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Research to support the Duty to Review the Implementation of the Mental Health (Wales) Measure 2010

Qualitative evidence on the views of service
users, carers and practitioners

FINAL REPORT: Summary



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Opinion Research Services

Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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At all stages of the project, ORS' status as an independent organisation engaging with service users, their carers and practitioners as objectively as possible was recognised and respected. We are grateful for the commission, and we hope this report will contribute usefully to thinking around the implementation of the Mental Health (Wales) Measure 2010 and will ultimately contribute to improvements in services for people living with mental health problems in Wales.

1 Introduction

- 1.1 Opinion Research Services (ORS) was commissioned by Welsh Government in June 2013 to undertake qualitative research to support the Duty to Review the Mental Health (Wales) Measure 2010.
- 1.2 Information and data were gathered by Welsh Government from a range of sources to inform the Review including this study, regular submissions from health board/local authority services, health board primary care satisfaction surveys and third sector surveys. Welsh Government was responsible for coordinating all inputs to the Review and for final reporting to Welsh Ministers.
- 1.3 This study by ORS provides qualitative evidence on the views of service users, their carers and practitioners on the implementation of Parts 1 to 4 of the Measure. The findings are presented in four separate reports; one for each part of the Measure and this overall summary report in Welsh and English versions.
- 1.4 An interim report¹ published in 2014 presents the background and methodology for this study in some detail.

Background

- 1.5 The Mental Health (Wales) Measure 2010 introduced a number of changes relating to the assessment of and treatment of people with mental health problems in Wales, the essential requirements of which are set out in four parts:
Part 1: Local Primary Mental Health Support Services
Part 2: Coordination of and Care and Treatment Planning for Secondary Mental Health Users
Part 3: Assessments of Former Users of Secondary Mental Health Services
Part 4: Mental Health Advocacy

¹ <http://gov.wales/docs/caecd/research/2014/140410-support-duty-review-implementation-mental-health-wales-measure-2010-en.pdf>

Part 1: Local Primary Mental Health Support Services

1.6 The aim of Part 1 was to strengthen the role of primary care by establishing local primary mental health support services (LPMHSS) throughout Wales for people of all ages who were experiencing mild to moderate, or stable severe and enduring mental health problems. These services were to be delivered by partnerships of health boards and local authorities and to operate within or alongside GP services. In brief, these services were to provide:

- Comprehensive mental health assessments
- Treatment by way of short-term interventions
- Provision of information and advice to individuals and carers about treatment and care and 'signposting' to other sources of support
- Provision of support and advice to GPs and other primary care workers
- Supporting the onward referral and coordination of next steps with secondary mental health services.

1.7 The statutory duties around Part 1 commenced on 1 October 2012.

Part 2: Coordination of and Care and Treatment Planning for Secondary Mental Health Users

1.8 This part of the Measure requires that care and treatment plans (CTPs) be provided for service users of all ages who have been assessed as requiring care and treatment within secondary mental health services. In brief, care and treatment plans were to:

- be developed by a care coordinator in consultation with the service user and mental health service providers;
- be in writing;
- record the outcomes that the provision of mental health services for the patient are designed to achieve;
- list these outcomes, record the services and/or actions to achieve the outcomes; and
- be reviewed and updated to reflect any changes in the type

of care and treatment which may be required over time.

- 1.9 Underpinning CTP is the concept of 'recovery' and the guiding principle is a belief that it is possible for each individual to achieve goals that enable them to live a fulfilling life despite serious mental illness.
- 1.10 Full assessments would need to consider the following eight aspects of a service user's life:
- a. Finance and money
 - b. Accommodation
 - c. Personal care and physical well-being
 - d. Education and training
 - e. Work and occupation
 - f. Parenting or caring relationships
 - g. Social, cultural or spiritual
 - h. Medical and other forms of treatment including psychological interventions.
- 1.11 Statutory duties around Part 2 commenced on 6 June 2012.

Part 3: Assessments of Former Users of Secondary Mental Health Services

- 1.12 'Part 3 of the Measure is concerned with assessments of former users of secondary mental health services. The aim is to enable individuals, who have previously been in receipt of secondary mental health services to refer themselves directly back to secondary services for assessment. This allows assessments to take place without individuals necessarily needing to go to their GP or elsewhere for a referral, therefore improving access'².
- 1.13 Statutory duties around Part 3 commenced on 6 June 2012.

Part 4: Mental Health Advocacy

- 1.14 This Part of the Measure introduced an expanded statutory scheme of independent mental health advocacy (IMHA) for patients subject to compulsion under sections 4 and 5(2) and 5(4)

² Source: Welsh Government, Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010

of the Mental Health Act 1983. In addition, Part 4 of the Measure expanded the IMHA service to individuals receiving care and treatment in hospital for a mental health problem who were not detained under the Mental Health Act 1983 but were voluntary (or informal) patients. The advocacy aims to assist inpatients in making informed decisions about their care and treatment and to support them in getting their voices heard.

- 1.1 Statutory duties around Part 4 commenced on 3 January 2012 for compulsory patients and on 2 April 2012 for informal patients.

ORS Role and Commission

- 1.2 Welsh Government identified their requirements of the qualitative research in relation to each of the four parts of the Measure through a series of clear instructions or questions which appear as subheadings within the 'Findings' section of this report.
- 1.3 The qualitative work with participants began once it had been established that the project was an evaluation (and therefore not subject to full ethical review) and once the seven Health Boards had given their permissions to proceed.
- 1.4 All ORS staff involved in the project were fully trained in the principles of medical and social research ethics and, in particular: potential participants' rights to clear and full information about the study; the importance of informed consent; the right to withdraw from participation at any time and recognition that potential harm to subjects takes many forms, including inconvenience and emotional stress. Each participant was required to read full information about the project and to sign a consent form before taking part.
- 1.5 The Government Social Research Ethics Checklist was completed and guided the project throughout.
- 1.6 Our methodology encompassed focus groups and individual face to face and telephone interviews with service users and carers across all parts of the Measure. The numbers involved throughout Wales were as follows:
 - Part 1: 38 service users; 2 carers

- Part 2: 60 service users; 39 carers
 - Part 3: 29 service users; 2 carers
 - Part 4: 14 service users; 2 carers
- 1.7 Focus groups and interviews were also conducted with 70 mental health practitioners from the statutory sector; 40 practitioners from the third sector and 36 staff from nine GP practices across Wales.
- 1.8 ORS encouraged participants to engage with the issues and express their opinions and feelings in their own words.
- 1.9 Although qualitative approaches cannot be certified as statistically representative samples of public opinion, the meetings and interviews reported here gave diverse groups of people the opportunity to be involved. Because the recruitment was inclusive and participants were diverse we are satisfied that the outcomes are broadly indicative of opinion based on direct personal experience. The outcomes reported here are, therefore, reliable as examples of the reflections and opinions of a range of informed people on the implementation of the changes introduced by the Mental Health Measure.
- 1.10 The following chapters draw upon the focus groups and interviews conducted with service users and their carers, with mental health practitioners and with GPs and their practice staff. The summary findings under each of the specific review questions are presented in turn in each chapter. Readers are advised to read the full Final Reports for each Part of the Measure for full commentary.

2 Part 1: Local Primary Mental Health Support Service

Review Question 1: Information, advice and assistance to primary care providers.

Assess the extent to which information, advice and other assistance to primary care providers is provided for the purpose of improving the services related to mental health which they provide or arrange as required under section 5 of the Measure.

- 2.1 Health Boards and LPMHSS staff had been raising awareness of the service amongst primary care practices through regular contact with individual GPs and by delivering printed information and presentations. GPs stated that day to day interactions with LPMHSS staff about individual patient cases was the main way they had gained understanding about mental health from the service; none of the GPs involved in this study had received any formal learning from the service. Some GPs said that the LPMHSS had increased their knowledge about third sector options for patients.

Review Question 2: Assess the satisfaction of primary care providers with this information, advice and other assistance.

- 2.2 Most of our GP practice participants said that the main way in which the LPMHSS was increasing understanding of mental health was through discussions with practice staff over individual patient cases. This was easiest where a member of the LPMHSS team was based for at least one day a week in the practice and/or where formal case meetings were held. However, most of them said they had hoped to learn more about how to manage patients with mental illness: to have the ability to retain patients; reduce the number of referrals and treat patients without prescribing.
- 2.3 GPs said that they would like feedback from the LPMHSS on:
- The number of patients that were seen and waiting times;

- The type of patients that were seen by age and disability, for example;
 - How the LPMHSS supported their patients;
 - Their own referrals and how they could improve them; and
 - The performance of LPMHSS more generally.
- 2.4 Many of the GPs in this study remained unaware or confused about the role of the LPMHSS or were uninterested in mental health and resistant to working with the service.
- 2.5 Some of the GPs said they would appreciate knowing more about third sector organisations - and, in particular, the effectiveness of local organisations - to build confidence in signposting to them.

Review Question 3: Assess the satisfaction of primary care providers with the local primary mental health support service overall.

- 2.6 It is not possible from the findings to make a simple statement concerning satisfaction with the LPMHSS overall. However, it is clear that it is good in parts; that progress is being made; but that there is some way to go to ensure that patients and their GPs are fully benefiting from the service. By and large the picture is that the LPMHSS teams are working hard to deliver a service which they and GPs consider to be underresourced for the existing demand. The following findings illustrate these points.
- 2.7 Some practitioners said that fewer cases were 'bouncing back' from CMHTs either because the LPMHSS provided another option or because it was helping to make sure that GP referrals were directed appropriately. However, some problems in accessing services persisted.
- 2.8 Some GPs said that since the Measure their patients had found it easier to access support for mental illness whilst others had seen little change, particularly in areas where primary mental health provision was in place before the Measure. A number of them would prefer the LPMHSS to take on more of their cases and some

- GPs said they were retaining all but the most serious cases or signposting to the voluntary sector to limit pressure on the service.
- 2.9 A range of pathways into primary care services was highlighted across Wales for certain groups including older people, young people and people with learning disabilities or other special needs. Some practitioners also believed that certain groups were missing out on LPMHSS including adults with autism and people living with OCD, severe anxiety disorders, learning disabilities or dementia, and carers.
- 2.10 Waiting times for assessment varied: some practitioners said their patients were seen quickly whilst others were aware that the guideline of 28 days was being breached. Telephone assessments were considered to be one way of increasing throughput although opinions varied on their suitability. LPMHSS staff frequently said that assessments in themselves could provide therapeutic benefits.
- 2.11 LPMHSS practitioners and a few GPs highlighted significant benefits arising from the therapeutic interventions provided by the LPMHSS including drops in the number of GP appointments, levels of prescribing and referrals to psychiatric care. Some GPs highlighted the timely responsiveness of the service and the benefits for their patients.
- 2.12 However, most GPs interviewed felt that the service was falling short of their expectations and complained that the LPMHSS either signposted patients or offered nothing at all. Where therapeutic interventions were provided, some criticised the limited time offer.
- 2.13 Physical access, agoraphobia, social anxiety and deprivation were considered to act as barriers to therapy by the service, and interventions based in local communities or via the telephone were suggested along with more group therapy sessions at times to suit working people and students.
- 2.14 Differing experiences of professional relationships between GPs and the LPMHSS were highlighted in the study. Whilst there were some examples of best practice, GPs and the service needed to establish more positive working procedures in many practices.

2.15 Underlying all of the issues and concerns was the capacity of the LPMHSS to deal with the volume of cases being referred to them; the resources at hand to address this level of need and the impacts of this pressure upon LPMHSS staff. Practitioners said that staff shortages; the restrictions upon the staff eligible to undertake assessments and staff sickness had compounded staffing problems in some areas. However, these pressures had led to new thinking by health boards, including open access group therapeutic interventions at Tier 0.

Review Question 4: Information and advice to patients and carers

Assess the extent to which information and advice about the services available to them as required under section 5 of the Measure is provided to patients and their carers.

- 2.16 Most Part 1 service user participants became aware of the LPMHSS via their GPs and a few via referral from their CMHT or through their involvement with third sector organisations.
- 2.17 Service users and staff highlighted the medication and self-help wellbeing advice offered by the LPMHSS, whether to help people during their waits for interventions or to support them in life in the longer term. Printed materials and websites were also recommended to some.
- 2.18 Some service user participants received signposting information from the LPMHSS.

Review Question 5: Assess the satisfaction of patients and their carers with this information and advice.

- 2.19 In general, participants were disappointed that information about the LPMHSS was difficult to find and not made available in GP surgeries. Finding out about the service for some was down to chance or via third sector contacts.

- 2.20 Relatively few participants in this study stated their satisfaction or otherwise with the information or advice offered by the service and the findings below should be understood with this in mind.
- 2.21 A few service user participants appreciated the signposting advice they received from the LPMHSS about third sector organisations especially where it led to satisfactory outcomes. However, more participants suggested that the statutory sector should keep up to date with organisational changes in the voluntary sector to improve their signposting and a few others would have liked the service to actively help them in their searches and highlighted the difficulties of doing this for themselves when feeling unwell.
- 2.22 When support materials were suggested or provided as part of therapy, these were generally found to be helpful. However, participants were relatively unsatisfied with the service when such information was not given to them at all or when it was all they received from the LPMHSS.

Review Question 6: Assess the satisfaction of patients and their carers with the local primary mental health support service overall.

- 2.23 It is not possible from the findings to make a simple statement concerning satisfaction with the LPMHSS overall. Service users involved in this study had mixed experiences: some very good and exceeding expectations, especially where they received therapy and support from the service which they felt contributed to improvements in their mental health. Others had little contact with the service and what they considered to be limited support or interventions which they felt did not meet their needs.
- 2.24 By and large, participants who were referred for assessments were seen within the 28 day target time and were generally satisfied with waits of up to four weeks. The experience of assessment for many service user participants was beneficial. A few people were less satisfied, however, because they had felt rushed or their appointments had been at difficult times or places. Several had

telephone assessments and highlighted both the pros and cons of undertaking assessments and communicating more generally by telephone.

- 2.25 If they were referred for therapeutic interventions, participants said that they had to wait for anything between one week to a year and some complained that the service should respond more speedily to prevent further declines in health.
- 2.26 Several participants received individual talking therapies from the LPMHSS and spoke of the professionalism of staff and the helpful strategies and tools which helped them to take control of their lives. Participants also generally appreciated the group interventions, whether they were CBT, ACT, mindfulness, other courses or self-help groups. They also felt they benefited from being amongst other people with similar issues.
- 2.27 Some were disappointed, however, because they had hoped for counselling and instead were offered advice, a course, bibliotherapy or signposting. Participants with agoraphobia or social anxiety felt the options were limited for them as courses were particularly difficult to access.
- 2.28 Although participants generally felt that short interventions allowed more people to benefit from the service and some were content with only a few sessions, several felt that the interventions had been insufficient for them. Following intervention, the offer of getting back in touch with the service was made to several participants who were grateful for it. Others said they would have liked to have that 'safety net' or the option to advance to further therapies, or to become involved in self-help groups.

3 Part 2: Care Coordination and Care and Treatment Planning

Review Question 1a: Do CTPs address the eight areas of life?

Assess the experience of service users, their carers and practitioners of the engagement and consultation process in the development, implementation and review of Care and Treatment Plans, particularly in relation to their previous experiences of care planning, for example:

- Do CTPs address the relevant eight areas of life, as set out in the Measure?

- 3.1 Very few practitioners made comment on this issue. A few service users and carers felt they had holistic care plans which covered all their areas of need, although many more felt that their plans missed key information under the areas of life. Many participants felt that the plan in itself was adequate but improvement was needed in how practitioners were using it. The tendency for some clinicians to focus on medication only was mentioned frequently and some practitioners and service users felt that it was a weakness within the code of practice that a minimum of only one area of life had to be completed whilst other practitioners considered it appropriate.

Review Question 1b: Is there a need for additional areas of life?

Assess the experience of service users, their carers and practitioners of the engagement and consultation process in the development, implementation and review of Care and Treatment Plans, particularly in relation to their previous experiences of care planning, for example:

- Has the need to address any additional areas of life regularly arisen?

- 3.2 In the main, participants agreed that the eight areas of life were adequate for adult service users and many welcomed the structured and holistic approach introduced by the CTP. Some service users and practitioners said that it was not always obvious

under which category to include certain information. There were no additional areas of life that regularly arose. There were, however, other frequently mentioned criticisms of the format and these are covered in the next section.

The CTP Format – other comments

- 3.3 Whilst a standard care plan format was considered to be helpful, many felt that the form encouraged a tick-box, formal approach and some felt because of this it gave the impression of being less person-focused than the CPA: participants would prefer that staff use the form as a guide rather than as a prescriptive document. Several also thought that space for carer and care coordinator inputs should be included.
- 3.4 Many felt that practitioners should identify short-term, realistic 'goals' with service users in a step by step approach to achieving longer term goals. An omission, considered to be significant by many, was that there is no section on the form for unmet needs. The format was also considered by many to be inappropriate for young people; people with learning disabilities or for older people with limited capacity.

Review Question 2: Outcomes and Recovery

Assess the experience of service users, their carers and practitioners of the engagement and consultation process in the development, implementation and review of Care and Treatment Plans, particularly in relation to their previous experiences of care planning, for example:

- Are plans outcome and recovery focused?

- 3.5 The requirement under the Measure for care plans to focus on recovery and service user outcomes was generally welcomed by participants although they acknowledged that this required significant cultural change which would take some time to imbed in practice.

- 3.6 Several service users highlighted how the CTP process had helped towards their recovery and that this was most effective when the plan was used as a live document to guide action and monitor progress. Most participants said that little attention had been given to completing their plans with them and acting on them and they believed the way the CTP process had been operated had not delivered for them. Some said that they had seen little difference or a worsening of care since the Measure. Many thought that capacity and resource issues were mainly to blame, along with what they considered to be a limited uptake of CTP staff training.
- 3.7 Some service users felt that the focus on outcomes had led to professionals having unrealistic expectations of them, particularly in regard to taking up employment, and that this had caused anxiety. A tendency for staff to over-emphasise any positive progress also caused anxiety, making some participants fearful that their needs were being ignored or that the service would be withdrawn.
- 3.8 The concept of 'recovery' in relation to people with learning disabilities and dementia was raised. Some questioned the relevance of the Measure at all for these people, whilst some practitioners were adapting the CTP for their service users.
- 3.9 Some participants also highlighted the need for services to focus on patient outcomes rather than service outcomes.

Review Question 3: Service user engagement and consultation

Assess the experience of service users, their carers and practitioners of the engagement and consultation process in the development, implementation and review of Care and Treatment Plans, particularly in relation to their previous experiences of care planning, for example:

- Is there evidence of engagement and consultation with service users and carers?

- 3.10 Some service users and carers highlighted experiences where they felt engaged and involved. They were particularly satisfied when they felt listened to; where the service was responsive and approachable and where they had built a relationship of trust with practitioners. A few believed that this had improved since the Measure.
- 3.11 However, many felt that their level of engagement was limited: services would not respond to telephone calls; would not inform service users of staff changes; failed to listen to them properly or staff were absent for long periods owing to illness or leave. Some service users felt their complaints had led to unfair behaviour towards them from practitioners.
- 3.12 Participants also complained about:
- Discharging service users for not attending appointments;
 - Making decisions about patients based only on their presenting symptoms rather than taking account of patient notes and the lived experience of the service user and/or their carer;
 - Failing to treat service users as individuals;
 - Failing to work with carers in the interest of service users;
 - Not communicating with service users in their language of choice – including Welsh.
- 3.13 Stretched staff resources and capacity were considered by participants to limit the potential for service user and carer engagement.

Review Question 4: Service user Involvement - co-production of plans

Assess the experience of service users, their carers and practitioners of the engagement and consultation process in the development, implementation and review of Care and Treatment Plans, particularly in relation to their previous experiences of care planning, for example:

- Is there evidence of service user involvement in co-production of plans?

- 3.14 Different levels of service user involvement were identified by participants, from no involvement through to 'co-production'. Most explained their level of involvement in terms of the professionalism or otherwise of individual practitioners or in terms of service user awareness of their own rights to being involved. The extent to which carers were involved in CTP production also varied and it was widely thought that the day to day experience and role of the carer was crucial to effective care and recovery and that as a matter of principle and practice, carers should be involved more in CTP production.
- 3.15 There was also a call for service user and carer involvement in CTP reviews and for person-centred approaches in these meetings and more generally when dealing with service users. The need for care coordinators to undertake training to change working practices in favour of involvement was mentioned by many.

4 Part 3: Assessments of Former Users of Secondary Mental Health Services

Review Question 1: Discharge period

Report on the experiences of service users, their carers and practitioners in relation to Part 3 and consider, for example:

- Is the relevant discharge period for Part 3 proving to be appropriate?

4.1 Service user participants were divided in opinion concerning whether the three-year self-referral period was appropriate. Whilst about half of them thought that three years seemed about right; others felt that it should be longer and some said that people should be able to self-refer at any time and that digital record keeping made this possible.

Review Question 2: Information on Part 3 entitlement

Report on the experiences of service users, their carers and practitioners in relation to Part 3 and consider, for example:

- How well have service users been informed of their entitlement to assessment?

4.2 Service user participants revealed a mixture of experiences concerning how they became aware of the Part 3 provisions. There was some indication that good practice was being introduced, with practitioners giving clear and full explanations in meetings with patients and then confirming these arrangements in discharge letters. Having meetings with patients and giving clear verbal explanations was considered to be highly important although not required within the current code of practice. The findings show that there is still some way to go in communicating effectively with patients and ensuring that all involved at discharge –practitioners as well as service users - are fully aware of the legal rights of the patient to self-referral and assessment.

Review Question Other: Self-referral

Report on the experiences of service users, their carers and practitioners in relation to Part 3.

- Other findings – The experience of self-referral

- 4.3 Participants were generally supportive of the principles of Part 3 and service users commented that they were reassured at discharge that they would be able to re-access the service if needed. Whilst a few participants involved in this study were pleased with their experience of the process, most of them found that securing an assessment was harder than anticipated and identified various barriers.
- 4.4 In many cases services seemed to have no knowledge of the person's rights under Part 3 and several of these were sent back to their GPs for referral, suggesting that the Part 3 entitlements were not yet ingrained in the working culture. In some cases the services simply did not respond – even to numerous requests.
- 4.5 Some service users and carers reported that they felt services had been intimidating or disrespectful during self-referrals or communicated in ways which they thought were inappropriate, like telephoning people who were not able to use the telephone when ill and having limited times when duty officers were available to accept referral requests from service users.
- 4.6 Some people lack understanding of their own condition or capacity to make decisions for themselves when they fall ill. Many service users, carers and third sector practitioners considered it appropriate, therefore, that referrals should be accepted from their carers or third sector support workers and that the code of practice should be changed to allow this.

Review Question 3: The assessment

Report on the experiences of service users, their carers and practitioners in relation to Part 3 and consider, for example:

- The experience of reassessment.

- 4.7 Service user participants were divided equally between those who had mainly positive experiences and those who had mainly negative experiences of their assessments. There were several factors that influenced their satisfaction. The approach and attitude of the assessors was considered to be important and participants valued having the time to express themselves, feeling comfortable to do so, being taken seriously and being listened to. They appreciated professionalism and thoroughness and were pleased when they were given hope or achieved an outcome with which they were satisfied.
- 4.8 Participants were disappointed with their assessments when they felt intimidated; were treated in an off-hand way by their assessors; were rushed; were subjected to a 'tick-box' approach to assessment or when asked to relay their whole history of mental health leading to too-long interviews. Participants were also disappointed with their assessments when outcomes did not meet expectations or where participants gained the impression that re-access was only available to people in acute need.
- 4.9 Practitioners highlighted the extra pressures placed upon them by Part 3, particularly having to repeatedly undertake assessments for people who did not meet their criteria.

Review Question Other: Outcomes

Report on the experiences of service users, their carers and practitioners in relation to Part 3.

- Other findings – Satisfaction with outcomes

- 4.10 Although the focus of this report is upon the assessment process, it is useful to follow up with some outcomes. The majority of our service user participants were able to reaccess services whether for a short period or in the longer term. Levels of satisfaction with the outcomes both for those who reaccessed and those who did not varied from highly satisfied to those who still felt in need of further support.
- 4.11 Some of the GPs that we interviewed felt strongly that GPs should receive better support from secondary services to manage patients discharged from secondary services and suggested group sessions and training.

5 Part 4: Mental Health Advocacy

Review Question 1: Experiences of Advocacy

Report on service users', their carers' and practitioners' experiences of the new Independent Mental Health Advocacy (IMHA) services introduced under the Measure.

- 5.1 Service user participants found out about the IMHA service in a number of ways: from nursing staff; from other patients; via posters and leaflets or directly from advocates themselves. Most felt it should be easier to find out about the service and their legal rights to it and suggested that patients (and carers) should be informed at admission and throughout the hospital stay. More awareness training by health boards for hospital staff was called for, and especially for staff within general and independent hospitals.
- 5.2 Service users said it was easy to get in touch with IMHAs and they were given enough time with them. Some received IMHA support under both detained status and informal status during their stay which was considered to be a positive change under the Measure.
- 5.3 Practitioners identified people they thought were missing the opportunity for IMHA support and these included people in general hospitals and independent hospitals; people with dual diagnosis; young people; older people and people living with dementia and their families.
- 5.4 Several service users felt that the role of the IMHA was too restricted; that they should have more influence over clinicians or that they should be able to help with practical matters like housing and finances that affected patients' mental health. The benefits of the same person acting as IMHA and community advocate were highlighted and some participants suggested that health boards should be mindful of this potential when commissioning providers.
- 5.5 IMHA practitioners highlighted their approaches to support minority language groups; people with limited capacity or other

communication needs. Although the IMHA service was generally able to support Welsh speakers, participants highlighted difficulties when involved in meetings with non-Welsh speaking mental health practitioners or those with non-British cultural backgrounds.

- 5.6 Even IMHA practitioners who said they had spare capacity felt the existing IMHA network would be unable to meet the potential demand from all in-patients with mental health problems. IMHAs and hospital practitioners stated working relationships were, at times, difficult. Fully understanding the IMHA role was considered to be key to improving these relationships.

Review Question 2: Service Users' Perceptions of Advocacy

Report on service users' perceptions of the impact of the new Independent Mental Health Advocacy (IMHA) services on their care.

- 5.7 IMHAs supported service user participants in various ways: providing information; working with them to prepare for ward rounds and meetings and accompanying them to meetings, CTP reviews and ward rounds. A few service users asked their IMHAs to access their records or speak to staff on their behalf.
- 5.8 Service user participants all acknowledged that the IMHAs made a positive difference to their stays in hospital and particularly appreciated having an independent, professional person 'on their side'.
- 5.9 They enjoyed their interactions with the IMHAs, often highlighting their personal qualities and their ability to reassure and calm them down; to listen and understand them; to accurately represent them and to make them feel safer, particularly when they were feeling vulnerable, frightened, unwell, confused or forgetful. They valued the way in which the IMHAs could make things happen for them and how they had been empowered through their relationship with the service.

5.10 Participants highlighted various positive impacts from their involvement with IMHAs which ultimately made their hospital stays easier and the treatment more beneficial:

- Reassuring patients and lessening their anxiety, meaning they could settle and participate fully in hospital treatment
- Answering their questions about hospital rules
- Helping to mend patient / consultant relationships by advising the patient of how best to prepare and communicate and take more control of the relationship and treatment
- Improving self-esteem
- Shortening the hospital stay and helping towards a sustained recovery
- Reassuring a carer that someone was on her daughter's side and advocating on her behalf.

6 Issues for Consideration

- 6.1 Suggestions concerning all four parts of the Measure were raised by service users, carers and practitioners throughout this study. Many of the suggestions are already covered by the Guidance for Part 1 and Part 4 of the Measure and in the Codes of Practice for Part 2 and Part 3. The suggestions presented here are for consideration by Welsh Government along with the various additional sources of monitoring information which have been collected for the Review of the Mental Health (Wales) Measure 2010.

Part 1: Local Primary Mental Health Support Service

Communications, Learning and Management
<ul style="list-style-type: none"> • Continue raising awareness of LPMHSS to GP practices.
<ul style="list-style-type: none"> • LPMHSS to have more contact time with GP practice staff for shared advice and feedback.
<ul style="list-style-type: none"> • Provide GP practices with performance data on the LPMHSS.
<ul style="list-style-type: none"> • GPs to be open and receptive to working with the LPMHSS.
<ul style="list-style-type: none"> • Strive for staff retention and continuity within LPMHSS teams.
Signposting
<ul style="list-style-type: none"> • Ensure that LPMHSS and GPs have comprehensive information about the third sector for signposting or referral and of online sources for support and advice.
Assessments
<ul style="list-style-type: none"> • Reduce waiting times by addressing DNAs and providing absence cover within LPMHSS teams.
<ul style="list-style-type: none"> • Aim to communicate via the most appropriate mode for the patient – telephone or face-to-face and in a person-centred way.
Therapeutic interventions
<ul style="list-style-type: none"> • Reduce waiting times.
<ul style="list-style-type: none"> • Introduce more evidence-based interventions (CBT, counselling, mindfulness and to address particular conditions including post-natal depression, eating disorders, self-harm).
<ul style="list-style-type: none"> • Offer more advanced second stage courses and length of interventions to match individual needs and facilitate self-help groups for support following therapeutic interventions.

<ul style="list-style-type: none"> • Ensure that interventions take place in settings to maximise patient access – e.g. locally for communities with high levels of deprivation.
<ul style="list-style-type: none"> • Increase expertise on the LPMHSS teams to ensure that the service is inclusive and age blind.

Part 2: Care Coordination and Care and Treatment Planning

<p>The Care and Treatment Plan – Format</p> <ul style="list-style-type: none"> • Introduce guidance in identifying short and longer term goals; short-term, achievable, step by step goals to give service users a sense of progress. • Tailor the template for CAMHS, older people, people with learning disabilities. • Ensure that the language of the form is accessible to service users. • Include a section for unmet needs. • Include a place for carer’s signature and comment on the form. • Include a space for Care Coordinator comments on the CTP.
<p>The Care and Treatment Plan – General</p> <ul style="list-style-type: none"> • Increase awareness of the CTP to service users, carers and practitioners including GP practices; its purpose and its legality. • Use the CTP form as a guide for person-centred communication. Avoid a tick-box / prescriptive approach to completion. • Ensure that all life categories relevant to the individual are covered by the plan and update the CTP regularly according to service user circumstances. Monitor change or progress towards goals regularly – not just at (yearly) reviews. • Involve carers - take on board their lived experiences with service users. Change the Code of Practice so that the advice regarding involvement of carers is clear and non-contradictory. • Implement actions included on plans. Ensure that support services are provided and sustained to contribute to care and treatment planning. • Make sure that service users are asked to sign the form to indicate their agreement. The only exceptions to be where service users lack capacity. • Provide service users with useful and comprehensive contact details including crisis services; out of hours services and third sector support organisations. • Provide more therapeutic interventions: psychotherapy; talking therapies; CBT. At signs of relapse, provide short interventions to prevent deterioration into crisis.
<p>Care Coordination</p> <ul style="list-style-type: none"> • Develop and maintain effective working between professionals.

<ul style="list-style-type: none"> • Provide cover for care coordinators during times of prolonged absence.
<ul style="list-style-type: none"> • Involve all care providers in discharge decisions. Care coordinators not to make unilateral decisions to discharge. Avoid discharging patients owing to DNA.
<ul style="list-style-type: none"> • Respect patient and carer confidentiality and treat these relationships with sensitivity.
<ul style="list-style-type: none"> • Establish clarity concerning which practitioners are responsible for care coordination for hospital inpatients and prisoners.
<ul style="list-style-type: none"> • Increase eligibility for care coordination to other professions.
<p>Communicating with Service users and Carers</p>
<ul style="list-style-type: none"> • Aim for more person-focused skills including being responsive, listening, allowing sufficient time, having empathy, being interested and understanding, being sensitive and building relationships of trust.
<ul style="list-style-type: none"> • Provide more staff resources to ensure more time with service users.
<ul style="list-style-type: none"> • Treat complaints from service users with respect and act upon them speedily. Avoid negative repercussions for the service user.
<ul style="list-style-type: none"> • Recruit Welsh speaking practitioners and provide sufficient funding for translation services.
<p>Reviews</p>
<ul style="list-style-type: none"> • Ensure that service users and carers are clear when CTP Reviews are held to avoid ambiguity.
<ul style="list-style-type: none"> • Ensure that service users are fully engaged in the decision making process.
<ul style="list-style-type: none"> • Arrange meetings so that family members, advocates and others can attend at the request of the service user. Ensure that meetings are person-centred.
<p>Staff Training</p>
<ul style="list-style-type: none"> • Continue to roll out care coordinator training and consider making this mandatory.
<ul style="list-style-type: none"> • Train care coordinators and other mental health staff in order to standardise good practice in person-centeredness.

Part 3: Assessments of Former Users of Mental Health Services

<p>Discharge arrangements</p>
<ul style="list-style-type: none"> • Ensure that GPs are trained and fully supported to care for former secondary sector patients. Allocate a named individual consultant or other team member to facilitate speedy access to advice.
<ul style="list-style-type: none"> • Institute systems for regular GP check-ups with former secondary patients.
<ul style="list-style-type: none"> • Introduce discharge, supervision, monitoring or recovery planning as appropriate to the needs of the individual patient.

<ul style="list-style-type: none"> • Ensure that support services like outreach, advocacy and day centres are available to patients following discharge from secondary care services to support mental wellbeing and stability.
<p>Communications and Information – Part 3 Provisions</p>
<ul style="list-style-type: none"> • All relevant service users and their carers to be informed of their discharge and their entitlements under Part 3 of the Measure and to be helped to understand this information. <ul style="list-style-type: none"> ○ Discharge letters to be written in clear and simple language giving full and clear explanations. ○ Individual meetings with patients to discuss discharge - ideally at CTP Review. ○ Communicate with patients in ways appropriate to their needs: for example people with limited capacity; limited literacy skills or living with anxiety.
<ul style="list-style-type: none"> • Continue to inform practitioners and GPs about patient entitlements under Part 3 and the Code of Practice stipulations.
<ul style="list-style-type: none"> • Provide patients with clear advice and signposting information at discharge; also about the Local Primary Mental Health Support Service.
<p>Referrals</p>
<ul style="list-style-type: none"> • Ensure that duty officers and reception staff are fully aware of service user legal entitlements under Part 3. Train staff on responding to self-referral requests.
<ul style="list-style-type: none"> • Offer flexible access for self-referral taking full account of the likely barriers faced by vulnerable service users: most appropriate times of the day and modes of contact – telephone, in person, by letter etc.
<ul style="list-style-type: none"> • Respond in a timely manner and efficiently to self-referral requests. Treat all requests with respect.
<ul style="list-style-type: none"> • Change the Code of Practice to include carers and third sector support staff as relevant sources of referral.
<p>Assessments</p>
<ul style="list-style-type: none"> • Follow up assessments with written reports or letters to service users including reasons for decision; advice and information.
<ul style="list-style-type: none"> • Where possible arrange for the assessment to be with at least one person who has worked with the service user and is familiar with their case.
<ul style="list-style-type: none"> • Treat patients with compassion and respect and aim for service user involvement.

Part 4: Mental Health Advocacy

Commissioning
<ul style="list-style-type: none">• Where possible, commission local providers to: reduce IMHA travel times; capitalise on local knowledge and Welsh language expertise and enable seamless interface between IMHA and community advocacy services.
Implementation of Part 4
<ul style="list-style-type: none">• Implement Part 4 provisions in all clinical units throughout Wales.
<ul style="list-style-type: none">• Include the IMHA service in acute care pathway development.
<ul style="list-style-type: none">• Standardise monitoring systems across Wales.
Information and Awareness
<ul style="list-style-type: none">• Increase awareness amongst clinical hospital staff of the role of IMHAs and the legal rights to the service of inpatients with mental health needs.
<ul style="list-style-type: none">• Include a requirement in admission procedures for verbal and written information on patients' rights to the IMHA service, the role of the service and how to access it - to be adopted in all mental health units, general hospitals and independent hospitals. Information to be given to patients and their carers.
<ul style="list-style-type: none">• Display posters and leaflets about IMHA on hospital wards. Signpost patients and staff to online information about the service. Ensure that patients are informed as appropriate throughout their hospital stay.
Access
<ul style="list-style-type: none">• Improve access for people with dual diagnosis and people with dementia and their families. Include training for IMHAs in specialist needs such as autism.
<ul style="list-style-type: none">• Consider extending the IMHA service to the community.
<ul style="list-style-type: none">• Give patients the choice over male or female IMHAs.
<ul style="list-style-type: none">• Ensure adequate resources to meet the demand for the IMHA service.