**Thurrock Emotional Wellbeing Forum Forum for Individuals, Families and Carers**

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**Wednesday 26th June 2019, 11:30am to 1pm**

**Thurrock Mind, 160 Bridge Road, Grays, Essex, RM17 6DB**

**Attendees:**

Ian Evans (Facilitator), Kelly Woolley (minutes), Joanne Pitt (Essex Partnership University NHS Trust), Toni Saliba (TDN), Harpal Kang, Gary Clark, Judith Nunn, Donna Sullivan, Dennis J. Hill, Susan Benson, Akbal Ghataorn, Sherrine Barrows (Inclusion Recovery College, Thurrock Mind), Glen Wareing, Clive Strong, Paul Lambert, Ewa Abama, David Eyres, Jeanette Lambert, Jessica Eatherton

**Apologies:**

No apologies were given.

1. **Welcome & Introductions**

Ian welcomed everyone to the meeting, introductions were given

1. **Minutes and matters arising from the previous meeting**

The minutes from the March meeting were read and agreed as a correct record. Dennis raised a concern about the timing of the Forum meeting today, he felt that not enough people knew about it, and that members of the Arts & Crafts Group had not been told and that the time for the Forum meeting should not limit the Arts & Crafts Group – Ian apologised if this was the case, and for any inconvenience caused and referenced the agreement for the Forum meetings to take place on the same day as the Arts & Crafts Group contained in the March minutes. Having the meeting at this time was an attempt to make it easier for people to attend and have their say, without having to keep coming to lots of different meetings. **Action – Ian to talk to Wendy Robertson about more convenient meeting times for people to attend the Forum**

1. **Open Dialogue – Presentation -** Sherrine Barrows (Inclusion Recovery College, Thurrock Mind)

* The service was first piloted in the U.K. by Kent and Medway NHS and Social Care Partnership Trust, with research and evaluation support from Canterbury Christ Church University.
* It is now being run in Thurrock by Inclusion, Mind and EPUT. It involves working with the whole family or network, rather than just the individual, and equipping staff of all disciplines with the key skills to do this, and thus effect change at deeper levels.
* Developed and implemented a Peer-supported Open Dialogue (POD) service for patients and their social networks, in an adaptation of a novel mental health care model from Finland.
* The service provides a more consistent and co-created understanding of mental distress than current service models, by accessing people's social networks to strengthen their recovery and maintain wellbeing.
* Current mental health treatment models often see high hospital admissions and use of psychiatric medication. Adult mental health care is predominantly individualised treatment and often means patients seeing a number of different clinicians and services.
* Open Dialogue is a novel approach to mental health care that originated in Finland in the 1980s. It involves people and their family or social networks being seen within the first 24 hours of crisis, and seeing the same clinicians throughout their care; so that hasty treatment decisions are avoided and all discussions are held in their presence.
* This approach can lead to reduced relapse rates, lower medication use and increased chances of employment.

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| **Open Dialogue Values**  The Open Dialogue model itself centres around regular network meetings. These involve the patient, together with his or her family members, as well as extended social network.  The network meetings are the only forum where decisions are made, with the client remaining at the centre of the process. This enables a strong emphasis on independence and long- term recovery from day one.  A further core element of the model -– as used in services such as New York -– involves the inclusion of peer workers within each team. Peer workers are seen as experts in their own right, working with patients and extending social networks where necessary, and they also work locally to cultivate a wider supportive peer community.  **Dialogue**: We think of mental health difficulties as expressions of distress and trauma that haven’t found words and meaning. The aim of the meetings is to develop a dialogue, giving a voice to all concerned putting the person at the centre. We won’t rush to find solutions but listen responsively to you.  **Authenticity**- We will come together as fellow human beings. We recognise that we all have struggles and difficult times in our lives. We do not see the world as divided between those who have mental health problems and those who don’t, not “them” and “us  **Openness**- We will be accepting, respectful and trusting of you and aim for us to have an equal relationship together. Colleagues working with you will respond respectfully within the sessions and will speak about what they are thinking as part of the process within the meetings  **Tolerating uncertainty**- one of the seven basic principles of Open Dialogue, we are taught to behave in a way that increases safety among the family and the rest of the social network. It is important to make contact with each person early in the meeting and thus, acknowledge and legitimize their participation. |

1. **Open Dialogue – Questions & Answers**

TS asked a question about Crisis care and which hours the Open Dialogue Project would be operating.

1. **Enhanced Primary Care Mental Health – Presentation -** Joanne Pitt (Essex Partnership University NHS Trust)

**Background -** A Thurrock Project Team has been set up to oversee local mental health transformation programmes in Thurrock. The intention is for all providers of mental health services to work together to provide a consistent pathway with the following aims and benefits;   
  
Early intervention targeted when conditions occur, Preventing serious conditions getting worse through providing help earlier, Care closer to home, Combining mental health care and physical health care, Support provided in the community when released from acute care

**Reasons for Change -** Mental health is complicated and various health and social issues can contribute to ill health. Individuals are currently going to different professionals to address different needs such as emotional, social and physical. Those with various issues can be passed around the system delaying treatment and care. The current system is disconnected and individuals are asked to repeat themselves several times to different professionals. Delays in treatment could make conditions worse

**Why have a new model?** Those needing support are seen by the right person, at the right time and in the right place. All providers will work together to ensure all needs are metEarly Intervention and prevention – Promoting good mental health and preventing poor mental health. Improving urgent and emergency care – crisis response and care**.** Care closer to home – integrating social care, mental health, and physical health**.** Waiting times will be reduced**.** More self-help to assist individuals to manage their condition better

**The proposed changes** are all related to the Five Year Forward View for Mental Health (2014), the Mental Health Crisis Care Concordat (2014) and most recently, The Long Term NHS Plan (2018)

**Aims of the local strategy -** Through strong leadership and innovative transformation, engagement with local people to deliver an integrated health, social care, physical and mental health service to improve lives

**Local Need,** it is well known that in Thurrock we need social care, crisis support, services for personality disorders, substance misuse, Support for serious mental illness, transitions between services medicines and so on.

**Local Vision** - Improving urgent and emergency care mental health – crisis response and care. Integrating social care, mental health and physical health – parity of esteem and care closer to home. A system that promotes good mental health and preventing poor mental health – early intervention and prevention.

Having a **Thurrock Enhanced Primary Care Team** in the new model will have the following benefits: People will live longer, people will have less time of their life living with a long term condition, people will have more choice in easy to access services to meet their needs and more local services, care and support at home and not in hospital.

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| **Feedback from the Forum**  Several attendees shared their experiences of crisis, needing help, but support systems failing resulting in thoughts of suicide or attempted suicide, but for the contact made by trusted individuals, for example, a social worker or griend.  **What is your experience of the service?**   * The current system for requesting support via telephone when in crisis is not good enough. It is too complicated. * Isolation and loneliness are important areas that need addressing * Support from the Samaritans is good (if you know it’s there) * People feel like they’ve been “kicked out” of the system   **What do you think of the proposed new model?**   * It needs to be available 24/7 * Needs to move away from people being “discharged” from services and support. Mental Health conditions don’t just disappear. * People need the right care at the right time in the right place   **What is most important to you?**   * Trust, empathy, listening, understanding, need someone to talk to. * To be spoken to, not spoken at. * To be listened to and to be heard * Training for all staff and partners involved     **Would you like to be involved in the process? And how?**  DE said he would like to be involved in the Project Group and would attend to share his views and to be listened to regarding lived experiences. |

Joanne agreed to come back to the Forum with an update on progress following their feedback.

Ian thanked everyone for attending.

**Date of Next Meeting – To be confirmed**