and support people with mental health problems? Walsall mental health services are beginning to address this in the form of an Asian mental health support worker whose remit is to work with clients on the CMHT caseload to help them develop practical and social skills to help them become more independent. In addition to working with service users the role of the mental health support worker is also to establish relationships with professionals in the statutory and voluntary sector; carers and families. The aim of this is to raise awareness among professionals about culture and mental health and the Asian community about mental health problems and to encourage them to use the services that are offered.

It is a unique and vital role as it goes some way to building bridges between service users and mental health services by dismantling people's preconceptions about mental health issues and thus encouraging individuals to make use of mental health services. Similarly, professionals are given more of an understanding of the issues affecting people from BME communities which will help them provide a better service. SCMH would like to know what impact this has had and whether there are plans to develop this role further.

The availability of primary care CPNs in GP practices is hoped to make mental health services more accessible to individuals who fear the stigma of using mental health services as it provides a means of accessing support more discreetly.

Interviews with service providers have highlighted that language and communication issues are a barrier to accessing services. People whose first language is not English or who are Deaf or hard of hearing will experience delays in accessing services at the very least. SCMH were informed that services had good access to translation and interpretation services but that they would not necessarily be trained to deal with mental health issues. In addition, there have been instances where family members have translated on

behalf of a client. This is problematic as family members may feel defensive or protective and thus unwilling to disclose information. One improvement, according to one interviewee, would be to develop relationships between mental health and deaf services to cater for the small number of Deaf people in Walsall who also experience mental health problems.

Funding should be available to establish or sustain services. An Asian Women's group was running up until 2003. It relied on volunteers and only received a small amount of funding. Attempts are being made to revive this service with the aid of Broadway North Centre resources. Similarly, Black Sisters felt that with more funding they would be in a position to provide services for Black people with mental health problems in Walsall who may find mainstream services difficult to access.

Black Sisters also felt that mainstream services hadn't improved in terms of meeting the needs of BME communities. They reported that mental health services may get a 'slapped wrist' from the government for not meeting needs but that services will blame lack of funding. It was reported that Walsall mental health services do have a mental health strategy for addressing the needs of Black and Minority Ethnic Communities but it was felt that it was just rhetoric,

'…*it's just a document. It's just words on paper…It doesn't mean anything.*'

There was praise however for attempts by Walsall mental health services to engage Black Sisters. They reported being consulted about various documents and invited to strategy meetings. Unfortunately, they felt placed in a catch 22 situation; the lack of resources means they have little time to engage with statutory services but without engaging they have little opportunity to influence the service which could provide them with more resources. In spite of this they felt that Walsall and other agencies as Dorothy Pattison, Archway and the Service User Network had always tried to work along side them.

From their perspective problems accessing services are the result of a lack of understanding by the statutory sector about the African Caribbean community and the lack of willingness to engage. It was felt that most people from BMEC would access mental health services via the police because they would be seen as being as aggressive. Difficulties were also identified in terms of an individual's ability to recognise their own problems and in doing so, knowing where to go. It was thought that GPs might not always know what to do, although some do refer to Black Sisters as they provide free counselling (as GPs are not willing to pay for it). Providing this service was thought to be important because otherwise they will just be given medication. People can self refer to mental health services but people are not necessarily aware of this and even if they are they may fear the stigma of being associated with mental health services.

In the view of Black Sisters, if statutory services are not prepared to provide care for BME communities, they should provide adequate funding for those who will because their cultural needs are not being met. SCMH were informed

that as a result of the themed review in this area, funding will become available for the voluntary sector to provide culturally appropriate services. Presumably mainstream services will also be adopting ways of providing services which are culturally sensitive.

Another problem for BME communities in terms of accessing mental health services was perceptions about Black culture. For example, that Black people are more expressive about their feelings which can be misinterpreted by White people. Behaviour that is not understood or viewed as unacceptable in White culture may quickly be labelled as aggressive. Interviewees from Black Sisters felt that there was an ethnocentric approach to Black people which prevents White professionals from listening to what a person is actually trying to say.

'…*rather than hearing what the person is saying, they'll come to the wrong conclusion.*'

This is a good example of how cultural barriers can come into effect. It also highlights that by maintaining a dialogue with services that can provide such insight, mainstream services can understand these issues and adapt their service appropriately.

Primary care team
The remit of the forthcoming primary care team specifically includes issues around BME and gender. In particular they will be looking at Asian women and domestic violence. Given that a significant number of women with mental health problems have experienced violence and abuse, this is welcomed. It is also considered to be a priority issue in the national guidance on women's mental health (Mainstreaming Gender, 2003).

CMHT
The CMHT held a similar view to that of the psychology service in that some BME groups (in particular the Asian community) are sometimes reluctant to engage with services. The South CMHT was reported as being diverse in terms of its composition with workers from African Caribbean and Asian backgrounds. When asked whether women had any difficulties accessing the service an issue was identified in terms lack of access to child care so that they could attend appointments. There is some money available to provide child care if necessary.

Inpatient care
Interestingly and disappointingly, inpatient care services admitted to a lack of knowledge or a lack of identification of barriers to their service with regards to culture.

'*We don't identify unmet need and don't identify cultural barriers as unmet need…we don't know whether there are or are not barriers to inpatient services.*'

Although individuals from different communities are represented in inpatient services (and indeed all parts of the mental health system) the extent to which they are under or over represented in mental health services is unknown. In spite of this, SCMH were informed, with regards to inpatient care that attempts are made to engage with people from different cultural backgrounds so that the service is able to learn how to make their service more accessible. For example, taking advice about the type of food that people want and meeting people's spiritual needs (something as simple as getting someone a copy of the Koran).

One interviewee perceived it as a case of 'how much we ask and how much [service users] ask'. However, it is important that an environment is created in which service users feel able to ask for what they want and that staff are proactive in finding out about people's needs. Interviewees with experience of staying in DPH felt that staff were too busy to spend time with inpatients. In view of the fact that having someone available to talk to is a priority amongst service user's consideration should be given to how staff can spend more time with patients.

As stated above, a group has been established to look at how recommendations following the David Bennett Inquiry can be implemented. From some of the responses received it would appear that there is considerable work to be done in terms of meeting even the basic needs of individuals from different communities. In terms of the inpatient ward there are inconsistencies with regard to the level of knowledge staff have about the facilities that are available. For example, whether there was an area in which people could practise their religion on the ward; whether people were able to ask for / receive appropriate food or whether there is a women-only space on what is a mixed sex ward. It is astonishing that this basic information is not known in certain quarters.

A dedicated women's lead has been appointed to work on women and mental health. There has been a lack of direction and clear strategy for women's services which is now starting to be addressed. Walsall does have women only day services and women only services but SCMH were informed that this was a result of taking opportunities as opposed to being part of an overall strategy. The inpatient ward at Dorothy Pattison provides mixed sex accommodation but there are separate wings for men and women. In spite of being a relatively new building (built seven years ago) it was designed in advance of guidance on single sex wards and has been unable to meet this target.

Women-only space is available however and there are high ratios of female staff and in fact a shortage of male staff (apart from doctors where the situation is reversed). It would be interesting to know how the design of the building was agreed and whether there was consultation with services users, in particular women, on how they felt the building should be designed. The government may provide guidance on how a service is to be organised but services should not wait for this before providing services which meet the

needs of their community. Provision in the design was made for a space for children to visit their parents and a play area is also available.

Dorothy Pattison was designed with a mother and baby unit, however, low demand resulted in its closure. Walsall mental health services have a contract with a Birmingham service but there a long waiting list for this service was reported (approximately six weeks). As a result of this one mother was treated within DPH but the service was unable to cater for the child. Given the needs of both the child and the mother at this crucial stage this is highly inadequate and also contradicts the view of another interviewee who stated that women with children will have a package of care built around their needs. In addition, how appropriate is it to send a mother to Birmingham for a service which will remove her from the support networks and possibly her other children? Work is underway to address the findings of the Daksha Emson Inquiry which highlighted (amongst other things) the need for mental health services to have a perinatal mental health strategy.

Psychology
Psychology services were aware that difficulties exist for particular communities in accessing mental health treatment and support. It was noted that the proportions of people accessing the service does not match that of the community. Reasons for this were thought to be a combination of barriers created by the service (for example, lack of cultural awareness) but also barriers created by communities themselves. Specifically, in terms of how mental health problems are defined and understood by different cultures.

Unlike a number of other interviewees, the solution was not to ensure that staff were representative of the local communities they serve (as prescribed in much of the policy in this area) but to address the cultural issues, such as how different communities perceive mental health. As *Breaking the Circles of Fear* (2002) highlighted, any one approach to ensuring services are culturally sensitive is likely to be insufficient and rather a number of approaches should be taken.

Anecdotal evidence from a service user perspective revealed the problems of an Asian client who had accessed the psychology service. Her experience was that she was unable to understand the type of language used by the psychologist. The interviewee described this as a cultural barrier because psychology services are designed for White Europeans and deal with concepts which may not be well understood in other communities. The ethnocentricity of Western therapy has been recognised at an academic level and developments are being made in the field of transcultural psychology / psychiatry to enable a 'remodelling' of established thinking in this area to accommodate the multi-cultural society we live in. (Fernando, 2003).

This would also have relevance in terms of asylum seekers and refugees although, as the psychology service identified, access to services is almost impossible for this group. Without status as citizens, they aren't entitled to access services in the community unless there is a crisis. In view of the fact

that many have entered the UK to escape war, persecution and torture, they are likely to have significant mental health needs.

In the case of accessing a service such as psychology there are additional problems. Psychology services consider it unethical to treat someone whose situation is uncertain; when treating posttraumatic stress disorder the starting point is to tell the client that their ordeal is over and they are safe, for an asylum seeker, the threat of deportation means that this promise could not be kept.

It is unclear what happens to individuals in this situation; especially in view of the fact the service has an extensive waiting list. If the service is inaccessible to most service users, how are asylum seekers likely to fare? It is also interesting that the psychology service 'feel a moral obligation' to help asylum seekers in any way they can – by attending court hearings or liaising with solicitors. How do these activities affect their waiting list? Moreover, how are asylum seekers with mental health problems managed? Do they become the responsibility of the GP or a voluntary sector service who are even less skilled to manage this group?

Crisis Team

The Crisis Team manage issues such as communication as they arise. If a person whose first language is not English contacts them then they will need to access the interpreting service. This means that a person may have to wait for a service (which is a paradoxical situation for a service like the Crisis Team). In terms of gender, the Crisis Team does try to ensure that a male and female member of staff are on a shift together or that a female can be contacted if necessary.

Assertive Outreach Service

The AOT aim to provide a needs based service to clients. In practice this means listening to what the client wants and trying to find a service or approach which can cater for them. The philosophy is one of looking at the 'whole person' thus taking into account needs based on culture, gender, faith and so on. The extent to which this is realised has not been measured in this report. It was thought that although there were sometimes difficulties in terms of language and communication with some communities that other issues such as gender were not a problem.

Whether or not this is the case is not the remit of the report but national guidance has shown that services are generally not sensitive to issues of gender or culture and care must be taken to avoid being 'blind' to such things or their impact on mental health. A number of comments made by service providers with regards to issues of culture or gender suggest that these factors are not been considered in any meaningful way. If access issues are to be addressed there needs to be more thinking about how the service is provided and whether it is able to meet the needs of specific groups of people.

Drug and Alcohol Service

The CDAS undertake comprehensive assessments which aim to take account of the social context of people's lives. The service does not see itself as very well culturally represented in terms of staff, although data suggests that the proportions of individuals from BME communities presenting to the service match the proportions within the population of Walsall. The CDAS produces regular information about their service including monitoring ethnicity which is a requirement of the National Treatment Agency. It is positive that this monitoring is carried out but it would be useful to know whether this information is used to inform service provision. Are some people under / over represented in the service?

There is a dedicated worker who deals with women who are pregnant or have a young child (up to 12 months). They receive a service which is closely linked with maternity and social services and relates to their drug use, preparation for pregnancy and medical needs during as well as managing child protection issues.

Day Services

The service acknowledges the need to engage with service users from different communities and backgrounds and has taken some steps towards achieving this. They use a cultural competence checklist to try and ensure that staff and service users are representative of the population served (which will be externally audited). In addition they are trying to ensure that their leaflets are accessible to BME communities by linking in with representatives of these communities. An initiative is also being developed around how to challenge racist remarks. It was recognised that more needs to be done however to engage with people from BMEC in order to provide a service which they will access.

In terms of factors such as gender and culture the service does try to meet people's needs. Day centres have traditionally been more focused on catering for men's needs, providing activities such as pool. Rethink aim to provide a user-led service so that all people have input into the service. There is also opportunity for service users to have a say in terms of meal planning and special dietary requirements are catered for.

The day centres are not insured for children which may be problematic for service users who cannot find or afford child care. This was an issue for the service as a current service user had given birth and Rethink were worried that she might be isolated. Rethink have liaised with a CPN about this and so there is awareness that it is an issue. Friends and carers are welcome to attend however.

Housing

Accessing housing support was recognised as being difficult for people with mental health problems in general. To address this issue a housing co-ordinator post was developed to provide a link between mental health and housing, although currently this post is vacant. In spite of this post being established it was still found to be problematic for service users. Historically,

there have been problems with housing providers who are reluctant to house people with mental health problems due to fears about anti-social behaviour. When layers of gender and culture (as well as issues relating to substance misuse) are added to the equation access appears to be even more difficult. A service provider informed SCMH that women who do not want to share accommodation with men may be placed in refuges which are ill equipped to meet their mental health needs.

It was reported that in Walsall, little has been done to address the issues facing BME communities. Few service users from these communities access housing support and those that do are perceived as being 'westernised'. For BME women access was thought to be even more difficult. It was reported that service users with children face an 'even worse situation' as it is difficult enough to find accommodation for single people.

SCMH were informed that although a range of temporary accommodation is available which caters for young people and people with families, there have been problems for service users in gaining access to them. Problems in securing tenancies have created a backlog in temporary accommodation services, which has resulted in an over reliance on bed and breakfast accommodation. Further difficulties arise when accommodation is obtained in terms of housing people near to friends and family; support networks which can be vital to a person's recovery

Walsall council, following a review of housing and a Comprehensive Performance Assessment audit have acknowledged that they have some 'tough targets' to meet with regards to this issue. A Housing Quality Network has produced a report on how homelessness decisions are made and how the process can be improved.

In terms of housing services, one interviewee thought that there needed to be a broader range of housing options for people. In particular it was thought that more 24 hour support accommodation; step down accommodation and community support were needed. It was also thought to be crucial that agencies that have an interface with mental health services have a better understanding of mental health.

'*When [services such as environmental health and the homeless team] are aware of mental health issues it makes such a difference*.'

The former issue has led to the employment of 'choice based' lettings which gives service users a range of options about the type of accommodation they would like. However, not all service users will be well or motivated enough to utilise this approach and support will still be needed to find the most appropriate placement. The latter point is also being addressed as training is being provided to the above and other services to increase their level of mental health awareness.

The floating support scheme and support workers in the CMHT were thought to have had an impact on improving access to housing. They provide service

users with support which helps to allay the fears of housing providers who have issues with taking on people with mental health problems. In addition, Housing Services successfully bid for a scheme to provide emergency accommodation for people with problems related to mental health; substance misuse; forensic issues and homelessness. The 21 bedded unit (with 10 beds for women and 11 for men) was developed in response to the problem of providing care and support for these individuals when no service would take responsibility (often resulting in out of borough placements).

Broadway North Crisis Residential Unit

The service is thought to be accessible to people from BME communities, although they would ideally like to have an interpreter available everyday. When interpreters are contacted they are not always appropriate, for example an Asian male interpreter will be asked to work with young, Asian women. If the need is identified, they can signpost people to culturally appropriate services. In spite of these shortcomings they aim to provide a service which meets the needs of the individual. Individuals are provided with a budget so they are able to buy their own food and they challenge racist behaviour with anti discriminatory practice (and would not accept referrals from overtly racist people).

Stigma

There was a view that in Asian communities' mental health problems are dealt with by and within the family due to fears about social standing. Arguably, this feeling of shame which is associated with mental health problems pervades all cultures and indeed one interviewee talked about 'different levels of stigma in different communities'. The concept of stigma has been described as being problematic in relation to mental health issues. According to Sayce (2000), it is more appropriate to talk about discrimination as it shifts the focus away from the individual and towards the structures which impact on mental distress or prevent access to services. For example, describing stigma as an issue which prevents people (particularly from the Asian community) from accessing mental health services removes responsibility from mental health services and at the same time reinforces widely held beliefs about certain communities. Rather, it is more appropriate to understand how having a mental health problem is compounded by issues of race and gender which represent further layers of discrimination which impact on their ability to access a range of services.

Nevertheless, most interviewees viewed stigma as a significant barrier to accessing mental health services. Those that were interviewed from White British backgrounds also reported having particular preconceptions about mental health and mental health services. Several interviewees commented on their fears about being 'locked up' or perceived as 'bonkers'. Once they had accessed mental health services however, their perceptions changed. It helped them to gain insight into their own problems and others. One interviewee noted the perceptions that people had about psychiatric hospitals,

'…"*they're all nutters I don't fancy going in there." That's not the case; people are going a patch in life that they have no control over.*'

Thus, stigma can be a real barrier to accessing services for all communities. If people are unwilling to acknowledge or deal with their problems early on due to fears of being labelled as 'mad', their illness may be exacerbated to the point when a crisis situation occurs. This is an undesirable pathway to services as the outcomes are generally not as good as for individuals who receive help at an early stage. Several interviewees reported accessing services in crisis – some because their GP did not provide appropriate support but some because of their own fears. It is crucial that professionals are able to identify the signs of mental health problems at an early stage to prevent a pathway to care which starts in crisis.

Whilst this demonstrates that stigma has an impact on people's ability to identify and accept having a mental health problem the issue is more complex. For example, there is evidence that help seeking behaviour is influenced by a number of factors including gender and ethnicity. Mechanic (1968) identified a number of factors which influence how people use health service. They include: a) the nature of symptoms; b) the influence of cultural factors, particularly beliefs about illness; c) the impact of symptoms on family and social functioning; d) the response of significant others and e) the range of treatment responses available (Morgan et al, 2004). Stigma is perhaps the result of the interplay of these factors, particularly in terms of how significant others respond.

By gaining a more detailed knowledge of the community and these issues, mental health services will be better equipped to raise awareness about mental health and the services available. One interviewee advocated a more proactive approach to dealing with stigma. Educating people in the community as well as professionals about mental health issues was felt to be a positive method of addressing the subject. Like a number of the issues reported here, this finding also emerged from the 1994 Mental Health First report. Therefore, these are not new issues but it may be that there has been a slow response to addressing them.

Physical and Sensory Impairment

One interviewee highlighted the issue of that a small number of people from the Deaf community experience mental health problems but are overlooked by mental health services. It was felt that there needed to be greater recognition of the fact that mental health problems transcend service boundaries and that more integration between Deaf services and mental health services is needed. The interviewee noted that as they are a small population it should be relatively straightforward to meet their needs. It is also unclear to what extent services for Deaf and hard of hearing people are available, such as clear signs, Mincom and hearing loop facilities. The findings indicate that no audit has been carried out to determine whether these amenities are available.

The physical accessibility of services is thought to be good in most buildings as many of them are relatively new. However, the location of services may cause problems for some individuals, particularly if there are mobility issues.

In addition, service users with dual problems of physical disability and mental health problems felt that training of generic workers in basic mental health would be beneficial.

Information

Management information

Within Walsall mental health services, information systems are currently being updated. The system used by mental health services is Careplus while the local authority system Paris is presently being implemented. Information sharing across health and social services will be facilitated with a system called Fusion which acts as a bridge between Careplus and Paris. All staff will be receiving training in Careplus and most importantly, staff will have access to (shared) computer terminals. It is envisaged that once Careplus is operational, more accurate and detailed information will be available to services as it will enable client information to be centralised so that all the interventions and services the client is receiving will be recorded in one place. In addition teams will be able to produce information on who is accessing their service which will highlight the level and type of usage by different communities.

Currently, research is being carried out to assess the impact of primary care CPNs on secondary care. SCMH were informed that they come into contact with 99% of referrals and aim to keep people away from secondary care services.

There is an annual Care Programme Approach audit which involves collecting data from clinicians' records including assessment outcomes; care plans and data from inpatient services. A service user and carer survey also forms part of the Care Programme Approach audit. In addition the Integrated Care Pathways (ICP) tool has an inbuilt audit process based on outcomes. The outcomes are derived from both national and local standards and best practice guidelines.

In addition work on the electronic health care record (EHR) is in progress. EHR will be a national record which will therefore be able to show Walsall in relation to the rest of the country. It will illustrate how different communities are served and whether they access mental health services. One interviewee acknowledged that a lot of work was required to ensure that systems are able to collect and record accurate data. Although more specifically, the emphasis needs to be on ensuring staff are well trained in using information systems and understand the importance of updating and maintaining client records.

Electronic CPA is reasonably well developed but more will be added to it. So far it comprises demographic information and in the future risk assessment and contingency planning information will be added. This should provide a more efficient method of recording information; a crucial part of planning and developing services. However, as stated above, information is only as good as the person who collects and records it. Walsall mental health services have invested a significant amount of money in developing IT systems and

providing computers for staff. Training, as previously mentioned, is at various stages and follow up support is also available.

Psychology services use the SWIFT CARE system and provide monthly returns on their contacts. They also produce an annual report for the wider psychology service to which each specialty contributes and are part of audit programmes across mental health services. It was reported that information is used to strategically to inform service delivery. A variety of data is collected and monitored including waiting times; untoward incidents; demography and referrals. An example of how this has influenced service delivery is the introduction of the Global Assessment of Functioning Scale as a triage tool and awareness that although BME communities do access the service it is not in the expected proportions (although how this was being addressed was unclear).

In psychiatry a new audit is being established to monitor the use of benzodiazepines. Will this audit monitor how they are prescribed in primary care – this could provide a means of looking at how GPs manage mental health issues that they are faced with (e.g. prescribing medication versus referral to mental health services).

Data collection in AOT was described as 'crude' and something that was collected for the Trust as opposed to informing service provision. However, the team are also 'crudely' monitoring the number of clients who are accessing GPs for physical health check ups. This is proving successful for their clients who have severe physical and mental health problems

Public information

Interviews highlighted that there is a lack of information aimed at the public about mental health problems and services, in terms of brochures and leaflets, but that individual practitioners do have knowledge that they can share with clients. It would be useful for individuals to have access to information explaining what mental health problems are; how they can be treated and what services are available. In particular self help is becoming increasingly important to policy makers as it provides a simple and effective way of making interventions available and accessible to people (NIMHE, 2003). Interventions such as Cognitive Behavioural Therapy (CBT) lend themselves to this approach and could be an effective means of reducing the burden on primary care services.

It was reported that there is a development group within the CMHT trying to develop a consistent approach to the use of information, including self help information. It would be of interest to see what the remit of this group is and whether there are plans to make self help information widely available. There is also a dedicated mental health promotion worker which has links with various agencies including public health and the voluntary sector.

The Assertive Outreach Service provides literature to their clients, mainly around medication management.

According to one interviewee more resources in primary care particularly in terms of information for service users will help to overcome the stigma of mental health. It was felt that information needed to be available on understanding mental health problems (especially depression and anxiety) that provides information on, as mentioned above, self help options as well as services that are available and how they can be accessed. Consideration also needs to be given to how this information is targeted. In addition to producing information in different languages and formats, there should be a strategy to raise awareness amongst those who cannot read and an appreciation of cultural variations in how mental health is understood.

Information should also be targeted at GPs so they are knowledgeable about the specialist mental health services available. Progress is being made on the latter point as a care pathway is being developed for depression which includes helping GPs to ask the right questions when a patient presents with depression (i.e. looking beyond the medical model). It was thought that communication between primary care and specialist mental health services needed to be improved. It was proposed that greater joint working would help to address this.

A need to provide better information to carers as well as service users was also highlighted. One service provider described how upon talking to a (Asian) carer at DPH found that she had received no information about her relative and the discharge process – including the importance of him taking his medication and attending outpatients appointments; what to do if he relapsed and who to contact in a crisis. From further discussion it emerged that this carer was in a lot of distress regarding financial issues which no-one had addressed. Are carers in Walsall, particularly those from BME communities aware of their entitlements to benefits and financial support?

SCMH were informed that Walsall MBC provides a range of public information and interviewees seemed to confirm this. However, it was thought that this was in need of updating. There is an information officer responsible for improving the accessibility of information for service users. Will this form the basis of an information strategy which covers health and social services? Information available for people with hearing impairment is produced by the Deaf and Hearing Impaired Team but there was a view that this wasn't the best use of their time.

Psychology services have a good source of self help information some of which they have developed and some which already exists. Individuals attending courses on cognitive therapy receive a manual developed in-house. They also provide training materials and relaxation guides. It would be beneficial if this information was made widely available so that potential as well as current service users could get access to it. The AOT also provide information leaflets about its service (but this will not necessarily improve the accessibility of their service due to its remit).

One of the challenges facing Walsall is targeting information at different and particularly 'hard to reach' communities. Although there are links with

voluntary sector organisations they are not being used to their full potential. There is expertise within this sector that should be utilised for more effective engagement with different communities. In addition, different strategies maybe needed to target different people and it is they themselves who will be best to give advice on what those strategies should be. Are BME communities voices heard within the statutory sector? An issue also raised was with regards to literacy. Some interviewees noted that a significant proportion of people are illiterate and therefore services will need to adopt innovative approaches to communicating their message.

Service user interviewees felt that access to mental health services could be improved if information was more readily available. This, it was suggested, could be achieved if mental health services were more proactive in terms of engaging with communities and providing information.

Service users reported that primary care CPNs do provide clients with information and signpost to other services. However, it would appear that there is not enough information about prescribed medication and potential side effects. Two interviewees who were using primary care services said they had experienced side effects from their medication including hallucinations and fainting. In one instance it was a result of being prescribed the wrong medication which was quite upsetting as it meant an unpleasant experience and also she then had to wait for the correct medication. The GP in question was apologetic and also appears to be an isolated incident according to our findings. However, it does highlight the importance of being aware of the effects of certain drugs and the importance of informing service users about possible side effects (as should be the case for any medication prescribed).

Information about mental health problems, including other support services that are available, are more forthcoming from primary care CPNs. Interviewees reported being given videos; books and so on. This type of self help information is being given more emphasis in government policy as it has numerous benefits. They can be used independently of a professional; individuals can use them in their own home at a time which is convenient for them and could ultimately reduce the pressure on mental health services for people with low level needs (NIMHE, 2003). Although such information is being used by primary care CPNs it could be even more beneficial if it was more widely available. This could also help to address people's fears about accessing mental health services as they would be able to find out information in a discreet way.

Conclusion

The aim of this research was to review the accessibility of mental health services in Walsall. When compared to the Mental Health First report published in 1994 it is clear that some of the issues that have arisen are not new to Walsall. Nevertheless, the report also highlights that mental health services have tried to address these concerns and there are numerous areas of good practice which can be built upon.

There are still concerns that there is lack of knowledge amongst professionals in terms of identifying mental health problems and directing clients to appropriate services. However, most service users were positive about their experience of GPs. The development of the primary care team should enable a more comprehensive service to be provided. They will enhance the capacity of primary care to respond to and manage mental health problems and they will also have a specific remit around BME communities and women which is encouraging.

At the time of this review, Walsall mental health services were (and still are) going through a period of considerable change which on the whole is perceived to be positive. However, when responding to the government agenda it is important to ensure that local needs are not overlooked. In particular the redevelopment of the Crisis Team as a Crisis Resolution / Home Treatment team which means that open access to this service will cease. Limiting options for self referral is the opposite of what service users want and even if the benefits outweigh the costs, services should ensure that service users feel that they have someone to turn to, should they need support.

A significant issue to be addressed in order to improve the accessibility of mental health services is that of social inequalities and their impact on mental health. Mental health services need to have a clear understanding of how gender, race, socio-economic status, disability and so on can contribute to mental health problems as well as determine the type of response provided by mental health services. Walsall mental health services have acknowledged that there is much work to be done with regards to this issue.

SCMH are pleased to hear that Black and minority ethnic communities' mental health is being reviewed but thinking about *all* social inequalities should be part of the main fabric of providing services to meet the needs of individuals. This may include thinking about more flexible referral procedures as formal referrals by GPs or professional letter may exclude certain groups or at least make access problematic.

The need to improve communication across service boundaries was also acknowledged. Relationships need to be established with services outside of mental health such as housing and education to ensure that they are aware of what is available and where to refer people. One useful suggestion was that there should be collaboration with a range of stakeholders comprising both mental health and non mental health services. It was felt that mental health services needed to be more 'outward looking'.

Stigma was identified as an important issue which creates a barrier to mental health services. People's fear of being 'locked up' or 'mad' is a serious deterrent to seeking help for mental health problems. Mental health services need to dispel these myths using campaign and information strategies. We know that the outcomes are better for people who access services at an earlier stage and people must be encouraged to do this.

It was reported that various protocols are in the process of being developed, for example, between learning disability and mental health services. In addition the crisis team; the homeless team and inpatient services have been working to develop procedures and protocols between their services. One interviewee described the importance of having protocols as they helped to consolidate informal relationships and so that people know what their roles and responsibilities are.

Certainly evidence from the interviews suggests that this comment is accurate,

'*At the point of delivery services are good but getting there is a problem.*'

A number of interviewees accessed the service in crisis due to their needs not being met at an earlier stage. However, SCMH would argue that accessibility and service delivery could be improved if staff are more aware of the reasons that people come in to contact with mental health services as well as their mode of access.

Limitations

One of the limitations of this research is that the perspective of general practitioners was not obtained. They are key to accessing mental health services and their viewpoint would have been a valuable addition to this report. It is hoped however, that in spite of this, the information obtained from other participants has provided an insight into some of the issues.

It was also difficult to find service users who had accessed the service in the last twelve months. Those who had accessed primary care CPNs tended to meet this criterion but others did not. Nevertheless it was felt that the experience and knowledge of all service users was valuable.

The low response to the service user questionnaire is also disappointing and highlights the problems with the use of postal surveys. It could also indicate consultation fatigue as the present government expects statutory services to consult the general public on a range of issues. Nevertheless, in total 30 service users contributed to the report which is very positive.

Qualitative research is an excellent technique for obtaining rich, detailed information about a specific topic. However, their aim is not to provide data which is generalisable or representative of any population. Thus, the reader should be aware that this report reflects the perspectives and experiences of particular individuals. However, many of the issues raised in this report are not new to Walsall, which adds authority to the findings.

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Review of accessibility of mental health services in Walsall

Karen Knowles

Researcher

January 2005

Aims

- To review accessibility of mental health service in Walsall
- To highlight barriers to services using a 'bottom up' approach
- To make recommendations for improving access

Aims (2)

- Today – to feedback the key findings and recommendations

Methods

- **Have Your Say Day**
  - Service user led event
- **Service user interviews**
  - 16 semi-structured interviews
- **Staff interviews**
  - 21 semi-structured interviews
- **Service user questionnaire**
  - 200 questionnaires sent out
  - Low response rate

Key themes

- Environment
- Pathways to care
- Assessment and care planning
- Relationships and communication
- Culture
- Information

Environment
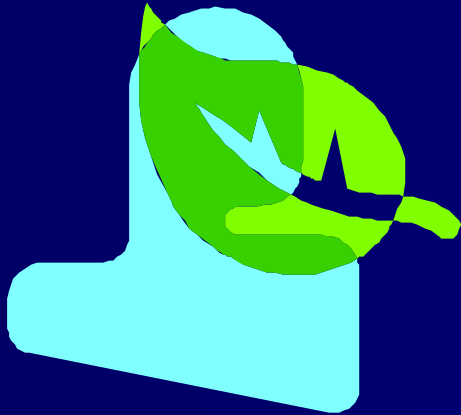
- Location of services

- Physical access

- Dorothy Pattison
  - Complaints
  - PICU

Pathways to care
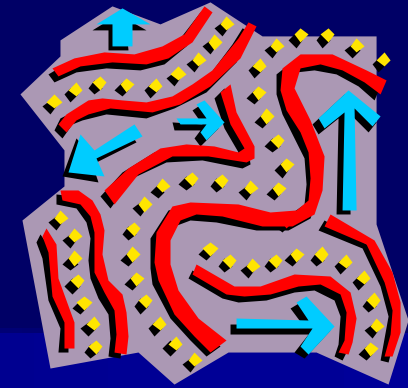
- Referrer / 'client' knowledge
- Help seeking behaviour – how do people access services?

"…[I] *wouldn't have accessed mental health services without the help of my friend and my GP. I probably would have killed myself.*"

- Availability of services

Pathways to care (2)

- Co-morbidity and Personality Disorder
- Self referral options / single point of access
- Day services
- Good practice examples
  - Primary care CPNs / Primary care team
  - 'Visiting' Psychiatrist
  - Broadway North Crisis Residential Unit

Assessment and care planning

- Meeting the needs of the individual

- Care planning - inconsistent

Relationships and Communication

- Roles and responsibilities
- Partnership working and liaison
- Change
- Links with non mental health services
- Links with voluntary sector

Culture

- Black and minority ethnic communities
  - Eurocentric services
- Women
- People with disabilities
- Stigma
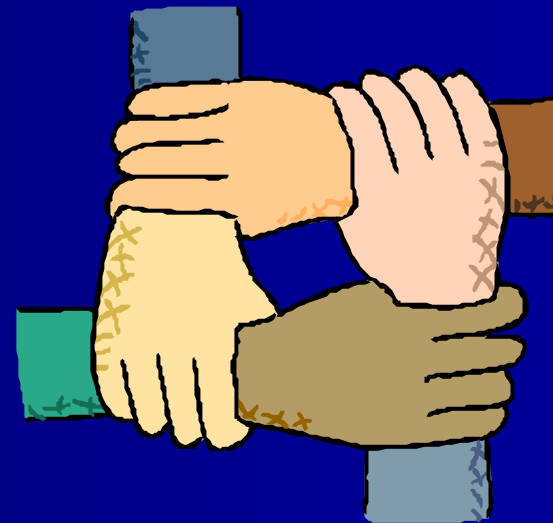
Information

- Public information
  - Medication and side effects
  - Self help / services available
  - Carers

- Management information
  - Consistent information management
  - Service development

Recommendations

- **Environment**
  - Needs assessment
  - Assertive outreach building
  - Complaints

Recommendations

The Sainsbury Centre for Mental Health

- **Pathways to care**
  - Research into help seeking behaviours
  - Increased opportunities for self referral / single point of access
  - Monitoring of primary care CPN 'opt in' letters
  - Mental health help line
  - Training in psychological therapies
  - Extend use of good practice models

Recommendations

The Sainsbury Centre for Mental Health

- **Assessment and care planning**
  - Gaps in care planning to be addressed
  - Reviewing care plans and monitoring outcomes

Recommendations

- **Relationships and communication**
  - Monitoring and evaluation of protocols
  - Training of non mental health staff
  - Stakeholder involvement to include representatives from different communities
  - Liaison workers / joint training / Fora

Recommendations

Culture (1)

- Ensure that there is leadership at senior level to take BME review forward

- Training strategy for BME issues

- Partnership working with BME communities and agencies

- Sustainable funding for voluntary sector providers

- Crèche facilities / child care support for parents to attend services

The Sainsbury Centre
for Mental Health

Recommendations

- – Audit of buildings to determine accessibility for Deaf and hard of hearing people
- – Anti stigma and discrimination campaigns

Recommendations

- **Information**
- Public information
  - Mental health promotion
  - Self help information
  - Medication information
  - Culturally appropriate

Recommendations

- Management information
- Monitoring and evaluation of information to inform service development