

**AN INTEGRATED MENTAL HEALTH STRATEGY**  
**FOR THE COMMUNITIES OF BLAENAU GWENT, CAERPHILLY,**  
**MONMOUTHSHIRE, NEWPORT, SOUTH POWYS & TORFAEN**

**2011 – 2016**

## FOREWORD

We are proud to present this very first integrated strategy for mental health services for the populations of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, South Powys 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 and carer 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.

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 sensitive enquiry and open dialogue.

The period of consultation on this strategy offers opportunity for a wide range of stakeholders to share their views on how the aims, can be turned into meaningful action.

Please take the time to consider the document, to comment on it, and to feel a part of shaping mental health services into the future.

***Signatures from the organisations***

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## 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<sup>1</sup> 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, South Powys 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.

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. Whilst therefore the aims we present do not discriminate on the basis of age, there will be actions contained within the document that are specific to a particular age group. We recognise that this innovative approach 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 service user involvement days which were held last year, through which 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 those days with requirements placed upon us by Welsh Government. In doing so, the strategy responds to both local need and national direction for health and social care services in Wales. As Partners we present the following vision:

*To enable all people facing a mental illness or poor psychological well-being living within Gwent and South Powys 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*

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<sup>1</sup> 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, customer etc.

*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 patients.
- Improve integration and continuity of care for patients between different professionals, settings and providers.
- Make best use of money and staff (resources) across health and social care.

We also recognise that to achieve a world class mental health service, we as organisations need to consider our individual current practices. We also 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.

We have therefore set ourselves 7 aims:

- Aim 1:** To work across the 7 organisations to establish a set of rules and a structure that supports our working together, to plan and deliver excellent mental health services (governance).
- Aim 2:** To communicate and work alongside service users, carers, staff and communities on the planning, monitoring and provision of mental health services.
- Aim 3:** To develop a wide range of services that support community well-being.
- Aim 4:** To provide a range of accommodation options.
- Aim 5:** To ensure that services based in the community can offer support, advice and where necessary assessment and treatment within this environment.
- Aim 6:** To provide specialist services that are available to people when they need them.
- Aim 7:** To ensure the best use of mental health resources.

The strategy document also makes suggestions on how we will meet these aims.

We would welcome your views on the vision, aims and suggested actions that you will see throughout this document. Please therefore see this document as one which remains in development, and one which you can influence, indeed one which we hope you will own alongside us. (Details of how and when you can do this are available on page 33).

Please note the strategy once approved through consultation will be supported by a detailed action plan that sets out timescales for achievement.

## 2. WHY DO WE NEED THIS STRATEGY?

Nationally, there is a wide range of requirements placed upon us. *'Making the Connections'* and *'Beyond Boundaries'*, set the context for public services in Wales. Within this framework the strategic direction for health is set through *'Designed for Life': A Strategy 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.'*

For mental health specifically, the policy landscape is rich, some of the key drivers are the Mental Health Act, the Mental Health Strategy for Wales, the Mental Health Measure, and the intelligent targets published for dementia, depression, first episode psychosis and eating disorders.

The common messages which can be drawn from the National work 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 individual's 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 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.

Responding to mental illness and supporting good psychological well-being is therefore 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 common challenge.

We have already undertaken a series of 'listening events' during 2010 with service users and their carers. A range of priorities emerged from these days and are summarised below. These have been built upon to develop our aims and suggested actions:

Adult services	Older Adult
<ul style="list-style-type: none"> <li>• Access</li> <li>• Information</li> <li>• Partnership</li> <li>• Integrated working</li> <li>• User and Carer involvement</li> <li>• Improved CPA process</li> <li>• Mental health promotion</li> <li>• Housing and accommodation</li> <li>• Meaningful activity and work</li> <li>• Reviewing in-patient requirements</li> <li>• Effective use of resources</li> </ul>	<ul style="list-style-type: none"> <li>• Access</li> <li>• Information</li> <li>• Partnership</li> <li>• Integrated working</li> <li>• Support for carers and involvement</li> <li>• Mental health promotion</li> <li>• Respite care and accommodation</li> <li>• Meaningful activity</li> <li>• Reviewing in-patient requirements and care</li> <li>• Effective use of resources</li> </ul>

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.

We have also reviewed our own position, and would summarise the challenge we all share as follows:

- Mental illness and poor psychological well-being in our society is increasing.
- When an individual experiences a deterioration in their mental health or wellbeing the solution is wider than simply the provision of treatment and social care.
- Service users across the age range express similar priorities for action.
- As service providers we could work more closely together than we currently do particularly in
  - developing a 'recovery' model of care
  - developing primary and community services particularly improving access
  - sharing our resources better.

### 3. WHAT WOULD WE LIKE TO DO : FUTURE VISION

#### 3.1 VISION

*To enable all people facing a mental illness or poor psychological well-being living within Gwent and South Powys 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 underpin this vision and the development of this 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 and South Powys 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 a period of illness.

- 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.

The formulation and basis of these values has been a foundation stone of our partnership relations, and therein of this strategy. We would like them to be more than a list and would like the reader to share an understanding of our thinking. We have therefore attached as Annex A to the strategy our detailed exploration of them.

### 3.2 THE SERVICE

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 health. 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.

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 and indeed a range of accommodation options for service users and their carers will be needed. 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.

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:

- |                               |   |
|-------------------------------|---|
| • 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 a period of illness                   |
| • Meaningful occupation       | With links to employment, volunteering, leisure facilities, social enterprises etc                  |
| • A range of                  | To ensure people have the necessary support to  |

accommodation  
services

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

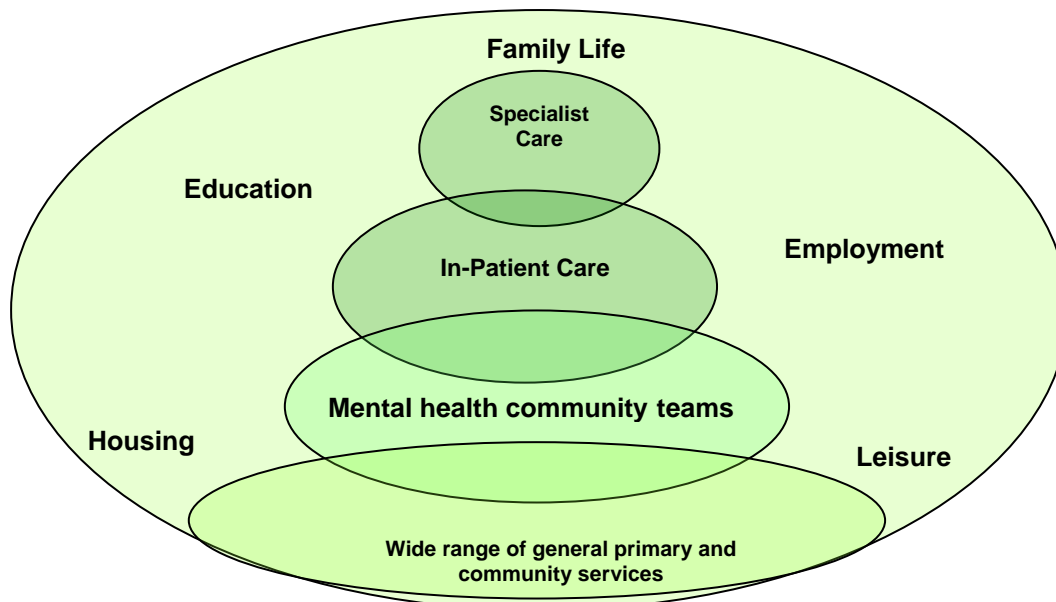
It is important that services are provided in a variety of environments, to offer flexibility and ease of access to service users and their carers. We want to ensure that all of our services respond in a timely fashion, particularly in an emergency. As a result we recognise that some services need to be available during traditional office hours (9-5), five or sometimes seven days a week, however, others need to be able to respond on a 24 hour basis seven days a week.

The way that as organisations we plan services is based on good quality care planning and comprehensive clinical risk assessment and management,

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.

### **3.3 DEVELOPING A STEPPED MODEL OF CARE**

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 who use the services. The model of service within this document takes account all of the factors previously outlined, and presents a stepped model of care. Stepped care is a range of integrated services between primary (GPs) and secondary care supported by health, the local authority and the third sector. The aim of the organisations that the Partnership represents is to enable individuals to remain on the lowest step as possible, relevant to their needs, only 'stepping up' to the next level (ie more intensive/specialist services) as clinically required. As a result, the level of professional input and specialist knowledge increases gradually, offering both clinical and financial advantages. The following diagram promotes an understanding of this:



The steps in our suggested model are described below :

Step	Provided for	By who	What will they do ?
1	All communities	Communities themselves, voluntary sector providers, Health Promotion teams, Housing, education and leisure departments, Employment agencies	Support people to remain within their communities and fulfil active lives, based on a wide network of support including interventions which are often not directly related to mental health services however which have a significant impact on an individuals well-being eg housing, employment.
2	Those who have a concern about their mental health and psychological well-being	These may be provided by statutory and voluntary sector organisations, and are likely to involve a mix of staff, some of whom are not necessarily trained in mental health but who play a key role in promoting mental health and referring people to services available within the mental health system. Help and support can accessed through GPs, health visitors, nurses, social services, tenancy support officers, drug and alcohol workers, resource centres	Offer specific mental health promotion, sign posting and access to general health and social care services.
3	People who access a tier 3 service may lack self-esteem or confidence. They may experience anxiety or fears which limit them in some way. They could be depressed, withdrawn, or engaging in risk-taking and aggressive behaviours that are harming their relationships with peers, parents or family members.	Professionals include counsellors, therapists and mental health specialists such as clinical psychologists, psychiatrists and community psychiatric nurses	Present the first tier of mental health specific support, however will still be provided in the community They will generally be based in a community setting and will provide an early intervention service to prevent general emotional and behavioural difficulties from becoming worse.
4	People who receive a Tier 4 service have often experienced mental health difficulties for quite a while. They may already been known to social services, education services	Services are provided in specialist clinics by multi-disciplinary teams of counsellors, therapists, psychiatrists and psychologists, social workers, occupational therapist and art, music and drama therapists	Specialist clinics help people who may be causing harm or risk to themselves or others; they may have substance-misuse difficulties, offending behaviour, phobias or emotional and behavioural disorders

	probation services, the police or youth offending teams. They may already be receiving help after being discharged from hospital		
<b>5</b>	For people who have mental health disorders that affect them in such a way as to risk putting themselves or others at serious risks of harm.	Professionals include community psychiatric nurses, social workers, psychiatrists, psychologists and therapists all work within specialist teams	Usually hospital based although teams do provide highly specialised out patient care for severe mental illness or suicide risk

We present the following aims to achieve the vision.

- Aim 1 :** To work across the 7 organisations to establish a set of rules and a structure that supports our working together to plan and deliver excellent mental health services (governance).
- Aim 2 :** To communicate and work alongside service users, carers, staff and communities on the planning, monitoring and provision of mental health services.
- Aim 3 :** To develop a wide range of services that support community well-being.
- Aim 4 :** To provide a wide range of accommodation options.
- Aim 5 :** To ensure that services based in the community can offer support, advice and where necessary assessment and treatment within this environment.
- Aim 6 :** To provide specialist services that are available to people when they need them.
- Aim 7 :** To ensure the best use of mental health resources.

The delivery of these aims is governed by the values we earlier outlined. How we would like to address these is outlined in the following section.

#### 4. HOW WILL WE DO IT ?

This chapter presents some of the actions we would like to take to deliver the aims.

#### **AIM 1 : TO WORK ACROSS THE 7 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 7 organisations. We need therefore to consider:

- Decision making in each of the organisations
- Legislative frameworks in each of the 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
- Opportunities to share posts
- Opportunities to share teams
- Opportunities to share finances
- Opportunities to share information

#### ***To achieve this we will:***

- Develop a set of rules as a framework for how we work together (by July 2011)
- Develop a structure that includes staff coming together from all organisations the financial, workforce, information sharing and joint working aspects of any integration programme (by July 2011)
- Develop a programme of development for the Partnership Board (by August 2011)
- Develop a clear work programme for each part of the delivery structure (by August 2011)
- Develop a timetable for integration of mental health services (by September 2011)

- Develop an integrated communication and engagement strategy (by December 2011)
- Develop an integrated staff training and development strategy that will ensure implementation of agreed actions (by March 2012)

**AIM 2 : TO COMMUNICATE AND WORK ALONGSIDE SERVICE USERS, CARERS, STAFF AND COMMUNITIES ON THE PLANNING, MONITORING AND PROVISION OF MENTAL HEALTH SERVICES**

Service users and carers are, and should be seen as, experts in health and social care service planning and delivery. They therefore need to be at the centre of developing their own care 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 patients adequate information is provided about their diagnosis, and or problem, and of the services available to them.

They 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'. Examples include the homeless or roofless, asylum seekers, travelling communities, 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.

Carers are a major source of support for people with a mental health illness or 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 or services can we improve the services we provide, and develop as a partnership the culture of a learning organisation.

***To achieve this 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 (by September 2011).
- Commit to an annual listening event on key issues.
- Offer service user representation through the service delivery group structures (by September 2011).
- Develop a continuous process of service user evaluation and improvement (by September 2011).
- Develop a shared resource of public engagement knowledge and expertise to support the activities of the Partnership Board (by August 2011).
- Undertake formal consultation on any major service change (as required).
- Ensure regular information about the work of the Partnership Board and varying service developments (monthly).
- Inform the development of the carer's strategy in each locality.

**AIM 3: TO 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 constitutional, social and environmental 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.

There are a number of steps that need to be undertaken within partner agencies in order to achieve an effective and co-ordinated impact.

***To achieve this we will:***

- Promote positive mental health with the general public.
- Ensure that service users are fully involved in developing work to address stigma.

- Develop a Mental Health and Learning Disabilities Health Promotion Strategy for Gwent and South Powys.
- Promote the understanding of mental health issues, in order to reduce the stigma associated with mental illness.
- Support national anti-stigma campaigns.
- Support the development of “stepped care” to psychological therapies.

There are also a number of specific actions we are planning in the areas of housing, employment and social inclusion. Housing actions are outlined in a later section; however employment and social inclusion are below:

- **Meaningful Occupation Activities/Social Inclusion/Work (Aim 3)**

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
- Provide a greater roll out of Direct Payments
- 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 South Powys 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.

***To achieve this we will:***

- Work through Local Government and Local Service Boards to enable a programme of action for meaningful activity that becomes embedded within communities.
- Develop a sheltered employment scheme.
- Undertake a community mapping exercise of service provision across all partner organisations in order to better understand the range of services that meets individual needs.

- Ensure a consistent approach to day activity.
- Develop integrated services within day service settings.
- Learn from “This is Me” Alzheimer’s Society research model.

#### **AIM 4: TO PROVIDE A 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.

Some of the actions we are considering are outlined below:

##### ***To achieve this we will:***

- Ensure that Housing/Supporting People are represented through both locality and the delivery group structure.
- Ensure closer working between mental health services, housing staff and housing associations.
- Develop opportunities to bring people back from out of area residential placements (repatriation).
- Review and further develop the policies which support consistent, informed and safe placements. Ensuring that vulnerable people can access services and exercise their rights.
- Enable service users who have lived long term in residential care to move into more independent community arrangements when possible.
- Support the use of Direct Payments in order to promote choice.
- Develop Step up/Step down accommodation in order to support those service users who require additional support during their illness.
- Improve access to respite care across Gwent and South Powys.
- Further develop accommodation options for individuals at times of crisis.
- Take part in the national homelessness programme and contribute through Partnership Board members to work on accommodation provision at a locality level.
- Develop further opportunities for Crisis Accommodation – in order to provide an alternative to admission.
- Develop opportunities for crisis respite.

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 and South Powys 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.

**AIM 5: TO ENSURE THAT SERVICES BASED IN THE COMMUNITY CAN 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 and South Powys 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 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 individuals 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 and South Powys in order to reduce reliance on hospital based care with the development of Crisis Resolution Home Treatment Services (CRHT) and services such as Advanced Clinical Assessment Team (ACAT) in Torfaen for older adults together with the incremental development of Assertive Outreach Teams (AOT). It is important to build on these initiatives by supporting these models with additional teams and appropriate responses outside of the in patient environment.

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 stepped approach as set out in this document.

***To achieve this we will:***

- Develop and enhance teams supporting primary care (Summer 2012).
- Enhance the Care Programme Approach (CPA) and care co-ordination process (January 2012).

- Identify routes for previous users of services to re-enter if they feel their mental health is deteriorating (January 2012).
- Strengthen advocacy services (January 2012).
- Review and enhance our Out of Hours service and develop more effective liaison with general teams in our hospitals.

## **AIM 6: TO PROVIDE SPECIALIST SERVICES THAT ARE AVAILABLE TO PEOPLE WHEN 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. These too are services which are likely to be centralised and not available in all communities.

### **6.1 Child and Adolescent Mental Health Service (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 peak. It is therefore essential that patients 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.

#### ***To achieve this we will:***

- Develop and implement a choice in partnership agreement with all children and teenagers accessing our service (Choice and Partnership Approach (CAPA)).
- Enhance transition between children and adult services.
- Develop a CAMHS strategy.
- Establish a CAMHS delivery group that supports the work of the Partnership Board.

### **6.2 Age, Frailty and Dementia**

The needs of older people often require a specialist response by staff with a particular expertise. The development of the Frailty service across Gwent, has offered an ideal opportunity for closer working between older adult mental health, adult mental health and general health services. Both the Frailty programme and this strategy have been strong in the communication that their service is not age specific, that people of any age can suffer frailty

syndrome or a mental illness. The same is of course true for individuals with dementia.

- ***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.

***To achieve this we will:***

- Develop an integrated memory assessment service across Gwent and South Powys.
- Develop a pathway for memory services.
- Enhance interfaces strengthening service provision and integration where necessary between the Gwent Frailty Programme, Older Adult mental health services and care of the Elderly services.

- ***Dementia Care Within A General Hospital Setting***

We recognise that some people may need to go into general hospital for a physical/medical health issue and whilst there may receive a mental illness diagnosis eg dementia. It is also recognised that patients who have a diagnosis of dementia will also have physical/medical needs that will be treated within a general hospital. It is important that all staff involved in the provision of care to these patients understand the differing needs of patients with dementia and that this group of service users receive an equitable service within a general hospital setting.

***To achieve this we will:***

- Redesign existing in-patient provision to better support those with dementia.
- Develop a dementia care pathway.
- Provide a consistent and more robust approach to the provision of dementia services in general hospitals across Gwent and South Powys.

- Develop a training programme for staff delivering services.
- Work across agencies to ensure that appropriate mental health arrangements are in place on discharge from hospital.
- Ensure in-patient care is of a high quality.
- Comply with single sex rooms.
- Enhance advocacy provision.

### **6.3 Younger People with Dementia**

“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 as an illness that only affects older people, there are sometimes significant age-related barriers for younger people trying to get access to dementia services.

For example, 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.

***To do this, we will:***

- Continue to support the third sector in the delivery of services with Gwent and South Powys.
- Recruit workers to support those with young onset dementia in line with Welsh Government policy.

### **6.4 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. Evidence indicates that recovery and eventual discharge is often negatively affected in individuals who have mental health problems associated with their physical illness, together we need to support a wider understanding of mental health issues in the broadest sense. We want to make this experience better.

***To achieve this, we will:***

- Develop a liaison service which will provide :

- Services to those that have self harmed and present to Local Emergency services.
- Services to those that present to Local Emergency Services with other psychological symptoms not related to self harm.
- Services to those individuals on general ward settings who are considered to have mental health problems associated with their physical illness.
- Specialist services to those who present with physical symptoms which are actually a representation of mental distress.

## 6.5 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 so that plans for prevention and early intervention can be established.

### ***To achieve this we will:***

- Develop and enhance the service pathway.
- Enhance links with health visitors and midwives.
- Appoint a clinical lead for this service.
- Develop a network of clinical specialists in post-partum mental health.

## 6.6 Neuro-Developmental Disorders

There are some lifelong disorders such as autistic spectrum disorder (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 patients. 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 patient of any age.

***To achieve this we will:***

- Develop an Attention Deficit Hyper-activity Disorder service.
- Appoint posts to support Asperger and Autistic Spectrum Disorders.
- Play an active role in the Neuro Development Clinical Network.
- Develop clinical pathways and community expertise to support sufferers and their families.

## **6.7 Individuals With Substance Misuse Problems**

Currently there are a range of agencies in Gwent delivering different responses to individuals with substance misuse problems. It is important that there is an overall vision for the delivery of these services. Referrers and service users need to be clear which part of the system can deliver the type of care required and that the care is delivered by the most appropriate agency.

There will need to be equitable access to a shared care service managed by primary care, however, with the support of specialist secondary care services and the third sector. It has to be a service which can equally respond to service users with substance misuse and other diagnoses such as mental health problems or concurrent physical problems and those who may be particularly complex. These are often referred to as co-occurring disorders and are generally most appropriately dealt with by specialist secondary service.

There needs to be a strong Public Health component to a substance misuse service and it is important that there is equitable access to help with *all* substances including alcohol.

We also know that substance misuse is a significant problem in general hospitals and affects many physically ill patients. It can significantly impact on recovery from physical illness and therefore access to specialist advice and services in general hospitals is essential.

***To achieve this we will:***

- Develop an integrated strategy for substance misuse across Gwent (via the Area Planning Board process).
- Develop a Partnership approach to care provision with the voluntary sector.
- Improve the information we capture to tell us about the service and how we can improve it.

## **6.8 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 patients 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 patients initially present for assessment of need and delivery of interventions which are evidence based.

***To achieve this we will:***

- Develop an Attachment and Trauma service.
- Develop appropriate pathways which include early intervention.
- Develop local services to support these service users.

## **6.9 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 patients.

***To achieve this we will:***

- Further develop training and awareness for all staff.
- Implement the intelligent targets for eating disorders.
- Further develop appropriate pathways into and through the service.
- Work with primary care to enhance early detection and referral.

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

Many people with mental health problems end up in the criminal justice system inappropriately and some in prison. It is important that services can detect 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.

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 patients are not discriminated against and stigmatised.

***To achieve this we will:***

- Establish an Integrated Mental Health Learning Disability and Criminal Justice Planning Forum in line with Welsh Government requirements.
- Develop a mechanism for incorporating views of service users and their carers into the design and planning of forensic services.
- Maintain and monitor the delivery of court & custody liaison services.
- Develop a comprehensive Forensic Service, integrating prison in-reach and court & custody liaison services.
- Produce and monitor a delivery plan for the repatriation of high cost out of county placements into Gwent & South Powys.
- Monitor the use and effectiveness of s.136 within Gwent & South Powys.
- Ensure the needs of people with a Learning Disability are fully embedded within all service design.

## **6.11 Veterans**

Patients 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 patients in the context of partnerships with all agencies.

**Actions we are planning in this area are:**

- Development of a specialist team.
- Develop further the relationships with wider Wales services.

## **AIM 7: ENSURE THE BEST USE OF MENTAL HEALTH RESOURCES.**

Together as organisations, both statutory and voluntary, we hold a significant budget and employ a high number of staff to deliver mental health services.

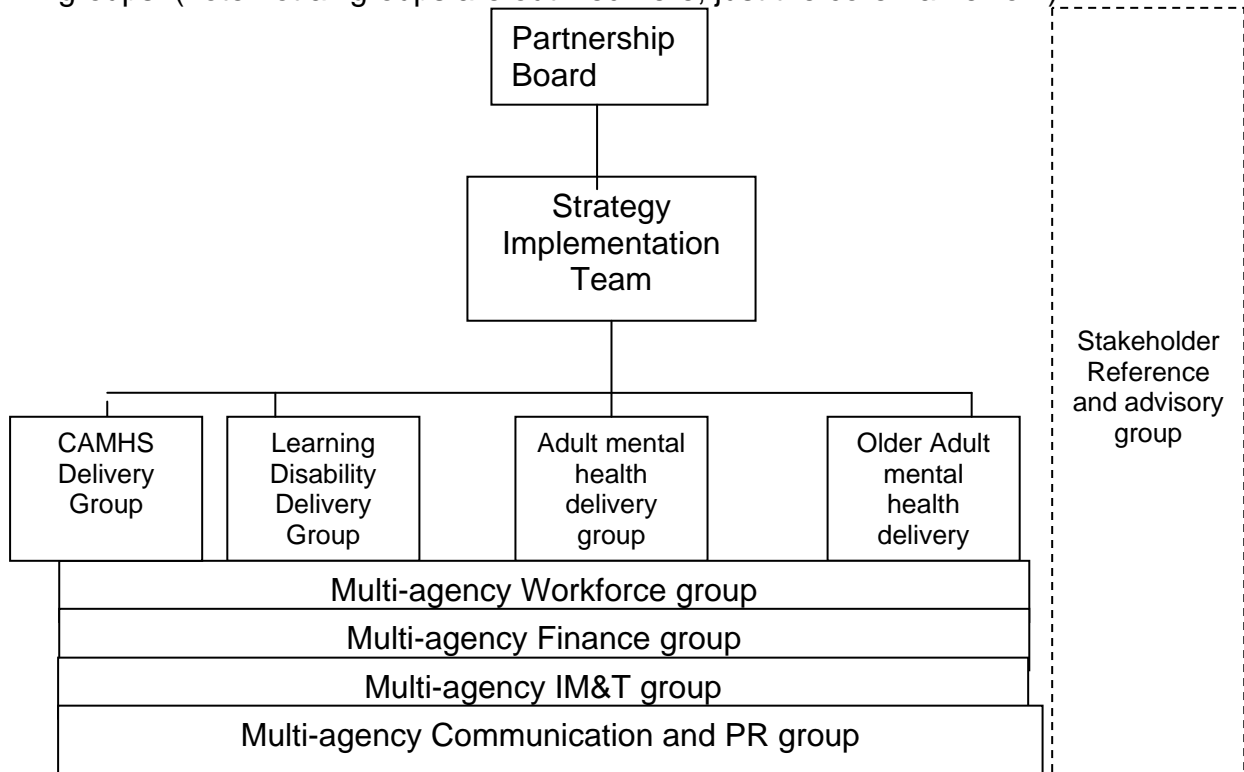
We want to be sure we are making best use of this money, and empowering our staff to deliver the best services. We have outlined some actions we wish to take in the resources section of this document.

## 5. WHO IS INVOLVED?

During Autumn of 2010, a Partnership and Learning Disability Board was established in the belief that organisations planning and delivering services for people with a mental health illness, or learning disability could achieve far more by working together. The Partnership Board has representation from:

- Service Users
- Aneurin Bevan Community Health Council
- Aneurin Bevan Health Board
- Powys Teaching Health Board
- Blaenau Gwent County Borough Council
- Caerphilly County Borough Council
- Monmouthshire County Council
- Newport City Council
- Powys County Council
- Torfaen County Borough Council
- Gwent Association of Voluntary Organisations
- Powys Association of Voluntary Organisations
- Torfaen Voluntary Alliance

The Partnership Board is supported to deliver its work through a range of groups: (note not all groups are outlined here, just the core framework)



The detailed work for each of these groups will emerge from this strategy, and will be detailed in the Partnership Board Establishment Framework which will complement and sit alongside this document.

## **6. HOW WILL WE RESOURCE THE STRATEGY?**

To deliver a strategy as ambitious as this, all future decisions related to staff and funding need to be guided by our shared vision.

### **6.1 THE PARTNERSHIP BOARD**

We will:

- Appoint a dedicated manager to develop the Partnership Board, develop our work programme, ensure we deliver and act as a link between the groups that support us.
- Make available staff from each of the organisations to support our work, enabling creative time for staff members to initiate and develop ideas that support the implementation of this strategy.
- Work together to understand each others business, ask questions when we do not understand, and identify learning needs we have as a group and find ways to address these.
- Consider the opportunity for integration and if supported move toward a clear implementation plan.

### **6.2 WORKFORCE**

We are also very 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 will be an essential element of this strategy.

We will:

- Bring together members of staff from across organisations to learn about each other's roles.
- Develop a set of rules and principles that set out how we should work with staff to deliver integration.
- Establish a map of the current health and social care workforce, recognising that a clear understanding of how this is currently organised will help when we need to consider how we best meet future service change requirements.

### **6.3 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. It should be remembered that all clinical decisions have resource implications and all resource decisions have clinical implications.

We will:

- Establish a map of where current spending on mental health takes place.
- Undertake a review of how we spend our money with the voluntary sector and strengthen provision in this area.
- Move where possible to pooled budget arrangements.

#### **6.4 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 accommodation will change. We believe we could make better use of these, through working together.

We will:

- Undertake a review of the existing estate within the context of many service changes and consider opportunities to work closer together.

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

### **7.1 OUR 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.

### **7.2 OUR 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'.

### **7.3 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. We will therefore:

- Develop a results based accountability framework as part of this strategy
- Undertake an equality impact assessment on the strategy through sessions at Partnership Board and the respective delivery groups.

## 8. HOW CAN YOU BE INVOLVED?

This strategy presents the commitment of all partners to jointly progressing the further development and modernisation of mental health services for the populations they represent. It has built upon listening to service users about what they want, and progressed to outlining some aims we have built based on these views. It has also started making some suggestions as to the actions we could undertake on some of these areas, and moved into thinking how we can make the workforce, finance and staffing infrastructure work more closely together to deliver better services.

We would like to hear your views on our work so far, specifically:

- Are we moving in the right direction?
- Have we listened to your views and begun making the correct assumptions about necessary service development and change?
- Do you agree with the vision – if not how would you change it?
- Do you agree with the aims in the document?
- Do you agree with the actions we are suggesting?

As well as consulting through the organisations that the Partnership comprises, we have also committed as a minimum to engage through the following routes:

- **Harder to reach groups**
  - Deaf clubs in each of the localities
  - Homelessness fora in each of the localities
  - Transient/traveller communities
  - Carers fora in each of the localities
  - Black and Ethnic Minority groups in each of the localities
- **Service Users & Carers**
  - Establish further listening event in each locality
  - Cascade via available networks
- **Staff**
  - Team briefs and presentations
  - Wide cascade of the summary documents
- **Stakeholders**
  - Local Service Boards
  - HSCWB Partnerships
  - Children & Young Peoples Partnerships (CYPPs)
  - Community Safety Partnerships

- Locality mental health planning groups
- Voluntary sector organisations
- Trade Unions
- National Voluntary Organisations
- Politicians
- Health Inspectorate Wales
- NLIAH
- Social Service Inspectorate Wales

We have attached a proforma as Annex B (the last page) that may help you formulate your response, however please do not feel restricted by this, please respond freely too.

Please return any comments to:

**By Post :**    **FAO: Mental Health Programme Manager**  
**St Cadocs Hospital**  
**Caerleon**  
**Newport**  
**NP18 3XQ**

**By Computer :**

[Consultation\\_mentalhealth.abb@wales.nhs.uk](mailto:Consultation_mentalhealth.abb@wales.nhs.uk)

Full copies of this strategy and a printable version of the summary leaflet are available via the following links

[www.blaenau-gwent.gov.uk](http://www.blaenau-gwent.gov.uk)  
[www.monmouthshire.gov.uk](http://www.monmouthshire.gov.uk)  
[www.newport.gov.uk](http://www.newport.gov.uk)  
[www.torfaen.gov.uk](http://www.torfaen.gov.uk)  
[www.powys.gov.uk](http://www.powys.gov.uk)  
[www.aneurinbevanhb.wales.nhs.uk](http://www.aneurinbevanhb.wales.nhs.uk)  
[www.powysthb.wales.nhs.uk](http://www.powysthb.wales.nhs.uk)  
<http://www.powysmentalhealth.org.uk/>  
<http://www.torfaenvoluntaryalliance.org.uk>  
[www.gavowales.org.uk](http://www.gavowales.org.uk)

**Also check out the Aneurin Bevan Health Board Facebook page**

## ANNEX A

### OUR VALUES: WHAT THEY MEAN

*We don't want our values to read as simply a list. We would like a shared understanding of what we mean, 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 a period of illness
- 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 HOMES 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 and South Powys 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 and South Powys 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 health. 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 and South Powys 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 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 patient. We also need to listen to their experience of mental health services so that we can continually adjust how we respond as organisations.

- **'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 patients, 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 the involvement of a range of agencies and organisations in the community. 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 patients and which they feel part of and understand.

- **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.

## CONSULTATION PROFORMA

<b>Are we moving in the right direction?</b>		
Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Comments	_____	
	_____	
<b>Have we listened to your views and begun making the correct assumptions about necessary service development and change?</b>		
Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Comments	_____	
	_____	
<b>Do you agree with the vision – if not how would you change it?</b>		
Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Comments	_____	
	_____	
<b>Do you agree with the aims in the document?</b>		
Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Comments	_____	
	_____	
<b>Do you agree with the actions we are suggesting?</b>		
Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Comments	_____	
	_____	
<b>Is there anything else you would like to tell us about this draft strategy ?</b>		
Yes	<input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
Comments	_____	
	_____	

