Shared Future
A Community Interest Company

The West Midlands Mental Health Commission:

Open Space Listening events

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Acknowledgements

Thank you to all those that attended the open space listening events and enthusiastically shared their experience and opinions in the hope that their efforts will make a genuine difference. Thanks also to Ajaib Paul and his team (including Maren Lilley) at Dudley Council who worked so hard to promote the events and deal with the tricky task of handling registration in an efficient and effective manner. Also, to all the convenors at the events who responded to the report author's requests to check the content.

About the authors

The recommendations produced by the participants of the open space listening events are reproduced here wherever possible in the words of the participants. The remaining content was written by Peter Bryant of Shared Future.

About Shared Future

We are a community interest company with associates based across the UK. Our aim is to provide an excellent service that makes a difference to communities and individuals and works towards a fairer, more equal society. Our mission is to move those we engage with towards greater individual and collective authority and autonomy, by supporting their ability to act wisely, confidently and in community with others. Since setting up Shared Future in 2009, we've built a team of experienced consultants and practitioners with a diverse range of skills. We work together on worthwhile and stimulating projects that reflect our personal values.

www.sharedfuturecic.org.uk

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1. Introduction

This report is a record of a series of three listening events commissioned by the West Midlands Combined Authority for the West Midlands Mental Health Commission. The events held in spring 2016 were an attempt to enable stakeholders from the region's mental health system to influence the deliberations of the Commission.

The Process

The events were publicised across the West Midlands. Stakeholders from organisations who consider themselves part of the mental health system were targeted as were people with lived experience.

The listening events were held on:

Tuesday 26th April: Coventry *Central Hall: Lower Hall and Eadon Hall 13:30-17:00*

Friday 29th April: Dudley *Town Hall: Main Hall: 13:30-17:00*

Tuesday 3rd May: Birmingham *BVSC: 13:30-17:00*

Those interested in taking part were invited to register on the West Midlands Combined Authority website. Each event had a capacity of 80 people. 219 people registered and a total of 125 attended (Birmingham 42, Dudley 45, Coventry 38.)

The aim of the series of three events was primarily for people to be able to tell the West Midlands Mental Health Commission what they think they should hear. Large public engagement events such as this are often problematic, all too often they consist of a series of presentations followed by a question-and-answer session which is dominated by people who feel eloquent and confident enough to do so. The aim of these events was to try to do something different. In order to achieve this the tried and tested 'Open Space' methodology was used by the facilitators.

Using this approach participants are invited to decide the topics they would like to talk about and then to form small discussion groups based on these topics. Members of the mental health commission

What is the West Midlands Mental Health Commission?

The West Midlands Combined Authority commissioned research in to mental health and its impact on the public sector. The commission is examining evidence from the West Midlands region and beyond including people with mental health experiences, as well as the professional mental health practitioners and mental health organisations.

The commission is chaired by Norman Lamb MP, former minister of state for care and support. The commission has identified the following key areas of enquiry: employment and housing, early intervention principles, criminal justice/troubled individuals, the role of employers and primary care.

The Commission will make recommendations to Government and Combined Authority on:

a) How public services can be transformed to reduce impact of poor mental health and wellbeing, within resources.
b) How resources currently spent on mental ill health can be re-directed to keep people mentally well and enable recovery.
c) Potential for, and content of, a 'devo' deal for mental health and wellbeing.

The commission aims to a) Assess the scale of mental health problems in the West Midlands and their cost and impact across the whole system, b) Examine best practice elsewhere nationally and internationally in both health and other service areas c) Establish the relative costs and benefits within the whole system of the application of this best practice to the West Midlands.

The Commission is expected to launch its final report and recommendations in September 2016. For more information visit

https://westmidlandscombinedauthority.org.uk/what-we-do/commissions/mental-health/

were present at each of the events (see appendix x for a full list of commissioners).

In Birmingham the event was attended by Paul Anderson, Steve Shrubb, Steve Gilbert, Norman Lamb and Chief Inspector Sean Russell (member of the MHC Steering group). In Coventry the event was attended by Prof Swaran Singh and Sarah Norman (MHC supporting officer) and in Dudley the event was attended by Steve Gilbert and Sarah Norman. Each event was facilitated by three members of the Shared Future facilitation team (Peter Bryant, Nick Beddow, Laurie Smith, Jenny Willis).

The Open Space methodology

Open Space can be described as an approach for working with large groups which enables the participation of all those who have an interest in an issue to talk about what they want to talk about. Open Space emerged internationally after a realisation that some of the best conversations during a conference happen during the coffee breaks, when people decide to talk about what they want to talk about, with people they want to. Open Space is an attempt to formalise this. Everyone is invited to think about an issue or question that they would like to start a conversation about, that will help to answer the over arching question. Those that want to volunteer to start the conversation (the convenors) write their issue/question on a piece of paper which is then slotted into the blank agenda on the wall. Throughout the meeting space there are a number of clearly labelled spaces where the conversations can take place. Once the agenda is full everyone moves to whichever conversation they want to start with, they are free to move between discussions.

The event started with a brief presentation from one of the Commissioners explained the aims of the events and what will happen next. At each event members of the mental health commission's citizens jury made a brief presentation explaining what they had found out so far and what they plan to do next.

Participants were then invited to go into small groups to answer the question 'what do members of the West Midlands Mental Health Commission need to hear?' before being introduced the Open Space approach.

Those present were invited to think of an issue they would feel happy leading a small group discussion on that helps to answer the following overarching question:

'How can public services be transformed within current spending limits to build well-being, keep people mentally well and reduce the impact that poor mental health and well-being have on public services, the economy and communities in the West Midlands?'

Volunteer convenors were asked to come up with conversation topics, to write them on a blank piece of paper and place them on the blank agenda on the wall. Participants were offered the opportunity to identify up to 16 different topics of their own choosing. Specific spaces were made available for the discussion groups around the venue and participants were offered two slots of 45 minutes each in which to host their discussion groups.

This approach ensured that people were able to decide exactly what they would like to speak about. The convenors responsibility was firstly to start the conversation secondly to record elements of the conversation on a flipchart and thirdly to remain with the group for the duration of the 45 minute round. Everybody else was free to move between whichever groups they chose visiting as many or as few as they desire. The Commissioners (and supporting offices and steering group members) also toured the groups to hear the discussions firsthand.

Each group was asked to write an absolute maximum of three recommendations. It was stressed that these should be concise and clear.

Over the three events 37 topics of conversation were identified by participants, 12 in Birmingham 14 in Dudley and 11 in Coventry.

The following part of this report lists all the small discretion group recommendations. The result is some 107 recommendations. There is great overlap between many of these. In an attempt to make this valuable information easier to process we asked members of the citizens jury to vote on their priority recommendations. Each citizens jury member was given 10 votes. The full list of their prioritised recommendations is in appendix 1.

The Mental Health Commission's Citizens Jury

Starting in April and finishing in May 2016 the Citizens Jury ran parallel to the commission's open space listening events.

The jury, made up of 15 people with lived experience from the West Midlands, was an attempt to ensure that the experiences of people with mental health problems were always at the forefront of the deliberations of the commission.

Over one hundred people applied to take part in the process. The diverse group of jury members met over eight sessions to attempt to answer the question:

'How can public services be transformed within current spending limits to build well-being, keep people mentally well and reduce the impact that poor mental health and well-being have on public services, the economy and communities in the West Midlands?'

This deliberative process enabled them to learn from each other's experiences and opinions as well as cross-examining a series of commentators before reaching a set of prioritised recommendations.

Three or four members of the jury attended each of the open space listening events.

The process used, the expert witness commentaries and the Citizen Jury's recommendations are documented in the Citizens Jury report available from the West Midlands Combined Authority website.

2. Discussions and recommendations

The following section of this report attempts to summarise the work of each small discussion group at the three events. Each discussion group topic is identified by a letter. The text below each topic is a summary of the conversation that took place in each group. Finally the group's recommendations are listed.

The author has attempted as far as possible to be true to the work of each group. During the production of this report the summary of each group's conversation and recommendations where possible, have been checked back with the convener by email. Unfortunately we were unable to reach all group convenors.

Birmingham

A. Build well-being – what does that mean? What determines it? How do we do it?

We need to be clear what well-being actually means and what determines it. One can have a mental illness and still have good well-being and vice versa. We need to use more positive language and to normalise mental distress.

We need to consider the determinants of well-being; (housing, employment, relationships, sense of belonging etc.) and build resilience (so that people are better able to deal with whatever hits them). We should remove the time limits for treatments and give people an ability to make choices and develop a sense of control. Future changes need to recognise it's not all about the money, we need to join stuff up (e.g. housing, employment, peer support) and support the grassroots by examining what is already working, why it is working and what is the learning. We need to raise awareness of wellbeing amongst front line staff. One approach is to use the New Economics Foundation 5 ways to wellbeing to start people talking about wellbeing, how it relates to them and how they can promote it.

Recommendation 1: recognise the importance of staff well-being. Our own well-being affects how we treat others.

Recommendation 2: invest in building resilience especially amongst children, young people and those at risk.

Recommendation 3: move away from the medical model for well-being and increase awareness of well-being across all agencies especially those working at the frontline.

Recommendation 4: in promoting well-being don't only talk to the 'usual suspects'. Find out what local groups have already done/are doing and build on it/learn from it.

B. Early Intervention: emotional resilience and well-being of young people and children.

We need to build a strength-based model, that is multiagency and is a holistic approach. We need to develop emotional resilience amongst parents and young people and work with our communities to challenge stigma. We need to focus on concepts such as well-being, resilience, self esteem, self-actualisation and mindfulness.

Recommendation 5: Embrace the 'open dialogue' approach (pioneered in Finland and now used in some NHS trusts.)

Recommendation 6: support a two-day training course for parents/carers whose young people are accessing mental health services.

Recommendation 7: invest in mental health first aid for communities, schools, professionals (midwives and health visitors etc).

Recommendation 8: Embed well-being and resilience throughout the curriculum.

Recommendation 9: Ensure a) parents (via places such as Childrens Centres, Sure Start etc) b) professionals (midwives, teachers etc) are educated, skilled up and informed on child development

C. Why do services not apply the feedback they receive from sessions like this?

There is concern that the motivation for sessions like this is not real ('ticking boxes'). Agencies seem blind to the fact that spending money today on effective engagement will save money tomorrow. Engagement will seem superficial to service users/carers unless action is taken as a result. Consultation should be wider and offer access to those who work and BME groups. There should be explanation back to the groups why things haven't been implemented. There seems no accountability for taking action. GPs also get funding for consultation but it is mostly wasted. There is often a lack of thanks for what happens next, this freezes people off and they walk away. Staff at the grassroots have ideas too but higher ups don't welcome it. This all applies not only to providers, but to Commissioners, social care etc.

Recommendation 10: In whatever body is set up to implement the recommendations of the MHC there must be a champion for rectifying inequalities in mental health need and provision as per the "5 year Forward View for Mental Health" document. Use the recommended champion for inequalities to help move this forward. This should be someone with undeniable 'clout'.

Recommendation 11: Encourage a re-launch of QIPP [1] as the essential goals of service improvement and quality seem to have gone off the boil recently.

Recommendation 12: Need to involve front line workers in how to implement things and make change happen (from grass roots up, not exclusively from top down).

Recommendation 13: Ensure the obviously desirable opportunity for teams that are considered to be 'weak' to exchange visits with those that are regarded as 'excellent' are exploited to the full

D. Barriers and the culture of 'no'

We need person centred care with people having an equal voice in care. We are focused on risk aversion, people thought of as a risk. Professionals need support and nutrition ensuring that they all have what they need to be well. Professionals often feel under pressure to 'move on' against their better judgement. Voluntary services have less of a culture of 'no'. Services can often seem 'tribal' (i.e. my service, my criteria, instead of responding to the individual).

Recommendation 14: We need an open approach – We don't want to hear "we can't do it 'cos that's how it is".

Recommendation 15: Services need to be flexible and tailored with different people working together in partnership. We need a combined person centred service: physical/mental health/housing. People need continuity (people knowing people) and to be given a 'menu' of what's available so they can choose for themselves rather than having choices made for them.

Recommendation 16: There should be a seamless flow of information (using common language) – trusting that your information is being treated well and will be responded to. People should only need to 'tell my story once' with this then being rolled out across health, social care etc. a 'maternity notes' approach.

E. How can we improve employment opportunities?

There needs to be a focus on person centred recovery; tailored support, that is all about the individual and is ongoing (whilst employed). One to one support with coaches should be available. We need to raise aspirations (what you can do, not what you can't do). Peer support that inspires others is important. There needs to be more support from the DWP when looking for employment.

Recommendation 17: Employers need Mental Health First Aid Training and a quality standard in

[1] ***QIPP*** *stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS.*

Mental Health training and support should be introduced and branded.

Recommendation 18: meaningful work is very important, we need a phased introduction into work with flexible benefits going into and out of work.

Recommendation 19: mentors should be available to all employees.

Recommendation 20: we should work with employers in designing recruitment strategy not just in interviews.

F. NHS staff have mental health issues too – how do we support them?

We need to make sure we listen to staff as individuals (not as part of a rulebook culture). Staff should be encouraged to come forward with agreed levels of anonymity. There needs to be recognition of management ability (or the lack of) to understand and deal with situations. Line managers need to be given opportunities to increase their awareness and up skill. There needs to be ongoing two-way dialogue between staff and management/decision-makers. If we don't tackle small problems in a proper manner they can grow into big problems.

Recommendation 21: Harness those with passion, skill and expertise to help, support and develop others.

Recommendation 22: Support NHS staff that have mental health issues through encouraging self-help and awareness, offering peer support at all levels, providing flexible and open services and the use of counselling supervision skills during supervision.

G. Making more use of community assets to support people

We need to make sure there are affordable and accessible places for community groups to meet. Good communication between people and groups should enable people to know what's available. There needs to be a focus on places where people go regularly. Mental health first aid training is important and should be built into the Birmingham Business Charter. There should be investment in developing a train the trainer package.

Recommendation 23: Explore the potential for funded services to subsidise/ offer free space to community groups + advertising. e.g. Along the lines of the Edgbaston Well Being Hub, Birmingham LGBT.

Recommendation 24: Look at the potential to apply models like the Local Area Coordination to connect those with mental ill health to community groups & services.

Recommendation 25: Implement Mental Health First Aid training or another recognised model in a wide variety of community settings so that people know how to respond appropriately to people with mental health issues e.g. libraries, faith groups, railway staff, bus drivers.

Recommendation 26: Create a series of 'safe zones' where people with mental health issues can go when they don't feel safe – could be anywhere from shops to railway stations e.g. Wetherspoons.

Recommendation 27: Get members of the public to nominate places that are mental health friendly and those need more training.

H. First contact: the initial contact should kick-start a holistic assessment, not merely a diagnosis of mental health.

Help needs to be person centred/client/service user led. Users/people having to repeat their story is akin to institutional abuse, when victims of sexual abuse have to relive the story for others.

Recommendation 28: All services to adopt a new principle, called 'First Contact' whenever anyone makes contact with any relevant service, it should kick-start a full client-led assessment of all their needs. This holistic assessment should: A) reduce the need for their story/history to be repeated (either via patient centred notes, via a trusted first assessment, picture book). B) Ensure that the person is referred to any and all services to help with the aspects of their life that are/maybe adversely affecting their mental health, housing, finance, physical health, domestic violence etc. All relevant professionals need FC initiative training and accountability. First contact should not only be for people in crisis and it should build on similar concepts such as Every Contact Counts.

I. Interaction between mind and body

The mind and body needs to work in harmony. We need to promote a holistic approach that gives people a chance to come together and this should be service user led. Such support work is cheaper than a consultant! Being part of peer support can be the key to recovery, providing hope and confidence for the future. Yoga helps connect the mind and the body, Zinnia is an example of good practice for social inclusion and well-being and could be replicated elsewhere, make friends with the library (books are the key to everything). Coercive intervention should stop. Cooperation instead of competition can save psychological and physical energy which can then be used for creativity and well-being. Media stories about mental health can be damaging for people with mental health issues who are just a normal part of the population and should not be demonised.

Recommendation 29: Promote service user led activities which provide social opportunities and a holistic approach to physical and mental well-being.

Recommendation 30: Medication: need proper reviews to stop over-medication (long term medication can be detrimental).

Recommendation 31: Patients need access to nature and to make contact with nature. Ecological niche stimulus is important as the mind reacts to our environment.

Recommendation 32: Coercive and regressive intervention should stop – some prescriptions may lead to death of patient but be labelled as suicide because people are avoiding responsibility.

J. How can we target resources towards community groups to promote prevention and early intervention to reduce spending on care & treatment?

Recommendation 33: In order to increase the delivery of activities by community groups that improve public well being, their financial monitoring should be appropriate and fair according to the level of funding, for example for a £500 grant only a one-page agreement and monitoring arrangement is necessary.

Recommendation 34: Help community groups to recognise the value of their work by providing clear information on how their activities can contribute towards improving public well being e.g. cook and eat sessions are providing more than just a cooking session they also reduce loneliness/isolation/ inc increase self-esteem etc.

Recommendation 35: We need to make sure community groups comply with good practice in terms of being safe and secure. e.g. CRB/DBS.

K. Drug and Alcohol Support Services need much stronger links with Mental Health Services because so often people with mental health issues self medicate.

Dual diagnosis; services need to work together to support the client. There is a frustration with the mental health system and the lack of treatment that leads to self-medication with drugs and alcohol. There is a lack of communication between agencies poor referral systems and a 'not my job' mentality.

Recommendation 36: Formal recognition by the Commission that substance misuse and mental health issues are inextricably linked – so services need to reflect that link by working together. We need better partnership working between drug and alcohol services and mental health services.

Recommendation 37: We need Floating Support workers with skills in addiction and mental health issues.

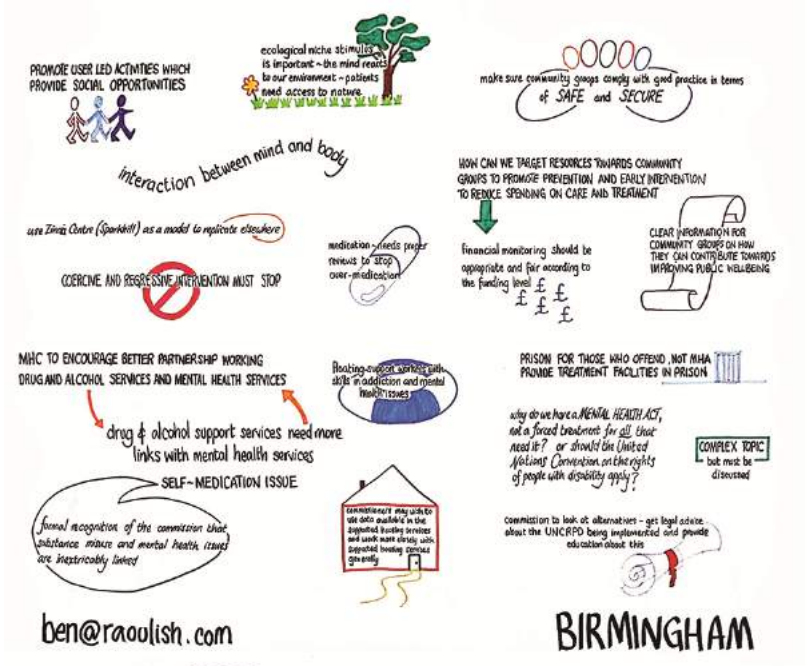
Recommendation 38: Commissioners should work more closely with supported housing services and use data available in supported housing services.

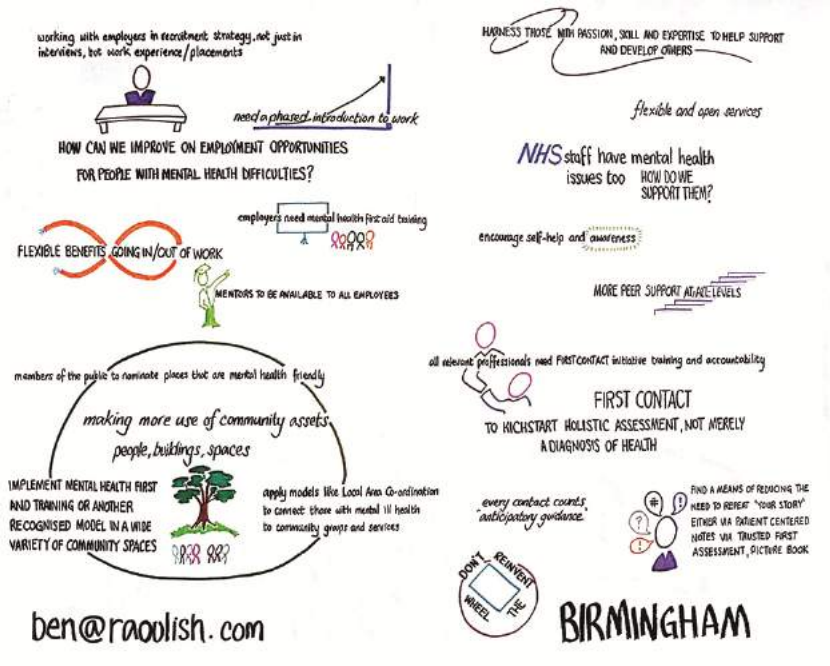
L. Why do we have a Mental Health Act, not a forced treatment for ALL who need it? Or should the United Nations Convention on the rights of people with disabilities apply?

Why do we have a Mental Health Act, not forced treatment for ALL who need it? Should the United Nations Convention on the Rights of People with Disabilities take precedent? Is there a role for the Mental Capacity Act in this instance? The Mental Health Act may be used to protect doctors from the consequences of their action. It leads to stigma &

discrimination which is why it should be abolished and replaced by UNCRPD.

Recommendation 39: The Mental Health Commission to look at alternatives. Get legal advice about the implementation of the United Nations Convention on the Rights of Persons with Disabilities (UNCCRPD) and provide education about this and how it should be implemented for all including those with offending behaviour.





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West Midlands Combined Authority (WMCA) Mental Health Commission

Listening Event Birmingham 3rd May 2016

A record of the Birmingham event by a graphic artist

Coventry

M. Carers

Recommendation 40: We need carer awareness training for psychiatrists, GPs and staff from all service providers and voluntary sector to understand the following:

1. **the issues that the carer is facing, their rights, information, advice and training needs.**
2. **The need for the following government documents to be implemented, the Care Act, NHS England's Commitment to Carers Legal rights and signposting for carers to include the person they support.**
3. **The Carer amendments to the Mental Health Act states five guiding principles, carers should be treated with respect, dignity, be involved, listened to and supported, take into consideration their views and involved when decisions are being made if appropriate, respect carers confidentiality.**

N. Services Shared Outcomes

Services do not know what their shared outcomes are. A shared outcomes framework will enable all services to see how their outcomes link up: increasing opportunities for collaboration and reducing areas of unnecessary duplication. In other words, "making public money work harder, making better use of resources and getting to those people with the most complex needs". A shared outcomes framework would comprise a table outlining services' outcomes. This would show, at a glance, how the work of different agencies is related and details of the activities agencies are engaged in in order to deliver these outcomes. This would allow agencies to see how their activities can complement each other.

This work needs to be done in collaboration with service users. We also need to recognise that services (such as transport) which we may not have expected to play a part in promoting mental health, may well be doing so in important ways: e.g. the fire service are a trusted service who can gain access to households who might otherwise be reluctant to allow in public services. They have a role to promote safety and mental health promotion can form part of this. This work may be better supported if there is an overarching information-sharing agreement, reducing any unnecessary barriers to collaboration.

Recommendation 41: We need a shared outcomes framework as part of a regional level mental health strategy. This will allow us to put all of our desired outcomes together, so that we can coordinate our efforts better and identify useful overlaps, as well as unhelpful duplication. This will help us develop a regional mental health strategy.

Recommendation 42: We need to recognise that other agencies can deliver some of our service outcomes. For example, we need areas like transport to contribute (reducing social isolation, supporting access to services). We should look for evidence-based approaches (e.g. IPS supported employment) and test ideas locally as well as part of a regional strategy.

Recommendation 43: We need a regional data-sharing agreement (to include the third sector) to support our use of a shared outcomes framework as part of a regional level mental health strategy.

O. Peer to peer support

The importance of being with people 'that get it' cannot be underestimated.

Recommendation 44: 'Use the experts', those with lived experience and employ 'us' to work within the mental health system.

P. Suicide and young people

Most people can be well with appropriate support. Self harming, guilt etc. may be signs of potential suicide and are an opportunity for help. Young people need supportive communities and positive informal relationships. Our youth services have declined, what funding is available? Young men are particularly difficult to engage but this is possible through the use of activities.

Recommendation 45: There is a need for training for those working with young people (youth workers etc) e.g. mental health first aid, suicide prevention, listening skills.

Recommendation 46: Generic services are needed so that young people are not stigmatised. Staff within those services need to be confident enough

to hold difficult conversations about suicide and their feelings and mental health.

Recommendation 47: We need flexible services so that young people are not 'lost' in transition between young people and adults services. This transition between services should happen when young people are ready and any time between 16 and 25 years, rather than having a cut off at 16 years and expecting the young person to access adult service.

Q. Meaningful participation.

Recommendation 48: We need a holistic approach to care. A system change that sees co-operation between services and is appropriate for diverse communities. Services which consider the participation of diverse communities at the outset rather than as an afterthought.

Recommendation 49: We need the coproduction (equal partnership) of services, including patient councils, 10,00 voices project/1001 lives project.

Recommendation 50: Encourage the piloting of ideas and projects even if they don't work so we can learn from it and improve next time. Don't be afraid to be brave!

Recommendation 51: Training required for professionals by service user organisations to help overcome barriers i.e. preconceptions, culture.

Recommendation 52: Publish all the proposals in this report even if they are not adopted.

R. Labels are dangerous? They have effects for the person and others

Labels are a stick and can be dangerous, they lump individuals into a 'box' with no right of appeal, staying on your records. Labels also enable treatment.

Recommendation 53: Labels are dangerous. Labels can and should change

S. Nothing has changed. Two suicide attempts 3 years ago. Agency failures.

We must ask ourselves when does a crisis end? Recovery is important and care is long term. Crises are dealt with, problems can 'fall between the cracks'.

Recommendation 54: We need mental health professionals in A&E. A quiet room at A&E is not enough.

T. Improving links to and between services

We need to improve the links between GPs, families, carers, social services, youth offending, CAMS, schools, adults etc. It gets to the critical stage before anything is done! Only 25% of cases from schools get to CAMS. There is a gap between CAMS and adult services; we should be looking at maturity not chronological age. We need a positive approach to staying mentally healthy. We need stronger links with other agencies into areas (e.g. schools, CAMS, prison service) where support could be given pre-crisis, this maybe the first point of contact and would show a positive approach.

Recommendation 55: Use of primary support worker for all. Wherever this first port of call is it should trigger all services through a multiagency approach.

Recommendation 56: Each person using a service should have a clear plan of sustained, personalised, holistic support (including all agencies and carers) using a multiagency approach.

U. Capacity building

We need to build safer communities leading to a more caring society. We must increase confidence in others apart from professionals, some people struggle to engage with the patient/doctor relationship and so informal relationships are very important. Professionals are people too and they get scared too.

Recommendation 57: Build capacity within wider community (not just professionals) to increase

people's confidence if they are presented with mental health issues e.g. children centre staff, fire prevention workers, teachers, neighbours, taxi drivers, faith group leaders etc. (either support at a low level or to be able to refer if necessary). Also, build capacity with staff so that if members of the community make contact the conversation is dealt with in a professional manner (no condescension, a non 'professional' opinion still matters.

Recommendation 58: Put protocols in place in the workplace, so staff know what to do and are encouraged to say something and not keep it to yourself.

Recommendation 59: Put in place a single phone number, single logo that everyone knows about (think NHS).

V. Returning to work is not always the solution.

The system needs to be more flexible, not so black and white. We need appropriate jobs not just jobs.

The workplace is increasingly under (economic) pressure for results and so people are even further away from paid employment. With this squeeze on the workplace will 'healthy' people be employed over better qualified but mentally ill people?

Who knows best, the individual or the experts? Some people don't want to work, others will rush back before they are ready.

There are great variations in terms of the amount of support offered in the workplace and there are failures and problems with this existing support.

Fear and assumptions are generated by the DWP and other services.

Recommendation 60: Volunteering is often more of a solution than paid employment.

Recommendation 61: Appropriate support should be in place before and during employment. The decision to return to work should be with the person not the system.

Recommendation 62: Employers to review their HR / health systems to support – employees to remain in the workplace e.g. explore job sharing as a possible solution.

W. Medication.

We need 'parity of esteem' i.e. would we tolerate the negative impact of drugs on physical conditions? We need acknowledgement of the side-effects. People need to be <u>really</u> listened to about their preferred treatment, this needs time which is a problem with short GP slots. There are different levels firstly, in confidence to speak up about experiences of medication and side effects and secondly, in professional knowledge (there is inconsistency and disagreement). Is it psychological or biochemical models?

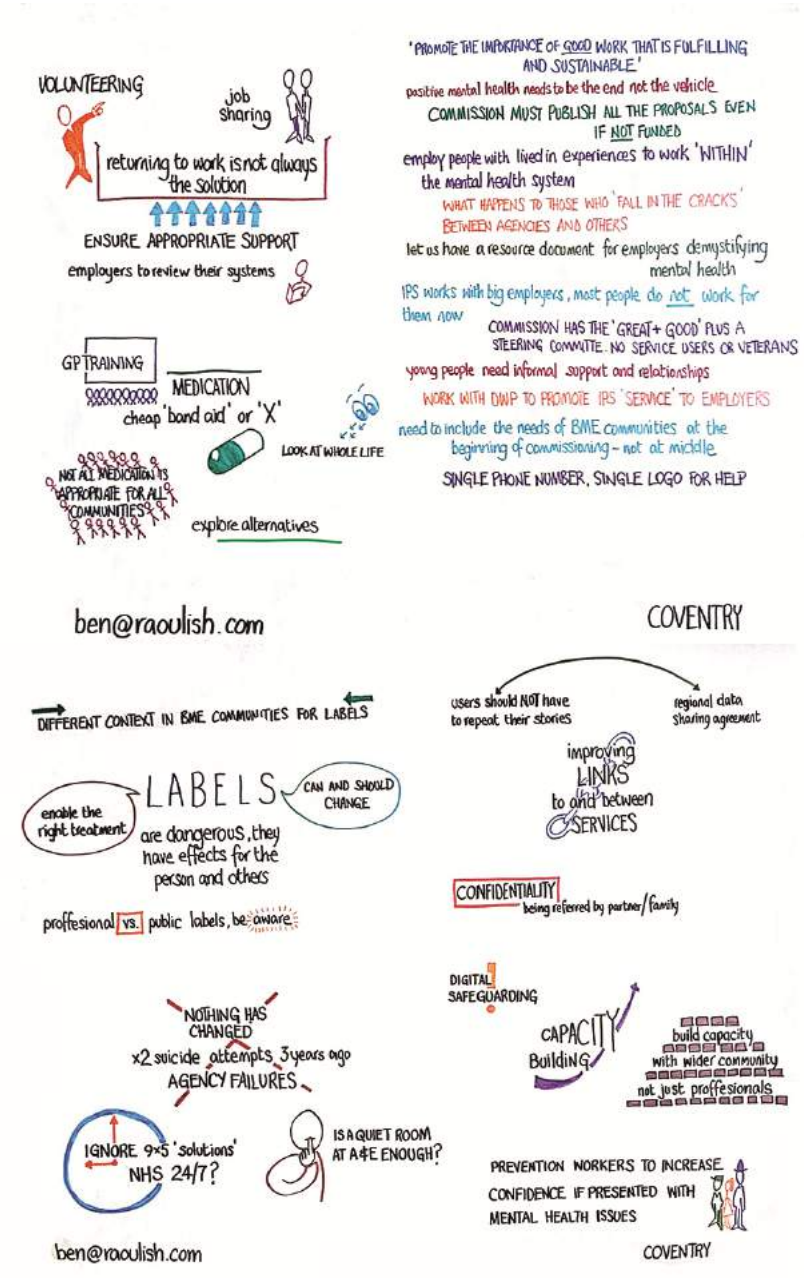
We don't want just drugs we need other approaches too!

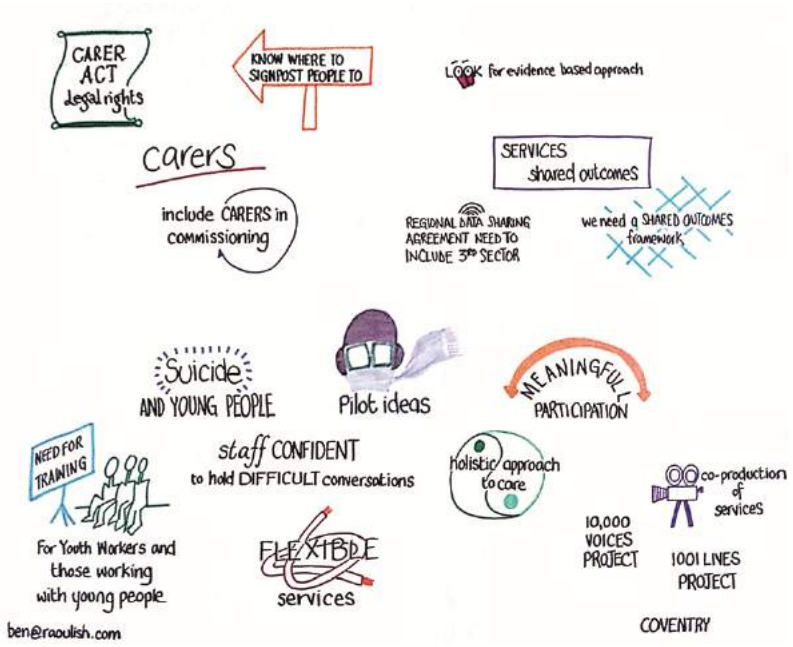
Recommendation 63: GP training should have a core mental health focus.

Recommendation 64: Psychiatrists need to increase their understanding of the side-effects of medication. They need to talk to each other about responding to multiple health needs.

Recommendation 65: Professionals need to look holistically at the whole life of the person (social conditions etc.)

Recommendation 66: Professionals need to explore alternative medication and treatments e.g. St. John's Wort, Magnesium, Primrose, Camomile (less side –effects?) (but, be aware of negative interaction with other medications).





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BIRMINGHAM • COVENTRY • DUDLEY • SANDWELL • SOLIHULL • WALSALL • WOLVERHAMPTON

West Midlands Combined Authority (WMCA) Mental Health Commission

Listening Event Coventry 26th April 2016

A record of the Coventry event by a graphic artist

Dudley

X. Education and employment (early intervention)

Recommendation 67: Support the implementation of "Future in Mind [(2)]" in schools and education.

Recommendation 68: Schools and employers to be working in collaboration with all partners.

Recommendation 69: Offer tailored therapy and support to employees and jobseekers to find employment and careers most suited to the needs of the individual. Learn from examples of good practice e.g. Walsall employment support services.

Recommendation 70: Appoint one specific body to raise awareness of services and opportunities to shape service development.

Y. Access to outside agencies for those in supported living.

People with mental health issues welcome the chance to engage with others who are empathetic

If people are in supported living they may need outside services to come to them rather than be expected to go outside (e.g. to see CPN, Dr. etc.) The Fire service offer support, the 'safe & well' check, this can be done in supported living environment.

Recommendation 71: Weekly/bi weekly surgery with Doctor and CPN.

Recommendation 72: Workshops for facility staff to gain a greater understanding of the vulnerable (word was questioned, then corrected).

Recommendation 73: Invest in mental health first aid.

Z. Good mental health improves physical health and vice versa.

There is potential here for big savings to the public purse, but how do we encourage people to continue doing physical exercise after leaving school?

Recommendation 74: Mental health budget & services need to be considered in the round (joined up?) e.g. prescribing to join a choir to improve mental health.

Recommendation 75: We need a willingness to experiment with ways of improving public mental / physical health. We need a fund to support lots of small scale innovation and to try especially non-clinical ways of getting clinical outcomes.

Recommendation 76: At time of public sector cuts we need to prioritise regeneration (green space, good housing, employment etc.)

AA. Saltbrook Place (supported housing scheme): 60 people, 75% ill, zero budget. Help!

Why are so many people in mental health ending up homeless? The current system is broken, we need to encourage staff to see this without them taking it the wrong way. Prevention is better than cure.

At Saltbrook Place 100% of the staff do a great job but there is zero budget.

Recommendation 77: Funding needed at Saltbrook Place. Other agencies to pull their weight i.e. DMBC, NHS, Rethink.

Recommendation 78: Develop a Joint Ownership of Mental Health & Homelessness and solve it across agencies – all services should own this issue. Observe what services are like from the customer's perspective.

Recommendation 79: Spend more on prevention, less on acute.

[2] Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

BB. How do we reduce the financial boundaries that affect service delivery and access?

We are often looking for 'back door' ways to deliver services because the rules don't allow agencies to provide the service that best suits what the person needs. Geographical boundaries are creating barriers to access services; different agencies provide different services but have "live" or "work" as criteria for access. Can we remove or reduce this?

People need continuity of care regardless of where the person may live e.g. hospital in Birmingham but at college in Derby.

We need a consistent approach to commissioning, perhaps using a wellbeing l M.H. Impact assessment tool.

Recommendation 80: We need a West Midlands wide care offer i.e. each Health & Social care economy has the same core offer.

Recommendation 81: Identify which services should be commissioned locally & what should be commissioned. On a wider foot print e.g. specialist tier 4 or public health programme such as employment, MH promotion.

CC. The use of volunteers and peer support to support paid services.

Everyone deserves a sense of purpose, volunteering can fill this gap. Opportunities already exist to give training to volunteers to support services, but this needs to increase. Volunteers are a useful resource because they are often experts by experience (e.g. for supporting tenders/service development etc.)

As volunteers people gain new experiences for new/changes of careers. Volunteers can support staff to relieve the stress of work pressures. We need to understand volunteers are not free but valuable as a support for low-level work,(e.g. using volunteers to make follow-up phone calls, supporting paid staff on visits etc. e.g. the NHS using volunteers to enhance care: everyone loves it).

There should be more opportunities for volunteer organisations to gather together to initiate joint working and support. We need better understanding of volunteering as a resource rather than a replacement service and we need to be smarter with how to recruit volunteers (e.g. where we recruit go out to get them or wait for them to come to us).

Recommendation 82: Consider the value of skills and knowledge and expertise volunteers can provide and increase joint partnership with the Third Sector.

DD. How do we create jobs and improve housing?

Unemployment **causes** mental illness. Since the breakup of the manufacturing industries there is no longer a sustainable economy making jobs. As a result there are not enough jobs and part-time zero hours contracts. Workplace bullying is a significant factor.

If you have a broken arm you don't have to wait for treatment. If you have broken thoughts you have to wait months.

Recommendation 83: We need more jobs and sustainable industry (WMCA must create jobs).

Recommendation 84: More supported / social housing for people with mental health problems (and generally). The right housing is important (Maslow's hierarchy).

Recommendation 85: In the work place employers must strive to remove stigma. Line managers should be really good role models (re. bullying) (training is needed) and make available workplace training to understand the impact of workplace bullying.

Recommendation 86: Training in Job Centres for staff is needed so that people's self esteem/self efficiency is built.

Recommendation 87: Special support is needed during transition to ESA to JSA for claimants (as this can be stressful , we need a gentler approach).

EE. Are thresholds too high? Do they get in the way?

We need investment in prevention. Crisis is more expensive. Surely prevention is better than interdepartmental and agency arguments about thresholds and the need for people to 'get worse' before we can help. We need to look at the costs of

'high-end' prevention. Prevention is more financially efficient but hard to evidence.

Silos create adversarial relationships including with advocates like the Citizens Advice Bureau. We need information sharing so avoiding duplication and repetition of the story.

Recommendation 88: Trial a 'No Thresholds' approach somewhere for a while to see what happens as a result. Commissioning led is bureaucratic; instead we need to develop a culture of trust not suspicion.

Recommendation 89: Talk to staff about their honest opinions/experience of the present system and act on problems they raise with it.

FF. How do we connect statutory services with community groups, social enterprises, charities to support & enhance statutory services to enable early intervention or prevention?

We should encourage the freeing up of silo working and the sharing of best practice. We need a central point for referrals. We should focus on the use of social values and on quality in commissioning. Let's consider social finance and the use of personal social impact action measurement systems (PSIAMS).

Recommendation 90: Larger services to encourage consortium bids that protect and include smaller organisations.

Recommendation 91: Look for flexible funding to kick start innovation.

Recommendation 92: Investigate how social value and added value can be included in tenders without breaching EU procurement laws.

Recommendation 93: Encourage commissioning groups to provide forums and training for the voluntary sector.

GG. Mental wellbeing impact assessments – how can we use this tool?

Have a framework to help people consider mental wellbeing in more detail when commissioning, delivering or developing strategy, service or initiative. Such a framework should help identify wider social determinants.

Recommendation 94: Use the Mental Wellbeing impact Tool, which would take into consideration protective & demotive factors for mental wellbeing. Available at www.apho.org.uk

HH. Are mental health services wasting money by putting (public) funds in the wrong places?

How do we know where the mental health trusts are spending money? We need hard statistics. There is a lot of waste e.g. community engagement days, glossy leaflets, administering the wrong brand of medication in secondary mental health services.

Recommendation 95: We need to see where the money is going so we can explicitly ask questions around how mental health trusts are spending money. This should be through easy to access financial information, that's easy to understand and is put on the website and in printable format for MIND and service users (e.g. a pie-chart of total spend).

Recommendation 96: Room hire costs for support groups should be waived (e.g. Bipolar UK/Depression Alliance).

Recommendation 97: Invest in body scans to determine your biological makeup and ensure you are taking the optimum medication.

II. Recognise the impact of alcohol and substance misuse.

Drugs and alcohol can be a sticking plaster for example for unemployment and psychological difficulties. The reasons for substance misuse may be the same as the reasons for mental illness. This is a complicated issue because we use alcohol to celebrate but it is also a depressant. Skunk proves the link with psychosis (and in some cases permanent mental illness). Recognise the large amount of alcohol related crime in prisons.

Recommendation 98: Agencies to work together to deliver services (Fire/Ambulance/ Police etc) and to identify people (the frequent flyers).

Recommendation 99: Commissioners need to join up re. substance misuse / mental illness services. (Don't commission in silos). Understand the

evidence base and examine the evidence re. dual diagnosis. (what are the reasons for substance misuse, e.g. the connection with e.g. unemployment.

Recommendation 100: Recognise the important work of the Fire Service. Use them for shared interventions in helping substance misusers to help drive fatalities down further! (fatalities have increased). Use the Fire Service for commissioned work i.e. falls prevention, safety checks, making homes safe when re-homing after hospitalisation or treatment rather than keeping in hospitals save funds – gets beds free and supports independent living.

Recommendation 101: Public Health need to focus on a preventative agenda.

JJ. How the use of creative or alternative therapies can benefit with mental health.

Promote activities to help with self confidence and mental health e.g. reflexology on a regular basis via prescription. Family and friends should be involved with the therapy to help with recovery. How do we fit this in to education; formal and adult education?

Recommendation 102: Commission the key lines of enquiry to adopt creative & alternative activities meeting all 7 points and improving mental health (activity leads to individual well-being, leads to community well-being, leads to economic well-being)

Recommendation 103: More Funding for small or big community projects to promote therapies/ activities

KK. What specific actions can be taken to ensure people are truly supported to recover?

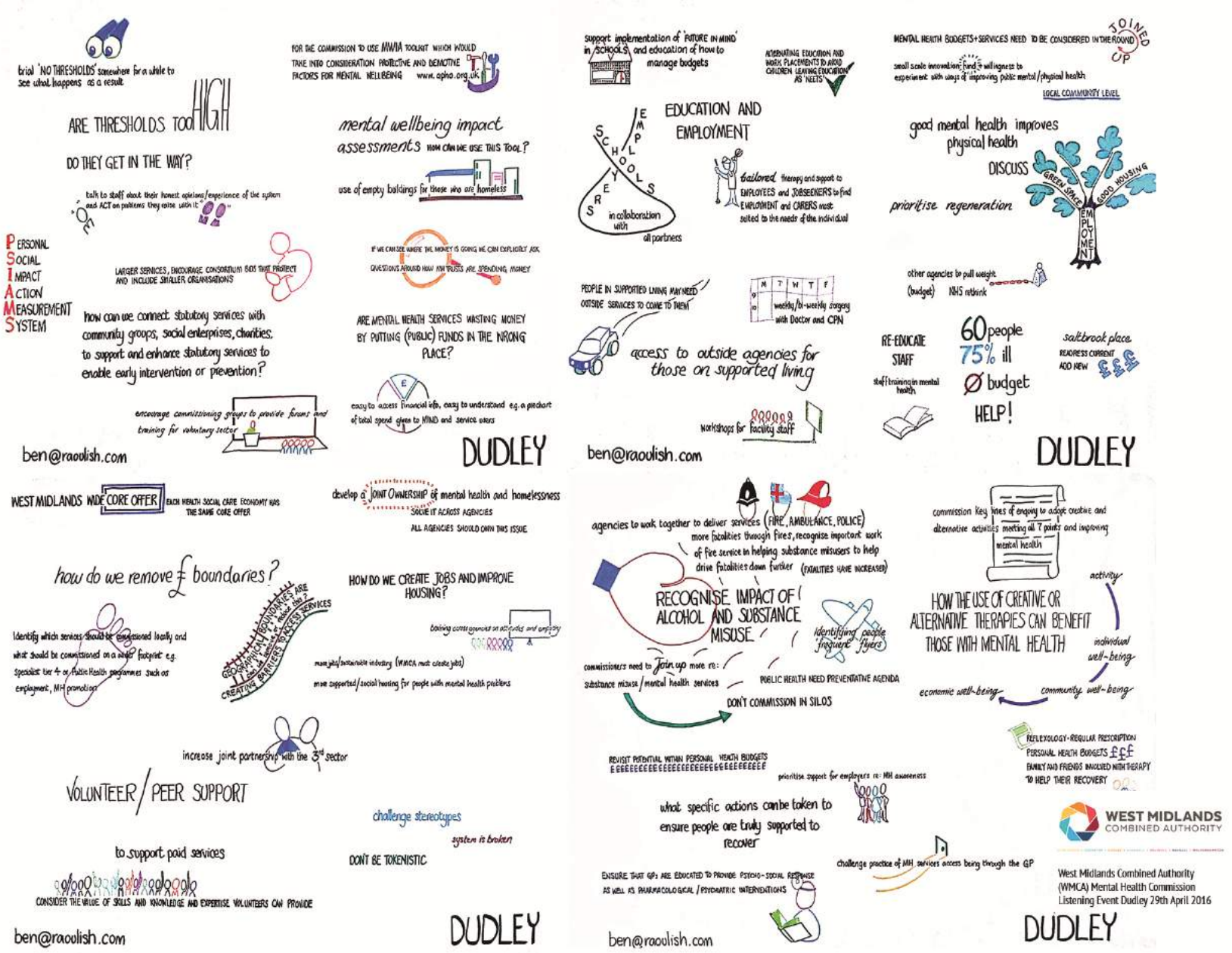
The use of personal health budgets, (taking a pot of money allocated to you and spending it where you think is best), can the current policy be extended to mental health? We must ensure that there is sufficient support to help people maintain/secure work. Is there a case for recycling money currently invested in services e.g. through improving efficiency and prioritising early intervention and employment support?

Recommendation 104: Ensure that GP's are educated to provide psycho-social responses as well as pharmacological/ psychiatric interventions.

Recommendation 105: Challenge the practice of mental health services access being through the GP (are they best equipped to do this?) and replace the current pathway wit a step up/ step – down seamless self-managing approach with access to specialist mental health services input as and when needed.

Recommendation 106: Revisit the potential within personal health budgets to promote choice and control over our own mental health and well-being.

Recommendation 107: Prioritise support for employers, mental health awareness et cetera to enable people to retain (early intervention) and secure work.


trial 'NO THRESHOLDS' somewhere for a while to see what happens as a result
ARE THRESHOLDS TOO HIGH
DO THEY GET IN THE WAY?
talk to staff about their honest opinion/experience of the system and ACT on problems they raise with it
FOR THE COMMISSION TO USE MWIA TOOLKIT WHICH WOULD TAKE INTO CONSIDERATION PROTECTIVE AND DEMOTIVE FACTORS FOR MENTAL WELLBEING www.apho.org.uk
mental wellbeing impact assessments HOW CAN WE USE THIS TOOL?
use of empty baldings for those who are homeless
PERSONAL SOCIAL IMPACT ACTION MEASUREMENT SYSTEM
LARGER SERVICES, ENCOURAGE CONSORTIUM BIDS THAT PROTECT AND INCLUDE SMALLER ORGANISATIONS
IF WE CAN SEE WHERE THE MONEY IS GOING WE CAN EXPLICITLY ASK QUESTIONS AROUND HOW NHS TRUSTS ARE SPENDING MONEY
how can we connect statutory services with community groups, social enterprises, charities, to support and enhance statutory services to enable early intervention or prevention?
ARE MENTAL HEALTH SERVICES WASTING MONEY BY PUTTING (PUBLIC) FUNDS IN THE WRONG PLACE?
encourage commissioning groups to provide forums and training for voluntary sector
easy to access financial info, easy to understand e.g. a piechart of total spend given to MIND and service users
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WEST MIDLANDS WIDE CORE OFFER
EACH HEALTH SOCIAL CARE ECONOMY HAS THE SAME CORE OFFER
develop a JOINT OWNERSHIP of mental health and homelessness
SOLVE IT ACROSS AGENCIES
ALL AGENCIES SHOULD OWN THIS ISSUE
how do we remove £ boundaries?
Identify which services should be commissioned locally and what should be commissioned on a wider footprint e.g. Specialist tier 4 or Public Health programmes such as employment, MH promotion
GEOGRAPHICAL BOUNDARIES ARE CREATING BARRIERS TO ACCESS SERVICES
HOW DO WE CREATE JOBS AND IMPROVE HOUSING?
having consequences on activities and capacity
more jobs/sustainable industry (WMCA must create jobs)
more supported/social housing for people with mental health problems
increase joint partnership with the 3rd sector
VOLUNTEER/PEER SUPPORT
to support paid services
CONSIDER THE VALUE OF SKILLS AND KNOWLEDGE AND EXPERTISE VOLUNTEERS CAN PROVIDE
challenge stereotypes
system is broken
DON'T BE TOKENISTIC
ben@raoulish.com
DUDLEY
support implementation of 'FUTURE IN MIND' in SCHOOLS and education of how to manage budgets
ALTERNATIVE EDUCATION AND WORK PLACEMENTS TO AVOID CHILDREN LEAVING EDUCATION 'AS 'NEETS'
EDUCATION AND EMPLOYMENT
SCHOOLS EMPLOYMENT SERVICES
in collaboration with all partners
tailored therapy and support to EMPLOYEES and JOBSEEKERS to find EMPLOYMENT and CAREERS most suited to the needs of the individual
PEOPLE IN SUPPORTED LIVING MAY NEED OUTSIDE SERVICES TO COME TO THEM
M T W T F
weekly/bi-weekly surgery with Doctor and CPN
access to outside agencies for those on supported living
Workshops for facility staff
ben@raoulish.com
MENTAL HEALTH BUDGETS+SERVICES NEED TO BE CONSIDERED IN THE ROUND
JOINED UP
small scale innovation; find + willingness to experiment with ways of improving public mental/physical health
LOCAL COMMUNITY LEVEL
good mental health improves physical health
DISCUSS
GREEN SPACE
GOOD HOUSING
EMPLOYMENT
prioritise regeneration
other agencies to pull weight
(budget) NHS rethink
RE-EDUCATE STAFF
staff training in mental health
60 people
75% ill
Ø budget
HELP!
saltbrook place
READDRESS CURRENT
ADD NEW
£ £ £
DUDLEY
agencies to work together to deliver services (FIRE, AMBULANCE, POLICE)
more fatalities through fires, recognise important work of fire service in helping substance misusers to help drive fatalities down further (FATALITIES HAVE INCREASED)
RECOGNISE IMPACT OF ALCOHOL AND SUBSTANCE MISUSE
identifying 'people frequent flyers'
commissioners need to join up more re: substance misuse/mental health services
PUBLIC HEALTH NEED PREVENTATIVE AGENDA
DON'T COMMISSION IN SILOS
REVISIT POTENTIAL WITHIN PERSONAL HEALTH BUDGETS £££££££££££££££££££££
prioritise support for employers re: MH awareness
what specific actions can be taken to ensure people are truly supported to recover
ENSURE THAT GPs ARE EDUCATED TO PROVIDE PSYCHO-SOCIAL RESPONSE AS WELL AS PHARMACOLOGICAL/PSYCHIATRIC INTERVENTIONS
challenge practice of MH services access being through the GP
ben@raoulish.com
commission key lines of enquiry to adopt creative and alternative activities meeting all 7 points and improving mental health
HOW THE USE OF CREATIVE OR ALTERNATIVE THERAPIES CAN BENEFIT THOSE WITH MENTAL HEALTH
activity
individual well-being
community well-being
economic well-being
REFLEXOLOGY - REGULAR PRESCRIPTION
PERSONAL HEALTH BUDGETS £ £ £
FAMILY AND FRIENDS INVOLVED WITH THERAPY TO HELP THEIR RECOVERY
WEST MIDLANDS COMBINED AUTHORITY
West Midlands Combined Authority (WMCA) Mental Health Commission Listening Event Dudley 29th April 2016
DUDLEY

Appendix 1: Recommendations as prioritised by the Citizens Jury

The following table contains the results of the prioritisation of all the open space listening event recommendations by members of the citizens jury on May 24th 2016. The top three recommendations are highlighted in the black boxes. Each participant was given ten votes.

Birmingham

Topic	Recommendations	No.	Position	No. of votes
Build wellbeing – what does that mean? What determines it? How do we do it?	Recognise the importance of staff wellbeing. Our own wellbeing affects how we treat others.	1	**=7**	**2**
	Invest in building resilience especially amongst children, young people and those at risk.	2	**=6th**	**3**
	Move away from the medical model for wellbeing and increase awareness of wellbeing across all agencies especially those working at the front line.	3	**=7th**	**2**
	In promoting wellbeing don't only talk to the "usual suspects". Find out what local groups have already done/ or are doing and build on it / learn from it.	4	**=8th**	**1**
Early intervention: emotional resilience and wellbeing of young people and children	Embrace the "open dialogue" approach (pioneered in Finland and now used in some NHS trusts.	5		
	Support a two day training course for parents / carers whose young people are accessing mental health services.	6		

	Invest in Mental Health First Aid for communities, schools, professionals (Midwives + Health Visitors etc)	7	**6**	**1st**
	Embed well being and resilience throughout the curriculum	8		
	Ensure a) parents (via places such as Childrens Centres, Sure Start etc) b) professionals (midwives, teachers etc) are educated, skilled up and informed on child development	9		
Why do services not apply the feedback they receive from sessions like this?	In whatever body is set up to implement the recommendations of the MHC there must be a champion for rectifying inequalities in mental health need and provision as per the "5 year Forward View for Mental Health" document. Use the recommended champion for inequalities to help move this forward. This should be someone with undeniable 'clout'.	10	**=8th**	**1**
	Encourage a re-launch of QIPP (3)as the essential goals of service improvement and quality seem to have gone off the boil recently.	11		
	Need to involve front line workers in how to implement things and make change happen (from grass roots up, not exclusively from top down).	12	**=8th**	**1**
	Ensure the obviously desirable opportunity for teams that are considered to be 'weak' to exchange visits with those that are regarded as 'excellent' are exploited to the full	13		
Barriers and the culture of No	We need an open approach – We don't want to hear "we can't do it 'cos that's how it is".	14		

[3] ***QIPP*** *stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS.*

	Services need to be flexible and tailored with different people working together in partnership. We need a combined person centred service: physical/mental health/housing. People need continuity (people knowing people) and to be given a 'menu' of what's available so they can choose for themselves rather than having choices made for them.	15	**=4th**	**5**
	There should be a seamless flow of information (using common language) – trusting that your information is being treated well and will be responded to. People should only need to 'Tell my story once' with this then being rolled out across health, social care etc. a 'Maternity Notes' approach.	16	**=6th**	**3**
How can we improve employment opportunities?	Employers need Mental Health first Aid Training and a Quality standard in Mental Health training and support should be introduced and branded.	17	**=3rd**	**6**
	Meaningful work is very important, we need a phased introduction into work with flexible benefits going into and out of work.	18	**=7th**	**2**
	Mentors should be available to all employees	19	**=7th**	**2**
	We should work with employers in designing recruitment strategy not just in interviews	20	**=7th**	**2**
NHS staff have mental health issues too – how do we support them?	Harness those with passion, skill and expertise to help, support & develop others	21	**=6th**	**3**
	Support NHS staff that have mental health issues through encouraging self-help and awareness, offering peer support at all levels, providing flexible and open services and the use of counselling supervision skills during supervision.	22		
Making more use of community assets to support people	Explore the potential for funded services to subsidise/ offer free space to community groups + advertising. eg. Along the lines of the Edgbaston Well Being hub. Birmingham LGBT	23	**=6th**	**3**
	Look at the potential to apply models like the Local Area coordination to connect those with mental ill health to community groups & services.	24		

	Implement mental health first and training or another recognised model in a wide variety of community settings so that people know how to respond appropriately to people with mental health issues e.g. libraries, faith groups, railway staff, bus drivers	25	**=5th**	**4**
	Create a series of 'safe zones' where people with mental health issues can go when they don't feel safe – could be anywhere from shops to railway stations, Wetherspoons.	26	**=3rd**	**6**
	Get members of the public to nominate places that are mental health friendly and those need more training	27		
First contact: the initial contact should kick-start a holistic assessment, not merely a diagnosis of mental health	All services to adopt a new principle, called 'First Contact' whenever anyone makes contact with any relevant service, it should kick-start a full client-led assessment of all their needs. This holistic assessment should: A) reduce the need for their story/history to be repeated (either via patient centred notes, via a trusted first assessment, picture book). B) Ensure that the person is referred to any and all services to help with the aspects of their life that are/maybe adversely affecting their mental health, housing, finance, physical health, domestic violence etc. All relevant professionals need FC initiative training and accountability. First contact should not only be for people in crisis and it should build on similar concepts such as Every Contact Counts.	28	**2nd**	**7**
Interaction between mind and body	Promote service user led activities which provide social opportunities and a holistic approach to physical + mental well-being	29	**=7th**	**2**
	Medication: need proper reviews to stop over-medication (long term medication can be detrimental)	30	**=6th**	**3**
	Patients need access to nature and to make contact with nature. Ecological niche stimulus is important as the mind reacts to our environment	31		
	Coercive and regressive intervention should stop – some prescriptions may lead to death of patient but be labelled as suicide because people are avoiding responsibility.	32	**=8th**	**1**

How can we target resources towards community groups to promote prevention and early intervention to reduce spending on care & treatment?	In order to increase the delivery of activities by community groups that improve public well being, their financial monitoring should be appropriate and fair according to the level of funding, for example for a £500 grant only a one-page agreement and monitoring arrangement is necessary	33		
	Help community groups to recognise the value of their work by providing clear information on how their activities can contribute towards improving public well being e.g. cook and eat sessions are providing more than just a cooking session they also reduce loneliness/isolation/ inc increase self-esteem etc.	34	**=8th**	**1**
	We need to make sure community groups comply with good practice in terms of being safe and secure. e.g. CRB/DBS.	35		
Drug and Alcohol Support Services need much stronger links with Mental Health Services because so often people with mental health issues self medicate	Formal recognition by the Commission that substance misuse and mental health issues are inextricably linked – so services need to reflect that link by working together. We need better partnership working between drug and alcohol services and mental health services.	36	**=6th**	**3**
	We need Floating support workers with skills in addiction and mental health issues.	37	**=7th**	**2**
	Commissioners should work more closely with supported housing services and use data available in supported housing services	38	**=8th**	**1**
Why do we have a mental health act, not a forced treatment for ALL who need it? Or should the United Nations Convention on the rights of people with disabilities apply?	The Mental Health Commission to look at alternatives. Get legal advice about the implementation of the United Nations Convention on the Rights of Persons with Disabilities (UNCCRPD) and provide education about this.	39	**=7th**	**2**

Coventry

Carers	We need training for psychiatrists, GPs and staff of all services and voluntary sector to understand. a) Carer support needs and issues the carer is facing. b) The Carers Act, Legal rights and signposting for carers and the supportee. c) Carer Amendments to the Mental Health Act that states we must listen to carers and act upon	40	**=8th**	**1**
Services shared outcomes	We need a shared outcomes framework as part of a regional level mental health strategy. This will allow us to put all of our desired outcomes together, so that we can coordinate our efforts better and identify useful overlaps, as well as unhelpful duplication. This will help us develop a regional mental health strategy.	41	**=8th**	**1**
	We need to recognise that other agencies can deliver some of our service outcomes. For example, we need areas like transport to contribute (reducing social isolation, supporting access to services). We should look for evidence-based approaches (e.g. IPS supported employment) and test ideas locally as well as part of a regional strategy.	42	**=7th**	**2**
	We need a regional data-sharing agreement (to include the third sector) to support our use of a shared outcomes framework as part of a regional level mental health strategy.	43	**=3rd**	**6**
Peer to Peer Support	'Use the experts', those with lived experience and employ 'us' to work within the mental health system	44	**=4th**	**5**
Suicide and young people	There is a need for training for those working with young people (youth workers etc) e.g. mental health first aid, suicide prevention, listening skills.	45	**=4th**	**5**
	Generic services are needed so that young people are not stigmatised. Staff within those services need to be confident enough to hold difficult	46	**=8th**	**1**

	Conversations about suicide and their feelings and mental health			
	We need flexible services so that young people are not 'lost' in transition between young people and adults services. This transition between services should happen when young people are ready and any time between 16 and 25 years, rather than having a cut off at 16 years and expecting the young person to access adult service	47	**=4th**	**5**
Meaningful participation	We need a holistic approach to care. A system change that sees co-operation between services and is appropriate for diverse communities	48	**=8th**	**1**
	We need the coproduction (equal partnership) of services, including patient counsels , 10,00 voices project/1001 lives project	49		
	Encourage the piloting of ideas and projects even if they don't work so we can learn from it and improve next time. Don't be afraid to be brave!	50		
	Training required for professionals by service user organisations to help overcome barriers ie. Preconceptions, culture	51		
	Publish all the proposals in this report even if they are not adopted	52	**=6th**	**3**
Labels are dangerous? They have effects for the person and others	Labels are dangerous. Labels can and should change	53	**=7th**	**2**
Nothing has changed. Two suicide attempts 3 years ago. Agency failures	We need mental health professionals in A&E. A quiet room at A&E is not enough.	54	**=7th**	**2**
Improving links to and between services	Use of primary support worker for all. Wherever this first port of call is it should trigger all services through a multiagency approach.	55	**=7th**	**2**
	Each person using a service should have a clear plan of sustained , personalised, holistic support (including all agencies and carers) using a multiagency approach	56	**=8th**	**1**
Capacity building	Build capacity within wider community (not just professionals) to increase people's confidence if they are presented with mental health issues e.g. children centre staff, fire prevention workers, teachers, neighbours, taxi drivers, faith group leaders etc. (either support at a low	57	**=8th**	**1**

	level or to be able to refer if necessary). Also, build capacity with staff so that if members of the community make contact the conversation is dealt with in a professional manner (no condescension, a non-' professional' opinion still matters.			
	Put protocols in place in the workplace so staff know what to do and are encouraged to say something and not keep it to yourself.	58		
	Put in place a single phone number, single logo that everyone knows about (think NHS).	59	**=4th**	**5**
Returning to work is not always the solution	Volunteering is often more of a solution than paid employment.	60	**=7th**	**2**
	Appropriate support should be in place before and during employment. The decision to return to work should be with the person not the system.	61	**=7th**	**2**
	Employers to review their HR / health systems to support – employees to remain in the workplace e.g. explore job sharing as a possible solution	62	**=7th**	**2**
Medication – cheap 'Band Aid' or 'X'	GP training should have a core mental health focus	63	**=8th**	**1**
	Psychiatrists need to increase their understanding of the side-effects of medication. They need to talk to each other about responding to multiple health needs.	64	**=7th**	**2**
	Professionals need to look holistically at the whole life of the person (social conditions etc.)	65		
	Professionals need to explore alternative medication and treatments e.g. St. John's Wort, Magnesium, Primrose, Camomile (less side –effects?) (but be aware of negative interaction with other medications)	66		

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Education and Employment (Early Intervention)	Support the implementation of "Future in Mind (4)" in schools and education	67	**=7th**	**2**
	Schools and employers to be working in collaboration with all partners.	68	**=8th**	**1**
	Offer tailored therapy and support to employees and jobseekers to find employment and careers most suited to the needs of the individual. Learn from examples of good practice e.g. Walsall employment support services.	69	**=5th**	**4**
	Appoint one specific body to raise awareness of services and opportunities to shape service development	70		
Access to outside agencies for those in supported living	Weekly/bi weekly surgery with Doctor and CPN	71	**8th**	**1**
	Workshops for facility staff to gain a greater understanding of the vulnerable (word was questioned, then corrected)	72	**8th**	**1**
	Invest in mental health first aid	73	**=6th**	**3**
Good mental health improves physical health and vice versa	Mental health budget & services need to be considered in the round (joined up?) E.g. prescribing to join a choir to improve mental health	74	**8th**	**1**

[4] Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

	We need a willingness to experiment with ways of improving public mental / physical health. We need a fund to support lots of small scale innovation and to try especially non-clinical ways of getting clinical outcomes.	75	**8th**	**1**
	At time of public sector cuts we need to prioritise regeneration (green space, good housing, employment etc.)	76	**8th**	**1**
Saltbrook Place (supported housing scheme): **60 people , 75% ill 0 budget. Help !**	Funding needed at Saltbrook Place. Other agencies to pull their weight i.e. DMBC, NHS, Rethink.	77		
	Develop a Joint Ownership of Mental Health & Homelessness and solve it across agencies – all services should own this issue. Observe what services are like from the customers perspective	78	**8th**	**1**
	Spend more on prevention, less on acute.	79	**8th**	**1**
How do we reduce the financial boundaries that affect service deliver & access?	We need a West Midlands wide care offer i.e. each Health & Social care economy has the same core offer.	80		
	Identify which services should be commissioned locally & what should be commissioned. On a wider foot print e.g. specialist tier 4 or public health programme such as employment, MH promotion	81		
The use of volunteers and Peer support to support paid services	Consider the value of skills and knowledge and expertise volunteers can provide and increase joint partnership with the Third Sector	82	**8th**	**1**
How do we create jobs and improve housing?	We need more jobs and sustainable industry (WMCA must create jobs)	83		
	More supported / social housing for people with mental health problems (and generally). The right housing is important (Maslow's hierarchy)	84	**=6th**	**3**
	In the work place employers must strive to remove stigma. Line managers should be really good role models (re. bullying) (Training is needed) and make available workplace training to understand the impact of workplace bullying.	85	**8th**	**1**

	Training in Job Centres for staff is needed so that people's self esteem/self efficiency is built	86	**=7th**	**2**
	Special support is needed during transition to ESA to JSA for claimants (as this can be stressful , we need a gentler approach).	87		
Are Thresholds too high – Do they get in the way?	Trial a 'No Thresholds' approach somewhere for a while to see what happens as a result. Commissioning led is bureaucratic, instead we need to develop a culture of trust not suspicion.	88		
	Talk to staff about their honest opinions/experience of the present system and act on problems they raise with it.	89		
How do we connect statutory services with community groups, social enterprises, charities to support & enhance statutory services to enable early intervention or prevention?	Larger services to encourage consortium bids that protect and include smaller organisations .	90		
	Look for flexible funding to kick start innovation	91	**=8th**	**1**
	Investigate how social value and added value can be included in tenders without breaching EU procurement laws	92		
	Encourage commissioning groups to provide forums and training for the voluntary sector	93		
Mental wellbeing impact assessments – how can we use this tool?	Use the Mental Wellbeing impact Tool, which would take into consideration protective & demotive factors for mental wellbeing. Available at www.apho.org.uk	94		
Are mental health services wasting money by putting (public) funds in the wrong places?	We need to see where the money is going so we can explicitly ask questions around how mental health trusts are spending money. This should be through easy to access financial information, that's easy to understand and is put on the website and in printable format for MIND and service users (e.g. a pie-chart of total spend).	95	**=7th**	**2**
	Room hire costs for support groups should be waived (e.g. Bipolar	96	**=8th**	**1**

	UK/Depression Alliance)			
	Invest in body scans to determine your biological makeup and ensure you are taking the optimum medication.	97		
Recognise impact - alcohol and substance misuse	Agencies to work together to deliver services (Fire/Ambulance/ Police etc) and to identify people (the frequent flyers)	98		
	Commissioners need to join up re. substance misuse / mental illness services. (Don't commission in silos). Understand the evidence base and examine the evidence re dual diagnosis. (what are the reasons for substance misuse, e.g. the connection with e.g. unemployment	99	**=7th**	**2**
	Recognise the important work of the Fire Service. Use them for shared interventions in helping substance misusers to help drive fatalities down further! (fatalities have increased). Use the Fire Service for commissioned work i.e. falls prevention, safety checks, making homes safe when re-homing after hospitalisation or treatment rather than keeping in hospitals save funds – gets beds free and supports independent living.	100		
	Public Health need to focus on a preventative agenda.	101		
How the use of creative or alternative therapies can benefit with mental health	Commission the key lines of enquiry to adopt creative & alternative activities meeting all 7 points and improving mental health (activity leads to individual well-being, leads to community well-being, leads to economic well-being)	102	**=8th**	**1**
	More Funding for small or big community projects to promote therapies/ activities	103	**=8th**	**1**
What specific actions can be taken to ensure people are truly supported to recover?	Ensure that GP's are educated to provide psycho-social responses as well as pharmacological/ psychiatric interventions.	104		
	Challenge the practice of mental health services access being through the GP (are they best equipped to do this?) and replace the current pathway wit a step up/ step – down seamless self-managing approach with access	105	**=8th**	**1**

	to specialist mental health services input as and when needed?			
	Revisit the potential within personal health budgets to promote choice and control over our own mental health and well-being.	*106*	*	*
	Prioritise support for employers, mental health awareness et cetera to enable people to retain (early intervention) and secure work.	*107*	*	*

Appendix 2: Membership of the Mental Health Commission

Norman Lamb MP, Chair of the Commission

Prof Kevin Fenton, Director of Health and Wellbeing, Public Health England

Prof Swaran Singh, Head of Mental Health & Wellbeing Division, Warwick Medical School

Steve Gilbert, Service User

Dr Geraldine Strathdee, National Clinical Director Mental Health, NHS England

Craig Dearden Phillips, Managing Director Stepping Out

Steve Shrubb, Chief Executive, West London Mental Health Trust

Dame Carol Black, Policy Advisor - work and health to the government

Paul Anderson, Managing Director, Deutsche Bank, Birmingham

Combined Authority Leader Champion, Darren Cooper Sandwell MBC

Supporting Officers:

Sarah Norman, Lead Chief Executive, Dudley MBC

Steve Appleton, Project Lead (steve.appleton@contactconsulting.co.uk)

Steering group membership

Lola Abudu, Public Health England

Sarah Barnes, Troubled Individuals Programme, Solihull MBC

Stephen Chandler, National ADASS Mental Health Lead

Dr Aquil Chaudary, Cross Birmingham CCG

Ruth Cooke, CEO Midland Heart

Dr Elizabeth England, Sandwell CCG/RCGP MH lead

Simon Gilby, Coventry & Warwickshire Mental Health Trust

Viv Griffin, Wolverhampton Council and West Mids ADASS and ADCS

Sarah Jury-Onen, DWP

Dr. Adrian Philips, DPH Birmingham

Sean Russell, West Midlands Police

Dr Paul Turner, Birmingham South Central CCG

Helen Wadley, Birmingham MIND

Shelley Ward, Prevention of Violence Against Vulnerable People Programme

West Midlands Mental Health Commission: open space listening events 2016

This report summarises the deliberations of stakeholders from across the West Midlands in 2016 who took part in a series of three events.

Shared Future
A Community Interest Company

For more information contact

www.sharedfuturecic.org.uk