Adult Mental Health Services for Wales

Equity, Empowerment, Effectiveness, Efficiency

Strategy Document

September 2001

IMPROVING MENTAL HEALTH SERVICES IN WALES:

A STRATEGY FOR ADULTS OF WORKING AGE

CONTENTS

FOREWORD BY JANE HUTT, AM, MINISTER FOR HEALTH AND SOCIAL SERVICES

I am pleased to endorse this new All Wales Mental Health Strategy and I am proud of the way it has been produced. The process of consultation was as open and inclusive as we could make it and provoked the most wide-ranging debate ever in Wales on mental health. This has ensured a balanced approach, with the contribution of the voluntary sector, users and carers fully recognised alongside the work of the NHS and local government.

This Strategy is for adults of working age and it forms one strand of our strategic approach to mental health. We have produced a similar strategy for children and adolescents and we are working on one for the elderly mentally ill so that we emerge with a comprehensive framework for mental health services in Wales.

The National Assembly has made mental health one of its 3 health priorities. This in itself is highly significant given the Cinderella status from which mental health has suffered over many years. I have been very heartened by the cross–party support for my attempts to raise the profile of mental health and I believe this reflects the evidence which now exists to show that mental illness is a hidden epidemic which blights the lives of so many people.

The Strategy will be followed by a National Service Framework for Wales which will set standards and outcome measures. Together, the two documents will form the template by which we assess and monitor services. These are genuine working documents and I intend to see that the guidance in them is fully implemented across Wales.

I accept fully that the National Assembly will have to provide extra funding to achieve all our aims and I have begun that process. On the other hand, it is up to the relevant authorities in each area to ensure that mental health is seen as a priority and that services are managed and organised in a way that makes best use of the very significant funding already provided and which exploits to the full, existing good practice and the expertise of so many of those working in these services. Together, I am sure that we can transform mental health services so that they become a source of pride for Wales.

Jane Hutt AM
Minister for Health and Social Services

1. INTRODUCTION

1.1 Purpose of the Strategy

This document sets out the National Assembly's framework for mental health services in Wales and is issued as guidance to the NHS and local government. Taken together with the National Service Framework for Wales, it will form the template against which mental health services are assessed and monitored.

1.2 Vision Statement

> *'Mental health services need a new vision. We need to focus on inclusion, not exclusion; on building welcoming communities rather than looking for problems; we need to focus on friendships rather than homicides.'*
>
> *Peter Bates, MIND 'Creating Accepting Communities' Inquiry witness*

In taking forward one of the top three health priorities of the National Assembly, this Strategy sets out a bold and challenging vision for the future of mental health for the population of Wales. This is a vision that holds at its heart people with mental health problems as valued and valuable citizens who have a right to access the same daily life opportunities within their own communities as anyone else.

Over the last ten years there have been significant developments in an approach to tackling mental health problems in Wales which, whilst still centred around service provision and targeted at symptoms, has moved away from large institutional services to more dignified community settings. Over the next 10 years the vision will develop further, based on people's rights to respect and to independent, fulfilled lives – moving on from considering specific mental health services as the only way of helping someone with mental health problems. This Strategy also acknowledges the importance of supporting those who care for individuals suffering from mental illness. The lives of families and carers are invariably affected. It is important to recognise this and ensure that they have access to the services they require.

The Strategy will take us towards a model of recovery – very much based on the individual's assessment and understanding of how they want services to help them. Mental health services, whilst having a key role in their own right, will also have a vital function in helping to make the links that enable people to access ordinary community support and facilities.

If services are able to make these changes, then genuine empowerment and challenge to stigma can start to occur. The current attitude and approach within services can often contribute to the disempowering and stigmatising views held by society. All those involved in addressing mental health needs in Wales must raise expectations of the services with regard to the potential, value and abilities of people with mental health problems including severe mental illness.

The vision of the Strategy requires a broadening of the concept of mental health, away from a purely illness and disease approach to one that makes the links between good mental health, poor mental health and the quality of life of individuals and communities. The response to the mental health needs of people in Wales can no longer revolve solely around the notion of services. Links must be made between the individual and the wider environment – addressing the social and economic determinants of poor health.

This Strategy also recognises that for a significant number of people access to a range of specific mental health services remains paramount. The Strategy sets out the principles on which services must base a high quality, empowering, person-centred and responsive approach. This is a service in which people have choices, and are supported in those choices. The Strategy reflects the commitment of the Assembly to a skilled and committed workforce which underpin such services – standards and best practice for which will be detailed in the National Service Framework for Mental Health in Wales.

Quality of life is at the centre of this Strategy, with mental health services having a role in helping an individual to maximise and fulfil their life opportunities –through providing appropriate and timely care, support when needed and in helping to facilitate the person's integration into community life.

This Strategy presents an opportunity to change fundamentally the day to day experience of people with mental health problems who are living in Wales. By addressing the stigma and resulting social exclusion and discrimination associated with mental health problems, this Strategy tackles one of the last taboos in the 21st century in our society – where ultimately people with mental health problems are *'a part of* the community rather than *apart from* the community'.

1.3   The development of the Strategy

This Strategy concerns itself with services for adults of working age, using the accepted mental health definitions. In normal circumstances this will be those aged 18-64. Other work is continuing in services for the elderly mentally ill and in child and adolescent mental health services.

The Strategy was developed from the report by an independent Advisory Group, which drew on a preparatory exercise on the future direction of mental health services in Wales run by the Centre for Mental Health Services Development and on a wider stakeholder conference held in Builth Wells in November 1999. Consultation on the Advisory Group report produced the most wide ranging debate on mental health ever held in Wales and many of the ideas and suggestions which flowed from that exercise have been incorporated into this final Strategy or into the National Service Framework for Wales which will be issued shortly. Together, these two documents will form the template against which services will be measured in future.

The National Assembly has designated mental health as one of three key health priorities. It sees this Strategy as a ten year plan to improve, modernise and develop mental health services in Wales to a position where they provide the best possible care for those with mental health problems. It has begun the process of providing the extra money necessary to achieve this. It needs the co-operation of all those in the services to secure the changes in attitude, culture and organisation which are required just as much as extra funding if we are to reach our goal.

The Advisory Group report identified the need for mental health services to be considered in the widest possible sense. Housing and employment are vital components of a mental health service that aims to improve the social inclusion of people with mental illness. Mental health services need to adopt a holistic approach and services should be designed to fit the needs of users and their carers. Users should not have to fit in with what services provide. Positive, imaginative health promotion must be a major plank in any attempt to improve services.

There is also a need for a pragmatic approach. There is much good practice in Wales, but there is no doubt that many services are unable to achieve compliance with today's accepted standards and basic requirements. We need to put that right as a priority. Much of this document gives aims and objectives that have been derived through a consensus about what is important. The Advisory Group did not attempt to devise new untested policies or initiatives but to state the basic standards underpinning mental health services. All the services in Wales should be able to provide a consistent, comprehensive and reliable level of service for everyone in need. At present, the provision of services is too haphazard both between and within services. The Assembly accepts that more investment is required to enable mental health services to meet these standards but extra resources are not enough without good organisation and the development of a culture within mental health services that is geared towards empowering users, enabling them to achieve their own goals, and providing a consistent, reliable and sensitive approach towards everyone.

The Strategy is intended to guide the development of services over the next ten years. Over that period we would expect a marked though evolutionary change in the users' experience of mental health services. The physical environment will no longer be in unsuitable and unmodernised institutions, but in buildings designed for a modern mental health service. All users and their carers will be given information and choices about treatments and services and these will be available within a reasonable distance from their home. Those who work in the mental health services will be well trained and supervised and have time to spend with users and carers to answer their questions and explain the care plan. There will be a variety of supported accommodation and employment opportunities in the locality, leading on to more independence.

2. THE STRATEGY IN CONTEXT

2.1   Prevalence of mental illness

Mental illness is common and disabling. There are a wide range of mental health problems ranging from common disorders of depression and anxiety with a prevalence of about 14% in the UK to the less common psychotic illnesses such as schizophrenia with a prevalence of less than 0.5% (Jenkins et al 1997). One in four people experience mental illness at some time in their lives and most will make a full recovery. However, a number of people continue to experience varying degrees of disability and distress for prolonged periods as a result of a mental illness.

Though the common mental disorders of depression and anxiety are sometimes less disabling to the individual, in aggregate they pose an important public health problem. In the past the public health importance of mental illness has been neglected as public health priorities have been dictated by statistics on mortality. The recent World Bank initiative to estimate the disability adjusted life years (DALYS) associated with various conditions has led to the conclusion that by the year 2020 depression will be the second most important source of disability in the world (Murray & Lopez 1997).

Mental illness still remains a relatively neglected and poorly understood area of medical and social research. Despite this, there is now good evidence for a number of effective pharmacological, psychological and social interventions and self-management strategies. Public attitudes still appear to regard mental illnesses as being untreatable and with a poor prognosis, an erroneous view that contributes to the stigma associated with mental illness. The stigma also affects the treatment of mental illness within health and social services. Mental illness services have often received a low priority within health and social services and have suffered from a lack of investment. Yet there is good evidence that extra resources for mental health can have a beneficial impact on outcomes. Changing public attitudes must go hand in hand with changing attitudes within health and social services.

2.2   Language

At present, the language adopted tends to have a medical bias as research has advanced rapidly in this arena but this is by no means a complete description. The lack of a common 'language', or shared terminology, has created particular inter-agency difficulties.

While precise definition that meets all circumstances is a challenging task, it is important to define the terms adopted here and, in the absence of an agreed language, this document uses the terms mental health problem, mental disorder and mental illness to provide a picture of the nature and extent of the tasks that face families and our service agencies. In the context of this Strategy, these are not phrases with interchangeable meaning.

The terms used in this strategy are summarised here.

- Mental Health Problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the development of concepts of right and wrong, and in distress and maladaptive behaviour. They may arise from any number or combination of congenital, constitutional, environmental, family or illness factors. Mental Health Problem describes a very broad range of emotional or behavioural difficulties that may cause concern or distress. They are relatively common, may or may not be transient but encompass mental disorders, which are more severe and/or persistent.

- Mental Disorders are those problems that meet the requirements of ICD 10, an internationally recognised classification system for disorder. The distinction between a Problem and a Disorder is not exact but turns on the severity, persistence, effects and combination of features found.

- In a small proportion of cases of mental disorders, the term Mental Illness might be used. Usually, it is reserved for the most severe cases. For example, more severe cases of depressive illness, psychotic disorders and severe cases of Anorexia Nervosa could be described in this way.

2.3   Relationship to wider NHS plan

Although it is described as the NHS Plan for Wales, the key National Assembly document, Improving Health in Wales stresses the need for all sectors to work together and is especially strong on this in its comments on mental health:

- NHS Wales, local government and the voluntary sector all have vital roles to play in improving mental health and in tackling mental illness. The sectors must work as partners, with full respect and genuine inclusion of all sectors at each level of planning and commissioning of services. All sectors need to take full account of the views and perspectives of users and their carers whose representatives should be involved in the planning process

- all agencies must make maximum use of the new budgetary, planning and commissioning flexibilities to ensure effective and efficient delivery of services

- treatment services should be based on effective, evidence-based practice

- health promotion has a key role to play in programmes to improve mental health and to reduce the incidence of mental illness in society

- there needs to be a major sustained, public education campaign to reduce the stigma attached to mental illness which impacts on opportunities for those who suffer from the illness in terms of housing, employment and social inclusion

2.4 Objectives and Milestones

Successful implementation of the Strategy will depend on:

- Closure of the remaining large Victorian institutions and replacement with modern facilities so that mental health services are delivered in settings which are fit for purpose – **this is an ongoing process but we expect to see year on year progress and the target fully achieved by the end of the Strategy's ten year lifespan**

- Availability of psychotherapy services in all areas – **we expect to see a progressive build up of provision with the target achieved by 2005**

- Strengthening of advocacy services – **we expect to see a progressive build–up of provision until all users have access to an appropriate range of services by 2005**

- Timely and appropriate assessments for all patients and, for those with complex needs, the provision of formal written care plans that will be subject to regular review – **we expect to see this achieved by mid 2003-the National Service Framework will provide guidelines**

- Additional staff to ensure effective liaison between mental health teams and the primary care, criminal justice, district general hospital and drugs and alcohol services – **we expect to see these staff in place across Wales by 2004**

- The establishment of a multi disciplinary group to oversee implementation – **we aim to establish this by end 2001**

The National Service Framework for Wales, to be published by the end of 2001 will set standards to improve quality, ensure equity of provision and produce a system of monitoring which will identify both shortcomings and good practice.

3.   PRINCIPLES AND AIMS

3.1   Principles

Four principles underpin the whole Strategy. They apply to everything written in this document and can act as a guide for everyone involved in planning, commissioning, managing, working in and using mental health services.

Equity

Mental health services should be available to all and allocated according to individual need, irrespective of where someone lives, their ethnic origin, gender, culture, religion, sexuality or any physical disability. Access to mental health services should not be restricted because of other existing health problems. There should be an end to unacceptable geographical variations in standards of care.

Empowerment

Users and their carers need to be integrally involved in the planning, development, delivery and evaluation of mental health services. This will require sustained support, care and information from mental health services. Empowerment should be at all levels, from encouraging self-management to formal involvement in local and all-Wales planning. Informed choice for all users is central to this principle. Those detained under Mental Health legislation should be encouraged to participate actively and willingly in their own care. There is a particular need to reduce the stigma which surrounds mental illness both within mental health services and the wider community.

Effectiveness

Mental health services should provide effective interventions that improve quality of life by treating symptoms and their causes, preventing deterioration, reducing potential harm and assisting rehabilitation. Within the NHS, clinical governance provides a mechanism to ensure that matters of effectiveness and quality are central. Many social and environmental interventions will be subject to Best Value and performance management considerations. The minimum care standards to be introduced under the Care Standards Act 2000 will also provide important quality frameworks. The growing importance of 'Quality of Life' measures in determining effectiveness is also reflected in this Strategy. Service providers must be accountable for the quality of services.

Efficiency

Mental health services must use resources efficiently and be accountable for the way public money is spent. There should be efficient interagency working especially between health, social services, other parts of local government, voluntary agencies and the private sector to achieve Best Value. Opportunities for joint working and for use of information and communication technologies should be exploited in order to increase efficiency.

3.2   Aims

The aim of this Strategy is to set the agenda for mental health services in Wales over the next decade. It is intended to lead to services that improve the quality of life of those experiencing, or recovering from, mental illness. The concept of community care is at the heart of this document, but community care is more than an alternative to hospital. People with mental illness are amongst the most vulnerable and socially excluded groups in our society. Mental health services are about enabling and empowering users so that they can take an active part in the community and realise their full potential. All the elements of a mental health service need to work together to enhance participation and inclusion of service users in the life of the community.

In particular, this document is designed to provide a framework for mental health services that have the following aims:

- to ensure good mental health promotion is at the heart of our approach to services;

- to educate the public about the effective treatments of mental illness in order to develop positive attitudes, reduce stigma and incorporate mental health into the wider health, well-being and social agenda;

- to provide equitable access to mental health services for all the people of Wales, irrespective of where they live, their age, gender, sexuality, disability, race, ethnicity or their social, cultural and religious background;

- to include users and carers in the planning, commissioning and delivery of services and take account of individual preferences and lifestyles;

- to ensure close co-operation between social services, health authorities and the voluntary and private sectors in order to commission effective, comprehensive and co-ordinated mental health services;

- to ensure good communication and co-ordination between different parts of the mental health service in order to provide efficient, responsive and seamless care;

- to promote support which will enhance the ability to cope, with the individual remaining in control of their lives and to facilitate integration of mental health service users into all aspects of community life;

- to assess the medical, psychological and social needs of service users and carers at an appropriate time and with reviews at regular intervals;

- to provide effective and high quality care based on the best evidence and including provision for the medical, psychological and social needs of service users and carers;

- to provide mental health services in settings that are fit for purpose and that provide dignity and privacy;

- to protect users, carers and the public from avoidable harm while respecting the rights of users and their carers;

- to recruit and retain highly trained staff of all disciplines who are confident of their skills and have high morale;

3.3 Relationship to other areas of government policy

There are many Government initiatives in health and local government that are relevant to this Strategy. We believe our approach has produced a policy which is flexible enough to take account of these issues and to inter-link intelligently with them. "Better Wales" sets out several themes that will influence the way in which the Assembly intends to develop its policies, budgetary priorities and programmes over coming years. These are:

- tackling social disadvantage – the development of an inclusive society where everyone has the chance to fulfil their potential;

- equal opportunities – the promotion of a culture in which diversity is valued and equality of opportunity a reality;

- sustainable development – meeting the needs of the present without compromising the ability of future generations to meet their own.

These themes need to be set against and used in the challenge of addressing the wider issues of mental health in Wales. Opportunities must be taken to relate the delivery of mental health services and the promotion of good mental health with the development of other strategies that involve the wider public. This engagement with the new policy agenda places greater responsibility on the wider community to recognise that mental health care – promotion, prevention and treatment – should not be limited to the formal mental health agencies. Plans should contain clear, coherent statements on how the overall mental health needs of communities will be met. This approach requires linkages to be made between the individual and the wider environment. Addressing the social and economic determinants of poor mental health can be as important as developing the mental health service models.

Equal opportunities

Equal opportunities within mental health services applies to all those involved – those using the services, their carers and those working within the services. It must be an integral feature of planning, employment practices and service delivery in both the statutory and non-statutory sectors. ***Where one lives should not affect provision of effective appropriate services. Rural and urban communities will have their own local needs and solutions.***

People with mental health problems and their carers must receive information, support, care and treatment in a manner that takes full account of their age, gender, sexuality, physical disability, race, ethnicity and their social, cultural and religious background. If a service does not reflect the background and personal cultural needs of an individual it is unlikely to feel accessible and may be perceived as excluding or even discriminatory. Particular attention should be paid to discrimination based on membership of ethnic minority groups. Services must be acceptable to members of ethnic minority groups and sensitive to their needs.

Everyone living in Wales must be able to access help through their chosen language when this is practicable. The use of Welsh is protected by statute. Service users from other ethnic groups should also be able to access interpreters from outside their family. The Mental Health Act Code of Practice recognises this principle in terms of expressing and receiving information through the language of one's choice when experiencing emotional distress.

OBJECTIVE

Mental health service users and their carers must be able to communicate in the language of their choice.

Mental Health Act Legislation & Criminal Justice System

The White Paper "Reform of the Mental Health Act 1983 " sets out a number of far reaching proposals. The National Assembly is in close touch with the work taking place on this and believes this Strategy is flexible enough to cope with any change in legislation. The report "The Future Organisation of Prison Health Care" will similarly impact on mental health service commissioning. There are links, too, with crime and disorder legislation, the Human Rights Act 1998 and government moves on provision for asylum seekers.

Relationship to other Strategies and National Service Frameworks

A number of other policy documents will have an important influence on mental health services for adults. These include the All Wales Strategy for Child and Adolescent Mental Health Services, the National Service Framework for Older People which will include guidance on services for the elderly mentally ill and strategy documents on Substance Misuse, Carers and Learning Disability. Perhaps most importantly of all, the Assembly paper " Improving Health in Wales" set out forthcoming changes in the organisation of the NHS in Wales and this has been talen forward by "Structural Change in the NHS in Wales: a consultation document". Health Authorities are to be abolished and Local Health Groups will be strengthened and have an increasingly pivotal role under their new name of Local Health Boards. Throughout this Mental Health Strategy we have referred to the existing organisation but again we believe the document is flexible enough to cope with the changes as they arise. We shall consider whether further guidance is needed as the operational details of the new system are worked out over the next 2 years.

4. MENTAL HEALTH IN THE COMMUNITY

4.1 Mental health promotion and the prevention of mental illness

Mental health promotion and the prevention of mental illness are central elements of public health. Population based initiatives are likely to become increasingly important as outlined in Better Wales. Initiatives to tackle social disadvantage including action aimed at reducing poverty, increasing employment, improving housing and addressing homelessness and other aspects of social exclusion will make a significant impact. Such programmes should be incorporated into the objectives of local health alliances, written into health improvement programmes, considered in local government community plans and should be the concern of Local Health Groups (LHGs) and the proposed Local Health Boards. Where community based health improvement initiatives are planned (for example, the healthy living centres initiative) then the mental health component should be a central element.

Local government has a new duty to promote the economic, environmental and social well being of its communities. It has a central role in combating social exclusion. Similarly employers now have a responsibility for the mental health of their work-force and this should link with local mental health promotion strategies.

Mental health promotion focuses on both maintaining good mental health and also on developing the skills and resources necessary to enable people to live with mental illness. Proposals for the personal and social education curriculum in schools includes the promotion of mental health and school based interventions aimed at improving self-esteem and social skills. High quality pre-school education and support for parents, such as Sure Start, may offer mental health promoting benefits.

Evidence based practice within the field of mental health promotion must be developed including drawing on users' own 'Strategies for Living' and self-management. Health Promotion Wales and the Health Education Authority in England have carried out reviews of interventions with the potential to promote mental health (Hodgson & Abbasi 1995; Health Education Authority 1997). This knowledge and the associated skills must be cultivated and disseminated through inter-disciplinary training and education.

The prevention of mental illness is also integral to the mental health public health agenda. The primary care setting, and the involvement of general practitioners in particular, is important in the achievement of this. However, professionals working in other health disciplines, as well as the social care and criminal justice arenas, must be alert to the possibility of mental health problems affecting the people they care for or work with.

4.2 Mental health services in Wales

The launch of the 1989 All Wales Mental Health Strategy (Welsh Office 1989) provided an impetus to the development of mental health services in Wales. Community orientated and

locally based services have been developed which have included the establishment of multidisciplinary Community Mental Health Teams (CMHTs) throughout Wales. A wealth of voluntary sector facilities have been developed including drop-in facilities, self-help groups and employment training. There has also been an important impact on primary health care which now has to provide services for a group who were previously cared for entirely within secondary care. These changes have enabled some of the large older institutions to be closed including North Wales, Parc, Mid-Wales and Pen-y-Fal hospitals. Some other services have moved in-patient units to more local facilities, notably in Gwent and Ceredigion. However, a number of the old institutions still remain and the agenda set by the 1989 strategy is still relevant in many areas of Wales. ***The National Assembly remains committed to the closure of the old out-dated mental illness institutions and their replacement with modern, fit for purpose buildings. It has provided funding to enable the closure programme to proceed.***

Mental illness may not be increasing in prevalence, but there has been a clear trend of increasing workloads in mental health services. There were 19,610 total all ages admissions in Wales in 1997-98 compared with 15,664 in 1989. The increase in general psychiatric admissions is greater than these headline figures suggest, as admissions for learning disability fell from 10% of the total in 1989 to less than 2% in 1997-8. There have been corresponding increases in the number of individuals seen in out-patient and community settings. Such increases in demand, combined with a diversifying pattern of provision, has increased workloads for staff in all sectors of care. There has been an increase in bed occupancy in recent years, though the reasons for this are not entirely understood. There have been many occasions recently when mental health services in Wales have been unable to respond to emergencies that require in-patient admission because of a lack of available beds. The increased workload has been felt also in primary care which has often had to deal with the consequences of overstretched secondary care.

1,718 admissions to in-patient units were under Mental Health Act legislation in 1997-1998, a rise of 21% over the preceding year and over twice the rate in 1989. 74 of these admissions were from the courts and 141 were place of safety admissions by the police. Proposed changes in the Mental Health Act are likely to further increase workloads.

4.3   Priority for the Severely Mentally Ill

The 1989 strategy stated that the severely mentally ill are a priority for secondary mental health services. Mental health services also have an important role in providing and supporting primary care in helping them to treat other mental illness. Some effective treatments, such as formal psychotherapies, are not available in primary care. Primary care also needs help with difficult or chronic cases and in the management of uncommon conditions. When resources are scarce, there is a tendency for mental health services to provide a "psychosis only" service. We believe this trend acts against the interests of all users, can reduce psychological treatment skills and would provide an unsatisfactory service for primary care. The policy that 80% of the workload of a mental health service should be with the severely mentally ill captures the sense of priority but guards against the possibility of too narrow a focus. Definitions of severe mental illness in this context should take into

account not only diagnosis but also the level of distress and disability that the individual is experiencing. Definitions are difficult in this area but in "Building Bridges" (Department of Health 1995) key elements were suggested to assist with local operational definitions of severe mental illness.

4.4   Local Government and Social Inclusion

Those with serious mental illness are amongst the most socially excluded people within our society. Local authorities have a crucial and important role in driving forward the joint planning, community regeneration and "drive for social inclusion" agendas, which are cornerstones of mental health policies. More needs to be made of these new agendas and flexibilities that will enable new and traditional partners to create new models and approaches to the development of mental health systems. It is also about good government, using resources wisely and efficiently, and listening to the users of services to provide services that meet their needs. Local authorities will play an important part in the achievement of quality and equity in the delivery of specialist mental health services through their community care and social care responsibilities. Through the planning process of social care they take account of the needs of people with mental health problems. This needs to be developed in order that participation and involvement in the planning and running of services leads to the full empowerment of service users and their carers.

OBJECTIVE

Each local authority health and wellbeing plan must include proposals to encourage mental health service users to use local educational, social and leisure amenities and each authority must ensure that its housing policy takes full account of the needs and rights of those suffering from mental illness.

4.5   Clinical Risk Management

Violence and harm caused by those with mental illness is often difficult to predict. A balance in risk management has to be struck between a custodial approach to care and providing treatment and support in the community to enable users to fulfill their potential. Despite the best efforts of mental health services, risk can never be eliminated. It is important that the legitimate and desirable aim of reducing public anxiety does not drive policy on mental health services inappropriately. Increasing understanding and reducing stigma are also important aims in the drive to reduce public anxiety.

Suicide represents a major risk arising from mental illness. Most people who take their own life have a mental illness and users of in-patient mental health services have a risk of suicide over 100 times that of the general population (Goldacre, Seagroatt, et al. 1993 86/id). Information about mental illness and the services available must be provided to meet the social and cultural requirements of high risk groups, such as the seriously mentally ill, young men, or the farming community. Suicide reduction is 1 of 15 Health Gain Targets for Wales (Welsh Office, 1998a) and is a priority for health services.

The risk of harm to others is low but there is understandable public concern about the potential risks posed by a small minority of people with severe mental illness. This anxiety must be acknowledged by those running mental health services. One of the aims of mental health services must be to reduce risks to members of the general public in addition to safeguarding users, carers and staff. (See Section 6.6).

Wales does not have the formal inquiry system used in England whenever there is a homicide involving someone who is known to the mental health services. There are clear arguments for and against such a system and its use in England is under review. The Advisory Group did not recommend that we adopt the current English inquiry system. We intend to await the outcome of the review in England before determining whether any changes are necessary in Wales.

4.6 Increasing public understanding

There is a clear need for improved communication and education initiatives to increase awareness and understanding of mental health problems and of issues relating to good mental health and its promotion. In the mental health field, information for users, potential users and carers is often not as good as in some other health and social care areas. Still less information is provided about other options for treatment, care and support which may not currently be readily available. Improved public information about treatments and services should help to empower users, potential users and their carers to request and obtain the services they need. Public health education about mental illness can also help to promote early recognition of mental health problems, the timely seeking of appropriate help and the development of life skills which should promote good mental health. Local mental health plans should include a programme for public education on mental illness and on local services. In addition, mental health providers should engage proactively with the media as far as possible, with sensitivity to the privacy of users and carers.

OBJECTIVE

Wales must have an education strategy to inform the public about mental illness and the availability of services. The National Assembly will co-ordinate this at national level but statutory and voluntary organisations must co-operate to establish local strategies.

4.7 Reducing stigma

People suffering from mental illness are at risk of being stigmatised. Much of this is based upon public misperception of mental illness which in turn is often due to misunderstanding and lack of knowledge. There is wide public acceptance that those with physical disabilities should be treated with equity in society. It is essential that the same principle of equity is applied to people with mental illness.

Sensationalised media coverage can create additional difficulties and contribute to stigma and discrimination. The stigma associated with mental illness needs to be tackled in a systematic and sustained way, to encourage an inclusive approach. Improved public

understanding should help to reduce stigma and social exclusion. It should also assist service users to obtain a fair share of housing, training, employment and recreational opportunities. Practical approaches need to be developed that focus on building positive relationships and mutual understanding between those with mental illness and the wider community. These could include:

- work with the private sector to promote mutual understanding, training and employment opportunities;

- links between mental health groups and voluntary leisure amenities such as sport clubs;

- partnerships with statutory services which do not have a direct brief for mental health, for example, housing and leisure services departments.

There has been significant research undertaken regarding the causes of stigma. For example, MIND have recently published a book on this topic "Creating Accepting Communities: Report of the MIND inquiry into social exclusion". Review of the existing research evidence and where appropriate further research should be undertaken in order to understand more about the sources of stigma in mental illness and in particular to establish the actions which are most effective in combating stigma and social exclusion.

OBJECTIVE

Action needs to be taken to reduce stigma and social exclusion. The National Assembly will review existing evidence and if necessary commission further research into the causes of stigma and the means to combat it.

5. PARTNERSHIP IN MENTAL HEALTH SERVICES

As this Strategy goes to print, there are well advanced plans for implementing the NHS plan for Wales and consultation is taking place on the new structure of the NHS in Wales. This will involve a major re-organisation both of health structures and of the NHS relationship with local government and with the voluntary sector. The proposals for Local Health Plans and for Health and Well Being Strategies developed and implemented by a partnership of the local authority, the new local health boards, together with NHS trusts, CHCs, the voluntary and independent sectors have particularly significant implications for mental health planning and commissioning. This chapter of the Strategy will be revised as soon as the new structures have been clarified. In the meantime, we lay down general principles which apply whatever system is in operation.

Effective liaison and co-operation between a wide range of agencies and individuals is required to provide high quality mental health services. No single group or organisation can provide the comprehensive care or the range of services needed for a modern mental health service. Health authorities, local authorities, housing associations, the independent and voluntary sector, users and carers are all involved in providing various aspects of care. Structures and organisations need to be established and maintained in order to foster joint working and to overcome barriers for co-operation.

5.1   Needs Assessment

The provision of services must be informed by a local needs assessment using the resources of the NHS and Social Service departments and led by a specialist in public health (Stevens & Raftery 1994). This must reflect the needs of the population rather than be based purely on the historical provision of services. The needs assessment should include epidemiological estimates, a description of local services and the experiences and views of service users, carers and mental health professionals. Evidence of effectiveness and an audit of unmet need are also needed.

 At present there is no certain way of determining the appropriate level of resources for a particular locality (Lewis, 1999). A pragmatic approach towards needs assessment is required that takes due account of needs determined locally. Further research is needed in order to provide a more rational basis for distributing resources in Wales.

OBJECTIVE

The distribution of resources must be based upon an epidemiological approach to needs assessments.

The National Assembly will review the present system and existing evidence and if necessary will commission research to investigate the geographical variation in need throughout Wales.

5.2   Joint Planning by Local Government and Health

As long as present structures remain, the Health Authority should provide through its Health Improvement Plan a strategy for the commissioning of mental health services and the improvement of mental health in its population. It needs to involve all relevant stakeholders in the process, including local government, the voluntary sector and users and carers. Each Local Authority/Local Health Group area must then develop its own local operational plan in line with the Health Improvement Plan. There are already statutory obligations on local authorities to produce plans for the delivery of mental health services. Community care plans, housing plans and the area strategic plan, all need to include sections on mental health services. Each area should have a Local Mental Health Strategic Planning Group made up of representatives from relevant statutory agencies, the voluntary sector, users and carers. It is important that these groups develop the strategic plan for each area, based on local need, and that this plan is then reflected in each agency's own business plan. These local plans need to take account of the emerging system of Health and Well Being Strategic Partnerships and local plans need to take account of the whole spectrum of need including health promotion and primary care.

Commissioning mental health services is complex and difficult because of the wide range of agencies that need to be involved. Whatever structures are in place, consideration will need to be given to the best way of representing mental health interests at planning and commissioning levels.

OBJECTIVE

Every Health Improvement Programme (HIP) and Social Services Social Care Plan must include a mental health plan.

Inter-agency co-operation and good joint working needs to be safeguarded during this period of change.

The National Assembly will issue revised guidance on planning and commissioning of mental health services once the wider re-organisation has been finalised.

5.3   Partnership between Local Government and Health Authorities

Whilst some authorities have already found effective and imaginative ways of delivering well co-ordinated and seamless care, there have been constraints which the Government has acted to remove. The Assembly has consulted on and will issue guidance on domiciliary charging powers in the Care Standards Act 2000.

Regulations and Guidance made by the Assembly under the provisions of the Health Act 1999 allow the NHS and local government to pool budgets, transfer payments in both directions, and undertake lead commissioning and integrated provision. They should plan carefully and move towards joint commissioning, bearing in mind the evidence that commissioning is more effective on a larger scale. In developing a flexibilities partnership

the statutory partners, the NHS body and the local authority should consider the positive contribution which can be gained from involving the voluntary sector in partnership arrangements and service provision.

OBJECTIVE

The Health Act flexibilities must be used imaginatively to increase opportunities for the better planning and provision of services both in the existing system and in any re-organisation.

5.4   Voluntary agency provision

The National Assembly is committed to working in partnership with the voluntary sector and has developed a statutory scheme to govern the way this partnership must operate. It is underpinned by the shared values about the role of individuals and communities in a modern democracy and the recognition by the Assembly of the contribution the voluntary sector can bring to the development of policy.

Voluntary sector provision to support mental health services in Wales is extensive, covering a wide-range of services including supported housing, employment schemes, drop-in centres, outreach services, counselling, self-help and self-management, social support, advocacy and welfare rights advice. The non-statutory sector forms a major part of community based services in many areas of Wales as well as providing valuable input to statutory services.

The voluntary sector should be seen as full partners alongside statutory health and social care providers. The term 'multi-agency' must always be taken to include the voluntary sector. This partnership extends from the services. This is achieved through the planning of services and their delivery at both local and area levels. For their part, voluntary organisations need to appreciate that their statutory sector partners have to shoulder legal responsibilities which can place unavoidable constraints on them and on the action they take. Agreed guidelines on confidentiality between the statutory and voluntary sector would assist the full participation of voluntary sector staff in mental health services.

Statutory agencies must be prepared to work with, and provide support to voluntary organisations in order to commission mental health services. An individual should be nominated at health authority, local authority and sector levels, to be responsible for liaison with voluntary organisations.

OBJECTIVE

The voluntary sector must be included as partners in the provision of mental health services.

Voluntary sector organisations must recognise the legal constraints and responsibilities of the statutory sector.

Every area must have a comprehensive range of services including voluntary sector provision.

5.5   Involvement of users and carers

User and carer empowerment and their full participation in all aspects of mental health services is a fundamental principle of this Strategy. This involves partnership at three distinct but related levels. The first is in the assessment of individual need and agreeing the response to that need, the second is in joint planning, development and monitoring of services and the third is in the running and management of services themselves. Carers' specific needs must also be addressed having regard to the National Assembly's Carers' Strategy in Wales Implementation Plan, the Carers' and Disabled Children Act 2000 and the Carers Recognition Act 1995. Carers play a vital role and must be valued and supported by statutory agencies services.

Statutory organisations must see user and carer involvement as attainable and integral to service delivery, development and provision. Full participation must be supported in a sustained and formalised way that does not simply fit users and carers into existing structures and systems. Agencies such as local authorities and local health groups must seek out ways in which users and carers can be fully engaged and provide a range of mechanisms and support structures to that end. For instance, as well as individuals having places as of right on local planning groups, information from users and carers can be gathered from satisfaction surveys, consultation meetings and conferences as well as from feedback from routine service monitoring.

Individuals, user and carer networks and other representative bodies must be resourced to undertake this work. As well as covering the costs of attendance and other work, training for users and carers to help them undertake their roles must be provided from statutory funds.

OBJECTIVE

Users and carers must be constructively involved at all levels of mental health services: National Assembly, Health Authority, LHG/Unitary Authority, Trust, Unit and Sector Teams.

6. STANDARDS OF CARE

The following standards should apply to all mental health services.

6.1 Evidence Based Practice

Mental health services should provide effective interventions that treat symptoms, reduce harm, prevent deterioration and aid rehabilitation. All mental health professionals require access to information on effectiveness. There is an increasing realisation that clinicians must rely more upon evidence from empirical studies, particularly randomised controlled trials and less upon clinical anecdote (Evidence Based Medicine Working Group, 1992). The Cochrane Library (Cochrane Library 2000) provides regularly updated information on effectiveness, the Welsh Health Bulletin – Mental Illness (Welsh Office 1998b), provides a summary of information that includes non-randomised studies and there is very useful data in the recently published Review of the Effectiveness of Mental Health Services (University of York, 2001). These sources of data will need to be better disseminated and regularly updated if they are to be useful. If mental health services are to compete for resources it is essential that mental health professionals and commissioners are aware of the evidence base, marshal the evidence effectively and direct resources into effective and appropriate interventions for mental illness. There will be increasing use of clinical practice guidelines to aid dissemination and implementation of best practice.

OBJECTIVE

All those involved in mental health services must be aware of the latest evidence on effectiveness relevant to their own work.

6.2 Clinical Governance & Best Value

Clinical governance is a mechanism to ensure that treatment and care provided is effective and of high quality. The principles are described in more detail in Quality Care and Clinical Excellence – Guidance on Clinical Governance (Welsh Office 1998c). Standards should be monitored by clinical audit and through clinical governance mechanisms. This document also describes the role of the National Institute of Clinical Effectiveness (NICE) and the Commission for Health Improvement.

Mental health services must also take account of the Mental Health Act 1983 Code of Practice (Department of Health & Welsh Office 1999) and the advice from the Mental Health Act Commissioners. Other groups, including the Social Services Inspectorate Wales, Audit Commission, Joint Review Teams and Confidential Inquiry system will also suggest good practice that will inform statutory agencies.

For local authorities, the key principles are those of Best Value, performance management and Modernising Local Government. Other initiatives to improve quality include:

- the Care Standards Inspectorate for Wales to be established from April 2002 which will bring about greater consistency and standards in the regulation and inspection of care homes and other provision;

- a Mental Health National Service Framework for Wales which will set standards, improve equity of access and monitor quality of services;

- the Care Council for Wales which is taking on responsibility for training and regulating the social care workforce from October 2001;

- the Social Care Institute for Excellence (SCIE) which is being set up in the Autumn of 2001 and will develop the evidence base for social care similar to that provided by the National Institute for Clinical Excellence (NICE) in health.

Best Value provides a framework for evaluating local authority services though it can also be applied to health care services. The following questions test whether services provide Best Value:

- how do we know we are doing the right things?

- how do we know we are doing things right?

- how do we plan to improve?

- how do we account for our performance?

OBJECTIVE

Clinical governance and Best Value mechanisms must be in place so that matters of effectiveness and quality are given high priority in mental health services.

6.3   The Needs of Users and Their Carers

Users

Users of mental health services will normally wish to live their lives as normally as any other person without such problems. The difficulties they experience mean that they require extra help to maintain this normality and often specialist help is required particularly at times of crisis or severe difficulty. People who require such specialist or intensive help often recognise the need for intervention in a crisis. Areas that may need extra help to achieve integration in everyday patterns of life include:

- housing;
- employment;
- leisure;
- relationships;
- family;
- access and mobility.

OBJECTIVE

This Strategy is designed to help people with a mental health problem to manage their lives with the greatest degree of normality.

Carers

Experience of mental health problems can be particularly difficult for family members and other carers. This can be bewildering and stressful and carers may need as much help in understanding and supporting people with a mental health problem as those they are caring for. They may need special help. Carers, family members and other significant people in the lives of service users are frequently a vital part of support to individuals. They are often the first to identify problems and know better than anyone what triggers difficulties. They should be seen as partners in the care process, their views should always be taken seriously and they should be helped to understand how the problems can be managed to secure an effective outcome.

OBJECTIVE

Services need to develop an approach that responds more effectively to the needs of users and carers. Different professionals need to come together as a team. They need to understand the total context in which mental health problems arise and manage the often complex problems in that context.

6.4   Care Plans

There has been considerable debate within Wales concerning the adoption of the Care Programme Approach (CPA) and its successor "Effective Care Co-ordination in Mental Health Services, Modernising The Care Programme Approach in England". Wales issued Guidance on the Care of People in the Community with a Mental Illness in March 1996 followed by Care Planning, Process and Documentation in February 1998. The Social Service Inspectorate for Wales inspection of Adult Mental Health Services in 2000 found that implementation of formal care planning and risk assessment with good documentation of process was patchy. User surveys confirmed this. The consultation confirmed significant support for the adoption of a formalised multi-disciplinary care planning process for those with complex needs. The Strategy is based on a commitment to move rapidly to introduce the widespread use of multi-discipline care plans for all those with mental health problems and where relevant their carers. Care planning in future must be based round a written care plan that will be available to the user and if appropriate, their carer. Further details on implementation and standards will be provided in the National Service Framework for Mental Health in Wales.

The care plan will ensure that users of mental health services should have a comprehensive assessment of their medical, psychological and social care needs. There should be locally agreed guidance on the time that may lapse between referral and assessment, particularly for emergency assessment. All users should be offered a written care plan. It is important

to support individuals to take prescribed medication with full knowledge and agreement, through effective medicines management.

For those with more complex or enduring needs a multi-disciplinary assessment is required. For these users, a written care plan must be provided to the patient and, where appropriate, the carer. Care plans must be drawn up collaboratively and negotiated with the patient or, if more appropriate, the carer or advocate. Efforts must be made to ensure that all stakeholders understand each element of the care plan, including possible outcomes.

The care plan should provide details of the full range of care and support services required and to be provided, including details of the medication to be taken as part of the agreed treatment plan, and the professionals involved, including who to contact in an emergency. Every user should have a nominated key-worker named in the care plan. Care plans should also specify any needs for information, identify the profession responsible for providing the information and give a named individual contact to provide the information. Care plans should be regularly reviewed by the multi-disciplinary team and administrative systems and support should be in place to ensure this occurs.

Under section 47 of the NHS and Community Care Act 1990, Social Services Departments have a duty to carry out an assessment of the needs for the provision of community care services. This process will be an important element of the multi-disciplinary care planning assessment and should not duplicate work done by other members of the team. Carers have a right to an assessment of their own needs.

OBJECTIVE

Written care plans, with copies given to the user and carer must be provided for all users with complex or enduring needs and offered to all users.

Care plans must be drawn up in collaboration with users and carers and must be regularly reviewed.

For those with more complex or enduring needs, care plans must be based upon a multi-disciplinary assessment.

Response times for urgent assessments must be locally agreed and monitored.

Carers must be offered an assessment of their needs.

6.5   Assertive Outreach

Mental health services need to maintain contact with users who have complex or enduring needs for health and social care or who might pose a risk to themselves or others if they became unwell. At times this will require an "assertive" model of care in which members of the sector team would maintain contact even if the user is unable or unwilling to attend because of their mental illness. The aim of an assertive approach is to reach out and engage people with the service but there is a risk of alienating users. As always a balance has to be

struck between the civil liberties of the user and the protection of the user and others from harm.

The term Assertive Community Treatment (ACT) has become associated with a particular model of care in which each key-worker has very low caseloads of about 12-15 clients. The Advisory Group concluded that such small caseloads are not justified (Burns et al 1999), though it recognised the controversies surrounding this area. However, if the multi-disciplinary team is to be able to maintain contact with some users, the caseload of keyworkers must be carefully managed in order to allow such assertive outreach to occur.

OBJECTIVE

Mechanisms should be in place that ensure that those with more complex and enduring needs stay in contact with services.

6.6   Risk Assessment

Every user in contact with mental health services should have a structured assessment of risk written in their case-records. Such assessments must be reviewed and updated on a regular basis. This assessment should cover risk of self-harm to the user, risk of harm to carers, other users and the public (Royal College of Psychiatrists 1996), and an assessment of the risk of exploitation. Risk assessment and subsequent management has to strike a balance between a more custodial, risk averse role with the therapeutic aim of helping an individual fulfil their potential (Munro & Rumgay 2000).

Mental health services have a responsibility to provide effective interventions for those at risk, to maintain contact with users who might pose a risk and when necessary, inform other relevant individuals and organisations of any potential risks a user may pose to themselves or others. There is a delicate ethical balance in such situations between an individual user's right to confidentiality and informing others in order to reduce potential risks to the user or others. Professionals who have to make decisions concerning this should be supported in making proportionate judgements so that risk is reduced when possible.

A recent report by the Standing Nursing and Midwifery Advisory Committee (1999a) identified a number of areas where the skills of acute mental health nurses might be improved, patient safety increased and issued practice guidance on safe and supportive observation of patients at risk. The National Assembly's guidance 'In Safe Hands' is also relevant.

The assessment of risk and ensuring the safety of users, carers and staff could be increased by:

- training mental health professionals in risk assessment and risk management (Appleby 1999);

- ensuring that risk assessment is multi-disciplinary and co-ordinated across settings including primary care;

- standardising the procedures for observation and restraint (Standing Nursing and Midwifery Advisory Committee 1999b);

- giving special attention to the needs of users such as adolescents and women, who may be particularly vulnerable to attacks or abuse;

- removing environmental dangers in the design and construction of our existing inpatient units (Appleby 1999);

- ensuring that there are sufficient trained permanent nursing staff on in-patient units to provide each patient with appropriate care (see Sections 10.1. 10.2);

- adopting the requirements of the Children Act and professional responsibilities for child protection (Falcov 1996).

OBJECTIVE

A structured assessment must be carried out for each user on the risk of self-harm, potential harm to others and of vulnerability to exploitation. The results must be written into case notes.

6.7   Information for Users and Carers

Clear, helpful, information, with support to understand and utilise it, should be freely available to service users and carers from the onset of any mental health problem and throughout its course. Information provided by professionals in times of crisis, should be repeated on several occasions as this is likely to assist users and carers to better assimilate it. The subjects on which users and carers most need information are:

- the mental illness or mental health problem involved;

- pharmacotherapy and psychotherapy including those not currently available;

- their rights;

- the availability of services and how to access them;

- how to cope with the effects of the mental illness;

- the help available for any physical problems, diet and smoking;

- where to obtain further information and support in the community.

Information should be available through a number of media including the Internet, Braille, audio tape, video with subtitles as well as in a range of languages. The legal status of the Welsh language must be recognised.

OBJECTIVE

Accessible and intelligible information must be provided for users and carers at a national and local level.

6.8   Self-help and complementary therapies

Self-help, in line with the principle of empowerment, must be valued and recognised by those working in mainstream mental health services. Self-help has a strong tradition amongst users and carers affected by mental illness. Particular developments of self-management for certain mental health problems such as manic depression and individual strategies for living with mental illness need to be encouraged by professionals and included as part of the overall approach to addressing mental illness.

Some service users may also wish to receive complementary therapies that would be provided, usually, outside the statutory sector. These choices should be accepted as a preference for some individuals as part of their care plan. These therapies should be subject to the same tests of effectiveness and quality as other treatments, and practitioners should be appropriately qualified.

OBJECTIVE

Self help strategies and evidence based complementary therapies must be recognised and supported by services.

6.9   Families and children of service users

Professionals need to be aware of the childcare responsibilities of service users. Mental illness may affect the user's capacity to meet the needs of children in their care. There must be effective collaboration between agencies to assess the needs of the children, provide support for the service user and consider local authority care for the children if that is necessary. Wherever possible services should aim to support the user in their parenting role. Multi-agency protocols and guidance will assist this process. Of particular concern are the needs of young carers, that is those young people who have to care for a parent or other family member. Each case will differ but professionals need to be aware of this issue. Where such circumstances apply, consideration of the support that should be offered to the young carer should be an essential element in case planning. The National Assembly has commissioned two pieces of research on the needs of young carers. These will report later this year and will inform future services and policy development for young carers.

OBJECTIVE

Care plans will include formal assessment, and where appropriate interventions of the needs of dependent children of service users. If appropriate, support needs of young carers must also be addressed.

7. GENERAL MENTAL HEALTH SERVICES

This chapter describes the core services that need to be provided in each locality or sector. Mental health services should be organised as sectors in which a single multi–disciplinary team in secondary care has overall responsibility for providing core mental health services for the sector. The population size of a sector will vary but is usually between about 20,000 and 50,000 individuals aged 18-64.

7.1   Primary Care

The Primary Health Care Team (PHCT) includes a wide range of different professions all of whom have a part to play in the management of mental heath problems. Practice nurses, health visitors, community nurses, counsellors, school nurses, pharmacists and the allied health professionals, as well as general practitioners, all have the potential to contribute to mental health care, and generally already do so. Mental health and its promotion, the management of mental illness and its consequences form a major part of the day to day work of all members of the primary health care team.

Most users with a mental health problem will be treated and managed by members of a PHCT. General practitioners (GPs) usually provide sole care for most users with the common mental problems of depression and anxiety. Almost 25% of consultations in primary care have a mental health component, though it is often difficult to identify psychiatric disorders particularly when associated with physical illness (Goldberg & Huxley 1992). The PHCTs also share the care of the more severely mentally ill and in particular have a responsibility for the physical care of those with severe mental illness.

GPs must be aware of the range of possible services and the routes to access these services. Clear referral pathways into the services should be defined locally. The Primary Care Strategy will inform developments in this area. There is a need for more research into the most effective ways of managing mental illness within primary care.

Mental health and the management of mental disorders are of paramount importance to every PHCT and there should be acknowledgement of the good care that is provided already. Examples of good practice such as those highlighted in the WHO Guide to Mental Health in Primary Care should be widely disseminated and promoted, as there is undoubted scope for demonstrable improvement in the quality of patient care in this aspect of every day clinical practice.

Psychological treatment techniques are appropriate in many conditions managed in primary care but are often unavailable because of a lack of trained staff. There is an inequity of provision of these services. This issue should be addressed as users in the primary care setting have shown a keen interest in the application of effective psychological therapies either as an alternative or a supplement to medication.

It is important that communication with patients and carers about mental illness is improved in primary care. For example, more information should be provided regarding illnesses and treatment options.

OBJECTIVE

Primary Health Care Teams must receive training and education in managing mental illness within primary care.

Effective psychological treatments must be available within primary care.

Effective information must be available to meet the needs of GPs/Primary Health Care Teams and users and carers.

7.2   Relationship between Primary and Secondary care

General adult psychiatry and specialist services must work with local GPs to define their respective roles in the care of psychiatric disorders. Clarity about which effective interventions should be delivered in primary or secondary care will aid this process. Communication between primary and secondary care is vital to ensuring effective care and the efficient use of resources. Agreement must be reached on the explicit aims of referrals and whether these are for consultation and advice, for provision of a longer period of treatment within secondary care or for long term 'shared care'.

There have been occasions when the emphasis placed upon the needs of people with enduring mental illness, a "psychosis only service", has led to a too rigid definition of the roles and responsibilities of the Community Mental Health Team (CMHT). This has contributed at times to a distancing between CMHTs and primary care. In part this is an understandable response to an increase in workload but collaborative working between primary and secondary care should be more efficient, and ease workloads while improving the care to the users and their carers. The other factor that has inhibited closer working is the differences in how the primary care and secondary care sectors view mental illness and the terms that they use. Joint working between primary and secondary care also requires joint education, training and audit.

The partnership between PHCTs and mental health services may be enhanced by:

- organising mental health services on a sector basis with each sector comprising an agreed number of GP practice boundaries;

- the allocation of specific CMHT members to liaise with each PHCT;

- the development of rapid effective communication systems e.g. electronic mail;

- joint exercises in clinical governance and agreements on guidelines for management and referral – including emergency and urgent assessments;

- personal contact between general practitioners and a senior psychiatrist;

- adherence to Patient Charter standards concerning acceptable delay for the arrival of out–patient appointment letters and discharge summaries at primary care;

- joint education for CMHT and PHCT members;

- supervision arrangements from specialists in the CMHT for PHCT members.

OBJECTIVE

There must be effective communication between primary and secondary care.

There must be agreed guidelines on management and referral between primary and secondary care.

7.3   Sectorisation

Mental health services should operate as "sectors" in which a Community Mental Health Team (CMHT) with a defined catchment area is linked to designated in–patient beds and to day–care, in which all users are cared for by a single multi–disciplinary team (Johnson & Thornicroft 1993). This arrangement should ensure continuity of care and encourage the development of local knowledge. It also encourages the rational use of resources especially of in–patient beds which are the most expensive aspect of care. Individual circumstances may require some flexibility in this arrangement and the principle of choice should be respected.

In–patient units, CMHTs and day–hospitals and other day services make up the core elements of the services provided. Within each of these core elements it is essential that agencies and professional disciplines work closely together to provide a comprehensive service for the user. Good communication between staff in the various settings has to be a priority. Discharge from in–patient units to the community is a particularly important time and associated with an increased risk of suicide. Ensuring proper discharge planning and good communication will support users during this difficult period and prevent them from losing touch with mental health services. The sharing and rotation of staff between sites should be encouraged.

OBJECTIVE

Sectors must provide seamless care for users irrespective of whether they are in–patients, attend the Community Mental Health Team (CMHT) or attend day services.

Discharge plans must ensure that all users are provided with suitable support and follow–up after in–patient admission.

7.4   Community Mental Health Teams (CMHTs)

CMHTs should be fully multi–disciplinary including medical, nursing, social work, psychology, occupational therapy and with access to other professions such as physiotherapy, pharmacy, dietetics, speech and language therapy and arts therapies, as

required. All professionals in the CMHT should work from an identifiable common base. Their remit should be clearly defined in the local strategic plan. The role and remit of the CMHT needs to be understood by all local agencies especially primary care. Management arrangements for workload and staff need to be clearly defined and supported by agreed protocols. All CMHTs should provide effective psychological treatment and social care services for their users, sometimes with the support of more specialised services.

Further development and evaluation of the CMHT model is required. In particular there should be expansion of teams and a review of caseload size and case mix. This is essential if the development of good links with more specialised services is to be successful. The physical environment of CMHTs, along with other elements of the service needs to be addressed. CMHTs need to be in accessible locations and provide sufficient space for staff to see users and carers in privacy.

OBJECTIVE

CMHTs must be developed and if necessary expanded to meet local needs in line with this Strategy to ensure appropriate caseload size and links with specialist services.

The physical accommodation of CMHTs and other parts of the mental health service must be fit for purpose, have sufficient space and be in accessible locations.

7.5   In-patient services

Hospital based services are required for emergency and planned admissions. Even where there are good community-orientated services, there is still a need for in-patient care. Minimum staffing levels for all professionals should be agreed within all in-patient units to ensure equitable provision across Wales. Care in in-patient units must also be multi-disciplinary. Effective co-ordinated discharge planning is an essential component of care.

At present many of the in-patient units in Wales are in old or otherwise unsuitable buildings. Adult general psychiatry in-patient beds require a pleasant, fit for purpose physical environment that provides privacy, dignity and security. Wards should be designed to provide opportunities for observation by nursing staff and should have access to intensive care facilities when these are required. Single sex areas should be developed and in-patients should have access to outdoor areas. The physical estate of psychiatric units in Wales should be reviewed to assess their suitability for a modern mental health service.

There has been an increasing expectation for women to be provided with in-patient accommodation that excludes male users. In reviewing the in-patient units, any future design should be flexible enough to ensure that women have separate facilities from men and access to a female only day area.

The recent Standing Nursing and Midwifery Advisory Committee report (1999a) has endorsed the opinion of users, carers and staff that the experience of admission to acute in-

patient facilities has become increasingly custodial. There now exists a greater risk of violence, towards both staff and patients, within these environments leading to an emphasis on observation and containment thereby reducing therapeutic activity. Patients within in-patient units are much more likely to be severely ill, have a dual or multiple diagnosis and have greater social needs. The complexity of care that such patients require is much greater now than in the past and yet little attention has been given to the development of clinical skills or resources needed to provide quality care in in-patient settings. Providing a local intensive care unit can help to provide a more suitable short-term environment for those who are very disturbed and make the general wards less custodial.

Improving the quality of care in in-patient units must be an important priority for mental health services in Wales. Admission to an in-patient unit should allow users to engage in therapeutic options that are unavailable outside hospital. In addition to improving the physical environment, this can only be achieved by training, education and supervision in these aspects of in-patient care (see section 10.2) and by ensuring there are adequate numbers of trained staff on all in-patient units (see section 10.1).

OBJECTIVE

In-patient units in Wales must all provide satisfactory physical accommodation.

Women must have the choice of a women only environment on in-patient wards. Milestones to achieve this goal will be identified in the NSF.

Staff must be provided with support and training to develop a therapeutic environment on in-patient units.

7.6 Day Services

Day hospitals and day services need to be properly integrated into the sectorised service. Staff in day services also need to be part of the same seamless service provided by the CMHT and in-patient unit.

Traditionally, day care has been provided in either day hospitals or day centres. In recent years this pattern of service delivery has been changing to provide people with more flexible support which includes social rehabilitation within settings which are available to the public as a whole. Day services should provide a network to cover clinical, social, acute and long term needs. They must be organised in a way that is flexible and responsive to the needs, preferences and interests of the client groups. Commissioners must focus on function and social inclusion rather than institution, creating a range of services. It will be particularly important to consider the Health Act Flexibilities (Section 5.3) in commissioning day services which incorporate both health and social services in an integrated setting.

Close links with employment, educational and recreational facilities must be fostered and services must be available at times to fit with normal patterns of daily life rather than just during office hours. Many examples of good practice are available. Local authorities and

others who provide recreation, leisure and cultural services must ensure that their services are equally accessible to users of mental health services as required by the Disability Discrimination Act 1995.

7.7 *Emergency Assessment and Out of Hours services*

Much of the work of community mental illness services is designed to prevent emergencies arising in known users of the service. However, there will always be a need for urgent assessment of known and unknown users. The care plan for those known to services should contain details of who to contact out of hours in an emergency and all agencies, especially primary care, should have clear details of how to arrange emergency assessments.

Assessments must be conducted within a locally agreed time interval and in an environment that is safe and private. NHS Trusts must ensure that user case notes are available at short notice 24 hours a day, until more sophisticated information systems supersede this (see section 9.7). Whenever possible, users who require emergency assessment should be assessed by mental health professionals who already know the user. During "office hours" these assessments would usually be made by members of the CMHT. The route to access emergency assessments needs to be widely known to users, carers, the voluntary sector, primary care physicians, the police, prison service and magistrates courts, including helplines and advice centres. An Assembly-funded out of hours helpline, Community Advice and Listening Line (CALL), now covers all of Wales.

The need for 24 hours crisis intervention services should be considered carefully in view of conflicting evidence about the cost-effectiveness of these services and the various models that have been developed (Joy et al 2000). In particular, out of hours services should not reduce the capacity of the sector team to provide services that might prevent crises. Further research may be needed to examine the needs of users presenting out of hours and to evaluate alternative means of providing care, taking account of the circumstances in different areas of Wales. In the meantime, services should consider providing a CMHT service with extended hours into the early evening and weekends.

The Mental Health Act 1983 Code of Practice (Department of Health and Welsh Office 1999) stipulates that each area has adequate numbers and availability of approved professionals to apply the Mental Health Act in an emergency. This has proved very difficult to implement in practice. The White Paper on Reform of the Mental Health Act makes proposals in this area.

OBJECTIVE

Case notes must be readily available 24 hrs a day.

Information technology must be used to improve the availability of important information.

Information on how to access services in a crisis must be widely publicised.

7.8   Employment

Employment is known to be beneficial. Most users of mental health services want to work. There are many reasons for this apart from the obvious financial benefit. Employment brings greater self esteem and reduces the stigma met by users. It plays a vital part in social inclusion. Employment and training-for-work is as important for users of mental illness services as for other members of the community. All users with serious mental illness must be assessed in order to determine any need for support in retaining their current employment, obtaining employment or for additional training. Such assessments need to be repeated annually as needs will change. Specific supported employment and training-for-work needs should be addressed separately from an individual's social or leisure activities.

A comprehensive range of employment and occupational opportunities should be provided. These should range from specialist employment and training for mental health service users to schemes that support users in general employment and training. Many examples of good practice are available. Health Authorities and Local Government need to commission them in conjunction with the independent sector. Statutory services should empower users and carers in developing their own schemes.

Links should be made with providers operating the Government's New Deal for Disabled People (due to be extended from July 2001) and Job Retention and Rehabilitation pilots, which are currently being developed. The New Deal for Disabled People will identify innovative ways of helping people on Incapacity Benefits to move into lasting employment, using a network of Job Brokers with the expertise and commitment to work with and support a client group with a range of disabilities and health conditions. The aim of the Job Retention and Rehabilitation pilots, planned to commence in 2002, is to test approaches for helping people on short-term sickness benefit to remain in employment rather than progress on to long-term Incapacity Benefits.

OBJECTIVE

A range of employment and training opportunities must be facilitated in collaboration with the statutory and voluntary sector and involving private sector businesses.

7.9   Housing and Homelessness

Good quality, well managed housing is among the most important ingredients of successful community care for people with mental health problems, (Audit Commission 1998) and is fundamental to achieving the security and well being of individuals. A comprehensive range of residential accommodation is needed with varying degrees of support. Local Authority Housing Departments should ensure access on an equal basis to local housing provision for users of mental health services including liaison with the independent sector. Some service users will need to stay in supported accommodation indefinitely. Where support services are available with accommodation these should work in conjunction with the mental health professionals in the CMHT and sector. A considered cross-disciplinary approach to housing needs is required in each area across Wales. Having consulted earlier

this year on its housing proposals the National Assembly has launched its National Housing Strategy for Wales with the publication of "Better Homes for People in Wales".

Appropriate arrangements need to be agreed between health authorities, local authorities, voluntary agencies and the independent sector to provide the range of long term care that is required. The responsibility for funding long term care lies with both health and local authorities. The respective contributions will vary according to the assessed health and social care needs of the individual user. Models of funding and good practice should be devised and piloted in Wales, using the mechanisms in the Health Act flexibilities. The National Assembly will encourage this and the dissemination of findings.

There is a strong association between homelessness and mental illness, and homeless people often find difficulties in accessing mental health and other care services due to their unstable circumstances. Homeless people with mental illness should receive a comparable quality of care to those who are housed. Local Authorities in conjunction with Local Health Groups and voluntary agencies should identify in their local health plans how they will assess and address this within their area. In areas with a large homeless population, specialist multi-disciplinary teams should be formed. In every area health, social services and the voluntary sector should establish flexible and collaborative working arrangements with users and carers to address the high levels of physical and mental illness, drug and alcohol misuse and social needs of this population (Gill et al 1996).

OBJECTIVE

Assist the provision of suitable accommodation to facilitate integration into communities.

A range of housing with varying degrees of support must be commissioned in collaboration with the independent sector and other partners.

7.10 Advocacy

Service users often experience difficulty negotiating with mental health professionals and ensuring that their own point of view is acknowledged. These difficulties apply both to the practical activities of daily life as well as help with their mental health problems. Users and carers often have little information about mental illness and the various alternatives for treatment and care. Advocacy seeks to address this imbalance by ensuring that their voice is heard, their choice is real and their rights are safeguarded. Every person who comes into contact with mental health services should have the right to an appropriate advocate. Access is particularly important for those subject to the Mental Health Act 1983 and for the more severely disabled.

Development of advocacy services and Patients Councils has been patchy across Wales. This needs to be addressed and in all areas attitudes must shift so that advocacy is established as a central aspect of mental health provision. As part of this process, the support and training of advocates needs to be fully resourced and best practice adopted across Wales. The voluntary sector will play an important role in supporting and facilitating these

functions, funded from public money. The White Paper on reform of the Mental Health Act makes proposals on advocacy for detained patients (and these need to be taken into account when local schemes are being devised) although it should be stressed that this Strategy's recommendations apply to all patients.

OBJECTIVE

Advocacy services must be available throughout Wales for all patients who require them.

7.11 Rehabilitation

The aim of rehabilitation is to empower patients to effectively manage their own illness and provide support when required. Some users will develop enduring illness, with complex needs and severe disability. They require a long term, integrated model of care and a network of rehabilitation services which aims to maintain or enhance the user's independence within the community, maximise functioning and reduce the chance of re-admission. The particular orientation of a rehabilitation programme, which requires systematic and structured work over many months or years, is difficult to sustain within a general mental health service. For this reason, the general services within a sector need to be able to refer to specialist multi-disciplinary rehabilitation services who may then refer back to the general team when and if appropriate. More specialised rehabilitation services also need to provide training, support and advice to CMHTs in their work in helping users who have complex needs.

Rehabilitation services provide an active therapeutic environment in 3 settings:

- 24 hour staffed fast track rehabilitation service in which most users will move on within 6 to 12 months to less intensively supported accommodation;

- 24 hour staffed slow track rehabilitation and longer term continuing care for the small number of users with such needs. Normally this provision will be in a community setting other than for those individuals with secure provision requirements;

- community rehabilitation services providing multi agency care for users with long term needs. These have similarities to the care provided in assertive community treatment.

OBJECTIVE

A comprehensive range of rehabilitation services should be available throughout Wales.

7.12 Psychological Treatment Services

We refered earlier to the importance of psychological provision in general mental health services. There is a need for this provision in the more specialised services too. There is now a considerable body of evidence that supports the effectiveness of psychological

treatments or psychotherapy for a range of mental illnesses. This has been summarised in the book "What works for whom?" (Roth & Fonagy 1996). More recent research has given support to the effectiveness of cognitive behavioural treatments with psychosis. At present psychological treatment services in many parts of Wales are poorly developed.

The NHS Executive in England produced a report (Parry & Richardson 1996) that provides a framework for the commissioning of psychological treatment services. Psychological treatment is required in all parts of mental health services, including in primary care. Every CMHT should also be providing psychological treatment. However, there is also a need for a more specialised service to provide the formal psychotherapies and act as a centre for advice and training about psychological treatments for all staff. Every service in Wales should have access to a comprehensive range of formal, high quality, psychotherapies. There are a variety of ways of ensuring this happens. It is important that management ensures that each area has a coordinated and planned psychological treatment service that provides access to a full range of psychological treatments from all parts of the service.

There are some important principles that concern the provision of psychological treatment services. At present the core provider for psychological treatments is clinical psychology. In the future the service should be multi-disciplinary and include input from other appropriately trained and supervised professionals.

One of the most important functions of a psychological treatment service is to train other professionals and support those working in CMHTs, in-patient units and day services in some of the key psychological treatment techniques. Providing effective formal psychotherapies is a specialised skill that requires dedicated and experienced individuals. However, all mental health professionals should be confident to apply some of the key techniques in their everyday work and to receive supervision in their use. Psychological treatment services should not become distant from the service but should be involved in raising standards of psychological treatments throughout the service and in all staff.

OBJECTIVE

A comprehensive, evidence based range of psychological treatment services must be available across Wales.

8. MORE SPECIALISED SERVICES

These services will tend to be commissioned over a larger area than a single sector but must be available for everyone in Wales.

8.1   General Hospital Mental Health Services

Each general hospital needs a truly multidisciplinary team including liaison psychiatry sessions to provide mental health services. There are two main aspects of care. The first is the provision of assessments for those that have deliberately self-harmed (DSH). There are about 300 admissions for deliberate self harm each year for each 100,000 people (Lewis et al 1997). These individuals have an increased risk of suicide up to 100 times the population average (Hawton & Fagg 1988). The prompt assessment of admissions for DSH is an essential function that also ensures that general hospital beds are appropriately used. It is particularly important that there is a formal link between General Hospital Mental Health Services and Accident & Emergency where many psychiatric emergencies present. Liaison psychiatric sessions should be commissioned providing specific provision for mental health services within A & E departments. A psychiatric nurse may be specifically allocated with responsibility to liase with the A & E department.

Secondly, a specialist mental health service should provide a service for the in-patients and out-patients of other specialities in the general hospital. Mental illness is twice as common amongst general hospital in-patients than in the general population and if inadequately assessed and treated can be inappropriately investigated. Attending to the psychological aspects of physical care can aid recovery from physical illness, hasten discharge and improve efficiency (Royal College of Physicians and Royal College of Psychiatrists 1995).

The public misperception of mental illness is frequently mirrored by health professionals unfamiliar with supporting mental health service users. This can prove detrimental to the physical health needs of mental health patients. The liaison team should also provide education, information and joint training in order to combat stigma and improve the comprehensive delivery of services.

8.2   Low Secure Services

Each Health Authority should consider providing low secure services as part of its needs assessment. Low secure services help to make the general in-patient units less custodial and provide a step-down from forensic services. Although the Specialised Health Services Commission for Wales (SHSCW) does not have a commissioning role for low secure services it seems sensible that Health Authorities should consult SHSCW on the provision of these services in view of the relationship to medium and high secure services. Planning and development of low secure services must use the networks of specialist services in Wales and the UK to ensure equity in standards of care and environment.

8.3   Mother and Baby Units

Women are more likely to be admitted to hospital with a psychotic illness after childbirth than at any other time of their life (Dean & Kendell 1981). This is at a particularly vulnerable time for the development of the child and for the relationship between mother and child. Specialist mother and baby units can provide women with the choice to have their baby with them when an in-patient. Such specialist units also provide a safe environment within which the parenting skills of women with mental illness can be assessed and enhanced. Specialists units also act as a focus for the management of all perinatal illness including those that do not require admission and can provide expert advice to the rest of the mental health service (Oates 1996).

Mother and baby units should be present in each Health Authority area. Collaborative schemes can also provide a range of other support for mothers including foster placements for mother and baby and self help groups. The National Assembly recognises the difficulties authorities face not only in financing these expensive facilities but in providing such units and making them safe in compliance with child protection guidance. We shall work with authorities to produce a Welsh plan for these units

8.4   Other Specialist Provision

The Specialised Health Services Commission for Wales has budgetary and commissioning responsibility for forensic high secure services and is in the process of taking on this responsibility for medium secure services. It will consider the needs of those with eating disorders and traumatic head injury including provision of specialist neuro-psychiatric services. It may also consider commissioning in-patient children and adolescent services.

OBJECTIVE

More specialised services must be provided. These are:

> **– General Hospital Mental Health Services**
>
> **– Low secure services**
>
> **– Mother and Baby units**

9. COMMUNICATION BETWEEN AND WITHIN SERVICES

Adult mental health services need to have robust links and good communication with a number of other services. Mechanisms should be in place to ensure that users receive the treatment they need and do not fall in between different services. We suggest that some members of the general adult multi-disciplinary team are given particular responsibilities to link with other services.

Mental health services have also become increasingly dispersed. Communication between members of the same multi-disciplinary team and between teams has become increasingly difficult and time consuming. Use of information and communication technology will be essential if good communication is to be maintained.

9.1　Drug and alcohol misuse services

A large proportion of users with mental illness also misuse drugs or alcohol. Such individuals use more health and social services and are more likely, it seems, to commit suicide and homicide (Weaver et al 1999). It is important that there is unambiguous clinical responsibility for these individuals at all times and that they have access to the services they need. It is important for general adult services to recognise that those with alcohol and drug problems can also develop mental illnesses that require treatment. Users with a mental illness who misuse drugs or alcohol are a particular vulnerable group at high risk. The report "Safer Services" (Appleby 1999) recommended that alcohol and drug services worked much more closely with general adult mental health services.

If a user has a psychotic illness or severe mental illness then adult mental health services should be the "lead" service. Members of the mental health team should have training and advice in the management of alcohol and drug misuse. There need to be effective lines of communication and shared education and training between mental health services and alcohol and drugs misuse services. These aims should be achieved by allocation of a link worker – a member of the general adult team who develops particular expertise in alcohol and drug misuse and spends sessions working in the alcohol and drug misuse service. The link worker would also have a role providing advice and organising training for other members of the multi-disciplinary general adult mental health team and would link with the Drugs and Alcohol Team.

If this is to be successful it is essential that all areas of Wales have a properly funded alcohol and drugs misuse service. At present there are many areas of Wales that have limited access to services. Without a specialist service it is impossible for the general adult mental health service to develop appropriate expertise for those with both mental illness and drug and alcohol problems. The absence of drug and alcohol services leads to increased pressure on general adult mental health services and primary care.

The National Assembly for Wales launched its drug and alcohol strategy "Tackling Substance Misuse in Wales" in April 2000. This Strategy is intended to reinforce the aims and objectives set out in that document.

9.2 Criminal Justice System

Effective local agreements need to exist between police, probation, health and social services to provide flexible arrangements for the urgent assessment of offenders with mental health problems in prison and in courts. The development of court diversion schemes has been encouraged by financial assistance from the Home Office. This financial assistance has now ceased though the National Assembly provided one year's funding to cushion services from the suddenness of this withdrawal. At present the NHS has little incentive to divert individuals into its overburdened mental health services. Issues around the funding of diversion and the costs to the NHS need to be addressed when the proposals for the Prison Health Service are implemented. The National Assembly will ensure that this is done. The National Assembly is providing funding over the next 3 years to enable inreach teams to work with the prisons to co-ordinate care on release.

OBJECTIVE

Designated members of each CMHT must act as "link workers" and work sessions with drug and alcohol misuse services and the criminal justice system.

9.3 Child and Adolescent Mental Health Services

The Child and Adolescent Mental Health Services (CAMHS) Strategy will provide the National Assembly with a strategic framework within which to develop services. It is likely to recommend that specialised adolescent in-patient unit(s) should be commissioned as a tertiary service and this would provide an appropriate environment for 16-18 year olds with psychotic and other severe mental illnesses. Towards the upper end of this age range, depending upon the individual needs of the young person, the Child and Adolescent team may refer a case to be looked after within the general adult mental health services but on wards that are appropriate for this purpose and in circumstances where all other solutions have been considered. Adult mental health services must have in place policies regarding admission criteria.

Adult mental health services should also keep a child centred focus when considering the needs of children of adults suffering from mental illness. In the rare cases where a child may be considered at risk of harm, the primacy of childrens' needs as defined under the Children Act 1989 must be taken into account. Child protection standards for this group and for children on adult wards should be written into Trust procedures and the importance of these standards underlined to all staff.

9.4 Mental health services for the elderly

There is a great deal of variation in the criteria for admission to general adult or elderly mental health services. These are often adopted for good local reasons but clear agreements

on the criteria for admission to either service are required. These should also include services for those with pre-senile dementia and elderly persons who have had long standing mental illness. In-patient units for general adult mental health services can be unsuitable environments for some elderly people with functional illness. The publication in England of the National Service Framework on Services for Older People provides useful pointers on the links between adult services and those for the elderly mentally ill. The National Assembly will consider how to take this forward in Wales and will draw on the audit of services for the mentally ill in Wales currently being conducted by District Audit who expect to publish their report in Autumn 2001.

OBJECTIVE

To ensure that a strategy is developed in Wales for services for the elderly mentally ill, drawing on the English NSF on services for older people and on the District Audit findings.

9.5   Learning disabilities

A small but significant number of individuals suffer from both a learning disability and a mental illness. Optimal care for people in this position requires effective liaison with specialist learning disability professionals and adult mental health services. For the treatment of the mental health component of their problem they should have the right of access to the appropriate part of the adult mental health service.

OBJECTIVE

Each service in Wales should have formal protocols in place to ensure equality of access to adult mental health services based on need for people with a learning disability.

9.6   Case notes

Clinical records or case notes are an important means of communicating information between professionals. There should be a common set of records that are shared between the professionals involved. In certain circumstances it may be appropriate for individual professionals to keep their own process notes. Ideally, the in-patient, day-patient and CMHT records should also be combined though this can sometimes provide logistical problems. The notes should be readily available out of office hours to provide information for emergency assessment.

The rules of record keeping should follow the guidelines relating to individual professional practice. A high standard of record keeping is essential. The following procedures should be employed at two key stages in the system:

- **Between multi-disciplinary teams**

  When responsibility for a patient is handed over between clinical teams there needs to be a formal hand over of important information including the most recent care plan and risk

assessment. This process should be formally recorded and these written records should form part of the audit process;

- **With other organisations**

  The multi-disciplinary team needs to be able to collaborate effectively with a wide range of other agencies. Good communication takes time, and adequate clerical, administrative and IT support should make this process more efficient. Passing information to other agencies should usually only be done with the agreement of the user and under the provisions of the Data Protection Act. There will be occasions when the public interest, or the health and safety of the user or others over-rides the duty of confidentiality towards the user.

OBJECTIVE

Case notes must be shared by all professionals in order to aid communication, increase efficiency and improve the quality of care.

9.7   Information and Communication Technologies (ICT)

There is potential for using ICT to improve communication between professionals, with other agencies and with users and carers. This potential has not been exploited in mental health services in Wales. Mental health services have a pressing need to develop ICT systems because of the dispersed nature of the service and the involvement of a wide variety of agencies. ICT will be an essential element for achieving many aspects of this Strategy, including good communication. Commissioners should recognise the improved quality of care and increased efficiency that should flow from use of ICT. For example:

- electronic case records (Section 9.6);

- access to records out of hours (Section 7.7);

- access to remote records, particularly in rural areas (Section 7.7, 9.6);

- improved communication across sectors (Section 9.6);

- NHS Direct Wales and the national helpline (Section 7.7).

Many of these issues are discussed in the National Assembly's Information Management and Technology Strategic Framework for Healthcare Improvement in Wales (Better Information and Better Health, WHC (99) 55).

OBJECTIVE

Information and communication technologies (ICT) must be implemented that are used by clinicians in order to increase the efficiency of mental health services and provide ready access to important information.

10. IMPLEMENTING THE STRATEGY

10.1 Workforce

Staff in many areas of mental health services are working with growing caseloads, increasing budgetary constraints and increasing levels of activity. Many staff feel stretched and, on occasions, unable to provide the standards of care they would wish.

The quality of care provided by mental health services relies upon the recruitment of the right type of people with the necessary personal qualities, attitudes and beliefs. These people require high quality training to ensure skill development and to support a process of lifelong learning.

It is essential that staff feel valued in order to maintain morale and ensure quality of care. To achieve this, staff across all agencies should have:

- clear job descriptions and job profiles;

- personal and professional development plans;

- adequately resourced training budgets;

- access to courses which respond to the needs of the service and lead to post-basic qualifications;

- regular supervision and professional support provided within a constructive problem solving environment rather than pursuing a culture of blame;

- mandatory training in essential areas i.e. health and safety, risk management, mental health legislation and child protection;

- the reassurance that ensuring staff safety is an important management priority.

The increasing integration of agencies and the growing involvement of users and carers brings together a diverse range of individuals with a variety of knowledge, expertise and experience. This will provide opportunities for joint training which must be fully exploited. Primary health care professionals could also become involved in such joint training initiatives.

All agencies should give urgent consideration to the issue of efficient workforce planning taking into consideration areas of actual and potential shortage e.g. psychiatry, nursing, psychology and therapy staff. Support staff who are committed to the service and show aptitude should be encouraged and supported to undertake professional training.

OBJECTIVE

All staff must have job descriptions, job profiles and personal and professional development plans.

Workloads must be regularly reviewed to ensure that staff are not overburdened.

The workforce must be planned to ensure that there are sufficient staff for the tasks required including time for training, education and supervision.

10.2 Training, Supervision and Education

Providing a high quality mental health service requires individuals who have been well trained and are kept up to date with new developments. In addition, all health professionals need regular clinical supervision and some professions have to fulfil mandatory requirements for ongoing education. In most settings and for most staff this does not occur to an adequate level. Staff in the voluntary sector also need to have an appropriate level of training. Key areas which a training programme needs to address include;

- user and family/carer education in diagnosis, symptoms and treatments;

- medication management and compliance;

- cognitive behavioural and other psychosocial interventions for psychoses, anxiety and mood disorders;

- relapse prevention and coping mechanism enhancement;

- identifying social networks and support;

- health promotion and education;

- problem solving skills;

- how to provide a range of ward based therapeutic activity groups for the more severely or acutely unwell.

OBJECTIVE

All staff in both the statutory and independent sector and at all grades and in all professions must have time allocated for regular training and supervision.

All staff in all settings, including the independent sector, must be given relevant training and supervision in the important aspects of their work.

All parts of the service must have a commitment to continuing professional development for all staff.

Relevant courses must be developed for all staff in mental health services, including those employed in the independent sector.

10.3 Research

Much research has been carried out on mental health issues but there is a need for more research and the dissemination and application of research findings. If Wales is to develop mental health services of the highest quality it will also need to have high quality research

including projects with practical implications for mental health services. Wales cannot always rely upon research carried out in other settings, although of course much of this will be directly relevant and should be utilised. Encouraging research in Wales will also help to develop a culture of evidence based practice and will aid recruitment and retention of staff. At present much mental illness research is dominated by psychiatrists. We will also need health, social care and social science research carried out by other professionals, as well as user led research. This will better answer questions of relevance to their needs.

The National Assembly accepts the Advisory Group's view that the Assembly should make research in this field a priority with the emphasis on projects which are likely to have a practical application in mental health services. It needs to be stressed, however, that this will not free us from the need to compete with other subject areas for limited resources. Responsibility for the dissemination of research findings should be the responsibility of the Assembly's enhanced Mental Health Development Group.

The Advisory Group identified the following research priorities.

- Stigma;

- Needs Assessment;

- Emergency and Out of Hours Care;

- Primary Care;

- User led research and research into the validity of quality of life measures;

- Research on the prevention of mental illness.

The consultation responses suggested that there was a need to undertake research into medicines management and concordance to find ways of improving patients' concordance with medication regimes. The National Assembly will consider the extent of current knowledge, and the scope for commissioning further research, in these areas.

10.4 Information on Mental Health Services

At present the information needed to describe the available services in Wales is not available. This is especially so for community based services. The National Assembly will need better information than that currently available if it is to plan, monitor and evaluate the progress of this Strategy and the National Service Framework for Wales. The Assembly is developing a performance management framework and linked information system. These systems should ensure that the NHS and local authorities can provide the Assembly and the Welsh public with a range of useful information about community resources and the level of activity associated with them. This information is needed in conjunction with a publicly available and intelligible account of NHS and local government expenditure on mental health services.

There is a widespread impression that mental health services are underfunded. There are also grave suspicions that mental health budgets are tempting targets for hard pressed

authorities to raid for other purposes. A transparent accounting system should be able to demonstrate each statutory agency's spend on mental health so that trends can be identified and any disinvestment tackled.

OBJECTIVE

There must be central monitoring of spending on mental health services in all health authorities and local authorities.

10.5 National Service Framework

The National Assembly plans to issue a National Service Framework for Wales. The English NSF provides a very useful base from which to work and we expect many standards to be identical in both countries. It is right, though that a National Service Framework for Wales (NSFW) should differ in some important respects from the English document as there are distinctive differences in emphasis that reflect particular circumstances in Wales. The standards set will be at least as good as those set for England.

The NSFW will provide more detail on the implementation of the strategic framework outlined here, together with more explicit methods for assessing progress and improvement in services.

10.6 Financial resources

The Advisory Group made clear their view that substantial, sustained additional investment was necessary if the ten year plan set out in the Strategy was to be achieved. The National Assembly accepts this and has already allocated additional sums to mental health as a signal of its intent to implement this Strategy. Specifically, in 2000/01 and 2001/02 it allocated

- £7m capital to begin re-provision of modern facilities to replace St David's Carmarthen

- £4m capital to allow closure of Sully Hospital and re-provision elsewhere

- £15.2m capital to fund new unit at Royal Glamorgan to end the isolation of mental health unit on old East Glamorgan site

- £ 1.1m transitional funding to help pay for continuing care for those people re-located from the now closed Mid Wales hospital

- £578,000 transitional funding to enable first re-provision from St David's

- £1.7m to enable continued upgrading at Whitchurch to accommodate ex-Sully patients

- £1m to fund projects aimed at taking forward the aims of this Strategy

- £3m to fund mental health voluntary sector organisations

We accept that additional funding will need to take place to achieve all the objectives listed in the Strategy and bids for additional funding will be made as appropriate through the National Assembly budgetary process. As mentioned earlier, we should not lose sight of the fact that mental health spending by Health Authorities in Wales runs at £220m and we must ensure that the most effective use possible is made of this existing provision as well as looking for additional funding. ***In particular, the increased flexibilities on joint budgets and commissioning should be exploited imaginatively by mental health services.***

10.7 Strategy Implementation Group

The National Assembly is determined that this Strategy shall be a working document against which services are assessed, monitored and judged. To ensure that this happens, we shall set up as a matter of urgency, an Implementation Group with representation from all sectors to work closely with officials to oversee implementation and to report regularly to Ministers on progress across Wales. We expect all services to co-operate fully with the Implementation Group in this concerted effort to raise standards and reduce inequity. The consulation paper "Structural Change in the NHS in Wales" envisages a particular role for the Implementaion Group in deciding upon the best system of commissioning mental health services and that will be one of its first major tasks.

EXECUTIVE SUMMARY

BACKGROUND

- Mental illness is common and disabling. It is a public health priority

- There are many effective health and social care interventions that improve outcome in mental illness

- There is now an opportunity to invest in better mental health services in Wales that will in turn lead to an improvement in the quality of life for users and carers

- The current Strategy builds upon the 1989 Welsh Mental Health Strategy and is designed to produce the policy context for drawing up the National Service Framework for Mental Health Services in Wales

- It aims to assist mental health services to improve the quality of life of those with mental illness and to enhance participation and inclusion of service users in the life of the community

- Secondary mental health services are expected to give priority to the severely mentally ill. However, they should avoid the danger of providing a psychosis only service in order to ensure a wide range of skills and to provide a service to primary care.

PRINCIPLES

Four principles underpin the whole Strategy. They apply to everything in the document and can act as a guide for everyone involved in planning, commissioning, managing, using and working in mental health services.

Equity

Mental health services should be available to all and allocated according to individual need, irrespective of where someone lives, their ethnic origin, gender, culture, religion or sexuality or any physical disability. Access to mental health services should not be restricted because of other existing health problems. There should be an end to unacceptable geographical variations in standards of care.

Empowerment

Users and their carers need to be integrally involved in the planning, development and delivery and evaluation of mental health services. This will require sustained support, care and information from mental health services. Empowerment should be at all levels, from encouraging self-management to formal involvement in local and all-Wales planning. Informed choice for all users is central to this principle. Those detained under Mental Health legislation should be encouraged to participate actively and willingly in their care. There is a particular need to reduce

the stigma which surrounds mental illness both within mental health services and the wider community.

Effectiveness

Mental health services should provide effective interventions that improve quality of life by treating symptoms and their causes, preventing deterioration, reducing potential harm and assisting rehabilitation. Within the NHS, clinical governance provides a mechanism to ensure that matters of effectiveness and quality are central. Many social and environmental interventions will be subject to Best Value and performance management considerations. The minimum care standards to be introduced under the Care Standards Act 2000 will provide important quality frameworks. The growing importance of 'Quality of Life' measures in determining effectiveness is also reflected in this Strategy. Services need to be accountable for the quality of service provided.

Efficiency

Mental health services must use resources efficiently and be accountable for the way public money is spent. There should be efficient inter-agency working especially between health, social services, other local government agencies, voluntary agencies and the private sector to achieve Best Value. Opportunities for joint working and use of information and communication technologies should be exploited in order to increase efficiency.

AIMS AND OBJECTIVES

The aim of this Strategy is to set the agenda for mental health services in Wales over the next decade. It is intended to lead to services that improve the quality of life of those experiencing or recovering from mental illness. The concept of community care is at the heart of this document, but community care is more than an alternative to hospital. People with mental illness are amongst the most vulnerable and socially excluded groups in our society. Mental health services are about enabling and empowering users so that they can take an active part in the community and to allow their full potential to be realised. All the elements of a mental health service need to work together to enhance participation and inclusion of service users in the life of the community.

In particular this document is designed to provide a framework for mental health services that have the following aims and objectives. After each objective the number in parenthesis refers to the relevant section of the Strategy document:

AIM 1 -

To educate the public about the effective treatments of mental illness in order to develop positive attitudes and reduce stigma. To incorporate mental health into the wider health, well-being and social agenda. To ensure good mental health promotion is at the heart of our approach to services.

OBJECTIVES

Wales must have a public education strategy to inform about mental illness and the availability of services. (4.6)

Research must be commissioned to investigate the causes of stigma and suggest action that would reduce stigma and social exclusion. (4.7)

AIM 2 -

To provide equitable access to mental health services for all the people of Wales, irrespective of where they live, their age, gender, sexuality, disability, race, ethnicity or their social, cultural and religious background.

OBJECTIVES

The distribution of resources must be based upon an epidemiological approach to needs assessments. (5.1)

Research must be commissioned to investigate the geographical variation in need throughout Wales. (5.1)

To consider the implications of the Older Persons National Service Framework on mental health services for the elderly. (9.4)

Each service in Wales should have formal protocols in place to ensure equality of access to adult mental health services based on need for people with a learning disability. (9.5)

There must be central monitoring of spending on mental health services in all health authorities and local authorities. (10.4)

The National Assembly will issue revised guidance on planning and commissioning of mental health services once the wider re-organisation has been finalised. (5.2)

Mental health service users and their carers must be able to communicate in their language of choice. (3.3)

AIM 3 -

To include users and carers in the planning, commissioning and delivery of services and take account of individual preferences and lifestyles.

OBJECTIVES

Users and carers must be constructively involved at all levels of mental health services: Welsh Assembly, Health Authority, LHG/Unitary Authority, Trust, unit and sector team. (5.5)

Advocacy services must be available throughout Wales for all patients who require them. (7.10)

Accessible and intelligible information must be provided to users and carers at a national and local level. (6.7)

This Strategy is designed to help people with a mental health problem to manage their lives with the greatest degree of normality. (6.3)

AIM 4 -

To ensure close co-operation between social services, health authorities and the voluntary and private sectors in order to commission effective, comprehensive and co-ordinated mental health services.

OBJECTIVES

Every Health Improvement Programme (HIP) and Social Services Social Care Plan must include a mental health plan. (5.2)

The Health Act flexibilities must be used imaginatively to increase opportunities for joint commissioning and operation of services. (5.3)

The voluntary sector must be included as partners in the provision of mental health services. (5.4)

Voluntary sector organisations must recognise the legal constraints and responsibilities of the statutory sector. (5.4)

Every area must have a comprehensive range of services including voluntary sector provision. (5.4)

Self help strategies and evidence based local complementary therapies must be recognised and supported by services. (6.8)

AIM 5 -

Provide support which will enhance the ability to cope, with the individual remaining in control of their lives and to facilitate integration of mental health service users in all aspects of community life.

OBJECTIVES

A range of housing with varying degrees of support must be commissioned in collaboration with the independent sector and other partners. (7.9)

A range of employment and training opportunities must be facilitated in collaboration with the statutory and voluntary sector and involving private sector businesses. (7.8)

Each local authority Health and Well Being Plan must include proposals to encourage mental health service users to use local educational, social and leisure amenities and each authority must ensure that its housing policy takes full account of the needs and rights of those suffering from mental illness. (4.4)

Assist the provision of suitable accommodation to facilitate integration into communities. (7.9)

AIM 6 -

To assess the medical, psychological and social needs of service users and carers at an appropriate time and with reviews at regular intervals.

OBJECTIVES

Written care plans, with copies given to the user and carer must be provided for all users with complex or enduring needs and offered to all users. (6.4)

Care plans must be drawn up in collaboration with users and carers and must be regularly reviewed. (6.4)

For those with more complex or enduring needs, care plans must be based upon a multidisciplinary assessment. (6.4)

Mechanisms must be in place that ensure that those with more complex and enduring needs stay in contact with services. (6.5)

Response times for urgent assessments must be locally agreed and monitored. (6.4)

Carers must be offered an assessment of their needs. (6.4)

Services need to develop an approach that responds more effectively to the needs of users and carers. Different professionals need to come together as a team. They need to understand the total context in which mental health problems arise and manage the often complex problems in that context. (6.3)

Discharge plans must ensure that all users are provided with suitable support and follow-up after in-patient admission. (7.3)

Care plans will include formal assessment, and where appropriate interventions of the needs of dependent children of service users. If appropriate, support needs of young carers must also be addressed. (6.9)

AIM 7 -

To provide effective and high quality care based on the best evidence and including provision for the medical, psychological and social needs of service users and carers.

OBJECTIVES

All those involved in mental health services must be aware of the latest evidence on effectiveness relevant to their own work. (6.1)

Clinical governance and Best Value mechanisms must be in place so that matters of effectiveness and quality are given high priority in mental health services. (6.2)

Effective psychological treatments must be available within primary care. (7.1)

A comprehensive range of rehabilitation services should be available throughout Wales. (7.11)

Staff must be provided with support and training to develop a therapeutic environment on in-patient units. (7.5)

More specialised services must be provided. These are:

- **– General Hospital Mental Health Services (8.1)**

- **– Low secure services (8.2)**

- **– Mother and Baby units (8.3)**

A comprehensive, evidence based range of psychological treatment services must be available across Wales. (7.12)

AIM 8 -

To provide mental health services in settings that are fit for purpose providing dignity and privacy.

OBJECTIVES

In-patient units in Wales must all provide satisfactory physical accommodation. (7.5)

Women must have the choice of a women only environment on in-patient wards. (7.5)

The physical accommodation of CMHTs and other parts of the mental health service must be fit for purpose, have sufficient space and be in accessible locations. (7.4)

AIM 9 -

Protect users, carers and the public from avoidable harm while respecting the rights of users and their carers.

OBJECTIVES

All users must receive a structured assessment of the risk of self-harm, potential harm to others and of vulnerability to exploitation. (6.6)

Case notes must be available readily 24 hrs a day. (7.7)

Information technology must be used to improve the availability of important information. (7.7)

Information on how to access services in a crisis must be widely publicised. (7.7)

AIM 10 -

To ensure good communication and co-ordination between different part of the mental health service in order to provide efficient, responsive and seemless care.

OBJECTIVES

There must be effective communication between primary and secondary care. (7.2)

There must be agreed guidelines on management and referral between primary and secondary care. (7.2)

Sectors must provide seamless care for users irrespective of whether they are in-patients, attend the community mental health team (CMHT) or attend day services. (7.3)

Designated members of each CMHT should act as "link workers" and work sessions with drug and alcohol misuse services and the criminal justice system. (9.2)

CMHTs must be developed and if necessary expanded to meet local needs in line with this Strategy to ensure appropriate caseload size and links with specialist services. (7.4)

Inter-agency co-operation and good joint working needs to be safeguarded during this period of change. (5.2)

Case notes must be shared by all professionals in order to aid communication, increase efficiency and improve the quality of care. (9.6)

Effective information must be available to meet the needs of GPs/Primary Health Care Teams and users and carers. (7.1)

Information and communication technologies (ICT) must be implemented that are used by clinicians in order to increase the efficiency of mental health services and provide ready access to important information. (9.7)

AIM 11 -

To recruit and retain highly trained staff of all disciplines who are confident of their skills and have high morale.

OBJECTIVES

All staff in both the statutory and independent sector and at all grades and in all professions must have time allocated for regular training and supervision. (10.2)

All staff must have job descriptions, job profiles and personal and professional development plans. (10.1)

Workloads must be regularly reviewed to ensure that staff are not overburdened. (10.1)

All staff in all settings, including the independent sector, must be given relevant training and supervision in the important aspects of their work. (10.2)

All parts of the service must have a commitment to continuing professional development for all staff. (10.2)

Primary health care teams must receive training and education in managing mental illness within primary care. (7.1)

The workforce must be planned to ensure that there are sufficient staff for the treatment and care required including time for training, education and supervision. (10.1)

Relevant courses must be developed for all staff in mental health services, including those employed in the independent sector. (10.2)

IMPLEMENTATION

- An enhanced Welsh Assembly Mental Health Development Group will be formed to oversee the implementation of the Strategy and National Service Framework for Wales.

- Routine information on mental health services in Wales is limited. Better information will be needed to monitor the progress of this Strategy.

- Research on mental health services needs to be commissioned in Wales to inform future developments. The Advisory Group identified a number of research priorities.

- Investment in staff and training will be an essential element of improving mental health services.

- There are a number of gaps in existing provision for mental health services. Additional financial resources will be needed if the Strategy is to be fully implemented.

- The National Service Framework for Wales will provide additional details on the implementation of this Strategy and provide standards for mental health services.

REFERENCES

The Cochrane Collaboration (2000) The Cochrane Library. Oxford (www.update-software.co.uk): Update Software.

Appleby, L. (1999) Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London: The Stationery Office.

Audit Commission (1998) Home Alone: The Role of Housing in Community Care. Audit Commission publications.

Burns, T., Creed, F., Fahy, T., et al (1999) A randomised controlled trial of intensive versus standard case management for severe psychotic illness. UK700 Group. The Lancet, 353, 2185-2189.

Dean, C. and Kendell, R. E. (1981) The symptomatology of puerperal illnesses. British Journal of Psychiatry, 139, 128-133.

Department of Health and Welsh Office (1999) Mental Health Act Code of Practice . Third Edition. London: The Stationery Office.

Department of Health (1995) Building Bridges .

Department of Health (2000) Effective Care Co-ordination in Mental Health Services, Modernising The Care Programme Approach.

Dunn, S. (1999) Creating Accepting Communities – Report of the MIND Inquiry into social exclusion and mental health problems. London: MIND.

Evidence-Based Medicine Working Group (1992) Evidence-based medicine. A new approach to teaching the practice of medicine. Journal of the American Medical Association, 268, 2420-2425.

Falcov (1996) Working Together Part 8 Reports Fatal Child Abuse and Parental Psychiatric Disorder. Department of Health.

Gill, B; Meltzer, H. Hinds; K. Petticrew; M. (1996) Psychiatric Morbidity among Homeless People. OPCS Surveys of Psychiatric Morbidity. Report 7. London: HMSO.

Goldberg, D., Huxley, P. (1992) Common Mental Disorders: a Biopsychosocial Approach. Routledge: London.

Hawton, K. and Fagg, J. (1988) Suicide, and other causes of death following attempted suicide. British Journal of Psychiatry, 152, 359-366.

Health Education Authority (1997) Mental Health Promotion: A Quality Framework. London.

Hodgson, R. and Abbasi, T. (1995) Effective Mental Health Promotion: Literature Review. 13. Cardiff, Health Promotion Wales. Health Promotion Wales Technical Report.

Jenkins, R., Lewis, G, Bebbington, P, et al (1997) The National Psychiatric Morbidity Surveys of Great Britain: Initial findings from the Household Survey. Psychological Medicine, 27, 775-790.

Johnson, S. and Thornicroft, G. (1993) The sectorisation of psychiatric services in England and Wales. Social Psychiatry and Psychiatric Epidemiology, 28, 45-47.

Joy CB, Adams, CE, Rice, K (2000) Crisis intervention for severe mental illness. The Cochrane Library. Oxford: Update Software (www.update-software.com).

Lewis, G., Hawton, K., and Jones, P. (1997) Strategies for preventing suicide. British Journal of Psychiatry, 171, 351-354.

Lewis, G. (1999) Population based needs assessment. Current Opinion in Psychiatry, 12, 191-194.

Murray, C. J. and Lopez, A. D. (1997) Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. Lancet, 349, 1498-1504.

Munro, E. and Rumgay, J. (2000) Role of risk assessment in reducing homicides by people with mental illness. British Journal of Psychiatry, 176, 116-120.

National Assembly for Wales (2001) Better Homes for People in Wales: The National Assembly's proposals for a National Housing Strategy.

National Assembly for Wales (2000) In Safe Hands – Protection of Vulnerable Adults in Wales.

NHS Centre for Reviews and Dissemination (2001) Scoping Review of the Effectiveness of Mental Health Services. University of York.

Oates, M. (1996) Postnatal mental illness: organisation and function of services. In Parental Psychiatric Disorder (eds M. Gopfert, J. Webster, & M.V. Seeman), Cambridge.

Parry, G., Richardson, A. (1996) The review of strategic policy on NHS Psychotherapy Services in England (Main Document). London: Dept of Health.

Report of the Royal College of Physicians and the Royal College of Psychiatrists (1995) The psychological care of medical patients: recognition of need and service provision. London: Royal College of Physicians.

Roth, A., Fonagy, P. (1996) What works for whom? A critical review of psychotherapy research. New York: Guildford Press.

Royal College of Psychiatrists (1996) Assessment and clinical management of risk of harm to other people. Council Report CR 53. London: Royal College of Psychiatrists.

Standing Nursing and Midwifery Advisory Committee. SNMAC (1999a) Mental Health Nursing: Addressing Acute Concerns.

Standing Nursing and Midwifery Advisory Committee. SNMAC (1999b) Practice Guidance: Safe and Supportive Observation of Patients at Risk.

Stevens, A., Raftery, J. (1994) Introduction. In Health Care Needs Assessment, the epidemiologically based needs assessment reviews. Vol. 1 pp. 1–30. Oxford.

Taylor, P. J. and Gunn, J. **(1999)** Homicides by people with mental illness: myth and reality. British Journal of Psychiatry, 174, 9–14.

Weaver, T., Renton, A., Stimson, G., et al (1999) Severe mental illness and substance misuse. British Medical Journal, 318, 137–138.

Welsh Office (1989) Mental Illness Services: A strategy for Wales. Cardiff: Welsh Office.

Welsh Office (1996) Guidance on the Care of People in the Community with a Mental Illness. Cardiff: Welsh Office.

Welsh Office (1998a) Better Health, Better Wales. London: The Stationery Office.

Welsh Office (1998b) Health Evidence Bulletins – Wales: Mental Health. Cardiff: Welsh Office.

Welsh Office (1998c) Quality Care and Clinical Excellence Cardiff: Welsh Office.

Welsh Office (1999) Partnerships for Improvement: The Next Steps. Cardiff: Welsh Office.

Welsh Office (2000) Statistical Report SDB26/99. Cardiff: Welsh Office.

Membership of the Adult Mental Health Review Advisory Group

Professor Glyn Lewis
Advisory Group Chair

Dewi Evans   CSW DMA
Social Services representative

Daphne James
Head of Mental Health Nursing
North Glamorgan NHS Trust

Philip Mallorie
Chairperson,
All Wales User and Survivor Network

Neil S Davies
Consultant Psychiatrist
Conwy and Denbighshire NHS Trust

Dr Quentin Sandifer
Director of Iechyd Morgannwg Health

Dr Peter Higson
Director of Patient Care
North Wales Health Authority

Clive Micklewright
Community Mental Health Team Leader
Llandrindod Wells

Martin Herbert
Head of Psychology Services
Clinical Psychology Department
Rhondda Cynon Taff

Lindsay Foyster
Director
Wales MIND

Christine Court
Chairperson
All Wales Health Care
Professionals Committee

Barry-Topping Morris
Head of Forensic Nursing
Caswell Clinic

Jeff Champney Smith
Nurse Lecturer Practitioner
Cardiff and Vale NHS Trust/University of
Wales College of Medicine

Stuart Fletcher
Chief Executive
Pembrokeshire and Derwen NHS Trust

Dr Huw Lloyd
Colwyn Bay

Bill Walden-Jones
Director
NSF Cymru

Micheal O'Leary
Director of Social Services
Bleanau Gwent CBC

Lynda Bransbury
Welsh Local Government Association

September