# *"TOGETHER FOR MENTAL HEALTH IN GWENT"*

Community Well-Being

Partnership in planning and delivery

Core Primary & social care

Accommodation

The Person

Primary mental health teams

Specialist Services

Community Services

In-Patient Services
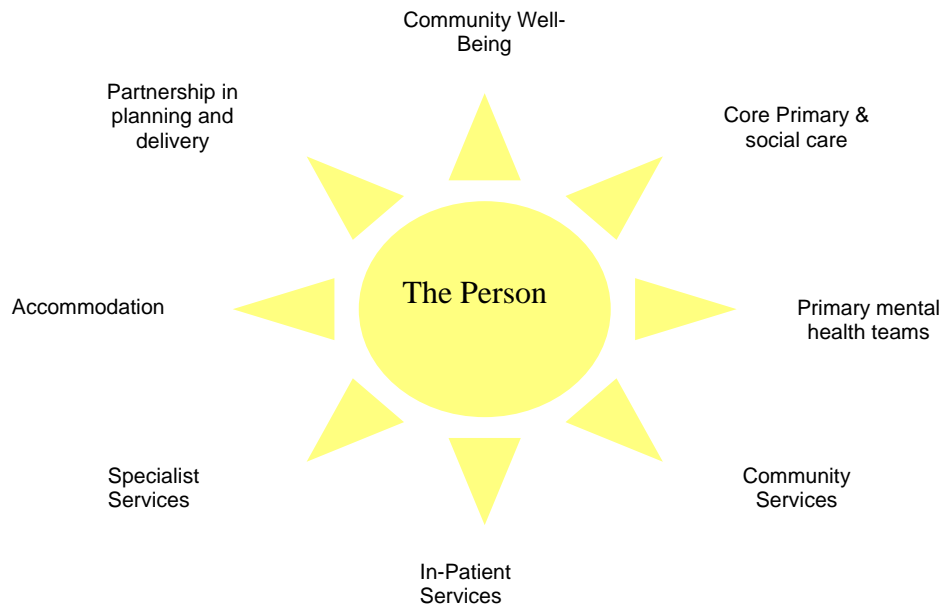
**AN INTEGRATED MENTAL HEALTH STRATEGY**
**FOR THE COMMUNITIES OF BLAENAU GWENT, CAERPHILLY,**
**MONMOUTHSHIRE, NEWPORT & TORFAEN**

**2012 - 2017**

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We are proud to present this very first integrated strategy for mental health services for the populations of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. Our pride comes not only from having worked together to produce a future direction for mental health services, but also from knowing we have built it based on service user, carer, staff and stakeholder views.

It is important that this strategy does not become a substitute for action, but provides the framework within which a wide programme of change and service improvement takes place. As Partners we have committed to delivering it together, and will produce detailed action plans to support its implementation. It will also be subject to regular review in order to respond to respond to changes that occur during its implementation period.

Our aim is to develop a future model for health and social care based on the principles of 'recovery' and person centred care. Successful delivery will therefore mean action in many areas across all of our services, both in the statutory and third sector. It is likely to lead to opportunities for us to work much more closely together to consider how we use our resources, and most importantly offer the best services to the populations we serve.

It is also a chance for us to recognise together the diversity of our population and as such to commit to an approach that enables people to be treated in the way they wish, as far as is possible. We therefore encourage a culture of customer service, sensitive enquiry and open dialogue.

We know that as we present this final strategy, that the economic climate we experience presents challenges to us all, the strategy therefore signals too a commitment to the best use of resources, as we move towards jointly using our finances and enabling our staff to support the priorities outlined. We also welcome at this stage the National Strategy : Together for Mental Health which will offers a strategic framework within which service users and staff from all organisations can develop and deliver world class mental health services. At the local level, we recognise that we can only do this through working as equal partners with service users, staff and other organisations, through creating trust in each other and the services we provide.

As a Partnership we can truly commit to working together with each other, other service providers and most importantly those accessing our services to deliver this strategy for and with the people in Gwent.
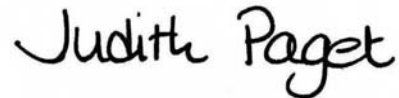
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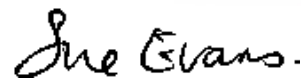Monmouthshire County Council

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*Note words are offered to give a general sense of the service or meaning they are not intended as a direct definition (reference is made where the work of others has been used)*

| | |
|---|---|
| **Assertive Outreach Services** | A service that works specifically with people who have a serious mental illness, for various reasons may find it difficult to engage |
| **Care & Treatment Planning** | The Care and Treatment Plan is for people receiving secondary mental health services – for example from a psychiatrist, community psychiatric nurse, social worker or other member of the Community Mental Health Team. If you are receiving secondary mental health services you have a legal right to a Plan. You will also be allocated a Care Coordinator – a professional who will complete the Plan with you and oversee the care and treatment process. (reference Hafal – guide to care and treatment planning) |
| **Crisis Resolution Services** | Crisis resolution teams are intended to act as a 'gatekeeper' to mental health services, rapidly assessing people with acute mental illness and referring them to the most appropriate service. (Reference NHS (1999) *A National Service Framework for Mental Health* |
| **Demographics** | Information that tells us about different groups of people. It can include the number of people living in an area, age, sex, income, illness and many more things. |
| **Early Intervention Service** | Services aimed to assess and treat patients who are at risk of or who are experiencing their first mental health problem |
| **Economic Inactivity** | Economic inactivity measures the amount of people not in employment and the impact this can have in an area. |
| **Educational Attainment** | The level to which an individual is educated. |
| **GDP** | Gross Domestic Product – The value of goods and services to a country |
| **Governance** | The framework or set of rules that determine how we manage or make decisions |
| **Holistic** | About the whole person. |
| **Inequalities** | The difference between the best and the poorest (e.g. lack of opportunity to access services or employment) |
| **Mental Health Measure** | The Measure has four main Parts: Part 1 of the Measure will ensure more mental health services are available within primary care. Part 2 makes sure all patients in secondary services have a |

| | Care and Treatment Plan. |
|---|---|
| | Part 3 enables all adults discharged from secondary services to refer themselves back to those services. |
| | Part 4 supports every in-patient to have help from an independent mental health advocate if wanted.. |
| **Multi-disciplinary** | Staff from different professions working together. |
| **Needs Assessment** | Understanding what communities and individuals need through looking at information systematically |
| **Person Centred** | Placing the person at the centre and planning support and services that meet their needs |
| **Psychological Interventions** | Interventions in Clinical Psychology are directed at preventing, treating, and correcting emotional conflicts, personality disturbances, psychopathology, and the skill deficits underlying human distress or dysfunction |
| **Recovery** | There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is hope – the belief that it is possible for someone to regain a meaningful life, despite serious mental illness.<br><br>For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem<br><br>Reference Mental Health Foundation |
| **Resources** | Money, staff, buildings and skills |
| **Risk** | The potential for something to happen that could have a negative impact |
| **Safeguarding** | A term used to describe the protection of vulnerable groups |
| **Service User** | An individual who accesses Mental Health Services. |
| **Statutory** | Something that is required by law. |
| **Stigma** | Being treated differently or labelled in a negative way due to having a disability or illness. |
| **Third Sector Organisations** | Not for profit organisations - Voluntary organisations. |
| **Transition** | Moving between services/support as a result of age or changing needs . |
| **Transparency** | Being open<br><br>Making decisions in a way that people can see, understand and at times be part of |
| | |

## 1. INTRODUCTION

The demand for services for people who currently or may in the future have concerns about their mental health is increasing. To meet the needs of these people appropriately, it is necessary, to work across organisations and to develop services which respond to the full range of service user[1] and carers needs, which we suggest are wider than those that may have been met through traditional health and social care provision.

This document represents the very first integrated strategy for mental health across the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. It has been developed by representatives of Local Government, Health and Third Sector organisations in each of these areas, but most importantly its development has been guided through service user views and experiences.

It presents a framework for how services should look, and aims to ensure the right response, from the right person and the right part of the service delivered, underpinned by an understanding of equality and diversity in its broadest sense. It considers mental health in its widest sense ranging from promoting good mental well-being to the provision of specialist services. The strategy takes a person centred approach; it therefore reflects many services and interventions required by people of all ages.

The strategy has purposely been written not to discriminate between people of different ages, however it recognises that at particular times in an individual's life, different needs may arise that require a different response. Previously these would have been responded to by an age defined service such as Children and Adolescent Mental Health Services or Older Adult Mental Health. We recognise that this non-discriminatory approach is innovative and may represent a shift in thinking for many who use or deliver services and hope you find this helpfully reflected through the general narrative of the strategy.

The strategy has been based on a series of listening days which were held last year, and through a recent period of consultation[2]. Through this dialogue, we as partners learned a lot about service user and carer experiences of the services we provide. We learned where there was room for improvement as well as hearing what those receiving our services thought we were doing well.

In this strategy we have aimed to join up the key messages from the consultation with requirements placed upon us by Welsh Government, as well as responding to the National strategic framework 'Together for Mental Health'.

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[1] We recognise this term is not comfortable to all, however has been used here as a term that would reflect other commonly used terms such as patient, survivor, person with lived experience, client and customer.
[2] Note not all groups in the population were represented in the listening events that informed the strategy

It is important too that we look to the future to make sure we are not only delivering services for now, but planning for the years to come. We therefore need to make sure that we take account of emerging needs and increases in the number of people experiencing them. We already know for example that there will be significant increases in people living with dementia, those with mental health problems and substance misuse (drug and/or alcohol) and those that have a mental health problem and find themselves in the Criminal Justice System. We too need to ensure we are aware of and responding to the challenging economic situation we operate within, which may mean that investment within one area will result in redirection of resources from another. In doing so, the strategy responds to both local need and national direction for health and social care services in Wales.

During the consultation period for this strategy a number of issues were raised that have resulted in some significant revisions to the framework. These are briefly outlined in Appendix A. The consultation process too demonstrated considerable support for the partnership approach through which the work has taken place, and also for the vision and priority areas presented:

*To enable all people facing a mental illness or poor mental well-being living within Gwent to lead fulfilling lives and have the same opportunities as others in society. Individuals with mental health problems and their carers will be able to access services that support their daily living needs such as housing and employment and have access to the full range of health and social care services, provided by a mix of professionals according to their need.*

To achieve this, it is recognised that the Partnership will need to:
- Work closely with service users and their carers to continually check that we are 'moving in the right direction'.
- Work closely with the organisations that provide services that support independence and 'recovery' ie employment, housing, leisure.
- Provide more services closer to home to support independence.
- Improve access to services both in terms of time and location.
- Ensure that services delivered meet acceptable standards of safety and quality, delivering the best possible outcomes for service users.
- Improve integration and continuity of care for service users between different professionals, settings and providers.
- Ensure organisational cultures are based on learning, safeguarding and safety.
- Enable a sustainable workforce that is confident, competent and who deliver interventions that are evidence based.
- Make best use of money and staff (resources) across health and social care.
- Be informed by and inform relevant research and development.

We also recognise that to achieve a world class mental health service, we as organisations need to consider our current practices. We need to consider how we spend our money and how we organise ourselves. We need to ask ourselves whether we can do this more effectively through much closer working and move towards resourcing our priorities together, consistent with the direction of this strategy. We will also seek to inform and be informed by relevant research and development. We can therefore only deliver the strategy in the context of organisations, staff, service users and their carers, trusting each other.

Through hearing the views of service users, staff and stakeholders through the consultation on the draft strategy, we have set ourselves 8 aims:

Aim 1 Communicate and work alongside service users, carers, staff and communities on the planning, monitoring and provision of mental health services

Aim 2 Develop a wide range of services that support community well-being

Aim 3 Enable the provision of a wide range of accommodation options

Aim 4 Ensure services based in the community offer support, advice and where necessary assessment and treatment within this environment

Aim 5 Provide specialist services that are available to people where and when they need them.

Aim 6 To facilitate an appropriate response from across organisations to the needs of people with dementia.

Aim 7: To ensure the best use of mental health resources.

Aim 8: To work across the 6 organisations to establish a set of rules and a structure that supports our working together, to plan and deliver excellent mental health services (governance).

The strategy document is intended to be directional and as such will be the framework that much more detailed activity will take place. We want to ensure continued openness and transparency and would wish therefore to offer service user, carer and third sector representation at the meetings we will hold to take this work forward. We will also hold annual 'How well are we doing' events with a wide range of stakeholders that include staff, the third sector, service users and carers.

Responding to mental illness, and supporting good mental well-being is quite clearly not the sole responsibility of any one organisation, indeed the challenge is one we all share. As a result there is increasing recognition that the wider issues that affect health and well-being (ie housing, education, employment) sit with equal importance alongside clinical diagnosis and treatment. At the local level, health, social care and third sector organisations have already committed to working as one to address the challenge.

## 2.1 Through Local Discussion

We have been working with service users, carers and staff to identify the priorities for this strategy. The process started during 2010 with a range of listening events that staff, service users and their carers[3].[4] were invited to. A range of priorities emerged from these days and are summarised below. These have formed the basis of the priorities outlined in the strategy.

| Adult services | Older Adult |
|---|---|
| • Access<br>• Information<br>• Partnership<br>• Integrated working<br>• User and Carer involvement<br>• Improved CPA process<br>• Mental health promotion<br>• Housing and accommodation<br>• Meaningful activity and work<br>• Reviewing in-patient requirements<br>• Effective use of resources | • Access<br>• Information<br>• Partnership<br>• Integrated working<br>• Support for carers and involvement<br>• Mental health promotion<br>• Respite care and accommodation<br>• Meaningful activity<br>• Reviewing in-patient requirements and care<br>• Effective use of resources |

As a Partnership, we noted the similarity between the issues, and this has further strengthened our decision to develop this strategy as one which is not discriminatory of age. The feedback has also given us a clear steer on what those who use services would wish to see in a strategy for mental health.

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[3] Note further work is required to engage as many views as possible, through a variety of means as appropriate to the needs of the service user (eg supported engagement will be needed for people who are living with dementia)

[4] The listening events would not have been representative of all protected characteristic groups and this is acknowledged

More recently we undertook an extensive consultation on the strategy which told us that

- The vision and themes of the document were unanimously accepted
- There is a need for more detailed action plans
- There was a request for more description on what is meant by each of the priorities
- There is a need to emphasise and focus upon the needs of the people with dementia
- There were some gaps in the document (eg domestic abuse, homelessness, stigma and training and development)
- There was strong commitment from a number of contributors to be involved in the onward process of strategy implementation
- People would like to understand the way in which services are/could be resourced more
- Our attempts at engagement have been well received, however that there is a need for this to be sustained and strengthened.

A number of reviews across the Gwent area undertaken by Health Inspectorate Wales have also made many recommendations that have added to the formulation of this strategy. These are the need to :

- Develop a range of community services
- Provide strong leadership to deliver effective management, supervision and support
- Strengthen multi disciplinary systems
- Strengthen transition processes
- Develop and implement information sharing arrangements
- Develop and implement procedures to be in place for Section 117 aftercare and care planning
- Strengthen risk assessment and risk management processes

We wish to continue an open dialogue with all interested parties as the actions to deliver this strategy are further developed and taken forward. There are many ways to be involved onward, and we would be delighted to hear from you if you are interested. *Strategy and Partnership Team, St Cadocs Hospital, 01633 436717.*

## 2.2    Through National Direction

*'Making the Connections'* and *'Beyond Boundaries'*, set a clear context for public services in Wales. Within this framework the strategic direction for health is set through *'Designed for Life': A S*trategy for the NHS in Wales, and for social care through *'Fulfilled Lives and Supportive Communities: A strategy for social services in Wales over the next decade.* Most recently Sustainable Social

Services (2011) and Together for Health (2011) set a new direction which place emphasis upon :

- Working across organisations for the most effective use of public monies
- Improving health as well as sickness
- Developing one system to enable integrated care
- Pursuit of excellence in all areas
- Transparency on performance
- New partnerships with the public and staff

For mental health specifically, there are many requirements, which are communicated through the Mental Health Act, the draft Mental Health Strategy for Wales : Together for Mental Health, the Mental Health Measure Wales, and the intelligent targets published for dementia, depression, first episode psychosis and eating disorders.

## 2.3    Understanding the common messages

The common messages which can be drawn from both local discussions and National direction are:

- The need to recognise the circumstances within which people live their lives and understanding that these wider factors (eg housing, employment and family life)  have a substantial impact on an individuals sense of well-being.
- The need to ensure a wide range of community based services which are provided through a mix of statutory and voluntary sector organisations working together.
- The need to ensure more services are provided closer to people's homes, and that the hospital setting is only used when absolutely necessary.
- The need to ensure a full range of accommodation and housing support options that can support people whatever their needs.
- The need to ensure that there are specialist services with the right expertise that people can access when this is the most appropriate response to their needs.

Quite clearly our intentions require public, private and third sector organisations to work as one to improve mental health and well-being for the people of Gwent.

## 3. THE COMMUNITIES WE SERVE

Positive mental health is a key factor for good health and relevant to the whole population. In 2007 the World Health Organisation stated that there is no health without mental health, which means that public mental health is integral to all public health work. Statistics show that one in four of the adult population have a life chance of experiencing mental ill health. Mental illness is the largest single cause of disability with 22.8% being attributable to mental illness, compared with 16.2% for cardiovascular disease and 15.9% for cancer. This is forecast to increase by 7.8% by 2030 (WHO, 2008). Self reported surveys show that 10% of adults in Wales report having a mental illness (Welsh Health Survey, 2010).

Mental illness can have multiple impacts upon society including poor educational attainment, increased substance misuse as well as increased anti-social behaviour and crime. There are also large economic costs of mental illness, with the estimated overall cost of mental health problems in the UK being over £110 billion in 2006/07, representing 7.7% of GDP. Care and treatment of mental disorders account for 13.8% of total NHS expenditure (Mental Health Strategies, 2008).

- **The Population of Gwent**

This strategy is applicable to adults living in Gwent. The geographical areas considered within this area are:

- Blaenau Gwent
- Caerphilly
- Monmouthshire
- Newport
- Torfaen

This presents a population base of approximately 550,000.

Whilst the following issues are not exhaustive, they offer the reader an insight to the life experiences of the people in Gwent, and are determining factors to good emotional well-being and prevalence of mental health.

- The areas are a mix of post industrialised as well as rural and urban communities with a wide range in health status and health related behaviours.
- Car ownership is relatively low in some areas with lack of public transport and issues of rurality in some areas are recognised as a challenge in accessing services.
- By 2031, the resident population in the ABHB area is projected to increase by 9% from 2006 to 2031, typically 2,000 people per year. In the same

period the numbers of people aged 75 and over will have almost doubled to over 82,000.
- Economic inactivity ranges from 29.9% in Blaenau Gwent to 20.6% in Monmouthshire.

Within the geographical areas covered by the strategy there are many defining characteristics.  For example,

- Newport (A Home Office distribution area for Asylum seekers) has the largest minority ethnic community population. Young men from Asian and African countries make up a large proportion of these.

- There is a prison population in the Monmouthshire population.

- There is a significant life expectancy gap between more affluent and more deprived areas across the Gwent.

The Welsh health surveys of 2009/2010, offer the following key messages for people in Gwent.  Readers should note that as these are self reported figures, the actual experiences are likely to be much higher.

- The percentage of those reporting being treated for any mental illness is higher in ABHB than the Welsh average. This varies across the five localities (only Monmouthshire being below the Welsh average). The percentage in Blaenau Gwent is significantly higher than the Welsh average.
- Across each of the localities a greater percentage of females report being treated for a mental illness.
- In respect of self reported well-being, the populations in Caerphilly Blaenau Gwent and Torfaen indicate that mental well-being is significantly lower than for Wales as a whole with only Monmouthshire reporting significantly higher mental wellbeing than the Welsh average.  Once again the male population report greater mental wellbeing than women.

Partners developing the strategy are clear that future services should be based on current and future need, reflecting both changing demographics and the changing nature of people's experiences.  It is important therefore that we do not start from a perspective of existing levels of provision, staffing or current locations, but from a *true* assessment of need.  Detailed needs assessment against each of our themes is an early commitment of our strategy.

## 4. VISION AND VALUES

Through discussion with a wide variety of stakeholders, The Partnership Board has placed a lot of importance on ensuring the development of a vision and set of

values that all can commit to.  The consultation process demonstrated that these were also aspirations that service users, their carers and third sector organisations can too own:

The vision presented is:

*To enable all people facing a mental illness or poor psychological well-being living within Gwent to lead fulfilling lives and have the same opportunities as others in society.*

*Individuals with a mental health problem and their carers will be able to access services that support their daily living needs such as housing and employment and have access to the full range of health and social care services, provided by a mix of professionals according to their need.*

Building on the views of service users and carers, and in the consideration of National requirements, the following core beliefs and values have underpinned this vision and the development of the strategy:

➢ There should be a **comprehensive** range of high quality mental health services delivered by a range of organisations as locally as possible.

➢ Service users, their families and referrers should have access to up to date, easily understandable **information** about their problem and which informs them of the services available to them and how they can access services according to choice.

➢ Community services should be delivered as **close to service users' homes**, families and social networks as is possible.  (With respect to in-patient services, the balance needs to be struck between this aspiration and creating clinically isolated services which could have an impact on quality and safety).

➢ Services should **intervene as early as possible** to get the best outcomes for service users.

➢ The right services should be accessible and delivered **when** they are needed and **where** they are needed.

➢ Services should be delivered in a way which is sensitive to the **diversity** present within the communities of Gwent paying special attention to those who find accessing services difficult.

➢ Services must be **acceptable** to those who use the services and to their families and carers.

➢ Services must strive to ensure that service users feel they can be an *equal member* of the community and that they can *recover* their place in the family, community and workplace after an intervention.

➢ Providing services in this way can only be achieved when all those who are involved *work in partnership* to use scarce resources efficiently.

➢ Services should aim to provide services using taxpayers' money as *efficiently and effectively* as possible with minimal waste

**As a result of consultation, the following core values have been added to the strategy**

- *Stigma* associated with mental health issues should be addressed in all communities. The Partnership will seek to influence this through existing locality mechanisms
- *Person Centred* user focused; promotes independence and autonomy rather than control; involves users choosing from reliable, flexible services.

The formulation and basis of these values has been a foundation stone of our partnership relations, and therein of this strategy. We would like to share them with you in more detail so that you can see how they have underpinned our discussions and how as partners we have used the formulation of these values as a common framework within which to develop our relationships and services.

- **COMPREHENSIVE SERVICES**

Partner agencies would want to deliver as many services as possible as locally as possible so service users can access what they need as near to their networks. These should include a range of community services in order to offer the least restrictive response as well as in-patient services when required and include the following; -

- a wide range of evidence based treatments and interventions
- the right levels of support at the right times
- the relevant support for primary care
- responsive, focused community mental health teams

Comprehensive services should also provide or support the provision of:

- assertive outreach services – for those who find staying in touch with services difficult
- crisis resolution services – for those who need urgent intervention but can be treated at home if adequate support is available

- early intervention services – to ensure we treat mental disorders early enough to minimise their impacts
- 'recovery' – to ensure people recover their place in their community after an intervention
- a range of in-patient services – so that people are admitted to in-patient services which are appropriate, safe and of high quality
- a range of accommodation services  - to ensure people have the sort of support to gain maximum independence
- access to a range of specialist services
- meaningful activities with links to employment, volunteering, leisure facilities, social enterprise etc.

It should be acknowledged that there will always be some specialist services which can only be safely delivered on a regional or even national basis but access to those must still be made available and further efforts in developing regional or sub regional services is required.

- **INFORMATION**

In order for service users and referrers to make informed decisions about what help they might need, they must have information about their diagnosis or problem and about the services available to them. This latter information should include what the services offer and how to access them, some of these services may not be offered through statutory services i.e. access to information relating to C.A.L.L. helpline and self help mental health promotion information. All information needs to be easily available at the point when someone initially describes their problem (most often in Primary Healthcare) and must be kept up to date.  It is also important to make it jargon free and have it available in a range of languages as necessary.

- **SERVICES AS CLOSE TO HOME AS POSSIBLE**

Most service users would rather be treated in their own homes with their families and carers providing elements of their support through community focused models of care.  However, in order to make that acceptable to service users and their families, support by mental health services, when needed, must be easily available. By and large Mental Health services in Gwent already have a strong community focus and much work has been done to configure these services around the communities they serve. However there is still inequity in some areas.

As previously mentioned there will always be a small number of service users who have specialist needs and as such may need to access regional or sub regional facilities. However the principle that they need to be catered for as locally as possible remains pertinent.  A range of repatriation schemes will need to be developed if the Gwent services are to succeed in returning service users closer to their communities.

- **INTERVENING AS EARLY AS POSSIBLE**

Evidence indicates that the earlier one intervenes in any illness the more likely it is to lead to better outcomes for the service user and this is equally true in mental illness. This means that we need to ensure there is the ability to identify potential mental health problems long before people require secondary services, e.g. during school years, in the workplace and in primary care. Sometimes an intervention by a non-statutory service at early stage can prevent the need for referral on to more specialist health or local authority services. To ensure this happens there must be the provision of access to high quality assessment by individuals who have received the right training and have the right level of experience and who work at the *heart of the community*. The introduction of the primary mental health teams as part of the mental health measure together with specialist early intervention services will help to develop this part of an integrated care pathway.

- **SERVICES WHEN AND WHERE THEY ARE NEEDED**

It is important that the right services can respond in a timely fashion particularly in an emergency. Some services need to be available during normal office hours and other services need to be able to respond on a 24 hour basis seven days a week. Carers also need to be able to access support when needed for themselves as much as for the relatives they are helping to support.

It is also important that services can be delivered in a variety of environments. For some individuals, coming to clinics and hospitals can be a daunting prospect so flexibility is crucial in working with service users who may find the prospect of visiting hospitals and clinics too difficult.

- **BEING SENSITIVE TO A DIVERSE POPULATION**

The Gwent community is rich with a variety of religions, languages, cultures, sexual orientation and lifestyles. Some of these are part of a person's history and constitution and some are through choice. These backgrounds can have a significant influence on mental health problems and their presentation. We need to recognise the need to adopt an approach which **treats people the way they wish to be treated** as far as is possible and therefore 'sensitive enquiry' is an essential quality in those who are delivering services. Particular attention also needs to be paid to those groups who tend not to access ordinary services and have been difficult to reach by services, such as the homeless or roofless, asylum seekers, travelling communities and deaf service users. The ability to respond creatively is, therefore, a necessary quality which services must adopt.

- **ACCEPTABLE SERVICES**

It is absolutely essential that services are acceptable to those who use them. Firstly, service users and carers need to be at the centre of developing their own care and treatment plans, ensuring that they are listened to and do not need to repeat themselves unnecessarily. Secondly, they need to be closely involved in the planning and designing of services. Service users should be recognised as experts in service provision and therefore should be involved in performance monitoring, service review and service evaluation. Lastly, service users and carers should also be equal partners in the training and the recruitment of staff. We know that service users often find it valuable to tell the story of their experience of being unwell and listening to that narrative can help us develop interventions and care plans which make sense to the service user. We also need to listen to their experience of mental health services so that we can continually adjust how we respond as organisations.

We also wish to ensure we enable services that are customer focused, that meet and greet, rather than make access difficult to a person requiring help.  Many people are anxious and worried about seeing a mental health service. They may be concerned about being labelled or even admitting to themselves they have a mental health problem. They may also be unsure what impact seeing mental health professional may have on their future lives and job prospects.  For these reasons it is important that when someone does make contact and ask for help, whether this is in primary care or through any other agency, that the response they get is one which encourages confidence in the system, allays anxieties and is as easy as possible to navigate. We must ensure a helpful and supportive first contact, support through what is sometimes a complex system.  We must ensure the minimum number of assessments and transparency of what the service user can expect. We must be reliable i.e. phone back when we say we will; responsive i.e. "how can we help?" and responsible i.e. "I personally can't help but I will find the person who will."

- **'RECOVERY' AND BEING AN EQUAL MEMBER OF THE COMMUNITY**

For all illness whether it is physical or mental there is a time early on when anxiety and worry about the future are high. At that point high quality assessment, diagnosis, information and treatment are essential. Wherever possible we should try to deliver these in a primary healthcare setting where the expected outcome is one where the service user will return to their normal routines. However some will need referral to specialist secondary services for more complex mental illness. These service users, after initial treatments and interventions have taken place, will then need to be supported to maximise their independence. Many are helped and will return to their normal everyday lives through an integrated pathway of care.  However some people may need to adapt to living with the long term effects of a major mental illness and this will

require both the involvement of a range of agencies and organisations in the community and the individuals hope, agency and sense of inclusion to achieve. Often individuals will need assistance in engaging with a range of organisations as they aim to return to the highest level of independence possible. This will include educational establishments, employment opportunities, meaningful activity and housing. It is vital therefore that relationships with organisations are developed and where possible integrated so that there is a seamless pathway for service users and which they feel part of and understand.

- **PERSON CENTRED CARE**

'Person-centred' or 'quality' care means that individuals personal characteristics such as gender, ethnicity and cultural background, as well as qualities, such as patience, compassion, sensitivity and empathy are identified as important to receiving good quality support/care. The relationship between the service user and those providing care is essential to the experience of good quality/person-centred care/support. The Partnership Board will seek to ensure a service that is user rather than service led, ensuring that the person receiving care truly is in the centre of all considerations about their care/support.

- **EFFICIENCY AND EFFECTIVENESS**

All partner agencies will assume the responsibility for ensuring that interventions undertaken with service users are as effective as possible. Partner agencies must aspire to deliver best practice and evidence based practice and additionally to learn from the experiences of others. Partners must also be kept abreast of new interventions and be creative and innovative in their approaches. As the guardians of taxpayers' money all statutory agencies have a duty to spend that money as wisely as possible. It should be remembered that all clinical decisions have resource implications and all resource decisions have clinical implications.

- **TACKLING STIGMA**

The extent to which mental health service users encounter stigma in their daily lives is a matter of substantial importance for their recovery and quality of life. People with mental health problems can however experience discrimination in all aspects of their lives. Many people's problems are made worse by the stigma and discrimination they experience – from society, but also from families, friends and employers. The Partnership Board will work at a community level and through National programmes to address stigma and promote anti-stigma behaviours at all possible opportunities.

*Through consultation we know that these values are shared by all, it is our commitment to apply these values to all of our work through the duration of this strategy.*

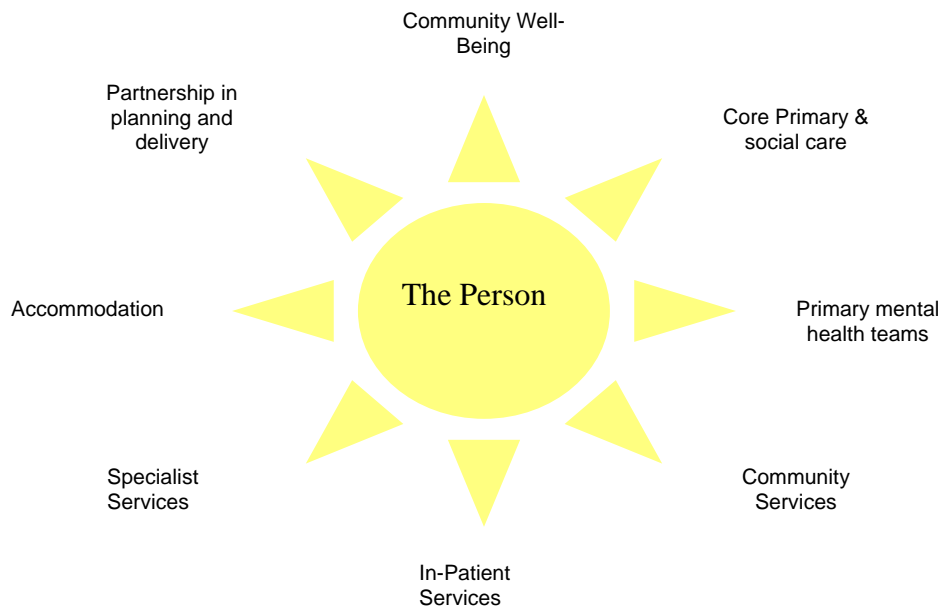## 5.    DESIGNING THE FUTURE SERVICE

As a Partnership Board we are clear that the future services we provide should have a new approach, that ensure service users are truly at the centre of their own care receiving evidence based interventions at the earliest possible stage which are easily accessed and delivered in a timely, flexible and responsive manner.  Services by all providers in the Gwent area should be simplified and integrated, arranged around people and not organisations, and therefore provided  across the public and third sector.

The design principles of our future service are simple.  They aim to:

- recognise the dignity of individual service users, respecting and valuing their diversity as well as acknowledging their major role in the process of planning and developing services
- be grounded in respect for all those people who engage with these services, not only those using them but also their supporters and carers
- provide practical advice and information for service users and their carers need as well as developing a consistently high quality, comprehensive package of care and support which minimises bureaucracy
- make sure that the best and most effective treatments are widely and consistently available
- be open to everyone providing age-appropriate care and support. It responds to people on the basis of need not age, ensuring that people with mental health problems are not discriminated against and have their mental health needs met
- be delivered through a person centred approach. This value base will be consistent across all service areas
- be based on the best evidence and be informed by (as well as informing) relevant research and development
- be of high quality, safe and with clear processes for safeguarding
- be focussed on interfaces between parts of the service to ensure this is smooth for the service user accessing them

We see the provision of services to people with poor psychological well-being or mental illness as a single system, regardless of provider.  We also aspire to enhanced collaboration between organisations at a population level that have an impact on good mental well-being ie housing, education etc, and therefore position this strategy in the wider system of community health and development.

Our model is presented below:

Community Well-Being

Partnership in planning and delivery

Core Primary & social care

Accommodation

The Person

Primary mental health teams

Specialist Services

Community Services

In-Patient Services

Achieving this requires detailed programmes of redesign (understanding what the service needs to look like) rebalance (understanding how we move towards it, and the benefits that will be achieved), and redirection of resources (understanding how we work with the staff we have and the financial envelope available to deliver it).

We know that service users and carers, would wish that we provide as many services as possible in a local setting. We share this view and know our services working closely together need to be able to provide or support the provision of:

| • Community based opportunities | Basic community activities such as housing, leisure, education, socialisation |
|---|---|
| • Primary mental health services | A bridge between primary and secondary care services<br>Access to a wider range of psychological interventions |
| • Assertive outreach services | For those who find staying in touch with services difficult |
| • Crisis resolution services | For those that need urgent intervention but can be treated at home if adequate support is available |
| • Early intervention service | To ensure we treat mental disorders early enough to minimise their impacts |
| • Recovery services | To ensure people recover their place in their community after an initial intervention |
| • Meaningful occupation | With links to employment, volunteering, leisure facilities, social enterprises etc |

| | |
|---|---|
| • A range of accommodation services | To ensure people have the necessary support to gain maximum independence |

We too know, however, that not all services can be based in all communities. There will be times when some individuals need access to hospital based or specialist services, and may need the services that can best be provided through them becoming an in-patient. Therefore the following are also necessary and much needed parts of our overall service:

| | |
|---|---|
| • A range of in-patient services | So that people are admitted to in-patient services which are appropriate, safe and of high quality |
| • Access to a range of specialist services | To ensure people receive specialist care where this is the most appropriate response to their needs |

We are aware that there is a wide range of services here. We believe it is vitally important that peoples transition between services is clear, and managed. We will strive to ensure that organisational, professional and service boundaries do not present a barrier to good service delivery and service user satisfaction and ensure good quality care planning and a comprehensive assessment of clinical risk.

Delivering health and social care is complex, however, needs to be thought of as a whole system of care. On the other hand it has to be easy to understand and easily accessible for those that use the services.

Through working with communities and all partners to achieve this vision, we believe service users and their carers can expect:
- More emphasis on good mental health and well-being in communities
- More community based services (eg primary care mental health services, home treatment services, crisis resolution services, memory clinics and Early Intervention Services)
- More focused hospital based services (beds being used in a different way, based on need and not on age)
- Strengthened relationships between general and mental health services
- Integrated teams delivering your services
- A service that responds to your needs not your age

## 6.   THE PRIORITIES

***Aim 1.       Communicate With And Work Alongside Service Users, Carers, Staff And Communities On The Planning, Monitoring And Provision Of Mental Health Services***

We believe this strategy offers us an opportunity for a new partnership with the public, where good mental health is co-produced and where the emphasis is on independence and community well-being. It is important that we engage with current and potential service users through a variety of means, and recognise the specific needs of those communities with particular characteristics (eg BME communities, rural communities etc).

We too want to ensure that communities are engaged in our pursuit of good mental well-being and that we play a role in the development of supportive and inclusive communities, supporting the national 'Time to Change' programme aimed at tackling stigma and discrimination.

Service users and carers are, and should be seen as, experts in health and social care service planning and delivery (should they choose to be so). They therefore need to be at the centre of developing their own care and treatment plans, ensuring that they are listened to and do not experience the often quoted complaint about health and social care services of 'being assessed repeatedly'. There is also a need to ensure that as service users adequate information is provided about their diagnosis, and or problem, and of the services available to them, in a format and language of their choice.

Service users should however also (if they wish) have the opportunity to be closely involved in the planning and design of services, performance monitoring, service review and evaluation, as well as being equal partners in the training and recruitment of staff.

We are working towards a position where service users feel equal partners in the planning and provision of services for mental health. We recognise that to achieve this, there will be times when we are seeking influence in a service development; times we are seeking feedback about our services and times we are simply offering some information. We recognise therefore that we need to be clear about the meaning of involvement and to ensure that those with whom we engage are offered a meaningful role within this process. We also recognise that for service users, the use of story telling in sharing their experience is an effective way of influencing changes in the services we provide.

We also know that some people in our community either through choice or situation are deemed 'harder to reach'[5]. Examples include the homeless or roofless, asylum seekers, travelling communities, carers (including young carers) and deaf service users. It is however increasingly recognised that whilst groups deemed 'harder to reach', may be so for the service seeking to reach them, they are often in touch with some parts of the community through accessing basic needs such as housing, benefits or indeed the family/community structure. It is therefore necessary to consider alternative means of engagement that are tailored to these individuals.

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[5] The most recent term is those with protected characteristics

Carers are a major source of support for people with a mental illness of poor psychological well-being, and too need a voice within our service. Indeed there are times when carers themselves will need support, the absence of which may result in a crisis response being needed to support the person they care for.
The Partnership has committed to the implementation of the Carers Strategies (Wales) Measure which is new legislation in which the Welsh Government has placed a new legal duty on both the NHS and Local Authorities in Wales to work jointly in order to publish and implement a joint strategy for carers.

Our commitment to engage is strong. As a partnership we know that only through open communication and shared ownership with those that use our services can we improve the services we provide, and develop as a partnership the culture of a learning organisation. We will set out an annual programme of involvement and engagement to obtain the views of service users, staff and carers at all levels of information, feedback and influence. In the spirit of our intention, third sector and service user representation will be invited throughout the delivery framework that will support this strategy.

### Aim 2.        Develop a wide range of services that support Community Well-Being

Positive mental health is an integral part of overall health and wellbeing. An individual's mental health can be affected by a range of factors and therefore knowledge about mental health issues has to be available in all settings and organisations, not just in mental health services. Poor mental health and illness have been linked to a number of particular risk factors including social isolation, deprivation, unemployment and social/racial discrimination, issues which need to be tackled as a community.

This strategy offers a holistic approach to mental health services. This includes addressing and promoting the well-being of the whole population as well as using client centred approach to support individuals experiencing mental health problems back in the community, with longer term aims such as employment, housing, leisure, etc by linking in with a wide range of professionals and organisations.

As such this theme includes sections on promoting positive mental health and well-being of the population, preventing mental health problems in those at risk and the mental health and well-being of service users.

- **Promoting positive mental health and well-being of the population**

Positive mental health is a key factor for good health and relevant to the whole population. Mental illness can have multiple impacts upon society including poor educational attainment, increased substance misuse as well as increased anti-

social behaviour and crime.  There are also large economic costs of mental illness.  Good mental well-being is therefore a key theme of this strategy.  It is well known that there are many determinants of good mental health, and this aspect seeks to ensure that positive mental health sits equally alongside the treatment of illness.  To this end this strategy will need strong interface with the community planning processes, housing organisations, educational establishments and third sector organisations.

We know from listening to service users that being able to fulfil a meaningful role in their community, with a regular daily routine has a positive impact on their well-being.  Support within the community needs to offer a sense of purpose and progression for service users, with the promotion of 'recovery' and social inclusion enabling service users' participation in regular community activities.

We would wish to see a full range of options available to people that:-

- Offer links to education
- Enable peer support and social contact
- Provide links to supported employment
- Enable links to leisure
- Offer vocational training
- Increase access to housing and advice
- Offer opportunities to volunteer
- Offer support for social firms to develop

The provision of such services should sit within a community framework aimed at supporting communities in the widest sense.  Partnerships between statutory and third sector providers are essential to the achievement of this.

Current service provision is varied across Gwent and as Partners we would wish to work at a community level with stakeholders to better understand this and develop the range of services more broadly.

- **Preventing mental health problems for those in risk**

Poor mental wellbeing is both a cause and a consequence of health and social inequalities.  People with mental health problems are more likely to have poor diet, smoke more and misuse drugs and alcohol. Research highlights that higher levels of deprivation and less access to resources lead to poorer physical and mental health.  Good mental wellbeing can reduce health inequalities (physical and mental), increase life expectancy and reduce risks to health by influencing positive health behaviours.  Good mental wellbeing is associated with improved educational attainment and subsequent occupation and wellbeing outcomes, reduced sickness absence from work and improved productivity and employment retention.

- **The mental health and well-being of service users**

Through the use of a recovery and reablement approach people are supported to manage their own mental health, physical health and wellbeing enabling them to live as independently as possible

Commonly, mental illness and well-being are seen as a continuum – people with poor well-being develop mental illness and people with positive well-being remain mentally healthy. However, it is generally accepted that mental wellbeing can co-exist with mental illness and there is a dual, rather than single continuum where mental wellbeing is more than simply the absence of mental illness (Mental health promotion strategy for Wales, 2005). There is now good understanding and evidence for some social risk and protective factors for mental health and wellbeing, which include individual lifestyle factors, social isolation, education, unemployment, economic status, poor housing, social or cultural discrimination, low self esteem or lack of accessible services or leisure opportunities (Foresight Report, 2010).

The poor physical health of people with severe and enduring mental health problems has been identified at a national and international level over a number of years. Individuals who access mental health services, in particular those with a diagnosis of schizophrenia or bipolar disorder often have poor nutrition, higher levels of smoking and alcohol use and are more likely to be overweight and take less exercise. They are also at increased risk of a range of physical illnesses, including coronary heart disease, diabetes, infections and respiratory disease. Statistics highlight that people with severe mental illnesses die on average 20 years earlier than the general population (HM Government, 2011).

Evidence shows that interventions currently exist that can promote mental wellbeing and prevent poor mental health. Opportunities for promoting and strengthening mental wellbeing in a population for those at risk of mental ill-health, people with symptoms and those with a diagnosed mental illness, include:

- Promoting mental wellbeing for all
- Building resilience (e.g. maintaining healthy lifestyles and environments, reduce risks, early diagnosis, treatment and recovery)
- Focus upon assets not deficits (promotion of positive health, prevention of mental health problems, management and care)
- Achievement of whole system improvements which contribute to improved mental health and well being of general population, increased rate of recovery

(Foresight Report, 2010)

We too adopt these as actions that will come from this strategy.

**Aim 3.        Enable the provision of a wide range of accommodation options**

Where people live has an impact on their psychological well-being, both positively and negatively.  Despite housing and accommodation being a high priority in mental health services for some time, there is undoubtedly much more we can do to consider and better respond to the housing needs of service users.  Our belief is that good housing whether independent or supported should be available, and this is the reason we have made this an aim of its own.  Working with statutory, third sector and supporting people organisations, we would wish to enable a range of accommodation options.

People with mental illness and mental health problems need differing levels of support.  This support ranges from independent living support, respite care and at times in-patient care.  Care will be needed in different environments.  This will include secure environments for those that pose a risk to themselves or others, as well as supported accommodation in the community that supports access to work, training and leisure opportunities.   Accommodation choices should include consideration of opportunities for developing or enhancing social networks and community belonging.

There will always be a small number of service users who have specialist needs and as such may need to access regional or sub regional facilities.  However, the principle that they need to be catered for as locally as possible remains pertinent.  A range of repatriation schemes will need to be developed in Gwent if services are to succeed in returning service users closer to their communities.  It should however be noted that individuals who have been in placements for many years, may now view that as their home, and open dialogue with service users and their carers will be required on an individual basis.

We know that particular attention needs to be paid to the housing needs/support of particular groups within our society ie those with dementia, and those who are often refused accommodation eg those with personality disorder or co-occurring mental health and substance misuse problems.

We know that achieving the aim set here is dependent on the engagement of many different individuals and organisations (private, statutory and voluntary).  Our commitment is to enable this.

**Aim 4.        Ensure Services based in the Community offer support, advice and where necessary assessment and treatment within this environment**

Most service users would rather be treated in their own homes with their families and carers providing elements of their support through community focused models of care with support from mental health services, when needed.  Mental

Health services in Gwent already have a strong community focus and much work has been done to organise services around the communities they serve. However there remains further work to be done.

We want to ensure that any person needing contact with mental health services can access services as soon as possible. For most people they will do this through their General Practitioner. Primary care plays a crucial role in delivering effective mental health care and treatment. A new requirement from Welsh Government (The Mental Health (Wales) Measure) aims to strengthen that role so that throughout Wales there will be local primary care mental health support services organised around GP communities. These services are aimed at individuals of all ages who are experiencing mild to moderate, or stable but severe and enduring, mental health problems and will include the development of primary mental health teams.

The services that will be delivered are :-

- Comprehensive mental health assessments for individuals who have first been seen by their GP, but for whom the GP considers a more detailed assessment is required. In some cases, individuals may be referred by secondary mental health services.

- Treatment by way of short-term interventions, either individually or through group work, if this has been identified as appropriate following assessment. Such treatment may include counselling, a range of psychological interventions including: cognitive behavioural therapy, solution-focused therapy, stress management, anger management and education.

- Provision of information and advice to individuals and their carers about treatment and care, including the options available to them, as well as 'signposting' them to other sources of support (such as support provided by third sector organisations).

- Provision of support and advice to GPs and other primary care workers (such as practice nurses) to enable them to safely manage and care for people with mental health problems.

- Supporting the onward referral and co-ordination of next steps with secondary mental health services, where this is felt to be appropriate for an individual.

This service will ensure those needing support that can be managed at this first contact with the mental health service can receive it. It will also ensure that the necessary service pathways are in place for onward referral to a wider range of mental health services that are available in the community such as early

intervention services, community mental health services, assertive outreach teams and crisis resolution teams. The role of the care co-ordinator and care and treatment planning process, along with increased availability of advocacy services will be central to the success of this approach.

We will strive to ensure that all of these services work to support the person seeking assistance. We will also ensure these services work together in a co-ordinated way. We want a hospital admission to only occur if that is appropriate to the individual's need, and as such is a decision that is made after the consideration of many other options. A number of key operational changes have already taken place within Gwent in order to reduce reliance on hospital based care with the development of Crisis Resolution Home Treatment Services (CRHT) and services such as Frailty CRTs together with the incremental development of Assertive Outreach Teams (AOT). It is important to build on these initiatives by supporting these models with alternative ways of intervening.

We would also wish to ensure that those that have had a previous mental health illness, and may have received services from a community or hospital based team (whether as an in-patient or in their own home) can access services quickly again if they feel their mental health is deteriorating. To do this we have to ensure that the right services are in the community, and that previous service users, know how to access the services when they need them, without needing a referral from their GP to re-enter the service.

As a Partnership we want to ensure that individuals and their carers can also access services that are provided out of hours in a timely way, and that when they do so, these services are responsive to their needs, supporting a matched approach as set out in this document.

### Aim 5. *Provide specialist services that are available to people when and where they need them*

As partners, we have a strong commitment to increase the amount of people who can receive care in their own community through increased community services. We recognise however, that there will be times that individuals need an in-patient stay, or the expertise of a particular specialist team. The following outlines the breadth and complexity of those services that require a specialist response from expert professionals. Due to the need to concentrate expertise, some of these services will not be available in all communities, with service users needing to travel to access them. They will however be available to all people in Gwent based on need.

- **Child and Adolescent Mental Health Services (CAMHS)**

The CAMHS service recognises that there are established benefits to an environment that supports children and families through pregnancy, childbirth

and the first years of life. Moreover that adolescence and emerging adulthood, is a time of social, emotional and physical transition, which can be challenging for the young person and their family. This is often the time where experiences of mental illness peaks. It is therefore essential that service users and their families are prepared for any changes in services, and that strong pathways of care are developed to enable a seamless transition from CAMHS into adult mental health services.

- **People with a Physical and Mental Illness**

The relationship between physical and mental illness is complex. Some people in general hospital settings may have mental health problems which lead to their reason for admission, e.g. depression leading to an individual failing to manage their diabetes appropriately. Additionally there are individuals who experience mental health problems as a consequence of their physical illness, e.g. depression and anxiety after a physical trauma. We also know the impact alcohol and substance misuse can have on prolonging recovery times for physical illness as well as the problem which can occur when managing withdrawal syndromes in hospital. Evidence is clear - that recovery and eventual discharge is often negatively affected in individuals who have mental health problems associated with their physical illness. Equally we also know that people with mental health problems have increased physical health needs and are likely to die younger. We must ensure that access to appropriate primary and secondary physical health care is available both in the community and in hospitals for people using mental health services. Mental and physical health services need to work much more closely together to improve awareness, training and ensure access to specialists in order to address health inequalities and ensure the best acute medical care.

- **Women Who Have Just Given Birth**

Being 'post-partum' can be a time of risk for some mothers in terms of developing a mental illness. Ten percent of women are likely to develop a significant depression after childbirth, which can persist and have very damaging effects on both mother and child if not treated and a much smaller number will develop a more distressing psychosis which requires urgent intervention.

Those most at risk are women who have had previous mental illness themselves, have a strong family history of mental illness or who are living in difficult environments. It is important that the mental health services work with primary care, health visitors, midwives and obstetric departments to help identify women who are at risk early in their pregnancy (or even before) so that plans for prevention and early intervention can be established.

- **Neuro-Developmental Disorders**

There are some lifelong disorders such as autistic spectrum conditions (where there are problems with language and social interaction) or attention deficit disorder where, although the consequences of such disorders can be devastating for the sufferer and their family, their symptoms are often not serious enough to require the input of a secondary mental health team. Primary care teams on the other hand often feel they do not have skills to manage such service users. This group need a complex partnership of social, psychiatric, psychological, educational and vocational supports to be able to achieve their potential and a service which can offer the right response to a service user of any age.

- **Individuals With Substance Misuse Problems**

Substance misuse services are planned and commissioned on behalf of the Gwent area by an Area Planning Board. This strategy therefore seeks to ensure that the needs of those with a co-occurring mental health and substance misuse issue are responded to and does not seek to duplicate the work that is on-going via the development of a substance misuse strategy for the area.

- **Individuals Who Require Complex and More Intensive Psychological Support**

There are some service users who have experienced such significant trauma that specialist psychological therapy is required. Some of these service users will have been diagnosed as having a personality disorder. The complexity and intensity of the psychotherapy required means that this needs to be provided by a specialist service sometimes working with the generic community mental health teams. The training and expertise required is significant but it is vital that such service users are detected early if interventions and outcomes are to be improved. We know that failure to help this group of service users can have profound consequences for the individual and for their community. There will be a need for integrated pathways which will include primary care and the general hospitals where many of these service users initially present for assessment of need and risks and delivery of interventions which are evidence based.

- **Individuals with an Eating Disorder**

Service users who present with eating disorders such as bulimia, or anorexia have very specific specialist needs and require dedicated and complex interventions. These can be at various levels from services for those with milder symptoms to those with very severe and life-threatening symptoms. Services required also include re-feeding and managing the physical consequences of eating disorders in general hospitals as well as intensive and complex therapeutic interventions delivered by a team who have specialist skills.

This service is already well established within ABHB.   With the recent establishment of a re-feeding bed in Nevill Hall hospital, supported by 1:1 nursing for high risk service users.

- **Those Who Have Mental Health Needs And Who Are Involved In The Criminal Justice System**

Many people with mental health problems find themselves in the criminal justice system inappropriately and some in prison.  It is important that services can identify and assess such service users before they are detained and placed where they are less likely to receive the treatment they require. Court diversion and forensic assessment as locally and quickly as possible for those who are arrested for an offence and who appear to have mental health problems is essential.  This needs to be supported by effective pathways onward into the correct services.  It is important too that there are effective links between services that play a part in this service eg Youth Offending Teams.

Making sure those who are in custody can access the right level of specialist psychiatric help is also an essential element.  It is important that relationships with the police and the rest of the criminal justice system are strong so that service users and public safety can be maintained at all times.   Clinical risk management of the highest quality as well as the right treatments are necessary to ensure that the public feel comfortable with services caring for offenders in the community where this is appropriate as well making sure mental health service users are not discriminated against and stigmatised.

- **Veterans**

Service Users who have been in the armed forces and who may have experienced the trauma of battle sometimes need specialist therapeutic help to recover when they return to their communities. This help should be delivered by a combination of statutory and voluntary sector organisations.  The service should aim to deliver the appropriate response to such service users in the context of partnerships with all agencies.

*Aim 6.*      *To facilitate an appropriate response from across organisations to the needs of people with dementia*

Dementia can affect anyone, irrespective of age, gender, class or race.  It is not as some believe, a natural stage in the ageing process but a progressive illness that tends to affect the individual in a gradual manner, moving from initial memory problems to the loss of the essential elements of mental functioning.

However, there is good evidence, in particular from people with dementia and their families, that where people receive an early diagnosis of dementia and are helped to access information, support and care, people are often able to adapt to

living well with dementia. Those with dementia and their families can also be helped by having access to appropriate information and responsive services. It is also very important that we make our society, and in turn our communities, aware and supportive by working to remove any stigma associated with the condition. We have outlined here some specific areas where we would wish to take action.

A driving principle of mental health services for people with dementia will be to enable each individual to live a dignified life despite encroaching loss of independence, and for autonomy to be respected as far as is possible. Service delivery will focus on the importance of the home environment: home assessments allow for an integrated and creative person-centred approach with Social Services, primary care, the frailty service and the voluntary sector involvement to enable maintenance of independence and home-living as long as possible, thus avoiding unnecessary hospital or residential/nursing admissions.

Person-centred services enable people living with dementia to access appropriate treatment, services, support and skilled care across all stages of the illness. Such support and care will aim to minimise disease progression and optimise quality of life through meeting a wide range of needs which may vary significantly at different points in the course of the illness. These include the need for early diagnosis, access to anti-dementia drugs, psychosocial interventions, emotional and practical support, high quality care in residential settings where necessary, and palliative or end-of-life care. The needs of family members and carers who support a person with dementia will also be a focus of dementia services - to be addressed through information, education, emotional and practical support such as respite care and guidance towards appropriate residential and nursing home placement if this becomes necessary. The implementation of the recovery model will be appropriate to enable people with dementia to live fulfilled lives, but it will be necessary to deliver this in a tailored way when skills of independence become compromised or deteriorate as the illness progresses.

Key psychosocial interventions will include measures to enable the person's individuality to be recognised and maintained. For example, the development of life story materials to be held by the individual can portray their background, lifestyle and life achievements which enable care services to maintain routines, patterns of behaviour and personal relationships, even in very late stages of the illness.

Through the natural course of the disease dementia may at some point compromise mental capacity for a range of decisions about care. Applied principles of careful consideration of decision-making capacity will serve to optimise and enable participation in decision-making, promote use of specialist advocacy, and facilitate skilled and sensitive "Best Interests" reviews.

In cases of difficult behaviours which challenge care, a holistic evaluation of the person's needs will ensure a full bio-psychosocial assessment and formulation. Expertise offered by nursing, occupational therapy and psychology staff endeavours to ensure that families and other carers are aware of medical and non-medical approaches in the management of behaviours that challenge. This knowledge will guide an appropriate intervention, thus minimising use of medication to control distressed, irritable or aggressive behaviours.

Good quality care for people with dementia whilst in a physical care bed is also a significant challenge to colleagues in physical health divisions. We recognise the need to work collaboratively with physical health services to allow them to respond to this challenge. To enable physical health services to deliver good quality care, mental health services for older adults will inform and support planners and managers within those services and those responsible for service redesign and delivery of care, using the following principles:-

- Co-development of a dementia care pathway through the physical care in-patient journey, identifying basic needs associated with dementia.
- Support for the development of robust staff development programmes to be delivered across all inpatient settings, to enable staff to maintain a focus on care principles driven by an understanding of dementia sufferers' needs for high levels of advanced support in areas such as nutrition, hygiene/toileting assistance etc.
- Application of enhanced advocacy principles.

We too need to give consideration to the palliative care needs of people with dementia, ensuring that they and their families are supported at this time, and that the staff supporting the service user are appropriately skilled.

"Younger people with dementia" is a term used when someone is diagnosed with dementia under the age of 65. Due to the perception of many, that dementia is an illness that only affects older people, however, there are sometimes significant age-related barriers for younger people trying to get access to dementia services. For examples, many dementia care services have a minimum age requirement of 65, and are not available to younger people. Where services are open to younger users, these may not be appropriate to their needs, with younger people often feeling that they are made to 'fit in' to a service, rather than the service fitting their needs.

It is important that services which are developed recognise the specific needs of this service user group, i.e. young family commitments, housing issues and financial commitments.

***Aim 7.        To ensure the best use of mental health resources***

To deliver a strategy as ambitious as this, it is clear that a common vision is shared, that becomes the basis for future decisions related to staff and funding.

Together as organisations, both statutory and voluntary, we hold a significant budget and employ a high number of staff to deliver mental health services.   We want to be sure we are making best use of this money, and empowering our staff to deliver the best services.

- **Leadership**

We are clear that competent and innovative leadership must be at the heart of delivering our vision with a strong emphasis on clinical, professional and political leadership. Developing our future leaders and ensuring a competent and confident workforce will be an essential element of this strategy.

We are committed to continue to meet as a Partnership Board and consider the best means of planning and delivering mental health services.  Within the period of this strategy, we will explore the opportunities that could be afforded to us through integrating our management structures and workforce.  Through the planning and delivery groups that support us, we will also communicate clear vision on the following service aspects that we will as appropriate redirect our common resources towards :

  - Community Well-Being/Recovery
  - Primary, and Community services
  - Hospital Based Care
  - Accommodation
  - Respite
  - Specialist Services

- **Workforce**

Our largest resource is of course our workforce, also those that provide services on our behalf through being commissioned or volunteering.  We will endeavour to provide a skilled and empowered workforce, one which focuses on quality and continuous improvement.

We commit to an open and transparent dialogue with staff about service development and design and encourage a culture that enables learning and growth to be embedded.

As this strategy signifies exciting and significant change in the way that services are provided, it too offers opportunities for staff in respect of integrated working,

learning about new disciplines and developing leadership roles in supporting the implementation of the strategy onwards.

- **Finance**

All partner agencies will assume the responsibility for ensuring that interventions undertaken with service users are as effective as possible. Partner agencies must aspire to deliver best practice and evidence based practice and additionally to learn from the experiences of others. Partners must also be kept abreast of new interventions and be creative and innovative in their approaches. As the guardians of taxpayers' money all statutory agencies have a duty to spend that money as wisely as possible.

We are already committed to the principles and priorities contained within this strategy, as such we are committed to the redirection of resources to meet these. There is a recognition that this redirection will result in the decrease of funds in some areas, as they are used to enhance other areas. (An example of this is how we provide more community services through providing less hospital based care).

The ambitions of the strategy will involve changes, reshaping of services, decommissioning of some services and the commissioning of new or additional services. The detail of this will become clear through the workplans that will support this strategy. One principle we are clear on is that at the point at which new services need to be developed that consideration will be given to who is best placed to provide them to meet the needs of people with mental health problems, whether that be health, social care, the third sector or a partnership of them all.

We will also use opportunities that are available to us to pool our money where we are seeking common aims and to commission services against these together.

- **Our Estate**

As Partners we own/occupy a number of different buildings from where our services are planned and or provided. As more services move from the hospital setting to the community, it is likely that our need for traditional accommodation will change. We believe we could make better use of these, through working together. Throughout the period of the strategy, we will undertake a review of the existing estate within the context of many service changes and consider opportunities to work closer together.

***Aim 8:*** ***To work across the 8 organisations to establish a set of rules and a structure that supports our working together, to plan and deliver excellent mental health services (governance)***

As Partners we have already made the commitment to work together to improve mental health services for the populations we serve. We do, however, have to ensure that we have the right rules surrounding the actions and decisions we make as we continue to be responsible to 8 organisations. We need therefore to consider :-

- Decision making in each of the organisations
- Legislative frameworks in each of the 8 organisations (legal and statutory duties)
- Clinical governance (including clear lines of accountability and responsibility for care)
- Corporate governance (including complaints and compliments, dealing transparently and thoroughly with mistakes and incidents and ensuring we learn from them, management and good record keeping)
- Performance and review frameworks of the partner organisations

There are other aspects of working together that we will need to consider too such as :-

- Joint training opportunities
- Joint funding
- Potential Integration
- Sharing of information at a service user level, and an organisational level

To achieve any of the above we will need to develop clear policies and procedures that support the delegation of responsibilities across organisations.

## 8.    HOW DO WE KNOW THAT WHAT WE ARE DOING IS SUCCESSFUL ?

We want to clearly demonstrate that we are meeting the priorities of this strategy. This means that as partners we have to find a way of being accountable together. We will know we are successful because :

- **Service Users Tell us**

As a Partnership Board, the most important test of whether we are moving in the right direction is when we hear service user feedback that reflects a positive experience of the services received, and indeed of the growth of individuals and their role in society. We will therefore:

- seek to employ a wide range of ways to share information
- get feedback on service experience and ideas

- enable wide influence in service delivery and redesign

- **Staff tell us**

Collectively we employ a significant amount of staff. These people play a key role not only in delivering services, but also in making suggestions about how they think services can be improved, and the quality of care they believe service users are receiving. We would like to ensure an openness that enables staff to learn from experience, make suggestions for development and be a driving force to manage any necessary change. We would wish for staff to be informed of the work of the Partnership Board, however also to feel they have a role to play in informing it and its work programme. We will therefore:-
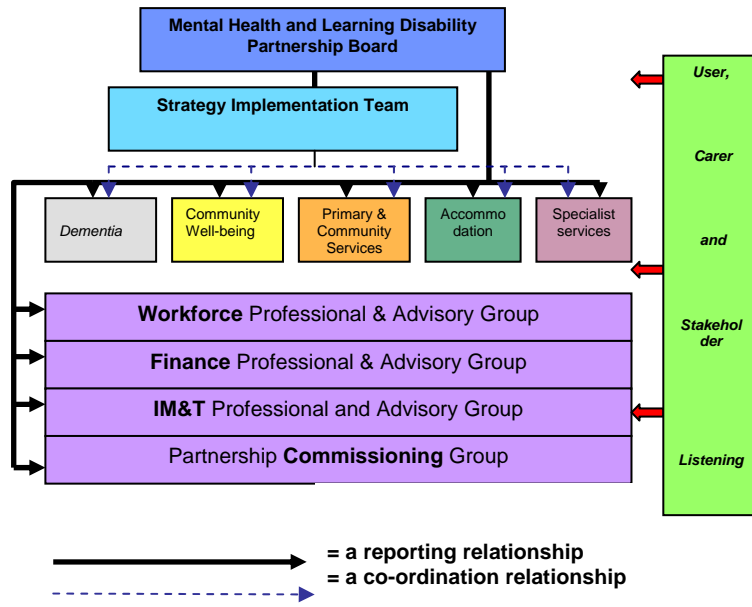
- Make available a core brief outlining all key decisions and actions agreed by the Partnership Board for wide cascade to all staff groups.
- Hold an annual listening event with staff across all sectors.
- Check sporadically and through a programme of specific issues 'what is going well', 'what is going less well' and 'how people believe improvements can be made'.

- **We meet the targets placed upon us**

Based on good practice, evidence base and expert knowledge, a number of targets are placed upon us as organisations, and as such the Welsh Government will monitor our success by compliance with these. Our commitment is clear, as a Partnership Board we want to be measured by our results, not simply our aspirations.

| 9 | MAKING IT HAPPEN |
|---|---|

This strategy is only the beginning. We will publish detailed action plans for each of the priority themes supported by an evaluation framework that helps us understand the impact of our actions through the eyes of staff, service users and stakeholders. We will also hold annual listening events that are open to all so that you can tell us how you think we are doing.

We will deliver through a multi-agency approach with delivery groups with appropriate representation helping us take forward the work :

**Mental Health and Learning Disability Partnership Board**

**Strategy Implementation Team**

Dementia | Community Well-being | Primary & Community Services | Accommodation | Specialist services

**Workforce** Professional & Advisory Group

**Finance** Professional & Advisory Group

**IM&T** Professional and Advisory Group

Partnership **Commissioning** Group

*User, Carer and Stakeholder Listening*

= a reporting relationship
= a co-ordination relationship

As a Partnership Board we look forward to translating this strategy into action, alongside service users, carers, staff and stakeholders – we hope it's a journey we can share.

## 10    FINAL COMMENTARY

This strategy signifies the beginning of an exciting period of development and redesign for mental health services across Gwent.  The journey that all stakeholders have embarked upon together will continue as we implement the vision we all share.

**APPENDIX A**

**SOME COMMON CONSULTATION MESSAGES AND HOW THEY HAVE INFLUENCED STRATEGY DEVELOPMENT**

| You told us …………… | We did …….. |
|---|---|
| You wanted to see clarity between mental well-being and mental illness | Made this much clearer through the descriptions in theme 2 |
| The terms service user and patient were both used through the document, and that service user was preferred | Ensured use of service user |
| It was unclear whether the strategy was for service users or the whole population | Clarified this in the document – its for all |
| Reference to domestic abuse was a gap in the document | We have conveyed the issues to the community well-being workstream of the strategy |
| That the needs of people with dementia were not strong enough in the document | This was a consistent message. We have developed a further priority workstream to ensure this critical area is addressed appropriately |
| That there is a need for training and awareness across all staff groups | We will ask each priority lead to give consideration to the training and awareness needs related to their area through their planning and delivery group |
| There is a need for cultural change across services | We will be developing a programme of cultural change and development at a staffing level (timescales to be confirmed) |
| That a concern is accessing GPs | We will ask the Chair of the Primary and Community services group to include this in their work-plan. It will also be picked up through implementation of the mental health measure |

| You told us …………… | We did …….. |
|---|---|
| Therapeutic interventions are under utilised | We will be considering the use of therapeutic interventions as part of creating primary care teams at the local level. |
| You wanted to see the values up front in the document, not appended | We have done this |
| There needed to be a good description of what recovery was | Included your suggestions for description within the strategy |
| There needed to be more voluntary sector representation on the Partnership Board | The Chair of the Mental Health Alliance has been asked to join the Partnership Board |
| Aims are excellent, but implementation is key | You have our commitment – we will publish implementation plans to support this strategy. |
| We need to find many different ways of gaining feedback influence and information | We agree, and would welcome your help with this |
| There needs to be more information on the existing staff, services and money | Each of the working groups will be asked to undertake a needs assessment of their area, to include a profile of existing resources. |
| There are worries about resources | Indeed we know the economic climate is a challenge to all – we need to ensure we spend all public money as wisely as possible to achieve this strategies intentions |
| Some of the language was confusing to some readers you suggested we include a 'jargon buster' | Right up front in the document |
| Be clear about how long the strategy lasts for | It's a five year strategy this is now on the cover page of the strategy |
| Separate functional from organic needs | We have now done this and will further realise the strategies intentions through a number of service changes that are planned |

# APPENDIX B

# THE PRINCIPLES OF RECOVERY

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.

- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.

- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward.

- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No 'one size fits all'.

- The helping relationship between clinicians and patients moves away from being expert / patient to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be "on tap, not on top".

- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.

- Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.

- The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.

- The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.

- Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

Adapted from *Recovery – Concepts and Application* by Laurie Davidson, the Devon Recovery Group. We gratefully acknowledge his permission to use this material