Perspectives

Experiences and Reflections on
Common Mental Health Issues and Assets in Dorset

Phase 1 report
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PROJECT BACKGROUND, METHOD & SAMPLING

Introduction

This paper reports on the findings of the first phase of the Perspectives project.

As part of their legacy, the Bournemouth, Poole and Dorset LINks (Local Involvement Networks) commissioned IONA to undertake research into mental health issues and assets in Dorset. The LINks then handed over the project to be taken forward by Healthwatch Dorset, which succeeded them in April 2013.

Healthwatch Dorset is one of 148 local Healthwatch organisations that were established throughout England in 2013, under the provisions of the Health and Social Care Act 2012. The dual role of local Healthwatch is to champion the rights of users of health and social care services and to hold the system to account for how well it engages with the public.

IONA is a high impact research and engagement business, helping organisations of every type – corporate, local government, public/ community focused – to better understand their stakeholders and better utilize assets at their disposal.

The project tests an approach to wider stakeholder engagement in understanding population health needs. Following discussion with a number of key stakeholders, it was agreed that the project considers common mental health issues amongst adults in two localities; central Bournemouth and north Dorset (to reflect both a geographic and demographic spread). Whilst this initial project focuses on common mental health issues in the adult population the approach is intended to be applicable to any health or social care issue.

The project approach involves two stages of engagement fieldwork.

In the first, interviews were conducted with people from three 'communities':

- Patients and carers
- Service providers
- Service commissioners

In the second phase, representatives of the above groups will be brought together to consider the findings of the first phase and to 'co-produce' areas for improvement in an 'integration workshop'.

The phase 1 report (this paper) details findings of the first phase of engagement field work. It is intended primarily to give 'food for thought' ahead of people coming together to consider ‘what next?’

This Phase 1 report details:

- The background to the project, its purpose and objectives
- An overview of the approach used in this first phase
- A summary of key issues raised in the research (potential start points for discussion in the integration workshop)
- Patient and carer insights
    - Characteristics of mental illness within the interviewees
    - Life-stage characteristics
    - Patient perceptions of services
- Provider insights
- Commissioner insights

Looking to Phase II: the integration workshop

The next stage in the project will bring together interviewees to discuss the findings of phase I, presented in this report. The paradigm here is one of co-production; seeking to draw on the experience and insights of all those interviewed with a stake in promoting better mental wellbeing in general and in supporting those with common mental health issues.

We will be looking to run this workshop in the late 2014/early 2015 and to report shortly after.

Overview of the project approach and method

In this section we provide a short summary of the first phase of the project. We address the questions of:

1. What were we trying to do?
2. How did we do it?
3. Who was involved?

1. The objective of the project is to investigate views, relating to common mental health problems, on:

- Issues
- Opportunities
- Assets for mental well-being and service experiences

Whilst deepening our understanding of needs is central to our project, we were also invited to explore with stakeholders the resources - be they personal, family or community based - which they access to either help them get better or to remain well. These we refer to as 'assets for mental well-being'.

2. The project investigates these from three distinct perspectives, those of:

- Patients and carers (the community)
- Providers of services
- Commissioners of services

3. Who was involved?

Patients

We interviewed 21 patients and 1 carer:

- 12 from central Bournemouth
- 9 from north / west Dorset.

We worked towards a spread of the following within our patient sample:

- Age/life-stage
- Working/non-working
- Gender
- Type of common mental health problems; depression, mixed anxiety and depression, panic disorder etc.
- Different levels of interaction with services, from not actively engaged to being on the fringes of secondary care

The patient/carer sample achieved was as follows:

Bournemouth x 12				
Age	Gender	Condition	Service interaction	Recruitment method
15-19	Female	Depression	GP/Counselling (Bournemouth university)	Leaflet in GP
20-24	Male	Depression	None	Leaflet in GP
20-24	Female	Depression	CBT/GP	IAPT (Improving Access to Psychological Therapies)
35-39	Female	Depression	None	Professional recruitment
40-44	Male	Depression/ anxiety	GP/CBT/Counselling	GP letter
40-44	Female	Depression/ anxiety	GP/CBT/Counselling	Professional recruitment
50-54	Male	Anxiety/ Depression	GP/CBT	IAPT
50-54	Male	Depression	GP/Recovery	Leaflet at First Point
55-59	Female	Anxiety/ Depression	GP/CBT/Counselling	IAPT
55-59	Male	Anxiety/ Depression	GP/CBT	IAPT
60-64	Female	Anxiety/ Depression	GP	Community noticeboard
65-69	Male	Anxiety/ Panic	GP	GP letter
North/ west Dorset x 9				
Age	Gender	Condition	Service interaction	Recruitment method
35-39	Female	Depression/ Anxiety	GP/CBT/Counselling	IAPT
35-39	Male	Depression/ Anxiety	GP/CBT/Counselling	IAPT
40-44	Male	Depression/ Paranoia	None	Leaflet in Positive Approach shop
45-49	Female	Depression	Peer support	IAPT
55-59	Male	Anxiety/ Depression	GP/ CBT/Counselling	Peer support (DMHF – Dorset Mental Health Forum)
55-59	Female	Panic/ Depression	GP/ CBT/ Counselling/peer support	Peer support (DMHF)
60-64	Female	Anxiety	GP/ CBT/ Counselling/peer support	IAPT
70-74	Female	Depression	CBT/Counselling	IAPT
75-79	Female	Depression	GP/ CBT/Peer support	Peer support (DMHF)

Interviews took place by agreement in an appropriate meeting place.

Providers of services

Interviews took place with 11 service providers. The interviewees were typically practitioners or service managers and worked in a mix of NHS (primary care and community services) and third sector organisations.

The sample achieved was as follows:

Bournemouth x 6						**North Dorset x 5**				
IAPT	IAPT	GP	Dorset Mind	EDAS	Recovery	IAPT	IAPT	GP	DMHF	Recovery

Service commissioners

Five commissioners were interviewed, these being a mix of NHS and local government commissioners of services.

The sample achieved was as follows:

Commissioners x 5				
Dorset Country Council	Dorset Country Council	Bournemouth Borough Council	NHS	NHS

Interviews and analysis of findings

Interviews were conducted by one of the Iona Insight researchers, Paul Iggulden and Roland Stout.

Discussion guides were developed for each of the three groups of interviewees (patients, providers and commissioners) and these were used to guide semi-structured interviews. Patient interviewees were invited to complete a pre-task ahead of being interviewed as this helps with recalling past events.

The interviews were face-to-face (with the exception of three conducted over the phone) and were recorded using digital voice recorders. The researchers used the recordings in the analysis phase; each researcher reviewed interviews and analyses were shared to identify consolidated key issues and themes.

Reporting focus

The focus of this project was on the voice of the patient – as the hypothesis was that this does not feature strongly in needs assessment work at present.

As such the majority of the report focuses on the feedback from the patient perspective.

The interviews we undertook with providers brought useful insights to complement patient perspectives; here, we have focused on the consistent messages relating to patient population needs rather than in-depth service provider issues.

Headline issues raised by research

The following section does not summarise the findings but highlights key issues to reflect upon within the detailed findings. We feel that these might also prove pertinent start-points for discussion during the subsequent workshop.

1. The importance of listening and being heard (especially where self-directed)

Many service users placed great value on 'being heard'. In particular, there was a proportion who were more self-directed i.e. valued independent research and/or reading over and above medical interventions but who nevertheless welcomed a listening ear.

2. The social aspect of IAPT

Many service users found the social elements of group meetings as valuable as the 'treatment' itself.

3. Life-stage transition and service design

Life-stage transition points (young, working age, old) seemed to have some impact on the incidence of depressive episodes. Also, different life-stages appeared to influence patient responses to service interventions e.g. younger people value more self-directed and are lukewarm towards formal processes, older people experience the greatest benefit from a social aspect.

4. Service reach

For different reasons, younger and older people appear to resist engagement with services more than people of working age.

5. Life beyond IAPT – continued recovery

The biggest challenge we experienced was that once on the path to recovery, how to keep people well? Those who were successful in doing so ascribed this to goal-setting and a wide frame that tended to encompass all of leisure and relaxation, work and career, and family contact. Those less confident about what lay ahead were lacking in most of these respects.

6. Life beyond IAPT - how do we stop people falling back into dysfunction?

Linked with the previous point. Once on the slippery slope back to dysfunction it appeared that the things which people do to stay well, e.g. exercise and eat well and socialise become less relevant. The question this raises is how do we spot (and arrest) this pattern especially if the person is lonely, isolated and/or (socially) withdrawing?

7. Life skills (Step 0/1)

Again linked to the above points. But we note the extent to which moving forward seems to come from the ability to reflect or set goals and/or the implementation of diet and exercise as a routine. Indeed, some tools and techniques that IAPT provide (relaxation etc.) might also be something that would apply to life in general. In this respect we might advocate what a formalised and readily accessible step 0/1 might look like.

8. GP issues

There was some resistance to drugs and medication in general. Yet, interestingly, patients seemed responsive to scientific explanation (perhaps the impact of television advertising). It is also clear that mental health also pre-determines a desire of the patient to be heard, which we note might be difficult within a 10-minute consultation.

9. Visibility of the Third Sector

It was surprising that there was not greater knowledge, both from patients and professionals, of the third (voluntary and community) sector offer.

10. Data & commissioning processes

Both data and commissioning processes tend to be service-based rather than reflecting wider community needs.

RESEARCH FINDINGS - PATIENT/CARER INSIGHTS

Introduction

Whilst each of the people we interviewed presents a unique story, the aim of conducting a number of interviews is to identify common themes, which may well apply to the wider population.

Our analysis of patient interviews suggests findings in four key areas of:

- Characteristics of the mental health issues of interviewees
- Assets for mental well-being
- Patient perceptions of services
- Life-stage characteristics

These are explored in the following subsections.

Characteristics of the mental health issues of the interviewees

Overview

We are concerned in this section with two key questions:

- What leads to the mental health issues in general and in particular to times when people are unable to cope?
- How do the issues impact on people's lives?

Patient interviews gave insight into what **triggered** episodes when they were no longer able to function. Typically, such episodes were found to be the result of a combination of:

- Life circumstances - stressors or life-stage transition issues; and/or
- Trauma from formative years

One interviewee referred to us all as having a breaking point; the metaphor of a bridge was invoked. Stressors in life often act in a cumulative way until the 'load' is too much and breaking point is reached. Interviewees talked generally of a gradual build up to breaking point. There were a smaller number of cases where interviewees referred to significant or sentinel events that triggered episodes against a backdrop of 'normality'.

We found the following as examples of stressors:

- Problems at work: bullying, pressure, change of circumstances and adjustment issues (people, standards)
- Being in the wrong role. We found some examples where (in our opinion) the role did not appear to suit the person per se
- Bereavement
- Divorce
- Moving home or setting up a home
- Living alone or supporting oneself
- Life-stage transitions

Trauma from formative years was found to weaken the mental bridge, lowering the threshold at which episodes would occur. For those reporting trauma from formative years the following were common themes:

- Fundamental absence of love or comfort or security
- Parents splitting up
- Abusive relationships – especially women experiencing mental abuse from men i.e. being bullied or controlled or undermined by men. This was seen in evidence across all ages
- “I’m not good enough” - this being more openly stated by women than men

Life-stage transitions

For many of those interviewed, life-stage transitions presented additional stressors and it was often at these times that significant past issues could no longer be contained and therefore surfaced.

By life-stage transitions we refer to the following periods that were detailed by interviewees:

- Late adolescence into early adulthood
- Independence or co-habiting to having dependents
- Working age to early retirement; and
- Early retirement to older aged with associated loss of physical and mental capacity

Implication: These life-stage transitions are an important finding; suggesting particular times when people may require additional or different support.

The transition from living at home with parents to setting up one's own home was a potential stressor in one of two ways. Firstly in terms of the adjustment to 'standing on one's own feet' - dealing with the myriad of practical, financial and emotional challenges which come with moving out from living at home with parents, however much the change is welcomed or not. Secondly, a change of circumstances gives a reflection point from which inherent problems develop and/or manifest themselves e.g. unhappiness during schooling being previously masked by routine or not having time to reflect.

Interviewees talked of anxiety or depressive episodes occurring in mid-life as a result of an overwhelming sense of being trapped by responsibility: having responsibility (either solely or shared) for dependents; for earning money to pay the bills; for keeping the house together; for delivering at work; and a general sense of being trapped in contrast to a previously-felt freedom. Being 'trapped' in unfulfilling or stressful employment was a key stressor in some of those interviewed of middle age.

Retirement is a key life-stage transition with people in this age group - and in particular the women of this age - referring to their lives being less busy and this giving time and space for problems and unhappiness to surface. For the women in particular, this period was one in which they were beginning to process and, following IAPT interventions, address long-standing self-esteem issues. In some cases these stemmed from long periods of put-downs from partners (be they current or previous).

Later into retirement interviewees talked of a further transitional stage, from young to older retiree accompanied by stressors relating to aging - a sense of having left it too late to achieve life goals, of loss of looks and physical capacity, and peers falling ill and the death of others being a powerful reminder of one's own mortality.

Presentation of mental health issues

There was little by way of surprises in terms of how the interviewees reported their mental health issues impacting on their lives. The presentations were very much "text book". Interviewees typically referred to one or more of the following:

- Being 'spaced'
- Tiredness/lethargy/lacking motivation
- Going through motions (at work especially)
- Anxiety/not sleeping/insomnia
- Not going out/hibernating – isolation/reduced social interaction
- Ceasing to be functional e.g. making mistakes, taking too much time, grinding to a halt (paralysis of analysis)

- Alcohol abuse.

Symptoms are not necessarily present all of the time. Interviewees talked of achieving normal function when situations demanded it e.g. where family responsibilities require them to carry on regardless and social interaction continues for the sake of children or other dependents.

Interviewees reported the gradual onset or build-up of the above symptoms and a gradual descent to a state of dysfunction, of "hitting rock bottom". But critically, in terms of identifying how and when to help, it typically was only when the interviewee hit rock bottom that help was sought. The majority of interviewees talked of retreating from the world, of "drawing in", as symptoms gradually developed. For some of those interviewed, this retreat from the world was unsurprisingly not noticed by others, as their social contacts were limited. More surprising was that even those who were typically very involved with local life, through a wide range of contacts, were able to quietly withdraw with nobody taking action. The reasons for this are clearly of interest and worth investigating further but are beyond this study. That this reflects fear of mental health issues, an 'English' reserve or people being 'too busy with their own lives' is at this stage merely conjecture.

Implication: Social capital and assets for mental well-being may well be beyond people as they gradually become anxious or depressed.

In a number of cases, interviewees reported being well supported by family and friends during the gradual onset of symptoms, when they hit "rock bottom" and during recovery. In a great many of the cases which talked to this point, the patient themselves, family and friends all seemed to 'normalise' behaviour at each point on the gradual decline and to adjust to the interviewees' behaviour such that the gradual worsening of symptoms and loss of function was not recognised as such until it was (well) beyond doubt. In a small number of cases, younger adults described a parent or close friend making an early call that help was needed and encouraging the person to go to their GP for help.

Implication: Is it possible to support people in these situations, and their family and friends, to facilitate recognition of this gradual slide towards rock bottom and seek help earlier?
For those with less extensive social and family networks, especially when isolated or when out of work, this might be harder to achieve.
The tendency for the patient, family and friends to adjust to changing behaviours and 'normalise' each point in a gradual onset of

mental ill health, suggests a role for objective assessment. This could be through either using a rating or through someone 'at a distance' checking in with the person.
As remarked by several patients in conversation, many long-term physical conditions lead to regular checks-ups; perhaps something similar is required for those with common mental health issues.

Assets for mental well-being

Overview

We recognised through the interviews a wide range of resources - be they personal, family or community-based - which interviewees accessed to either help them get better or to remain well. These we refer to as 'assets for mental well-being'. Our analysis found these 'assets for mental well-being' to relate to:

- Individual characteristics or coping-mechanisms
- Connections with family and friends
- Community resources and specialist advice and support
- Goal setting

Individual characteristics/ coping mechanisms

A number of those interviewed described how they sought to rationalise their problem e.g. using books or courses to *understand* their condition and how it works. Typically this was more than simply a way of managing their condition. With this came *acceptance* and a self-permission to 'park it and move on'. That having been said, for many of the interviewees, finding their *own* way of *dealing with issues* was important and valued as a means of regaining control.

It was clear that for many of those interviewed, validation that what is happening is not untypical was very important. Interviewees spoke of the beneficial effect of knowing they 'were not alone' through connecting with others with similar issues. This connection was achieved through a variety of means: reading books, articles, on-line peer group sites and discussion groups, face-to-face discussion with others with similar experiences.

Almost half of the people we interviewed were recruited as a result of their attendance at IAPT sessions. For most of those attending IAPT group sessions, face-to-face discussion with others with similar experiences was highly valued. Amongst those recruited through other means, a large number talked of high levels of resourcefulness in accessing literature and the views of others, often through the internet. Some of the explanations and interventions identified through personal research were beyond the orthodoxy followed by conventional Western medicine and might well raise eyebrows amongst GPs and IAPT counsellors.

The route taken to understanding, acceptance and/or potential solutions varied between the interviewees who approached their condition in this way. However, what was common to them were:

- High levels of self-directed intellectualisation
- Resourcefulness in accessing literature/the views of others
- Openness to try new things
- Ability to reflect on whether these worked or not

The above were loosely associated with levels of education and ‘emotional quotient’ (the ability and confidence to monitor, process, regulate and manage emotions in order to navigate life).

Closer inspection of this theme suggested that a combination of level and nearness (in time) of structured training or education with a reflective element was important in promoting self-directed understanding and solutions.

> Implication: Structured training or education with a reflective element, be it work place or otherwise, can be valuable in helping people develop the skills and confidence to self-manage.

Connections with family and friends

Many of those interviewed described family and friends as being supportive, although it was not always clear what form this took. Listening and “giving space” were suggested by a number of those referring to family and friends as being supportive.

For many of those interviewed, the onset of symptoms is accompanied by withdrawal. This in part was explained by “not wanting to be a burden” to others. Interviewees also talked of people without mental health issues as being unlikely to be able to understand their situation. As discussed earlier in the report, withdrawing and gradual onset of symptoms are often missed by family and friends.

> Implication: Increased awareness of signs and symptoms of mental health issues amongst the wider population as a whole, and family and friends of existing sufferers in particular, might increase the likelihood of early detection of signs and symptoms, and hence of earlier intervention.

Interviewees were more receptive to engaging with family and friends when they were perceived as being able to empathise and if they had similar or shared experiences. Friends or family who had similar experiences were, in turn, most likely to connect with the interviewees.

A great many of those interviewed had positive experiences of social contact with peers (people with similar experiences). Peer groups provide a means of people regaining some social interaction that is often lost as symptoms develop and people withdraw. Engaging with peer groups was both a sign of being on the way up again and a valuable help in becoming functional again. Many remarked of the powerful, positive impact of “not feeling alone any more” and “having something [an event] to look forward to”.

Interestingly, some people were ambivalent about the therapeutic value of IAPT but still enjoyed and saw benefits from the social interaction that came with being part of a group-based course.

A number of those interviewed had been recruited through their having attended IAPT group-based courses. Participants were mixed in terms of how useful they found the tools and techniques (goal setting) they had been introduced to. They were almost unanimous and often highly enthusiastic about the social side of attending the groups. Indeed, all three of the groups from which interviewees were recruited looked likely to be leading to self-directed follow-on groups. In one case, this was being initiated by someone having had peer-support training provided by Dorset Mental Health Forum (DMHF). In the others, we witnessed people who had enjoyed each other’s company finding further opportunities to do so on a regular basis.

Implication: the structure and organisation of IAPT might appear to be as valuable as the teaching itself. Beyond therapy we note the role a continued framework might play in keeping people well. Further, what scope is there for increased support for peer groups? In the rural Dorset context, the issue was raised of facilities for holding meetings.

Community resources, including specialist advice and support

The importance to interviewees, of ‘being heard’, or listened to, was expressed, particularly by those with more robust levels of emotional quotient who were more inclined towards developing their own coping approaches.

Talking things through was seen to bring external structure to what is happening and a means of (re)gaining control. Experience of counselling was very limited amongst those we interviewed, so it is unclear from this study whether this need to “clarify thinking through verbalising” would be met by one-to-one counselling. Indeed, from the interviews, those benefitting from this “clarifying through verbalising” were more likely to want an effective listener rather than be seeking advice. These interviewees expressed the value of a non-judgemental listening ear and of being able to clarify thinking through their own verbalisation.

> Implication: The key support for those with a more robust emotional quotient is that of a listening ear; advice and guidance is not a plus.

For those we interviewed with a more fragile (less robust) emotional quotient, self-directed understanding, acceptance and problem solving was less likely. For these people, advice and support was highly valued and GPs, IAPT and other counsellors were highly valued resources.

A wide range of community assets was discussed by interviewees. We heard about how people:

- Enjoyed the company of friends
- Go walking, cycling, running
- Take part in the Church
- Listen to music and in some cases play in groups
- Take part in community-based groups and, in some cases, volunteer their time
- Go to the gym or swim
- Read and write
- Draw and paint
- Take care to eat well

To varying degrees, people expressed awareness of the positive impact of looking after the body on their mental well-being. The following are of particular note in relation to the above:

- The importance of transport to access these things, particularly an issue in the rural context and a big concern for those on benefits or low incomes
- Many of the above play an important part in maintaining good mental health and re-engaging with these is often a clear sign of recovery for many of those interviewed
- It was less clear how receptive people are to the above as symptoms of illness begin to develop. Many talk of withdrawing and stopping doing the very things which may well be protective against symptoms developing

Implication: For many it seems that early onset of symptoms is accompanied by withdrawing from participation in the activities that are protective against illness developing further. At this point in time, could we conceive a coaching intervention that supports people in arresting the slip towards social withdrawal and a downward spiralling of symptoms?

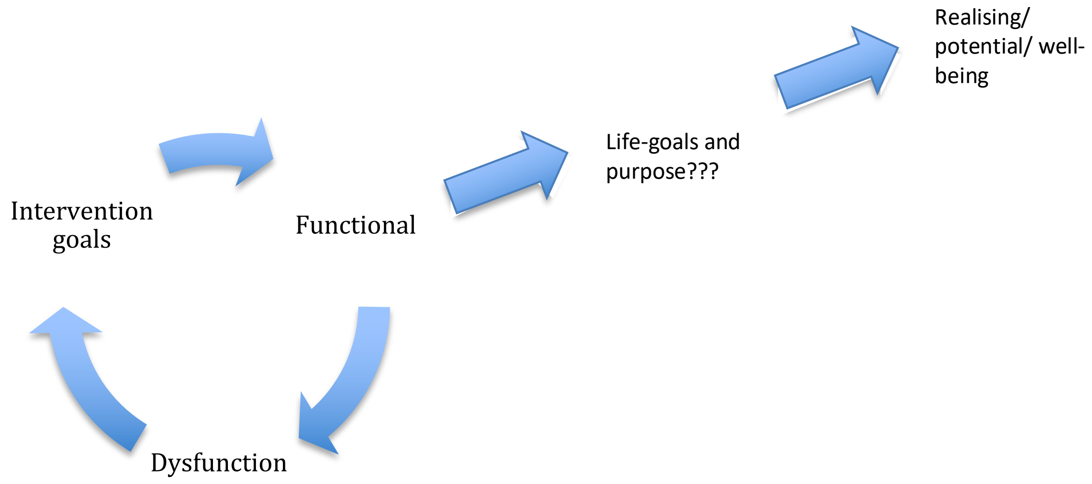
Goal setting

Having goals was seen by all as the means to recover and maintain well-being. In the midst of depression, patients spoke of smaller goals or interventions, e.g. going out to the shops, going for a walk on a daily basis (and not simply staying in).

However, there was also incidence of larger goals or projects, e.g. overcoming one's fear as a means of therapy or trips or holidays to plan and look forward to. Some also spoke of retraining, renewing or redeveloping job skills - in goals that might allow them to park what had happened and move forward.

It also seemed clear that where patients had fallen off the wagon there was perhaps a lack of purpose and goals beyond medical (but short term) intervention.

The following diagram shows how goals and service contact appear related:



The cycle to the left, dysfunction-intervention goals-functional, represents current service provision; helping people recover from dysfunction. What a proportion of interviewees suggest is that this is often a short-term fix and over time the attitude, tools and techniques used to restore function ebb away and the person slips back into dysfunction.

The suggested coaching branch builds on function to consider longer-term “life” goals and purpose with a view to supporting the person realising potential/ well-being.

Implication: whilst small steps/goals/interventions get people moving again, it is their capacity to take charge of their life, reflected by bigger goals and purpose, which seems a key means of sustaining well-being. In this respect, services might want to consider how they can better facilitate this agenda.

Implication: we note that this agenda goes beyond healthcare and into the realms of (life) coaching more generally.

Reflections relative to the Five Ways to Well-being framework

The **Five Ways to Well-being** are a set of evidence-based actions that promote people's well-being. They are:

- Connect
- Be Active,
- Take Notice,
- Keep Learning
- Give

These activities are simple things individuals can do in their everyday lives.
The Five Ways to Well-being were developed from evidence gathered in the UK government's Foresight Project on Mental Capital and Well-being. The Project, published in 2008, drew on state-of-the-art research about mental capital and mental well-being through life. It asked the New Economics Foundation (NEF) to develop the Five Ways to Well-being to communicate its key findings (http://www.neweconomics.org/projects/entry/five-ways-to-well-being).

Health organisations, schools and community projects have used the Five Ways across the UK and around the world to help people take action to improve their well-being. They have been used in lots of different ways, for example to get people to start thinking about well-being; to develop organisational strategy; to measure impact; to assess need; for staff development; and to help people to incorporate more well-being-promoting activities into their lives.

Generally, the interviews attest to the Five Ways to Well-being. Mindfulness of this framework - through increased awareness - may benefit in encouraging wider adoption of the actions suggested. Across those interviewed there was little or no mention of people undertaking structured learning beyond recent attendance of IAPT sessions. It is also noteworthy that within the group interviewed a number had explored in great depth on-line evidence of diet as another aspect of mind-body connection; you are what you eat.

Patient perceptions of services

The following key observations were made regarding (local) services:

GPs

Most patients indicated some delay in approaching the GP. Across many there was a fear of medication and, ironically perhaps, an underlying concern that medication would bring a *loss* of control or perspective.

To some extent this may be exacerbated by a perception that GPs may be too busy to understand and might resort to prescribing anti-depressants – the *"5 minutes plus anti-depressants routine."*

However, we also note, especially amongst older patients, a greater incidence of poor experience and zombie-like state, especially in the past. Certainly a real fear of 'getting stuck' on anti-depressants was evinced. In one case we note one patient had been on the same anti-depressants for 30 years with a lack of a proactive plan in getting them off.

But we also observed how several patients talked in detail about how anti-depressants work and alluded to serotonin. It was indeed as if a proportion of people, through becoming educated (from their GP and other sources) on the science, had learned to embrace anti-depressants. But this also suggests that resistance might have remained in place in the absence of knowledge.

> Implication: whilst it is evident that a proportion of GPs take the time to educate patients there does appear scope to strengthen such messaging so that those on the edge of services do not delay in engaging.

Patients' experience of GPs was variable. In the worse cases we heard stories related to the dumbing down of the condition or being unsympathetic to 'palming off with pills'.

However, what was apparent was the appreciation of GPs who took a wider 'listening' brief, taking time to understand the wider picture, who also might use 'social prescribing', e.g. (step 0) diet or exercise referral or family support. We even heard one incident of a GP suggesting homeopathy. Notably, these GPs were reported as being younger, under 45 years old.

Group CBT (IAPT)

Group CBT (Cognitive Behavioural Therapy) was well received by people in both locations.

Despite the wide spectrum of people (with different levels of intellect) passing through CBT/IAPT, course content was largely felt to be accessible and easy to digest. Time and again we heard patients talk about what they had learnt about concepts like avoidance, rumination, facing fears and challenges, and also practical strategies such as relaxation, ‘changing state of mind’ and coping. Clearly, CBT workshops seemed to be successful in embedding learning, at least in the short term. In addition, people also spoke of the social side and comfort they felt being amongst a group of people with similar experiences.

Where patients were in a more critical condition (and the tendency here is to be younger and/or to desire self-directed learning) it was more that the workshops did not yield additional insight or understanding of their condition. i.e. why is this happening to me? However, here we might proffer that such patients may not in fact be suited to CBT but rather other interventions, e.g. counselling.

There were some criticisms about the wait for assessment and treatment but these were hardly pronounced (although this may be the perspective of patients when feeling most dysfunctional). However, far more evident was questions pertaining to what happens after a course of therapy. Whilst people tended not to be openly critical, there was an uncertainty about what lay ahead and in some cases a profound lack of (self) confidence that they would (or could) remain well.

Interestingly, in some cases patients suggested that they had the ‘ear’ of someone in the service and were but a phone call away from further help.

Individual counselling

Counselling tended to be beyond the experience of most of our respondents as we focussed on the more common end of mental health conditions.

However, where touched upon, most described finding the experience of talking things through therapeutic and a key stage in moving forward (understanding what’s happening, helping them to park issues and move forward)

> Implication: the value of a listening ear was seen as a key need across the piece. We believe that approaches that champion being listened to are relevant to all levels of learning, teaching and intervention.

Recovery

Again, focus on recovery (and socialisation) was limited. Within north/west Dorset and Bournemouth such services were more oriented to mental health patients from secondary care.

However, where experienced (1 case in Bournemouth) it was seen as a huge positive and constructive experience and a means to rebuild life where there was lack of direction, means or social confidence.
In particular, we note that the framework of bi-weekly meetings and promotion of self-reliance (patient guided but not hand held) as bringing direction, purpose and momentum to recovery.

Peer support

Peer support was only experienced in north/west Dorset (there was only one example in Bournemouth).

We met a number of people there finishing IAPT group courses for whom on-going support was highly valued and who had embarked on peer support. The group had developed in an organic (and informal) fashion, the enthusiasm for meeting starting from within the group. One person had gone on and trained as a peer support worker with DMHF. Yet we note that north Dorset venues for meeting were perceived as a major obstacle.

Third (voluntary and community) sector

We were surprised of the low level of awareness of the third sector. There were exceptions (e.g. one person was being trained by DMHF as a peer support worker), but these were few and far between.

There was scarcely any mention of using voluntary or community groups. People in north/west Dorset felt that transport might be an issue in accessing groups and that it might be easier should they live in urban centres. However, interestingly those in Bournemouth were not aware of offers in this respect.

The only example given in Bournemouth was of the Samaritans – praised for their listening brief - i.e. awake, alone in the night and need to share thoughts – but use stemmed from generic awareness and not local signposting.

Life-stage characteristics

In the following charts (pages 27-29) we summarise characteristics of the interviewees by life-stage against the three key themes of:

- Characteristics of mental illness within the interviewees
- Assets for mental well-being
- Patient perceptions of services

The intention here is to provide a 'snap-shot' of findings. In providing a summary in this way we begin to see similarities and differences across the broad age groups. The charts organise insights by theme (presented in columns), there is no intended read across the columns.

> Implications: Whilst each interviewee has his or her own unique story to tell, there do seem to be prevailing patterns in terms of key life-stages. The analysis we present below, in terms of life-stage, raises questions of how well needs are being met, the relevance of some service provisions and hence the potential benefits of targeting universal services to population sub-groups.

Life-stage	Key theme		
	Characteristics of mental illness	*Assets for mental well-being*	*Service interactions*
Young adults	Trauma from formative years + life-stage transition often the driver Drivers – life-stage tension point: leaving home, stepping off conveyor belts of school/home – do I want this, does it make me happy questions as relates to education, employment, re-evaluation of relationships with family, peers, partners Race/ethnicity can accentuate issues/isolation especially if move away from parental home e.g. education Often this appears to be about trauma from formative years (lack of love/self-esteem) being allowed to develop and become pronounced/fully established	More evidence that young adults deal with independently > self-direction – internet search, look in chat rooms/ discussions Age group closer to process of researching/ schooling per se Indeed, determination for this age group is about how they retain sense/ semblance of control Self-directed tools enable them to retain such control Interestingly, managed to maintain social connections/ interactions better than other life-stages	Real resistance to service involvement. Certainly, drugs = loss of control (although this runs across many) It's a weakness to seek help, especially when only just starting out on life-path – tend to view as confirming fears rather than provision of solution Less contact with health services (cf. other life-stage groups) who because of family life/ageing, are more closely in contact with services. Essentially if interact with service inclined to believe that lose sense of self-direction control. Also because life-stage stresses/ attritional factors are fundamentally less pronounced, life-stage has more of a resilience because less likely to have concerns such as dependents, mortgages etc. Initially resist finding answers vs. other life-stages who are more open (or worn down) Where have interacted with service - boosts self-esteem/confidence. And in social group tend to see self a lot more positively cf. other (older) people

Life-stage	Key theme		
	Characteristics of mental illness	***Assets for mental well-being***	***Interactions with services***
Working age	Mental illness brought on by trauma from formative years and/or life-stage transition/ life-stage circumstances Furthermore, life circumstances can be enough by themselves to create spiral (cf. young adults where combination of issues forces episodes) Key drivers – problems at work, family responsibility, money, divorce, bereavement, changes at work so that can no longer ignore fact that job not the best fit, mid-life crisis, other changing circumstances such as moving home (which removes network/ structure that may have hitherto masked problems) Where more trauma from formative years less resilience because of pivotal point in life and associated pressure, perhaps biggest challenge to keep people functional (and prevent slipping back to dysfunction)	Mixed response – some waiting to be taught (‘rabbit in the headlights’ response to episodes) and tools/ techniques have value etc. But some, because they have ability to find solutions or having learning aptitude/ gained confidence from training appear to get less out of community resources But for most being part of peer group has benefits – indeed for many re-introduces social interaction	Initially resistant to drugs – but level of despair means most cave in Generally quite high initial engagement with interventions The social side of interventions seems strong benefit cf. the teaching in the group – which is the most important But beyond this, and amongst those we’ve seen, service fails to address major issues of why people fall into service in first place – especially where not recently in learning or training Lack of goals/ purpose in evidence e.g. we saw major issues with suitability of job, choosing a path that might not deliver the fresh direction away from past, lack of purpose/ structure/ direction. Conversely, where people had moved themselves out of dysfunction a zealous ‘goal’ orientation/ determination/almost ‘project’ focus to getting well.

Life-stage	Key theme		
	Characteristics of mental illness	*Assets for mental well-being*	*Patient perceptions of services*
Older age/ retirement	Similar in many ways to young people. Transition that comes with stepping off the conveyor belt of working life bringing time to self-reflect, especially women Essentially sense that one can no longer get away with any lingering inherent unhappiness, where previously masked by work and caring responsibilities Extra life pressures – retirement, relocation, aging – attractiveness/ decline of physical capacity are further triggers of mental health episodes	But something worrying – people seem to have slipped into service by accident e.g. referral for another condition prompted GP to suggest IAPT assessment Indeed, a generation that soldiers on – in fact this is what makes the short-term and somewhat 'surface' nature of IAPT intervention appropriate – but the hypothesis is that many are slipping under the radar Indeed, no desire to open up further (counselling etc.) as this would just open up a can of worms which they may not have the desire to rectify e.g. unhappy relationship but better the devil you know. Indeed, if there is a gap here it seems to be about visibility and communication of service rather than services themselves.	Actually light therapy that is IAPT appears to work well – something about a framework/toolkit to 'manage' the voices that tips one towards anxiety/ despair In fact you can make something worse by thinking about it/addressing it too much

Research findings – provider insights

Overview

We note how providers tend towards thinking about patient need from the perspective of their own service. They demonstrate great passion and understanding of their contribution to the clinical care pathway. This was consistent across all providers.

What was less prevalent was provider understanding of alternative care providers, be they third sector or genuinely "alternative".

On the whole, most of those providing care were primarily focussed on treatment rather than prevention. The exceptions to this talked very passionately about the need for, and potential benefits of, reminding people to look after themselves along the lines of the Five Ways model.

For a range of reasons, the providers tended to talk in short time horizons. In primary care that probably reflects the incessant flow of patients to their door. In the third sector, uncertainties around funding. And for IAPT, perhaps a symptom of being a relatively new service.

Consequently, examples of long-term planning and service development to meet future needs were limited. Service managers clearly worked positively with local commissioners to agree short-term developments, typically prompted by national policy and guidance.

But there was also a very positive example of SPELT analysis (social, political, economic, legal, technical) being employed to anticipate need.

The following sections will pick up on the provider perspective and what we learned in relation to

- Factors impacting on population demand
- Service issues, needs and gaps

Factors impacting upon population demand

A number of issues were picked up by providers that were believed to be impacting upon the incidence of common mental health problems within the local area (and demand on services):

- Property values in Bournemouth and surrounding areas are out of balance with wages, creating some financial pressure at a population level
- Stresses from work (especially Bournemouth where there are significant financial and insurance-related employers) and not being in work (especially in north/west Dorset)
- Lack of affordable homes or social housing creates high levels of referral in north Dorset
- Interestingly, a reported increase in 40-50 year old men seen in the last 12 months; associated with job pressures
- Isolation issues in north Dorset
- Some providers feel that Bournemouth is more of a transient, less community-orientated population when compared, for instance, with Poole

When encouraged to consider trends and future demands on services the following emerged:

- An increasing presentation of older people with anxiety and depression (arising from increasing social isolation and increasing number of people living with long term conditions)
- Providers recognise well-developed local CAMHS (Child and Adolescent Mental Health Service) treatment services for those with more severe mental health issues but less so preventative interventions delivered in a way that is appropriate to teenagers and young adults
- Providers also expressed concerns around the extent to which the care system was sufficiently supporting the health and social needs of carers
- The importance of the recovery agenda
- An increased role for the voluntary and community sector in meeting these needs

Services issues, needs and gaps

What was apparent was the extent to which time and resource pressures were felt.

GPs described the challenge of working within the pressures of keeping to a 10-minute consultation time and separating what was ‘normal’/‘the blues’ compared to something more clinical. Indeed, such could only be determined by giving ‘listening time’ which was rather in conflict with the demands of ‘paperwork’. MUPS (medically unexplained physical symptoms) presented even more of a challenge in this respect, not least the time required to navigate to diagnosis and client trust (which might take several consultations).

Across IAPT it was interesting to note the extent to which waiting times were cited by third party providers as being an issue, yet refuted from within IAPT or rather attributed to short term resourcing issues. Indeed, it ought to be noted that resourcing appears to be a challenge. The service necessitates the use of graduate practitioners who will require significant supervision before they acquire the (life) skills to work with a client group that tends towards being largely older than themselves. And career progression demands that the graduates will feel a pressure to move on.

All of the above are magnified by issues of geography in rural Dorset. The nature of the locality can make it difficult to provide and resource services. And of course for patients, services can be difficult to get to.

> Implication: there may be scope for greater use of web-based platforms in engaging with and delivering services to patients in rural Dorset.

Many providers felt that the ability of IAPT to put people on a path to well-being in 6-12 weeks could be challenging. But, interestingly we did hear lead practitioners alluding to services being ‘flexed’ to accommodate critical cases e.g. one-to-one interview (not counselling) to keep the patient ‘in the loop’ and check on progress until the next available therapeutic intervention becomes available.

> Implication: whilst time limited packages of care make sense from a resource management perspective they do not always fit with patient needs and it would be beneficial if the funding of patient packages allowed a degree of flexibility.

What was apparent was the recognition of skill-set challenges within IAPT staffing, for example the ability of graduate practitioners to work with older people. In fact, a belief that the system tends to militate against non-graduates who might have relevant life skills.

Yet, relative to these issues, we also note how the lead practitioner will influence the flavour of service: Bournemouth Step 2 where a social work background creates more of a social (and wider determinants of well-being) versus a purely medical model, Bournemouth Step 3, where a more clinical and psychologist background is flexing the service so that there are more clinical inputs.

Many cited recovery (socialisation) and prevention as a priority. A greater role for life-style advice (Step 0/Step 1) to build resilience and prevention was also identified. IAPT in both areas claim that a small proportion of GP referrals (or self-referrals) do not qualify for treatment and that a period of watchful waiting or lifestyle interventions would have been more appropriate.

> Implication: is there an increased role for a step 1 coaching style approach that can be delivered online/through front line 'providers' i.e. GP surgeries, housing association/the third sector, pharmacies not as a preventative step and involves approaches which embed relaxation, coping techniques, lifestyle/diet advice etc. and aligns with the Five Ways? We are aware of recent initiatives around primary care mental health projects and would hope that these embrace this agenda.

The separation of mental health issues from addiction was often discussed with increasingly support for more holistic care models.

Many professional providers recognise the value and potentially positive impact of the third sector but in practice find that services can be transient and find it extremely difficult to keep up with such a changing landscape.

Patient feedback and service user views were recognised as important, though strategies for obtaining these are yet to mature.

Research findings – commissioner insights

Overview

In this section we feed back on the following:
- Current approaches to needs assessment
- Challenges and issues for the future

Current approaches to need assessment

The following means of understanding need were identified
- JSNA (Joint Strategic Needs Assessment)
- Hard national data (collected through GP registers) being adjusted to local level
- Creative analysis of local data
- Service provider focus
- Current service user focus
- DMHF

Most of the above, with the possible exception of the use of local data and to some extent the JSNA, were felt to have limitations relative to need assessment. It was acknowledged that a re-weighting of national data might naturally miss geography and rurality issues that would apply to north/west Dorset. As regards the JSNA itself, it was felt to be a step forward in that it had highlighted a mismatch between the presentation and allocation of resources in west Dorset (supporting frustrations with IAPT waiting lists) but lacking in a sense in that it did not capture the 'patient's voice' or the spirit of co-production. In fact, all commissioners acknowledged the value that qualitative research would bring to the understanding of need.

It was implied, and even openly acknowledged, that commissioning is not necessarily driven by need but more by the retendering of contracts and the reaction to problems in services. Or rather 'how can we make what we're doing function better or more efficiently?' rather than 'is it right for the service user?' Or as one commissioner put it 'historic incrementalism', whereby service activity creates the service specification. It was also observed that clinical commissioning in Bournemouth was facilitated by a group including GPs and providers, rather than the provider being more distinct from the purchaser.

Furthermore, many noted how service improvement is in effect steered by the current service user who engages with services, rather than the wider community and/or people who might reject services.

It was also questioned whether the existing agency for understanding customer experience – DMHF – was sufficiently representative and/or objective as again the non-service user is typically missed. We also note the issue of "reach" as raised in patient insights – north/west Dorset tends to be more. There is less evidence of Bournemouth service users being connected to the organisation].

All of this said, we did witness creative analysis of local data e.g. neighbourhood level data analysis to map single people, elderly people, people living alone to identify more vulnerable groups with accordant commissioning and allocation of resource. However, we also suspect that these processes create skill set and resource issues of their own.

Challenges and issues for the future

The following themes were identified:

- Joint partnership working and how to get there
- How to leverage and work better with community assets and resources
- Prevention, recovery and life-skills

It was noted that the propensity to block-contract encourages service fragmentation that may not be in the best interests of service users. The demarcation of mental health and drug and alcohol treatment was raised as a case in point. But it was felt that the advent of personal budgets might, in the future, enable service users to be in better control of their care pathway.

Across the piece it was implied that commissioning was somewhat 'inward looking' – driven by service activity and current service users rather than embracing the wider community from both a resource and potential client perspective.

There was a need and desire amongst commissioners to engage with local communities and identify ways of addressing need. There was also a sense that financial resource was allocated disproportionately towards the specialist (and medical) end of treatment compared to well-being and recovery promotion.

Commissioners appeared united in the importance of well-being (prevention) and recovery, and the creation of resilience. In effect, how do we better support people to take control and move beyond dysfunction, compared to simply treating illness?

> Implication: across commissioning we see a 'professional' medical approach to mental health service provision that may not fully address all aspects of what we understand about patient needs.

Next steps

Looking to Phase II: the integration workshop

The next stage in the project will bring together interviewees to discuss the findings of phase I, presented in this report. The paradigm here is one of co-production; seeking to draw on the experience and insights of all those interviewed with a stake in promoting better mental wellbeing in general and in supporting those with common mental health issues.
We will be looking to run this workshop in early 2015 and to report shortly after.

APPENDIX

Pre-task

Thank you for agreeing to take part in this research for the Dorset, Poole & Bournemouth LINk. As you will know the research is designed to help the LINk better understand common mental health problems, methods of getting and staying well and also what you think about local services. Before you come to the interview please spend a few minutes thinking about the questions below and make a few brief notes in the space provided or somewhere else if you can't print this out. ☺ Please remember to bring this along with you to the interview . Many thanks, Roland & Paul

LIVING WITH A COMMON MENTAL HEALTH CONDITION

We're interested in how common mental health problems affect people day to day; please jot down a few areas in your life e.g. family, work, socialising, daily tasks, diet, finances, living arrangements which has been impacted by your mental health condition

GETTING AND KEEPING WELL

We're keen to understand the methods you've used to get (or try to get) better; please jot down a few thoughts on the key things that have worked for you: this can include support from written/online information; family and friends; mental health services/ community e.g. GP, CBT, STR, MIND, other; support from general social welfare services e.g. job centre, benefits, housing association; diet & exercise; credit union; anything really

BARRIERS TO GETTING AND KEEPING WELL

What hasn't worked or where have you felt let down by services/ the community in general? What would have made a difference to getting better sooner or staying well?

Discussion guide – patients

ENGAGEMENT WORK; CLIENT DISCUSSION GUIDE

INTRODUCTIONS (5 mins)

- Introduce selves – research professional but not mental health experts
- Introduce aim of interview: to gain a warts and all view of what its like to suffer from mental health problems and how services have helped or not
- Confirm anonymity – but encourage them to go with flow …
- Participants to introduce self: name, family situation, working status (and/or recent unemployment); interests/ how spend free time

MENTAL HEALTH HISTORY (10 mins)

- Mental health diagnosis > and establish whether 1st time or repeat; if repeat establish incidence over time
- Establish stage of treatment (if any) > pre/ during/ post or other
- Bring to life to me how this (has) effects(ed) you day to day; what is/ was difficult > moderator to explore spontaneously and then probe in detail
    - Family life
    - Diet & Exercise
    - Socialisation
    - Work
    - Daily tasks
    - Other …
- Explain that you'd like to understand path to treatment (or not)
    - When did you start feeling ill > or did somebody point out to you or did you realise yourself
    - First steps to diagnosis … what did you do next e.g. … go to GP, go on web/ get books, go to community
    - Was there a period of denial – probe in detail

GETTING & KEEPING WELL (10)

- How are you feeling now: getting better, feeling worse, somewhere in between etc.
- Why do you think this is
- Talk me through what the key things you've done to try to get well and how its worked (or not worked)
    - This can encompass information, NHS services, private services, diet and exercise, family support … anything
- What factors have made it easy or difficult locally e.g. transport links, access to meetings etc.

SERVICE EXPERIENCE (15 mins)

- We'd now like to explore services in more detail (in reality there might be some overlap with the previous section)
- For each explore
    - Summarise type of interaction e.g. one 2 one or group
    - 3 key words to describe
    - Positive aspect – where its delivered for you
    - Weak elements, what's missing
- Services to explore include (some of as relevant to participant)
    - IAPT/ psychological therapies esp. CBT
    - GP practice
    - STR (support, time & recovery) n.b. likely secondary care focus
    - EDAS (Drugs & Alcohol service)
    - NHS care network as a whole
    - Exercise referrals (Littledown, Stokewood, Pelhams)
    - Community organisations/ hubs/ places e.g. Dorset Mind, Positive Approach Shop, Dorset Mental Health Forum, Boscombe Resource Centre
    - Private service/ counselling/ stress management arranged through work
    - Online resource/ apps e.g. Mindgym, patient.co.uk, Calmzone, MIND, Dorset Mental Health forum
    - Social welfare e.g. Welfare & Benefits, Social Services, Housing Association, Job Centre
    - Helplines – Samaritans/ Saneline
    - Credit Union
    - Citizens Advice Bureau

THE FUTURE (5 mins)

- Single best factor from service experience
- Single gap/ missing element from service experience
- Single element in life that would help them get well and stay well (beyond services)

Discussion guide – providers of services

ENGAGEMENT WORK; PROVIDER/ COMMISSION DISCUSSION CHECKLIST

INTRODUCTION

- (Re)affirm objectives of the project; ultimately purpose is to enhance the dialogue around patients' needs and what this might mean for service design
- Introduce self: research profs but not greatly familiar with mental health map

- Provider: Job role and purpose/ vision of organisation
- What services/ support organisation provide and where fit into the map

ISSUES AND ASSETS

- what are the major local (B/ ND) challenges for mental health services locally
- What are the key local factors that affect patients and service delivery, in positive or negative way re i) the patient ii) service delivery
- Mental health prevalence – what specific to Bournemouth/ North Dorset
- Local assets – and any that are underutilised

ORGANIZATIONAL DELIVERY RE COMMON MENTAL HEALTH:

- Strengths – what does it do well …
- Weaknesses – what's difficult, where fall short
- What are the main areas it can build/ improve
- What external barriers/ threats can in the way of delivery

THE INTEGRATED CARE NETWORK:

- Gather perceptions of services/ offers that function well *locally* why
- What, in particular seem the weak links
- What wider opportunities are there for better service provision

Service checklist
NHS (GP services, IAPT Levels 2 & 3, Recovery, Drugs and Alcohol Service, PCT Emergency response, NHS Direct)
Community (Mind, Local Peer groups, Positive Approach Shop)
Other organisations (Rethink, Saneline, Samaritans)
Digital technology (not local but worthwhile exploring) – computer CBT and management tools (e.g. Living Life to the full, mood gym), smartphone apps (various) e.g. which do they advocate – do they have a digital strategy?

THE FUTURE:
How might mental health services be better configured to suit the patient – ideal world and pragmatic compromise

Discussion guide – commissioners

ENGAGEMENT WORK; Commissioner DISCUSSION GUIDE

INTRODUCTIONS (5 mins)

- Introduce selves – research professional but not mental health experts
- Introduce aim of interview: to gain a warts and all view of what its like to suffer from mental health problems and how services have helped or not
- Confirm anonymity – but encourage them to go with flow …
- Participants to introduce self: name, role and experience

MENTAL HEALTH common disorders - what are the needs (10 mins)

- sense of scale
- how big a problem locally - what do we know of the issue and how is it known
    - epidemiology
    - trends
    - who is effected
    - factors likely to increase needs

MENTAL HEALTH common disorders - what assets are there locally (15 mins)

- factors likely to promote resilience / preventative
- what available
- how could these be better harnessed?

Commissioning process (15 mins)

- gathering needs
    - how
    - what works well
    - what do we need to do more of
- translating needs into services
    - how does commissioning progress
    - is the market in need of developing?

How are needs being met now (10)

- service options for common MH disorders
- what is commissioned - NHS
- how does this link to LA?
- the pathway
- known issues
    - access variability
    - wait times
    - bottle necks / pressure points
- evidence
    - what does it suggest
    - any challenges / gaps locally

So looking to the future ... (20 mins)

- Threats
    - the challenges ahead
- Opportunities
    - the assets to develop
    - Needs assessment
    - commissioning
    - pathway / service models

Sample recruitment leaflets (posted on noticeboards, surgeries etc.)

Would you be interested in helping us to improve local services for people with common mental health problems?

Are you an adult with recent experience of a mental health problem such as anxiety or depression? Do you live in North or West Dorset?

If so, you can help us. Dorset, Bournemouth & Poole LINk, a network of local people and groups who want to improve health & social care services, are keen to talk with people affected by common mental health problems.

The LINk want to understand how people are affected by mental illness on a day-to-day basis, what methods they use to overcome their difficulties and in particular what their experience is of local services.

£25 is available to you as a thank you for giving your time to this project.

If you would like to be involved, please contact us directly on 07542 103563 (text us and we will get back to you) or email paul@iona-insight.co.uk. The researchers at Iona-Insight will contact you to arrange to gather your views and experiences.

This phase of our research is taking place during March to May 2013, so please register your interest as soon as possible.

LINk
Your voice on local health and social care

Dorset
Mental Health
Forum
promoting wellbeing & recovery