CHANGING THE METHODOLOGY OF MENTAL HEALTH CARE IN THE UK

Prevention & pre-emption to reduce acute unplanned care

DISCUSSION PAPER -JULY 2020

The purpose of this paper is to change the way Mental Health is assessed and supported in the UK, so that early intervention will significantly reduce suicide rates.

The long-term aim is to make the UK the world leader in mental health provision through 'Prevention & pre-emption to reduce acute unplanned care'.

INTRODUCTION

Failing Mental Health provision in the UK has seen suicide become a major concern and almost daily there are headlines in our national and local newspapers reporting more death by suicide.

The aim of this paper is to highlight the current failings in the mental health process leading to the volume of suicides and seeks to address the whole care pathway from the beginning of a mental health illness, to PreCare, to treatment and to hopefully a cure and beyond in terms of AfterCare.

This is a fresh, radical approach involving a change in thought process and actions enabling 'Prevention & pre-emption to reduce acute unplanned care'. We have called this new approach 'The Integrated Plan'.

We would welcome comments and views on the issues and questions set out in this paper. Your comments will help to inform the development of this new policy statement and should be sent to mentalhealthchange@outlook.com, and the aim is to respond to every email received.

RECENT HEADLINES REGARDING MENTAL HEALTH ISSUES

A short list of some of the more recent headlines/media outputs to give some context to why change in how we provide care for mental health issues is needed now.

Mental Health: The Next Pandemic?

- 7th July 2020
- File on 4 investigates the impact of coronavirus on the nation's mental health - and asks if services will be able to cope in the aftermath of the pandemic.

A third of young people having more mental health difficulties during lockdown

- 30th june 2020
- Children's charity Barnardo's asked 4,000 children and young people aged eight to 24 how they'd been feeling during the coronavirus pandemic. At least a third said they'd experienced an increase of mental health and wellbeing issues

Black mental health organisations to reach out to for support

- 30th June 2020
- 'Living in a state of anxiety and chronic stress is exhausting for the body's nervous system and mental health,' therapist explains.

6 harmful effects of lack of sleep — and why it's unhealthy

- 7th July 2020
- A lack of sleep can lead to many mental health issues.

This paper focuses on the integrated plan and its intrinsic details. The appendices provide the rationale and background data.

TABLE OF CONTENTS

Introduction 1

Recent Headlines Regarding Mental Health Issues 1

Table of Contents 2

Summary of the integrated plan 3

The outline of the integrated plan 8

1. 555 Mental Health helpline 9

2. **Mental Health nurses at GP surgeries** 11

3. **The 3-day assessment programme** 12

4. Mental health wards specialisation 20

5. The specialisation of crisis care support for PreCare and AfterCare services 22

6. **Removal of Temporary Workers as a nor**m 24

Summary of what these changes will achieve 26

Appendices 27

Background & Overview 27

What needs to change 30

The major types of illness impacting mental health 32

Anxiety & panic attacks 32

Bipolar disorder 32

Depression 32

Eating disorders 32

Insomnia 32

Obsessive-compulsive disorder 32

Personality disorders 32

Post-Traumatic Stress Disorder (PTSD) 33

Psychosis 33

Schizophrenia 33

Self-harm 33

Suicidal feelings 33

The key players 34

The team behind the report 35

SUMMARY OF THE INTEGRATED PLAN

The basis of the integrated plan is very straightforward and will provide numerous benefits across the country, which will enable it to be fully self-funded.

It will provide help, direction and structure to patients suffering from mental health issues, with greater emphasis on the patient / carer / NHS working as a cohesive team to bring health to the patient rather than the current situation where treatment must be fought for, unless there is a crisis position.

It will provide opportunity for medical services to fully understand the individual and appreciate their needs in detail and to work with them in an holistic manner, having seen first-hand the issues they are facing and struggling to deal with.

It will provide fresh job opportunities for staff and at the same time facilitate change and utilise current resources.

It will provide patients and carers with a fresh, new and engaging approach so lacking at the moment.

It will significantly reduce the suicide rate through more focused and directed treatment. In the UK in 2018, there were 6,507 deaths by suicide (a rate of 11.2 deaths per 100,000 people)[1].

- It will be seen to be self-funding at a national level. POOR MENTAL HEALTH COSTS THE

> In implementing this integrated plan, we believe we will be able to significantly reduce suicide in two years, due to active and planned treatment being implemented so much sooner in a patient's journey through the nightmare of poor mental health and the current methods of mental health provision, which are often completely failing patients, and this is being ignored by the NHS.

UK ECONOMY - IN TERMS OF LOST OUTPUT - BETWEEN £74 BILLION AND £99

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

BILLION PER ANNUM[2]. BY INVESTING IN THIS PLAN, BILLIONS OF £'S WORTH OF LOST PRODUCTIVITY WILL BE SAVED FOR THE ECONOMY.

- It is a win-win-win-win-win proposition for all stakeholders.

As you will see from the background, mental health services are focused on dealing with crisis when in reality this is far too late. THE SERVICE IS REACTIVE AND NOT PROACTIVE.

The problem is very simple in that patients are not assessed correctly by professionals as they are seen for such a short space of time, often merely on a 30 – 60 minute basis at best and that maybe only once every 3 – 6 months or longer, which is totally unacceptable for a caring society attempting to help / cure an individual suffering from mental health issues. DURING THIS TIME THE PERSON WILL USUALLY PUT ON THEIR BEST FACE AND THE REAL PROBLEMS FAIL TO BE SEEN.

IT IS UNREALISTIC THAT ANY PROFESSIONAL, NO MATTER HOW COMPETENT CAN BE EXPECTED TO GATHER ALL THE FACTS FROM A PATIENT IN A 30 – 60 MINUTE MEETING.

The professional cannot experience what happens when an individual feels a need to self-harm or they experience the distress of insomnia, panic attacks and / or psychosis.

The best a professional can hope to do is make broad assumptions from what they are being told and the experience of previous patients, but in reality, each patient is different and has different needs and should be treated as an individual.

THE STEVENSON / FARMER REVIEW "THRIVING AT WORK" COMMISSIONED BY THE GOVERNMENT AND PUBLISHED 25TH OCT 2017 HAS CALCULATED THE ECONOMIC COST OF FAILING TO ADDRESS THE EFFECT OF MENTAL HEALTH ISSUES IN THE WORKPLACE.

IT NOTES THAT THE ANNUAL COST OF POOR MENTAL HEALTH TO EMPLOYERS IN THE UK AT £33-£42 BILLION IN SICK LEAVE, STAFF TURNOVER AND LOSS OF PRODUCTIVITY.

---

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf

POOR MENTAL HEALTH COSTS THE UK ECONOMY - IN TERMS OF LOST OUTPUT - BETWEEN £74 BILLION AND £99 BILLION PER ANNUM.

BY INVESTING IN THIS INTEGRATED PLAN, IT WOULD BE POSSIBLE TO SIGNIFICANTLY REDUCE THE COSTS BEING LOST, MAKING IT TOTALLY SELF-FUNDING.

THE INTEGRATED PLAN TAKES A COMPLETELY DIFFERENT APPROACH IN DEALING WITH A MENTAL HEALTH ISSUE AT THE START OF A PERSON'S ILLNESS, RATHER THAN WAITING FOR A CRISIS.

Simply this can be said to be 'Prevention and pre-emption to reduce acute unplanned care'

IT HAS COME TO THE POINT WHERE CHANGE IS VITAL AT A NATIONAL LEVEL TO ADDRESS THE WAY MENTAL HEALTH PROBLEMS ARE CURRENTLY HANDLED.

By focusing on '**Prevention and pre-emption to reduce acute unplanned care'**, mental health cases will reduce significantly, but this will require investment to make it happen and this will be self-funding by a significant reduction in those people deteriorating through the mental health process and its impact on society.

Table of Contents

THIS IS A MAJOR WIN-WIN-WIN-WIN-WIN FOR ALL 5 MAJOR STAKEHOLDERS

- **Patient**
  - Immediate access to support 24/7 through a 555 helpline
  - The best possible assessment possible of their condition diagnosis and recommended treatment.
  - Structured care plan following the 3-day assessment.
  - Treatment from the outset, with focused staff familiar with their specific needs.
  - Potential group therapy with those suffering similar conditions and enabling more focused therapies within the wards.

- **NHS staff working in mental health**
  - Early intervention to enable prevention, rather than attempting to deal with situations where the illnesses has become entrenched.
  - Dealing with patients from the start, to facilitate a better understanding of individual issues
    - Knowledge of key people associated with the patient.
  - Improved specialised training in specific areas staff are working in.
  - Less risk of threats to staff, as patients are being treated at an earlier stage of their illness.
  - Reduced need for temporary staff.
  - Greater emphasis on working with the family / carer / advocate, making this a three-way plan for improvements to the patient's health.
- **Family / Carer / Advocate**
  - Immediate access to support 24/7 through a 555 helpline
  - Being able to work with the system, not fighting to get treatment.

    - Being provided with focused education of the patient's diagnosis to enable them to assist to the maximum with caring for them.
    - Knowledge of the key staff at all levels involved with the patient's care.

- **Government**
    - Reduced levels of suicide.
    - Reduced sick days for patients & carers.
    - Reduced NHS A&E costs.
        - With greater focus on the individual, the development of the illness should be restricted, leading to a lower need for crisis involvement.
    - Reduced policing costs, due to a lower level of crisis involvement.
    - Increased tax revenue through increased work attendance and lower SSP.
    - Increased national productivity and output.

- **Employers / Schools**
    - The patient may choose to involve their employer / school if they have knowledge of a clearer diagnosis and what is involved in treating their illness.
    - Employers / schools could be made aware of the 3-day assessment and where appropriate, would hopefully be willing and able to provide compassionate leave for this to take place, if the patient is willing to make it known to them.
    - A greater awareness and acceptance of mental health provision to be pursued and established with employers / schools.
    - Patients & carers would require less time off work / school compared with the current situation.
    - Reduced staff turnover rates for employers

THE OUTLINE OF THE INTEGRATED PLAN

There are six elements to the integrated plan, the 3-day assessment being the most fundamental change.

1. The introduction of a new mental health helpline, 555 that operates 24/7 like 111 to enable immediate support for patients, carers, and any associated people needing to talk. This would be similar to 1737 in New Zealand which started in June 2017 and is government funded. Ref www.1737.org.nz

2. Mental health nurse availability in all large GP practices and accessible to all.

3. The introduction of a 3 day or day / night assessment programme at the start of an illness.

    - In addition, education and coordination of carers and advocates, making this a three-way focus (Doctor/patient/carer) of cure, rather than two-way (Doctor/patient). This is also recommended by the University of Bath and the University Bern Switzerland in its paper Psychiatric Services "Contemporary public perceptions of psychiatry: some problems for mental health professions" 12/12/2017.

4. The changing of generalised to specialised mental health wards where there would be greater focus on the major types of diagnosis, with specialist personnel trained in those specialisms.

5. The specialisation of crisis care staff and support for PreCare and AfterCare services.

6. To remove the broken system of temporary workers as a norm, through recruitment training, career plans and greater responsibility for junior staff.

    - To provide this, mental health services will need 27,460 new posts, which are additional to the 21,000 posts specified in the mental health workforce plan for England. Ref King Fund Oct 2019

1. 555 MENTAL HEALTH HELPLINE

It is now well established that 111 is used for NHS support in the UK, that provides support 24/7 for all illness across the UK.

The people suffering from Mental Health and their carers / friends require a similar helpline run by trained counsellors who can provide;-

- Listening support
- Advice
- Resources that can be distributed via email or reference to websites that may assist
- Can have access to NHS systems to enable the ability to register an individual for help through mental health services if needed.
- In any emergency, act as necessary to get Police / Ambulance support
- This is not intended as a replacement of Samaritans line; this goes far further and provides far greater support and action.

The current Long-term plan have this idea as a flexible option merging with 111 [3]which makes no sense as the knowledge and skills sets required are vastly different and is not aimed at being implemented to 2023/2024. This could be achieved easily and planning started almost immediately.

Mental Health Crisis Care and Liaison	• By 2020/21, all areas will provide crisis resolution and home treatment (CRHT) functions that are resourced to operate in line with recognised best practice, delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute inpatient admission • All acute hospitals will have mental health liaison services that can meet the specific needs of people of all ages with 50% of mental health liaison services meeting the 'core 24' standard	• There will be 100% coverage of 24/7 age-appropriate crisis care, via NHS 111, including: ○ 24/7 CRHT functions for adults, operating in line with best practice by 2020/21 and maintaining coverage to 2023/24; ○ 24/7 provision for CYP that combines crisis assessment, brief response and intensive home treatment functions; ○ A range of complementary and alternative crisis services to A&E and admission (including in VCSE-/local authority-provided services) within all local mental health crisis pathways; ○ Mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response in line with clinical quality indicators • All general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults

Excerpt from the NHS long-term plan referenced below.

[3] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

Current charity run services

1. **Clic**
   https://clic-uk.org/

   Clic is a free on line support community for people suffering from a mental health issues. Clic is brought to you by Mental Health UK. At Mental Health UK, they connect with people and organisations to provide mental health advice, information and support that makes a difference.

   Clic know about the importance of staying socially connected to mental health, and we believe that no one need be lonely or isolated.

   Launched initially by our founding charity, Hafal, in Wales four years ago and in part lottery funded, Clic is now brought to everyone UK-wide so more people can connect and thrive.

2. **Give us a shout**
   https://giveusashout.org

   Give us a shout is a text based mental health support charity, part lottery funded and run by volunteers with no link to the NHS.

Why charities are not the answer

As good as both charities probably are, part of the proposed 555 line, as it will be government / NHS funded, is for the link to be there for an individual's health records. This is vital in terms of timeliness and for the person taking the call to understand the current position, if any, with the mental health team.

2. MENTAL HEALTH NURSES AT GP SURGERIES

THIS IS THE MOST EASILY IMPLEMENTED PART OF THE INTEGRATED PLAN and is the starting point for any patient being seen by a GP.

- A mental health nurse would be present in all large medical practices and available to see patients referred to them by smaller practices. Some of these do already exist, but it is not a standard arrangement.
- These appointments would be coordinated through a simple database and appointment system and the nurse would be able to refer to the community mental health team, if necessary.
- The GP & mental health nurse would cooperate to establish the need for movement of the patient to community / specialist care or where appropriate, immediately recommend the 3-day assessment programme.
- It is supported by Kent & Medway Primary Trust (KMPT) – Helen Greatorex CEO 26/11/2018

"At a local county level, our Sustainable Transformation Partnership (STP) is fully committed to driving up the standards of care across a range of services, mental health included. One of the areas that we are already implementing is the provision of Registered Mental Health Nurses in GP practices." – Helen Greatorex

3. THE 3-DAY ASSESSMENT PROGRAMME

IN MOST OF CASES, NO PROFESSIONAL KNOWS AND UNDERSTANDS THE PATIENT AS WELL AS THE CARER.

A proposed 3-day assessment programme based around the initial assessment of the NHS which requires a patient at the start of their illness TO VOLUNTARILY attend a ward for three days or three days & nights depending on the type and severity of illness being experienced and the relevance of night observation, which may be due to insomnia, panic attacks, nightmares etc…

This provides a tool for the NHS / patient and any carer / advocate to be brought together to enable a unified plan of help and for all parties to be known and approved by each other.

Carers and advocates would have the chance to be provided with education of the condition the patient is suffering. A three-way partnership of recovery would be formed
The NHS would have communication points beyond the patient and carers / advocates would be "officially" advised as to the plan for the individual.

THIS IS RECOMMENDED FROM THE CONCLUSIONS & RECOMMENDATIONS BY JEREMY DIXON & • DIRK RICHTER OF THE UNIVERSITY OF BATH AND UNIVERSITY BERN PSYCHIATRIC SERVICES IN THEIR PAPER "CONTEMPORARY PUBLIC PERCEPTIONS OF PSYCHIATRY: SOME PROBLEMS FOR MENTAL HEALTH PROFESSION". An excerpt from this paper is included below for convenience.[4]

> 'In addition, more needs to be done to engage with the views of family members. Although mental health policy has commonly emphasised the need for professionals to work with families and carers, research shows that many carers continue to feel alienated from services, believing that their views are ignored or discounted (Ewertzon et al. 2010).

[4] https://www.researchgate.net/publication/321765085_Contemporary_public_perceptions_of_psychiatry_some_problems_for_mental_health_professions

Research also indicates that mental health staff remain reluctant to work with service users and families together. Workers commonly worry that family work may compromise patient interests, may breach confidentiality or may act in tension to the medical model (Eassom et al. 2014). Engagement with carers may also get lost to competing staff priorities and staff may also lack confidence in working with carers. However, although patients may refuse family involvement, this should not be assumed.

For example, a recent study found that 78% of users wanted families to be involved in their care and indicated that they favoured a broad level of involvement (Cohen et al. 2013).

In our view, there are two ways that psychiatry and allied mental health professionals need to respond to the issues raised above.

First, mental health professionals need to be transparent about their socially constructed state of knowledge. Psychiatry still cannot be sure whether its main target is the human brain or the human mind, nor whether there is such a thing as the mental realm (Schramme 2013). As a consequence, mental health professionals cannot plausibly draw sharp lines between sanity and insanity or between normality and abnormality.

Furthermore, the origins of most major mental disorders remain unclear. Recent worldwide searches for the genetic causes of disorders such as schizophrenia or major depression have not revealed clear-cut biological causes. In taking this line, we adopt a position congruent with writers such as Hacking (1999). That is, that we accept that some symptoms of mental disorders may have a genetic or other biological component, but that current categories reflect constructs of mental disorder that are negotiated within the profession in order to promote inter-rater reliability rather than validity. As efforts to align categories of mental disorder to genetic evidence remains some way off, we submit that mental health professionals need to be clearer that these instruments are social constructs used to describe problem behaviours (rather than illnesses).

Second, mental health professionals need to explore the patient's model and to adjust the therapeutic options accordingly. In taking this approach, we are advocating a position where patients who have legal capacity to make decisions about their care and treatment should be supported to do so. Patients who follow a more biomedical model can benefit from supporting psychoeducational information and adherence therapy, as a recent systematic review has suggested (Gray et al. 2016). **However, if a patient rejects the biomedical model they are diagnosed with, one can expect that there is a high risk of medication non-**

adherence. Approaches that aim at convincing patients about a model that they reject result in frustration and the breakup of the therapeutic relationships (Lysaker et al. 2013). Alternative approaches such as autonomous dose reduction/discontinuation of medication and their risks and psychosocial therapies seem to be much more promising for those service users. In addition, treatment for these individuals should align with their preferred construction of mental disorder or distress. Recovery models offer a way in which individuals may be enabled to cope with personal impairments and everyday stressors whilst developing strategies for making the best of one's life. Acute treatment settings may learn from psychiatric rehabilitation approaches in this regard where the disorder does not stand in the centre of interventions, but solutions are sought for psychosocial problems such as returning to work or finding appropriate accommodation. **In addition, the views of the family need to be taken into account throughout the recovery process where service users consent to this. Newly emerging models of decision-making may support these options. 'Supported decision-making' is currently being promoted in line with the United Nations Convention on the Rights of Persons with Disabilities**. **Supported decision making implies that the person with disability has the ultimate choice on issue of life and treatment (Gooding 2013).** The professional part of this model is to supply all information needed in a way that the person with disability is most likely to understand in order to make a sound decision in their best interests. Supported decision-making is also in line with recovery and empowerment approaches that stress autonomous decision-making. These approaches are not based on any specific model allowing involvement from a range of users. Supported decision-making frameworks also allow for the perspectives of carers to be highlighted and incorporated within discussions around recovery. These models assume that where an individual has decision-making capacity to make a decision about their care then they should be enabled to do so and that professionals should only act against an individual's wishes where they lack capacity (Szmukler et al. 2014).

Of course, these options will lead to further dilemmas for professionals. Being transparent about the limits of their knowledge and the therapeutic options available will present a different picture of a therapist or physician than is usually known by patients and professionals. This option may provoke insecurity in some patients, but it may also strengthen the position of those who are critical about the professional power of providers in the mental health care system. **Treating patients with the same diagnosis differently according to their own beliefs may also provoke frictions within the professional community. Such an approach challenges standardised treatment recommendations and will certainly face opposition by therapists who**

follow specific models of mental disorder. And to be clear, avoiding medical terminology will advance the de-professionalisation of psychiatry in the eyes of many medically oriented professionals. However, in the light of its socially constructed knowledge base, there is no option for psychiatry and the mental health system than to acknowledge the contingency of the illness model and the resulting therapeutic options. Although it may appear like a confession of weakness to other fields of medicine and poses a challenge to traditional forms of professionalism, such an approach, if practised, will lead to better therapeutic relationships s and will de-escalate many of the inherent conflicts in the field of mental health care.'

Authors

Jeremy Dixon - Department of Social & Policy Sciences, University of Bath, Bath, United Kingdom

Dirk Richter - University Bern Psychiatric Services, Center for Psychiatric Rehabilitation, Bern, Switzerland & Bern University of Applied Sciences, Department of Health, Bern, Switzerland

- **This would provide a new tool for GP's to commence effective mental health care at the start of the patient's illness, which in turn would promote better prevention and earlier cure.**

  (Note - if in the view of community Psychologists / Psychiatrists the patient is too ill, then current practices and procedures would be necessary for them in terms of admission to a mental health unit.)

  Some examples (the list is not exhaustive) of when a GP might recommend a patient to attend this 3 day / night treatment would be when NHS staff observe the following signs and symptoms:-

  - Suicidal thoughts
  - Desire to self-harm
  - Start of eating disorders
  - Severe depression – after anti-depressants have been tried.
  - Insomnia leading to other symptoms

- During the 3 days, the following would happen: -
  - At least one psychological assessment
  - At least one psychiatric assessment
  - Observation of social interaction and personal wellbeing by interactive staff on the ward
  - Interactive Staff communicating with the patient on a friendly, informal 'one to one' basis to discover as much as possible about the personal issues the patient is experiencing.
  - At the end of the three days, a detailed personal plan would be prepared for the individual which specifies: -
    - The diagnosis of the patient's illness.
    - An understanding of the most likely cause of the problem.
    - The team which will support the individual.
    - Actions the patient can take to help themselves.
    - Actions the carer / advocate can take to help the patient and things to watch out for should the illness develop.
    - Any medication the patient needs to take.
    - How to integrate the above into the patient's and carer's /advocate's daily lives.

It is essential that a structure is provided for the ongoing welfare and well-being of the individual and for them to have clarity of how they are being treated and who is involved in their care.

The reasons why the '3 days' is used: -

- Patients would hopefully be allowed time off work or school without it having a major impact or anyone really noticing, as their short absence could be viewed as minor sick leave.

Ideally, employers / schools would see this as a positive step and this would be given as compassionate leave.

- Some of this could be over a weekend, enabling even less time off work / school.
- ‘3 days’ provides enough time for professionals to meet with the patient and if there are night-time issues, the chances are many of those would be experienced and assessed during that period of time.
- It would also provide an opportunity for the patient to focus on themselves and to learn from professionals what they can do to help themselves and to ask questions in a non-threatening and safe environment.

What is needed for the 3-day assessment plan

1) The 3-day assessment plan specifies that four new wards are established in every hospital to address specific individual issues for patients. There would need to be night-time provision and potentially provision for parents in the under-18 wards.

2)

As previously mentioned, only patients experiencing night issues would be required to stay, so these can be observed and understood.

Male	18 +
Female	18 +
Male	under 18
Female	under 18

Each set of wards would have at least

- two psychologists
- two psychiatrists
- **Enough trained medical staff on site 24/7 with experience and expertise in how to assess people’s actions, plus counselling skills to be able to engage with them.**

3) Staff should be recruited who are full time and dedicated to delivering what is required. An extensive recruitment drive and investment in encouraging training would be necessary.

4) There would need to be a training plan for staff to develop interaction, counselling and assessment skills to ensure consistent and competent interaction with patients, so that it is not regarded simply as a policing role.

5) There would need to be a budget holder, with authority and power to provide funding where appropriate to support community-based or individual work related to specific mental health issues.

What will this provide for the patient?

- It would be a carefully planned way forward for them to have their symptoms properly understood and assessed following the 3-day assessment programme.
- It would provide them with a structure of what they need to do to assist themselves in their journey to health.
- It would create an Action Plan they need to follow, plus details of their medication regime.
- The patient would know that their individual needs are being treated by specialists rather than generalists, as is currently the case.
- It would provide them with a set of contacts whom they know they will be seeing going forward, and even if these should change, they would know the type of roles those individuals are undertaking.

What will this provide for the NHS?

- **It will provide a tool not currently in place to assist in the healing of mental health and provide a cornerstone in dealing with each individual's care. This will provide hope where currently there is little or no hope, or action the NHS can provide before it becomes too late.**
- It will provide a detailed record of the individual and their specific needs, which is accessible to all NHS staff dealing with their care.
- It will reduce the number of crisis calls, as individuals will feel confident that their issues are being dealt with in a professional manner and they have known points of contact they can confidently approach.
- It will reduce the pressure on A&E Depts., as fewer crises are likely to arise.

- It will reduce the number of suicides and their aftermath.

What will this provide for the carer / advocate?

- To be known by the NHS and the relevant staff and be recognised by them in terms of communication and authority.
- To be provided with information and insight into what is happening to the individual based on the diagnosis determined after the 3-day period, which would include: -
    - Educational documents of the patient's diagnosis
    - Planned course of treatment / care
    - What they themselves can do to assist in the process
    - What to look out for in terms of improvement or further deterioration
    - When to act and when to communicate further with the NHS
    - A recognised pathway for those who are suffering mental health issues at school, work or home.

4. MENTAL HEALTH WARDS SPECIALISATION

Mental health wards ought to be specialised, rather than the current practice where all too often, all those suffering poor mental health are treated by a general psychiatrist, who is charged with attempting to deal with the whole spectrum of mental illness, whereas the needs are quite diverse depending on the condition of the patient.

The aim is for specialised wards to be created around each county in the UK specialising in the most common mental health illnesses.

For instance, there could be specialist wards in separate towns for: -

- Depression, anxiety, panic attacks & bipolar disorders
- Personality disorders & self-harm
- Post-Traumatic Stress Disorder (PTSD)
- Eating disorders
- Psychosis & Schizophrenia
- Sleep disorders, e.g. insomnia, nightmares, night panic attacks

This would enable more specialism to exist & for training to be given across all staff and enable patients to receive a far more effective level of care.

NB - This could be done immediately, using existing wards with a change of focus.

A summary of mental health illnesses can be seen here.

Using Priority House in Maidstone as an example, it has three general wards and one specialising in older patients.

These four wards could be turned into wards for: -

- Depression, anxiety, panic attacks & bipolar disorders, as there are ECT facilities in place.
- Sleep disorders e.g. insomnia, nightmares, night panic attacks
- Personality disorders & self-harm
- Post-Traumatic Stress Disorder (PTSD)

while Canterbury or Margate could focus on: -

- Eating disorders
- Psychosis & Schizophrenia
- Depression, anxiety, panic attacks & bipolar disorders, as Margate has ECT facilities

5. THE SPECIALISATION OF CRISIS CARE SUPPORT FOR PRECARE AND AFTERCARE SERVICES

“Only one crisis team out of 180 meeting national guidance”

Only one mental health crisis team in the country is meeting all the national staffing and access standards, according to new study – Health Service Journal, 6 July 2018

- Survey finds only one crisis team for mental health patients is meeting national standards
- It has led to calls to introduce the four-hour acute target for mental health patients set out by Lord Crisp in 2016
- The Royal College of Psychiatrists also said some of the new cash for the NHS must be used to prioritise community mental health services

---

“How can this be any surprise when the staff in these team are so stretched and have to cover 24-hour care? From personal experiences with a number of service users, including my wife, their services are limited at best and advice and support is also restricted due to their lack of training in specialised care.

My wife was advised to go for long walks away from home a day before she attempted to electrocute herself by the crisis care worker who had no idea what she was talking about. **My wife would have been dead had she done so**.”

Alastair Deards – Mental Health Advocate

They have to cover every form of mental health for patients in both PreCare and AfterCare.

There simply is not enough members of the teams to cope with everything that is thrown at them.

Patients who become regular callers are also treated in a different way, such as an offhand manner or worse totally ignored. They are not always given the consideration they require due to staff being "too busy".

There is direct evidence of this from a number of service users, many who have had to give up using this service.

In line with the mental health specialisation above we are requesting that the crisis teams are also provided with specialised training, so experts are available to support service users in more detail than is the current norm.

6. REMOVAL OF TEMPORARY WORKERS AS A NORM

INVESTING IN DIRECTLY EMPLOYED STAFF TO SAVE OVER £0.5 BILLION THAT IS CURRENTLY BEING GIVEN AWAY TO AGENCIES.

It is absurd that we have got to a position where 20% of the NHS workforce is known to be temporary. No private company would look at staffing it employees in that way unless they needed the flexibility which is not the case in the NHS.

The following arguments show by taking leadership and actively recruiting, training, and paying staff at the right level the benefits can be seen to assist the NHS finically, the staff morale and the patient experience. Here are the arguments to support this statement.

Financial Argument

To provide this, mental health services will need 27,460 new posts, which are additional to the 21,000 posts specified in the mental health workforce plan for England. Ref King Fund Oct 2019

Evaluating this statement on the basis of the following assumptions

In 2016/17, the total cost of NHS staff was £47.6 billion which amounted to 44.9 per cent of the NHS budget. These statistics do not include temporary staff, GPs or employees from the Department of Health and Social Care and other national bodies such as NHS England and NHS Improvement.8 Nov 2019

Headcount. There are roughly 1.5 million people employed by the NHS across the UK. By country, the NHS directly employs around: 1.2 million staff in England.1 Jun 2017

Average cost of employed staff = Total wage cost of £47.6 b / 1.2 m employees = £39,666 per annum

It is appreciated that not all staff are recompensed equally, nevertheless, this example shows that 48,460 *average* posts are fully staffed by temporary agency workers.

Let us assume a 30% premium is paid to locum agencies - £11,900 per year

Therefore, the cost being given to agencies by not fully staffing is 48,460 *£11,900 = £576m

SO THAT IS WELL OVER HALF A BILLION £ BEING WASTED THAT COULD PROVIDE SELF-FUNDING FOR OVER 14,500 STAFF OF THE SHORTFALL!

Staff Argument

To have a fully team constant team is going to be so much more effective in the treatment of patients and provide time for proper training.

At present millions of hours are wasted in planning and finding the temporary staff being needed to cover the shortfall in the current staffing.

This would be incredibly motivational to all of the staff currently employed not to see staff coming in earning more than them for doing the same job and in many cases to a lesser standard without the same upward managerial responsibility levels.

Patient argument

From experience life for the patient is confusing enough suffering from mental illness. To have the continual rotation of staff differing on a daily basis is so confusing and relationships, and understanding both ways is far more limited than necessary.

It is so important for the staff to truly understand the patients' needs at all times of the day and night and simply providing night "guards" is in no way doing this and could be seen as a failure of duty of care to those numerous patients suffering, panic attacks, night terrors etc… **mental health is a 24/7 illness.**

Conclusion

BY TAKING LEADERSHIP AND CHANGING THE CULTURE THROUGHOUT THE NHS STAFFING POLICY, A FORTUNE CAN BE SAVED, PROVIDING IMPROVED SUPPORT FOR THE PATIENTS AND IMPROVING STAFF MORALE. THIS IS THROUGH ACTIVELY RECRUITING THE CURRENT SHORTFALL OF STAFF AN MAKING THE ROLES MORE ATTRACTIVE.

SUMMARY OF WHAT THESE CHANGES WILL ACHIEVE

By implementing all elements of the integrated plan, it will enable the following to happen; -

- **A recognised and full integrated pathway for people who are suffering mental health issues** at school work or home from start to finish.
- **A greater understanding of the issues the patient is experiencing through first-hand experience with the NHS** providing a detailed record for all parties.
- **Earlier intervention & education** for patient, carer, doctors & the NHS.
  Improved 3-way communication between the NHS / carer and patient, so vital in enabling treatment to be effective and timely.
- **Improved focus and specialisation in the treatment of specific types of mental health illness**.
- **Improved PreCare & After Care treatment for patients.**
- **A significant reduction in suicide rates.**
- **Reduced pressure in terms of mental health units, and A&E**.
- **Financially, it will be self-funding through**
  - Reduction in sickness and time off for mental health issues, not only for patients, but also carers.
  - Increased national output
  - Less money spent on temporary staff
- **As shown, this is a win-win-win-win-win for all stake holders**

APPENDICES

BACKGROUND & OVERVIEW

- In recent years, centrally prescribed mental health policies, funding, and programmes have made less impact than had been hoped, to the point where mental health provision and suicide are now at crisis point.
- The Government has recognised this with the appointment of a suicide minister and a £1.8 Billion push to reduce the number of people committing suicide.
- It is committed to increasing the provision to help share responsibility across society and some of the ideas include:
    - The Chancellor highlighted an additional investment of £250 million in new crisis services including: 24/7 support via NHS 111, children and young people's crisis teams in every part of the country, comprehensive mental health support in every A&E by 2023/24, more mental health specialist ambulances, and more community services such as crisis cafes. The focus on people in crisis is important, as this is when they are most vulnerable and in need of professional support.' [5]

These ideas although worthy fail to address the complete spectrum of mental health treatment at all levels and particularly Prevention and Pre-emption that the integrated plan attempts to address.

The integrated plan has already shown how Crisis care fails to correctly support mental health conditions as has been highlighted. Even as I write this today evidence of failure can be seen.

- [5] https://www.kingsfund.org.uk/blog/2018/10/mental-health-funding-2018-autumn-budget

From the Guardian 28/11/2018

'The health secretary, Matt Hancock, is facing mounting calls to intervene in England's worst performing mental health trust after it was rated inadequate for a third time.

The Care Quality Commission (CQC) found "significant concerns" when it inspected Norfolk and Suffolk NHS foundation trust in September **including patients harming themselves and taking overdoses while waiting to be see**n.'[6]

- There were instances of people who had significant needs being denied a service and records showed some patients harmed themselves while waiting for contact from clinical staff.

- A large and diverse range of voluntary and community organisations continues to work with individuals and support groups. They are well placed to understand local needs, but are unable to address the national picture, which requires major fundamental change.

- There is a significant distinction between young people under 18 and adults and the integrated plan tackles this through the provision of 4 specialist wards to cater for single sex and different age ranges.

- The Stevenson / Farmer review 26 Oct 2017 has calculated the enormous economic cost of failing to address mental health issues in the workplace. It estimates that the cost of poor mental health to employers in the UK to be £33-£42 billion per annum in sick leave, staff turnover and loss of productivity, and costs the UK economy - in terms of lost output - between £74 billion and £99 billion per annum.[7]

- Statistics from the Department of Work and Pensions reveal that 300,000 people with a long-term mental health problem leave the UK workforce each year.
    - An example taken from 'The Times', dated 15th October 2018 [and one very applicable to the Government]

---

[6] https://www.theguardian.com/society/2018/nov/28/ministers-urged-to-act-over-norfolk-and-suffolk-mental-health-trust

[7] https://www.gov.uk/government/publications/thriving-at-work-a-review-of-mental-health-and-employers

Table of Contents

‘Civil servants took more than 300,000 days off over mental ill health last year’[8]

assuming an average cost of £100 a day, that is £30,000,000, which could be significantly reduced.

Most core Government departments are losing thousands of days of work because of mental illness or stress.

In 2017, more than 53,000 days sick leave were taken for mental health reasons in the Home Office, about 2,000 fewer than in 2016, but 8,000 more than in 2015.

There has also been a rise at the Foreign Office over a similar period, from 2,180 days sick leave in 2015 to 4,734 in 2017.”

[8] https://www.thetimes.co.uk/article/mental-ill-health-costs-whitehall-300-000-sick-days-jvgwfwggv

WHAT NEEDS TO CHANGE

In our opinion, the following changes are required.

- **The whole focus of mental healthcare must move to the start of the illness not when the issues have become so severe that both danger to life and dramatic increases in costs are drastically heightened.**.
    - **It is incredulous that in this day and age, people can waste years of their lives waiting to be treated and unless they have someone to fight for them, they will continue to be ignored and dealt with solely by a care coordinator in the community, who has minimal power to enable change to take place for the patient.**
    - In many cases, it is only when the patient resorts to suicidal attempts that they are likely to be admitted to a ward. Prior to that, they are usually sent away, knowing that self-harm, overdosing and worse are all an extremely high probability.
- **The focus needs to be a three-way process with help from the NHS, not only for the patient, but also providing education and support for any carer / advocate involved.**
- **At present, one of the biggest issues mental health wards have is attracting and keeping staff to work in them**.
    - The level of temporary staff is enormous, **and the Government is paying a massive premium for them**. This is a futile practice and a real waste of money, as such staff solely act as security guards and provide no support for the patients.

      The NHS also outsources mental health treatment to private hospitals, again at a premium, which would not be necessary on such a regular basis if this integrated plan is implemented.
- **The safety of mental health wards.**
    - **By changing the focus to treating people who have not yet developed the full range of mental health illness, the staff would be in a safer environment and their role would be more attractive leading to reduced staff turnover**.
    - By focusing on specialised treatment areas, better staff will have a better knowledge of what to expect

- **The involvement of caring staff working with the patient**
    - New careers would be created, and the staff engaged would be as valuable and as critical as the professionals in the process of determining the diagnosis of the patient.

THE MAJOR TYPES OF ILLNESS IMPACTING MENTAL HEALTH

This is not an exhaustive list but covers the major types of illness and patients can experience a number of these at the same time.

ANXIETY & PANIC ATTACKS

Anxiety is a normal emotion, but it becomes a mental health problem when someone finds they are feeling this way all or most of the time. A panic attack is the abrupt onset of intense fear or discomfort that reaches a peak within minutes and includes at least four of the following symptoms:1) palpitations, pounding heart, or accelerated heart rate 2)sweating 3)trembling or shaking 4)Sensations of shortness of breath or smothering.

BIPOLAR DISORDER

Bipolar disorder, formerly known as manic depression, is a condition that affects your moods, which can swing from one extreme to another.

People with bipolar disorder have periods or episodes of:

Depression – feeling very low and lethargic

Mania – feeling very high and overactive (less severe mania is known as hypomania)

DEPRESSION

This is a diagnosis given to someone who is experiencing a low mood and who finds it hard or impossible to have fun or enjoy their lives.

EATING DISORDERS

This is a diagnosis given to someone who has unhealthy thoughts, feelings and behaviour about food and / or their body shape.

INSOMNIA

Insomnia is a sleep disorder that is characterized by difficulty falling and/or staying asleep. People with insomnia have one or more of the following symptoms: Difficulty falling asleep. Waking up often during the night and having trouble going back to sleep.

OBSESSIVE-COMPULSIVE DISORDER

This is a diagnosis given to someone who experiences obsessive thoughts and compulsive behaviours.

PERSONALITY DISORDERS

If someone has this disorder, some aspects of their personality might affect them in a way which makes it very difficult for them to cope with day to day life, especially when it comes to relationships. Different types of personality disorder include: -

Category	Type
Suspicious	Paranoid, Schizoid, Schizotypal, Antisocial (ASPD)
Emotional	Borderline (BPD), Histrionic, Narcissistic
Anxious	Avoidant (anxious), Dependent, Obsessive (OCPD)

POST-TRAUMATIC STRESS DISORDER (PTSD)

Post-traumatic stress disorder (PTSD) is an anxiety disorder caused by very stressful, frightening or distressing events. Someone with PTSD often relives the traumatic event through nightmares and flashbacks, and may experience feelings of isolation, irritability and guilt.

PSYCHOSIS

A person experiencing psychosis perceives the world in a different way to those around them, including hallucinations, delusions or both.

SCHIZOPHRENIA

Schizophrenia is a mental disorder characterized by abnormal behaviour and a decreased ability to understand reality. Common symptoms include false beliefs, unclear or confused thinking, hearing voices that others do not, reduced social engagement and emotional expression, and a lack of motivation.

SELF-HARM

This is when someone deliberately hurts themselves, usually to cope with intense emotional distress.

SUICIDAL FEELINGS

These arise when someone feels they wish to end their life for a variety of reasons, which may be related to mental health issues, crises, insomnia, depression and the like. The list is complex and can be very individual.

THE KEY PLAYERS

The key players in mental healthcare are:

- **NHS** – providing and administering mental health provision throughout the UK.
- **Government** – setting vision, creating the legislative framework for reform, and facilitating and co-ordinating the overall system to function effectively.
- **Cams.care** - its mission is to research, train, consult, develop technology, and provide cutting-edge leadership and related professional services in an evidence-based approach for suicide prevention in clinical settings and larger healthcare systems.
- **Charites and self-funded groups**
    - MIND – providing advice and support to empower anyone experiencing a mental health problem and campaigning to improve services, raise awareness and promote understanding. MIND won't give up until everyone experiencing a mental health problem gets the support and respect they need.
    - Mental Health Foundation – dedicated to finding and addressing the sources of mental health problems.
    - Time to change – wanting to end mental health discrimination through changing attitudes supported by MIND & the National Lottery.
    - Mental Health UK - bringing together four national mental health charities working across the UK - Rethink mental illness, Support in Mind Scotland, Hafal in Wales & Mind wise in Northern Ireland

- **Employers** - as seen through the statistics cited above, employers are suffering from loss of productivity and workforce through the failure to address mental health issues in an appropriate, effective and open manner.
- **Patients** - who suffer the trauma of their world falling apart and are forced to make enormous changes to try and cope with what is happening in their lives, often without immediate help and support, until an appropriate cure can be found.
- **Carers** – those directly involved on a day-to-day basis in caring for the patient.
- **Advocates** –those who are helping the patient, but not directly involved on a day-to-day basis, and provide advice & support to secure the most appropriate treatment for the patient through the NHS.

THE TEAM BEHIND THE REPORT

The team who are proposing these changes and fighting for these needed changes include a psychiatrist, a retired Medical director, a lawyer and mental health advocate, a member of parliament, a mental health advocate campaigner for her daughter, a serial entrepreneur, an IT expert and another mental health advocate who is a retired accountant and has been a carer for his wife.

Dr. Faisal S. Shaikh, F.R.C.Psych

Consultant Psychiatrist

As a seasoned senior psychiatrist with recent experience of coaching middle to senior managers, professionals and board level executives,

Umesh Prabhu

Retired Medical Director

Medical Director of NHS for more than 15 years (Bury NHS Trust 1998-2003 and Wigan (2010 -2017)

Grant Pritchard

Lawyer and Mental Health Advocate NZ

Legal Beagle • ILANZ President • Mental Health Advocate I'm a lawyer, technology enthusiast and workplace mental health advocate at Spark -- New Zealand's leading telecommunications, media and digital services company.

Helen Grant

MP at House of Commons for Maidstone and the Weald

Helen Grant was first elected to represent the Parliamentary Constituency of Maidstone & The Weald in 2010 and has held the post ever since.

In January 2018 Prime Minister Theresa May appointed Helen Conservative Party Vice Chairman for Communities. It is a role that takes her nationwide as a party ambassador; engaging with ethnically diverse, disabled, disadvantaged and LGBT+ groups; listening, acting on concerns and suggestions, and feeding back to the Party and to Government.

Andrea Attree

Mental Health Advocate Campaigning for Change and Outstanding Provision of Mental Health Services.

Andrea recently presented at the Human Rights committee led by Harriet Harmen MP regarding the 4-year detention of her autistic daughter due to misdiagnosis.

Stephen Petherbridge

Serial Entrepreneur

Stephen has worked in recruitment for 30 years in various sectors in the temporary marketplace. The last 20 years have been spent mainly in Education recruitment. He has started, run and sold two major supply teaching companies.

Andrew Norris

Independent IT consultant, project manager and operations manager.

Andrew is a highly experienced in IT management. He has several close family members with mental health difficulties and is very keen to see positive change in the provision of care.

Alastair Deards

Mental Health advocate

Alastair is a Mental Health advocate who has assisted a number of mental health patients receive full mental health support from the Kent and Medway Trust with the support of Helen Grant MP. He has also been in the role of a carer for his wife who experienced a mental health ward twice, the second time being thrown out with a diagnosis that was not “robust” leading to another suicide attempt 5 days later . Alastair retired from Accountancy in 2018 to support change in the Mental Health and support those he encountered, unable to get NHS help through lack of resources, following the misdiagnosis and mis-treatment of his wife.

WHY IT IS NECESSARY FOR CHANGE TO HAPPEN NOW?

ALASTAIR'S REASONS

Having experienced the torment of mental health issues suffered by my wife on two occasions and battled with the NHS to get treatment for two further individuals who have suffered so badly at the hands of the existing system, I know first-hand how the current methods and practices within the NHS are absolutely failing patients and leading to them not being treated in an appropriate manner and leaving them prone to successfully ending their lives.

During the past three years, I have been involved with several patients and mental health staff at all levels from juniors on the ward to CEO's of the Trust. All my experience has been with the local Kent & Medway Trust and I have been in contact with Helen Grant MP and her staff for the majority of that time.

After witnessing the absurd situation of how it's almost impossible to secure proper and adequate care for patients for three years, in September 2018, I voluntarily stopped working to focus entirely to create this integrated plan and getting the proposed changes the integrated plan made at a national level, so that no one has to suffer in the way a number of people I have been involved have done which has been fully documented and seen by Helen Grant. The process was delayed by personal illness and is now being run by the team mentioned in the report who fully support the aims and recommendations outlined within the docuent.

After pressure on the NHS, I have succeeded in getting treatment arranged for three individuals, including my wife, but this was only after long battles to secure funding to enable any attempt of curing them to take place.

From my experience, the NHS trust management currently does its best with a flawed system as has been evidenced so much recently. The fact is the system fails to protect vulnerable individuals liable to self-harm and overdosing, as they have no facilities to prevent this from happening.

Trust management fails to take preventive actions when they know what is going to happen, as there is no provision for them to do so (I have a mountain of evidence to prove this,

including a patient sent home 20 times in 2 months from repetitive self-harm / overdosing of medical drugs). Trust management are reactive and fail to pre-empt events they can foresee will happen.

I have invited all the people who have been involved in the most recent case to contribute to this report, as there can be no doubt that the system is flawed and is failing to keep patients safe and treatment is not routinely provided unless a case can gain a NHS trust CEO's and / or political attention.

This report has been sent out to patients, carers, doctors, senior management of KMPT an MP, friends and family to gain feedback and improvement on the integrated plan.

I truly hope this discussion paper can be taken forward and addressed to improve the mental health provision across the UK and reduce the current level of unacceptable suffering for patients, family friends and carers.

Ideally, with urgent action, this could be put in place as soon as possible. The team are willing to be involved to help make this happen