Health and Social Security Scrutiny Panel Review of Mental Health Services

A submission from Contact Consulting (Oxford) Ltd

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Introduction

Contact Consulting is pleased to provide this submission to the Health and Social Security Scrutiny Panel as part of its review of mental health services.

Contact Consulting is a consultancy and research practice working in health, housing and social care. First established in 1995, Contact Consulting has worked with government departments, local authorities, housing associations, NHS organisations and commercial and voluntary sector bodies. Mental health, learning disability, substance misuse, older people and housing provision and the needs of other vulnerable groups are among the areas of expertise and experience that Contact Consulting offers.

Appendix One provides more detail about Contact Consulting. Appendix Two sets out the professional background of Steve Appleton, Managing Director of Contact Consulting.

Contact Consulting, in collaboration with the Health Services Management Centre at the University of Birmingham, led the review of mental health services and produced the five-year mental health strategy for Jersey. Our work was commissioned by the then Deputy Director of Commissioning at the Health and Social Services Department. Our appointment followed an open tender process.

The development of the mental health strategy

The strategy was developed by drawing upon local data in relation to current and unmet need, performance and financial information and relevant policy and legislation. It also involved a review of published and grey literature and evidence on best practice.

The approach taken was one of co-production with local professionals and organisations. Engagement with the public, professionals and service users was a central part of the process. Innovative engagement techniques, including the use of a Citizen's Jury, Open Space listening events and action learning sets were used to help to develop the key themes and recommended priority areas for action within the strategy.

The approach, the first of its type conducted in Jersey, has been internationally recognised as a model of good practice, being referenced at conferences in Australia, the United States and Scandinavia. The approach has also been highlighted in academic literature, specifically in 'Integrated Care in Action', by Dr. Robin Miller, Hilary Brown and Catherine Mangan, published in 2016.

The strategy intentionally took a life course approach and also included work related to substance misuse and mental health and criminal justice.

The strategy was signed off the by the Chief Minister and the Health Minister at the end of 2015 prior to the commencement of implementation. Contact Consulting were subsequently engaged to support elements of the implementation process and in May 2016 reviewed progress against the delivery of the strategy. At that time implementation was on track with locally agreed action plans and milestones.

It is important to remember that the strategy was not simply about mental health services, by which we mean, statutory services provided by the States including specialist in-patient and community based services for people with serious mental illness. It was also intended to provide a focus on services and approaches for those with mild to moderate mental health problems, mental health promotion and prevention and suicide reduction.

Response to the Scrutiny Panel's questions

What are the current trends in mental health in Jersey?

For all the uniqueness of Jersey as a place, the trends in mental health and mental illness on the island are not significantly divergent from those in the United Kingdom. One in four people will experience a mental health problem at some point in their lives. Among those aged under 65 almost half of all ill health is mental illness.

We believe that the information within the strategy remains accurate, in that around 2-3% of the population of Jersey experience a serious mental illness, this equates to around two to three thousand individuals. Mild forms of mental health problems are experienced by around 12% of the population, leaving between 4-6% experiencing some moderate mental health problem. Approximately 21,000 of the total population of the island can expect to experience some form of mental ill health.

The strategy set out predictions about the trends over the next 10-15 years, based upon modeling used by the Institute of Public Care at Oxford Brookes University. This showed that by 2030 the island could expect to have around 10,500 people aged 16-64 who would experience a common mental health problem, a slight fall on 2011 levels. This is counter intuitive to the current demand for access to services if taken in isolation, but the reduction is in line with the projected reduction in the total population and therefore the demand as a percentage of that population remains the same.

We do not have access to current data on the wider range of service contacts and admissions. However, in 2015/16 admissions to adult psychiatric inpatient care were around 180 per year, of which almost 60% were male. Orchard House, the acute inpatient ward was operating at 80% capacity. In 2016/17 the number of readmissions to hospital within 30 days of discharge is lower in Jersey when compared to the UK for older adults but higher for adults of working age.[1] We would expect to see that in common with other jurisdictions, the proportion of those people who are on the ward voluntarily would be lower than those detained under the provisions of the Mental Health Law.

2% of children living in Jersey are on the active caseload of Child and Adolescent Mental Health Services (CAMHS), higher than most parts of England.[2]

In 2016 there were a total of 858 attendances at the Emergency Department (ED) of the General Hospital for a range of mental health issues (including attempted suicide, deliberate self-harm and psychiatric concerns). The ED referred these individuals to the adult mental health liaison team on 495 occasions.[3]

Prior to the development of the strategy there had been concern about the rate of completed suicide in Jersey. This appeared to be linked to a cluster of suicides within a relatively short space of time. Rates of completed suicide in Jersey have in fact been reducing consistently since a peak in 2008/09.

Our own work identified a rate of 10 suicides per 100,000 population (aged 10 and over) between 2012-14 which is lower that the European Union rate of 12.6% per 100,000. The current age-standardised suicide rate for the UK is 16.0 per 100,000 for males and 5.0 per 100,000 for females.[4]

In common with other jurisdictions, Jersey continues to experience a high demand for specialist mental health services. There may be a number of factors driving that demand. Some attribute this to the greater awareness of mental health and mental illness, the reducing stigma surrounding it and the resulting willingness of individuals to seek help.

[1] Mental Health Quality Report States of Jersey 2017
[2] ibid
[3] ibid
[4]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registrations

The period 2011-2016 saw a 178% increase in reported mental health incidents and a 37% rise in welfare incidents attended by States of Jersey Police. The causes of this large rise are not clear, but our assumption is that it may be related in part to previous lack of recording or inappropriate 'coding' of incidents. Nonetheless, the trend appears to suggest a rising number of mental health crisis presentations and that these often involve the engagement of the police.

Mental health issues within the prison remain significant. Although much work has been done, the likelihood of a reduction in presentation of mental illness and poor mental health is small. Of 31 prisoners expected to be released in the next three months, 12 required support with mental health issues.[5] Around 33% of prisoners reported a mental health problem in response to a survey conducted by HMP La Moye in September 2017.

Despite the development of Jersey Talking Therapies, rates of prescription for benzodiazepines[6] remain high when benchmarked against comparable populations. This suggests a continuing reliance by General Practice on poly-pharmacy as a first line treatment for mild mental health problems rather than utilising psychological therapy. Work has been undertaken to review the JTT service and changes are being made, including plans to make it an open access service that does not require GP referral.

We know that like the United Kingdom, the population of Jersey continues to age and that by 2030 the number of people aged 85 or over will have more than doubled. Looking more broadly, the number of people aged 65 or over will have grown by over 10,000 and will comprise just over 23% of the total population of the island. This will inevitably lead to a rise in the number of people experiencing functional mental illness as well as those experiencing organic disorder, such as dementia.[7]

In summary, although we do not have access to current data from the island, we believe that the predictions in relation to prevalence contained in the mental health strategy remain valid, though it would be prudent to review and update them. Equally, we make the assumption that demand for specialist secondary care mental health services continues to rise. This assumption is based on our review of trends in other jurisdictions, notably in England, Wales and Scotland.

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[5] Local mapping data provided for the MH/CJ forum July 2018
[6] Benzodiazepines are a type of medication that is used to treat anxiety, Rethink Mental Illness Factsheet
[7] Jersey mental health strategy

What progress has the States of Jersey made on implementing its mental health strategy? What further work is required?
How have services changed since the launch of the mental health strategy?

Following the publication of the strategy at the end of 2015, considerable work was undertaken to plan the implementation of actions arising from the recommendations and priority areas. This work was led by the then Deputy Director of Commissioning, and was overseen by a Mental Health Implementation Group.

Contact Consulting was not initially involved in the implementation process, but we were subsequently commissioned to lead work on the re-design of older adult mental health services. This involved a review and re-writing of the service specifications for older adult community mental health services and delivering a process to establish and recruit to new services including a primary care mental health service for older people. The Jersey Memory Assessment Centre received Royal College of Psychiatrists Memory Services National Accreditation (MSNAP) validation, which was in part due to the changes made in the service redesign process.[8]

Work was undertaken to establish a Recovery College for Jersey. We believe this to have been an especially welcome development. Not only is the establishment of the Recovery College a tangible development arising from the strategy, it is a very positive example of collaboration between statutory and voluntary and community sector stakeholders. Over 70% of those students attending the Recovery College have said that it contributed to their personal recovery.[9] The Recovery College remains a vehicle to deliver a much wider variety of support using approaches that government could never be able to do or indeed should be doing. It offers the potential to support a much broader number of people living with mild and moderate conditions, but this would need additional investment to create capacity in the service.

Progress has been made in relation to mental health and criminal justice. A three month 'street triage' pilot has been conducted and a mental health and criminal justice forum has been established. The future of that group is currently under review as a consequence of reform of public services in Jersey and the establishment of new departments and the recasting of their responsibilities.

[8] Detail of the MSNAP:
https://www.rcpsych.ac.uk/quality/qualityandaccreditation/memoryservices/memoryservicesaccreditation/msnapstandards.aspx
[9] Jersey Mental Health Quality Report 2017

The Jersey Talking Therapy Service (JTT) was established prior to the strategy being written. However that service has been reviewed and is currently being reshaped.

We are aware that work was undertaken to review the mental health services estate, which included estimating future demand, as well as examining the structure and fabric of locations where services are provided. We understand that current planning is for mental health in-patients to be on one site in a new build. This is welcome but it will also be critical to get the community mental health services to a place that is high performing, innovative and efficient as this will inevitably influence the level of investment required of any future in-patient service. This is the key lesson of the past 20 years of mental health policy that has yet to be fully learnt, understood and acted on in the UK. Appropriately funded and available community services, matched with sufficient bed capacity are both needed. The two services should not be seen as mutually exclusive.

A programme of training in mental health awareness in schools took place in 2016 and 2017, enhancing the knowledge of education staff in identifying and responding to the mental health needs of students.

Work was undertaken to develop a Quality and Outcomes Framework for Mental Health. This involved, amongst others, the NHS Benchmarking Network, who we introduced to Jersey colleagues. In May 2017 the first Jersey Mental Health Quality Report was published. We believe this to be an important step in good governance and transparency in relation to quality. Clear outcome measures make it possible to review progress and identify where improvement is needed. This is central to the overall improvement process.

Looking from the outside, it appears to us that there was significant work undertaken and much progress made in the first year to 18 months of implementation. It is also fair to point out that many of the improvements to services that were sought were always likely to take some time to achieve, hence the need for a five-year strategy.

The revision of the Mental Health Law is a welcome development, it has been a long time in the making, and it must be hoped that the new law, once enacted alongside new Mental Capacity legislation, will ensure better protection of human rights and enable effective intervention when detention under the law is deemed necessary.

The leadership shown by senior managers in health, including the then Director of Redesign, Deputy Director of Commissioning and Chief Executive of the Health and Social Services Department were especially important. They created the conditions for the development of the strategy and enabled implementation by making financial resources available. Mental health was not their only responsibility, far from it, but they prioritised it and should be applauded for having done so. All three demonstrated a commitment to mental health that had not always been present in Jersey. All three endorsed and supported a collaborative, co-productive process that continued on from the strategy development into implementation.

The initial progress on implementation appears to us to have slowed in more recent times. In our judgment the loss of the Deputy Director of Commissioning, who moved to another more senior post at another department had a direct impact on delivery. It resulted in loss of organisational memory, of mental health knowledge and of leadership of the programme. The subsequent splitting of that role, combined with the impact of structural and organisational change has resulted in a lack of day to day, focused leadership.

There has been improvement. New service models and teams for older adult services, the development of clear outcome measures, an evolving talking therapy service, the Recovery College, service user engagement are some examples that we have highlighted. However, there is much still to be done to achieve the vision set out in the strategy.

Mental health services in Jersey remain overly based around inpatient beds and community services are not as well developed or integrated as might be expected. The inpatient unit remains one that requires considerable improvement in terms of the estate and plans for its reprovision should be progressed.

At present there remain gaps in inpatient provision. Jersey does not have a Psychiatric Intensive Care Unit (PICU) nor does it have Medium Secure beds. The latter is understandable. Such beds are intended for those people who require conditions of Medium Security and have generally committed an offence in the context of their mental ill health. These are high cost low volume beds and Jersey has neither the level of demand or the resources to provide such beds on the island. Arrangements do exist to ensure access to these services in the United Kingdom and those who need them are conveyed to the UK.

The lack of PICU is problematic. Without it those people who require additional treatment and support, additional nursing, observation and some degree of secure containment, do not have access to such a service. This also impacts on the Prison in Jersey. The arrangements for transfer of prisoners who require inpatient hospital care remain challenging and result in prison staff having to escort prisoners to the acute adult mental health ward, and to remain with them through their inpatient stay. It is our view that consideration of the provision of PICU beds, perhaps through redesignation of existing beds at Orchard House should take place. If, as we understand, new build re-provision is being considered, PICU provision should form part of that new build.

Primary care mental health remains underdeveloped and JTT has yet to realise its full potential. Creation of a suitable Place of Safety for people to be assessed at when in mental health crisis is an outstanding action and should be resolved with some urgency.

There remain inequities of access to services, not least in respect of psychological therapy for those in prison, and the development of a court liaison and diversion service has not yet come to fruition.

There is work to be done to reduce waiting times further, to reduce sickness absence and to address workforce issues relating to recruitment and retention, given the reported 30% vacancy rate in mental health services.[10] Improvement in integrated working and joint working across services remains a work in progress.

In Jersey 10% of the population has a long-term illness or condition that affects their day-to-day life. The top three causes of death in Jersey are ischemic heart disease, stroke and lung cancer. This suggests that there is a high likelihood of significant co-morbidity in relation to mental ill health. Given that mental health services in Jersey, as in many other places, are separate from physical health services, there remains a challenge in responding to mental health and physical health needs with any degree of parity.

The strategy was not simply about services and there is more to do to embed a population based approach to improving mental health and well being that involves other States departments and makes mental health everyone's business. This includes mental health promotion, suicide reduction and prevention and further development of employment support for people with mental ill heal, as well as the provision of appropriate housing and housing support services.

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[10] Mental Health Quality Report States of Jersey 2017

It should be remembered that health is not the only stakeholder in this. Colleagues in education, children's services, justice, police and social security all have a part to play.

Over the past 18 months the link between strategy and operational delivery has not been clear enough and this has hampered progress. In the midst of the current organisational change there is a very real risk that mental health development could continue to stutter. It is our view that it requires dedicated leadership that is empowered to take forward implementation over the remaining life of the current strategy. This needs to be supported by prioritisation of actions allied to the vision and the agreed outcomes, and where necessary, sufficient financial investment to enable improvements, supported by a clear governance structure to oversee implementation to assure politicians, States of Jersey senior leadership and the public that progress is being made.

What support is in place to ensure the organisations which provide mental health services are able to work in partnership in the best interests of the individual concerned?

Our experience of local practitioners and clinicians is that they strive hard to work together effectively. There is little role cross over and clinicians and practitioners tend to operate within the boundaries of their professional codes, which is right and proper.

What strikes us most however is that much of this partnership at practitioner level appears to rely on goodwill and the establishment of good relationships between individuals.

There does not appear to be any framework for partnership working between professionals in the field. At a managerial and leadership level the same is true. While there are examples of very effective cross-departmental working and leadership, there is little in the way of formality about this.

There are Memoranda of Understanding between different services, we are aware for example of MoUs between the Police and Health colleagues that do provide a clear template for how the services work together. Where these do not exist, there remains the risk that when dispute occurs, it could adversely impact on either the working relationships or the service delivered to the person in need.

Our own experience of facilitating work in Jersey to establish improved partnership in children and young people's mental health demonstrated that there remains some way to go to establish joint ambition and shared outcomes. Gaps in understanding and different cultures were identified obstacles to partnership working.

Partnership working tends to be more straightforward when things are going well. It can become more challenging when that is not the case. Our own review of the Safeguarding Partnership Board highlighted an issue that is perhaps an example of a wider problem in local services. Our observation is that there has been a failure of the system in Jersey to establish a culture of constructive professional challenge. This can result in friction between individuals and departments. Such tensions are only amplified in the context of a small island, where the same leaders encounter each other in a range of settings on a daily basis.

What are the potential risks and benefits of separating child and adult mental health services? How could any potential risks be mitigated?

We have been engaged in the development of good practice guidance for the commissioning of Child and Adolescent Mental Health Services (CAMHS) and of CAMHS transitions services for the Joint Commissioning Panel – Mental Health, hosted by the Royal College of Psychiatrists. Our response is therefore rooted in that guidance and our work in that field.

CAMHS are generally provided through a network of services which includes universal services such as early years services and primary care (Tier 1 CAMHS) targeted services such as youth offending teams, primary mental health workers, and school and youth counselling (including social care and education) (Tier 2 CAMHS) through to specialist community CAMHS (Tier 3 CAMHS) and highly specialist services such as inpatient services and very specialised outpatient services (Tier 4 CAMHS).

As CAMHS is a multi-agency service, a multi-agency approach to commissioning and provision is required. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to better meet the needs of the populations they serve, and achieve wider system efficiencies.

While there is no prescribed 'best practice' model, and services need to relate to local need and circumstances, a good CAMHS should be able to provide care that is:

- **Timely** – delivered without long (internal or external) waits for interventions appropriate to the age and needs of the child or young person

- **Effective** – have sufficient numbers of staff with the right skills to be able to offer evidence-based interventions that meet the needs and goals/wishes of children, young people and families

- **Efficient** – with a delivery model that best focuses the capacity of the service to the demands of the population.

It is our view that the potential benefit of the recent change to host CAMHS separately from other mental health services is that it provides particular focus on the mental health needs of children and young people. It more clearly defines the service and aligns it with other services for children and young people.

However, we do see a potential risk in relation to transition from CAMHS to adult mental health services. The challenges faced by young people moving from adolescence into adulthood have been well documented. The extra challenges of negotiating service transitions at the same time have received similar attention. What should, for all young people, be a time of increasing independence and opportunity can, for young people with mental health problems, signal a period of uncertainty and even deterioration in their mental health.[11]

Barriers to transition are not restricted to the often quoted issue of age differentiation. There can be differences between CAMHS and adult mental health services in relation to thresholds regarding acceptance criteria, professional differences and service structures/configurations all of which have been found to affect the transition process.[12]

CAMHS and adult mental health service professionals often take differing approaches in the ways in which they work. This lack of common understanding of young people's mental health needs as they make the transition to adulthood can have an impact on the experience of transition. Research has indicated that this has prevented areas of common concern from being recognised or addressed, and that the training of professionals has also exaggerated differences between specialties rather than developing areas of mutual interest.[13]

The aim of transition for young people should be to help to improve the chances of recovery and independence through the provision of high quality, effective health and social care services that continue seamlessly as the individual moves from adolescence to adulthood.[14]

If this can be embedded in the strategic and operational aims of CAMHS and if the ambition of good transition is central to that thinking then the risks of separating the service may be mitigated. If not, there will remain a risk that children and young people with ongoing mental health needs will fall through the gap between the two sets of services.

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[11] Stressed out and struggling: Two steps forward, one step back. Pugh, K. McHugh, A. McKinstrie, F. Young Minds 2006. Transitions, Young Adults with Complex Needs, Social Exclusion Unit Final Report 2005, HASCAS CAMHS to AMHS Transition: Tools for Transition, Right Here Mental Health Foundation, Minority Voices, Street et al, Young Minds 2005

[12] Planning mental health services for young adults – managing transition Appleton, S. & Pugh, K. National Mental Health Development Unit/National CAMHS Support Service 2011

[13] ibid

[14] Tools for Transition Anderson, Y. HASCAS 2006

What examples of best practice are available from other jursidictions that Jersey could learn from?

This question is broad in its scope and as such there are probably very many examples of good practice that could be cited here. However, we have set out links to some resources that may be of interest to the panel and could be used to further inform the implementation of the mental health strategy:

Population based approaches to mental health and wellbeing:

West Midlands Mental Health Commission Action Plan and report – Thrive West Midlands

http://www.contactconsulting.co.uk/wp-content/uploads/2017/01/WMCA-Thrive-Full-Report.pdf

Thrive London

https://www.thriveldn.co.uk/wp-content/uploads/2017/07/ThriveLDN-Publication.pdf

Isle of Wight Blueprint for the future of mental health services

http://www.isleofwightccg.nhs.uk/get-involved/public-consultations/Mental%20Health%20Blueprint%201701.pdf

Employment

Individual Placement and Support

https://www.ncbi.nlm.nih.gov/pubmed/19085404

https://www.centreformentalhealth.org.uk/Pages/Category/employment

Criminal Justice

Street triage

https://www.ucl.ac.uk/pals/sites/pals/files/street_triage_evaluation_final_report.pdf

Court diversion

https://www.evidence.nhs.uk/Search?ps=30&q=court+diversion

https://www.rand.org/pubs/research_reports/RR1283.html

Commissioning services

Refer to Joint Commissioning Panel – Mental Health website for access to free and downloadable guides setting out good practice in a wide range of mental health services

https://www.jcpmh.info

CAMHS

i-Thrive model

http://www.implementingthrive.org/about-us/

Transition

https://www.scie.org.uk/publications/guides/guide44/introduction/

https://www.rcpsych.ac.uk/pdf/RT%20planning-mental-health-services-for-young-adults--improving-transition.pdf

Zero suicide approach

Merseycare NHS Foundation Trust

https://www.merseycare.nhs.uk/media/3190/sd38-v2-zero-suicide-uploaded-29-nov-16-review-oct-19.pdf

https://www.merseycare.nhs.uk/about-us/striving-for-perfect-care/our-zero-suicide-initiative/

Zero suicide alliance

https://www.zerosuicidealliance.com

Mental Health First Aid

https://mhfaengland.org

Trauma informed approaches to care

https://www.emeraldinsight.com/doi/full/10.1108/MHRJ-01-2015-0006

Appendix One

About Contact Consulting

Contact Consulting works at the intersection of health, housing and social care. We provide consultancy and research services including service evaluation and review, strategy and good practice development. We conduct independent investigations of serious incidents including domestic homicide review and mental health homicide review and also undertake investigations relating to governance, practice and professional conduct.

Contact Consulting has worked with a wide range of agencies in the UK and internationally. They include government departments, NHS organisations, local authorities, community safety partnerships, housing associations, commercial and voluntary sector bodies.

Contact Consulting can offer a range of consultancy and research services.

- Service reviews and evaluations, including service modelling, benchmarking and strategies for service delivery. Strategic and operational planning.
- Identifying and documenting good practice at national and regional levels. The development of specific tools, guides, products and services to support the new commissioning environment.
- Project development and management. Expert support to task and project groups.
- Advice and guidance on legislation and policy
- Handling statutory inquiries, including DHRs, serious case reviews and work to review serious untoward incidents, including unexpected deaths, suicides and homicides
- Investigations relating to issues of governance, practice and professional conduct
- Facilitating the interface between voluntary, commercial and statutory sector bodies.

Our website www.contactconsulting.co.uk provides further information about our work and team.

Appendix Two

About Steve Appleton

Steve is the Managing Director of Contact Consulting (Oxford) Ltd. He has 30 years experience of working in health and social care, as a practitioner, operational manager and as a strategic and performance management lead. Steve started his career in learning disability services, working directly with clients in residential settings, then with older people and then in the mental health field, working across all age groups.

Steve qualified and worked as a social worker and was a senior practitioner and Approved Social Worker before moving into management of a range of community based mental health services, working both in local authorities, the NHS and through integrated arrangements between the two. Prior to working independently, Steve was a senior manager with lead responsibility for mental health, learning disability substance misuse and offender health within a Strategic Health Authority (SHA) covering the Thames Valley and the South of England.

Since leaving the NHS he has built a successful consultancy portfolio through Contact Consulting, working both in the UK and internationally. He has worked with government departments, arms length bodies, NHS Trust, Clinical Commissioning Groups and Commissioning Support Units, local authorities, community safety partnerships, housing associations and the independent and voluntary sector. His work focuses on the needs of those with mental health problems and other vulnerable groups, including those with substance misuse problems, older people, and the homeless.

Steve has conducted a range of strategic and commissioning reviews, evaluations and service development projects. He project managed the work of the West Midlands Mental Health Commission for the West Midlands Combined Authority. Rt. Hon. Norman Lamb MP chaired the Commission. Steve led the project, working closely with Norman and the commission members. Steve led the writing of the final report, which was published in January 2017.

Steve led work for the States of Jersey government in 2014/15 to review mental health services and developed a five-year strategy. He has since worked with the States of Jersey on a range of projects relating to service development and improvement, including older peoples services, CAMHS, criminal justice and mental health gap analysis and a recovery network. He also conducted an option appraisal on parent/infant psychotherapy as part of the 1001 Critical Days Programme for the Community and Constitutional

Affairs department. Steve recently completed a review of the Jersey Safeguarding Partnership Boards which was published in June 2018.

He has recently worked with the Healthy London Partnership, NHS London and the Greater London Authority on the Thrive London programme. Steve led the development of the final report, producing the narrative for the document, which was published and launched by the Mayor of London in July 2017.

Steve has produced mental health strategies for London Boroughs and Clinical Commissioning Groups including Tower Hamlets and Southwark, as well as most recently developing a blueprint for the future of mental health services in the Isle of Wight.

Steve provided expert evidence to Lord Crisp's commission on acute inpatient psychiatric care for adults, has participated in Health Service Journal roundtable events and spoken on mental health, housing and safeguarding at national and international conferences and events.

Steve is an Associate of the Health Services Management Centre at the University Birmingham. He is also an Associate and advisor to the Centre for Mental Health, a leading UK mental health charity that focuses on the translation of policy into practice.

Steve serves as the UK Liaison Manager for the International Initiative for Mental Health Leadership (IIMHL), co-ordinating their activity with colleagues in the United States, Canada, Scandinavia, Australia and New Zealand. He takes a lead role in work relating to international city and urban mental health development working with New York, Toronto, Christchurch, Stockholm, London, Bristol and the West Midlands.

Steve also serves on the Board of the Association of Mental Health Providers, the representative body for voluntary sector mental health organisations in the UK.

Examples of national publications

Steve has produced a range of national guidance, briefings and good practice, the following is a selection of these:

- The future of the mental health workforce
  With Andy Bell, Graham Durcan & Jessica Stubbs
  Centre for Mental Health for NHS Confederation Mental Health Network
  September 2017

- Thrive London*: towards healthier, happier lives*
  Mayor Of London, Health London Partnership, London Councils, Public Health England - London
  July 2017

- Thrive West Midlands: An action plan to drive better mental health and wellbeing in the West Midlands (with Rt. Hon. Norman Lamb MP et al.)
  January 2017

- Growing old together – what the evidence tells us. A literature review to support the independent commission on Improving Urgent Care for Older People.
  (NHS Confederation) January 2016

- Multiple exclusion homelessness: is simplicity the answer to this complexity?
  Journal of Integrated Care, Vol. 23 Iss: 1, pp.23 – 34 February 2015
  (with Dr. Robin Miller, Senior Fellow, University of Birmingham)

- Guidance for commissioners of older people's mental health services
  (JCP-MH/RCPsych) June 2013

- Guidance for commissioners of drug and alcohol services
  (JCP-MH/RCPsych) May 2013

- Defining mental health inpatient services: promoting effective commissioning and supporting QIPP
  (NHS Confederation) February 2012

- Housing and mental health
  (NHS Confederation) December 2011
  (*With Peter Molyneux*)

- QIPP, Housing and housing related support in mental health and learning disability
  (Dept of Health - Yorkshire & Humber/NMHDU) March 2011

- Planning services for young people – Managing Transition
  March 2011 (NCSS/NMHDU)

- Practical guide to mental health commissioning: Volume One
  (JCP-MH/RCPsych) March 2011

- The new commissioning landscape and its impact on housing and care for older people (Housing LIN) August 2011

Qualifications

BA in Professional Social Work Studies
Oxford Brookes University

Diploma in Social Work
Oxford Brookes University/CCETSW

Advanced Social Work Award
(including Approved Social Worker qualification)
CCETSW/Oxfordshire County Council

Diploma in Higher Education (Distinction)
Oxford Brookes University

Certificate in Management Studies
University of Westminster