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Conservative Party Mental Health engagement event
Summary report and recommendations
March 23rd 2009

Overview

On Monday 23rd March, over forty Rethink mental health service users, carers and members met with members of the Shadow Health, Children, Schools and Families, Work and Pensions and Justice teams in Parliament. The event was organised by Rethink and the Conservative Party as both consider it essential that the people who use mental health services and their carers have a real say over the services they receive and how they are delivered. It was also a timely way of helping to ensure that service users and carers have an opportunity to feed into the Party's ongoing policy development.

The event involved five focus groups, each with a Party Spokesperson and Rethink facilitator and note-taker. Each group worked through a set of questions with participants outlining their experiences and agreeing possible solutions. This report is a summary of these discussions and the recommendations made.

Conservative Party representatives in attendance

Shadow Health Team:
Andrew Lansley CBE MP, Shadow Secretary of State for Health
Anne Milton MP, Shadow Health Minister
Earl Howe, Shadow Health Minister

Shadow Children, Schools and Families Team:
Tim Loughton MP, Shadow Minister for Children

Shadow Work and Pensions Team
Mark Harper MP, Shadow Minister for Disabled People

Shadow Justice Team
Edward Garnier QC MP, Shadow Justice Minister

Anna Biles, Representative of David Cameron's Office

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NHS and Social Care

There were two groups focusing on health and social care issues. They began discussions by considering what worked well within the NHS regarding the treatment of mental illness.

There was consensus that the move towards providing care in the community, and the discontinuation of the old asylums is positive on most levels. Specifically, participants noted good practice within the Royal Bournemouth Hospital's A & E as it has a Physical Health lead for Mental Health in the Trust. They also described role play techniques as being useful in terms of developing social skills for people who have become institutionalised.

Discussions then focused on key areas that require improvements, and the themes below were highlighted:

- **Communication and information sharing**

The group stated that problems are caused by poor communication and information sharing between health professionals and carers. Carers experience being excluded, even though this is not good practice, and are simply told that this is due to 'confidentiality'. This is even experienced when a close family relative, a daughter in the case given, attempted suicide.

The views of carers are important because someone with a mental illness may not wish to, or be able to give an accurate description of their health (for a range of reasons). One carer gave an example of what happens when health services don't listen to carers: "*6 years of fighting to make a complaint is ridiculous as it takes up valuable time and energy that should be spent on caring for my son rather than trying to get the NHS to provide the best care".* Carers feel they have to fight to get the respect, empathy and support they need.

Access to services and information about available services needs to be improved. Often the support and services do exist but people don't know they are there or have to struggle to get access to them.

Some carers also raised the importance of arranging 'Out of Area Treatments'. People should be moved nearer to family when they are ill and the cost of keeping them far from family, both to the family and to the health services, could be reduced by moving them.

- **Stigma**

Service users and carers also felt that attitudes towards mental illness can lead to a lack of sensitivity or empathy. A diagnosis should be given with a hopeful, recovery-focused approach. One person reported that the doctor had told them that schizophrenia was the *"diagnosis of no hope".*

Health professionals should also treat people with mental illness with the respect they would afford to patients with physical health conditions. Professionals should not be frightened of patients who are intelligent and have done their own research. These attitudes and expectations seem to be due to the stigma attached to mental illness, even amongst the psychiatry profession.

There was agreement that things have improved a lot since the removal of asylums and now that people with mental health problems are expected to live in the community and be part of society. There was some concern in the group that the introduction of Community Treatment Orders could undermine this progress and increase stigma.

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- **Access to quality treatment**

Help should be offered before people reach crisis point. Primary and A & E staff may not be able to pick on up mental health problems, so that the opportunity for early intervention is lost. It was felt that people end up getting sectioned due to the onset of illness not being detected. Lack of awareness also extends to service staff such as receptionists. One person said she was locked in a room by a receptionist who didn't know what to do, which was very distressing. Nurses (especially in early intervention stage) need more training, but all hospital staff need mental health training whether mental health is part of their remit or not.

There is a lack of consistency in people's treatment due to limited capacity in hospitals, locum health professionals etc. The group said it was very important to build up relationships with health professionals, and that it is difficult having to explain everything over and over again to new people. They would like to see less reliance on locum psychiatrists.

Some people are also sent on hospital leave when still quite unwell and then returned to a different bed which is confusing. One person said they had been moved back onto a ward for people with learning disabilities. People do not want their treatment to be disrupted by a lack of capacity or resource. There is a feeling currently that if someone is not a danger to themselves or other people, there is no support or help.

The move towards care being provided in the community has been positive in most respects, but can lead to some people becoming isolated and left to 'languish' long term on benefits because the cost of getting them well would be expensive. This is bad for the economy because people left this way are unable to participate in society or work. The direction to provide care in the community can also mean that the acute care that people need is not provided. It is important that people are not left in the community without the care they really need.

The group discussed the need for support during the period between 'well' and 'acute'. Several felt they would benefit from being able to visit a service, or a 'safe haven' at weekends in case they feel very panicked or paranoid. Crisis services and respite are also very important during this period.

Mental health patients should also have the freedom to have treatment in a different area (as physical health patients are able to through 'Choose and Book'). Participants would like to know why mental health care is excluded from the Government's commitments on choice.

- **Aftercare / social care**

The groups noted that even when you have had treatment or therapy, you still need some kind of contact or support from time to time afterwards. Floating support and building-based services are good for this so it's important that these are available.

The group had mixed experiences of social care after being in hospital. A participant who had been based in Yorkshire said that social services were expert in mental health and provided as many visits as she needed. Other experiences were that hospital was safe, but that they felt totally unsupported on leaving hospital. This support should be flexible according to people's level of illness and personal support networks. One person said that support at home had been provided by a housing association with no expertise in mental health, because they had the contract to provide care, and it was not appropriate. It is very important that support at this crucial stage of recovery is provided by specialist organisations.

Support often comes from those not trained, but who really care. 'Befrienders' such as the Rethink scheme have been the most effective part of treatment for some participants - again illustrating the importance of a holistic approach to recovery.

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The Community Psychiatric Nurse (CPN) is the only source of support in some cases, and this support is highly variable. CPNs also have paperwork to deal with, and the level of bureaucracy varies in different parts of the country so some CPNs have more time for clients than others.

- **Psychological therapies**

Difficulty accessing psychological therapies is a common experience, and waiting lists can be extremely long. There is some concern that 'online CBT' could encourage social isolation.

It was felt that people should be assessed for several types of talking therapies, not only CBT, as there might be a different approach that would be more appropriate depending on a person's needs. The importance of more research into the most effective duration of therapies for different conditions was noted as there is concern that not enough sessions are offered.

- **Outcomes for mental illness**

Accurate measures of outcomes of treatment are difficult to determine because mental health fluctuates so much. Targets are misleading because a person is not necessarily better or worse health-wise if the decision has been taken to hospitalise them; it can be difficult to get a bed, and some people are in hospital for a long time because there is nowhere else for them to go. Outcomes can only really be judged on quality of life, and tailored to the life and interests of the individual.

Several people said they were pushed into doing certain activities during recovery that were of no interest to them and they would have befitted from the opportunity to do something relevant to them (e.g. a quiet place to read can be more beneficial for some than people forced to do arts and craft because they are expected to interact with other people.)

There is a great deal of concern that when someone is achieving certain 'outcomes', such as engaging in work or education, they are told they are too well for the support they know they need to continue engaging with these things. It may not be a realistic for everyone with a mental illness to be expected to recover and engage with work completely independently with no support. There was a strong feeling that the NHS expects patients to fall into their 'boxes' of illness and wellness, but that actually support must be tailored to the real needs of people.

- **Prescription charges**

Everyone agreed that paying for prescriptions is unfair. One person said they know someone with several health conditions so they don't buy all of the medications they need due to the cost. Also, if you are on a medication licensed for a condition exempt from charges you have to explain in public that you are not getting it free because you have a mental illness.

- **Funding for mental health**

The group felt that funding needs to be better balanced as mental health patients account for around 50% of NHS patients treated, yet only 14% of NHS budget. They also highlighted issues regarding responsibility for funding certain types of support. Both NHS and social services may claim that a type service (the example given was a therapeutic community) does not fall within their remit.

- **Commissioning**

More people with mental health problems should be involved in commissioning. This should not be on a voluntary or consultative basis, but formalised and written into contracts.

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- **Physical health needs**

The physical health of people with mental illness tends not to be addressed until patient is in danger. For example, despite the recommendations that the diabetes check is run every time the prescription is collected, the Trust had never done this for one participant. It was only when the patient's blood sugar level was so high it almost induced a coma, that the doctors ran the checks. This is despite the carer researching the side effects and constantly telling the doctors of the dangers. Carers also need to be alerted to side effects without scaring them, as often happens

Rethink's Physical Health Check was described as helpful and many are promoting it to their Trusts. Participants acknowledged that the GMS contract specifies that an annual physical health check up should be carried out for all patients on the SMI register, but that this does not always occur.

Physical exercise should be promoted for many reasons (fitness, managing weight and emotions) but this can be hard if a service user is socially isolated. Providing information on physical activities without providing support to engage in these was seen as problematic. The point that people frequently need support and encouragement to remain motivated was highlighted. It was stated that a befriender might help in this instance, but that the cost of these activities might make them prohibitive.

- **Personal health budgets**

Many service users and carers are currently unaware of direct payments, and these should be publicised to these groups. People who have used direct payments said they were very beneficial, and that the support they were able to buy was a lot less expensive than the cost of treatment should they relapse.

Recommendations: Health and Social Care

1. Stigma amongst NHS staff must be addressed as this can have a direct impact on a person's recovery.
2. Staff in Primary Care and A & E should be trained in mental health so that they can detect signs of onset of mental illness and facilitate early intervention.
3. Health professionals need to better understand the benefits of involving carers, and how to offer carers the respect and support they should have.
4. The benefits of Out of Area Treatments near family should be taken into account when planning care.
5. Services should be available to people in the stage between 'well' and 'acute'.
6. The same freedom to choose health services should be afforded to people using mental health services and those accessing treatment for physical health conditions.
7. Training for health professionals to be able to offer psychological therapies to people with mental illness should be an urgent priority.
8. People with long term mental illness should not have to pay prescription charges.
9. More formal structures for involving mental health service users in commissioning should be established.
10. All service users should have a care plan.
11. Physical health needs should be an automatic part of each patient's plan and tools such as the Rethink Physical Health Check Tool should be promoted and used more widely.
12. Direct payments should be promoted more widely with people with mental health problems, and support provided so that people can use them.

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Children and young people

Seven young people involved in Rethink's U-think project in Bournemouth attended the event. Uthink is a Rethink Emotional Wellbeing and Recovery Programme for Children & Young People aged between 14 – 25 years. Key themes and recommendations are outlined below:

- **Mental health awareness among professionals**

The group agreed that teachers require mental health awareness training to help them recognise problems and effectively signpost people to help. One participant had experienced school staff missing early signs of their mental health problem and felt that if they had received help earlier for emotional problems, they may have been able to avoid psychosis.

Another participant stated that their university disability service does not proactively approach students who may be in need of support for mental health problems, and they felt it should.

Also, the group felt that mental health should be treated equally to physical health within schools and universities.

In primary care, participants felt that GPs lack knowledge on mental health issues.
One person said that the first GP they visited suggested counselling - even though the symptoms were more extreme. The second GP had better mental health awareness and understanding, and that's when appropriate help was accessed. The group felt that levels of GP knowledge and interest affects outcome and that all GPs should have a good level of understanding of mental illness in order to meet people's needs.

- **Bullying**

The group discussed bullying and argued that this needs to be addressed, particularly when people experiencing mental health problems are targeted by bullies. It was felt that bullying is bad for everyone, but is particularly difficult for those with mental health issues, and that additional support needs to be in place.

- **Parents**

Parents need more support to understand their children's health. The group suggested that parents should be provided with an emotional first aid book (similar to the information schools send out for sexual health and substance misuse). Information on mental health could also be given out at parents' evenings. One person said that it took being admitted to hospital for their parents to understand what was happening to them.

- **Prescription charges**

The group agreed that prescriptions for essential medication should be free. Participants stated that the cost of prescriptions when attempting to return to work puts them off taking medication, which can have considerable repercussions for their health.

- **First experiences of accessing help and support**

Experiences of the first time asking for help were mixed in the group. It was felt that teachers may downplay worries, even when the young person is suicidal, which puts the person off asking for help again. One person reported that their teacher had said "*I thought you were one of the normal ones"* when they tried to talk about their concerns.

One person had a positive experience of being supported by a teacher who supported their learning at home, and visiting them whilst they were away from school. The group expressed a wish for such good practice to be shared and learned from.

An issue particular to young people is that parents may know about a diagnosis before they do and will not necessarily share this with them. The group felt strongly that it is beneficial for young people to understand their own health condition and for this to be discussed with them.

- **Experience of mental health services**

Young people over 18 may find adult wards difficult to relate to and potentially harmful to their recovery. The group suggest transitional wards for people between 19-25 years.

The experience of mental health services has been positive, except that much earlier access to these is essential.

It was felt that peer support and programmes like Uthink are beneficial and can help raise people's confidence. Two of the participants had attended the Uthink weekend residential course and they said that spending time with people and taking part in activities had been very helpful.

- **Impact on life goals**

Mental health problems can greatly affect people's confidence to go into work, and whether to disclose their condition to employers. Feeling unable to disclose health problems can lead to being pressured to cope with stressful work situations and even work more hours. The latter can affect benefits if someone is working part time within their permitted limit.

One participant said that they did not not finish their A levels due to their mental health problems and that being able to talk to someone within the education setting would have greatly helped them.

Another made a film about their psychosis as part of school project. However, the teachers said they had to ask his parents, psychiatrist, and classmates' permission to show it. When they did eventually show the film, the class responded positively. This is a clear example of the stigma attached to people's experiences of mental illness.

Recommendations – Children & Young People:

1. Mental health awareness (including stigma) to be a mandatory part of teacher and GP training, along with guidance on how to support young people affected by mental illness.
2. More information for pupils - voluntary organisations / young people with direct experience going into schools.
3. Information to be available for parents to inform and support them.
4. Transitional inpatient wards for 19-25 years olds to be available for better recovery environment.
5. Informal, peer support for young people to be provided to boost confidence.
6. Young people with mental health problems to be provided advice about applying for jobs and disclosing disabilities to employers.

Welfare Reform and Mental Illness

Discussions began with the group considering what has been effective in helping people affected by mental illness return to work, and then outlining what more needs to be done. Key issues are summarised below:

- **Accessibility**

The group felt that there is a lack of clarity and guidance on how the benefits system works. For example, one member of the group was not informed about tax credits, or the various types of support that are available. For this person, who was experiencing severe anxiety, the Job Centre was a daunting place to access. There seemed to be endless form filling with little guidance, and benefits were stopped on the day of the return to work, leaving a 6 week pay gap. After 15 years out of employment, it was a scary prospect to return to work and give up benefits when there was a potential to fail and knowing that the process would have to begin again.

Another person came to a point where they felt secure enough to move into work after volunteering for a long time, and their social worker sent them to the Job Centre. However, the first visit was so daunting they left in tears. A friend eventually told them about a particularly good Disability Employment Adviser – who had a waiting list – but became a key ally in navigating the system and explaining the process. The Adviser was excellent and helped give confidence and support.

There was feeling amongst the group that the benefits process adds to any stress people are experiencing as a result of their mental health problem. One member of the group claimed that there was no way she could have grasped her way through the 'minefield' of the benefits system alone, without the support of a Disability Employment Adviser. Many in the group noted that they did not have this support available to them.

- **Staff understanding of mental health**

Poor training of Personal Advisers and Job Centre Plus staff often means that people with mental health problems are either not taken seriously or inappropriately referred. People with mild to moderate mental health problems may present well at interview, so will not be offered appropriate support. This is essentially because the illness is not visible, in the way a physical impairment might be.

There needs to be more understanding from Job Centre Plus Advisers on what mental illness is like, and what it means to experience it. The experience of Job Centre Plus was that it was inflexible, confrontational and rigid. Participants described 'Steps to Work' programme staff as being much easier to deal with. With Job Centre Plus Advisers, participants described it feeling like a stark choice between Incapacity Benefit and Job Seekers Allowance. There was more pressure to take up employment that they considered inappropriate.

One participant described that*: 'There seemed to be no recognition of how debilitating a mental health condition can be on a day to day basis.'*

Similarly, mental health is rarely addressed in terms of reasonable adjustments at work, as defined under the Disability Discrimination Act. The group fed back that advisers need to have much greater awareness of what a reasonable adjustment looks like for mental illness as currently "*it's all about arm rests*". Rethink is currently producing two toolkits on this issue – one for employers and one for employees, which we can share with interested participants.

It was also felt that training should move away from a 'one size fits all' approach to disability. One member of the group was sent by the Job Centre Plus to literacy and numeracy classes,

when she already had a degree. This claimant was told: "*You don't look like you have a mental health problem"* and "*you're far too intelligent to have a mental illness".* The stigma is all pervasive and must be challenged if people with mental health problems are going to have a positive experience of getting back to work.

It was also felt that any training offered to Job Centre Plus staff should be at least in part delivered by mental health service users. Their 'real life' experiences of navigating the benefits system as well as their experiences in the workplace would offer a valuable contribution. Also, research has shown that by people who have used mental health services discussing their experiences with professionals, it can help normalise and humanise the diagnosis and can be the most effective way of tackling stigma and discrimination.

- **Join up between health services and Job Centre Plus**

It was felt that the Community Mental Health Team (CMHT) should ideally have a link to the Job Centre so that people affected by mental illness are directed to the right place in the first instance. One participant was only referred on to the Disability Employment Adviser through peer support rather than official channels.

- **Lack of flexibility in benefits and Pathways system**

The system was described as inflexible for people with mental health problems: *"I have a great adviser, she'd love to help me but the system won't let her."* In this case, the only thing the adviser could do was send the claimant to Pathways, who in turn told her she was too ill to work. In reality, the claimant feels perfectly able to work, but her condition (Obsessive Compulsive Disorder) does not fit neatly into a Job Centre Plus box. Pathways required a certain amount of hours a week and those hours were rigid.

There was absolutely no advice on freelance work or self employment, which can be really helpful for people with mental health conditions.

Physical health problems are often visibly identifiable and well understood, but mental health problems are not. They don't fit neatly into boxes and will affect people in different ways. The system has to be flexible enough to accommodate that. People should not be forced back into work that is not good for them, or that damages their health.

Experiences of the workplace

- **Discrimination**

One member of the group described an experience of employment. During this period (two months) the person was taking lithium, the side effects of which include slurring and shaking. The employers assumed that she was drinking and took her aside to discuss it. She informed them of her mental health condition (bipolar disorder) and they said that was fine. Two weeks later she was sacked. This all happened within the six month probation period and there was no recourse for action.

In this case reasonable adjustments could have been made – for example, being able to work later hours or being able to attend appointments with a healthcare professional. It was felt that with a mental illness, it was even more difficult to complain about lack of reasonable adjustments or discriminatory practice because people assume you are being paranoid or 'tetchy'.

It was also felt that there is more acceptance of some mental health conditions than there are others. For example, the group stated that depression might be more acceptable to some employers than schizophrenia. People noted experiencing stigma from peer colleagues as well as from line managers.

One participant stated *'I definitely feel that declaring my mental health problems has stopped me getting work in the past'.*

- **Disclosure and pre-employment questionnaires**

Pre-employment questionnaires were described as a major barrier to finding employment, and that they allow discriminatory practice to go on unseen. There was some discussion within the group on the benefits of the US system where people only have to disclose a health condition after a job offer has been made. There also needs to be a mixture of legislation to protect people, and education to challenge stigma and negative attitudes.

The group discussed where they had been open with employers. One member of the group worked in service user involvement in education, where openness was a necessary element of the work. However, she found the management appalling, and stated that there was no focus on supervision or managing stress in the workplace.

- **Healthy working**

It was felt that good practice for people with mental health problems could be good practice for everyone – checking people were taking adequate breaks, not staying too late, managing stress etc.

It was also noted that a lot of people experiencing mental illness 'temp' as a way of working and managing their condition simultaneously. In this instance you are effectively being managed at a distance and there may be problems as a line manager is less likely to take responsibility for your wellbeing.

- **Training for line managers**

The group discussed the most effective ways of getting this information and education to frontline managers. The group discussed making it standard practice as part of either health and safety or equality and diversity training. It was stated that there should be no special fanfare for those with mental health problems – mental health conditions are common as one in four people will experience them, and as such they should be normalised within standard training.

Recommendations – Welfare Reform:

1. Advisers should be trained to understand mental health problems in order to make appropriate decisions.
2. Voluntary work should be recognised and valued as a key way back into employment for people with mental health problems.
3. Voluntary work could be extended into the general employment process. It could operate as work trials do as a way of seeing how people cope, and a trial for the employer as well as the employee.
4. The use of pre-employment health-related questions which are not directly relevant to the candidate's ability to do the job they have applied for should be prohibited.
5. Mental health specific Condition Management Programmes are essential, but are not widely available.
6. Pathways to Work should open up to incorporate more flexible approaches to work.

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Criminal Justice System and Mental Illness

This group was a mix of people who had either come into contact with the criminal justice system themselves or had cared for somebody who had. All of those who had encountered the system had been in contact with mental health services before this. Two participants are also currently magistrates. Below outlines the issues discussed and key recommendations:

- **Sharing information on arrest**

The group agreed that mechanisms need to be in place for greater information sharing between health and criminal justice professionals. This would ensure that those with a mental health problem receive the appropriate care and treatment.

Whilst the group acknowledged that this information needs to be handled very carefully, many participants felt that a system that would 'flag up' that someone had a severe mental illness is essential. This system would not offer details on the mental illness, but would be used by a Custody Sergeant and offer contact details for a carer, CPN or Appropriate Adult. Such a database would draw upon the information currently collated by GPs.

Alternatively, some felt that a system similar to that used for those with conditions like diabetes might work, whereby someone with mental illness could wear a bracelet that would inform people of their condition in a crisis. This voluntary system would also include details of a person's key worker / carer.

It was felt that this is required as police do not always recognise symptoms of mental illness and people with a mental illness might not always explain this or might not look 'ill' to police staff. This is particularly important due to case studies of people having to make statements to the police when they are experiencing symptoms of mental illness that can impact upon their understanding of reality.

- **Mental health solicitors**

Participants each described their experiences of how the criminal justice system did, or did not, take mental health conditions into account. Discussions highlighted the importance of having a specialist mental health solicitor, but also the limited access to this quality of legal representation.

One participant described being advised by her solicitor not to mention her diagnosis of bipolar disorder as it *"would lead to a bad character reference".* She then received a custodial sentence, which was then reduced when her medical condition was raised at a later stage.

It was suggested that there be panels of specialist solicitors who have experience and training, as exists for family and youth work. Lists of these solicitors' details should be made available at police stations and magistrates' courts.

- **Mental Health Awareness Training**

A clear theme within all discussions was that there is a considerable need for all staff involved in the criminal justice system to receive mental health awareness training. It was felt that this is greatly needed for custody sergeants, Forensic Medical Examiners, police, social service and prison staff. Participants also felt that training should involve sessions with service users and carers who have experienced the criminal justice system.

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- **Diversion**

Diversion is the process in place to ensure that people with mental health problems who enter (or are at risk of entering) the criminal justice system are identified and provided with appropriate mental health services, treatment and any other support they need.

Participants described being offered very little information on diversion with one person stating that *"other prisoners knew of diversion, but my solicitor didn't".* It was felt that whilst some areas do have good court diversion schemes in place, many do not and there is a great need for consistency across the country.

Ideally triage would be available within police stations, but the group acknowledged that this will not be affordable for all stations.

Within the court system, it was felt that more mental health professionals should be employed so that people can be assessed and for the process of diversion to occur more quickly. Participants outlined examples whereby even when diversion systems are in place people often need to wait up to a week in custody to be assessed by a mental health professional.

Currently some courts are piloting a fast track system whereby reports are sent prior to sentencing from CPNs or Psychiatrists attached to the courts, which the group considered a positive move.

- **Appropriate adults**

The group discussed the importance of the Appropriate Adult and whether this person should be known to the individual. All agreed that this person should be independent and not working for the Trust concerned. Some participants felt that it would be beneficial for the service user to know the Appropriate Adult as they are likely to have a good understanding to the individual's mental health needs. Other's felt that this person should be completely independent, but that they should make contact with a carer or health professional who knows the service users' mental health history.

One participant described there being some confusion over the role of an Appropriate Adult and the training required as this differs between local authorities and the NHS.

- **Support for Carers**

Many of the group felt very strongly that carers need much more support and should not be excluded from the process. This support includes information on what to expect from the process and from professionals involved and signposting to advice. For example, a number of the group described having no information shared with them on their children's health, nor being asked for information.

One participant described having particular problems with the secure facility, Rampton. She noted that families can't visit the patient after a court hearing and that much more compassion needs to be shown to the family and patient.

- **Treatment of mental health treated in prisons**

When asked to discuss support within the prison setting, participants described great inconsistency between the support they received there and within the community. For example, one participant had medication removed from her when she entered prison because the doctor felt she didn't *"look"* like she needed it. This had been prescribed by her GP before entering and clinical practice suggests that medication, if changed, is done so gradually and carefully.

Participants also described another recent case whereby medication was removed from someone when they left prison as it had been prescribed within the prison and essential they had ownership of it. He was told to get the medication he needed from a GP. At this stage he didn't have a GP and it took some time to get one and receive the essential anti-psychotic medication he needed.

- **Support available on returning to the community**

Participants described having very little support upon returning to the community. This was described as being in part due to systems not being in place to join up support, but also due to a high turnover of staff. It was also felt that good aftercare is less likely to be in place if the individual receives a lesser sentence.

One member of the group suggested a step care model being in place (using crisis teams / supported housing), so that people are eased back into the community. It was also suggested that a single care coordinator should be appointed to ensure that key documentation has been completed in good time for release; regular contact is made with professionals in the community; and constant support is available.

- **Provision of Psychiatric Intensive Care Units**

The group felt that each Mental Health Trust should have a Psychiatric Intensive Care Unit (PICU) in place. Participants described having to travel across the country to visit family and noted that due to limited NHS provision, patients are often sent to very expensive private units which the group deemed to be an inefficient use of government funds.

Recommendations: Criminal Justice System

1. Information needs to be effectively and sensitively shared between primary care professionals and the police to identify people with a mental illness coming into contact with the criminal justice system. This may be through developing a database to flag up to a Custody Sergeant any additional needs that an individual may have, along with key people to contact, or some form of ID that a person will carry or wear.
2. Panels of specialist mental health solicitors should exist and lists of these need to be readily available at police stations and magistrates' courts.
3. Mental Health Awareness training needs to be provided for all custody sergeants, Forensic Medical Examiners, prison staff, duty solicitors and Appropriate Adults. This is to be delivered by service users and carers as this approach is most likely to change behavior.
4. Information on diversion needs to be more widely available to people who come into contact with the criminal justice system and their families. It is especially important that duty solicitors become better informed on this.
5. Carers need to be more involved (if the service user agrees), and be offered information and support to help them through the process.
6. Treatment and services within prisons and hospitals should be the same as care provided within the community.
7. Upon release, a single care coordinator should ensure that key documentation has been completed in good time for release; regular contact is made with professionals in the community; and constant support is available.
8. Each Mental Health Trust should have a Psychiatric Intensive Care Unit (PICU) in place.

Conclusion

We hope that this offers a clear overview of the key areas of concern. Despite the groups covering different departmental portfolios, clear themes emerged from each, such as the need for mental health awareness training for professionals, including GPs, teachers, Job Centre Plus staff and those working in the criminal justice system. Issues around stigma were also prevalent, and the need for much more information and support for service users and for carers. We would be happy to offer any further research and information on any of the issues raised as well as offer advice on the policy work the Party is undertaking.

Rethink is hoping to host events like this with all three of the main political parties, for key spokespeople to hear directly from mental health service users and carers about the issues that affect them. We hope that it is an effective way of outlining the problems people face and making recommendations for changes to improve the lives of those affected by mental illness. Given that all parties are currently drafting manifestos, we hope that these events are particularly timely.

Finally, Rethink would like to thank the MPs and Peers who attended the event. In particular, we would like to thank Anne Milton MP and her researcher James Clayton for helping to organise the event and for ensuring support from colleagues. We would also like to thank all of the participants who travelled from across England and shared their experiences and insights to make the day so powerful.

About Rethink

Rethink, the leading national mental health membership charity, works to help everyone affected by severe mental illness recover a better quality of life. We provide hope and empowerment through effective services, we offer support to all those who need us and we campaign for change through greater awareness and understanding. Each year we help around 50,000 people through our locally and nationally contracted services, support groups and by providing information on mental health.

For further information on Rethink's campaigning work, please contact Victoria Walsh, Campaigns and Policy Manager, on victoria.walsh@rethink.org or 020 7840 3149.