Middlesbrough Council

Middlesbrough moving forward

AGENDA ITEM:

HEALTH SCRUTINY PANEL

DECEMBER 2008

EMOTIONAL WELLBEING & MENTAL HEALTH

FINAL REPORT

PURPOSE OF THE REPORT

1. To present the DRAFT Final Report into Emotional Wellbeing & Mental Health for the Panel's consideration, following a detailed and thorough evidence gathering process.

RECOMMENDATIONS

2. That the Panel considers the attached DRAFT Final Report and following any amendments felt necessary, approves the attached document.

TERMS OF REFERENCE

i) To investigate the extent to which emotional wellbeing is an integral part of the local health and social care economy's planning.

ii) To investigate the level of services currently available to promote Emotional Wellbeing in the primary and secondary sectors.

iii) To establish whether gaps in local services exist, in relation to Emotional Wellbeing and Mental Health.

iv) To investigate whether local services approach the topic of emotional wellbeing in a proactive or reactive manner.

v) To investigate the wider determination of Emotional Wellbeing.

vi) To receive advice and gather evidence from sources the Panel deemed appropriate

BACKGROUND

3. Emotional Wellbeing & Mental Health remains something of a difficult subject to quantify in modern healthcare and a great deal of stigma continues to be attached to poor mental health and the one in four people[1] who it is estimated suffer from it each year.

4. The topic of Mental Health has historically being referred to as the 'Cinderella service' of the NHS. By that, it is meant that Mental Health services have often been perceived as getting given a poor deal in respect of funding and have lost out to the other, higher profile endeavours that the NHS is engaged in.

5. In recent years, the NHS has gone along way to rectifying the matter through a series of measures to improve how Mental Health services are funded, regulated and delivered. This is partly due to the changing way in which Mental Health is viewed in society. According to the Kings Fund, since 1999 mental health services have been supported by a increase in investment of more than £1.5billion, which equates to around a 50% increase[2].

6. In society, there is more of an understanding that poor mental health is not a person's 'fault', nor is it something to be ashamed of or hidden away. Mental Health is often determined by biological and chemical factors that can also determine that someone has poor physical health. Society has also started to understand the implications of good or bad mental health for someone's physical health.

7. Society has got better at facing up to poor mental health, understanding it more, and what it may mean for individuals and their communities. As a result, services have become better at addressing people's needs and become less institutionalised, with a notable departure away from the older asylum model, which arguably created as many problems as it sought to solve.

8. A key area of contemporary national debate, which the Panel was extremely keen to explore, was whether or not current services are correctly configured. This means whether services are sufficiently focussed on promotion of emotional wellbeing or on treating poor mental health. It is the classic prevention versus cure debate, or put another way, proactivity versus reactivity.

9. Such a debate centres around whether people should be left to their own devices until they reach a point whereby they have an established problem requiring (often expensive) treatment, or should the system look to provide services aimed at promoting wellbeing and keeping people well?

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[1] 1 in 4 people will experience some kind of mental health problem on the course of a year. Data can be found at www.mentalhealth.org.uk/information/mental-health-overview/statistics/

[2] Please see *Paying the Price – the cost of mental health care in England to 2026.* Page xvii, in executive summary. Can be accessed at www.kingsfund.org.uk

10. It must also be noted, however, that not all instances of poor mental health have strictly medical roots. The Panel also has a great interest in exploring societal causes of poor mental health and considering what non-medical interventions could be made to improve emotional wellbeing.

11. Connected to both of these points is the nature of local commissioning strategies, how much money is spent on Emotional Wellbeing & Mental Health Services and the type of services that the money is spent on.

12. The Panel was also keen to explore the topics of Emotional Wellbeing & Mental Health from the perspectives of Young People and Older People, which have dedicated chapters in the report.

13. With the above in mind, the Panel has considered the matter in great detail and sets out its evidence, together with its observations in the report that follows.

Evidence from Middlesbrough PCT

14. As a starting point to considering the topic of Emotional Wellbeing & Mental Health (EWB & MH) in Middlesbrough, the Panel received an initial briefing from the Middlesbrough Director of Public Health.

15. The Panel heard that historically, the mental health agenda has tended to focus on the problems associated with Mental Health diseases and conditions. As such, good mental health has often being defined as the absence of a mental health condition. It should be noted, however, that the World Health Organisation (WHO) defines mental health as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community."

16. The Panel noted that this is quite a different definition from the concept of good mental health resulting from the absence of poor health. It would appear that the WHO is looking to advance the argument that good mental health is about a positive state of being and is fundamental to overall health.

17. The Panel was told about the WHO's European Declaration on Mental Health (2005) states "There is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment. Mental health and mental well being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens."

18. The Panel heard that as far as national policy is concerned, a key document is the National Service Framework (NSF) for Mental Health, was published by the Department of Health in 1999. The Panel was advised that the NSF addressed the mental health needs of working age adults (up to the age of

65) and set out national standards; national service models; local action and national underpinning programmes for implementation; as well as a series of national milestones to assure progress. Local Implementation Teams (LITs) were established to co-ordinate and lead on the work required to deliver the mental health NSF. On the point of the NSF, the Panel heard that there is a significant body of opinion that whilst it has had some useful impact, the NSF has not particularly dealt with developing a systematic approach to addressing poor mental health and promoting Emotional Wellbeing. The Panel also noted that the NSF will expire in 2009. This point was highlighted by the Panel as something it wanted to explore as the review progressed.

19. The Panel also heard that improving mental health was identified as a national priority and one of the six priorities for action in the White Paper *Choosing Health* (2006). On a local level, the Panel heard that one of the broad aims of the Middlesbrough Community Strategy is to improve the lives of people living in Middlesbrough. The health, happiness and wellbeing of the people in Middlesbrough is critical to achieving this vision.

20. The Panel heard that there are significant challenges to improving the mental health and wellbeing of the Middlesbrough population, as Mental Health problems are very common. The Panel was advised that estimating the prevalence of common mental health conditions is by no means straightforward and relies upon estimates and modelling from national surveys such as the national psychiatric morbidity survey.

21. It was said that at any one time, 16% of adults aged 16 to 74 have a neurotic disorder such as depression, anxiety, panic attacks, phobias, obsessive compulsive disorder or a combination of two or more. More serious psychotic disorders are much less common, affecting approximately 4 per 1000 adults aged 16-64.

22. Mental health problems in older people (over 65s) are also very common. It is estimated that up to 40% of GP attendees, 50% of general hospital patients and 60% of care home residents suffer from a common mental health problem. The Panel heard that the trend in the death rate from suicide and undetermined injury is often used as a proxy indicator for population mental health. Suicide rates are highest among 20-24 year olds and ranks consistently as one of the leading causes of death for adolescents between 15 and 19 years of age. In young people aged 15-24 years, suicides accounts for approximately 30% of all deaths.

23. The Panel heard that deaths in young people are also strongly patterned by socio-economic status and account for almost a quarter of the gap in life expectancy between those living in the most disadvantaged areas and those living in the most affluent areas.

24. Suicide rates are also patterned according to socio-economic status. The suicide rate amongst men aged 20-24 in social class V is four times as high as that in men in social class I. The relationship between socio economic status and suicide is likely to be mediated through a number of different

factors such as poor housing, unemployment, social fragmentation and living alone. Nationally, suicide rates have been declining in all age groups. Between 1994 and 2004, across Middlesbrough, there has been a steady rise in the number of suicides in men. Within the last 2 years, however, the suicide rate has fallen. The Panel noted that whilst this may not be sufficient data to illustrate a long term trend, it is certainly promising.

25. The following table provides *estimates* of the number of people with common mental health conditions in Middlesbrough.

Condition	**Estimated Number**	**Middlesbrough rate per 100,000**
Any neurotic disorder	19,883	198.1
All phobias	2,367	23.6
Depressive episode	3,669	36.6
Generalised anxiety disorder	5,641	56.2
Mixed anxiety depression	10,158	101.2
Obsessive compulsive disorder	1,176	11.7
Panic disorder	1,097	10.9

Source: Mental Public Health Observatory, 2006

26. The Panel heard that more recently, the North East Public Health Observatory (NEPHO) has published a comprehensive assessment of mental health need in the northern region, which was recommended to the Panel as a useful source of information. The Panel has subsequently considered the report at various junctures and its contents has informed the Panel's thinking on the topic.

27. The Panel heard that mental health conditions are strongly associated with socio-economic deprivation and the association between rates of mental illness and other factors such as poverty, unemployment and social isolation is well established. The Panel was shown the following table, which summarises the evidence and rationale presented in the NEPHO document in the risks, protective factors and wider determinants of mental health and wellbeing.

Risks, Protective Factors and Wider Determinants of Mental Health *Summarised from Indications of Public Health in the English Regions: Mental Health*	
Deprivation	People with a neurotic disorder are more likely to belong to socioeconomic class V and least likely to belong to

	socioeconomic class I. Higher prevalence of mental health disorders among children of families from lower socioeconomic groups.
Employment	Unemployment is associated with social exclusion, which has a number of adverse effects, including reduced psychological wellbeing, and a greater incidence of self harm, depression and anxiety. Two-thirds of men under 35 who commit suicide are unemployed. There is considerable evidence to support the beneficial effects of employment on an individual's mental health. Employment can protect a person's mental health by boosting confidence and self-esteem; unemployment can be both a consequence and cause of mental health problems.
Incapacity benefit	The North East has the highest rate of adults aged 16 to 59 years claiming incapacity benefit or severe disablement allowance with a diagnosis in the mental and behavioural disorders.
Limiting Long Term Illness	The North East has the highest proportion of adults with limiting long term illness. Poor quality of life through physical illness is known to be closely related to mental health problems. People with mental health problems are up to twice as likely to report experiencing a long-term illness or disability; over two-thirds of people with a persistent mental health problem also have a long term physical complaint. Limiting long term illnesses impact upon an individual's ability to work and be economically active, which increases the risk to one's mental health.
Alcohol	Evidence suggests an association between increased alcohol consumption and mental ill health. Alcohol consumption can be a cause of mental ill health, or a resulting factor. Middlesbrough has the third highest rate for alcohol related hospital admission in the country.
Drugs	Addiction is seen as a mental health problem in its own right. Drug misuse is linked to mental health through a number of different mechanisms.
Physical Activity	There is strong evidence for the impact of physical activity on mental health: as a treatment or therapy for existing mental health problems; to improve the quality of life of people with mental health problems; to prevent the onset of mental health problems; and to improve the mental wellbeing of the general population.
Healthy Eating	There is reasonable evidence to suggest that nutrition may

	have an important role in maintaining good mental health.
Participation in Society	Participation and involvement in the community appears to have an important effect on mental health and acts as a buffer against conditions such as depression.
Religion	There is some evidence, which suggests that involvement in religion, or spirituality may be an important factor for mental wellbeing. For example, religious involvement has been shown to be associated with positive mental health outcomes such as a lower incidence and prevalence of depression.
Social Support	There is a clear relationship between social support and risk of morbidity and mortality. A lack of social support has been shown to be associated with depression and other mental health problems.
Social Networks	There is a well-described relationship between social networks and mental health. Those with few social contacts are known to be at a greater risk from mental health problems. Social networks can also protect against stress and also an important factor in the recovery from depression in women.
Neighbourliness	Neighbourliness is seen as an important component of social capital and understood as people's willingness to 'co-operate for mutual benefit'.
Education	Education has significant bearing upon employment and social inclusion, both of which impact upon mental health. Certain groups of people are at higher risk of common mental health problems; these groups include those with no, or low level, qualifications and the unemployed. Psychiatric disorders and suicidal attempts are most likely to occur in people facing socio-economic disadvantage, such as those in unskilled occupations or unemployed, and who lack formal qualifications. Individuals with a psychotic disorder are most likely to have left school before reaching sixteen years of age, and hold no qualifications.
Learning and Development	People who flourish at school enjoy better health and wellbeing than those who do not, though the effect may not be causal. Adults who participate in adult education in their 30s tend to enjoy positive transformations in their health and wellbeing more than their peers who do not. Adult learning is also associated with positive outcomes in health and wellbeing of adults who did not flourish at school.
Violence and	Crime, particularly violent crime, is linked to mental health in a

Safety	number of ways. Firstly, it may have similar determinants such as drugs, alcohol and deprivation. Secondly, victims of crime are more likely to suffer mental health problems such as depression. Those who suffer from mental illness are more likely to be victims of crime than to commit crime, although violent crimes committed by people with mental illnesses are more frequently reported. One would therefore expect areas with higher levels of violent crime to have higher levels of mental health problems.
Gambling	The UK is the largest gambling nation in Europe, accounting for just over 22% of the total European market. Over three quarters of the UK population are estimated to gamble; when excluding the National Lottery this falls to just below half (46%). Online gambling already allows for 24 hour access and is a rapidly growing market. Addiction to gambling is both a problem in its own right and may result in debt, which, in turn, can give rise to other mental health problems.

28. When it comes to considering national policy, the Panel heard that whilst much of national policy has focused on mental health per se, there has been a noticeable shift in recent years away from mental illness and towards mental wellbeing.

29. The Panel heard that the Treasury commissioned the Wanless reports of 2002 & 2004, acknowledging both the economic and public health case for a greater focus on promotion and prevention within the NHS. It was said that Wanless emphasised that health promotion policy must address 'individual behaviour and lifestyle risk factors, as well as wider determinants of health such as poverty and education'. The report also stated that population health cannot be assessed solely in terms of morbidity and mortality data, but also requires measures of positive physical and mental health[3].

30. The Panel heard that as a result, there is now an increasing focus on promoting mental health and mental wellbeing within the community. Such a development is reflected in the increasing amount of literature (including published academic papers) on mental health, happiness and wellbeing.

31. The Panel heard that such priorities are reflected within the Local Area Agreement, which has prioritised the following targets, with a direct association to positive mental health:

31.1 % of people who feel they can influence decisions locally

[3] Choosing Mental Health: A Policy agenda for mental health and public health. The Mental Health Foundation 2005

31.2 % of people who believe that people from different backgrounds get on well together in their local area

31.3 % Participation in regular volunteering

31.4 % Engagement in the arts

32. In a similar fashion, the Children & Young People's Plan for Middlesbrough has prioritised the mental health & wellbeing of children within the plan with the following target:

32.1 % of secondary pupils stating that they are happy most of the time

Emotional Wellbeing & Mental Health for Older People

33. As part of the review into Emotional Wellbeing & Mental Health in Middlesbrough, the Panel wanted to have a section of the Final Report that focussed specifically on Mental Health issues for Older People. As such, the Panel asked a smaller group of Members to make contact with officers of the local authority and ask their views on the major challenges associated with keeping Older People in good mental health. The Panel also visited Pennyman House, a residential development in North Ormesby for Older People within a sheltered environment. The rest of this section documents the evidence gathered by the Panel by speaking to Heads of Service and visiting Pennyman House.

34. Councillors met with the Department of Social Care's Head of Older People and Head of Mental Health & Learning Disabilities, to gather their views in relation to the topic of Older People's Emotional Wellbeing & Mental Health.

35. In discussions, we were told that it is quite typical for a fairly high percentage of those in residential care to have depression, although it quite often goes undiagnosed and untreated. We heard that this can be for more than one reason. Firstly, symptoms of depression in older people are often confused with symptoms of dementia. Of course, some people may actually have both conditions, which can make it difficult to unravel people's circumstances and needs, but it is concerning that such assumptions might be made.

36. Secondly, we heard that at times some may view depression amongst older people as inevitable, simply because 'they are old'. Whilst it could be argued that such matters of losing spouses, friends and ill health may mean older people may be more predisposed to depression, we would reject such an assertion that it is inevitable or to be expected. We would hope that with appropriate actions put in place, as outlined later in this report, there is no reason to accept depression amongst older people as a mere inevitability of the ageing process.

37. We heard, nonetheless, that depression amongst older people is a real matter of concern. When one considers the demographics of the UK, with an ageing

population, it is a problem for which approaches should be devised now. We heard that there are a number of reasons for depression amongst older people, although issues such as social isolation, loss of contact with familiar people/surroundings and inactivity would be significant causes.

38. We were interested to consider the role Residential/Nursing homes play in the town and the role they could play in promoting emotional wellbeing & mental health, given the large number of Middlesbrough residents that live in such locations. We heard that, ultimately, what happens in private residential and nursing homes, on a day to day basis, is up to the manager and proprietor. It is difficult, for the local authority to have a direct say on what happens in such locations. Nonetheless, we learned about a quality grading system that the Council employs in relation to residential and nursing homes that was agreed by the Executive on 19 December 2006 and rates facilities from grades 1 to 5. The tool developed for rating local establishments centres on four key components which are

38.1 Physical aspects of the buildings/accommodation
38.2 Quality of care received by residents, as they perceive it
38.3 Quality of care perceived by family members
38.4 Views of staff (via a survey)

39. It is important to note that carers, staff and residents all have an important say in what sort of rating an establishment obtains. In addition, we heard that the Department of Social Care completes regular visits to establishments, in a contract monitoring capacity and will include the views of family and carers when considering the performance of such facilities.

40. We heard that the Commission for Social Care Inspection (CSCI)[4] tends to focus its inspections on such matters as buildings and care plans. By having the star ratings, it was felt that Middlesbrough was going further in attempting to place a certain focus on 'softer' topics, such as the quality of staff. It was felt that there were still improvements that could be made around in capturing people's experiences and giving a richer picture in assessing the standard of residential and nursing homes in Middlesbrough. Nonetheless, it was felt that the grading system was a good step forward and would empower people to make more informed decisions about their care and where to live.

41. We learned that there is a piece of work for the Council to undertake to gather intelligence around the experience of people who pay for their own care, known as 'self funders'. It was explained that the Council has a lot more involvement and knowledge of a particular establishment if it pays for the care of people there, as it is required to undertake care management reviews of the individual's care, at least once a year. The Council is less able to understand matters from a self funders perspective and would like to increase this knowledge in the near future.

[4] The Commission for Social Care Inspection (the regulatory body) will be replaced by the Care Quality Commission in April 2009.

42. In addressing matters such as emotional wellbeing and mental health, it is widely reported that physical and mental activity can have a significant impact on people achieving, or maintaining, good mental health. On this point, we learned that national guidelines for the running of residential and nursing homes indicate that such facilities should have an activities co-ordinator, although it was felt that some activities co-ordinators can be better than others. Nonetheless, all staff should play a role in providing meaningful activities for residents.

43. We learned that the Council's role in advocating the sorts of activities it would like to see in residential and nursing homes is fairly limited. All such facilities are run at arms length from the Council, given their nature as commercial businesses. Further to that, the local authority is fairly limited as to what it can specifically demand in contracts in relation to activities for residents.

44. We learned that a key element in improving (or at least maintaining) good mental health in older people was in keeping as many people as possible out of residential and nursing care, to enable those people to lead as independent lives as possible, even if they are in need of care of some sort.

45. We learned that one of the best models of this sort of arrangement is Pennyman House in Middlesbrough. Pennyman House provides supported tenancies, in an environment that also provides care on a 24 hour basis. The service is managed and run by Tees Valley Housing, with services commissioned by the local authority. As part of this work, we visited Pennyman House.

46. Pennyman House was opened by Tees Valley Housing Group in June 2007 and was built at a cost of around £5.8million[5]. It is an extra care facility, which offers a mix of independent and assisted living to people from across the Middlesbrough area. We heard that extra care offers independent living with additional assistance when needed and the tenants are older people from across the local area.

47. We found that the scheme has 11 one-bedroom apartments and 31 two-bedroom apartments. Residents of and visitors to Pennyman House have access to a number of communal facilities, including a restaurant, hairdressing facilities, faith room, assisted bathing and laundry.

48. On our visit it was confirmed that during the day, visitors have free access to the public areas, such as the restaurant and beauty salon, but cannot gain access to the private areas, which give access to tenants apartments. On our visit we noted that the security of the private areas was maintained via a security fob system, which was discreet but effective.

49. We were most impressed with what Pennyman House had to offer and the standard of accommodation was very impressive. We learned that people living there have tenancy agreements with Tees Valley Housing, which have

[5] www.teesvalley.org/newsdetails.php?newsid=171&source=list

to be respected like any other tenancy agreement, but any social care or nursing care is accessed via the appropriate agencies and available on site.

50. We specifically noticed what a hive of activity the communal areas were, where various classes and activities are run. On our visit, we could see the value of having such extra care available if it was needed by people. Its worth noting that it is also simply an address for some people, similar to living in a block of apartments, but with that extra support available should it be needed either temporarily or permanently. We could certainly see the value of this model, with people having their own front door, whilst having all necessary support under one roof.

51. In our discussion with the Department of Social Care, we also heard that it could be argued that there are too many 'homes' in Middlesbrough, whether that be residential or nursing, with a fairly high number of vacancies. Further, it could be argued that national policy is moving away from such models, towards more independent living type arrangements.

52. It was confirmed that people placed in residential or nursing homes are required to have a review of their status and needs once a year as a statutory minimum, where it is considered whether their current location is in the best interests of the individual. It was noted that there is no statutory requirement to complete a yearly assessment for people who are self funding, although such people can ask for one.

53. It was said that the Council is trying to encourage more and more people to live their lives in a way that may prevent poor mental health, as opposed to dealing with its ramifications once it has arrived. The Council is trying to do this through such initiatives as the Independent Living for Older People Project (ILOP) by encouraging earlier intervention and proactive activities such as dance clubs, although it remains a challenge to provide/stimulate such activities.

54. In respect of older people's mental health services, we heard that the Tees Esk & Wear Valleys provides 3 full time community psychiatric nurses (CPNs) to provide services to residential and nursing homes across Redcar & Cleveland and Middlesbrough. We were interested to hear as to whether or not this was thought to be enough, given that there are around 1600 residential and nursing home beds in Middlesbrough alone.

55. The feeling was that it was probably not enough, although it represents an improvement on where the local health and social care system found itself a few years ago. It was felt that if a debate about improving the service and increasing capacity was to be had, it would need to involve the PCT very heavily, given their specific role in purchasing health services for the community it represents.

56. The role that Direct Payments can play in people's emotional wellbeing and mental health was emphasised. Direct Payments are fundamentally about choice in an activity or service to be accessed, that will enhances an

individual's quality of life. An assessment of someone's need is made and if a need is established, Direct Payments will be made. This is something that an individual can take on and lead if they have the capacity, or assistance can be offered to deal with the administration of Direct Payments if people so wish. It should be noted that Direct Payments are not limited to what people would traditionally consider to be 'nursing' care, but can be used to fund activities as wide ranging as a golf club membership, or paying for someone to assist in going shopping.

57. As was noted in the Social Care & Adult Services Scrutiny Panel's Final Report into Direct Payments in 2004, there are a lot of people who can be quite reluctant to take on Direct Payments for a number of reasons. Nonetheless, it would seem that for those who have taken up Direct Payments, it has had a marked impact on their lives, for the better. It also clearly enhances people's feeling of self-empowerment and self worth. They become an active decision making partner in their care, as opposed to a passive recipient of a service they may or may not particularly value.

58. We learned that the Council offers day care services, at a number of day centres with the intention of giving carers a break and avoiding isolation.

59. On a national policy level, we learned that there is an argument to suggest that older people with mental health problems actually fall between the two stools of the Older People National Service Framework and the Mental Health National Service Framework. In addition, it would appear that recent national moves to increase the focus put on dementia do not seem to include substantial sections on depression. As such, it would appear that there is a policy gap in relation to Older People with Mental Health problems.

60. In terms of what could be done in the future, we heard that the local authority would be making great progress if it worked to fully implement the Older People's Strategy. It was also said that it would be of great benefit if the local health and social care system sought to intervene earlier, in an attempt to prevent the causes of such poor emotional and mental health in older people. Further, the view was also put forward that the town's older people would benefit from more extra care housing and less residential type homes.

61. It was also felt that it would be of benefit if the local health and social care system could give older people options about their care/living arrangements sooner in the process, as this would increase feelings of people having a degree of empowerment over their arrangements. It is often the loss of such empowerment/influence that can inspire depressive feelings.

62. We also heard of a challenge that is facing the whole country, not just Middlesbrough, pertaining to eligibility criteria for provision of services for older people accessing social care. Namely, budgets are increasingly challenged for older people's social care and eligibility criteria for Social Care reflect that reality.

63. The Government launched the Fair Access to Care Services (FACS) framework five years ago (in England), to address inconsistencies across the country about who gets support and to provide a more transparent system. The guidance incorporated important principles about

63.1 Trying to ensure a needs let not a service led approach

63.2 People with similar needs having similar outcomes, though not necessarily similar services

63.3 Taking a non-discriminatory and human rights approach

63.4 Ensuring carers' needs are taken into account

63.5 The role of councils in supporting people who are not eligible with information, advice and alternative services

63.6 Adopting a preventative approach

64. Importantly, the guidance reaffirmed that councils should take their own resources into account when settling eligibility levels locally (using the national framework it described). To clarify, FACS sought to increase consistency and transparency but within a discretionary system whereby each authority could determine its overall funding for adult social care.

65. Since then, however, the policy on personalisation has further developed, evidenced by the *Putting People First* concordat. In addition, increasing attention is being paid to promoting general wellbeing and to targeted prevention, i.e. investment to support people to prevent or defer the need for more intensive help. These policy developments, alongside councils' increasing tightening of their eligibility criteria in order to manage their budgets in a cash limited system, have together highlighted tensions between the implementation of FACS and new approaches to prevention and personalisation.[6]

66. It does, therefore, raise a policy issue as to where the public purse allows the eligibility criteria to be set. Nonetheless, we heard that all national targets indicate that more should be done earlier in people's lives to prevent some needs becoming critical or substantial. As such, a challenge is presented to intervene earlier, before needs become "critical" or "substantial", when they are nearer "moderate" or "low" as outlined in the eligibility criteria.

67. Whilst budgets are an issue which will always be high on the agenda, we heard that the local authority could be extremely instrumental in assisting people with lower level needs by signposting them to other forms of appropriate support. We heard that Age Concern offers a programme called the Phoenix Project, which effectively provides a range of activities/classes,

[6] Please See Cutting the Cake fairly – CSCI review of eligibility criteria for social care, October 2008. Executive Summary on Page 3 and 4.

aimed at people over 55 to stay active and prevent social exclusion. As such, as budget pressures relating to eligibility criteria will probably always be an issue, a local authority should make it its business to know about as many local groups as possible offering relevant services, which people can be guided to. Following such signposting, a local authority should then follow up those individuals to ascertain the outcomes for them, following such advice.

Evidence from Middlesbrough PCT

68. The Panel met on 12 September 2008, and started its evidence gathering with hearing from Middlesbrough PCT and specifically, from officers based in the Mental Health Commissioning Directorate.

69. The Panel heard that historically, Mental Health services have been a poor relation within the wider NHS and this was always reflected in policy and the amount of money spent on them. That anomaly was corrected to some extent by the Mental Health National Service Framework (NSF), which was published in 1999 and constitutes a ten year plan, thus expiring in 2009.

70. The Panel heard that the NSF set out a ten year strategy for the development of mental health services. The NSF set national standards, national service models and was supported by policy implementation guidance and considerable central government investment to ensure delivery against key milestones. Local Implementation teams (LITs) were established to co-ordinate, lead and deliver against the NSF and are required to report annually to the Strategic Health Authority (SHA) on progress.

71. The Panel heard that the focus of the NSF was to cover mental health promotion, assessment and diagnosis, treatment, rehabilitation and care and has made considerable improvements in the quality and access to services for people suffering from mental health problems. Investment since 1999 has driven the development of prison mental health teams, custody diversion teams, primary care mental health teams, assertive outreach teams, crisis resolution and home treatment teams and psychiatric liaison teams, which have delivered outcomes of improved access to services, better, more responsive services and a reduction in the usage if mental health inpatient beds.

72. Whilst the NSF ‘expires’ in 2009, the Panel heard that current policy sees a greater focus on wider emotional and mental wellbeing and not simply focussing upon the treatment of mental illness. The Panel heard that whilst the NSF was fundamentally an important and influential document, which had driven numerous improvements, if there was to be a criticism, it would be that it placed too much focus on the treatment of mental illness, versus the preventative agenda. Nonetheless, the Panel felt that maybe it was necessary to improve more advanced services as a priority, if change was urgently needed, and then concentrate efforts further upstream in due course. The Panel felt that the key point was now to ensure that the increased focus on preventative services was followed through, as systematically as the NSF seemed to demand for more advanced mental health services.

73. In so far as NHS expenditure on mental health is concerned, the Panel heard that it is mainly focussed on one major contract with TEWV, which is broadly divided as in the table below. The Panel also learnt, however, that figures are not available for a number of activities, including costs of prescribing and primary care counselling.

Tees, Esk and Wear Valleys Contract 07/08 budget

services	**Expenditure £`s**
Adult mental health (18-64 years)	9,662,085
Older Peoples Mental Health	3,105,368
Child and Adolescent Mental Health	1,411,687
Substance misuse	376,096
Total	14,555,236

Tees Esk and Wear Valleys service spend 07/08

Service	**Costs £`s**
Adult	
In-patient – acute	2,759,728
In-patient rehabilitation	646,031
In-patient – intensive care	189,828
In-patient – mother and baby	28,811
Out-patients	828,072
Community Mental Health Teams	3,237,474
Assertive outreach team	526,934
Early Intervention in Psychosis	427,509
Crisis resolution team	601,795
Primary Care mental health	299,555
Eating disorders	116,348
Substance misuse	376,096
Total adult	**10,038,181**
Older Peoples Mental Health	
In-patient	2,009,936
Out-patient	221,237
Community team and Day Hospital	874,159
Total Older Peoples mental health	**3,105,368**
Child	
In-patient – acute	289,995
Out-patients	111,144
Community team	1,010,548
Total Child	**1,411,687**

74. In addition to this expenditure, Middlesbrough PCT spend £4,770,296 on specialist and secure placements both locally and on out of area provider

75. The Panel heard that whilst a sizeable contract managed the commissioned mental health activity, contracts for mental health services are not as sophisticated as those one would find in the 'physical health' sector, either planned or non planned care. The Panel heard that this was largely due to the fact that mental health services are a lot more difficult to quantify than other services and have a less obvious episode of care, than say someone having a hip replaced. It was acknowledged that such a contract arrangement would require modification in future commissioning negotiations, as large block contracts now seem somewhat out of step when one considers the contractual relationships between a PCT and a traditional District General Hospital for instance.

76. When one considers the mental health spend for adults (18 to 65 year olds in this instance), it is easily noticeable that there are huge differences in how and where the 'cake is cut'. As an example, the Panel noted that in a budget of around £10m, just under £300,000 was spent on Primary Care Mental Health. It was confirmed to the Panel that Primary Care Mental Health would be the area of service that people with mild to moderate depression would typically be dealt with. The Panel noted that this is around 3% of total adult expenditure to cover (probably) the most common element of mental illness. When it is put in such a format, the Panel felt it was quite stark just how much of the available money goes towards high end, more specialised services and how relatively little goes toward more preventative, low intensity services. The Panel felt that this was a useful example of the sort of shift that national policy seems to be trying to achieve and that needs to happen, although such a shift is not without difficulty.

77. The Panel heard that in considering its future commissioning actions, the PCT will very much be looking to focus on much more primary level care in relation to mental health. Nonetheless, the money being currently spent at the higher end of the mental health care spectrum is needed, as there are people who are recipients of those services. The Panel heard that it is a moot point as to how many of those people would require those advanced services, had there been sufficient intervention earlier in those peoples' lives. Nonetheless, it was clear to the Panel that for a period of time, current expenditure would have to be maintained at the high end of service delivery, together with a greater expenditure at the primary/preventative end of services, until such time that less people were hopefully working their way through the system, as primary services would have intercepted more people and arrested the escalation of their conditions. As such, the Panel heard that it was certainly a future goal of the PCT to be in a position to safely and responsibly dis-invest in higher end services, as they hopefully would not be needed as much, as other programmes would have increased people's resilience and general wellbeing.

78. The Panel was interested in discussing the topic of psychological therapies and their availability in the local health economy. The Panel heard that traditionally, such therapies have been aimed at the more severe end of the spectrum. As such, there has been a concept of adopting a 'watch and wait policy' whereby people's health has to deteriorate to a certain point before

they can get access to services. Such an approach seems quite odd to the Panel and it was pleased to hear that the PCT is looking to change that mindset as a priority. As such, the Panel heard that the University of Teesside is currently training therapists, although developing such staff takes time and is not a quick fix. Nonetheless, the Panel felt that the NHS starting down this path was an important symbolic step.

79. Related to this point is that even if people's poor mental health is being identified and acted upon earlier, it probably does not do much to identify and combat the reasons for poor mental health. This raised the concept of NHS money possibly being spent on 'non NHS' type services, but can play a huge part in keeping someone active and well. Examples of such an approach would be NHS monies paying for debt counselling, if debt was the root cause of the problem, or art classes at MIMA[7] for example, to promote activity and social inclusion. It was discussed that historically, NHS money has been spent on 'treatment' and has therefore being spent in isolation to the rest of the person's life. Whilst that is wholly understandable, the Panel express the view that now is possibly the time to start addressing the root causes of problems in people's lives and not merely the symptoms. This was felt to be especially so in Mental Health, and it will most probably save money in the long term for the public purse.

80. The Panel heard that levels of deprivation have a causal relationship with poor mental health, with the poorest areas tending to have the worst mental health. As an indication of the mental health challenge facing Middlesbrough, it was confirmed that 11of 23 wards are in the highest 20% of need and no wards are in the lowest 20% of need.

81. Another theme mentioned in relation to this was the merits of exercise in keeping people in good physical and mental health. As an extension to this, the Panel raised the concept of NHS monies being used to pay for discount leisure services, particularly for people from deprived backgrounds, who could not afford such services otherwise. The Panel heard that this was a good example of money being spent to hopefully save money in the future by preventing people from developing health problems. It was said that this was an approach that the PCT would be interested in exploring.

82. The Panel heard that older people's mental health problems are even more common with estimates of 40% of GP attendees, 50% 0f acute hospital patients and 60% of care (nursing and residential) home residents suffering with a mental health problem. In James Cook University Hospital in 2006/7 there were around 20,000 admissions of people over 65, of which 12,000 would be expected to have a common mental health problem.

83. The Panel heard that the Joint Strategic Needs Assessment (JSNA) for Middlesbrough reports that 10% of children and young people living in the borough could have some form of mental health problem[8]. The Panel also

[7] Middlesbrough Institute of Modern Art

[8] Later during the Panel's evidence gathering it would hear that such a figure could be nearer 20%or 25%.

heard about a recent survey of secondary school children in Middlesbrough, where 20% reported feeling lonely and 4% said that they rarely or never felt happy.

84. Employment opportunities for people with mental health problems are apparently very limited and of those long-term unemployed claiming incapacity benefit, two thirds have a mental health problem.

85. In terms of addressing future need, the Panel heard from the PCT that the recent development of primary care mental health teams now gives access to services for those people with mild to moderate mental health problems. Whilst innovations such as computerised cognitive behaviour therapy which is available from October 2008 in Middlesbrough, will go some way towards meeting demand, there remains a significant shortfall in access to effective, high quality psychological therapies.

86. The Panel was interested to learn about the NHS Improving Access to Psychological Therapies strategy (IAPT). It aims to change the way resources are allocated by targeting considerable investment, £170m nationally, in a system of NICE[9] recommended local psychological therapy services across England. The aim is to treat 900,000 patients suffering from depression and anxiety over the next three years. IAPT services will be staffed by high intensity and low intensity therapists and aim to promote social inclusion by helping people remain in employment or return to work, offering access to effective treatments before people's conditions become complex or intractable.

87. The Panel heard that Middlesbrough PCT is aiming to develop a bid for year 2 (2009/10) of the IAPT programme, which if successful, will result in approximately £800,000 of recurring national investment to train and develop the IAPT workforce[10]. On this point, whilst the Panel was pleased to hear of such potential investment, it would be keen to ask what would happen if a bid was not successful. The Panel would also hope that if a such a need exists to justify the application for the funding, if unsuccessful, the PCT would look for other means to fund such services.

88. The Panel learned that the mental health strategy for Middlesbrough outlines a number of strategic objectives for children and adolescents, working age adults, older people and for people with specialist needs. It was reported that all objectives have cross cutting themes which are that services will be safe, built on best practice, service user and carer focussed, support social inclusion, work in partnership, local, timely, and equitable. They should also be efficient and cost effective.

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[9] National Institute for Health & Clinical Excellence – known as NICE. NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
Please see www.nice.org.uk for more information.

[10] The Panel has subsequently learnt that this bid was successful

89. The Panel was given an example of the local NHS' increasingly proactive approach to Mental Health, which was the mental health first aid programme. The Panel heard that such training does not teach people to be therapists as such, but it does teach people how to recognise early symptoms of mental health problems, such as depression, anxiety and psychosis. It teaches people how to provide initial help and how to guide a person towards appropriate professional and self-help.

90. In its infancy, the project is to be aimed at Cleveland Fire Brigade, Cleveland Police, North East Ambulance Service, Probation Services, South Tees Hospitals NHS Trust, Health & Safety Executive. The Panel heard that the contract to deliver the training for mental health first aid was awarded to Middlesbrough MIND, and will offer free training to all employers who express interest. Later in its evidence gathering, the Panel heard that around £5,000 had been allocated to this project for the whole of Middlesbrough, which does not sound a great deal. The Panel expressed an interest in exploring the amount of funding given to such an initiative in more detail.

91. It was confirmed that the strategy for high cost specialist placements is essentially two fold. Firstly, to review across Tees all of the placements with a view to commissioning local services for these individuals. Secondly, whilst obtaining suitable local services, to review the case histories of these individuals to ascertain where outcomes could have been improved, through the use of different service models.

92. The Panel heard that it is expected that an emerging strategy for mental health and wellbeing is that by targeting services more effectively in prevention and early intervention, less people will progress to specialist and complex services. Over time, this should have the impact of enabling a significant shift in investment from the severe and complex services towards earlier intervention and prevention models.

93. In summary to the PCT's evidence, the Panel heard that mental health needs are demonstrably higher in Middlesbrough than the national average. As such, the promotion and development of good mental health is essential to the human, social and economic development of the borough. It was said that whilst the development of high quality mental health services is of paramount importance in delivering this agenda, the potential to promote good mental health lies with a number of agencies such as housing, regeneration activities, social care, employment, leisure and health.

Evidence from Middlesbrough MIND

94. In considering the issue of Emotional Wellbeing & Mental Health and how local services are currently approaching the issue, the Panel felt it important to hear the views of Middlesbrough MIND. As such, the Chief Executive of Middlesbrough MIND attended the Panel and spoke at length about the organisation's perspective.

95. The Panel heard that Middlesbrough MIND is a small, independent charitable company, with a most recent annual turnover of £350,000. It employs 20 full and part time staff and is supported by 28 volunteers. Middlesbrough MIND has a number of open access services for Middlesbrough residents, which currently include:

Listening Support – confidential emotional support

Mental Health Support – confidential psychological support for mental health problems, provided in a structured way over a number of weekly sessions

Open MIND centre – an open access community resource centre, providing social support and personal development opportunities

Carers Support – information, emotional and practical support to family and friends (informal carers) of adults with mental health needs

Employment Support – support for people with mental health problems who have been long term unemployed but are interested in employment, education or training

Service User Involvement – support for people who use mental health services to become involved in mental health service policy, planning and decision making

Young People's Support – support for young people aged 11 to 21 with mental health needs

Mental Health First Aid training programme – a training programme licensed by CSIP and being delivered across the North East by a partnership of MIND organisations.

96. The Panel also heard that Middlesbrough MIND is a member of the MIND network, which is the largest voluntary sector provider of mental health services. As well as providing services, the MIND network aims to influence policy and decision makers both locally and nationally to create a better life for everyone who experiences mental distress.

97. In preparation for the Panel meeting, Middlesbrough MIND was asked to consider a number of questions that the Panel wanted to cover. Those questions and the accompanying answers are outlined below.

How does Middlesbrough MIND feel that Mental Health Services are currently performing in Middlesbrough?

98. The Panel heard that much has already being achieved under the Mental Health NSF, but there is much more to be achieved. It was said that some of the standards have not, as yet, been fully implemented including the standard on mental health promotion.

99. The Panel learned that it is very hard to say on a general and objective basis how NHS Mental Health services are performing in Middlesbrough. It was said

that there is very little meaningful information about the quality of services in terms of outcomes for people who use the services, such as whether the people who use the services have got better or whether they feel that they have benefited from the service. As far as Middlesbrough MIND is aware, targets for services concentrate of such matters as types of service, numbers of staff, opening hours and waiting times, rather than meaningful outcomes for people, which admittedly are much harder to obtain.

100. Nonetheless, whilst undoubtedly harder to capture, the Panel felt that service providers should be making strenuous attempts to obtain such qualitative data to inform service development. Further, the Panel would expect the PCT as a principal investor into the service to make efforts to ensure the services are meeting the needs of those people, on whose behalf the services are commissioned and paid for.

101. On a subjective basis, Middlesbrough MIND told the Panel that its impression was that services in Middlesbrough are no better and no worse than others in the region provided by TEWV, with feedback that Middlesbrough MIND hears being mixed. Middlesbrough MIND has contact with people who are perfectly happy with the services they receive. Nonetheless, as a voluntary organisation that aims to work with people who find it hard to access mainstream services or fall between services, inevitably the people that Middlesbrough MIND comes into contact with are people who have experienced or are experiencing difficulty in accessing services for their mental health needs. The Panel heard that the experience of such people is that inequalities in services still exist.

102. The Panel was told that Middlesbrough MIND provides a range of services for individuals with mental health needs and their families, but the majority of people approach Middlesbrough MIND in distress do so because they want to talk to someone about their distress who can offer them time and understanding. The Panel heard that they want to feel respected, listened to, and understood. They also want to deal with people who are flexible, provide open access and can see the person, as distinct from the illness.

103. The Panel also heard that, in Middlesbrough MIND's view, partnership working between services also needs improving. Many people with mental health problems in Middlesbrough still have very poor quality of life and need more than medication or symptom management to improve that. The Panel was told that the services they require to improve such matters as their economic, social and personal circumstances are often those best provided in the voluntary or independent sectors. Middlesbrough MIND put forward the view that those organisation which operate within a medical model of care for mental health, can have difficulty in understanding what the voluntary sector can offer people who experience mental health problems. The Panel heard that services would be significantly improved through more systematic and frequent engagement with service users and carers.

Does Middlesbrough MIND feel that services in Middlesbrough promote emotional wellbeing as well as treating poor mental health?

104. The Panel heard that on the whole, it is felt that mental health services in Middlesbrough treat mental illness. Whilst some services and professionals take a holistic approach to the health and wellbeing of the people they work with, the majority treat and manage symptoms. The Panel was told there are public services across the town (statutory and voluntary sector) promoting mental health and wellbeing, although very few of them are doing so as an explicit objective or with a good understanding of how they are doing it.

How would Middlesbrough MIND look to improve emotional wellbeing and mental health in Middlesbrough and the services provided to deal with such issues?

105. The Panel heard that one of the most important aspects to effectively promoting emotional wellbeing was for society and the NHS specifically to not be so wedded to the medical model of mental illness. Whilst no-one disputes the fact that clinical services are crucial for those people who genuinely need them, they are an aspect of mental health services and should not be viewed as being a panacea to the entire range of mental health issues.

106. It was emphasised that to really improve mental health and wellbeing, mental health cannot be seen exclusively as a health and social care issue, it is a matter of concern for all.

107. The Panel heard that Middlesbrough MIND would seek to put forward the following interpretation of wellbeing as

107.1 Valuing and accepting yourself

107.2 Having the resilience to cope with the majority of difficulties

107.3 Participating in positive activities that contribute to good health and happiness.

108. The Panel heard that in the view of Middlesbrough MIND, a shift needs to take place, whereby the current medical model is replaced by a more integrated model, which takes into account the affects of social and economic circumstances on mental health, alongside psychological factors. When asked for detail, Middlesbrough MIND felt that the following actions could improve mental health and wellbeing in Middlesbrough

109. For mental health services – full adoption of a person centred approach in NHS services, which supports the recovery of quality of life, with the adoption of appropriate outcome measures; improved partnership working, greater choice of services and service providers, with more services commissioned outside the NHS; much more effective user and carer involvement in the planning of services.

110. Whole population promotion and education. The Panel heard that public attitudes of fear and stigmatisation are ingrained and pervasive. Education

around such matters can increase awareness of the common nature of mental health problems and reduce stigma as well as increase early recognition of problems and intervention. The Panel heard that the local community needs a great deal more local work to tackle stigma and discrimination, as well as involvement in national campaigns.

111. It was said that targeted prevention and early intervention programmes for those at risk also need prioritising and resourcing. The Panel heard that although much good work is done, it is often of a piecemeal, ad hoc nature and not part of an overall strategy. Some examples of targeted work were given as parenting programmes that include psychological needs of children as well as physical needs, promoting good practice in the workplace to reduce stress and support employees who experience mental health problems, or providing support for older people to maintain their social lives.

112. At this juncture, the Panel was keen to make a comment about the Mental Health First aid programme that it has heard. A commissioning group made up of the Tees Valley & County Durham PCTs has invested £50,000 into the Mental Health first aid programme, with another £250,000 coming from the Big Lottery Fund, administered by the North East Strategic Health Authority. Over a three-year period, that £300,000, the Panel heard equated to around £5000 for Middlesbrough. Whilst the mental health first aid programme is an excellent initiative and worthy of support as far as the Panel can ascertain, £5000 for Middlesbrough seems a paltry amount to provide it with, to make an impact in the areas it is hoped it will. If such a programme is deemed worthy of support with NHS monies, the Panel feels that it should be given a realistic sum with which to work.

In the view of Middlesbrough MIND who are the groups who tend to be at highest risk of poor mental health?

113. The Panel heard that factors associated with increased risk of developing mental health problems include

- Poverty, low income and debt
- Unemployment
- Poor housing
- Poor educational attainment and low skills levels
- Experiences of violence, neglect and abuse (in childhood or adulthood)
- Homelessness
- Involvement in criminal justice system
- Physical illness
- Use of drugs or alcohol
- Social isolation

114. The Panel heard that conversely, personal and social factors can enable people to protect themselves, or overcome, any difficulties they may experience. An important point to recognise is that even psychological therapies will only impact upon the symptoms, whereas other matters as

outlined below can act to prevent the causes of poor mental health. These factors include

- Autonomy and empowerment
- Positive childhood experiences
- Education and employment
- Friendship and positive personal relationships
- Social support and community engagement
- Physical health and exercise

Children & Young People's section

Evidence from representatives of the Children's Trust

115. Whilst this report is about the topic of Emotional Wellbeing & Mental Health, the Panel wanted to place a specific emphasis on the Emotional Wellbeing & Mental Health of Young People. As such, the Panel was keen to speak with experts in this field. At its meeting on 28 October 2008, the Health Scrutiny Panel heard from representatives from the Middlesbrough Children & Young People's Trust (CTs).

116. The evidence began with the Panel hearing that CTs are a combination of a number of partners, whose principal aim is to commission and deliver services to meet the five outcomes from the every child matters framework. It was also said that there is a number of activities ongoing to review Child & Adolescent Mental Health Services (CAMHS), so it was felt that the work being undertaken by the Health Scrutiny Panel was particularly timely.

117. The Panel heard that the CT has identified the early support of young people and the prevention of poor mental health as a priority. The Panel heard that there are a number of initiatives already in place, which it is hoped will play a part in delivering on this priority. The Panel heard that the town has an anti-bullying co-ordinator and is in the process of delivering a parenting strategy across the town. It was said that the parenting strategy could have a big impact on families' behaviour and improve parental awareness of issues surrounding their and their children's mental health. Related to this point, the Panel also heard that a number of Parenting Programmes have been established across Middlesbrough, which were evidence based and provided in such locations as Children's Centres and Holme House Prison. The Panel heard that they were felt to be having a positive impact on people's parenting skills and therefore their family lives.

118. It was said that there is a family information service, based at Middlesbrough Bus Station, as well as 12 operational Children's Centres across the town, with another two Children's Centres under development. The Panel heard that

the ‘Forget me not’ bereavement service is commissioned specifically for Children & Young People across the town.

119. It was felt that the agreement of a Common Assessment Framework (CAF) by statutory partners across the town had been beneficial in ensuring that people were being helped from a common starting point, when assessing Children & Young People’s needs. In so far as schools are concerned, the Panel also heard that a great deal of belief was placed the Social & Emotional Aspects of Learning programme (SEAL), which is presently in primary schools, with a rollout to secondary schools expected soon. The Panel heard that this programme was quite integral to a child’s development, as it focuses on breeding a culture whereby confidence can develop, barriers to learning are avoided and aspirations are raised. There has been a mental health awareness campaign entitled “Whats Up?”, which seeks to de- stigmatise the topic of mental health and make it ‘ok’ for young people to speak about their mental health and how they feel. The Panel also heard that the importance of diet in ensuring good mental health could not be underestimated and as such, it was pleasing to see that 67% of schools were accredited to the Healthy Schools programme.

120. The Panel was also interested in hearing from the CT representatives about where it was felt that the service could be developed. The Panel heard that a more systematic approach to the identification and support for children and young people with mental health problems was required. To build on this point, it was felt that at present, there is too much of a haphazard approach of ensuring that children and young people with mental health needs get the assistance they require. There is no universal or shared referral methodology, which the Panel found strange given that there is now a CAF, apparently shared across all relevant agencies. The Panel heard that the importance of ensuring school staff, particularly teachers, were ‘mental health aware’ could not be underestimated. It is often school staff who may be in a position to notice certain traits in behaviour in young people at the earliest juncture, and thereby be able to provide assistance or refer the matter to someone else. From the Panel’s perspective, this supports the notion of ensuring that all teachers (and other schools staff with pupil contact), should have the opportunity to receive mental health first aid training, with periodic refresher dates.

121. In other areas of activity, the Panel heard that there was a substantial piece of work to do in ensuring that local services for attention deficit hyperactivity disorder (ADHD) are fit for purpose following recent NICE guidelines.

122. The Panel also heard that there is work to do in the field of autism. Specifically, the development of a multi agency assessment template (MAAT), in line with the National Autism Plan published in March 2003[11]. In respect of Autism, the Panel heard that it is probably a bigger issue in Middlesbrough than is currently known about, as services do not have reliable figure on the incidence of it in Middlesbrough. The Panel heard that, in the view of those

[11] http://www.library.nhs.uk/ChildHealth/ViewResource.aspx?resID=5805

present, it would be prudent for Commissioners to establish some baseline figures in this field. Such figures would be required before any investment in autism services could be properly planned.

123. The Panel learned that in the field of substance misuse, it was felt that improvements could be made in the extent to which services are joined up. Specifically, the Panel heard that links require improvement between the CAMHS teams and specialist substance misuse teams. It was also felt by those addressing the Panel that services could and should respond quicker to families in crisis.

124. The Panel heard that Deliberate Self-Harm (DSH) and Mental Health protocols and how such pathways are interpreted into schools could be improved. It was said that more investment in schools, particularly on educating school staff would be a positive step as there are around 150 cases per year of DSH in Middlesbrough.

125. The Panel also heard that developments in services are needed in the fields of attachment disorder, transitions into adults services and better linkages between CAMHS and Learning Disability services. The Panel was also interested to hear about the improvements felt necessary in providing services to BME communities. The Panel was told that extremely small numbers of young people from such communities access Mental Health Services, even when one considers the percentage of populations that BME communities make up. It was felt that work was required to investigate what would make such services more attractive to BME communities.

126. The last section of the submission considered by the Panel covered next steps for Children's & Young People's Mental Health. The Panel heard that services would like to strengthen services in the support they give to increase families' resilience and it there should be increased CAMHS training for school staff, in addition to the roll out of SEAL.

127. The Panel was interested to hear that services would like to improve processes and associated intelligence regarding outcome measures, in demonstrating efficiency and value for money. It was felt that the workforce requires development on a multi agency basis, to ensure that training provides a core range of competencies for anyone who will work with children. The Panel heard there needs to be better links between universal services (preventative and proactive services aimed at everyone) and the more specialist type of services, so it is much easier for people to negotiate their way through services.

128. The Panel also learned that the workforce needs to be audited, so service planners are better informed with reference to skills and capacity. The Panel heard that a thorough investigation of funding streams and joint commissioning is required, so a baseline is established from which point services can be better planned. The Panel was also told that services need to substantial improve their ability to react to service user and carer feedback.

129. Following the initial briefing received, a debate took place about the points raised. It was confirmed that around 10% of children and young people nationally would be expected to have a mental health problem, which would equate to around 4500 for Middlesbrough. It was noted, however, that social deprivation is higher in Middlesbrough and that, along with family breakdowns, is a substantial cause for mental illness. As such, the Panel heard that instances of mental illness in Middlesbrough amongst young people may be as high as 20-25%, although it was said there has been no detailed analysis done to quantify this. This concerned the Panel on two fronts. Firstly, that the rate of mental illness amongst children and young people in Middlesbrough may be double the national average. Secondly, that no detailed analysis seems to have been done to properly assess the need is a matter that the Panel feels requires attention as a priority. This is especially the case if services are going to be commissioning effectively and from a position of knowledge. The Panel also heard that it was estimated that around 40% of children looked after and youth offenders will have a mental health problem.

130. It was said that there are around 650 referrals a year into the Middlesbrough CAMHS team, which covers the spectrum of Mental Health problems. The Panel heard that every November, the service tries to take a snapshot of services, the sorts of services accessed and with information pertaining to the frequency by which they are used. The Panel heard that the latest exercise of this kind has shown some gaps exist in service provision and it is hoped that this intelligence will be able to inform commissioning strategies and associated work, aimed at plugging those gaps. It was noted with interest that according to such analysis, emotional problems and attention problems are the biggest service areas and the demand would appear to be rising. It is not clear as to whether this is down to better diagnosis or the incidences of such problems genuinely rising, although it would appear to be logical that if awareness of such conditions is increasing, referrals and associated diagnoses will also increase.

131. The Panel was interested to hear about what was felt to have changed in the last ten years, given the increased national investment in children's services and the hugely significant legislative and policy framework around children's services. The Panel raised this issue as Members felt that gaps in service and calls for greater strategic integration were topics being discussed ten years ago.

132. The Panel heard that there was a lot of evidence of different professionals working together at 'the front line' to provide excellent services, although it was accepted that strategic organisational links needed to improve.

133. The Panel heard about a number of national initiatives, including Sure Start, which were felt to be making an impact. Nonetheless, it was noted that with Sure Start particularly, the benefits may not be properly known or demonstrably clear for another 10 to 15 years, as its users grow up and become parents in their own right. The Panel felt that as Middlesbrough has, in some instances, problems that are worse than the national picture, there

should be plenty of activity initiated locally and not simply the implementing national policy. Nonetheless, it was felt that the importance of national direction was sometimes important in ensuring that all local services were aware and conscious of the need to change and the merits of the change.

134. The Panel heard of the importance of making all services aware of the impact they can have regarding Mental Health, including tier one professionals such as schools staff. It was noted, however, that some people would prefer to not enter the 'mental health' field, or become involved in it, as people can be scared or intimidated, which is probably symptomatic of the remaining stigma in wider society. It was emphasised to the Panel however that one of the key steps to be taken that could have a dramatic impact on the mental health of young people, by ensuring they get the services they need, is by improving referral pathways into services from schools. At present, the Panel heard at present it is a rather sporadic process as to how someone requiring such services end up accessing those services.

135. The Panel was told that it was felt that the CAF was showing signs of working well, by ensuring that children's cases were being laid before a joint panel where different services can offer various aspects of assistance, whilst also identifying a lead practitioner for that case. It was emphasised that increasingly, multi agency teams should be in place on a universal scale to work on children's needs analysis and diagnosis.

136. One of the key challenges, the Panel heard, in ensuring such multi disciplinary teams become the norm is that ensuring different professions are placed in positions where they are happy to work together and bring their different skills to bear, without any group of professionals feeling they are not being sufficiently involved. The key point, the Panel heard, was that different specialities will have different expertise, although all professionals should have a core set of competencies, which becomes the basic standard for those working with children and young people[12].

137. The importance of Sure Start in the development of services could not be underestimated. It was said that Sure Start will soon have universal coverage across the town, although it was felt that Sure Start could do more to actively engage with families who do not presently visit facilities and become a more proactive presence it the areas they serve.

138. Given the higher rates of mental health problems amongst Children Looked After, as mentioned earlier in the report, the Panel was interested to hear about the special efforts made around their mental health and particularly around what leisure services they were offered. The Panel discussed how such Children & Young People had put forward the view that they valued access to leisure facilities and it inspired positive feelings, yet at the Panel it was not entirely clear how well funded this programme was. The Panel felt that this was a good example of a proactive service that could be

[12] This concept has recently being espoused as essential in the recently published national CAMHS review – Children & Young People in Mind, the final report of the national CAMHS review

commissioned though the joint mechanisms of the Children's Trust. Further, it was also felt that it would be a fairly inexpensive method of doing something of real value for a group in need of such assistance.

139. The Panel was not able to find any information indicating that the Children's Trust funds such activity for Children Looked After, which having heard that it is particularly valued by that group seems perverse. Subsequent to the Panel meeting, it was discovered that the Council provides free leisure services for Children Looked After as a pilot. It is hoped it will continue to be funded, and that the partners on the Children's Trust should take on some of the cost of such a worthwhile scheme. To build on this point, the Panel felt that the Children's Trust, given its greater buying power and wider membership, should look at the possibility of providing Looked After Children's carers and foster parents natural children with such entitlements, to provide a greater opportunity for family activity. The Panel would also ask how well publicised this is.

140. In respect of ensuring more staff, particularly school staff, were more 'mental health aware', the topic of mental health first aid programmes were raised. The point was made that such programmes are not aimed at making all staff qualified therapists or highly qualified experts, but more aware of patterns or changes in people's behaviour which may highlight problems were being encountered. Such knowledge can often be all that is required to ensure that people are referred onto those experts who are able to offer detailed assistance. In that sense, it is very similar to the concept of physical first aid, which identifies problems and then ensures that more qualified people can 'step in'.

141. The Panel felt that the Mental Health First Aid programme was the sort of tool that could be extremely useful across services aimed at Children & Young People and tailored to the subtleties of Child & Adolescent Mental Health. The panel felt that this further begged the question as to why only around £5k has been invested in its roll out across Middlesbrough so far.

142. The view was expressed that as in adult services, spending on CAMHS needs to shift from specialist services to earlier intervention and prevention. The Panel accepted that the difficulty is achieving that vision, as opposed to stating it, as important as having the vision is.

143. It was said that more money needs to be spent at the front end of the process, in prevention and that was starting to happen through Sure Start and parenting schemes. However, until the benefits of earlier investment begin to come on stream, spending needs to be maintained on specialist care, as the need still exists. This is the dilemma for the public purse, although as a Commissioner, it is the CT that is key to driving this agenda.

144. Given the partnership ethos of the Children's Trust policy initiative, the Panel was interested to hear whether there were any pooled budgets for children's services, as it had learned in other research that they were important in delivering better outcomes. The Panel heard that there are no pooled budgets

in Middlesbrough. It was said that pooled budgets can be quite complex to establish, although what was more important was that there was a shared vision about what should be done and aligned budgets, whereby organisations could put money into shared priorities.

145. The Panel returned to the point around commissioning and enquired as to extent to which the Children's Trust would start commissioning services it wanted to see developed, or whether it would 'commission' by paying for what is provided. The Panel heard that it was important for the CT as a commissioner to start to stimulate and develop the market and act as a true commissioner, although it was felt that this would not happen immediately.

146. In addition, the Panel heard that one of the most produce steps that policymakers in particular could be taken at this juncture, was actually to take a step back and allow the current system to develop. It was felt that current national policy has placed a lot of important building blocks, now a period of reflection was required to allow those to begin to bear fruit.

Evidence from Young Minds

147. As part of the evidence gathering, the Panel sought the views of Young Minds, which is a national charity specialising in the mental health of children and young people. In so far as a national context is concerned, the Panel heard that Approximately 20% of children and young people between 5 and 15 years old experience some sort of mental health problem and around 10% meet the criteria for a disorder (ONS 2005).

148. The Panel was advised that Mental health and mental ill health are widely interpreted by the public, the media, professionals, young people and parents and carers, with little shared understanding. The mental health and psychological wellbeing of children and young people raises broad, cross cutting issues and must be understood within a developmental framework and a bio-psycho-social model. There is considerable stigma associated with having a mental health problem and evidence that perceptions of mental health are formed at an early age (Warner Gale 2007).

149. National policy is shaped by the National Service Framework (NSF) for Children, Young People and Maternity Services, in particular Standard 9, and by the Every Child Matters – Change for Children agenda. The NSF sets out a vision for comprehensive Child and Adolescent Mental Health Services (CAMHS):

150. An improvement in the mental health of all children and young people

151. Multi-agency services, working in partnership, to promote the mental health of all children and young people, provide early intervention and meet the needs of children and young people with established or complex problems

152. All children, young people and their families having access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

153. The Panel noted with interest that there is a current Review of CAMHS in England, which was due to report in November 2008 with recommendations, for next steps in developing services to ensure better outcomes for children and young people. At the core of the national policy framework is the idea that children and young people's mental health is 'everybody's business' and that effective services will provide a range of support at universal, targeted and specialist levels. This reflects the four-tiered model of services first set out in Together We Stand (Health Advisory Service 1995) and reiterated in the NSF.

154. The Panel heard that Young Minds' view is that the current policy framework provides a good basis on which to achieve improvement across the spectrum of mental health needs. It was said that the emphasis now has to be on supporting implementation of national policy and on removing or overcoming the barriers that exist at local and national level. It was felt that the vision is an ambitious one requiring radical change.

155. Young Minds advised the Panel that, in its view, real progress has been made as described in the Report on Implementation of Standard 9 of the NSF (DH 2004) and in the National CAMHS Review Interim Report (DCSF 2008). Nonetheless, Young Minds believes that service provision remains uneven across the country, with few areas fully meeting the criteria for a comprehensive CAMHS. In particular, the Panel heard that Young Minds would highlight the following as areas where further work is required;

156. There is a need for leadership which creates a shared, long-term vision, identifies clear, child centred outcomes and ensures action and accountability.

157. Joint Working supported by multi-agency training and development as a means for building bridges across professional boundaries, creating shared understanding, developing mutual respect and trust and valuing different contributions

158. Relationships are central to children and young people's development and to effective work by professionals with children and young people. More attention needs to be given to human systems issues in leading and managing change.

159. Terminology and an understanding of how colleagues from different professional backgrounds use different terms and language in relation to young people's mental health remains a barrier to good integrated working.

160. The stigma associated with mental health problems acts as a barrier to access to services and requires work at every level to lead a more open and honest debate about the issues.

161. Commissioning of CAMHS remains patchy across the country with some areas making good progress towards integrated, needs driven and evidence based approaches and others lacking a coherent approach. There is scope for much greater use of pooled budgets to enable services to develop and be sustained.

162. Monitoring and Evaluation is often under-developed and there is a need to work out how to measure the right things locally, assessing impact and outcomes. Outcomes need to be shared across children's services and build on work carried out elsewhere on the children's agenda.

163. Referrals and consultation models based on shared local referral protocols are needed so that all practitioners know how and where to obtain support or refer on. Joint training has a key role to play as well.

164. There is often poor understanding of cultural competence and of the best approaches for working with families from different cultural backgrounds despite evidence that culture is central to wellbeing.

165. The Panel was advised that implementation is a complex process involving radical change to long established ways of working and requiring agencies and individuals to develop shared agendas and mutual trust. Change on this scale requires dedicated support and will take time to achieve. It was said that rather than any large scale change to the national policy agenda, Young Minds we would prefer to see an increased focus on support available to local areas to enable them to increase the pace and effectiveness of change. Those speaking to the Panel that the priority is not new policy, but getting better at implementing the ones we have felt it.

166. A key driver behind the NSF was the recognition that CAMHS had developed in many areas on the basis of historical patterns of provision, clinician's areas of expertise and interest and compromises resulting from chronically under resourced provision. The Panel was advised that the starting point for creating a comprehensive CAMHS has to be a comprehensive local needs assessment.

167. This will combine a public health approach to epidemiological data with work to engage stakeholders at every level in developing an understanding of local needs and a description of local services. Prevalence of mental health problems varies significantly, in some cases dramatically, with socio-economic variables (ONS 2005) and service planning must reflect these local patterns, anticipating levels and types of need. Communities shape and are shaped by the mental health of their populations. Local history, culture, geography, economic wellbeing and a host of other factors are part of the environment in which mental health is developed and sustained.

168. It was re-iterated to the Panel that the needs assessment should be the basis of a CAMHS strategy and action plan with a vision and outcomes shared across partner agencies locally including the local authority, PCT and other health bodies and the third sector. The Panel heard that the strategy should

be informed by and owned by all of the stakeholders including children and young people, parents and carers and both the commissioners and providers of services. The Panel heard that it would ideally be able to draw on pooled budgets from partner agencies in order to work towards shared outcomes.

169. It was emphasised to the Panel that the strategy should look at universal, targeted and specialist levels (the four tiers) and will consider the pathways between levels or tiers that enable young people to access and move between services, based on needs. It will pay particular attention to transitions between services and between settings, for example primary to secondary school or CAMHS to adult mental health services.

170. The Panel heard that it should describe and analyse existing services at each level and evaluate the extent to which they are needs led and the degree to which they impact positively on mental health outcomes. It should also explicitly recognise the contribution of improvements in mental health to key activities in other areas, for example young people's attainment and achievement, crime reduction and social cohesion. The Panel was advised that the CAMHS strategy should present the legal, clinical, social, educational, political and economic arguments for investment in mental health in order to secure the widest possible local ownership.

171. It was acknowledged that in every local area resources are finite. It will be necessary to make choices about where to invest those resources to achieve the best possible outcomes. It was put to the Panel that those choices should be informed by evidence of what works; drawn from the published literature, from consultation with stakeholders (about what is needed locally and about what users of services perceive to be effective) and from the input of service providers – evidence based practice and practice based evidence.

172. The Panel was advised that Investment in comprehensive CAMHS remains well below the level required in most areas of England (DH 2004 and RCP 2006). The Panel heard that levels of investment appear to vary widely between PCT/Children's Trust areas, although it can be difficult to make meaningful comparisons. It was put to the Panel, however, that Young Minds strongly believes that increased resources alone will not bring about the required change and that creative approaches to integrated service provision can transform the effectiveness of services.

173. As an example, the Panel heard that, whole school approaches to emotional wellbeing, where staff, pupils and parents are able to work together to promote mentally healthy school communities are more about different attitudes and ways of working than about additional financial investment. The Panel was advised that Young Minds strongly supports calls for additional resources, but not as a panacea in the absence of innovative approaches.

174. It was said that within the framework set by national policy there will be local priorities. The CAMHS proxy measures provide minimum national standards and these are complemented by the markers of good practice in the NSF. It was said that Local Area Agreements may set objectives relevant to the

CAMHS agenda and the local Children and Young People's Plan will include specific priorities that will need to be co-ordinated with the CAMHS strategy. The Panel heard that the more successful areas are in achieving integration between key strategic plans affecting young people, the more likely they are to be able to resource and deliver a comprehensive CAMHS strategy.

175. The Panel heard that the tiered model is an integrated model. Work at tier 1 should not happen in isolation from work at tier 3 or 4. Equally it is not a case of prevention *or* care and treatment but one of prevention *and* care and treatment. The Panel was advised that there is good evidence that early intervention is more effective clinically and financially (leading to reductions in later use of a wide range of children's services) but early intervention will not remove the need for specialist services working with those young people with complex needs. The Panel noted that the benefits of early intervention may take many years to become evident in improved social cohesion, better educational attainment, reductions in youth crime and less dependence on social care services. Indeed, some of the benefits are inter-generational.

176. The Panel heard that today's young people are tomorrow's parents - and parents are almost always the most important influence on the mental health of children. On this point, the Panel noted that for long term and far reaching initiatives such as Sure Start to deliver the desired outcomes, a degree of political and organisational courage was required in standing by such investments, when there is little evidence of an immediate impact and there are other calls on budgets.

177. In so far as service configuration was concerned, the Panel heard that effective specialist CAMHS are engaged in supporting staff in universal settings through consultation, training and advice and through clearly defined care pathways and referral processes. Many specialist services have staff based in tier 1 settings, either on a short term or permanent basis, and this can help to build relationships and lead to more cohesive services. Better trained tier 1 staff will be more aware of mental health issues and more able to respond to young people's needs but that is likely to lead to more appropriate referrals, rather than less referrals for specialist help. The issue is about the functioning of the whole system of services locally rather than its constituent parts in isolation.

178. The Panel was advised, and accepted, that all of this leaves difficult choices for those with responsibility for allocating resources locally. It was felt that a realistic assessment of current services and of the scope of needs locally is the starting point. A shared vision, well communicated to and owned by all stakeholders, is essential. Recognition that change will take time and will involve hard choices is unavoidable. Acceptance that staff need help to achieve change is important. The Panel also noted that political courage to argue the case for proven, supportive services rather than punitive ones is necessary. The Panel learned that above all recognition that good mental health fundamentally underpins children and young people's development and their capacity to achieve against all of the five outcomes in the Children Act is

the key to shared ownership of the agenda and shared investment in outcomes.

179. In summary to Young Minds' evidence, the Panel heard that to act on any of the issues raises above we need to create a shared conceptual model of children and young people's mental health. A health and social care economy cannot discover a shared agenda if its constituent parts all have different understandings of what they are trying to achieve. An agreed foundation is needed to revert to when different pressures and priorities begin to have an impact. *Young Minds* believes that children's mental health is about:

180. A capacity to enter into, and sustain, mutually satisfying and sustaining personal relationships

181. Continuing progression of psychological development

182. An ability to play and to learn so that attainments are appropriate for age and intellectual level

183. A developing moral sense of right and wrong

184. A degree of psychological distress and maladaptive behaviour within normal limits for the child's age and context

185. In developing services locally or nationally it's these characteristics that services are trying to enhance.

Evidence from The Mayor

186. As part of the evidence gathering into the review, the Panel wanted to speak to the Mayor and consider his views on the topic of Emotional Wellbeing & Mental Health for Children & Young People.

187. As part of opening remarks, the Panel heard that the Mayor welcomed the study of this particular topic by the Panel and was pleased to have the opportunity to speak to the Panel about a topic which was felt to be of vital importance.

188. The Panel heard that the Mayor felt that as political leader of the local authority, there was a responsibility on the position to identify areas of importance for the town and make statements on those topics, thereby hopefully giving the matter some political and public profile. As an observation, it was felt slightly odd that public health is probably the biggest issue for the town, yet the Council doesn't have a key service area for public health.

189. Specifically relating to Mental Health, the Panel heard that people tend not to think about the topic, or realise its an area of concern for the town, until it affects them. The 'invisible' nature of mental health problems (as opposed to

physical health problems) can, incorrectly, indicate that there are no such problems.

190. The Panel heard that the Mayor was particularly interested in considering the amount of emotional stress that the town's children & young people were under. It was said that at times, the 'establishment' does not provide enough empathy for young people, but looks to monitor different things such as GCSE attainment, as opposed to happiness or wellbeing. The Panel heard of a particular instance where the Mayor had asked a number of Looked After Children about their priorities in life. It was said that when some young people may have had three homes in 18 months, educational attainment is less important that having a settled home and a settled address. The Panel noted that the current indicators of performance do not seem to cover much of this sort of need/ambition.

191. The Panel was told that a particular interest to the Mayor was the topic of self-esteem amongst children and young people. A key ambition of the Council and partners in Middlesbrough had to be striving to ensure young people felt positive about their futures and safe in their daily lives. It was noted that it is highly probable that there are more children & young people suffering from poor mental health in Middlesbrough than are known about by statutory services.

192. It was noted, however, by those around the table that the prevention of such feelings of low self esteem and the impact of such preventative approaches is extremely difficult to quantify. Indeed, the Panel heard that the public health system has struggled with the topic for a long time, although more thought was being given to the topic now than ever before. It was said that with strong leadership, Middlesbrough could be a pioneer in researching and establishing such methodologies.

193. The Panel heard of the importance that being in work could have in ensuring that people maintain good mental health and maintain good levels of self-esteem. It was noted that regeneration activities across the town are vitally important, although people's own attitudes or feelings are also critical and it is those sorts of areas that services could work to improve.

194. It was also noted that at times services could be fairly arbitrary for those with mental health concerns. It can often depend a great deal on luck as to which element of the statutory services identify someone and begin working with them. It could be youth justice, local authorities, health services and whichever service is involved can often result in a different sort of label being attached to someone.

Evidence from the Tees Esk & Wear Valleys NHS Trust

195. The Panel also received evidence from the Tees, Esk & Wear Valleys NHS Trust (TEWV), which is the principal service provider of Mental Health Services. As the first step, the Panel was interested to hear about the

principles by which TEWV runs its services and sorts of services in has local to Middlesbrough, before moving onto TEWV's strategic vision.

196. The Panel heard there are a number of overarching principles that inform and guide service provision, from TEWV. They are

- Personalised care
- Care in the least restrictive environment: usually at home
- Recovery focus
- Specialisation (for quality and best outcomes)
- Evidence based approach
- Pathway approach
- "Lean" principles
- Improved access and discharge
- New roles and a skilled workforce

197. As far as specialist provision is concerned, the Panel heard that the following themes were critical

198. Create – Simplicity, Standardisation, Specialisation, and Integration along the whole care pathway – community and in-patient

199. De-mystify – The current complexity of services has been caused by "bolting on" of new models of functionalised services, on top of old generic community mental health teams. As a rule of thumb, for any one geographical area over the last 10 years there has been a doubling of community teams.

200. Dismantle – the generic community teams and develop a smaller number of larger, more specialist teams that incorporate NSF functions such as assertive outreach. This will promote consistent, seamless community and in patient interfaces for service users.

201. Redesign the workforce – a culture shift in services will mean that people with the most experience and skills will work face to face with people who have the most complex needs.

202. In respect of operational change, developing further quality and improving outcomes, the Panel heard that the following points are critical to TEWV:

203. New ways of working;

204. Establishing advanced nurse practitioner role & nurse prescribing

205. Establishing nurse-led clinics

206. Supporting development of psychological therapies and interventions through consultant psychologist led psychological therapy networks

207. A culture of shorter periods of active intervention to achieve stated personalised outcomes rather than long term monitoring

208. Involvement of users and carers, in delivering services that fit around them, rather than their having to fit into services.[13]

209. The Panel was also interested to hear about the sorts of services that are available to people in Middlesbrough, requiring mental health assistance. In so far as adult services are concerned, the Panel heard that the following is provided in Middlesbrough

- Teesside Hospice Counselling Service (Teesside Hospice)
- Custody Diversion Team (Parkside)
- Primary Care Mental Health Service (Sandringham House)
- Liaison Psychiatry (St Luke's Hospital)
- Crisis Resolution Team (11A Sunningdale Road)
- Day Services (St Aidan's / Lothian Road)
- Affective Disorder Service (Lakeside)
- Psychosis Service (incorporating assertive outreach) (Parkside)
- St Luke's Hospital (Acute In-patient wards)
- Park House (Rehabilitation)
- Phoenix Lodge (Continuing Care)

210. In so far as CAMHS is concerned, the Panel was told of the following

- Middlesbrough Specialist CAMHS Team (Rosewood Centre)
- South Tees Looked After Children Team (Rosewood Centre)
- South Tees Child Learning Disability Team (Flatts Lane Centre)
- Specialist Adolescent Psychiatric inpatient Service (Newberry Team)
- Low Secure Adolescent inpatient service (Westwood Centre)
- Eating Disorder Services (Lancaster House, Stockton)
- Early Intervention in psychosis services (Viscount House, Stockton)

211. In so far as Learning Disabilities are concerned, the Panel was told of the following

- Community Mental Health Team (Vancouver House)
- Challenging Behaviour Team (Bankfields Court)
- Assertive Outreach Team (Various local locations)
- Health based short term care/respite service (Bankfields Court & Stockton)

212. In so far as Mental Health for Older People is concerned, the Panel heard of the following

- Acute in-patient ward – Wells Villa (St Luke's Hospital)
- Acute in-patient ward – Bath Villa (St Luke's Hospital)
- Community Mental Health Team (Woodside Resource Centre)
- Day Hospital (Woodside Resource Centre)

[13] Please see Appendix 1 for a diagrammatic explanation of how TEWV sees its service provision.

- Developing Memory Clinic (Woodside Resource Centre)
- Home Care Liaison Service (Guisborough Hospital)
- Acute Liaison Service (James Cook University Hospital)
- Young Onset Dementia Team (Eastbourne Road)

213. In respect of Substance Misuse, the Panel heard that there is a Tier 3 Community Alcohol Treatment Service in North Ormesby.

214. The Panel felt that the above augured quite well for Middlesbrough residents and was pleased to note that there are great deal of services located in Middlesbrough. This is emphasised by the fact that the Roseberry Park development (which is a large capital project to replace St Luke's on the same site) is situated in Middlesbrough. As such, this demonstrates that Middlesbrough has a great deal of services 'on its doorstep'. A point that the Panel did note, however, was that most (if not all) of the services outlined above relate to the more specialised end of mental health services and there appears to be something of an imbalance between primary mental health services and more specialised services.

215. In so far as future ambitions go, the Panel heard that TEWV wishes to expand their role in the provision of services in primary care, with the intention of providing a smooth interface with secondary care and being able to provide expert clinicians and leaders. The Panel heard that TEWV's involvement in primary car would continue a long tradition of providing psychological therapies and associated training. The Panel heard that it would also provide an opportunity for the Trust to provide earlier intervention, to promote social inclusion and recovery at the earliest opportunity.

216. The Panel noted the future change of emphasis being outlined by TEWV, which to some extent reflected changes to national policy, but was also being driven by anticipated changes in Commissioner behaviour. As PCTs look to commission more and more activity of a primary care nature, and hopefully prevent people from progressing to more specialised services, provider trusts such as TEWV will have to diversify to maintain revenue streams.

217. In addition to expanding primary care, the Panel also heard that there is work to be done to improve local severe eating disorder services, which are often bought from providers outside the area and prison mental health services.

Acute Inpatient & Crisis Services

218. In so far as Adult Services are concerned, the Panel was advised that the following remain priorities

- Maximisation of alternatives to admissions
- Simpler and speedier access to services
- Consistent high standards of care
- Safe and therapeutic environments
- Comprehensive skills to provide effective and meaningful interventions

- Effective pathways providing optimum care co-ordination – recovery and inclusion

219. As far as CAMHS is concerned, the following are priorities for action

- Specialist inpatient Eating Disorder provision
- Specialist challenging behaviour services for children with a learning disability

220. As far as Older People are concerned, the following service areas are priorities

- Development of an inpatients speech and language therapy unit

- Further exploitation of forensic services of older people

221. Specialist provision for functional and organic patients and utilisation of area for those patients with challenging behaviour – through capital developments such as Roseberry Park.

Day Services/Community Services/Partnerships

222. In respect of Adult Services, the desired improvements would be around the following

- TEWV aims to provide intensive day support during periods of crisis

- TEWV does not see itself as a provider of traditional day care

- Aim to transfer current day care services to other agencies, which are better placed and possess greater expertise

- In respect of CAMHS, the desired improvements would be around the following

- An enhanced community provision across both Tier 3 CAMHS and CAMHS/LD

- Specialist resource for schools to manage self harm

- Dedicated training resources to support Tiers 1 & 2

- Implementation of the National Autism Plan for Children

- In respect of Older People's Services, the desired improvements would be around the following

- Implementation of the National Dementia Strategy (due Autumn 2008) and associated recommendations

- Increase in the numbers of multi disciplinary personnel to form teams for acute liaison and better response to referrals for Older People

223. In so far as Rehabilitation & Medium Term Treatment Services are concerned, the Panel heard that TEWV will continue to provide intensive, recovery focussed, time limited (less than 2 years as inpatient) rehabilitation services to assist people to return to fulfilling lives. The Panel heard that TEWV would like to expand the concept of rehabilitation to include services to:

- People with eating disorders
- Personality and behavioural disorders
- Survivors of severe trauma
- Neuropsychological issues (as well as the traditional psychosis group)

224. In respect of continuing care, the Panel heard that TEWV wants to withdraw from the provision of non-forensic continuing care in NHS settings. The Panel heard that this is because it is now established opinion that NHS inpatient care is not appropriate for long-term living. It is also felt that a plurality of provider will lead to greater choice. In essence, it was said that TEWV's overriding aim is to work with commissioners to modernise services for "Continuing Care" patients, into individualised supported living arrangements provided largely by the third sector.

225. Another area of NHS mental health activity which TEWV spoke about, which the panel is particularly interested in, is the spot purchasing of specialist placements. The Panel heard that in the view of the local NHS, there are many people being treated outside of the area. The Panel heard that there are opportunities to achieve better outcomes more cost effectively by the provision of focussed local services. The Panel heard it has been suggested that a joint analysis of such placements is conducted, following which improved local services can be planned. The Panel would support such an analysis, although the idea of many people being looked after in local services is of concern to the Panel on two fronts. Firstly, and most importantly, it cannot be beneficial for service users to be accommodated away from their home area and the associated support that friends and family would be able to provide. Secondly, it would be much more beneficial for the local economy that money spent on such services is spent within the immediate area, in providing well paid jobs and all of the associated economic benefits.

226. In summary to the evidence provided, the Panel heard that TEWV is committed to developing effective partnerships with commissioners at all levels, with a shared vision emerging between TEWV and commissioners regarding priorities for detailed work. The Panel also heard that TEWV feels that the review and development of primary care level services is of paramount importance, whilst the rehabilitation and continuing care review and modernisation is essential. In addition, the importance of joint work to design 'upstream' services to prevent out of area placements was considered essential.

Evidence from the Citizens Advice Bureau

227. The Panel wanted to focus on some wider social issues pertaining to mental health and the possible causes of poor mental health. As such, the Health Scrutiny Panel approached the Middlesbrough Citizens Advice Bureau, in an attempt to gather information and views around the nature of debt in Middlesbrough, the challenges it poses and its impacts.

228. The Panel heard that Middlesbrough Citizens Advice Bureau is a registered charity and a limited company. It was established in 1939. It's main business is to provide free, confidential and independent advice and information to people who live in or travel to Middlesbrough. Each year it deals with about 25,000 enquires from around 12,000 people. To deal with these enquiries it has a team of 50 volunteers and 30 paid staff. Of the paid staff 7 are employed as debt caseworkers.

Debt Enquiries

229. In 2007-08 the bureau handled almost 8,500 debt enquiries, as set out in the table below.

Type of Debt	**Number of Enquiries**
Mortgage & secured loan	326
Rent arrears	332
Utilities	1206
Council Tax arrears	956
Overpayments of Benefit	526
Bank overdrafts	534
Credit card debts	1322
Unsecured loans	1310
Unpaid fines	234
catalogues	460
Other	1272
Total	**8474**

230. The assistance provided by the bureau includes:

- Drafting financial statements
- Negotiating with creditors, including landlords
- Representing at the county court
- Negotiating with bailiffs

231. The Panel heard that each year the CAB helps service users manage in the region of £8 million of debt.

Debt and Mental Health

232. There is a close relationship between debt and mental health problems. The Panel heard that the CAB estimates that 1 in 4 of the debt clients it sees at

the bureaux have some form of mental health problem. The most common are anxiety/stress and depression. About 1 in 8 of the CAB's debt clients are receiving treatment for a mental health problem.

Mental health as a trigger to debt problems

233. The panel was advised that mental health conditions vary widely, as do their effects. However, mental health problems can lead to debt problems. This often when an episode of mental illness results in loss of employment or reduced earnings, and subsequent inability to meet financial commitments. Among the people who ask the CAB for assistance, the panel learned that the most common form of mental illness causing loss of earnings is depression/stress. Some of the people the CAB sees are receiving treatment; many are not.

234. Some mental health conditions create behaviour patterns that lead to financial problems. For example, the Panel heard that the CAB has assisted a number of people with bipolar disorder. Bipolar disorder is often characterised by dramatic mood swings, from an elevated mood to severe depressive moods, separated by *normal* moods. For a number of the people that the CAB has assisted, their debt problems have come about because they had spent or given away large amounts of money while undergoing an elevated mood swing.

Debt as a trigger to mental health problems

235. The Panel heard that in many of the cases the CAB sees, debt has contributed significantly to deterioration in the mental health of the person, for example:

Client suffers from depression and anxiety, self harms and has psoriases. Attacks of psoriases coincide with debt problems, e.g. council tax demands. CAB makes arrangements but client's mental state is such that they default, usually after a few months, and the circle of default letters - depression - psoriases starts again.

236. In another case the client's mental state was such that their concerns about their financial situation were disproportionate, and to some extent unfounded, but nevertheless contributed to a further deterioration in health.

Client is off work sick with stress/depression. We arranged token offers with creditors, and some creditors have agreed to write off debts because of severity of client's condition. However, client gets extremely disturbed when he receives any letters from his creditors. He is terrified of losing his house. We have investigated and there is at present no problem with arrears - but client's condition is such that he tends to associate any letter from any creditor with the loss of his house, and this causes his condition to worsen.

Mental Health and the management of debts

237. The Panel heard that from the perspective of the bureau, the management of debts for people with mental health problems raises particular issues. In particular, the CAN advises it can be difficult to obtain all of the information it needs from the client, and when arrangements are made with creditors the CAB's clients often find it difficult to sustain the arrangements. For example:

Client suffers from depression. Has a number of non-priority debts, mainly credit cards and store cards. Financial statement compiled and offers made to creditors and accepted. After about 3 months creditors contacted CAB because client had stopped paying. CAB wrote to client but did not get a response for a number of weeks. When client contacted CAB, client explained that they had been severely depressed, making them incapable of dealing with their affairs, and had stopped making payments to creditors. CAB renegotiated arrangements with creditors. Client again stopped paying when depression returned. This cycle has been repeated 5 times in 2 years.

Mental Health and the attitude of creditors

238. The Panel heard that the response of creditors to clients with mental health problems varies, and appears often to be based more on the attitude of the individual managing the account than on the application of any codes of practice. The Panel was advised that in some cases, creditors will go as far as writing off debts if the CAB can provide them with evidence that the client's mental health is such that the likelihood of recovering the debt is very small. In other cases creditor can be persuaded to write off the debt because there is evidence that at the time the loan agreement was made the client did not have the capacity to understand the agreement they were making.

239. The Panel heard that at the other end of the spectrum are cases where the creditor has exploited the client's vulnerability:

Client was off work with depression and severe stress, to the extent that they were on suicide watch. They had a mortgage and a secured loan. The secured loan was with X. After being on sick for a month the CAB client was contacted by X in what appears to have been a cold call to get them to take out more finance. After the CAB client explaining their position, X suggested the CAB client would stop worrying about their finances if they took out an additional secured loan to "tide them over" their sickness. They agreed, but now have to pay an additional £100 per month and cannot afford to pay both this and mortgage.

240. In summary to the CAB's evidence, the Panel heard that the government is currently promoting its Financial Inclusion strategy. As part of the strategy the Dept of Work & Pensions is in the process of appointing sub-regional Financial Inclusion Champions, who will be tasked with raising the profile of financial inclusion work, among organisations who have contact with those groups that are most excluded. The Panel leanred that in the Cab's view, when the Financial Inclusion Champion is appointed, they be encouraged to put the needs of people with mental health problems high on the agenda.

Evidence from Middlesbrough PCT

241. At its meeting on 19 November 2008, the Panel received evidence from Middlesbrough PCT representatives relating to the PCT's Mental Health Commissioning Strategy for the next three to five years. The PCT prepared and submitted a paper outlining its views on the matter, which can be viewed as part of the background papers.

242. The Panel heard that national policy for Mental Health is beginning to focus on early intervention and mental health promotion, alongside developing the healthcare market to include a greater degree of mental health provision from the voluntary and independent sector.

243. In so far as a regional perspective is concerned, the Panel heard that the "Our NHS, Our Future" hold mental health as a key theme. It gives a commitment to a model of care for mental health conditions, which focuses on early detection and intervention. This model has an emphasis on treatment optimism that aims for a return to normal or maximum levels of functioning. This is referred to as the recovery model.

244. The Panel was advised that the adoption of this approach requires the recognition of the long term nature of many mental health conditions. Therefore a balance needs to be struck between the planning of services to address vulnerability in the long term and focus on the wellbeing of people with pre-existing mental health conditions, in equal measure to the agenda across the population.

245. In respect of a local vision, the Panel heard that it can be summed up in two key statements:

245.1 Supporting people to live healthy, resilient and engaged lives, supported by appropriate and personalised mental health services

245.2 To raise the profile of mental health and promote an integrated system to improve the wellbeing of the population, supporting personalised and holistic care

246. The Panel heard that underpinning the local vision is a mental health strategy under 5 specific themes as follows.

Stepped approach to supporting mental health and wellbeing

247. The Panel heard that the current model of healthcare does not always align the most appropriate skills and resources to deal with the needs of the individual, leading to waiting times for some therapies and inappropriate interventions.

248. The stepped approach looks to work with a range of partners to develop integrated programmes including 'back to work' and 'mental health first aid',

alternatives to sick notes with GPs, education and condition management programmes.

249. The Panel was told that this will require commissioning activity through joint arrangements with key partners to identify and implement the key preventative measures to improve mental health wellbeing based on mapping and benchmarking of existing services, investments, performance and activity to identify opportunities for improvement.

250. The Panel was advised that the outcomes of this approach would be equity of access to a range of services and support options, which are easily understood by service users. People will have an understanding of wellbeing issues and develop skills to manage life stresses and anxieties in a positive manner. The Panel was advised that local services can be measured and service users and the public will be able to contribute to commissioning and planning.

Improve Access to Psychological Therapies (IAPT)

251. The Panel heard that people currently wait too long for access to psychological therapies and the quality of the services provided is variable. To address this issue, the PCT told the Panel that the following is proposed

252. To enable the development of new models of service and ways of working that increase and improve access to psychological therapies and significantly reducing waiting times for treatment.

253. To enable and support the implementation of local social inclusion plans which will target vulnerable groups to access mainstream services, establish settled accommodation and pursue employment opportunities.

254. The Panel heard that the outcome of these changes will be that service users, carers and families will experience early access to diagnosis, support and high quality personalised care. Vulnerable groups will access mainstream services and feel able to develop connections to their local community and people with mental health problems will be supported in maintaining a normal life for example by staying in employment.

255. At the meeting, the Panel spoke at some length in relation to IAPTs and the process by which they will be delivered. The Panel has heard on a number of occasions from MIND, Young MINDs, Middlesbrough PCT and through wider research about the merits of Psychological therapies in tackling mild to moderate depression and anxiety. Further, the importance of ensuring that sufficient capacity is available to ensure that the people in need of such services, can access them without an undue delay.

256. As such, the Panel was extremely interested to hear about a fund being held by the North East Strategic Health Authority (SHA), which the PCT was applying to receive funds from to roll out the IAPT initiative. The Panel heard

that if a bid was successful, it would mean £800,000 would be granted to the PCT, to be matched by around £400,000 of PCT money[14].

257. Firstly, the Panel acknowledged that this was an exciting development and would very much like to see the PCT be successful in gaining additional monies for such a worthy project. The Panel heard that there was a degree of risk involved with the bid, as presently people were being trained at the University of Teesside to work as therapists and if the bid was unsuccessful, there was a good chance that those therapists would go elsewhere once trained.

258. One point that the Panel did explore, however, was why it seemed to take a pot of SHA money for the roll out of IAPT to be accelerated. The Panel queried that as all evidence indicates that psychological therapies are hugely beneficial and should be introduced, why wasn't the PCT simply commissioning the service from its standard budgets, as the principal health services commissioner for Middlesbrough. The Panel expressed the concern that IAPT has only being developed so quickly in response to the position taken and finance provided by central government. The Panel was told that there is no doubt that when central government attention is concentrated on something, it does focus minds, although the PCT felt that such projects as IAPT would have developed anyway through the PCT's developing commissioning strategy. Nonetheless, the Panel's concern remained as to why such a project as IAPT, given its substantial evidence based, was not already being commissioned by the PCT for people with relevant mental health conditions.

259. It was acknowledged by all around the table, however, that the fact that IAPT was now higher up the agenda was a positive thing and the money that may come its way was to be welcomed, as historically primary mental health services have been somewhat under funded.

260. On a point linked to funding for mental health services, it was confirmed to the Panel that a great deal of work is required to fully understand the nature of the contract with the TEWV Trust. It was confirmed to the Panel that at present the PCT cannot fully quantify what it gets for the money it provides to TEWV, nor does it know the cost of treatments per se, or the costs of treatment provided to individuals. This surprised the Panel. Whilst accepting that mental health services and their cost may be more difficult to quantify than acute sector services, it was a surprise to the Panel that so little is known about how the money is spent once it is provided on behalf of the Middlesbrough population. It was noted, however, that national policy did not provide a great deal of incentive or instruction for provider trusts to do so. Nonetheless, the Panel heard that the PCT hoped to have such baseline information in its possession by April 2009.

261. As far as other service priorities are concerned, the Panel also heard that the PCT would seek to:

[14] Since this discussion, the Panel has learned that this bid has been succesful.

Reduce the impact of dementia on people's lives

262. The Panel heard that Dementia has a devastating effect on patients, carers and families. It was said that the PCT will address this issue by the systematic implementation of the national dementia strategy.

263. To achieve this the PCT have undertaken to:

263.1 Develop robust and clearly understood pathways for identification, diagnosis and treatment of dementia across all care settings.

263.2 Develop personalised packages of care in partnership with social care

264. Implement everybody's business and the recommendations of the national dementia strategy through mainstream service reforms.

265. The Panel was told that the outcome of these developments will be that patients, families and carers will have earlier access to information, diagnosis and support and the quality of care will be improved and personalised to meet the needs of those accessing the service.

Address the needs of dual diagnosis (substance of misuse)

266. People with a mental illness who abuse substances can find it difficult to access services that recognise and meet the needs of both conditions meaning that neither of them is managed effectively.

267. To address this, the Panel was told that the PCT will:

267.1 Accurately determine local need, including information on the prevalence of drug and alcohol misuse.

267.2 Develop protocols and pathways of care for people with a dual diagnosis, recognising the need to provide support to children under new service models.

268. The outcome of this will be that service users will be supported in implementing their own harm reduction measures and feel confident in using them. Families and carers will be helped to support those with dual diagnosis, having information available to them regarding services available.

Ensuring safe and quality outcomes

269. To pickup a point previously identified, the Panel heard that commissioners currently have limited information in regard to quality, effectiveness and value for money of services procured through block contract arrangements. Improved effectiveness in managing mental health problems can be achieved through better training of all staff in recognising and understanding mental health problems.

270. To address this, the PCT said that it will:

270.1 Introduce rigorous and consistent monitoring of contracts with increased emphasis on improving value for money and cost effectiveness.

270.2 Develop a workforce development programme to fully educate and training health and social care staff in recognising mental health problems at the earliest opportunity.

270.3 Ensure that all health and social care strategies are aware of and address mental health and wellbeing issues.

271. The outcome of this will be that through benchmarking we will ensure that we maximise the benefits of the significant investment we make in mental health services (outlined in previous paper) freeing up resources for further investment. We also expect that earlier diagnosis of mental health problems will be achieved as a result of more staff being able to recognise the early symptoms.

Measures of Success

272. The Panel heard that in addition to the expected outcomes listed above, the PCT would expect that the implementation of these strategies would result in the following for the people of Middlesbrough:

272.1 Reduced waiting times for access to psychological therapies so that maximum waiting times are consistent with those for acute hospital treatment.

272.2 An increased number of people with a mental health problem will be living in settled accommodation and in employment

272.3 Fewer people will be presenting at hospital as a consequence of drug or alcohol misuse

273. The Panel wanted to explore further with the PCT what, if the strategy was successful, would mental health services look like in five years time. The PCT expressed the expectation that access to appropriate services will be swift and there will be a gradual shift away from the culture of prescribing anti-depressants and more talking therapies will be available. In addition, the PCT told the Panel that there will be much more robust tools in operation to assess the impact of such initiatives, which do not presently exist.

274. As a result of the above, there should be less people entering the health system at crisis point, or worse entering the entering the criminal justice system as a symptom of their illness. On the point, of the criminal justice system, the Panel also heard the views of serving police officer situated in custody services. The Panel heard that on a very frequent basis, people enter the criminal justice system who have mental health problems and yet the system is not equipped to address their needs. As a result, their health needs

are ‘pushed to the back of queue’ of priorities or worse are ignored and only their criminality is addressed, despite their criminality often being a direct symptom of their mental health concerns. The Panel noted that cognisance of this sort of theme would also be invaluable in assessing the impact of new mental health commissioning strategies and service redesign.

Evidence from Cleveland Local Medical Committee

275. The Panel was also interested in gathering the views of the Cleveland Local Medical Committee (CLMC) on the current approaches that the NHS traditionally adopts in dealing with mild to moderate depression and anxiety, when patients typically present to a GP surgery.

276. The Panel had read a great deal of information about the role that GPs can have in approaching mental health concerns and the further debate about when GPs can and should make an intervention, aimed at dealing with the mental health concerns.

277. In particular, the Panel was interested in a piece of work compiled by the charity the Mental Health Foundation, in a document entitled *The Fundamental Facts*[15]*.* The Panel learned that in 2005, doctors wrote 29.4 million prescriptions for anti-depressants, which is 4 million more than in 2004. The number of prescriptions written for anti-depressants has tripled since the early 1990s, after a newer class of drug called selective serotonin reuptake inhibitors (SSRIs) such as Prozac became available.

278. The Panel read with interest that NICE guidelines state that anti-depressants are not recommended for the initial treatment of mild depression, as the risks may outweigh the benefits. According to the Mental Health Foundation paper, although 57% of GPs say that antidepressants are overprescribed, 55% use them as their first treatment response to mild or moderate depression, although only 35% believe they are the most effective intervention for mild to moderate depression. 78% have prescribed an anti-depressant in the last three years, despite believing that an alternative treatment might have been more appropriate, most commonly because the alternative was not available or there was a long waiting list for it.

279. The Panel also considered the topic of exercise on referral and asked the CLMC’s views as to whether the above reflected local medical opinion. It was largely felt that it did, although a common problems GPs have is in persuading people that exercise can be as good for them as evidence appears to indicate that it is. It was felt that the local Get Active on Prescription (GAP) was a positive development and seemed to help a lot of people in the local area. Nonetheless, it would appear that there is still work to be done in ensuring GPs have a proper and full range of choices when deciding how and what to prescribe when dealing with people with mild to moderate depression.

[15] Please see page 52. The Fundamental Facts – the latest facts and figures on Mental Health. Mental Health Foundation 2007 edition. www.**mentalhealth**.org.uk

Conclusions

280. As touched upon elsewhere in the report, the Panel has considered Mental Health issues from the perspective of older people, children and young people and the wider population of the town. The following conclusions are divided into those categories.

Conclusions specifically pertaining to the Emotional Wellbeing & Mental Health of Older People

281. The Panel was impressed with the model on display at Pennyman House and could see the benefits of such a model being employed. However, The Panel also considered that buildings and models of service can only deliver so much. It is vitally important that all facilities occupied by older people have a range of meaningful and (where appropriate) requested activities for older people, to combat matters such as social exclusion and inactivity. The Panel feels that this would represent a major step forward to addressing poor mental health in older people.

Conclusions specifically pertaining to the Emotional Wellbeing & Mental Health of Children & Young People

282. The Panel was unable to find any substantial evidence of the Children's Trust as yet, asserting itself as a prime commissioner for children's services, or striving to develop the market for children's services in respect of Mental Health & Emotional Wellbeing. This is something that the Panel would like to revisit in the near future.

283. The Panel heard that organisational links at a strategic level in respect of Children's Trusts could be improved. The Panel has also received evidence indicating that as yet, there are no pooled budgets within the Children's Trust, will would seem to make joint commissioning much more difficult.

284. On the basis of the evidence heard, the Panel feels that the referral process for CAMHS is often fragmented and in need of development. The Panel has heard that a universal CAMHS referral protocol for Middlesbrough would greatly improve matters and ensure that those in need of services are placed on the most appropriate pathway, irrespective of who is making the referral.

285. In terms of commissioning CAMHS services for children & young people across Middlesbrough, the Panel has received evidence to indicate that current intelligence is lacking regarding incidences of poor mental health and the types of poor mental health prevalent in Middlesbrough. As an extension of this, it strikes the Panel that this makes it extremely difficult to effectively and intelligently commission mental health services for children and young people.

286. In addition, the statistics in relation to Children Looked After are fairly stark. The Panel has heard that 40% of children looked after will develop a mental

health problem, against a national expectation of 10% for all children and young people. The Panel feels that this single statistic should be sufficient, to ensure the creation and implementation of an assertive and wide ranging emotional wellbeing & mental health programme, aimed at children and young people, with a specific emphasis on Children Looked After. The Panel does not feel that the present CAMHS service is assertive enough in offering support, with the referral system somewhat unclear and operating without the benefit of a full and contemporary needs assessment.

287. The Panel would like to draw attention, again, to the results of a survey referred to in the Joint Strategic Needs Assessment for Middlesbrough. Specifically, a recent survey of secondary school children in Middlesbrough, where 20% reported feeling lonely and 4% said that they rarely or never felt happy. The Panel is troubled to read such statistics and ultimately saddened by them. The Panel considers that part of the problem in this regard is parts of a media that seems quite intent on demonising young people and labelling them as a problem, often when there is very little evidence to do so.

289. The Panel would implore the local authority to not rest in its efforts, to ensure that Middlesbrough is a good, healthy and safe place to grow up, where ambitions can be realised. The Panel would make the point that this should especially focus upon Children Looked After. Such young people are already disadvantaged and that disadvantage should not be compounded by mental health services which are not sufficiently knowledgeable of, and therefore responsive to, their needs.

Conclusions pertaining to the Emotional Wellbeing & Mental Health of Middlesbrough

290. After considering the available evidence the Panel has noted that there is a distinct lack of PCT investment in proactive mental health services, which would be based in the primary care sector. According to figures received by the Panel, investment in primary mental health services equates to around 3% of adult mental health funding. The Panel welcomes the recent strategy detailing the need and organisational will to invest in more primary care mental health services, although the Panel would like to see that starting to show in resource allocation.

291. The Health Scrutiny Panel would endorse the PCT's change of focus in respect of Mental Health services, particularly with an increased focus on primary care services. Nonetheless, in the evidence considered by the Panel, there has been a lack of detail regarding how the PCT will implement that strategy. As such, the Panel would like to hear more from the PCT as to how and when they will implement the strategic vision.

292. The Panel has considered a great deal of evidence which seems to support the merits of psychological treatments, such as talking therapies, when people present in primary care with appropriate problems. The Panel is aware of a PCT bid for some money held by the Strategic Health Authority under the

IAPT programme. Whilst the Panel hopes that the PCT is successful in its bid, the Panel concludes that such is the apparent need for the service, it should be commissioned from mainstream PCT funding if the bid is not successful.

293. On the strength of the evidence received, the Panel considers that there is considerable merit in the concept of using public money to fund projects, aimed at reducing the incidence, or at least the severity of poor mental health. The Panel would consider that debt counselling, leisure facilities for looked after children and their carers and activities for older people would be a reasonable starting point. Whilst not 'treatment services' per se, the Panel has received evidence to indicate that such services would 'pay for themselves' in the long term.

294. The Panel has heard several arguments as to what good mental health means. Traditionally, the argument would be the absence of a diagnosable mental health condition meant that someone would be in good mental health. As understanding and knowledge has developed, there are arguments that would indicate the importance of being able to live an active life as part of a community, as having a role to play in determining good mental health. This has been put forward by such organisations as the World Health Organisation. In a recently published national CAMHS review, the Panel noted a particularly enlightening view, put forward by a young person spoken to as part of the CAMHS review. They said

"It doesn't mean being happy all the time, but it does mean being able to cope with things"[16]

It is precisely that sort of resilience that the Panel has heard is so crucial for services to engender.

295. The Panel has heard a great deal of evidence, particularly in the field of young people, that mental health first aid is absolutely critical in ensuring that changes in people's behaviour are noted and help can be sought earlier in someone's life. Such programmes are not aimed at ensuring all recipients of the training become mental health experts, but do know the early signs, and feel qualified to and capable of calling in further expertise. With this in mind, the Panel cannot reconcile the programme's importance, with an investment of only £5000 in mental health first aid for Middlesbrough. The importance of such programmes in relation to Children & Young People has already been identified by the national CAMHS review[17].

296. The Panel has noted that the evolution of mental health commissioning arrangements is somewhat behind that of the acute sector. The Panel finds it quite surprising that this far into the reform programme for NHS finance, the PCT is still not fully aware of what its block contract with the Tees Esk & Wear Valleys Trust buys. The Panel has heard that the PCT is not entirely sure of

[16] Please see Please see Children & Young People in MIND – the final report of the national CAMHS review. Can be accessed at www.dh.gov.uk Quote is from Chair's foreword

[17] Please see Children & Young People in MIND – the final report of the national CAMHS review. Can be accessed at www.dh.gov.uk . Reference is from page 11, Point 1 in executive summary.

the cost of interventions, nor how its (circa) £14m per annum investment is precisely spent.

297. Initiatives that have been put in place, such as Sure Start, and the policy framework around them, appear to have the support of all professionals the Panel has spoken to. In addition, it strikes the Panel that the benefits of such initiatives such as Sure Start are long term, even intergenerational. Whilst the Panel accepts that waiting for long term gains can be challenging in a democracy with general elections every four or five years, the Panel calls for period of time whereby CAMHS is 'allowed to breathe' and develop in a way that the policy framework indicates.

298. The Panel notes that Social Care departments in particular are placed in an invidious position between emerging policy and the very real constraints of the public purse. Financial constraints increasingly mean that eligibility criteria for older people receiving social care only covers severe and critical need, despite much of emerging national policy enthusing about the impact that highly quality preventative services can have. There appears to be an inevitable tension between the two points, on which the Panel is unclear of the way forward. Possible routes to mitigate the impact of this dichotomy are the funding of social inclusion projects from local government or PCT budgets and local government being as aware as possible of local third sector ventures, which may be able to assist people with 'low' needs.

299. Following an extensive investigation, the Panel has concluded that the local health & social care economy's approach to Mental Health can best be described as management of the problem. The Panel has not seen any substantial evidence to indicate that the local health and social care economy is innovative in its approach to investing in Mental Health services, and seems to prefer taking a lead from central government as to what services, or courses of action should be priorities. The Panel finds this concerning and would hope to see more innovation taking place in the locality, following what have been significant rises in funding in recent years.

Recommendations

In respect of Older People

300. The Panel would like to hear from Middlesbrough's Dept of Social Care and Middlesbrough PCT, how they are planning to implement the emerging national policy, regarding more preventative services. This is especially so around the prevention of social isolation, which can lead to poor mental health. The Panel would welcome the opportunity to contribute to that work and would be interested to hear how the local authority and PCT are making budgetary provision for such programmes.

301. The Panel would like to see the local authority make it easier for community groups providing activities for older people to access community grant monies, to enable such activities to have a surer financial footing and become more sustainable. This could be done through increased advertisement or

awareness raising. The local authority could target specific groups to ensure their awareness of such monies if felt appropriate.

302. The Panel feels that as a condition of financial support being granted to Community Councils, a proportion of that figure should be spent on activities for older people in their area of influence. Such programmes could be aimed at combating social isolation and specifically targeted at those in perceived danger of social isolation.

303. The Panel would like to receive progress reports on the two recommendations above at 301 and 302.

Children & Young People

304. The Panel recommends that Middlesbrough PCT, Middlesbrough Council and partners use their best endeavours to deliver a mental health first aid programme, specifically designed for Children & Young People. Further, that all staff working with children & young people be given the opportunity to attend that specialist mental health first aid training, when it is operational.

305. The Panel recommends that school governors, investigate how that particular school can seek to address emotional wellbeing training for staff.

306. The Panel recommends that the Children's Trust seeks clarity on how it is identifying the mental health and emotional wellbeing needs of children. The Panel would like to hear the outcome of that exercise and hear the examples of the services being commissioned.

307. The Panel recommends that a systematic audit takes place to inform the incidence of poor mental health in Middlesbrough amongst children and young people. Until this is done, a commissioning strategy and associated investment cannot be reliably undertaken. This should be completed as a priority.

308. The Panel would encourage the Children's Trust, to support Looked After Children and their foster families in accessing leisure facilities.

309. The Panel recommends that Middlesbrough Council, as a corporate parent, continues to invest in leisure passes for Looked After Children and their foster families.

310. Middlesbrough PCT looks to actively support Looked After Children their foster families in undertaking leisure activities, which would be beneficial for their physical and mental health.

Wider Mental Health issues for the town

311. The Panel recommends that Middlesbrough Council and PCT extend services for Adult Mental Health first aid across the town, so it is accessible for all people who would benefit from the training in the performance of their job.

The Panel would envisage that this would necessitate extra investment in the programme.

312. The Panel recommends that the PCT commissions a comprehensive range of services, from as wide range of providers as possible, aimed at assisting people with mental health concerns, at the earliest possible juncture. This would assist General Practice in being able to have more options of appropriate support for people, such as debt advice where relevant and talking therapies.

313. Connected to the above, the Panel would recommend that the PCT support this policy shift by committing substantial investment to its implementation. The Panel would not seek to suggest a precise sum, but would recommend that it is substantially more than the current 3% spend on primary care services out of the budgetary provision for adult mental health services.

314. The Panel would, in the near future, like to see evidence of the PCT and the Middlesbrough Council implementing joint investment plans for the emotional wellbeing and mental health services in Middlesbrough, which is very much a shared priority.

315. As a final observation, the Panel notes that there will be indicators that can be devised to ascertain whether the suggested actions above have had an impact. For example, the success of a Commissioning Strategy will largely be borne out as to whether GPs feel that there are more options in prescribing services for poor mental health. It would also be indicative of an improved commissioning strategy, if General Practice felt that services were improving. In addition, the success of more mental health first aid training for those in contact with young people or older people may mean an increase in accurate and appropriate referrals.

316. The Panel would suggest that in considering new commissioning strategies, such performance measures are investigated.

Councillor Eddie Dryden
Chair, Health Scrutiny Panel

BACKGROUND PAPERS

The following papers were used in the production of this report

Children & Young People in Mind – The Final Report of the National CAMHS review, Published in November 2008, Dept of Health and Department of Children, Schools & Families.

Paying the Price – The cost of Mental Healthcare in England to 2026,
The Kings Fund, 2008.

Up & Running – Exercise Therapy and the treatment of mild or moderate depression in primary care, Mental Health Foundation, published 2005

Depression: Management of depression in primary and secondary care, Published by National Institute for Health & Clinical Excellence, published in Deember 2004, with amendments April 2007

The Fundamental Facts, the latest facts and figures on mental health published by Mental Health Foundation 2007.

Children & Young People's Plan – Middlesbrough 2007/8

Are we there yet? Improving governance and resource management in children's trusts – Published by Audit Commission in October 2008.

Measuring the Quality of Residential Care, Report to Middlesbrough Council Executive, 19 December 2006

Meeting papers for the Health Scrutiny Panel on 30 July, 20 August, 12 September, 2 October, 28 October, 19 November (all in 2008).

Direct Payments, Social Care & Adult Services Scrutiny Panel Final Report. November 2004.

Indications of Public Health in the English Regions: Mental Health, Published by Association of Public Health Observatories.

Contact Officer:

Jon Ord **-** Scrutiny Support Officer

Telephone: 01642 729706 (direct line)
Email: jon_ord@middlesbrough.gov.uk