

Social Perspectives Network for modern mental health

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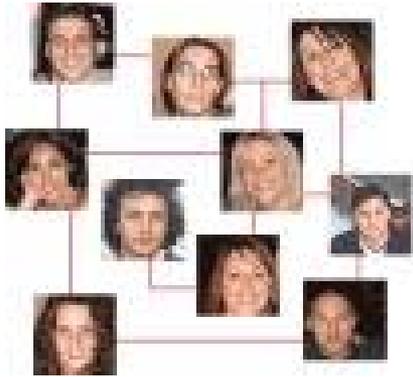
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What is SPN?

- **A national membership based mental health network and charity, which is open to all stakeholders in mental health, which aims to put social perspectives at the heart of the mental health policy, practice, research and legislative agendas**

Social factors in mental well being



social networks



discrimination



access to services



housing

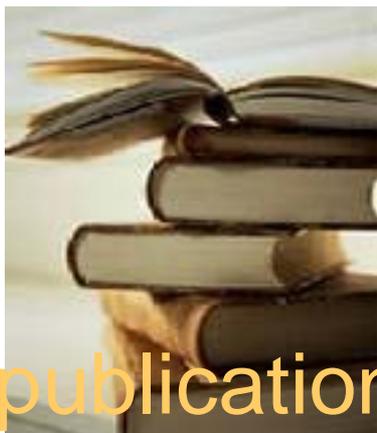
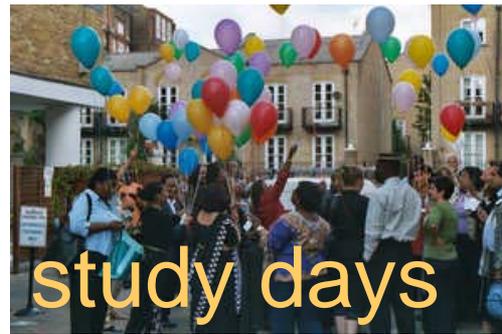


finances



employment

What does SPN do?



SPN's work around personalisation

- **2 national study days to date attracting over 200 people**
- **Direct lobbying of Lord Darzi to ensure mental health will be part of personalised options & response to New Horizons**
- **5 workshops attracting 300 people with representatives from all boroughs in London to develop the agenda in the capital**
- **Forthcoming events - 2 December 2009 study day looking at personalisation in recovery context, Feb 2010 personalisation and diversity study day planned**
- **Workshop and Speakers at Mental Health Today conference 8th December 2009.**
- **Personalisation Workbook with Pavilion Publishers**
- **Regular column in MHT magazine *'The Bigger Picture'***

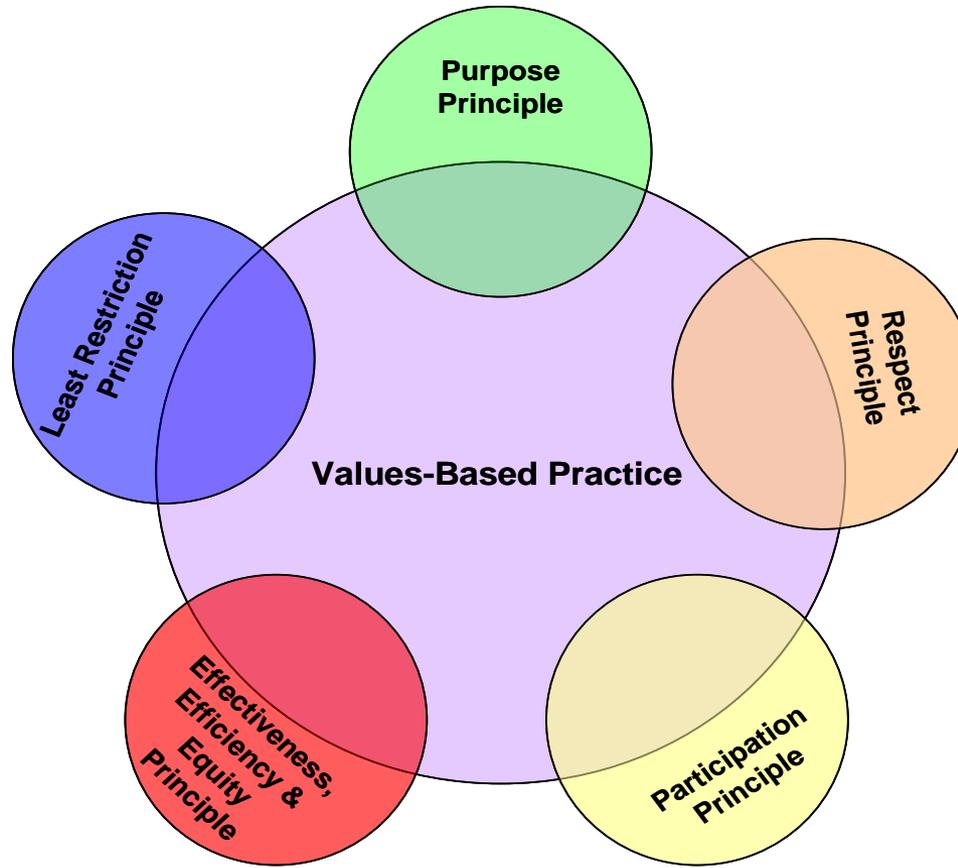
Putting People First: the elements of a personalised approach



what principles underpin personalisation?

- **More choice and control for service users and carers**
- **Positive risk taking**
- **Social inclusion**
- **Universal Services**
- **Better information**
- **Partnerships**
- **Community involvement & Social Inclusion**
- **Equality and Social Justice**
- **Prevention & Early Intervention**
- **Independent Living**
- **Outcomes rather than activity**
- **Recovery**

what principles guide the work of AMHPs?



how can the MHA COP principles underpin working in a more personalised way?



what will be some of the opportunities/challenges for AMHPs to working in a more personalised way?



Scenarios – Questions to Consider:

- **For each scenario identify the following:**

How can the principles of personalisation & the principles of the MHA inform your decisions and actions?

How will you support choice and control in each case?

scenario 1 putting personalisation into practice as an AMHP

Raj is a 68 year old man of Indian origin. He has been in England since he was 10 years old when his family emigrated. He has had contact with mental health services for approximately 35 years and has a diagnosis of paranoid schizophrenia. He has two sons who are working in India and one daughter who lives 130 miles away from him. His wife died 3 months ago and following the funeral his children returned to their respective homes and work. This has left Raj living alone in his bungalow. Despite the support of a Social Worker, from the local community mental health team, and a support worker from a local private (non-statutory) organisation his symptoms have increased and he has been more distressed as a consequence. He has been offered an informal admission to hospital for assessment and medication review but this could only be offered on an elderly ward where a lot of the patients have dementia. Raj declined this and has been trying to manage in the community.

scenario 2 putting personalisation into practice as an AMHP

Andrew is a 56 year old gentleman and has had a diagnosis of schizophrenia for 34 years. He has just been detained under the MHA as a result of a relapse in his mental state. He has previously been on several different types of antipsychotic medication and has led a rather sedentary life style over the years. He has also recently being diagnosed with diabetes and is recognised as being clinically obese.

scenario 3 putting personalisation into perspective as an AMHP

Diana is 28 year old living with her husband and her 7 year old son in a busy part of town. She has been working in a book shop for her father-in-law for the past 4 years. Diana was diagnosed with Bipolar disorder 9 years ago. She has been detained under a section of the mental health Act on 2 occasions previously when she became hypomanic. On both occasions the police were involved and Diana felt greatly ashamed for months afterwards and felt she was the talk of the local area. Despite this she is happy to presently accept contact from secondary mental health services so long as it does not interfere with the rest of her life. As a consequence her CPN visits every 4 to 6 weeks when Diana is managing well and she has promised to call the CPN if she begins to feel unwell.

scenario 4 putting personalisation into perspective as an AMHP

Eddie is 19-years-old. He has been taken to the police station under section 136 of the Mental Health Act. This was due to Eddie wandering among traffic and he was removed to a place of safety by a police officer who he subsequently assaulted. This is the first time he has been involved with the police. Eddie was seen by a psychiatrist three weeks ago for an initial out-patient appointment and has been referred to a Community Mental Health Team. He has not, as yet, been allocated a care coordinator. He suffers from auditory hallucinations and is quite withdrawn at present. He did disclose that 'voices' told him to walk into the road but is not saying much else. He is known to use cannabis and amphetamines, but has not been drug screened yet. The Forensic Medical Examiner is of the opinion that Eddie is not fit for interview under the Police and Criminal Evidence Act 1984 and that a Mental Health Act Assessment is required.

scenario 5 putting personalisation into perspective as an AMHP

A Mental Health Act assessment is requested by a GP on Sarah, a 26-year-old female, who is presenting with paranoia, low mood and deliberate self-harm.

On requesting further details it transpires that Sarah has a history of heroin and intermittent crack cocaine use. She is not known to mental health services but is known to the local voluntary sector drug agency where she has attended the crack cocaine drop-in service periodically over the past twelve months. She also has a care coordinator at the specialist service who are prescribing her with 60 ml methadone per day on a substitute prescribing regime overseen by the addiction service attached Consultant Psychiatrist. The GP has not yet consulted with these services and is unable to provide further details

Summary

- Personalisation views people as participants in their communities, friendships and family relationships. Individuals with lives and relationships.
- The principles of the MHA place the individual as central to the process and considers the whole circumstance and context.
- Both approaches consider the whole system in terms of support that's available for people to stay independent for as long as possible.

“Ensuring older people, people with chronic conditions, disabled people and people with mental health problems have the best possible quality of life and the equality of independent living is fundamental to a socially just society.”

DH (2007) *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*