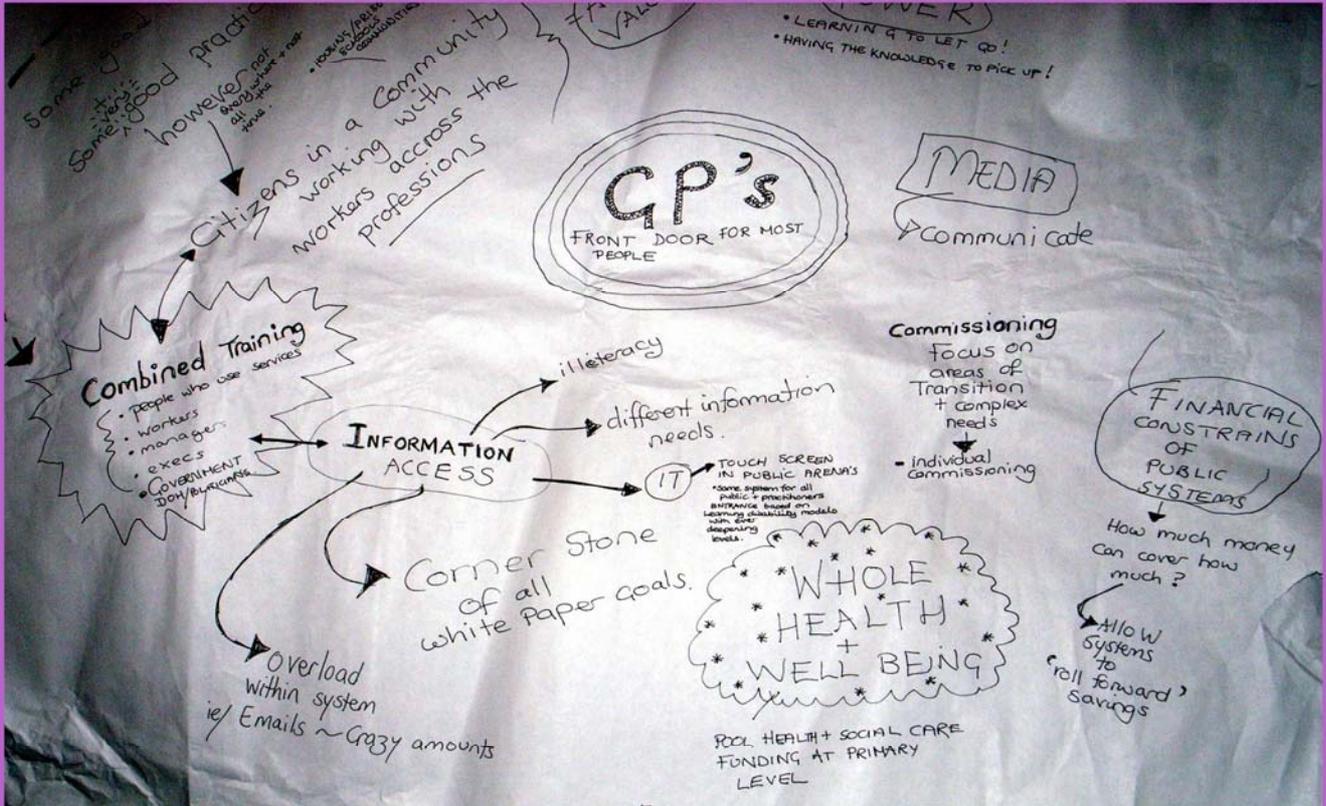


"Whose health, whose care, whose say?"



The opportunities and challenges of contemporary policy for people with complex mental health needs.

**Report of CSIP Eastern and SPN Study Day
January 2007**

Foreword

Raza Griffiths from Social Perspectives Network and **Ruth Allen** from Care Services Improvement Partnership Eastern introduce the 'Whose health, Whose care, Whose say?' Study Day Report.

The study day organised by CSIP Eastern and SPN in January 2007 examined the potential opportunities offered by the health and social care White Paper (Our Health, Our Care, Our Say, OHOCOS), the Local Government White Paper and other related policy, for meeting those mental health needs frequently considered complex and sometimes intractable.

Following an overview presentation from Chris Rowland, Social Inclusion Programme Manager for CSIP Eastern, and a rousing warm up from our performance poet, Rob Gee, the study day explored five topics within workshop discussion groups: the interface between learning disability and mental health; personality disorder; substance misuse; the criminal justice system and mental health needs and homelessness and mental health. These areas of need all represent types of problem that providers and commissioners have particular difficulty in responding to effectively, they all carry considerable social stigma and they are all associated with extreme marginalisation from mainstream services and from ordinary community life. They all, at times, attract the descriptor 'complex'.

A long way to go?

It was apparent from the lively and productive discussions throughout the day of the conference that the opportunities of OHOCOS and related policy are not yet well understood by providers, commissioners, by people using services, by carers and by the community at large. There is a huge role for the regional social care programmes of CSIP, in their current and future forms, to increase understanding of the envisaged transformation of social care and health. There is a requirement also upon lead organisations within each locality – in particular Local Authorities' Directors of Adult Social Services, Directors of Public Health and Commissioning leads – to attend to the learning of all those with a stake in the changed social care and health landscapes that are emerging. Without this attention, the creative and transformative potential may be lost within the misapprehensions and wariness of people who wonder if this is just another 'round of restructuring' rather than an opportunity for a fundamental, positive and sustainable shift in the relationship between citizens and welfare systems.

The Papers

The following papers in this short collection arise from and build upon the presentations and discussions at the study day. They consider the ways in which OHOCOS and related policy can help us to look afresh at our taken-for-granted perspective on complex mental health problems. There are no definitive answers offered here; rather, there are explorations and prompts for readers to use in their consideration of how new policy directions can help us shift our thinking and our practice; away from stigmatisation, labelling and exclusion, towards better empathy, empowerment and mainstream engagement.

In the first paper, Ruth Allen suggests how OHOCOS, the Local Government White Paper and related policy offer the opportunity for a conceptual shift in thinking about 'complex needs'. In the second paper, Chris Rowland details how a range of recent policies have accumulated to define an exciting new direction of travel for social care and health. And in the third paper, Raza Griffiths offers a critical perspective on recent policy, not least considering the potential policy contradictions between OHOCOS and proposed mental health legislation.

The five workshop reports are a combination of descriptions of the free-flowing discussions that happened on the day and post-facto digestion of ideas arising from those discussions, drawing out themes and reflections on OHOCOS and related policy.

Thanks to all the workshop facilitators and colleagues from both SPN and CSIP for their hard work on the day, particularly Val Gamble, conference administrator. Particular praise is also due to our Performance Poet, Rob Gee, whose collective chanting exercise implanted the main themes from the White Paper in our minds - despite the unpromising, non-poetic language of Whitehall as it base material!

**"More choice and a louder voice
Better prevention and early intervention
Tackle inequalities and improve access
More help for long term needs"**

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Complex mental health needs and the opportunities of the 'Our Health, Our Care, Our Say' White Paper and related health and social policies

Ruth Allen, Social Care Advisor for Eastern CSIP, suggests that a fresh perspective on complex needs is promoted by recent policy.

A complex future landscape of services in social care

Personalisation, choice, self-determination, control – these concepts thread their way through many of the current policies that are shaping social care and health. They each form part of the drive to ensure that the *individual* nature of people's needs and wants are at the heart of how commissioners and providers will do their business in the future. They indicate a largely unknown landscape of changed services and new relationships between citizens and the resources they have a right to access. In as much as we can imagine this landscape, it looks increasingly complex, driven by many, varying individual choices. The 'one size fits all' approach to social care services should diminish and eventually disappear. 'Services' might become as varied as all the individuals using them. And the relationship between people providing services and people using them is expected to shift from the 'professional gift' relationship to one of 'consumer choice' and citizenship rights.

A pressing challenge for services and staff in this emerging world is how to become much more flexible and adaptive in response to the new types of demand that are emerging? This diversity of demand will arise from acknowledging the particular complexities and uniqueness of each individual human life within the processes of assessment (including self-assessment) and support planning.

The changes envisaged are also a challenge for people who use services, now and in the future - and that means a challenge for the whole community. We are all being asked to move away from necessarily expecting a 'prescription' from an expert regarding how our needs (or the needs of our loved ones) can be met – particularly our social care needs - and towards determining what we think will help. Policy envisages an increasingly more knowledgeable, self-aware, educated and self-managing population with 'expertise' being shared more widely through new information technologies. This approach may ensure that the time and skills of highly specialist 'experts' are reserved for the most pressing and complicated situations whilst maximising the effective sharing of their broader knowledge and skills with other staff, with people using services and with carers.

Complex mental health needs or being human?

The focus of the January 2007 CSIP/SPN Study Day – “*Whose health, whose care, whose say?*” - was upon how these new policy directions can meet the needs of people with mental health and other coexistent, complex problems. The term ‘complex needs’ is used frequently in the mental health field, but there is no generally agreed definition of the term. It is often used to denote circumstances where people have many interrelated needs that seem to require multiple, coordinated responses from service providers. It is also sometimes used to denote needs which seem intractable, which service providers perhaps don’t fully understand or respond to effectively. It is often used as a term of distinction, separating the ‘complex case’ from the straightforward. It is also often used to allocate scarce resources, particularly when coupled with the descriptor ‘severe’. It is frequently used pejoratively because of its association with people who seem ‘difficult to help’ and thus who challenge providers’ ideals of themselves as effective and useful! People who are ‘hard to help’ become ‘unpopular’ in services and such subjective negativity can become institutionalised into exclusion and stigmatisation. Providers and commissioners may define people as complex when they don’t fit into their service silos.

If one takes as a starting point the idea that all human life is complex and unique, as suggested in the first few paragraphs of this paper, the notion of ‘complex needs’ as a separate category, requiring distinctly different approaches to care, starts to unravel. People’s lives and needs may be *more* complex or more ‘challenging’ to address on a continuum, but it might be more important to consider the commonality across this continuum rather than highlighting stark differences. Most of us have, or have had, ‘complex’ family issues to deal with, hard to resolve housing problems or periods of impairment and vulnerability that have made our relationship to the world more complex and more difficult. If we start to see the complexity of all lives and the connections between our complexities and those ascribed to people using services, perhaps service providers have a better chance of developing truly sensitive and non-stigmatising approaches.

This perspective on complex needs is clearly rooted in the social model of disability. This holds that the disability anyone experiences is created in the relationship between their vulnerabilities and the social world they inhabit. It is the attitudes displayed by other people, the diminished access to material and other resources and reduced access to the power required to determine one’s own life choices, that create ‘disability’. It is not the vulnerability or need in itself. Thus, the often apparently intractable problems associated with ‘complex needs’ are created *between* the person using services and the

social world they inhabit. Modern service providers' responsibility is to work against contributing to the social disabilities of people labelled 'complex' and instead to respond positively and sensitively to their humanity. When people's lives and needs are more complex, they may be most vulnerable, yet least able to articulate their needs straightforwardly. Modern social care providers are tasked with constantly, consciously remembering this. Service providers need to hold clarity in the midst of such complexity, helping people navigate service systems and avoiding contributing to the confusion – or defensive avoidance – that can sometimes seem to surround people with multi-layered, multi-factorial problems.

Policy Contexts: 'Our Health, Our Care, Our Say' and 'Strong and Prosperous Communities'.

The 2006 health and social care White Paper *Our Health, Our Care, Our Say* ('OHOCOS') is intended as a major shaper of the future world of more personalised health and social care. In many ways it represents the next step in the deinstitutionalisation of care and support in England and Wales. If institutions are founded on labelling and categorising people and their needs in order to control them – whether within four walls or in the community – non-institutional social care is about empowering and enabling people to live their lives their own way. In the United Kingdom, we have closed the bricks and mortar of most of the old mental health institutions, but we have retained institutional thinking and practice in both contemporary inpatient and community settings. And people using services have continued to have their lives overly shaped by their use of services still largely provided according to providers' and commissioners' standardised blueprints. OHOCOS and related policy signals a potential break with our institutional past, pushing forward to a future where people direct their own care and support according to their *own* blueprints.

The Local Government White Paper, *Strong and Prosperous Communities* (2006) is another crucial policy which points to a political recognition of the inherent, positive complexity of our social and personal worlds and the need for integrated, partnership-based responses to solve problems. This policy points to the importance of local authorities becoming 'place shapers' and using their powers to bring together all the agencies and individuals necessary to have an impact on complex issues. As the document states:

"we need to give local authorities and their partners the freedom and powers to meet the needs of their communities and to tackle complex cross-cutting issues".

Within social care and social inclusion work, it is crucial that the intentions of OHOCOS are aligned, locally and nationally, with the potential of the Local Government white paper to bring about innovative strategic linkages across and within agencies and departments. These are powerful policy drivers for a positive – rather than pejorative – approach to human needs within real community settings. ‘Social care’ in this context becomes a vital part of a much greater conception of our social world - one that might become better able to support people in vulnerable situations through the development of ‘social capital’. Standing at the heart of a reinvigorated view of civil society, ‘social care’ may become redefined as ‘social facilitation’ - of communities’ abilities to develop informal, sustainable supportive networks and of individuals’ abilities to take greater charge of their lives. The challenge with the most excluded, disengaged and voiceless is to enable them to find *their* voice and determine *their* place within this hopeful view of the future.

Brave New World?

The Potential Creativity of New Policy in Social Care and Health

Chris Rowland, Social Inclusion Programme Manager for CSIP Eastern, gives an overview of the potential benefits of recent social care and health policy, particularly 'Our Health, Our Care, Our Say' White Paper.

Over recent years, working in or using health and social care services has often been a changeable, sometimes tumultuous experience. There has been wave after wave of new initiative, new pilot sites, policies and guidance. Service restructurings have often been stormy and health and social care systems have been confronted with huge cost-pressures. Individual staff have struggled to keep their heads above the waters of uncertainty - about future employment, changing roles, and ever-increasing expectations.

Shakespeare provides a quote I often use when presenting on social policy around the region:

*"How beauteous mankind is! O brave new world, that has such people in it!"
The Tempest, V.i.*

The tempest of the play represents stormy times like ours. But these lines also capture for me something exciting and important about the creativity that can spring from tumult and uncertainty. And this is the present context of health and social care service development and delivery.

Try to look for a moment beyond the turbulence, and I believe there is an increasingly clear vision and a path being forged towards it. It is fundamentally a vision which recognises the individual worth of people, a vision of a society which accepts, supports and includes every member within it as having value, and something to offer. The developing body of health and social care policy and legislation focuses on putting the individual at the centre, exercising choice and, increasingly, self-directing how they get their own needs met. Policy directions focus on health promotion and well-being as essential outcomes for provider organisations and on dignity, respect and equality. They focus on communities, integration and inclusion, where community engagement and building social capital are seen as core to the business of health and social care.

This is a vision which will be both familiar, and welcome to all of us who have a leaning towards the values and principles that have increasingly

underpinned the best of social care thinking and delivery. But as a policy-driven, whole system change, this vision represents an important shift in emphasis. It is a change which promotes the importance of social care practice and values, as well as the role of Local Authorities in health service delivery (as increasingly enshrined in for instance the recent Local Government White Paper, *Stronger and Prosperous Communities*, and exemplified by the recent appointment of David Behan as Director General for Social Care on the Department of Health Board). There is an ever greater emphasis on joint (rather than “joined-up”) working, with joint appointments, shared commissioning arrangements, and single planning processes. And it is not so much a direction away from ‘health’ service delivery as towards it – away from the ‘National Illness Service’ to one rooted in the possibility of greater wellbeing across the population

The current policy context

A range of recent policy and guidance provides the backdrop to this change. *Choosing Health* the Public Health White Paper (DH, 2005) outlined key issues that we need to address if we are to improve the health of our population - and not just the obvious ones like smoking and obesity, but also issues around mental health and well-being. It emphasised the importance of recognising individuals’ responsibilities in making decisions that affect their lives, as well as their rights to do so.

Improving the Life Chances of Disabled People (PMSU, 2005) offers a 20-year vision for disabled people, stating boldly that “by 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society”. This will involve challenging social attitudes to disability, and the services which we provide. The document accepts a truly social model of disability – i.e. that it is not any impairment I may have which causes me to be disabled, so much as society’s attitudes, and the material obstacles put in my way that disable me.

The Social Care Green Paper *Independence, Wellbeing & Choice* (DH, 2005) began to develop this vision into a set of principles for how and why services might be developed in the future. The title, I think, says it all, but it also contains as clear a description as anywhere of the direction of travel we are following:

“Our starting point is the principle that everyone in society has a positive contribution to make to that society and that they should

have a right to control their own lives. Our vision is to ensure that these values will drive the way we provide social care. The vision we have for social care is one where:

- services help maintain the independence of the individual by giving them greater choice and control over the way in which their needs are met;*
- services are of high quality and delivered by a well-trained workforce or by informal and family carers who are themselves supported;*
- we provide services with an emphasis on preventing problems and ensure that social care and the NHS work on a shared agenda to help maintain the independence of individuals;*

Through:

- ...[allowing that] the risks of independence for individuals are shared with them and balanced openly against benefits.*
- wider use of direct payments and the piloting of individual budgets to stimulate the development of modern services delivered in the way people want;*
- greater focus on preventative services to allow for early, targeted interventions, and the use of the local authority well-being agenda to ensure greater social inclusion and improved quality of life*

Alongside these generic documents there have been key pieces of policy addressing the needs of particular groups of people, whether *Every Child Matters* for children, *Valuing People* (DH, 2001) for learning disabled people, *Mental Health and Social Exclusion* (SEU, 2004) for people with mental health problems, *Reaching Out: an action plan for social exclusion* (2006): All drive different parts of the service system reform and delivery, but all with a shared focus on inclusion and well-being.

Our Health Our Care Our Say – the key themes

And so to the White Paper: *Our Health Our Care Our Say* (DH, 2006). I describe it to people as the most important piece of legislation for the development of health and social care services in recent years. It develops the ideas in *Independence Well-being and Choice*, and the vision of *Improving the Life Chances of Disabled People*, but takes them further; not only making health and well-being the business of social care (and wider local authority run services), but also placing social care values, principles and practice, at the heart of health service delivery.

The wide-spread public consultation on *Independence Well-being and Choice* showed that people are pleased with the direction of travel of health and social care service delivery, but that they expect more: more personalised services meeting individual needs; greater support for healthier, independent lives; more promotion of well-being; better support for those with high level needs; and services shifted to local communities. This is not therefore to reflect negatively on the positive practice that has been offered before. As a comparison, ten years ago, air-bags on a car would represent an enhanced or added value product feature, but no-one would buy a new car today without them; public expectations change and increase!

Our health our care our say supports a change of emphasis on how services are offered in the community, around four key themes.

- Putting people more in control of their own health and care, with **more choice, and a stronger voice** in service design and delivery (as Patricia Hewitt suggest in the introduction “*All public services should put the person who uses them at their heart. This applies especially to Health and Social Care because all care is personal*”).
- Enabling and supporting health, independence and well-being through **better prevention and early intervention services**,
- Doing more to **tackle health inequalities and improve access** to community services.
- Rapid and convenient access to high-quality cost-effective care, especially **support for those with long term conditions, or who need it the most**.

It goes on to outline a number of key outcomes for successful change within health and social care services. If we get this right, the policy suggests we will see health and social care services delivering improved health and emotional well-being, and improved quality of life outcomes; people empowered to make

a positive contribution, and having greater economic well-being; people having greater choice and control over their support; and services provided in such a way as to ensure personal dignity, and with freedom from discrimination.

One of the nice things about working to support this agenda is that I come across very few people who disagree with the principles of it. However, there are plenty of people who are quick to highlight the challenges of making it a reality, and not surprisingly: To delivery it will require some significant strategic shifts, both in thinking, and in service design and delivery. Shifting focus (and funding!) from acute responses to preventative services; from hospitals to communities and care closer to home; from service inputs to outcomes for people and communities; from decision making in Whitehall to local communities of interest; from doing “to”, “for” and “with” people to being “led by” people; and from separate performance and commissioning frameworks to more joined up approaches.

At a practical level, *Our health our care our say* outlines how all of this will require:

- Strong local commissioning shifting towards prevention and early interventions, with practice based commissioning in primary care and individualised budgets in social care
- A shift of resources into prevention, and into community services
- Allowing variety and contestability in provision of care to encourage innovation in service delivery, especially around the possible roles of social enterprise and the third sector.
- Developing outcomes which apply to both NHS and social care, with aligned performance measures, assessments, and inspection, and aligned planning and budget frameworks drawn together through Local Area Agreements.

So plenty to be getting on with then!!

One of the strengths of the White Paper is that as well as giving the direction of travel, and the underpinning system changes that this will require, it also contains a wealth of details of things that we can / should do to get us there; and importantly, they represent a huge breadth of very different things, cutting across health, social care and community services. Grouping them under four main headings, examples include:

- Helping people to make choices and take control by understanding their own health and lifestyle better, with more support on prevention and promoting their independence (including piloting a new NHS Life

Check: more emphasis on mental health and support to deal with isolation and depression; increased use of Direct Payments and Individual Budgets, and improving information)

- Offering people easy access to help when they need it, and in a way that fits their lives (including new initiatives to support carers; a guarantee of registration onto a GP practice list in their locality; greater information about choosing a GP practice and about what health and local authority services are available in their area; incentives for GPs to work in areas that are under provided for at present, and improved access to GP practices through more flexible opening hours etc).
- Meeting the whole of people's needs and supporting their well-being and health, not just focusing on sickness or an immediate crisis (including a strengthened roles for the Director of Adult Social Services and Director of Public Health, and more joint appointments; health and social care jointly responsible for understanding the needs of their communities and providing the right services to prevent ill health and support independent living; a common assessment framework to ensure less duplication across different agencies and allow people to self-assess where possible).
- Providing safe and cost-effective care closer to where people live (including a fundamental long term shift from hospitals to community facilities and from institutional to home-based care; piloting outpatient appointments in the community for common conditions such as dermatology, and a new generation of community hospitals to provide a wide array of non-urgent services in a community setting).

The opportunity and the challenge.

It begins to become apparent just what a huge agenda this represents; how it cuts across health and social care service provision, but extends well beyond this as well; and by implication, that it will require strong leadership across health and social care services and beyond, and ongoing political commitment to realise the changes. But there are some real opportunities for driving change forward at the present time: not just a strong political will and a body of social policy to back this; but also - and increasingly - systems which support community integration, development of social capital, and the reduction of health inequalities.

Within the Eastern Region, we have a Regional Social Strategy and Regional Health Strategy which focus on social inclusion and the reduction of health inequalities. And at a local level, Local Area Agreements (LAAs) have the

potential to make a huge difference in how local strategic join-up happens. The significance of LAAs is set to increase in light of the Local Government White Paper, increasingly drawing together the development aims of local communities, and maintaining a focus on health and well-being as in need of support from across social systems.

We have the policy guidance (and the legislation) in place to be able to move the money away from illness-treating services and into preventative health care, promoting community services; to focus on the people most in need with the aim of reducing health inequalities; to increase the already positive impact that individualised support (whether direct payments, In Control, or individualised budgets) have had for people; to empower local neighbourhoods and communities of interest; to provide choice and access to services. And we have the technological solutions to maintain support to people, even at crisis point, within their own homes and communities. There are also ever more opportunities for service development and innovation using new technologies, whether assistive, pharmacological or surgical.

But there are also some significant challenges for us to think about and plan for. As I suggest above, people will say: these are nice ideas, perhaps it would even be difficult to fault some of them in theory...but what about in practice? And that is the central challenge: how do we realise the vision, how do we get from where we are now to where we need to get to?

Change processes are notoriously difficult to take forward in large organisations (and the NHS is the largest employer in the UK!) and they take a long time to bed in; how can we change quickly, and change well? How do we change ingrained commissioning behaviour within new systems; how do we change staff behaviour, attitudes and values to put the user and carer genuinely in the driving seat of their life and support system; can and will systems of health and social care really involve the customer in redesign? And whilst the change is in process, what (or who) might get lost in the process: how will it affect patients and services users?; how will it affect staff?; how might it impact on service reputation or the good will of communities if changes have unforeseen negative outcomes in the pursuit of longer term goals?

How can we move to a situation of choice and control, and, if we support people's rights to make health promoting and self-caring decisions, how can we support these to be "rational" (e.g. give up smoking, take preventative action on disease)? And if their choices are not 'rational', how do we balance positive risk taking with the duties of care we will still hold?

In the context of the SPN/Eastern CSIP study day, it is particularly important to consider how we might empower the most vulnerable to take more control over their health and social care needs. The people with the types of need being discussed at this event have often been multiply disadvantaged over long periods of time by stigma, exclusion from mainstream society's activities, from any economic power and poor access to empowering information. To facilitate the engagement of people considered to have the most complex mental health needs to have more power over meeting their own needs is a challenge at every level in the system; a challenge for the detail of frontline practice, for managers of the allocation of local resources and for strategic planners of health and social care systems. These are the thorny issues that participants wrestled with at this study day.

All change?

Raza Griffiths, service user and SPN joint project co-ordinator, takes a critical look at the White Paper and what it means for service users

In choosing *Whose health? Whose care? Whose say?* as title of this study day, we sought to apply critical thinking to some of the claims made for the White Paper, particularly as it applies to a number of marginalised and seldom heard groups, whose mental health needs services have hitherto found difficult to meet. Whilst not forgetting this context, many of the questions raised on the study day are also of relevance to *all* mental health service users. As someone who has used mental health services myself, I am acutely aware of how disempowering this experience still is for far too many people experiencing mental distress. It remains to be seen whether the agenda set out by the White Paper will result in any *real* change rather than just signalling in another re-organisation of the system with a new lexicon and new acronyms to learn. So we will have to wait and see.

In principle, the health and social care White Paper, *Our Health Our Care Our Say* (OHOCOS), makes a valuable contribution to setting out a positive future direction for the way mental health needs are met. In drawing together the learning on what works best, it emphasises service user outcomes (defined by service users) rather than service outputs, and prevention and treatment in the community rather than acute care. It's buzz words are personalised care, greater control and choice for service users, and more joint working to deliver the best care, albeit with more of a focus on primary care and public health than social care.

Mixed messages

However, there is a certain hesitancy on my part, even at such a seemingly positive move forward, and this needs some explaining. Any one initiative needs to be seen in the context of the overall policy and legislative context within which it is located. And the current situation is one of mixed messages, many of them counter to the agenda of service user empowerment that OHOCOS sets out to champion. In particular, the Government backed Mental Health Amendments Bill is currently being debated in Parliament and is strongly opposed by service users and the rest of the mental health world because it takes away control and choice from service users. At the same time, we have a comparatively progressive piece of legislation in the shape of the Mental Capacity Act which, in place of the Bill's concentration on pre-emptive incarceration and forcible treatment, emphasises capacity unless

formally disproved and also offers advocacy services to empower service users, in direct contrast to the Bill.

In other ways, too, we are at a tipping point. The language of empowerment, of user-led perspectives on recovery and the reform of the Care Programme approach are all threatened by financial pressures which could subvert good intentions. We need to ensure that the White Paper's agenda is steered in line with its true vision. We do not, in the name of 'empowerment' and the general shift from secondary to primary care, want to see a situation where financially costly but necessary acute in-patient services for service users are cut back to the point at which people who need this treatment are unable to get it.

Valuing practitioners

The White Paper sets out root and branch cultural change for mental health workers. Whilst the benefits of OHOCOS if implemented properly will become apparent in the long run, the short term added burden on staff may make them feel even more overwhelmed and disaffected, particularly if the White Paper is seen as yet another top down bureaucracy-led initiative.

But it does contain a lot of good stuff. The Social Perspectives Network where I work as Joint Project Co-ordinator and which jointly hosted this study day with NIMHE/CSIP Eastern, is committed to contributing to new developments in mental health and as such, we will continue to play our role as 'critical friend' to all agencies involved in the evolving White Paper agenda.

The need for joint working

Particularly to be welcomed is the White Paper's emphasis on better collaborative working across service boundaries. This challenges the 'silo' mentality of traditional service categories, which often work against the best interests of service users, particularly those from the seldom heard and marginalised groups this study day focused on. Their needs are often complex and best met by different agencies working together. However, one omission to joint working is the White Paper's lack of reference to young people. As the findings of the criminal justice workshop showed, there needs to be much more work around seeing the needs of offending parents and young people as parts of an inter related whole, beyond the narrow mentality of separate adult, young peoples and family mental health services following specialisation in service structure.

On a wider policy level, SPN is pleased to see that the emphasis on joint working is also taken up by the parallel local Government White Paper *Stronger and Prosperous Communities*. This highlights joint agency working between social care, local authorities, the health and the voluntary sectors to help shape the social environment which has such a powerful influence on mental well being.

The bigger picture

The OHOCOS White Paper aims to empower service users through individual budgets and direct payments. In theory, this will allow disadvantaged groups to have more of a say in choosing from a smorgasbord of options to get what they really want, as opposed to relying on the blunt instrument of an unwieldy and unresponsive mental health system which may not always deliver what they really need. However, policy also needs to take into account the influence of social factors in creating unequal life chances, particularly people from the highly marginalised groups the study day looked at. These people have unequal access to relevant, accurate and good quality information needed to make *informed* choices. Over and above this, policy must not neglect to engage directly with eliminating some of the broader structural factors that directly impact on well being, such as lack of affordable housing in the case of homeless people, and the fact that intergenerational social disadvantage is passed on, for example, by young people born to offending parents.

One of the most important social factors inhibiting positive engagement with services is the constantly burning issue of stigma and discrimination suffered by people with mental health issues. In my own case, stigmatising images about people with mental health issues stopped me seeking help from my doctor before it was too late, with the result that I had to be admitted as an emergency case. This led to my forcible medication. What use is a plethora of choice and early intervention/prevention initiatives, if people feel inhibited from accessing help because they don't want to be written off as useless, as dangerous, or any of the other stereotypes applied to people with experience of mental distress?

So, we must remember that empowerment of the individual must take account of the wider context the individual is located within.

Short changed

Having choices is a good thing in principle. But will the White Paper allow people to get the choice they want? Choices will only be available within strict budgetary constraints imposed on what is still seen as the 'Cinderella service'

of the NHS. We have to guard against cheaper options being offered as a panacea when a more expensive option might be the better alternative. This already seems to be the case for long term psychotherapy, which is even now being cut to fund cheaper and short term cognitive behavioural therapy (CBT). CBT, sometimes delivered over the internet in the aftermath of the Layard report. But it is not the best option for everyone.

It is the ongoing scandalous under-funding of mental health which makes offering valid choices difficult. Under-funding is an issue in all sectors of mental health. One of the most frequently mentioned services being cut at the moment is Citizen's Advice, which offers advocacy services for example around preventing eviction. The undermining of advocacy services will mean that the most vulnerable and information-poor service users (many of them from the groups this study day focused on) will be unable to navigate successfully to find the treatment choice that is right for them, leading to structural inequality and disadvantage being reproduced, with negative consequences for their mental health.

There will always be a small minority of service users who are especially vulnerable, and who cannot exercise much choice and live the independent life in the community that is seen as the White Paper's major goal. We have to ensure that the often financially costly services they require are still available despite the cut backs that will inevitably have to happen in this shift of focus from secondary to primary care.

SPN will continue to press for progressive movements in mental health from a social perspective, around OHOCOS and the other central issues of the day. We look forward to contributing to ensuring that the progressive and enlightened potential of the vision of the White Paper is fully developed.

Workshop Report – The Interface of Learning Disabilities and Mental Health

The workshop was facilitated by **Joan Maughan (National Development Team) and Anne Webster (Hertfordshire Partnership Trust)** and included a range of participants including provider staff, commissioners, users and carers.

Better prevention and early intervention:

‘I don’t want to be critically ill before I get care and support’

The entrenched stigma and social barriers faced by people with learning disabilities and mental health needs was a theme that went throughout the workshop. The workshop suggested service users are ‘caught in web of limitations’ which are underscored by lack of respect for the opinions of service users themselves. The importance of community inclusion and responsibility – of attitudinal change in the community at large – was highlighted in relation to preventing deterioration in mental wellbeing. There was also a call for the community to have a ‘duty of care’ and to know and acknowledge the rights of people in need of services so that if a GP is slow to act, for instance, the citizens in the community will know what treatment is available. As well as pointing up the stigma service users can face within their communities, there was also acknowledgement of the experience communities have of living with and supporting people with complex problems.

There was general support for the enhanced role of GP/primary care practices as portals both for useful, targeted information and for more creative signposting and referral on. However, the current capacity of GPs and other primary care practitioners to comprehend, assess and work with complex problems – with people who do not fit into predetermined service user categories - was questioned. The call was for a ‘must do’ rather than avoidant attitude on the part of primary care staff; not necessarily to provide services (*‘GP’s, although able to refer to salsa classes, would not be able to run salsa classes!’*) but to become properly linked into the web of community activities that might be beneficial to service users. Primary care centres were envisaged as developing into centres of wellbeing, linking effectively out to the community sector and up through secondary and tertiary services. The advent of practice based commissioning by primary care was referenced as a particular opportunity for the development of more creative, timely options for this user group.

The need for primary care practitioners to have access to information themselves was also discussed: could web-based information on learning disabilities and complex needs be enhanced and made easily usable for busy practitioners?

The importance of earlier intervention with young people was also discussed. There were suggestions of more mentoring systems to support people in schools – child/child and adult/child. The importance of regular health and well being checks from childhood onwards was also noted – including the importance of ensuring both physical and mental well being were addressed. The importance of support to whole families to make earlier interventions was discussed. It was felt to be important to stop treating young people in isolation from their families and carers. And those young people might be the designated service user or might be carers themselves in some situations, in need of and having entitlement to support in their own right.

Choice and voice

The ability of people with learning disabilities and other complex needs to exercise choice, have a voice and take more control over their lives is often disbelieved. The group talked specifically about the impact of the Mental Capacity Act on the practice and perceptions of practitioners. This will provide a framework for ensuring that it is service users and not professionals who drive decisions and that capacity is assumed until demonstrated otherwise. At present, the parents of adults with learning disabilities assume the right to control their child's life and the Act fundamentally challenges that assumption.

There was particular discussion of the use of Direct Payments. There was felt to be still a lot of professional ignorance and a lack of consistency (a 'postcode lottery') in offering Direct Payments, base largely on lack of belief in people's ability to make their own decisions. A huge attitude and practice shift - a Mindset Revolution - was felt to be needed 'from the top down' for the expansion of Direct Payments and to make Individual Budgets work effectively in the future.

The inadequacy of consultation processes with this service user group was discussed; consultations often do not deal with the real concerns of the real lives of people using services and are not sufficiently linked with positive action.

Commissioning for Choice

The importance of commissioners thinking more broadly both about the community they serve and about how needs can be met was discussed. To

extend choice, commissioners must think way beyond traditional service boundaries, to encompass a wide range of community activities and options.

There was a call for strategic needs assessment to overtly include people with learning disabilities – they too have rights as citizens and their inclusion is a matter of social justice. Having undertaken community needs assessments and consultations, it was felt to be important that commissioners shared their information more freely with the communities of interest. The model suggested was to *consult/involve – act – inform and evaluate*.

Budgets are often still organised such that creativity is stifled and new solutions cannot emerge. Joint commissioning arrangements across learning disabilities, mental health, substance misuse and homelessness, for instance, were flagged up as vital. The whole notion of who controls money is crucial in all of this. Individual budgets will bring all social care finances much more into control of people using services and their carers. To whom does the money 'belong'? What is the entitlement and how do commissioners set parameters to meet population level needs whilst facilitating individual choice?

One of the problems with policy implementation at present is there are separate pots of money – we need pooled arrangements and should look at what money is available 'globally' on a local, regional and national level, address fragmentation problems and pull money together

Inequalities and access

The scope to improve equitable access to information was discussed. This related to where information could be made available for people using services and for carers and it also related to the language and formats used to communicate with people with learning disabilities. Again, the Mental Capacity Act will emphasise that the user's choice (with whatever help they need to exercise that choice), not the professional's choice, should predominate in most situations, thus supporting people with learning disability to have better equality of access to the things they want to assist them.

Support for long term needs

"It's a mindset revolution"

The needs of both service users and carers were discussed – as was the strong relationship between the two over the long term. Informal carers are obviously the main people meeting long term needs. The need to have a sensitive, non-stereotypical view of carers was discussed, for instance,

recognising that people with learning disabilities can themselves become long term carers of ageing parents. And young people can be carers to parents with learning disabilities. The health including the mental health of carers of all ages needs to be understood – and they need to be seen as individuals in their own right.

Regarding risk, the need for a fundamental shift in attitudes from the top down was discussed in order to let people manage their own risks over time. Services' perceptions of risk impact on how services respond. This includes the perception of staff that they need to manage all risk on behalf of people. The way in which carers and service users can get caught in the long term between mental health and learning disability services each concerned about risk liability, was discussed. Service users should be able to manage their own risk. Ongoing training and local leadership was felt necessary to change professional's attitudes.

The importance of employment opportunities –for service users and carers - was discussed as an issue in maintaining people's long term wellbeing.

Summary of important points

- Shared responsibility of all in community
- GP as focus for information access
- Inclusive approach to training (across professional and service boundaries)
- Importance of the Mental Capacity Act
- Importance of positive values
- Overcoming Professional Differences
- Overcoming Cultural Differences
- Inclusive approach towards people with learning disabilities from service users upwards to top ranking professionals

After lunch, the group were invited to write down important points in the areas of Service Users, Carers, General Community, Commissioners and Providers. The following points were raised.

Service Users

- Caught between a web of limitations, need to break down barriers and push boundaries.
- We need to respect values and opinions of service users, not just 'go through the motions'.

- Community Involvement and Support are crucial.
- Real consultations needed that lead to real actions (Do consultations usually relate to people in their real lives?)
- Getting individualised budgets (“In control”) and direct payments where appropriate – for those with learning disabilities and supporting carers.
- “Stop the vouchers!”
- Educate and challenge those in power!
- Universal understanding and commitment to the recovery model within mental health to include learning disabilities.
- What does ‘person centred’ mean? Seems to be an over used term that bears little relation to it’s origins and experiences of many service users.
- Professionals don’t seem to understand Direct Payments and Individual Budgets, so how can promote them or support service users in using them
- Early Intervention – ‘I don’t want to be critically ill before getting care and support’. Invest in services for young people

Carers

- Monitoring carers needs – taking their overall health and well being seriously.
- Taking carers issues into consideration and listening to carers.
- Involvement of carers in planning of services
- Getting ‘Confidentiality issues’ into perspective: developing an inclusive and open approach with social networks.
- Recognising that people with a learning disability sometimes become carers of those originally caring for them.
- Need to provide support to prevent carers developing their own mental health problems.
- Provision of advocacy and mediation for when choices of carers and choices of service users are in conflict.
- Improved access to services – individuals and carers shouldn’t have to fight to get needs met, just because needs don’t “fit the system” Services should meet needs, not deny access.
- Employers to give true recognition to carers
- Enabling access to Carers’ benefit.
- Recognition to young carers (financial support, anti-bullying, anti-stigma, focusing on achievements)

General Community

- Relevant information needs to be available in relevant format.
- Creativity needed in outreach work into the community.
- Information days at GP's on certain days, by relevant individuals, where possible, including service users and family carers
- Ensure use of language that community members can understand.
- Ensure information is shared by organisations with local communities; the community should have a voice and when an organisation makes changes, they should feed back to all those involved and affected.
- Respect the experience the community has.
- Have involvement strategies that bring in a range of people.
- Use mentoring system in schools/colleges to support users and carers – child/child and adult/child
- Within University education, use Information to promote empowerment, and anti discriminative/anti oppressive
- Children to be advocates for others within schools.

Commissioners

- 'Consult/involve – action – inform those involved and evaluate'.
- Think wider than actual service provision eg how faith impacts on mental health. Can there be support provided to community groups to provide this?
- Share information – don't hold onto
- Local strategic needs assessment is key and must include people with learning disabilities (from a social justice for citizens perspective)
- Do we see the real face of commissioning?
- Practice Based Commissioning: Links are crucial across service user groups and between primary and secondary commissioning activities.
- Partnership boards are an important part of system
- Need for linkage across budgets.
- Need joint commissioning for all adults, - learning disability, mental health, substance misuse etc

Providers

- Be generous with our expertise – second people into different parts of the service, share knowledge and develop skills capital beyond our systems.
- GPS – understand clarity of learning disability roles, web based info for GPs would be useful. They should provide a single point of access and clearly defined care pathway

- People with learning disabilities need all the primary health care that everyone else needs: health checks, diabetes screens, dental care, women's health care, blood pressure check etc.
- Training to develop appropriate skills needed that can tackle fears of practitioners.

4 most important things

- How and where money is spent and who is in control. Fundamental concept of "investing to transform and save"
- For the first time, commissioning is becoming truly outcomes-driven.
- Reducing duplication of assessments and service provision is crucial: these usually don't link to each other and are a dreadful waste
- Values and attitudes deliver behaviour. How to change that and balance having a more open market for provision with social justice

Innovative Solutions

- Relevant outreach work – building community.
- Resources, links and networks.
- Advocacy (citizen advocacy for people with a learning disability).
- Supporting Young carers.
- Strategic needs assessment (learning disability/mental health as a main issue).
- Young people – family support. Stop treating individuals in isolation, provide support for the whole family (early, holistic intervention).

Workshop report – Personality Disorder

The personality disorder workshop included a diverse range of people including those who have used services and people from commissioning, housing, voluntary sector day services, specialist personality disorder services, CSIP eastern, child and adolescent mental health services and specialist services for women. The facilitators were **Reg McKenna and Heather Shackleton from the Haven** (a specialist personality disorder service from Colchester which was set up as one of the national pilot new models of service in 2003) with **Chris Rowland, Social Inclusion Programme Manager from CSIP Eastern**.

Better prevention and early intervention:

Personality disorder is well acknowledged as having its roots in early experience. The group discussed the importance of earlier intervention to prevent the worsening of distress and other problems associated with personality disorder in adulthood.

There are opportunities to be seized within the OHOCOS White Paper's intention to target preventive interventions in primary care settings, potentially supporting people of all ages to seek help and manage their emotions and psychological needs better. The importance of picking up on abuse of all kinds in early life was also emphasised and the need to cross reference the White Paper's intentions with policy for Children's safety, wellbeing and achievement was clear.

Earlier intervention with young people in primary care and schools settings offers the possibility to prevent some of the more severe psychological problems of adulthood that are described as personality disorder. The idea that input into schools may not always be best provided by statutory health and social care providers was discussed, as was the potential value of enabling access to emotional and psychological help in other places that young people use.

The literature on personality disorder and recent government initiatives ('No Longer a Diagnosis of Exclusion', 2004; Personality Disorder Capabilities Framework, 2005) have highlighted how the cycle of unsatisfactory contact with and rejection from services perpetuates and worsens aspects of the personality disorder. This experience of repeated ineffective contact with unhelpful services is almost the opposite of the early, timely, appropriate and effective interventions envisaged by the White Paper. The document envisages services that are much more conscious than hitherto of their role in

the lifelong, self-directed recovery of service users and carers and that can manage even the most challenging interactions with people in need in a way that moves things forwards not back.

Part of understanding one's needs often involves naming them. The group discussed the extent to which early diagnosis is helpful to people considered personality disordered. A 'diagnosis' potentially locates personality disorder within the realm of 'health' and, therefore, legitimate need potential liable for an early response. However, a value-laden, stigmatised diagnosis brings a weight of unhelpful negativity. Having for years been a 'diagnosis of exclusion' is the culture of services and society more widely really shifting towards allowing personality disorder to be a diagnosis of legitimate access to help and understanding? The governmental discourse on personality disorder in recent years has used the diagnostic term (whilst also sometimes recognising the controversy that surrounds it). The group raised a doubt about how helpful the term is in ensuring people get the help they need.

If services could be developed and commissioned that were rooted in positivity, potential, resilience and the possibility of change, would this benefit people seeking help, their families and carers and wider society? These themes are all in keeping with the White Paper and the culture of 'optimism' and 'self-determination' that current flavours most cutting edge social care thinking and policy.

The White Paper's emphasis on enabling people to live ordinary lives and take responsibility for themselves suggests that that it could be a very helpful framework for thinking about helping people considered personality disorder and practitioners

Choice and voice

A key issue raised in relation to choice and voice was – 'we can only choose if we know what is there'. The need to improve information availability and relevance runs throughout the White Paper and it is a crucial issue for all marginalised groups. How can providers tailor mainstream information so that those currently at the margins of service usage can access it and how can information be targeted specifically at people with personality disorders and related complex health and social needs?

For many years, people with personality disorders have been reporting the experience of using services that perpetuate stigma, their low self-esteem and sense of not deserving help and of not being helped to understand their own problems. The White Paper offers a vision of a new relationship between

provider and user of services that is founded on respectful partnership. 'Professionals' are seen not as privileged holders of protected knowledge but much more as brokers and intermediaries between those in need and the resources that might help them. This facilitation of making choices and enabling people to find their voice is a theme throughout the White Paper.

Information and knowledge can be 'an end in itself' such as when it fosters individuals' understanding of their own mental health conditions and helps them to develop their own coping strategies and perspectives on needs. However, information about services and brokerage of resources needs to be matched with reliability of services and budgets. The spectre of recent health funding cuts across the region was discussed in the workshop. How to 'do more with less' is a key theme now and, arguably, is perpetually a theme in health and social care in the UK. The language of 'efficiencies' runs through health and local government bodies.

The White Paper is in part predicated on an acknowledgement of the growing need for health and social care services for an ageing population. The emphasis on responsibility and self-management of long term conditions in OHOCOS and related policy documents is part of the government's response to this demographic reality. In this context, the possibility of people with personality disorders exercising their 'louder voice' and having 'more choice' seem at risk of continuing to be marginalised as the profound physical and mental health needs of older people, particularly the very elderly, grow.

Commissioning for choice

Within a commissioning-led health and social care world, there is a need for mainstream mental health commissioners to understand personality disorder issues much better, to acknowledge the legitimacy of needs and to redesign money to address personality disorder issues. However, the discussion moved beyond traditional notions of commissioning from statutory organisations for personality disorder to encompass discussions about how smaller, non-statutory organisations and user groups can access resources to provide diverse responses to personality disorder needs. This might include the development of social enterprises to deliver personality disorder support. The shift in services being accessed through 'brokers' rather than direct service providers as laid out in the White Paper was discussed: how could this model be made to work with people with personality disorders and their carers?

There was a suggestion that CSIP or another body could have a regional role in sourcing and brokering resources for creative community support initiatives

with a focus on the most complex and excluded groups. Through this sort of coordinated commissioning, the needs of people with personality disorder might be met better through partnership commissioning of creative responses to needs that break down some of the traditional 'silos' between groups – e.g. between personality disorder and homelessness or drug and alcohol services.

There is an Eastern region Personality Disorder reference group hosted by the Strategic Health Authority which oversees the development of commissioning, service provision and educational opportunities across the region, in community and forensic sectors. Eastern CSIP has also coordinated a considerable amount of learning opportunities in recent years also. But the group's discussion focused on how local initiatives could be supported and the real voices of users and carers close to the ground could be better heard in commissioning. There was also a view that CSIP might have a role in evaluating the quality of data and information used by local commissioners when making their resourcing and planning decisions.

Inequalities and access

People with personality disorder have been directly and indirectly excluded from services over the years which can be interpreted as a form of discrimination. Their profile has been raised by recent national policy developments and by the development of innovative pilot projects around the country. In Eastern region, the Haven in Colchester has been well evaluated and is an example of a voluntary-sector, peer-support led resource working very closely with the local statutory mental health services, locally redressing inequalities in access to services.

The fact that mental health services are often unclear or non-communicative about what they do and do not provide for people with personality disorders was discussed: how can inequality and inaccessibility be judged when services aren't clear about what they think they are offering to people with personality disorder? The fact that services sometimes still have differing definitions of personality disorder - and differing perspectives on whether services should be offered – remain as obvious obstacles to provision of accessible services and fair treatment of people with personality disorder needs.

Support for long term needs

The workshop discussed the balance between supporting long term needs and the need for efforts to prevent adults developing personality disorders.

There was a lot of consideration of the role of mental health promotion and education in schools. Personality disorder is acknowledged as a disorder that arises out of adversity in early life that is often compounded by re-traumatisation in adulthood. Some of this re-traumatisation can occur because of the actions of traditional psychiatric services which don't understand personality disorder.

Personality disorder is increasingly acknowledged as responding to interventions, to various forms of therapy and support. In the past it was often seen as a 'diagnosis of despair' and associated with hopelessness. The concept of long term needs in the White Paper is not a hopeless one; it is an acknowledgement that some people have ongoing need for and right to support from health and social care services, but that a lot of this can be self-facilitated if people are empowered and provided directly with resources. Thinking about how this approach can be applied to people with personality disorders is important: how can people be better helped to be aware and make sense of their own needs, to learn how to make best use of the help that is on offer and to take more responsibility for their ongoing well-being? The importance of peer support for ongoing needs was discussed. It is a corner stone of innovations such as the Haven.

However, there was also discussion about whether more traditional forms of support – such as day centres run by organisations *for* service users – still have a place. The White Paper's expectation that people will become more empowered and self-determining is a huge challenge not only to service providers and commissioners but to service users themselves.

Key themes

- Confirming and defining the legitimacy of needs associated with personality disorder and then planning and delivering services on an equal footing with other mental health needs.
- The importance of prevention: 'primary prevention' with young people and 'secondary prevention' ensuring services reduce their re-traumatisation of people.
- Learning from the innovations in personality disorder services e.g. the Haven in Colchester. These evaluated services offer excellent baselines for the development of services on a terrain that is currently much undeveloped.
- Making more innovative services possible through more creative and informed commissioning.
- Enabling networks of users, carers and practitioners regionally and locally, to learn from each others' experiences and support good practice.

Ideas for action

- Develop regional networks of experience and practice outside of the statutory sectors.
- Make sure local commissioning for personality disorder is driven by the knowledge from the national pilot sites and by the principles of the White Paper.
- CSIP and others regionally to continue to promote the equalities and anti-discrimination imperative of developing better personality disorder services.

Workshop Report: Substance Misuse & Mental Health

The workshop was attended by a wide range of participants, from commissioners, to providers, to service users and advocacy services, and as such there were a variety of perspectives and agendas that were discussed and debated throughout the day. The workshop was facilitated by **Daisy Bogg, Consultant Practitioner in Mental Health Social Care** and the notes were taken and prepared by **Georgina Wood, ASW Trainee**

Overview and background

The main theme for the workshop was services for those with a dual diagnosis and substance misuse. This term may be seen as a useful label in defining a group of people using services (Hawkins and Gilbert, 2004) but is not a 'diagnosis' (Banerjee *et al* 2002). 'Dual diagnosis' denotes a very mixed group of individuals experiencing different dimensions of severity of illnesses and dependency/misuse. Common examples of dual diagnosis include the combination of psychosis with amphetamine use, depression with alcohol dependence, anxiety and alcohol dependence, and alcohol and poly-drug use with schizophrenia (DoH 2002). Unfortunately, this label can lead to the individual experiencing prejudice and stigma and may even act as a barrier to care (Banerjee *et al*, 2002 p 2). Social prejudice, negative attitudes, and stereotyped perceptions are widely held amongst health and social care professionals (Banerjee *et al* 2002, Rassool 2006). This is sometimes because people with dual diagnosis are seen as a 'drain on resources' and may also give rise to an attitude of anxiety and misconception among the professionals working with them.

There were a range of key ideas that permeated throughout the day. Most participants had a sceptical view of the white paper. Whilst there was no argument as to its principles of high quality, responsive, person centred care, there were a number of concerns relating to how this could be achieved and the timescales and partnership work that would be required in order to effectively achieve what will be for many large scale cultural and social change.

The group looked at the four key themes of the white paper in detail, in each case the question was asked – what does this mean for those with dual diagnosis issues?

Better prevention and early intervention:

The general consensus in relation to prevention and early intervention

provisions was that the changes are under threat due to the lack of resources and, without substantial investment, any change that does occur will be tokenistic and not sustainable. Whilst services go through the process of making changes to their operation and ethos, there will still be a requirement to perform as a consistent provider and, as such, the conflict in relation to resourcing and capacity is a real concern: how do you change and keep doing the fundamental business at the same time?

There are a number of different agencies involved in the provision of services to clients with dual diagnosis on both a national and local level; these include health, social services, criminal justice, community safety, the voluntary sector, and user organisations. Each of these has a different agenda, its own set of performance indicators and cost pressures and differing priorities. For these services to join up and offer preventative and early intervention services there is a need to reconcile these differences and it is unclear how to achieve this. One key example is the Fair Access to care criteria that social services departments use to allocate community care funding to service users. Usually, only those with high need levels are allocated resources and as such, this does not allow for resource allocation in prevention.

Concerns were also raised that there needs to be better recognition that voluntary services cannot provide the innovative and often preventive interventions expected of them without appropriate funding and short term funding arrangements often lead to a lack of consistent provision.

The group discussed the fact that there is real danger that an insecure workforce will not be able to perform existing or changed tasks as envisaged in the white paper. The increasing emphasis on performance and outcomes requires engagement and commitment from the workforce and at present this is not in place and it is not clear how this can be achieved in such a pressurised environment that many (staff) see as bureaucracy led rather than person led.

Evidence and effectiveness

Evidence is difficult in terms of the efficacy of education for the population at large. In terms of drug-use prevention, prevention education does not appear to make a significant impact in terms of the numbers entering into problematic usage and hence treatment services.

There is a tension between longer-term and shorter-term services. Treatment services have a finite resource pool and require a throughput if new service users are to have access. As such it is necessary to ask the question: what effect does a focus on short term treatments have on service users?

There needs to be a wider use of services – tight gate-keeping limits access (such as using the Care Programme Approach). For the dual diagnosis client group, there is evidence to suggest that low threshold access to treatment and support services when motivation is high is more effective in terms of engagement and efficacy of treatment. This also enables the opportunity for users to be asked for their opinion regarding prevention and what would make things different for them (i.e. alternative therapies, talking therapies).

Choice and Voice

The group discussed that engaging the dual diagnosis client group in terms of making choices and expressing their voice is a difficult task. This group are often chaotic, disengaged from service providers and the nature of addiction is that the individual often operates on a self-destructive pathway that does not sit easily with the government's visions of increased self care and management of problems. In addition, the choices available are exercised within limited constraints: there are a finite number of options and whilst we may aspire to offer what people want this is rarely realistic or achievable. The assumption that services are acceptable to users is prevalent and it may be the case that central policy may have misinterpreted what service users want. It is stated that service users want good quality local services, but it is unclear what this actually means. Substitute prescribing would be a key example: Service user groups differ in their opinions of this. Some advocate the use of widespread methadone prescribing whilst other revile it – how do we reconcile these issues? The group discussed the meaning of choice, i.e: do users want much choice other than easy access, quality, and local to them i.e do they really care whether there is a plethora of choice or is what they really want easy access to good quality local services?

There are paradoxes within the system. At present mental health and substance misuse operate on different sets of criteria. Health and Social Care Substance misuse services operate on an ethos of motivation from the person. Criminal justice agencies use coercion to get individuals to accept treatment and mental health services still operate an often risk averse protective model in many cases. These three approaches are not compatible, and the user often has no choice over which they access. As such the system, is not one of empowerment for those who use it. Very few service users have the confidence to participate in forums and other involvement processes to get their voice and their real views heard more effectively..

Inequalities and access

Dual diagnosis services are very limited and patchy across the country in

terms of what is provided. There are a range of models and no specific agreement on best practice within this field. In addition there is a high level of chaos and disengagement from services, defaulted appointments are common, and staff attitudes are often disparaging and negative.

In addition, the following issues need to be considered:

There is currently very limited provision for older people in relation to substance misuse, and the older people's teams are not equipped or trained to deal with this complex need. Many substance misuse teams work with people in the 18 – 65 years age bracket which creates a large gap in services. Knowledge of issues and risks for older people is necessary to facilitate a comprehensive assessment. Specific risk factors must be taken into account such as higher rates of illness, risk of suicide, risk of violence and a greater risk of stigmatisation and exclusion from existing service provision.

There are limited services for alcohol problems. Whilst the government has published a model of care for alcohol treatment, there is no funding to support this and many alcohol services that do exist are either on a good-will, charity or donation basis, none of which are sustainable. As dual diagnosis issues are often in relation to alcohol use (with or without a drug problem too) this limits the options available to a high risk and complex group of service users.

Substance users are often excluded from the provision of Direct Payments which further limits their choices and options, and in many cases primary care services are reluctant to engage with people using substances. In reality this can mean that people with dual diagnosis who have high levels of health need, are excluded rather than included in basic health care provision.

In addition, there are a range of issues relating to parenting which create a barrier in terms of willingness to access services. Those with mental health and substance misuse issues are often fearful of service involvement as they feel that they will be judged and potentially will be at risk of losing their children.

Support for long term needs

People with mental health/substance use dual diagnosis tend to have longer stays in hospital, have more readmissions and are less likely to consistently use prescribed medication. Research shows that people with dual diagnosis are at increased risk of suicide, contracting blood born viruses, other physical illnesses and accidental injury.

When dealing with a client group who are involved with services on a long-term basis a number of considerations need to be made. These relate to the risk of institutionalisation or 'career service users'. The promotion of

independence requires services to reduce dependence and as such there is a clear issue in relation to providing long term support that enables and empowers the user. Additionally in the case of the dual diagnosis client group, there is a an unwillingness of society to support the care needs of this group of people, with media images and moral judgements dominating. The provision of services needs to look towards social inclusion and destigmatisation which in themselves are difficult to achieve.

Some models of intervention for long term needs

Three different intervention models are often distinguished for mental health/substance use dual diagnosis: serial, parallel or integrated. The serial (or sequential) model is where one treatment follows the other, but is not offered simultaneously. The parallel model is based on treatment being delivered by both substance misuse teams and mental health teams concurrently. The integrated treatment model is favoured by the government and is based on a single treatment system (see DoH 2002 Hawkins and Gilbert, 2004, Banerjee *et al*, 2002). The individual's substance misuse and mental health problems are treated simultaneously by one mental health practitioner. There is a clear body of evidence suggesting that sequential and parallel models of working are inefficient in meeting the needs of the patient (Banerjee *et al* 2002, DoH 2002, 2006, Hawkins and Gilbert, 2004). Expertise is not shared across teams and there are difficulties engaging patients in treatment and reducing non-compliance which, in turn, is associated with poor coordination, and fragmentation of the care delivery process" (Edeh 2002). The integrated model requires a long-term approach delivered by workers who have good knowledge of both mental health and substance misuse problems. In fact, dual diagnosis key workers need to be "cross trained" through inter-agency training, theoretical and skills-based training and practice development and supervision (DoH 2002, Hawkins and Gilbert, 2004, Banerjee *et al*, 2002). The lead key worker being a CMHT worker.

"Individuals with dual problems deserve high quality patient focused care. This should be delivered within mental health services" (DoH 2002).

This model will require a cultural shift within the services.

Questions and more key themes

The workshop raised a lot of other questions and themes which are outlined below:

How? Why? What? How long for?

- What are the consequences of short term politics on people with substance use and mental health issues? The vote-winning potential of substance misuse treatment and the stereotypical media portrayal of the mental health patient creates a reactionary system where the patient is often the last consideration rather than the first.
- What is do-able? What are the priorities? Whose priorities dominate and can they be locally determined?
- Can the Care Services Improvement Partnership raise challenges with regard to efficacy of policy?
- Do users want 'choice', if so what sort of choice and who defines choice? How does choice relate to effectiveness and efficiency?
- How can we reconcile long term views with short term targets and budgetary concerns and how are the white paper initiatives going to be financed?
- What makes a difference in prevention terms in *both* mental health and substance misuse, and can the two areas be tackled together?
- How do Practice Based Commissioning/GP interests align with strategic direction? And how do we get GP's on board and educated in relation to treating dual diagnosis service users?
- How do we distribute Individual Budgets/Direct Payments and will dual diagnosis service users be more easily included?

Conclusions:

The workshop looking at the white paper in terms of dual diagnosis service users appeared to raise far more questions than solutions. People with these problems have a wide range of health and social care needs yet do not fit easily into any particular service area. Whether looking at physical health, housing, access to benefits, psychosocial support or commissioning effective services, many issues arise. There is a general theme of disengagement between the user and society in relation to dual diagnosis, and as such it is difficult to know how to gain user's views to determine what is best in relation to service planning.

The aims and principles of the white paper were fully supported by the group throughout the debate, and it was felt that these values were essential, however for many they were seen as the foundation blocks rather than any real plan or strategy, and the lack of ring-fenced resources, specific guidance and prescribed timescales created an atmosphere of ambivalence among professionals and providers, and an overall cynicism as to the commitment that was really being offered to health and social care services from central and local government organisations with regard to those with the most complex needs..

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Rassool, H (2006), Dual Diagnosis Nursing (Ed), Oxford Blackwell Science:

Workshop report: Criminal justice (and young people) workshop

The group was a mix of ASW's, social workers, and service users. The discussion did focus upon people in prison and the criminal justice system, although there was also a lot of general discussion on mental health and preventative work with and for young people. The group was facilitated by **Sara Lewis, SCIE and Rowena Coleman, Suffolk County Council and Mental Health Trust.**

The opportunities of OHOCOS for the offender population were sometimes hard to define in the discussion. This is partly because OHOCOS does not contain too much detail about offenders although it does include the statement (see p102):

'During the your health, your care, your say consultation, offenders voiced the opinion that public services were hard to access and that there was little support with finding housing, jobs or health services.'

Better prevention and early intervention

The discussion about how OHOCOS would be implemented was very wide ranging, and highlighted concerns about how models of care currently meet the needs of an ever-increasing criminal justice and prison population. There was particular concern at the lack of joined up thinking and policy across government departments, and that this would continue to impact negatively on offenders and not address their needs. Even once they are in the system, they will not automatically receive the support they need.

It was felt there is too much emphasis on risk rather than care in relation to offenders and that this is reinforced by the media with little understanding / reporting of the social factors that may have contributed to the offending. A better balance between the two is needed, and it was acknowledged that preventative measures, such as better housing, easier access to health and social care support could reduce offending rates.

Young people and children

There was particular concern for the lack of prevention and early intervention for young people. This was particularly in relation to detention as young people could end up miles away from their families. For some, they may not have a parent actively involved, and for others, there is the possibility of discrimination especially if the young person has been in the care system.

These issues are also exacerbated for people with learning disabilities, and young people from minority ethnic communities.

Early intervention for young people would see much greater awareness of issues in schools. Clearly, this would require training, and it was felt that CSIP should have a role in training teachers about mental health.

One concern was that child and adult services social workers have a very high threshold and a large workload so might not be able to respond to every concern. Yet, if we are serious about early intervention, this would need to change. At the moment, it seems as though intervention only occurs when a situation reaches crisis point, rather than being pro-active.

There are early intervention initiatives in some areas. For example, in Haringey there is a new initiative where social workers go directly to schools, rather than being mediated through social services.

So, clearly the big question is 'How do we shift the emphasis onto more preventative work'?

Choice and Voice

It was felt that the White Paper was right to offer service users much more choice and control over the services they receive, and this prompted a long discussion about direct payments and their merits. It is clear that service users need to be fundamentally involved in the design and commissioning of services to ensure that delivery reflects the need. It is also something that needs to be thought of from a locality perspective. For example, the Eastern region has several prisons, which will inevitably have an impact upon the type of services required.

Inequalities and Access to services / joined up services

The need for joined up services was a recurring theme throughout the day. The issue of how offenders can get access to health, welfare benefits and social care and especially a GP before release, was considered essential. This is particularly significant for those being released into a new locality, where they have little knowledge about local services and networks. Developing positive social networks is essential in helping to reduce the risk of re-offending.

The experience of the group was that good practice is very local and ad-hoc. One example was given of an HIV service for men in prisons based on the fact that the local team saw a need and pushed for the service. The upshot of this is that people from marginalised groups in the 'wrong' area are even less likely to receive the services they need.

The discussion moved on to consider people on shorter sentences, who may be at risk of losing their home and family contacts, as well as slipping through the gap of what little provision there is. Whilst care is supposed to transfer with people, this doesn't always happen.

A further concern and one that can be quite key to someone's mental health, is that moves around the prison estate can happen at very short notice and this is particularly the case with current overcrowding. This can be extremely isolating for people who are miles away from family and friends, and can mean that the person misses out on services as they are not in one place for long enough

Once in court substance users are given the choice of DRR (Drug Rehabilitation Requirement) in the community or prison – it would be good to get to people before this stage, but how do you motivate people to seek such support before they reach a crisis?

Support for long term needs

Children of prisoners

SCIE is undertaking work about children of prisoners. Much of the literature suggests that a high percentage of children of prisoners will go on to offend themselves. Their experiences can have an impact on their development and ability to sustain relationships, and is stigmatising. It is estimated that between 150 -200 000 children are affected each year.

The Ormiston Trust is one of the main organisations providing support to children and families in this field, and they operate across the Eastern region (<http://www.ormiston.org.uk/timeforfamilies/index.html>)

One comment in response to this is that this inter-generational effect happens when children have been abused irrespective of context. It is also not clear how much socio-economic factors affect offending rates. Thus, the importance of positive family environment was emphasised. Recognising mental health issues is not straightforward as the signs are not always visible.

There is a need to break out of the 'silo' mentality and for services to look after children's wellbeing irrespective of the service in which they work. People do not fit neatly into the traditional categories of provision but require a more holistic approach over a significant period of time to meet their needs.

This has to be linked to making services more accessible and outcome focused rather than trying to meet targets. The bureaucracy often blocks creativity, for example the production of a simple leaflet for young people took

five years. Another example is of young people interviewed by Barnardos, who said they would not access a statutory service for teenage pregnancy.

Referrals into statutory services for young people with mental health needs

There is a huge issue around eligibility and high thresholds in local authorities. Social workers in the group said that they try not to encourage entry into services for children as a lot of what is presented is normal growing up behaviour, and the use of mental health services is stigmatising in itself. Also GPs have high levels of referring on, perhaps because they have little time and CMHT may be better able to assess. It will be interesting to see if the new PCT-commissioning will improve this?

It was felt that the linking up of services used to happen more, for example social workers used to link up with GP practices where they had shared meetings with the practice nurse, midwives, health visitors etc. This saved a lot of time because they could look at who could help and how.

'Life-care checks':

This was considered to be a positive in the White Paper, especially for vulnerable people. However, it is unclear if they would be provided in the prison setting. Most prisons have an in-reach service and have to do a health screening. Yet, the issue is how the check will follow them through the system(s) so they continue to get the care and services previously identified. This is an opportunity to provide something effective and targeted to a captive audience.

Forensic mental health services:

"Social workers are a special breed" (said by a social worker in the group).

Social workers are the main-stay for social care within a medical model institution, and there is some understandable concern that social care will be swallowed up by health particularly with the proposed introduction of the Approved Mental Health Professional role in place of Approved Social Workers. Recognising the different and important contribution of social work to forensic and other mental health care settings is essential to meet complex needs.

Joined-up model

Effective local models of practice include those that engage all the different parts of the system, including social workers, and service users. For example, there is a regional cross-panel independent advisory group (IAG) with the

police service and in Essex there is a county-wide group from which training comes. Perhaps the two models could be combined for CSIP to emulate/learn from? Social care and health should also initiate meeting with the probation service as part of joining up, to enable a more shared language and common understanding.

Other Key themes:

How could CSIP help? Education and training

- CSIP could provide a strategic perspective on how people outside the mental health system identify and work with mental illness through education and training (for example with the police).
- Case studies need to be an integral part of training teachers so they can recognise signs in people that may be a cause for concern. For example, helping teachers to distinguish between the processes of growing up, and early stages of psychosis or other mental disorder and any associated offending behaviours by providing training and information on evidence based good practice.

Ideas for action

Numerous ideas for action were generated by the group:

A universal system

- Need for national guidelines and system (with protocols and specific responsibilities) for health and wellbeing of offenders
- guidance only works if all organisations sign up to it, to agree it has to be implemented, reviewed and evaluated;
- Need for universal language and assessment to avoid systems working against each other, fragmentation or duplication of information.
- protocols may be needed in order for OHOCOS to work, some 'must-do's as there are now for adults' and children's services e.g. local areas could be obliged to consider the impact if they are considering withdrawing a service;
- including standards of practice for the workforce;
- the police have similar issues, could discuss with them e.g. they have a 'gold standard' for lower level officers (that acts as a motivator);

- Named person needs to be tasked with continuity of care. In OHOCOS the GP is the centre of the model, but could use somebody else with a care coordinating function who could influence the purchasing decision;
- A care coordinator may be able to log unmet need which supplies evidence of the need for a service (role of GP in purchasing care and thus biased re costs).

Service user involvement

- Meaningful involvement of service users to make sure this is being done well and that services and commissioning actually reflects the need.
- Budget cuts means people can't always access even existing services e.g. women who have been referred as needing the services of the Maudsley but can't go because of shortage of funds.
- Meaningful service user involvement is crucial at every stage;
- Messages need to be channelled through user groups;
- Joint service user and professional work needed to raise awareness and money;
- relationship between mental health and criminal justice: sometimes a person will commit a crime because (s)he can't get mental health support, they might just want someone to listen to them;
- What do service users find helpful / unhelpful especially re early signs and prevention?
- Direct payments need to be more widely available and easier to access and use. At the moment, offenders are not eligible.

How can different organisations work better together?

- People on the ground are talking to each other but government departments are not e.g. Home Office and immigration service duplication of forms;
- Systems can work against each other, but need to work together;
- Basic improvement to communication is needed, for example, in some areas, housing and homelessness don't talk to each other;
- Care planning processes and language are not the same across adults and children's social care and education resulting in discontinuities of care and misunderstandings.
- People using services need to know that the document or assessment form they have spent time on has value; that it will be recognised across service boundaries as a legitimate

assessment of their needs and will enable access to a variety of services without having to repeat information. Services should recognise that people may have more than one need requiring a number of support services to be involved but that meeting this need must be carefully coordinated..

- Need for transferable paperwork (similar problems were found in adults and children's services) presumably lack of transferable paperwork leads to the issues in the above point?

Workshop report - Homelessness

The well-attended workshop on homelessness had a mixed group of participants including representatives of local user groups, specialists in public and patient involvement, workers with young peoples projects and a policy adviser to the East of England Assembly. The facilitators were **Steve Gardner from the Homelessness Training Unit and Robin Oldfield, Associate Director for Social Care, South Essex Partnership Foundation NHS Trust**. The discussion was grouped around the themes of the White Paper.

Better prevention and early intervention:

It was acknowledged that the specific references to housing and homelessness in the White Paper were limited. Prevention in the context of housing meant the creation of an adequate supply of affordable housing but this was not being carried through in public policy.

The separation of mental health from local authority services has made it difficult to create joined up services across health, social care and housing. Tenancy support and mediation services could make a difference and bring about earlier intervention in housing difficulties, thus preventing homelessness, but needs to be accompanied by better understanding of mental health in the front line staff of housing departments.

The tension between using specialist mental health services to secure housing and the rights to housing which people with mental health problems may be entitled to as citizens and members of local communities was discussed. In pursuit of developing policies of inclusion for people with mental health accessing housing as citizens, the emphasis on partnership working in the White Paper was welcomed. The key task for health and social care professionals is to influence others in housing and education and to broaden their knowledge and sensitivity to mental health issues. That means awareness of 'seizing the moment' in mental health recovery, minimising use of temporary accommodation and adequately preparing people with mental health problems for the responsibility of being a householder.

Homelessness was discussed as potentially being both a symptom and a cause of mental health difficulties. Despite the rhetoric of strengthening communities and enhancing the provision of information advice and support, there was some scepticism about the reality of the implementation process more generally and with particular regard to preventing and solving

homelessness amongst people with mental health needs. The point was made that preventive services may be difficult to access unless one has a diagnostic label, suggesting that people need to be 'caught up' in the mental health system before they can access support to prevent further deterioration in their housing situation.

Choice and voice

"What choice" was the question from users? The stigma of the mental health label meant that at every level of interaction with the housing system, service users faced discrimination; from access to banking facilities through to use of the private rented sector.

The role of statutory social services agencies in relation to determining eligibility for social care (and supporting people) funding may militate against the developmental role of social care advocated in the White Paper. Thresholds for services were being raised as resources tightened further militating against any choice for users.

Advocacy services are important in giving expression to user voices and their role in preventing evictions was discussed. Creating a dialogue between those providing and those using services was essential to work out the balance between rights and responsibilities with regard to housing, to prevent breakdown of tenancy arrangements.

Some creative ways in which users could be empowered were discussed. The 'In Control' pilots bringing together Supporting People funding and direct payments could be a model .

For those people caught in the interaction between mental health, substance misuse and homelessness (a growing group with seemingly intractable problems), an assertive outreach approach was favoured.

Inequalities and access

This section of the discussion focussed on the vulnerability of voluntary groups in the current funding climate. The rhetoric of partnership was fine, it was suggested, but was not always carried through in practice. Cuts to Citizens Advice Bureaux funding were undermining the delivery of well informed advocacy services and many voluntary organisations will not be around to sustain partnerships unless they are given positive protection.

It was suggested that part of the problem was how we thought about homelessness as a problem for *other people* and not as something, like relationship problems, which could affect us all. This perspective separates us from homeless people and reduces our ability to empathise and therefore, to imagine what might help.

Access required accurate and consistent information and advocacy support available to help service users find their way through the system. Yet this was still one of the most fragile parts of mental health services and the most imperilled by short term decisions.

CSIP was seen as having a role in promoting best practice in this area and sharing ideas.

Support for long term needs

Individual budgets and direct payments were seen as the right way forward in giving users a sense of ownership over their lives. The principle of early intervention was warmly supported.

While the picture varied greatly across the region, concern was expressed that some adult services departments were disengaging from mental health with the transfer of staff to mental health trusts.

A model care pathway for homeless people using direct payments could usefully be developed by CSIP. Could the model of assertive outreach teams developed in London for homeless people be a transferable model in a more widely scattered population?

While individual budgets were welcomed some anxieties were expressed about a) the degree to which professionals would continue to control access to funds and how they were spent b) the applicability to young people

Key themes of the workshop as a whole:

- Information in varying formats perhaps name different types of format? tailored to users
- Advocacy to counter stigma
- Education of front line staff in agencies
- Benefits trap for part time employment
- Getting mental health on PCTs' agenda

Ideas for action:

- More affordable housing
- Influence local Supporting People strategy and Homelessness strategy
- Push for Partnership board under Local Area Agreements for marginalised groups
- Ensure health participates actively in Supporting People Commissioning body
- Get service users to define quality outcomes
- CSIP role in spreading best practice

Selected Resources for further reading and research on Complex Mental Health Needs and Contemporary Policy

Useful general websites – government departments

Department for Communities and Local Government
www.communities.gov.uk

Department of Health www.dh.gov.uk

Directgov – “public services all in one place” www.direct.gov.uk

Home Office www.homeoffice.gov.uk

Useful general websites – other

Care Services Improvement Partnership aims to improve outcomes for service users and carers through helping provider and commissioning organisations to improve and implement national policy. www.csip.org.uk

Commission for Social Care Inspection registers, regulates and inspects social care services. www.csci.org.uk

National Social Inclusion Programme is co-ordinating the overall delivery of the Mental Health and Social Exclusion report and is bringing together individuals and organisations from a range of backgrounds and social inclusion expertise. www.socialinclusion.org.uk

Social care online offer a comprehensive range of on-line resources. It is run by the **Social Care Institute for Excellence**. www.scie.org.uk

Social Perspectives Network exists to promote understanding and action on the social aspects of mental health. www.spn.org.uk

Turning Point provide services for people with a range of complex needs and have produced numerous publications on relevant topics www.turning-point.co.uk

Health and social care policy and national guidance

Commission for Social Care Inspection (2006) *Relentless Optimism. Creative Commissioning for Personalised Care. Report of a seminar held by CSCI on May 18th 2006*. London: CSCI

Department for Communities and Local Government (2006) *Strong and Prosperous Communities* London: DCLG

Department of Health (2005a) *Independence, Wellbeing and Choice* HMSO:London

Department of Health (2005b) *Delivering Race Equality in Mental Health Care: an action plan for reform inside and outside services and the government's response to the independent inquiry into the death of David Bennett*, London: Department of Health

Department of Health (2006a) *Our Health, Our Care, Our Say; Health and Social Care White Paper on Out of Hospital Care*. London: Department of Health

NIMHE/Department of Health (2003c-l) *Cases for Change: (booklets) Introduction, Policy, Community Services, Hospital Services, Primary Care, Anti-discriminatory practice, Emerging areas of service provision, Forensic mental health, Partnership working in health and social care, User involvement*. London: NIMHE

NIMHE/Department of Health (2003n) *Fastforwarding primary care: Graduate primary care workers mental health workers. Best practice guidance*. London: Department of Health

NIMHE/Department of Health (2004a) *From Here to Equality*. NIMHE

NIMHE/Department of Health (2004b) *The Ten Essential Shared Capabilities: A framework for the whole of the mental health workforce*. London: Department of Health.

NIMHE/Department of Health and partners (2005) *New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts*. London: Department of Health.

Office of the Deputy Prime Minister (2004) *Mental Health and Social Exclusion*. London: The Social Exclusion Unit.

Social constructions of health and disability

Pilgrim, D. & Rogers, A. (1999) *A sociology of mental health illness*. Buckingham: Open University Press.

Rogers, A. & Pilgrim, D., (2003) *Mental Health and Inequality*. Hampshire, New York: Palgrave MacMillan

Shakespeare, T. (1998) *The Disability Reader: Social Science Perspectives* (Ed). London: Cassell.

Tew, J. (ed) (2005) *Social Perspectives in Mental Health: developing social models to understand and work with mental distress*. London: Jessica Kingsley.

Complex needs - general

Rankin, J. & Regan, S. (2004) *Meeting complex needs: the future of social care*. London: Turning Point/IPPR.

Learning disabilities

Department of health (2001) *Valuing People: a new strategy for Learning Disability for the 21st century*. London: Department of Health.

Useful website: www.learningdisabilities.org.uk

Useful website: www.valuingpeople.gov.uk

Personality Disorder

Lewis, G. and Appleby, L. (1988) Personality Disorder: the patients psychiatrists dislike. *British Journal of Psychiatry*, 153, 44-49

NIMHE/Department of Health (2003a) *Personality Disorder: No longer a diagnosis of exclusion*. London: NIMHE

NIMHE/Department of Health (2003b) *Breaking the cycle of rejection. The Personality Disorder Capabilities Framework*. London: NIMHE

Pilgrim, D (2001) Disordered personalities and disordered concepts. *Journal of Mental Health* 10, 3, 253-265.

Useful website: www.personalitydisorder.org.uk

Substance Misuse

All Party Parliamentary Drug Misuse Group (2000) *Drug misuse and mental health; learning lessons on dual diagnosis*. Available from: <http://www.drugscope.org.uk/uploads/goodpractice/documents/DMH-APGpdf.pdf>

Department of Health (2002) *Mental Health Policy Implementation Guide: dual diagnosis good practice guide*.

Available from: <http://www.doh.gov.uk/mentalhealth/dualdiagnosis.htm>

Useful website:

www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Substance misuse

Criminal justice system and mental health

Department of Health (2005) *The Offender Mental Health Care Pathway*. London: Department of Health.

Useful websites: www.revolving-doors.co.uk
www.prisonreformtrust.org.uk

Homelessness

Bevan, P (2002) *Good practice briefing: multiple needs*. London: Homeless Link

Randall, G., Britton, J., Brown, S. & Craig, T. (2006) *Getting through – access to mental health services for people who are homeless or living in temporary or insecure accommodation: a good practice guide*. London: Department of Health, Care Services Improvement Partnership, Department of Communities and Local Government.

Useful websites: www.homelessuk.org