



briefing

Mental health services in Wales: a guide for independent members



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Purpose of Paper

One of the desired benefits of the reformed NHS Wales was to give greater focus and attention to mental health services and their improvement across the whole range of services, from child and adolescent through to adult services and services for older people.

This document has been written as a high-level guide for independent members to support them in this aim and in discharging their governance responsibilities as board members in the area of mental health.

This brief overview is split into the two following sections:

1. The basic building blocks of a good mental health service
2. The challenges facing NHS Wales as it seeks to implement and improve upon these building blocks

A brief history of mental health services

The history of mental health care in Britain from the Victorian era onwards has been shaped by the gradual move away from compulsory detention to an emphasis on prevention, treatment and a social model of recovery.

In 1948, the creation of the NHS encouraged the beginning of the transition from institutional based care. The resident population of psychiatric hospital beds began to decline in the 1950s following the introduction of day hospitals and social methods of rehabilitation.

The era of community care began in the 1960s and has been official policy ever since. Even though the psychiatric hospital population halved between the mid 1950s and mid 1980s, progress providing adequate community care was patchy and it was 1986 before the first psychiatric hospital was fully closed. Many of the large old hospitals followed in the late 1980s and early 90s.

In the late 1980s, multi disciplinary Community Mental Health Teams were introduced to provide community-based care. In 1991, the Care Programme Approach was introduced to improve care and ensure that people with mental health problems received appropriate levels of support. Devolution in 1999 allowed the development of separate mental health strategies for Wales. Each of these documents focused on improving the quality and standards of services, with an emphasis on the further development of community based models of care, inter agency working, and the social model of recovery.

Basic components of a good mental health service

The emphasis in this section is on identifying the core functions that an optimal mental health service would need to perform, rather than specifying the structure that would be needed to deliver it. Flexibility according to local need and relationships between stakeholders would decide the best arrangements to be developed in each locality, but with certain common functions outlined below.

Primary care mental health services

Some simple figures demonstrate the pivotal role of GPs and primary care staff in the care of people experiencing mental distress, and therefore the need to ensure that primary care staff are trained, confident and competent in recognition and low-level intervention:

- 80% of all contacts in the NHS take place in primary care
- 90% of people with mental health problems are cared for entirely within primary care
- Around 30% of people who see their GP have a mental health component to their illness.

Primary care services, and GP practices in particular, are the first port of call for most people with mental health problems. It is important to note that although all GP trainees will have considerable exposure to people with mental illness in the course of their 18 month attachment in general practice, not all GP trainees will have undertaken a specialist attachment to a psychiatry post. Primary care professionals therefore need the proper education and training to recognise early symptoms and risk, and to take appropriate action.

The National Assembly's Health, Wellbeing and Local Government Committee in its inquiry into community mental health services found that whilst some GP practices are well equipped to provide a responsive service, others are not. The Wales Audit Office baseline review in 2005 depicted a very uneven pattern with about two thirds of GP practices saying they needed more support and guidance from specialist services to help them manage patients in primary care.

As a consequence, some patients are inappropriately referred to specialist mental health services, which can be costly, unnecessary and damaging to the service user's self-esteem. The committee report highlighted a need for more clarity around the role and expectations of GP mental health services, and also called for stronger incentives to be in place for primary care practitioners to ensure adequate provision of mental health services.

Gateway Workers

Some areas have introduced the role of specialist Primary Mental Health Workers, or Gateway Workers, who act as an interface between universal first contact services, such as the GP, and specialist mental health services. Gateway workers are usually positioned on the boundary between GP services and specialist teams, such as Community Mental Health Teams (CMHT), although sometimes they form part of the CMHT itself.

The gateway worker role strengthens services by supplementing capacity and capability within community and primary care, helping the first point-of-contact services (health, social care, voluntary sector and in CAMHS; education, youth justice) in

relation to early identification and intervention.

The aim of gateway workers is to work across boundaries to develop a co-ordinated response to ensure the service user is directed to the most appropriate service relative to their level of need. They may do this by facilitating access to more specialist services, or by providing a direct service to the service user in an accessible and less institutional environment, thus reducing the risk of stigmatising the service user.

Specialist mental health teams working in the community

Treating people in more inclusive and engaging settings positively impacts on the relationship of the staff/service user and the course of the service user's recovery. Familiar, non-institutional settings can also influence the public perspective of mental illness and diminish stigma and discrimination.

Community Mental Health Teams

Community Mental Health Teams (CMHT) provide a crucial role providing specialist services and support for service users and their families in community settings.

CMHTs are multi-disciplinary teams comprising social workers, nurses, support workers, psychologists, occupational therapists and psychiatrists. They provide help for service users who are experiencing a variety of moderate to severe mental health problems through the following three main functions:

- Giving advice on the management of mental health problems to other professionals – in particular advice to primary care and a triage function enabling appropriate referral.
- Providing treatment and care for those with time-limited disorders who can benefit from specialist interventions.
- Providing treatment and care for those with more complex and enduring needs.

Once referred to the team, the care of the service user is co-ordinated by a named team member who will become the individual's Key Worker.

Psychological therapies for the treatment of anxiety and depression

Over 250,000 people experience depression in Wales each year. NICE Guidelines recommend that most patients with depression and anxiety disorders should be offered evidence-based psychological therapies.

The evidence underpinning these guidelines shows clearly that talking therapies, such as Cognitive Behavioural Therapy, are as effective as drugs when treating depression and anxiety in the short term, and tend to have more durable effects. The Royal College of Psychiatrists has found that many people feel a great deal of benefit from therapy, even after comparatively few meetings. The College says that CBT can deliver improvements in a number of areas, including symptoms, social and occupational functioning, family and other relationship patterns, personality change and reduction in the relapse rate of severe mental illness.

Studies have shown that even the new generation anti-depressants have no more effect than a placebo for people with mild or moderate depression. The research suggests that the effect of the drugs may be largely psychological - people feel better because they believe they are taking a medication that works. This study is especially pertinent to Wales where the South Wales Valleys has the highest rates of anti-depressant prescribing anywhere in England and Wales.

There is also a strong financial case for investment in psychological therapies. Funding to improve provision of psychological therapies in the treatment of depression and anxiety would positively impact on the number of people who are fit to work, leading to potential savings for all public service sectors.

Assertive outreach services

Assertive outreach is a way of working with adults with severe and lasting mental illness who cannot or will not engage with traditional services.

Typically, staff working in assertive outreach look for

individuals who have a diagnosis of severe mental illness, and a history of erratic or non-engagement with mental health services, or non-compliance with medication resulting in impaired mental health. In assertive outreach, professionals work with service users in their own environment. Research into the effectiveness of assertive outreach has shown it can result in a 35% decrease in hospital admissions and a 62% reduction in the number of days in hospital.

Attention in Wales has been drawn in recent times to the importance of assertive engagement with children and young people who have experienced mental distress. The recent joint review of CAMHS in Wales found that many children and young people who miss appointments are, as a consequence, 'discharged' by specialist CAMHS teams. The report says this lack of routine follow-up of missed appointments can put children at risk.

Crisis service

Severe psychiatric illnesses are often episodic in nature, with stable periods of less intense symptoms interrupted by periods of crisis in which symptoms become intense.

Crisis Resolution Home Treatment (CRHT) teams are multi-disciplinary teams that help people through short-term mental health crises by providing intensive treatment and support outside hospital, ideally at home.

Crisis teams perform an important gatekeeping role, ensuring that only service users who need inpatient treatment are admitted to an inpatient facility. The benefits are numerous. Home-based crisis resolution services can reduce hospital admissions by between 55% – 66 %, and therefore decrease the use of hospital beds. Where admission to hospital does occur, the intervention of a crisis resolution service can reduce length of stay by up to 80% through earlier discharge, as the service can provide users with the same support as the hospital. For example, the team can visit the service user several times a day, monitor their progress and administer medication.

Where mental health services make full use of CRHT,

it costs £600 less per crisis episode than services where CRHT is not available. Studies also show that clinical outcomes are similar to inpatient treatment and that service users experiencing crises prefer the non-inpatient solutions that CRHT provides.

In August 2006, Gofal Cymru opened a Community Crisis House in Cardiff, to provide an alternative to hospital admission for those experiencing an acute crisis in their mental health.

The house currently provides short-term (up to seven days) intensive 24 hour, specialist mental health support to people who are assessed by the local Crisis Home Treatment Teams as needing additional support to avoid admission to hospital.

In collaboration with the crisis teams, the project delivers support in a safe, comfortable and supportive environment without the stigmatizing effects of hospital admission. There is a high staff: service user ratio, and support is based around a social model of recovery, meaning advice on healthy eating and exercise, or encouraging social contact, may form part of the support offered, as well as more traditional interventions.

An evaluation report by Gofal found that 88% of those who used the service to the year ending March 2008 were successfully supported in avoiding acute in-patient care and were able to return home following their stay in the house.

Crisis Resolution: How it differs from assertive outreach

	Crisis resolution	Assertive outreach
Length of involvement	Short term, usually 2-3 weeks	Longer term, frequently several years
Clients	May have no previous contact with psychiatric services	Established psychiatric history
Referrals	Accepted from GPs, A&E department and clients themselves (if already known)	Usually require referral from secondary service
Hours of operation	Always 24 hour	Usually more limited
Service delivery	Rapid response – usually within one hour	Longer response time, especially for clients not previously known to service
Other	Act as gatekeepers to inpatient beds	Usually no gatekeeping role

Source, *Mental Health Topics: Crisis Resolution*, The Sainsbury Centre for Mental Health, 2001

The Care Programme Approach

The Care Programme Approach applies to all people who are under the care of secondary mental health services (health and social care), regardless of care setting. CPA ensures that a full and proper assessment is made of the service user's physical care, therapeutic and social needs. Care planning in an inpatient setting should not be confined to admission and discharge arrangements.

The main elements of the CPA are:

- An assessment of health and social care needs.
- A written care plan agreed with all those involved in the delivery of an individual's care including the Community Mental Health Team, GP and carer.

- The nomination of a Care Co-ordinator who acts as the main point of contact, overseeing the delivery of an individual's care.
- Ongoing and regular reviews of an individual's care plan and health and social care needs.

A 2009 Review of the Care Programme Approach found wide variation in compliance across Wales, with many plans focused on maintenance rather than recovery of the individual. It also found that IT systems could be cumbersome and bureaucratic and recommended that information sharing protocols to be developed with social services, with consideration of common targets needed.

Acute inpatient care

The purpose of an acute psychiatric inpatient service should be to provide a high standard of treatment in a safe and therapeutic setting for service users in the most acute stage of their illness. Acute inpatient care should be for the benefit of those service users whose needs are such that they cannot be treated at home or in a less restrictive residential setting. Inpatient provision is still the single element on which we spend the greatest proportion of the adult mental health budget and employ the greatest number of staff.

Rather than being isolated from the communities they serve, inpatient services are most effective when they are integrated into community-based services and vice versa. Inpatient services can have a more positive impact if they maintain contact with key agencies in the community that aid, and are central to, recovery, such as housing, benefits, employment, education, leisure etc. A lack of overall co-ordination

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Standards in the environment for acute mental health wards need to be at least equivalent to those required for any other NHS inpatient wards. Inpatients admitted to a mental health facility are at an extremely vulnerable time in their lives, both emotionally and physically, so the physical inpatient environment must be designed to ensure optimum safety, privacy, dignity and comfort. Cramped conditions and lack of privacy are often linked to violent incidents on wards. Specific attention

must also be paid to ensuring the physical and psychological safety of women. As such, there is specific advice to provide separate women only sleeping, washing and dayroom accommodation.

A recurring theme in many reports on inpatient care is 'lack of something to do'. Meaningful activity should be determined within an individual care plan negotiated with the service user. Poor amenities and lack of structured activities and stimulation promote untoward incidents and create risks.

Psychiatric intensive care units

Every acute inpatient facility should have access to an identified PICU. Patients who cannot be safely managed on open acute wards should be considered for referral to PICUs. Psychiatric intensive care units are highly structured locked units. Due to the high levels of disturbance on these units, it is essential that patients remain on these units for the shortest time necessary, and that travel to an identified PICU is as least disruptive as possible. Following a programme of intensive care and therapy, it is expected that patients will return back to a less intensive environment as appropriate to their needs, typically open acute wards.

Other services

Forensic services

Forensic mental health services play a very important role in diverting people with mental health conditions away from, or out of, prison. Forensic services provide secure detention in special hospitals with an emphasis on care and treatment rather than punishment.

The vast majority (nearly 97%) of people transferred on restriction orders directly from prison to forensic services are received in medium and high secure hospitals.

Despite the often serious nature of the offences

committed by those in forensic services, and an increase in the numbers recalled after a conditional discharge, re-offending rates two years after discharge are extremely low compared to those who are released from prison.

A recent review of secure services by the Welsh Assembly Government resulted in 33 strategic objectives, including reducing reliance on high and medium secure units and the independent for profit sector through additional low secure facilities and community services within the NHS, local authority and voluntary sector, and introducing mechanisms to improve information sharing between health, local government and justice agencies.

For more information, please see the report in full: <http://wales.gov.uk/docs/dhss/consultation/090501reporten.pdf>

Prison services

The level of need for mental health care in prisons is particularly high, because of the much greater prevalence of mental illness, especially severe mental illness, among prisoners than among people of working age in the general population. For example, some estimates suggest that as many as 9 out of 10 prisoners are affected by mental illness.

Prison inreach teams play an important role in providing specialist mental health services to people in prison that are provided by community-based mental health teams for the population at large.

In-reach services have been established at all Welsh prisons. These services were established in order to deliver secondary mental health care within prison environments, to assist transfers into NHS facilities where appropriate, and to coordinate transfers into community mental health services for prisoners on release from custody. The Prison Health Pathway which sets out the detailed model of service for prisons was formally launched by the Welsh Assembly Government in October 2006.

Analysis by the Sainsbury Centre for Mental Health

found that while more is spent per head on mental health care in prisons than in the wider community, this is not nearly enough to accommodate this much higher level of need.

In a recent report, analysts Laing & Buisson claim that if prisoners with a serious mental illness in England and Wales received proper psychiatric care the collective cost saving for public services per year would be £1bn.

Advocacy services

Evidence suggests that advocacy can lead to an improved experience of mental health services for individuals, due to the potential for advocacy to create choice, improve involvement in decision making, and promote access to a range of different services. Advocacy can help to counteract the experience that many service users describe of not being listened to within the mental health system.

The advocate's role is to provide information to help people make an informed choice, and then to represent that view or support the service user to do so for themselves. Effective, independent advocacy can help to achieve positive outcomes for service users in terms of securing the most appropriate aftercare, housing arrangements, medication and so on. Advocates do not express an opinion or give advice about what a person should or should not do.

There are now many small, local mental health advocacy schemes around the country. Many are entirely independent and often user-led, whilst others are run and managed by larger charities such as Mind and Rethink.

In terms of the Mental Health Act, the mental health advocate helps people to access proper legal advice and representation as well as offering moral and practical support. Independent mental health advocates provide an important safeguard for certain patients treated under the compulsory powers of the Act.

The forthcoming Mental Health (Wales) Measure

provides for an expanded statutory scheme of independent mental health advocacy, both for patients subject to compulsion under the Mental Health Act 1983, and for those in hospital informally (in other words, not subject to the 1983 Act).

Child and Adolescent Mental Health Services (CAMHS)

Many of the elements already described are applicable to the provision of Child and Adolescent Mental Health Services. However, there are a number of additional factors that impact upon the way CAMHS is designed and delivered.

50% of mental disorders will have started by the time a person is aged 16, and 75 per cent by the age of 25. The early phases of certain serious mental illnesses also begin in young age, including eating disorders, early onset schizophrenia and bipolar disorder. There are also a number of developmental disorders such as attention deficit hyperactivity disorder and autism.

The Welsh Assembly Government, in research for its CAMHS strategy, *Everybody's Business*, found that in Wales:

- More than 40% of young people have recognisable risk factors;
- 30% to 40% may at some time experience a problem; and
- Up to 25% (depending on environment and circumstances) have a disorder.

CAMHS professionals tend to work in one or more of the following places:

- Community CAMHS clinics
- Out-patient clinics or alongside paediatricians in general hospitals
- Specialised in-patient, day patient or outpatient units
- In schools and some GP practices
- Alongside social services or youth offending services
- In children's centres
- In addition to offering appointments in the above places, some CAMHS professionals can also occasionally see service users in their own homes.

The 2009 joint report from the Wales Audit Office, HIW, Estyn and CSSIW said that the challenges faced by those providing CAMHS services are "considerable". Children and young people often

have complex and wide ranging needs that require a co-ordinated response from different professionals and agencies in the fields of health, social care and education, which means that close working and shared values are crucial.

Maintaining the Momentum, a report from the NHS Confederation's Mental Health Network on children and young people's mental health, spells out the strong "invest to save" argument for CAMHS services. The report shows how investing in these services can prevent problems persisting into adulthood, with the accompanying vicious circles of social exclusion, lost productivity and heavy service use.

It says those planning and providing mental health services for young people hold a huge amount of power to influence the long-term life chances of those at risk of, or already, experiencing, difficulties and distress.

Eating disorders

Eating disorders are serious and may be enduring mental disorders that require appropriate responses from healthcare planners and providers. The effects of eating disorders can be devastating and, in a smaller number of cases, life-long or life-threatening.

Early identification and appropriate intervention improves the clinical outcome for many people who have an eating disorder. Public and media attention is often focussed on the small number of people who require high cost tertiary inpatient care, but the overwhelming majority of cases should be handled by local generic services with access to specialist advice and support.

A new framework for eating disorder services was published by the Welsh Assembly Government last year, and is available here:

<http://wales.gov.uk/topics/health/publications/health/guidance/eatingdisorders/?jsessionid=1J2DLTMJv0nL19mchFNssLjY8Phc1QhGy2k3Zd8R1vwJ5yWDc6sW!81960802?lang=en>

Services for Older People

In the next 20 years, the number of people aged over 85 in Wales will double to 137,000, and those aged over 100 will increase fourfold to more than 2,000. Our ageing population presents a ticking time bomb in terms of the demands this will place on mental health services, for both the health and social care sectors.

Promotion and protection

People over 65 are more likely to have a range of additional risk factors for mental health problems, including living alone, having poor health and/or difficulties with everyday activities, having no access to a car, and needing care and support.

A great deal can be done to support mental well being for older people, notably by working to change attitudes and raise expectations about health in old age.

Interventions to alleviate social isolation and loneliness among older people such as group activities like discussion and self-help groups, bereavement support and counselling, have been found to be effective in protecting the mental health and wellbeing of older people. Walking and regular social activities are positively associated with successful ageing and good quality of life.

The Welsh Assembly Government's Strategy for Older People outlines initiatives to promote social inclusion, increase economic activity among the over 50s and benefit take-up and encourage volunteering. A wealth of initiatives are already underway in Wales, including older people's councils, mentoring and volunteering schemes and arts clubs.

For more information, see the Strategy for Older People's Annual Report, available here: <http://wales.gov.uk/docs/caecd/publications/090922strategyolderpeopleannualreport0809en.pdf>

Maintaining independence

Older people with mental health problems need a range of supports to enable them to remain independent in their own homes. The service may need to increase input as the ability of the person (or their carer) to cope deteriorates.

For older people at risk of admission to older people's mental health in-patient services, mental health professionals can offer a range of interventions to avoid hospital admission wherever possible.

Intermediate services can help to maintain or recover their independence by providing specialist assessment from the older people's mental health services, usually home-based. Service users may also require day care, e.g. psychotherapeutic group and/or individual therapy, psychiatry, arts therapies, function, aid to daily living assessment etc. The service user's care plan should be integrated with other statutory agencies, independent sector and voluntary providers.

Services that provide support to older people in their own homes could involve many different agencies, including health, social care or the voluntary sector. The type of services provided vary and could involve aids and adaptations services, specialist community mental health teams for older people and home-based care in a crisis.

Dementia

One in six people over 80 has a form of dementia. The total number of people with dementia in the UK is forecast to increase by 38% over the next 15 years and 154% over the next 45 years.

A report from the Alzheimer's Society says that an historical lack of attention has led to dementia care being delivered in a piecemeal and inefficient fashion. With the numbers of people with dementia set to rise so sharply, meeting the challenge will need careful consideration from the public, private and

voluntary sector to find good quality, cost-effective options to meet the needs of people with dementia and their families.

Dementia is a common disorder and so is routinely dealt with in primary care. However, the Alzheimer's Society report found marked variation in GPs' skills in diagnosing and managing dementia.

Many modern services have almost entirely done away with clinic or GP practice-based outpatient assessment and follow-up, due to the difficulty of assessing the patient's true level of functioning outside of their own home. Transportation to unfamiliar surroundings carries increased risk of further disorientation and behavioural disturbance.

In addition, older people are particularly likely to have multiple health conditions – chronic physical diseases coexisting with mental and cognitive disorders – which presents a further training challenge for general hospital and healthcare staff. Dementia itself complicates the management and rehabilitation of all other disorders, so people with dementia have longer lengths of stay in hospital and more readmissions than those without dementia.

Joint solutions between health and social care will be needed to develop the skills and capacity of staff, and to develop an integrated, comprehensive range of care models to help maintain people's independence in their own homes.

The Welsh Assembly's dementia action plan has yet to be finally published, but the consultation document is available here:

<http://wales.gov.uk/consultations/healthsocialcare/dementiaactionplan/?lang=en>

Support for Carers

Estimates suggest that individuals caring for people with dementia save public finances approximately £294 million per year.

Many carers themselves experience a high level of burden and mental distress, which presents a further

challenge to health services. Research has reported a high prevalence of depression among the carers of older people with depression, dementia or physical disability living in community settings.

Without commitment to provide an improved package of support for carers, an increasing number will be unable to continue caring and pressures on formal long-term care services will increase.

Carer support falls broadly into two main categories: psychological therapies including carer training and support groups, and quality respite care.

In November 2009, the Welsh Assembly Government achieved legislative competence to introduce new legislation on carers rather than rely on existing reinforcement means alone. The government is now seeking to establish a Measure (Welsh law), which will introduce a new requirement on the NHS and local authorities in Wales to work in partnership to prepare, publish and implement a joint strategy in relation to carers.

Liaison psychiatry services

Up to 40% of older adults in general hospital beds have dementia, 53% have depression and 60% have delirium.

Liaison psychiatry brings together the diagnosis, treatment and management of patients with both physical and mental disorders. Most services are based in acute hospitals or are located somewhere in between the primary and secondary care border.

The Assembly's strategy for adult mental health, published in 2001, set out the aim of introducing liaison psychiatry services in each general hospital.

However, in research carried out on behalf of the Royal College of Psychiatrists in 2008, three of the previous NHS trusts in Wales had no dedicated liaison psychiatry service and only one of the eight with a service had a full-time consultant liaison psychiatrist.

A report by the NHS Confederation's Mental Health

Network argues the case for investing in liaison psychiatry services. They say there is good evidence, from a variety of different sources, which suggests that identifying and treating the mental health needs of acute inpatients early has a direct impact on the recovery of their physical health.

The report says that liaison psychiatry services improve clinical outcomes, decrease length of stay and reduce re-admissions and costs.

What are the challenges we face?

Having described the basic key components of a mental health service, we now turn to look at some of the strategic challenges facing board members in implementing these components and improving upon services already in place.

Implementing a social model of recovery

For all of the core functions described in this report to operate effectively, the underpinning focus of all health, social care and voluntary sector mental health services must be to help restore, and then enrich, the quality of life of those who turn to services for support – not simply to aim at removing symptoms.

The Recovery Model is the model commonly used to encapsulate these aims. The Recovery Model evaluates the effectiveness of any intervention for those suffering mental distress according to broad quality-of-life dimensions which are identified by service users as important to them, alongside traditional medical interventions. It centres on the ability of the individual to build a meaningful life for themselves beyond their illness, and furthermore, to feel in control of their illness and their life.

A commitment to the Recovery Model places demands on services that no one discipline or agency can meet alone and it is therefore necessary to have an integrated system of effective care coordination for all services to work together for the benefit of the service user.

At present there are few agreed outcome measures for mental health, principally because it is hard to agree what constitutes a 'good outcome' and because so many variables affect mental health.

Routine use of outcome-based measures to assess the effectiveness of services requires an ongoing commitment to secure the co-operation of service users, track their views throughout their care, and incorporate their goals and ambitions into care plans.

This is reflected in the requirement that everybody on the Care Programme Approach (CPA) must have a plan that addresses their occupational, housing and benefits needs, thus creating a framework for looking at the individual's broader needs.

For more information, see the Assembly's Policy Guidance on the Care Programme Approach: <http://www.wales.nhs.uk/documents/mental-health-policy-implement-guide-e.pdf>

Joint working with social care

Nearly three quarters of primary care staff in Wales say that lack of infrastructure to work in synergy with social care limits their ability to deliver improvements in mental health care.

A 2009 review of the Care Programme Approach recommended that information sharing protocols need to be developed with social services, with consideration of common targets needed. The review showed that it is not unusual for social work colleagues to be unable to access health records and for health staff to be unable to access social services records. A great deal of work is being undertaken to bring forward the vision for joining the two systems, under the direction of the NHS Wales Informatics Service.

The development of shared values, closer working and joint ownership between health and social care staff will become increasingly important as we face the two main challenges of our time: the growing financial pressure on public services and rising demands for services from our ageing population.

Both bring into sharp focus the need for closer collaborative working to develop integrated systems, delivered in the most cost-effective way.

Increasing early intervention

An emphasis on early intervention can prevent problems escalating to crisis point, with the result that people need the 'expensive end' of services. Early intervention has been shown to improve the long-term course of some conditions, resulting in less need for hospitalisation, more rapid recovery and reduced risk of relapse.

Mind Cymru, in its most recent manifesto, say that although the importance of promotion and early intervention is recognised in much of the Assembly Government's strategic and policy guidance, many service users and carers indicate that they can only obtain access to specialist support if they are experiencing a mental health crisis

The particular challenges posed in rural areas emphasise again the crucial need for early intervention to 'prevent the preventable', ensuring that minor issues do not develop into something more major that requires specialist support, when access and travelling times become more problematic.

Early intervention has particular importance in child and adolescent mental health services. Early childhood experiences are strongly linked to later resilience, ability to cope with adversity and, ultimately, mental health. Identifying 'at risk' families needing support, sometimes even before the birth of the child, and providing parenting support have been identified as the most effective methods of preventing mental ill-health.

Dual diagnosis

A recent review of the Care Programme Approach in Wales found that 39% of clients had a co-morbidity of a mental health and substance misuse problem. The review also noted that there was little evidence that these dual needs were being properly addressed

in the care plans for these individuals.

Service users with a dual diagnosis are more likely to be non-compliant and fail to respond to treatment than people with substance misuse issues or a mental illness. People with a dual diagnosis are also more likely to be homeless or be involved with the criminal justice system, which underlines the need for good collaborative working between the many key stakeholders in dual diagnosis.

Transition Points

CAMHS to Adult

The services that provide for children and for adults have to work well together to ensure a smooth transition for those with ongoing needs.

The recent joint review into CAMHS in Wales found that there are inadequate arrangements to ensure a smooth and effective transition from CAMHS to adult mental health services in many parts of Wales, increasing the risk that young people disengage from services.

The review found little evidence of active forward planning and management of cases that were approaching the point of transition, even where guidelines or protocols were in place. They also found little evidence that the expectations of young people and their parents were being managed to reflect the differences between CAMHS and adult services, such as the move away from the ethos of treating the young person within the context of their family.

Adult to old age

The National Service Framework for Mental Health requires health boards to develop protocols to cover adults in transition to older people's mental health services.

The Royal College of Psychiatrists emphasise that the transition must be needs-led and not triggered by age. Transition arrangements should incorporate the views of the user and their carer, and subject to a joint review of the service user's care plan.

The National Service Framework for Older People states clearly that age is not to be used in eligibility criteria to restrict access to services. Older people with mental health problems should be treated no differently to adults with similar problems.

Rural areas

Although mental illness has a lower prevalence in rural areas than in urban areas, an increasingly elderly population means the number of people with dementia is likely to increase, with evidence indicating that rural areas are not well equipped to deal with the expected rise.

The Rural Health Plan for Wales identifies a number of challenges that need to be overcome:

- Access to primary health care in rural areas can be problematic. In rural mid-Wales travel time to a GP is predominantly above 21 minutes.
- Access to social care is poor in rural areas where there are low levels of social housing, residential care and day care.
- Lack of local skilled community care and a shortage of specialist staff.

The Rural Health Plan also highlights the importance of the Welsh language in rural communities. Especially among older people, the loss of capacity through stroke or dementia can mean that the ability to communicate in a second language is diminished, limiting their ability to interact with health and social care workers through the medium of English.

The Rural Health Plan is available to download here:
<http://wales.gov.uk/docs/dhss/publications/100118ruralhealthplanen.pdf>

Conclusion

The Welsh NHS Confederation has published this briefing to support independent board members in their ongoing development. We hope it will provide a useful guide and resource to those who are new to the area of mental health, or those who need a quick reference point.

The new structure of the NHS in Wales offers many opportunities to improve standards of care and facilitate joint working across the many different services and agencies that have a stake in the the population's mental health and well-being.

Much progress has already been made to improve services and make care more seamless across boundaries. Work is being driven by clear Ministerial leadership and the National Programme for Adult Mental Health, co-chaired by Mary Burrows and Stewart Greenwell. The Programme Board is currently taking forward work to pull together all the NHS action plans for mental health into a set of "high impact" changes.

The forthcoming Mental Health (Wales) Measure has been broadly welcomed across Wales and this will see increased scrutiny of mental health services in Wales. The Wales Audit Office is also shortly due to publish its follow-up review to its 2005 report on adult mental health services in Wales. This will be an important document to re-establish the base that Local Health Boards in Wales must build and improve upon.

Your ongoing feedback and input into our board development activities is always very much welcomed. If you have any comments about this publication, please contact us using the details below:

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About the Welsh NHS Confederation

The Welsh NHS Confederation represents the organisations making up the NHS in Wales: trusts and local health boards. We act as an independent voice in the drive for better health and better healthcare through our policy and influencing work, and by supporting members with events, information and training. To find out more about us go to -

www.welshconfed.org