

# A Commissioning Strategy for Adult Mental Health Services in Caerphilly County Borough

2015 – 2020



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# 1. Introduction

## 1.1 Scope of the document

This strategy sets out a vision, of how services to people with a Mental Illness within Caerphilly County Borough Social Services Directorate, will develop over the next five years.

## 1.2 Purpose of Commissioning

Commissioning is a key element to the process of delivering effective mental health services within Caerphilly County Borough. It draws together the views of key stakeholders; the findings of local needs assessments; information about unmet needs; information on evidenced based best practice and the requirements of local and national strategic objectives.

The Commissioning Strategy has four key purposes:

To take account of the experiences and feedback from people who have used mental health services within Caerphilly County Borough and their carers

To set out priorities, developments and commissioning intentions for mental health services within Social Services in relation to the support needs of adults within the County Borough

Shape the range, type and amount of service provision to meet the identified needs of the existing and future population of the County Borough and achieve positive outcomes for service users and carers over the next five years.

We aim to provide a process for developing actions to meet the outcomes set within the Mental Health and Wellbeing Strategy for Wales October 2012

## 2. National Policy Context

The Mental Health (Wales) Measure 2010 is a new law passed by the National Assembly for Wales and, as such, has the same legal status in Wales as other Mental Health Acts. However, whilst the 1983 and 2007 Mental Health Acts are largely about compulsory powers, and admission to or discharge from hospital, the 2010 Measure is all about the support that should be available for people with mental health problems in Wales wherever they may be living.

The Measure became law in December 2010 but significant preparation was needed before it could be implemented. So the main provisions only began to take effect between April and October 2012.

The Measure is intended to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs. It has four main Parts (Parts 5 and 6 are essentially about administrative issues), and each places new legal duties on Local Health Boards and Local Authorities to improve service delivery. The four Parts are as follows.

- **Part 1** seeks to ensure more mental health services are available within primary care.

- **Part 2** gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.
- **Part 3** gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services.
- **Part 4** offers every in-patient access to the help of an independent mental health advocate

The Welsh Government launched its new mental health strategy, "Together for Mental Health - A Mental Health and Wellbeing Strategy for Wales" in October 2012, and in it sets out its "vision for 21<sup>st</sup> century mental health services". It states that "Together for Mental Health" should be seen alongside "Together for Health Wales' 2011 strategy for the NHS, and Sustainable Social Services, Wales' 2011 vision for Social Services, and that together, these provide the mental health strategic context for the next 10 years 'Together for Mental Health' replaces three previous Welsh Government strategic documents:

- 2001 strategy for adult mental health services "Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness and Efficiency"
- 2001 strategy for Child and Adolescent Mental Health Services "Child and Adolescent Mental Health Services: Everybody's Business"
- 2005 Mental Health National Service Framework (NSF) that set out a range of Standards and Key Actions to ensure the successful implementation of the strategy

Some of the key points of 'Together for Mental Health' are;

**Mental Health and Wellbeing** - It is Wales' first mental health and wellbeing strategy, and has the aim of promoting mental wellbeing and preventing mental health problems, as well as improving mental health services. It also has the aims of intervening early when people are diagnosed with psychiatric illness and of reducing the impact of serious mental illness.

**A Strategy for all Ages** - It is also Wales' first mental health strategy to include all age groups - children, adults of working age and older people. Services will continue to be delivered separately to these three age groups, but the Strategy seeks to improve transitions for people who move between these services.

**The Mental Health Measure** -The Strategy builds on the Mental Health (Wales) Measure which the Welsh Government passed in 2010 and which places legal duties on Health Boards and Local Authorities to improve how treatment, care and support are offered to people with mental ill-health. The focus on improved individual Care and Treatment Planning, and on recovery and enablement, are a key feature of the Mental Health Measure and is central to the Strategy.

**The Sustainable Social Services for Wales: A Framework for Action** recognises the new challenges faced by Social Services particularly in light of the changes in demographics, expectations of social services and changes in families and communities.

**The Social Services and Wellbeing (Wales) Act 2014**, provides the legislation required for the change programme outlined in the Welsh Government's White Paper 'Sustainable Social Services for Wales: A Framework for Action'. The key themes of the Act include: the introduction of national eligibility criteria so that people receive care they need regardless of where they live, stronger voice and control for citizens, and ensuring a strong national direction for local accountability and delivery.



[The Social Services and Well-Being \(Wales\) Act 2014](#) became law on 1 May 2015 and lays the basis for an overhaul of how adult and children's social services operate in the country. The Act will be implemented in April 2016.

It now provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales.

Changes include the creation of portable assessments that follow individuals when they move between local authorities and a National Outcomes Framework that sets out what children and adults can expect from social services.

The Act also gives carers rights equivalent to those they care for and introduces measures designed to increase the use of direct payments.

Others measures in the Act include extensive revisions to the regulations concerning looked-after children and rules designed to ensure people are assessed on their needs rather than on what services are available locally.

Local authorities will also be required to provide or arrange preventative services and promote the provision of these services through social enterprises, co-operatives, user-led services and the voluntary sector.

This Act, will not replace the Mental Health (Wales) Measure 2010, implemented in April 2012.

## 2.2 Local Policy Context

Gwent Strategy for Mental Health an integrated strategy for mental health across the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen 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. It also considers mental health in its widest sense ranging from promoting good mental wellbeing to the provision of specialist services. The strategy takes a Person Centred Approach; it therefore reflects many services and interventions.

In April 2013, Caerphilly Local Service Board approved a Single Integrated Plan for the County Borough of Caerphilly called **CAERPHILLY DELIVERS**.

This plan replaces a number of existing plans that the county borough was previously required to produce, such as the Health, Social Care and Well-Being Strategy, Children and Young People's Plan, and the Community Safety Plan. Working with our partners in the Aneurin Bevan University Health Board, Gwent Police, Gwent Association of Voluntary Organisations, and Welsh Government, the aim of the plan is to improve the quality of life for all communities within Caerphilly County Borough. This means people:

Are healthy, fulfilled and feel safe  
Are well qualified and skilled within a vibrant economy  
Live, work or visit in a greener living environment.

Identified within the Plan are five key thematic areas. These are:

Prosperous Caerphilly  
Safer Caerphilly  
Learning Caerphilly  
Healthier Caerphilly

The strategic direction for Adult Services within the Social Services Directorate is informed by the various national and local strategies and the performance of each service area against national and local monitored performance indicators. All performance indicators are reflected in the Caerphilly Adults Service Improvement Plan that sets out arrangements for service improvement against key objectives.

### **3. Vision & Principles**

This section sets out the vision and principles that underpin all decisions and actions within the Commissioning Strategy. The visions and principles have been established nationally by the Welsh Assembly Government and agreed locally with service users, carers and partner organisations and agencies.

#### **3.1 The core principles of the Commissioning Strategy are:**

##### **3.2 Prevention**

Helping people to maintain independence through the provision of relevant and useful information, on health promotion and the prevention of mental ill health. Through improved access, services will enable people to access a wide variety of service provision that allows them to self manage and take control of their condition, make informed decisions, deal with crises more effectively, feel less socially excluded, take up opportunities for training, employment etc. and access interventions that will improve their sense of health and social well-being. Accessing such health promotion interventions will prevent people needing to access mental health services and enable adults with mental health problems to become more integrated into community activities, gain an improved sense of well being and prevent further progression of their illness.

##### **3.3 Recovery**

The Recovery Model acknowledges the potential and capacity within each individual for growth and development and that people with mental health problems can make significant improvements in their lives towards self-management, independence and self-control. Recovery goes beyond a maintenance approach in seeking, through evidence-based practice, to identify and promote those abilities that engender recovery and development.

Mental health problems extend far beyond a medical condition, affecting every facet of an individual's life, creating difficulties within relationships, employment, social networks, finances and housing. Therefore recovery has to be seen in broader terms than medication and symptom management, but is about achieving a better quality of life and providing hope of change. The Recovery model makes few assumptions about an individual, preferring to focus on the kind of support individuals need following a disruptive experience or trauma. While not denying the real problems that individuals experience, the model does not concentrate on pathology, what is wrong or what is missing, but instead concentrates on the individual's strengths, capacities, and abilities to achieve established goals.

##### **3.4 Self- Management**

The main focus of any mental health service model is upon the provision of services that enable individuals with mental health problems to develop, relearn and maintain the emotional, psychological, social skills and social networks required to function

independently within the community. The purpose of mental health services is to enable people with mental health problems to re-integrate into mainstream community services through taking self-control over their lives and by preventing dependency.

### **3.5 Early Intervention**

The service model emphasis is upon early intervention that prevents people with mental health problems deteriorating to the point where they would require hospital admission. Services will be able to respond to individual need by providing alternative supports within the community, enabling individuals to receive care in settings away from institutional care and will enable individuals admitted to hospital to be discharged that much earlier with appropriate support services.

### **3.6 Crisis Resolution Home Treatment Team (CRHTT)**

Crisis Resolution and Home Treatment Teams provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both the number and length of hospital admissions and to ease the pressure on inpatient units.

The team works in a more collaborative manner with service users, providing a service in the least restrictive environment as possible, while providing a 'gate keeping' role for people with the potential for hospital admission.

The benefits to people being treated at home are:

It is humane to provide help as soon as possible to people who are in crisis. Interpersonal problems make a major contribution to many psychiatric crises. If people can stay at home at the time of crisis, team members can observe these problems first-hand, as most people behave more naturally in their own homes. The team can then work with the service user and their social network to address these problems.

Hospital admission may initially take the 'heat' out of interpersonal conflicts, but doctors do not have the opportunity to observe these conflicts and the care they offer centres on controlling behaviour and treating symptoms. The conflicts remain, to surface later and trigger another mental health crisis.

Evidence repeatedly shows service users do not like hospitals. They prefer to be treated at home or at least expect that a range of alternatives will have been considered prior to the decision to admit them to hospital.

Early intervention and treatment prevents deterioration and leads to quicker improvement. Service Users believe being a psychiatric inpatient, carries more social stigma than being treated at home.

### **3.7 Service User**

Currently the number of people with a Mental Illness, known to the Community Mental Health Teams (CMHT) is increasing.

While this Strategy is for Adult Mental Health, it is worth noting that the number of people aged 65 and over is predicted to grow due to the increased life expectancy. It is likely that there will be a corresponding increase in demand on social care services for the service user and their carers as they become older. For those people who need little or no support from social care, the need for prevention and promotion of wellbeing will be

key. Enabling people to maintain their well being in their own homes drawing upon their own communities as sources of support, is essential in this time of reduced budgets.

For those who do need more support, we need to work in partnership with them and those who care for them, to ensure service responses are appropriate, proportionate and enabling.

### **3.8 Service User and Carer Participation**

Mental health service users have to be fully involved in decisions about their own care and involved in the planning, design, delivery, monitoring and evaluation of the services they receive. Service Users are experts with an in-depth knowledge of the mental health services they receive and of living with a mental health problem. These experiences are an important and valuable resource that can help improve individual care as well as services in general. Service User and Carer participation promotes social inclusion and is beneficial to individuals, helping to increase confidence, raise self-esteem and develop new skills.

## **4. Local Population Needs Analysis**

The Health, Social Care and Well Being (HSCWB) Needs Assessment (Caerphilly Teaching Local Health Board, 2007) describes the demography and needs of the local population as:

The population of Caerphilly County Borough has remained relatively stable over the last decade or so at around 170,000 people. However, population numbers within the South have increased whilst those in the North have decreased. This is considered to be due to increased employment opportunities. There is a change in the age demographic with increasing numbers of older people and decreasing numbers of young people. The number of people at retirement age and over is projected to increase significantly. This will have an enormous impact on health and social care services within the County Borough, as this age group is a significant consumer of health and social care services.

The population of the County Borough is unevenly distributed with the areas at the northern extremes of the North and East localities having geographically large electoral divisions with fewer than 2,750 people living in them. The centre of the Caerphilly basin is more heavily populated with Bedwas, Trethomas, Machen and Penryheol having 13% of the total population of County Borough.

Overall, the adult population of Caerphilly County Borough is predicted to rise from 139,097 in 2008 to 148,582 by 2020, a rise of 6.8% (Welsh Assembly Government, 2007). Within this, it is anticipated that the adult population up to 65 years old will only increase by 1.5%, whilst the adult population aged 65 years and over will see an increase from 27,771 to 35,545, an increase of 27.9%. Mental Health service design will need to be developed taking into account this demographic change.

### **4.1 Mental Health Needs Analysis**

Information on the mental health and well being of people in Wales has been taken from the Health Needs Assessment 2010

Surveys indicate the perceptions people had of their mental health and the impact it had on their daily lives. When asked to rate their mental health, Caerphilly County Borough residents rated their mental health as the fourth worst in Wales. It should be noted that different people's perceptions of what constitutes good or poor mental health may vary



considerably as will an individual's perceptions vary from day to day. However, this is a good indicator of how residents in the County Borough perceive their mental health.

It is accepted that stressful life events and deprivation factors have a strong correlation with the prevalence of mental health problems. For instance, people are three times more likely to have mental health problems if they have experienced a financial crisis than if they have not (29% compared with 9%) about twice as likely to have mental health problems if they have ever experienced a serious illness, injury or assault to themselves (14% compared with 7%) and if they have experienced separation or divorce (18% compared with 9%) (Source: Singleton et al. 2001).

Multiple deprivation is a combination of different but related factors e.g. health, housing, income, education, skills and training, employment, physical environment and access to services. These factors are then weighted and combined to produce an overall index of multiple deprivations.

Numbers of CMHT Service Users by Age Band in Caerphilly over the period of years shown, known to the North & South CMH Teams

Age Band at Date	2009	2010	2011	2012	2013	2014	Trend
5-17 Years	1	1	3	3	1	0	↓
18-30 Years	53	77	75	81	90	151	↑
31-64 Years	178	212	254	280	395	550	↑
65-74 Years	24	19	18	24	38	51	↑
75-84 Years	0	0	0	0	1	1	↑
85+ years	0	0	0	0	0	0	
<b>TOTAL</b>	<b>256</b>	<b>309</b>	<b>350</b>	<b>388</b>	<b>525</b>	<b>753</b>	

## 5. Current Mental Health Services Demand

### 5.1 Primary Care Mental Health Services - Adults

It is estimated that approximately 80% of people having mild to moderate mental health problems could be treated at primary care level. Planning for this group involves a 'stepped and matched' care" approach, with multi-agency support, designed to promote a sustainable recovery that includes:

- Access to self-help materials, bibliotherapy, book prescriptions etc
- Living life to the full and Mood Master courses
- Links with Communities First to who can work to develop self help groups
- Individual counselling
- Therapeutic Interventions
- Mental Health Assessments
- Provision of information and advice to individuals and their carer's about care and treatment as well as 'signposting' to other sources of support including voluntary organizations

- Short-term interventions including counselling, a range of psychological interventions and solution-focused therapy, stress management, anger management, education and group work
- Provision of support and advice to GPs and other primary care workers to enable them to safely manage and care for people with mental health problems
- Referral onto secondary mental health services where appropriate

## **5.2 Community Mental Health Teams (CMHTs) for Secondary Mental Health Services**

CMHTs offer a community-focused integrated mental health and social care service to adults with mental health problems of sufficient severity or complexity, to require specialist intervention. CMHTs are committed to working within a model of recovery to promote social inclusion and optimum functioning within the service user's community. The teams are multi-disciplinary, and made up of Community Psychiatric Nurses, Social Workers, Occupational Therapists, Psychiatrists, Psychologists, Support Workers, and Admin staff, providing services alongside a variety of statutory and non-statutory organisations.

There are currently two CMHTs providing services within Caerphilly County Borough Council. The North CMHT is based in the North Resource Centre, Rhymney and the South CMHT is based in Mill Road, Caerphilly.

CMHTs provide a comprehensive range of services in the community. Mental Health practitioners within CMHTs provide assessment and care management to users of secondary mental health services under the Mental Health (Wales) Measure, via the Care and Treatment Planning process.

CMHT staff also manage access into Secondary Mental Health services via the Central Referral Point (CRP) process. All referrals into mental health services are directed into CRP, which is staffed by practitioners from both CMHTs. CRP staff screen referrals, direct as appropriate, and provide urgent assessments when required.

CMHT practitioners also carry out a care co-ordinator function and liaison role for service users who are receiving services from specialist mental health services, such as the Eating Disorders Team, Home Treatment Team and Gwylfa Personality Disorder Team.

In addition the CMHT is currently in the second phase of a pilot programme to look at working differently with mental health needs, using the Vanguard initiative. The "Listen Enable Act and Participate" (LEAP) team follows this initiative, to see how Caerphilly might work with citizens who present with a mental health need differently to current statutory service provision. This involves practitioners talking to service users and staff about what is important to them, and how we commission services into the future.

## **5.3 Assertive Outreach Service**

The Assertive Outreach service employs a whole team approach that is specifically tailored to meet the needs of the most severely mentally ill clients in the community. The team is proactive in developing and maintaining a lasting, supportive and therapeutic relationship with service users and their carers. The team's aim is to maximise individual's strengths and abilities and acknowledge the limitations and problems imposed by their disorder.

We offer a service in the clients preferred setting, giving respect and consideration to cultural and spiritual diversity, working with people who have severe mental health problems who find it difficult to maintain contact with services and as a result have a history of relapse and frequent hospital admissions. The AOT team is multi agency and has a small caseload in order to provide intensive support 7 days a week 9-5pm.

#### **5.4 Early Intervention Service**

The Early Intervention Team usually has a caseload of between 10 and 15 service users; each of whom it is anticipated will be involved with the service for approximately three years, the identified critical period that shapes the outcome of schizophrenia. Team members adopt a multi faceted role, delivering a holistic service to each service user from initial identification and engagement through housing, benefits, medication, psycho-educational family work and cognitive behavioural therapy, through to future goals and discharge. In addition, the team members run wellbeing groups, deliver health promotion presentations, provide therapeutic interventions and work with service users preparing them for the transition to education and employment. There is currently no Social Work post in the team.

#### **5.5 The Mental Health Community Support Service**

The Multi Agency Partnership Service (MAPS) is a collaboration of current provision, which has principles of recovery and continual development at its core. The development arose from taking the key tasks of modernisation, improving aspirations and choice for service users, while reducing the partial duplication that has been present where sectors and services have operated in greater independence, with only informal communication. Its purpose is to ensure an effective and efficient service, with one point of access to a comprehensive range of social and vocational opportunities. Currently the team is working with 172 Service Users.

The MAPS Partnership currently consists of the following services:

- Social Services Support Service
- Gofal
- Hafal
- Communities First
- Inside Out Arts Project
- Pathways to Employment Service

#### **5.6 Forensic Service**

Forensic mental health services mainly work with people who have a mental illness and have been involved with the police, court or prison. There are currently 41 individuals with a forensic background from Caerphilly county borough, known to Mental Health Services, of which 27 are subject to section 117 aftercare. Sixteen of these people are within Secure Hospital provision or secure community placements. Apart from the independent hospital, Llanarth Court, all such provision is outside the Gwent area and scattered geographically amongst 9 different sites.

CCBC continues to engage with the 'In One Place' collaborative programme between ABUHB, 5 Local Authorities and Nine Housing Associations from South East Wales, that improves accommodation and care services, for people with health care needs, to consider the future accommodation needs, for people with a mental illness living in the borough

Secure Accommodation = 16

High Secure =3

Medium Secure = 8

Low Secure = 5

Residential = 4

Locked Rehab = 4

Unlocked Ward Rehab = 4

Community = 10

Source: Forensic Team

## **5.7 117 Aftercare**

Anyone who is in need of community care services is entitled to a social care assessment when they are discharged from hospital to establish what services they might need. However, Section 117 goes much further than this and imposes a duty on health and social services to provide aftercare services to certain patients who have been detained in hospital under the Mental Health Act.

Section 117 states that aftercare services must be provided to patients that have been detained in hospital:

For treatment under section 3

Under a hospital order pursuant to Section 37 (with or without a restriction order) or Following transfer from prison under section 47 or 48. However, 117 does not apply to:

Patients detained in hospital for an assessment under Section 2

Patients detained in an emergency under Section 4

Patients detained while already in hospital under Section 5(2)

Patients who were not detained under any section (Informal or Voluntary Patients)

Currently Caerphilly County Borough has a joint responsibility with ABUHB for **238** people, who are subject to 117 Aftercare, this figure includes, 174 Adult Mental Health, 27 Continuing Health Care, 28 worked with by the Older Persons Mental Health Team and 9 Learning Disability.

## **5.8 Supporting People Programme**

The Supporting People has a budget of £739,997.02 for Mental Health services, this is 10.5% of their budget, it was realised that there was under investment in mental health services, and have gradually been commissioning new services, to respond to the increasing demand/need exhibited by referrals being received by the team. The Supporting People Programme is to develop flexible housing related support and advice services, to promote independence and choice for vulnerable adults. Such support reduces levels of social exclusion, poverty, and institutionalisation, rent arrears, evictions and homelessness for people with mental health problems.

Home From Home	Blackwood Road	134,720.41
Gofal Cymru	Floating Support	260,000.00

Reach	Floating Support - Crisis	59,775.00
	Floating Support - Mental Health - long term	50,000.00
Gofal CYMRU	Ty Osborne and Jubilee	180,000.00
GOFAL CYMRU	PRS Support worker	25,000.00
GOFAL CYMRU	CAERPHILLY FAMILY FS	40,501.61
MIND	Caerphilly FS - Step down	15,000.00
		<b>739,997.02</b>

**The Caerphilly Supporting People Programme currently funds:**

8 Residents within Ty Osborne

4 Residents within Jubilee House

**Mental Health Accommodation Schemes  
Accommodation Based Places Available**

Home from Home 8

Gofal 12

**Total 20**

**Mental Health Housing Support Schemes  
Floating Support Places Available**

Gofal - family support 9

Gofal - tenancy support 48

Mind - 12 (Step down service)

Homeless prevention - 20

Reach - 28 (Long term MH)

**Total 57**

**Home from Home Medium Support Accommodation  
Resident Date of Placement Length of occupancy**

Client 1 August 2000 7 years, 11 months

Client 2 September 2000 7 years, 10 months

Client 3 November 2001 6 years, 8 months

Client 4 March 2003 5 years, 4 months

Client 5 July 2002 5 years

Client 6 July 2005 3 years

Client 7 May 2006 2 years, 2 months

Client 8 May 2008 2 months

The average length of occupancy within this project is currently 4 years and seven months. Additional work is needed to develop 'move-on' accommodation with appropriate levels of support to assist client's achievement of greater independency. There remains the risk that this accommodation service could become blocked without the availability of other resources.

**Gofal**



The Housing Advice and Support Project provide a range of support to people who are at risk of becoming homeless or threatened with homelessness. The project provides advice, information and ensures individuals can access ongoing mental health and other support and assists individuals to access appropriate emergency accommodation and secure housing. The Project aims to prevent unnecessary hospital admissions, family break ups and other social crises. The work of the Project has been affected by the lack of opportunities for alternative and sustainable accommodation over the last year, due to the lack of single bed accommodation.

Homeless Prevention - A support worker has been employed to work with the local authorities housing options team to assist with homeless prevention and particularly to provide support to those who exhibit mental health issues

In July 2013 a new 8 bed supported housing scheme was opened in Caerphilly, which provides 24hr support for up to two years and assist people to move on into full independence.

### **Rhymney Valley MIND**

A new service was commissioned in July 2014, which provides a 'step down' service from the more mainstream floating support services and allows clients to access the complimentary MH services already delivered by MIND

### **Reach (Long Term Mental Health)**

Reach operate a floating support service that delivers a minimum level of support to clients who require limited but regular contact to ensure that they are able to maintain their tenancies and prevent relapse

### **Future Plans**

A location is being sought in the mid Rhymney Valley for a further 8 bed supported housing scheme,

## **5.9 Approved Mental Health Professional (AMHP)**

Approved Mental Health Professionals are mental health practitioners who have undertaken further training and gained the qualification, to enable them to carry out assessments under the Mental Health Act 1983 (amended 2007).

AMHPs are responsible for organising, co-ordinating and participating in Mental Health Act assessments both in hospital and in the community. It is the AMHPs responsibility to make the application for detention into hospital, to consult with the nearest relative, and to co-ordinate conveyance into hospital where required. AMHPs also assess and apply for reception into Guardianship, and assess and make recommendations for Community Treatment Orders.

As of March 2015 there are 10 full time AMHPs, 2 part time AMHPs operating within the CCBC area. Of these, one is based in the Older Person's Mental Health Team, three are within the Assertive Outreach team (including one Team Leader), and nine are within CMHTs (including one Team Leader, and one who is currently on maternity leave).

AMHPs within CCBC are responsible for providing Mental Health Act assessments primarily within their own teams. This is a 24/7 7days a week response that includes Emergency Duty Team (EDT). All AMHPs are also expected to participate in the

Countywide AMHP rota, which acts as a 'back-up', and ensures the provision of an AMHP service in the event of an AMHP not being available from within the local team.

Assessments by AMHPs and detentions under the Mental Health Act 1983 have been monitored over the last 3 years and are shown in the table below.

#### **Number of AMHP assessments over a three-year period.**

<b>Year</b>	<b>No. of AMHP Assessments</b>	<b>No. of detentions</b>
11/12	266	117
12/13	195	84
13/14	214	92

#### **5.10 Accommodation and related services**

Between April 2013 and March 2014 there were a total of 21 service users within residential or nursing home placements as follows.

In County Borough Residential Placements	1
In County Borough Nursing Placements	1
Out of County Residential Placements	9
Out of County Nursing Placements	10

#### **5.11 Transition**

The Transitional Operational Group (TOG) is a multi-agency group of professionals which meets on a bi-monthly basis. The TOG accepts referral from Children's Services in order to identify children who are in receipt of services and support from the Local Authority/Health Board, and are reaching the age when they will require transition from Children's into Adult's services.

The purpose of the TOG is to identify these children in advance to ensure that the appropriate adult teams are aware of individual's needs, resulting in efficient and timely assessments, and aiding teams in budgeting and commissioning for services according to requirements. Senior staff from Children's Services, including the Leaving Care Team/16+ team) Adult Social Services (including Mental Health, PDSI, LD and Substance Misuse) and ABHB Learning Disabilities services regularly attend the meeting.

As a result of the TOG group, it is anticipated that Young people with disabilities and those with complex difficulties are supported to ensure they receive the services that they need into young adulthood, in order to maximise their potential and lead fulfilled lives through equality of access to social inclusion.

Referrals into TOG can be made from the age of 16 enabling joint adult/children services assessments to be carried out, and transition plans developed.

#### **5.12 Section 115**

Section 115 of the Crime and Disorder Act 1998 allows information to be shared for the purposes of community safety between numbers of 'relevant authorities'. The relevant authorities are the Police, local authority, Probation, Fire and Rescue, Health Authorities and Registered Social Landlords. For Mental Health service users within the Caerphilly area, the Team Leader of the Crisis Resolution/Intensive Home Treatment Team coordinates the s115 meetings.

The purpose of s115 meetings is to facilitate the two way exchange of information for the purposes of detection, prevention and/or reduction of crime and disorder under Section 115 Crime and Disorder Act 1998.

In the first 6 months of 2014, there were a total of 75 115 meetings held across Adult Mental Health Services in Caerphilly borough.

### **5.13 Communities First**

The Communities First Programme provides funding for Lead Delivery Bodies within local authority areas known as Communities First Clusters to narrow the economic, education/skills and health gaps between our most deprived and more affluent areas.

#### **There are 4 Clusters in Caerphilly County Borough:**

1. Caerphilly Basin - including Bedwas, Trethomas and Machen
2. Mid Valleys East - including Argoed, Cefn Fforest, and Crumlin
3. Mid Valleys West - including Aberbargoed, and Bargoed
4. Upper Rhymney Valley - including New Tredegar and the Darren Valley

Making up a third of 12 areas (or clusters as the Welsh Government has labelled them) across Wales, Caerphilly County Borough is set to get a slice of £19 million in funding up to March 2015.

The 12 clusters are the first to be announced by Welsh Minister for Local Government and Communities. The others are four in Cardiff, one in Gwynedd, one in the Vale of Glamorgan and two clusters in Flintshire.

Each cluster has a Community First Mental Health Officer (CFMO) who works as part of the broader cluster Communities First Programme Projects. They will provide support and advice specific to mental health and well being matters; often directly with other Communities First staff and staff from other agencies and organisations.

The CFMO's are involved in delivering a broad range of activities and self help group opportunities across the cluster areas in response to the needs of local community residents, who experience issues relating to low to moderate mental health and wellbeing issues.

## **6. Prevalence of Mental Health Problems**

It is possible to obtain an estimated baseline figure for prevalence of mental health problems within Caerphilly county borough, by applying UK prevalence rates against the population of the county borough. It is not possible to apply these rates at a ward level though it is anticipated the actual figures within each ward would be higher where higher levels of multiple deprivation exist.

The estimated prevalence figures are set out in the table below. It should be noted that these are indicative figures, and is not an attempt to identify the prevalence of all mental disorders within Caerphilly County Borough. It should be noted also, that attempts have proved unsuccessful in obtaining comparative data on the prevalence of mental disorders within Local Authority areas across Wales. Data on an All Wales basis would be extremely useful for the next Commissioning Strategy and further efforts will be made to obtain such information.

## 6.1 Prevalence of mental health problems in Caerphilly, based on 2008 mid year estimates of population

	Age	Prevalence rate estimated	Population Figure
All mild to moderate Mental Disorders	16-64	18.2% of total population	20,261
Depression	16-64	27.8 per 1,000 population	3,095
Anxiety	16-64	58.2 per 1,000 population	6,475
Probable Psychotic Disorders	16-64	10.8 per 1,000 population	1,213
Schizophrenia and related disorders	16-64	5 per 1,000 population	556
Eating Disorders	16-34	0.34% of total population	181
Personality Disorder	16-54	78 per 1,000 population	3,489
	55-74	58 per 1,000 population	2,163

## 6.2 Future prevalence

Recently, research and reports from a variety of organisations have highlighted the increase in mental health problems. In 2004, the World Health Organisations predicted an increase of 15% in mental disorders by the year 2020 and the impact this would have (WHO, 2004). In June 2007, the Chartered Institute of Personnel and Development reported that mental ill health was the second largest cause of time lost due to sickness absence in UK organisations, coupled with the huge increase in the proportion of people claiming incapacity benefit over the last ten years due to mental health problems (CIPD, 2007).

The future indicative prevalence rates for Caerphilly County Borough have been obtained by applying current UK prevalence rates to the population increase projected by the Welsh Assembly Government. The largest increase in mental health problems is predicted to be in the over 65-age group reflecting the ageing demographic in the County Borough. The impact of this predicted increase could be altered by taking action to address the determinants of mental ill health, introducing earlier interventions to prevent the development of serious mental ill health and the introduction of appropriate support services to people with mental health problems.

To demonstrate future prevalence, the table below includes people aged **over 65 years**.

	2010	2015	2020
<b>Depression</b>			
16-64 years (1)	-0.12%	+ 0.12%	+ 2.52%
65 years + (1)	+ 4.62%	+ 17.79%	+ 28.24%
<b>Anxiety</b>			
16-64 years	+ 4.62%	+ 17.79%	+ 28.24%
65 years + [1]			
<b>Psychosis</b>			
16 – 64 years [1]	-0.16%	+ 0.98%	+ 4.20%
65 years + [2]	+ 4.33%	+ 18.05%	+ 28.15%

<b>Eating Disorder</b>			
16 – 34 years [1]	- 1.10%	- 3.86%	- 6.62%
<b>Personality Disorder</b>			
16 – 54 years [1]	- 0.42%	+ 0.25%	+ 0.97%
55 – 74 years [1]	+ 0.65%	+8.59%	+ 15.30%
<b>Dementia</b>			
40 years + [3]	+ 3.63%	+ 10.89%	+ 27.29%

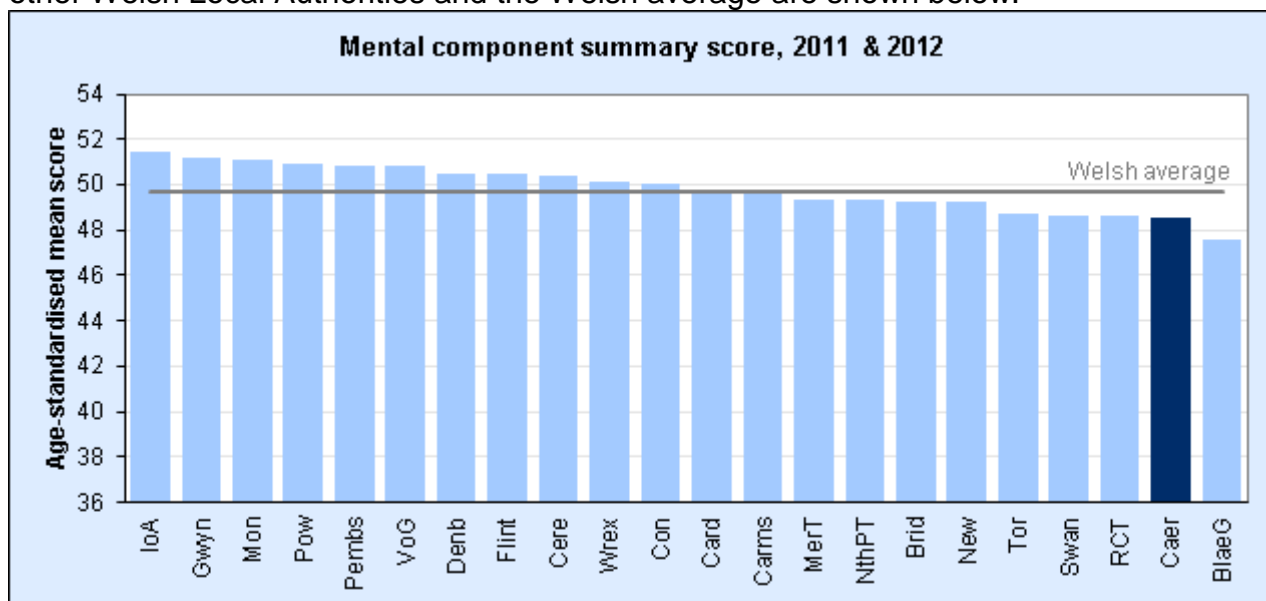
### 6.3 Summary

The high prevalence of mental health problems in the County Borough can clearly be linked to the high levels of multiple deprivations in the area, together with the high levels of long-term physical illness. In parallel with neighbouring Local Authorities, much of this is associated with being part of the main coal and steel producing areas of the South East of Wales. Residents in the seven South East Wales Valley areas have a low perception of their mental health and six of the Valley areas have the highest number of residents being treated for a mental illness.

A further examination would reveal high levels of economic inactivity, reliance of Incapacity Benefits, poor academic attainment and other related factors across the area. Whilst partnership working is required within the Local Authority and partner health agencies to tackle these causal factors and strengthen the resilience of individuals, families and communities, the increasingly ageing demographic must be taken into consideration and services prepared to meet this challenge. This applies equally to mental health services that will need to be ready for an increase in the prevalence of mental health problems within the County Borough.

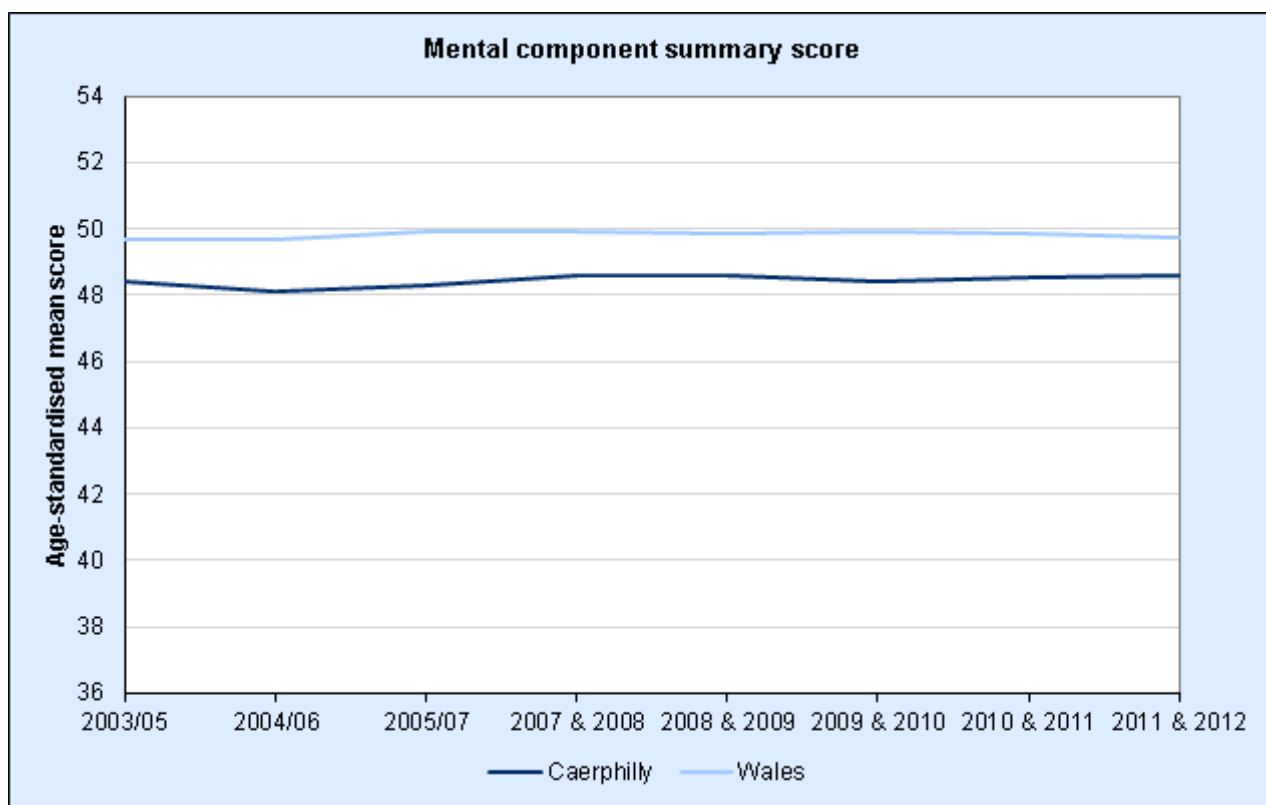
### 6.4 Mental Component Summary Score

The mental component summary score is a relative measure of mental well being and is sourced from the WHS adult datasets (WG) The latest data for Caerphilly, relative to other Welsh Local Authorities and the Welsh average are shown below.



The chart below shows the recent trend in the mental component summary score for Caerphilly compared to the trend for Wales as a whole.





The mean mental component summary for 2011 & 2012 was lower than the Welsh average, indicating poorer mental health and well-being

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65 years + [1]			
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16 – 34 years [1]	- 1.10%	- 3.86%	- 6.62%
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55 – 74 years [1]	+ 0.65%	+8.59%	+ 15.30%
<b>Dementia</b>			
40 years + [3]	+ 3.63%	+ 10.89%	+ 27.29%

## 6.5 Summary

The high prevalence of mental health problems in the County Borough can clearly be linked to the high levels of multiple deprivations in the area, together with the high levels of long-term physical illness. In parallel with neighbouring Local Authorities, much of this is associated with being part of the main coal and steel producing areas of the South East of Wales. Residents in the seven South East Wales Valley areas have a low perception of their mental health and six of the Valley areas have the highest number of residents being treated for a mental illness.

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## 7. GAP Analysis

This Commissioning Strategy looks at future commissioning of services for adults with mental health problems. It will need to address the likely demand, as the number of users of social care and health services increases. Decisions about which services to commission, will need to be done in the context of reductions in budgets and a focus on sustainable services, while enabling people to have more choice and control in their lives.

This section has used information based on population trends and actual service use within Secondary Mental Health Services. This will identify what gaps there are in service provision and outline changes needed in the type of services commissioned.

It is noted that mental ill health is on the increase and often links emerge that crosscut with other vulnerable client groups' needs. There is a relatively good supply of mental health services in the Caerphilly borough, more specifically floating support. However, costly out of county placements still occur. Gap analysis conclusions demonstrate that there are high links in particular between mental health and substance misuse/offending/domestic abuse. The need for dual diagnosis supported accommodation especially in terms of persons with both mental and substance misuse issues is regarded as a priority. The need for supported accommodation is also recognised in relation to provision of preparatory living, young people, crisis intervention, women with children and specifically for men.

## 8. Achievements since last Mental Health Commissioning Strategy 2009-2012

<b>Actions Achieved for 2009/2012 Commissioning Strategy</b>	
<b>1</b>	CMHT Service Specifications agreed
<b>2</b>	Performance Management information agreed
<b>3</b>	Social Work skills audit completed
<b>4</b>	Mental Health Act Policies and Procedures Completed

5	New Candidates successfully completed the AMHP Training
6	Agreement reached with the Trust about non Local Authority AMHPs
7	DoLS process implemented across Gwent
8	Best Interests Assessors Training Completed
9	Development of 8 Bed Supported Accommodation Scheme at Ty Osborne
10	Development of a mental health employment service
11	Achieved the market supplement for all AMHP's

## 9. Priority One:

### 9.1 Accommodation:

The key principles on which this strategy is based are: -

Where possible, people should be able to live in the place or home that they choose, with the support that they require to live there. Support is based around their needs and is not attached to the accommodation they live in, so that if their needs change they do not have to move.

We need to look at how we commission services for people in accommodation crisis i.e. current accommodation that is not suitable at point of discharge from acute inpatient units. Where the individual is not deemed to be 'homeless' but temporarily unable to return home.

#### **Next Steps**

Look at what is happening for people in services now; through quality assurance and effective contract management of the services that are purchased

Develop a process that ensures future need for accommodation is identified in order to plan for the future.

Increase the range of services available, providing a range of accommodation and accommodation support required, with clear pathways in and out of the service.

Review all Care and Treatment Plans (CTP's) that identify accommodation needs to indicate the numbers of people with current and future housing needs.

Reduce the deficits in how Service Users access housing opportunities

Development of a Social Services, Housing, 3<sup>rd</sup> Sector and Health Information Sharing Protocol

Develop a range of temporary accommodation for people who no longer require inpatient treatment, but are not at the stage where they are able, for a variety of reasons, to return to their previous accommodation. Currently this has resulted in a longer than necessary stay in an acute setting.

### 9.2. Priority Two:

### **9.3 Inclusion for people with a mental illness, in the South East Wales Shared Lives Scheme (SEWSLS)**

South East Wales Adult Placement / Shared Lives Scheme offers a service for vulnerable adults with Adult Placement Carers in their local community. Individuals using adult placement services are given the opportunity to be supported in carers' homes and local communities, this service is not currently available to Service Users with Mental Health problems.

#### **Next Steps**

Increase the opportunities for people with a mental illness to access the South East Wales Adult Placement Shared Lives Scheme. (SEWAPS)

Invite Practitioners within Mental Health Services, to the SEWAPS Strategic Planning Events, to raise awareness of the service and promote the benefits of the scheme.

Co-ordinators for the South East Wales Shared Lives Scheme, to attend regular Mental Health Team Meetings for questions and answers sessions and keep staff informed of updates to services.

### **9.4. Priority Three:**

#### **9.5 Access the Volunteer Service for People with a Mental Illness**

People often say they volunteer because they've benefited from a service and want to put something back. People who have received a lot of health and social care services may have additional reasons for volunteering such as

- They want to improve that service for other people in the same situation
- Volunteering provides them with opportunities to develop themselves
- To be seen as active citizens rather than recipients of services

#### **Next Steps**

Work with the Volunteer Service to include those with low to moderate levels of risk.

Develop Peer Schemes where Service Users who want to give something back to their communities and network at the same time.

### **9.6 Priority Four:**

#### **9.7 Implementation of the Alternative Method of Working – Vanguard Systems Thinking - Introducing the Listen, Engage, Act and Participate (LEAP) Team**

Service Users, Staff and Stakeholders often tell us our mental health services can be confusing, or that there are some things that get in the way of being able to do a good job. This required mental Health professionals going 'back to basics' and talking to service users and staff about 'What is important to them' and 'what gets in the way of doing a good job'? We then asked people in our services across Health and Social Care in Gwent, to do the same. Just over a 100 people engaged with this process, and the outcomes were found to be very similar.

As a result of experiencing the system in a different way, partners developed a new operating principle. It was also agreed that the first point of value to the citizen receiving

services was the first meaningful conversation. As such, they considered how a pathway may look (what are the value steps) if starting from this point, and not the traditional model of 'assess' 'diagnose' 'treat'.

#### **Next Steps**

- Continue with the LEAP initiative to look at alternative ways of working with people with mental health needs..
- Work closely with the all GP Surgeries in the North of the Borough
- Determine appropriate services in the appropriate place, ensuring we commission where there is need.
- Test the proof of concept, that there is a different way of working within mental health and to understand the conditions required to enable that to happen.
- Identify new demand/referrals for secondary care.

#### **9.8. Priority Five:**

#### **9.9 Gwent Wide Commissioning Service of 3<sup>rd</sup> Sector Providers of Mental Health Services**

The Health Board and Local Authority Partners currently spend approximately 1.9 million on mental health services delivered through the Third Sector. These services have been developed over a number of years through locally based planning arrangements; therefore not all services are available in all areas of Gwent. The levels of investment in services in each area are very different with some areas having a greater selection of services than others.

The current arrangements for the administering of this funding, is complex and is supported through a range of grants, service level agreements and contracts. This suggests a need to review the funding and administration arrangements to use our resources in a better way and align our money with the evidence of community needs to ensure that people have access to services regardless of where they live in Gwent.

#### **Next Steps**

- Develop a Gwent wide Commissioning process for 3<sup>rd</sup> Sector Mental Health Services that ensures all our services promote well being, build resilience and enable recovery from mental illness.
- Ensure services are available to people who need them regardless of where they live in Gwent.
- We need to work together to develop and deliver services across organisations and areas.
- The Third Sector has a lot of skill and experience in developing and delivery of mental health services in Gwent and we need to build upon and learn from it.
- The experiences of people who use our services are vital in helping to shape the future.
- When making decisions about our services we need to use processes that are fair, transparent and equitable.

#### **10. Financial resources associated with services to people with a Mental Illness in Caerphilly County Borough.**



	Original Budget 2014/15	Original Budget 2015/16
<b>Total Mental Health Services</b>	<b>£3,611,265</b>	<b>£3,894,009</b>
<b>Residential Care</b>	<b>894,973</b>	<b>961,976</b>
<b>Day Care</b>	<b>618,211</b>	<b>668,144</b>
<b>Sheltered Employment</b>	<b>69,500</b>	<b>70,543</b>
<b>Total Home Care and Other Domiciliary Care</b>	<b>1,889,394</b>	<b>2,061,169</b>
<b>Voluntary Organisation Contracts</b>	<b>139,187</b>	<b>132,177</b>

## 11. References

The Mental Health (Wales) Measure 2010  
 Together for Mental Health Wales 2011 Strategy for NHS  
 Sustainable Social Services, Wales 2011 Vision for Social Services  
 Together for Mental Health. A Mental Health and Wellbeing Strategy for Wales 2012  
 Caerphilly County Borough Council Single Integrated Plan- Caerphilly Delivers 2013  
 Social Services and Wellbeing (Wales) Act 2014  
 Caerphilly County Borough Service Improvement Plan (SIP)