Leeds Health and Wellbeing Board

User Engagement Workshop: Improving Mental Health and Wellbeing in Leeds

Summary of key messages

24th February 2015

The Joint Health and Wellbeing Strategy (JHWS) for Leeds has as one of its four commitments to 'improve people's mental health and wellbeing'. Partners across the city, including commissioners, providers, the 3rd sector and patient representatives, have recently come together to develop a 'Mental Health Framework' , which was discussed at the February 2015 HWBB. The Mental Health Framework is complemented by a range of wider activity to improve population mental health and wellbeing across the city, including programmes addressing the wider factors affecting good mental health and key public mental health programmes (e.g. suicide and self-harm prevention and promoting good mental health throughout the life course).

This subsequent workshop was held at Inkwell Arts on the 24th February, and involved 7 service users coming alongside the board to provide 'expert-by-experience' input to three questions the board were asked to discuss:

1. How can the Board influence the wider societal determinants of good mental health?
2. How can the Board ensure high-quality prevention, recovery and crisis mental health services in Leeds?

A mentally healthy city

To achieve our goal to become a mentally healthy city, we need to continually assess our progress and our direction. We need to ask ourselves how we are getting assurance that the state of mental health and wellbeing is improving, and if strategic plans such as the Joint Health and Wellbeing Strategy are measuring the right things (i.e. how useful is IAPT as an indicator?) or if it has a structural bias towards physical health. Moreover we should adopt an OBA 'What difference has it made' approach to data collection, focussing upon the patient journey and outcomes rather than organisational input around use and activity (as is current practice). As a Board, members need to harness their capacity to influence strategic investment, and consider if certain areas should be protected from cost improvement plans.

There was broad agreement that we need to change the way we talk about and treat mental health. It is vital that if Leeds really hopes to become a mentally healthy city, that we change the over-medicalised discourse that surrounds it, to allow for more holistic and preventative solutions. Leeds needs to adopt a proactive approach which considers not only how we respond in a crisis, but how we keep the people well.

Overcoming stigma surrounding mental health

Participants discussed the pervasive nature of stigma in all areas of society and provided some insight into to the impact of stigma on their lives. The examples cited were numerous and varied, and the 'experts by experience' reported a palpable sense of stigma in many interactions between generations and within communities. It was believed this was principally derived from a lack of understanding of mental health issues or the experiences of those affected by it. One service user identified the attitude in her Pakistani community as prone to categorising mental health issues as 'something wrong' with a person; an impression compounded by the frequent misrepresentation of mental ill health in Asian media as psychosis. Another service user cited the stigma within the LGBT community as particularly prevalent. It was felt that stigma had an implicit effect on the type of advice and support which people with mental health issues are offered. Service users reported that

they had experienced difficulty claiming benefits whilst mentally unwell, and limited practical guidance around the type of support available generated a pressure to prove mental health issues. These cultural conceptions had a profound effect on people's experience of mental health issues and pivotal in shaping their responses. In the case of one service user, fear of her family finding out led to careful concealment and suppression of her problems.

Multiple service users emphasised that service providers and health and social care professionals need to be aware that mental health issues and addiction can affect any given individual at any given time. The indirect effect of unconscious profiling of the types of people likely to be affected by mental health issues or assumptions about prior knowledge was considered to be extremely harmful. Attitudes such as these were extremely disempowering for one service user who was made to feel that as a social worker she ought to know more about which services were available to her.

There was recognition that mental health issues in the workplace were often exposed to direct and indirect forms of stigma and discrimination. Mental health issues, particularly problems which require sick leave remain a problem which colleagues and employees are reluctant to discuss openly. It was suggested that mental health is described in very sanitised and opaque language, which could mean that 'off work with stress' could encompass a whole range of mental health problems. It was observed that work and workplace health are still considered in a very Victorian way which prioritises health and safety over health and wellbeing. There was a call for organisations to talk more openly about stress and anxiety in the workplace, for greater support for those struggling with mental ill health in the workplace, and better processes for supporting people back into work following periods of mental ill health. This was considered of particular importance in light of the recent requirement to declare mental health issues in job applications. It was stated that this legislation had had a real impact on the employment opportunities of those struggling with mental illness, and that such prejudices must be addressed.

Parity of esteem

Participants were unanimous about the urgent need to develop parity of esteem between mental and physical health services. The health inequality experienced by those suffering with mental health issues was judged to be unacceptable, and the statistic of a 20 year shorter life expectancy of someone with psychosis provided sobering emphasis to this reality. It was agreed that as a city we need to work together to make significant reductions in the health inequalities derived from mental health issues. Participants acknowledged that such progress could only be made if partners set more ambitious quantitative targets around parity of esteem and improving mental health (i.e. to correspond to physical health issues, such as cancer) . Moreover it was agreed that such improvements could only be realised if supported by a transformation of budget allocation and funding. Timeliness of care was highlighted as a key issue in the parity of esteem debate, participants emphasised the relative ease of access for check-ups on physical issues in comparison with that of mental issues

Prevention

Participants discussed the early onset of their mental health difficulties and the need to resource early interventions. One service user described two instances in which trusted

professionals missed opportunities to enquire about her mental wellbeing as a child. Participants agreed that it was urgent that TAHMS (Targeted Adolescent Mental Health in Schools) and CAMHS (Children and Adolescent Mental Health Services) continue to work to identify and treat issues earlier, before individuals develop negative coping mechanisms such as drinking or self harming. Whilst participants supported the valuable contribution of specialist youth services, they also considered schools vital in improving the general mental wellbeing of all young people. It was considered that this high priority should be systematically addressed through PHSE lessons and restorative practice, to ensure that problems do not escalate.

Workshop attendees recognised the difficulty of diagnosing mental health issues and describing symptoms of mental ill health. For instance the colloquial and clinical use of the word 'depressed' vary significantly and this indicates a wider incapacity of society to name or correctly identify mental health issues. With regard to low level anxiety and depression, this ambivalence of language is further complicated by the persistence of stigma which makes saying you're 'stressed' more socially acceptable than describing a mental health problem. Whilst it is true that describing an experience of a mental health issue is often more difficult than describing the pain of a physical condition, one service user commented that the common misconception that mental health is invisible and its symptoms undetectable can be extremely harmful. People from all backgrounds (especially those who work in frontline or people-oriented services) need to become better at identifying the signs of mental health issues, through registering changing behaviours (such as uncharacteristic lateness or untidiness).

Increasing awareness and vigilance in identifying these signs is critical if we are to prevent issues before they escalate. Participants agreed that early intervention had the capacity to circumvent the development of bad habits and coping mechanisms (especially in young people) and ultimately reduce the distress and damage incurred through late diagnosis. It was acknowledged that these early conversations about mental health issues could be challenging, and that medical professionals should seek to facilitate this process by encouraging people to write down their thoughts and to perhaps bring a friend to interject and support.

Prevention constitutes a critical component of this mentally healthier city. Stigma has been frequently cited as a barrier for people accessing support for low level mental health issues. It is critical that we work to break stigma down and offer services which are accessible for everyone, to ensure that more problems are resolved at a primary level. Dial House was considered by service as a high quality and constructive service which presented a viable alternative to A and E crisis services. Social media was also cited as useful resource capable of providing vital peer support and anonymity. It was suggested that media such as these could be further developed, by providing young people with more of an instant messaging service. Primary approaches such as these require continued investment to prevent issues from spiralling.

There was consensus that preventative services and treatment for mental health issues need to be built around recovery as a core principle. It was agreed that the impact of hope could be profound, and yet this alternate model of care required resourcing. One service user discussed her experience of recovery as a frightening and disempowering process. She described how cycles of illness and treatment can become a fundamental framework within people's lives, and that support is predicated upon crises. Specialist services need

to be planned over a long-term to enable individuals to achieve their goals and to outline a recovery plan which supports people through their recovery and its maintenance.

Integrated services

The fragmentation of services and the disparity between mental and physical health services was a grave concern for all participants at the workshop. The disconnect between services was considered especially problematic in crisis situations, in which care plans and options were not sufficiently explained and service users encountered lots of different members of staff. It was acknowledged that individually staff were doing a good job, but that overall care was not cogent or comprehensible. This lack of integration was also noted in preventative care in which there was a lack of provision for people facing dual issues.

Whilst the 'experts by experience' commended the skill, care, and compassion of some of the practitioners they had encountered, and praised the efficacy of simple solutions such as peer support groups; they agreed that the current medical treatment model has a long way to go before it becomes as person-centred and recovery –based as it needs to be.

In spite of the holistic and interdependent nature of physical and mental health, there is a systemic disconnect between these issues which is manifest from an organisational to a personal level. Poor integration between mental and physical health services can mean that two discrete appointments are booked for physical and mental health conditions when there is a causational link between the two, for instance a stomach problem exacerbated by anxiety. Conversely it can allow doctors to overmedicalise issues, treating the body and putting the mind to one side, by attributing low mood to a thyroid condition, or simply skipping to prescription. It was acknowledged that although day to day general practice business comprise combined physical and mental health issues, medical training has a predominantly physical focus.

It is clear that the relationship between clinical professionals and patients requires reconfiguration. The 'experts by experience' challenged healthcare professions to listen to what their patients are telling them and respect the issues they would like to be prioritised. There was a call for greater sign posting to talking therapies and other supportive services and follow up appointments. It was, however, acknowledged that a critical obstacle to providing this more personalised service was the limitations on GPs' time

Crisis care

Service users and participants stressed the deficiency of crisis care as it currently operates. There was an acknowledgement that the predication of crisis services on risk of self harm, creates a perverse incentive for people with mental health issues to allow their problems to escalate to access the intensive care and support they need. The quality of crisis care was considered to be of a high standard, and efficient in its organisation of care plans and support.

Emergency care requires investment and greater coordination between different agencies across the city. Participants acknowledged that the police and A and E provide the only truly 24/7 services in the city, and as such become implicated in crisis care which they are not always most appropriately placed or trained to provide. The limited around the clock

services mean that people facing mental health crises routinely end up in a high-stress frenetic A and E which is not in a position to address their needs. The high quality contribution of the police was commended, however there was a call for a stronger multi-agency approach in such settings as an emergency mental health centre or an adapted A and E setting which has space and capacity to address mental health crises.
However participants identified a tension between the need to provide people the care they need when they need it, and the limited of the capacity of services like SPUR to respond to all calls with the same level of urgency and support. The subjectivity of risk and emergency generate complex questions about how you categorise and rank these experiences, and the responsibility of the individual and the organisation. It was acknowledged that not all crisis calls escalate into emergencies; however participants reiterated the need for service providers to respect people's assessment of their own condition of health.

Next steps

The table below lists the key messages highlighted during the session and indicates which issues were most important for the future work of the Health and Wellbeing Board, through a simple voting exercise done at the end of the session.

Key issues	Number of 'votes'
Working practices **Work/ life balance** **Culture in organisations** **Board as role models**	2
Emotional resilience with particular focus in school settings and non-formal 'mental health' settings	3
Peer support	
Place-based integration of services **Primary care** **Community** **3rd sector** **Housing etc** **To build community resilience and suicide prevention**	8
Tackling stigma and discrimination including PD **Lived experiences champions**	7
Intensive support for CYP in schools **Building resilience** **Early intervention**	7
Role of HWBB to 'normalise' mental health problems→ **Champion a 'how are you feeling campaign' to complement the #hellomynameis**	7
Supporting the development of shared policies across health and housing services and dealing with private rented/social housing management	1
24/7 services apart from A + E and police	2
Crisis support **Households and secondary prevention**	4

Need for training – WWBB need assurance	2
Investing in early intervention	1