Joint Strategic Needs Assessment 2012

Mental Health in Doncaster; the perspective of the voluntary sector

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Contents

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Executive Summary

i   This study captures the views of voluntary organisations working in mental health in Doncaster. The study used a written consultation to contact the organisations and gather data. This data was then analysed to form the basis of a focus group, investigating some issues in more detail.

ii The written consultation received a response from 17 organisations, of which nine attended the focus group. This focus group discussed three topics; people falling through the gaps, increasing or changing demand and the commissioning process.

iii People with mental health issues can struggle to access services if they have unclear or changing diagnoses. The system requires a pathway for people to be referred into services by other organisations. It is important to expand self referral to provide anonymous options that do not create a mental health record.

iv Mental health attracts a stigma in some BME communities, especially for women, but services also need to be more culturally sensitive. In a similar vein, some young people leave CAMHS at 18 but find adult services are not appropriate for them. Service users are not sufficiently engaged in service design and delivery.

v   Older people require greater choice of mental health services; they are not offered the same range of services as people below the age of 65. There is also a need to address social isolation for older people.

vi The recession and debt issues are affecting people's mental health. The recession is also impacting mental health through behaviours such as alcohol use and gambling. Changes to the benefit system, such as Work Capability Assessments, are also having a negative impact on people's mental health.

vii There is a shortage of good quality housing in appropriate areas. The housing application process can disadvantage people with mental health issues.

viii There are concerns regarding personalisation in terms of people being able to access an online system and also the potential exploitation of vulnerable users.

ix The future challenge is to take a preventative approach to mental health; supporting resilience and wellbeing, managing stress and anxiety.

x   Local voluntary groups struggle to meet administrative costs and are finding it difficult to access funding. Short term contracts are becoming more frequent and complex procurement processes can disadvantages small organisations. There is a danger of losing local 'grassroots' organisations.

xi If repeated, the process could increase participation and engage some key organisations that did not contribute this time. This would facilitate multiple focus groups which could then be used to target specific topics within mental health.

xii Further work is required to address the issues raised. One suggestion is a workshop open to all providers and commissioners, discussing a combination of the issues in this document and the priorities of other stakeholders. It would also be beneficial to map the scope/reach of the voluntary organisations to understand these assets at a community level.

xiii This report will be submitted to the Health & Wellbeing Board Development Group to ask whether this work is useful. Is it an informative way of engaging the voluntary sector and increasing 'public voice' in the JSNA? If so, are there specific areas that the Board would like to cover in the future?

xvi Appendix 1 contains a response from local partners to this document.

Introduction

1.1 This is a qualitative study of mental health in Doncaster from the perspective of voluntary sector groups. It has been created to supplement numerical data in the Joint Strategic Needs Assessment (JSNA) and a mental health profile by the North East Public Health Observatory (NEPHO, 2012). Numerical data on mental health can be inadequate for population needs assessments; recorded demand is accepted to be the tip of the iceberg (White et al, 2008) and prevalence of mental health conditions often rely on modelled estimates.

1.2 The initial scope of the study was to increase public voice in the JSNA, to add context and an alternative perspective. In the absence of resources to conduct a local survey of mental health and given ethical concerns around overly consulting vulnerable groups, it was decided to harness the knowledge of the voluntary sector as advocates for vulnerable and seldom heard groups. It is important to note that this study represents the views of voluntary sector groups and is not a direct measure of service user's opinions. Nevertheless, these data will include the experience of service users and are a useful addition to quantitative data.

1.3 The study will contribute to the JSNA 2012/13. This coincides with a difficult financial climate, reforms to the NHS, the transfer of Public Health to Local Authorities, the creation of Health & Wellbeing Boards and the introduction of HealthWatch. These are rapid and dynamic changes; a qualitative approach presents an opportunity to map these impacts in a timely fashion.

1.4 This study is a pilot. Part of the remit is to test an approach that captures public voice in the JSNA, recording successful practice and noting areas for improvement. Subsequent studies may focus on a different morbidity, or specific demographic groups, but should build on the lessons learnt.

2. The context

2.1 The Health & Social Care Bill became law in March 2012. This legislation establishes Health & Wellbeing Boards in upper-tier and metropolitan Local Authorities in England. These Boards provide a forum for the collaboration of local commissioners across the NHS, Public Health, Social Care, Elected Representatives and HealthWatch. The Boards will develop joint health and wellbeing strategies and increase the democratic legitimacy of decisions. From April 2013 commissioning of health services will be administered locally by Clinical Commissioning Groups and regionally through the NHS National Commissioning Board. Public Health responsibilities will pass to Local Authorities and Public Health England.

2.2 The JSNA will play a key role informing these strategies, identifying the current and future health and wellbeing needs of the population. Health & Wellbeing Boards have a duty to involve service users and the public (DH, 2011). HealthWatch will operate at a national and local level from April 2013, replacing Local Involvement Networks, acting as a local champion for service users, patients and the public (DH, 2012a). As the aim of this study is to capture the views of the voluntary sector, NHS Doncaster worked with Doncaster Community & Voluntary Service (CVS) to coordinate engagement with the local organisations.

2.3 The Localism Act 2011 will support Health & Wellbeing Board, community groups and individuals by decentralising power. A General Power of Competence will free Local Authorities to innovate where previous legislation failed (DCLG, 2011).

2.4 Doncaster Community Healthcare transferred to Rotherham, Doncaster & South Humber Mental Health NHS Foundation Trust (RDaSH) in March 2011 under the national programme Transforming Community Services. In light of these and other changes, the Doncaster Joint Mental Health Strategy was refreshed for the period 2011-14. This strategy sets out an action plan for the six priority groups; children and young people, people accessing services for the first time, people with short term needs, people with ongoing mental health needs, people with dementia and people with complex needs.

2.5 This study contributes to a wider suite of evaluations for local mental health services. In August 2010 RDaSH implemented a new Adult Service Model for Adult Community Mental Health Services in Doncaster. The model reconfigured community mental health teams into specialist services, moving from generic locality-based teams to multi-disciplinary, borough-wide specialist teams (RDaSH, 2010). The model was subject to consultation prior to change and evaluated in January 2011, which included a service user evaluation report and carer evaluation report (RDaSH, 2011a). A similar evaluation for the second year of operation will be published in 2012, reflecting on commitments in year one.

2.6 The Department of Health are introducing Payment by Results (PbR) to adult and older people's mental health services (DH, 2012b). Individuals will be allocated to 21 clusters separating non-psychotic, psychotic and organic conditions into varying levels of need. PbR will operate in shadow form during 2012/13 and is overseen by the Pathway & Currency Development Group.

2.7 Doncaster MBC and RDaSH are working together to make personal budgets available for secondary care mental health service users with FACS (Fair Access to Care) eligible social care needs, identified by an integrated health and social care assessment. This work is overseen by a sub-group of the Doncaster MBC Personalisation Board, referred to as the RDaSH personal budget Project Team.

2.8 Since October 2010 Child & Adolescent Mental Health Services (CAMHS) have been delivered by RDaSH, including Tier 2 and 3 interventions. The work plan for 2012/13 includes a review of CAMHS out of hours support, a review of services for ADHD and Autistics Spectrum Disorders, and a review of the IAPT extension (Improving Access to Psychological Therapies) to children at risk of developing mental health problems.

2.9 Maple Lodge provides services to older people including care for severe Dementia. These services have been reconfigured and will undergo an impact assessment in 2012/13. Wider Dementia work is coordinated through the Older People's Mental Health Steering Group. The Steering Group aims to meet recommendations in the National Dementia Strategy by 2014 with four of these a particular priority; early diagnosis, better care in acute hospitals, better care in care homes and better care at home (NHS Doncaster, 2011). Patient and public involvement for Dementia is facilitated through the Doncaster Dementia Forum.

2.10 RDaSH also has an overarching Patient, Carer and Public Engagement Strategy for the period 2010-2013 that includes a Trust User Carer Partnership Council, bringing together patient/carer groups and senior Trust managers (RDaSH, 2011b).

2.11 Appendix 1 contains a response from local partners to this document. Appendix 2 contains national policy/guidance for mental health and personalisation.

3. Methodology

3.1 A steering group was established between Public Health Intelligence (NHS Doncaster), Doncaster CVS, Doncaster Advocacy, Platform 51 and Doncaster Alcohol Services. The group reviewed the JSNA 2011/12 to identify topics that would benefit from a voluntary sector perspective and the discussion established mental health as a previous limitation.

3.2 The steering group developed a written consultation for mental health (see Appendix 3) which was sent to approximately 600 groups in receipt of an electronic CVS newsletter. The consultation began in October 2011 and closed 4 weeks later in November 2011.

3.3 On reviewing the initial respondents, it was agreed that a number of key mental health groups had not contributed. These groups were contacted by members of the steering group and asked to complete the form. A total of 17 groups replied to the consultation; Age UK, Alzheimer's Society Doncaster, Autism Plus, Big Ambitions, Clouds Community Counselling, DCVS Gypsy & Traveller Voice, Dial Doncaster, Doncaster Advocacy, Doncaster Alcohol Services, Doncaster Citizens Advice Bureau, Doncaster Community Arts (darts), Doncaster Rape And Sexual Abuse Counselling Service (DRASACS), Mind, Open Minds, Personalisation Forum Group, Platform 51 and South Yorkshire Centre for Inclusive Living,

3.4 Data analysis took place in December 2011 and involved reading and assigning codes to the particular passages. This coding was carried out separately by Public Health Intelligence and Doncaster CVS, then the two sets of analyses were cross referenced, organised and the emerging themes agreed.

3.5 These themes formed the basis for a focus group discussion taking place on 14th February 2012. The focus group, 1.30hr in length, was based around the following 3 statements/questions, which were intentionally broad;

    i)   People falling through the gaps.

    ii)   What are the important issues for the groups in terms of changing demand? What are the longer term impacts and what can be done to mitigate against these?

    iii)   What are the important issues for the groups in terms of how services are commissioned and funded?

3.6 All respondents to the written consultation were invited to participate in a focus group. The following nine groups attended; BME Community Forum, Clouds Community Counselling, Dial Doncaster, Doncaster Advocacy, Doncaster Alcohol Services, Doncaster Rape And Sexual Abuse Counselling Service (DRASACS), Mind, Open Minds and Platform 51. The audio recording was reviewed and coded (but not transcribed) by Pubic Health Intelligence to formulate the findings in section 4 (the findings include some written data where a group could not attend).

3.7 The written consultation included reassurances that all data would be anonymised. The focus group was digitally recorded and quotations have been used in the findings. However, the focus group was assured that all contributions would be anonymous and the recording deleted once analysis was complete. This was essential so that the study captured an open and honest account of the issues.

4.   Findings

The main headings (4.1, 4.2 and 4.3) represent the specific wording used to prompt discussion in the focus group. The subheadings within these sections have been created during analysis of the audio recording, drawing the discussion into conceptual topics.

4.1   People falling through the gaps

Diagnosis and assessment

4.1.1 A theme emerged around the barrier of formal diagnosis, or through changing diagnosis, particularly when accessing RDaSH services. Pathways operate through the Access Teams, however service users have an expectation that if *"they think that they have a problem then it should be addressed"*. In reality they may not fit the criteria of various teams. The voluntary groups feel they need to support people into RDaSH services rather than simply refer them.

4.1.2 One particular example is the crisis service; *"criteria are based around a psychological crisis, so if this isn't the case then where do you go?"*. There is a particular problem where people are sent to A&E for crisis assessment out of hours; *"for someone in crisis, this isn't the best place to sit…and a crisis assessment ought to happen quicker than two hours"*.

4.1.3 Service user's needs may change. They may have predominant needs around one issue, for instance learning disability. If mental health becomes a concern then *"it is not always very straightforward because the person is repeatedly referred back to LD* (learning disability) *services"*. The focus group summarised the point; *"do the services respond as well as they should to people with unclear issues?"*.

4.1.4 People sometimes access mental health services through a voluntary group rather than their GP and this was considered appropriate, especially for people requiring low level support. However, there is an important advocacy issue for people who struggle to access services. The voluntary groups routinely advocate for people requiring psychological assessment. Trust is essential when dealing with complex psychological issues but the Access Team assessment slots are too brief; *"it takes time for people to disclose serious psychotic conditions"*. The process works where there is a good relationship between the advocating group and the Access Team but it is hit and miss.

4.1.5   One of the voluntary groups summarised the point; *"I'm not sure there is an answer to that though. You have to be realistic that the Access Team…cannot spend a couple of hours getting to know someone first. The key for us is getting a pathway so that people can be directed back into services by another organisation"*.

Person centred, confidential services

4.1.6 The focus group feels there is too much focus on Cognitive Behaviour Therapies (CBT). Some people are tool vulnerable or have personality disorders incompatible with CBT.   *"There is a lot of danger in the quick win approach",* at times CBT *"can be a sticking plaster"*. Research has focused on evidencing the effectiveness of CBT but other counselling methods are also successful when

evaluated; *"it is the relational approach that matters"*. CBT has its place but at times alternative methods are more appropriate despite taking longer. Services need to offer more choice and *"move towards a person centred approach"*.

4.1.7 The focus group feels it is important that service users can approach them anonymously, although few opt for complete anonymity. Importantly, this means there is no need for a mental health record; *"it is really important for people because they feel stigmatised enough without having that additional measure"*. People are referred through community therapy services and through their Doctor, but these can also provide a signpost for self referral. *"We have to maintain the right* (of self referral) *for people otherwise you can limit the services…and it increases the difficulty of access, another lengthy process for someone at a difficult stage"*.

Children and young people

4.1.8 Young people are less likely to access services via a GP or other formal route, particularly with sensitive issues of domestic violence and sexual abuse. Young people *"become involved in a social way and realise there is support and, once they develop a relationship, they can share that information…they never would have if they had to make a formal appointment"*. There is a need to maintain and expand discrete self referral and offer quick access to children at a time of need.

4.1.9 The voluntary groups have had success working with young people in schools; directing mental health support by working jointly with the young person, the youth worker and the counsellor. However this work is complicated by the evolving structures in education; *"in the new Academies they are not being allowed time out…they have to access services in the evening, in some cases from the boundaries of the Borough"*.

4.1.10 RDaSH won the contract to deliver mental health services to young people in Doncaster. The tender set out working in schools, similar to approaches Rotherham that raise awareness and support for mental health. The voluntary groups agreed to work in partnership to deliver the contract but have not been involved, suggesting a gap in joint working.

4.1.11 The focus group also identified a gap in the transition from CAMHS to adult mental health services. *"Young people 18 and upwards who no longer fit into children's services but are not appropriate…for adult services. There is just a huge gap in service there"*.

The Black & Minority Ethic (BME) community

4.1.12 The focus group feels there is a high level of stigma attached to mental health diagnosis in BME communities, especially for young women. Service users can approach the groups for an unrelated reason and then access counselling independent of medical models. But the groups are concerned at the number of people not engaged, asking *"how many people slip through the net?"*.

4.1.13 This is stigma is present in the Gypsy and Traveller community; *"Many end up at the severe end of the scale before they access services, and once in the system they find it difficult to get out, due to a lack of understanding of the culture"*.

There is a lack of research into the health of the Gypsy & Traveller community and generally speaking demographic ethnicity data is poor.

4.1.14 Though the group feels it is important to raise awareness of cultural differences, it is also important question how appropriate services are; "*is it a problem within people's cultures, or is it problems within the services?*". One group questioned whether there is a mental health stigma across the board. Drawing on an example of psychological therapies; "*Newham in London, with a very high ethnic minority population…did not have a problem with people accessing services, and I think that is because the services were culturally sensitive…I don't think our services in Doncaster are in any way culturally sensitive*".

4.1.15 The focus group feels there is a need to raise awareness of their services to young people and the BME community. People are only signposted when it becomes apparent they have a need; "*they aren't going to know that we exist unless they are jumping up and down for help…BME people don't tend to be referred to us, but once they do* (get referred) *we don't have a problem with them accessing the service*".

4.1.16 Working with minority groups can incur translator costs. The voluntary groups meet these costs but this is not recognised contractually; "*it has relied hugely on good will and the commitment of people working in the third sector who will not turn people away*". This is especially relevant in Doncaster given local changes to translation services; provision for those who do not speak English will become more challenging in the future.

Older people

4.1.17 There is a need to improve choice of mental health services for older people as a whole; "*we have a healthier older population who have mental health issues which are not to do with their age, and yet they don't always get the most appropriate service*". The focus group feels that older people are not offered the same range of services as people below the age of 65.

4.1.18 The focus group acknowledged that older people are often provided with better quality housing, but that this had unintended consequences for mental health; "*they have moved into much better standard of living accommodation, but they are completely isolated*". The voluntary groups feel it is important to plan how to support these people in the future, especially given the lack of community funding.

Service user engagement

4.1.19 The focus group does not believe service users are sufficiently engaged in the design and delivery of services; "*that's the only way that we know the service will be appropriate for those types of people…so involving people, for me, is a major gap*". Budgets have been removed for service user engagement despite greater involvement in the Health & Social Care Bill; "*people being involved actively and meaningfully doesn't come free…they need to accept there is a cost and it needs supporting and resourcing*".

<u>Availability of services</u>

4.1.20 The focus group raised a number of gaps relating to the geographical reach and timing of services. The discussion raised out of hour provision a number of times; "*If somebody has a crisis in the evening or at the weekend it is very difficult to get hold of the appropriate people to help*". In another example, a client regularly threatens suicide and has been referred back to the NHS; "*this person seems to have fallen through the net… the call is always in the evening or at a weekend and I have given up trying to get hold of the relevant team. I now call the police who bring an ambulance*".

4.1.21 Geographical barriers were also raised, the following being an example of counselling in the East of the Borough; "*there are access problems, physically, in Thorne because people have to travel to Intake or to Tickhill. They can't afford it and some of them aren't well enough to do it*".

<u>Mapping out services</u>

4.1.22 The focus group identified a knowledge gap within both voluntary and statutory services*. "We still struggle to understand the services… yet we are working with them every day, what's it like for someone new?*". This is particularly important as the voluntary groups are often the first point of contact for people seeking help.

4.2   What are the important issues for the groups in terms of changing demand? What are the longer term impacts and what can be done to mitigate against these?

"We can all see there is a huge wave coming up".
"I think the wave has already hit us".

The impact of the recession

4.2.1 The current financial climate is having has an effect on mental health; *"It's a downward spiral because they can't pay their mortgage, they've no money coming in, then mental health issues follow like depression"*. The focus group also feel it is necessary to consider the effect the recession beyond the immediate client, the wider harm; *"5 or 6 years down the line, the impact this will have on families and broken homes?"*.

4.2.2 It is time consuming to support people with financial problems and *"some people, particularly with more severe mental health problems, need that advice in a way that can manage that mental health issue as well"*. The voluntary groups face a challenge working with clients through debt issues and the implications of benefit changes.

4.2.3 Doncaster has a high rate of public sector workers. One voluntary group expressed a concern that public sector cuts could disproportionately affect women. *"Lots of different problems are coming our way; abuse of different kinds…If a woman needs to support her family, she will use whatever means she needs...The implications are huge"*.

4.2.4 The voluntary groups also think the recession could impact mental health by exacerbating other lifestyle behaviours; *"the biggest growth area in shops is betting shops… When people are struggling most they look to a miracle solution, the impact of that is huge issues around gambling and drinking"*.

Changes to the benefit system

4.2.5 The voluntary groups have seen an impact from changes to Work Capability Assessment and changes to housing benefits. *"We are seeing a lot of people deteriorate…they come to us with existing mental health issues…who will probably not work unless they can resolve those issues. But they are getting kicked off benefits because they are deemed fit for work"*. Similar issues may arise in 2013 if Disability Living Allowance transfers to a Personal Independence Payment, with new qualifying assessments.

Personal budgets

4.2.6 There is concern at the prospect of people managing their own personal budgets; *"I talked to someone, who has mental health issues, who has interviewed a number of people in their own home for a personal assistant"*. The focus group worries that the applicants will not need specific qualifications or CRB checks, so that the process will be open to abuse.

4.2.7 The focus group also had concerns about the development of E Market Place, where personal care services may be purchased online; *"at the moment it is at one level where you can see what services are available…the long term aim is that people will go online, have their budget, click and buy that service"*. There

is concern of the quality of care if it is purchased 'unseen' but also concerns about equality of access; "*not all people can go online*".

<u>Housing</u>

4.2.8 The focus group feels that people with mental health issues are living in poor quality accommodation; "*appalling housing, wet running damp* ". It is very difficult to support people in a tangible way given the lack of money but services have been commissioned to provide housing related support. The issue in the private sector accommodation is even more difficult; "*the problem in private accommodation is that you have to take a much stronger lead and threaten to take them to court*". Some private landlords are taking advantage of vulnerable people.

4.2.9 People are required to bid for particular properties. Although this is fairer in some ways, it disadvantages people with mental health issues as application forms can present a barrier. One group provided an example of their client; "*he comes to us for counselling but he also comes for help form filling, he see's it and he is immediately paralysed*". However, there are specific housing support services and the groups agreed that these should be used appropriately, rather than trying to support a client's accommodation needs on their own. This requires greater information sharing to ensure services are fully utilised.

4.2.10 Sometimes people are offered accommodation of suitable quality but the area is inappropriate; "*if you are well you can keep yourself to yourself. If you are vulnerable…it all falls apart. The local drug dealers quickly find out you are vulnerable…We have workers who can't go into someone's home anymore because it's too dangerous*". The safety of neighbourhoods is as important as the quality of the housing, but there is a shortage of that level of accommodation.

<u>Dementia (including early onset Dementia)</u>

4.2.11 The focus group has observed increasing numbers of people suffering dementia with links to lifestyle behaviours; "*there has been a huge increase in dementia, early onset dementia…with long term alcohol abuse as a trigger*".

<u>A sense of hopelessness</u>

4.2.12 The focus group worries that there is a sense of hopelessness in young people, who risk falling into petty crime, drugs and alcohol; "*I worry there is a cohort, not a Black issue or Asian issue, but across all NEETs*". But the issue does not end at the NEET category; "*young professional people aged, say, 24 to 30…with a sense of hopelessness…and they wouldn't think of accessing services* ".

<u>Determinants of mental health</u>

4.2.13 The group were asked to rank social determinants, such as housing, employment and crime, in terms of their impact on mental health. Initially the group perceived them to be indistinguishable; "*it's all one big messy pot*". On further discussion, and thinking from the perspective of mental health service users, they agreed people "*would say housing is important…employment isn't that important, it's a luxury*". In fact the most important issue would be connection; "*isolation and loneliness and not having someone in their lives…the thing that they ask for most is a partner*".

4.2.14 Social interaction provides the foundation and everything else comes after that; *"people will put up with poorer accommodation if they have social integration…then housing is crucial, then come the other things like employment and money and health"*. The focus group feels that mental health would actually be a service user's lowest priority; *"whether they know that that would be better if the other things were better, instinctively I think people know that"*.

4.2.15 Once this foundation is in place, the progression should be towards gainful employment as vocational activity improves and protects mental health. Knowledge among professionals and the public regarding these benefits is generally poor but the impacts are stark - being out of work is equivalent to smoking 200 cigarettes a day and unemployment is a significant suicide risk factor. There are gaps in service for vocational support in Doncaster for people with mental health difficulties, but a new service has been introduced.

4.2.16 There is strong evidence to show the impact of vocational rehabilitation is comparable with traditional psychotherapy methods but the former tends not to be resourced. The Centre for Mental Health suggests psychological therapy services should place more emphasis on holistic peer support for issues such as employment, debt, housing and welfare.

4.3 **What are the important issues for the groups in terms of how services are commissioned and funded?**

A preventative approach

4.3.1 The focus group believes services currently meet the needs of the small number of people with severe mental health problems. The future challenge is to engage *"the other 75% that, if they don't get the right support, will develop mental health problems"* - supporting resilience and wellbeing, managing stress and anxiety. The voluntary groups need to convince commissioners to fund services for people that are not ill, *"that is going to be the challenge…how we commission services that have clear outcomes, legitimate services, but the goal is to keep people well and not deal with them when they are ill".* The sector is well placed to lead this preventative approach as people may be more inclined to walk through their door.

4.3.2 Doncaster is getting better at teaching resilience in schools but more can be done. One voluntary group raised the example of a Dutch system where social workers are based in the education system rather than the Local Authority, engaging with children and families earlier. While acknowledging this would be difficult to implemented locally, *"it makes me realised how important schools are in mental health and how much more we need to get into secondary schools and primary schools".*

The value of self referral

4.3.3 The focus group feels *"it is important that the value of self referral is retained".* Current contracts were based on medical referral routes but have been renegotiated to include self referral. *"When you are dealing with people who have gone through traumatic events, you are not necessarily going to see them through a medical referral…I am very pleased that they have acknowledged that, and that stream of people are going to be taken care of".*

Working with the statutory sector

4.3.4 *"I think we tend to get seen as a brilliant free service that fills a gap".* Though a number of the voluntary groups offer free services, there are still costs associated with premises, insurance and travel; *"it is becoming more and more impossible to find this core funding…we are running on empty".* The groups seek funding from statutory organisations but tend to be passed from one to another or told there is no evidence that the service is needed, *"yet they refer to us".*

4.3.5 The focus group feels it is *"difficult for the statutory and voluntary sector to look at each other with anything other than their own mindset".* The voluntary groups find it difficult to engage with statutory organisations because they are so large and it is not clear where responsibilities lie. Alternatively, statutory bodies find the voluntary sector diffuse; *"when I have been out to GP practices they have asked – how do we find out who is out there and how do we know if they are any good?".* Currently knowledge is shared by word of mouth, *"that takes a heck of a lot of doing, if they are not engaging with us it is probably because it is too hard".* There is a will to collaborate but it requires a different mindset from both parties.

<u>Procurement and contracts</u>

4.3.6 The focus group raised the limitation of short term contracts, "*the Government talk about reduced bureaucracy and improved sustainability of the sector…but there is more bureaucracy and I have never had shorter term contracts*". Short contracts place a stress on the organisations but are also detrimental to service users; "*the benefits you get, the experience, the improved service you could deliver in a second or third year, would be very tangible*". There are initial hurdles when setting up a project in a new area and the service users do not see the benefit if a project ends prematurely. "*Length of contract should be considered, but at the same time from our perspective we need to be able to prove value for money*".

4.3.7 The focus group feels that procurement processes should be proportional to the size of the contract. This is exacerbated when tenders have a short time scale; "*the people who will be best placed to bid for that are the big national organisations who have teams and can pull things off the shelf*". There is a danger of losing local grassroots organisations and experience; "*in the charity world in general there are five or six super charities that subsume all the little ones*". It is hoped that future systems will use simple and more realistic procurement processes. Contract monitoring could also be more reasonable, and the collated data could be used to evidence service effectiveness.

<u>Cooperation between voluntary groups</u>

4.3.8 The procurement process thrives on competition but organisations need to work together where possible. The voluntary groups plan to re-establish a system of organisations in the mental health sphere, using technology to maintain a loose network.

5.   Brief restatement of findings

People falling through the gaps

5.1 People with mental health problems can struggle to access services if they have an unclear or changing diagnosis. The system requires a pathway so that people can be referred back into services by other organisations.

5.2 It is important to retain and expand self referral for children and adults. Service users also require anonymous treatment options that do not create a mental health record.

5.3 Services should move towards a person centred approach. CBT has been favoured in the past and this funding has generated an evidence base, but other treatment options are also effective.

5.4 Some young people leave CAMHS at 18 but find the adult mental health service is not appropriate for them.

5.5 There is a stigma attached to mental health in some BME communities, especially for women, but services also need to be more culturally sensitive. Translator costs will make it harder to provide a service to people who do not speak English.

5.6 Older people require greater choice of mental health services - they are not offered the same range of services as people below the age of 65. There is also a need to address social isolation for older people.

5.7 There are some gaps in the geographic reach and timing of services.

5.8 Service users are not sufficiently engaged in the design and delivery of services. This engagement needs to be resourced.

Increasing or changing demand for voluntary groups

5.9 The recession and debt issues are affecting people's mental health. This can be a challenging and lengthy process if the client has pre-existing mental health issues as advice needs to be delivered appropriately. The recession may also impact mental health by exacerbating behaviours such as alcohol use and gambling.

5.10 Change to benefits, such as Work Capability Assessment and housing benefit, have had a negative impact on people's mental health.

5.11 People are required to bid for housing but this can disadvantage people with mental health issues where application processes can present a barrier. Additionally, there is a shortage of good quality housing in appropriate areas.

5.12 Increasing numbers of people are suffering Dementia and early onset Dementia, sometimes triggered by long term alcohol abuse.

5.13 There are concerns regarding E Market Place in terms of people being able to access an online system and also the potential for people to take advantage of vulnerable users.

<u>Funding and commissioning</u>

5.14 The future challenge is to take a preventative approach to mental health - supporting resilience and wellbeing, managing stress and anxiety.

5.16 It is important to retain the value of self referral.

5.17 Local voluntary groups are struggling to meet administrative costs and are finding it more difficult to access funding.

5.18 Short term contracts are becoming more frequent and procurement processes are inappropriate for the size of contract - at present it is too complex and disadvantages small organisations. There is a danger of losing local 'grassroots' organisations.

5.19 Contract monitoring should be more reasonable and the collated data could be used to evidence effectiveness.

5.20 Procurement processes thrive on competition but voluntary organisations need to work together where possible. The groups plan to re-establish a loose network of groups working in mental health.

6.   Recommendations on the process

These recommendations reflect on the study as a process rather than commenting on the specific findings;

6.1 The steering group were happy with 17 responses and these provided a rich source of data. However, subsequent projects could seek to increase coverage.

6.2 Some key mental health organisations did not participate despite a follow-up phone call. It may be more systematic to identify the key organisations and engaged them directly from the outset then use the blanket approach (CVS news) to contact a wider audience.

6.3 The significance of the JSNA and Health & Wellbeing Board could be raised within the voluntary sector to generate greater interest.

6.4 Some large organisations are focused towards a regional or national level and different methods are needed to engage these at a local level.

6.5 Greater participation would allow the study to run more than one focus group. Additional sessions would triangulate perspectives and identify other issues.

6.6 Multiple focus groups would allow sessions to be dedicated to a specific topic such as a demographic group, e.g separating children, adults and older people. The single focus group might have tried to cover too much.

6.7 Voluntary organisations should test the findings of this study with their service users. This would strengthen the validity of the process.

6.8 Further work is required to address some of the issues raised in this study. The steering group could coordinate a workshop open to all providers and commissioners. This could discuss a combination of the issues in this document and the priorities for other stakeholders. If approved, this work should continue under the banner of the Mental Health Partnership Board.

6.9 CVS provided an essential conduit to communicate with the voluntary sector groups. There is scope to improve working practice so that CVS can widen voluntary sector input into other projects.

6.10 It would be beneficial to map the scope and reach of the organisations to understand these assets at a community level. A useful starting point would be the CVS directory (http://doncastercvsdirectory.org.uk/) – which broadly filters organisations by geographic area, service type and target audience.

6.11 This report is to be submitted to the Health & Wellbeing Board Development Group to ask whether this type of work is useful. Is it an informative way of engaging the voluntary sector and increasing 'public voice' in the JSNA? If so, are there specific areas that the Board would like to cover in the future?

7.   References

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8.   Appendices

Appendix 1 - Partnership Response to the JSNA report Mental Health in Doncaster: The Perspective of the Voluntary Sector

This mental health needs assessment offers a useful insight into population need and will combine with other work commissioned by the Mental Health Partnership Board to inform mental health strategies. It offers a unique perspective focusing exclusively on the voluntary sector, and these messages need to be communicated to the providers of mental health services.

The document makes reference to a lack of service user engagement. This is acknowledged to be an issue for all service users, not just for young people and ethnic minorities. The Mental Health Partnership Board strives for excellence in patient and public involvement, and aspires to achieve the highest competency (level 4) within World Class Commissioning, but more needs to be done. 'Think Local, Act Personal' is a sector-wide commitment to moving forward with personalisation and community-based support and will ensure more choice and control for service users. Doncaster Council is working with service users and user groups to actively develop a co-production approach to social care commissioning and policy development.

Local partners also operate a Patient and Public Involvement (PPI) Forum to facilitate engagement. However, these processes can be limited to those who are already willing to participate, and may not represent a whole community. A wider range of techniques need to be applied to public engagement in the future. GP practices conduct patient forums which assist in obtaining patient voice. Commissioners are also using the contracting and CQUIN processes to ensure providers are putting patient and user care at the centre of their experience, while also ensuring safety and outcomes remain paramount. It will be a core requirement of providers to obtain user feedback and to respond appropriately to that feedback.

The introduction of Clinical Commissioning Groups has facilitated greater clinical engagement, informing strategy and service design. It is important to capture the knowledge of GPs and clinicians who work with local residents and understand local need. There are also opportunities to capitalise on the expertise of the voluntary sector and other professions. There are many examples of good practice and the key is to communicate what already works, as well as highlighting areas for improvement. This document is a starting point but it would benefit from a wider range of stakeholders including service users, commissioners and providers. The challenge is to capture this intelligence in a systematic way that contributes to the Joint Strategic Needs Assessment.

On a similar point, there is a lack of available data to support decision makers. Providers hold lots of useful data but tend to be too conservative within the confines of Information Governance. An improved culture of information sharing would create a more accurate picture of population need and identify gaps in service. The Health & Wellbeing Board has an opportunity to drive this agenda and integrate commissioning across health and social care. The Board can draw on contributions from the wider determinants of mental health, which are not presently used to their full potential, such as employment, housing and education.

It is the role of commissioners to stimulate the market so that the public have a greater choice of provider, but this diversity is not available at present. Personalisation of care will improve choice and control, which will empower people

to take greater responsibility for their health and wellbeing. This document highlights some concerns regarding personalisation. The eMarketplace system has minimum accreditation criteria that will safeguard vulnerable people and guarantee the quality of services provided. Assessment Care Management Teams will provide mobile access to the system that can be taken into people's homes – providing equality of access.

Dual diagnosis and unclear diagnosis are traditional problems within mental health. The new Adult Service Model combines staff into multidisciplinary specialities, rather than operating via generic localities, and Payment by Results introduces a cluster tool that standardises assessment of need. These changes should help address these issues. This year's contract sets out proper provision for people with dual diagnosis, while providers are required to demonstrate the interface between the Business Teams that manage each 'cluster' care pathway. The system is still relatively new and is subject to evaluation, so will be refined and improved over time. Dual diagnosis does require a more preventative approach, addressing issues upstream to stem the flow of entrant service users as well as reacting to the needs of those established in the system.

From a children and young person's perspective the report is welcomed as it not only comments upon the assessment/diagnosis route for C&YP, but also recognises the need for organisations to develop resilience in their ability to accommodate young people once a diagnosis has been made. A clear example of this is the need to develop inclusive environments in mainstream education that enable young people identified as having needs on the ADHD/Autistic spectrum to access education in their community mainstream school.

Some Autistic young people are high functioning in specific areas, but find themselves isolated from mainstream education as their needs are perceived as being too challenging. As this report indicates, Teachers and educational environments could play a crucial role in accommodating C&YP within their community if the knowledge and understanding on specific methodologies which help to manage behaviour were more generally available. This does not require every Teacher to become a 'specialist' in Autistic Spectrum needs, but with more understanding on how these conditions present in young people their needs could be understood and better accommodated.

The issue of funding preventative interventions at an early stage is very challenging in the current climate, joint training across professional bodies is rarely achieved. Children and young people are more likely to present at an early stage to their GP or Teacher yet GP's have very little training on specific areas such as Autism and Teachers have little training on child development.

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Appendix 2 – National Policy & Guidance

- Green Light for Mental Health – DH 2004
http://its-services.org.uk/silo/files/green-light-for-mental-health-part-a.pdf
http://its-services.org.uk/silo/files/a-green-light-for-mental-health-part-b--the-tools.pdf

- Mental Health Act 2007
http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_089882

- Valuing People Now – A three year strategy for people with learning disabilities – DH 2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377

- Listening, Responding, Improving – A guide to better customer care – DH 2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_095428

- A vision for Adult Social Care: Capable communities and active citizens – DH 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

- No Health without Mental Health – DH 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

- Delivering better mental health outcomes for people of all ages – DH 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123737

- The economic case for improving efficiency and quality in mental health – DH 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123739

- 'Think Local, Act Personal', A sector-wide commitment to moving forward with personalisation and community-based support by January 2011 – Think Local, Act Personal Partnership 2011
http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/THINK_LOCAL_ACT_PERSONAL_5_4_11.pdf

Appendix 3 – Written Consultation

Name	
Organisation	
Phone number / email	

What is the main theme of your work (for instance substance misuse, learning disabilities, older people)?

Please list the services that you provide.

What part do mental health issues play in the work of your organisation?

Are there any issues/gaps you have identified from working with service users in relation to mental health?

Are there any emerging trends that could become problematic in the future? This could range from local issues to changes at a national level.

Do you submit routine contract monitoring information as part of a performance structure? If so please could you provide a named contact with the commissioning body?

What quantifiable information do you hold about your service users? Tick box where appropriate;			
Number of clients engaged	☐	Type of treatment or support provided	☐
Presence and/or type of mental health issue (e.g. anxiety, depression, severe psychosis)	☐	Number of clients with a satisfactory outcome	☐
Other (please specify);			

Is client information recorded in greater depth? Tick box where appropriate;			
Age	☐	Postcode	☐
Gender	☐	Referral to other treatments or supports	☐
Ethnicity	☐		

Do you undertake specific activities to capture service user's views on mental health? If so please give a brief description.

Does your organisation produce reports (e.g. annual reports or evaluations) that capture any of the information above? Would you be willing to share this with CVS, NHS Doncaster and Doncaster MBC?

Can we contact you in future to discuss these issues further and gather additional information?