Who Cares

The health & social care Local Involvement Network for North Lincolnshire

Experiences of Mental Health Services in North Lincolnshire

Voluntary Action North Lincolnshire

Advancing Local Voluntary Action

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Who Cares is hosted by Voluntary Action North Lincolnshire. To become a member or to take part in any of our activities please contact us using the details below.

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1. FOREWORD

The Mental Health Sub-Group of *Who Cares* has had a busy and eventful year. It is worth remembering that this group was set up as a result of public consultation into which topics of health and social care *Who Cares* should look at. An investigation into the experience of mental health service users and carers was one of three topics chosen, and this report looks into the findings and recommendations resulting from those investigations.

Contrary to the belief that the Sub-Group is only attended by mental health service users, it is made up of a wide range of people. The group has attendees who are Carers and representatives from Carers Support Services, Scunthorpe and District Mind, VOICE (Of Service Users), Rethink and the Alzheimer's Society. As well as this there are representatives from a wide range of other health and social care related groups, as well as interested individuals. It is also pleasing to have input from statutory partners Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust, (RDaSH), management and staff from Great Oaks Mental Health Unit, NHS North Lincolnshire, North Lincolnshire Council and a local registered social landlord, North Lincolnshire Homes.

This diverse mix of attendees to the group has created a strong and influential working group to push the project forward, as well as look into other areas of work.

Of these other projects, the main one has been looking into the 2010-2015 NHS North Lincolnshire Commissioning Strategy for Mental Health, as well as the proposals for the modernising of mental health services in North Lincolnshire. The liaison of group members with senior management and staff of both RDaSH and NHS North Lincolnshire has seen a number of positive suggestions put forward throughout the consultation to address issues which service users and carers felt needed addressing.

At the time of writing this consultative work is still ongoing, and whilst this has been at times challenging, the Sub-Group have been assured that these suggestions will be investigated and hopefully taken on board. Only time will tell.

The positive suggestions and recommendations continue throughout this report, and it is reassuring to be able to report on encouraging findings which can be seen in a number of the experiences gathered.

However, there are many areas in which service users and carers have real concerns. It is apparent that there is real room for improvement and it is vital that the service user voice is listened to, and the suggested recommendations are considered carefully.

I would like to thank the hard work and drive of all the many people who have been involved in the Sub-Group over the course of this project. I would also like to thank the host staff, Helen Kirk, Lindsay Barnett and Kristian Reed for their hard work and support.

Richard Leach
Mental Health Sub-Group Lead

2. INTRODUCTION

This document reports on the work conducted by the staff and members of *Who Cares* during 2010 into the experience of service users engaging with mental health services across North Lincolnshire. This piece of research was initiated by the Mental Health Sub-Group after approaches made to the Executive by members, service users, carers and concerned professionals.

One of the initial areas of concern which prompted the work surrounded the adult mental health unit at Great Oaks, which is based in Ashby. Concerns at Great Oaks included reports of poor staff attitude and the lack of empathy demonstrated by them towards service users and carers. Likewise the amount of time spent conducting therapy sessions with patients, the number and variety of therapeutic activity which was available to patients, the contact time between staff and patients (particularly in a one on one scenario).

3. *WHO CARES*

Who Cares is the Local Involvement Network (LINk) for North Lincolnshire. LINks have their origins in the Local Government and Public Involvement in Health Act 2007. This act requires each local authority to ensure that a network of local people is established in their areas to investigate the quality of health and adult social care services.

Who Cares has a membership of over 250 and a proactive Executive Board of 20. The Mental Health project is the latest research to be undertaken by the team and is subsequent to concerns raised by LINK members.

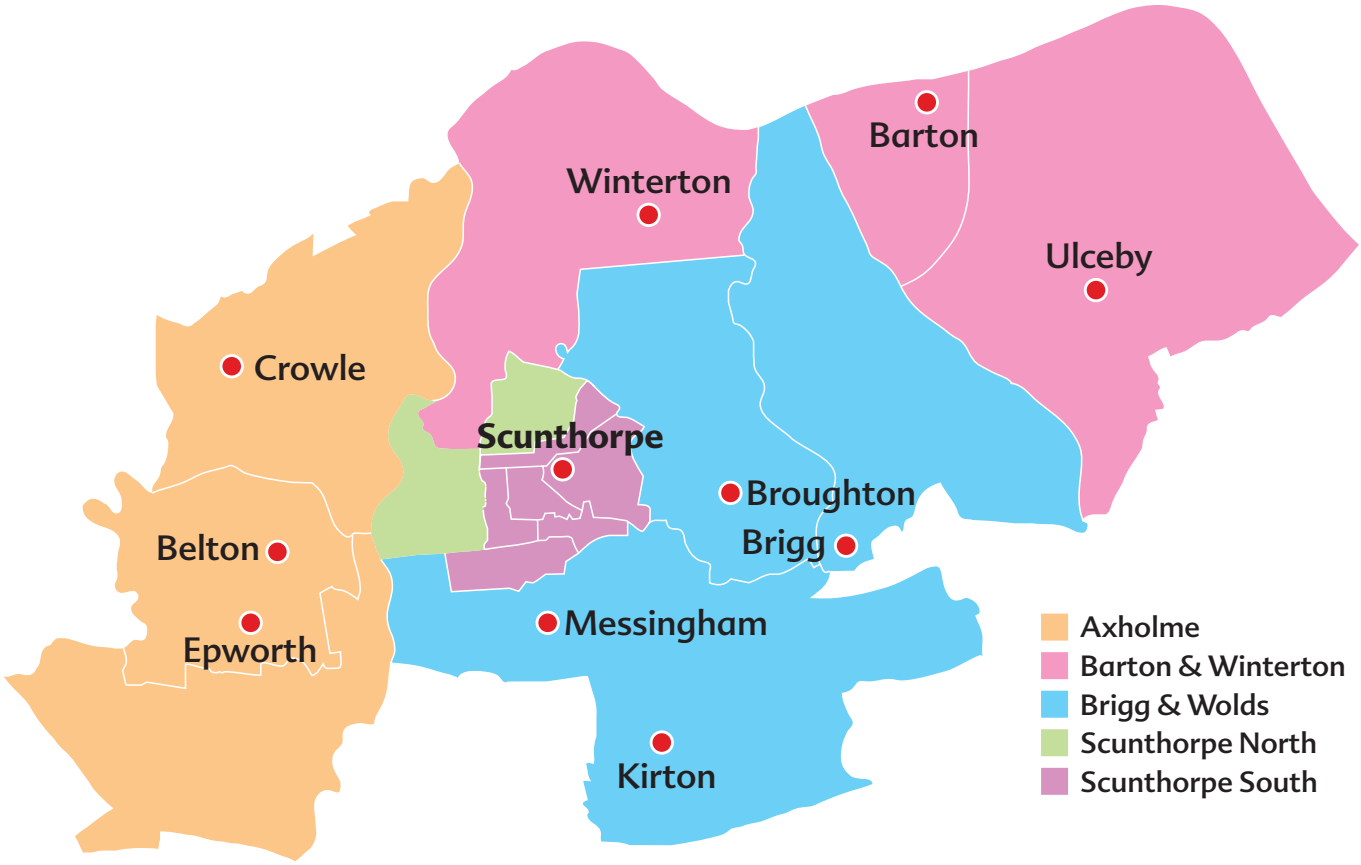
4. BACKGROUND

Mental Health is the biggest spend within NHS nationally & in North Lincolnshire it accounts locally for 9.5% of the budget.

It is estimated that 12,000 people aged 16-64 suffer from common mental health disorders in NL. Depression is also said to affect between 11 — 15 % of our older population (2,900 — 4,300 people), with 3 - 5% experiencing depression in its most severe form. Prevalence of depression almost doubles for older people suffering ill health and disability.

Moving Forward Joint NL Mental Health & Well Being Commissioning Strategy, produced by NHS NL in 2010 informs us that:
The prevalence of schizophrenia is estimated to be 6 per 1,000 or an estimated 480 adults of working age in NL, as well as between 70 — 140 older people in NL with an enduring mental health need such as schizophrenia. This varies by age and is slightly higher for males.

The number of people with bipolar disorder and related conditions is higher, ranging from 4 — 39 per 1000 adults, depending on age: the highest rates being amongst the under 45's.



Map showing North Lincolnshire wards.

Axholme	Barton & Winterton	Brigg & Wolds	Scunthorpe North	Scunthorpe South
58	180	176	145	515

Fig.1: Number of adults (1074) with psychoses on GP registers [Source QoF, 2009]

The population of North Lincolnshire population is approximately 161,000.

A summary of national data cited in Moving Forward Joint NL Mental Health & Well Being Commissioning Strategy (2010) indicates that:

- An estimated 1 in 4 older people in the community (7,000 in NL) may have symptoms of depression that are severe enough to warrant treatment. Yet only 1 in 3 are likely to discuss this with their GP.
- Of those that do, only half are diagnosed and often treated with anti depressants.
- A third of people who provide unpaid care for an older person with dementia, have depression.
- Delirium or acute confusion affects up to 20% of older people in a general hospital setting.
- Two thirds of NHS beds are occupied by people aged 65+, of which 60% have or will go on to develop mental health needs during their admission.
- In 2009, just over 2,000 people of working age were unable to work and were claiming incapacity benefits in NL as a result of ill health.

Currently in NL there are 273 children with a diagnosis of ADHD, of which 69 are 16-17 years of age.[1]

Joint Strategic Needs Assessment

The 2010 Joint Strategic Needs Assessment for North Lincolnshire acknowledges that Mental Health problems are a major cause of disability in this country and by 2020 is projected to be the second leading cause of loss of disability adjusted life years in the world. Suicide accounts for 1% of all deaths in this country and nearly two thirds of those deaths occur in depressed people.

Much work has been undertaken and statistics collated to provide detailed background in order to inform service provision across North Lincolnshire.

The document can be found at: www.northlincolnshire.nhs.uk/healthintelligence/jsna

Attention Deficit Hyperactive Disorder (ADHD)

ADHD is a widely recognised complex development disorder in childhood. Prevalence estimates for childhood are thought to be in the region of 3-9%. The same characteristics transferring into adulthood has gained some recognition and research is being undertaken because at present there is a lack of robust epidemiological data on its prevalence. Longitudinal studies have demonstrated the persistence of ADHD into adulthood suggesting that up to 15% of adults diagnosed with ADHD as children may retain the full diagnosis at the age of 25.

[1]Moving Forward Joint NL Mental Health & Well Being Commissioning Strategy

5. NORTH LINCOLNSHIRE SERVICES

Mental health services in North Lincolnshire are commissioned by NHS North Lincolnshire and provided by Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH).

RDaSH has been managing all mental health services in North Lincolnshire since June 2008.

The trust provide the following services in North Lincolnshire.

- Adult Mental Health
- Older People's Mental Health
- Children and Adolescent Mental Health
- Substance Misuse Services

See appendices (page 23) for a brief overview of the range of adult, older people's and substance misuse services which RDaSH provide in North Lincolnshire. These also detail other statutory services, voluntary sector and additional support services available

6. METHODOLOGY

By its very nature Mental Health is a sensitive issue, there are perceptions and many natural and understandable barriers to easy discussion. Access to service users, carers and health care professionals is not as easy as might first be imagined. In some situations health care professionals are defensive of their positions for a range of reasons. People with mental health issues do not always want to talk about their experiences, be it they have moved on and learned to cope, they are still 'in the system' and fear reprisals if they are seen to be critical.

Questionnaires were considered as a means of gathering information on people's experiences, but a proactive and qualitative approach was felt to be a more useful insight to convey people's real experiences. This data would also be more useful to commissioners than quantitive responses to questionnaires. There was also a view that they would be competing for peoples time as currently there were a great many 'consultations' being conducted at the time. There is also the issue of the language used, some people with mental health issues might also have learning difficulties so struggle to respond or they may have a drink and or substance mis-use problem which can contribute or prevent engagement or participation.

Organisations, particularly charities and voluntary groups who work with service users were approached and asked if they would make our research quest known to their clients. Service users and carers were far more approachable within their own comfort zones and 'safe environment'. In these situations of one to one informal interviews great detail was forthcoming and a willingness to tell their story. Some of these interviews revealed some very harrowing experiences.

Research was also undertaken through and with a service user group Fresh Steps. Working with 'experts by experience' and using a Privileged Access Approach researchers were able to gain valuable insight into mental health issues associated with substance misuse.

Much of the research took the form of one to one interviews. These were conducted at a venue comfortable for the service user or carer. This might have been in their own home, at a drop-in centre or they were invited to the project office.

The relaxed atmosphere was conducive to open dialogue and people were keen to tell of their experiences and especially keen that their views on how improvements might be made to services so that others could benefit was apparent. Many of the suggestions made, based on experience and observations were very simple and in the main easy to implement. Clearly communication and empathy were crucial to improving their state of mind, self esteem and general mental well being.

7. LIMITATIONS

Forty-seven service users and carers is a relatively small sample size. However, it is believed that the quality of the data outweighs the sample quantity. The data covers long term service users who have known and experienced the old and the new models and who are able to compare and contrast provision over time. It is drawn from past users and also recent entrants to services.

Whilst conducting one to one interviews is a lengthy process they provide a greater depth of information and insight. Interviews are able to get to the root of issues and have been able to illustrate patterns because the experiences are not isolated but repeated across a spectrum of service users.

Whilst some drift occurred in the interview focus there was the opportunity to return for clarity of issue. A relaxed approach resulted in service users able to talk with ease about the full range of their experiences. However, this meant that a consistent approach was not the priority although the regularly recurring themes and issues were evident and could be explored in more depth.

Direct prompts and leading questions were avoided. Access to Black and Minority Ethnic (BME) and emerging communities was difficult. A general approach was made through various network contacts but with limited success. This generic approach about access to services by BME communities was a partnership approach with Safer Neighbourhoods and the Migrant Advancement Partnership (MAP). A visit to a mosque, as well engaging with Eastern European, Muslim and Sikh groups established the difficulties in raising the topic of mental health. This unease was echoed across all emerging communities. There was an even greater difficulty accessing women's groups within these communities.

8. RESULTS

8.1. Sample profile

- 47 service users and carers have provided a range of responses to our research.
- Of these 16 were female, 15 were male, gender could not be determined in thirteen returned questionnaires and three were returned by health care professionals.
- To supplement these the Patient Opinion website has been utilised to locate comments specific to North Lincolnshire. Where these comments have been incorporated within the report they are identified by (PO) after use of the quote or detail.
- Three quarters of those who provided information are current or recent service users (within the last 6-12 months). Of those about two thirds would describe themselves as still 'being in the system' i.e. they are long term service users. This is helpful as they are able to compare and contrast the changes made in service provision over time. One respondent has been able to offer insight into thirty years of interaction with Mental Health Services.
- Whilst there has been a suggestion made that they are not able to provide objective data, it has been revealing to learn that they do appear to be able to date and detail experiences and people they have met. Greater detail has not been sought as the research was not to act as a 'fishing expedition' for complaints, nor did it seek to raise either service user or carers expectations of resolution to ongoing issues they were experiencing.
- Medication was raised by about half of respondents, as was Great Oaks. Psychiatrists by around a quarter, and general attitude and approach by MH professionals was raised by about a sixth of people interviewed.
- Of the returns, there were six regularly recurrent themes.

8.2. Themes

Great Oaks	Psychiatrists	Medication	Treatments & Therapies	Crisis Team	Dual Diagnosis
2:24	2:13	1:19	1:16	1:6	0:6

Fig.2: Shows the number of references made by respondents to each of the recurrent themes. Where the number is represented 2:1 for example, 2 represent positive comments as opposed to 1 adverse comment.

It is clear that many of the respondents raised more than one issue, however given the range of experience and length of time as service users it is hardly surprising. However, new entrants to services also report the same issues.

There were other topics reported and these are detailed over the next few pages.

8.2.1 Great Oaks

Staff attitudes at Scunthorpe Hospital compared to Great Oaks and Community Staff teams was a regularly raised issue.

One respondent mentions witnessing patients being "touched up", although the incident was reported there appeared no sanction.

Staff have been witnessed shouting at patients, one who later took an overdose. The respondent who witnessed this felt guilty for not reporting the incident at the time but fear of reprisal causes reluctance.

Of Sycamore .... "Is like being thrown to wild animals, hope you come out alive". When Great Oaks "first opened there was lots to do, now there aren't enough staff to give you a push when you need it." "Place of high hopes but now a place of hell." Female Great Oaks patient 2008 – 2009, current service user.

"Preferred W18 to Great Oaks, more staff socialised with patients". "Nursing station is a barrier".

"During a three week stay in 2009 I escaped five times whilst held on a Section 3. Care was negligible".

"A lack of willingness to engage with patients by staff through verbal interaction, psychological therapy or provide distractions from own thoughts by art, computers, tai chi or quizzes etc."

"Would do anything to stay out of Great Oaks".

Two respondents reported that Great Oaks "felt like a prison".

"As a visitor you are not made to feel welcome".

One respondent reported that there was "A lot of physical violence , but a reluctance to use PICU as too short staffed."

The implementation of the smoking ban has prevented communal gatherings and prevented relationship building between patients and staff.

Conversely some positive comments about Great Oaks were reported:

Great Oaks building much different to Tennyson Ward. The standard of care received at Great Oaks was "much much better than Tennyson".

One service user described the Great Oaks "facilities and food like staying in a hotel."

Recommendations

Many of the suggestions made by the service users and carers are both inexpensive and simple to implement. Many relate to improved communications between professionals and service users and carers.
A high proportion of service users reported poor staff attitude and a lack of empathy. Real or perceived it is a simple matter where improvements need to be driven through the care pathway.

8.2.2 Treatments & Therapies (inpatient and community based)

"Meaningful activity should be determined within an individual care plan negotiated with the service user...the creation and maintenance of a therapeutic activity milieu needs to include evening and weekend activities and opportunities both on and off the ward. This may include educational, social, artistic, recreational and leisure activities...There is currently an imbalance of emphasis and deployment of staff skills in organisation of inpatient wards...It is important that adequate priority and resources are given to a structured regime of activity and service user engagement and that staff skills and time allotted to such work are protected in the face of competing demands."**2** - Department of Health, 2002.**2**

Department of Health, 2002, Mental Health Policy Implementation Guide. Adult Acute Inpatient Care Provision.

Long term service users have provided copies of old activity programmes and when these are compared to therapies and activities currently on offer, it is evident that there has been quite a drastic reduction in activities offered. When this was raised with staff at Great Oaks the response was that they were in the process of reviewing activities or that there were statistics available which provided data that service users had participated in activities. When pushed it was established that the definition of activities could be getting up and out of bed in a morning or getting dressed. When asked about working with carer groups or local voluntary sector groups to deliver activities there was a decided lack of enthusiasm or interest evident.

Recommendations
More meaningful therapy sessions during inpatient stays. Service users recognised that by focussing on activity it banished 'bad thoughts.'

Potential activities mentioned included more use of the art room at Great Oaks, and greater use of Sandfield House for arts and crafts based therapies. Photography, cookery and gardening (both on site at Great Oaks, and through community based allotments) were other options offered.

8.2.3 Dual Diagnosis

Occasional Paper OP75 (June 2010) Looking Ahead Future Development of mental health services: recommendations from a Royal College of Psychiatrists' enquiry.
Recommendation 14: *Mental health services should remove dual diagnosis / substance misuse as an exclusion criterion and ensure that staff are trained in substance misuse issues.*

Interaction with service user and carer support groups indicate that there are serious issues when drugs or alcohol are involved in any incidents or situations.

"Patients not searched on entry. Have seen people with drugs."

Another respondent also offered the observation that security after public visits was poor, bags were searched but not pockets or anywhere else where drugs could be hidden.

Of Great Oaks "Takes too many people who are suffering from drug/alcohol problems".

"Creates a bad relationship between the patients".

"Unreasonable to expect mental health patients with drug or alcohol misuse patients".

Attendance at a recent NL Substance Misuse Team Needs Assessment Event (December 2010) which also saw contributions from service users with Dual Diagnosis revealed the cost of crisis accommodation through an eight week event process. The example quoted illustrates an incident leading to an arrest and progress through the system. This is the worst case scenario, and fully acknowledges that not everyone will encounter the Criminal Justice System. However, taking the Criminal Justice figures out of the equation, it still illustrates a high service level cost.

Costing Statement: Psychosis with coexisting substance misuse. (2011) NHS National Institute for Health and Clinical Excellence. "To date, no single UK study has attempted to estimate the combined total costs to healthcare and society of treating people with a diagnosis and coexisting substance misuse". Costs of inpatient mental health episodes per occupied bed day.

Description	National Average Unit Cost
Adult : intensive care	£613
Adult : acute care	£304
Adult: rehabilitation	£274
Children	£594
Elderly	£310
Low level secure services	£418
Medium level secure services	£481
High dependency secure provision: mental health / psychosis	£763

Costs of inpatient mental health episodes per occupied bed day

This figure is an incredible drain on a range of services (Local Authority through Safer Neighbourhoods), the Criminal Justice System through the Home Office and the Police service, and the VCS. A case could be made that these costs (often not fully budgeted for) could be better spent delivering better outcomes through intervention schemes. Development of effective joint working practice to provide intervention would also provide volunteering and training opportunities for service users and families to self help. Mentoring through 'expert by experience' opportunities would provide a degree of sustainability beyond the consequence cost.

The figures used are unfortunately somewhat out of date, but they do illustrate that it would be more cost effective to provide crisis accommodation / half way house or hostel in order to avoid repeat offenders causing a constant drain on limited and in many cases now reduced budgets.

Discussions with dual diagnosis clients clearly illustrated a need for intervention to prevent constant re-entry to the cycle. Whilst 'care in the community' and re-integration is heralded as the desired outcome there is an acknowledgement from many clients that they do benefit from a structured regime such as hostels and half way houses. Clearly the number of repeat offenders demonstrates that there needs to be a review and in some circumstances a cost benefit analysis of the local situation and provision made for treatment centres or specialist accommodation.

Estimated cost of a repeat offender

The annual estimated cost of each individual repeat offender is **c.£8,530.14.**
If there were 10 individuals in North Lincolnshire the cost would be **c.£85,301**
Or if there were 20 individuals, it would cost **c.£170,602**

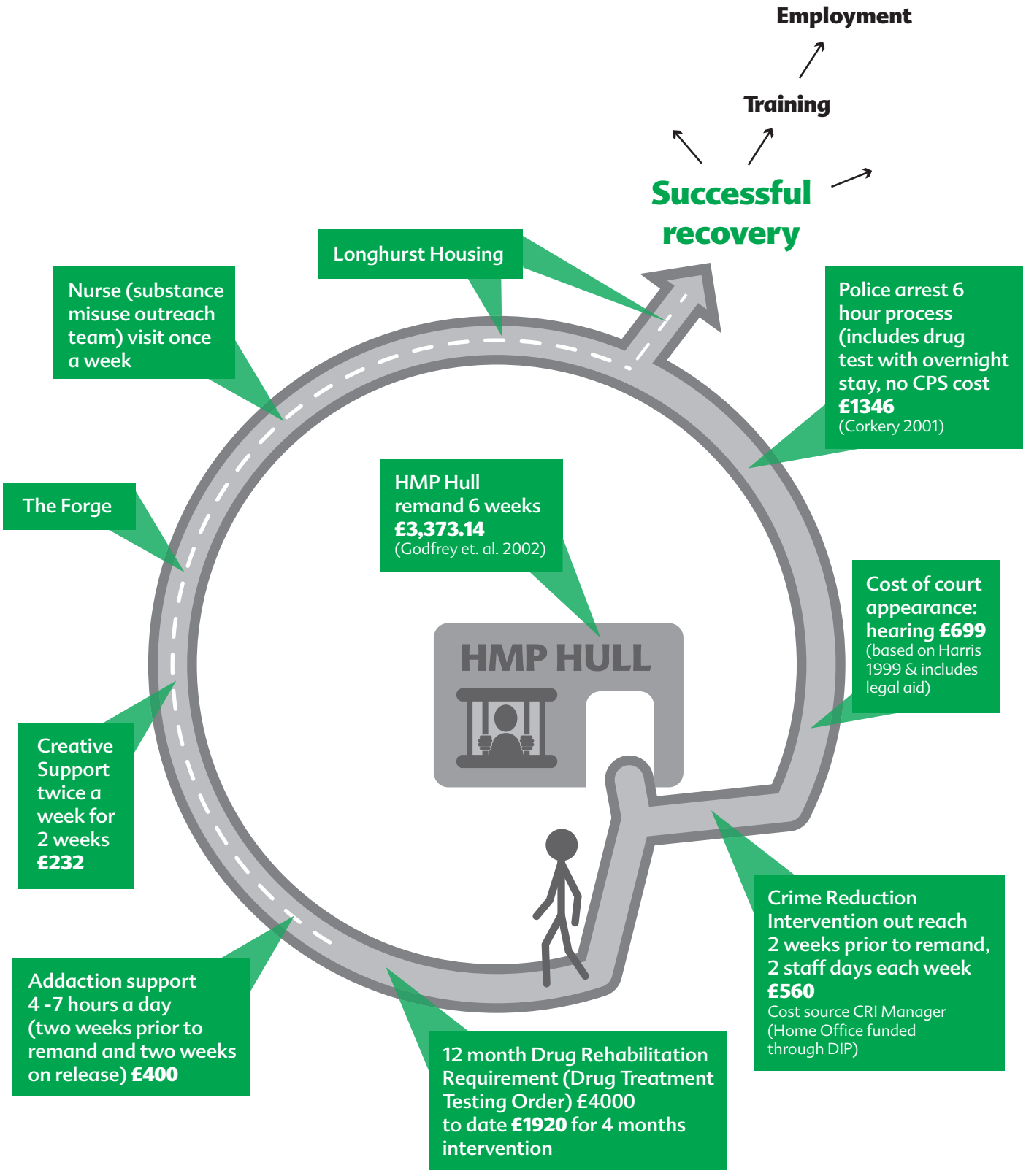


Fig.3: Illustrates the estimated cost of one individual repeat offender

8.2.4 Medication

One of the fundamental issues surrounding medication is that use or change is not communicated to service users. Service users do have an ability to understand the effects of medication and it is also reasonable to expect that they know their bodies and their state of mental well being, conversely that they are heading downwards into or towards a crisis. One service user did not wish to come off medication because of the drastic swings, the "highs were not there without the lows". Good communication by professionals is crucial to building trust and rapport with service users and their carers.

One respondent expressed concerns that no notice is taken in terms of medication and any desire to work towards decreasing the amounts. To decrease amounts requires a Doctors consent, respondent cited incidences of refusal to take extra medication. A carer of an agoraphobic with a history of substance abuse has reported noticeable change resulting in deterioration since change of medication 'antibuse'.

"Too much medication, throwing tablets at people."

"Side effects of medication not explained".

"Communication is appalling".

"No point being given medication. Keeps at a level, but no good if not experiencing highs to have lows."

"If people know how to cope then don't put on medication. People on medication are vulnerable."

Conversely one respondent reported that the "medication prescribed had helped tremendously."

Recommendations

Health professionals need to ensure that patients have an understanding of what is happening when changes, increases or decreases are introduced. Communicate the information to the service user and their carer.

Staff to show a 'listening' approach to service users, carers and patients that they have 'heard'.

Medication should be used as a last resort, after other interventions and therapies have been explored.

Continual monitoring and dialogue between health professionals and the service user is key to improving wellbeing and assisting recovery.

8.2.5 Psychiatrists

A common complaint was lack of continuity in getting to see the same psychiatrists, having to go over case with new staff was not helpful to their state of mind.

One respondent expresed concern about the six month wait between GP referral and psychiatrists appointment.

Another respondent noted that there was no seasonal cover over the Christmas period and this was a known period of need for service users and their providers.

"It is difficult to build up trust and rapport with a psychiatrist when you see a different one each time you have an out patient appointment. It can also be very distressing to have to keep repeating your story each time. On telephoning Great Oaks I found the psychiatrists secretary to be the most helpful." Female service user.

"People seem to get kicked off the psychiatrists panel, deeming people to be well when they are not. This seems to have been happening more and more over the last six months." Current service user.

"On each occasion I saw a psychiatrist it was a different one. There is no continuity. One psychiatrist would say one thing and another psychiatrist would say something different. There would seem that there was a total lack of communication. Some of them certainly need training in communication skills."

Positive comments:

"Psychiatrists have been very good throughout."

One carer reported via Patient Opinion that after receiving 12 sessions of CBT at West Street (Scunthorpe) through signposting by his psychiatrist that her husband had for the first time in 18 years felt he was listened to by a professional. Shortly after the treatment he showed signs of relapse but was able to avoid a crisis by using the strategies and techniques learned through the CBT.

Recommendations

Communication is crucial, patients and carers need to understand the benefits and any side effects of treatment and conversely psychiatrists would benefit from building rapport with patients.

Consistency where practicable and continuity in psychiatrists assigned to patients.

8.2.6 Crisis team

A number of comments were received regarding the Crisis Team, particularly in relation to accessing the team and their response to requests for help.

"No response from Crisis Team" (to messages left). Female 50 – 60

"Access to the Crisis Team should be easy, particularly if you are known. "

"Not good for anyone to have to go to A&E and for them to phone the Crisis Team".

Female, 30 years a service user. Recently let down by Crisis Team three times. "No help, no support. Words are not enough".

Carer for a Dual Diagnosis client. "The lack of support or help from any of the professionals has been appalling".

Recommendations

Service to be available out of hours, evenings and weekends as well as office hours. Clear communication lines needed and easier access away from Accident and Emergency setting.

Communications with service users need to be ongoing and consistent to ensure they feel supported and reassured at all times

8.2.7 Case study

One service users tale was so graphic in their ability to dispassionately regale recent experience that it is included below The experiences detailed are from the autumn of 2010, so are offered as recent.

Engages with: GP (Poeisis), In Patient and Out Patient, Community Mental Health Social Worker, Options Team, Crisis Team

Prior to my last admission (my fourth this year) I have tried to access services as I was concerned about my declining state of mind. I had been on a gradual slide for the previous two weeks but this had escalated on the Wednesday prior to my admission in the early hours of Bank Holiday Monday.

On the Thursday morning I called my mental health social worker who was unavailable so I left a message on his voicemail asking him to contact me. By early afternoon I called again to be informed he had been dealing with an emergency but was now back in the office so would pick up his messages. I rang again at 4.30pm to be told that he had left for the day.

"I left the house with the intent to kill myself."

On the Friday afternoon my daughter, who was growing increasingly concerned, called him but again he was unavailable and she was put through to voicemail.

On Saturday morning I tried contacting my doctor's surgery and after one and a half hours of getting an engaged tone I drove down to the surgery. The receptionist informed me that there were no emergency appointments available and all regular appointments were taken. If I needed to see a doctor I had to contact the out of hours service.

By early afternoon I was feeling more desperate and drove into town to see the Samaritans but they were closed. In the early evening I telephoned the Lincsline. This went straight to answer-phone and I left a message asking someone to contact me.

Having received no response from Lincsline on Sunday morning I could not cope with my pain any longer and felt that death was preferable. I left the house with the intent to kill myself.

I was picked up by the police in the early hours of Monday morning and was taken to Great Oaks. At the time there was no suitably qualified member of staff available so I waited with the police while an agency psychiatrist was brought in from near Manchester. A couple of hours later I was seen by him and admitted onto the ward — reluctantly.

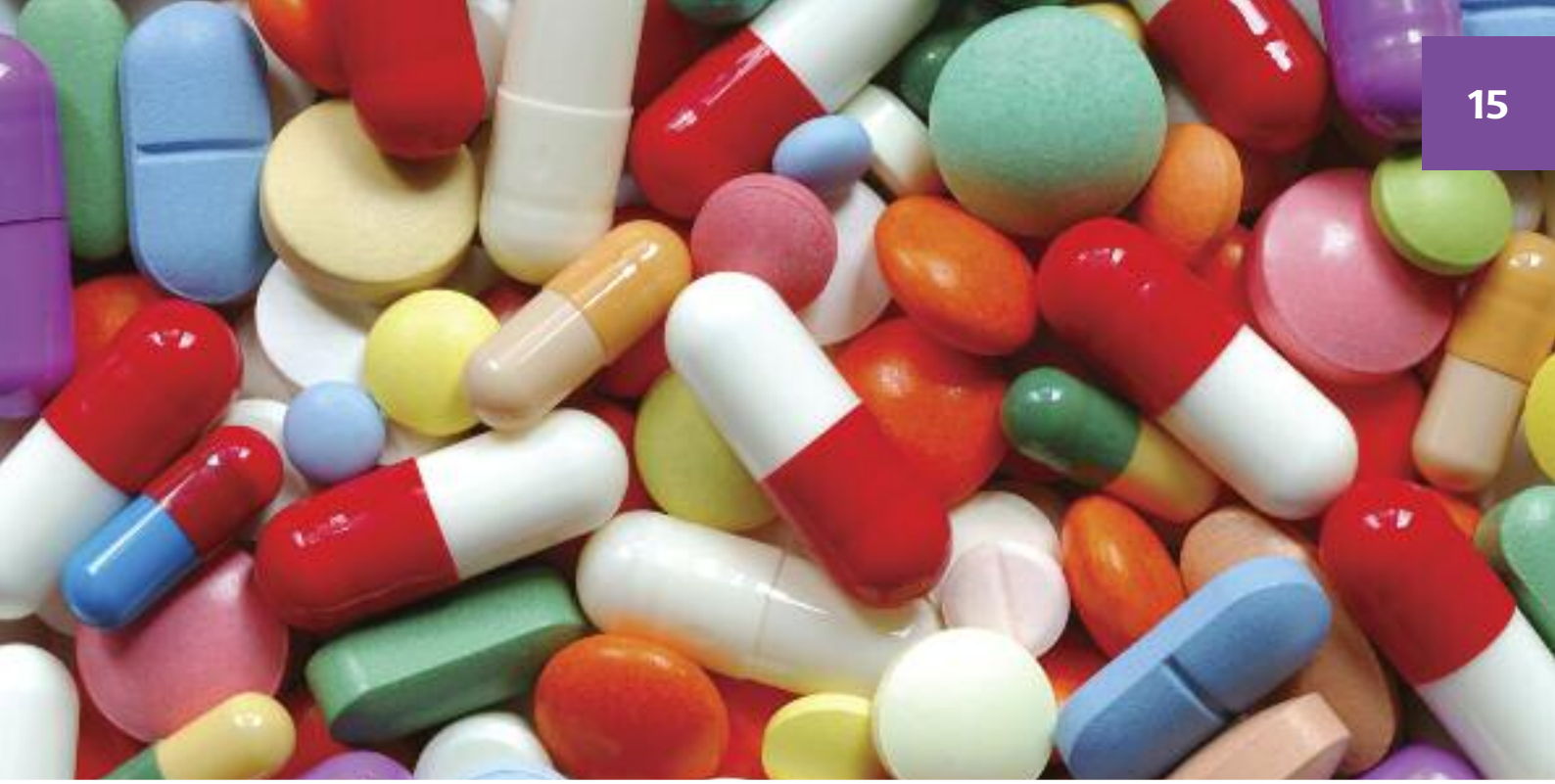
Before going to bed I was seen by another doctor who agreed to give me some medication to help me sleep. After about half an hour I asked the staff nurse for this medication but she couldn't give it to me as the doctor hadn't written it up.

Over the next few days I saw a further three different psychiatrists, one who started me back on medication that had stopped on a previous admission. I only realised this when they came round with medication and I queried what I was taking. I queried this with the next doctor I saw and he couldn't understand why it had been restarted and immediately withdrew it.

Other than the brief contact with psychiatrists and the twice daily blood pressure/temperature checks there was very little interaction with the staff members. Nobody asked me how things were going, what I was feeling/thinking, how I was coping or checked whether I had been eating/sleeping.

I had approached staff on a couple of occasions asking to speak to someone and was told that someone would be available later. I also raised concerns about another patient who was urinating in the quad and drinking the milk direct from the bottles. He was asked not to do this but was left to his own devices and carried on regardless.
On the Thursday I requested home leave as I did not feel anything was being achieved. The hospital dropped me off at home and I spent several hours out before being dropped back the hospital by a friend in the early evening.

When I returned to my room, on the table was care plan. Looking through it not only was it incomplete but on the reasons/purpose for admission it states that I was *"not concordant with prescribed medication!"* I took this up with the staff nurse on



duty who agreed that this was not appropriate and deleted this statement, although I've no idea whether this happened to the one on their files. He advised me that the care plan should collaborative and that he would ensure that my named nurse would make time to complete it with me.

On the Friday I again took leave but my friend had to give assurances that she would be responsible for me and to have me back by an agreed time — although the day before it had been fine for me to be dropped off unescorted!

It had been a very difficult day and when I got back to the ward a nursing assistant did come to speak to me. Although I think she had read some parts of my notes she had not taken in the bigger picture and suggested that I was *"bringing things on myself"* and that *"life is full of injustices and that I should just get on with it."*

Her interventions only lead to my feelings of depression, frustration, isolation and hopelessness to escalate. I asked her to leave as I didn't wish to speak with her anymore and her response was that *"nothing will be resolved if I didn't talk."* (sic)

Again feeling that there was no purpose to my admission I requested home leave and on Saturday morning I was dropped off and asked to return to the ward at lunchtime. Once at home I just felt empty and paralysed. I didn't return to the hospital and when they phoned I told them I wouldn't be returning. This resulted in a visit from the Crisis Team, I presume to check that I was at home, but at no point did anyone ask why I didn't feel I could return etc.

After a difficult night I left home early in the morning and walked into Scunthorpe. Feeling increasingly desperate I telephoned the ward who advised me to go back. A member of staff picked me up and took me back to the ward.

On returning to the ward the same nursing assistant who had spoken to me on the Friday then asked me what I was doing back on the ward as I shouldn't be there!

After tea I had my first one to one session with my names nurse to complete my care plan. My feeling was that she had read some of my notes and had made a number of assumptions, that she didn't really understand me and that she had her own agenda. I also felt that some sort of misunderstandings were due to cultural differences and that she attempted to minimise my experiences. Again I felt that there was little point in engaging as I was going round in circles.

The following morning during ward round the psychiatrist asked me what I wanted and I stated that I wanted to be discharged and go home. I was somewhat hesitant in stating this opinion as on my previous admission making that statement had resulted in me being sectioned. So that was it, without any further questions I was discharged. He told me he would write a prescription for PRN medication and arrange a lift home.

I was asked to get my belongings together and wait in the lounge area, which I did. After three and a half hours waiting for my prescription and lift I decided to make my own way home without either.

A week and a half later I contacted Great Oaks about my prescription, aware that a difficult weekend lay ahead and that I needed to have some available. The receptionist put me through to the secretary but this was an answer phone so I left a message asking her to contact me. The following afternoon she returned my call and I explained the situation to her. She said this would not be a problem and she would call me as soon as it was ready to collect. Unfortunately she never called back.

The following week I brought this up with my social worker who said that Great Oaks had phoned him that afternoon to say he could collect the prescription and deliver it to me. He advised them that this was not possible. Despite this the prescription had been delivered to him on the Monday morning.

Today I have received a call from my surgery asking me to go and have some blood tests. When I asked why she said all she knew was that my psychiatrist had requested them. I told her that I knew nothing about any tests so she said she would get the nurse to phone me back. The nurse explained that I had some tests done whilst in hospital and there was some problems so they wanted to re-run the tests to see if anything had changed. None of this had previously been explained!

This admission had been quite typical of previous admissions with variations on a theme. I feel that after each admission I feel more despondent, isolated and that I am never going to get a more stable and optimistic frame of mind.

The key issues seem to revolve around communication, staff attitudes and providing a basic level of care. As an inpatient you should be able to feel safe, listened to and to be shown humanity, dignity and respect.

Throughout this admission at no point were my bags ever checked even though when I was picked up by the police I was suicidal and had items with me to self harm.

On the whole the attitude of the staff appears to be one of indifference. When specific incidents are raised with more senior members of staff the first question is usually *"who was it!"* Unfortunately name badges are not always on display so it makes it difficult to identify who you have been talking to. Perhaps a photo board on display might make this easier.

At times I have witnessed members of staff goading, demeaning and laughing inappropriately at other patients.

There is no consistency. I can't remember the last time I saw a psychiatrist twice in a row, either as an inpatient or outpatient. Each one has different ideas about your diagnosis and treatment.

Agreement has been reached on a referral to psychological services. This was supposed to have been done during my last admission in June, was going to be done at my outpatients appointment in July, has supposed to have been done during my latest admission but still hasn't happened.

The one to one contact doesn't happen so there is no time to explain what is happening, why and possible solutions. On a couple of occasions my care plan has been about working to reduce anxiety, learning relaxation techniques and looking at thought patterns. To date this has never happened.

"life is full of injustices and I should just get on with it."
Nursing assistant - Great Oaks

Another major issue is the lack of activities — there is nothing to do either therapeutically or recreationally. I find this raises my anxiety and frustration levels and leaves me ruminating about all the negative thoughts, feelings and events. Everything is magnified.

Even things like eating regularly are not a priority. Nobody checks whether you're aware meals are being served or that you have eaten at some point during the day. At breakfast you can't have a cup of tea or coffee as the kitchen doesn't serve it and you're not allowed to take a drink off the ward.

In the general areas things can be quite crowded, even more so if another patient is becoming verbally

or physically aggressive. Although there is a female lounge on my last couple of visits quite often this has not been available due to it being used for meetings and the television has been out of order.

Even in your bedroom it can be hard to escape. On my previous admission the lady in the next room spent most mornings in the shower singing, shouting and banging on the walls.

Privacy is also an issue when it comes to visitors. There is only one room available for private visits but this is not available if it is required for staff use. This means that visiting takes place in the dining room where you are regularly joined by other patients looking for a distraction.

Talking to other patients/service users I know that I am not alone in my feelings or experiences and that with a number of small changes the experience could have a much more positive and productive outcome. On a more positive note there are a small number of staff who are dedicated and professional and very approachable.

My experience of the community mental health services has been totally different. I have an excellent social worker, who is also my care-coordinator, who has built a very open, honest and collaborative relationship with me. He has been the one constant in a very inconsistent service. My main concern now is that with the new changes due to be implemented over the next few months he will be allocated to a team that does not cover my diagnosis so I start all over again!

Carers case study

Carers too need to be heard and understood and below is a contribution from 'an unsung hero' one of the hidden and neglected army of volunteers who do actually care and deliver the required level of service but all too often receive neither thanks nor support for their role.

Being a carer is a fairly new experience for me, I've been a carer for about 2 years and I've been shocked at how little support there is both for service users and carers. My main concern, like most carers I've spoken to is that there should be a good quality service for the person I care for as that would reduce my own need for support. Unfortunately my experience has been very negative; my husbands care consists of medication and occasional visits from his social worker. The only time there is any real input from services is when my husband has a crisis but my needs are not considered at all. The last time my husband was acutely ill I found services to be very difficult to navigate, inflexible and in some cases obstructive. There was no support for me to carry on working even though my husband was discharged from hospital when he was still very unwell.

I asked his worker if there was any provision for my husband to have some occupational therapy or some kind of activity to distract him from his distressing symptoms and also to give me a break...

On one occasion when I was really struggling to cope, I asked his worker if there was any provision for my husband to have some Occupational therapy or some kind of activity to distract him from his distressing symptoms and also to give me a break. I was told that nothing was available until my husband was well enough to access adult education! The staff from the Family Carer Team are really supportive and helpful but from their perspective a direct payment/personal budget should be used in this kind of situation, when we have enquired about this we have been told it is not available. Basically this means that as a carer I'm left with little support, no respite from the caring role and a lot of stress due to the difficulties of trying to maintain a full time job, run a home and care for someone with a severe and enduring mental illness.

Carer support seems to consist of 'token gestures' to keep carers sweet. I do not mean this as any criticism of the Carers Centre at Brigg or the Family Carer Team who all do a wonderful job within the limitations of their funding etc.
As a carer I can access lifelong learning but I can't access support to keep my job. I can leave my job to care for my husband but if I do that there is very little financial support and we would undoubtedly lose our home. Rethink organise occasional days out but when you work full time and care for someone with a severe and enduring mental health problem you don't have the time or the energy to go off on a day trip at the weekend as you have to catch up with household jobs/ shopping etc at the weekends.

Basically this means that as a carer I'm left with little support, no respite from the caring role & a lot of stress due to the difficulties of trying to maintain a full time job, run a home & care for someone with a severe and enduring mental illness.

Day to day things are very difficult for me, if my husband has a bad night I get very little sleep as he needs support to cope. Once he has settled down and gone back to bed I have to get ready and go to work and spend the day totally exhausted and worrying how my husband will be feeling when he gets up? Will I get phone calls or text messages from him in a panic and unable to cope? I can't even discuss these concerns with him as he hates to think he is a burden and if he feels he is causing me stress then that can make him ill too.

All in all, it's not a lot of fun being a carer. Carers save the country billions of pounds each year but I feel that locally services just leave carers to 'get on with it'. If someone has a carer then services take more of a back seat and let the carer struggle on. With the proposed reduction in beds and move towards more home treatment I am very anxious about the future. I fully support the idea of home treatment but question whether there will be enough staff with the right qualities, skills and experience to really provide the care needed to support people in the community. My concern is that once again carers such as myself will bear the brunt of these cost cutting changes to local services.

8.2.8 Other areas of concerns

Single point of contact

- It is easy to see from the appendices the plethora of services available in North Lincolnshire. A case might be made that it is confusing to try to understand how anyone might enter the 'system'.

  Signposting through a GP appears to be the usual route.

  However, where dual diagnosis sufferers have been unable to register with a GP, they lose intervention opportunities and can fall through the system and as a consequence can end up entering the criminal justice system.

- Lack of time outreach staff were able to spend on home visits.

  Many service users understood that staff had workloads but were clearly distressed when an outreach worker could only stay ten minutes or so when they were in a distressed state.

- A number of respondents felt that all the services were centrally based and that more should be available in rural areas not just Scunthorpe.
- Lack of consistency in standards of support workers, almost luck of the draw situation/postcode lottery
- Fear was a concern and what other patients [in Great Oaks] might do to them.
- There appeared to be a universal view that crisis was better dealt with by the services in 'office hours' and that the problems were usually at weekends or evenings.
- "The system is rigid and not sufficiently flexible or bespoke to a situation".
- One GP was criticised for an apparent lack of understanding around any form of mental health.
- Counselling Services criticised for cancelling courses, lack of access to buildings for anyone with a physical disability requiring the use of a chair.

Positives

- Kirton GPs were rated as very good in terms of support.
- Assertive outreach team very good.
- Praise of regular support from worker but lost after move to the Isle. Lost one worker who was not replaced.

GPs responses

- Need more/increased capacity for counselling services for young people. Help needed for young people 16+ after discharge from paediatric ADHD services.
- Good service from the POESIS Team who are based in GP clinics.
- Enjoy good communications with POESIS Team.
- Normally get good response from the Crisis Team.

9. EXTERNAL, STATUTORY CONSULTATIONS

Who Cares staff and members agreed to take part in two consultation events organised by North Lincolnshire Mental Health Services. These took the form of interactive events. One was designed and focused towards service providers and professionals and took place at the Wortley Hotel. The other a half day event aimed at engaging with service users and encouraged their attendance by offering sample therapy sessions such as reiki and hand massage.

The Future of Adults and Older People Mental Health Service in North Lincolnshire was a statutory consultation and offered options of response. The consultation sought specific responses to a defined model and the questions were designed to reflect this. Web responses were made available shortly after the consultation closed. Respondents *Who Cares* engaged with at the event were fearful over the relocation of older peoples services to a state of the art facility at Great Oaks. Many of their responses were very similar to and consistent with the reports received through the project research undertaken by *Who Cares* staff.

Concerns included staff attitudes, therapies available, loss of home service and lack of outreach care.

Concern was also expressed around dual diagnosis and family support. Intervention for youngsters affected by alcohol was also flagged up.

Concerns were also expressed about the desire to pigeon hole or label rather than addressing issues from a whole person perspective.

Admission to A&E was seen as far from ideal, from both the hospital and the service user perspective.

The Crisis Team were also flagged up as not having sufficient time to really assess in depth the best options for service users.

There were options as to how interested parties might respond to the consultation and the responses made on line appear to corroborate *Who Cares* research findings. There are nine responses to view. *Who Cares* is not certain how the on line responses will be validated but assumes that they will be moderated and this explained in any evaluation methodology.

10. RECOMMENDATIONS

Areas of concern	Recommendations
Great Oaks	Ensure that regular training updates and opportunities made available to staff. Encourage all staff to interact with patients to break down the 'them and us' culture.
Treatment & Therapies	Activities are offered as diversion from negative thoughts to aid recovery. Statutory service providers to work with VCS to offer meaningful options.
Dual Diagnosis	Ensure that there is accommodation available and separate for mental health and drug/alcohol patients. Re-evaluate and re-instate the provision of crisis accommodation. Consider establish 'half way house' type of hostel through joint working.
Medication	Ensure that changes, alterations to levels &c. are communicated to patients to provide understanding. Many patients are aware of the impacts of alterations to dose on their systems. File notes regularly updated and communicated to other health professionals to ensure consistency of approach.
Psychiatrists	Thorough communication is essential to gain trusts and confidence. Ensure that notes are communicated. Ensure consistency and continuity of assignment.
Crisis	Ensure that Crisis help is available 24/7 . This provision can be delivered by Crisis Team, LincsLine &c.
Poesis	Ensure that GPs are trained in Mental Health and able to recognise the need for early intervention.

Other areas of concern	Recommendations
Access	Work towards a single point of access for patients, whether first instance or existing service users or carers. Ensure that the telephone number is widely available through media campaign, GP surgeries, libraries community centres &c. Ensure that access to services are promoted through rural community newsletters, centres, GP surgeries &c.
Rural access	Rural isolation can exacerbate impact so care needs to be taken to ensure that if service users return home to rural isolated properties then they are not just signed off but progress followed up.
Staff	Ensure that health and social care professionals receive regular training opportunities in mental health and wellbeing treatments.

Other areas of concern	Recommendations
Crisis	Access to crisis services must be made available out of office hours, in the first instance through a helpline and in an emergency as accommodation
GPs	Ensure that they are offered and encouraged to take up training opportunities to update knowledge and skills.
Services	Counselling services need to ensure that service users expectations are not built up only to be dashed by cancelled sessions and failure to follow up with alternatives.

11. ACKNOWLEDGEMENTS

By far the greatest debt of gratitude is owed to those service users, carers and patients past and present who laid bare and made available some traumatic experiences so that future service users might benefit from anonymous disclosure in order that lessons can be learned and services made fit for purpose.

Service users, carers and patients want desperately to see a better understanding and de-stigmatisation of mental health issues. For their time and patience in helping *Who Cares* staff to understand and present this, their case for reform, thank you. There are so many unsung heroes that we can not name them all, they would not all want to be named but they know who they are. We hope you feel that we have done justice to your trust.

To Stewart Atkinson (North Lincolnshire Council) and Kev Wheaton (Addaction) thanks are extended for the many introductions to service users and carers who suffer dual diagnosis. To Kim Kirby (Safer Neighbourhood) for facilitating training which greatly enhanced our understanding of the complexities of dual diagnosis, its cost to individuals, their families as well as society.

To Claire Chapman who was always willing to make introductions, answer questions and act as a guide through the maze that is service provision for anyone suffering from mental health related illness.

To Sheli Begum (Safer Neighbourhoods) and Aaron Meda (MAP) for their help in accessing BME and emerging communities thanks are recorded.

John Berry (PCT) a veritable filing cabinet of useful information and networking suggestions and always a willing contact, thank you.

To the *Who Cares* sub-group, its volunteers and statutory visitors there 'opening doors' and making useful introductions, a big thank you.

"Mental illness is nothing to be ashamed of, but stigma & bias shame us all..."

Bill Clinton

Kristian Reed, Helen Kirk & Lindsay Barnett, April 2011

12. REFERENCES

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13. APPENDICES

RDaSH Services in North Lincolnshire

Adult Inpatient Service
The Trust provides assessment and treatment inpatient services in North Lincolnshire at the Great Oaks site which is located in Ashby. Great Oaks caters for service users who are suffering from an acute episode of mental ill health, some of whom may be detained under the Mental Health Act Great Oaks comprises two wards, Willow and Sycamore, as well as a Psychiatric Intensive Care Unit (PICU).

Willow House is the admission point for the Great Oaks. It provides assessment and short term treatment packages/interventions for up to 7 days.

If a service user requires an inpatient treatment period longer than seven days they will be transferred to Sycamore House. Sycamore has 14 beds, four of which can be provided to the Psychiatric Intensive Care Unit (PICU), dependent upon the number of service users residing in the PICU at any one time.

Older People's Inpatient/Outpatient Service
At the time of writing Older People's inpatient services are provided at the Carer Unit, located at Scunthorpe General Hospital. The Unit has two wards; Wesley and Tennyson.

Wesley Ward is an acute inpatient mental health facility specialising in the assessment and treatment of older people with functional mental health problems, i.e. anxiety, depression, psychosis, alcohol dependence, phobias and other related conditions. Tennyson Ward is an inpatient service specialising in the assessment and treatment of service users with organic mental health problems, i.e. the full range of dementias and disorders related to brain degeneration. The Carer Unit also provides outpatient clinics

Crisis Team
Crisis resolution and home treatment services provide advice, assessment and treatment at home or through crisis beds to prevent hospital admissions.

Community Mental Health Team
Integrated community mental health services are provided from a number of bases across North Lincolnshire. Community Mental Health Teams are comprised of nurses, social workers, psychological therapists, occupational therapists, consultant psychiatrists and support staff and provide advice, assessment, treatment and follow up to individuals experiencing a range of mental health problems.

Early Intervention Team
Early intervention services provide advice, assessment and intensive treatment to individuals experiencing their first episode of psychosis. The help and treatment available includes: family education and support; medication management; health promotion; nutritional interventions and practical support to in accessing community resources.

Psychological Therapies Team
The Psychological Therapies Team provide a range of high and low intensity therapies for adult service users. Some of these include cognitive behavioural therapy (CBT), behaviour management, medication management, counselling, advice and support. A number of computer based therapies are also provided, as well as e-clinics which can be accessed by all.

A number of specialist mental health interventions are also provided by the team, including: specialist assessments, art therapy, psychodynamic therapy and Dialectic Behavioural Therapy (DBT) — group work.

Recovery Services
Rehabilitation and recovery services provide different levels of support to individuals recovering from mental health problems as part of planned programmes to support independent community living.

Assertive Outreach
Assertive outreach services work with individuals who have serious mental health problems and find engaging with services particularly difficult. Care and support is available in a number of setting, including in a service users own home or other community setting, at times suited to them.

POIESIS
POIESIS is a service available in all GP surgeries within North Lincolnshire. Mental health practitioners work alongside GPs to help and treat people who are experiencing mild to moderate mental health problems.

Learning Disabilities
Working together to support people with learning disability is a team of social workers, learning disability nurses, and a psychiatrist, housing specialist, speech and language therapists. CLDT work closely with other council services and the NHS.

- Crisis intervention and safeguarding adults - if someone is in danger or a crisis develops, we will offer support.

Substance Misuse

The Junction

The Substance Misuse service provided by RDaSH is The Junction. This is service for those aged 18 and over with drug and alcohol problems. It provides access to advice, information and assessment, structured counselling and specialist prescribing for those with complex needs such as dual diagnosis. The Junction also provides a structured day programme, stimulant service and supports local GPs in shared care.

The other substance misuse services in North Lincolnshire are provided by other agencies, with brief summaries of these services below.

Drug Intervention Programme (DIP)

DIP is run by Crime Reduction Initiatives (CRI) and provides a range of services to people over the age of 18 affected by drug use and involved with the criminal justice system. Services offered include Arrest Referral, Prison Resettlement, 1:1 support including harm reduction, Outreach and referral into treatment. An out of hours helpline is also available.

Addaction

Addaction provide the interventions for those clients on Drug Rehabilitation Requirement (DRR)/Drug Testing and Treatment Orders (DTTO). The organisation works in partnership with the National Probation Service, Drug Interventions Programme and other relevant agencies to treat substance users, referred and sentenced by the courts.

Addaction also run the Structured Day Programme SDP). This serves all Substance users in North Lincolnshire, offering interventions and a thirteen week rolling programme.

Fresh Steps

Fresh Steps is a support service for people in recovery, or ex-users. It provides one to one support, a support group, as well as training opportunities. The group is hosted by Voluntary Action North Lincolnshire and is funded by NHS North Lincolnshire.

Empathy

Empathy is a support service for people living with or affected by someone else's drug use. It provides one to one support, a counselling service and a support group. Volunteers run with the support of VANL.

Other Support Services

Humbercare

Humbercare is a voluntary organisation working in partnership with statutory agencies, voluntary agencies and the community organisation.

It was established over twenty years ago to work with the Humberside Probation Service to — *"Educate, rehabilitate and promote the mental and moral improvement of offenders or any other persons in need, and the rehabilitation of persons discharged from penal institutions."*

The organisation offers support, advice and guidance on a wide range of issues including accommodation, mentoring, employment and training, as well as positive use of time.

Services such as volunteer befriending and the user involvement projects work with people with mental health problems, substance misuse problems, offenders, the homeless young people in the process of leaving Local Authority Care and other socially excluded groups to provide person centred services.

Creative Support

Creative Support is a not for profit organisation which provides person centred social care services for people with learning disabilities, mental health and other needs.

Creative Support provide a range of services, including supported living, supported housing, residential care, community and home support, floating support, extra-care and day services.

Creative Support also develops and manages housing to provide supported accommodation.

Creative Support offer services in 43 local authority areas, including North Lincolnshire.

Cloverleaf Advocacy

Cloverleaf Advocacy provides an independent advocacy service across Yorkshire and the Humber, including in North Lincolnshire.

Advocacy is provided for people with mental health needs, people with a learning disability, people with physical and sensory impairment, people on the autistic spectrum, older people and carers in a number of areas across Yorkshire and Humberside.

The organisation facilitate a number of self advocacy and service user involvement initiatives.

In North Lincolnshire these include training, providing the Independent Advocacy Qualification, and service user and carer consultation/research.

The advocacy services aim to support people in/at risk of being in oppressive situations to have their views heard and responded to appropriately by significant others e.g. health and social care services.

Cloverleaf has a number of specialist mental health advocates whose work can include support for appeals under the Mental Health Act, support at meetings and reviews, accessing information and signposting and supporting to access other appropriate services., which include:

Advocates can offer support in a number of ways:

- Supporting and representation in ward rounds or Care Planning Approach meetings.
- Raising concerns and making complaints on behalf of individuals.
- Accessing information on medication and diagnosis.
- Understanding individual rights if you are detained under the Mental Health Act.
- Help to contact a solicitor or other legal help.
- Accessing other services in the community.
- Finding appropriate advice, for example about housing or benefits.

Services are provided in a range of settings; in the community, in hospitals, psychiatric units (including medium and low secure units), residential and nursing homes.

As well as offering a specialist one-to-one confidential service, Cloverleaf also offer regular open access sessions in hospitals.

All services are free, confidential and independent from health and social care providers, the NHS, Social Services, Residential Homes and Hospitals.

- **MIND**
- Scunthorpe and District Mind provides social support for local people affected by mental health issues. We have a drop in centre which is open Monday — Friday 9.30 to 12.30 and 1-4. We offer various group activities, trips out etc organised by the Services Co-ordinator when resources permit. We also provide a 1:1 listening service which is facilitated by the Service Co-ordinator. We have a team of volunteers who offer support and participate in activities within the drop in. We also provide information and sign posting.

- **VOICE**
- VOICE of Service Users is a group for local people who use mental health services; our aim is to have a meaningful voice in the local mental health community and to contribute to the continued improvement of mental health services. VOICE members are involved in a wide variety of activities for example attending meetings, conferences, consultation work etc. The group members also participate in training and recruitment by arrangement with local service providers and we are currently preparing training sessions for local psychiatrists. The group also takes part in national consultations and has an active role in the National Survivor and User Network. We are passionate about peer support and recovery, not only do group members receive support via VOICE but we are also involved in the local WRAP (Wellness Recovery Action Planning) group which provides a framework for the self management of mental health problems. More information can be found on our website www.voiceofserviceusers.co.uk

Rethink

Rethink is a national mental health membership charity which aims to make a practical and positive difference to people by providing hope and empowerment through effective services, information and support.

The organization provide a range of services, support groups and information on mental health problems. As well as carrying out this work, Rethink also carry out research which informs both internal and national mental health policy.
In North Lincolnshire, Rethink provide a Carers support service and the Lincs Line telephone support line.

Mencap
Mencap is a national charity focusing on supporting people with a learning disability, their families and carers.

Work areas include:

- Providing high-quality, flexible services that allow people to live as independently as possible and be an active part of the community
- providing advice through our helplines and websites
- campaigning for the changes that people with a learning disability want.
- Supporting people to get a job, take a college course, or we can help them find a place of their own to live in.
- Advising about things like respite care, individual budgets or transport services.
- Running residential/day care services and leisure groups that are so important to so many people with a learning disability, and their families and supporters.

Mencap has over 500 affiliated groups nationally, including a group in North Lincolnshire. Local groups are individual charities in their own right, with the national body providing additional support.

Samaritans
Samaritans is a national voluntary sector organisation and has a branch located in Scunthorpe. Samaritans are available 24 hours a day to provide emotional & confidential support for people who are experiencing feelings of distress or despair. Services are offered by phone, email, letter, or face-to-face in most branches.

WANTED

YOUR STORY
YOUR INPUT
YOUR HELP...

... local solutions to health
& social care issues.

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Published April 2011. Kristian Reed, Helen Kirk & Lindsay Barnett

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