Caring Together
Western Bay
Health and Social Care Programme
Gofalu Gyda'n Gilydd
Bae'r Gorllewin
Rhaglen Iechyd a Gofal Cymdeithasol

WESTERN BAY POPULATION ASSESSMENT 2016/17

BRIDGEND AREA

MENTAL HEALTH

1) OVERVIEW OF CURRENT AND FORECASTED NEEDS

The estimated prevalence of adult mental health problems has been surveyed within the UK every seven years since 1993, with the survey in 2000 being the last year for which data has been published that included estimates for Wales, as well for England and Scotland. The 2000 survey and subsequent years, surveys those aged 16-74.

It was published as Psychiatric Morbidity among adults living in private households, 2000, and described as "the report of a survey carried out by Social Survey Division of the Office for National Statistics on behalf of the Department of Health, the Scottish Executive and the National Assembly for Wales".

The 2007 survey was England-only. Results of the 2014 survey have yet to be published.

The term "survey" understates the range of methodologies involved in the periodic assessment of the prevalence of mental health problems: a range of screening instruments are used and face-to-face interviews are also involved, including both lay and clinical researchers.

The estimates of prevalence and service use in this section are derived from the Psychiatric Morbidity for 2000, unless otherwise specified. Furthermore, the headline figures from the 2000 survey that reported Wales-specified estimates for Common Mental Disorders (CMD) and probable psychosis have been used throughout. The graphs showing "Wales (PMS2000)" in the titles are calculated from prevalence rates for Wales in 2000. GB (PMS2000) denotes whole survey results for 2000. Projections marked as "(PMS2007)" denote derivation from the England/Scotland 2007 survey.

Defining Mental Illnesses

The terms used in this document relate to the terms used within the survey of psychiatric morbidity.

The common term **Common Mental Disorders (CMD)** refers to a specific range of six of the most common mental illnesses –

- Mixed anxiety and depressive disorder
- Generalised anxiety disorder
- Depressive episode
- Phobias
- Obsessive compulsive disorder

- Panic disorder

In the 2000 survey, CMDs were referred to as “neurotic disorders” which is terminology no longer used.

The term **probable psychosis** is used in the 2000 survey to describe mental illnesses that is more severe than the CMDs and mostly relates to schizophrenia and schizotypal illnesses, as well as more serious affective illness (mood disorders), such as bipolar affective disorder. Given the nature of the survey methodology, an accurate diagnosis of psychosis is not possible and is therefore described as “probable”. The 2007 survey found that methods used to assess “probable psychosis” resulted in a slightly higher proportion of people (0.5%) identified than survey instruments that more accurately assessed a diagnosis of psychosis (0.4%).

The term personality disorder relates to the following categories:-

- Avoidant
- Dependant
- Obsessive compulsive
- Paranoid
- Schizotypal
- Schizoid
- Histrionic
- Narcissistic
- Borderline
- Antisocial
- Passive-aggressive
- Depressive

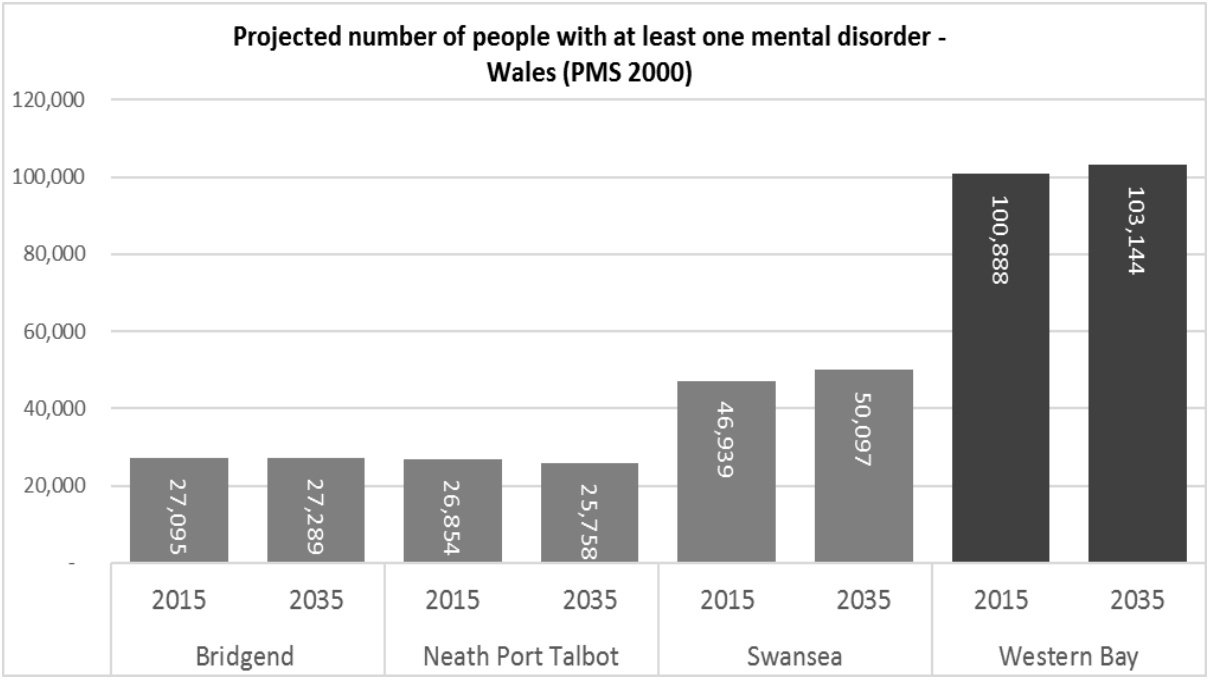
The 2000 survey also looked at drug and alcohol misuse and dependence, but this will be covered in more detail elsewhere.

The term **mental health disorder** refers to all mental illnesses covered by the survey, and thus includes all the above. The 2007 England survey extended the range of diagnoses covered by the survey and some material from that survey is extrapolated to Wales in this document.

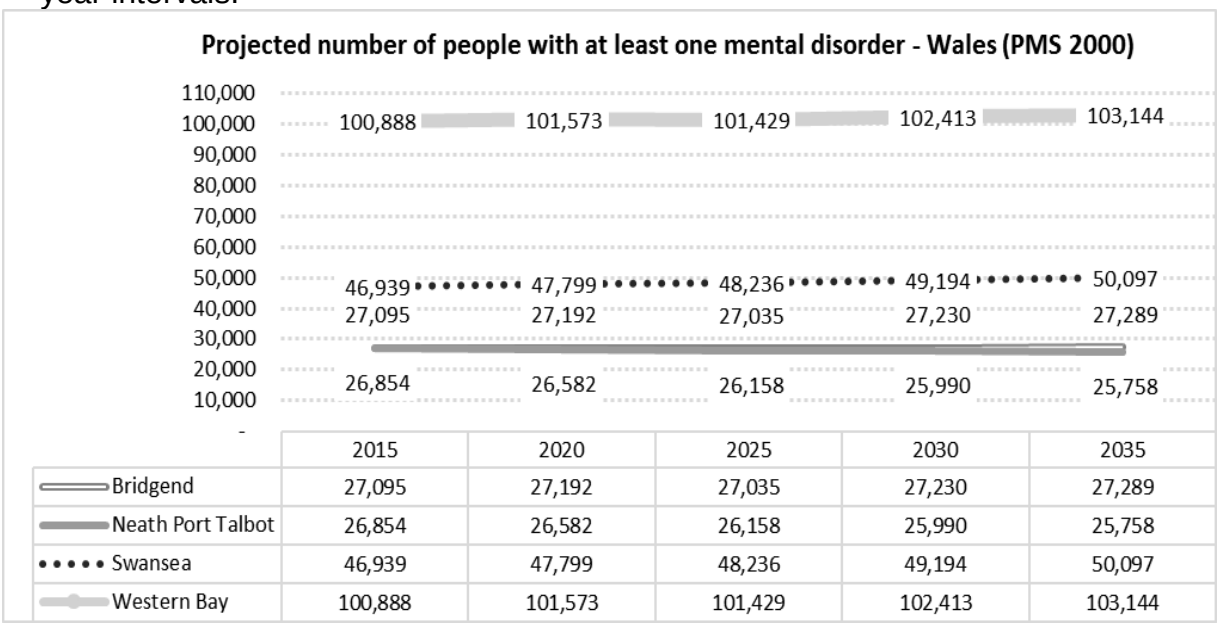
Adults with a mental health disorder

Mental health disorders are very common. The overall proportion of people experiencing at least one mental health disorder within the previous year for the UK in 2000 was 23%. For Wales, this was 26%. The 23% figure for any mental disorder remained stable for England in 2007. As such it is assumed that the Wales prevalence estimate of 26% has also remained stable.

The chart below shows what 26% of the population represents in 2015 and in 2035 for Western Bay.



The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals.



	2015	2020	2025	2030	2035
Bridgend	27,095	27,192	27,035	27,230	27,289
Neath Port Talbot	26,854	26,582	26,158	25,990	25,758
Swansea	46,939	47,799	48,236	49,194	50,097
Western Bay	100,888	101,573	101,429	102,413	103,144

As the projections are essentially based on population sizes, the projected results are largely based on changes in population size. The figures above thus reflect modest increases in the population size of Swansea and Bridgend, but a modest reduction in adult population in Neath Port Talbot by 2035.

Prevalence of Common Mental Disorders (CMDs), Personality Disorders and Probable Psychotic Disorder

The prevalence of Common Mental Disorders was slightly higher in Wales (19% of people) compared to the overall Great Britain result of 16.4%. The 16.4% figure for any CMD remained fairly stable for England in 2007, dropping from 16.4% to 15.1%. However, the prevalence for the age group 16-64 was much more stable: 16.3% in

2000 and 16.4% in 2007. Since the under 65s are the larger proportion of people, it is assumed that the Wales prevalence estimate of 19% has also remained stable.

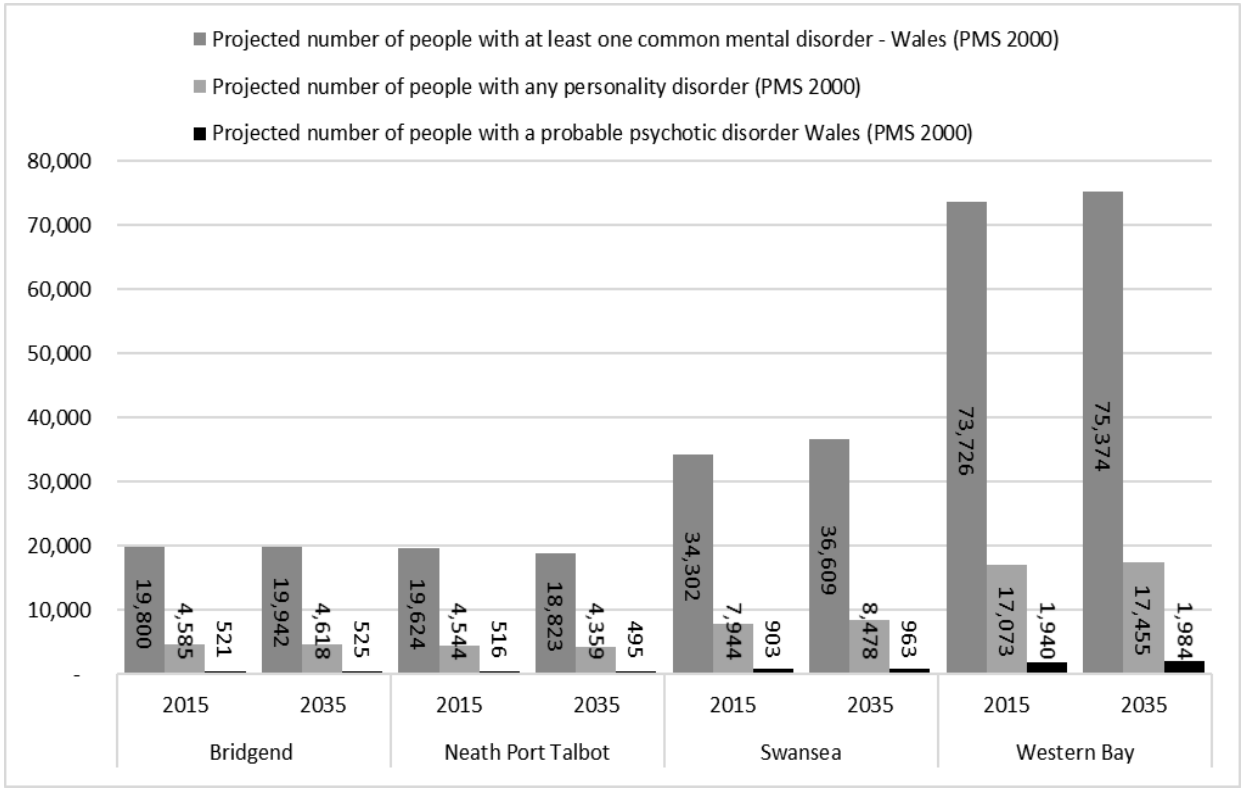
The prevalence of personality disorder in 2000 was 4.4% of the population. The 2007 survey focussed on only two personality disorders.

The prevalence of probable psychotic disorder was the same in 2000 for Wales as for Great Britain at 5% of the population. The prevalence rate in 1993 had been similar at 0.4% of population. The 2007 survey for England also found the same prevalence of 5%.

The chart below shows for 2015 and for 2035 the estimated prevalence expressed as % of people aged 16-74 for each category:-

- 19% with a CMD as per Wales figures in 2000 survey
- 4.4% with a personality disorder as per 2000 survey
- 0.5% with a probable psychotic disorder as per all surveys 1993-2007

Note that the following graphs show the two types of illness but there will be a level of overlap with some people experiencing both. See section below on co-morbidity.



As the projections are essentially based on population sizes, the projected results are largely based on changes in population size. The figures above thus reflect modest increases in the population size of Swansea and Bridgend, but a modest reduction in adult population in Neath Port Talbot by 2035.

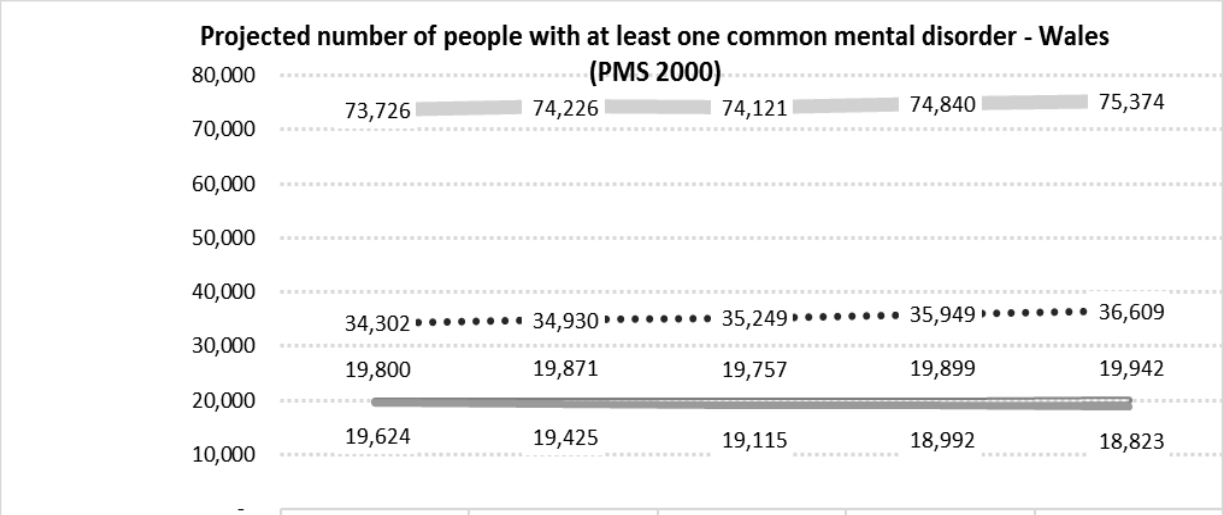
Projected Prevalence of Common Mental Disorders

CMDs are the most commonly occurring type of mental disorder for which people are likely to seek treatment or support. The disorders are:-

- mixed anxiety and depressive disorder,

- generalised anxiety disorder,
- depressive episode,
- phobias,
- obsessive compulsive disorder
- Panic disorder.

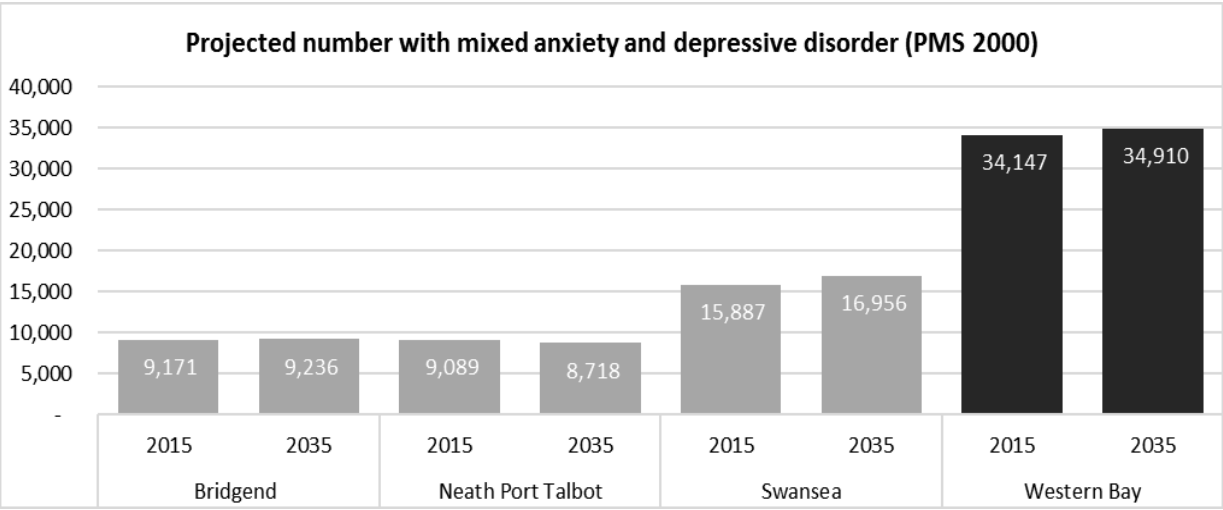
The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals given a prevalence of 20% of the adult population.



	2015	2020	2025	2030	2035
Bridgend	19,800	19,871	19,757	19,899	19,942
Neath Port Talbot	19,624	19,425	19,115	18,992	18,823
Swansea	34,302	34,930	35,249	35,949	36,609
Western Bay	73,726	74,226	74,121	74,840	75,374

Specific Disorders

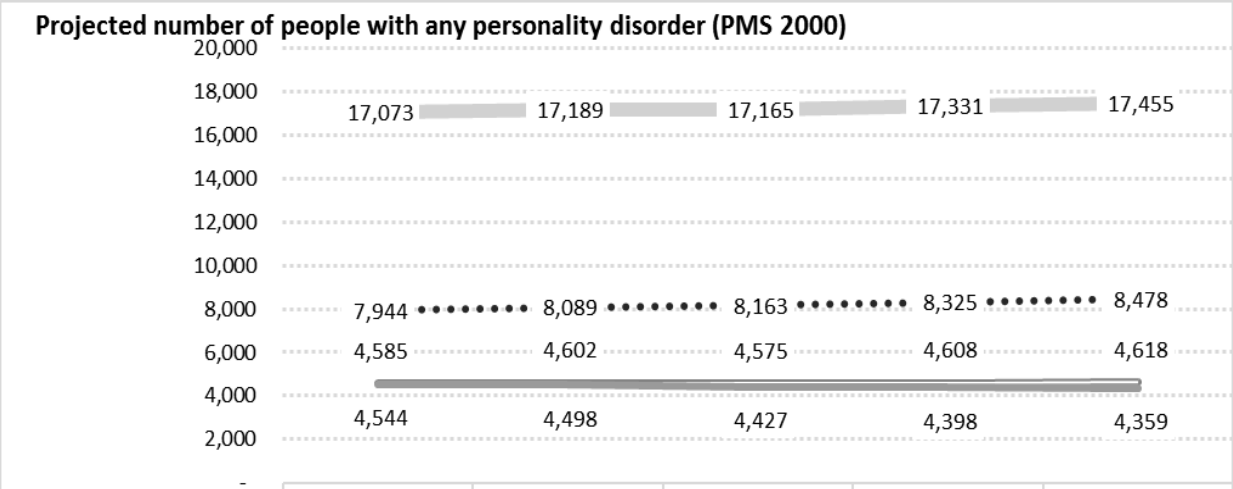
The most frequently-occurring CMD is mixed anxiety and depressive disorder, (sometimes called cothymia) with 8.8% of the adult population experiencing this disorder:-



Projected Prevalence of Personality Disorders

Personality disorders are persistent and they are often expressed as dysfunctional patterns of behaviour that are found to be pervasive and adversely affecting the person's life. Levels of distress and treatment-seeking vary across the personality disorders. In many cases, personality disorders are extremely difficult to treat, if at all.

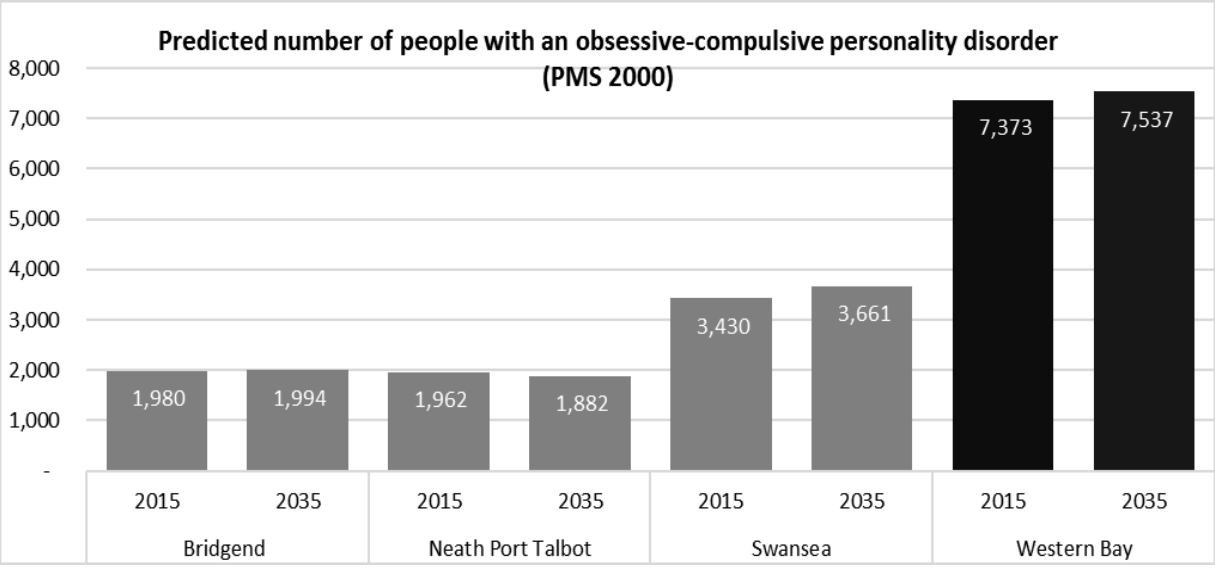
The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals, given a prevalence of 4.4% of the adult population.



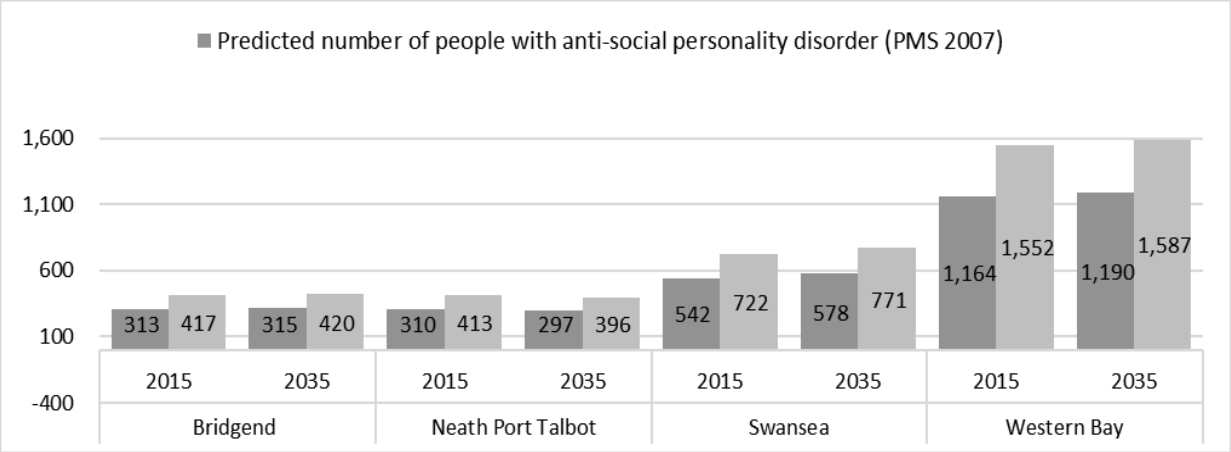
	2015	2020	2025	2030	2035
Bridgend	4,585	4,602	4,575	4,608	4,618
Neath Port Talbot	4,544	4,498	4,427	4,398	4,359
Swansea	7,944	8,089	8,163	8,325	8,478
Western Bay	17,073	17,189	17,165	17,331	17,455

Specific Personality Disorders

The most frequently-occurring personality is obsessive-compulsive personality disorder, (sometimes called cothymia) with 1.9% of the adult population affected:-



Using estimates from the 2007 survey, it is possible to estimate the prevalence of antisocial and borderline personality disorders, at 0.3% and 0.4% of the population respectively.

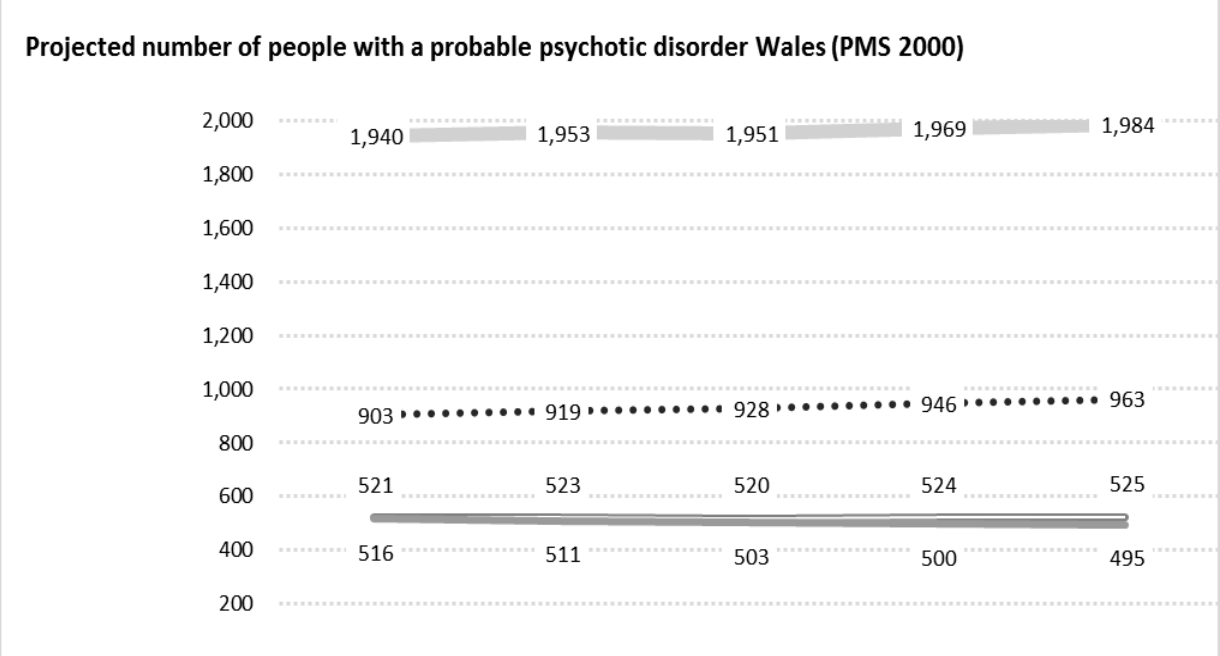


Note these two disorders may co-occur (probably rarely) so there could be some overlap between people in each category.

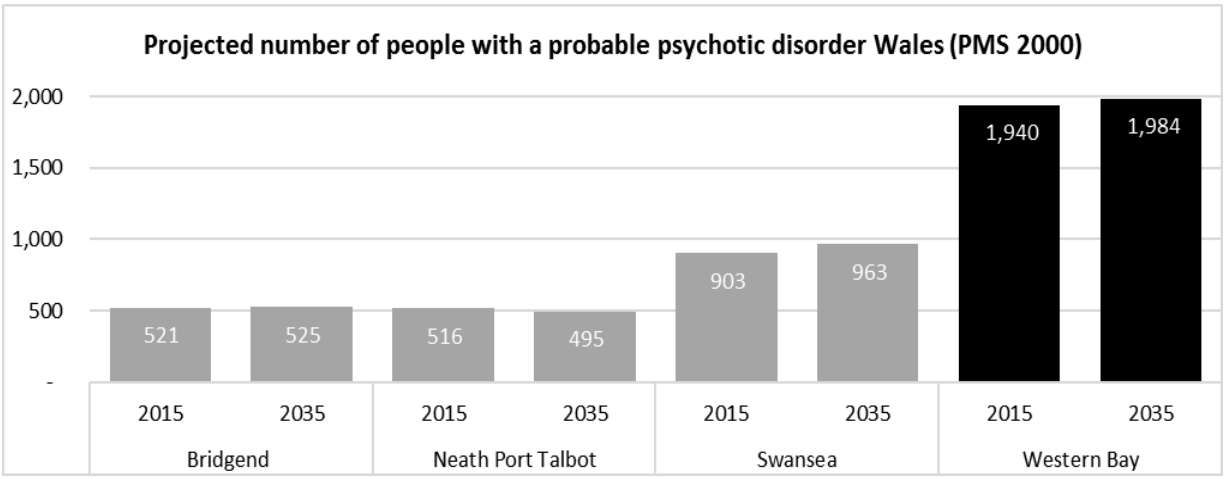
The least prevalent are dependent and schizotypal personality disorders, at 0.1% of the population.

Projected Prevalence of Probable Psychotic Disorder

The following chart shows the projected numbers of people with probable psychotic disorder across Western Bay to 2035 at five-year intervals, given a stable prevalence of 0.5% of the adult population across the surveys carried out 1993-2007.



	2015	2020	2025	2030	2035
Bridgend	521	523	520	524	525
Neath Port Talbot	516	511	503	500	495
Swansea	903	919	928	946	963
Western Bay	1,940	1,953	1,951	1,969	1,984



Projected Numbers Receiving Treatment, Contact with GP & Receiving Community Services

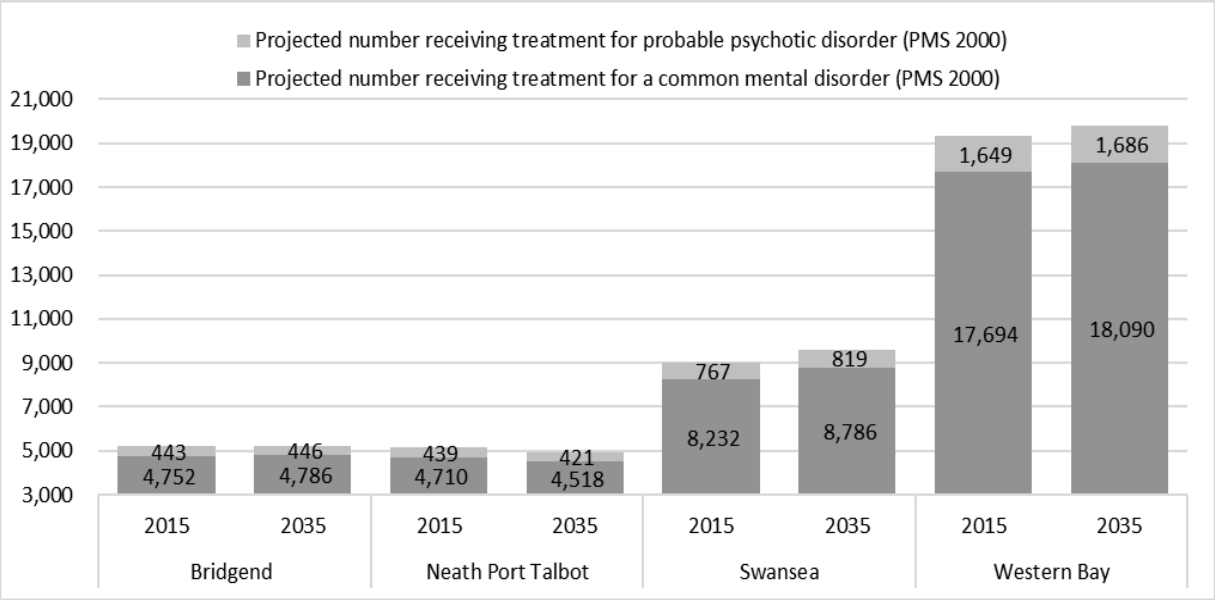
The projected numbers in these sections are based on the projected prevalence rates set up above and compared to the findings of the 2000 survey regarding these topics as related to CMDs and probable psychotic disorders. We present only treatment data for CMDs and probable psychosis due to absence of data for personality disorder.

Receiving Treatment

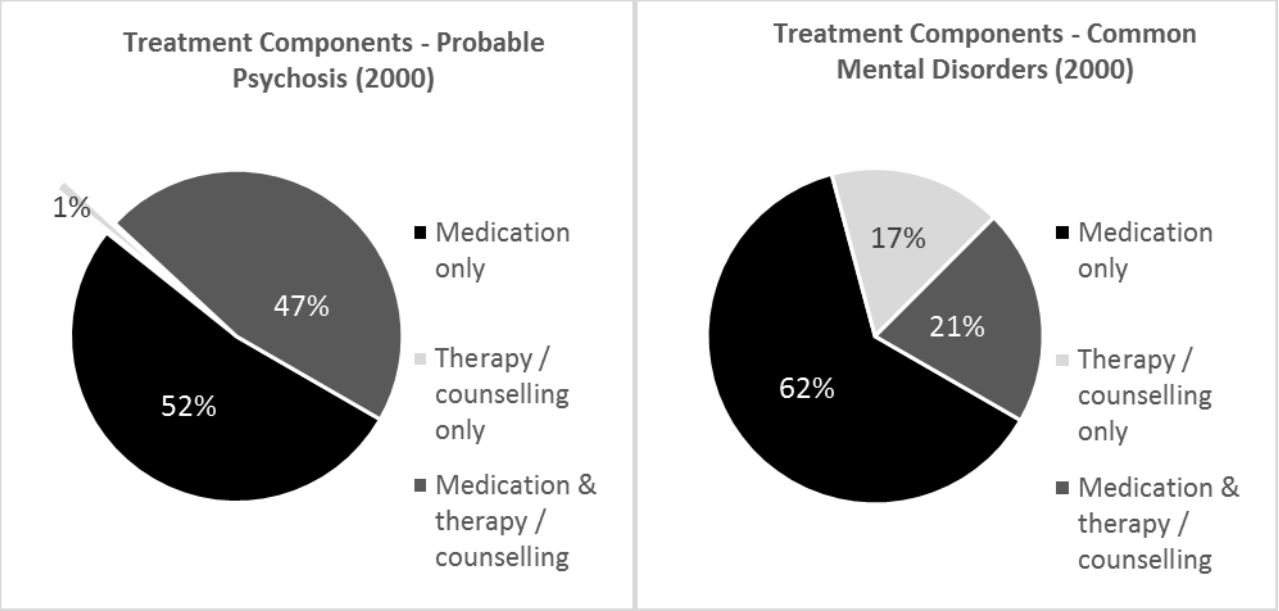
Treatment is explicitly defined in the survey as those receiving the following in the previous year:

- Receiving medication **and / or**
- Receiving counselling / therapy.

In 2000, 24% of people with CMD were projected to be receiving treatment, as were 85% of people with a probable psychotic disorder. The 2007 survey for England showed 81% for probable psychotic disorder while treatment for CMDs remained at 24%. The 85% treatment rate has been retained as the 2007 data for probable psychosis was regarded as less reliable due to smaller sampling rates. The 24% treatment rate for people with CMDs is also used.



It is possible for a person to experience both and therefore there will be some overlap in the two sets of numbers.



The treatment used most often for CMDs and probable psychosis is medication, with 99% of those with probable psychosis receiving medication as part of their treatment, and 83% of those with CMDs receiving medication as part of their treatment. 48% of those with probable psychosis receive some form of therapy / counselling, while just 38% of those with CMDs receive this form of therapy. 62% of those with CMDs receive only medication as treatment.

Talking to GP about a Mental or Emotional Problem

General Practitioners consider that a large proportion of their consultations relate to mental health problems. The data from the 2000 survey suggests people with mental health problems may be much more likely to speak to their GP about a mental or emotional problem than those who do not have such problems.

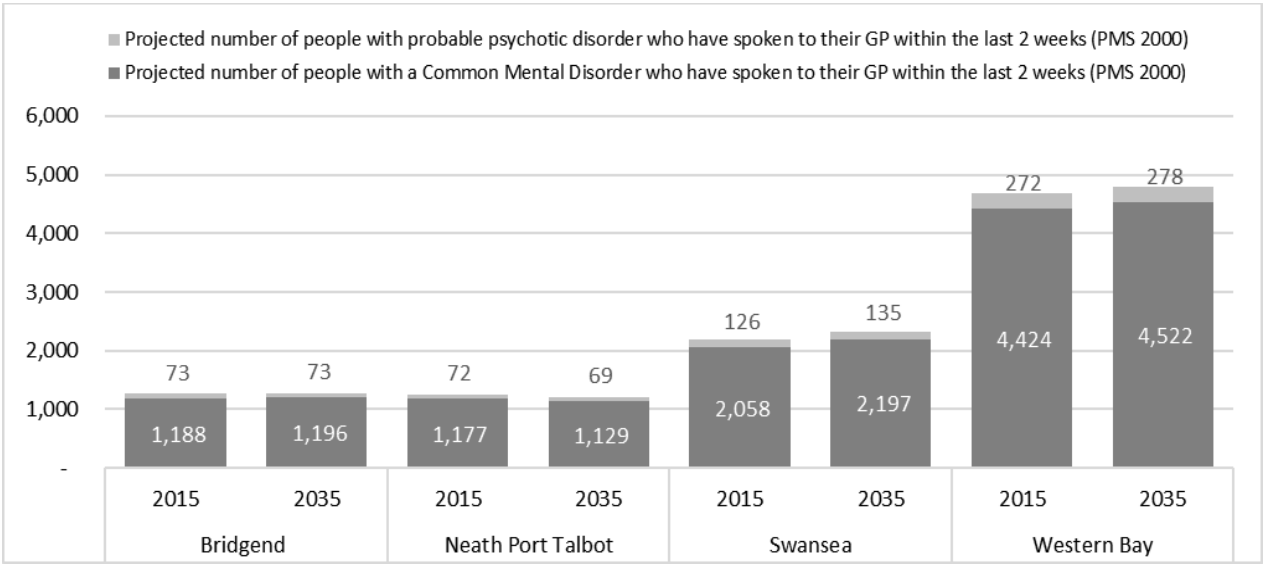
The table below shows that 14% of people with a probable psychotic disorder spoke to their GP about a mental or emotional problem in the last 2 weeks compared to 2% of people who do not have such a disorder: a seven-fold difference. Similarly, those with CMDs are six times more likely to have spoken to their GP than those without CMDs.

	% of people spoken to GP about a mental or emotional problem			
Have spoken to GP about a mental or emotional problem	**With CMD**	**Without CMD**	**With probable psychotic disorder**	**Without probable psychotic disorder**
Within previous 2 weeks	6	1	14	2
In the last year	39	6	71	11

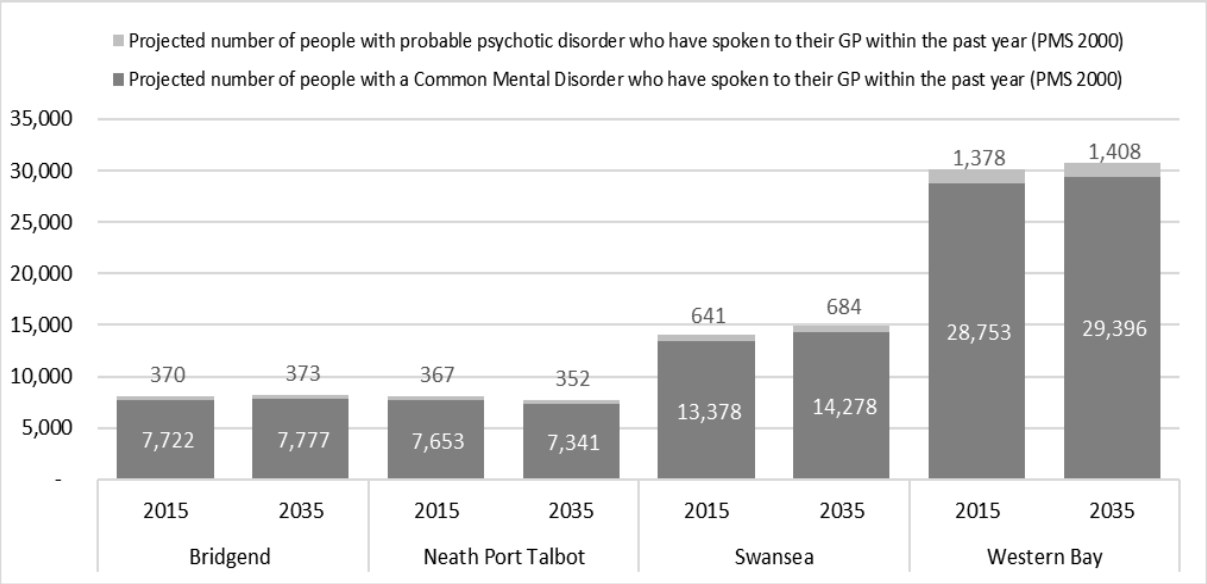
Looking at the whole of Western Bay using the projection for having seen GP within last 2 weeks for 2015 in the graph below, approximately 4,700 GP consultations in a fortnight were carried out with people with CMDs or a probable psychotic disorder.

Over a 52-week period, this is over 122,000 consultations (125,000 by 2035).

It should be remembered that there will also be a considerable number of additional consultations that relate to substance misuse or to personality disorder.



The graph below shows the projected numbers of people with CMD/probable psychosis who had spoken to their GP within the previous years.



For a whole of 2015, approximately 30,100 patients with CMD / probable psychosis will have spoken to their GP about a mental or emotional problem. Compared to the 122,000 calls, it could be suggested that each CMD / probable psychosis patient, on average, will speak to their GP about a mental or emotional problem roughly 4 times in a year.

Accessing Community Services

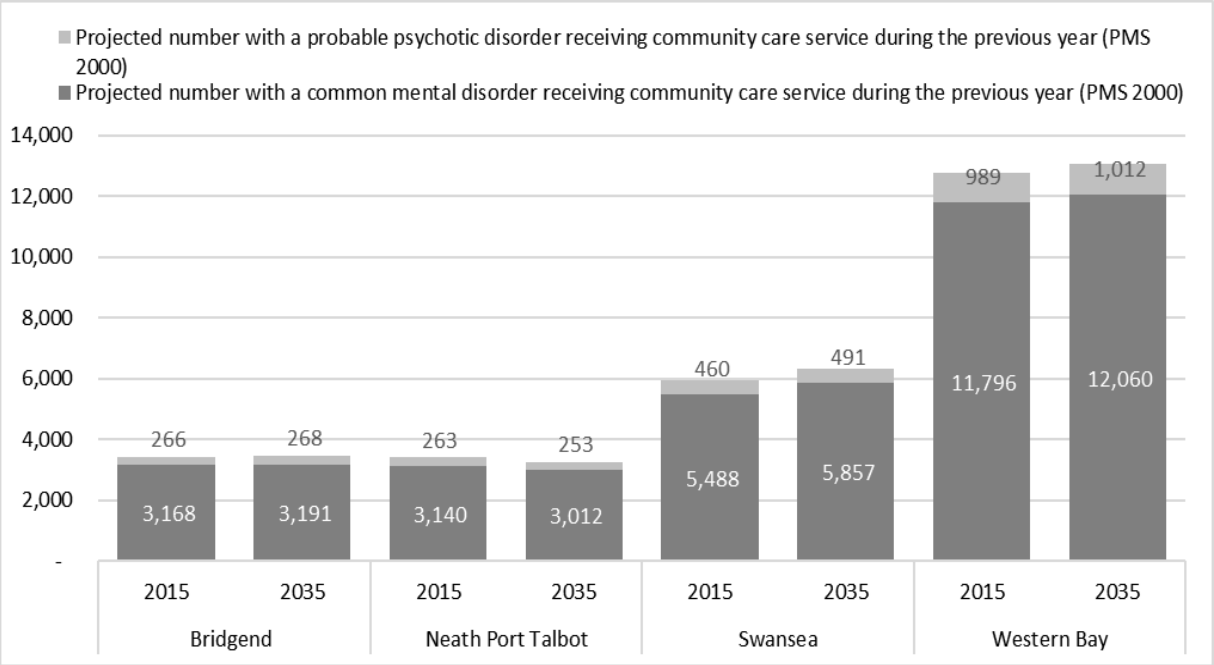
Definition of community services

GPs treat the highest proportions and numbers of people with mental disorders. People who have more serious mental health problems would be more likely to access more specialist services. Within the psychiatric morbidity survey, these are known as **community services**.

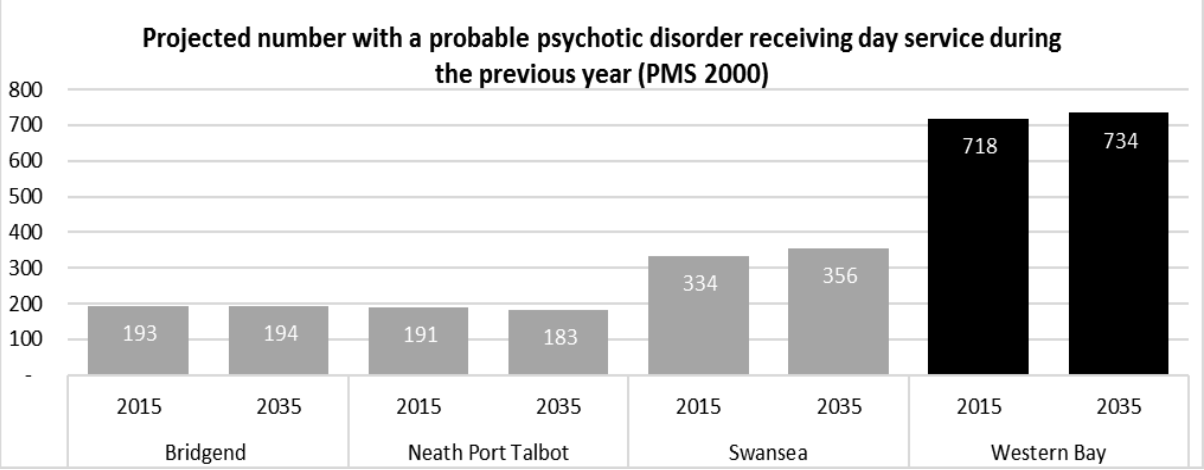
The term community services relates to any of the following:-

- Psychiatrist
- Psychologist
- Community psychiatric nurse
- Community learning difficulty nurse
- Other nursing services
- Social worker
- Self-help/support group
- Home help/home care worker
- Outreach worker

18% of people with a CMD are anticipated to use community care services within a year, while 51% of those with a probable psychosis are also anticipated to use community care services.

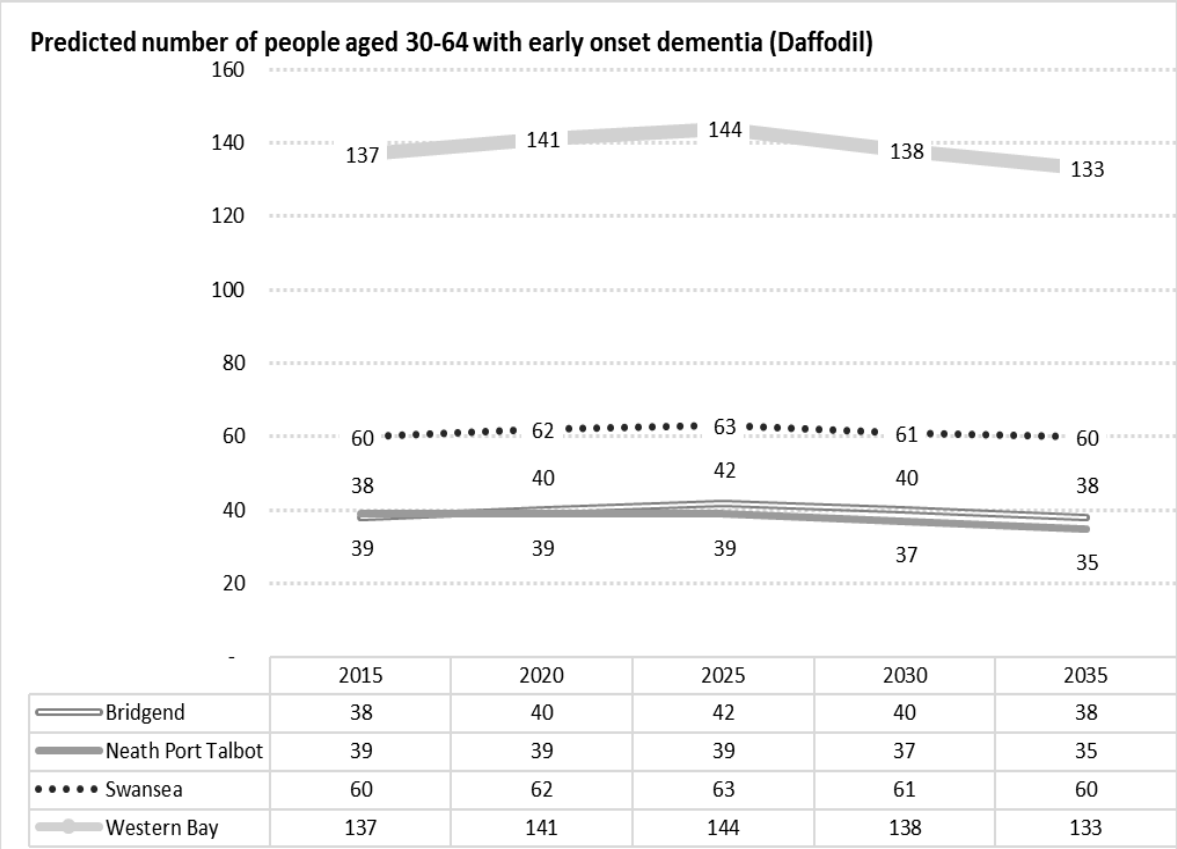


Day service is another aspect of community provision and is usually most focussed on those with the most serious disorders, particularly psychotic disorders. Only 3% of people with CMDs use day services compared to 37% of people with a probable psychosis.

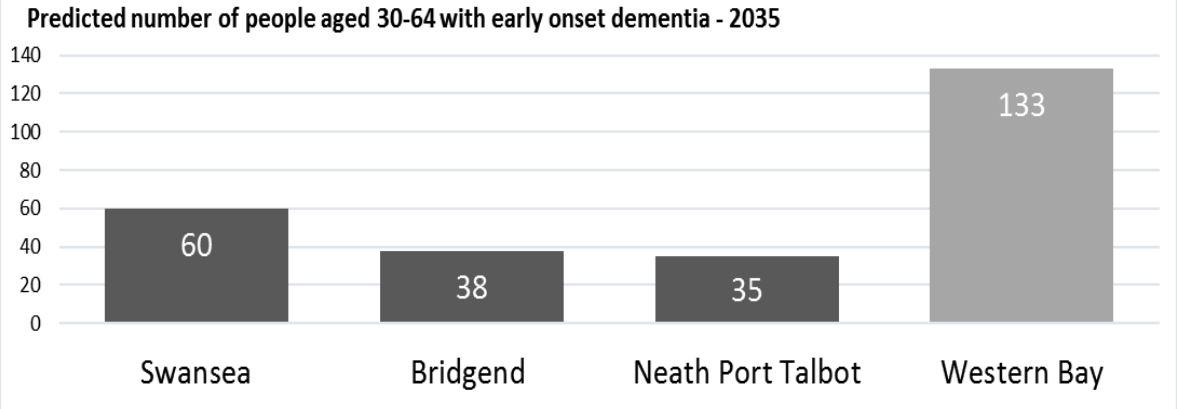


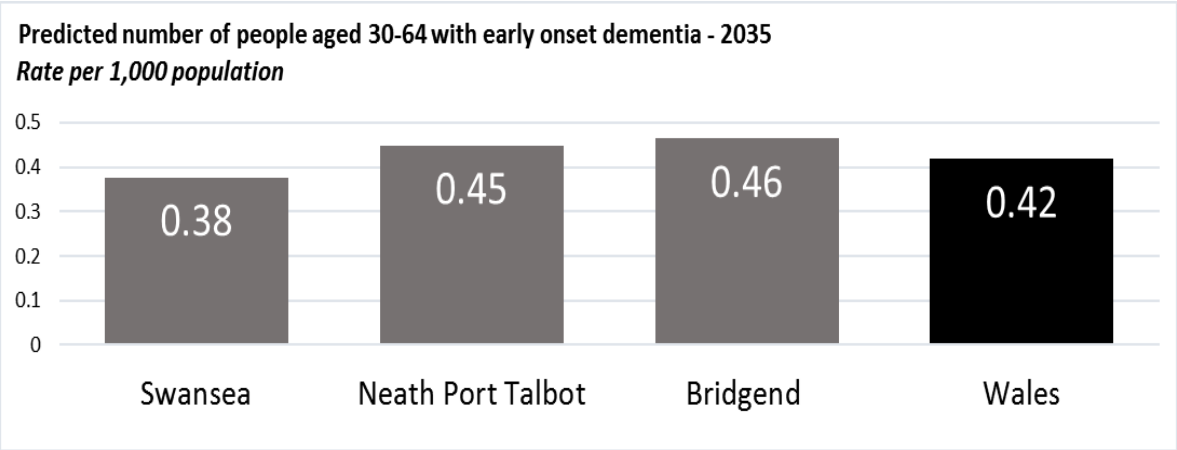
Early-Onset Dementia

Numbers in this population group are projected to remain stable.



	2015	2020	2025	2030	2035
Bridgend	38	40	42	40	38
Neath Port Talbot	39	39	39	37	35
Swansea	60	62	63	61	60
Western Bay	137	141	144	138	133





Strategic Considerations

The Mental Health Commissioning and Delivery Plan complements our Adult Social Care (ASC) Commissioning Plan, *Living Independently in Bridgend in the 21st Century (2010-20),* it is intended to be a vehicle for implementing our vision for ASC and to align and deliver the values and objectives specified in key local and regional strategic commissioning documents. This plan embraces the principles set out in the Welsh Government strategy and delivery plan for mental health and wellbeing in Wales: *Together for Mental Health* and supports the Western Bay Health & Social Care Programme *Moving Forward Together: Joint Commitments for Mental Health Services* and will help to drive forward the implementation of *Social Services and Wellbeing (Wales) Act 2014*. To ensure that our direction of travel will deliver the outcomes that matter to those who require services, this plan has been developed in consultation with key stakeholders and partners, including Service Users and Carers.

Collaborative and integrated approaches to planning, commissioning and delivery are key elements to successfully taking forward our intentions and commitments. Our commitment to partnership working can be seen through our involvement with the Bridgend Local Services Board and our continuing work as a member of the Western Bay Health and Social Care Collaborative, which is a partnership between the City & County of Swansea, Bridgend County Borough Council, Neath Port Talbot County Borough Council and Abertawe Bro Morgannwg University Health Board (ABMU).

In the context of this Plan, support includes meeting the individual's health, social, housing, personal, wellbeing and educational needs. The main focus of this Plan is adults with mental ill health and their families and/or Carers within the county borough of Bridgend but also has links into the Children's and Adolescent Mental Health Team (CAMHT), the Older People Mental Health Team (OPMH) and the regional picture within the Western Bay Collaborative. It complements the development and implementation of Bridgend's ASC *Dementia Commissioning and Delivery plan*, which specifically concentrates on dementia and older people mental health services.

Our definition of mental health problem, mental illness and mental ill health has been taken from *Joint Commitments for Mental Health*:-

Mental health problem - emotional distress that may not constitute a mental illness but may be a predisposing factor to mental illness.

Mental illness – a diagnosable condition including both common mental health problems and severe and enduring mental health problems.

Mental ill health – a term which incorporates mental illness and mental health problems.

Our vision is for all the people who receive support from Adult Social Care and it applies to people requiring mental health services and Carers and families that require support. This vision supports the Council's improvement priorities of 'working together to improve lives within the borough' as set out in our corporate plan, *Working Together to Improve Lives.*

Our vision is:-

"To promote independence, wellbeing and choice that will support individuals in achieving their full potential in healthier and vibrant communities" (Wellbeing Directorate Business Plan 2008-11).

This will mean promoting the principles of choice, independence, empowerment, opportunity, dignity and respect. It will involve safeguarding vulnerable people and developing preventative approaches to ensure that people receive the most appropriate level of assistance, in order to reduce the need for long term support from statutory Agencies.

The establishment of a new model of assistance and support will enable us to achieve our vision. This model requires a change in traditional commissioning practices to a person-centred approach that promotes positive outcomes for individuals and offers value for money. Our model has five key elements which are linked to our assessment process and strives to enhance a person's independence by providing appropriate responses to identified needs.

Key Elements of our model:-

1. **Enabling Approaches** that allow people to make better-informed decisions about the type of support they require.

   This will be achieved by:-

   - **Improving signposting and information** about support options to enable people to continue managing their needs themselves;
   - **Expanding the range of independent advocacy support** available to assist people to make informed choices and decisions about support arrangements that impact on their lives;
   - **Promoting and improving the take up of direct payments** and encouraging people to become involved in the planning of their support and to have more control over their own future;
   - **Supporting Carers and families** by increasing the offering and take up of carer assessments, continually improving the involvement and engagement of Carers and improving the consultation process and flow of information to Carers.

2. **Preventative Approaches** that focus on early identification of changes to a person's needs that constitute a risk to their continued independence and ability to manage their own needs.

   This will be achieved by:-

   - **Supporting independence in the home** by increasing the range of options for maintenance of independence and targeted assistance in a person's own home;
   - **Increasing community opportunities** by expanding the use of individually planned support arrangements in a range of integrated community settings that reduce high dependence on statutory services;
   - **Increasing the range of short break options** in the community for Service Users and Carers which are appropriate, accessible and flexible outcome focused breaks;

- **Creating more opportunities for supported employment** which enable people to access voluntary or paid work and reduce the need for formal support;
- **Providing intermediate care and reablement approaches,** which offer short term intensive support that enables people to either regain or maintain their level of functioning for living independently;
- **Remodelling community support facilities** into integrated specialist community support resources that can deliver specialist and intensive support packages for people on a time limited basis.

3. **Specialist Preventative Approaches** that provides alternative options of support for those who are at high risk of requiring long term support and/or face unnecessary prolonged support in settings that reduce independence.

This will be achieved by:-

- **Providing rapid responses and supporting people at a time of personal crisis** by increasing the range of specialist support arrangements so that unnecessary admissions to traditional care settings which reduce a person's independence are reduced.

4. **Integrated Living** that enables people with complex needs who have become socially isolated to access some form of flexible social care housing related support, and in some circumstances, to access integrated community based housing schemes where there is access to higher levels of social care support.

This will be achieved by:-

- **Consolidating and increasing the number of supported independent housing schemes** for people with more challenging needs through the development of a progression pathway model;
- **Refocusing and coordinating social care housing support arrangements** more closely with mainstream community and integrated health and social care responses and work with partners to enhance the range of housing and support options for people with a range of needs.

5. **Interventionist Approaches** for people who require more specialist inputs and whose needs cannot be met without intensive packages of support.

This will be achieved by:-

- **Developing integrated specialist health and social care resources** based on the reablement model of support and tailored to the individual needs of the person;
- **Developing a range of permanent interventionist support models** for people with specialist and complex needs in partnership with local and regional partners and preferably linked to their local community networks of support.

Successful delivery of our new model of assistance and support will be achieved through the development of effective evidence based commissioning and

planning arrangements. Improving of our commissioning approach will enable us to respond to the assessed needs of individuals and maximise people's independence through the procurement of quality services that offer value for money and achieve positive outcomes for the individual.

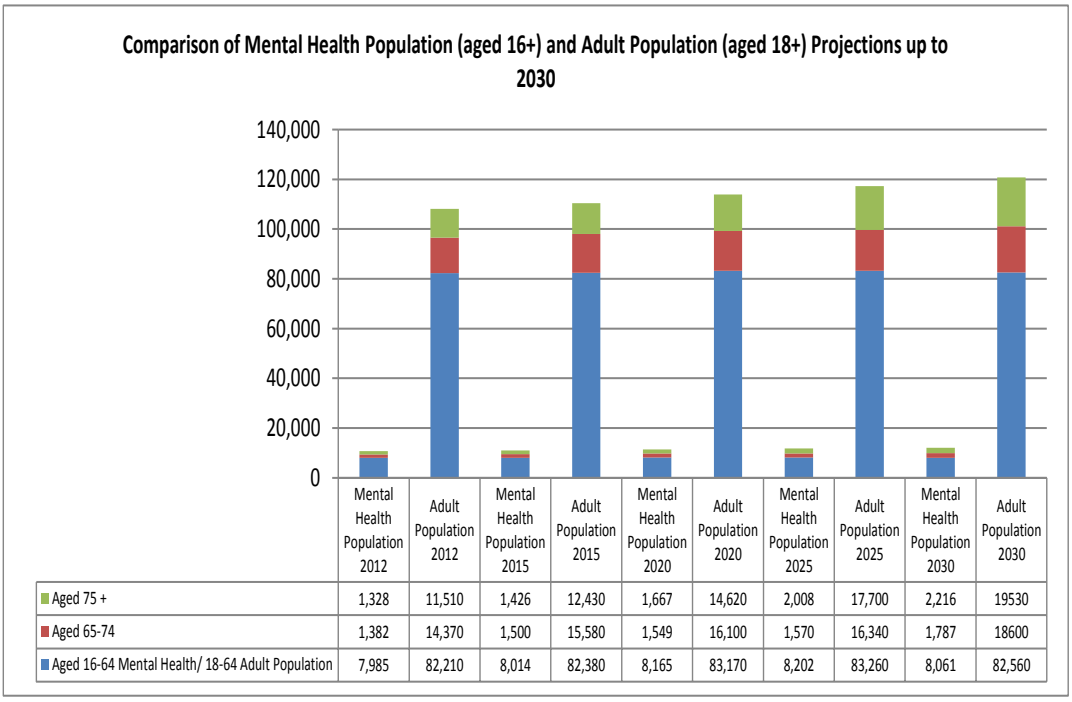
Current Position within Bridgend

In Wales, 1 in 4 adults will experience some kind of mental health problem or illness within their lifetime and 2 in 100 people will have a severe mental illness such as schizophrenia or bipolar disorder (*Together for Mental Health 2012*).

The below information helps to set out Bridgend's current picture and projected changes with regards to the boroughs adult mental health population, their needs and our available services. This data does not include dementia figures as this is contained within the Dementia Commissioning Strategy.

The Welsh Health Survey (2012) states that in Bridgend, 13% of adult respondents report as being treated for a mental health illness. The survey also highlighted that in Wales a higher percentage of women (14%) than men (8%) report being treated for a mental illness.

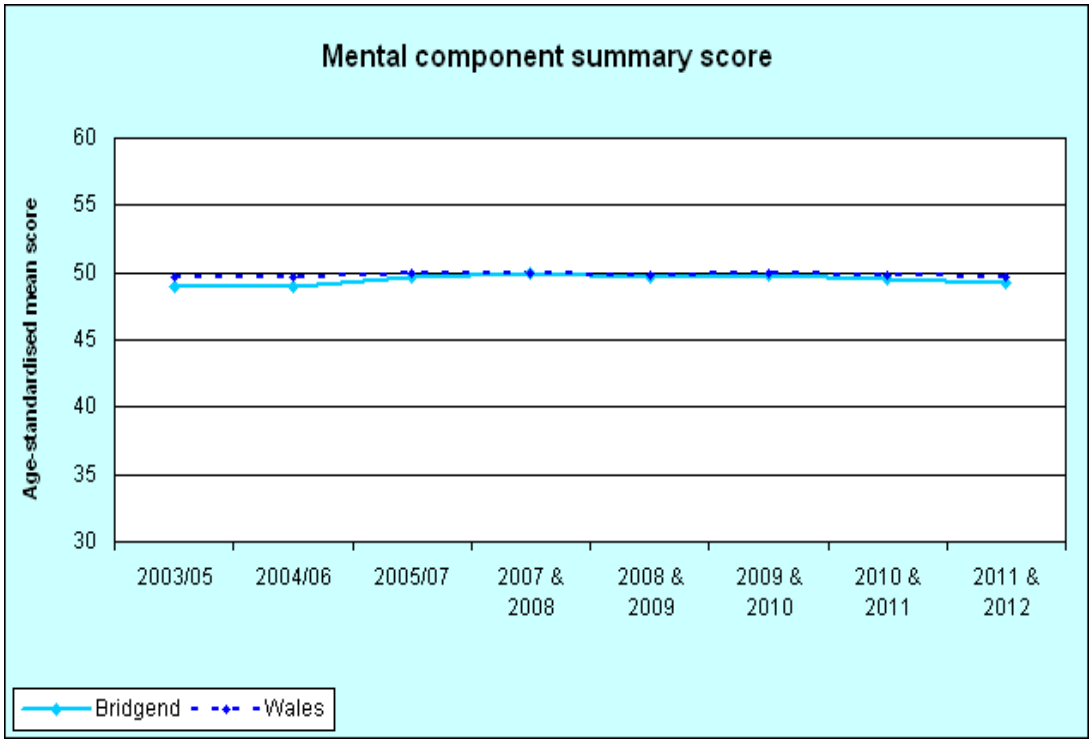
Projection of need: The below diagram shows the predicted number of people in Bridgend with a mental health problem. These predictions are based on projection data from *Daffodil* using information taken from the Welsh Health Survey. Adult respondents were classified as having a mental health problem if they reported as currently being treated for depression, anxiety or 'another mental illness'.



	Mental Health Population 2012	Adult Population 2012	Mental Health Population 2015	Adult Population 2015	Mental Health Population 2020	Adult Population 2020	Mental Health Population 2025	Adult Population 2025	Mental Health Population 2030	Adult Population 2030
Aged 75 +	1,328	11,510	1,426	12,430	1,667	14,620	2,008	17,700	2,216	19530
Aged 65-74	1,382	14,370	1,500	15,580	1,549	16,100	1,570	16,340	1,787	18600
Aged 16-64 Mental Health/ 18-64 Adult Population	7,985	82,210	8,014	82,380	8,165	83,170	8,202	83,260	8,061	82,560

Mental Component Score: The below diagram taken from the Welsh Government's *Statistics for Wales: Local Area Summary Statistics for Bridgend* compares the mental component summary score for Bridgend against the trend

for Wales. The score, which is a relative measure of well-being, shows that although there has been a slight decline over the last few years, the mean score for 2011/12 was not significantly lower than the Welsh average.



Our service and financial data indicates the following emerging themes:

- A significant proportion of the ASC mental health budget is spent on a small number of high cost residential and nursing placements. This demonstrates a need to review high cost placements to ensure that people are receiving appropriate levels of support in the most appropriate settings and that this is supported through models of support that promote the progression pathway. It also highlights the need to explore options for developing a brokerage service for high cost placements with our Western Bay partners.

- The number of people supported in residential or nursing placements has remained roughly the same over the last few years, yet at the same time, the number of Service Users receiving domiciliary care has risen. There has been an increase in the number of people receiving domiciliary care in Mental Health and a rise in the number of assessed and delivered hours. This may indicate that demand for traditional models of support has been reduced and that those who require services want to receive support within their own homes and communities.

- More people are choosing to receive direct payments and the net budget for this has significantly risen year on year to reflect this increase in demand although there is still low take-up in Mental Health services. We therefore need to ensure that those who choose to directly purchase services are able to access appropriate information and advice.

- The majority of accommodation based services, including supported living establishments, are located in or around Bridgend town centre and there is very little provision within the valleys. In order to enable people to remain within their own communities, we must look at the range of support models across the borough that supports independent living, including the promotion of community based support networks.

- There has been a reduction in the number of people being referred into the Crisis Resolution Home Treatment Team. We must continue to focus on early intervention and development of preventative models of support to ensure that Service Users receive appropriate and timely responses and we have clear pathways in place to support those who are experiencing a crisis.

- Since the introduction of the Mental Health Measure, there has been a reduction in the number of people being referred to the Mental Health team and an increase in people being referred to the Assisting Recovery in the Community Centre (ARC). This reduction appears to indicate that we are successfully enabling more people to access primary care services in line with part 1 of the Mental Health Measure.

- Data shows that there has been a reduction in the number of people requiring services provided by the Assisted Recovery in the Community (ARC) service including community support day care provision. This combined with the increase in the number of people being referred to ARC appears to demonstrate that people are being successfully signposted to non-statutory community support services. By working collaboratively with community groups, third sector and voluntary organisations, we can further maximise opportunities for local services to offer support networks.

Challenges for the Future

There are a number of national and local factors that impact on ASC, which are key drivers in terms of strategic planning such as:-

- **Demographics -** It is expected that demand on all social care services will grow due to the anticipated demographic changes in Bridgend. Projections indicate that Bridgend will see an increase of people with a mental health problem. In order to facilitate choice, control and long-term independence, we need to explore and invest in a range of preventative and supportive services within the community.

- **Citizen Directed Support** - The Welsh Government's approach to Citizen Directed support requires Local Authorities to:-
    - Extend the use of Direct Payments;
    - Work in a person-centred and outcome-focused way;
    - Develop support pathways in collaboration with key partners.

ASC expenditure on Direct Payments has significantly increased over the last five years. It is important to ensure that those who receive services directly commissioned from ASC and those who are in receipt of direct payments

have sufficient information, advice and advocacy to make informed decisions about their care and are involved in their care planning as much as their capacity allows.

- **Prison Population –** A significantly high number of prisoners have a mental health problem, with 9 in 10 prisoners experiencing a diagnosable mental health and/or substance misuse problem (*Together for Mental Health 2012*). HMP/YOI Parc is the largest prison in Wales and there are plans to further expand the prison. Approximately 80% of prisoners from HMP/YOI Parc were released to live in Wales (HMP/YOI Parc Inspection Report, July 2013). Unless prisoners in Wales have made themselves intentionally homeless, they are guaranteed accommodation on release. Therefore, we must ensure that services are able to meet the needs of those with offending behaviours in a timely manner and that we work in partnership with other agencies to ensure that they receive appropriate support.

- **Substance Misuse –** In Bridgend, 45% of adult respondents to the Welsh Health Survey reported that their daily alcohol consumption was above guideline amounts. The number of referrals in Bridgend for alcohol misuse in 2012/13 was 364 and in the same year there were 304 referrals for drug misuse (StatsWales). The Welsh Government's 2008-18 substance misuse strategy *Working Together to Reduce Harm* highlights that substance misuse can be both a symptom and cause of a mental illness and notes the negative effects that a person's substance misuse can have on the health and wellbeing of their families. In order to deliver effective support that meets the complex needs of Service Users with co-occurring substance misuse problems, it is important to work collaboratively with other organisations and Agencies to deliver coordinated treatment pathways.

- **Complexity of need and co-occurring conditions** – There has been an increase in the number of people with a mental illness who also have other health and/or wellbeing issues. It is important to work in partnership with Health and other Agencies to develop services that can meet these needs and develop integrated pathways to ensure that Service Users receive a holistic response. Some of the most frequent co-occurring conditions in Bridgend include:-

    - Substance Misuse;
    - Personality Disorders;
    - Offending Behaviours;
    - Autistic Spectrum Disorder;
    - Women with complex, chaotic and offending behaviours;
    - Sensory Impairment;
    - Physical frailty and physical disability.

- **Carers** – According to 2011 Census data, there were 17,919 Carers in Bridgend. It is acknowledged that this figure is likely to be much lower than the actual number of Carers in the area. Local Authorities are keen to find ways of offering and providing support and assistance to help Carers and families care for their loved ones. The Social Services and Wellbeing (Wales)

Act 2014 places Carers on an equal footing to those they care for and ensures access to assessments and the appropriate services. In addition, The Carers Strategy (Wales) Measure 2010 also places new legal duties on the NHS and Local Authorities to work together in consultation with Carers to publish and implement a joint Carers Information and Consultation Strategy.

- **Financial drivers** – Local Authorities are facing a challenging financial future and will have to face difficult decisions in terms of services and how they will be delivered. The financial climate and the need to make significant efficiencies requires us to look at innovative ways of service improvement, including collaborative models and to review the balance between what is directly owned and provided by the Authority and what is provided by external partners. Despite the challenges posed by the current financial situation, the **key** driver for this plan is to develop the way services are delivered to make them person-centred and focused on delivering independence, rehabilitation and recovery approaches.

- **Section 117 of the Menial Health Act –** Health and Social Services have a statutory joint duty to work in partnership with other relevant agencies to provide aftercare to certain patients that have been detained for treatment in hospital under particular sections of the Mental Health Act. Service Users in receipt of aftercare provided under S117 cannot be charged for these services.

- **Rurality-** Bridgend has a number of rural and valley communities. Current accommodation based support commissioned by ASC is largely based in and around Bridgend town centre. It is important to look at the services we commission to ensure that Service Users can remain within their own homes when possible and receive support and care within their communities.

- **Deprivation** – Evidence suggests that there is a link between poor mental health and deprivation. Factors including homelessness, poverty, abuse, social isolation and poor working conditions can have a negative impact on a person's mental wellbeing.

- **Enabling Independence** – Moving away from traditional care models will require us to work closely with Service Users, Carers and families to help vulnerable people attain the skills and confidence that will enable them to attain maximum independence and also to support people to maintain their levels of independence for as long possible. This will also require changes to our care co-ordination and assessment processes to ensure that there are positive responses to risk taking and that support is appropriate to the level of need.

- **Collaboration –** The progression of the collaboration agenda requires robust governance procedures and the need to develop processes for sharing risks, funding and ownership in order to progress our shared agendas.

Strategic Drivers

There are a number of national, regional and local strategic drivers that have and continue to shape the development and delivery of mental health services.

National objectives -

- **Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales and Delivery Plan; 2012 16** – Aims to improve outcomes for those who require mental health services, their Carers and their families and improve the wellbeing of the wider population. It places the Service User at the centre of service delivery, emphasises the importance of partnership working and promotes a 'recovery and enablement' approach to help people to live independently and reach their full potential. The Strategy focuses on six high level outcomes:-
    1. To improve whole population mental health and wellbeing;
    2. To reduce the impact of mental health problems and/or mental illness on individuals, families, Carers and their communities;
    3. To reduce inequalities amongst people experiencing mental illness and mental health problems;
    4. To increase the feeling of control that people in receipt of assessment, treatment and services have over decisions made that affect them;
    5. To demonstrate the long term economic advantage of a whole population, all ages approach to improving mental health and wellbeing and treating mental illness;
    6. To improve the values, attitudes and behaviours of staff within the public, independent and Third Sector in relation to mental health and wellbeing.

  The associated Delivery Plan sets out key actions for the Welsh Government and key partners to deliver the six high level outcomes.

- **Mental Health (Wales) Measure 2010** - Places a legal duty on Local Health Boards and Local Authorities with regards to the assessment and treatment of people with mental health problems and will improve access to independent mental health advocates. The Measure will result in an increase of services available within primary care, ensure that all patients receiving secondary services have a Care and Treatment plan, enable adults discharged from secondary services to refer themselves back into services for assessment and provide opportunities for all in-patients to receive help from an independent mental health advocate if required. The four Parts of this Measure are:-

1. Part 1 - Local and Primary Mental Health Services – places a legal duty on Local Authorities and Health Boards to establish local primary mental health services across Wales within and alongside GP settings, including assessment, short term interventions, information and advice, and where appropriate, onward referral to other services;
2. Part 2 – Care Co-ordination and Treatment Planning - gives all people who receive secondary mental health services an individual Care and Treatment plan;

3. Part 3 – Assessments of Former Users of Secondary Mental Health Services – allows eligible adults discharged from secondary care to self-refer directly into secondary services without the need to see a GP if they believe their mental health is worsening;
4. Part 4 – Independent Mental Health Advocacy – extends the Independent Mental Health Advocacy (IMHA) scheme to enable all inpatients in Wales in receipt of assessment or treatment to request support from an IMHA.

- **Social Services and Wellbeing (Wales) Act 2014** - Aims to empower those in need of social care services and their Carers and to promote their independence by affording them a stronger voice and giving them more control over the services they receive. The Act emphasises the promotion of equality, improvement of service quality and provision of information and stresses the need for commissioners to achieve a shared focus on prevention and early intervention. Key elements of the Act include:-

    - Revised assessment, eligibility and care support and review arrangements and practices;
    - New ways of providing information, guidance and wellbeing support for the public;
    - Strengthening early intervention, reablement and prevention services;
    - Further strengthening our work with and support for Carers;
    - Revising safeguarding arrangements;
    - Strengthening Direct Payments arrangements;
    - Promoting social enterprises, co-ops and the third sector in the provision of care, support and preventative services;
    - Duties to meet the needs of self-funders on request;
    - Clarification charging arrangements.

- **Carers Strategies (Wales) Measure 2010** – Intends to improve the lives of Carers by placing a legal duty on Health Boards to lead on the development of a joint carers' information and consultation strategy with partner Local Authorities. Both the Health Board and Local Authorities have a responsibly to commit to and implement the joint strategy, which will ensure Carers:-

    - Receive appropriate information and guidance;
    - Are actively engaged with and involved in decisions about the provision of services they, or the person they care for, receive.

- **The Williams Commission Report 2014** – Recommends a proposed reduction in the number of Local Authorities in Wales based on mergers of the existing 22 Local Authorities. At date of publication, the future shape of local government in Wales was still uncertain; however, this report emphasises the importance of collaboration and partnership working with neighbouring authorities.

<u>Local and Regional Objectives</u>

- **The Western Bay Heath and Social Care Collaborative** – Aims to provide improved sustainable services that meets people's needs by working in partnership to identify gaps in service provision, reduce duplication and deliver

new service models. The Western Bay Mental Health Project sits within this collaborative and has identified the following work streams to progress:-

- Development of community resources;
- Provision of effective unscheduled care models;
- Implementation of the Mental Health Measure;
- Development of community support and accommodation models.

- **Western Bay Health and Social Care Programme: Moving Forward Together, Joint Commitments for Mental Health** – Sets out how we, with our Local Mental Health Partnership Board partners will deliver the high level outcomes within *Together for Mental Health.* The commitments place a focus on:-
    - Promoting mental wellbeing and helping to build resilience for people, families and communities;
    - Working together with people in providing support and care;
    - Working together between and within organisations;
    - Holistic care for the most vulnerable.

- **Abertawe Bro Morgannwg Carers Partnership Carers Information and Consultation Strategy 2013-16 –** This is a response to the Carers Strategies (Wales) Measure 2010 and sets out how the partnership will support Carers through the provision of information and ensuring Carers are involved in decisions about the services that they, and those they care for, receive.

- **The Local Services Board (LSB) Single Integrated Partnership Plan: Bridgend County Together April 2013 – March 2018** - Sets out the vision for Bridgend as '*a healthy, prosperous and safe county where people can reach their full potential'*. One of the four priority areas within this vision is to ensure that '*people in Bridgend are healthier'*. To achieve this priority, the Plan goes on to state that it will focus on care within the community as opposed to hospital or residential care.

- **BCBC Corporate Plan: Working Together to Improve Lives (2013-2017) –** Explains the Council's vision for the borough and identifies its priorities for improving the lives of citizens within Bridgend. These improvement priorities include:-
    - Priority 4 - working together to help vulnerable people to stay independent;
    - Priority 5 - working together to tackle health issues and encourage healthier lifestyles;
    - Priority 6 - working together to make best use of resources.

  The Plan emphasises the need to work with partners to develop a range of accommodation and support options to help sustain or achieve independence and the development of services that enable people to live healthy independent lives.

- **BCBC Wellbeing Directorate Business Plan 2014-15 –** Identifies how the Wellbeing Directorate will contribute to the Council's improvement priorities in

2014-15. The Plan sets out the Directorate's priorities, commitments and milestones for 2014-15. With regards to mental health these include:-

- Pilot the single point of access to Mental Health services in Bridgend;
- Co-ordinate the wellbeing information and advice service so that Service Users know about support that is available to them;
- Develop a dementia plan to ensure that the right services are available to support people with dementia.

- **BCBC Adult Social Care Commissioning Plan: Living Independently in Bridgend in the 21st Century (2010-20)** - Sets out a range of principles that meets the requirements and objectives of local strategies and provides a framework for exploring the potential of integrating the ASC and local NHS agenda. A key theme of the strategy is to promote collaboration and partnership across organisations, communities and individual people. It highlights that there is a need to move from traditional commissioning practices to more person-centred enabling approaches that promote positive outcomes for individuals.

- **BCBC Supporting People Local Commissioning Plan 2013/14** – Highlights mental health as one of the dominant lead needs for housing related support (7%). The Plan's vision is to develop a range of 'joined-up' services that will provide a number of options to support a person's independence. A key message within the Plan is the need for preventative and emotional support services, the creation of community support networks and the development of a range of care models that offer more flexible levels of support.

Journey So Far

Over the last few decades there have been significant changes to the delivery of Mental Health services, not only in Bridgend but across the UK. Current models of support have moved away from traditional inpatient based care, which focused on 'treatment', towards multidisciplinary community based approaches that promotes the 'recovery' philosophy.

There are many interpretations of the recovery philosophy but the underlying concept within the Mental Health (Wales) Measure 2010 is 'the belief that it is possible for someone to maintain, gain or regain skills that help them to live as fulfilling a life as possible, despite serious mental illness'.

Current Services

The current model for mental health services in Bridgend is largely a result of incremental changes in service design in response to policy developments, local pressures and organisational transformations. There is a recognition locally that there needs to be a greater investment in the development of a wider range of mental health services, for example the expansion of more community based approaches. We must therefore, work in partnership with stakeholders to ensure that the services we provide meets, and continue to meets, the changing needs of the population through effective planning and commissioning.

Key components of our current model include:-

- CMHTs are the main source of community mental health services. They are at the core of the mental health system and are specialist, multidisciplinary, multiagency teams which provide mental health assessments and support to individuals accessing services. CMHTs prioritise interventions based on need, risk, and vulnerability for individuals whose complexity of care cannot be met within primary care services;
- The multi-disciplinary and multi-agency Home Treatment Team to support people experiencing crisis within their own homes in order to avoid admission or readmission into mental health inpatient services;
- Outpatient consultant clinics to support people within the community;
- A Primary Mental Health Support Service developed in partnership with ABMU HB under the provisions of Section 2 of the Mental Health (Wales) Measure 2010 to support and secure local provision of mental health services;
- Structured day opportunities, psychological and psychotherapeutic interventions provided out of the ARC centre;
- The specialist Perinatal Response Management Service (PRAMS) for those experiencing significant stress and/or other mental ill health in pregnancy and up to a year after birth;
- A range of inpatient specialist services at Princess of Wales Hospital and Glanrhyd, including assessment, respite, rehabilitation and long-stay beds;
- Residential and nursing care establishments for people with high or intensive support needs;
- Glyn Cynffig Hostel to provide support and assistance to adults recovering from serious mental illness, including those with co-occurring serious mental illness and substance misuse;
- Supported living accommodation providing supportive environments to enable people to live independently within the community;
- Floating support to provide targeted and flexible responses to assessed need;
- Domiciliary care providing personal and practical support within a person's home;
- A range of voluntary sector services providing a range of information, support, advocacy, activities and befriending for Service Users and Carers.

What have we done and what are we doing

Within the last few years, there has been a great deal of activity across mental health services in order to drive forward our commissioning and service objectives. Some recent and upcoming projects include:-

- Working with our colleagues in Supporting People to create a short-term fixed accommodation service for individuals with mental health problems who are also experiencing 'vulnerable and chaotic' lifestyles;

- Progressing the development of a community service model based on a circle of support in partnership with our colleagues in Supporting People;

- Appointing a Mental Health Elected Member Champion to help tackle stigma and discrimination attached to mental illness;

  Creating of a local primary Mental Health Support Service, which delivers:-
  - Comprehensive primary mental health assessments;
  - Short term interventions;
  - Information and advice about treatment to Service Users and Carers;
  - Support and advice to GPs and other primary care workers;
  - Support to Service Users in regards to their onward referral to secondary mental health services.

- Developing a service to boost community resilience, combat discrimination and provide services to those affected by suicide;

- Progressing the development of community support services that will focus on prevention, information, signposting, early intervention and improving community resilience with our Western Bay partners;

- Establishing a complex case panel to ensure that Service Users leaving hospital are appropriately supported in the community;

- Moving away from traditional day centres by providing day opportunities within the community.

Opportunities

We have been able to identify a number of opportunities to further progress our commissioning and service objectives, including:

- Supporting people to move into services that offer more appropriate levels of support through the development of a progression pathway model;
- Developing a range of accommodation options, including crisis provision and alternatives to traditional inpatient facilities for those with complex needs;
- Working with accommodation providers to develop a more flexible market, which is able to meet demand and provides greater independence;
- Reviewing high cost placements to ensure that people are receiving appropriate support in an appropriate model of care;
- Working with colleagues in Supporting People to maximise joint commissioning opportunities;
- Improving information flow from Social Workers to the Commissioning Team so that practice knowledge informs commissioning activity;
- Building on our collaboration with partners in Health to develop integrated services. In the context of Western Bay, consider ways to pool budgets and holistically purchase services and expand the range of therapeutic responses for individuals exhibiting behaviour deemed to challenge services;
- Evaluating the quality and outcomes of Care and Treatment Plans to ensure that they are person centred and deliver outcomes that are important to Service Users;

- Developing a single point of access across the Western Bay area so that there is equitable and consistent access into mental health services across the region;
- Undertaking a review of unscheduled care and crisis provision to reduce likelihood of hospital admission and support early discharge;
- Encourage the take up of Carers assessments and exploring opportunities to further support Carers to continue in their caring role;
- Improving the way we measure outcomes of services for Service Users so we know what difference our modernised services are making.

What we want to Achieve

We aim to work with our stakeholders and partner organisations to reshape existing services in order to achieve our vision of providing person centred services that enable independence, maximise personal potential and are flexible and responsive to need, whilst ensuring effective use of funding within the context of BCBCs Medium Term Financial Strategy. Below are some high level objectives, which we intend to take forward over the next three years.

Care Coordination

Continue to ensure that care plans and reviews are person centred;

- Build on current assessment processes to deliver clear outcome focused care planning that supports the recovery approach and the progression pathway;
- Work with colleagues in children's services at earlier points to develop more effective transitions to adult services;
- Promote positive approaches to risk taking with partner agencies and Service Users by building on current risk management approaches to enable independence and reduce the need for more intensive support whist identifying and appropriately supporting those who are at increased risk of suicide, self-harm, self-neglect and/or harm to others;
- Ensure that Service Users are supported to be involved in the decisions that affect them as much as their capacity allows and follow best practice to assess mental capacity, to enhance mental capacity and utilise the most appropriate ways of helping Service Users make their own decisions;
- Continue to develop processes that enable Service Users to define the outcomes that matter to them;
- Provide information to Service Users and Carers so they can play an informed part in their Care and Treatment pathway;
- Develop a single point of access for people requiring mental health services.

Range of Care Models

Develop a clear progression pathway through different models of support and accommodation, which provides alternatives to hospital admission and supports the recovery approach;

- Establish effective care pathways that promotes integrated support, care planning and service delivery so that Service Users who have a mental illness alongside other health and social problems experience holistic support and treatment;
- Work with the provider market and stakeholders to develop a wider choice of and increased access to 'move on' accommodation and housing related support models, including enabling, step down and floating support;
- Create needs-led services that supports Service Users at the appropriate level and for appropriate periods of time and promotes 'move-on' into lower levels of support in order to attain maximum independence;
- Increase opportunities for people to receive support that enables them to remain in their own homes;
- Support the maintenance of mental health by working proactively with other agencies and partners to encourage the development of community based support networks and models, including information, community and non-specific mental health services;
- Develop appropriate and specialist models of care to support those with complex needs and co-occurring conditions;
- Provide robust care pathways for those in crisis and develop a range of support models to ensure that those in crisis receive appropriate and timely responses;
- Develop preventative and specialist models that help people remain out of traditional care services and reduce the likelihood of crisis situations.

Independent Living

- Promote the development of local support networks in the community and prevent social isolation by maximising opportunities for local services to offer natural support networks;
- Continue to expand opportunities for individuals to develop life skills that promotes and enables independence;
- Work with community groups, third sector and voluntary organisations to collaboratively develop localised support networks;
- Improve opportunities for individuals to access training, education and work;
- Further develop ways to enable Carers to continue in their caring role by providing appropriate information, advice and services.

Collaboration

Respond to national policies and objectives, such as the implementation of the Social Services and Wellbeing (Wales) Act, the Mental Health (Wales) Strategy, the Cares Strategy (Wales) Measure and Together for Mental Health;

- Progress the Western Bay Collaboration agenda and respond to the Williams Report by working with neighbouring Authorities and Health Boards to identify possibilities for jointly commissioning and delivering services;
- Seek further opportunities to pool budgets and align services to improve experiences for Service Users through the provision of coordinated care models;

- Work alongside partners to help people to move on from traditional care settings to more community based and needs led services that offer flexible levels of support;
- Work with colleagues in Supporting People to identify housing related support solutions in order to develop effective and sustainable community based lower level support and preventative services, which promote independence;
- Work with other agencies, including Health and the Third Sector to enhance quality of services and improve effectiveness of services provided to Service Users, especially those with co-occurring conditions;
- Optimise opportunities to identify and attract funding from partner agencies to further develop services;
- Explore opportunities to develop a regional brokerage service for high cost placements.

Commissioning and Planning

- Implement clear mechanisms for improving the information flow from practice to commissioning so that practice knowledge informs commissioning activity;
- Carry out further development activity to ensure that the local market can respond to future demand;
- Strengthen engagement approaches so that Service Users and Carers are involved in the planning, development and implementation of the services they require;
- Produce a robust and transparent market position statement that outlines our commissioning intentions to transform and shape services for the future.

Equalities

Underpinning everything we do is our commitment to our public sector duties of advancing equality of opportunity between people who have protected characteristics and people who do not, fostering good relations between those who have a protected characteristic and those who do not and eliminating discrimination, harassment and victimisation. With this in mind, we will continue to progress our commitment of ensuring that:-

There is equitable access to services which are responsive to, and inclusive of, the individual needs of those with protected characteristics;

- People are not discriminated against or stigmatised because of their mental ill health;
- Welsh speakers are able to receive services that meet their linguistic preferences

2) PROFILE OF SPEND AND ACTIVITY

Social Services & Wellbeing - Adult Social Care (SERBA) Budget Monitoring Summary

15/16

	FULL YEAR BUDGET			ACTUAL TO DATE			FULL YEAR FORECAST				
AOSBAD - ADULTS MENTAL HEALTH NEEDS	Budget Exp	Budget income	Net Budget	Actual Exp	Actual Income	Net Actual to Date	Full Year Forecast Exp	Full Year Forecast Income	Full Year Net Forecast	Projected Variance (Under) / Over	Comments
DOSB24 - RESIDENTIAL CARE											
7412 RESIDENTIAL/NURSING MH	1,949,510	(805,280)	1,144,230	1,989,162	(864,916)	1,124,246	1,989,162	(864,916)	1,124,246	(19,984)	0
Total	1,949,510	(805,280)	1,144,230	1,989,162	(864,916)	1,124,246	1,989,162	(864,916)	1,124,246	(19,984)	
DOSB25 - SUPPORTED & OTHER ACCOMM											
7400 GLYN CYNFFIG	567,720	(422,580)	145,140	460,138	(376,360)	83,777	460,138	(376,360)	83,777	(61,363)	project spend
Total	567,720	(422,580)	145,140	460,138	(376,360)	83,777	460,138	(376,360)	83,777	(61,363)	
DOSB26 - DIRECT PAYMENTS											
7418 DIRECT PAYMENTS MH	76,680	(7,000)	69,680	84,189	(45,167)	39,022	84,189	(45,167)	39,022	(30,658)	
Total	76,680	(7,000)	69,680	84,189	(45,167)	39,022	84,189	(45,167)	39,022	(30,658)	
DOSB27 - HOME CARE											
7411 MH SUPPORTED LIVING	119,060	(2,870)	116,190	123,914	(960)	122,954	123,914	(65,179)	58,735	(57,455)	
7413 INDEPENDENT DOM CARE-MH	256,190	0	256,190	464,309	(45,828)	418,482	464,309	(45,828)	418,482	162,292	
7419 HOME CARE MENTAL HEALTH	0	0	0	0	0	0	0	0	0	0	
Total	375,250	(2,870)	372,380	588,223	(46,788)	541,435	588,223	(111,006)	477,217	104,837	
DOSB28 - DAY OPPORTUNITIES											
7421 ASSISTED RECOVERY IN THE COM.	636,610	(296,800)	339,810	625,463	(296,806)	328,657	625,463	(296,806)	328,657	(11,153)	
Total	636,610	(296,800)	339,810	625,463	(296,806)	328,657	625,463	(296,806)	328,657	(11,153)	
DOSB29 - OTHR SERV MENTHLTH NEED ADULT											
7444 BRIDGEND ASSERTIVE OUTREACH TM	0	0	0	239	0	0	481	0	481	481	
Total	0	0	0	239	0	0	481	0	481	481	
DOSB30 - ASSESSMENT & CARE MANAGEMENT											
7430 MENTAL HEALTH (ACMT)	775,810	(190,770)	585,040	740,978	(191,432)	549,546	740,978	(191,432)	549,546	(35,494)	
7438 CASWELL CLINIC	294,290	(258,880)	35,410	292,211	(258,877)	33,334	292,211	(258,877)	33,334	(2,076)	
Total	1,070,100	(449,650)	620,450	1,033,190	(450,309)	582,881	1,033,190	(450,309)	582,881	(37,569)	
Total AOSBAD	4,675,870	(1,984,180)	2,691,690	4,780,603	(2,080,346)	2,700,018	4,780,845	(2,144,565)	2,636,280	(55,410)	
AOSBAF - OTHER ADULT SERVICES											

3) CURRENT PRIORITIES

Priority Actions, Outcomes, Delivery and Monitoring

The Reshaping Mental Health Project Board has been established with the strategic aim of working with key stakeholders, to review and remodel current mental health services. The overall aim of the Project Board is to create a sustainable mental health service that focuses on the prevention of mental illness and recovery for those who become unwell. This will be achieved by:-

- Responding to national and local strategies through the reshaping of existing services;
- Creating sustainable services that can continue to respond to the future needs of citizens within the Borough and are responsive to demographic changes;
- Improving outcomes for people with a mental illness through the development of a range of suitable accommodations options.

The key objectives of the Project Board are to:-

- Optimise opportunities for community networks and support systems;
- Create a progression pathway model for accommodation based services, which promotes the recovery philosophy;
- Review current unscheduled care and crisis provision;
- Undertake a review care coordination and CMHTs;
- Develop a local dementia commissioning and delivery plan that provides a response to future demographic pressures.

This Plan sits under the Project Board and we have a clear project plan to deliver the changes and progress our strategic objectives as part of the ASC Remodelling Programme.

Our vision for the future of mental health services is ambitious; we must therefore prioritise our strategic objectives in order to deliver these changes within the next 3 years. Prioritisation of our objectives has taken into account the following factors:-

- Responding to the individual needs of people with a mental illness who potentially require ASC services;
- Delivering statutory duties;
- Meeting national, local and regional objectives and performance targets;
- Effectively managing allocated resources;
- Meeting the financial demands within the Council and meeting the requirements of our Medium Term Financial Strategy.

The key priority actions for change over the next 3 years, the outcomes and the leads for taking forward our priorities within our timescale are set out in the below table. Progression against the priority actions by the relevant leads will be overseen by the Reshaping Mental Health Project Board, who will report to the ASC Remodelling Programme Board. An annual report by the Director of Social

Services will set out how we have progressed against our identified priorities within the previous year, which will help us to focus our attention on achieving our aims and identify how to proceed over the following 12 months.

The Commissioning and Transformation team regularly obtain information on incidence, prevalence, activity and demographic data in order to assess and project need within the borough. This information, alongside service performance and quality data obtained by the Contract Monitoring Team, will help us to understand the way in which this Plan is delivering our identified outcomes and monitor the impact of this Plan on those requiring ASC services.

We will regularly review our plan to ensure that the identified actions are relevant and responsive to changes this will be undertaken through population needs mapping, market analysis, service reviews, Service User and carer feedback and evaluating our practice against national policy, local strategic plans, research and best practice.

PRIORITY ACTION	**OUTCOME**	**LEAD**
<u>Collaboration Agenda</u>		
Progress the Western Bay Mental Health Programme agenda to identify opportunities to pool budgets, align services and develop mechanisms to jointly commission and procure services.	The development of collaborative approaches to the commissioning and delivery of support and care will provide a joined up approach between the Western Bay partners. This will result in seamless services, improved individual outcomes for Service Users and financial efficiencies.	Western Bay Mental Health Programme Board
Work with Partners within the ABMU HB footprint to respond to national policies, such as the Social Services and Wellbeing Act, Carers Strategy (Wales) Measure and Together for Mental Health.	The overall health and wellbeing outcomes of citizens will be improved.	Western Bay Carers Executive Group Western Bay Mental Health Programme Board Western Bay Partnership Board
Work with colleagues in CAMHT and Children's Services to develop a transition strategy. Implement practices and cultures which ensure identified support needs are continued and planned at the right time.	The development of a Mental Health Transition Strategy for young people entering into adulthood.	BCBC
Work with other agencies to deliver coordinated, joined-up support to those with co-occurring conditions.	Service Users with co-occurring conditions will receive holistic, timely and seamless responses for their individual needs.	BCBC

Develop a single point of access for people requiring mental health services.	Those that require services will have improved experiences through the provision of seamless and timely responses, which provides consistency and avoids unnecessary duplication of information. Service Users will have equitable and consistent access into mental health services across the Western Bay region.	Western Bay Mental Health Programme Board
Develop robust care pathways and crisis provision and models of support that prevent hospital admission and promotes early hospital discharge.	Those who experience a crisis will receive safe, appropriate and timely responses that are recovery and reablement based so that disruption to their lives is minimised and they are enabled to achieve more control over their lives and discover/rediscover a sense of personal identity which is distinct from their mental illness. Services will be able to respond to the individual needs of those requiring urgent responses in a manner that is least restrictive to the Service Users independence.	Western Bay Partnership Board

Reshaping CMHT		
Have a planned approach and rationale to specialist placements to ensure people receive the right levels of support and that specialist placements are achieving positive outcomes for Service Users.	People receiving specialist care are supported to achieve their maximum independence. Reviewing these models of care with our stakeholders will help ensure longer term sustainability of specialist placements.	Western Bay Mental Health Programme Board
Enhance person centred assessment and review process by ensuring Service Users are better able to play an informed role in the development of care and treatment plans through the provision of information and advice.	Service Users will feel supported to realise their aspirations which are central to the support planning process. Goals will be clearly set and reviewed, and progress will be effectively monitored so that Service Users are able to lead meaningful and satisfying lives as defined by them.	
Enable Carers to support their loved ones by encouraging the take up of carer assessments and through the provision of appropriate information and	Providing Carers with the right support and information at the right time will improve the health and wellbeing of Carers as individuals in their own right.	

advice.	Supporting Carers to maintain their caring role at their chosen level will reduce instances of crisis intervention and result in more planned transitions. Carer support will empower both the Carer and Service User to make informed choices about future care arrangements and where appropriate, prepare both parties for transition into alternative support arrangements.	
Implement clear and consistent protocols for the sharing of information between agencies, Service Users and Carers	Agencies, Staff, Service Users and Carers will have access to appropriate information and will have a clear understanding of the legal protocols.	Western Bay Carers Executive Group
Develop clear mechanisms to improve the information flow from practice to commissioning, to ensure that practice knowledge informs commissioning activity through a seamless approach. Reinforce Social Workers and the CMHT's role in the commissioning and monitoring process of mental health services. Ensure that assessment and reviews systems are strengthened and link into the planning and commissioning process, including the development promotion of preventative services.	An evidence based approach to commissioning will ensure services are responsive to identified support needs and create sustainability of the care market. Service users will have a range of support options to meet their individual needs. Options will offer the right levels of support in order to maximise their independence and fulfil their aspirations. Preventive services will reduce the need for more intensive support and reduce risk to Service Users independence.	
Enhance processes for Service Users and Carers to inform commissioning activity and improve their role in the commissioning process.	Services and responses will be informed by those that require them and ensure that they are responsive to need.	
Take a positive approach with partner agencies and Service Users around risk taking. Build on current risk management approaches to promote greater independence and reduce the need for managed interventions to help empower citizens.	Integrated working will provide partner agencies with a better understanding of how they can support the Service User to take positive risks. Creating a supportive environment in which the Service User feels safe to take positive risks will empower the Service User to have greater control, choice and independence over their lives.	

Accommodation Progression Model		
Work with colleagues in Supporting People to identify housing related support solutions to help refocus energy to community based services and lower level support services which stimulate independence. Strive to develop preventative models of intervention which help people remain out of traditional care services.	A comprehensive range of appropriate and flexible accommodation and housing related support services, which will provide Service Users with opportunities to live as independently as possible, for as long as possible, within their communities. Evidence progression through the mandatory Supporting People Outcomes Framework tool.	Supporting People Planning Group
Work with colleagues in Supporting People to identify housing related support and care solutions, which encourage independence and promotes the recovery philosophy through the utilisation of community based and lower level support services.	A comprehensive range of appropriate and flexible accommodation and housing related support services will provide opportunities for Service Users to live as independently as possible, for as long as possible, in their own communities. Progression will be evidenced through the mandatory Supporting People Outcomes Framework tool.	Supporting People Planning Group
Carry out further market development activity to ensure that the local market for support and accommodation is able to meet demand for support from Service Users.	Local support and accommodation services will be sustainable and responsive to future demands and will meet the needs of Service Users that are not currently having their needs met locally. Service Users will have appropriate accommodation options that will meet their support needs and promote their independence within their local communities.	Mental Health Accommodation Group
Drive forward and develop a clear "Progression" pathway building on transition through support planning that focuses on the support needed to help each Service User "Progress" to be as independent as is possible for them as an individual.	Support packages will be as individualised as possible, utilising a range of community-based options, so that Service Users are encouraged and facilitated to live as independently as possible and enabled to reach their full potential.	Mental Health Accommodation Group
Work with our current provider market and stakeholders to develop a wider choice and increased access to appropriate accommodation and housing	A range of robust accommodation and housing related support options will be made available to Service Users, which will empower them to live	Mental Health Accommodation Group

related support. In particular, flexible and enabling support models that encourage "progression" and supports reablement approaches so that Service Users are supported to move towards and/or retain maximum independence.	independent lives within their local communities. Service Users will be appropriately placed in care settings that offer the correct levels of support and maximises their independence.	
Local Area Coordination on Mental Health		
Strengthen approaches to community development by maximising opportunities for local services to offer natural support networks for people with mental ill health. Work with community groups, third sector and voluntary organisations collaboratively to offer localised support networks.	Greater choice of sustainable community based opportunities will reduce the number of Service Users requiring long term paid support. Good community networks will reinforce and promote the role of Service Users as important and valued members of their community and reduce stigma relating to mental ill health. Service Users will be given further opportunities to make positive contributions to their local community as equals and reduce instances of social exclusion.	Western bay Community Services Project
Promote and improve the mental and emotional wellbeing of the general population within Bridgend.	Citizens of Bridgend will be able to better deal with the stresses of everyday life and be productive members of their communities. Bridgend will be a healthier, fairer and more productive society.	Western bay Community Services Project
Ensure that Service Users are supported to access a range of social and day time opportunities within their local communities, including education, volunteering and employment.	Service users will have access to a wide range of meaningful activities that will develop their confidence and independence. These opportunities will empower Service Users to fulfil their ambitions and reach their full potential.	
Development of a Dementia Commissioning and Delivery Plan		
Develop a vehicle for implementing our vision for ASC dementia services and to align and deliver the key principles and objectives specified in key local and regional strategic documents.	The development of a commissioning strategy and the implementation of a delivery plan will ensure people in the borough with a diagnosis of dementia receive flexible and supportive care interventions, which promotes or maintains their	

	independence for as long as possible. People with a diagnosis of dementia will receive appropriate and flexible interventions based on good practice to maintain their quality of life and lead fulfilling lives.	

4) EXISTING STRATEGIC GROUPS

Platforms for Engagement

We recognise the importance of developing robust mechanisms to ensure that stakeholders, partners, Service Users and Carers are involved in the planning, consultation and monitoring process of ASC services. To facilitate effective planning and delivery of support, it is essential that commissioners take full account of stakeholders' experiences when assessing the effectiveness of commissioned services.

We also recognise that Service Users and Carers are central to the development of future plans. We believe that their contribution in shaping our commissioning objectives will help place them at the heart of all we do and enable us to deliver effective, outcome focused service models.

Our vision for engagement models for people with mental ill health places Service Users and Carers at the centre of the process and we are committed to further developing the way in which those who receive services, and their Carers, are involved within the commissioning process. The aims of engagement are to achieve robust platforms that will enable stakeholder to help us:-

- Shape current and future objectives;
- Influence and test priorities;
- Help facilitate delivery of priorities;
- Help drive forward and develop localised community services;
- Focus on what matters to Service Users and families;
- Facilitate better planning and coordinated market development.

This Plan has been developed in consultation with all stakeholders, including Service Users, Carers, practitioners, the third sector, providers and strategic partners from Health and Supporting People. Below is a summary of the emerging themes from feedback received from a series of consultation events we held to help inform our commissioning objectives.

Service Users

Develop mechanisms to ensure that Service Users and Carers are involved in the planning, development and implementation of the services they require;

- Support Service Users to be involved in the decisions that affect them as much as their capacity allows;

- Continue to develop processes that enables Service Users to define the outcomes that matter to them;
- Provide information to Service Users and Carers so they can play an informed part in their care and treatment pathway;
- Ensure there are robust care pathways for those in crisis and develop a range of support models to ensure that those in crisis receive appropriate and timely responses;
- Support the maintenance of mental health by working proactively with other agencies and partners to encourage the development of community based support networks and models, including information, community and non-specific mental health services;
- Develop processes to help people progress to be as independent as possible in their own communities;
- Promote the development of local support networks in the community and prevent social isolation by maximising opportunities for local services to offer natural support networks;
- Continue to expand opportunities for individuals to develop life skills that promotes and enables independence and improve opportunities for individuals to access training, education and work;
- Work with community groups, third sector and voluntary organisations to collaboratively develop localised support networks;
- Improve the understanding of mental health problems within the community and combat the stigma attached to poor mental health;
- Explore uses of information technology in the support and care process;
- Ensure that that there are clear information sharing processes across all agencies;

Carers

Engagement approaches should be strengthened so that Service Users and Carers are involved in the planning, development and implementation of the services they require;

- Ways to enable Carers to continue in their caring role by providing appropriate information, advice and services should be further developed;
- Put in place mechanisms to improve the take up of carer assessments;
- Have a focus on promoting day time opportunities that will offer respite for families and Carers – perhaps by maximising opportunities for local services to offer support;
- Develop process to help people progress to be as independent as possible in their own communities;
- Ensure there are robust crisis pathways and provision;
- Continue to progress person centred Service User assessments and review processes;
- Work with CAMHT to ensure that transitions into adult services are well planned and that young people are supported to make the transition into adulthood;
- Improve the provision of information and focus on ensuring Carers are involved in decisions about the services that they, and those they care for, receive;

- Further strengthen links between agencies responsible for the delivery of support to a Service User;
- Continue to respond to the Social Services and Wellbeing (Wales) Act 2014 so that those in need of social care services and their carers are empowered by affording them a stronger voice and giving them more control over the services they receive;
- Ensure that there are clear information- sharing processes across all agencies.

Practitioners

Young Service Users need to be supported to make the transition from CAMHT to CMHT in order to help prepare for the move into adulthood;

- Clear crisis pathways should be developed to provide Service Users with timely and appropriate responses;
- The development of robust community links and improving social inclusion could help Service Users to remain within their own communities and reduce reliance on statutory support services;
- There is a need to ensure that Service Users can be supported within their own homes and communities;
- Carers should be provided with education, advice and support to help enable them to support their loved ones;
- Accommodation-based support should be person-centred and needs led;
- Consideration should be given to increasing the provision of independent accommodation options with floating support;
- Services need to be responsive to changing needs and able to meet the wider needs of those with co-occurring conditions.

Providers of Mental Health Services and the wider Third Sector

Ensure there is equitable access to services and improve availability of services across the borough;

- Develop a wider range of community and social opportunities that are more age and gender appropriate, including opportunities that are open to the wider population not just those with mental health problems;
- Continue to work with partner agencies to deliver holistic care and support to those with co-occurring issues;
- Promote person centred and outcome focused approaches, including time-limited support, which is tailored to the individual and/or fluctuating needs of Service Users;
- Implement practices that focus on building the resilience and confidence of Service Users so that they are able to live more independent and fulfilling lives without the need for formal staff support;
- Expand the range of accommodation models to enable progression into more independent living arrangements;
- Further enhance promotion of independent advocacy and increase access to information and advice so those who receive care are able to be fully involved in decisions that affect them as much as their capacity allows;

- Look at ways to help the wider community and Carers acquire the knowledge and skills to help support those with mental ill health and assist the development of natural support networks;
- Develop robust crisis pathways and signposting to ensure timely and appropriate responses;
- Explore opportunities to pool budgets and collaboratively commission services with other Local Authorities and Health;
- Have a range of appropriate 'step-down' and 'move-on' accommodation.

5) EXISTING STRATEGIC PLANS

Mental health services have changed hugely over the last few decades. There is a shift away from an illness and 'treatment' model to a 'recovery' model with an emphasis on community provision as opposed to hospital and institutional care. Within the Council there is recognition that mental health services need to be improved and have service users and carers at the heart of the commissioning process.

Collaborative and integrated approaches to planning, commissioning and delivery are key elements to successfully taking forward our intentions and commitments with respect to mental health services. Our commitment to partnership working regionally can be seen through our involvement with the Western Bay Health and Social Care Collaborative. Locally, collaboration is evident in our work with the Bridgend Local Health Board and our Reshaping Mental Health project which is part of our Remodelling Adult Social Care programme.

The Mental Health (Wales) Measure 2010 has introduced important changes to the support available for people living with mental health issues in Wales. It places new legal duties on Local Health Boards and Local Authorities regarding assessment, treatment and access to independent mental health and advocacy.

Welsh Government has also embraced its responsibility to deliver improvements in mental health and wellbeing. It has published 'Together for Mental Health' (2012), a cross cutting strategy that sets out the vision for improvement of mental health and wellbeing for the people of Wales and recognises that mental health and wellbeing are not the sole responsibility of one organisation.

As part of the Western Bay Collaborative, a joint strategy for mental health services was published in 2013. During 2014 we have produced a Bridgend Mental Health Commissioning and Delivery plan which is currently out for consultation. This plan will be the main vehicle for implementing our vision for mental health services over the next three years.

The Caswell Clinic Social work team has continued to provide a service for the patient population detained in the medium secure service which maintains regular numbers of approximately sixty patients. The team also currently provides aftercare and monitoring to between 20 and 25 service users discharged from the Caswell Clinic across the sixteen local authorities who the service represents.

6) FUTURE USE OF RESOURCES

Priorities identified for 2015/16

- Improve access to availability information advice and assistance.

Key Objectives for 2015/16

- Detailed needs mapping to inform service developments with respect to accommodation;
- Improve the interface between Parts 1 and 2 of the Mental Health Measure to ensure a seamless service and positive outcomes for individuals;
- Fully integrated I.T. and client data base system and information sharing protocol;
- Improve engagement with service users and carers;
- Work with colleagues in Western Bay to review the model for CMHTs;
- Work with colleagues in communities to maximise supporting people opportunities;
- Develop a crisis provision;
- Enhance prevention and wellbeing provision in preparation for the Social Services Wellbeing Act;
- Progress S 33 agreement in respect of the Caswell integrated team;
- Review the outcomes of the Caswell social work/community team.

What did we do in 2015/16?

The Local Primary Mental Health Support Service (LPMHSS) continues to go to from strength to strength. Customer service questionnaires have indicated that 90% of those who have received the service have regarded it as helpful and would recommend it to others. Comments from those who have used the service include; **"it has helped me come off my medication and keep my job", "My new interests will help me negotiate my blackest days".** With respect to how the service could be improved the Directorate received the following comment; **"I would have liked the service for longer".**

The ARC service is also developing innovative approaches to respond to need such as mindfulness and stress control programmes. 104 people have attended drop-in stress control sessions, 68 people have attended activity sessions and 56 people have attended anxiety and depressions sessions. One service user who attended made the following comment "this is just the first step in my life of change".

In relation to GP referrals, the introduction of a new system for signposting referrals has been piloted. This prescription for signposting involves the GP completing a form with the service user to present at ARC when attending regularly arranged drop in clinics. Since the trial of this system 48 people have attended signposting clinic.
A single point of access (SPA) for GP referrals into secondary mental health services has been successfully piloted in Bridgend. This is currently being evaluated with a view to rolling out the scheme in Neath, Port Talbot and

Swansea. Interviews are being undertaken with staff that operate the system and with General Practitioners who refer into the SPA The Bridgend scheme will be developed this year to include all referrals to secondary mental health services which will improve access for those who are most vulnerable.

A review of community mental health teams is currently being undertaken in order to establish a new model of service. This review is in response to a regional review of mental health services commissioned by Western Bay which identified a number of recommendations such as; enhancing the single point of access, reviewing current models and improving crisis interventions. Visits are taking place to crisis units in other parts of the country which will help inform a future model.

An accommodation work stream has put in place a single procurement and brokerage process for high cost specialist mental health placements. Within Bridgend we have seen more cost effective placements as a result of adopting the process as well as better outcomes for individuals. A common policy and procedure for aftercare services (under s117 of the Mental Health Act 1983) has been agreed enabling consistency across the region. Recently the work stream has undertaken an accommodation needs mapping exercise. This data is being used in Bridgend to inform adult social care commissioning plans. It is also enabling us to collaborate with colleagues in communities to develop specific mental health housing projects such as increasing the provision of floating support and a specialist housing project for those with complex mental health issues.

Improving provision for those in crisis is a key objective in the mental health commissioning plan. Work is currently being undertaken with health colleagues to scope the development of a crisis service and Bridgend was represented on visits to Crisis facilitates in Leeds and Hereford. This is in response to service user and carer feedback which has indicated that it is an area which needs improvement.

Within the Caswell Clinic integrated team the outcomes in terms of aftercare has demonstrated that the established systems are achieving satisfactions for over 50% of the service users who are now living independently or other community placements. This does also indicate that 50% are transferred to low or high secure units and/or returned to prison. Whilst this may not be a satisfactory outcome for the service user it does evidence that the team is also meeting the public protection remit of the service.

Engagement with service users and carers is improving. A ‘Stronger in Partnership’ group (SIP) brings together professionals, service users and carers across the Western Bay region. This ensures mental health plans are more responsive to need. An example of this is that carers had raised concerns about the sharing of information. A guidance document has been produced which will be promoted and circulated widely and training for staff on information sharing is ongoing.

The Time to Change Wales (TTCW) campaign is a Welsh Government initiative aimed at changing attitudes within the Welsh workforce in relation to mental health. TTCW aims to work with organizations to sign a pledge and develop action plans to create 'mentally healthy' workplaces where staff are actively encouraged to talk about mental health. It is also designed to raise awareness, understanding and tolerance of poor mental health. Bridgend will be signing this pledge as part of a Western Bay commitment in February 2016.

Addressing issues of stigma and discrimination is also a priority in the mental health commissioning plan. Training concerning mental health and wellbeing is being rolled out across the Council to raise awareness. An E learning package will be launched across the Council in November to raise awareness of mental health; the different conditions and interventions and issues of stigma and discrimination.

A meeting has been arranged with head teachers to enable the Authority to raise awareness regarding young people and mental health and wellbeing in schools. This initiative also aims to help early identification of mental health concerns regarding young people and facilitate early intervention.

As part of the Western Bay collaborative the Authority has supported the development of an electronic library of on line self-help guides to offer information and advice on a wide range of subjects including anxiety, dealing with bereavement and alcohol dependency. In the first two months there have been 1624 visits to the electronic library across the region.

Supporting carers to continue in their caring role is a priority in the commissioning plan and a specific forum for carers who support people with mental health issues has been established. There have also been initiatives to support carers at work such as events to raise awareness and provide information as well as a Facebook page for council employees. To date, seven employees have accessed this page; the intention is to further promote this to encourage carers at work to share their experiences.

As part of the preparation for the Social Services and Wellbeing (Wales) Act 2014, a Local Area Coordinator has been appointed to focus on early intervention and signposting. 30 individuals with mental health issues have accessed the service to date. Individuals are being supported within their community networks to access wellbeing activities which is resulting in better outcomes for those individuals. One example is that a gentleman suffering from depression and anxiety was unable to work. He has since been referred into a woodworking work project to regain confidence and share his skills with view to eventually returning to work.

Who is better off?

- The process of Care Co-ordination under Part 2 of the Measure ensures that objectives are set for individuals which are outcome focussed. It is also empowering to uses of the service. (MH013)

- The Measure continues to improve performance in relation to the number of service users who have now a valid care and treatment plan.
- The consultation undertaken in relation to the Mental Health Commissioning and Delivery Plan has improved communication with service users and carers.
- There has been improved collaboration between health and social care which resulted in better outcomes of individuals. An example would be the Single Point of Access Development.
- The Western Bay Brokerage and Complex Case Panel has enabled better outcomes for service users requiring community accommodation.
- The drop in referral system at ARC combats high rates of referrals, re referrals and non-attendance as well as increasing the responsibilities of the individuals to have control over their support needs and interventions.
- Between Oct and Dec 236 people were seen for assessment or initial contact with the ARC service and 97% people were seen within the target of 28 days.
- 204 individuals were referred for support in relation to employment and training between April and Dec. Of these 46 people were already in work and were supported to maintain their employment.
- The accommodation needs mapping has informed supporting people and adult social care commissioning plans.
- The range of accommodation has increased which has improved outcomes for those individuals with accommodation needs.
- Service users have reported positive outcomes from attending ARC services – **"it has helped me negotiate my darkest days**".
- The electronic library of mental health self-help guides received 1600 hits during the first two months of operation.
- The initial evaluation of the Single Point of Access with those operating the service has been positive.

Preparation of Core Processes

Whilst there is general compliance with the Mental Health Measure requirements, there is need to ensure that monitoring of care and treatment plans is undertaken by managers routinely to ensure quality outcomes for service users.

Assessment and Care Co-ordination Processes are currently being revisited to ensure consistency across Adult Social Care in preparation for the Social Services and Wellbeing Act implementation.

Clear systems with respect to financial processes need to be established and mental health services need to be compliant (especially with regard to Section 117 of the Mental Health Act).

Social Services and Wellbeing (Wales) Act 2014

The Social Services and Wellbeing (Wales) Act aims to empower those in need of social care services and their carers to promote their independence by

affording them a strong voice and giving them more control over the services they receive. The Act emphasises the promotion of equality, improvement of service quality and provision of information and stresses the need to achieve a shared focus prevention and early intervention. Current priorities and service objectives will respect to mental health fully reflect the Act's vision for delivering services.

Partnership Working/Collaboration

With respect to mental health services, partnership working is integral to all service developments. This can be evidenced at a national, regional and local level. The Local Primary Mental Health Support Service, Community Mental Health Teams and Mental Health Older Peoples team are multi-disciplinary. The ARC service is provided in collaboration with health and is subject to a Section 33. ARC continues to forge positive and productive links with community groups to provide opportunities for individuals and supports the Act's prevention and wellbeing agenda. The future aim is to forge stronger collaborative links in the delivery of opportunities, networks and support services.

The Western Bay programme is collaboration between Bridgend, Neath and Swansea local authorities plus ABMU. Third Sector organisations as well as service users and carers are also represented on the Western Bay Project Board.

A number of multi-agency forums meet to steer the implementation of the Mental Health Measure and progression and delivery of the Joint Strategy for Mental Health.

The strength of the Caswell social work team lies in the experience of the team in working in a multi-disciplinary team and in forensic practice. It is also a service which collaborates with the 16 local authorities it serves which is dependent on good communication and liaison.

Developments in relation to reshaping mental health services are also being progressed with colleagues in Communities, Third Sector and independent providers.

Service User/ Carer Engagement

- Service user and carer engagement has been an integral component in developing services for adult mental health and sit on planning forums such as the regional mental health partnership. Feedback has informed service priorities and plans have been amended accordingly.
- Engagement with service users and carers is improving. A stronger in partnership group brings together service users and cares across the Western bay region. This ensures future plans are more responsive to need. An example of this is that carers had raised concerns about the sharing of information. A guidance document has subsequently been produced and is being circulated widely and training for staff on information sharing is ongoing

- Officers regularly attend service user and carer forums to improve communication and engagement.

SUMMARY

With respect to the Adult Mental Health service, we are able to demonstrate improved access to early interventions, the Local Primary Mental Health Service is going from strength to strength and improved care and treatment planning is resulting in better outcomes for service users and enabling them to have better control over their lives – **"my life is so much better with these tools and I am slowly on the road to recovery".**

We have also improved our relationship with colleague in Supporting People and we are developing new accommodation projects specifically for mental health. There is however, still much to do.

The following priorities for improvement have been identified for 2016/17 –

- Bridgend is an early adopter of the integrated Health and Social Care Systems. (WCCIS) The Mental Health Service will need to fully implement the new system during 2016/17.
- Development of a collaborative approach to wellbeing across sectors including service users, cares and the public.
- The authority is seeing a change in the profile of those requiring mental health supports. More than 60% have a substance misuse issue or other conditions such as physical frailty or a sensory impairment. There are many who have a Personality Disorder, an offending history or are a concern to their communities. The service needs to be remodelled to be able to respond to those complex individuals.
- A crisis provision needs to be developed in collaboration with health as an alternative to hospital.
- Whilst relationships with partners are positive, some arrangements/problems need revisiting such as the use of 136 and conveyance concerning the Mental Health Act.
- Efforts to progress a S 33 in relation to the team at Caswell have not progressed during 15/16 , it will be necessary to confirm during 2016/17 that health do not wish to proceed.
- There is a need to have clear transitional plans for young people with mental health issues.
- People who live with mental health issues are telling us that they still face discrimination and hostility which needs to be tackled.
- There is a need to improve emotional wellbeing resources and mental health support for council employees.
- Focussed attention is required to implement the early intervention, information and prevention requirements of the Social Services and Wellbeing Act in mental health.

WESTERN BAY POPULATION ASSESSMENT 2016/17

NEATH PORT TALBOT AREA

MENTAL HEALTH

7) OVERVIEW OF CURRENT AND FORECASTED NEEDS

The majority of people with mental health issues either live in the local community with minimal support from Adult Social Care (ASC) or from specialist mental health services i.e. they self-manage, have family/community support and access primary health care.

There are also a significant number of people with mental health support needs who are supported to live in the community by specialist community mental health services. This table details the range of community based mental health services and teams that serve NPT. Notably 961 people are currently supported by two Multi-Disciplinary Community Mental Health Teams (CMHT). (August 2016)

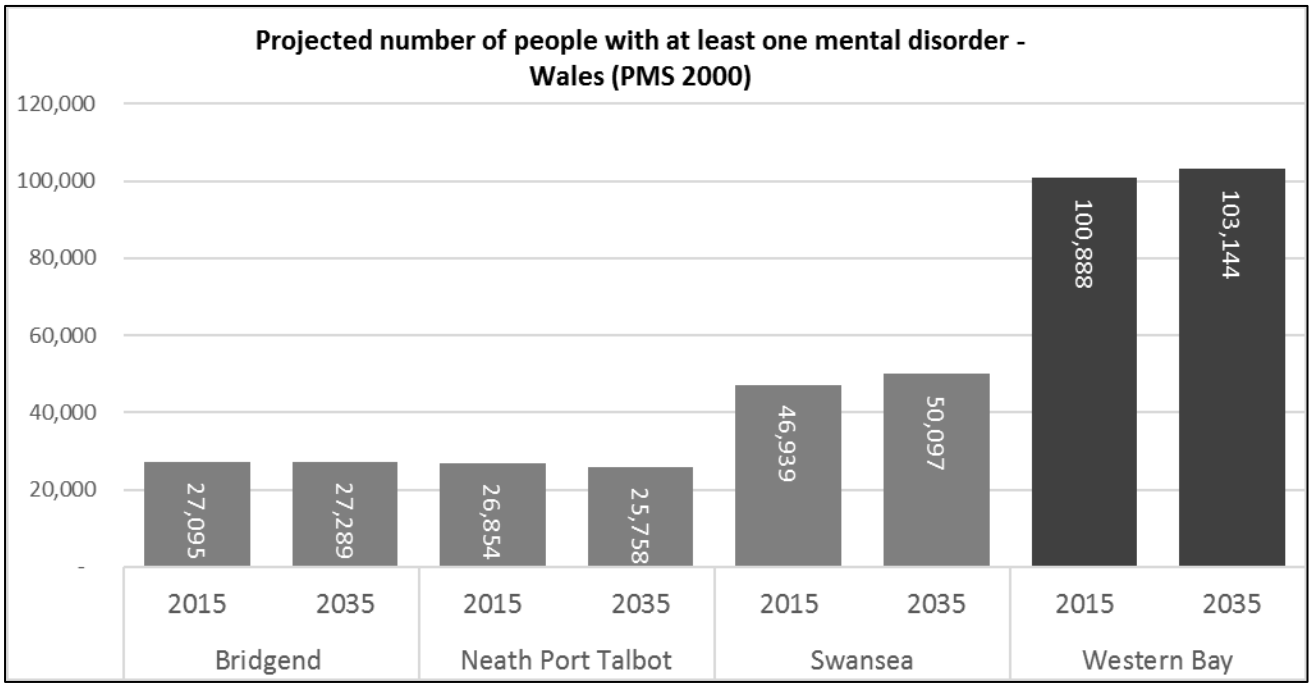
Service/Team	Description
Complex Needs Services for Women – Dechrau Newydd	Community Dialectical Behaviour Therapy service for women with mental health complex needs (primarily borderline personality disorder). This service works with patients in secondary care in close partnership with CMHTs and in-patient services.
Crisis Resolution Home Treatment teams (CRHTT)	Function is to offer support and care for those people who without it would be admitted to hospital. They are act as the gatekeeper to inpatient beds in order to ensure that all alternatives to inpatient care have been explored. Also support the early discharge of those people who have required inpatient care. Provide advice and signposting to people referred to them, but who they assess as not requiring their services.
Crisis Recovery Units (CRU).	A day hospital type environment for people who require more support than can be delivered in their own home but do not require hospital admission.
Prison In-Reach Team (PIR)	Community Mental Health Team based within both HMP Parc and HMP Swansea. The service provides assessment, management and Care Co-ordination of prisoners who are presenting with serious mental illness. Close liaison with probation (MAPPA) and

	wider third sector services to manage presenting risks.

There are 72 people from NPT who have more complex mental health needs and who are either jointly supported by ASC and ABMU or who are supported in NHS low or medium secure settings, but who will probably need joint support from ASC/ABMU if and when they are discharged from secure NHS settings.

Mental health disorders are very common. The overall proportion of people experiencing at least one mental health disorder within the previous year for the UK in 2000 was 23%. For Wales, this was 26%. The 23% figure for any mental disorder remained stable for England in 2007. As such I have assumed that the Wales prevalence estimate of 26% has also remained stable.

The chart below shows what 26% of the population represents in 2015 and in 2035 for Western Bay.



8) PROFILE OF SPEND AND ACTIVITY

Current support models

An effective mental health care pathway will ensure:

- People experiencing an acute mental health episode are kept safe and provided with a therapeutic environment to begin to recover. Often these settings need to be secure;
- Access to recovery and rehabilitation services when the initial crisis has passed and the person is ready to continue their recovery;
- Resettlement/step down services to help people make the move back to the community when they no longer need more intensive support; and
- Medium to long term on-going community based support so people with

mental health needs are supported to live where they choose e.g. in supported living, in their own tenancies, with host families etc.

How we expected people would be supported in NPT

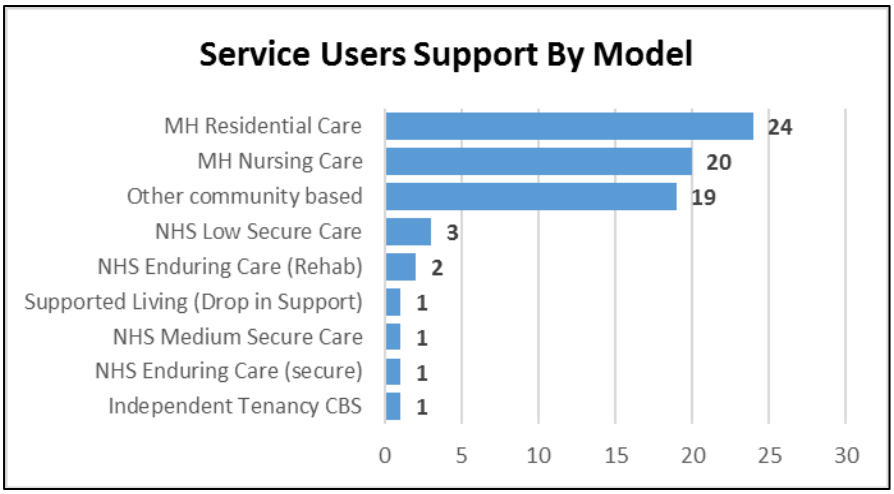
With the above care pathway in mind it is expected that people with complex issues would be accessing services at each stage in the pathway with the community based segment using a mixture of supported living, shared lives, independent tenancies and a small number temporarily in residential/nursing care settings.

How people are actually supported in NPT

Figure 1 shows that a small number of people (5 or 7%) are temporarily supported in secure settings, as expected, but:

- Very few (just 2 or 3%) are in recovery/rehab services,
- None at all are in services that focus on step down, and
- Long/medium term on-going care and support is over reliant (44 or 61%) on residential and nursing care with other community based options being under represented (21 or 29%)

Figure 1: Support Models Currently Used:



The current pattern of mental health support is not yet in line with the model laid out as an effective mental health care pathway concern and individual service user outcomes, levels of independence etc. may be better supported. (17th March 2016 Cabinet Report.)

Mental health support now

Whilst progress is being made a lot more still needs to be done. For example, a paternal ethos still exists and that leads to risk adverse practice too often.

This risk aversion is further reinforced by a lack of:

- Community based services such as supported living schemes and shared

lives within Neath Port Talbot.

- A 24/7 crisis response service that could respond out of normal office hours if a service user had a mental health relapse.

- Joined up approaches between different services highlighting that managers said resembled “silos” with tight gate keeping.

All these factors combine to create the conditions whereby residential or nursing care (often out of area) is over used.

Over reliance on secure, residential and nursing care

Secure settings, residential care and nursing care are used more than it should be and service users can stay in them longer than is ideal. Reasons for this include a lack of:

- Specialist mental health respite/short term crisis beds to use to stabilise a person during a mental health relapse so to be safe staff may opt to use residential care,
- Specialist mental health step down services to help people make the transition from hospital or from a residential care setting back to the community so there is a tendency to support people residential setting for longer,
- Acute mental health beds which means there is significant pressure to discharge people from hospital as quickly as possible. Sometimes this is before people are ready to move back to their home in which case a safe place needs to be found,
- Specialist community mental health recovery/ rehabilitation service to continue to support people to recover in a community setting, and
- Community based support services that can meet the needs of people with complex mental health needs, notably behaviour that is challenging to services. This includes a lack of:
    - Mental health supported living services
    - Shared lives carers with mental health expertise
    - Housing (specialist and disbursed) that is suitable for adults with mental health needs

3) CURRENT PRIORITIES

The strategy being implemented to transform services for people with mental health needs is based on the following principles:

- To change social work practice adopting more proportionate risk based management, rather than risk adverse practice. This should both lead to improved outcomes for service users and their carers, with added benefit of a reduction in unit costs of service provision;

- To adopt progression-based models that support people to maximise their independence and quality of life, at whatever point in their life and whatever their needs;

- Increasing the profile of people with learning disabilities in safeguarding

arrangements.

The adoption of this strategy means:

- Upskilling of the social work workforce to adopt less risk averse practice;
- Remodelling of service provision, working with housing and other support providers to ensure progression based models of service replace the existing dependency-inducing models;
- Encouraging use of models that enable more personalised services, for example direct payments and social co-operatives;
- Reviewing s117 Mental health Act after care arrangements
- More effectively responding to transition cases from children's services

Operationally, key changes we are planning for include:

- Maintaining a multi-disciplinary single point of entry and associated assessments;
- Operating a multi-disciplinary resource allocation model to ensure that the allocation of resources is transparent and equitable and person-centred;
- Continuously seeking to ensure interventions/support are aimed at early intervention and prevention, seeking to always avoid the need for reactive responses
- Identifying gaps in provision and ensure this is effectively fed back into commissioning processes to address the gaps
- Ensuring that there is effective integration of mental health services, with substance misuse and anti-social behaviour services to as to holistically meet the needs of the service user
- Increasing the profile of people with mental health within safeguarding arrangements
- Taking forward our plans to re-model day service opportunities:
    - Developing our Bspoked[1] service to provide employment and training opportunities for adults with a learning disability, mental health need or physical disability

[1] SCHH Cabinet Board 31/07/15 – Work, training and employment service proposals – renaming and rebranding of the vocational skills service

- Developing our Cyfle y Dyfu[2] service to provide employment and training opportunities for adults with a learning disability, mental health need for physical disability
- Developing the community connector[3] model to move away from establishment based provision to supporting people to have their care and support needs met through mainstream community resources

Need to improve Transitions from Children's Services

Transitions planning should start at an early age and needs to focus on skills development and building resilience for young people. Currently mental health needs are not always detected during transitions work and plans to meet mental health needs are not put in place

Adult Population

Currently people with mental health needs can often only access generic support until they experience a mental health crisis that brings them into contact with specialist services. When this is the case, individual outcomes and wellbeing suffer and support costs escalate.

Specialist mental health respite/short term crisis beds are used to stabilise a person during a mental health relapse which could lead to use residential care

Need to build up the community infra-structure to better support people with mental health needs

There is a need to develop:

- The skills of staff so they better support people with mental health needs,
- Provider services to better support people with complex mental health needs and in particular to better support people with behaviour that is challenging,
- Better information and advice so that service users and staff are better able to access or advice on how to access the existing community infrastructure,
- A clinical crisis response service that provides a 365 24/7 response as the current service only operates from 9 a.m to 9 p.m.
- Non-clinical crisis house services in the main towns. These could also house an information hub, drop in services etc. to help people self-manage their mental health needs,
- More effective employment support for people with mental health needs.
- Peer support networks to offer low level support to people self-managing their mental health needs (including social activities) across all of NPT e.g. MIND is known to be active in Neath but not in Port Talbot.
- The Mental Health care and support market and the local community

[2] SCHH Cabinet Board 14/05/15 – Work, training and employment service proposals – partnership project with Cyfle y Dyfu

[3] SCHH Cabinet board 26/11/2015- Direct Services, Integrated Community Model

infrastructure each need to be improved.

- Improve the "Whole System" of care and support for adults with mental health needs so that new and existing service users from across the whole spectrum of need all have support that:
    - Maximises their overall health, well-being and resilience,
    - Supports them to exercise self-determination,
    - Facilitates them to achieve autonomy, and
    - Enables them to participate as fully as possible in their local community.

Key areas to prioritise are to:

- Improve transition planning and access to children's mental health services so the transition is as smooth as possible.
- Improve early intervention services so mental health crisis are minimised.
- Reduce reliance on residential/secure care models by resettling people where possible when their existing residential placement is not appropriate and by reducing new admissions to a minimum.
- Develop community capacity as an alternative to res/secure care so there are:
    - Less new admissions to res/secure care, and
    - A range of alternatives for people to choose from when they are resettled from an existing placement.

- Improve the "Fluidity" and "Flexibility" between existing services so support can more easily be flexed as the mental health needs of individual service users fluctuate.

4) FUTURE USE OF RESOURCES

Mental health support needed in future

There is a need to develop the "*Whole System*" of care and support for citizens living with mental illness in Neath Port Talbot in line with the Welsh Government's 10 year strategy to improve mental health services and outcomes -"Together for Mental Health"[4].

In particular the "Whole System" needs to become more co-operative, more integrated and it needs to take a more proportionate approach to risk that enables people with mental illness to:

- Maximise their overall health, well-being and resilience,
- Exercise self-determination,
- Achieve autonomy, and
- Participate as fully as possible in their local community.

[4] "Together for Mental Health".

This requires a more joined up, responsive and flexible "*Whole System*" of care and support that enables citizens living with mental illness in Neath Port Talbot to access "*just enough*" of the support they need, at the "*right time*" and for "*just long enough*" to maximise their recovery from mental illness and build their resilience against future threats to their mental health and overall health and wellbeing.

WESTERN BAY POPULATION ASSESSMENT 2016/17

SWANSEA AREA

MENTAL HEALTH

1) OVERVIEW OF CURRENT AND FORECASTED NEEDS

Estimating Adult Mental Health

According to the World Health Organisation (WHO),
"Mental health problems account for 20% of the overall "burden of disease", a larger share than any other single health problem, including cardiovascular diseases (16.2%) and cancer (15.6%).

Poor mental health and mental illness have a significant impact on individuals, society and the economy overall."

Compared to some other areas there appears to be less current published data available on prevalence. The estimated prevalence of adult mental health problems has been surveyed within the UK every seven years since 1993, with the survey in 2000 the last year for which data has been published which included estimates relating to Wales, as well as for England and Scotland. The 2000 survey and subsequent surveys looked at those aged 16-74. It was published as Psychiatric morbidity among adults living in private households, 2000, and was described as 'the report of a survey carried out by Social Survey Division of the Office for National Statistics on behalf of the Department of Health, the Scottish Executive and the National Assembly for Wales'. The 2007 survey was England-only Results of the 2014 survey have yet to be published.

Psychiatric morbidity among adults living in private households 2000

The term 'survey' understates the range of methodologies involved in the periodic assessment of the prevalence of mental health problems: a range of screening instruments are used and face-to-face interviews are also involved, including both lay and clinical researchers. The estimates of prevalence and service use in this section are derived from the Psychiatric Morbidity for 2000, unless otherwise specified. Furthermore, the headline figures from the 2000 survey that reported Wales-specific estimates for Common Mental Disorders (CMD) and probable psychosis have been used throughout. The graphs showing 'Wales (PMS2000)' in the titles are calculated from prevalence rates for Wales in 2000. GB (PMS2000) denotes whole-survey results for 2000. Projections marked as '(PMS2007)' denote derivation from the England / Scotland 2007 survey.

Defining Mental Illnesses

The terms used in this document relate to the terms used within the survey of psychiatric morbidity. The term Common Mental Disorders (CMD) refers to a specific range of six of the most common mental illnesses:-

- mixed anxiety and depressive disorder,
- generalised anxiety disorder,
- depressive episode,
- phobias,
- obsessive compulsive disorder
- panic disorder.

In the 2000 survey, CMDs were referred to as 'neurotic disorders', which is terminology no longer used.

The term probable psychosis is used in the 2000 survey to describe mental illness that is more severe than the CMDs and mostly relates to schizophrenia and schizotypal illnesses, as well as more serious affective illness (mood disorders), such as bipolar affective disorder. Given the nature of the survey methodology, an accurate diagnosis of psychosis is not possible and is therefore described as 'probable'. The 2007 survey found that methods used to assess 'probable psychosis' resulted in a slightly higher proportion of people (0.5%) identified than survey instruments that more accurately assessed a diagnosis of psychosis (0.4%).

The term personality disorder relates to the following categories:-

- Avoidant
- Dependant
- Obsessive compulsive
- Paranoid
- Schizotypal
- Schizoid
- Histrionic
- Narcissistic
- Borderline
- Antisocial
- Passive-aggressive
- Depressive

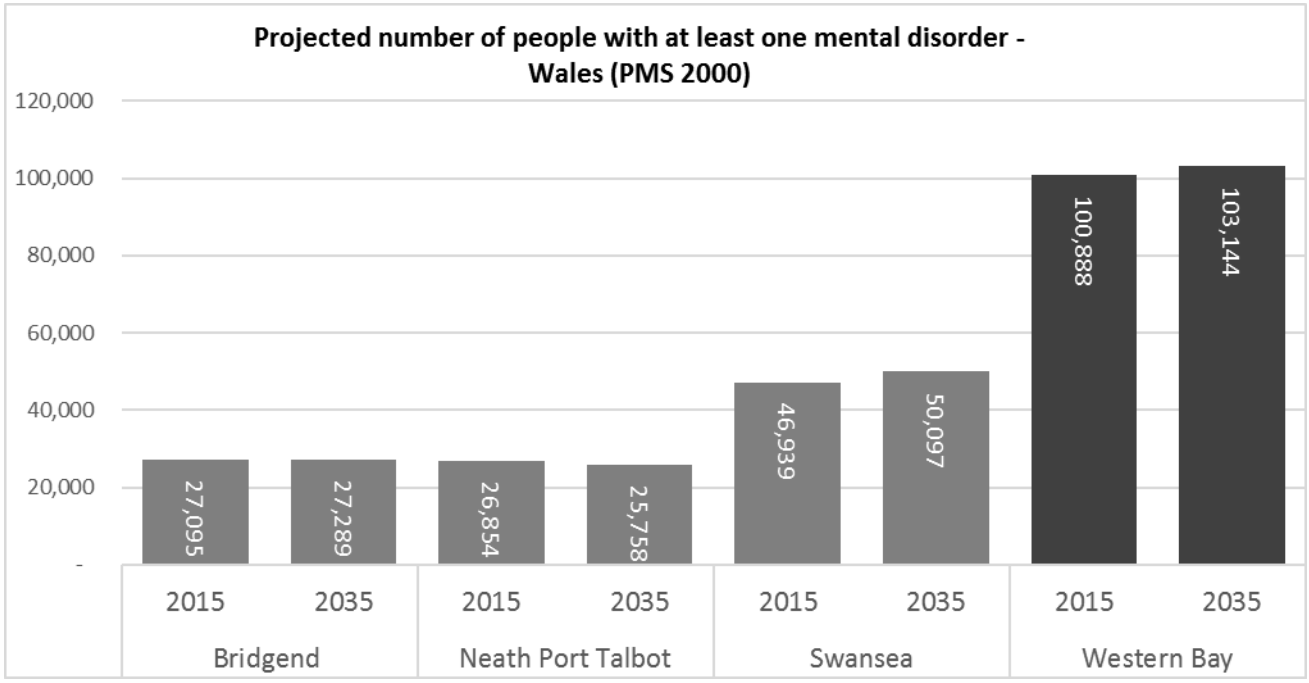
The 2000 survey also looked at drug and alcohol misuse and dependence, but this will be covered in more detail elsewhere.

The term mental health disorder refers to all mental illnesses covered by the survey, and thus includes all the above. The 2007 England survey extended the range of diagnoses covered by the survey and some material from that survey is extrapolated to Wales in this document.

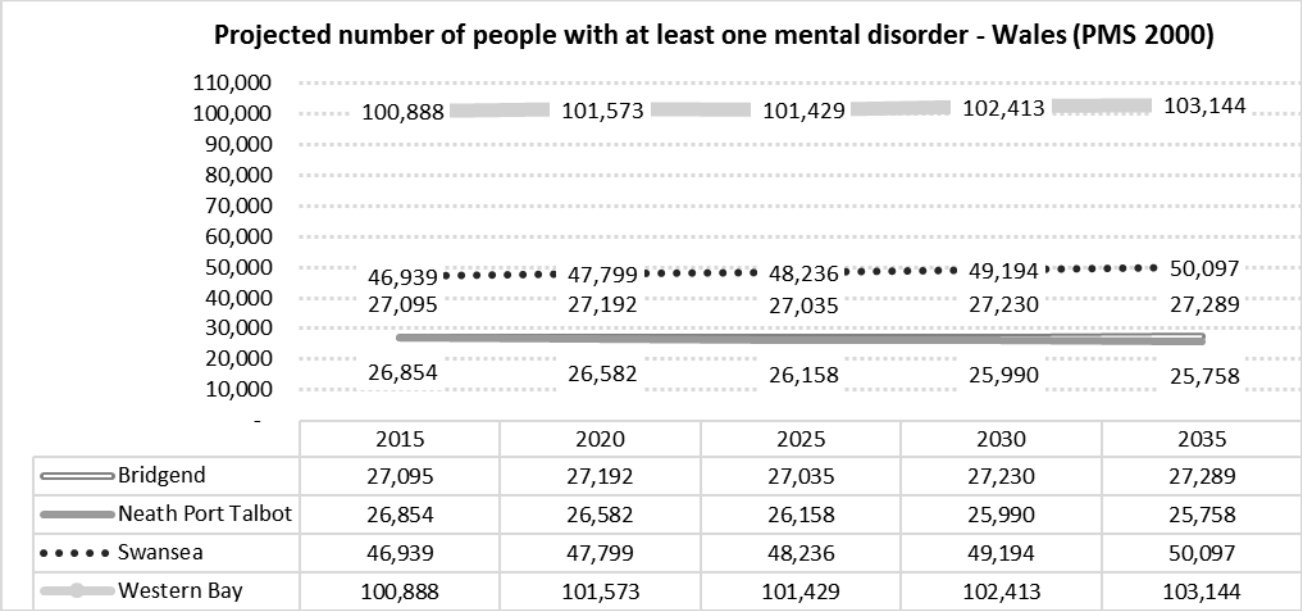
Adults with a mental health disorder

Mental health disorders are very common. The overall proportion of people experiencing at least one mental health disorder within the previous year for the UK in 2000 was 23%. For Wales, this was 26%. The 23% figure for any mental disorder remained stable for England in 2007. As such, it is assumed that the Wales prevalence estimate of 26% has also remained stable.

The chart below shows what 26% of the population represents in 2015 and in 2035 for Western Bay.



The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals.



	2015	2020	2025	2030	2035
Bridgend	27,095	27,192	27,035	27,230	27,289
Neath Port Talbot	26,854	26,582	26,158	25,990	25,758
Swansea	46,939	47,799	48,236	49,194	50,097
Western Bay	100,888	101,573	101,429	102,413	103,144

As the projections are essentially based on population sizes, the projected results are largely based on changes in population size. The figures above thus reflect modest increases in the population size of Swansea and Bridgend, but a modest reduction in adult population in Neath Port Talbot by 2035.

Prevalence of Common Mental Disorders (CMDs), Personality Disorders and Probable Psychotic Disorder

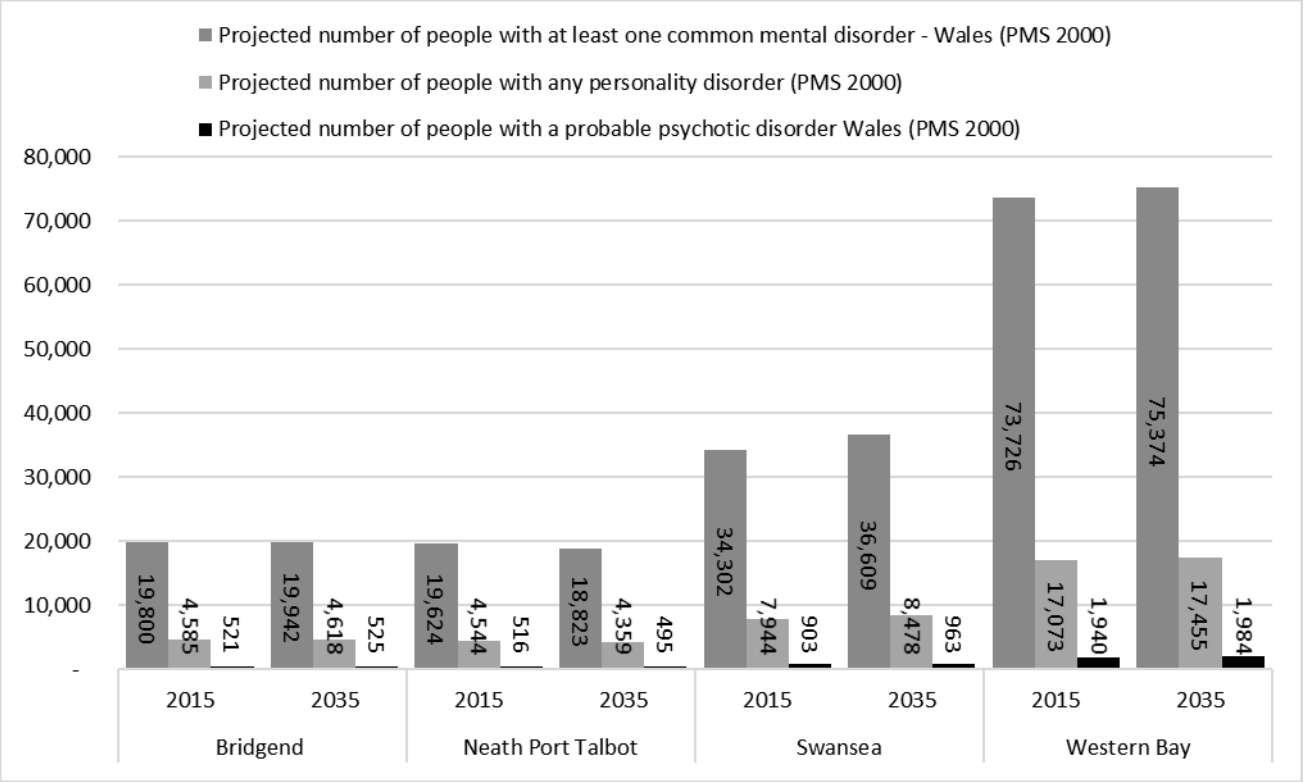
The prevalence of Common Mental Disorders in Wales was slightly higher in Wales (19% of people) compared to the overall Great Britain result of 16.4%. The 16.4% figure for any CMD remained fairly stable for England in 2007, dropping from 16.4% to 15.1%. However, the prevalence for the age group 16-64 was much more stable: 16.3% in 2000 and 16.4% in 2007. Since the under 65s are the larger proportion of people, it is assumed that the Wales prevalence estimate of 19% has also remained stable. The prevalence of personality disorder in 2000 was 4.4% of the population. The 2007 survey focussed on only two personality disorders.

The prevalence of probable psychotic disorder was the same in 2000 for Wales as for Great Britain at 5% of the population. The prevalence rate in 1993 had been similar at 0.4% of population. The 2007 survey for England also found the same prevalence of 5%.

The chart below shows for 2015 and for 2035 the estimated prevalence expressed as % of people aged 16-74 for each category:-

- 19% with a CMD as per Wales figures in 2000 survey
- 4.4% with a personality disorder as per 2000 survey
- 0.5% with a probable psychotic disorder as per all surveys 1993-2007

Note that the following graphs show the two types of illness but there will be a level of overlap with some people experiencing both. See section below on co-morbidity.

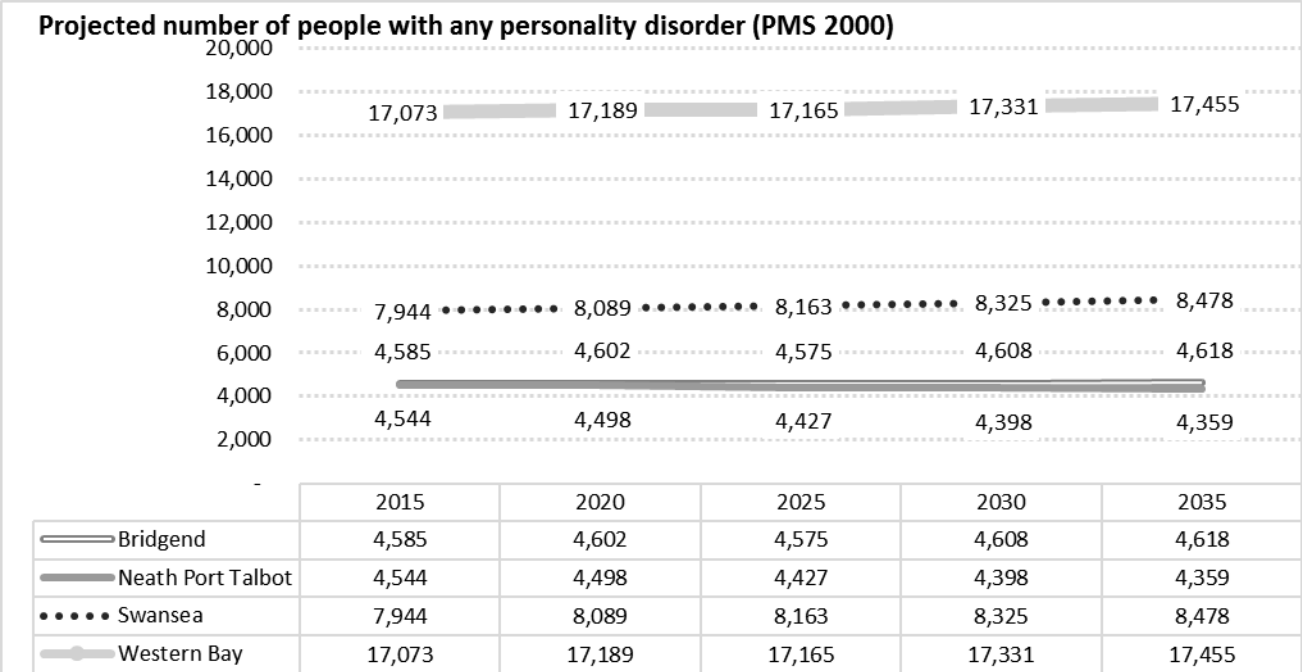


As the projections are essentially based on population sizes, the projected results are largely based on changes in population size. The figures above thus reflect modest increases in the population size of Swansea and Bridgend, but a modest reduction in adult population in Neath Port Talbot by 2035.

Projected Prevalence of Personality Disorders

Personality disorders are persistent and they are often expressed as dysfunctional patterns of behaviour that are found to be pervasive and adversely affecting the person's life. Levels of distress and treatment-seeking vary across the personality disorders. In many cases, personality disorders are extremely difficult to treat, if at all.

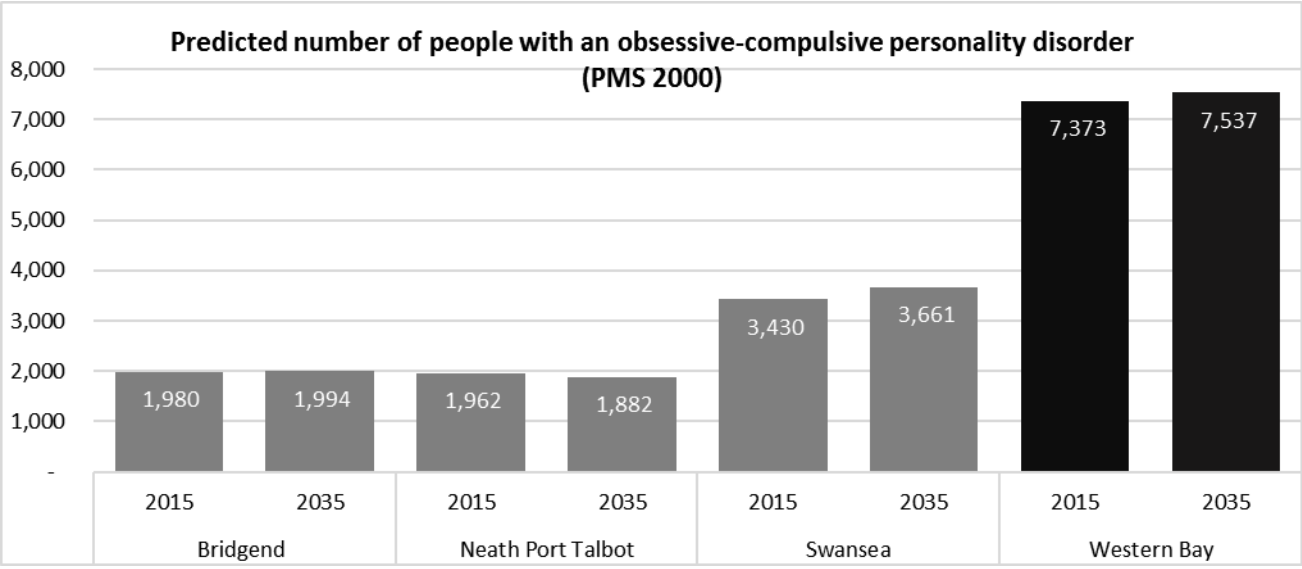
The following chart shows the projected numbers across Western Bay to 2035 at five-year intervals, given a prevalence of 4.4% of the adult population.



	2015	2020	2025	2030	2035
Bridgend	4,585	4,602	4,575	4,608	4,618
Neath Port Talbot	4,544	4,498	4,427	4,398	4,359
Swansea	7,944	8,089	8,163	8,325	8,478
Western Bay	17,073	17,189	17,165	17,331	17,455

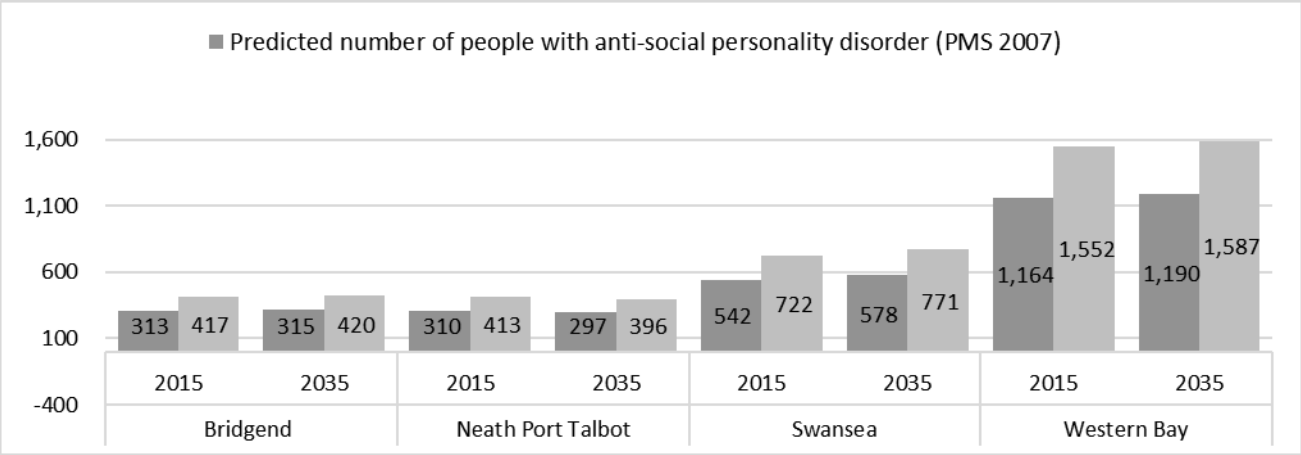
Specific Personality Disorders

The most frequently-occurring personality is obsessive-compulsive personality disorder, (sometimes called cothymia) with 1.9% of the adult population affected:-



Using estimates from the 2007 survey, it is possible to estimate the prevalence of antisocial and borderline personality disorders, at 0.3% and 0.4% of the population

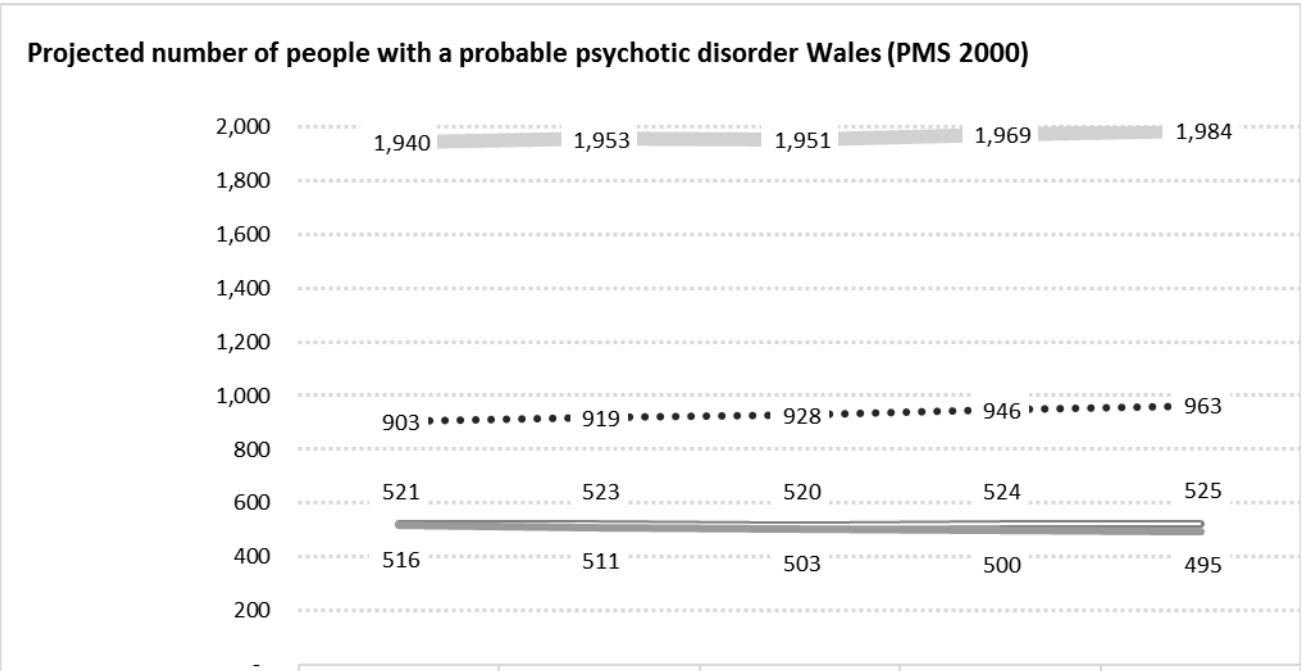
respectively.



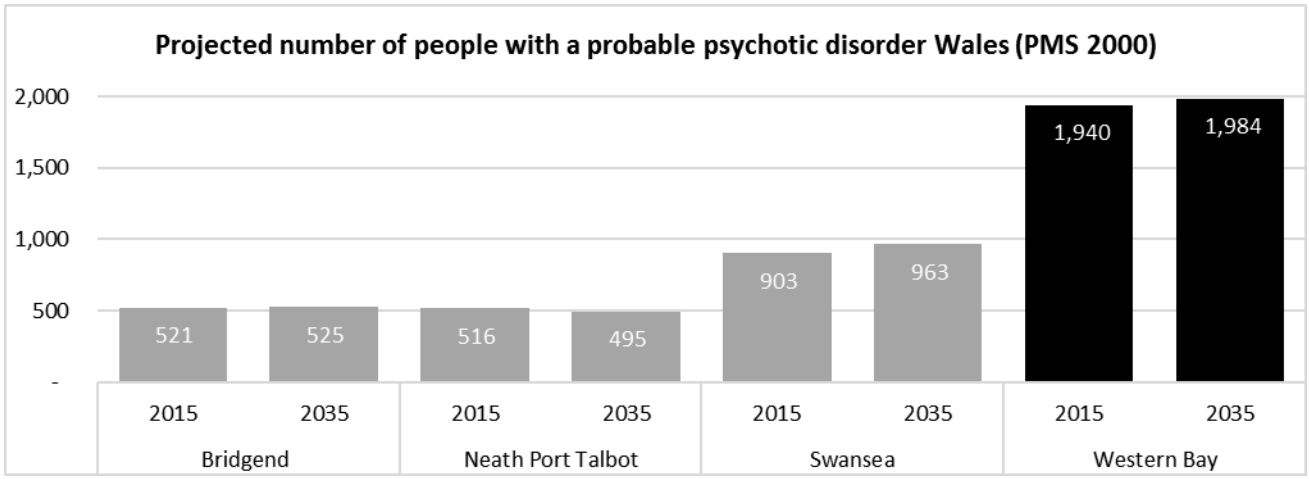
Note these two disorders may co-occur (probably rarely) so there could be some overlap between people in each category. The least prevalent are dependent and schizotypal personality disorders, at 0.1% of the population.

Projected Prevalence of Probable Psychotic Disorder

The following chart shows the projected numbers of people with probable psychotic disorder across Western Bay to 2035 at five-year intervals, given a stable prevalence of 0.5% of the adult population across the surveys carried out 1993-2007.



	2015	2020	2025	2030	2035
Bridgend	521	523	520	524	525
Neath Port Talbot	516	511	503	500	495
Swansea	903	919	928	946	963
Western Bay	1,940	1,953	1,951	1,969	1,984



Projected Numbers Receiving Treatment, Contact with GP & Receiving Community Services

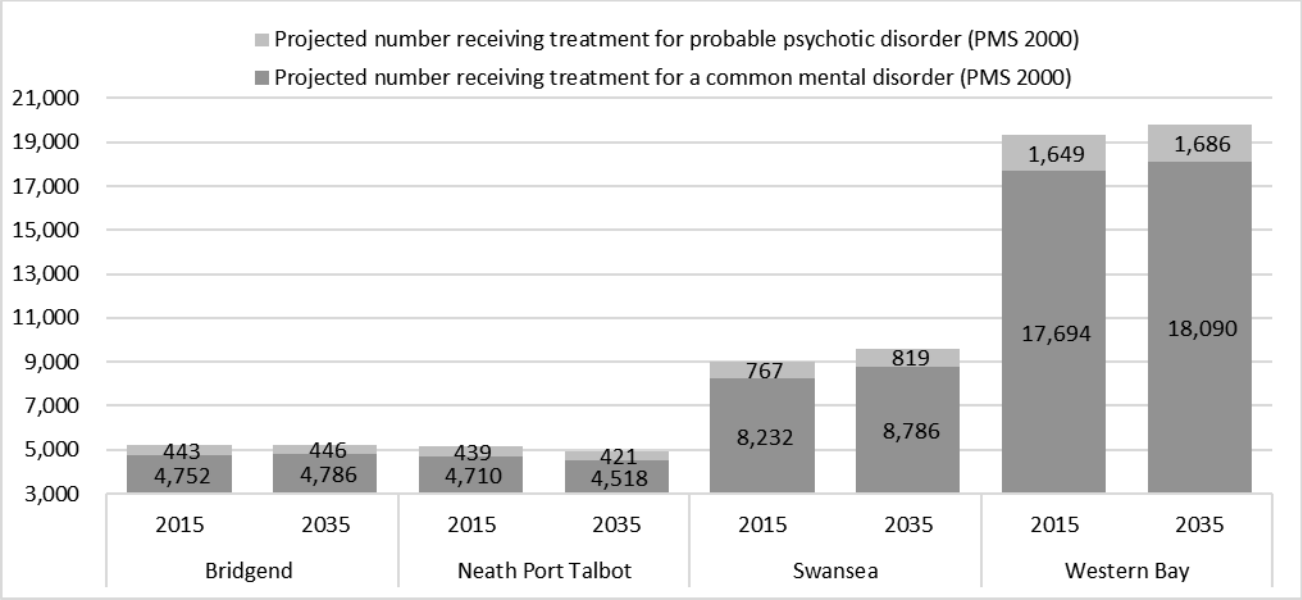
The projected numbers in these sections are based on the projected prevalence rates set up above and compared to the findings of the 2000 survey regarding these topics as related to CMDs and probable psychotic disorders. We present only treatment data for CMDs and probable psychosis due to absence of data for personality disorder.

Receiving Treatment

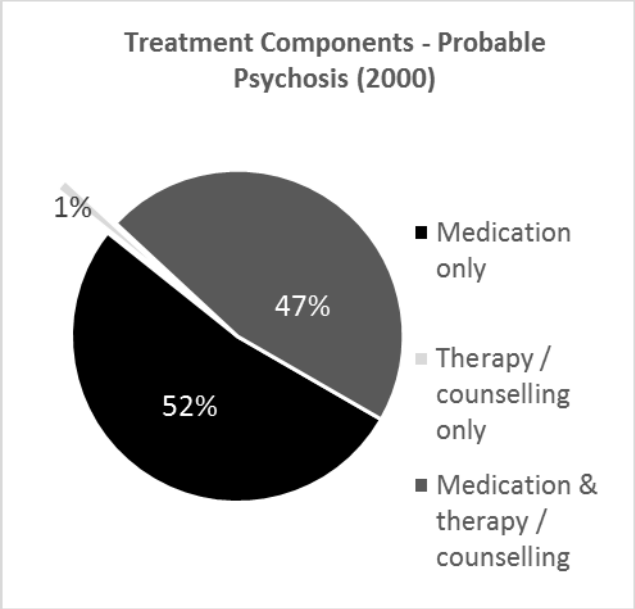
Treatment is explicitly defined in the survey as those receiving the following in the previous year:

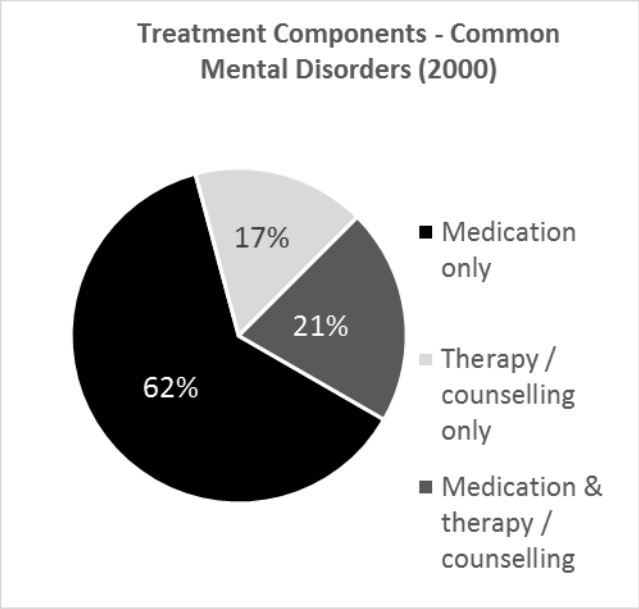
- Receiving medication **and / or**
- Receiving counselling / therapy.

In 2000, 24% of people with CMD were projected to be receiving treatment, as were 85% of people with a probable psychotic disorder. The 2007 survey for England showed 81% for probable psychotic disorder while treatment for CMDs remained at 24%. I have retained the 85% treatment rate as the 2007 data for probable psychosis was regarded as less reliable due to smaller sampling rates. The 24% treatment rate for people with CMDs is also used.



It is possible for a person to experience both and therefore there will be some overlap in the two sets of numbers.





The treatment used most often for CMDs and probable psychosis is medication, with 99% of those with probable psychosis receiving medication as part of their treatment, and 83% of those with CMDs receiving medication as part of their treatment. 48% of those with probable psychosis receive some form of therapy / counselling, while just 38% of those with CMDs receive this form of therapy. 62% of those with CMDs receive only medication as treatment.

Talking to GP about a Mental or Emotional Problem

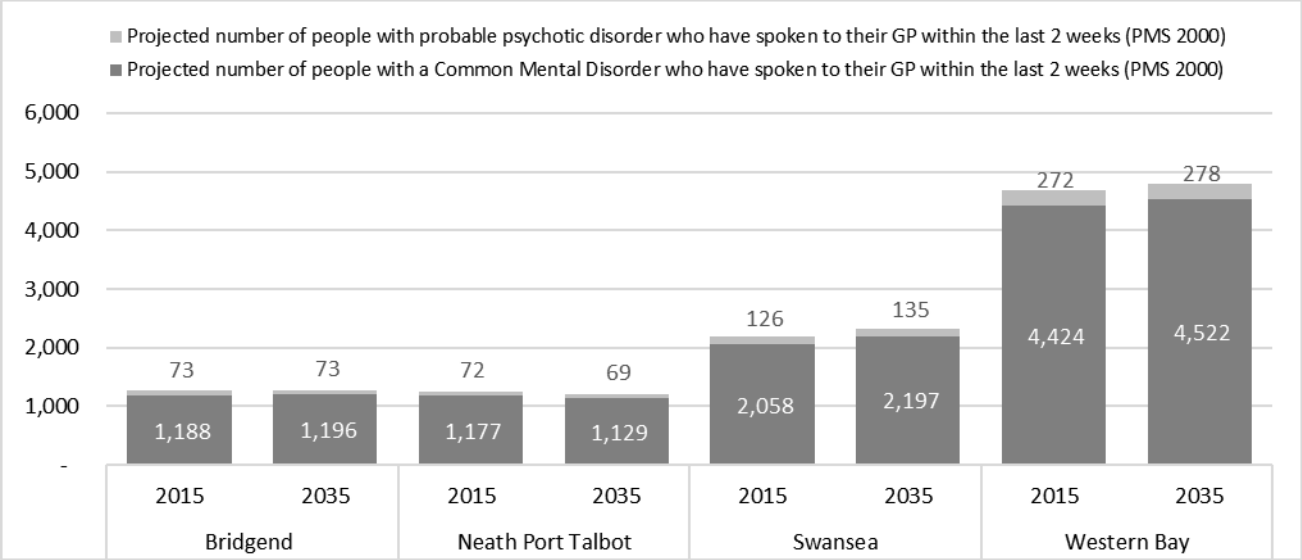
General Practitioners consider that a large proportion of their consultations relate to mental health problems. The data from the 2000 survey suggests people with mental health problems may be much more likely to speak to their GP about a mental or emotional problem than those who do not have such problems.
The table below shows that 14% of people with a probable psychotic disorder spoke to their GP about a mental or emotional problem in the last 2 weeks compared to 2% of people who do not have such a disorder: a seven-fold difference. Similarly, those with CMDs are six times more likely to have spoken to their GP than those without CMDs.

	% of people spoken to GP about a mental or emotional problem			
Have spoken to GP about a mental or emotional problem	**With CMD**	**Without CMD**	**With probable psychotic disorder**	**Without probable psychotic disorder**
Within previous 2 weeks	6	1	14	2
In the last year	39	6	71	11

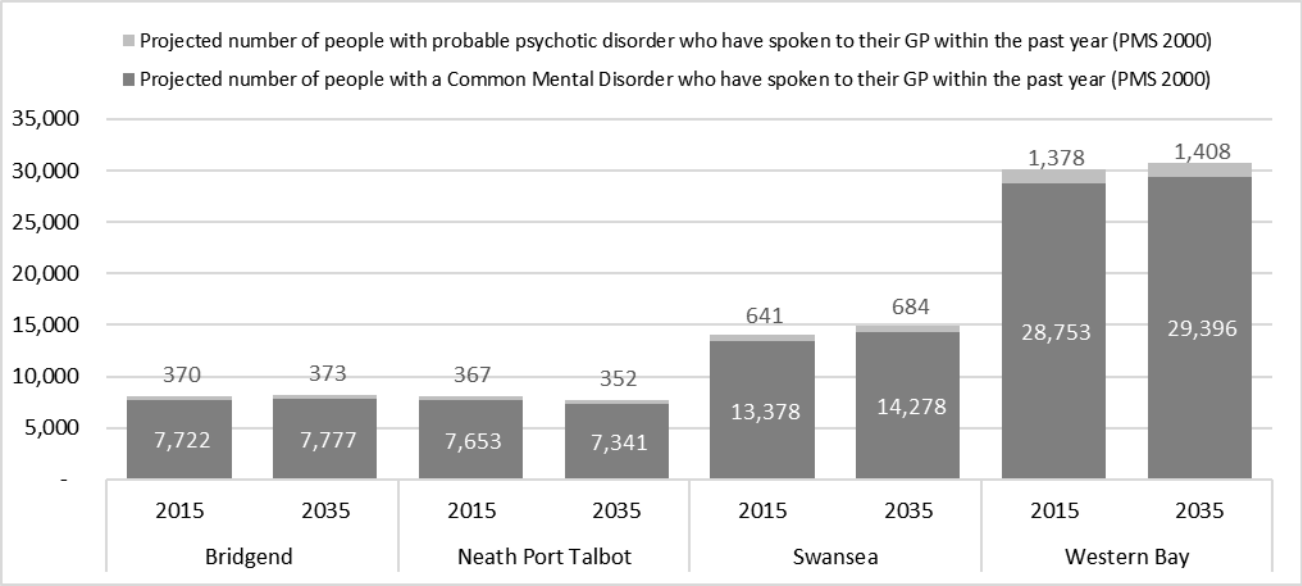
Looking at the whole of Western Bay using the projection for having seen GP within last 2 weeks for 2015 in the graph below, approximately 4,700 GP consultations in a fortnight were carried out with people with CMDs or a probable psychotic disorder.

Over a 52-week period, this is over 122,000 consultations (125,000 by 2035).

It should be remembered that there will also be a considerable number of additional consultations that relate to substance misuse or to personality disorder.



The graph below shows the projected numbers of people with CMD / probable psychosis who had spoken to their GP within the previous years.



Accessing Community Services

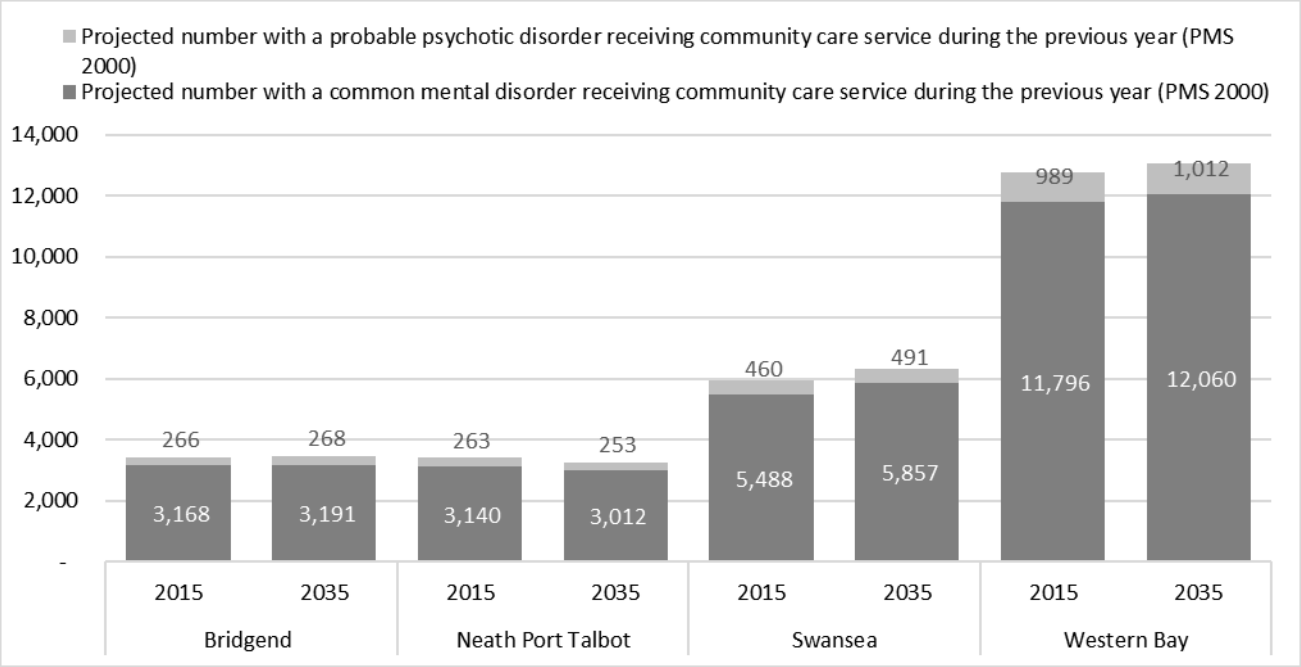
Definition of community services

GPs treat the highest proportions and numbers of people with mental disorders. People who have more serious mental health problems would be more likely to access more specialist services. Within the psychiatric morbidity survey, these are known as **community services**.

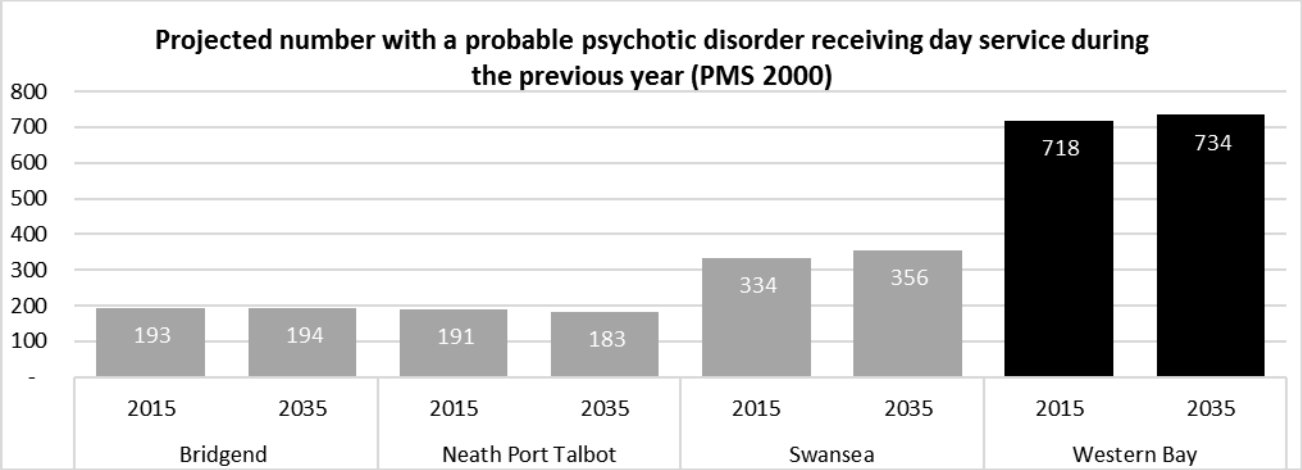
The term community services relates to any of the following:-

- Psychiatrist
- Psychologist
- Community psychiatric nurse
- Community learning difficulty nurse
- Other nursing services
- Social worker
- Self-help/support group
- Home help/home care worker
- Outreach worker

18% of people with a CMD are anticipated to use community care services within a year, while 51% of those with a probable psychosis are also anticipated to use community care services.



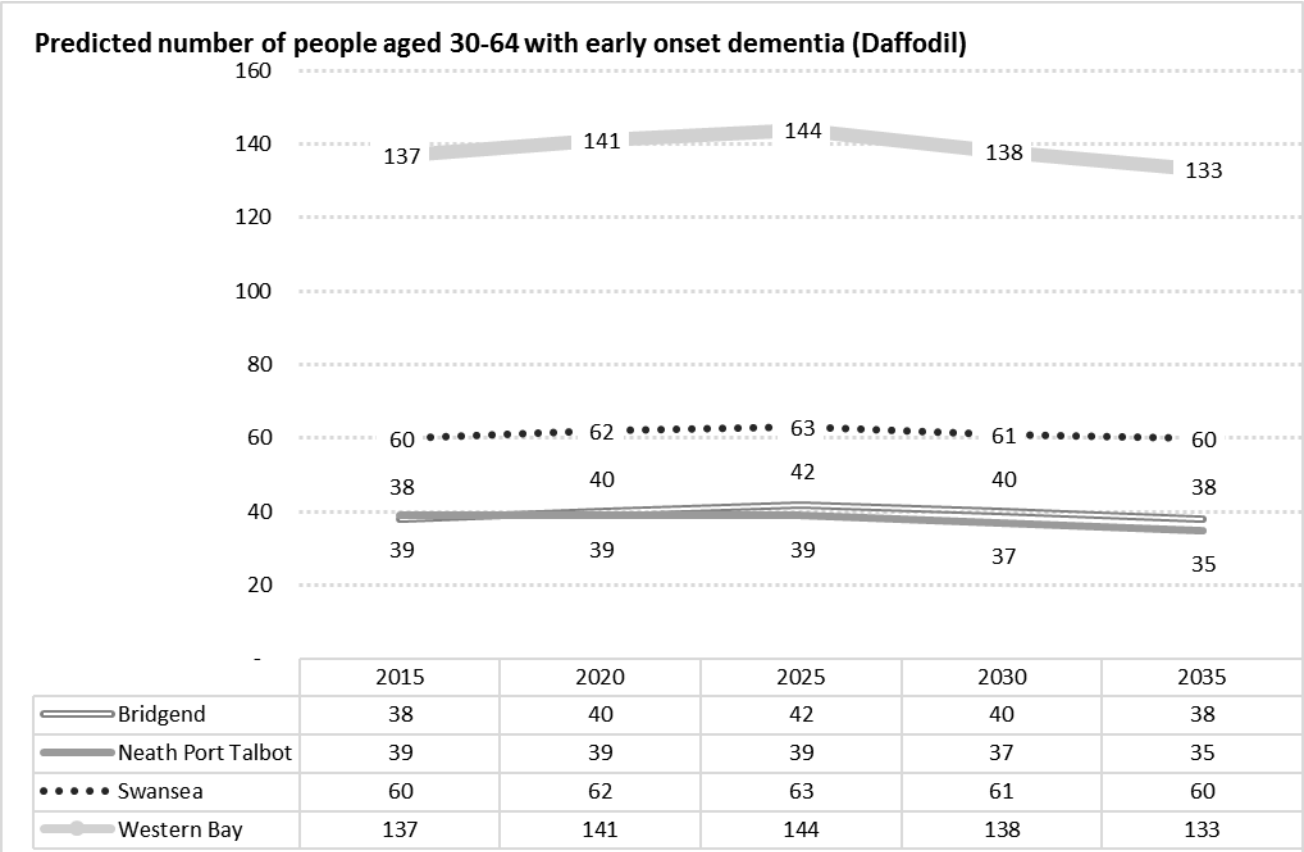
Day service is another aspect of community provision and is usually most focussed on those with the most serious disorders, particularly psychotic disorders. Only 3% of people with CMDs use day services compared to 37% of people with a probable psychosis.



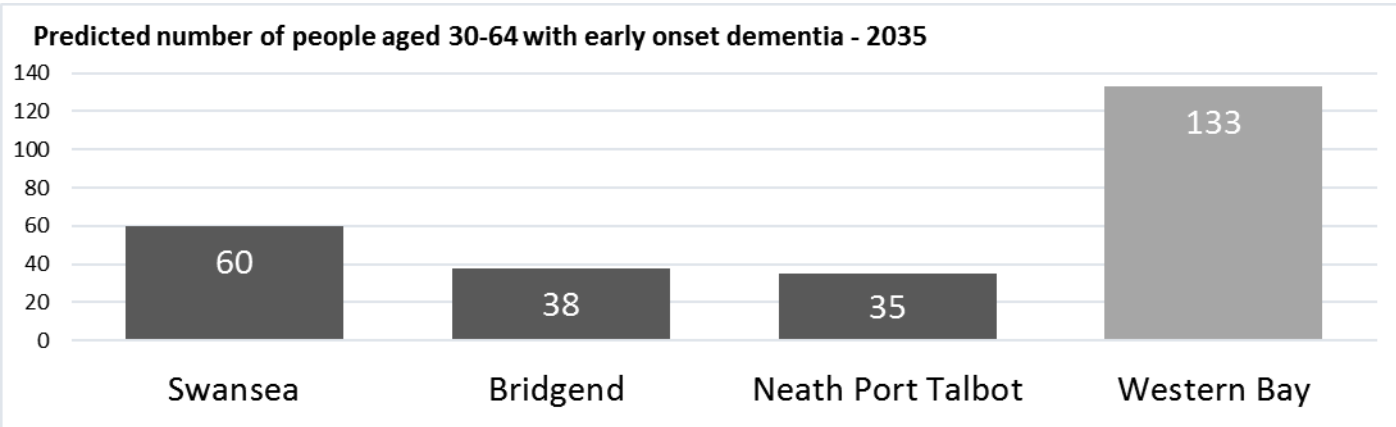
For the whole of 2015, approximately 30,100 patients with CMD / probable psychosis will have spoken to their GP about a mental or emotional problem. Compared to the 122,000 calls, it could be suggested that each CMD / probable psychosis patient, on average, will speak to their GP about a mental or emotional problem roughly 4 times in a year.

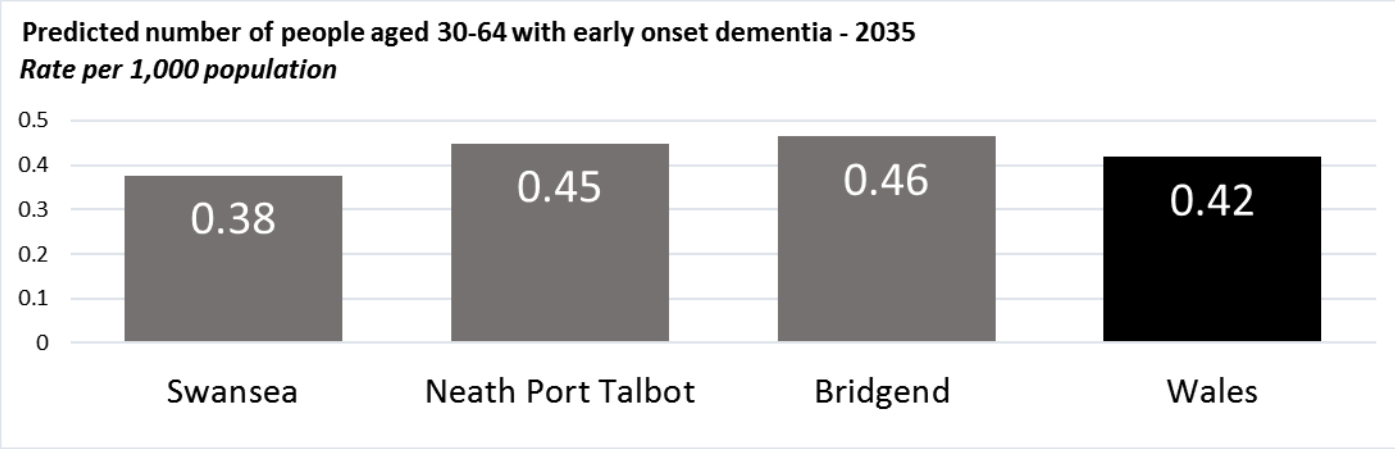
Early-Onset Dementia

Numbers in this population group are projected to remain stable.



	2015	2020	2025	2030	2035
Bridgend	38	40	42	40	38
Neath Port Talbot	39	39	39	37	35
Swansea	60	62	63	61	60
Western Bay	137	141	144	138	133





Together for Mental Health Strategy Overview of Mental Illness In Wales

In 2012 Welsh Government published the Together for Mental Health Strategy and below outlined the key population statistics. The key headline statistics that they at the time showed:

- 1 in 4 adults experiences mental health problems or illness at some point during their lifetime.
- 1 in 6 of us will be experiencing symptoms at any one time.
- At a time of recession, when levels of stress and anxiety inevitably rise, more people will be affected and suicide rates are likely to increase.
- 2 in 100 people will have a severe mental illness such as schizophrenia or bipolar disorder at any one time.
- 1 in 10 children between the ages of 5 and 16 have a mental health problem and many more have behavioural issues. There is evidence this is increasing.
- Approximately 50% of people with enduring mental health problems will have symptoms by the time they are 14 and many at a much younger age, demonstrating that mental illness can affect people across the course of their lives.
- Between 1 in 10 and 1 in 15 new mothers experience post-natal depression.
- 1 in 16 people over 65, and 1 in 6 over the age of 80, will be affected by dementia.
- Current estimates are that approximately 43,000 people in Wales are experiencing dementia and this is predicted to increase by over 30% in the next 10 years.
- 9 in 10 prisoners have a diagnosable mental health and/or substance misuse problem.

Risk Factors

Links to Deprivation

"National data shows a clear social gradient with 17.6% of adults in Wales in the 20% most deprived communities reporting being treated for any mental illness compared to 8.3% in the 20% least deprived communities."

Common mental health problems such as depression and anxiety are distributed according to a gradient of economic disadvantage across society

with the poorer and more disadvantaged disproportionately affected from common mental health problems and their adverse consequence

The WIMD indicates Swansea has:

- An above average number of Lower Super Output Areas (LSOAs) in the 10% most deprived LSOAs in Wales.
- 12.2% of its LSOAs are ranked within the 10% most deprived LSOAs in Wales. This is a total of 18 LSOAs.
- 51.4% of its LSOAs are ranked within the 50% least deprived LSOAs in Wales.

Swansea Disability Living Allowance (including PIP) - all entitled cases as at May 2015

People aged 18-24 entitled to DLA or PIP	-	834
People aged 25-34 entitled to DLA or PIP	-	1,363
People aged 35-44 entitled to DLA or PIP	-	1,923
People aged 45-54 entitled to DLA or PIP	-	3,494
People aged 55-64 entitled to DLA or PIP	-	4,392
Total people aged 18-64 entitled to DLA or PIP		**12,006**

DWP Data from Daffodil

At a national level the DWP analysis indicates among adults on long-term benefits as a result of ill-health, 43% suffer primarily from a mental health problems. A 45% rate is equivalent to 5,400 individuals with a mental Health issues on DLA or PIP in Swansea.

Employment and support allowance		
Population aged 18 and over, receiving ESA, Incapacity Benefit, or Severe Disablement Allowance, as at May 2015		
People aged 18 and over in receipt of ESA	12,680	
People aged 18 and over with the most severe conditions in receipt of ESA	7,080	
People aged 18 and over in receipt of Incapacity Benefit or Severe Disablement Allowance	910	

Again if we apply the 45% rate that is equivalent to 9,300 individuals on ESA with a mental health issue.

Mental Health Links to Physical Health

There are strong links between physical and mental health problems. A 2012 report by The King's Fund found that 30% of people with a long-term physical health problem also had a mental health problem and 46% of people with a mental health problem also had a long-term physical health problem.

Premature mortality is a well-known phenomenon among people with severe mental health problems, with an average reduction in life expectancy of 10-25 years (15 years for women, 20 years for men) compared to the general population. Although suicide is a factor, most of these deaths are due to chronic physical medical conditions (e.g. cardiovascular, respiratory and infectious diseases), and socio-economic and healthcare risk factors.

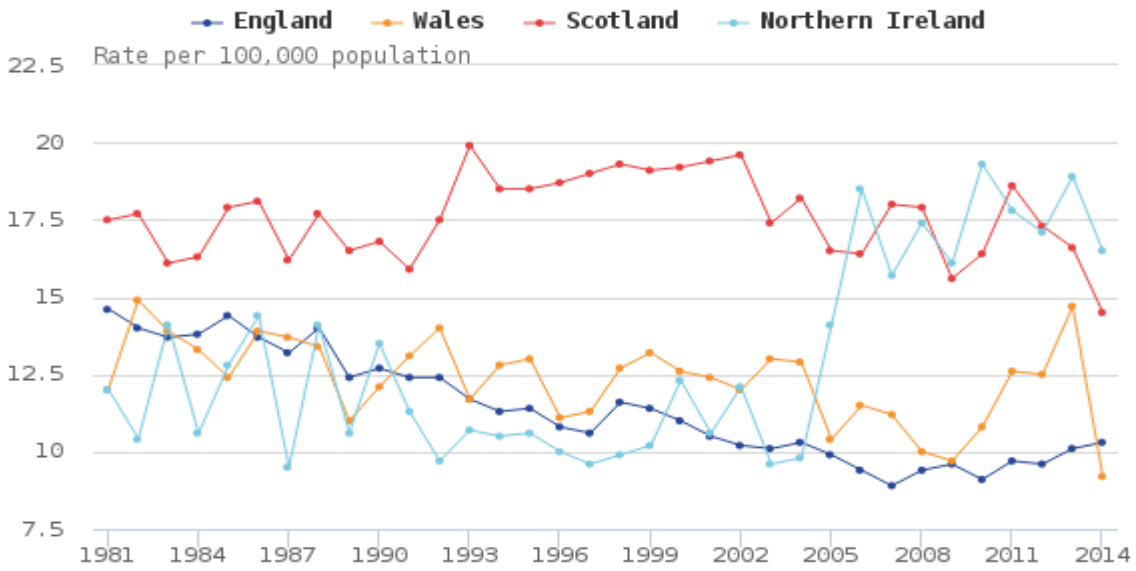
Secure Estate

Data suggests 9 in 10 prisoners have a diagnosable mental health and/or substance misuse problem. The City & County of Swansea has a prison and bail hostel and with responsibility for assessing and meeting any social care needs under Part 11 of the health Social Services and Wellbeing (Wales) Act. There is a separate population needs assessment topic paper for secure estate.

Suicides - UK data

ONS published data 4 February 2016 in relation to 2014 based on the coroners classification.
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2014registrations

- There were 6,122 suicides of people aged 10 and over registered in the UK in 2014, 120 fewer than in 2013 (a 2% decrease)
- The male suicide rate was more than 3 times higher than the female rate, with 16.8 male deaths per 100,000 compared with 5.2 female deaths
- The male suicide rate in the UK decreased in 2014 from 17.8 to 16.8 deaths per 100,000 population; while the female suicide rate increased from 4.8 to 5.2 deaths per 100,000 population
- The highest suicide rate in the UK in 2014 was among men aged 45 to 59, at 23.9 deaths per 100,000, slightly lower than the record high seen in 2013. This age group also had the highest rate among women, at 7.3 deaths per 100,000 population
- The most common suicide method in the UK in 2014 was hanging, which accounted for 55% of male suicides and 42% of female suicides
- The suicide rate in England increased in 2014 (10.3 deaths per 100,000). The increase was driven by a rise in female suicides.
- Suicide rates decreased in Wales (9.2 deaths per 100,000), Scotland (14.5 deaths per 100,000) and Northern Ireland (16.5 deaths per 100,000)
- The highest suicide rate in England was in the North East at 13.2 deaths per 100,000 population; London had the lowest at 7.8 per 100,000



Wales Suicides

There were 247 suicides in people aged 10 and over in Wales in 2014 (199 male, 48 female suicides); this is a decrease of 146 deaths since 2013. The age-standardised suicide rate for all persons dropped significantly in 2014 from 14.7 deaths per 100,000 population in 2013 to 9.2 deaths per 100,000 population in 2014 (a 37% decrease). This is the lowest suicide rate observed since the beginning of our time series in 1981.

Similar trends were seen in males and females in Wales.

The age-standardised suicide rate for males decreased significantly, from 24.5 deaths per 100,000 population in 2013 to 15.3 deaths per 100,000 population in 2014; this is the lowest since 2008, and the second lowest since 1981.
The male suicide rate in Wales was significantly higher than the rate in England between 2010 and 2013. However, the sharp fall in the suicide rate in Wales in 2014, means that the Welsh suicide rate is now lower than in England.
For females, the rate decreased from 5.5 to 3.4 deaths per 100,000 population; the lowest since the beginning of our time series in 1981. The female suicide rate in Wales was slightly higher than in England between 2010 and 2013, but the contrasting trends in England and Wales in 2014 mean that the suicide rate in Wales was significantly lower than that seen in England in 2014.
In 2014, there was a lot of activity surrounding the consultation on the new “Talk To Me 2” Welsh suicide prevention strategy which may have had a positive effect in reducing the number of suicides in Wales. However, it is too soon to tell if the sharp fall in the suicide rate in Wales in 2014 is the start of a downward trend or simply a large annual fluctuation. Analysis of when the deaths occurred suggests the decrease may not be as large as it appears. Not all suicides that occurred in 2014 have been registered yet; however, when late registrations of deaths that occurred in 2013 and 2014 are included in the figures, the drop in the suicide rate between 2013 and 2014 is no longer significant.
Blaenau Gwent had the highest suicide rate of all Welsh local authorities in the aggregated period 2012 to 2014 (16.0 deaths per 100,000 population). The

lowest rate was in Torfaen where the rate was 5.4 deaths per 100,000 population.

Estimates of Future Demands

In terms of predictors of future prevalence of mental ill-health, there is some evidence that mental health problems increase during periods of economic recession, low growth and insecurity. There is also some evidence that the welfare reforms are having a significant negative effect on people who receive benefits.

Key points from ABMU Health Board 2015 Joint Strategic Needs Assessment

- Data on mental health remains limited in ABM University Health Board despite mental health being the largest area of health care spend.
- There has been a slight increase in the proportion of adults reporting being treated for any mental illness between 2007-2008 and 2013-2014 both in ABM University Health Board and across Wales.
- In 2013-2014 just over one in ten adults reported being treated for any mental illness.
- National data shows a clear social gradient with 17.6% of adults in Wales' 20% most deprived communities reporting being treated for any mental illness compared to 8.3% in the 20% least deprived communities.

In the 2014 Welsh health Survey indicated 11.7% self- reported as currently being treated for a mental illness. In the 2015 Welsh Health Survey 13% of adults self- reported currently being treated for a mental illness. This suggests an increase of 1.3% in self -reported mental health.
http://gov.wales/docs/statistics/2016/160622-welsh-health-survey-2015-health-status-illnesses-other-conditions-en.pdf

If the ratios identified in the Together for Mental Health Strategy were very simply and crudely applied to the total population of Swansea 242,000 (mid *2015 estimate)* it would mean that:

- About 60,000 people in Swansea are likely to experience some form of mental health issue during their lifetime.
- About 40,333 are likely to be currently experiencing a mental health issue.
- About 31,460 are likely to have an awareness of and are actively engaging in treatment for a mental health issue.
- Daffodil predicted for 2016 around 35,000 adults would have a mental health issue rising to 35,767 in 2019. A 2.1% increase.

Daffodil City & County of Swansea People aged 16 and over predicted to have a mental health problem, by gender, projected to 2019					
	2015	2016	2017	2018	2019
People aged 16 and over predicted to have a common mental disorder	32,646	32,817	32,979	33,138	33,286

People aged 16 and over predicted to have a borderline personality disorder	913	918	922	926	930
People aged 16 and over predicted to have an antisocial personality disorder	703	709	714	719	724
People aged 16 and over predicted to have psychotic disorder	811	815	819	823	827
People aged 16 and over predicted to have two or more psychiatric disorders	14,573	14,658	14,737	14,814	14,889

NHS Hospital statistics for people with a mental illness
In 2014-15:

- There were 1,441 resident patients at 31 March 2015, a decrease of 45 (3 per cent) from 31 March 2014 (table 10.1).
- There were 1,644 average daily available beds, a decrease of 59 (3 per cent) from the previous year (table 10.1).
- There were 1,662 formal admissions to hospital, an increase of 205 (14 per cent) from the previous year (table 10.1).
- 96 per cent of formal admissions were under Part II of the Mental Health Act (table 10.2).
- 17 per cent of mental illness hospital discharges were for a diagnosis of mood affective disorder and 16 per cent were for schizophrenia, schizotypal and delusional disorders (table 10.4).
- Almost three quarters of hospital discharges were following one month's stay (table 10.5).
- 47 per cent of the people resident at 31 March 2015 were aged 65 and over (Table 10.7).

Each year on the 31st March there is a census of people who on that day are in Mental Health hospital provision by the local authority they are from. There were 172 inpatients from Swansea on that day.

10.9 Resident patients by Unitary Authority of residence and age, 2015 (a)

	Age Groups						
	Under 18	18-24	25-44	45-64	65-74	75 and over	All Ages
Unitary Authority							
Isle of Anglesey	2	2	3	8	3	5	23
Gwynedd	0	5	10	3	3	8	29
Conwy	1	4	13	11	6	8	43
Denbighshire	3	8	7	10	5	7	40
Flintshire	1	4	3	9	3	9	29
Wrexham	1	6	17	11	6	8	49
Powys	1	2	4	14	10	27	58
Ceredigion	0	2	9	6	4	5	26
Pembrokeshire	0	3	14	10	8	7	42
Carmarthenshire	1	4	16	8	7	9	45
Swansea	0	3	31	26	33	79	172
Neath Port Talbot	0	2	13	17	20	38	90
Bridgend	0	1	13	12	16	40	82

10.4 Hospital discharges, by diagnostic group (a)

Number

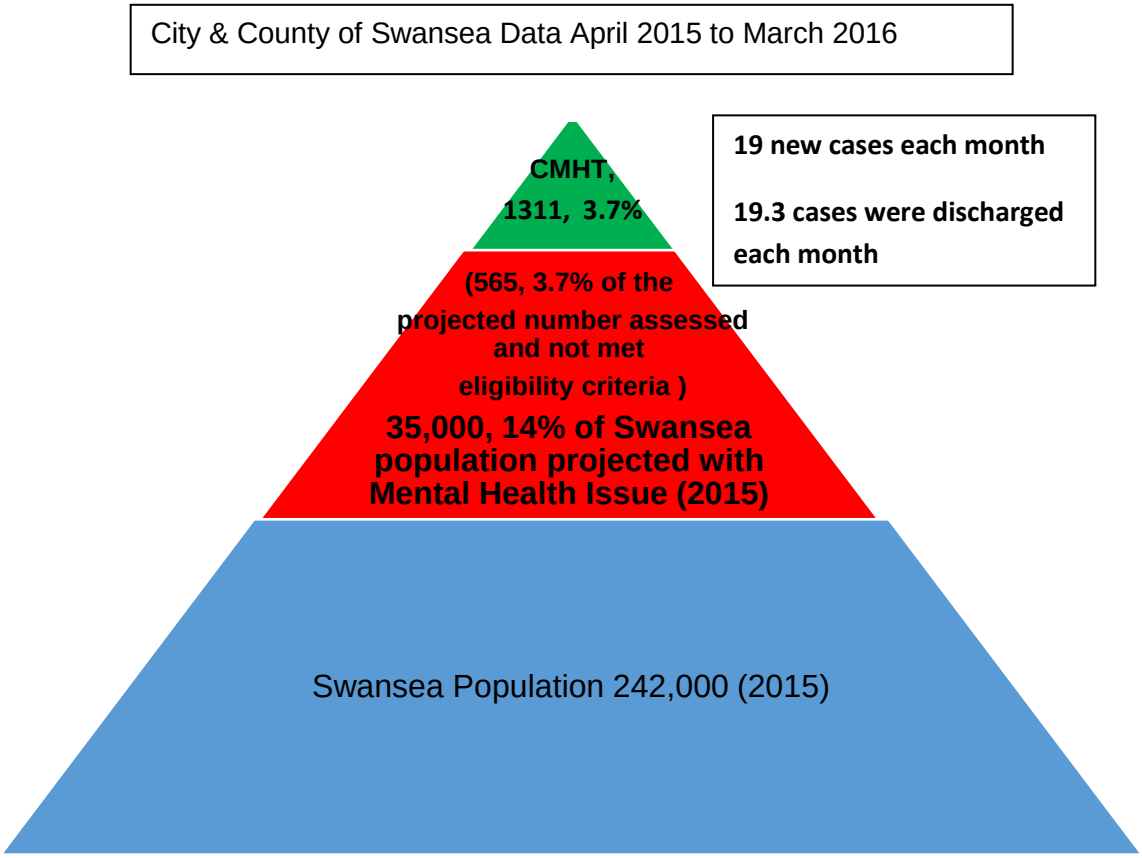
ICD-10 Code	Diagnostic group	2010-11	2011-12	2012-13	2013-14		2014-15
F00-F09	Organic, including symptomatic,						
	mental disorders	1,317	1,108	1,731	1,955	(r)	1,768
F10	Mental and behavioural disorders						
	due to use of alcohol	491	468	495	492	(r)	442
F11-F19	Mental and behavioural disorders						
	due to psychoactive substance use	260	282	332	344		383
F20-F29	Schizophrenia, schizotypal						
	and delusional disorders	1,412	1,631	1,679	1,631	(r)	1,691
F30-F39	Mood (affective) disorders	2,000	2,168	2,009	1,885	(r)	1,825
	of which:						
F31	Bipolar affective disorder	613	668	566	624	(r)	581
F32	Depressive episode	1,005	1,054	1,111	938	(r)	970
F40-F48	Neurotic, stress-related and						
	somatoform disorders	731	736	780	793		758
F50-F59	Behavioural syndromes associated						
	with physiological disturbances and						
	physical factors.	84	58	60	78	(r)	63
	of which:						
F50	Eating disorders	76	51	54	61	(r)	54
F60-F69	Disorders of adult personality						
	and behaviour	490	609	682	767		940
F70-F79	Mental retardation	4	12	7	8		15
F80-F89	Disorders of psychological development	32	34	41	54		35
F90-F98	Behavioural and emotional disorders						
	with onset usually occuring in childhood						
	and adolescence	19	12	20	22		31
Z75	Respite care	488	377	305	251		58
	Unspecified mental disorder	4,683	4,636	3,020	3,099	(r)	2,808
	All diagnosis (b)	12,011	12,131	11,161	11,379	(r)	10,817

http://gov.wales/docs/statistics/2016/160128-health-statistics-wales-2015-summary-en.pdf

2) PROFILE OF ACTIVITY AND SPEND

City & County of Swansea Data - April 2015 to March 2016:

- Number of assessments undertaken by the CMHT's was 1763
- Of those assessments the number identified as not eligible for secondary mental health services 565 (32%)
- There were 526 (30%) individuals who were new to secondary Mental Health CMHT.
- An average of 19 new cases each month. (Jan 2013 to Dec 2013 15.5cases)
- An average of 19.3 cases were discharged each month (Jan 2013 to Dec 2013 17.4)
- There was an average of 1311 individuals supported each month and based on the Daffodil projection of 35000 for 2015 that is approximately 3.7% of the population with a mental health issue.



City & County of Swansea expenditure on MH 2014/15

Social Services Revenue	14/15	15/16
Create	327,576	221,009
Community Mental Health Team 1	287,911	324,800
Community Mental Health Team 2	340,309	858,241
Community Mental Health Team 3	494,917	0
Crisis Resolution & Home Treatment	96,423	99,804
C M&A Central Management (MH)	35,134	0
Mental Capacity Grant	12,992	12,550
DEL MH Residential Care	1,976,373	2,174,091
Direct Payments Wag Grant	168,877	280,885
C M&A Service & Staff Dev (MH)	67,932	67,462
Llanfair (*part funded by SPPG)*	515,154	455,383
Total Expenditure	4,323,598	4,494,226

External MH 3rd Sector Community Services	
External MH Day Service/Respite Provision	£117,000

Supporting People Programme Grant (SPPG)

In 2015/16 Mental Health supported living £3,217,392.95

PROVIDER	SCHEME NAME	Units 0-6 months	Units 6-24 months	Units 24 months +	Units 0-6 months	Units 6-24 months	Units 24 months +	Total
Caer Las	New Mill Road			6				
Caer Las	The Willows			7				
City & County of Swansea	Llanfair House		26					
TSU in house	Mixed Community Care inc MH				14			
Family Housing	Bernard Street			6				
Family Housing	Sketty Road			6				
Family Housing	Wish Slate Street		12					
Family Housing	Wish St Helens			15				
Family Housing	Wish Clos Y Orsaf			4				
Family Housing	Wish Floating Support					3		
Family Housing	Gorseinon & Hazel Ct			6				
Family Housing	The Manse			6				
Family Housing	Wish King Edward			4				
Gathen	Gathen House			13				
Gofal	Floating Support					43		
Isaac	Pen Y Waun			2				
Eastgate	Eastgate			5				
Holder	Kenfield			6				
Esgyn	Cluster Floating Support						30	
Esgyn	Supported Housing			58				
Gwalia Care & Supp	Mental Health						12	
		0	**38**	**144**	**14**	**46**	**42**	
								£3,217,392.95

Include information relating to the range and type of services available to those

affected by mental ill health, such as: preventative community services, accommodation and support services, counselling, crisis services and respite and short breaks services. Include costs of service provision where possible.

3) CURRENT PRIORITIES

The Adult service commission framework document is in place and the City & County of Swansea are in the process of identifying the specific priority areas within mental health.

4) EXISTING PLANNING GROUPS

City & County of Swansea is in the process of establishing its Strategic Mental Health Commissioning structures with ABMU. This group will inform the Head so service for the City & County of Swansea of any specific local issues at the Western Bay level. An Initial workshop was held 26th October to map and understand the interdependencies and dependencies and delegation and communication flow. A paper will be forwarded to the next Western Bay LD/MH Commissioning Board.

5) EXISTING STRATEGIC PLANS

The City & County of Swansea is the process of developing a new 3 year strategic commissioning plan. The draft is due to completion in December.

6) FUTURE USE OF RESOURCES

The pressures that are emerging that need to be planned for are:

- Local Government revenue settlements
- Specific grant settlements such as Supporting People Programme Grant (SPPG), Community First, Carers Grant.
- Impact of welfare reforms on individuals circumstances and need for advice and information and care & support.

SUMMARY

The numbers of people with Mental Health issues will generally increase with the increase in population in Swansea.
Increase in general awareness of Mental Health and therefore more requests for support.

- More people are presenting to the CMHT's for assessment
- More people are self -reporting in the surveys
- Admissions for mental health are increasing.
- The number of hospital beds are decreasing.
- The length of stay in hospital is reducing.

Some impact of the shift to care and support in the community apparent requiring further development of community based early intervention and prevention services which do not require formal identification of mental health

as an issue/diagnosis.

Swansea has a number of the risk factors for increased Mental Health

- Areas of Deprivation
- A gap in the average life expectancy
- High levels of long term limiting illness and suitable service for those with co-occurring issues.
- A prison
- There are age range and male gender related to increased risk of suicide
- Links to substance misuse
- Student population
- Links to homelessness
- Refugee resettlement

This identifies opportunities for targeted areas of work.