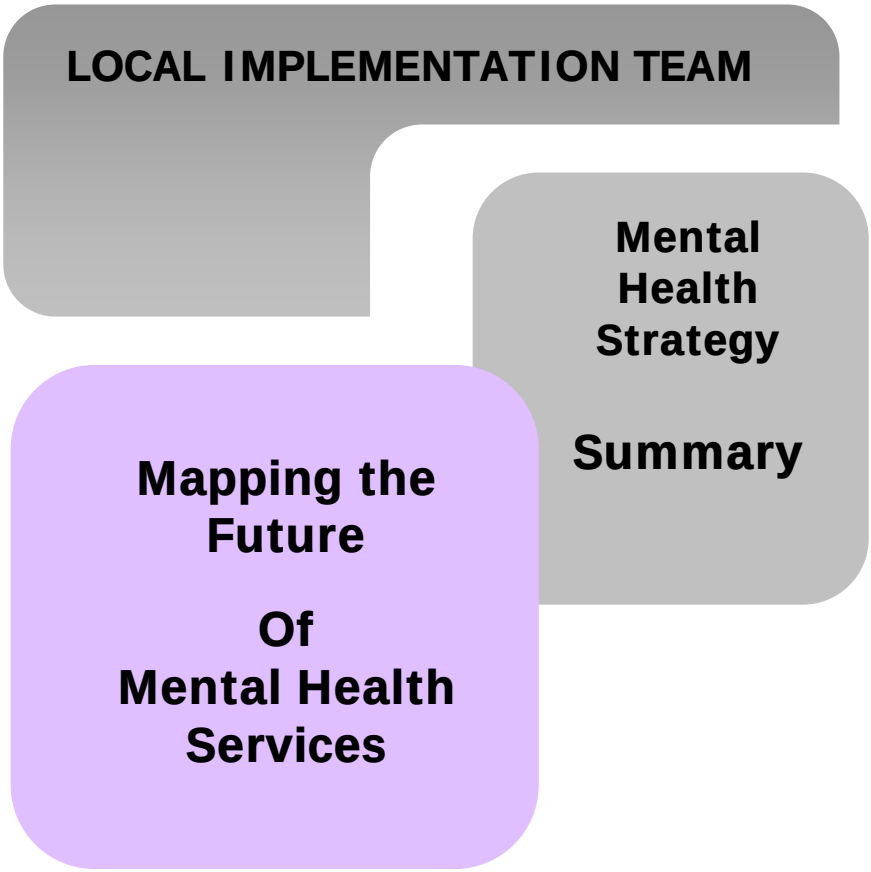
Dudley Mental Health Board



A Joint Mental Health Strategy for Dudley Health and Social Care Economy 2005-2010

Contents

1. Foreword

Good mental health is every bit as important to the way we live our lives as good physical health. Mental health influences how we think, feel, communicate and understand; without good mental health it is hard for us to achieve our full potential. It can be a vicious circle. If we have poor mental health it can be hard or impossible to take part in day-to-day life. And if we can't take part, we become excluded and isolated which make our mental health problems worse.

According to evidence 90 per cent of people with a mental illness – including 30 per cent with a serious mental illness – are only in contact with primary care services[1]. There is further evidence that suggests that users are not always offered patient centred care[2] and quality is variable.

Dudley's Mental Health Strategy 2004 – 2010 has been developed based on consultation, experience and evidence and sets out a local vision for moving forward in the development of an alternative, patient focused model of mental health service planning, commissioning and delivery.

The model described in this strategy reflects the principles being applied to service delivery across the range of health care services provided for the local population:

- Services closer to home
- Alternatives to hospital admission
- Increased capacity in primary care

This strategy reflects the determination of Dudley's Local Implementation Team to drive change within the structure of mental health service delivery and outcomes and develop the philosophy of Mental Health for All.

The document sets out the commitment to re-design and refocus specialist mental health services building on the detail contained within the Needs Assessment undertaken by York University in 2000 / 2001 and from the foundations laid by the locally agreed Mental Health Promotion strategy, emphasising the role of primary care in driving service development.

In recent years there has been a wealth of literature, which has continued to remind all of us engaged in developing mental health services of the reason why fundamental change is necessary and of how services might be improved to better meet the needs of all service users[3].

A whole system approach to mental health will require a cultural change for everyone and all elements of the service will need to be considered, the extent of the change process is not underestimated however if there is to be continuity for the patient through the care pathway all elements have to interact.

This strategy builds on the foundations of change already in place and the strength of partnership working and alliances, this should be seen as a starting point and as a means to an end – not as an end in itself.

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[1] Kendrick et al (2000) Are specialist mental health services being targeted on the most needy patients? British Journal of General Medicine: 50,121-126

[2] Thompson et al (2000) Effects of clinical practice guidelines and practice based education on the detection and outcomes of depression in primary care: Hampshire Depression Project RCT: Lancet, 355, 185-191

[3] NIMHE (2003) Cases for Change: Primary Care

2. Engaging Users and Carers

The views and perspectives of service users and carers are valuable assets in all aspects of mental health service planning, development, delivery and evaluation. Policies such as the National Service Frameworks cannot be successfully implemented without the real and effective involvement of users and carers.

More important than policy statements though is the real place of users and carers in our services. Our services are designed for people and the way to know if they are working or how to improve things is to ask those people. The real measure is their understanding and experience of the services, whether they are a user, carer or a staff member. When working collaboratively it should be borne in mind that service users, their carers and staff may not always agree about what services will meet service users needs. Despite differences in perspective, service users, carers and staff need to work together to achieve consensus around service development priorities. All perspectives are valid and should not be ignored so any infrastructure to support involvement should allow the safe and open expression of all participants. It is also important that any infrastructure to support the involvement of users, carers and staff encourages collaboration between these groups.

Mental health Services in Dudley will provide responsive accessible services designed to meet the individual needs of users and their carers. We will actively seek to involve users, carers and other stakeholders in the development, delivery and monitoring of services. In our endeavors to provide best care, we will promote evidence review and reflective practice among all staff through systematic training and research involving users and carers.

There has been considerable development of user and carer involvement at planning and operational levels through the redesign programme and on the development of relationships with staff and advocacy services. These developments need to be maintained, enhanced and developed.

Individual care level

In order for service users to be fully involved in their own care and treatment, it is necessary for all staff to:

- Treat everyone with courtesy, respect and dignity.
- Respect and value individuality and difference.
- Treat people fairly and equally.
- Provide timely and meaningful information, in a range of appropriate languages and formats, to enable individuals to make informed choices and decisions about their care.
- Listen and act on individual views and ideas.
- Recognise and promote individual strengths.
- Deliver care that is guided by a commitment to hope, recovery and promoting independence.
- Promote honest and open discussion as well as negotiation in formulating care plans.
- Create an environment in care planning meetings that enables individuals to be involved in making choices and decisions as equal partners.
- Ensure people have the support to enable them to contribute to decisions about their care (e.g. interpreters, independent advocates).

Users and Carers are ‘experts by experience’. Their perspectives are not only essential to the planning and delivery of their own care and support, but also required in all aspects of mental health service planning, development, delivery and evaluation of services.

This strategy is committed to the meaningful and effective involvement of users and carers across all tiers of this document. Whilst the successful delivery of the modernisation set out in this document will provide a framework to improve service users and carers experience of mental health services, more is required to ensure that services users and carers are equal partners both in terms of decisions that are made about their own care and the development of services at a strategic level.

What can Service Users and their Families expect from Mental Health Services?

The new style of service delivery puts people who use services at the centre – a style of services organised around people, instead of expecting people to fit in with services.

The vision and values identified by local service users will be reflected through the delivery of the new model of working which include the understanding that:-

- Services will be fully integrated between agencies
- Services will be easily accessed, timely, consistent and equitable
- Service users will be at the centre of planning, delivery and monitoring services
- Resources for mental health services in primary care will be increased
- The mental health of the local population will show improved outcomes
- The role of families and carers will be strengthened through support

People with mental health problems can expect that services will:

- Involve service users and their carers in planning and delivery of care
- Deliver high quality treatment and care which is known to be effective and acceptable
- Be well suited to those who can use them and non-discriminatory
- Be accessible so that help can be obtained when and where it is needed
- Promote their safety and that of their carers, staff and the wider public
- Offer choices, which promote independence
- Be well co-ordinated between all staff and agencies
- Deliver continuity of care for as long as this is needed
- Empower and support their staff
- Be properly accountable to the public, service users and carers

Department of Health 1999

A shift in culture towards Choice, Person Centred Care and Mental Health Promotion is a key imperative across national and local service development. People who use services and their families continue to report not being listened to, being marginal to assessment and care planning and being rendered helpless rather than being helped by service use.

There is national drive to ensure that all staff have training in what are described as the essential care capabilities[4] – locally we are committed to meeting that aim and then to taking the training out into local communities so that people working in other organisations such as education or employment will have the skills to begin to meet the needs of people who have suffered from mental health problems

[4] Ten Essential Shared Capabilities: A framework for the whole of the mental health workforce: DoH 2004

The Ten Essential Shared Capabilities for Mental Health Practice

Working in Partnership. Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.
Respecting Diversity. Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.
Practising Ethically. Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.
Challenging Inequality. Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.
Promoting Recovery. Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.
Identifying People's Needs and Strengths. Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users their families, carers and friends.
Providing Service User Centred Care. Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.
Making a Difference. Facilitating access to and delivering the best quality, evidence-based, values based health and social care interventions to meet the needs and aspirations of service users and their families and carers.
Promoting Safety and Positive Risk Taking. Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.
Personal Development and Learning. Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

The Ten Essential Shared Capabilities (DoH) 2004

Action

- Dudley will be a pilot site for the implementation of the 10 Essential Shared Capabilities for Mental Health during 2005 and will develop an action plan for rollout in 05/06
- User involvement at all levels of care and service development will be strengthened through effective recruitment, support, networks, training and monitoring.
- Greater links will be made with local communities through education, information and access to develop a programme of mentorship for users that will facilitate seamless but supported access to mainstream leisure and social networks – particularly for young people.

3. What are the mental health needs in Dudley?

Mental illness is as common as asthma and the costs for depression alone are as high as for coronary heart disease (Department of Health, 1998a). According to the mental health charity Mind (2000):

- One in four people seek help for mental health problems at some time in their life.
- Over 4,000 people take their own lives each year.
- More than two million prescriptions are issued every year for major tranquillisers, while minor tranquillisers account for over 19 million prescriptions.
- Over 250,000 people are admitted to psychiatric hospitals annually.

The relationship between mental health and social inequalities is interlinked. For example, having a mental illness can reduce an individual's ability to retain employment thus leading to social isolation, which consequently exacerbates the problem. Furthermore social inequalities increase the risk of developing a mental illness.

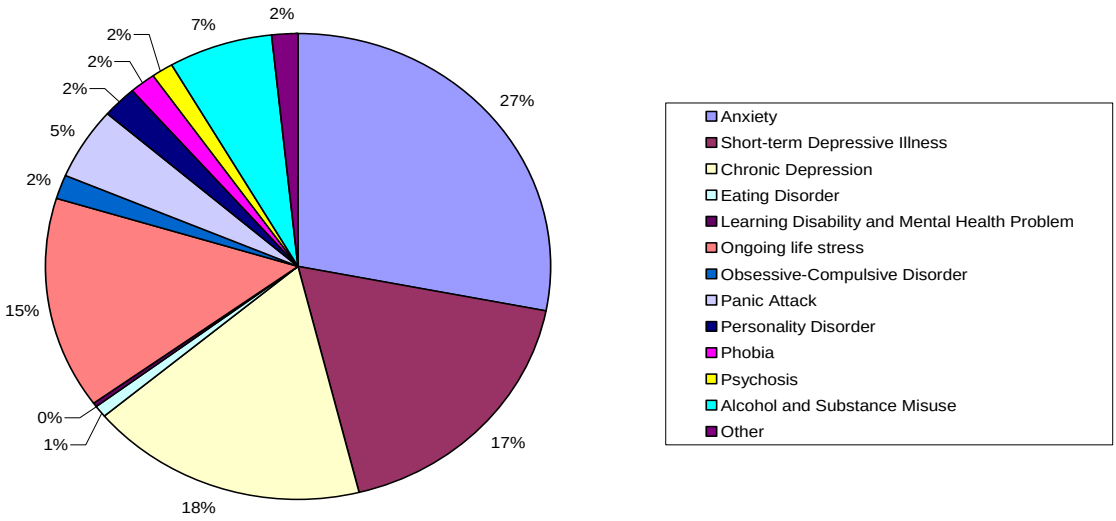
In the UK, 16% of the population will be affected by mental ill health (1 in 6) during their lifetime. Mental well-being is influenced by many factors, including genetics, childhood experiences, life events, individual's ability to cope, levels of social support, adequate housing, employment, financial security and access to appropriate healthcare. Groups who face a high risk of developing a mental illness include, black and minority ethnic populations, people who sleep rough, people in prison and people experiencing physical illness.

It is difficult to reliably determine the level of mental ill health in the population. Short-term or mild mental health conditions such as depression, anxiety, eating disorders and agoraphobia are difficult to capture from data collected from GP surgeries.

The Figure shown below in Table 1 is based on some extensive needs analysis undertaken by York University and Acton Shapiro[5]

Percentage Prevalence of mental health problems in Dudley

Table 1.



[5] [5] Mental Health in Dudley. Perceptions of Needs and Services: Final Report September 2001. York University Health Economics Consortium & Acton Shapiro.

Mental health issues are a massive 'burden' for primary care and the scale is important in terms of the motivation for primary care to manage this area effectively. This has been recognised for some time. Whilst the majority of mental health problems presenting in primary care may relate to transient life stress or mild to moderate problems of anxiety and depression, which may remit over time, many individuals with severe mental illness problems are also successfully managed within primary care – often supported by specialist mental health services.

"**The public health burden of the common mental disorders is immense and is growing. Much of this burden falls to primary care... and because people with depression and anxiety are generally extremely heavy consulters in primary care, the benefits to be gained by adequate assessment and management are immense..**"[6]

Dudley Mental Health Services will build upon the detail contained within the Mental Health Needs Assessment undertaken in 2000/2001

Action

- A revised profile of service uptake related to gender, ethnicity, age and diagnosis / presenting problems will underpin future service development – Public Health Profile of Mental Health will be undertaken by **December 2005.**
- Further analysis of public health and related data on suicide and self-harm will be undertaken to monitor progress and further develop the suicide prevention strategy and workplan by the Standard 7 subgroup of the LIT.
- A detailed plan will be developed, reflecting improved liaison between partner organisations, including risk assessment, training on identification and management of self harm, access to services, treatment and continued learning. **March 2006**
- Public Health data will provide a baseline for evaluation of services in respect of Social Inclusion and Inequalities
- Further profiling of service uptake related to gender, ethnicity, age and diagnosis/presenting problems will guide service development

[6] Sainsbury' Centre for Mental Health (2001) Setting the Standard: The New Agenda for Primary Care Organisations Commissioning Mental Health.

4. The future of service provision

A Model for the Future

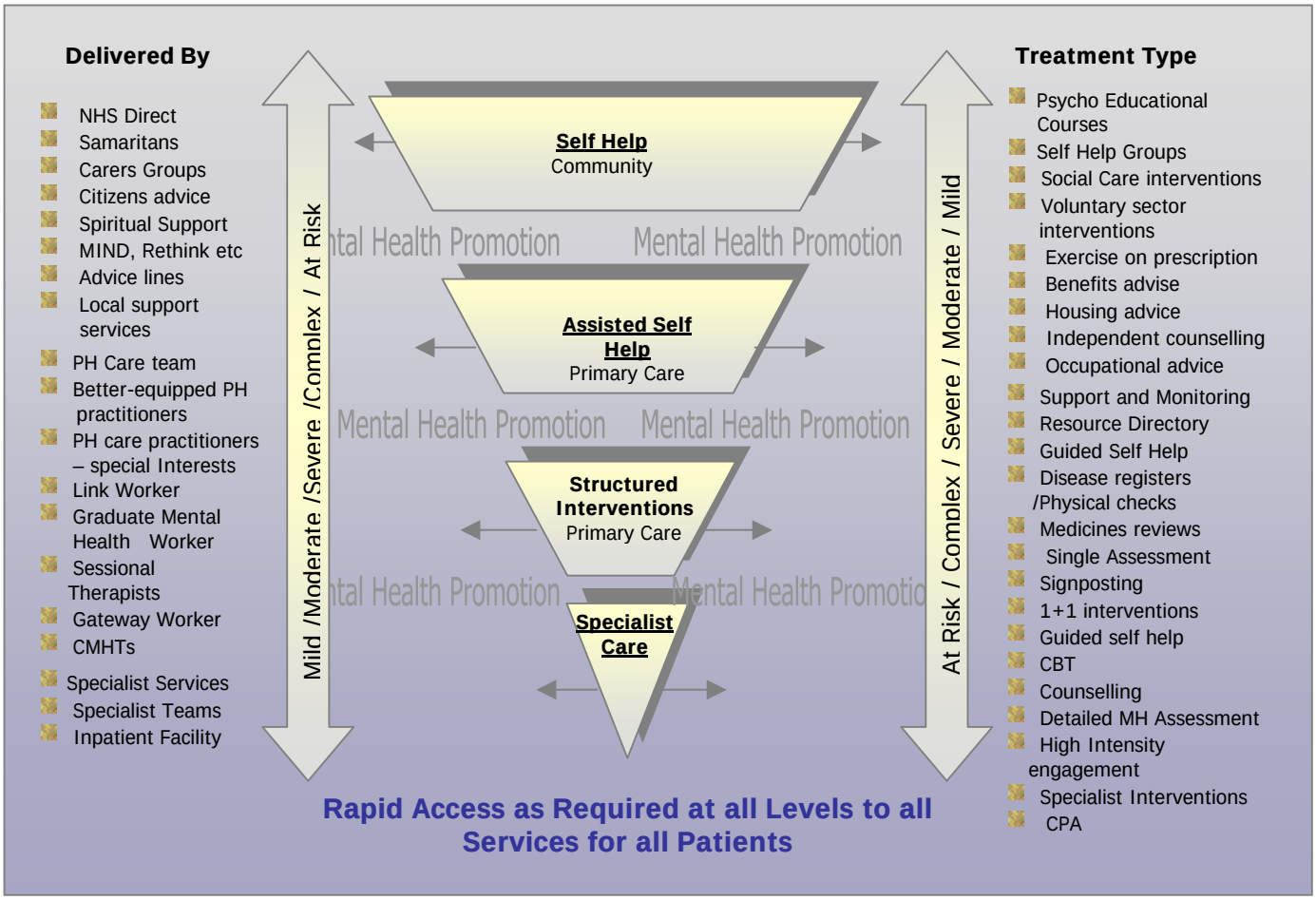
The Model Approach for Dudley reflects the principles applied to the delivery of all services across the economy:

- To deliver patient focused services
- To develop services outside the hospital
- Prevent avoidable admission to hospital and reduce delays in discharge
- To support clinical decision making in primary care

The right services will be delivered:-

- In the right place – as close to home as possible
- At the right time – offering choice to the service user
- By the right person

Model for the Delivery of Mental Health Care in Dudley



This model is 'instead of' what we have currently – not 'as well as' and will provide opportunities for people working in mental health care to develop their range of skills, and gain experience through working in new ways.

Issues, Tensions and Challenges

The drivers for change are detailed in the Local Strategic Framework document[7], which also reflects the enormous amount of progress already achieved in respect of the National Service Framework standards and it is in light of these developments that this new strategy, taking us through until 2010, will deliver an integrated service that is balanced to meet need.

So what are the major challenges we face in Dudley? There are predominantly four major areas:

National Influences

- A national drive to reshape and restructure health and social care services will have a local impact and we need to ensure that everyone has the opportunity to be involved in the future direction for mental health services through effective consultation and engagement at every stage.[8][9]
- The implementation of national policy in respect of Practice Based Commissioning and Payment by Results will demand a focus on the direction for mental health commissioning at all levels.
- The modernisation Agency in 2004 published 10 high impact changes (HICs) for accelerating service improvements in the NHS – this is being developed to include mental health services and should be considered in service development.

Philosophies

- A service which is driven from primary care is a total change in the culture and shape of mental health services locally, and will demand changes to the way key professionals work so perhaps the greatest challenge of all for primary mental health care services is the need to determine how we evolve from a reactive, medical model service into one that is proactive, addressing social origins of mental ill health, building partnerships with users and carers and whole communities and is fully accessible to all sections of the community?

- How do we effectively include users, carers and communities? How do we respond to the desire of patients for services like counselling, stress management and alternative treatments? How do we improve access whilst knowing so little about local needs? How do we reconcile our wish and the capacity in Primary Care to undertake this transformation?

Policies

- The management of services has highlighted challenges in the light of integration– particularly in ensuring that all staff work within the appropriate clinical governance framework. We wish to work in partnership with other agencies but also be able to evidence their role in the primary mental health care service. What is the role of the voluntary sector in core provision, what is the role of social care? Who should manage a primary care service and are there the skills and expertise to do so? How do we reconcile the suspicions and anxieties that have grown around the primary and secondary care interface? Do we have a commissioning framework that will support the change agenda?

Practicalities

- There is a massive training need and we have to find the resources to meet this. We have to recruit people with scarce skills, our needs assessment is not sophisticated enough to ensure targeted delivery in terms of location and access issues. What models and therapies represent the 'best value' investment? Already scarce resources are targeted to achieve key national targets and performance indicators but this has to be balanced with the need to evolve into a 'changed service'

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[7] Dudley Health and Social Care Economy: Framework for Delivery of the Joint Mental Health Strategy (2004)

[8] Commissioning a Patient Led NHS: DoH (2005)

[9] Your Health, Your Care, Your Say DoH (2005)

Key features of the service will include:

- Fully Integrated Services – a “Whole Systems Approach” for individuals and families
- Greater community awareness and understanding of mental health issues
- Social Inclusion
- Fully inclusive – good services for everyone in need
- Improved access to education and employment
- Housing
- Primary Care Led – but greater access to specialist services when needed
- Psychological and Social models to have equivalent status to medical model
- Comprehensive Service
- Appropriate services to meet needs
- Treatment in the right place – as close to home as possible
- Accessible, Timely, Consistent and Equitable service delivery
- One Standard for all across Dudley
- Clear Pathways between services
- Choice
- User Centred Service
- Involvement and Empowerment
- Meeting and then Exceeding Expectations
- Underpinned with sufficient resources
- Funding
- Cost-effective services
- Workforce trained and equipped to meet needs

5. Developing a whole system of mental health care

This model recognises that most mental health problems that people may experience are addressed by various self-help and community supports. If problems persist, people may consult their primary care practitioners and a proportion of these individuals may be offered structured mental health interventions within a primary care setting. Only those with the most complex, severe or enduring mental health problems are treated by specialist mental health care services.

It is sometimes helpful to consider the types of illness that will commonly present to focus service responses – from psychological disturbances (stress, bereavement) to common illnesses (depression, anxiety) to more complex states (phobias, eating disorder). However, a preferred distinction than diagnosis is thinking in terms of the duration and degree of disability the illness causes (and the risk to self or others): depression in this sense may demand specialist help whilst someone with schizophrenia with good support may have that illness well maintained but have significant contact with primary care for physical health needs.

The system of care attempts to describe care across some of the traditional boundaries of primary (based around local GP surgeries) and secondary care (specialised mental health focused services) – as well as demonstrate some of the links to tertiary (very specialised) care services.

It is important that services are developed within a framework that patients and clinicians can use to determine the most appropriate approach to care to meet the needs of individuals and Dudley has a model to address both the balance of primary and secondary care services and patient choice.

The approach is based on a 'Stepped Care' approach building a menu of services from which a person can choose the intervention most suitable to them. Stepped care refers to a model stepping up from simple and low intrusive interventions to more complex approaches as and when appropriate.
Through careful risk assessment demand on specialist services can be reduced and a more graded discharge route out of specialist services can be supported. This would begin to address the baseline of a whole systems approach to service development.

The model sets out a broad range of functions and modes of delivery however it does not determine the definitive structure for how the functions should be delivered and what the range of responses within some areas should be e.g. Anger Management techniques may be generally available for people in the community through information leaflets, booklets and self help groups but it can equally be available for patients through specialist services, delivered at a level to meet the more complex needs of the individual – the model supports this degree of flexibility.

Also, in practice, people may be using a range of service functions set out at any one time, especially those with severe and enduring mental health problems, and their families/carers.

The range of agencies that must be involved in delivering this model is wide and varied but must include health, social services, the voluntary sector, advocacy services, housing, employment, education, leisure, benefits, and the criminal justice system.

Action

- The range of supported housing for people with mental health problems in Dudley will be reviewed, linked with the Local Authority Supporting People Strategy
- Further development of supported employment opportunities and access to education for people with mental health problems in Dudley

The model does not attempt to say who the employer of people delivering any given services should be but services must be effectively coordinated, managed and led.

Services will focus on treating people in the most appropriate setting including in their homes or in alternative community venues developing the real issues of choice, which then supports an individualised response to need.

Care will be planned, managed and reviewed within an integrated framework, which, for those patients with a severe and enduring condition, will include the Care Programme Approach (CPA).

To ensure that people are receiving the right care/treatment good risk assessment and management skills are required for all individuals involved in the care process.

It is important to locate this in the overall development of primary care strategies for both Dudley South PCT and Dudley Beacon and Castle PCT, but the challenge is also to ensure that the primary care approach is integrated within the wider 'Modernising Mental Health' agenda.

We have used the locally agreed model for developing services in the community as a framework to shape thinking – based around the concept of an appropriate skill mix to deliver the range of therapies required as close to home as possible thereby reducing the demand on inpatient services.

We recognise the need to link a new response with existing services and other agencies and future funding will be sought in order that we can build a new service based on good practice – key elements of this are the measurement of outcomes and the involvement of users and carers in service design and delivery.

Action

- A service re-design plan will be produced by December 2004 which will:-
  - Describe the process for the release of resources, through redesign,
  - Implement the policy of rebalancing service delivery from Secondary to Primary Care
  - Review current role and function of Inpatient, Day Care and Community Mental Health (CMHT) services.
- Further development of partnership working with the community and voluntary sector to strengthen services promoting mental health and social inclusion in relation to housing, education, employment, day services, family/carer support, advocacy and user-led initiatives
- To deliver meaningful user/carer involvement at all levels, equity of access, flexible and comprehensive services, quality and continuity of care, addressing special needs and measuring outcomes

The first step in establishing accountability has been through local stakeholders agreeing to this Joint Strategy. This agreement represents a commitment to implementation of the strategy.

The Government has identified that the lead responsibility for mental health care lies jointly with the NHS and Social Services. It is therefore the role of these two agencies, strengthened through effective integration, and all the organisations within them, to ensure that local partners continue to work together to implement the National Service Framework.

Action
Dudley Mental Health and Social Care Services will be fully integrated from April 2005 in respect of: -

- Operational Management
- Service Planning and Commissioning

The integtrated Mental Health Service will bring services closer to the user, reflect local issues and encourage greater partnership working between primary and secondary care services.

Right Treatment at the Right Time

Most people would prefer to receive effective treatment for their mental health problems within a primary care setting which has less stigma within the community than most traditional specialist mental health services.

- Individual patients' experience of the same illness will vary and for each individual their needs may also vary over time. Patients may move across services in these circumstances.
- There are a range of treatments and supports that are effective for any illness – including combination therapies. Patients' preferences should inform the treatment they receive and who delivers it. This may include a desire to be treated in a familiar and non-stigmatising setting. GP practices and Health Centres offer this. It is important to recognise the social origins of illness and the need for social support in regaining mental health and in maintaining mental well-being. People need coping and life skills and the primary care team should be equipped to provide an effective response in this area too.
- 90% of all patients with mental health problems only use primary care services
- Though a team approach would enable specialists to be shared - equipping a range of professionals with appropriate mental health skills makes best use of limited resources.

The approach in Dudley has to be informed by thinking about needs, at both individual and population levels, the response required, the skills and competencies to deliver that response and who is or could be trained to deliver them.

The model for mental health care will mirror the principles of the model adopted across the economy in that care, treatment and support will be delivered by the most appropriate person, in the most appropriate setting at the right time.

Care Close to Home

Most people prefer to receive mental health services as close to home as possible and this also includes the opportunity for treatment to be delivered within the person's home.

A service re-design plan will aim to release resources across mental health services to implement the policy of re-balancing delivery from Secondary to Primary Care Services and will review current role and function of both inpatient and Community Mental Health Team (CMHT) services

Action
A 30% reduction in acute capacity will be achieved by the end of 2006 through the development of an effective supporting infrastructure including implementation of:

- Crisis Resolution/Home Treatment
- Assertive Outreach
- Early Intervention Service
- Enhanced Skills /Service provision in Primary Care
- Dudley will develop effective services within an integrated system of care

6. How the change process will be managed

A project structure is in place for the redesign of existing services and implementation of the new developments with a timetable for completion that matches the strategic intent. A robust audit / evaluation of the effectiveness of specifically Crisis Resolution / Home Treatment will be undertaken to assure confidence of the bed releasing capacity as the funding issues are in part being dealt with through

- The re-design of current services
- The planned changes in investment arising from the reduced dependence on hospital services
- New investment identified through the LDP process.

A bed management strategy will be developed to reflect a year on year reduction in acute bed usage built from a baseline set in 2003/2004 reflected in the strategy and it is expected that the impact of Crisis Resolution / Home Treatment will be reflected with effect from January 2006.

It is proposed that the LIT workplan be seen as the final working document with acknowledgement that it may be adapted based on discussions at clinical forums – particularly those focused on the development of primary care.

Work will continue within the current project arrangements – driven through the joint commissioning structure, and associated action plans will be produced which will: -

- Reflect the achievement of key national targets
- A standard project format across all work streams
- Action plans to include workforce and financial implications
- Initial risk assessments will be undertaken and further refined to include contingency planning
- Action plans will be further refined to give confidence of the project relationships and interdependencies with others and resource usage.

It is expected that the key priorities will be achieved during 2004/2005 and the action plan will be a working document reflecting the strategic direction for mental health services into the future.

Action
A Strategy Implementation Plan will be developed building on the existing LIT workplan, by October 2004.

An annual review process on progress made will be undertaken through the LIT, which will continue to be the driving force for change and they will endeavour to ensure that all component parts are able to sustain the scrutiny of a robust project management appraisal.

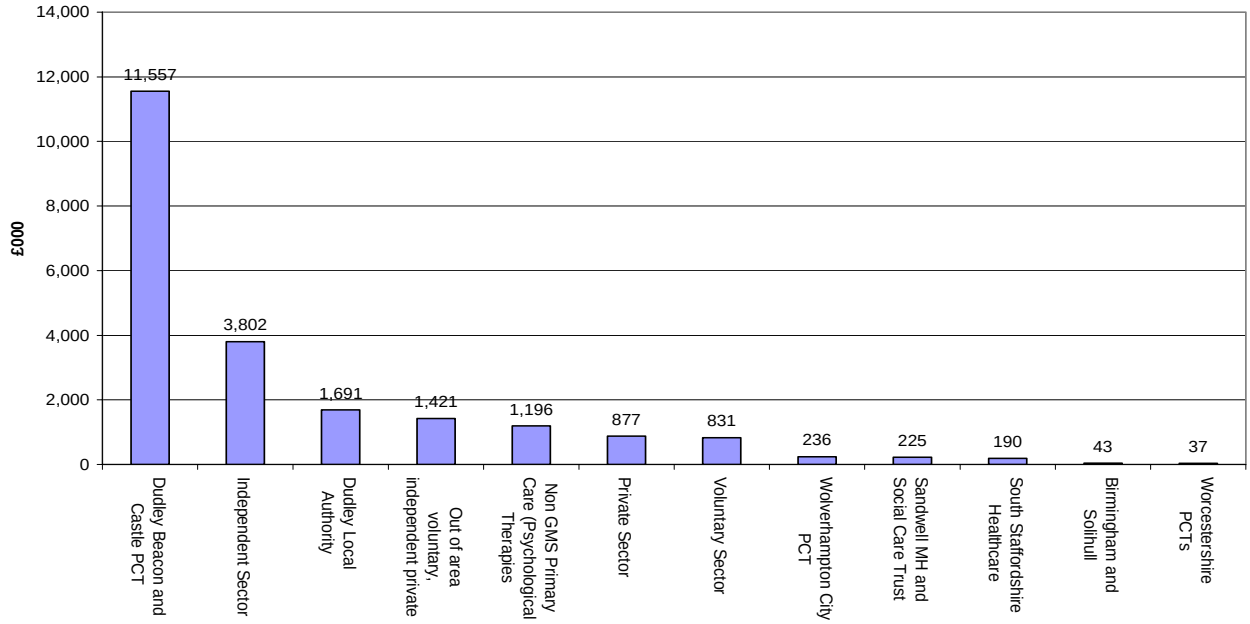
This approach will reflect the reporting structure for the Local Implementation Team illustrated in Appendix 1. which is integral to Economy wide commitment to a partnership approach and the wider public health agenda. Delivering against the NSF standards remains the focus for structuring operational delivery and reporting,

It is important to recognise and reflect throughout the strategy the need to ensure that all agencies are addressing mental well being; this will demand an effective inclusion policy for all agencies to contribute to a whole systems approach to commissioning and delivering services.

7. Financial Implications

Dudley already has a reasonable level of investment from Health and Social Services in adult mental health care. Separate investment is also made in out of area placements and continuing care programmes.

Table 2 **Overview of total expenditure on Mental Health in Dudley by provider agencies (2003/4 figures)**

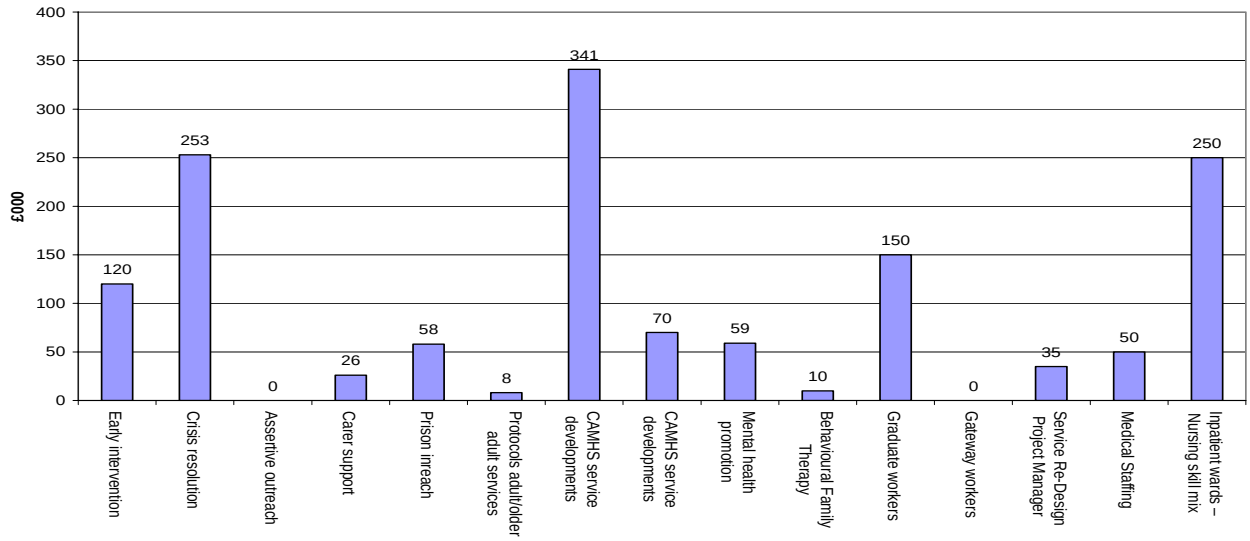


It is therefore expected that the type of service desired could be partially funded from the current level of investment through creative use of existing financial resources and redesign of existing services. The challenge will be 'double running' of some existing services alongside the new desired service (or services) to replace them.
This is really only an issue during periods of time where new teams of staff are being developed and need some dedicated time to prepare as a team.

New resources for service development

A Local Delivery Plan has been agreed to release resources for mental health service development during 2004-2006 for various priority developments.

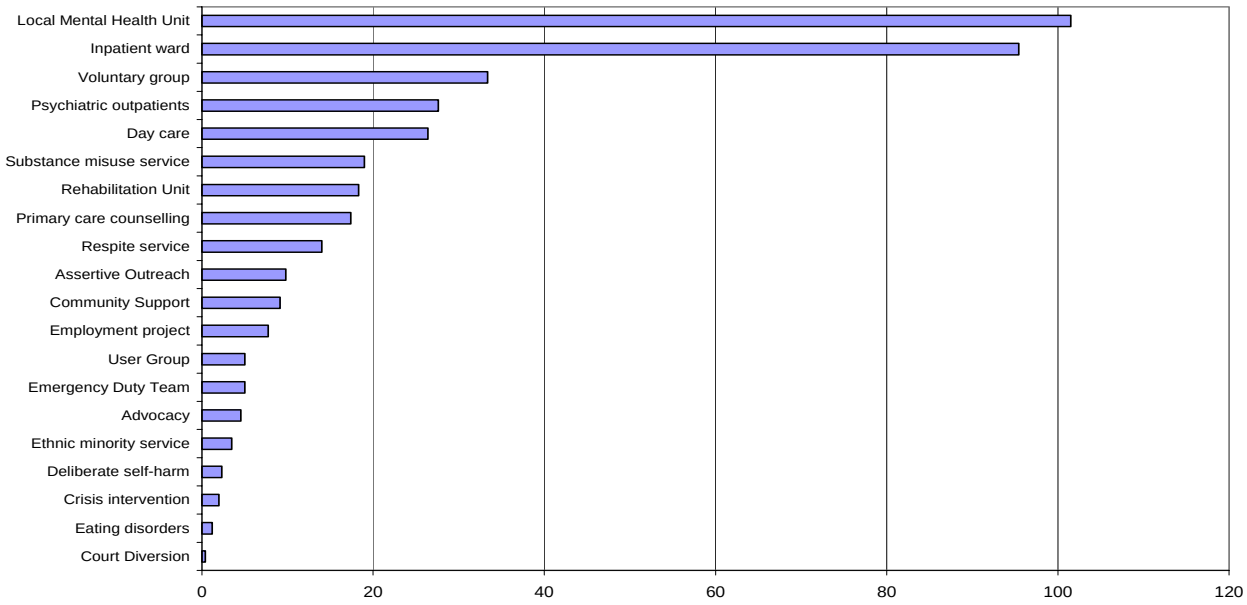
Table 3 **Local delivery plan health economy investment in mental health 2004-2006**



Better use of existing resources

The Figure below indicates the number of staff currently employed in various types of services in Dudley.

Table 4. **Number of staff (w.t.e) by service type in Dudley (Durham Database 2003)**



In the first instance, all provider organisations will be asked to look at how they deploy the resources they have currently. This means resources of all types, including the workforce, their time and the financial resources received. The purpose of this will be to see how much of the model can be implemented very quickly through creative and flexible thinking about how resources can be deployed in different ways. This will also allow organisations to confirm which functions within the model they are already delivering effectively, which things they are doing that are not within the model, or properly within the remit of their organisation – which will need to be ceased. Organisations will need to talk with their staff and involve them in this thinking. Staff will need to develop an understanding of the service model and give some thought to where they would like their role to be in the future and how the future might be shaped. Where such changes can be achieved, the proposals will be put to the mental health Commissioning Group for discussion, negotiation and agreement.

Action

- The service re-design plan will describe programme of redesign and the associated release of resources to implement the policy of rebalancing delivery from Secondary to Primary Care Services and describe the revised current role and function of inpatient, Day Care and Community Mental Health Team (CMHT) services.
- A Bed Management Strategy will reflect a year on year reduction in acute bed usage built form a baseline set in 2003/04 reflected in the Mental Health Strategy. The Impact of Crisis Resolution/Home Treatment will be reflected with effect from January 2006.
- Further development of partnership working with the community and voluntary sector to strengthen services promoting mental health and social inclusion in relation to housing, employment, day services, family/carer support, advocacy and user-led initiatives

8. Shaping services for the future

Many members of the primary health care team treat people with both common and serious mental health problems with little appropriate training or supervision. With the rise of community care, primary care has begun to move away from being simply a filter or referral pathway to specialist services to being a provider of specialist mental health care itself.

The aim is to develop a fully integrated mental health service that is driven from the Community, a comprehensive service that undertakes screening, assessment for treatment and supportive interventions; and as a second line provides therapeutic interventions, and resolution services.

Traditional methods of delivering psychological treatments are unlikely to ever be able to meet the growing demand for services therefore within the structure are new roles including **Graduate Mental Health Workers,** placed to facilitate self help within a supported environment where a level of gate keeping has been introduced.

The **Link Workers** (addressing the role of Gateway Workers described in the PIG) are mental health trained clinicians who are integral to the Primary Health Care teams and provide triage, assessment, screening, signposting, mental health consultation and referral on to specialist services. In the future **Practice Nurses** could be supported to provide physical and mental health checks for those on the SMI register. We recognise that the stimulus for change in service delivery may be external but the primary motivator for accomplishing change resides with the organisations and they have taken steps towards developing an infrastructure within Primary Care that will drive forward the Primary Mental Health Agenda and the first steps towards separation from the regular organisational structures.

Action

- Dudley will develop the skills of clinicians already working in Primary Care including GPs, Practice Nurses and Pharmacists and introduce protocols for the management of patients with a range of problems/disorders including:
  - Depression
  - Anxiety
  - Schizophrenia
  - Dementia
  - Substance Misuse
  - Eating Disorders
- Assessment tools will be introduced and Primary Care staff will be fully supported by experienced mental health professionals and have direct access to specialist teams for further comprehensive assessment and interventions
- There will be clear protocols to ensure that those patients with mental health problems receive appropriate access to health screening and assessment – particularly those patients on Primary Care Mental Health Registers, those subject to CPA and specifically women with mental health problems will be supported to access cervical and breast screening programmes.
- 5wte Graduate Workers will be in place and delivering a service by March 2005
- 3 Gateway Worker posts will be developed and delivering a service by March 2005.
- A programme of training and education will be developed for primary care staff to develop the skills and knowledge required to meet the changing role of primary care.
- Clear protocols for the transition between services will be achieved by 2004- specifically linked to Crisis Resolution, Early Interventions, Assertive Outreach, CMHTs, CAMHS and Older People's Services

Unless compulsory treatment under the mental health act is assessed as the appropriate response, anyone accessing support or treatment for a mental health problem should be aware that they have the right to 'opt out'. If this is their choice, then the service at all levels should be able to offer rapid access back into it if necessary – this can be achieved through the provision of detailed information and contact numbers.

Access to effective psychological, psychosocial and family interventions:

There are a number of psychological approaches that have been shown to be effective in the treatment of people with mental health problems. Qualified staff working within CMHTs should be able to use these interventions to work directly with individuals. Equally, family intervention approaches, which support whole families to carry on living with mental health problems within it, will be essential skills across the care continuum.

Action

- The Meriden Approach of Behavioural Family Therapy (BFT) will be fully implemented across the entire range of services with staff trained and supervised appropriately.
- Cognitive Behavioural Therapy (CBT) approaches will be developed at all levels from Guided Self Help through to intensive therapeutic interventions undertaken by counsellors and therapists across primary, community and hospital services.

Over the next 5 years mental health services will move towards a service that compliments traditional medication with talking therapies but more importantly offers people a real choice. The recommendations of the psychology review undertaken in 2004 proposes a new model for delivery of psychology services which creates 3 divisions:

- **Adult Mental Health** – for patients with severe or enduring mental health problems and linked to CPA
- **Primary Care** – for patients with complex emotional problems who would benefit from a programme of sessions of single handed psychological therapy
- **Older Adults** - Primary Care service for older adults requiring therapeutic interventions and integrating psychological interventions into all aspects of practice

Action

- An investment profile to achieve the recommendations of the psychology review will be developed and progressed through the LDP process (2005-2008)

Effective services for effective care

Work that has been undertaken in recent years has seen significant development in respect of new services including:

- Assertive Outreach
- Early Intervention Service
- Crisis Intervention/ Resolution

Assertive Outreach

Support and access to services - assertive outreach workers engaging with those who find it difficult to sustain contact with services, and other specialist workers should provide the care co-ordination role for individuals including those cared for within the integrated Care Programme Approach (CPA).

Assertive outreach is a specific model of service delivery and to be effective, needs to be delivered in a prescribed way. The approach is also only effective if targeted appropriately. The target groups are those who would not by choice stay in contact with other services, but would benefit from support and treatment. These include people with personality disorders, dual diagnoses[10], the homeless and those whose illness prevents them from creating any stability within their lives on a day-to-day basis. It has been shown that if not appropriately targeted; it is no more effective than standard care co-ordination.

Such services also need to provide practical support for people to enable them to achieve the best possible quality of life.

Action
The Assertive Outreach Team will extend its provision in relation to:

- Dual Diagnosis (Mental Health and Substance Misuse Co-Morbidity)
- Improving Links with Criminal Justice Agencies, including Prison In reach

Target activity will be achieved and maintained from 2004

Early Intervention

Early intervention services aim to reduce the duration of untreated psychosis to a service median of less than 3 months and provide support for the first three years for all young people who develop a first episode of psychosis. The model approach adopted locally supports the social inclusion and mental health promotion focus and will link closely with partner organisations and key stakeholders including mainstream education and leisure services.

Action

- An initial phase team will be in place by December 2004 with further investment identified for 2005/06
- Activity will achieve defined targets from March 2005

Crisis Resolution / Home Treatment

The 2 Crisis Resolution Teams in place will act as the gatekeeper for all admissions to Bushey Fields – evidence suggests that this will result in a reduction in the demand for hospital beds of 30-50%. Therefore a programme of bed reduction will be agreed from 2006, which will release resources from secondary care to further develop community and primary care services.

Action

- Activity will be in line with targets from March 2005
- A bed reduction programme will be agreed from 2006, which will release resources from secondary care to further develop community and primary care services

[10] Department of Health (2002f) Mental health policy implementation guidance: Dual diagnosis good practice guidance. http://www.dh.gov.uk/assetRoot/04/06/04/35/04060435.pdf

Action

- Detailed Operational Policies including protocols for entrance and exit from the service, guidelines for practice and strategies for the interface with other services will be developed and in place from December 2004.
- Quality and Outcome monitoring indicators will be developed with the lead commissioner for mental health.
- Deliver the 10 High Impact Changes for Mental health following publication of an evidenced based programme in 2006.

Acute inpatient beds

Admission to acute inpatient beds will be the option of choice where people have a high level of very rapidly changing needs requiring active treatment interventions and will be delivered in accordance with the Adult Acute Inpatient Care Provision guidance[11]

- Ideally entirely single gender facilities
- Provided within a good physical environment
- Provide a safe environment within which to access acute treatment.

Action

The Capable Acute Care Forum will develop, oversee and coordinate a local action plan for the implementation of the DoH Acute Care Policy Guidance – Key Recommendations in respect of: -

- Integrating inpatient care within a whole system approach
- Care pathway arrangements
- Admission and reception
- Structuring inpatient ward arrangements
- Leadership
- Staffing
- Education and training
- Ward environment
- Developing and sustaining improvement

Day Treatment Service

Day services offering a range of evidence based psychosocial interventions can be extremely effective in helping people with mental health problems and their families.

Action

- A review of day services will be undertaken to determine the current effectiveness and future direction of day services in meeting the needs of people with mental health problems
- Day services for people with mental health problems in Dudley will be characterised by:
  - Extended Hours
  - Rapid access
  - Responsive assessment and acute care provided to address rapidly changing need. This includes medical assessment to treat acute problems, and possibly the prescribing of medication.
  - Essentially an acute treatment environment – using people's beds in the own homes at night

[11] Department of Health (2002) Adult Acute Inpatient Care Provision: Policy Implementation Guidance.

Day Facilities will be provided in each geographical locality building from existing resources within the CMHTs and strengthening the partnerships with voluntary organisations and community groups.

Crisis beds in non-hospital setting

Crisis or recovery beds can be effectively provided within non-hospital settings and will provide 'time-out' for people with a mental health problem, removing responsibility for daily living tasks and providing a place where people can receive care from the home treatment service if their own home circumstances are not suitable at the time of crisis.

Action

- Crisis beds will be provided in the community linked to review of existing resources within the community rehabilitation service, including services sensitive to the needs of women and black and minority ethnic people.

These will be provided from existing resources linked to the community rehabilitation service.

Intensive care beds

A Psychiatric Intensive Care Unit (PICU) will ultimately be provided within the acute hospital facility for people who require very high levels of care and support to manage risk to self and others. This is currently accessed through placements out side of local services, often within the independent sector.

Action

- A clear pathway will be developed for patients requiring PICU to ensure a seamless transfer into and out of PICU facilities outside of local services.
- Intensive care beds will be provided within the context of a safe environment with a detailed specification that reflects the care required to manage high risk patients.
- Local services will develop a proposal for provision of a local PICU
- Consideration will be given to the repatriation of patients receiving care outside of the area and specifically those in the independent sector.
- Closer links will be developed, through pathways, with West Midlands Specialised Services Agency (WMSSA) in respect of those patients receiving or assessed to need a secure provision based on forensic needs.

Respite care in a non-hospital setting

Respite care can provide options for both the service user and/or the carer to leave the home environment. For example, enabling the carer or service user to take a break with family elsewhere or in a guesthouse where own resources are not available.

This could also be providing an opportunity for a whole family to move elsewhere whilst a family member is receiving treatment – where other pressures could be temporarily removed to enable the family to focus on resolving the problems within it. This needs to be considered within the framework of Breaks for Carers.

Support to Carers:

Support to those who care for people with mental ill health is vital to ensure that these carers can continue is essential.

Action

- Review of local support available and gaps undertaken
- Additional carer support worker to be appointed/identified 2005/2006 in line with target of 4 carer support workers
- More carer breaks for mental health carers
- Improved support network services for carers
- All carers of people on Enhanced Care Programme Approach have a written care plan which addresses their own mental health and physical needs.

Delivering co-ordinated care programmes

The Care Programme Approach (CPA) / Care co-ordination will mean that there is one approach to needs assessment, care planning to meet needs, and review of the care package, across health and social care agencies. This process will be supported by one set of documentation used by all involved in the process. Service users, and their carers with consent from service users, must be involved at every stage of the process, and should have a copy of their agreed care plan.

In negotiating a care plan, the Care Coordinator (responsible for the process for the individual in question), must provide information to people about the options that are available, to enable informed choices to be made. The lack of an appropriate option should be recognised as an unmet need and recorded. The care coordinator must always seek to find creative ways of meeting an unmet need, as well as identifying the issue to inform future service planning.

Because it is recognised that carers perform a vital role they will be offered an assessment of their caring needs and an agreed plan drawn up, including general and caring information, crisis help and respite arrangements. Their own Care Coordinator will be allocated, and will be available for advice. Care Coordinators must always be qualified professionals.

Action

- A CPA process will be in place that fully delivers all aspects of good practice and guidance
- Housing needs are addressed within the Care Programme Approach Care Plan
- Benefits advice will be accessible via all mental health services and will be routinely addressed as part of the care programme approach
- Employment and occupational needs are routinely addressed as an integral part of the Care Programme Approach

The work for the next 5 years is to address the gap between the current position and the desired situation which ensures that the balance of developments reflects the burden of illness and that services reflect the most effective use of every £ spent on mental health services.

The Local Implementation Team will change the focus of their activities to ensure service change and development is consistent with the agreed strategy and making timely progress.

Individual commissioners will have performance management roles within the service agreement process – to ensure agreements are appropriate and are delivered.

Individual provider organisations have responsibilities through their own quality improvement processes for ensuring that the services they deliver are of the highest possible quality. Equally there is a responsibility to be reflective and to explore problems and concerns to learn from them and continue to develop.

Many of the above processes are evaluative in nature. This doesn't remove the need for specific evaluations of services as they change and develop. Also, to follow on from events held during the months taken to develop this strategy members of the LIT will be joining people from a range of organisations in to hear how, as a whole system we have progressed, and how we might continue to do so.

Action

- Dudley mental health services will utilise various qualitative and quantitative outcome measures in collaboration with mental health service providers to monitor the effectiveness of service delivery
- These measures will form an important part of Service Level Agreements with providers
- The LIT will monitor progress in relation to the annual "Autumn Assessment" of mental health services and associated Department of Health Planning and Priorities Framework Targets and implements appropriate Action Plans to address any gaps and shortfalls in performance.

Personality Disorder Services

The National Service Framework for adult mental health sets out our responsibilities to provide evidence based, effective services for all those with severe mental illness, including people with personality disorder who experience significant distress or difficulty.

The guidance aims to builds on standards four and five in the national service framework and sets out specific guidance on development of services for people with personality disorder. It brings this often neglected and isolated area of mental health into focus for the first time.

Personality disorders are common and often disabling conditions. Many people with personality disorder are able to negotiate the tasks of daily living without too much distress or difficulty, but there are others who, because of the severity of their condition, suffer a great deal of distress, and can place a heavy burden on family, friends and those who provide care for them.

As with all forms of mental disorder, the majority of people with a personality disorder who require treatment will be cared for within primary care. Only those who suffer the most significant distress or difficulty will be referred to secondary services.

People with a primary diagnosis of personality disorder are frequently unable to access the care they need from secondary mental health services. And are often treated at the margins – through A&E, through inappropriate admissions to inpatient psychiatric wards, on the caseloads of community team staff who are likely to prioritise the needs of other clients, many clinicians and are reluctant to work with people with personality disorder because they believe that they have neither the skills, training or resources to provide an adequate service.

The changes proposed in the draft Mental Health Bill – the broad definition of mental disorder, the abolition of the so-called "treatability test" in relation to psychopathic disorder and the provisions enabling compulsory treatment in the community – will highlight the need for new community and in-patient services. This also places an emphasis on the need to provide new training in the assessment and diagnosis of personality disorder, in order to ensure clinicians and practitioners are equipped with adequate information about treatment options and service models.

Guidance has been produced to facilitate the implementation of the National Service Framework for Mental Health as it applies to people with a personality disorder.[12]

Action

- Local development of a specialist multi-disciplinary personality disorder team to target those with significant distress or difficulty who present with complex problems.
- Consider the development of specialist day patient services in areas based on a needs assessment to determine the level of need locally
- To determine the training needs of staff and commission training to meet those needs
- To consider the implications of personality disorder services on adult inpatient services against the programme of service re-design

[12] Personality Disorder: no longer a diagnosis of exclusion. NIMHE (2003)

9. Role and scope of a primary care driven mental health service

There are essentially, four components to the role and scope of Primary Care Mental Health services if it is to meet the needs of communities:

- **The promotion of the mental health and well being** of all sections of the community and the promotion of positive attitudes to mental health and illness
- **Intervening**: the screening, diagnosis, treatment, care and support of individuals, and their carers, living in the community who are experiencing mental distress. This will include the need to address physical health and social supports.
- **Appropriate liaison with colleagues in secondary settings**, and other agencies, to co-ordinate the care needs of individuals in receipt of or in need of secondary services and further networking with other provider agencies
- **Ensuring that patients and their carers are routinely involved** in determining treatment options and in the planning and evaluation of services

Modernisation is a key phrase in health and social care policy documents that reflects a desire to set aside accepted practice and embrace a philosophy that reconciles evidence with the views of service users but what does that actually mean for primary mental healthcare?

The policy emphasis in the National Service Framework (NSF) primarily concerns severe and enduring mental illness a policy focus that is reflected in Dudley, where a programme of developments for the needs of those with severe and enduring illness has been developed as a priority governed by performance indicators and national targets, but this strategic gap has meant that until now there has been little structure or framework for developing primary care mental health service delivery.

Obviously local structures and resources will shape this but local discussion has supported models for secondary services to assist primary care management of people with the severe and enduring mental health problems Nevertheless the kind of values and principles contained in the NSF apply equally to those with milder forms of illness and these values have been incorporated into the approach we have taken in Dudley. Integration of Health and Social Care is an early priority and closer integration between primary and specialised services is also important

Community Self Help

People experiencing mental health problems and their carers may choose to seek help from a range of agencies in the community. Many people will receive the right response to meet their needs without needing to go to specialist mental health services (secondary care).
These may include such agencies: (This is intended to be an example and is not descriptive)

- Self help groups/Support agencies
- Community Groups
- Housing agencies
- Local Authority departments
- NHS Direct
- Employment counselling
- Helplines
- Religious leader

All of these services will be strengthened to work together with Primary Care teams facilitating greater awareness, understanding and access to resources within a community setting.

Action

- Services will build on the strengths of community organisations for example, people could opt to make direct contact with a 24 hour single point of access to services and community agencies will use the single point of access to gain further advice and information to help them provide support to an individual, or to facilitate referral to a more appropriate agency.

Support and Advocacy

The role of unqualified support workers to facilitate access and provide support will be key to high quality care. Equally, advocacy services will be essential to ensuring the voices of some service users and their carers are heard, who feel unable to speak for themselves, as they would wish to.

Action

- The roles of Primary Care Graduate Workers and Support Time and Recovery Workers will be developed across the range of services through Community Groups, Voluntary Organisations, Primary Care, CMHTs and Specialist Teams.
- Community Development Workers will create robust links into BME communities and those 'hard to reach' including refugees and Asylum seekers.
- Carer support workers will reflect the range of carers including young carers to extend the support to all parts of the community.
- Training in the 10 essential capabilities will be extended to staff in other agencies including employment, education, housing, leisure and benefits to raise understanding and awareness and reduce discrimination and exclusion.

10. Mental health promotion and social inclusion

"Mental health promotion includes any activity which actively fosters good mental health, through increasing mental health-promoting factors, such as meaningful employment and decreasing those factors which damage or reduce good mental health, such as abuse and violence.[13]"

Mental Health Promotion works at three interconnected and interdependent levels, each of which may be relevant to the whole population, individuals at risk, vulnerable groups or people with mental health problems.[14] It is important that planned interventions are, as far as possible, based on effective evidence based models. The evidence base for mental health promotion interventions[15] although somewhat limited, provides some clear guidance. Broadly speaking, interventions that have been shown to prevent or minimise mental illness amongst adults include:

- Public education mass media campaigns to improve attitudes towards mental illness. The impact of such campaigns is greater when accompanied by focused community activity.
- General health promotion programmes that incorporate client involvement, a positive approach and regular evaluation
- Action to prepare people for life changes: e.g. Brief interventions when a close relative has a serious illness, Brief interventions for those going through divorce etc.

Examples of more specific interventions for which higher quality effectiveness evidence is available (systematic reviews of randomised controlled trials) include[16]:

- **Social support and problem solving** or cognitive-behavioural training for the unemployed to improve mental health and employment outcomes
- **Social Prescribing** to link vulnerable people to a specific programme such as arts or learning on prescription, which is part of a framework for developing alternative responses to mental distress and is part of a wider recognition of the influence of social and cultural factors on mental health outcomes.[17]
- Providing **respite care** and some psychosocial support to long-term carers to prevent or minimise mental health problems
- **Counselling and group work** to give general support and develop coping skills for those going through divorce or separation
- **Home visits to socially disadvantaged pregnant women** providing social support to improve the mental well being of mothers and their children

Mental health promotion forms an explicit or implicit part of the remit of a large number of staff and organisations in the statutory and non-statutory sectors.

During the year 2005, the Dudley Local Implementation Team, through the Mental Health Promotion Group – which was made up of a wide range of key stakeholders – reviewed the way we promote positive mental health and deliver effective mental health promotion interventions.

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[13] HEA, Mental Health Promotion: A Quality Framework, London, 1997
[14] Mental Health Promotion, Briefing 24, SCMH. London 2004
[15] Effectiveness of mental health promotion interventions – a review, HEA 1997
[16] Mental Health Promotion in High Risk Groups, Effective Health Care, NHS Centre for Reviews and Dissemination, University of York, 1997
National programme for improving mental health and well-being: National Advisory Group. Scottish Executive 2004.

This is dependent upon expertise, resources and partnerships across all sectors and disciplines as most of the factors that influence mental health lie outside the remit of health and social care. Programmes will include initiatives to promote positive mental health in schools, workplaces and neighbourhoods, for individuals at risk and groups that are most vulnerable, to respond to the challenge of promoting mental well being for all.

Action

- The Standard 1: Mental Health Promotion Group has been reformed ads the main planning group to with a remit to review membership of the Standard 1 Mental Health Promotion Delivery Group: Members will come from a wide range of backgrounds, including the voluntary and statutory health, social care, education and criminal justice sectors. Community representatives, users and carers will also be sought.
- Ongoing co-ordination of the programme and gap analysis of mental health promotion activity and resources in Dudley set against the Mental Health Strategy
- Using existing local reports and data sources to assess local mental health promotion needs
- Agree a revised mental health promotion model and structure for Dudley based on the evaluation process
- Devise a costed mental health promotion workplan with structures for steering and monitoring implementation of the workplan
- At an early stage the group will consider local interventions to tackle stigma and discrimination against people with mental health problems ensuring a policy of inclusion for all representative groups within the community
- Promotion of access for people with mental health problems to further education and training
- The Model for Mental Health Promotion in Dudley will form the foundation for the development of Mental Health Services
- There will be robust mechanisms in place for the monitoring and evaluation of Mental Health Promotion Programmes/Strategies

'Millions of people suffer from mental health conditions at some time in their lives…even with changing attitudes in society, those suffering from mental distress still find themselves excluded from many aspects of life the rest of us take for granted…this exclusion has a huge impact on the individuals concerned and on our wider society…it frequently leads to a downward spiral of unemployment, poverty, family breakdown and deteriorating health……..mental health conditions are more common and their impact greater in our more deprived areas…there are also particular barriers and problems faced by those from ethnic minority communities…..'[18]

Dudley Local Health Community will tackle social exclusion supporting re-integration into the community as an integral part of effective mental health services. Earlier access to services regardless of age, ethnicity, gender or social status, support to access to employment and education, support for families and wider community participation to strengthen opportunities for integration into the wider community through sports, arts and leisure … all of these will contribute to a remove the barriers facing people with mental health problems. This can only be achieved through effective partnership working and a co-ordinated approach to service development and delivery.

[18] Mental Health and Social Exclusion – SEU report London 2004

Action

- Develop a social inclusion action plan to include: -
  - Redesign mental health day services to promote social inclusion during 2005/06
  - Improved access to vocational and social support
  - Improved access to education and training opportunities
  - Targeted support for families through dedicated support workers
  - Improved access to sports and leisure opportunities
  - Improved access to financial and legal advice

Improving Services for Black and Minority Ethnic Groups

Mental Health services will be developed to be inclusive of the needs of all sections of the community ensuring that specific issues are not dealt with in isolation but that all services are culturally sensitive and appropriate to the needs of all groups.

In support of this statement the BME forum, as a subgroup of the LIT will drive the agenda for delivering culturally competent mental health services

Action

- Investment and Partnership working will actively support the voluntary sector and community initiatives to promote, innovative and accessible services, including the appointment of Community Development Workers.
- Develop Dudley BME Strategy Paper and Action Plan and Audit Process based on the themed review in 2003 and the BME Themed review undertaken as part of the 2004 Autumn Assessment
- Undertake a mapping of existing services and identification of gaps and shortfalls, to include evaluation of new posts and services and develop proposals for future investment / development.
- Access – by addressing the language barrier by improved access to interpreting and translation facilities for residents whose first language is not English
- Improve public information about mental health services – available to the BME community improving access.
- Providing support to BME voluntary sector initiatives
- Enhance and strengthen support to BME carers building upon the Dudley Carers Strategy.
- Developing and implementing training and awareness for all staff in Race Equality and Culturally sensitive services and delivering culturally appropriate services
- Check that data is being collected in accordance with the guidelines (EL(94)77) in relation and used to change and develop more appropriate services for BME groups
- Promote improved community engagement with BME groups linked to appointment of Community Development Workers
- Understanding and addressing the needs of refugees and asylum seekers

Developing Gender-Sensitive Services

The Women's Mental Health agenda will reflect the strategy for Women's services with an identified lead to drive the workplan.

Action

- Develop Dudley Women's Strategy Action Plan and Audit Process
- Staff trained in gender awareness/sensitivity
- Gender sensitive assessment and care planning in place
- Effective services for women who have experienced domestic violence and/or childhood sexual abuse
- Women's safety, privacy and dignity needs addressed in inpatient and residential settings
- More women-only day services available
- Criminal justice diversion alternatives to custody for women offenders
- Staff trained in assessment and intervention re: women who self-harm

Successfully tackling Mental Health Promotion and Social Exclusion is dependent upon a workforce that is sufficiently skilled to take on this challenging agenda...Dudley is actively supporting the roll out of the national framework for the whole of the mental health workforce – The 10 Essential Shared Capabilities which offers a comprehensive and inclusive approach to education and training and sets out the minimum requirements or capabilities that all staff across all sectors should possess if there is to be significant progress in removing the barriers that face people with mental health problems.

11 . A system of care for people with mental health problems and their carers:

The new service model is based on the development of an integrated system of care with primary care at the heart of effective service delivery.

NSF Standards 2 and 3 require primary care services for treatment of common mental health problems and ensuring 24-hour access to services in times of crisis.

Action

Building upon NHS Direct, Dudley will facilitate a local service offering advice, information, and supported referral onto a range of other agencies, including secondary mental health services through arrangements set out in joint operational policies – based on agreed assessment procedures this may include direct links to other specialist helplines.

The telephone contact will be enhanced, where appropriate, with face-to-face contact with Gateway Workers or Crisis Intervention/Crisis Resolution teams delivering outreach to people wherever they might be.

Staff and user safety issues need to be given due consideration in developing outreach service responses which may include:

- Telephone advice and information from people with a range of experience and knowledge matched to need
- Advice, information and support for carers
- Redirection to other agencies, e.g. CRUSE, Relate, Benefits Advice, Housing Advice, Citizens Advice Bureau, Primary Care, Substance Misuse Services, other age focused services
- Support to access other agencies
- More detailed assessment to determine referral to other parts of the mental health service
- Activating responses set out within risk management plans for people known to local services. A system for workers believing that a person may be particularly vulnerable at a particular point to lodge a pre-agreed risk management plan with the service should be within operational policies
- Advice specifically to other health professionals outside of specialist mental health services, including medical advice on prescribing and management
- A&E Liaison

12. Suicide prevention:

"Saving Lives: Our Healthier Nation" set a target reduction in suicide rates by at least one fifth by 2010 from a baseline of the average during the period 1995-1997.

Suicide is an important cause of premature mortality, particularly in young men and there is also a higher suicide rate amongst young Asian Women.

Preventing suicide is complex, and many of the factors, which increase the risk, are not amenable to intervention. However, the best evidence suggests that a combination of "population" and "high risk" strategies are needed.

Prevention can be considered as primary ("population approach") or secondary ("high risk"), although there is often overlap between these approaches.
Primary prevention includes:

- Reducing risk factors in the population (e.g. mental illness or unemployment),
- Reducing access to means.

Secondary prevention might include:

- Improving detection, diagnosis, risk assessment and follow-up of people with mental ill health who are at high risk of attempting or completing suicide

Action

A local suicide prevention and reduction action plan has been developed which will form part of a detailed suicide Prevention strategy developed through the health and well-being partnership, involving key stakeholders from all agencies including:

- Police and Criminal Justice System
- Public Health
- Health Professionals
- Social Services
- Young Peoples' Partnership representation
- Voluntary Organisations

Implementing the Mental Health NSF outlines that implementing Standards 1-6 should prevent suicides. These are covered in the earlier part of the strategy. In addition, however the NSF highlights further actions under standard 7 namely:

- Supporting local prison staff in preventing suicide among prisoners
- Ensuring that staff are competent to assess the risk among individuals at greatest risk
- Developing local systems for suicide audit to learn lessons and taking any necessary action

There are a number of possible areas which could be covered by the action plan. Many will be addressed in delivering this strategy; however the four major areas (linking to standards 1-6) will be:

1. Reducing access to means:-
    - Ensuring safe hospital and treatment environments
    - Linking with work on accidents to identify any local places where suicide or attempts occur
2. Addressing underlying risk factors
    - Target setting in relation to unemployment and safe antidepressant prescribing (both type and quantity – see below).
    - Prescribing – monitoring types and prescribing patterns
3. Improving detection, diagnosis, risk assessment and follow-up
    - Shared protocols for the management of people with certain diagnoses. Protocols developed to facilitate and support 24-hour access to appropriate assessment and service responses.
4. Continued learning and improving dissemination of findings following incidents.

Implementing the proposed service model, which has at its heart the need to work in partnership, will also support activity to reduce suicide, by providing more appropriate, coordinated service responses. As well as shared training, and shared protocols, there is a need to develop the audit processes across agencies to monitor the effectiveness of the implementation of protocols and develop a better understanding of the local service improvement needs

Action
Further analysis of public health and related data on suicide and self-harm will be undertaken to monitor progress and further develop the suicide prevention strategy and workplan by the Standard 7 sub-group of the LIT a detailed plan will be developed to improve: liaison, training (especially with primary care teams on identification and management of self harm), access to services, risk assessment, treatment and continued learning, professionally and from incidents

13. Underpinning structures and principles

Links Between Adult Mental Health Services and Other Services

Age Boundaries: The NSF refers specifically to services for adults aged between 16 and 64. Careful planning during the implementation phase will need to be undertaken to address the issues of transfer between CAMHS and Adult services and Adult and Services for Older People:

Action

- Clear protocols for transition between services will be achieved by December 2004.
- Care pathway co-ordinator to be appointed during 2005/06
- Further investment planned in Child and Adolescent Mental Health Services to develop new services and address capacity issues

The Criminal Justice System: In practice, there are already links between elements of the criminal justice system and the mental health care system through the Court Diversion Scheme and with the Police through forums set up to undertake planning and evaluation of aspects of service delivery.

Action

- There will be a project group set up to link these areas with group issues related to prison health care, involving public health professionals with responsibility for mental health public health issues.

Learning Disability Services: There are many people living with a learning disability that also experience physical and/or mental health problems. In recent years the term 'dual diagnosis' has been largely assumed to refer to people who have a mental health problem and a substance misuse problem (drugs and/or alcohol), and the needs of those with other 'dual diagnoses' have been less often discussed.

Action

- Individuals will need to have heir needs met through close collaboration in the implementation of the service model between those providing mental health services and those providing learning disability services.

Drug and Alcohol Services

Some people with a mental health problem also have a substance misuse problem. Indeed, there is often debate about which is the main problem that a person has. This debate is unhelpful and what is required are service responses to meet the needs that individuals have, regardless of the combination of problems. Therefore, it is essential that all people working within either field have an at least basic understanding of the treatment and support needs of such individuals.

Action

- A core function of substance misuse provider agencies is to provide mental health assessments and to work in partnership with Hospital and Community Mental Health Teams for clients with dual diagnosis. It is acknowledged that the links between substance misuse services and mental health services can and will be improved further.
- An action plan will be produced to describe the relationship between mental health and substance misuse in respect of dual diagnosis to be considered through the LDP process during 2005 / 2008

14. Developing the mental health workforce

The development of the new model will need to be supported by a comprehensive programme of education, training and development for all staff across the organisations, disciplines and boundaries between primary and secondary care as this approach will actively encourage people to work across a range of settings and in flexible ways, that support the needs of service users and carers.

A Mental Health Workforce, Training & Education Project Team in partnership with the StHA has already completed some work to look at the competencies required within the workforce to deliver services consistent with the NSF.

These competencies have been discussed with local providers of education and training – who are looking at how best to ensure access to the right type of educational experience, for the people with various roles within the service system including the development of new roles and enhancing the skills of staff to enable them to work in a different way. The challenge will be in ensuring that staff are supported to access the training and education they need.

The Ten Essential Shared Capabilities provides a framework for the whole of the mental health workforce and describes the capabilities that all staff should be expected to have and what would be expected by some specialists...Tragic events evidenced by reports such as the Bennett inquiry, illustrate the need to ensure that all staff have training that will equip them to deliver a service which is underpinned by key principles including user/carer involvement, mental health promotion, values and evidence based practice, working with families, multi disciplinary working and working with diversity.

New models of care focused on integrated working will depend on a number of changes in the culture and service delivery of care: -

- There will need to be a commitment from primary care staff to mental health as an issue
- Specialist staff will need to move into instead of taking over primary care working
- There will need to be a mutual understanding of the culture of each part of the service
- Good communication must exist across the interface as the services develop
- PCTs must commission services that enable better integration

A workforce plan will reflect the implications of developments contained within the strategy on the current workforce in mental health services and in primary care. The issues of flexible ways of working, new roles and skill mix will be taken into account in assessing the workforce demand and supply balance for service delivery. .

The workforce plan aims to identify:

- The main local service drivers for change
- The current baseline of staff in post
- The demand for additional staff to deliver the targets and priorities
- Local plans to meet demand through recruitment and retention policies
- The gaps to be filled through changes in working practice and skill mix.

Action

- A detailed Workforce Development Programme will be developed to support the implementation of the Strategy reflecting new roles and new ways of working by September 2004.
- Participate fully in the development and implementation of the 10 Shared Essential Capabilities across the workforce and wider stakeholder groups
- Full recruitment to “new roles”
- Improved recruitment and retention of key staff to provide services
- Reduced expenditure on agency and locum staff
- Training strategy developed and implemented for staff at all levels
- Workforce reflects diversity of local population
- Culturally competent service is delivered

New roles will be developed to support the integration of community groups into mainstream services – an increase in investment in local community groups through the development of such roles of Support Time and Recovery Workers, Carer Support workers and Community Development Workers will be reflected through investment and redesign.

15. Improving information systems

Information and data collection are essential to the monitoring and evaluation of mental health services both for activity monitoring and for reporting on service developments and performance management.

The development of integrated information systems across agencies will be key to underpinning interagency working and coordinated planning.

It will be essential that the LIT work closely with the Local Information Strategy Group (LIS) to prepare for the Mental Health Information Strategy and its implementation. One of the first aims to achieve is to create integrated information systems to support the integration of CPA and Care Management into a single system.

Action

- The development and implementation of a new mental health information system will reflect the information needs across the economy enabling services to respond to need through better quality and more intelligently used information and will improve the accessibility of care plans and promote information sharing in the context of multi-disciplinary working.
- Robust performance monitoring mechanisms will be developed to ensure transparency in service monitoring and will form part of service level agreements with all providers
- Services will demonstrate that they are delivering care within the standards laid down in 'Standards for Better Health' including those provided from within the independent sector.

16. Monitoring and managing our performance

Performance Management will take place through a number of routes. The High Level Performance Indicators set out for the NHS and Social Services will indicate progress against key targets / PSA targets, Table 5 below indicates some of the key National targets to be achieved over the next few years and progress will be measured regularly by the Department of Health.

The Healthcare Commission will work with PCTs and providers to support and monitor mental health services to continuously improve the quality of our service delivery and the outcomes we achieve for individuals and their families in line with the standards set out in 'Standards for better health'[19]

Table 5

Extract of Mental Health Key Indicators / Targets	
Crisis Resolution:	
Assertive Outreach:	Target number of Teams in Place by December 2003 Achievement of activity against trajectories
CMHTs Integration	CMHTs must have fully integrated management, policies and systems
CPA	Care plans are held on a central database which is regularly updated and available 24 hours a day. Effective systems are essential to provide seamless care for users with a severe mental illness
Patients with copies of their own care plan	Proportion of patients on enhanced CPA with their own copy of their written care plan. Proportion of patients on enhanced Care Programme Approach with their own copy of their written care plan. Standard 4 of the Mental Health National Service Framework states that all mental health users on the Care Programme Approach should have a copy of a written care plan which includes the action to be taken in a crisis by service users.

Through the commissioning process, quality and outcome monitoring will form the basis for evaluating the level of services provided:

For Example CPA

- All patients on CPA will have electronic care plans accessible 27 hours 7 days per week
- All patients to have a named Care Coordinator
- All patients to receive a full CPA review at least every 6 months
- All patients on CPA will be seen within 7 days of discharge- within a community setting
- Services will be audited for CPA compliance at least annually
- Evidence of carers assessments being offered where appropriate
- Evidence of structured risk assessments and risk management process
- CPA will be given to all staff as part of induction training and part of the annual training cycle
- Evidence of user involvement in CPA reviews and care planning
- All services must have up to date information on CPA

[19] Standards for Better Health' DoH (2004)

17. Choice

Wherever possible in the NHS, patients will have an informed choice of treatment options, treatment providers, location for receiving care, and type of ongoing care." **Creating a Patient Led NHS (March 2005)**

Giving people more control over the mental health services and other support they need is at the heart of national policy for the further modernisation of health and social care. The Mental Health Choice Programme was established to develop a strategy for supporting mental health communities in extending the scope, range and equity of choices that are available to local people.

The programme draws together key policy drivers to provide a simple tool to support local systems make tangible improvements in the provision of choice. These drivers include:

- Creating a Patient-led NHS
- Independence, Well-Being and Choice
- Choosing Health
- Social Exclusion Unit

The Mental Health Choice Programme has developed a 'Choice Checklist' to engage and encourage local mental health services to improve and extend choice they provide to people who use their services. *'Our Choices in Mental Health – The Checklist'* identifies key 'choice points' along the care pathway where offering the ability to choose will add the most value to people using services. This methodology provides local systems with ideas for extending choice and gives people who use mental health services clarity about where they can expect to make choices. The Checklist also cites positive practice examples from around the country of innovations in extending choice across care pathways.

The 'choice points' identified in the Checklist are:

- Promoting and supporting life choices
- Access and engagement with services
- Assessment (including the mental health choose and book agenda)
- Choices in care pathways

Action

- A baseline assessment will be undertaken to determine the basis of an action plan for moving the choice agenda in Mental Health forward.
- Key Choose and Book targets will be achieved in line with national expectations
- A referral pathway will be agreed to facilitate both the implementation and monitoring of the choice agenda as applied locally
- Information and choice will be the foundation on which services are provided across the spectrum of care.

18. Summary

Mental health care is not easily defined and developed into neat pathways but is a confused mixture of symptoms which are often difficult to disentangle and rarely conform to case definitions.

We acknowledge the progress that has been made towards the achievement of some of the critical targets contained within this strategy – a project structure is in place for the modernisation of existing services and implementation of the new developments with a timetable for completion that matches the strategic intent.

A robust audit / evaluation of the effectiveness of specifically Crisis Resolution / Home Treatment will be required to assure confidence of the bed releasing capacity as the funding issues are in part being dealt with through

- The re-design of current services
- The planned changes in investment arising from the reduced dependence on hospital services
- New investment identified through the LDP process.

A bed management strategy will be developed to reflect a year on year reduction in acute bed usage built from a baseline set in 2003/2004 reflected in the strategy and it is expected that the impact of Crisis Resolution / Home Treatment will be reflected with effect from January 2006.

It is proposed that the LIT work plan be seen as the final working document with acknowledgement that it may be adapted based on discussions at clinical forums – particularly those focused on the development of primary care.

Work will continue within the current project arrangements – driven through the joint commissioning structure, and associated action plans will be produced which will: -

- Reflect the achievement of key national targets
- A standard project format across all work streams
- Action plans to include workforce and financial implications
- Initial risk assessments will be undertaken and further refined to include contingency planning
- Action plans will be further refined to give confidence of the project relationships and interdependencies with others and resource usage.

It is expected that the strategy and associated action plans will be working documents reflecting the strategic direction for mental health services into the future.

An annual review process on progress made will be undertaken through the LIT, which will continue to be the driving force for change and they will endeavour to ensure that all component parts are able to sustain the scrutiny of a robust project management appraisal.

Successful implementation of this strategy and significant improvement in opportunities and outcomes for people with mental health problems can only be achieved through closer partnership between organisations and services that are designed around the needs and aspirations of individuals.

Stigma and discrimination can have a greater impact on people's lives than the mental health problems themselves, it limits people's aspirations and can make it difficult for them to work, access services, participate in communities and enjoy family life. People with mental health problems can regain the things they value in life regardless of their diagnosis or symptoms. This requires more than medical treatment, it requires a positive response from communities to accommodate individual needs and differing contributions. This strategy attempts to at least begin to address some of the issues through a framework for change for those people whose needs are best served outside of the hospital setting.