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The Five Year Forward View for Mental Health: Thoughts from some services…

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Learning Disability & Older People

- Brief mention within the report only
- Lack of attention to dementia and crisis responses for both groups
- '*Older people should be able to access services that meet their needs – bespoke older adult services should be the preferred model until general mental health services can be shown to provide age appropriate care*'.
- 'Hidden in Plain Sight': Age UK report, October 2016
  - 2011 target of 12% of referrals to IAPT to be for OA -> 6.1% currently
  - B. Journal Psychiatry: compared the ability of general adult and old age MH services to meet the needs of people with enduring MH problems. The group under adult services had twice as many unmet needs after treatment. 'Concerning' that some areas are moving towards all age services.

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OA & LD (2)

- IAPT needs to consider the needs of older people and people with a learning disability and autism.
- Need to avoid the direct or implied notion of ‘adding on’ of older people or people with a learning disability, to service specs. Consideration should be integral.

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Physical Health

- Great that IAPT should be extended to be accessible for people with LTCs but attending to people's emotional needs doesn't always mean psychological therapy.
- All physical healthcare staff should be asking about people's wellbeing, and have skills to help keep people psychologically healthy (Everybody's Business: everybody being able to manage distress to a degree)
- IAPT would need to accommodate the needs of people with LTCs e.g. home visits, shorter sessions, not discharging people who miss a session/s due to physical health issues.
- Not everybody who is distressed and has a PH condition will be experiencing clinical anxiety or depression, but their distress might still impact on their engagement with physical healthcare.
- Social care should be a crucial consideration (housing issues etc.)

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Physical Health (2)

- A number of high profile projects have delivered gains through cultural change (e.g. Birmingham's RAID model of liaison MH input, NW London diabetes collaborative, Tower Hamlets primary care consultancy service)
- Achieved through being embedded in the services allowing opportunities for consultation & conversation. This sort of work isn't 'counted' currently.
- Our model of psychology input in stroke tells a similar story – the MH specialist is embedded in the team supporting "level 1" interventions that help keep people psychologically well (consultation & supervision plus direct input) East Lancs: commissioned MH practitioners into Integrated Neighbourhood Teams.

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Medically Unexplained Symptoms (MUS)

'An increase in access to psychological therapies will be targeted: two thirds of the additional people receiving services will have co-morbid physical and mental health conditions or persistent medically unexplained symptoms.'

- MUS and physical health / LTC should not be grouped together
- Planning needs to recognise that patients with MUS can be extremely complex and significant input to training and supervision would be required for the majority of IAPT staff. Despite not always meeting DSM criteria, or presenting in crisis, patients with MUS or NEAD can be highly complex. '…..***top-up training in new competences for LTC and MUS***' for IAPT staff is perhaps overly simplistic?

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Concluding comments

- Welcome the focus on recognising that mental and physical health services have suffered from lack of parity of esteem
- Welcome the attention to inequalities in access, across the board
- Implementation plan: no sections dedicated to OA or LD
- Neither the FYFV or implementation plan talks of dementia care
- Integrated care: do we know what that looks like and how we can achieve it?
- http://www.nationalelfservice.net/social-care/integration/integrated-care-for-the-physical-health-of-people-with-severe-mental-illness-no-easy-answers/?mc_cid=10889d7d85&mc_eid=66f3f39778
- Do we need to put more MH services into PH care, or can we work with our physical health care providers to better understand the psychological needs of their patients - or both?

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Concluding comments (2)

- A range of staff (and therefore, bandings) would be needed to recognise the complexity and diversity of the presentations staff would be expected to work with - and staff well-being must be a priority.
- Must maintain a focus on appropriateness and outcomes, not just access, for older people, people with a learning disability and those with acquired neurological deficits.
- The current roles, service models etc. that may work well for “pure” mental health issues may need to be looked at again to think about how they deliver integrated care, as opposed to easier access to psychological therapy for people with physical health issues, which are both laudable, but separate concepts.