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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

Part 1 FINAL REPORT: Local Primary Mental Health Support Services



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Opinion Research Services

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

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A Research Advisory Group comprising practitioners from statutory and voluntary sectors guided the project and we are grateful for their support and advice throughout.

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

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
CAMHS PMHS	CAMHS Primary Mental Health Service
CAVAMH	Cardiff and Vale Action for Mental Health
CBT	Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
CPA	Care Programme Approach: the main way of assessing, identifying and recording 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
DNA	Did Not Attend – referring to service users who do not attend appointments
EMDR	Eye Movement Desensitisation and Reprocessing therapy
IAPT	Improving Access to Psychological Therapies
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
LD	Learning Disabilities
LPMHSS	Local Primary Mental Health Support Service
MHDO	Mental Health Development Organisation
OPMH	Older People's Mental Health
OT	Occupational Therapist
PAMH	Powys Agency for Mental Health
PTSD	Post Traumatic Stress Disorder
UAP	Unified Assessment Process
WaMH in PC	Wales Mental Health in Primary Care
WWAMH	West Wales Action for Mental Health

1 Introduction

- 1.1 Opinion Research Services (ORS) was commissioned by Welsh Government in June 2013 to undertake qualitative research to support the Duty to Review the Mental Health (Wales) Measure 2010.
- 1.2 Information and data are gathered by Welsh Government from a range of sources to inform the Review including this study, regular submissions from health board/local authority services, health board primary care satisfaction surveys and third sector surveys. Welsh Government is responsible for coordinating all inputs to the Review and for final reporting to Welsh Ministers.
- 1.3 This study by ORS provides qualitative evidence on the views of service users, their carers and practitioners on the implementation of Parts 1 to 4 of the Measure. The findings are presented in four separate reports; one for each part of the Measure and an overall summary report in Welsh and English versions.
- 1.4 An interim report¹ published in 2014 presents the background and methodology for this study in some detail which are not repeated in the final reports. This report presents findings from qualitative interviews conducted between July 2014 and April 2015 involving participants with direct experience of Part 1 of the Measure.
- 1.5 The Mental Health (Wales) Measure 2010 introduced a number of changes relating to the assessment of and treatment of people with mental health problems in Wales, the essential requirements of which are set out in four parts:
Part 1: Local Primary Mental Health Support Services
Part 2: Coordination of and Care and Treatment Planning for Secondary Mental Health Users
Part 3: Assessments of Former Users of Secondary Mental Health Services
Part 4: Mental Health Advocacy

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

Part 1: Local Primary Mental Health Support Services

- 1.6 The aim of Part 1 was to strengthen the role of primary care by establishing local primary mental health support services (LPMHSS) throughout Wales for people of all ages who were experiencing mild to moderate, or stable severe and enduring mental health problems. These services were to be delivered by partnerships of health boards and local authorities and to operate within or alongside GP services. In brief, these services were to provide:
- Comprehensive mental health assessments
 - Treatment by way of short-term interventions
 - Provision of information and advice to individuals and carers about treatment and care and 'signposting' to other sources of support
 - Provision of support and advice to GPs and other primary care workers
 - Supporting the onward referral and coordination of next steps with secondary mental health services.
- 1.7 The statutory duties around Part 1 commenced on 1 October 2012 and Welsh Government recommended that agreed schemes should be in place by May 2012.

ORS Role and Commission

- 1.8 Welsh Government identified their requirements of this qualitative research project in relation to Part 1 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.
- 1.9 The findings from the research presented in this report adhere to these requirements.

Ethical Considerations

- 1.10 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 to proceed from the health boards via their Research and Development sections.
- 1.11 Examination of the Research Ethics Committee decision tool² clearly identified the project as 'evaluation', meaning that it was not subject to full ethical review. All seven Health Boards gave their permissions to proceed. In addition, The Government Social Research Ethics Checklist was completed and guided the project throughout.
- 1.12 All ORS staff involved in the project were fully trained in the principles of medical and social research ethics and, in particular: potential participants' rights to clear and full information about the study; the importance of informed consent; the right to withdraw from participation at any time and recognition that potential harm to subjects takes many forms, including inconvenience and emotional stress. Each participant was required to read full information about the project and to sign a consent form before taking part.

Methodology – Part 1 Qualitative Focus Groups and Interviews

- 1.13 Our methodology encompassed focus groups and individual telephone interviews with Part 1 service user participants. We relied heavily upon help from statutory and third sector organisations to recruit service users and carers across Wales; 38 service users and two carers were involved (See Appendix 2 for profiling information).
- 1.14 Five case studies were prepared from the interviews. These are presented in Appendix 1 and provide insights into individual patient experiences of the LPMHSS.

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

- 1.15 Focus groups were held involving 29 primary mental health practitioners in three health board areas and throughout the study other statutory and voluntary sector mental health practitioners also commented on the provisions for and implementation of Part 1.
- 1.16 In addition, 36 practice staff including 22 GPs from nine GP practices across Wales were involved in group discussions or individual interviews by telephone or face-to-face.
- 1.17 We encouraged participants to engage with the issues and express their opinions and feelings in their own words. Focus group sessions lasted for up to two hours and interviews for about half an hour.
- 1.18 Although qualitative approaches cannot be certified as statistically representative samples of public opinion, the meetings and interviews reported here gave diverse groups of people the opportunity to be involved. Because the recruitment was inclusive and participants were diverse we are satisfied that the outcomes are broadly indicative of opinion based on direct personal experience. The outcomes reported in this report are, therefore, reliable as examples of the reflections and opinions of a range of informed people on the implementation of the changes introduced by Part 1 of the Mental Health Measure.
- 1.19 The views expressed by participants 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 with reporting them. This should be borne in mind when considering the findings. Where possible any such issues are flagged up in the report.
- 1.20 Verbatim quotations are used throughout, in indented italics, for their vividness in capturing points of view. ORS reports the opinions as given and does not necessarily endorse the opinions in question.

2 The Findings: Part 1

- 2.1 This chapter draws upon the focus groups and interviews conducted with service users and their carers, with mental health practitioners and with GPs and their practice staff. The findings under each of the specific review questions are presented in turn and in the order in which they were presented in the original Welsh Government project briefing document. A summary for each question precedes the more detailed presentation of the findings.
- 2.2 The findings presented here complement those from patient and GP practice self-completion surveys administered by the health boards and analysed by Welsh Government to input to the overall Review report.

Review Question 1: Support to primary care providers.

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

Summary

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

Comments

Information about the LPMHSS

- 2.4 Health Boards and LPMHSS staff have raised awareness of the service amongst primary care practices through regular direct contact with individual GPs; presentations and printed information.

All practices had to have a training session that lasted two hours. They did a presentation about the groups and the workshops and things that were available out there. (GP)

There is an ongoing programme of raising awareness of the Measure with GPs who are asking why things have changed. (LPMHSS)

When we're in the GPs' surgeries we network with all the staff. So we're gradually making inroads and being a part of that surgery. They're getting used to us. (LPMHSS)

Managing Patients with Mental Health problems

- 2.5 None of the GPs involved in our research said that they had received formal presentations or advice on how to manage patients with mental health conditions. However, LPMHSS staff said that formal learning sessions were ongoing. Several of the GPs said that they were gaining some knowledge via routine day-to-day interactions with service staff and from patient notes. Also, in a few practices, regular case meetings between practice and LPMHSS staff had been established:

Last year we facilitated a mental health primary care mental health day for practice nurses. And then we did it again this year and (therapist) came and did a session on mindfulness and lots of other things that they weren't really aware of, you know, that they can actually tap into. (LPMHSS)

She writes in our clinical notes, so when I see the patient again ... she's flagged it up ... everything she's mentioned is there ... (GP)

Ordinarily we see a patient and send a report back. If there's a query, or if there's any risk attached I would normally phone and

give a bit more information. (LPMHSS)

Some GPs do tend to discuss the referrals with me before they put them through. (LPMHSS)

- 2.6 In one Health Board area, GPs were able to send requests for advice via the single point of access electronic system: the uptake for this service varied widely amongst GPs.

Information about Local Services

- 2.7 Some GPs said that they had learnt about third sector services from their interactions with the LPMHSS:

We've had information about lists of other counsellors and that sort of thing (GP)

Because there are so many organisations ... if a patient doesn't need to see her, and then I just want some advice, where can they go, you know? Yeah. And she's quite helpful. (GP)

We offer GPs a signposting service to appropriate groups or resources that are going to make their [the patients'] lives a little bit more purposeful and meaningful. (LPMHSS)

Review Question 2: Satisfaction of primary care providers with the support

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

Summary

- 2.8 Most of our GP practice participants said that the main way in which the LPMHSS was increasing understanding of mental health was through discussions with practice staff over individual patient cases. This was easiest where a member of the LPMHSS team was based for at least one day a week in the practice or where formal case meetings were held. However, most GP practice staff interviewed said they had hoped to learn more about how to manage patients with mental illness: to have the ability to retain

patients; reduce the number of referrals and treat patients without prescribing.

- 2.9 GPs said that they would like feedback from the LPMHSS on:
- The number of patients that were seen and waiting times
 - The type of patients that were seen by age and disability
 - How the LPMHSS supported their patients
 - Their own referrals and how they could improve them
 - The performance of LPMHSS more generally
- 2.10 Some of the GPs said they would appreciate knowing more about third sector organisations - and, in particular, the effectiveness of local organisations - to build confidence to signpost to them.
- 2.11 Many of the GPs in this study remained unaware or confused about the role of the LPMHSS or were uninterested in mental health and resistant to working with the service.

Comments

Awareness of the LPMHSS

- 2.12 An issue that arose frequently throughout the study - from service users and LPMHSS staff - was that many GPs were still unaware of the LPMHSS or uninterested in mental health and resistant to working with the service. It appears that GPs remained confused, mistaking the service for social care or counselling. The implications were that knowledge around the management of mental health and the number of referrals would be limited in these practices:

Some GPs have never heard of LPMHSS and don't know that they're part of the system. (CMHT)

The stance in his particular surgery is basically we don't want to know and if you do tell us we're not going to listen. (LPMHSS)

I went in (to a networking meeting) and gave a presentation regarding the service. I had to go back there again three months later to do exactly the same thing because they still didn't know what our service was doing there... and again since that time and

there's still no change ... (LPMHSS)

We tried to do a roadshow of the Measure ... Only one of their GPs bothered to turn up and that was half an hour late. ... the GP said he was going to have nothing to do with it. (CMHT)

I think they feel that the CMHT is coming in and doing an assessment in the surgery (LPMHSS)

- 2.13 LPMHSS staff in one health board area felt the Measure had resulted in fragmentation between primary and secondary care mental health services and that pathways to care remained unclear:

We're actually less integrated now and it seems like we're battling amongst each other ... everybody's putting up their boundaries and shutting down their gangways ... so although you want to educate and communicate more with people ... some of the information we can't give them because we don't have it ourselves. (LPMHSS)

- 2.14 Some GPs admitted that they should take responsibility upon themselves for establishing working relationships with the service:

To be fair, if I talk to them then I get answers... It's just having the time; knowing where they are, and how to contact them. (GP)

It needs for us to be receptive as well. You can't teach people who don't want to learn. (GP)

We had one GP in particular who came to a mindfulness course. Oh, she's over the moon with it now ... we can convert them. But it's getting them there. (LPMHSS)

Advice, Learning, Information

- 2.15 For the most part, GP practice staff felt that the information and advice from the LPMHSS around clinical management, in particular, had not yet met their original expectations. Whilst GPs generally agreed that prioritising assessments was appropriate in the early days of Measure implementation, most remained disappointed. Indeed, one GP scored their LPMHS service a 'zero'

for the learning provided. Only a few GPs, who had formed positive relationships based on regular meetings, were relatively more satisfied:

There's been no information or advice from the LPMHS service (GP)

I think the ask there is huge. I'd like to give them 20 years to get there. (GP)

It would be great if they could run a training course for us to upskill but ... I think they're putting the priority in the right place in the initial phase ... You can't expect to hit the ground running when you have a cultural stigma and all of the intransigent inertia, rehearsed professional practice – take these pills and go away ... (GP)

... when we have our meetings we'll discuss the caseload ... so we'll discuss the most appropriate way for this person to be helped ... they'll also provide a psychological view on that. (GP)

In the general consultation it's very useful to have some back up in terms of current knowledge as to how you might impart some psychological support to people who have distress for other (health) reasons for example diabetes, cancer or heart conditions. I think with the minor ailments if you get those right and empower people to deal with those ... then you can quickly move on. (GP)

Information on Third Sector Services and Signposting

- 2.16 Some of the GPs were relatively positive about the information they received from the LPMHSS about statutory and third sector services, although they would appreciate knowing more so that they could signpost more confidently themselves. In particular, learning **about the effectiveness of local organisations** and how they have supported patients would be helpful. Some participants suggested that the mental health development organisations (MHDOs) could help GPs to signpost to the Third sector:

When they write back with their recommendations you can see

where they've signposted people to and you can say, 'oh I didn't realise that service existed'. So that has its uses. (GP)

I'm getting a better feel as to what services are available. The LPMH worker writes quite clear letters highlighting what sort of services this person has been signposted on to. (GP)

She is signposting to courses and ... If we had a list of everything that was available it might be easier sometimes to pass people on without having to go through those services. (GP)

We don't know how many people actually rang them (voluntary organisation). And the ones who rang them, how many people did they actually take on, or just give them a leaflet. (GP)

There needs to be a service that does the signposting so all the doctor needs to do is say go and talk to x, they have my number and then I can do the signposting. Like a third sector broker. (MHDO)

Feedback on Patient Cases

- 2.17 There was a wide range of opinion amongst GPs about feedback on patient cases. Whilst a few GPs had established good working procedures with the LPMHSS and were relatively pleased; others had not, and were clear about the changes they would like to see:

It all works very well. We meet with them every Monday and we meet with one of their representatives at our fortnightly practice meeting. And we prefer to meet because there are various things you wouldn't want to write in a letter or are difficult to write about. (LPMHSS)

And I've had feedback from the primary care team as well. When they've reassessed and seen them, they've come to me and said how they are getting on, so there has been some continuous care. (GP)

We have very little idea of what goes on in LPMHSS so you can't call that a close working relationship. We don't know if patients are

attending and what's happened unless the patient tells us. (GP)

What I need is a summary at the end of the episode to go in the record. I do not need to know what it is they're doing. Unless, of course, I can learn some of that skill. (GP)

I would like the service to say when a case is closed and that the patient has been given the resources to manage the distress themselves next time. Which is a useful thing to have in the records because the next time an event occurs sometimes all you need is to have a brief intervention ... and they quickly pick up. I think the way it's closed is not as structured ... The most common report says the patient came to three sessions and then stopped turning up. (GP)

Feedback - Service Effectiveness

- 2.18 GPs said they would be interested in learning about the effectiveness of the LPMHSS; patient outcomes; DNAs and throughput so, if necessary, they could assist the service to reduce waiting lists. Having this knowledge would provide the confidence needed to refer patients on to the LPMHSS:

It would be really nice to know what the performance of our local LPMHSS is. What we need is outcomes – we don't need all this noise about performance. (GP)

Is anyone measuring the CPN's outcomes? Because I've had some feedback which is not great: patients feeling that they're not getting much better. (GP)

The things we wanted to know were things like their DNA rate, their waiting list and how successful their service was. We really want them to nail it down ... we want to know every time a patient is missing; and what we can do about that... Their illness means they're not going to turn up. That's normal. And if they're not going to turn up, we can fill the slot. (GP)

We don't really know a lot of what goes on apart from when patients come back and tell us what they've done. (GP)

Feedback - Referrals

- 2.19 A few GPs and LPMHSS staff highlighted how they were already working together over referrals. However, several GPs said that they would like to learn and improve on their referrals. They also said that learning more about mental health would enable them to retain more patients and thereby reduce the pressure on the LPMHSS:

I will ask her first sometimes to see whether it's worth her seeing, or whether they can go somewhere else. (GP)

If you have a good, experienced primary care worker it can sometimes prevent a referral... that person will advise the GP and it might mean they're not referring ... (LPMHSS)

If I've got the diagnosis right and it is a severe and enduring mental illness but it's bounced back... what was wrong with my referral? ... and that's really where the feedback is missing. (GP)

If they gave us feedback on our paper-based referrals and said 'you could've done this; and I've signposted this to this' then I would learn and might not do the paper-based referral like that next time. I wouldn't be remotely offended. (GP)

We don't give her any feedback and perhaps we should. We may be able to coordinate our referrals better, then, rather than send somebody with complex needs on. (GP)

Some of that is our fault as well. It's quicker to fill in a paper referral than it is to fiddle about trying to get hold of somebody (LPMHSS staff) ... (GP)

- 2.20 Liaising over referrals could also prevent GPs from raising unrealistic expectations of the service or patients missing out on appropriate services:

So, they refer a lot of people through to us for counselling, and counselling plays such a small part of what we actually offer. (LPMHSS)

I went to talk to a lady ... and her experience of accessing the primary care support service was that the GP did know about it but his attitude was 'I'll send you to see the girls' and who the girls were, were the practitioners who were delivering the courses in the community about mindfulness and stress management so she wasn't given a holistic assessment. (MHDO)

A Practice-based Service

- 2.21 Having the LPMHSS based within the GP practice was considered to ease professional communications and learning. However, in many GP practices this was not possible owing to room shortages and their patients were typically seen in CMHT offices or other community spaces:

We could easily talk to the people that are involved in the service. They're on site – so we know them... (GP)

If we'd had an attached person it would have helped educate us over what else is out there. It would have been a process that would have been more learning and the patients would have had more face to face contact and we'd have much more idea of what's going on ... (GP)

We went down to a meeting and they were very open minded about everything, very receptive of what we had to offer, asked lots of appropriate questions and then told us, 'well unfortunately we haven't got a room for you', so that was the end of that. (LPMHSS)

Another thing is that GP surgeries are limited sometimes in their time slots they can offer you. I've sent appointments out today, which far exceed the 28 day target; I could have fitted them in well within the time in my diary - the surgery can't accommodate me and then that looks bad on me. (LPMHSS)

We're seeing more and more people in our spaces now (central clinics and hospital settings). (LPMHSS)

- 2.22 Aside from spending time at GP surgeries, primary mental health professionals also stated that being based in offices alongside their

secondary sector colleagues provided them with invaluable professional support:

It's enabled the primary care workers not to feel as isolated as they did previously. Because they can be out in GP surgeries by themselves, but now they know there's a team behind them ... so that enabled people to feel a lot more supported ... I think the team feels able to take on more complexity ... Now the worker will assess them and with supervision hopefully stay with that person. But if they need to be seen by a Tier 2, they're seen by a Tier 2. Because we sit in the same building, we can walk along the corridor and there's somebody there. (LPMHSS)

Review Question 3: Satisfaction of primary care providers with the service overall

Assess the satisfaction of primary care providers with the local primary mental health support service overall.

- 2.23 It is not possible from the findings to make a simple statement about satisfaction with the LPMHSS overall. However, it is clear that it is good in parts; that progress is being made; but that there is some way to go to ensure that patients and their GPs are fully benefiting from the service. By and large the picture is that the LPMHSS teams are working hard to deliver a service which they and GPs consider to be underresourced for the existing demand. The following comments are intended to illustrate these points.

Summary

- 2.24 Some practitioners said that fewer cases were 'bouncing back' from CMHTs either because the LPMHSS provided another option or because it was helping to make sure that GP referrals were directed appropriately. However, problems in accessing some services persisted.
- 2.25 Some GPs said that since the Measure their patients had found it easier to access support for mental illness whilst others had seen

little change. A number of them would prefer the LPMHSS to take on more of their cases and some GPs said they were retaining all but the most serious cases or signposting to the voluntary sector to limit pressure on the service.

- 2.26 A range of pathways into primary care services was highlighted across Wales for certain groups including older people, young people and people with learning disabilities or other special needs. Some practitioners also believed that certain groups were missing out on LPMHSS including adults with autism and people living with OCD, severe anxiety disorders, learning disabilities or dementia, and carers.
- 2.27 Waiting times for assessment varied: some practitioners said their patients were seen quickly whilst others were aware that the guideline of 28 days was being breached. Telephone assessments were considered to be one way of increasing throughput although opinions varied on their suitability. LPMHSS staff frequently said that assessments in themselves could provide therapeutic benefits.
- 2.28 LPMHSS practitioners and a few GPs highlighted significant benefits arising from the therapeutic interventions provided by the LPMHSS including drops in the number of patient appointments, levels of prescribing and referrals to psychiatric care. Some GPs highlighted the timely responsiveness of the service and the benefits for their patients. A particular benefit of the service was identified as supporting people to take control of their own lives rather than developing dependent relationships with mental health services.
- 2.29 However, most GPs interviewed felt that the service was falling short of their expectations and complained that the LPMHSS either signposted patients or offered nothing at all. Where therapeutic interventions were provided, some criticised the limited time offer.
- 2.30 Physical access, agoraphobia, social anxiety and deprivation were considered to act as barriers to therapy, and interventions based in local communities or via the telephone were suggested along with more sessions at times to suit working people and students.

- 2.31 Differing experiences of professional relationships between GPs and the LPMHSS were highlighted in the study. Whilst there were some examples of best practice, GPs and the service needed to establish more positive working procedures in many practices.
- 2.32 Underlying all of the issues and concerns was the capacity of the LPMHSS to deal with the volume of cases being referred to them; the resources at hand to address this level of need and the impacts of this pressure upon LPMHSS staff. Practitioners said that staff shortages; the restrictions upon the staff eligible to undertake assessments and staff sickness had compounded staffing problems in some areas. However, these pressures had led to new thinking by health boards, including open access group therapeutic interventions at Tier 0.

Comments

Services provided by the LPMHSS teams

- 2.33 Practitioners and service users highlighted the range of activities, services and interventions delivered by the LPMHSS, and practitioner satisfaction with these is discussed in this section. Service user and carer satisfaction is discussed later in this chapter (from paragraph 2.107).
- 2.34 Aside from taking referrals, the LPMHSS across Wales provided the following:
- Surgeries for mental health assessments and therapeutic interventions based in GP practices, health centres or CMHT offices. The number of GP-based sessions varied between half a person-day a week to 2.5 person-days a week.
 - Referrals and signposting to statutory and third sector organisations.
 - Individual and group interventions: Counselling, Mindfulness, Stress Pack, Cognitive Behavioural Therapy (CBT), Anxiety Management, Stress Control, Mood Management, Assertiveness, Social Skills, Self-esteem, Anger Management, Coping Skills, Action for Living, OCD therapy, Post Natal Depression therapy,

Post Traumatic Stress Disorder therapy (PTSD), Healthy Living and Eye Movement Desensitisation and Reprocessing therapy (EMDR).

- Bibliotherapy – including access to a range of written, online and digital information.

2.35 Interventions were being delivered both at Tier 1 and Tier 0 by the teams and in one health board, Community Development Workers and a specialist primary care centre were providing access to healthy living options to patients including self-help support groups, walking, cycling and one to one talking therapies.

2.36 Interventions, whether at Tier 1 or Tier 0 normally lasted from four to six weeks although self-help groups were not time limited. Courses were held in a range of community locations including church halls, hospitals, libraries, third sector organisations and supermarkets. Some of the open access (Tier 0) courses were delivered to very large groups – some of them for 70 plus individuals at a time – and were repeated regularly or on a rolling basis.

Referrals and Access

2.37 Some practitioners thought that the LPMHSS had resulted in fewer cases ‘bouncing back’ to GPs from CMHTs either because there was another option or because the LPMHSS assisted in placing referrals. However, some said that the issues over pathways into specialist support persisted:

In all fairness when we used to refer to the CMHT most would be bounced back and now they see a lot more people – I find it’s made a big difference ... (GP)

We’ve had some cases that have bounced back but the GP referred it to the LPMHSS who did an assessment and referred it to the CMHT where it stayed. (Practice Nurse)

We’re getting more appropriate referrals coming into secondary care. At one point we seemed to be bouncing most of them back. (CMHT)

I actually had a letter back from PMHSS this morning and it was a patient I had referred to CMHT who'd been diverted to them, which is fine. We'd wanted a single point of access; we'd not wanted them to return it to us. (GP)

When the referrals come in every week ... we'll ring up the Primary Care Team, have a chat with them and if they're happy with it, then we'll just send the referral across to them. We'll write and explain to the GP. (CMHT)

We've referred straight to CMHT and they've said it's just not appropriate and then we have tried the local mental health team and that's been okay, but not always what I've thought was completely appropriate. So there are still some kind of issues getting people seen who are less urgent. (GP)

- 2.38 For some GPs the process of referral was straightforward and efficient:

The referral process is great. It's easy. I just phone my secretary or see her and say can you ask J's team to list them and it gets done. (GP)

I do three referrals: for in-house counselling; to LPMHSS when I think they need CBT and then I do direct referrals to psychiatry when they need to see a consultant psychiatrist. It works for me. (GP)

She's referred on appropriately to secondary care for people who I've not picked up because we have ten minutes and she has more time to go in depth ... she's certainly picked up on extra things that I haven't. (GP)

- 2.39 The advantages of having a single point of access were highlighted although one GP thought that the system resulted in some delays:

It enables us now to track a referral. We can see when it came in, when it went on the system, where it went from there; whereas having bits of paper flying around is unsafe. GPs can access the

system and check that the referral has been picked up ... it's being managed and they don't have multiple points of access. ... and it gives us far more information about the patient. (LPMHSS)

Service users are saying to us that they find it hugely beneficial when the GP is putting a referral together and sending it electronically while they are sitting there. Speedy, improved, streamlined. (LPMHSS)

But the time it takes for me to send a letter in; for it to be looked at by the team meeting and then for it to come to her ... That can take two to three weeks Whereas before, fine she might have a few weeks waiting list but you could go along to her and say, look I think I've got one that needs to be seen fairly soon and she would play with the waiting list ... And we've lost that flexibility. (GP)

- 2.40 Some GPs said that they tended to retain patients rather than refer on to the LPMHSS for all but the most serious cases. Whilst a few believed this was the proper approach, others said they would prefer to refer more patients but the limited capacity of the LPMHSS was an impediment. Also some complained that the LPMHSS mainly signposted patients to the third sector and that if GPs could do that themselves this would streamline access to support:

We had a meeting where we had a presentation...the loud message was 'don't refer' (GP)

If they don't sort out the problem for a few weeks, you might as well signpost them. The result of that is that we tend not to refer to the mental health team in the first place. (GP)

Referrals went up initially. This always happens. You test a service and if it works well, they get more and more. They then become overburdened and you then refer fewer and fewer people. (GP)

You're referring to a service that re-directs them whereas in the old days we referred directly to the service that you wanted them to attend. (GP)

Some patients are particularly keen that they don't want to be on medications, and that's fine, and so we would actually probably use (LPMHSS) faster than normal. (GP)

I refer very few people to them, because I feel that I end up giving the same service without them ever actually going through. I'm aware - as they tell us quite a lot - how over-stretched they are... (GP)

We should be keeping these patients in primary care and only referring ones that we can't cope with. (GP)

- 2.41 Whilst some GPs had witnessed real improvements in access to primary mental health provision, others had seen little change and particularly those that hosted primary mental health services before the Measure:

A few years ago when they removed NHS counselling services, we had to refer everything privately. That was extremely difficult. ... It's nice to have some sort of a solution to a problem. It doesn't happen very often does it? You feel for people and you want to help them. And if the only option is to pay for private counselling, some of them just can't afford it. (GP)

We were under the impression that they dealt with mild disorders - we haven't seen that. (GP)

We had a virtually non-existent service and we still have a virtually non-existent service ... (GP)

From my point of view, it doesn't feel much different to how it was before. We operate pretty much in the same way in that we refer to the Primary Care Mental Health Team in a way that we would have done directly to the counsellor. (GP)

I'm absolutely delighted with our primary care and CBT counselling service – it's brilliant. But the Measure didn't really impact or change what happened. (GP)

The general feeling is that it's a failure. There's quite a massive

gap between what we thought we were going to get and what we ended up with ... We were expecting mental health people to be here in the practice ... with an ongoing dialogue between them ... we feel our service was cut. (GP)

An Inclusive Service

- 2.42 The research revealed a range of pathways into primary care services across Wales for certain groups including older people, young people and people with learning disabilities or other special needs. For instance, not all health boards provided LPMHSS for young people:

The CPN will see teenagers that I've referred. Yes, and I think that works quite well. (GP)

The LPMHSS team aren't allowed to see them if they're under 18. It doesn't tend to work very well if you refer people back to CAMHS – they get sent back. (GP)

There's no support system for school, for the kids and the parents; they're all flocking to general practice because they don't know what to do. But we don't have the answers. (GP)

There is a proportion of existing specialist CAMHS which covers Part One but it's a variable amount. An average team is probably between four and five FTEs [full time equivalents] so they are tiny and it doesn't take much to disable a team – a couple of maternity leaves, long-term sickness ... (CAMHS PMHS)

- 2.43 Practitioners felt there were other groups who were missing out on primary mental health services:

OCD and severe anxiety disorders. It's more with luck whether they see anybody, rather than any structured programme. (GP)

Learning difficulties, dementia ... (GP)

And also you get people like autistics ... if you're a child it's fine, but when you get older, there's nobody to look after them. (GP)

You see a lot of carers go into crisis because they have to look

after someone who's got dementia; they don't have anywhere to go except their GPs. A lot of times, they are in crisis. And then they get admitted to hospital. (GP)

- 2.44 However, a few practitioners were more positive about the 'cradle to grave' offer and one of them said:

From the older persons' point of view, I think it's great that that part one service covers everybody, because it means that I can direct older people who would benefit to groups to which they wouldn't have had access before. (Older Persons practitioner)

- 2.45 Some practitioners felt that access via GPs was problematic:

When it first got going the third sector were saying you could see problems ... that going through the GP might be a barrier. (Third Sector)

The GP is the wrong funnel for child referrals because that's not where kids spend their time. (CAMHS)

Assessments

- 2.46 Waiting times for assessment varied somewhat. Whilst some practitioners said that their patients were seen quickly, others were aware that the guideline of 28 days was being breached:

They wait for two to three weeks. Yeah, there's been no issues there at all. She sees them very quickly. (GP)

The problem is obviously now she's inundated with her clinic. They're not hitting their four weeks wait target ... sometimes they don't get to see patients who need an urgent appointment within the four days ... (GP)

- 2.47 LPMHSS staff frequently said that assessments in themselves could provide therapeutic benefits. However, whether or not to undertake assessments by telephone was a subject of some debate: although they increased throughput and efficiency, some questioned their quality:

A lady happened to phone me last week during a session which

had been cancelled; a patient had DNAed and I ended up actually providing a telephone assessment to her at that time, so that was good use of an hour slot. (LPMHSS)

But in primary care, where there is a long-term relationship with patients, the telephone is used often. If it's your only way of speaking to them I think you can give them some basic CBT instruction – a straightforward menu of things to do. (GP)

For myself I would rather see the child. I am lucky at the moment, the LPMHSS that I'm affiliated to, they see everybody – they don't do any telephone consultations. I don't know for how much longer they'll be able to manage that ... (Psychologist)

There is a risk that due to increased demand on primary care that assessments are 'dumbed' down and referees only get a telephone review / assessment. This could potentially be detrimental in terms of risk assessment and/or engaging with clients. The very nature of emotional mental health is the therapeutic relationship. (Manager, CAMHS)

I want to know I've done my job properly, and I don't necessarily feel comfortable assessing patients on the phone (LPMHSS)

Therapeutic Interventions

- 2.48 According to practitioners, the waiting times for therapy varied widely. Whilst awaiting therapy, GPs relied on prescribing to help patients and/or lifestyle advice and signposting were offered by GPs and the LPMHSS. Some patients even received interim support from CMHTs:

The waiting list for one to one therapy varies between four to nine months throughout the localities, and groups - you may wait up to a year, because the OCD group only runs once a year in some localities. (LPMHSS)

There was a counsellor onsite, which had been going on for a few years – and worked well. We had a waiting list of about two months, and we now have a waiting list of about four months – so

that's a drop. (GP)

If you ask somebody of course they'd probably say the most frustrating thing is the length of time it takes people to access therapies ... (LPMHSS)

That causes more work because they come back saying I haven't been seen yet. (GP)

One of the biggest issues is likely to be over-prescribing by GPs – I don't know what else to do! (GP)

We try to recommend exercise and things like that and all the other lifestyle things; and a lot of web advice tools... (GP)

With some I suggest various things if people are waiting - sort of online CBT, bibliotherapy ... (LPMHSS)

We write out to people again when they've been on the waiting list, say six months - do you still want to be on the list? And often that gets rid of another 30% of people. (LPMHSS)

They've got to go to secondary care for a bit, in the wait, until primary care can see them. (CMHT)

- 2.49 Some practitioners highlighted significant therapeutic benefits for patients from the LPMHSS. One GP practice also witnessed a fall in the amount of prescribing and attributed this to the stress management courses:

Primary Mental Health services are a very positive development. It is extremely encouraging that patients with mild/moderate conditions are able to access CBT. (LD Manager)

Our need for psychiatry services is really greatly reduced by it. I might only make a referral to psychiatry once a year. (GP)

And all of the things that are within the primary care groups that are going on around helping people think about how they might deal with those (physical and cognitive) problems are really helpful. (Older Person's practitioner)

What our primary care have done which I think is really, really great is they're running a lot of therapeutic groups which are about stress control; which are about mindfulness ... which are really, really helpful. (GP)

The feedback we have is that the patients love the time they have with them. (GP)

I've had people asking to be seen because their brother has been seen by these people and they've been really effective and they want to be referred. (GP)

Mental health facilities for people who've got distress over the last four or five years is much better than it was. I wouldn't be surprised if the Measure has got something to do with it. (GP)

Well it means the patients here are seen and dealt with in a timely and appropriate manner. (Practice Manager)

On the questionnaires I get back from people 99% love the service they got. Really overwhelming; I've never known feedback so positive. (LPMHSS)

- 2.50 Some practitioners stated the advantages of groups over individual therapies:

Well, individual therapy we try to keep to a minimum. We try to get them to a course or something first to learn general understanding of how issues affect you. And very often we find that if we get them to a course first they often don't want the one-to-one afterwards. (LPMHSS)

There are very, very few people who come through primary care who actually need one-to-one first off. Very, very few. (LPMHSS)

GPs don't seem to be aware how hard it is to go through counselling. So people come to counselling and sometimes we make them feel worse. (LPMHSS)

- 2.51 A particular benefit of the service was identified as supporting people to take control of their own lives; limiting dependency on services and avoiding being labelled as 'mental health patients':
- Very often they were getting referred into the CMHTs and were starting to see themselves as mentally ill when really it was normal psychological distress. (LPMHSS)*
- People were generally losing the ability to sort themselves out or were losing the belief that they needed to do something to sort themselves out. And now we've got a service where we can pull them off and actually deliver more appropriate approaches to the level of their need. (LPMHSS)*
- It's all about enabling people and it's about psycho-education so normalising things so people realise when you're suffering from grief you're going to be upset. So, you know, you put in that piece of work, people feel better ... (LPMHSS)*
- 2.52 However, most of the GPs interviewed felt that the service was falling far short of expectations and complained that following assessment the service either signposted patients or offered nothing at all:
- There is no intervention. You'll get an assessment but there is no intervention from that point on. (GP)*
- It's a long way short of the original projection which was supposed to be a mental health worker attached to the practice that we could talk to and engage with and who would put direct support into patients. (GP)*
- Now the PMHSS has become the answer, but they don't have any solutions. (GP)*
- I don't think the patient will think it's a good outcome. They were told, 'oh dear that's a pity. That must be difficult for you. Carry on'. And there we are. No ongoing support. (GP)*
- There's a lot of signposting going on but I don't know how much*

therapy is going on. (GP)

- 2.53 Whilst practitioners appreciated that the limited time offer for therapeutic interventions (up to eight sessions) prevented dependency, several argued for a more flexible approach based on patient need:

Some of the therapies were going on for several years. That's about dependency then isn't it? (GP)

Sometimes you can't just push a client through in six to eight sessions ... ethically you continue working with the client because you can't say, okay we've had the eight session now, okay we haven't completed the process ... so we carry on. (LPMHSS)

If clients were very emotionally distressed and come under primary care, sometimes it can take four to six sessions to gain somebody's trust and to have stabilised their mental condition in relation to engaging the therapy. (LPMHSS)

- 2.54 Physical access and deprivation were identified as barriers to therapy and a few GPs, therefore, recommended that the services deliver interventions within local communities. Also, whilst in some areas, group interventions were held at times to suit working people and students, in other areas these people were disadvantaged:

That's where our drug and alcohol services now are. It moved not so long ago, and it's been great for the local population. Because I think the issues ... particular to this sort of population here ... is deprivation, and poverty. (GP)

Yes, it's financial. It's getting a bus isn't it, down to (town)? Have you got a spare fiver? Are you going to feed your kids ...? (GP)

Those workshops - they're in Asda and people can't access them very easily ... It's not local to us, which is a disincentive big time. (GP)

And that's another thing about the workshops: they're only Monday

to Friday in the working day. They're not evenings or weekends, so people who are working don't have any access to them either...also young teenagers don't have access to them because they're in school. (GP)

The Measure has forced us to think differently about how we deliver primary services ... and provide services to people who are in work and don't want to take off half a day for six or eight weeks. Instead we have been running whole day stress management sessions which people have found incredibly helpful. (LPMHSS)

- 2.55 Delivering therapy over the telephone was one option suggested for overcoming these barriers:

For the last couple of years now I've been doing CBT on the telephone. I've just finished with a lady this week ... I've never met her face-to-face and she's had ten sessions of telephone work and she's fine. She's a mother with small children and she lives quite far away so it suited her. (LPMHSS)

- 2.56 As a consequence of the Measure, health boards introduced open access therapeutic groups at Tier 0 to ease the pressure on LPMHSS and address the large demand for support. These courses run with large numbers and provide a service not hitherto available:

It gives the GPs the opportunity to bypass the primary care service because they know the person doesn't need another assessment and it gives the services an opportunity to refer or signpost people to those courses after they've assessed them, so it's got dual function. (LPMHSS)

DNA (Did Not Attend) Rates and Making Appointments

- 2.57 Some GPs were concerned about patients failing to attend their appointments and that the service should work to increase attendance rates to reduce waiting times. LPMHSS staff said that opt-in and book-and-choose systems were helping to overcome these issues in some areas.

They're not valuing something they're not paying for. If you tell people the cost of the stuff you're giving them, they're more likely to use it ... I think it's honesty, openness, transparency with patients – we are using public money that everyone pays towards. (GP)

If you actually look through the appointment book there are gaps that they haven't filled in, yet there's a four month waiting list. What's that all about? Plus, if they start at 9:00 they usually finish by 12:30, so what's happening in the afternoon if we're supposed to have a whole day? ... it's just scandalous having her there twiddling her thumbs, when we've got a long waiting list for a really precious resource. (GP)

- 2.58 Whilst some GP practice staff thought the LPMHSS had resulted in fewer GP appointments, others had seen little difference and said:

The service probably has helped some patients identify things and it gives an option to us but I wouldn't say it's made a difference to the number of times I'm seeing patients to chat to them and support them and help them through. (GP)

Professional Working Relationships

- 2.59 A clear message from the findings was that positive professional relationships were key to effective service delivery and satisfaction in service outcomes. Markedly different experiences in these relationships were revealed:

I get a wonderful welcome every time I go there. And the GP will regularly say to me, do you know this service is wonderful, simply wonderful, and they are so grateful for it. And he says, sometimes I sit back and I can't believe we've got a service like this. (LPMHSS)

It hasn't reaped the joint working that I was expecting. On paper it looks very, very good but in practice it hasn't. (GP)

We have very little idea of what goes on in LPMHSS so you can't call that a close working relationship. (GP)

If you've got a GP that's interested that's fine because they do work

with you. You can go into a surgery literally across the road and a GP won't raise their head; they're not interested; we are in some ways an imposition, rather than a guest in this service and somebody who's there to work with them. On many occasions I've not been made to feel welcome. (LPMHSS)

It's the minority who are willing and happy to work with us; the majority I don't think have got any interest whatsoever. (LPMHSS)

But I think what I heard from our team is the younger GPs who are now coming into the surgeries are much, much easier to communicate with as opposed to the older generation ones who've been there for donkeys' years. (LPMHSS)

- 2.60 A few practitioners highlighted how working together could ease the path to timely patient support:

I don't see them very often, but emails work well...when we ask them things they respond reasonably quickly. (GP)

What used to happen (in area) was that if you were being seen by primary care you would have to go to a CMHT for medication review ... you were waiting at least 10 weeks ... so what's happening now is that the primary care worker will just go directly to one of the consultants to say, 'can we change from this to that' and, if necessary, they will talk directly to the GP so that has certainly speeded things up a lot. (LPMHSS)

- 2.61 The importance of working with a range of primary care professionals was highlighted by LPMHSS staff, who also observed that over recent years the increasing fragmentation of services had imposed a strain on these relationships:

It's really, really difficult on occasions to see other health care professionals within the practice - nurses, anybody - because they're always kept up in their own clinics. (LPMHSS)

I mean I haven't got a contact name any more now if I need to speak to a dietician. It's ludicrous, absolutely ludicrous ... there

were chiropodists; there were all sorts of healthcare professionals and of course now a lot of them have actually been moved out from the surgeries into the local resource centres etc. - that integrated practise that I knew, and was part of, has gone. (LPMHSS)

- 2.62 Pressures of work and staff shortages were considered to threaten professional relationships and a few GPs complained that they saw primary mental health workers less frequently in their practices than before the Measure:

We feel our service was cut. They're only seeing four patients in a whole day... I think it's difficult, because we have quite a good relationship with them ... If you're complaining about the service, you feel like you're complaining about them as a person – and you're not. (GP)

As soon as, say, you have to pull out because you've got staffing problems, you immediately notice a change in referrals ... So it's maintaining that continuity that is key for the long term. (LPMHSS)

We see all the clients because they come to see us in the (central clinic) but actually getting in there has been quite difficult for me to cover all those surgeries as well as the surgeries I do myself. So, it does affect that relationship, really. (LPMHSS)

The girl who does the practitioner role is very much based in the health team, although she's come out to see us once or twice but I don't think she's got the time to do any more than that and certainly she's not collaboratively working. (GP)

Capacity and Resources

- 2.63 Underlying all of the concerns raised so far was the issue of capacity of the LPMHSS to deal with the volume of cases and the resources at hand to address this level of need:

It's a bottomless pit isn't it? If we had a counsellor here full-time, we could easily employ them. (GP)

The resource is so limited that its rationed - only the illest get

referred through for the one to one therapy; slightly less ill maybe to the group but even then they're still high need and we try and filter everybody else off to any other agencies offering counselling ... And the assessors work hard at this - they really do. (LPMHSS)

I bet that they would like to be doing certain therapies, but they can't, because they have got too many clients and they're too thinly spread. It's the same with mental health all over the UK. (GP)

I would have thought that the nurses, social workers and CPNs on the mental health team probably feel incredibly burdened, as they are managing clients day in and day out with very little supervision and support. (CMHT)

I think what the measure has done, it's turned every practitioner into a tennis player and all they're trying to do all the time is to back people away. (GP)

You have to plan and implement the thing properly. It should be good. I mean it's a good model but it's got to be funded and supported. (GP)

- 2.64 The impacts of this pressure upon LPMHSS staff were highlighted by many.

The only reason that we're meeting the targets now, I feel is because of good will. A lot of us are working extended hours; we come in early in the morning, and we finish late in the evening. We come in at weekends, and, again, without that good will its not sustainable. (LPMHSS)

I think there's pressure on the primary mental health services to take ever increasingly severe presentations. I think that has led to some possible burn-out issues. (CMHT)

- 2.65 The increasing tendency in some areas for secondary care patients to be referred to Tier 0 and Tier 1 courses was questioned by some participants who felt they were either not appropriate for the level of need or created additional pressures upon primary services:

If they've been in secondary care mental health services, then they're probably not going to fit into one of the courses whether it's a Tier 1 or Tier 0. (LPMHSS)

I wasn't taking any secondary care clients in the primary care mindfulness group because what you'd find is they were sort of hijacking the whole group. (LPMHSS)

If someone has a CTP they're allowed to refer into primary care for group intervention. It feels like we're just bombarded with everything you know – everybody can refer to us and we're supposed to take it. (Primary Care Centre Manager)

You know, and I'm not trying to be discriminatory but the secondary care service needs to deliver those courses itself. (LPMHSS)

2.66 Other management demands of the service were highlighted:

We've been asked to put dementia prescribing into the hands of the LPMHSS teams which I think is going to overwhelm their service and yet the drum is being banged at a senior management level in the health board. (Older Person's practitioner)

Psychiatrists discharging to primary care will have implications for primary services. There might need to be more resources diverted to primary from secondary care. (LPMHSS)

2.67 Practitioners said that the level of staffing had been less than expected and that the restriction whereby counsellors were not eligible to undertake assessments along with staff sickness had added to staffing problems in some areas:

When it was first being set up the view was certainly more staff than there have ended up being. (GP)

When it's staffed, it works very well. For three months recently because of sickness in the team there was nobody coming, so there was no service at all. (GP)

Yes the good news is our sickness rates are actually the lowest of the directorate ... We've actually got staff in work and we still can't

meet the targets. (LPMHSS)

In the smaller teams, you get one person going on long-term sick and you've lost 25% of your capability ... and it does really hit us hard. (LPMHSS)

In the eyes of the Measure, counsellors cannot assess clients. So on paper it looks like we have 4.5 full time equivalents but what we actually have is 2.5 who can assess for interventions. (LPMHSS)

- 2.68 One LPMHSS Manager observed that the high pressures on the service to deliver targets had led to new thinking around service delivery:

We won't meet the targets and one of the reasons we won't meet the targets is because these people have to look after their own mental health ... because of their core values and their need to see people, these practitioners were at serious risk of burnout and not being well ... And if that means it's not meeting targets, then my job is to sit and tell the directorate management team why ... Because ultimately we'll end up with long-term sickness problems. These Tier 1 targets ... they are driving our ability to encourage the board to look at alternative ways of meeting the demand ... there are a number of projects that we're trying to develop to support this service and develop Tier 0. It is driving within the organisation a greater focus on mental health and how we're going to achieve what we're supposed to. (LPMHSS)

Review Question 4: Information and advice to patients and carers

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

Summary

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

Comments

Raising Awareness about the LPMHSS

- 2.72 Most service users interviewed first heard about the LPMHSS via their GPs although some had been referred by secondary care services as part of their care and treatment planning or were redirected to the service following assessment:

I went to see him (GP) because at the time I was very, very depressed, not sleeping and it was through talking to him that he decided I ought to be put on the list. (Service user)

I went to my GP first and she referred me for an assessment. There was somebody that came to the surgery every Tuesday – she said there's a bit of a waiting list but it shouldn't be too long and the week after that I got a phone call. (Service user)

And this is part of the first step in the care apparently ... and it was part of the care plan along with tablets. (Service user)

We do have some secondary care people who dip in and out. My

understanding was that (patient's) involvement was part of the step down process. (LPMHSS)

- 2.73 Some said that they had come across leaflets in health clinics, CMHT centres and third sector organisations:

My daughter went to a trainee doctor and she referred her to a clinic for anxiety and when I was with her I saw all this (information)... (Service user)

I was at the (CMHT) and saw two brochures – one for stress control management and one for action for living and that's how I read about it, gave them a call and ... After I got that information, I pretty much attended the course. (Service user)

I work with Interlink and a few other organisations. (Service user)
Community City and Guilds mental health care ... I think that's when I first heard about primary mental health teams. (Service user)

- 2.74 Participants were also made aware of the Tier 0 services run by the LPMHSS either during assessment or following interventions by the service itself:

I think it was a CPN that gave me the information about the courses. (Service user)

The saving grace was that he did refer me to (name's) team which had started up a new group in the church ... He said, perhaps you should go there, try that, meet other people ... and (later) he said how are you getting on with (name's) team? And I said oh well, I'm finding that good. (Service user)

- 2.75 The community development workers employed in one of the LPMHSS teams said that they held information clinics in GP surgeries and hospitals throughout their area to raise awareness of the service and offer wellbeing information and advice:

...and what (we) provide within these information sessions is contact details for ourselves so that whoever picks up these leaflets, or

whoever we give these leaflets to is able to just pick up the phone, ring us, ask us for advice or information, or guidance, and we can provide that over the phone sometimes and they don't come near the mental health services. One of the things that we add on the end of that is you're entitled to a mental health assessment - you need to speak to your GP if you want one ... We give out a lot of details for stress control, because I advertise it on a board ... I give it to everybody that I see. (LPMHSS)

Signposting to other services

- 2.76 Many participants said they had received information from the LPMHSS about third sector organisations:

He said if you're not suicidal, here's a list of people you can go and speak to. He suggested about three from this list and I picked up two. (Service user)

I had independently looked at counselling you pay for yourself. They suggested I go with that if I was Ok to pay. It was good that they were honest. (Service user)

At the beginning of the course she gave out pamphlets about what is available from Mind and reminded us of those at the end. (Service user)

- 2.77 The importance of keeping on top of organisational changes in the voluntary sector was highlighted by a few staff:

She's a very good working knowledge of all the agencies that we can access and these things change and you can refer someone to an agency that may have folded six months ago. She tends to keep very up to date with what's going on ... (LPMHSS)

The wealth of knowledge that staff in each locality have about their own area and what's out there is immense, constantly is updating, and the links that all three areas have got with the voluntary sector and everything are very well established, and giving information that GPs couldn't possibly keep up with. (LPMHSS)

- 2.78 Staff in one of the LPMHSS teams said that they felt they were fulfilling the requirements of the Measure to provide information and signposting advice to service users and that this had improved over the life of the service:

100% really because every time we see somebody we try our best to identify their needs, speak to them, ask them what they think would help them, and then we would provide them with the relevant information. If we can't at that point we would come back here, maybe speak to colleagues ... research it possibly, and then post it on to that person so I think we do fulfil that part of the Measure.
(LPMHSS)

Advice

- 2.79 Throughout the interviews, service users and staff highlighted the medication and self-help wellbeing advice offered by the LPMHSS, whether to help people during their waits for interventions or to support them in life in the longer term.

Well the feedback that I've had is that it's very informative of basic stuff that we do - a lot with anxiety, where the GPs haven't got that time to spend ... and I mean some people come to me and they haven't a clue, they're taking anti-depressants, they haven't really been explained about the anti-depressants ... they stop taking them. It's basic stuff really, but they get more of a better service really. (LPMHSS)

There were suggestions of voluntary work and group therapy and things like that. The idea was that I took things on to build confidence and to give myself targets each week to try and convince myself I could do these things. (Service user)

The counsellor gave me hints on how to go to sleep. (Service user)

They recommended in the meantime to take time off work, take it very, very easy and relax but we'll be in touch. (Service user)

I was also recommended to try and go out more and put myself in situations where I was mixing with people ... the only way to get

over social anxiety is to put yourself in social situations. (Service user)

- 2.80 One participant said that they can rely on the service for ongoing advice and support whenever the need arises. This is born out of a long association with the service and consistency of staffing:

If you're having a bad time and you don't need any clinical or medical intervention, just, perhaps, a friendly chat with a CPN or a social worker or someone like that. It doesn't have to be face to face. It can just be over the telephone ... I think it's very important to build up a rapport with people in primary care. Because they get to know you and you feel confidence in that person. (Service user)

- 2.81 The use of bibliotherapy was mentioned by several participants including advice around accessing websites and digital materials as well as books and leaflets:

With some I suggest various things if people are waiting - sort of online CBT, bibliotherapy ... (LPMHSS)

I got a book from the GP – a course dealing with panic, distress and anxiety. It was a really easy to read book – nice and accessible. (Service user)

I was given some leaflets about assertiveness. (Service user)

Review Question 5: Satisfaction of patients and carers with information and advice

Assess the satisfaction of patients and their carers with this information and advice.

Summary

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

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

Comments

Awareness of the LPMHSS

- 2.86 Very few participants overall (only ten) made any comment on the quality of the information or advice provided to them by the LPMHSS in terms of signposting or written information from the service and the findings in this section should be understood with this in mind.
- 2.87 However, many more commented on the availability of information about the LPMHSS itself. Many participants were disappointed that information about the service - and particularly the courses on offer - was not easier to come by. Some said they would have expected to see information in their GP surgeries or that they had become aware through their own researches or by chance. Several participants also commented that their own GPs seemed to be unaware of the service:

And I knew more by coming to the courses here and reading things

myself than anything anyone told me. I didn't know it was there. I didn't know I could access it through my GP, I didn't know I could put myself down for counselling, I didn't know any of it. (Service user)

There's not enough information. It was only by talking to a counsellor in the surgery that I heard about it. She said, 'have you heard about this Action for Living course'? So I turned up for it and that's how I became aware. (Service user)

I've been to the doctors and they never refer me to anything and I never saw anything on the board or anything. (Service user)

I found out about the PMHSS through (third sector organisation). So I went to my GP – he was really good – he's a training GP – but he knew nothing about the LPMHSS ... Because I haven't got access to the (CMHT) or anywhere, I don't see the leaflets. So there's nothing in the surgery. (Service user)

I was told by someone at LPMHSS that the reason they don't promote the courses too much or put dates of courses on the flyers is because even as it is it's still massively overcrowded. They had to turn about 20 away from the ACT session. This is something that is not promoted, not online. It was only people like me at the course who said, I'm going to make the extra effort to try and find something. (Service user)

2.88 It is interesting to note that at a meeting with the mental health forum in one area, only one person out of 13 was aware that their GP practice was supported by the LPMHSS.

2.89 However, participants who were made aware of the service and gained access to it through consultation with their GPs were relatively satisfied in the way they were informed of the service:

I went to my GP first and she referred me for an assessment. There was somebody that came to the surgery every Tuesday – she said there's a bit of a waiting list but it shouldn't be too long and the week after that I got a phone call. (Service user)

Signposting to Third Sector Support

2.90 A few participants cited instances where signposting by the LPMHSS had really worked for them. However, several others were disappointed when they found that the LPMHSS would only offer them signposting information and would not directly provide any therapeutic interventions. A few others felt that the service should actively help service users to select the most appropriate services and were genuinely frustrated by the difficulties in accessing the information for themselves, particularly when feeling unwell:

I got referred to Gofal by (LPMHSS) because I had a bit of a crisis ... I had problems financially and it caused me to go downhill rather rapidly to the point where I was contemplating things I shouldn't contemplate ... and they sorted out the particular problem I had at the time and by that being sorted, other things sorted themselves out as well. The person I saw, she was superb. She was with me every step of the way. (Service user)

What happens is that you get an assessment that says it's mild. You will get seen within 28 days but from that point on the only means they've got to target that is through voluntary organisations. They'll offer Mind; they'll offer (support group) which is what we are on and any other voluntary thing that will be there so that's all they're in a position to offer ... but they're voluntary people and you won't be guaranteed a structure necessarily. (Service user)

But choosing a counsellor is so personal ... So they provide a crib sheet, they call it, on the sort of questions you might want to ask. That assumes that you have an understanding of what all these therapies mean. If you're thinking of committing to that, you're going to pay hundreds, possibly a couple of thousand pound there that you could have just totally flushed down the drain. (Service user)

People aren't always sufficiently stable or capable of exploring

these options for themselves. (Service user)

I was told, why don't you go home and Google it and maybe there'll be something. You are in a crisis place. He didn't say hop into my car and I'll take you to a place that will help you ... make sure you go there; make sure you get the attention. ... They mentioned mindfulness ... but I wasn't told, 'did you know that five minutes from your house is (Charity) that runs mindfulness courses for free?' ... or suggested contacting them and booking it for me - that would be absolutely brilliant and I don't think that would be too difficult to make it happen. When people are desperate, rather than being given possible options, this more definite help would be more beneficial. It's like being shot in the head and being told, there are various options to consider rather than saying, let's stop the bleeding. (Service user)

And it wasn't until I was nearly at the end (of the assessment) that I realised what was happening; that actually he's going to give me a list of possible places where I could get further help and I can actually choose who I go to see but he never indicated where he thought I might get the most appropriate help. (Service user)

- 2.91 Several participants felt that LPMHSS staff were unaware of the full range of third sector options or complained that they had not received signposting information at all:

There were no self-help materials offered; no sign-posting to other services – only to those they were providing: courses and different treatments. (Service user)

Now, you see that sort of information (on third sector organisations) should be provided. (Service user)

Everything's so fragmented and there's no structure to know where to find it. (Service user)

- 2.92 Several service users said that they found out about third sector support via friends or from other voluntary organisations rather than the statutory sector:

The third sector – that's where all the information seems to be.

(Service user)

I found out about (charity) through a friend and if I hadn't started going to (another charity) I would never have met that friend – all of these other things I found out about were via (charities) or via my support worker. (Service user)

- 2.93 Several participants suggested ways in which the services could be kept better informed to improve their signposting. This included using existing directories or compiling directories of local organisations:

CAVAMH has got a directory on the website – the service could direct people to that. (Service user)

Information is available at CMHTs on a range of opportunities – walking, courses etc. But if you don't get to those offices how do you access the information? (Service user)

I feel there isn't a giant database of every support network and there really should be and it should be very easy ... (Service user)

Maybe LPMHSS could encourage service users to feedback information on local groups and third sector services. (Service user)

Information to support assessment

- 2.94 Several service users mentioned the standard questions asked as part of the assessment and said that they had found these informative and especially so once any intervention had ended and they could see the amount of progress made:

On the last session I was asked to fill out another assessment and he said on the first tick sheet you were only a couple of points away from being referred to a psychiatrist. And the sheet I did at the third session was down to 40 which is down to mild. That was a big eye-opener. (Service user)

Found it helpful. They're obviously doing it for their bosses but it

actually does help the individuals. It's much more positive. (Service user)

Learning materials to support therapy

- 2.95 A few participants mentioned that support materials were suggested or provided as part of their therapeutic interventions. These were generally well received and participants found them useful within the context of their treatment:

He offered further counselling. He also recorded a CD for me on his own blank CDs – relaxation therapy. The next time I saw him he delivered them back to me – I do still listen to them. They are helpful. (Service user)

You go to a session and then over the week you're thinking about it and you're given homework as well ... and you're sort of implementing it – re-challenging your thought processes and beliefs – and then you discuss it. (Service user)

The course is supported by paperwork and sometimes just reading through that helps. They give you homework and they give you pamphlets that are discussed in the session so you can go over it at home. And there's loads of other leaflets too. (Service user)

You get emergency numbers if you really are having a bad time. (Service user)

- 2.96 However, one participant made a criticism:

At the end they say the library here has these books – you're then telling 30 people and there may be one or two copies of these books. (Service user)

Other advice and information

- 2.97 It appears that participants were relatively unsatisfied with the LPMHSS when information was not given to them at all or when information was all they received from the service:

It would be good if they could 'prescribe' books to read and courses to attend. (Service user)

He was more concerned about getting me a book on prescription – you know he showed me a list of about ten different books and for me to pick which books I fancied and then for him to write it down on this little form and I could go to the library, which I didn't want to do because the local library is local so really then people behind the desk in the library knew that I had mental health issues ... it makes it more public then. That's all I was offered (by LPMHSS).
(Service user)

Bibliotherapy was not at all helpful. (Service user)

Review Question 6: Satisfaction of patients and carers with the service overall

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

Summary

- 2.98 It is not possible from the findings to make a simple statement concerning satisfaction with the LPMHSS overall. Service users involved in this study had mixed experiences: some very good and exceeding expectations, especially where they received therapy and support from the service which they felt contributed to improvements in their mental health. Others had little contact with the service and what they considered to be limited support or interventions which did not consider to have met their needs.
- 2.99 Some GPs were considered to deal with people with mental health problems more effectively or sympathetically than others. Several service users - particularly those who had been discharged from secondary mental health services to primary care - said they lacked confidence in their GPs over their medication and general mental health support. Some also questioned whether GPs were competent in signposting to local organisations.
- 2.100 By and large, participants who were referred for assessments were seen within the 28 day target time and were generally satisfied with

waits of up to four weeks. The experience of assessment for many participants was beneficial: they felt listened to; were not rushed; felt able to 'open up' and at the end of the session felt optimistic that the service could help them. A few people were less satisfied, however, because they had felt rushed or their appointments were at difficult times or places. Several had telephone assessments and highlighted both the pros and cons of undertaking assessments and communicating more generally by telephone.

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

Comments

Support from GPs

2.105 As already discussed in this chapter, one role of the LPMHSS is to work with GPs, increasing their knowledge and confidence to support patients with mental health problems. It is useful, then, to highlight the opinions of patients about their GPs, some of whom dealt with people with mental health problems more effectively or sympathetically than others: It should be noted that these comments arose spontaneously from service users throughout the study and not only from service users interviewed in regard to their experiences of the LPMHSS. The comments did not arise from direct questioning from ORS and may, therefore, be subject to some bias:

I feel like one of the lucky ones. The doctor I see makes sure I come back every two or three weeks regardless of what's going on and regardless of whether there's any change and I think that's over and above what she should be doing. (Service user)

... basically I'm under the care of my GP. Fortunately she's pretty good. She understands about mental health. (Service user)

I made a point of looking through to see what each doctor offered and the particular doctor I chose then to see actually specialised in psychiatric mental health...he was very, very good I have to say. (Service user)

My experience is that GPs are quite inexperienced in mental health issues apart from issuing anti-depressants. The GP that stands above that is a pretty rare thing ... if you've got one, you'd be very lucky. (Service user)

It's all about trust and relationships isn't it and I have a reasonably trusting relationship with one GP purely because I've seen him for four years ... but I can't always get to see him ... and I'm trying to hold myself together and ... you don't want to have to explain the whole story at every appointment and they've only got 10 minutes

anyway so... (Service user)

The LPMHSS service has a way to go in training doctors. I've had some bad experience with doctors not understanding mental health ... A lack of care and kindness basically. (Service user)

Doctors need to be educated ... to them it's easier to deal with the physical side ... they need to meet every so often and be taught as to what problems the patients face; they would then realise that the patients that are coming to them aren't coming to them because they THINK they have mental health problems - they DO have mental health problems. (Service user)

- 2.106 A few participants - particularly those who had been discharged to the primary sector from psychiatric care - said they lacked confidence in their GPs over their medication and mental health support more generally. One who had been told by her GP to stop her medication said:

And I got really ill. I went back to the GP – because I didn't really want to be in secondary care – I'd rather stay in primary care and I said to the GP, look put me in with a psychiatrist so you can't mess with my medication. (Service user)

The GP was very good and said oh we'll send you to a child psychologist and that was the end of my involvement with the GP but my friends ... they go and see a GP and it is the first port of call to be on anti-depressants ... (Service user)

- 2.107 One service user believed that the number of suicides in their area had increased as a result of GPs being unwilling or unable to support patients discharged from the secondary sector:

When they (GPs) get somebody discharged they send the letter back to the mental health services saying, 'oh well we can't see this person; we don't have the time; we haven't got the resources. You've got to sort this out'. (Service user)

- 2.108 Service users highlighted varying capabilities amongst GPs concerning signposting to local organisations:

Some GPs are on the ball. You're sitting there and they're on the phone to Mind saying this patient needs to be seen straight away. This is in-between before you get to see the CPN. They're always up to date with information. (Service user)

My GP remembers from the last time I've seen him even if it's a couple of months – I know he has my notes in front of him – but it's personal ... my GP emailed me from his personal account – he said I'll find out about it and I'll email you. He went home, found out about it and sent me the link. (Service user)

The communication between doctors and other sectors is poor and the signposting seems to be non-existent to my mind. (Service user)

GPs don't have the knowledge of what local third sector organisations can support people with, particularly during the time that they are being referred to specialist services and having to wait. (Service user)

- 2.109 A few service users suggested that learning about the interplay of physical ailments and mental illhealth would assist GPs to treat patients more holistically:

The thing that I feel most passionate about is the fact that I am going to the GP surgery presenting with a whole load of mid-life ailments that are, I know, down to the fact that my stress levels are through the roof. So I'm getting acid reflux; I've got irritable bowel; the NHS are spending a fortune on sticking things where they shouldn't be sticking things. The reality is that if GPs could actually engage with this process more actively they could be saving themselves so much money by offering the service of how you deal with anxiety first instead of sending the person to a hospital clinic to see a consultant. (Service user)

I'm in the unhappy situation of having three GPs in the last 11

months which hasn't made things easier. My latest GP is a very new recruit and I think he's on a bit of learning curve himself ... He hasn't said a word about referral on to the Local Primary [Mental] Health Service. He may not be aware. (Service user)

Assessments – Waiting times

- 2.110 By and large, participants who were referred for assessments were seen within the 28 day target time and were generally satisfied with waits of up to four weeks. There were a few exceptions, however:

I went to my GP; got referred for an assessment. Other people think I was lucky. I got seen fairly quickly (two weeks). (Service user)

I didn't think I'd waited a long time at the time (five weeks) – to me it seemed quick. I didn't know that there was a target of four weeks. (Service user)

I appreciate the time between referral and assessment could have been a bit quicker but it was just about manageable. (Service user)

I think I waited about six weeks for a referral but it got cancelled three times yes, sick leave, so then it was another month on top of that then – ten weeks altogether. (Service user)

It took six weeks I thought it was a bit long to be waiting because I had to pluck up the courage to go and see the doctor first of all. It's really hard to tell anyone that you're feeling really down; you're feeling hopeless. (Service user)

Yes, a week to two weeks I think would be far more appropriate. (Service user)

It's a really dangerous time for you because you have left yourself completely vulnerable at that point. (Service user)

- 2.111 Some participants said they coped whilst awaiting their assessments by receiving support from their GPs or other community organisations. Others said they waited it out as best they could:

I see it from the other person's point of view. There are a lot of people that are a lot worse off. Even just coming down and chatting to one of the doctors – they were willing to do that – they helped out when they could. I've got nothing to complain about the service.

(Service user)

I saw my GP roughly every fortnight. I was worrying – because having been through a really bad depression a few years ago, I realised I'd got into that state where I was before (suicidal) ...

(Service user)

I do think that period of going to the doctors and then getting in to the primary is too long. You're in limbo and you're afraid and you need something during that period. (Service user)

I knew it would take about that length of time ... you do get a telephone number if you feel suicidal ... but I have social anxiety – I have trouble meeting people or using the phone so it can be another daunting thing to do. (Service user)

I knew there was going to be a waiting list at every stage and I really felt desperate. And I thought, I can't wait; I can't wait.

(Service user)

Assessment – Positive experiences

- 2.112 Most participants who commented about the LPMHSS had an assessment and many of these participants felt that their experience of assessment had been highly beneficial and gave various reasons for this: feeling listened to; not being rushed; being able to 'open up' and feeling optimistic at the end of the session that the service could help:

It lasted 45 mins to an hour. I felt this was long enough. They ask you questions which the average Joe wouldn't ask. They offered me mood management and then were trying to decide if it was tier 1 or tier 2. They've always tried their best. I never felt they just palmed me off. (Service user)

And the fact that they allowed it to go on for two hours I was very

grateful for because it's so often the case that you'll be in the middle of saying something and they'll go, 'well, time's up now – come back next week'. Initially that helped a lot. (Service user)

At the end of the assessment I felt I would absolutely get help from the service. I had confidence in him. (Service user)

So I think the assessments are very good. They're very friendly and informative and you're made to feel quite comfortable. (Service user)

What was good about it was it made me reflect. It wasn't prescriptive at all. (Service user)

I didn't realise it was an assessment, I didn't know what to expect, and I sat down and we introduced ourselves to each other and that's when I just opened up and poured everything out ... I found that session excellent. (Service user)

At the end of the assessment – I felt relief that it went as well as it could and I opened up ... and he said that I did have an issue and wasn't wasting his time. It was a relief (knowing she'd get counselling). I knew I could work through this. (Service user)

Assessment – Negative Experiences

2.113 Some people were dissatisfied with their assessments for a number of reasons: feeling rushed or having appointments at difficult times or places were particularly mentioned. None of the participants that we met said that they had been given a choice of appointment times. Although most were not inconvenienced by this, for a few people this was an issue:

The appointment was for very early in the morning – half past eight I would have preferred a later time in the day. I'd have had time to gather my thoughts ... He explained that he was going to listen to me and try and assess me within half an hour ... and I thought I can't say what I want to say ... so I was trying to summarise everything ... (Service user)

The original telephone assessment was an hour. It was late. It was due for ten o'clock and I was really anxious, you know, not using the phone because I was waiting for this call. Like ten past ten so that put me on edge. (Service user)

It suited me at that time ... it felt very formal. I had to show up at a certain time at the clinic and it was as if I was going for an interview and that was pressure on its own. I didn't think it would have been a good idea to ask for a different appointment time having waited what was seven weeks by this time. It was very much, if I can't make this, how long will I have to wait? (Service user)

- 2.114 A few participants had their appointments changed at the last minute and described how it coloured their experiences of assessment:

Now I always thought that when you get an appointment in a letter form like that that is a legal agreement as to your appointment and it is yours. But ... because I realised my appointment would be made later I said 'I'll come down now' ...and I nearly got speeding points because of the stress of that. This person that didn't know me, didn't know what my issues were or anything was asking me to change my appointment ... And I was angry when I got to meet this woman, this nurse. It was not good at all. (Service user)

I wasn't happy with the initial assessment because somebody phoned me – my appointment was 10:30 in the morning and the CPN I think it was who was assessing ... phoned me at 20 past nine and said, can I come down there and then?' (Service user)

- 2.115 Some, were disappointed with their assessments because the outcomes did not meet their expectations:

I guess I was maybe hoping that something a little bit more immediate and drastic might have happened. Like you immediately need fixing. I came out with mixed feelings – being told go home, relax and wait to hear from us ... a week can feel like a year when you're feeling like that. So I enrolled on that (ACT course) and I'm

glad I did because I didn't hear from the LPMHSS again for about three weeks. (Service user)

The initiative was very much on me to do my research and then I had to do the next move. But I also realised that that was the end of it; that I had this assessment; that I wasn't suicidal and his assessment was that I should perhaps try this ... and that was going to be that. He didn't leave the door open – there was not a suggestion of come back and see me; make another appointment. (Service user)

The assessment didn't bring anything I could have waited for six months for six sessions of CBT – so I had to go elsewhere – for private counselling (and it's not cheap either). I don't regret going for the assessment. I got a certain amount out of it but it highlighted to me quite clearly the limited range of options. (Service user)

When they did the telephone assessment at the end it was like, OK, we'll send you something in the post but that's the end of our involvement. If you want to get back in touch with us you can. (Service user)

- 2.116 A number of participants highlighted their own personal barriers to accessing the LPMHSS. These included alcoholism, social anxiety and agoraphobia. They felt that this limited their options in terms of the LPMHSS offer:

It took me months and months. They wouldn't have anything to do with me. I tried to explain to everybody I was drinking heavily because I wasn't well. The drink was my crutch, basically. So I went into rehab –I still have the illness and I made a promise that when I came out of rehab they're going to try to make me well. I've only seen a primary care worker, but they did promise me that when I came out I would see a psychiatrist. (Service user)

I didn't want group therapy. I didn't feel comfortable talking about it in front of other people. (Service user)

I felt like it was a complete waste of time. He kept wanting to put

me in a group even though I told him I can't do a group. (Service user)

But at the end I was so shocked when they said thank you for your time and that's it – if you want to get back in touch with us ... Well, what am I going to get back in touch with you for? I don't know what you can do for me because I can't get to the courses. You're just sending me information. It's basically signposting. There are services out there for me but I can't get to them and I won't go to any drop-in centres because it's fear of the unknown. (Service user)

I told him I couldn't go to a group appointment – he made the appointment anyway. I just couldn't face it and they haven't got in touch with me since. They didn't follow up. (Service user)

I think that's a failing of self-help books or any form of counselling that whatever your issues are, when you're in the pit – whether it's bipolar, depression or feeling anxiety – you can see the lifeboat but you don't want to grab them ... you are aware of what you should be doing; should be thinking. However, you need like a personal trainer, because when you really need to put these things into effect you can't. (Service user)

- 2.117 A few participants were not sure if they had had an assessment at all, complaining that this should have been explained to them whilst a few others did not know whether their assessments were conducted within the primary or secondary sector:

I didn't realise – well, I didn't know it was an assessment. (Service user)

Possibly (it was an assessment) – nothing was made clear to be honest. (Service user)

The Assessor

- 2.118 The qualities of the assessor that participants particularly appreciated were calmness, professionalism and being approachable:

When I heard a man's voice I thought I want to speak to a woman but it didn't make any difference because he had humour that was appropriate and he was very professional, very reassuring in his approach. (Service user)

I felt that he was very calm and I thought he was very approachable and I wouldn't be worried about coming back a second time. I felt listened to and understood. (Service user)

I had a preconception that she'd be condescending and you know sort of doing it because it was her job and it was nothing like that – it was totally the opposite, in fact. It was as if she wanted to help. (Service user)

I felt comfortable with him. (Service user)

And the trust was there. I completely trusted him (Service user)

When I was with her there was loads of hope. (Service user)

And the attitude that they take is you are important to us They're asking what you'd like to do, giving you all the options and seeing what you'd like to try which I've done. (Service user)

It's great round here – they're quite quick getting back to you and keeping in touch with you. There's a bit more care. (Service user)

2.119 Very few participants felt in any way unhappy with their assessor:

I have to say I found him a bit patronising. I felt he was over compensating for the fact that the time was pushed – the things he was talking about – relaxation tapes and so forth. I felt I can get a magazine and do this. This is not helping me. I need to talk to somebody on a level properly. I actually didn't want to tell him a lot of personal stuff because I felt uncomfortable. Even if I'd been with him for an hour I wouldn't have said very much. (Service user)

Me and my children went to see the same primary care worker – I thought he was a child psychologist because he kept treating us as children. Speaking down to us and things. (Service user)

I was very, very upset at the assessment. I felt terrible. It didn't feel like an understanding person chatting to me about how I was feeling. It felt like I was being scrutinised and assessed carefully ... One of them was asking me very pointed questions. It really seemed like the good guy and the bad guy. I just cried throughout. I was very distressed. I felt laid bare and wrecked at the end of it. I didn't feel any warmth. (Service user)

Assessment - Mode

2.120 Several service users had telephone assessments and highlighted the pros and cons of undertaking assessments and communicating more generally by telephone:

I like the phone because I was in my own home and I was in control. (Service user living with agoraphobia)

Sometimes if I'm having a particularly bad time, I don't want to go out. I don't want to face people so going three quarters of a mile up the road really isn't an option, so I could just phone up. (Service user)

Depending on how great someone's need is, I think a quick phone call – a chat over the phone is fine but some people will need something far more than that – it's not the same really, especially for someone in distress. They might not want to talk over the phone perhaps anonymously. (Service user)

I realise it's about budgets and manpower but that's a tough call to make just over the phone rather than seeing someone's body language. I can't believe it's acceptable to do that. (Service user)

Assessment/Therapy – the place

2.121 Participants generally said they preferred to be seen by the service in a place that was familiar to them, easily accessible and where their confidentiality was assured. For many, the GP surgery was the ideal place whilst others stated the advantages of being in a mental health setting:

Took place at the GP surgery ... was quite happy about that

because I knew the place; it was convenient. (Service user)

It was held at the GPs. That was absolutely fine – your name comes up and it's like any other appointment – no one would know any different. That is really good. (Service user)

The timing of the appointment was when GPs were seeing patients. So it could have caused a lot of embarrassment ... because everybody knew me and I didn't want anyone to know that I was weak or depressed or had a problem. (Service user)

I hate waiting in the waiting room although when you see someone across from you who looks as bad as you feel, it can make you feel better because I don't feel so lonely ... it gets me away from feeling that the world revolves around me - God hates me, everyone hates me and life wasn't meant for me, kind of stuff. (Service user)

... you know that everyone has mental health problems. I think you recognise your anxieties more when you're in a room of other people that haven't got your problems. (Service user)

Therapeutic Interventions – Waiting times

2.122 About half of the Part 1 participants in this study received any kind of therapeutic intervention from the LPMHSS. Following assessment participants said that they had to wait anything between one week to a year for Tier 1 counselling or group interventions. Whilst some were fairly resigned to waits within the NHS, others complained that the service should respond more speedily to prevent further declines in health:

Following assessment I waited a month for the first counselling session. It's long enough. I wouldn't like it to be any longer. (Service user)

If it's a psychologist, that can take up to 18 months or three years in some cases and in the meantime if you're lucky you might be seen by the community psychiatric team but ... they may well send you back to the primary care system, at least you get some counselling in the meantime ... (Service user)

Where's the help and support? Where's the continuation? They want people back to work but where's the support to help them? If you don't have the continuation and support particularly with mental health issues, you feel so degraded and helpless and useless.

(Service user)

In my waiting time I became quite insular ... I wasn't going outside the door and by the time I did have my appointment my world had gone so small. (Service user)

Therapeutic Interventions – positive experiences

Individual Interventions

- 2.123 Several participants had received individual talking therapies from the LPMHSS and spoke of the advantages of gaining strategies and tools to cope and take control of their lives. A few said they felt empowered by the experience or that they appreciated the professionalism of staff:

It was the ability to talk to somebody who understood. ... here was a guy who was trained to get into your mind and he succeeded. I could almost feel the depression lifting each time I saw him.

(Service user)

I had about nine or ten sessions with her. From the third session on it was like this whole weight started lifting off me – it was just, well it was magical that's all I can say. (Service user)

I went through that process having already had some skills and knowledge and it was very positive – because this was like a refresher course and I found it incredibly empowering. (Service user)

I've certainly benefited from it, it's helped me answer, ok I've got to deal with things myself and move on but it's given me the incentive to move on. (Service user)

When thoughts start like that, do the irregular tut and it just stops that train of thought. I tried it and it really does work. It's made a difference. (Service user)

Group Interventions

2.124 Twice as many participants in this study had experience of group sessions than of individual therapies (15 as against 7). Again, participants appreciated learning coping techniques from the group sessions, whether they were CBT, ACT, mindfulness therapy or other courses or self-help groups. They also felt they benefited from being amongst other people with similar problems, providing mutual support; an understanding of not being alone in having these problems and an opportunity to 'be themselves' in a social setting:

I got a surprising amount from the (ACT) course even though they were scratching the surface: four, two hour sessions and a bit of homework for each one. (Service user)

I think it was called mindfulness and it does that. One of the things I find useful in a panic situation is to try and get back into the here and now... and that has been very useful for me. (Service user)

I look forward to it every time – because you're addressing the issue. We're drained after it in a good way. You're tackling it kind of thing. You go to a session and then over the week you're thinking about it and you're given homework as well on what you've covered that week and you're sort of implementing it – re-challenging your thought processes and beliefs and such and then you discuss it. You're having light bulb moments all the time. (Service user)

Yes, I gained from the relaxation. That's helped me enormously. (Service user)

It's having people around that are on the same ocean. (Service user)

It to some extent lifts me because I'm not the only one suffering and by comparison with some folks, I'm well off. (Service user)

You can discuss things in a group and you can see what people are going through and you might be doing something that will help

them and they might be able to help you. (Service user)

And I think this service (self-help group) is worth its weight in gold quite honestly. (Service user)

At least twice a week now we are who we are (self-help group). I think that's a very big step rather than be a one to one with a CPN which would make it very much formal. I think this way is better – it's a softer kind of approach. (Service user)

Therapeutic Interventions – negative experiences

2.125 Some participants felt that once the assessment was over, the LPMHSS had nothing further to offer than, possibly, signposting to other services or suggesting reading materials. Several participants who experienced group interventions, felt that these did not go far enough and were no substitute for counselling:

I felt at the end you've got your notes; there are these books, thank you very much ... but that was it ... (Service user)

For many people you need targeted treatment – not to cure it, but to manage it ... with the best intentions of the groups – it's not possible to enter into that realm. The present structure is such that you have to make your own decisions about where you're going to take it from there. (Service user)

It's really good to learn techniques for dealing with anxiety and panic attacks (in courses) but I really need to speak to somebody about why I'm getting anxiety and panic attacks, so I don't need to cope with them. I felt a bit fobbed off. (Service user)

So the ... course was just the basics of mindfulness. They just introduced the concepts and then they said, yeah, to get into more detail you'd have to attend another course for another six weeks. It was very basic. (Service user)

I have social anxiety so being in a group environment causes anxieties and stress in itself but I was never offered any one on one or anything – also some of your darkest thoughts you don't like

talking about in a group environment and they're the ones you need the most help with. (Service user)

- 2.126 Two participants complained that the interventions offered had been inappropriate and had, in fact, caused them additional stress:

I was offered CBT and to be honest at that point I couldn't even begin to look at a piece of paper and try to get my head around things like planning or answering questions about things, I was struggling to even get out of bed so I found that process of only being offered CBT very difficult. (Service user)

I mean I can't even read a paper and she's giving me stuff here that I'm not ready to do. And all that's done now is put me under a lot more pressure. I didn't like to say because you know they're doing their best for you ... I don't think things are moving fast enough for me – I feel I need a hell of a lot more ... I feel like I've been let down to be honest. (Service user)

Therapeutic Interventions – course evaluation

- 2.127 A few of the participants criticised the evaluation of the courses. One participant felt that the evaluation measured her satisfaction with the course rather than the outcomes for her own mental health. Others who had been asked to complete before and after feedback forms felt that these were imprecise and potentially misleading measures of change. One participant, in particular, who had private counselling at the same time as her LPMHSS course felt that if taken at face value her results would give an overly positive reading for the LPMHSS:

Anyone seeing the effect would have seen that I improved but the fact was I was having private counselling at the same time. So their figures will be skewed. (Service user)

Therapeutic Interventions – duration

- 2.128 Whilst some participants were content with only a few sessions, others felt that the interventions for them had been insufficient and would have preferred a longer relationship with the service:

He explained that it wasn't going to be an open-ended process. I was happy enough with it. I think he was prepared to offer sufficient time and foresaw that things would improve. If he thought that things weren't going to improve he might have taken a different tack. (Service user)

I'm concerned over what happens when it's finished. Four weeks is not enough. I think there's a lot more issues that need to be covered. I'm not ready to be told you're on your own and I don't think any of us are. (Service user)

It did help but I could have done with a few more sessions. But what is enough? You never can tell can you? (Service user)

It was six weeks I was offered and she allowed me to have eight because she could see a positive outcome at that point. (Service user)

A longer course would provide more skills so that it becomes the normal way of thinking and you don't need to have tablets to keep you on the straight and narrow. (Service user)

It's not enough – it's a sticking plaster over a wound and if you're lucky the wound will fade ... (Service user)

- 2.129 Some participants appreciated that the short courses allowed for more people to benefit from the service and were an efficient use of limited resources:

Ideally a lot of people would like a longer period and more help but when there are so many ... all they can do is what they can do and you've got to realise that they're trying their best. (Service user)

It's too easy to become dependent on them. I think at some point you have to think you've got to get on with this and do it yourself. (Service user)

One of the obstacles that they face though is people actually turning up – numbers have fallen week by week – so if you make the courses longer, how many other people are suffering because

those people aren't turning up. It's a waste of staff time. (Service user)

Ongoing Access to LPMHSS

- 2.130 The offer of getting back in touch with the service was made to several participants and they were grateful for this:

I feel secure that I can get hold of somebody. What I've done each time, I've phoned into the reception ... and I used to ask for (name) and I used to get a personal service. I feel privileged to get that but I feel that there's not enough of it. (Service user)

She said any time you need to, just pick up the phone and contact primary care and I'll get in touch with you straight away... and then if you need to come back you can come back. (Service user)

The courses are going on all the time and at the end of the course, the leaders say you can come back. (Service user)

- 2.131 Others said they would have liked to have that 'safety net' offer or to advance to further therapies. One participant, for instance, said that she would have liked for the 'door to be left open' at the end of her sessions so that she could see her therapist without an assessment. Others said:

I feel now I've been left out on a limb. There's no-one to turn to when I'm having blips. (Service user)

It was only four sessions but I would recommend it (ACT course) ... my only criticism was that at the end ... I would have been very interested in going on an advanced version. (Service user)

But I do feel I need support still. Like even coming here today I can feel my confidence is really bad. (Service user)

I don't think you could contact the service between appointments. And I think for the sake of the CPN it's a good thing because if you're constantly bombarded with people who can't cope with things ... they can't be on call all the time. (Service user)

3 Issues for Consideration

- 3.1 This section summarises suggestions for the LPMHSS raised by service users, carers and practitioners throughout this study. These suggestions are for consideration by Welsh Government along with the various additional sources of monitoring information being collected for the Review.
- 3.2 It should be noted that many of the suggestions are already included within the Guidance for Part 1 of the Measure.

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

Appendix 1: Case Studies

The case studies here concern people with direct personal experience of the LPMHSS. The real names of the participants have not been used. The case studies are derived from interviews with service users only and do not, therefore, encompass the reasoning and opinions of the practitioners involved in their cases.

Findings from these case studies have been included within the main body of the report and are intended to provide additional evidence to highlight the journeys made by individuals in accessing and receiving support from the LPMHSS.

Case Study 1: Terry

- Two interviews (June and October)
- A man in his late thirties currently unemployed and suffering from chronic depression
- Receiving a programme of support by group therapy and lifestyle advice
- Learning points: benefits of a planned approach and a mix of treatments

Assessment

At the time of the first interview, Terry had moved to live with his parents. He felt that he had been suffering from depression for some time but only sought help this time because his family had started to notice.

Terry heard about the LPMHSS from his GP:

I was diagnosed (with clinical depression) last year and he tried to treat it with medication and it only had limited success so he thought I should see a mental health practitioner. He tried different kinds of medication. Some had side effects and some didn't work very well and I saw him most of last year – once a month – it was getting OK but it wasn't improving enough and he referred me late last year.

He was unsure of how long he waited for an assessment but whilst waiting he returned to the GP for an increase in his medication:

It was a couple of months before I heard back from the team – it wasn't that long really. I can't be sure. I thought it would be longer actually because I've known people who've been waiting six months to see someone. It wasn't that bad.

Terry was pleased with the assessment as the practitioner was able to put him at his ease and listened to him:

They said we can fit you in on this day. Is that convenient? ... It was at the GP surgery. It was local. It was fine ... The lady that did the assessment was very good. It was the first time I'd really dealt with any mental health issues so I was kind of nervous, anxious and she knew what she was talking about.

On leaving he was feeling better: positive about the plan she had put in place for his treatment and confident that she would provide the treatment as promised. On offer was a mood management course, relaxation and counselling.

Primary Care Support

At the time of the first interview he had completed the six week mood management course a few weeks previously and was attending the four week relaxation course and had future courses planned:

The relaxation course is OK, yeah. It's a bit odd. I don't know what to make of it. It's a lot of breathing exercises. It's a bit different ... I've also booked on to four one day sessions in July – one of the sessions is to help with depression; one for confidence and two for assertiveness and they're as well as the one to one counselling. They're called self-help recovery workshops.

Unfortunately the mood management course happened at a time when he was 'in a bad way' and he felt he was not able to benefit fully from it:

I could have done with more mood management sessions just because of the way I was feeling at the time. If I'd been 100%, I would have got more out of it. I went into my shell a bit.

The LPMHSS suggested that he watch something on YouTube and he was given some DVDs and handouts in the class. He felt that he already knew the information but that it was useful as an aide memoire.

Terry believes that the combination of the exercise, fresh air and drugs had contributed to him feeling better:

I do feel better but if that's the medication, I'm not sure. I'm trying to be more active – they said that exercise releases endorphins in the brain and they gave me referrals to a fit (area) scheme where I can go to a gym and I've had my induction today ... Rather than being cooped up indoors all day the doctor said I should get outside and get some fresh air. I've been doing that.

He also felt that the LPMHSS had tried to put together a good programme of support for him, although he had not yet had any counselling:

I'm pretty satisfied with the service so far. It's better than I thought it would be because I didn't really know what to expect because it's the first time I've been to a mental health team. It's quite good. My brother's said I'm more back to my old self. I'm starting to see friends again.

The only thing I've had trouble with is accessing the one to one counselling. I've heard nothing about that. The woman that did it has retired. I know they've replaced her but I don't think she's started the job yet.

He felt that if he wanted to access someone at the LPMHSS, he'd be able to do so and was given a phone number.

At the second interview Terry was slightly less positive about the impact of the group therapies he had received. He felt that the workshops had provided helpful hints and added structure to his life but that he had hoped for more:

They were trying to change the way of thinking and the way you look at things. Easier said than done. I was hoping it (relaxation) would help me sleep but it didn't.

He was still keeping active with gym and martial arts and had started a computer course. He was still accessing workshops also and was about to attend one about health and wellbeing which was run by the LPMHSS. He was uncertain whether all the activities or the increased medication was making him feel better. However, he did feel that having a plan in place from the LPMHSS had helped him:

I think I like to have a structure in my life – to know what I'm doing from one day to the next. On a Monday and Tuesday I'm at Gym; on a Wednesday it's Tai Chi; on a Thursday it's martial arts. Having that structure in place has been helpful.

He was about to start the counselling sessions and by this time had been waiting for eight months. He was aware that the number of counselling sessions was between six and eight although he believed there might be some leeway around this and was unsure whether at the end of the counselling his programme from the LPMHSS would be finished. However, he

felt good about having a named person to contact if needed and about being given contact numbers for other support organisations. He did say though that it would have been beneficial to have had an individual case worker to check up on him when he had his down period whilst on the mood management course.

Terry said that he was going to make a concerted effort to get back to work in the following year and in conclusion about the LPMHSS, said:

I was hoping for a magic pill I suppose but that's not really realistic.

ORS tried to contact Terry to check on how the counselling went. However, we were unable to establish contact on a third occasion.

Case Study 2: Matthew

- One interview (June 2014)
- A man in his late twenties living alone; suffering depression
- Received Part 1 assessment and signposting advice
- Learning points: exemplary support for patient in an emergency; partly helpful assessment; tardy and inadequate follow up

Access

Matthew had been taking anti-depressants for two years and had asked the GP to be referred for counselling as he wanted a more natural treatment than medication:

So they put me on a waiting list but it seemed to be one of those waiting lists that's a million miles long – over a year I think.

A few months on he felt he was having a breakdown. His friends took him along to the GP who referred him to the LPMHSS. Unfortunately as this happened on a Friday the service was not able to see him until the following Monday:

... but what they arranged to do is to phone me the very same day – in half an hour – to have a kind of emergency chat and diagnosis. They said if you can't wait till Monday they could arrange an emergency helpline. That was very good in that it wasn't an appointment in the future. It was, 'we realise you need help as soon as possible and we will try and accommodate you as best we can until the appointment'. Obviously I was in crisis - suicidal mode - so telling someone wait three days can seem like a huge deal. So they recognised that and said we're going to chat with you now and offer you a little bit of basic support ... It was very friendly, informal – like a friendly person ringing up for a chat. I thought that was very good.

He was given some numbers and a website address to tide him over till Monday and although it was a difficult weekend he felt that having the meeting arranged meant that he had something definite to look forward to.

Assessment

Matthew was informed that the assessment would take half an hour but was pleased that it took as long as he needed which in the end was two hours. It was unclear if this was a primary or secondary care assessment as it involved two practitioners; he thought one of them was a counsellor. He was encouraged to open up and felt *'properly listened to'*:

I was very grateful ... The fact that there wasn't somebody saying, you're taking up too much time. Go away. Initially that helped a lot.

A number of options were suggested during the assessment:

They were advising rather than saying this will happen or that will happen. They said we can try and get the counselling bumped up and chatted about some other options. I had independently looked at counselling you pay for yourself and they said I should go with that if I was Ok to pay. It was good that they were honest. They mentioned the leaflets for courses in the waiting room. They said that this has been an assessment so what we will do is have a chat and at the end of every week they compare notes and talk to a consultant psychiatrist or whoever it is and decide what each individual case needs.

At the end, they informed him that they would be in touch within a week with other options. In the meantime they recommended taking time off work and taking it easy:

It was good to talk and I was glad that they would be in touch. I guess I was maybe hoping for something a little bit more immediate and drastic might have happened. Like you immediately need fixing. Go to this place, crisis appointment or I don't know exactly what but I came out with mixed feelings – being told go home, relax and wait to hear from us ... a week can feel like a year when you're feeling like that ... I left there (assessment) thinking that within a week I would hear from them with ... here is the local suicide prevention group. We've made sure that you've got a place – see you there. Something like that. Something a bit more proactive. I

suppose I lost a bit of confidence in them.

Primary Care Support

Matthew went to stay with his parents for support and whilst there Googled various therapies including mindfulness. He had also picked up a leaflet on ACT from the waiting room and phoned the number on the leaflet to find out more and subsequently attended the course which started about two weeks after his assessment. This was a course of four two hour sessions with homework in between.

I got a surprising amount from the (ACT) course. Each (session) is a very basic introduction to an approach within acceptance therapy. At the end of the course the intention is that you will be aware of these approaches but not an expert. Even though they were scratching the surface, I learnt a surprising amount and I've recommended it to all the people who go to (voluntary organisation). But it's difficult to get on there because it's so popular ... and it was a really good course. It was only four sessions but I would recommend it ... my only criticism was that at the end they didn't say if you're interested in expanding with further reading ... I would have been very interested in going on an advanced version. Under my own steam ... I Googled and I found an online mindfulness course which I'm currently doing which has helped a bit.

He felt that the assessors could have offered more information and advice about this and other options at the assessment itself. As it was, they contacted him three weeks following the assessment to inform him about the ACT course that by this time he was already attending:

It's interesting that what really made the difference, was me under my own steam ... It's great that they introduced me to certain concepts but it would have been so much more ideal if right back at the start they said, look here is a mindfulness course you can go to. Here is a group therapy within the next week, rather than hang on. If I hadn't on my own steam booked on to the course, it would have

been too late to start the course. The next one was two months later. So it was a bit like an anti-climax ... the whole thing was a bit redundant. At about that time I got a call from the GP counsellor saying you've been bumped up to the top of the list.

However, he had already started going to private counselling and was recommended against having more than one counsellor. In any case the primary care service could only offer up to six sessions:

It all seemed like too little, too late in both cases.

He also accessed group therapy from a local third sector organisation which his friends informed him about. He felt that the assessors should also have been aware of this organisation and others and informed him about them or actually made direct bookings with them on his behalf:

Certainly I wasn't told, 'well wait to hear from us but in the meantime did you know that there's a support place that you can go to for free? So we recommend that you go there tonight and check it out' ... 'You are in a crisis place - hop into my car and I'll take you to a place that will help you ... make sure you go there, make sure you get the attention'

When people are desperate, rather than being given possible options, this more definite help would be more beneficial. It's like being shot in the head and being told, there are various options to consider rather than saying, let's stop the bleeding.

I would have far rather they said here is our comprehensive database of every single thing in your area.

Matthew said that he knew two people with similar experiences of the LPMHSS: being unclear of the purpose of the team and being told to Google to identify third sector support. One friend had been warned off the six-week counselling course by the LPMHSS:

That will just be enough to start releasing the pressure valve and identifying issues but it's not enough to deal with them and resolve them so we feel you'd be in a worse place because once all of your

problems are unleashing, we go OK, bye. While it was very good that they were honest ... surely what they should be saying is, clearly you need counselling, and in our opinion you need far more than six sessions, so we're going to arrange that you have 20 sessions, rather than saying don't have it at all.

Matthew suggested that it would have also been good if the assessors had prescribed books for him to read. He also felt that making therapy more widely available would benefit the NHS:

I feel that the NHS could save an awful lot of money that goes on anti-depressants if they only invested in a few more mindfulness and acceptance therapy courses and say to people ... we recommend you take this eight week course to train your brain to relax a bit more ...

In conclusion, Matthew said that having an assessment was beneficial as it led to the ACT course but that:

There could have been more of a focus on immediacy and more local knowledge. I think I should have been referred to something with some degree of seriousness because I feel if I hadn't had the support network of friends, I might not be here today ... I did think that after all that (initial response) there was a little bit of an anti-climax.

Case Study 3: Pauline

- Three interviews (July 2014, November 2014 and May 2015)
- A woman in her late fifties living alone; suffering depression related to bereavement and fibromyalgia
- Receiving Tier 0 support since March 2014
- Learning points: benefits of social support from self-help group

Assessment

The GP referred Pauline to the Local Primary Mental Health Support team and she waited two weeks for an assessment. Pauline felt the assessment went well and was pleased that it took place at her GP practice. She welcomed the informality of the assessment and was glad of the opportunity to discuss how they could help her as she wasn't sure of what she wanted. The assessor recommended her to a self-help drop-in group:

I was able to go and see her at the surgery. Practically that was good. There were actually two ladies there and it was nice, it was informal. It was around 45 minutes and it was just giving a picture of the last three years. At that time it wouldn't have taken much to tip me over the edge. And they asked me what they could do for me and I said I don't know. I know I needed to talk to someone. So they said they didn't think there was any form of therapy that they could offer me that would be useful. Then she said she could pass my details onto the community support worker. She said that you don't have to talk about the issues that are causing the depression; it is just a social group. Which I thought was good. I will be meeting new people.

Primary Care Support

By the time of the first interview, Pauline had visited the drop-in group over several weeks and felt it had made a positive difference to her:

The group meets every other Thursday. We talk about all sorts, not just mental health. I have been there about five or six times. I have met new people. If there is anything I need to talk about privately, I can go somewhere and talk about anything that is bothering me -

which is good. It is more like a social club than anything. I think the idea behind is to get you talking to people, because when you are depressed you can be quite isolated. It has made a difference. I am miles different. I don't think there is anything else they could have done.

Unfortunately, by the second interview, the fibromyalgia symptoms had worsened which had caused Pauline to fall several times. As a result, she had become less mobile and had not attended the group. She felt that she was becoming isolated and realised that this could worsen the symptoms of depression. Pauline phoned and left a message with the group facilitator to ask when the next group was taking place – nobody called her back to pass on this information or to enquire why she had not been to the group:

I do miss the companionship - getting there is going to be a problem for me now.

By the third interview Pauline had been diagnosed with stage 4 lung cancer with secondary tumours in her brain and ribs. Pauline spoke frankly regarding her diagnosis and explained that she was receiving treatment that would possibly prolong her life expectancy. She was extremely upbeat about her situation and when asked about the depression she explained that in some respects she no longer felt depressed. She had been in contact with some members of the support group who had set up a group of their own which meets each week in a room within her supported accommodation and this was accessible for Pauline.

Case Study 4: Annette

- Interview in September 2014
- A 60 year old working woman
- Received assessment and signposting from LPMHSS
- Learning points: lack of understanding of role of LPMHSS by GP and misinformation about the service to the patient; inconsiderate appointment time; rushed assessment but beneficial signposting advice

Assessment

Annette heard about the LPMHSS service from her GP who referred her and informed her that the service would provide counselling. She had had counselling before and was unsure if it would help her:

I went to see him because at the time I was very, very depressed, not sleeping and it was through talking to him that he decided I ought to be put on the list.

She had an assessment at her GP practice within a month and was pleased with the speedy response. The wait did not cause any problems and she was hopeful that some action would be taken to help her cope and to sleep since at that time the medication was taking a while to take effect:

I thought it would take longer than that – in the scheme of things I thought that a lot of people would be looking for counselling so I was very surprised to hear within a month.

The appointment was for half past eight in the morning (she had not been offered a choice of appointment):

The time could have been better. Given that most people with depression don't sleep very well or they sleep all the time it was possibly a bit early to get my head in gear ... I would have preferred a later time in the day. I'd have had time to gather my thoughts.

She was given half an hour and was not impressed with the assessment which she described as follows:

I was called along to a small consultation room with the guy that was assessing me and we sat on two hard chairs facing one

another. It was very awkward; very uncomfortable ... although he did try to make me feel at ease. I was under the impression that he was there for that day to assess a number of patients and that he had to stick to a timeline and that I was the first one on the list. He explained that he was going to listen to me and try and assess me within half an hour. I thought for me to have reached that particular point where I was going to see someone was a massive thing for me ... so I was trying to summarise everything and I felt it definitely wasn't enough time. To reach a point where you seek outside professional help is a milestone in your development and that half an hour early in the morning is not an ideal scenario. It takes so long to describe how you feel and it's the result of all sorts of things in your life that I thought what can I say to indicate to him how I'm feeling in a realistic way in that timeframe? You're thinking this man doesn't have an awful lot of time on his hands here.

Her disappointment with the interview continued when she realised that the assessor was not going to refer her for treatment within the LPMHSS:

And it wasn't until I was nearly at the end that I realised what was happening; that he wasn't going to be my counsellor; that he was actually going to give me a list of possible places where I could get further help and I can actually choose who I go to see ... He indicated where he thought I might get the most appropriate help, but I thought if I had longer, maybe those indications would have been different.

However, a positive aspect was that she was affirmed as not being suicidal and that there were other organisations that could help her:

He suggested about three from this list and I picked up two: (name) counselling and Women's Aid (for counselling).

He also offered to copy a relaxation DVD for her but she declined. He did not inform her whether any group therapies were available from LPMHSS. She was under the impression that the LPMHSS was a signposting service only; except for people who were suicidal who would be offered something

else. She said she was in a negative frame of mind at the end of the assessment because the onus was very much on her to take the initiative. She also felt that she would have preferred to be assessed by a woman:

A woman cannot help but sympathise and empathise with another woman because most of the problems will be related to the woman's role as a mother, as a daughter, as a woman and I felt I certainly didn't give him a very clear representation of what was really the problem. I have to say I found him a bit patronising. I felt he was over compensating for the fact that the time was pushed – the things he was talking about – relaxation tapes and so forth. I felt I can get a magazine and do this. This is not helping me. I need to talk to somebody on a level properly. I actually didn't want to tell him a lot of personal stuff because I felt uncomfortable. Even if I'd been with him for an hour I wouldn't have said very much.

In conclusion, Annette was grateful that the assessor had made her aware of Women's Aid: at the time of the ORS interview she was receiving a free counselling service with which she was very pleased. However, the LPMHSS by no means met her expectations:

I would like to have been made aware at the outset that this was an assessment and not a counselling session. I feel actually I was a bit short changed. I thought I was going to see a counsellor for about an hour and I would become one of his regular patients. The GP had even encouraged this viewpoint by telling me it's good to talk. He didn't leave the door open – there was not a suggestion of come back and see me; make another appointment. Fortunately I came out and did my own thing but some people may not have. There are some people that might not have been able to express themselves as well.

Case Study 5: Marian

- Interview in October 2014
- A woman in her late sixties with physical health problems that were making her feel very down
- Received counselling support from the LPMHSS
- Learning points: benefits of one to one therapy and a course long enough to bring real benefits

Assessment

Marian went to her GP looking for help to cope with life. She was keen to avoid medication as she took anti-depressants for eight years when she was younger and experienced difficulties in withdrawing from them. She was anxious about accessing mental health services because her mother had suffered from breakdowns and depression. She believed she waited six to eight weeks for her assessment (this was at the time when the 56 day rule was in place):

I know the CPN at that surgery was very busy ... I was in a pretty bad state ... I coped because I knew there was some help at the end of the tunnel. You felt that there was going to be support.

The assessment took place at the GP surgery and she had no complaints about the timing. She was pleased with the assessment overall as she felt listened to and understood and although it lasted only half an hour, this was long enough:

I felt that he was very calm and I thought he was very approachable and I wouldn't be worried about coming back a second time. It's always a difficult thing to do because you know it's going to be upsetting and you know you're going to break down – talking about things you don't want to talk about really. And yet you know if you don't you're trying to cope with it alone.

At the end of assessment, Marian felt relieved, hopeful and confident that the service would be able to help:

What I needed to be told was that it wasn't such an unusual thing and that people cope with it and it's not the end of the world. So

that was very helpful at that stage.

Primary Care Support

Marian waited a month for the first counselling session and said that she would have found it difficult to wait longer. She had 14 sessions which lasted for two years (some missed appointments and gap with retirement of first CPN). The sessions were about a month apart and she thought this was about right:

It's good because it gives you time to really think about what's been said and try to put it into action. If it's longer than a month it is difficult – sometimes it is if the CPN's on holiday or something like that. But at least you know it's coming back ... if you can't cope they are going to be there in the future.

The CPN reminded her throughout that the sessions would come to an end. Marian also felt that she had enough sessions:

I think at some point you have to think you've got to get on with this and do it yourself.

She briefly described how the therapy helped her:

I think all the way through it's been suggestions of how to cope with the circumstances I was finding it difficult to cope with.

I think they helped me feel more normal, because it isn't normal to be so anxious and lacking in confidence. I wouldn't say I feel wonderful but I feel as if I have more tools and that what I'm feeling isn't as outrageous as I thought it was because I was absolutely convinced I was going mad and they were going to lock me up. And there are ways of coping with the things that cause me extreme anxiety. Reassurance is the most important thing for me. I can now go into supermarkets without worrying too much about it.

Marian was given an assessment at the end of the course of sessions which was helpful to her:

Actually that does make you realise how much progress you've made. It was a whole string of questions about how many times in

the last week have you felt anxious ... would you harm yourself; would you harm others; do you feel isolated ...? They're obviously doing it for their bosses but it actually does help the individuals. It's much more positive.

Although Marian was offered information about groups and courses, she did not find these suggestions useful as she was 'not a joiner' and preferred not to discuss her issues in front of other people. However, she did agree to take part in the ORS focus group and said that, 'for me that was a massive step':

There were suggestions of voluntary work and group therapy and things like that. The idea was that I took things on to build confidence and to give myself targets each week to try and convince myself I could do these things.

Marian was informed that there was a more serious option for her: secondary care but she was fearful about this. She was more reassured when the LPMHSS CPN left the door open to her:

Don't worry. If you can't cope just go back to your GP and ask to be referred back to me. ... I'd feel I'd failed if I did, but at least I know it's there.

Marian hoped, however, that she could cope without doing this as she supported the principle of reducing dependency and building self-confidence even though she said:

But now I have finished it I still feel anxious that it is finished.

In conclusion, Marian said that the LPMHSS had exceeded her expectations and scored the service 10/10:

I was feeling so desperate I didn't honestly think that one person could help me through it. And I thought both the CPNs I saw are exceptional people – very, very good at what they do. I think it's brilliant. It's exactly what I needed. I have absolutely no criticisms of them whatsoever.

Appendix 2: Part 1– Profiling information: Service users and carers/relatives

	Total:40 Service users: 38 Carers: 2
Age	
16-24	1
25-34	5
35-44	3
45-54	9
55-64	17
65-74	4
75+	-
Working status	
Working	6
Volunteering	4
Ethnicity	
White British	39
BME	1
First language	
English	39
Welsh	
Other	1
Physical Illness/disability	
Limits a little	9
Limits a lot	4
Living with learning disability	-

Appendix 3: Mental Health Practitioners involved in the study

Mental Health Practitioners working in each of the seven Health Boards in Wales participated in interviews or focus groups throughout the study in relation to the four parts of the Measure. Their job roles are presented below.

Primary Care Practitioners

Three focus groups – one in each of three Health Boards involving 29 practitioners:

Strategic Leads and/or Programme Managers and County Managers for Part 1 of the Measure; Nurse assessors and practitioners; Senior Nurse OPMH; Community Development Workers; Operations Manager; Psychologist; Psychiatrist; Team Leaders; Mental Health Development Manager; Managers of CAMHS Primary Mental Health Support

Secondary Care Practitioners

Four focus groups – one in each of four Health Boards; qualitative interviews and written responses involving a total of 41 practitioners:

Heads of Adult Services, Children's and Family Services and Children's Services;
Team Manager, Assistant Managers, Heads, Clinical Psychologist and Occupational Therapist for older adults services; Team Leaders/Managers, Assistant Head; Community Services Manager; Occupational Therapist and Student Nurse in specialist learning disabilities services;
CTP Trainer; CTP and Audit Officer;
Team Leader, CPNs, Occupational Therapist, Social Worker, Integrated Manager in CMHTs;
CPN Lead for Forensic Team;
Prison in-reach Nurses;
Service Improvement Partnership Lead and Part 4 Lead;
Manager, Assistant Head of CAMHS;
Service Improvement and Partnership Lead;
Psychiatrists;
Member of Home Treatment Team;
Adult Social Services Manager;

Day Centre Nurse Manager;

Social Work student.

Voluntary Sector Practitioners

Representatives from the following organisations were involved in practitioner focus groups and interviews (20 participants). It should also be noted that voluntary sector staff participated in many of the service user/carer sessions and were invited to share their opinions. A further 19 were involved in this way. In the end, 39 staff from the following voluntary organisations were involved in the study:

Advocacy Support, Cymru; Barnardo's; Cais (Parabl); Cardiff and Vale Action for Mental Health (CAVAMH); Conwy and Denbighshire Advocacy Service; Flintshire Advocacy Service; Gofal; Gwynedd and Ynys Mon Advocacy Scheme; Hafod Care; Mind; Hafal; Gwent Association of Voluntary Organisations (GAVO); Interlink; Eiriol; Mental Health Matters Wales; Patients' Council; Powys Association of Voluntary Organisations (PAVO); Tros Gynnal Plant; Unllais; Vale Council for Voluntary Services; West Wales Action for Mental Health; YMCA

The table below presents a distribution of practitioner type by Health Board area.

	ABMU	ABU	BCU	C&VU	CTU	HDU	PT
LPMHSS	✓		✓		✓		
Primary CAMHS	✓			✓	✓	✓	
Memory clinics		✓		✓		✓	✓

CAMHS	✓			✓	✓	✓	
CMHT				✓			✓
Crisis							✓
Learning Disabilities		✓				✓	
Forensics				✓			
Older People's Mental Health		✓		✓		✓	✓
In-patient							✓
Prison in-reach				✓			
Third Sector	✓	✓	✓	✓	✓	✓	✓
Advocacy organisations	✓	✓	✓	✓	✓		✓