healthwatch
County Durham

YOUR VIEWS ABOUT MENTAL HEALTH SERVICES IN COUNTY DURHAM

April 2019

Mental Health Report

Contents

Healthwatch County Durham

Healthwatch County Durham is the county's consumer champion for health and social care, representing the voices of current and future users to decision makers.

We listen

We listen to patients of health services and users of social care services, along with their family members or carers, to find out what they think of the services they receive.

We advise

We advise people how to get the best health and social care for themselves and their family. We provide help and information about all aspects of health and social care provided in County Durham.

We speak up

We make sure that consumers views are heard by those who provide health and social care. Wherever possible we try to work in partnership with providers to influence how they make improvements.

Executive Summary

In 2017 Healthwatch asked the public in County Durham what their priorities were for us to look at in 2018. Based on intelligence gathered from our signposting work and information provided by partner organisations there were six proposals to choose from. Mental Health Support was one of the proposals selected as a priority by the public.

The focus of our work was to find out more about Mental Health Support. This included:

- How referrals are being made
- The therapies being accessed
- Were there any significant waiting times for services
- Did patients understand the support they were offered
- Aspects of life affected by poor mental health

In addition to patient experience we also looked into staff views on working in mental health. This included:

- Work related stress
- Workplace health initiatives
- Support in the workplace
- Relaxation outside of work

Based on the research we carried out, both with patients and mental health service staff, we have the following recommendations for TEWV trust and mental health support providers to consider.

Processes and staffing

- When TEWV launch their new website and when any other new publications are produced, they should ensure that this is done collaboratively and shared with other relevant organisations. This would help patients find links to this advice and information regardless of where they first looked for support
- Mental Health service providers should continue to ensure they support staff to manage their own mental health and wellbeing, looking for new initiatives which help staff to feel able to share their own mental health concerns
- Service providers should continue to monitor the caseload of support staff especially when new initiatives are introduced which might increase the numbers of patients that can been seen and / or change existing working practices

Patients, therapies and appointments

- Clinicians to have, and use, the flexibility to be able offer additional therapy sessions or changes to the therapy plans for individual patients where required
- Consider implementing interim support services whilst patients are waiting for treatment
- Offer a regular SMS or email service providing tailored and practical support and advice, as an effective means of keeping in touch with patients – particularly for patients who are waiting to start their treatment
- Introduce an appointment reminder service, either through phone call, email or SMS; whichever works better for the patient
- Introduce a direct referral route to debt advice and / or advocacy services to help manage financial hardship that often accompanies poor mental health

Raising awareness of mental health

- GP mental health champions (also known as Link Workers within TEWV) to be appointed to raise awareness of the additional support services that can be accessed alongside clinical treatments and therapies
- Some of the GP practice allocated training time to be dedicated to partnership working with mental health charities and organisations
- Mental health charities and organisations to be included in the annual TEWV GP Conference (November 2019)

Case Study:

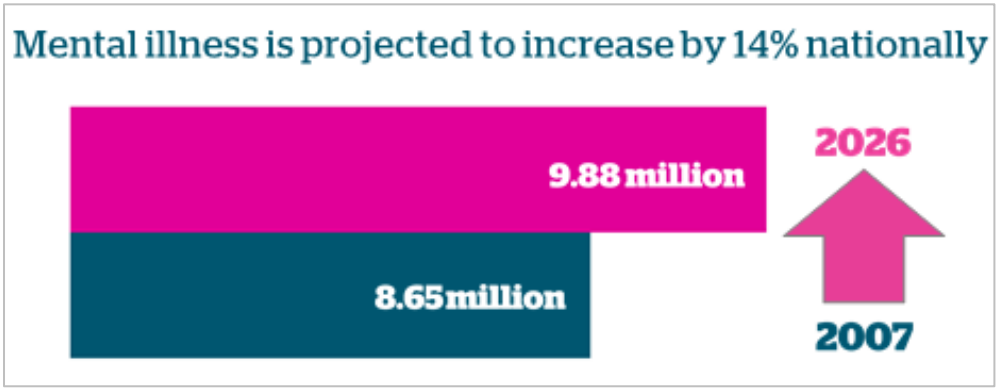
Q has experienced poor mental health for most of her adult life. She has a young family to care for and at times struggles to leave the house, which makes even the school run a near impossibility on some days. Q found it difficult to get a referral to the community mental health team and felt that the delay meant her mental health suffered a further 12-month deterioration while she waited, with self-harming, dissociation and suicidal thoughts. Q says she has struggled to stay afloat while waiting for NHS services – with waiting times for higher intensity therapies like CBT and EMDR more than eight months in her experience. She has turned to third sector organisations for support in the interim but has found even some of these have waits of several months. Even so, she describes their support as the thing that has held her together while she has been waiting to access NHS therapy services. She has especially found a lifeline in the art therapy provided by one local charity. She thinks she was lucky she had the ability to look for the support she needed as information about local organisations is not readily available and can be hard to navigate and understand.

Q thinks support could be offered between therapeutic interventions via text messages, phone calls or emails, to make sure vulnerable people like herself do not feel totally abandoned. She feels one of the biggest problems is not being able to access other support services while on the waiting list for something – her counselling sessions were stopped as soon as she was on the waiting list for EMDR, which led to a severe decline in her mental health. Q also thinks medical notes should be accessible to all healthcare professionals as in her experience the first 15 minutes of each therapy session is spent updating professionals on information that could have been read in the history; this reduces actual therapy time and it can be traumatic to repeat things.

Background

In 2017 Healthwatch asked the public in County Durham what their priorities were for us to look at in 2018. Based on intelligence gathered from our signposting work and information provide by partner organisation there were six proposals to choose from. Mental Health Support was one of the proposals selected as a priority by the public.

Levels of mental illness are projected to increase. By 2026, the number of people in England who experience mental illness is projected to increase by 14% from 8.65 million in 2007 to 9.88m (*ref: County Durham Public Mental Health Strategy*).



Furthermore, the CQC's 2018 Community Mental Health Survey showed that "*people's experiences of the care they received have continued to get worse. Access to care, care planning, and support for people with mental health conditions in relation to physical health needs, financial advice or benefits are specific areas of worry.*"

Good mental health provides the bedrock for good physical health and for a range of other important life skills, capacities and capabilities.

Our aims were:

- To gather the views and experiences of adults who are, or have experienced, poor mental health within County Durham
- To understand the problems experienced by people using mental health services
- To make recommendations for the providers of local NHS services based on our findings in order to improve mental health services for the people who need it
- To understand the challenges faced by staff working within mental health services

To help us achieve our aims we wanted to find out the following from patients

- How referrals are being made
- The therapies being accessed
- Were there any significant waiting times for services
- Did patients understand the support they were offered
- Aspects of life affected by poor mental health

In addition to patient experience we also looked into staff views on working in mental health. This included:

- Work related stress
- Workplace health initiatives
- Support in the workplace
- Relaxation outside of work

The Research

We started by speaking to mental health staff and practitioners from both the NHS and the private sector to gain an insight into how they felt current practices and protocols were working, what if any the barriers were, what works well and what could be improved.

Throughout the research we engaged with over 300 mental health service users and staff working in mental health. We carried out surveys, one to one case studies and held information stands at various venues in the county including the two specialist mental health hospitals, Lanchester Road Hospital in Durham and West Park Hospital in Darlington.

We quickly learnt that some people experiencing poor mental health found it challenging to complete a detailed survey. To overcome this, we adopted an approach of asking a simple question, "***What one thing could have improved your experiences of mental health services?***" allowing as many people as possible to share their views with us

We promoted our work through social media, mental health charities and organisations, and also through Tees, Esk and Wear Valley Trust (TEWV) and Talking Changes to allow as many staff to also provide their views on working in mental health services. The surveys were live between July and December 2018.

13 individual case studies were carried out with service users and/or their carers. These were carried out on a one to one basis at a venue where the service user felt most comfortable. The case studies were arranged by individuals contacting us. We made it clear that they could end the conversation at any point and we would only share their experiences (*anonymised*) in our report if they were happy for us to do so. Where relevant or appropriate the client was offered signposting advice and referrals to relevant agencies, including RT Projects, Rethink Mental Health and Talking Changes.

Case Study:

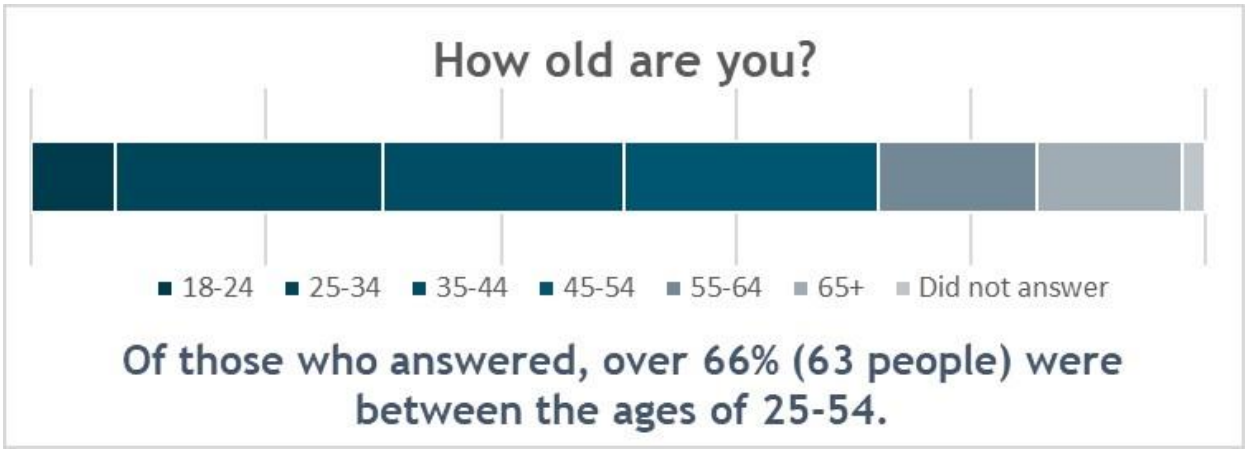
H has experienced behavioural and emotional difficulties since childhood due to trauma and abuse. As a child, the mental health support he received was not consistent. Periods of therapy were followed by sudden breaks in support, on one occasion purely because of differing funding policies between local authorities. H has also struggled to get the right support from adult services. His carer says having to go through his case history during appointments brings up all the unresolved emotions from his childhood experiences but these are not addressed or treated.

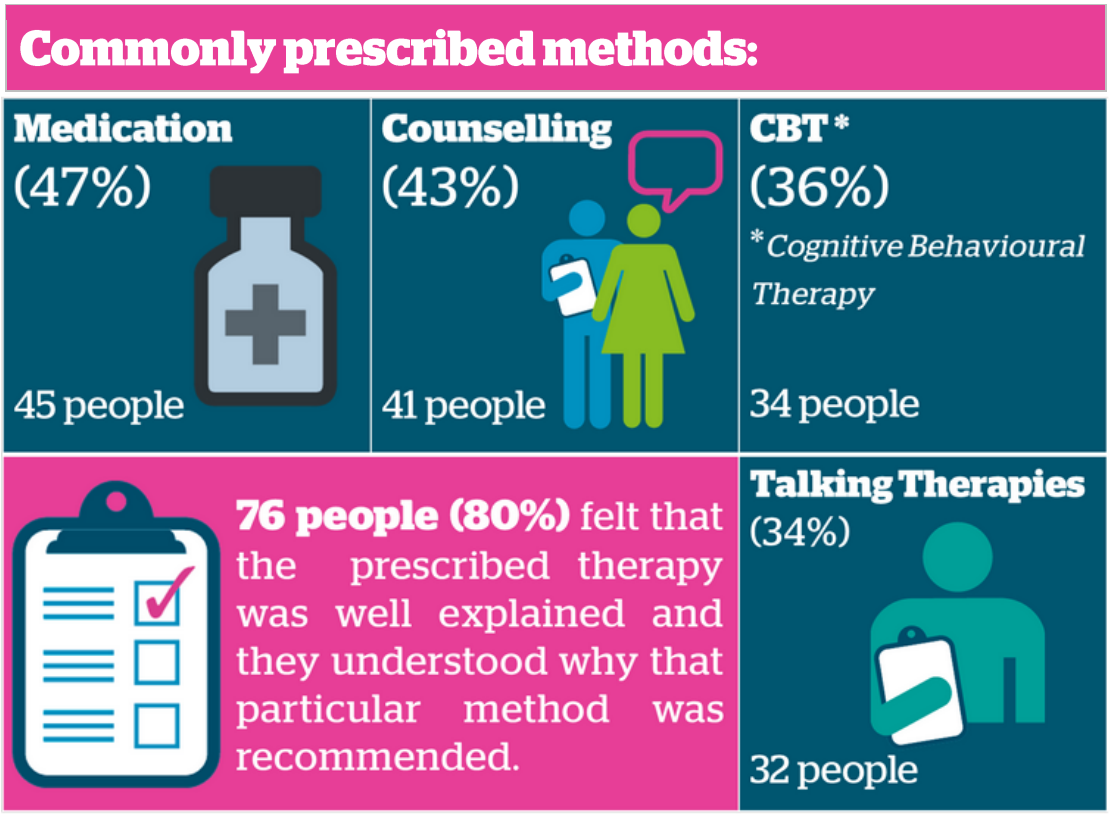
During a psychotic episode, his carer phoned the crisis team 15 times in a single night but nobody responded to the calls. His carers knew that he was at risk of hurting himself and others, if not worse. He was eventually referred to the psychosis team following sectioning under the Mental Health Act but even this wasn't simple: initially an appointment was sent for a consultation with an entirely different team and H's carers had to challenge the decision to ensure the in-patient psychiatrist's original advice was followed. They feel GPs and hospital staff need more training to help them recognise who should be referred to the crisis team so there is no delay for those who need this support. They also think communication between the services on either side of the sectioning process could be improved so those in need receive more seamless support – the sectioning process itself was faultless, but to get to that point was immensely challenging.

Observations and Recommendations

From the information provided in our surveys and our discussions with patients and carers we have made the following observations and recommendations for commissioners and service providers to consider. We have worked closely with TEWV to ensure that wherever possible, the recommendations made are feasible, achievable and can add value to the patient experience.

Patient Survey





Case Study:

W has been involved with mental health services for 20 years, including two episodes as an inpatient. He has used spending and alcohol as coping strategies, struggling with debt and alcoholism as a result. However, mental health professionals for a long time regarded these problems as precursors to his mental health difficulties and therefore did not address them. W feels it was not until he attempted to take his own life that he received the level of support he needed. He feels strongly that health professionals must explain their interventions more clearly so people understand what to expect from different drugs and therapies and how they might end up feeling. He also believes patients should have more choice and flexibility over the counsellors and therapists they work with, as having good rapport with health professionals is key to recovery. He thinks more collaboration between health services and other agencies would also improve patient care.

The majority of people accessing mental health services did so through their GP or another medical professional. The other answers indicated that people made their own referral (sometimes after being given the details by their GP), through their employer/workplace, or after contact with another agency. Self-referrals were largely made by telephone.

Over 75%* of referrals were made by a health care professional, such as a GP.

*** (67 of 88 answers)**

57 people (60%) have accessed mental health services within the last 12 months.

There are ongoing national campaigns to promote early intervention and access to support, the aim being to de-stigmatise and encourage people to talk more openly about mental health. There is a push for more trained mental health first aiders in the workplace and in schools and colleges. Our research from our survey demonstrates that over half of people accessing mental health services have experienced poor mental health for over 12 months, and less than 5% seek help within the (NHS) recommended 2 weeks of experiencing symptoms such as low mood, lack of interest or enjoyment in life and worrying more than normal.

The main concerns surrounding service access appears to be:

- how long it takes for people to seek help
- how long it then takes to start therapy and
- the time it takes for mental health to improve once therapies have started.

Many people we spoke to said they reached 'breaking point' before admitting they needed help.

In addition to this, it was raised that people experience difficulties in finding information on local mental health services. Many reported that they simply did not know where to go for help or information and GP appointments were not always readily available. Information is published by individual organisations and charities, alongside the NHS and local hospital trust, however, there is no single point where the information is readily available with clear details on referral pathways and contacts.

TEWV are working on making self-referral easier with a new website commissioned for March 2019. It is Healthwatch County Durham's recommendation that the launch of the website and production of any other publications, should be done in partnership with other organisations and agencies. Potential service users would not necessarily look to TEWV for help in the first instance and any information needs to be widely publicised in the forums where people look for support; including mental health charities, GP surgeries, social media and other support organisations.

Case Study:

B was prescribed a series of medications by his GP to help with psychotic episodes that left him unfit for work as he could not concentrate. B struggled with this as he felt he had lost his purpose in life but the GP told him it was unavoidable. B says he then began to spend compulsively to try to "buy happiness" and built up large debts. B found a private mental health nurse who prescribed him medication that is not available on the NHS. The medication, together with regular treatment sessions with the nurse, enabled B to retake control of his life and return to work. He can now recognise when he is at risk of relapse and seeks help from the nurse to prevent falling into a downward spiral again. B believes NHS resources are overstretched and feels GPs do not have sufficient knowledge or experience of mental health issues. He says he is lucky he has been able to pay for alternative treatment but that good care should not be a lottery.

In terms of appointments, two out of three were unchanged, leaving one in three being changed at short notice.

Cancellations and appointment changes are often as a result of staff absences and in many cases this is unavoidable. Daily huddles are held by management teams to discuss appointment schedules. If there is staff absence, the caseloads are re-prioritised and patients will either still be seen by another practitioner or, their appointment re-booked for a later date.

TEWV has advised that there is a high level of staff vacancies across the trust, and posts are advertised as soon as possible; this is a national issue that NHS England are aware of. Early intervention and the use of group therapies are seen as a key factor in terms of both efficiency (treating groups of people as opposed to on an individual basis) and effectiveness. Many people that we spoke to feel the group therapies are not ideal as their issues are personal to them and they want their therapy to be on a one to one basis. There is also a perception that group therapy is generalised and compared to sitting and chatting with people as per a social group. More work could be done to promote the content of group sessions and the success rates. Case studies could also be used to promote the successes and recovery elements. This may help people to better understand the therapy and be more willing to engage.

Over half of patients felt that their prescribed therapy was not successful in treating their illness, and over a third of those patients went on to receive additional treatment.

It is believed that this is as a direct result of the 'stepped care' model whereby the lowest level of therapy is prescribed first in line with NICE guidelines, the patient's presentation and clinical assessment. It is acknowledged by TEWV that there is some inflexibility when it comes to a clinician's 'freedom' to prescribe a more intensive therapy in the first instance. However, lower level intervention is more cost effective and treatment is prescribed on the grounds of evidence based intervention and the effectiveness of that treatment.

A number of service users expressed concerns that having completed their initial course of therapy and believing they required the next level of treatment, the assessment guidelines did not render them 'unwell enough' to receive additional therapy. Some patients and carers also told us that they had been advised to 'exaggerate' their symptoms in order to be stepped up on the treatment model. Some patients had also had to experience relapse and a severe decline in their mental health in order to access next level therapy. This occurrence was also supported by staff members throughout our engagement.

TEWV have advised that there is a Relapse Prevention Pathway in place, whereby clinicians and their patients develop a self-management plan at the point of discharge from a service. This focuses on identifying triggers and signs of relapse, agreeing a self-management plan and a self-referral route back into the service, negating the need to return to the GP. In the event that the patient requires stepped up treatment, a comprehensive re-assessment will be carried out to gain a more in-depth understanding of the patient's situation and mental health condition.

Healthwatch County Durham recommends that there should be the flexibility in the model to either permit a clinician to offer additional therapy sessions at the same level or, to have the freedom to use their own clinical judgement (with relevant support) to step up a patient's treatment where necessary. A number of patients told us they felt that some additional counselling sessions on top of the standard eight sessions would have benefited them and possibly prevented a re-referral at a later date. It is understood that lower level therapies are more cost effective, however, the cost of relapse over continuing therapy should not be dismissed.

In terms of waiting times, the majority of the people we spoke to were seen within 12 weeks, with 18% still waiting for treatment after this time. (The national target is 18 weeks).

Patients raised with us that there is very little interim support during the period from referral to staring treatment. In our initial meeting with Talking Changes we were

advised that the emphasis is on self-help and that support is minimal until a patient starts their treatment / therapy.

Healthwatch County Durham would recommend looking at implementing interim support services for patients are waiting for treatment or going through the discharge process. A daily SMS or email offering tailored and practical support and advice, could be a relatively low intensity resource and effective means of keeping in touch with patients. Such messages could be broadly categorised to the patient's condition and scaled down once discharge is complete, and a relapse prevention plan is in place.

Approximately half of respondents are affected by debt as a result of their mental illness. Some patients told us that their illness leaves them unable to work and debts mount because of their inability to pay bills. Others told us that when they are feeling well they tend to spend excessively on family and friends to make up for being ill. The majority told us they received no help or advice in relation to debt.

The mental health charities and support services that we spoke to, advised us that debt has a negative effect on a large proportion of their service users, often exacerbating and the roll out of Universal Credit, is exacerbating the problem.

Healthwatch County Durham would recommend implementing a direct referral route, from the initial assessment, for debt counselling, advocacy services, agencies and/or charities. This would help to ensure that those patients experiencing debt have a full benefit entitlement check as well as advice and support on how to manage their finances.

88% of respondents (84 out of 95) said that they experience problems with their memory and concentration. Some said that they had missed appointments or been late because of a memory lapse.

Healthwatch County Durham would recommend an appointment reminder service, either through phone call, email or SMS; whichever works better for the patient.

When speaking to TEWV we were informed that contact details, other than the patient's address, are not routinely provided by the GP on referral. Therefore, current practice is that an appointment letter would be sent out but not followed up, unless the patient failed to attend, in which case they would receive an additional letter asking if they still require an appointment, ultimately delaying the start of treatment.

We have been advised that there is a new standard referral form being explored that could mean all referrals have full patient contact details included. This would make the referral process more efficient; it would be easier to keep in touch with patients and issue appointment reminders while also reducing the number of missed appointments. Healthwatch County Durham raised that other NHS referrals for other services already have a telephone / SMS reminder service and questioned why this is not the case for mental health services.

Throughout our engagement, we spoke with a number of mental health charities and community support services. The unanimous feeling was that there needed to be a more joined up approach between themselves and NHS services. It is felt that the support services offered outside of the 'clinical settings and therapy sessions' is equally as important as the treatment itself.

The support services are seen by both the service user ('patient') and staff, as fundamentally critical to the success of conventional treatment, and, in relapse prevention. It is widely acknowledged that the pressure on services is ever increasing with demand predicted to increase. However, In many cases it was felt that GP's could have better understanding of the non-clinical support that is available, and how it can add value to patient recovery, overall wellbeing and ease some of the pressure on GP services.

Healthwatch County Durham recommend exploring the appointment of mental health champions within GP practices to raise awareness of additional support services and to signpost/refer patients as appropriate. Where this role already exists, to promote to the wider community.

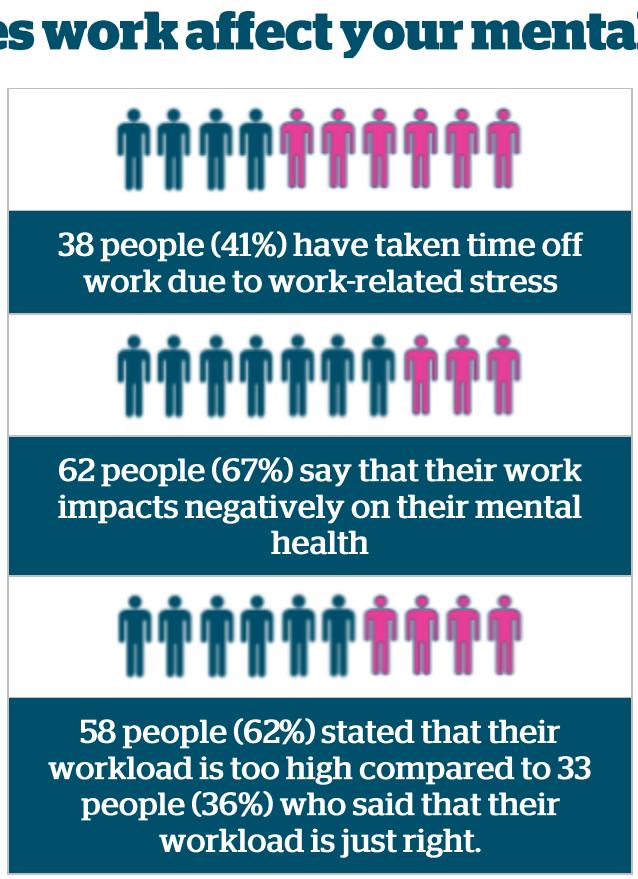
GP practices should use some of their allocated staff training time to engage with support organisations to better understand how the services can complement one another. In addition to this, mental health charities and organisations should be included as part of the annual TEWV GP conference (next scheduled for November 2019).

Case Study:

F is a carer for her partner who has depression and rarely leaves the home. While under NHS care, F's partner had four different care coordinators within an 18 month period, which they feel exacerbated his condition. All the NHS services offered to him have involved a degree of travelling, which has become impossible for him as his condition has worsened. So, for the last four years the family has paid for a private consultant psychiatrist to visit the home each week. The couple are socially isolated and F is concerned about what will happen to her partner should she die or be unable to continue caring for him. F feels health professionals can sometimes be more concerned with their own development than patients' needs and believes there should be more continuity of care as constant changes in the personnel providing care and support can be detrimental to recovery.

Staff Survey

81% (75) of our surveys were completed by NHS staff, the remaining were a mixture of mental health charity / organisation workers with almost half of the respondents reporting that they felt that mental health is not adequately supported in their workplace.



When asked what could be done to improve mental health support in the workplace suggestions included; reducing caseloads, flexible working, listening to staff concerns and more support beyond a phased return to work.

The Trust are currently exploring a new clinical record system (CITO) which aims to make recording clinical notes easier and more efficient. Staff have been involved in the development and the focus is around streamlining the details recorded in order to keep notes to a minimum, without jeopardising care. In theory this will reduce the time spent updating records following appointments, which is currently one of the most time consuming elements for staff.

Another method implemented to improve efficiency is hosting services in hospital / clinical settings (such as GP surgeries) in order to reduce travelling time and therefore

increase the number of patients that can be seen on any given day. It was noted that some staff have shown resistance to have having their time managed in this way.

Some staff reported positive thoughts about mental health in the workplace, there were comments such as 'good support', 'supportive teams' and 'good teamwork' However others stated that mental health in the workplace 'needs more awareness and resources', 'staff need encouragement to access support', there is 'stigma', and that 'burnout from intense caseloads is a problem'

TEWV advised that staff health and wellbeing surveys are conducted and when the results are analysed they demonstrate that non-work related stress can, in a number of cases, manifest itself to the point that time off work is needed and this may be interpreted and/or recorded as work related. Provisions are in place to support staff in trying to identify root causes to absence and assist accordingly; for example, managers are trained in how to recognise traits of someone experiencing domestic violence. It was noted that the annual NHS wide staff survey is done in addition to the Trust's, however, the time it takes to publish the results often leaves the information out of date.

There is a Health and Wellbeing Service available to all staff, it provides access to various services, all free of charge. In addition to this the Trust run a Wellbeing Wednesday Initiative along with regular national awareness campaigns.

TEWV Staff Health and Wellbeing Service
Staff retreats
Chaplaincy support
Occupational health
Counselling
Psychology service
Mindfulness programme

It was noted during engagement with TEWV that a staff wellbeing presentation had been given to all managers and that the onus had been placed on line managers to cascade such information and promote the staff support services within their teams. It was also noted that this 'should be' a standing agenda item for team meetings.

The Trust have a dedicated staff intranet, however, despite all staff having access to PCs / laptops and relevant training, this does not necessarily lend itself to daily working practices. Some staff reported that their jobs do not routinely involve accessing a computer and others that their workload meant that there was little time to sit and look at the intranet etc. Therefore, some staff are missing the messages and promotions that are shared electronically.

Healthwatch County Durham would recommend exploring more inclusive ways of getting key messages to staff. Straplines around support services, wellbeing tips, and awareness raising could be printed onto payslips, guest slots could be included on team meeting agendas for representatives from relevant support services to promote the work and encourage an open dialogue about staff wellbeing and in particular, personal mental health. In addition to this the Wellbeing Wednesday Initiative could be incorporated into team meeting agendas with short mindfulness sessions, or similar activities being incorporated. Promotional materials such as posters could be used in communal areas, however, we were advised that these did not fit with infection control protocols.

Healthwatch County Durham will continue to monitor and collate information on the experiences of patients accessing mental health services. We will continue to work with relevant organisations, and support services to ensure that those who are experiencing poor mental health, have the necessary support and advice needed to improve and maintain their mental wellbeing.

The recommendations made in this report are purposely realistic in terms of achievability. We will continue to engage with TEWV to ensure that wherever possible those recommendations are delivered for the benefit of everyone, including patients, carers, mental health staff and the Trust as a whole.

Appendix 1 – Case Studies

Experiences of local mental health services as shared by individual patients and carers

Case Study #1

G has struggled with mental health since her teens. She has anxiety, depression, and also shows signs of ADHD and compulsive behaviours, including hoarding. She is a mother and her young children witness her mental health difficulties. She has run up large debts due to impulsive behaviours and is reliant on services such as the local foodbank to survive and support her family. She wants help to address her mental health needs but is currently unable to access any support as she is also alcohol dependent. G started to use alcohol as a coping strategy to deal with her poor mental health but mental health professionals see the alcoholism as coming first and will not support her until this has been treated. G has enrolled on an alcohol treatment programme but, because the mental health needs which caused the alcoholism remain, the chances of relapse are high. Interruptions to the programme due to staff illness and holidays also mean the support is disjointed, making it even harder for G to work towards recovery. G thinks mental health assessments need to be more thorough and look beyond the "standard" anxiety and depression so the deeper root causes of behaviours are properly addressed. She believes financial advice and support should be offered to all those with mental health issues as debt is an associated problem for many. G also thinks a single point of access and allocated key worker system would make it easier for people to access the right support, as the number of agencies and professionals can be difficult to understand and could be off-putting for those less confident in asking for help.

Case study #2

Q has experienced poor mental health for most of her adult life. She has a young family to care for and at times struggles to leave the house, which makes even the school run a near impossibility on some days. Q found it difficult to get a referral to the community mental health team and felt that the delay meant her mental health suffered a further 12-month deterioration while she waited, with self-harming, dissociation and suicidal thoughts. Q says she has struggled to stay afloat while waiting for NHS services – with waiting times for higher intensity therapies like CBT and EMDR more than eight months in her experience. She has turned to third sector organisations for support in the interim but has found even some of these have waits of several months. Even so, she describes their support

as the thing that has held her together while she has been waiting to access NHS therapy services. She has especially found a lifeline in the art therapy provided by one local charity. She thinks she was lucky she had the ability to look for the support she needed as information about local organisations is not readily available and can be hard to navigate and understand.

Q thinks support could be offered between therapeutic interventions via text messages, phone calls or emails, to make sure vulnerable people like herself do not feel totally abandoned. She feels one of the biggest problems is not being able to access other support services while on the waiting list for something – her counselling sessions were stopped as soon as she was on the waiting list for EMDR, which led to a severe decline in her mental health. Q also thinks medical notes should be accessible to all healthcare professionals as in her experience the first 15 minutes of each therapy session is spent updating professionals on information that could have been read in the history; this reduces actual therapy time and it can be traumatic to repeat things.

Case Study #3

H has experienced behavioural and emotional difficulties since childhood due to trauma and abuse. As a child, the mental health support he received was not consistent. Periods of therapy were followed by sudden breaks in support, on one occasion purely because of differing funding policies between local authorities. H has also struggled to get the right support from adult services. His carer says having to go through his case history during appointments brings up all the unresolved emotions from his childhood experiences but these are not addressed or treated.

During a psychotic episode, his carer phoned the crisis team 15 times in a single night but nobody responded to the calls. His carers knew that he was at risk of hurting himself and others, if not worse. He was eventually referred to the psychosis team following sectioning under the Mental Health Act but even this wasn't simple: initially an appointment was sent for a consultation with an entirely different team and H's carers had to challenge the decision to ensure the in-patient psychiatrist's original advice was followed. They feel GPs and hospital staff need more training to help them recognise who should be referred to the crisis team so there is no delay for those who need this support. They also think communication between the services on either side of the sectioning process could be improved so those in need receive more seamless support – the sectioning process itself was faultless, but to get to that point was immensely challenging.

Case Study #4

W has been involved with mental health services for 20 years, including two episodes as an inpatient. He has used spending and alcohol as coping strategies, struggling with debt and alcoholism as a result. However, mental health professionals for a long time regarded these problems as precursors to his mental health difficulties and therefore did not address them. W feels it was not until he attempted to take his own life that he received the level of support he needed. He feels strongly that health professionals must explain their interventions more clearly so people understand what to expect from different drugs and therapies and how they might end up feeling. He also believes patients should have more choice and flexibility over the counsellors and therapists they work with, as having good rapport with health professionals is key to recovery. He thinks more collaboration between health services and other agencies would also improve patient care.

Case study #5

B was prescribed a series of medications by his GP to help with psychotic episodes that left him unfit for work as he could not concentrate. B struggled with this as he felt he had lost his purpose in life but the GP told him it was unavoidable. B says he then began to spend compulsively to try to "buy happiness" and built up large debts. B found a private mental health nurse who prescribed him medication that is not available on the NHS. The medication, together with regular treatment sessions with the nurse, enabled B to retake control of his life and return to work. He can now recognise when he is at risk of relapse and seeks help from the nurse to prevent falling into a downward spiral again. B believes NHS resources are overstretched and feels GPs do not have sufficient knowledge or experience of mental health issues. He says he is lucky he has been able to pay for alternative treatment but that good care should not be a lottery.

Case study #6

T has had difficulties with her mental health for a number of years. She identifies the death of a relative and breakdown of a relationship as the catalysts for these problems but has never been offered any treatment other than anti-depressants. She has not been able to hold down a permanent job because of repeated episodes of sickness due to mental health and has built up significant debts. She feels GPs have a limited understanding of mental health and that medication is an easy way for them to "get rid" of patients like herself and avoid digging deeper into the root causes of people's problems.

Case study #7

F is a carer for her partner who has depression and rarely leaves the home. While under NHS care, F's partner had four different care coordinators within an 18 month period, which they feel exacerbated his condition. All the NHS services offered to him have involved a degree of travelling, which has become impossible for him as his condition has worsened. So, for the last four years the family has paid for a private consultant psychiatrist to visit the home each week. The couple are socially isolated and F is concerned about what will happen to her partner should she die or be unable to continue caring for him. F feels health professionals can sometimes be more concerned with their own development than patients' needs and believes there should be more continuity of care as constant changes in the personnel providing care and support can be detrimental to recovery.

Case Study #8

X has struggled with work-related stress and depression for several years, which has resulted in him needing time off work. He feels better when not at work and relapses when returning. The support he has received from occupational health at work has been minimal, with the disciplinary procedure for frequent episodes of sickness being specifically highlighted to him. X has seen his GP who prescribed antidepressants and advised him to find a new job, however, as yet he has not managed to secure different employment. X accepts there is a limit to what GPs and health professionals can do for patients when the cause of their difficulties is work based. However, he feels antidepressants are an "easy option" and more input from care coordinators combined with more support from employers would be a more successful way to help people in his position.

Case Study #9

P first accessed mental health services several years ago. He has long-term conditions that impact on his mental health and has tried to take his own life on two occasions. For two years he had the same mental health support worker and team. He feels this was crucial to maintaining an equilibrium in his mental health. However, the funding for this support ended after two years and nothing was offered to replace it. P was re-referred to the original service by his GP but this referral was rejected. P's mental health has since declined. P believes continuity of care and consistency of support staff is crucial for people with mental health needs as it allows time to build trusting relationships, which are key to recovery. He says it also avoids people having to endlessly repeat their story to each new member of staff, which can be upsetting as well as eating into therapy time.

Case Study #10

M has been accessing mental health services for around a year but says she has already given up asking for advice and feels she will never get better. An "urgent" check on her welfare took three weeks to be carried out and the crisis team would not support her, despite her being incoherent and inappropriately dressed when she approached them. She has been told to "exaggerate" her situation if she wants them involved. She says some days she can't make treatment appointments because it just feels "too much" and she has even considered taking her own life as she can't see another way out. M says there needs to be better coordination and collaboration between the different agencies involved in supporting people with mental health difficulties as advice about where to go for help can be conflicting. She also feels there should be more support and advice for relatives of people with poor mental health and that there should be more recognition that people's problems will sometimes mean they struggle to make their appointments.

Case Study #11

R is a carer for someone with poor mental health and has also accessed the Talking Changes service for her own mental health needs. She says it took four months to get a face-to-face appointment with a Talking Changes support worker after the initial telephone assessment and that there was no contact with any support worker in that period. R feels the service is so overstretched that if somebody says they are "fine" this will just be accepted as it is seen as an easy way to reduce workload. She thinks that relatives and carers could sometimes give professionals a more realistic picture of how someone is managing in case they are putting on a front. She also believes there should be a way for people to admit themselves for inpatient mental health treatment without being sectioned due to the stigma often associated with this process.

Case Study #12

J works for an NHS mental health service. When she realised workload and work pressures were causing her own mental health to deteriorate she was tempted to cover it up for fear it would harm her career prospects. However, it became clear that carrying on without any support would not work and she decided she must tackle her difficulties or face a mental breakdown. It took her six months to build the confidence to confide in her line manager but when she did she received immediate support. This included a supported visit to her GP; time off

work; counselling; occupational health input and a phased return to work. J is grateful for the support she received from work once her line manager was aware she needed help but thinks better supervision might have identified workload as an issue sooner. She also feels it was only because she was ill that her concerns about workload were taken seriously as she had tried raising them before. She thinks she gained quicker access to services because she works in the field and while she is very thankful she got the support she needed without waiting she does not feel this is fair.

Case study #13

A has experienced depression since becoming a father. He went to see his GP who prescribed antidepressants, which leave him unable to safely look after his children. He asked his GP for additional help but this was declined. He then visited other GPs but their only solution was to offer different medications. A was not aware that he could self-refer into the Talking Changes service until he spoke to Healthwatch County Durham – none of the GPs gave him this information. A is worried that if his condition worsens he may not be able to work and then the family would not manage financially. This anxiety is making his mental health even worse. A has not told his partner or any of his relatives or friends about his diagnosis as he feels like a failure. He feels GPs do not have time for people's mental health problems and so they are dismissive of them. He thinks there should be more support for new dads and self-referral pathways into mental health support services like Talking Changes should be publicised more.