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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

Scoping Study Report

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Scoping Study Report

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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Glossary of acronyms

ACT	Acceptance and Commitment Therapy
ADHD	Attention Deficit Hyperactivity Disorder
BDI	Battelle Developmental Inventory
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CPA	Care Programme Approach: the main way of assessing and identifying the care needs of people with a mental illness receiving secondary mental health services in Wales up to 2012. Replaced in Wales by CTP in 2012.
CTP	Care and Treatment Plan introduced by the Measure and operational from 2012
CAVAMH	Cardiff and Vale Action for Mental Health
DNA	Did Not Attend – referring to service users who do not attend appointments
IAPT	Improving Access to Psychological Therapies
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
LPMHSS	Local Primary Mental Health Support Service
OPMH	Older People's Mental Health
PAMH	Powys Agency for Mental Health
PTSD	Post Traumatic Stress Disorder
UAP	Unified Assessment Process
WMHiPC	Wales Mental Health in Primary Care
WWAMH	West Wales Action for Mental Health

Summary

Introduction

1. Opinion Research Services (ORS) was commissioned by Welsh Government in June 2013 to undertake research to support the Duty to Review the Mental Health (Wales) Measure 2010.[1] The project will provide qualitative evidence of the views of service users, their carers and practitioners of the implementation of all four parts of the Measure.
2. This Scoping Study presents indicative qualitative findings arising from two early focus groups and 25 scoping interviews with a range of mental health professionals. The key messages that have been identified need to be further explored during the subsequent stages of the research. The full report provides an overview of the planned research for the remainder of the contract.
3. The views expressed in this study might or might not be supported by available evidence; that is, they may or may not be accurate as accounts of the facts. ORS cannot arbitrate on the correctness or otherwise of people's views when reporting them. This should be borne in mind when considering the findings.

Findings from Stage 1: the Scoping Study

Early feedback - Primary Care Services

4. Teams are generally based in GP practices or in community-based clinics. The location of services in non-mental health community settings is considered to be beneficial for service users. In some health boards the Local Primary Mental Health Support Service (LPMHSS) teams are co-located with the Community Mental Health Teams (CMHTs) which is helping inter-team liaison.
5. As a general rule, staff working in primary care settings prior to the Measure have been re-deployed to the new teams alongside new appointments funded by the Measure. Consultees highlighted the importance of taking the time to recruit and train the right staff.
6. Consultees described various methods being used to raise awareness of LPMHSS. Nevertheless, there are varying levels of referrals from GP

[1] For further information on the Mental Health (Wales) Measure 2010 and the Duty to Review, visit http://wales.gov.uk/topics/health/nhswales/healthservice/mental-health-services/measure/?lang=en

practices and continuing liaison with GPs is seen as a priority to ensure that GPs are supported in making appropriate referral decisions.

7. The high volumes of referrals into LPMHSSs in some areas are considered to be unsustainable; waiting lists are building and teams are being challenged around how to respond to demand. Staff are concerned that the highly skilled staff in the primary teams are able to deliver therapeutic interventions as well as assessments.
8. It was felt that Tier 0 services, and effective referral to such services by GPs or by direct service user access, serve to ease the pressures for assessment experienced by LPMHSS and focus attention on service users requiring more expert attention from the teams.
9. The tendency for younger people to be less likely to access their GPs and related services was highlighted along with the potential for the Measure to support teams in liaising with the education sector to reduce the number of young people accessing secondary care.
10. Welsh Government monitoring and target setting is considered by some to be focusing the activity of LPMHSSs on assessment and intervention to the detriment of the other Part 1 priorities like GP liaison. Moreover, staff are struggling to comply with the new 28 day target, a change that is considered to be highly ambitious.

Pathways to Primary Care and Secondary Care

11. Different referral pathways exist across Wales. Consultees noted that for a significant minority of service users, there are difficulties in distinguishing eligibility between Parts 1 and 2 and that the Measure has not completely overcome the problem of 'bouncing' certain service users between primary and secondary sectors.

Part 2 and Secondary Care

12. The vital importance of continuous training and staff development was acknowledged and particularly training about the Measure; in Care and Treatment Plans (CTP) and the recovery planning approach.
13. Many professionals have genuine concerns over the quality of CTPs. Some pointed out that there is a tendency for care coordinators to only deal with areas of the CTP with which they feel confident or which are within their areas of expertise. Furthermore, some mentioned that

formalising care planning through legislation and the introduction of increasing scrutiny has led to anxiety amongst staff and that some are unwilling to take on the care coordinator role.

14. The timescales and targets for CTPs were considered to have placed pressure on performance to the detriment of quality especially in the early phase of implementation. Some consultees said that there are significant numbers with no CTP at all.
15. Many consultees argued that the Measure persists with a medical model of care which in practice is neither recovery nor outcome focused and which takes little account of the social care needs of service users. To make the recovery process work as embodied in the Measure, there is a need to take positive risks with service users by allowing them to lead the process. However, this requires a complete change of culture.
16. The definition of secondary mental health services for people with learning disabilities was highlighted as an issue, partly because of the broad range of conditions within this service user group. Also, whilst a learning disability is a mental disorder, there were questions around whether all people with learning disabilities should have CTPs with some suggesting that care planning should focus only on people who also have complex problems and/or mental illness.

Part 3

17. Consultees observed that there has been little change in practice or in numbers re-referring and that re-referral and re-admittance levels are very low across Wales. Those not re-entering are generally referred to primary care or signposted to third sector services.
18. Some consultees had witnessed confusion amongst some people discharged from secondary services. If information about discharge and Part 3 is being provided, it appears that at least for some people, it is not being read or understood. Consultees suggested that written advice and information is insufficient and that real engagement person-to-person would be necessary for many service users and particularly those with limited literacy.

Part 4

These services are being delivered through contracts with four advocacy providers across Wales. Some consultees said that there should be more advocates working in general hospital settings and that more promotion is needed to increase uptake particularly in larger clinical units and with older and younger people.

The Third Sector

19. The importance of third sector organisations to the delivery of the Measure by providing additional resource and complementary or specialist services was frequently mentioned. Third sector expertise, culture of working to a recovery model and support for collaborative working were all seen as essential qualities for holistic client support. The number of third sector service users is increasing as a consequence of the Measure and signposting from statutory services. However, some third sector organisations are themselves experiencing capacity shortfalls owing to financial cutbacks.

Conclusions

20. The early scoping stage of the project has provided valuable background and has highlighted examples of good practice and issues of concern which will be further explored with participants in the remaining stages of the research in relation to all four Parts of the Measure.

21. Whilst mental health practitioners interviewed so far support the principles and aims of the Measure and welcome the opportunity to improve and develop services and formalise good practice, there are many who are concerned over the scale of the changes required; the increasing expectations of service users and the cultural shifts in approach and practice which the Measure demands. For many, the speed at which these changes are expected to take place are particularly daunting; for others confusion remains over referral pathways and the definition of primary and secondary care services. However, practitioners also admit that it is still early days; that services and practices will be imbedding for some time to come and procedures and priorities will adapt and change in response to local demands, whilst adhering to the spirit and legislative demands of the Measure.

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. This followed submission of the successful tender to Welsh Government by ORS in May 2013.

1.2 Information and data are being gathered by Welsh Government from a range of sources to inform the Review. These include regular submissions from health board/local authority services, health board primary care satisfaction surveys and third sector surveys. This commissioned project will complement and add to these sources by providing qualitative evidence on the views of service users, their carers and practitioners of the implementation of Parts 1 to 4 of the Measure.

1.3 Welsh Government is responsible for coordinating all inputs to the Review, including the qualitative research findings, and for final reporting to Welsh Ministers which is required within four years of the commencement of each Part of the Measure.

1.4 This Scoping Study presents indicative qualitative findings arising from two early focus groups and scoping interviews with a range of practitioners undertaken as part of the contract and an overview of the planned research for the remainder of the contract.

Background

1.5 The Mental Health Measure 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

1.6 The detailed aims and guidance for implementation of all four parts of the Measure have been provided in a comprehensive range of

documents that are available on the Welsh Government website. In this section, the main aims of each part of the Measure are briefly presented to provide context to the following sections of this report and, in particular, to the emerging findings presented in Chapter 3.

Part 1: Local Primary Mental Health Support Services

1.7 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.

1.8 Welsh Government funding was made available according to Welsh Government's standard health board discretionary allocation formula to support health boards and local authorities to provide LPMHSS.

1.9 The statutory duties around Part 1 commenced on 1 October 2012 and Welsh Government recommended that agreed schemes should be in place by May 2012.

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

1.10 This part of the Measure requires health boards and local authorities to work in a coordinated way to improve the effectiveness of mental health services. It also 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 will:

- 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
- Be reviewed and updated to reflect any changes in the type of care and treatment which may be required over time.

1.11 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.

1.12 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.

1.13 Statutory duties around Part 2 commenced on 6 June 2012.

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

1.14 The aim of Part 3 was to enable eligible adults, following discharge from secondary care services, to refer themselves directly back to secondary care services if they believed that their mental health had deteriorated to such an extent that it required care and treatment. They were enabled to do this without first accessing their GP or elsewhere for referral.

1.15 Statutory duties around Part 3 commenced on 6 June 2012.

Part 4: Mental Health Advocacy

1.16 This part of the Measure introduced an expanded statutory scheme of independent mental health advocacy (IMHA) for patients subject to compulsion under the Mental Health Act 1983 and for those in hospital voluntarily.

1.17 The Welsh Government provided health boards with an additional £1.4m per annum to support this expansion of advocacy provision.

1.18 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

Objectives of the Study

1.19 Welsh Government identified their requirements of the qualitative research project in relation to each Part of the Measure as follows:

Part 1 - Local Primary Mental Health Support Services

1. To assess the extent to which information, advice and other assistance to the primary care services is provided; their satisfaction with this and the LPMHS service overall.
2. To assess the extent to which information and advice about the services available to them is provided to service users and their carers; their satisfaction with this and the LPMHS service overall.

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

3. To 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.

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

4. To report on the experiences of service users, their carers and practitioners in relation to Part 3 (arrangements for assessment of former users of secondary mental health services) and to consider, for example:

- Is the relevant discharge period for Part 3 proving to be appropriate?
- How well have service users been informed of their entitlement to assessment following discharge?
- The experience of reassessment

Part 4 – Mental Health Advocacy

5. To report on service users, their carers and practitioner experiences of the new Independent Mental Health Advocacy (IMHA) services introduced under the Measure
6. To report on service users' perceptions of the impact of the new Independent Mental Health Advocacy (IMHA) services on their care.

1.20 It is important to note that the Measure covers all elements of mental healthcare provision across Wales – that is, services for children and adolescents and older people as well as adults. Also, the services under review are extensive and have varied implementation across the seven health boards in Wales.

1.21 A Research Advisory Group is guiding the research and includes representatives from key stakeholders including health boards, local authorities, third sector organisations and service user groups. Their role is to provide advice and comment on research materials and reports and to provide advice around participant selection. Quarterly meetings are arranged between the Research Advisory Group, the ORS team and Welsh Government and are supported by electronic and telephone communications where appropriate.

1.22 The research will be completed by December 2015 following submission of a final report in mid-September 2015. A comprehensive programme of evaluation work has been planned and an overview of this is presented in Chapter 2. Chapter 3 presents early findings from practitioner interviews and focus groups undertaken during the scoping phase of the project and Chapter 4 is the Conclusion chapter.

2 The Research Programme

Introduction

2.1 The ORS tender comprised a number of separate qualitative evaluation elements, designed to meet the Welsh Government's overall requirements as identified in the previous chapter. In this chapter these elements of the overall programme of evaluation are presented, identifying how they will address the requirements for each Part of the Measure. The methodology and timetable were further developed during the post-commission scoping stage of the project.

Stage 1: Scoping Study

2.2 This phase was incorporated to ensure maximum value from the study and was completed in December 2013. This phase included four main elements which are presented in turn below:

a. **Interviews with practitioners** to establish an understanding of the structure, stage and implementation of the Measure across each health board and to offer guidance on the selection of participants throughout the rest of the research programme. Interviews were undertaken by telephone or face to face with 25 mental health professionals across Wales, focusing primarily on health board staff with responsibility for implementing the Measure, but also including practitioners from local authorities and the third sector. The aim was to include a broad spectrum and a list of the positions these people held and organisations included, is available at Appendix 1. Interviews lasted from 20 minutes to 2.5 hours.

   It is important to note that these were not formal evaluation interviews but 'scoping' discussions. However, consultees were keen to share their initial experiences of the Measure's implementation and management, and these are included as indicative findings in Chapter 3 of this report.

b. Ethical considerations

For this project the qualitative work with service users could not begin until the project team had:

1. Determined whether an ethical review was needed for the study and if so, had achieved Research Ethics Committee approval
2. Gained permission from the health boards via their Research and Development sections.

Examination of the Research Ethics Committee decision tool[2] clearly identified the project as 'evaluation', meaning that it was not subject to full ethical review.

The Research & Development sections of the seven Health Boards were informed of the project and permission was sought to proceed. All seven Health Boards have given their approval to involve service users.

The Government Social Research Ethics Checklist has been completed for the project.

It is pertinent to mention here that all ORS staff involved in the project are fully trained in the principles of medical and social research ethics and, in particular: potential participants' right 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.

c. Project planning including timetabling and plans for the recruitment of participants at each Phase of the project and preparing a draft focus group discussion/interview guide for practitioner evaluation sessions.

d. Conducting two practitioner focus groups: one with a LPMHSS team and one with Gofal Area Managers. These sessions helped to pilot the discussion/interview guide and provided further insight for this Scoping Study Report (Chapter 3).

[2] http://www.hra-decisiontools.org.uk/research/; http://www.wales.nhs.uk/sites3/Documents/952/RES_Defining_Research_Sept_2013.pdf

Stage 2: Discussions with practitioners

2.3 About one day will be spent in each health board conducting focus groups and interviews with practitioners from the statutory and third sectors in order to identify good practice and any benefits and issues arising from implementation of the Measure. The focus will be upon the key evaluation questions identified in paragraph 1.19 above.

2.4 It is recognised that these sessions will take place relatively early in the implementation process, especially for the LPMHSS teams, and allowances will be made for this in reporting. Also, although this is the main phase for involvement of practitioners in the project, the ORS team will be seeking guidance and advice from practitioners in all regions as necessary throughout the life of the project.

Stage 3: Discussions with service users and carers - Part 1 and Part 2

2.5 The aim of this stage is to recruit and involve up to 21 focus groups or corresponding interviews across Wales with a diversity of service users and carers who have direct personal experience of Part 1 and/or Part 2 services.

2.6 ORS were advised by consultees during the scoping stage of the project to recruit participants via third sector Mental Health Development Organisations (MHDO). These organisations have the expertise and access to service users willing to give their time and share their opinions for projects such as this one. Contacts have also been established with several practitioners within the statutory teams who have offered help with recruitment.

2.7 Some issues were identified by consultees at the scoping stage concerning the recruitment of Part 1 participants since for many their involvement with the service has been brief or has only involved sign-posting or involvement in group sessions. However, this will be explored further with managers and with third sector organisations during recruitment. One suggestion for recruiting Part 1 participants is via the satisfaction questionnaires sent by health boards to service users. A request for participation in a discussion group could be circulated with the questionnaires, requesting direct return to ORS.

2.8 Recruitment and fieldwork with service users and carers will be guided by professional practice and the guidance included in the project's Ethical Checklist agreed between ORS and Welsh Government. Informed consent will always be secured prior to the sessions.

2.9 The ORS evaluation team will work closely with third sector and statutory sector 'gatekeepers' to ensure diversity and to develop a schedule of consultations within each health board area which contributes to a cross-Wales representation.

Stage 4: Service user longitudinal case studies

2.10 During Stage 3 the research team will identify and recruit about 14 service users across Wales who have taken part in the service user focus groups/interviews or who have been identified separately by the 'gatekeepers'. These participants will be given the opportunity of telling their stories and updating them over a period of about nine months. An initial interview of about 30 minutes will be followed up by two short follow-up interviews. This longitudinal dimension will be of particular value in finding how people interact with the various support services over a longer period and offer a 'narrative' rather than a 'snap-shot' account.

2.11 The usual information and consent procedures will be undertaken as for all stages which involve service users and carers, and participants will be facilitated by ORS staff to tell their stories in their own words during each separate telephone call.

2.12 ORS would aim to involve a diversity of participants in this stage by age and service type at least and will, again, be guided by the experienced 'gatekeepers' in the recruitment of suitable participants.

Stage 5: GP focus groups

2.13 Survey feedback is being collected from GPs to inform the Duty to Review via health boards' satisfaction surveys and a survey of GPs by Wales Mental Health in Primary Care (WMHiPC).

2.14 To complement and augment these findings, this project will undertake three focus groups with GPs to seek their perspectives on changes brought about by the Measure which have affected their practice. It is anticipated that questioning will focus around the communications with

and advice and information from the LPMHSS teams to general practices; the levels of satisfaction with the service and underlying reasons for their opinions.

Stage 6: Consulting service users and carers - Part 4 advocacy services

2.15 This part of the programme will start in summer 2014 but initial planning will take place at stage 2 during which representatives from the four advocacy providers across Wales will be interviewed. At the same time these providers will be asked for advice concerning the recruitment of and participation of service users in the project and the feasibility of accessing their contact information.

2.16 It is anticipated that the evaluation of the Advocacy Services will be undertaken via a two stage process:

a. A focus group discussion with service users to understand their experiences and any issues concerning the service received

b. An on-line or telephone survey to involve as many service users as possible using both closed and open questions

Stage 7: Telephone interviews with service users and carers - Part 3 assessments

2.17 The aim of this stage is to conduct about 35 in-depth interviews by telephone. The approach will be based on ‘patient stories’ to elicit their experiences in the context of the information provided about part 3; their expectations of the service; whether or not they were able to directly re-access secondary care and what happened if they were not able to do so.

2.18 In this context, and if possible, the ORS team will be seeking to involve service users who were successful in re-accessing services and those who were not. Once again, ORS will depend on third sector mental health organisations to assist in the recruitment of service users.

2.19 Because consideration of the needs of Welsh speakers is a requirement of the Measure, the coming consultations will include the experiences of bi-lingual service users and carers in relation to opportunities to use Welsh when receiving support from mental health services.

3 Findings from Practitioners during the Project's Scoping Stage

Introduction

3.1 The scoping stage of the project involved interviewing a range of practitioners to gather knowledge, advice and information for planning the schedule of research. Most of these practitioners, referred to throughout as 'consultees', also offered their opinions on the Measure.

3.2 Also, two focus groups were held during the scoping phase: one with nine members of a LPMHSS team which included CPNs, OTs and a Social Worker, and one with four Gofal Area Managers and their Head of Services. The draft discussion guide, included as Appendix 2, was piloted during these sessions and was updated following further input from the Research Advisory Group in early 2014. Practitioners taking part in the focus groups are referred to throughout this chapter as 'participants'.

3.3 The findings presented in this chapter have been gathered from the scoping interviews and focus groups. Detailed notes and/or transcriptions from each interview or group were analysed by coding into main themes and sub-themes for presentation.

3.4 This chapter presents the sentiments and judgements of consultees and participants about all aspects of the Measure; its implementation, management, examples of good practice and issues arising. Outputs from the forthcoming practitioner focus groups and interviews at Stage 2 will build on these early findings.

3.5 Verbatim quotations are used in this chapter, in indented italics, for their vividness in capturing points of view. ORS does not endorse the opinions in question, but seeks only to portray them accurately and clearly.

3.6 The views expressed by participants and consultees in this study might or might not be supported by available evidence; that is, they may or may not be accurate as accounts of the facts. ORS cannot arbitrate on the correctness or otherwise of people's views when reporting them. This should be borne in mind when considering the findings.

The Measure – Underlying Principles and Opportunities for Change

3.7 Most consultees offered their opinions on the principles underlying the Measure and these were positive without exception, with many expressing enthusiasm, even passion, for the Measure and a commitment to ensuring its success:

> *An intelligent use of legislation … the most innovative introduction since the creation of CMHTs. (Mental Health Manager)*
>
> *The Measure has given us status. We have a voice and exist as a separate entity. (LPMHSS Manager)*
>
> *The Measure has driven us to put integrated systems together. In the past care coordinators were not identifiable. (Part 2 Lead)*

3.8 They highlighted the benefits of codes of practice under the Measure in terms of making referral pathways clearer; ensuring consistency and providing accountability for care planning. Imposing deadlines for assessment and treatment was also considered to be helpful.

3.9 Consultees said that through implementation of the Measure, services are encouraged to review management practices, innovate and review outcomes, and to continuously adapt their practices. To this end, multi-disciplinary and cross organisation implementation groups, forums and sub groups have been established for review and for planning mental health services at regional level. The challenge remains of how to deliver the Measure as a standard whilst also meeting local needs.

3.10 One consultee suggested that the Measure, particularly the CTP, should be prioritised in the syllabus for Registered Mental Health Nurse students at Universities across Wales as many will become care coordinators in time.

3.11 The rest of this chapter presents the main findings and themes arising from the early scoping phase of the project. These are arranged by each Part of the Measure in turn starting with Part 1.

Part 1 and Primary Care

Models of Delivery in Primary Care

3.12 Welsh Government identified their requirements of the qualitative research project in relation to Part 1 - Local Primary Mental Health Support Services - as follows:

1. To assess the extent to which information, advice and other assistance to the primary care services is provided; their satisfaction with this and the LPMHS service overall.
2. To assess the extent to which information and advice about the services available to them is provided to service users and their carers; their satisfaction with this and the LPMHS service overall.

3.13 This scoping study touched on these questions and the following stages of this study will cover them in some detail. However, participants and consultees involved in the scoping study were keen to share a range of additional issues concerning the LPMHS service and these also presented in this report.

3.14 People accessing the LPMHSS include the following:

- People who formerly fell between primary and secondary care services because they were ineligible for secondary care mental health services and the range of services was not available in primary care.
- People formerly held by secondary care because they needed services that were not previously available in primary care.
- New people to mental health services who were previously not being seen at all as they were ineligible for mental health services.

3.15 Holistic assessment takes about an hour; is conducted either face to face or over the telephone and can result in:

- Signposting to a service
- Advice and tips plus return appointment

- Providing therapy either by team members or through referral to third sector organisations
- Referral to secondary care

We try to offer people things in the short term that they can work on and offer a phone call a week further on to see how they're getting on. We signpost because we know in the long term we won't be there … It's centred on that person – they make the decisions.

3.16 Information, advice and signposting is offered to service users by the teams along with high intensity one to one therapies and low to medium intensity therapies delivered to large or small groups, including:

- Acceptance and Commitment Therapy (ACT)
- Bibliotherapy
- Cognitive Behavioural Therapy (CBT)
- Counselling
- Living Life to the Full
- Mindfulness
- Mood Master
- Stress Management
- Parabl: talking therapy for common mental health difficulties or challenging life events (in BCU HB)

3.17 The location of LPMHSS services in non-mental health settings within communities is considered to be beneficial for service users. Teams are generally based in GP practices or in community-based clinics offering *care on the doorstep* which is considered to be *enormously helpful for lots of groups* including young people in care and people with limited mobility.

Staffing and Resources

3.18 In most existing LPMHSSs, staff were working in primary care settings prior to the Measure. These include, for example, people who had been counsellors, Primary Care Liaison Nurses and Gateway Workers.

These staff have, in the main, been re-deployed to the new teams alongside new appointments which have been funded by the Measure.

3.19 As a consequence, teams in most areas are larger than they would have been if funded solely from Part 1 funds and are providing services above the minimum level as specified by the Measure (equivalent to one team member per 20,000 population). Indeed, one health board is aiming for a ratio of 1:10,000 which is double the recommended resource. Primary sector services have been completely redesigned there:

> *… realigning existing services with the spirit of the Measure.*

3.20 This model has not been adopted in all areas however. In another health board, the LPMHSS team has been recruited solely from Welsh Government funding. The pre-existing primary care counselling service is still in place; the 35 existing staff have not been re-deployed to the LPMHSS and it operates as a separate service. This means that compared with other health boards, which have invested substantial resources of their own into the new primary sector teams, in this area the team is relatively small and is still building its complement of staff. As this model of service is untypical, the comments from this team reported in the following sections should not be considered to represent all LPMHSS teams and should be treated with caution.

3.21 Members of this small team were very concerned that their service is subject to unfavourable comparisons with other teams in Wales owing to this difference in organisation:

> *To me the stats that we send in each month are completely arbitrary because we might be seeing 400 referrals a month and another one might be having 1000 and they'll say, look, they're doing way more than you but actually we're a team of 9 and they have 50 staff. It's not comparing like with like.*

3.22 Managers across Wales highlighted the importance of taking the time to recruit the right staff to the LPMHSS teams. So too was training in a range of therapies and in working with people of all ages. As a consequence, some consultees said that not all health boards had teams in place at the start of the scheme in October 2012.

3.23 Various training courses have been delivered for LPMHSS staff across Wales including in CBT, ACT, emotional coping skills, working with older and younger people, child and family supervision, cognitive deterioration, eating disorders, substance misuse, smoking and stress control. This training varies by health board according to resourcing, management priorities and local need.

3.24 In this way the Measure is considered to have been highly beneficial to staff by providing valuable developmental opportunities and increasing their employability.

3.25 Some consultees mentioned that to date the offer of therapy has lagged behind the provision of assessments and signposting to other services and will continue to vary across teams as staff become fully trained, confident and competent to deliver therapeutic interventions. Some consultees were worried about capacity, fearing that they may not always have sufficient staff to adequately provide therapies. It is also significant that the Welsh Government targets have tended to focus LPMHSS activity into assessments rather than other LPMHSS work responsibilities including therapeutic interventions.

3.26 The LPMHSS service across most areas is dominated by health staff although there is a stated desire for social workers to join the teams and for more real engagement with local authorities in delivering the service. The composition of the teams varies between areas. Whereas CPNs are dominant, and in some teams they are the only qualified staff, others are more mixed comprising, for example, social workers, occupational therapists, psychologists, counsellors and community development workers (in one area only).

3.27 In some teams individual staff members are given diverse roles, in others the teams are split into assessors and therapists.

3.28 Tier 1 CAMHS services are incorporated into primary care in some health boards, although not within the LPMHSS teams themselves - in Aneurin Bevan, Betsi Cadwaladr and Cwm Taf, for example - although the number of CAMHS staff is very small (only 1.5, for example on average in each of the five boroughs in Aneurin Bevan).

3.29 The role of administrative staff on the teams is considered to be crucial for inputting service user data and recording referrals, assessments and interventions, sending out letters and helping with client work notes. Also there is a considerable administrative task in recording the personal details and evaluation forms for people attending large group sessions which can involve over 100 members. In the absence of administrators, professionals are undertaking these routine tasks, reducing their contact time with service users.

3.30 One team has, however, found a creative solution to this problem by recruiting volunteers to help with large group sessions so that five volunteers and five team members can manage a session of about 120 members. The potential to recruit additional volunteers to help is being considered, although volunteer recruitment and training is an additional task for a team already under pressure.

> *We have far more potential volunteers than we have the capacity to deal with … Ten have started already and ten are waiting in the wings. The calibre is amazing.*

Liaison with GPs

3.31 Consultees mentioned varying levels of referrals from GP practices with some GPs being resistant or slow in using the service and others being very responsive. Building relationships and networks with GPs is considered to be one of the significant challenges and consultees and participants acknowledged that liaison needs to be a continuing activity even when patient numbers are large and staff are under pressure. Consultees/participants also described how they are continuing to raise awareness amongst GPs and the public for LPMHSS services through personal meetings with GPs and practice managers and via printed information including posters, leaflets and monthly newsletters in surgeries and in community settings. Consultation telephone lines are also available for GPs and the use of these has dwindled as the service has imbedded. Promotional campaigns targeting non-responsive GPs have been run in at least one health board and these will be repeated.

3.32 Staff in one LPMHSS said that although the referrals from GPs are mostly appropriate, they feel that they need to work with GPs more to

help them make decisions rather than always submitting full referrals to the team. For example, it is unnecessary to submit a full referral in order to access stress control or ACT group sessions. Also in one area, there is some confusion amongst GPs concerning whether to refer to LPMHSS or the separate Tier 1 Counselling service as at the moment there is no single point of entry. This LPMHSS has recently provided GPs with a 'decision grid' to overcome this issue which has been well received. A decision making tool for GPs is also being developed in another Health Board area.

3.33 Consultees report that GP staff are positive about therapeutic interventions for service users and are pleased when their patients receive supporting interventions. This will be explored further during consultations with GPs later on in this project.

3.34 By and large it seems that the LPMHSS teams have established positive working relationships with GPs and good practice around feeding back information by word of mouth or in short reports concerning patient support.

3.35 In addition an early priority was to raise awareness of the Measure amongst mental health practitioners generally in primary and in secondary sectors.

3.36 In some areas it is acknowledged that pathways still need some work as confusion persists amongst GPs and referrals are being bounced between teams. This is particularly the case for accessing CAMHS and memory assessment services. Consultees also highlighted problems for people with certain conditions like autism, Asperger's syndrome and ADHD who can be left in limbo between primary and secondary care.

3.37 However, possible solutions to these issues are being trialled as the service develops by, for example:

- Encouraging GPs, if in doubt, to refer to the LPMHSS teams who will then refer on directly to other teams if necessary
- Establishing a single point of entry for all services whether primary or secondary care

- Developing decision making tools for GPs.

3.38 There was some criticism from consultees outside of the primary teams, including GPs, that service users are receiving information and signposting rather than support through therapeutic interventions:

> *GPs would expect that there would have been much better access to simple psychological therapies … there are wide differences in how it's being implemented … in some areas these are not being offered at all.*

3.39 However, it was also generally acknowledged that it is early days yet, that the system is new and needs to settle down and imbed.

Liaison with Secondary Sector Services

3.40 In some health boards the LPMHSS teams are co-located with the CMHTs which helps inter-team liaison. Team members in one area feel that by and large they have established good working relationships with CMHTs in the relatively short time (six months) since the primary team was established in April 2013. They cited some examples of best practice in inter-team working:

- LPMHSS and CMHT services are together piloting an OCD medium intensity group and evaluating the feasibility of mixing primary and secondary service users.
- The team receives about 15 referrals from one CMHT and are together looking at the transitional support they can offer to long-term service users.

3.41 However, there is still work to be done on raising awareness of the LPMHSS to ensure that referrals are appropriate. Participants in one of the focus groups and other consultees highlighted a tendency among secondary services to refer anyone who does not fit their own criteria on to the primary care teams:

> *They are thinking 'here is a service that might fit'. … they need to understand what we can provide … just because we're here doesn't mean that everyone that you don't take has to come to us …*

3.42 Moreover, it seems that liaison is variable and there is still a way to go to establish good inter-team communications. For example, whilst some CMHTs are happy to have LPMHSS staff at screening meetings, others are not:

> *I've received an email saying 'we're discussing CMHT next week so there's no need for you in Primary to come. It sort of makes us feel separate and we shouldn't be – it should be a continuum.*

3.43 Interventions introduced through the LPMHSS teams are generally available to secondary care service users either by open access or referral from secondary care teams.

3.44 It is considered to be important to liaise with services across the board, whether in primary or secondary care; that all should be working together and be able to refer into one another. Consultees mentioned services like memory clinics, PTSD, psychiatric liaison and prisons, for example.

IT and Reporting

3.45 The importance of having an efficient integrated and easy to use IT system was highlighted. Cumbersome and antiquated systems in some areas are involving staff in double recording and extra administration. In some areas systems will be under review and development for some time. In other areas, however, managers are satisfied that their systems are adequately supporting their governance pathways, enabling accurate reporting and informing the planning of services:

> *IT and stats are integral to what we do. I am satisfied that the stats I am returning (to Welsh Government) are accurate.*

3.46 Some health boards have adopted the patient clinical outcome measurement tool, CoreNet, and some are considering introducing it to their practice. Measuring satisfaction and outcomes pre and post intervention using CoreNet will give some measure of success. Some areas use different evaluation tools, including Battelle Developmental Inventory (BDI), for their medium intensity groups. Outputs are considered useful for planning services and using resources effectively for patient well-being.

3.47 Improvements in IT systems could considerably reduce the burden of administration and several examples were highlighted. Staff reported difficulties in sharing patient assessment information via email because secure emailing systems are not in place. They suggested that the Welsh Government should consider having the whole of Wales on NHS Net, as is the case in England, to aid information sharing.

3.48 In one Health Board staff have been looking at the potential for texting appointment reminders to service users to reduce administration but *there is a minefield around IT security issues.*

3.49 One team would like to develop a website for GP and public access which they feel would help to reduce the number of referrals by providing information and self-help advice. A site could also provide an option for booking on to low intensity courses. However, the resources are not available to develop the website.

Issues of concern – pressures, capacity and reporting

3.50 The **high volumes of referrals into LPMHSS** in some areas are generally considered to be unsustainable; waiting lists are building and teams are being challenged around how to respond to demand. A team member said:

> *My concern as a practitioner and team leader is that we don't get overwhelmed by it and that we don't have burn out like IAPT services have in England … that we maintain our professional integrity so that everybody gets a gold standard service when they come to us.*

3.51 **Workloads** in this small team mean that staff regularly work out of hours:

> *At the moment that suits us fine but … unless we meld with other primary care services, I don't see how in the future we will maintain our creativity.*

3.52 Some said that they are fearful of becoming a first access service *which is totally against the ethos of the Measure* rather than delivering therapeutic interventions.

3.53 Concerns are around ensuring the highly skilled staff are able to deliver therapeutic interventions as well as assessments. This is important for

staff satisfaction and retention. Nevertheless, the staff enjoy working on the team and appreciate the potential it provides for working with clients in a range of different ways – whether in large or small groups - or individually.

3.54 It was noted by members of the team that an assessment done well can be a very powerful tool by itself. They also asserted that valuable assessments can be conducted by phone and that in their experience, service users value the anonymity this offers and being in their own homes at a time of their choosing. Team members also said that as well as assessments, there is scope to carry out interventions over the phone:

> *A few of us have got clients that we have never met but we provide structured therapeutic time over the phone. When there is a limit of time, creativity is needed. I have two clients, in particular, that I speak to monthly. They work full time so we set time aside. It works fine. One of them has said that's protected time for them.*

3.55 However, whilst this might suit some clients, according to Gofal, some criticise the service for feeling remote. Also service users were missing telephone calls and then finding it difficult to get hold of the LPMHSS contact to re-book, involving delays that they considered to be too long:

> *It seems a bit clunky and resource led.*

3.56 However, Gofal participants reported that once service users had established contact by phone they were generally positive about the outcomes.

3.57 Counselling staff on other LPMHSS teams – including those who were working in primary services prior to the Measure – are not eligible to undertake holistic mental health assessments. This means that in some teams of, say, 20 staff, only two or three staff are now undertaking assessments. This is considered by some to be restrictive and adding to delays.

3.58 Consultees also regret that pressures of work in many health boards are currently limiting the amount of one to one interventions that are possible.

3.59 **Welsh Government monitoring and target setting** is considered by some to be focusing the activity of LPMHSSs on assessment and intervention to the detriment of the other Part 1 priorities like GP liaison.

3.60 Many consultees said that Welsh Government target data should be interpreted carefully and questioned how meaningful the data are in terms of patient satisfaction and outcomes. Many argued that statistics provide only a crude indicator of performance. Staff appeared unaware of the other sources of information that were being sought:

> *It would be really helpful if we could tell the Welsh Government our story and provide them with an annual report to illustrate all the things we are doing. When they look to the future it would be really good for them to see which models have worked really well. That's a lot more rich than counting numbers.*

3.61 Once the 56 day target for assessments was halved to 28 days managers and staff were struggling with non-compliance and this was causing concern and anxiety within teams. The fact that these targets were halved only a year after the service was introduced was considered to be highly ambitious:

> *A year is a short time in the public sector to deliver the massive change. Targets are useful for patients but stressful for managers.*

3.62 One manager thought that breaches in meeting deadlines in his area were partly down to poor IT systems, low computer literacy of health staff and staff failing to report. The large cultural changes that accompany the Measure for health staff were highlighted by many:

> *This is the biggest issue. I know that we are reporting worse performance than is actually happening. We need to improve staff reporting procedures … this is a change in culture for us. We have never had that transparency of information or level of scrutiny before.*

3.63 In many areas simpler documentation and procedures have been introduced or are being planned to reduce bureaucracy for staff and performance is being monitored.

3.64 Consultees mentioned that Welsh Government only collects data on referrals from GPs and not from the other sources: CMHTs, crisis teams, psychiatric liaison/outpatients clinics. This means that numbers are being under-recorded, although it is the case that most referrals are, in fact, from GPs.

3.65 The Measure is not addressing DNAs in reporting. These can be high: one consultee mentioned an overall rate of 45%. These are considered to be higher in GPs surgeries and lower in central clinics. A number of reasons were suggested for DNAs:

- Fear of lack of confidentiality
- Crisis has passed
- Busy/working
- Inconvenient appointment time

3.66 At least one health board has targeted DNAs by offering central clinic appointments and introducing a self-booking system. DNAs have fallen dramatically as a result.

3.67 Another reporting anomaly was mentioned and is described in the following example. In this case they would have breached the deadline and there is no means of capturing this in the returns:

> A patient is offered an assessment within 28 days and then phones in to request a later appointment.

3.68 **Travel** was mentioned as an issue by some. In Powys, where the population is sparse, LPMHSS staff are travelling long distances to GP surgeries, which is reducing time with patients. Geographical spread also means that it is difficult for teams to meet together.

3.69 In order to deal with the volume of referrals and reduce travelling time, as already mentioned, staff in one area tend to conduct assessments by telephone. However, this is not appropriate for all service users:

> *We need them in the surgery where they are … but if I have an appointment out in [an outlying area], that takes a whole morning. We have to be mindful of that. It impacts on how many assessments we can do.*

3.70 Staff in one team highlighted the importance of allowing time for **formal and informal supervision**:

> *A lot of us have been shocked and emotionally affected by a lot of the issues … it's lone working – you are making the calls, making the decisions largely by yourself … and I think you really do have to have that facility (supervision).*

3.71 Some participants stated that **resources allocated to Part 1** are inadequate to the task in hand and that there is only a limited budget for publicity, travel and venues. A member of one team said:

> *To cope with the massive number of people, we need an actual budget … the existing good service can't be sustained on good will and magic forever.*

Tier 0

3.72 It was felt that Tier 0 services, and effective referral to such services by GPs or by direct service user access, would help to ease the pressures for assessment experienced by LPMHSS and focus attention on those people requiring more complex attention of the primary care service. Such services would include information, advice and therapies, some of which could be provided by the third sector. These pathways and services are in development in some Health Board areas who are also exploring how to promote access to them. For example:

- Hywel Dda is developing low intensity and high intensity therapist and stress control courses run in non-health venues in the wider community for large numbers. These can be accessed via GPs or open access and are run by the LPMHSS teams.
- Similarly, in Cwm Taf the LPMHSS service is holding mindfulness courses, adapted for delivery to large audiences, and stress control courses in every Valley for one evening and one afternoon per week. Tier 0 services for older people are also being considered.
- Betsi Cadwaladr has commissioned a third sector consortium managed by Cais (under the Parabl brand). A

one hour assessment is offered within a week of contact followed by referral to primary care or an offer of Parabl counselling, other third sector services, group work or self-help advice.

- In Abertawe Bro Morgannwg, community development workers are employed on the teams to deliver Tier 0 services to support people with general life problems. These services include befriending, rambling group and gardening group, all of which offer social connections. The ARC project in Bridgend also provides similar options.
- In Torfaen a directory of services has been produced for GPs and service users giving information on Tier 0 services.

3.73 One consultee firmly believed that Tier 0 services should be delivered by Public Health and that it was regrettable that the Measure did not legislate for this:

> *In the next five years if there was another element of legislation around that emotional well-being for the community that should be delivered through Public Health, not Mental Health, definitely … there are certain parts where we shouldn't be taking the lead … it shouldn't always be a service response. It's about education isn't it?*

3.74 Consultees would like the Measure to address currently high levels of prescribing by investing more in counselling and other therapies as an alternative. Of interest in this regard is a feasibility study underway in Cwm Taf around the potential to source funding for the delivery of Tier 0 services through savings made on the prescribing budget:

> *What we need to do in our community is have a Tier 0 project to prevent people from going to the GP owing to low mood owing to life problems … by working with pharmacy teams we can start working with GPs to reduce prescribing. When you have 10% on drugs there's got to be something wrong.*

Part 1 and Young People

3.75 The tendency for younger people to be less likely to access their GPs and related services was highlighted. Some consultees felt that the Measure does not address the emotional well-being of young people since they do not access the service and suggested that there is a valuable job to be done in the teams by liaising with the education sector. They consider that only by accessing young people in this way will the Measure be effective in reducing the number of young people who are accessing secondary care:

> *The emotional well-being of young people still isn't addressed in the Measure.*

3.76 There are limited resources available in primary and secondary schools for addressing mental health and well-being compared with the high volume of pupils. For example, pastoral care is provided from few specialists and the service is advisory only.

3.77 Moreover, consultees stated that the CAMHS service in some areas is dispersed and engagement is not as good as in the adult teams. Others agreed that resources for CAMHS in primary care are limited.

3.78 Also, one consultee stated that even before the Measure primary care CAMHS were overwhelmed and waiting lists were growing, partly because the specialist Tier 2 CAMHS would only admit service users who had exhausted Tier 1 services. This same consultee said that in order to meet the need from young people, some CPNs in LPMHSS teams are dropping their age limits so they are able to see service users in their mid-teens (but no younger).

3.79 Some consultees said that group work for adults under Part 1 would be highly relevant for young people and their parents (for example, stress control, ACT and mindfulness), but some also thought that adult courses should not be promoted to young people for child protection reasons.

3.80 Running groups for young people is currently low priority and counselling expertise at primary level for young people is also limited, although signposting to third sector services is ongoing (for example, in

Cwm Taf where service users are signposted to Eye to Eye which specialises in counselling young people).

3.81 The transition between child and adult services is problematic and services are using the Measure as a vehicle for operationalizing this.

Part 1 and Older Adults

3.82 One group said that older adults are not using the LPMHSS service as much as expected. Although older adults are attending open access courses, it seems that GPs may not be referring them to the LPMHSS. As a result, those aged 65+ represent only 4% of all referrals to the service. It is unclear why this is happening and this will be explored during following stages of the project.

Pathways to Primary Care and Secondary Care

3.83 Different referral pathways exist across Wales for example:

- In Betsi Cadwaladr every referral no matter whether primary or secondary is accessed via a central hub
- In South Powys a hub model is in development. Currently staff pick up referrals for themselves
- In some areas the main pathway for GPs is direct to the LPMHSS teams who will refer on if necessary to secondary services. In other areas GPs refer directly to secondary services.

3.84 Some managers believe that the Measure has considerably helped with the distinction between primary and secondary care services:

> *It's been really good to have that legislated because the primary/secondary care interface was something that we struggled with for many years.*

3.85 Some consultees said that the border between primary and secondary sectors had been eroded somewhat by the Measure and that this was a highly positive change:

> *Previously people worked in silos … What we can do now is be far more flexible about using secondary care resources but delivering services in primary care.*

3.86 However, many identified difficulties in defining primary care and secondary care services and in consequence the Measure has not completely overcome the problem of 'bouncing' certain service users between primary and secondary sectors.

3.87 Consultees said that the definition of secondary care varies across Wales with service providers deciding on the definition for themselves largely according to capacity. Even within one health board, the proportion of older people being accepted into secondary sector teams varies widely between counties, the implication being that different selection criteria are being applied.

> *(They are) tinkering to define what is a secondary mental health service and what isn't*.
>
> *Most Health Boards don't have a clear definition between the two. At the border it gets very blurry.*

3.88 It remains the case that there is still an issue for people who are ineligible for a Part 2 assessment but who have long term needs. According to an LPMHSS team member, these people are still left to *muddle along* and:

> *Some people come to the service almost by default because they do not fit anywhere else … We offer them what we can but obviously we can only offer short term solutions … and then they come back to the service later and we can only offer them the same again.*

3.89 One manager said that this is putting pressures on staff who become anxious; worrying about the implications if they make a wrong decision and uncertain of the ramifications for non-compliance. Some felt that the Welsh Government should have been clearer in their definitions of secondary care to overcome this issue:

> *There are questions around, if I want to keep seeing this service user, then I'll need to do a CTP which becomes a purely administrative task in some cases rather than being of benefit.*
>
> *If someone is having their medication monitored by a GP, is this secondary care?*

3.90 Another example was highlighted by a consultee who queried whether care planning should be necessary for all service users with short term needs which have been met by crisis teams at home. Such cases, including, for example, transient psychological emergencies, traumatic experiences and substance abuse, might only require interventions of up to six weeks. This consultee suggested that it was necessary to fit processes to need and this was an example of where CTPs would be inappropriate.

3.91 The potential for introducing a new classification, 'Primary Plus' for people falling between Parts 1 and 2 was mentioned by some. These would include people who consultants felt should not be discharged from secondary care but for whom a CTP was considered to be unnecessary. Many consultees felt that psychiatrists are currently seeing service users that they do not need to see; people who have enduring but stable conditions that require drug monitoring. It was felt that these service users could be managed by GPs.

3.92 Changing models of delivery are being developed which aim to address the issue of high caseloads in outpatient clinics to ensure a more effective use of resources by freeing consultants to focus upon serious and complex cases:

- Primary care consultant run outpatient clinics are being considered or in development in some areas
- Systems for advice and support for GPs from clinical consultants over the care of people with long-term but stable conditions including post discharge from secondary sector
- Nurse-run clinics within the primary sector
- Recovery workers in the primary sector (a pilot project in Hywel Dda)
- Psychiatrists providing consultancy services to care coordinators and having no lists of service users themselves.

3.93 Another issue concerns people with long term psychological disorders including people with drug and alcohol problems and anti-social behaviour. Gofa participants said that the Measure does not support these people and that many of them remain outside of the statutory support sector. These are people who know least about how to access services and support and where services are currently failing to reinforce healthy behaviours. For those that try to access statutory services, they are offered no long term support and Part 1 can be seen as a *mop up* for them where they typically attend a ten-week intervention and return later for another round of the same.

3.94 Other issues raised by consultees around accessing Part 1 and 2 services include the following:

- Consultees pointed out that there are people who are not receiving coordinated care owing to capacity issues.
- Some service users, after receiving psychological therapies at Part 1, still have needs and are encountering two year waiting lists for services at the next level.
- The transition from Part 1 to Part 2 is from a primarily psychological service delivery model to a medical model.

Part 2 and Secondary Care

Staffing

3.95 Consultees mentioned that staff have received training in the Measure and its implementation and in CTP and the recovery planning approach. The high importance of continuous training and staff development was acknowledged.

3.96 Referral levels to CMHTs have varied across Wales in response to the Measure and the new primary care teams. Some secondary care managers said that their teams had experienced little significant difference in case loads as a result of the Measure. Referral levels are still as high and particularly so in areas that had gateway workers and other primary care provision prior to the Measure, as in Betsi Cadwaladr and Cardiff and Vale.

3.97 On the other hand, some areas have experienced a fall in the number of referrals and an increase in the proportion of appropriate, profoundly unwell people being referred to secondary services. People with less severe illnesses are now being referred to a robust service in primary care. This has impacted on CMHTs but also other secondary sector teams. For example, prior to the Measure people requiring short-term moderate interventions, like, for example, a short course of CBT, might have been supported by a crisis team and/or home help team. Since the Measure, these teams have been able to find a more appropriate service in primary care for these service users and are now able to focus on those in crisis.

3.98 As a result some areas have seen a fall in staff caseloads. For instance, in Denbighshire before the Measure, CMHT staff had an average of about 100 cases each and these have dropped to about 20. Managers in Hywel Dda also noted that the Measure was starting to impact positively on the number of referrals to CMHT and other secondary sector teams.

3.99 In areas that are experiencing decreases in secondary caseloads resources are under review; decisions are being made over whether services remain open and staff are being reallocated – some to primary care. This is providing an opportunity to properly review their secondary services based on a recovery model.

Care and Treatment Planning

3.100 Some managers said that **the Measure has formalised good practice** by introducing targets and tighter timescales for CTPs. However, they also said that the demands of the Measure in terms of change management has been variable with areas that had not fully embraced the CPA requiring more management input over a short period of time.

3.101 A key issue raised by many is that the Measure has required **a change in mindset for nursing staff** who are now required to be care coordinators and who have been introduced to the need for scrutiny.

3.102 There are professionals working with the Measure who have genuine **concerns over the quality of CTPs** and procedures for evaluating and

reviewing them. Some pointed out, for instance, that there is a tendency for care managers to only deal with areas of the CTP with which they feel confident or which are within their areas of expertise.

3.103 Several consultees made the distinction between CTPs produced by health staff as against social workers and the different professional cultures underling these differences. Writing detailed assessments, care plans and risk assessments to high standards and providing evidence of need and fair access to services is part of the professional practice of social workers. However, this has generally not been so for clinical staff.

3.104 Some social workers have been contributing to plans prepared by health care coordinators to ensure the comprehensive and holistic approach to care planning as required by the Measure. This has added to the work load of social workers.

3.105 Some consultees mentioned that health **staff have been generally fearful of the Measure** even though the care planning framework is not a lot different from formerly. It is thought that formalising care planning through legislation and the introduction of increasing scrutiny has led to anxiety and there is some evidence that staff are unwilling to take on the role:

If I can avoid being a care coordinator, I can get on with my job.

3.106 The **timescales and targets for CTPs** were considered to have placed pressure on performance to the detriment of quality especially in the early phase of implementation. Many consultees mentioned that quality auditing is now in place to monitor outcomes for service users and to ensure that staff are using the CTP appropriately.

3.107 One manager considered that a balance needs to be maintained between the quality of CTPs and the **administrative burden** that they bring. Another highlighted the additional workload pressures for CPNs and Social Workers alike in undertaking assessments as a result of the Measure. Although in some areas case numbers are falling in response to the Measure, staff now have to do more with the cases they have.

3.108 Administrative support for care planning was suggested as a solution to case load pressures along with an accompanying edict from Welsh Government in support.

3.109 It seems that relatively few consultant psychiatrists are currently taking on the **care coordinator role**. This is partly explained by their still generally very high case loads, particularly in outpatient clinics and the added administration required to undertake CTPs. Where consultants are part of CMHTs, there is a tendency for CPNs and/or social workers to undertake the role of care coordinator which is increasing case load pressures for these staff.

3.110 One manager highlighted also that prior to the Measure their care plan reviewing team comprised both qualified and non-qualified staff. Now that only care coordinators are eligible to review care plans, this has added to work pressures for qualified staff (CPNs and Social Workers in the main).

3.111 Consultees highlighted the significant issues around the role of care coordinators and longer term planning linked to the philosophy of recovery, which was not embodied in the CPA. The need for the **continuous training** for care coordinators in all disciplines – but particularly for health staff - was acknowledged. Also, health staff now have a role in commissioning and care management which has further implications for staff training. (Local authority staff are accustomed to these procedures).

3.112 The need for training in team development was also identified as necessary to enhance integrated working for the delivery of CTP. To this end, the Aston Team Development Approach has been delivered to adult and older age teams in Carmarthenshire over the last 18 months.

3.113 **Integrating the management of CTPs** with other plans required for care management (e.g. domiciliary care) requires extra administration and implications for IT management. One Health Board has configured their system such that the CTP template can be linked with plans devised by all disciplines involved in an individual's whole package of care.

3.114 There was some concern expressed over the likely implications for staff of the forthcoming Social Care and Well-being Bill and whether additional statutory duties will befall health and social care staff working with older people. Some mentioned concerns over the burden of having to prepare both UAPs and CTPs for individual service users. However, a social services team leader in one area mentioned that working with UAPs and CTPs is not a problem and that they have devised a system so they work together.

3.115 Many consultees argued that the Measure persists with a **medical model of care** which in practice is neither recovery nor outcome focused. Although welcoming the identification of eight strands within the CTP framework, in actuality social care needs of individuals were often not thoroughly considered nor planned for. Some local authority managers and third sector consultees said that they had contributed to care plans produced by health and social work staff to ensure that social care needs were included:

> *The Measure didn't go far enough in terms of the level below clinical interventions because not all mental health problems are clinical in terms of the solution; they are a mix of social determinants.*

3.116 The Gofal participants doubt that social workers and health staff fully understand the meaning of a 'recovery model' and that no amount of training will change that. They believe that the service user / practitioner relationship is one of power imbalance which will persist owing to professional cultures. They also questioned the amount to which service users were/are actually involved in their care planning either under the CPA or CTP systems:

> *If I look at people who have been in services a long time I'd say, 'are they involved?' The answer is 'no'. The plan is regurgitated with no evidence that the person has moved on. It's a management document rather than anything aspirational.*
> *It feels like you need a real culture shift, not just training.*

3.117 The Gofal participants also said that they were aware of people who had been in secondary services a long time who did not have CTPs at

all. Where CTPs are being produced, they consider that attention to accommodation and benefits planning is particularly poor and that the opportunity to input third sector specialist expertise in this and related areas is rarely sought:

> *There is a lack of understanding about critical issues and details needed for a transition to be successful.*

3.118 There are a few exceptions, however, and the forensics service in one health board was cited as one.

3.119 Participants said that occupational therapists work to a recovery model but unfortunately there are falling numbers of them working in mental health:

> *They see a person not just an illness.*
> *Mental health services are becoming increasingly monochrome.*
> *OTs are being marginalised.*

3.120 Participants argued that a medical model is not conducive to lateral thinking around an individual person's support. Typically, if treatments do not work, there is a tendency to *write the person off*. To illustrate this they mentioned a case where a psychiatrist recommended to a young person, who had just had their first psychotic episode, that they should sign themselves off permanently sick when the young person wanted to carry on working. A tendency for health professionals to encourage service users on to benefits was considered to be quite commonplace and illustrative of the risk-averse, clinical-led culture which is considered to persist within health settings:

> *… if the attitude is 'we need to treat you before you can consider anything else', it keeps people in a place.*

3.121 Participants said that to make the recovery process work as embodied in the Measure, there is a need to be taking positive risks with service users by allowing them to lead the process. This requires a complete change in culture.

3.122 One consultee said that some service users could be put off by the **CTP template** and called for CTPs to be more easily accessible to a range of service users, including people with limited literacy. If the CTP is to be service user driven then the wording and appearance of the

template should be less like a formal document. However, another consultee had encountered no problems with the template and said that their staff had been trained to avoid jargon, acronyms and health terms when drawing up CTPs. This consultee said that the headings were sufficiently broad to allow flexibility of interpretation.

3.123 Other issues in relation to CTP as raised by consultees include:

- Early work on implementation involved working with IT providers to ensure that the PARIS system was operating efficiently to ensure that CTPs were fully accessible to practitioners.
- As a result of the Measure, service users are considered to have higher expectations of services and staff are challenged to meet those expectations without any additional funding in support.
- Some service users resist having a CTP, leading to difficulties for practitioners. Educating service users to be more proactive is a challenge.
- Changing definitions mean that some service users might want to remain in secondary care (for some this might be to ensure eligibility for social care benefits) but practitioners want to discharge them to avoid the need for care planning.
- Whereas social workers are comfortable and familiar with risk management, the Measure has created issues concerning risk management for health staff.
- One manager thought that the Measure had been designed primarily for the complex few but that it has included everyone and that 'one size does not fit all'. In particular the perspectives of Older Adult Teams and CAMHS should have been considered when developing the Measure.

The Measure and Older People's Secondary Care Services

3.124 As a recovery model it was argued by some that the Measure does not fit with older people's services, as services to maintain independence

and well-being typically increase, rather than decrease, for older people over time.

3.125 Older people's mental health services were considered to be dominated by health rather than social support services. In at least one health board social workers are not care coordinators as they sit outside of the OPMH service and access to social work assessments is often problematic. In another area, health staff alone typically decide on allocating cases to Part 2 services without the involvement of social workers. As a result these decisions heavily focus upon clinical factors rather than taking an holistic approach. Decisions on discharge are similarly made by health staff alone in this area:

> *We don't operate a shared duty system. Nowhere near. I would have hoped that the Measure would have driven us closer. Engagement is missing. We could help one another with this.*

3.126 Also, the fact that these two professions are not working physically together from the same offices (as for CMHTs) and operating separate record keeping means that team working and communications are more challenging than in the adult teams. Difficulties in accessing patient notes held by psychiatrists are a particular source of frustration for social worker care coordinators in one area.

3.127 In one area, the specialist older people's team has been disbanded and older people are now being seen by the three locality teams which cater to a range of adult services and are led by social workers. This structure is considered by consultees to deliver an inadequate service to older people suffering from mental illnesses for a number of reasons. Firstly, social workers who have not worked in mental health before are becoming care coordinators for Part 2 or, secondly, are more usually bypassing Part 2 altogether in favour of the Unified Assessment Process (UAP) alone.

3.128 Professional differences in standards of care planning between health staff and social care staff were raised by several consultees. In particular, health staff are considered by social workers to neglect risk assessments and they consider that their contingency planning is inadequate:

Health is struggling with outcome focused care plans for older people.

3.129 Another cultural difference between the two professions was highlighted in that waiting times of six weeks are considered to be acceptable for CPNs but not for social workers.

3.130 An IT issue was also identified in one area where CPNs are writing their CTPs by hand, creating extra work and access problems for care managers. On the other hand, the case notes, referrals, assessments and support plans of social workers are computerised and accessible.

3.131 The fact that local authority and health boundaries are not aligned in some areas hinders integrated working which is at the heart of the Measure. This particularly impacts older people's mental health services, if social workers and health staff are located within different health board areas.

3.132 Some mentioned that these operations are under review and that they are looking at quality improvements which at the same time must contain costs, bearing in mind the growing numbers of older people with mental illness.

3.133 There was some interest in an all Wales assessment tool for older people and whether CTPs would be required if this was introduced.

3.134 Consultees mentioned the difficulties in care planning for people with significant memory problems and in ensuring that CTPs reflect the wishes and outcomes wanted by the service user. Although, in principle, the CTP should be written along with the service user, this is not always achievable. Although not strictly within the letter of the Measure, to constructively shape the CTP for people with severe memory loss, staff in at least one health board are listening to relatives and carers and taking the patient's wishes over a long time into account.

3.135 There are, of course, a wide range of people in older adult mental health services capable of contributing to their care plans including people in the latter stages of dementia and people with functional illness.

The Measure and Secondary Care Services for People with Learning Disabilities

3.136 The definition of secondary mental health services in relation to those with learning disabilities was highlighted as a particular issue partly because of the broad range of conditions within this service user group; from those being supported around epilepsy to those with physical disabilities.

3.137 One consultee mentioned that parents are often highly vocal against CTPs because they consider them to be inappropriate.

3.138 Whilst having a learning disability is a mental disorder, there were questions around whether all people with learning disabilities should have CTPs:

> *If patients are getting well-coordinated care without a CTP how worried should we be?*

3.139 Several consultees said that CTPs should focus only on people who most need them; people who would previously have been subject to CPA and these would be the relatively few with learning disabilities who also have complex problems and mental illness.

3.140 Another issue concerns people living with autistic spectrum disorder since some exhibit behavioural challenges. Debates continue at a national level over the relevance of care planning for these people.

Secondary sector IT systems and reporting

3.141 In some areas IT systems are causing difficulties and staff are working at service improvements to facilitate communications between all professionals involved in care planning and enabling online access to CTPs. In some areas these are already in place but others are in development:

- This is a particular issue where mental health services are delivered by a strategic partnership; each partner with their own systems.
- One manager mentioned that since the Measure, Social Workers on CMHTs have had double the work in updating

client management systems for the CTP as well as the system for their own standards.

3.142 Some areas are also working towards electronic recording of referrals whereas in others, these are already in place.

3.143 Part 2 returns to the Welsh Government only ask for acceptances and not referrals whereas for Part 3 they include referrals, acceptances and assessments. One health board is now recording referral rates and sources for Part 2 as this is considered by them to be highly useful information.

Part 3

3.144 Consultees had little to comment upon regarding this part of the Measure with some saying that there has been little change in practice or in numbers re-referring.

3.145 Re-referral levels are considered to be relatively low across Wales. For instance:

- Between October 2012 and October 2013 there were 55 requests for referral in Betsi Cadwaladr.
- In Cardiff and Vale there are about 30 referrals a month and about a third of these are converted to admissions.
- In Aneurin Bevan there are 30-40 referrals a month and 20-30 of these are readmitted.

3.146 Those not re-entering are assessed and told why they are not re-entering secondary care and are referred to primary care or signposted to third sector services.

3.147 One manager said that within their health board they are ‘hammering home’ that contingency plans signed up to by service users and teams should be in place. They also said that comprehensive care plans that focus on outcomes and build in contingency would offset the need for Part 3.

3.148 One consultee, speculating over the low referral rate, suggested that the low numbers might be explained by the fact that it is easy to be referred and that perhaps not all cases are being picked up in data collection and reporting.

3.149 Consultees mentioned some variability in reporting referrals to Welsh Government. Some record referrals from service users only whereas others are including carer referrals also.

3.150 Gofal participants had witnessed confusion amongst a few people discharged from secondary services; some saying that they were unaware that they had been discharged and others were unaware of the pathway to re-accessing the service as defined by the Measure. Participants were also aware that some service users are going back to their GPs as they would if they were a new patient. Even if the information is being provided, it appears that at least for some people, it is not being understood or taken in. Participants questioned whether merely giving written advice and information is sufficient and that real engagement person-to-person would also be necessary for many service users and particularly those with limited literacy:

> *It's a good idea but the communication around it needs improving.*
>
> *Some people have literacy issues and don't read letters.*

3.151 Gofal participants said that they would like to be informed when support is ending for a service user that they have been involved with. This is currently not happening although:

> *If we end support for someone, we always tell the referrer.*

3.152 They also highlighted their approach to explaining discharge to service users and suggested that this should be adopted in the health service:

> *We sit down with people and talk to them about tapering off our support or referral to another service .. and end it in an appropriate way.*

Part 4

3.153 These services are being delivered through third sector contracts with the following providers:

- MAP in Hywel Dda
- Advocacy Support Cymru (ASC) in Abertawe Bro Morgannwg, Cardiff and Vale, Cwm Taf and Powys
- Unllais in Betsi Cadwaladr

- Mental Health Matters in Aneurin Bevan

3.154 All consultees were positive about the professionalism of these providers and they especially commended them for catering to diverse needs by offering, for example, advocacy for the hard of hearing; use of braille and having BME advocates.

3.155 Consultees mentioned that in advance of the measure they provided training to nurses in general hospitals to raise awareness over Part 4. They also held meetings with staff - especially those dealing with older patients in general hospitals – and attended clinical meetings to raise awareness. This promotional activity involved considerable effort but is considered to have been highly successful. Other awareness raising methods included:

- On ward literature and posters
- An e-learning package has been developed by ASC for health staff in Wales
- Intranet information including scroll messages: *your patients are now eligible for this service*

3.156 This part of the Measure is considered to have been very positive for people in acute care with a more robust focus than before on ensuring that they have access to IMHA services. Patients receive information on advocacy on admission.

3.157 Consultees said that advocates are involved in multi-disciplinary on-ward patient review meetings and on the power to discharge groups. They are also working positively with other third sector organisations towards patient support.

3.158 A positive aspect arising from the Measure is the CTP reporting which helps in focusing on the patient and monitoring their access to advocacy services.

3.159 Another positive outcome is that the service supports policies on inpatient care:

> *The service has ruffled a few feathers but has been useful because inpatient services have improved as a result.*

3.160 In one health board area initial difficulties arose when advocates encouraged patients to complain leading to tensions with clinicians. Liaison meetings were arranged and these issues were resolved and a new complaints procedure instituted.

3.161 Generally speaking, clinicians believe that advocacy services benefit themselves and patients although one consultee suggested that it is still necessary to shift the understanding of clinical staff from seeing the advocates as a threat. This same consultee said that there should be more advocates working in general hospital settings and that more promotion is needed to increase the uptake particularly in larger clinical units.

3.162 It is considered, also, that advocacy services could involve more older and younger people.

3.163 A consultee mentioned a Welsh Government reporting issue. Some people enter hospital as informal patients for short term interventions but then convert to Part 2 or Part 3. This service is now capturing this information under their new system and thereby only counting a patient once.

The Third Sector

3.164 The importance of the third sector to the delivery of the Measure by providing additional resource and complementary or specialist services at Part 1, Part 2 and Part 4 was frequently mentioned:

> *Given the low numbers, we partner a lot with voluntary agencies. We have done an anger management group with MIND recently where we co-facilitated. It makes logical sense that we deliver things across the board. If you draw firm lines, you lose some of the value.*

3.165 Arrangements with third sector organisations include the following, for example:

- On discharge from the secondary sector many service users are referred to organisations where the statutory sector has service level agreements for non-care coordinated services.

- Third sector partners have been instrumental in helping to develop regional LPMHSS schemes and are represented on monitoring and review groups.
- Third sector organisations have been commissioned to deliver counselling and therapeutic services at Tiers 0, 1, and 2.
- Statutory services signpost people to third sector organisations as appropriate.
- Third sector 'markets' or awareness raising sessions and regular meetings are hosted by the statutory sector to raise staff awareness of Third Sector providers.

3.166 Third sector organisations appear to be preferred by a small cohort of people who have quite chaotic lives and who have no contact or only limited contact with the statutory sector. These are typically males aged 18-35 years who are involved in the criminal justice system owing to violent episodes and/or substance misuse. Gofal participants said that Third Sector organisations fit with these people's ideas of the type of services they want. Also statutory services see these organisations almost as a last resource for certain service users:

> *A referral will come to us because people don't know what to do with them … they have bounced around the criminal justice system; they may have bounced around the healthcare system but without any consistent longer term engagement.*

3.167 These can include people leaving prison; although numbers are small, the impact and disruption caused can be large.

3.168 Gofal participants also identified that they see people with learning disabilities who have mental health problems but who do not fit the criteria for either statutory service.

3.169 Some health boards consider that their arrangements with Third Sector organisations are going beyond a commission relationship to partnership working. However, this is rarely formalised and so far only one example has been identified by this project: Gofal is running the Crisis House in Cardiff in partnership with health and Gofal staff now

have honorary contracts so they are able to access the NHS database. There is a jointly agreed operational plan between the Crisis Service and Gofal. This is a rare exception and contracts are usually arranged by commission. Also some health boards appear to resist working with the Third Sector at all.

3.170 Third sector organisations think this is regrettable, particularly since they have expertise in a range of specialist services; are used to working to a recovery model and see collaboration as essential for holistic client support. A Gofal participant said:

> *Because we work to a recovery model and we always have, we can't ever see ourselves as the only solution to a person's problem so the only way of doing that is through effective collaboration … very few organisations are prepared to give up control. To deliver the best outcomes for the service users, it is their needs that are primary.*

3.171 The Gofal participants believe that there is a role for the third sector in brokering communications between professionals within the statutory sector:

> *… stepping into the breach if you like and saying, 'right, if you people are not speaking to each other as regularly as you should do, we can do that' – and I think effectively that's what we've done.*

3.172 Third sector service users are increasing as a result of the Measure and signposting from LPMHSS teams. However, although working with third sector organisations is generally welcomed by GPs they are cautious about signposting to them directly unless they have been commissioned by the statutory sector.

3.173 Another 'signposting' issue was mentioned by Gofal participants and other consultees: service users are being advised to approach third sector organisations because of a shortage in capacity within statutory services. However, some third sector organisations are themselves experiencing capacity shortfalls owing to financial cutbacks.

3.174 Some managers mentioned that existing third sector contracts were under review to determine whether they fit within or alongside the

primary care service or whether they can offer services to fill any gaps in service provision or reduce waiting lists for specialist services. For example, one consultee mentioned that there is a two year waiting list in their area for counselling child abuse victims and they are considering commissioning a third sector organisation in support.

3.175 Although not a third sector organisation it should be pointed out that in Cwm Taf, LPMHSS staff work with Communities First teams who offer a range of services including walking groups, social groups and Weight Watchers along with community venues for group work and the promotion of services to the public.

4 Conclusions

4.1 This report has presented the overall approach to the qualitative evaluation project, the findings from which will contribute to Welsh Government's Duty to Review the Mental Health (Wales) Measure. This project includes several elements, each of which will aim to represent the diversity of practitioners, service users and carers across Wales who have been and are affected by the Measure.

4.2 The early scoping stage of the project has provided valuable background and has highlighted examples of good practice and issues of concern which will be followed up with participants in the remaining stages in relation to all four Parts of the Measure.

4.3 Whilst mental health practitioners interviewed so far support the principles and aims of the Measure and welcome the opportunity to improve and develop services and formalise good practice, there are many who are concerned over the scale of the changes required; the increasing expectations of service users and the cultural shifts in approach and practice which the Measure demands. For many, the speed at which these changes are expected to take place are particularly daunting; for others confusion remains over referral pathways and the definition of primary and secondary care services. However, practitioners also admit that it is still early days; that services and practices will be imbedding for some time to come and procedures and priorities will adapt and change in response to local demands, whilst adhering to the spirit and legislative demands of the Measure.

Appendix 1: Scoping Phase Consultees

Scoping Phase consultees included the following job roles:
Strategic Leads and/or Programme Managers for the different parts of the Measure, Acute Care Lead, Chair, Clinical Programme Manager, Performance Improvement Manager, Social Work Team Leader Older People, Head of Partnership, Development and Integration, Executive Director, LPMHSS Managers, Principal Officer, Adult Mental Health, Patient Experience Manager, Mental Health Manager

The following organisations were represented in the consultations:
Aneurin Bevan Health Board, Abertawe Bro Morgannwg University Health Board, Hywel Dda Health Board, Wales Mental Health in Primary Care, Public Health Wales, Betsi Cadwaladr University Health Board, Caerphilly County Borough Council, Swansea C&C, Gofal, Hafal, Cwm Taf Health Board, Cardiff and Vale University Health Board, Powys Teaching Health Board

Appendix 2: Draft Practitioner Focus Group/Interview Script

This script will be finalised following publication of this report.

Mental Health Measure 2010 – Qualitative Consultations as input to Review

Draft Practitioners Discussion Guide 2013

Introduction

Introduction to Moderator/ORS

Honest messenger – independent - not part of Welsh Government but here to report back people's views to them.

ORS a member of MRS

Explanation of focus groups – ground rules

Want YOU to do the talking

Please say what you think – all ideas have value and there are no right or wrong answers

Respect others' opinions - even if you don't share them!

One at a time please.

Informal session about 90 mins

Turn off mobile phones or switch to silent

Confidentiality and permission to record

Background

The Measure places a duty on Welsh Ministers to review the operation of the Measure and to publish reports within four years of the commencement of the key provisions – that is, Parts 1, 2 3 and 4.

Information is being provided from various sources to inform this Review – including, for example, the regular submissions provided by Health Boards and Local Authorities.

To add to and complement these sources, the Welsh Government has asked ORS to provide **qualitative** evidence on the views of service users, their carers and practitioners on the implementation of Parts 1 to 4 of the Measure and we'll prepare a report of the findings from these towards the end of 2015.

Before Christmas (or over the last few weeks) we've consulted with about 25 mental health professionals throughout Wales to help in planning the study.

We are now holding focus groups like this with a number of local primary care teams and CMHTs and as we go along we'll be in contact with other practitioners as the need arises. Later in the year we'll discuss Parts 1, 2 and 3 of the Measure with Service users and carers and early next year we'll move on to Part 4.

The purpose of today's meeting is to discuss all aspects of the Measure although, of course, you are sure to want to focus on certain aspects.

Introduction to group

Name and role? How long in the job?

[Facilitator: Particularly if LPMHSS team member BRIEFLY probe around role prior to current role]

Introduction to Measure

What do you think about the Measure in principle? Why? (Briefly)

Part 1 of the Measure

First let's talk about **partnership working**. How far are LPMHSS team members working effectively in partnership …

… with each other?

… with GPs and other primary care staff?

… with colleagues in the secondary sector?

… with colleagues in the Third sector?

What has been put in place to create effective working relationships?

Has this been effective?

Are there any ways in which these working relationships could be improved?

How are the **referral** and **assessment** processes working?

Numbers? Waiting times?

How could these numbers be reduced? **[Facilitator: probe around Tier 0 services]**

What kinds of people are being referred to the LPMHSS service?

What did they do before LPMHSS?

How is the distinction between primary care and secondary care working in practice?

To what extent are all people supported within the existing system? Are any missing out? Who? Why?

To what extent are you satisfied that the team is providing effective **information, advice and signposting** for service users?

What are you satisfied with?

How could this be improved?

Are there barriers to improvement (time, resources)?

In what ways is the team providing **information, advice and support to GPs**?

What are you satisfied with?

Are you aware of any concerns around this?

How could this be improved?

Are there barriers to improvement (time, resources)?

In what ways is the team providing treatment by way of **short-term interventions**?

Which interventions do you offer and how / *by* whom?

Which ones seem to be working and *for* whom?

What, if anything, are you content with about this requirement of the Measure?

What are your concerns, if any, about this requirement of the Measure?

[Facilitator: probe for numbers of referrals; waiting times; pressure of work; pressure of assessments impacting on ability to deliver interventions]

What is being done/could be done to overcome these issues?

To what extent has the training available to staff provided them with the skills and confidence needed?

What, if anything, are you satisfied with?

Are there any concerns around this? Any additional training needed?

Are there barriers to training (time, resources)?

Any other comments about Part 1?

Part 2 of the Measure

The Measure calls for **coordinated working** for the effective delivery of services. How is this working in practice? How far is this being applied within Secondary Care?

Are there services where this is not happening? Why?

[Facilitator: probe for CMHTs, Older Adult services, CAMHs, LD services, other services]

What are the impacts of this for:

- Staff?
- Service users?

What needs to change to improve coordinated working?

How has the **introduction of CTPs (as opposed to CPA or other plans)** impacted on:

- Staff?
- Service users?

[Facilitator: probe: for positive and negative impacts – e.g. workloads, role of psychiatrists, defining what is secondary care]

Has **training** in writing, reviewing and revising the CTPs been made available to staff?

How useful was this training?

Is any other training needed?

Are there any other concerns about using the CTP?

[Facilitator: probe: professional differences between clinical and social work staff; accessibility of layout and language for service users, care coordinator eligibility]

Part 3 of the Measure

What are your experiences in the administration of this part of the Measure?

What is working well?

What is not working so well?

How relevant is the discharge period for Part 3 proving to be?

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

What happens to people who are not eligible to re-enter secondary care?

To what extent is primary care meeting their needs?

How could this be improved?

What are the barriers to improvement?

Part 4 of the Measure

What are your experiences in the administration of this part of the Measure?

How is advocacy being delivered / by whom?

What is working well?

What is not working so well?

How is this service promoted to patients and how effective is it?

Are there any concerns about access to the service?

Is advocacy available to all who request it?

Wind up

Before we close, are there any further points you would like to make around the Measure?

Summarise the group's views.

Thank and close.