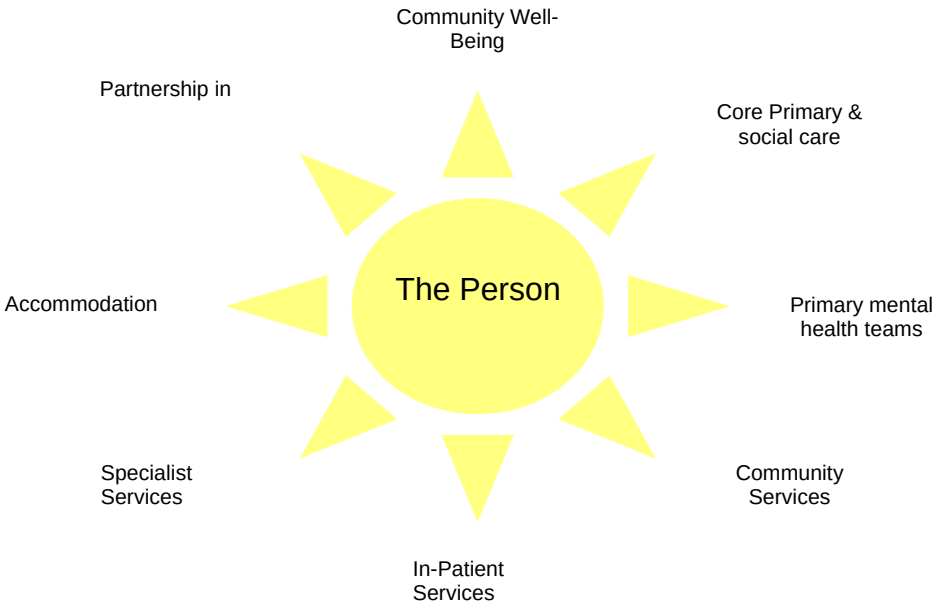
“TOGETHER FOR MENTAL HEALTH IN GWENT”



	working together, to plan and deliver excellent mental health services (governance).	

FOREWORD

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 populationrypeo Tdoy tlsice

Organisations Signatures

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Judith Paget
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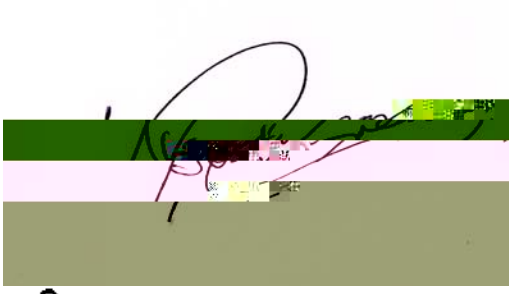

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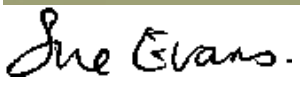

JARGON BUSTER

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

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 cous by7(co)-5(us by7(co)-5(u n).1521.15b-0.00c 0.1ratMC nise-0.0s t inter).110(a se

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

2. TOGETHER IN GWENT : HOW WE DEVELOPED THE STRATEGY

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**
x Access x Information x Partnership x Integrated working x User and Carer involvement x Improved CPA process x Mental health promotion x Housing and accommodation x Meaningful activity and work x Reviewing in-patient requirements x Effective use of resources	x Access x Information x Partnership x Integrated working x Support for carers and involvement x Mental health promotion x Respite care and accommodation x Meaningful activity x Reviewing in-patient requirements and care x 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.

[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

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.

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 requirem

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).

ƒ The Population of Gwent

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:

- ¾ There should be a ***comprehensive*** range of high quality mental health services delivered by a range of organisations as locally as possible.

- ¾ 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.

- ¾ 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).

- ¾ Services should ***intervene as early as possible*** to get the best outcomes for service users.

- ¾

¾ 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.

¾ Providing services in this way can only be achieved when all those who are involved ***work in partnership*** to use scarce resources efficiently.

¾ 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

x ***Stigma*** associated with mental health issues should be addressed in all communities. The Partnership will seek to influence this through existing locality mechanisms
x ***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.

x **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.

x **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.

x **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**

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.

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

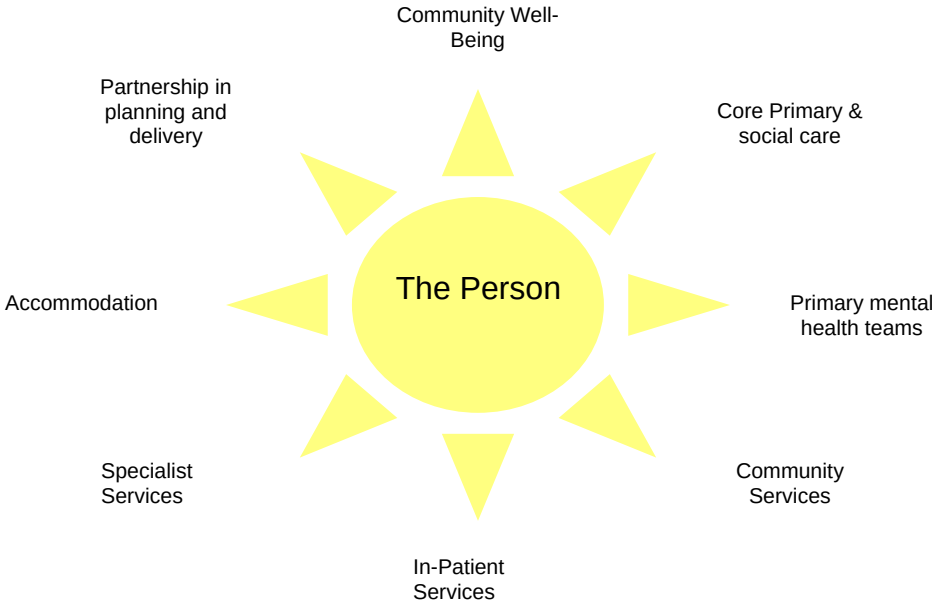
As a Partnership Board we are clear that the future services we provide should have a new approach, that ensure service users are truly at the centre of their own care receiving evidence based interventions at the earliest possible stage which are easily accessed and delivered in a timely, flexible and 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:



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:

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

x 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:

x A range of in-patient services	So that people are admitted to in-patient services which are appropriate, safe and of high quality
x 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

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

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 conta MCID 9

- **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

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

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 thoT -1.eOBt74 s deteriorating. ital 6w 13.022.4 Td (on tuicwith)Tj are nity or d m

- **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

living well with dementia. T

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 de

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 effe

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

- 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 py cCi IT 8 15.84 re f BM pyouad [(gr)Tj 0sT l00.9 TT

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.
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