



Newsletter

**The Stein Centre
St Catherine's Hospital
Birkenhead CH42 0LQ
Tel 0151 488 7708
E-mail family.tree@cwpa.nhs.uk**

Feb 2011

Volume 7 Issue 1

Inside this issue:

Notes from the meeting with Sheena Cumisky	2
Not only but also	2
Treading on eggshells	3
Wirral Future Consultation feedback	4

Apologies for the weightiness of this newsletter but there really has been a lot going on that we needed to report to you.

As a result the Family Tree programme from February to Easter and booking forms have been put together in a separate section at the back of this edition.

Fernleigh



A meeting was held at Fernleigh respite centre on Monday 17th Jan. Most of those present were service users with some carers and some professionals. Fernleigh currently provides respite for around 130 people with severe mental health problems, usually for around 3 days at a time. It gives them somewhere to go that is quiet and restful, where they get support from staff and other residents who understand them. Many said that being able to go into respite when they need it has kept them out of hospital for years. It also gives their carers a break.

Those present were told by Peter Tomlin from Wirral Department of Adult Social Services that following the consultation with Wirral residents (see p 4) the council had taken the decision to stop providing services directly and to become a commissioner/buyer of services from other organisations in the private, independent, voluntary or faith sectors.

As a result Fernleigh would be closing before 31st March (final date not decided yet). Staff had been offered either early retirement or redeployment. All those who currently receive a service would be interviewed by their CPN and given the opportunity to discuss what they wanted in terms of respite in the future. If they wanted a personal budget this could be used to pay for their respite.

There was a very strong feeling in the room that they didn't want Fernleigh to close but if it had to, then they wanted a very similar model to be provided elsewhere.

Fernleigh also has four crisis beds, with an average occupancy of two. The proposal here is to buy a two-bedded property in the community where the crisis team will also be based overnight. The local authority don't think it is right to have crisis and respite beds together but there was strong feeling in the room against that. People often moved between the two as their condition changed and to have to move to another building was felt to be too disruptive.

One of the main concerns was the speed of this closure and great anxiety that there would be a gap in respite care before new arrangements could be put in place.

Users of the service were told that they would get further information in the next two weeks.

Family Tree and Wirral Mencap have sent a letter to all elected representatives expressing concerns about the effects the closure of respite homes for people under 65 will have on service users and their carers.

The NW launch of the Triangle of Care

The triangle of care is the model of working which is being adopted initially in acute hospital settings and crisis services. It means that the patient, the carer and the professional are partners in the care team. This should mean more direct involvement of carers and better relationships between carers and staff.

Carers and service users are needed to take part in three groups to plan how this is going to be implemented in CWP. The groups will focus on confidentiality, training and advanced statements. If you would like to get involved or for more information please contact this office or Josien Harmens on 482 7656

Summary of Discussion between members of the Family Tree and Chief Executive Sheena Cumiskey on how CWP can improve partnership working with carers

- Requirement for single number for 24/7 response in a crisis; current number linked to GP out of hours service is not effective.
- Named person within CMHT not always known, particular issue when someone moves house and therefore team.
- Not always a good understanding from the care co-ordinator of role of carers within care plan.
- Suggestion that there are other models of care e.g. family therapy and in particular work funded via Family Tree.
- Need to ensure all staff use triangle of care principles in sharing information appropriately with carers, this would make a huge difference, currently this is not consistent. (see p 1 if you want to get involved in this)
- Concerns about GP commissioner knowledge of mental health. There is a huge opportunity for an “invest to save” scheme by GPs being able to signpost carers to support.
- Mental Capacity Act – application needs to be improved as it is integral to assessment.
- Concern on the impact of changes to Assertive Outreach Team. Need to ensure this involves carers.
- Concern about potential push/pull social service and health in relation to responsibility for care and funds.
- Understanding of eligibility criteria. Need better involvement from perspective of carer.
- Telephone access to crisis service e.g. issue of if been drinking post midnight – do people come out?
- How well do professionals engage with carers both commissioners and providers?
- Need to ensure implementation of triangle of care.
- Senior leadership role is making change happen.
- Need to ensure implementation of John Boyington report.
- Carers advice needed in potential solutions e.g. single point of telephone call.
- How do we ensure services work with carers?
- Respite services Fernleigh. What is the future?
- Communication of service changes – Engage magazine doesn't do well enough.
- Financial value of carers to health and social care. Vital we work in partnership.
- Need to be able to identify who carers are appropriately. Use of definition in triangle of care.
- Training and knowledge to support carers, opportunity to share with carers.
- Some carers do unfortunately become service users e.g. impact of social isolation.
- Potential positive effect of positive care coordinator - when it works well it is very positive.
- Issue of personalisation—is it understood?

Not only but also

We have now had the last two of these sessions. Firstly we covered issues for carers who had extra issues themselves such as caring for more than one person or being a service user themselves. Then we looked at the problems associated with caring for someone who doesn't accept that they have a problem. The last session looked at caring for someone who had experienced domestic and/or sexual abuse and issues for people from ethnic minorities or the gay, lesbian and transsexual community.

Carers who are also service users reported that being a carer did affect their own mental health and it wasn't always taken into consideration during assessments. Carers who cared for more than one person were sometimes caring for people with different problems. Appointments were difficult to manage, social life was affected and money was an issue.

Carers of people who didn't accept they had a problem felt particularly vulnerable. If the person you care for isn't in the system then you don't get support either. Some felt at risk physically. They also felt they weren't listened to even when they are the only people who can alert someone that the person they care for is deteriorating. It was felt that in these circumstances professionals should take more time and be very patient in trying to persuade the person that they had a problem.

Those caring for people who had been domestically or sexually abused felt that unresolved issues about the abuse still affected their mental health and usually pre-dated their mental health problems. Things shouldn't be swept under the carpet but dealt with.

Unfortunately there was very little response to the last half of that session for minority groups but we do know some of the problems from previous contact with carers from those groups. These include the lack of culturally appropriate services, especially where the person being cared for doesn't speak English. Those from the lesbian, gay and transsexual community may feel awkward meeting socially with other carers who they feel may not understand.

Carers wanted to discuss the issues raised in this series of discussions with professionals from health, hospital and social services and other relevant agencies.

This has been arranged for Monday 21st February 10.00 -12.30 at St Saviour's Parish Centre.

Panel members include representatives from CWP, drug and alcohol services, crisis and home treatment team and Social Services.

Although this is mainly for those people who came to one or more of the sessions anyone else who is interested is very welcome to come along.

Treading on Eggshells Mick McKeown University of Central Lancashire

Mick started by setting the scene and talking about research that has been done with carers across the board asking what they really needed. The results were, not surprisingly

Information

Support – both physical and emotional

Involvement

He then went on to talk about Psycho-Social Interventions which include Talking Therapies such as CBT and Family Intervention There is evidence that these and Medication all work for some people for some of the time but not for all people all of the time.

There are some political and monetary constraints. Training in talking therapies and FI is costly up front but may have longer term gains. Most of the funding for research into mental health conditions is done by drug companies so they have a vested interest.

The Camberwell Project did some research where they interviewed families for four hours and measured the number of times a particular form of behaviour was noticed. They identified several types of behaviour demonstrated by carers and family members which were likely to lead to the relapse of the service user.

These were

Criticism – needed 6 incidences

Hostility – (arguments, tension, nagging) only 1 incidence needed

Emotional over involvement (doing everything for someone instead of letting them do it for themselves)

Self-sacrificing e.g. giving up work, stopping going out with friends, not being able to talk about the situation without getting upset.

Family Intervention is designed to help people with these issues by helping them to explain why they get to the end of their tether.

One way of explaining why some people experience acute psychological distress is to look at the stress vulnerability model. This shows life as a series of waves with some higher peaks which relate to major lifetime events. Whether someone succumbs to such events will depend on where they are on the scale of vulnerability. How vulnerable someone is can depend on their experience of trauma (physical or emotional), on genetics, on brain chemistry (e.g. the effects of drugs and alcohol) and on brain injury.

A study in Buckinghamshire developed a model of Family Therapy. Based on psycho-education this is very specific to the family and looks at what is working and changes and develops what isn't. It is all around communications and relationships and depends on people being able to sort out their problems themselves by working through them.

What goes wrong is understandable because of normal human relationships but where there is a severe mental illness the family may need to focus on doing things differently and counter-intuitively.

The programme has several strands

Paying positive attention to people

There should be a focus on the positive things, however small that a person does. This will not necessarily change things in the short term but will in the long term and will make the carer feel better.

Making positive requests – this is the antidote to nagging.

Being really clear about what you want done and how it would make you feel. Make the request realistic for the level of mental health problems / medication (for example if someone is staying in bed until 5 pm it is unrealistic to expect them to get up at 9 am but to work towards 2 pm would be more realistic).

Expressing negative feelings but avoiding arguments

Keeping calm can be very difficult but families need to have a way of expressing negative feelings.

Explain how something makes you feel and ask for suggestions as to how it could be improved.

Negotiation doesn't work if you are shouting.

Have to be clear what you want but it has to be something the person can deliver. For example, if the person you care for thinks you are poisoning them with medication the carer could respond by saying "it really upsets me when you say that". It is not the time for a logical conversation in the heat of the moment but could use logic later on in calmer moments.

(Messages about the efficacy of medication in general are better coming from professional rather than the family)

People can become trapped in a pattern of stressful behaviour because they are only ever seen as those who cause arguments and stress in others. By using the above techniques they may gradually change and see themselves in a more positive light.

Mick then looked at the factors that are likely to lead to a relapse

1. Medication helps prevent relapse where there is high expressed emotion down to 51 % from 92 %
2. Medication has little effect where there is low expressed emotion 15% down to 12%
3. There is something protective about spending less time with people
4. A nine month study showed a 0% - 8% relapse rate for those who stuck with Family Therapy for that period of time.

When people are expressing bizarre beliefs or paranoia – don't agree with the belief but accept that they believe it.

CBT leaves the core beliefs alone but looks for evidence to undermine what they are believing. By listing alternative explanations (either the therapist or preferably the person themselves) this doesn't affect their emotional security.

Beliefs are often linked to lack of self-esteem. Paranoia shows to the person concerned that if people are spying on them then they must be important

CBT is not a magic bullet – it's a slow crawl.

Wirral's Future - Be a part of it.

Wirral Council's consultation with residents of the borough ended at the end of Oct 2010. There were four areas covered, Living in Wirral, Economy and Regeneration, Children and Young People's Services, but the one that is of most relevance to us is Adult Social Services.

There were 6 questions in this section, the (shortened) questions with the results and recommendations are below.

Question 1 Should the Council stop directly providing care services in people's own homes and residential respite care (*Fernleigh for mental health—see p 1*) and buy them in at the same quality but at a lower cost from the private and voluntary sector and others?
48.8% yes 36.5% no and 14.6% no strong opinion.
More detailed investigation is required before any proposals are made.

Question 2 Should the Council make a small charge for the technology that is provided to enable people to remain independent in their own homes?
63.5% yes 23% no 13.5% no strong opinion
Broad agreement but with the proviso that charging is linked to people's ability to pay.

Question 3 Should the council reduce the amount it pays to private care homes to bring it into line with neighbouring areas?
58.9% yes 23.4% no and 17.8% no strong opinion
Broad agreement with the need to maintain standards and quality of care and focus on value for money.

Question 4 Should the Council work with voluntary organisations and community groups to provide help with everyday tasks such as washing, dressing and shopping to people with substantial needs?
65.9% yes 24.4% no and 9.6 % no strong opinion
The need for the Council to retain responsibility for monitoring. The need for the Council to provide help to the voluntary and community sector to deliver services including training and financial support.

Question 5 Do you agree that the Council should continue to fund Day Centres for people with learning difficulties until more people choose to stop using them?
79% yes 9% no and 12% no strong opinion
Strong support for this proposal (but it only talks about day services for people with learning dis

abilities not mental health even though services are becoming more integrated)

Editor's comment This is very much linked in with the personalisation agenda—with more people from all groups being offered personal budgets there is the strong possibility that Day Centres won't be viable in the long run because not enough people will choose to use them and those that do want to will then no longer have that choice.

Question 6 Should the Council charge more for domiciliary services to bring it into line with neighbouring authorities?
45.5% said yes 36.6% said no and 15.9% had no strong opinion
This recommendation needs further work on means testing before being taken further.

As well as ticking boxes there was the option of adding comments. As you can imagine there were a lot of these (200 pages on this section alone—if you want to read them all - and the report on the other areas of interest go to www.wirral.gov.uk)

There were however some very strong themes which emerged from the comments and these were

- Whether it would be possible to maintain the same level of service if it was provided by others at a lower cost.
- The importance of regulating and monitoring service standards and quality
- The importance of protecting vulnerable people
- The need for the Council to deliver services cost-effectively
- The need to consider whether people can pay
- The benefits of supporting people in their own homes rather than in residential accommodation
- Understanding why Wirral is currently paying more than neighbouring areas
- The need to support voluntary and community groups properly
- The ability of voluntary organisations to meet demand.

Plus comments specifically about the importance of day services in delivering positive outcomes for service users and making sure they are accessible and cost effective.

The Adult Social Services Task Force made some recommendations based on this consultation which went to Cabinet on Dec 9th 2010

Family Tree Mailing List

Please **remove** my name from the mailing list

Please **add** my name to the mailing list

Name

Name

Address.....

Address.....

.....Post code.....

.....Post Code

Tel No.....

Tel Noe-mail