Rethink Mental Illness

Cambridge Rethink Carers Group
incorporating Peterborough & Fenland
the local Rethink Mental Illness voluntary carer support groups

The Cambridge and the Peterborough and Fenland Groups help the carers of those with severe and enduring psychotic illnesses including schizophrenia

Chairman/Co-ordinator: David Jordan 01354 655786 email: d.jordan994@btinternet.com

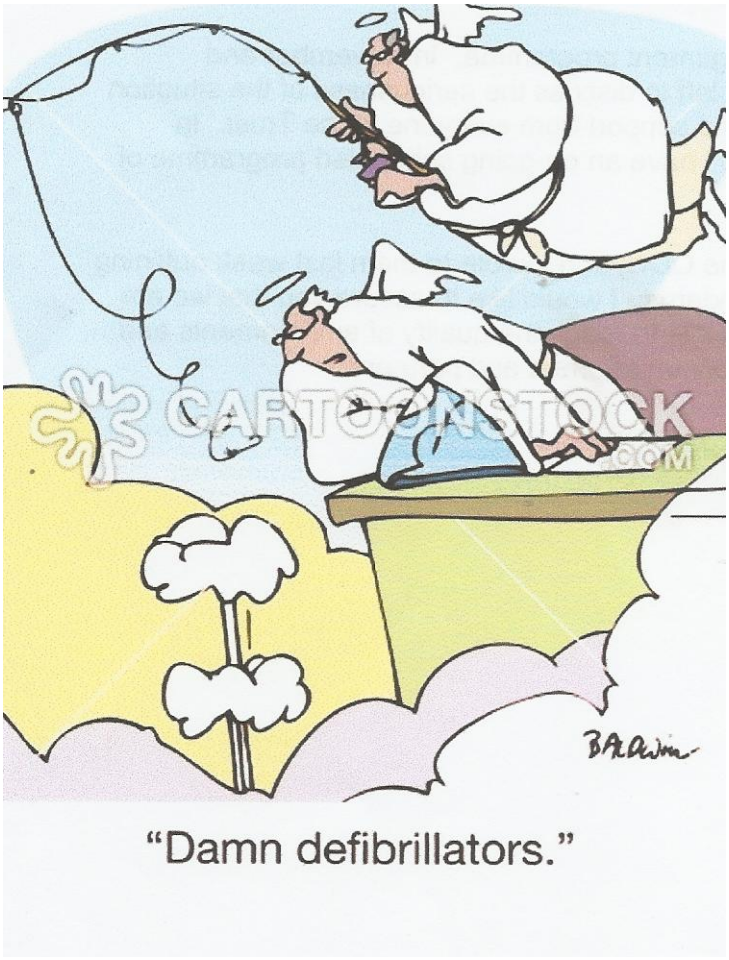
Newsletter 293 *April/May 2014*

Wednesday 25th June 2014 – 7.30pm

ANNUAL GENERAL MEETING
Followed by a Discussion Evening

Please see further important details of the AGM on Page 8

Venue: Mind in Cambridgeshire offices, 100 Chesterton Road, Cambridge
Parking can best be found in the side streets off Chesterton Road



Last Meeting – Wednesday 28th May 2014 – Kim Dodd

Kim Dodd, Mental Health Lead for Cambridgeshire County Council (CCC), accompanied by Balinder (Bal) Kaur, Interim Head of Social Care, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).

Kim advised that CCC and CPFT are working together towards a formal agreement. I am sure that this is a time consuming and frustrating exercise. From the experience of other CCC leads, quoted to me over many years, I fully recognise the constraints encountered.

I look forward to hearing more from Kim and 'Bal' over the next few months.

Recently the former health secretary, Stephen Dorrell, resigned the chair of the Commons health committee apparently frustrated at lack of progress in the move towards integrated health and social care. Mr Dorrell said that he is "primarily interested in the challenges facing the health and care system over the next five to ten years and the need for system to change".

Kim said that CCC, together with the SUN Network (Service Users) and Healthwatch Cambridgeshire are consulting the users of adult and older people's mental health social care services asking them what helps them to stay well and how this could improve their mental health and social care.

The CCC are currently looking at how they provide adult social care support an important part of which is personalisation. In mental health services, personalisation means that the person receiving support has information that assists them in managing their mental health and be as independent as possible.

The questions include: "What is the most useful thing to keep you well ?". This could be for instance, doing something for someone else, meeting friends or relatives or just going out at least once during the week.

Another question might be: "In your local community, what are the things that are important to you, what helps to keep you well ?". This could be your church, shops and/or your safety.

"How can these be part of my care package ?".

These are questions you may be able to answer on behalf of those you care for, there may be others. Please forward them to me and I will pass them on to Kim.

Following Kim and Bal's departure we discussed various topics relating to the concerns of carers and the ones they care for.

The over arching concern of carers and the ones they care for is that of loneliness and sometimes of a feeling of uselessness.

Interesting points were made of various opportunities available. I am grateful to Anne for the information printed below.

The Silver Line 24 hour telephone helpline for over 50's is 0800 470 80 90. This helpline was set up by Esther Rantzem to reduce loneliness.

Another 'outlet' which is popular with many of our 'older citizens' is The University of the Third Age in Cambridge which runs art classes: Telephone 01223 321587 or www.u3ac.org.uk

Meeting – Wednesday 30th April 2014 – Discussion Evening

We were pleased to welcome Dr Julie Draper who is a member of the Citizens Senate for the East of England and Midlands. The Citizens Senate is consulted by the Strategic Clinical Network about the views of the users of health and social care services.

Although there had been several apologies from 'regulars' the meeting was well attended (there was a shortage of chairs and coffee mugs!). Again there were one or two new faces, which we are always pleased to see.

As usual there was not set agenda but this did not stem the discussion of current concerns and observations on the delivery of mental health services in the area.

There are continuing concerns of the proposals to improve older peoples and adult community services. Experience of the reduction in services at the Deighton Centre at Ida Darwin over the past two years has done little to comfort the carers of those needing respite care.

The proposals set out the Consultation document, in my opinion, cannot be faulted in it's wish to accommodate the patient's needs. Time will tell if this is backed up with sufficient funding !.

Following the meeting, Dr Draper sent me a copy of an email she had sent to the Citizens Senate recording matters we had raised and discussed, included in this were:
 # The difficulties experienced with the constant changes of professional staff treating patients, a lack of consistent care.
 # There are some 'good stories' of interested, supportive and respectful GPs.
 # Weekend cover by CPNs remains at 8.00am to 10.00pm when a patient needs to be on a crisis list to access it. Often patients are no longer on the list, not in crisis but still need support, which is not available till the Monday.
 # Care plans are too long and not particularly helpful and are often not used or updated. The forms need shortening and updating.

Donations to the Cambridge Rethink Carers Group

Thank you for your generous donations received during the past few months from several 'members' and friends of the Group. Thanks to Bob and Jeannie we will be able to enjoy coffee or tea and biscuits at our meetings for at least one year.

Thanks also to those who have sent donations towards the cost of the Newsletter which some of our members and friends who, like me, are not computer literate prefer to receive by post.

We are pleased to hear from family carers, friends, relatives, CPN's and other professionals who know of a carer, a user of services or from an organisation who are aware of someone being discharged from hospital or from supported accommodation into independent living, who may need help to purchase a fridge, a cooker, washing machine or carpet . Thanks to the generosity of Kurt and Sylvia Heinemann we have reserved funds to help, please contact me on:01354 655786 email:d.jordan994@btinternet.com or write to: David Jordan, PO Box 50, March, Cambs. PE15 8XE

New Chair for Cambridgeshire and Peterborough NHS Foundation Trust

I am pleased to record the appointment of Julie Spence as the new chair of the trust. Julie, who was the Chief Constable for Cambridgeshire joined the trust as a non-executive director in 2012, she attended one of our meetings soon after. She is very committed to the welfare of carers.

Supported Mental Health Accommodation in Cambridgeshire

Introduction

This paper gives an overview for carers of the way supported accommodation for people with mental health issues is organised in Cambridgeshire.

What is Mental Health Supported Accommodation ?

Cambridgeshire County Council supplies accommodation support to people with mental health issues so that they can live as independently as possible in the community.
Support is given by staff employed by housing support providers working under contract with Cambridgeshire County Council. The Council funds the support.
Nearly all the supported accommodation projects were re-tendered in 2012.
The largest provider of support is Metropolitan Housing.

What is available ?

Supported accommodation is part of an overall strategy to ensure the right level of support is available to the person. Accommodation is organised into "various tiers of support", meaning that some projects are set up with higher levels of staff support where there is a staff office on site and staff can stay overnight if required. With other projects at the lower end of support needs, support staff will visit the person during the week by arrangement.

The philosophy behind the supported accommodation is to match the level of staff support to the person's needs. An identified gap before the tender was that there was insufficient support available for those people with higher levels of need.
This has now been addressed by the development of two projects, one being in Garden Walk, Cambridge and the other in at Cambridge Road, Fulbourn. These projects have an office on site and accommodation is in self contained flats and houses. People are not expected to share accommodation (they have their own kitchen and bathroom), although there is the option to share if some individuals want to do so.

Other projects have been developed on the basis of a cluster of flats where people can have their own space but other people are nearby for mutual support. A survey of people being supported was undertaken as part of the tender in 2012 and there was an overall preference for self contained accommodation.

How is the Supported Accommodation Assessed ?

A meeting, known as the Accommodation Forum, takes place on a monthly basis at Fulbourn Hospital. The meeting is chaired by a senior social care manager. Supported accommodation providers and representatives of the District Councils Housing Department, the later may be able to offer accommodation.

The Mental Health Homelessness Prevention (MHHP) officer also attends. This is an important position. This post is employed by the Street Outreach Service under a contract to the County Council. The MHHP officer's role is to assess all people coming into the psychiatric wards for their accommodation needs. This ensures that they do not lose their existing accommodation or, where this has to change, contact can be made with the District Councils for alternative provision or a referral to the accommodation panel if supported accommodation is required.
Continued on Page 5

Supported Mental Health Accommodation in Cambridgeshire – Continued from Page 4

Care Co-ordinators employed by the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) also attend as they will assess the person with mental health needs and will apply to the panel for a placement in supported accommodation.

The overall aim of the panel is to ensure that the resources available are used effectively and that people will be placed at the right accommodation project for their level of need.

Once a place is offered then the care co-ordinator will work with the support provider to arrange for the person to move to the accommodation.

What happens when the person moves to the supported accommodation ?

The overall expectation of the County Council is that people are worked with using the philosophy of 'Recovery' meaning that the supporter provider is expected to work with the person to identify what goals the person has and how to achieve these. It is recognised that people will vary in what level of independence they can achieve but staff are expected to work to maximise this.

There will be regular reviews with the person and they will all have support plans. Working with carers and relatives of the person is expected. Staff are expected to support the person over such things as taking medication, and not being taken advantage of by others and in spending money appropriately.

How is the support offered in the Supported Accommodation projects monitored ?

There is regular feedback on what is happening with the projects in the Accommodation Forum. As the services operate under contract to Cambridgeshire County Council, who pay for the support hours, there are also regular contract meetings involving the support providers and the Mental Health Commissioning Manager and the Contracts Manager of the County Council.

The services are also visited by a contracts officer of the County Council to ensure they meet standards.

Should there be any problems then these are addressed with the support providers and they are required to present an action plan setting out how any identified issues will be addressed.

What should you do as a carer/relative if you have concerns ?

Cambridgeshire County Council is committed to ensure that these services support the person appropriately. If a carer/relative does feel that there is an issue then this should be taken up with the support provider for the service and the (CPFT) care co-ordinator.

Carers/relatives can consult the Cambridgeshire Carer Support Service for a discussion of their rights as carers. (contact details on Page 8)

Many thanks to David Frampton, Cambridgeshire County Council Mental Health Commissioning Manager, for this very helpful article.

If you have any queries relating to Supported Accommodation please contact David Frampton or Louise Tranham on: 01223 570143

Careline – a helpline for the carers of those with psychotic illnesses including schizophrenia can be accessed 24/7 on: 01354 655786 or 07860 589758 or by email on: d.jordan994@btinternet.com.

During April and May Careline could easily have been mistaken for **CAMEOLINE** due to the number of telephone and email contacts made by the mothers (it's always the mothers) about the problems they were experiencing following the **early** withdrawal of the early intervention team from the family.

These contacts, actually there was a telephone call from the sister of one young man, were **not** from persons who had seen my article in the February/March Newsletter, but from those who had been referred by other readers.

The young lady I mention above had contacted her brother's GP to be advised that they were unable to discuss her brother's case with her but 'get her brother to come to the surgery', at that time her brother was, in her words "wrecking her kitchen". Her brother had stopped taking his medication. I can hear some of you say "he would have done this with or without CAMEO", but – would he ?.

A mother, whose daughter had also been recently discharged from CAMEO, telephoned in distress that her daughter was back in an acute ward having slashed her wrists (she said that she wanted to die). The mother was ringing from her mother's house as she dreaded going back to her house to face the blood in her kitchen.

Another problem which continues to be the blight of a carers life – **Confidentiality –** the word heard by carers from those who have little, if any, understanding of caring for a person with the diagnosis of having a psychotic illness.

It continues to amaze me, honestly, that so many psychiatrists, psychologists, clinicians and team members are unaware of the propensity of their patient to use guile which may hide the true state of their mind, illness when at a review.

A carer recently contacted Careline concerning her son, who was, at the time, in an acute ward, and of a written report of a review, to which she had not been invited. The report, which after some difficulty, she read, contained statements which reflected an entirely contrary record of family life. Her son acknowledged that he may have been 'misunderstood' !.

Obviously not all in fact, few, carers can attend each and every review and therefore they need reassurance that those attending the review and, in taking a record, should be experienced and trained to recognise the 'nuances' and facts.

A further, constant concern expressed by carers in calls and emails to Careline, relates to the confidentiality issue and GP's. Often the carer and the 'one cared for' will have the same GP or a GP in the same practice.

Last week I received an email from a carer whose son had, again, stopped taking his medication causing his mother concern that he would need acute care. The last time this occurred (last year), no bed was available locally and he ended up in an acute ward many miles from home which made it impossible for his mother to visit. Continued on Page 7

Careline – continued from Page 6

We exchanged several emails discussing the possibility of contacting her son's GP, who in this case, although in the same practice, was not her GP.

As 'partners in care' carers are a part of the 'team'. The Department of Health state: "Issues around confidentiality should not be used as a reason for not listening to carers, nor for not discussing fully with service users the need for carers to receive information so that they can continue to support them. Carers should be given sufficient information, in a way they can readily understand, to help them to provide care efficiently."

Careline is used by carers in Cambridgeshire, Huntingdon, Peterborough and Fenland.

Careline is operated by volunteers who care for someone with mental ill-health. They will listen to and/or read your email and provide information to help you, based upon their own experience of caring for a person with a mental illness.

This can include signposting you to a service which they feel may be better able to advise you on a specific issue. A volunteer will not give advice but may relate a situation which reflects a situation similar to your own.

Rethink Mental Illness

The contact telephone number for Rethink Mental Illness is 0300 5000 927. Through this you can access all departments including the Rethink Advice and Information Service.

You can also apply for membership, the annual subscription being only £2 per month (£24 annually) for this a member will receive the quarterly magazine, Your Voice, receive up-to-date information on all matters relating to mental health services and research world-wide.

You do not have to be a member of the national organisation to attend meetings of a local Rethink Carers support group or receive this Newsletter.

Data Protection Act – Important Information

Limited information is recorded on computer in respect of those who receive this Newsletter and/or contact the Cambridge and the Peterborough and Fenland Rethink Carers Groups.

The record is basic information only for the following purposes, list of names, postal and/or email addresses used for the preparation of address labels or electronic delivery or reference purposes by officers of the groups.This information will not be communicated to third parties without your written permission.

Unless the Co-ordinator is advised to the contrary, we will assume that you have no objection to your name being included.

Do you now receive your Newsletter electronically.? If you do not but you are 'ready, willing and able' to do so, please make contact by emailing: d.jordan994@btinternet.com.
Apart from the obvious – saving the forests – we will then be able to forward many interesting reports consultations and information on local meetings concerning mental services.

Diary 2014

Wednesday 25th June 7.30pm	Annual General Meeting followed by, at approximately 8.15pm, a discussion evening
	The agenda will be tabled and include Financial and Management Reports and the election of Committee for which there are three vacant places
	An item on the agenda will be to consider a proposal to amalgamate the Peterborough and Fenland Rethink Carers Group and the Cambridge Rethink Carers Group.
	The two groups have been involved since 1997 becoming closer in 2002 when the Peterborough Group became a 'virtual' group.
	Sadly we are losing our Hon Treasurer, Angie Jupe after many years 'looking after the book's'. We are urgently seeking her replacement. Please contact me !

Venue: Mind in Cambridgeshire Offices, 100 Chesterton Road, Cambridge.

Wednesday 30th July 7.30pm	Discussion evening

Please note there will not be a meeting in August

Wednesday 24th September 7.30pm	Aidan Thomas, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust

Peterborough Carers Support Service

Peterborough City Council decided to tender for a generic carers support service from 30th June 2014. Rethink Mental Illness which has provided the service for twelve years decided not to tender as the Charity provides services solely for the carers of those with severe and enduring psychotic illnesses.

Despite repeated requests to the Peterborough City Council commissioner of services, to date, I have not received information of the provider of services from 30th June 2014. I will advise you as soon as possible.

Cambridgeshire Carer Support Service – Making Space

Making Space provide carer support services in Cambridge City, South and East Cambridgeshire, Fenland including Whittlesey and Huntingdon.

Call Pauline Mansfield on: 01480 211006 or email: Pauline.mansfield@makingspace.co.uk

Address: Suite 4, The Stables, Church Street, St Neots, Cambs. PE19 2BU

Crisis Resolution Teams: how are they performing ?

Crisis Resolution Teams are now an established part of mental health services, but their performance across the country varies as recent research has shown.

Crisis Resolution Teams (CRTs) provide short-term, intensive home treatment for people experiencing an acute mental health crisis. In some areas, CRTs are called Crisis Assessment Teams, or Intensive Home Treatment Teams. They aim to minimise inpatient bed use by, preventing hospital admissions where possible, or supporting people to leave hospital promptly.
CRTs work closely with families and other involved services to provide additional support during a crisis.

The introduction of CRTs in the NHS has been a big mental health success story. Before their introduction following the NHS (National Service Framework) plan in 2000, it was rare for any help outside hospital to be available at evenings or weekends for people in mental health crisis. Now, CRTs are a standard part of mental health services and research has shown they can be effective in reducing admissions to hospital and increasing the acceptability of crisis care.

But CRT teams differ in how they are set up and organised across the country and their impact on hospital admission rates varies. Service users have also criticised CRT teams for not always offering time to talk through problems and for the limited range of support available beyond medication.

The performance of CRT services is being assessed by the CORE Study, a research programme funded by the Department of Health's National Institute for Health Research (NIHR) and led by Professor Sonia Johnson, University College, London. It aims to review and gather evidence about how CRT services function most effectively to help people in mental health crisis as effectively as possible. So far, the CORE study has conducted:
A review of existing evidence regarding best practice in CRTs
A survey of CRT managers
Interviews with more than 200 mental health staff, service users and carers about their views on best practice in CRTs.
A survey of CRT team performance through a one day audit process.
What follows are some emerging views on how to optimise CRT services and the evidence about how CRTs are performing.

Access to CRTs
There is widespread agreement that rapid access to CRTs and prompt assessment of people in crisis are crucial if they are to manage risk and prevent hospital admissions. Ideally, CRTs should be accessible 24 hours a day, seven days a week, 52 weeks of the year and accept referrals from a range of referrers with minimal paperwork or bureaucracy, arrange prompt assessment of all appropriate referrals. In practice, in England:
Only 40% of CRTs provide a full 24/7 service while 85% provide some cover 24/7
More than three-quarters (77%) of CRTs accept referrals from GPs, 55% from known service users, 20% from service users new to services. Some but not all CRTs accept referrals from housing and emergency services and respond immediately to access people brought to a place of safety by the police under section 136 of the Mental Health Act.
Some teams set and achieve four hour targets from referral to assessment, but in many CRTs assessment the day after a referral is routine practice.

CRT service delivery
There is a consensus among service users, carers and many clinicians that CRTs should offer holistic care and provide, medical, psychological and practical help as required to resolve mental health crises. **Continued on Page 10**

Crisis Resolution Teams: how are they performing ? Continued from Page 9

CRT service delivery – continued
This should include opportunities to form relationships with staff and talk through problems, access to brief psychological interventions, and help with urgent practical problems, such as lack of food, money or shelter.

But service users and some staff see CRTs as too often providing a minimal risk management and medication delivery service. Service users and families dislike visits by CRT staff which are too brief to allow any time to discuss problems and how to address them, and they also do not like being seen by many different people who may not always well informed about them.

On the other hand, good continuity of care and compassionate, engaged staff with time to listen are highly valued. In practice:
CRTs vary in how far they provide a multi-disciplinary staff team: 90% of CRTs include a consultant psychiatrist, 32% a psychologist, 74% a social worker, and 47% an occupational therapist.
CRT staff team's access to training, supervision and manualised resources to support the provision of brief psychological and psychosocial interventions and family working varies greatly.
Most stakeholders agree that CRTs should provide practical help to someone in a crisis to meet basic and an acceptably clean house. However, only a minority of CRT teams help with these tasks themselves. A minority have systems to limit how many different staff a service user sees during an episode of CRT care and minimum expectations for the duration of visits.
A small minority have systems to monitor and develop staff's therapeutic engagement skills: e.g. CRT manager accompanying staff on home visits and providing feedback, user and carer involvement in staff training.

Minimising inpatient bed use
CRTs are best able to prevent admissions if they provide a full 'gate-keeping' service. This involves assessing everyone in person before they are admitted to an inpatient ward to see if home treatment is a feasible alternative. CRTs need support to fulfil this role from acute wards and from across local acute care systems, they should also work closely with wards to identify people who could leave hospital with CRT support earlier than would otherwise be possible.

In practice:
The extent of gate-keeping by CRTs varies. Only 47% of CRTs aim to assess all patients in person, including attending Mental Health Act assessments, before hospital admission.
In some teams, gate-keeping typically involves only a telephone consultation rather than thorough CRT assessment.
Only half of CRT managers consider effective arrangements are in place to support early discharge of patients from acute wards.
Only 35% of CRTs have access to non-hospital crisis beds and 22% have access to an acute day service. These additional acute services can promote the availability of therapeutic interventions, support management of high risk patients without hospital admission, and reduce isolation and increase social support to service users in crisis.

Maintaining the CRT focus within the care system
CRTs are designed to work in partnership with involved mental health continuing care services to support service users during a severe crisis that would otherwise result in hospital admission. Good communication and responsiveness from community services is required to enable CRT's to discharge service users following a crisis. Continued on Page 11

Crisis Resolution Teams: how are they performing ? Continued from Page 10

A shared understanding of the CRT's distinct role and referral criteria is required across a local service system. In practice:
Many CRTs seem to be working less intensively – for example, visiting every few days – with a wider client group who are not all experiencing a crisis severe enough to be at immediate risk of admission. This sometimes reflects shortfalls in the system as a whole, for example, where there are long waits for other community services.
In a number of areas, CRTs are also required to fulfil other functions, such as running psychiatric liaison services in accident and emergency departments or providing seven-day follow-ups for all patients discharged from acute wards. This dilutes their ability to focus on crisis home treatment.
In some parts of the country there are clear alternative sources of prompt support for people experiencing a crisis that may not be severe enough to warrant CRT support. Theses might include crisis lines and drop-in services, or services that can offer an appointment for an urgent assessment within a few days. Elsewhere, the CRT is the only option for accessing prompt help.
In many areas, staff receive little initial or on-going training that is specific to CRT working: thus it is likely to be difficult for them to understand fully the intended role of the teams and the ways of working that are most effective and acceptable in a crisis.

Improving CRT services
The CORE study team has developed some new resources based upon the best available evidence and they are designed to help CRTs improve the service they provide to people in mental health crisis.
The CRT Fidelity Scale is a measure to assess how far teams are achieving a model of top quality CRT practice. Through a one-day review process by a team of "fidelity reviewers" services are scored on the measure and given a detailed report highlighting service strengths and targets for improvement. Seventy five CRTs took part in a national fidelity survey, which was completed in April.
The CORE resource pack team is an online resource to support teams in achieving excellent practice. The content includes best practice resources collected from CRT s nationally and guidance and strategies to support implementation. This is about to be tested in 15 CRTs; it will be freely available for use in the NHS in 2015. following this.

The findings from the CORE study have already been fed into NHS England's Crisis Care Concordat and mental health charity Mind's Crisis Care campaign.

Hopefully the emerging evidence about optimizing CRT services and the service improvement resources being developed can help CRTs become even more effective at reducing the need for hospital admissions and supporting people to recover successfully from a mental health crisis.

The CORE study is independent research funded by NIHR under it's Programme Grants for Applied Research programme. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

For more information on CORE contact Professor Sonia Johnson: s.johnson@ucl.ac.uk or Dr Brynmor Lloyd-Evans: b.lloyd-evans@ucl.ac.uk . You can also visit the website at: www.ucl.ac.uk/core-study

In 2002 I was introduced to the concept of the Crisis Resolution and Home Treatment Teams (CRHT) at a presentation at The Cresset in Peterborough by the Camden and Islington 'pilot' CRHT – I was an immediate convert.

About FACE !

It is possible, even probable, that you have not heard of a FACE team, therefore you are not likely to know that the service is being closed down due to lack of funding.

FACE or the Frequent Attender, Care Enhanced (FACE) Team/s were established in 2011 firstly in Cambridgeshire and, from 2012, the project was being 'piloted' in Peterborough.

Frequent users of emergency services, A & E departments, ambulance services, police, fire and out of hours GP was, in 2006, identified as costing the NHS £2.5 billion a year

Frequent Attenders are often those with complex needs, with a chaotic and high risk life-style. Over 50% of attendees will have harmful, hazardous or dependent drinking patterns, 20% will have dual diagnosis (mental illness and substance misuse) whilst 30% have a personality disorder.

The FACE project was initiated following a multiagency stakeholder event which highlighted that there was a vulnerable group in society who were not receiving the services they required and in the process costing the health system financially through frequent and inappropriate use of emergency services.

The project's aim therefore was to identify if the health outcomes and experience improved and reduced the cost of emergency services. In the first year, the service has paid for itself in avoided cost. This was despite the inevitable time taken during the early months to recruit staff, make the necessary contacts with partner agencies, embed processes and has demonstrated that through intervention there have been improved outcomes.

During the short 'life' of the project there was a 19% reduction in admissions and a 45% reduction in attendances. In monetary terms £246 k in just one year, it was anticipated that in year two the saving would exceed £305 k

There is a clear link between the duration of the 'pathway' and the results achieved. 'Clients' surveyed said that 8 weeks was too short a duration to have an impact (the average duration was 10.1 weeks. The shorter period was linked with a relapse into using emergency services.

The FACE Team consisted of 5.1 WTE including 4 WTE clinical staff. The cost of the service for 2013/14 was approximately £130,000k.

Despite positive feedback from clients, other multidisciplinary teams and involved organisations FACE has fallen to the funding cuts which appear to have no regard to the contribution made to the overall mental health economy and the health of their clients.

NHS 111

NHS 111 was launched in Cambridgeshire in November 2013 and in Peterborough in February 2014. The number of calls has risen to around 20,000 per month, this despite the lack of funding for a country wide publicity campaign.Over 97% of these calls being answered within 60 seconds. Ambulance dispatches, as a percentage of total calls received are around 7% (the national average is over 9%).
If you have contacted NHS 111 concerning a mental health concern and/or the Out of Hours service, will you please let me know of your experience, all in strict confidence of course.
Telephone David on 01354 655786 or email: d.jordan994@btinternet.com

The Cambridge and the Peterborough and Fenland Rethink Carers Groups

No health without mental health !

I honestly cannot recall who said this and when but what I do know is that precious little appears to have happened to indicate that anyone really cares or who is making an effort to ensure that those showing signs of developing a mental illness are treated.

At two events I attended recently a young lady, the same young lady, who said that she suffered from depression/anxiety and that as a result she became a hypochondriac, visiting her GP on a very regular basis presenting him with very real symptoms of various disorders resulting in appointments with consultants, visits to clinics etc all of which was charged to the NHS

This lady is not alone. I have direct experience of a similar experience where the patient, over a four year period was sent to: a Pain Clinic, a Cardiology Consultant, a Dermatologist, a Muscular/Skeletal Clinic, a Podiatrist, an Endoscopy and for a Brain Scan.

In that four years the patient, a ‘professional’ did not work and the employer was committed to pay long term sickness benefit. The total cost to the NHS and to the employer must be in the ‘ten’s of thousands’ bracket.

I , you see in the Health section of newspapers, magazines etc similar stories on a daily basis. Some are of celebrities but many are not and many are never recorded.

Obviously not all are easily treated and some may well be ‘pre-disposed’ to experiencing mental illness but the large majority could be helped to live or resume a ‘normal’ life.

Some, many years ago were introduced to IAPT (Increased Access to Psychological Treatment) – Cognitive Behavioural Therapy (CBT), it seems like only yesterday ‘government’ announced an increase of funding for IAPT. In fact I believe this has happened more than once in recent years.

CBT is not the panacea for all those experiencing a depressive or anxiety based mental illness, but for those it helps, it can be a lifeline and, being the skinflint I am – it could save money.

A ‘cross section’ of mental health organisations, including Rethink, Sane, Mind and the Mental Health Foundation are funding a survey – Questions about depression ?.

To help inform their research they want to hear from patients, carers and clinicians about what questions need to be answered. Questions can be about any aspect of depression; prevention, causes, diagnosis, treatments or care.

The partners in this project will work together to rank all the questions they receive into a list of top priorities. These will be made available to the public, researchers and research funders.

The aim is to inform research and provide a strong connection between researchers and the needs of patients. It is hoped to encourage research that can make a real difference to people's lives. Visit www.depressionarg.org to take part

The problem of beds

The experience of a long term carer (and supporter) highlighted the local situation concerning the availability of beds in acute wards for a patient, living in the community, experiencing a psychotic episode. Continued on Page 14

The problem of beds Continued from Page 13

This problem demonstrates the dearth of acute beds which is leading to patients being sent 'out of area', sometimes up to 300 miles away from their home.

In this instance there was a resolution and a local bed was found. Happening on a Bank Holiday weekend the patient, who was known to the services, contact the Crisis Team based at the local hospital resulting in the carer taking the patient to the team for assessment.

The assessment determined that the patient needing to be admitted but, after a determined effort by the CRT leader, it was found that no beds were available. The patient was advised that the nearest available acute bed was in Southampton, probably over 200 miles away.

However, thanks to the crisis team and being a 'regular customer', all the 'stops were pulled out' and a bed was found in the local hospital.

The national situation is dire, data from Freedom of Information requests to 30 of the 58 mental health trusts in England revealed that last year (2013) the number of people sent out of area has more than doubled in the past two years. In fact last year 3,024 were sent out of their local area whereas in 2012 only 1,301 were sent 'out of area'.

Most trusts reported that many psychiatric wards are running at more than 100% capacity, while 1,700 mental health beds have closed over the last two years, a 9% reduction in the total number of beds available.

We also know that funding of mental health services has fallen by 2.3% in real terms in the past two years. Specifically, crisis care funding has fallen by 1.7%, despite referrals having increased, on average, by 16%. Remember that health budgets are supposed to be protected at the moment.

The Department of Health 'make the right noises' about improving care and giving mental and physical health 'parity of esteem' but services – primary and secondary – continue to be cut, as are the number of mental health beds.

This has an impact on the quality of care, meaning that more people are reaching crisis point where they need to be hospitalised, which takes us back to the point about more people being sent out of area, which costs more.

The cost to family carers in financial and emotional terms cannot be estimated even if they are physically able.

The ARC

Apologies but I am, sincerely, unable to confidently translate this acronym but I believe that it may be the Assessment and Recovery Centre.

But for my purpose I see the ARC as becoming the single access point to mental health services which we have been promised for more years than I care to remember.

In April this year the Cambridgeshire and Peterborough NHS Foundation Trust carried out a ‘lean’ review of the ARC, despite many requests I am still waiting for the consultation document, there needs to be a process which allows patients and/or their carers direct access to secondary care.