City & County of Swansea

Mental Health Commissioning Strategy

Appendix 1

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City & County of Swansea
Mental Health Wellbeing Strategy 2017

Introduction

Mental health, like physical health can be lost, maintained or improved and there are wide ranges of factors that can positively or negatively affect it. Mental health is about how we think, feel and behave.

One in four people in the UK has a mental health problem at some point, which can affect their daily life, relationships or physical health. One or two in every 100 people will experience a more severe mental illness such as schizophrenia or bipolar disorder.

Mental health problems can affect anyone. Without support and treatment, mental health problems can have a serious effect on the individual and those around them. However, the majority of people who experience mental health problems can get over them, or learn to live with them, especially if they get help early on. The overwhelming positive aspect of mental ill health is the potential for recovery and self-management. However, without the right kind of support there is an increased risk of decreased longevity and poor physical health and suicide.

In general, the prevalence of mental health in a population is stable increasing in line with population increases. However, there are ranges of risk factors that can mean that a person and or an area is more likely to be affected by mental health issues.

Understanding how quickly people are able to access services, what sort of care they are receiving and what outcomes they are experiencing is vital to good care.

Consistent and reliable data in mental health is essential; however, data still lags behind other areas of health & social care. There may be information collected, but there is room for improvement in co-ordinating, analysing and sharing usefully between health and social care to inform commissioning.

This document sets out how the Local Authority has engaged to identify the level of mental health and the specific risks within the Swansea population.

The document then sets out the priorities, which have been coproduced for the Swansea area with people with mental health issues and their carer's. It then sets out to develop a plan on how the LA will fulfil its responsibilities, use its own resources, influence others and work in partnership to improve and maintain the Mental Wellbeing of the residents of the City & County of Swansea.

In the strategy development the local Authority has strived to apply, the principles of coproduction as outlined in the Social Services & Wellbeing Act have. It had been developed alongside the development of the new Adults Service Operating models for Swansea.

Defining Mental Health - What do we mean?
In the past, mental health symptoms have in the main been divided into groups. They are classed as either ‘neurotic’ or ‘psychotic’ symptoms.

‘Neurotic’ refers to those symptoms which can be regarded as severe forms of ‘normal’ emotional experiences such as depression, anxiety or panic. 'Neuroses’ are now more often called ‘common mental health problems ’.

'Psychotic’ symptoms, which are less common, are those that interfere with a person’s perception of reality. This may include the person hallucinating. That is they see, hear, smell or feel things that no one else can.

There is no single cause of mental health problems and the reasons why they develop are complex.

The Talk to me 2. A Suicide and self-harm prevention strategy for Wales 2015-2020. http://gov.wales/topics/health/publications/health/reports/talk2/?skip=1&lang=en uses the following definitions for Suicide and self-harm.

Suicide is death resulting from an intentional self-inflicted act.
Suicidal behaviours range from suicidal thoughts, planning suicide, attempting suicide to completing suicide.
Self-harm is usually defined as intentional non-fatal self-poisoning or self-injury. This covers a wide range of behaviours, including isolated and repeated events: self-cutting, poisoning, scratching, burning, banging, hitting, hair pulling and interfering with wound healing. It challenges the individual, families and professionals alike.

Behaviours associated with substance misuse, risk taking or eating disorders are generally not considered self-harm because usually the harm is an unintentional side effect of the behaviour. However, boundaries can be blurred, meanings differ in different contexts and there are often associations.

Long-term outcome research in adults consistently highlights the association between self-harm and suicide. Those who repeat self-harm are at significantly greater risk of completing suicide than those who have a single episode. Self- harm is an important public health problem in its own right, regardless of intent. It is one of the top five causes of hospital admissions in the UK. Many actions to prevent and reduce suicide will have benefits for those who self -harm.

National Legislative & Policy Context

Most mental health law applies in England and Wales. However, since the Government of Wales Act, the Welsh Assembly has been able to pass its own laws and make changes to England-Wales laws as they apply in Wales. The main laws, which affect mental health services in Wales, are:

Mental Health Act 1983 (revised 2007).
The Mental Health Act 1983 Code of Practice for Wales (the Code) is issued under section 118 of the Mental Health Act 1983 by the Welsh Ministers. The Code came into force on 3 October 2016.
http://gov.wales/docs/dhss/publications/160920mentalacten.pdf

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
The Act sets out in law what happens when people are unable to make decisions, for example, when they lack capacity to make a particular decision.
http://gov.wales/topics/health/nhswales/mental-health-services/law/mentalcapacityact/?lang=en

Mental Health (Wales) Measure 2010.
This law places new legal duties on local health boards and local authorities about the assessment and treatment of mental health problems. The Measure became law in December 2010. http://gov.wales/topics/health/nhswales/mental-health-services/law/measure/?lang=en

The Measure has 4 main parts:

- part 1 of the Measure will ensure more mental health services are available within primary care
- part 2 makes sure all patients in secondary services have a Care and Treatment plan
- part 3 enables all adults discharged from secondary services to refer themselves back to those services
- part 4 supports every in-patient to have help from an independent mental health advocate if wanted.

The Social Services and Wellbeing Act 2014 came into effect April 2016.

The fundamental principles of the Act are:

- **Voice and control –** putting the individual and their needs, at the center of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being.
- **Prevention and early intervention –** increasing preventative services within the community to minimize the escalation of critical need.
- **Well-being –** supporting people to achieve their own well-being and measuring the success of care and support.

- **Co-production –** encouraging individuals to become more involved in the design an delivery of services.

The Social Services and Well-being (Wales) Act changes the social services sector:

- People have control over what support they need, making decisions about their care and support as an equal partner
- New proportionate assessment focuses on the individual
- Carers have an equal right to assessment for support to those who they care for
- Easy access to information and advice is available to all
- Powers to safeguard people are stronger
- A preventative approach to meeting care and support needs is practiced
- Local authorities and health boards come together in new statutory partnerships to drive integration, innovation and service change

Wellbeing of Future Generations (Wales) Act 2015.
Wales faces a number of challenges now and in the future, such as climate change, poverty, health inequalities and jobs and growth. The Well-being of Future Generations (Wales) Act is about improving the social, economic, environmental and cultural well-being of Wales. It will make the public bodies listed in the Act think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach. The Wales well-being goals that have been set out in the Well-being of Future Generations Act. These are:
• **A prosperous Wales**: An innovative, productive and low carbon society which recognises the limits of the global environment and therefore uses resources efficiently and proportionately (including acting on climate change); and which develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing decent work.
• **A resilient Wales**: A nation which maintains and enhances a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience and the capacity to adapt to change (for example climate change).
• **A healthier Wales:** A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.
• **A more equal Wales**: A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio economic background and circumstances).
• **A Wales of cohesive communities:** Attractive, viable, safe and well-connected communities.
• **A Wales of vibrant culture and thriving Welsh language:** A society that promotes and protects culture, heritage and the Welsh language, and which encourages people to participate in the arts, and sports and recreation.
• **A globally responsible Wales:** A globally responsible Wales. A nation which, when doing anything to improve the economic, social, environmental and cultural well-being of Wales, takes account of whether doing such a thing may make a positive contribution to global well-being and the capacity to adapt to change (for example climate change).

National Policy Context

Together For Mental Health - a strategy for mental health and wellbeing in Wales http://gov.wales/topics/health/nhswales/mental-health-services/policy/strategy/?lang=en

At the heart of the strategy is the Mental Health (Wales) Measure 2010, which places legal duties on health boards and local authorities to improve support for people with mental ill-health.

The main themes of Together for Mental Health are:

- promoting mental wellbeing and, where possible, preventing mental health problems developing,
- establishing a new partnership with the public, centered on:
    - Improving information on mental health
    - Increasing service user and carers involvement in decisions around their care
    - Changing attitudes to mental health by tackling stigma and discrimination
- delivering a well designed, fully integrated network of care. This will be based on the recovery and enablement of service users in order to live as fulfilled and independent a life as possible,
- addressing the range of factors in people's lives which can affect mental health and wellbeing through Care and Treatment Planning and joint-working across sectors,
- identifying how we will implement the Strategy.

The Strategy is focused around 6 high level outcomes and supported by a Delivery Plan. http://gov.wales/topics/health/nhswales/plans/mental-health/?lang=en

The 2016-19 delivery plan is the second of three plans which sets out the actions to ensure the strategy is implemented.

Talk to me 2. A Suicide and self-harm prevention strategy for Wales 2015-2020.
http://gov.wales/topics/health/publications/health/reports/talk2/?skip=1&lang=en

The Strategy identifies both risk and protective factors around suicide, suicidal behaviours and self-harm. It identifies those that are most at risk and the priority groups and places to target protective and preventative approaches.

The aims of the strategy are:

1. Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in Wales
2. To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm
3. Information and support for those bereaved or affected by suicide and self harm
4. Support the media in responsible reporting and portrayal of suicide and suicidal behaviour
5. Reduce access to the means of suicide
6. Continue to promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action

Local Vision:

"People in Swansea will have access to modern health and social care services which enable them to lead fulfilled lives with a sense of wellbeing within supportive families and resilient communities. We will help people to keep safe and protected from harm and give opportunities for them to feel empowered to exercise voice, choice and control in all aspects of their lives. Our services will focus on prevention, early intervention and enablement and we will deliver better support for people making best use of the resources available supported by our highly skilled and valued workforce".

Our Draft Social Services model to deliver this vision is based upon the following six key elements:

- Better prevention
- Better early help
- A new approach to assessment
- Improved cost effectiveness
- Working together better
- Keeping people safe

The service model comprises four levels of health, wellbeing and social care support for our population. We think it will help us to deliver "better support at lower cost".

This Commissioning Strategy will support the delivery of Swansea's corporate priorities with particular emphasis on safeguarding vulnerable people and building sustainable communities:

- Safeguarding vulnerable people
- Improving pupil attainment
- Creating a vibrant and viable city and economy
- Tackling poverty
- Building sustainable communities,

At the same time, across Wales, public sector funding is under increasing pressure and therefore in Swansea, we need to reduce expenditure on adult social care. Added to this pressure is a growing population, which is placing additional demand on our service. This means we need to save money and meet the additional demands placed on our service whilst delivering the requirements of the Act.

In the document "Better Support at Lower Cost" (2011)[1] the Social Services Improvement Agency notes:

"It is increasingly recognised that the twin goals of improving efficiency and delivering better outcomes for service users are not necessarily in conflict with each other. Some councils recognise that the kinds of service transformation they are now contemplating would make sense in terms of service improvement even if current financial constraints…. were not present"

Our Commissioning Strategy therefore needs to deliver:
Our Corporate Priorities, and • The local vision for Social Services • The savings required through the Sustainable Swansea Programme • The co-produced outcomes for adults with a Mental Health issues in Swansea • Mental Health (Wales) Measure 2010. • The requirements of the Social Service and Wellbeing (Wales) Act 2014 • The Together for Mental Health delivery plan 2016-2019 • The Talk to me 2 A Suicide and self-harm prevention strategy for Wales 2015-2020 • The ways of working expected under the Well-being of Future Generations (Wales) Act 2015.

[1] "Better Support at Lower Cost" SSIA 2011

Section 1

Population Assessment

Estimating adult mental health issues – How many of us are affected?

This section will give an overview of some of the published data available and explores how we estimate the overall adult mental health of the population of the City & County of Swansea.

Who gets it and how serious is it?

Public health Wales indicate that there is no single cause of mental health problems - the reasons why they develop are as complex as the individual. mental health problems are more common in certain groups, for example, people with poor living conditions, those from ethnic minority groups, disabled people, homeless people and offenders.

Sometimes people with mental health problems are discriminated against. This can lead to social problems such as homelessness, and may make the mental health problem worse.

Particular mental health problems are also more common in certain people. For example, women are more likely than men to have anxiety disorders and depression. Drug and alcohol addictions are more common in men, and men are also more likely to commit suicide.

Mental health problems can also develop from difficult life events, such as moving house, losing your job or the death of someone special. Drinking too much alcohol over a long period of time, and using illegal drugs can contribute to mental health problems, particularly in people who are already vulnerable.

As well as the suffering caused by a mental health problem, mental ill health can have a negative impact on employability, housing and household income, potentially leading to severe economic deprivation. Mental health problems can also lead to social exclusion.

For example, adults with mental health problems are less likely than others to take part in leisure, arts and community activities; be living in appropriate or private housing and have access basic services such as health and banking services.

People with psychotic disorders such as schizophrenia are over three times more likely to be separated or divorced and over twice as likely to be living on their own as those without.

Without care and treatment, mental health problems can have a serious affect on the individual and those around them. Every year more than 250,000 people are admitted to psychiatric hospitals and over 4,000 people commit suicide in the UK.

Key data on numbers
The Together For Mental Health Strategy - A Strategy for Mental Health and Wellbeing in Wales states based on 2012 data indicated :

- 1 in 4 adults experiences mental health problems or illness at some point during their lifetime.
- 1 in 6 of us will be experiencing symptoms at any one time.
- 1 or 2 in 100 people will have a severe mental illness such as schizophrenia or bipolar disorder.
- 1 in 10 children between the ages of 5 and 16 has a mental health problem and many more have behavioural issues.
- Approximately 50% of people who go on to have serious mental health problems will have symptoms by the time they are 14 and many at a much younger age.
- Between 1 in 10 and 1 in 15 new mothers experiences post-natal depression.
- 1 in 16 people over 65 and 1 in 6 over the age of 80 will be affected by dementia.
- 9 in 10 prisoners have a diagnosable mental health and/or substance misuse problem.

Most of the recent published data sources are from individuals self-defining their mental health needs such as the Welsh Health Survey.

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

This suggests an increase of 1.3% in self -reported mental health.

NHS Wales Hospital statistics for people with a mental illness
Each year on the 31st March there is a psychiatric census of people who on that day are in Mental Health hospital provision by the local authority they are from. On the 31st march 2015 there were 172 inpatients from Swansea on that day.

Other data from hospital census published in 2014-15:

- There were 1,441 resident patients at 31 March 2015, a decrease of 45 (3 per cent) from 31 March 2014 (table 10.1).

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

"Key points from ABMU Health Board 2015 Joint Strategic Needs Assessment

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

What does this say about Swansea levels.

For Swansea using the Wales average ratios from the Together for Mental Health applied to the Swansea 242,000 (mid 2015 population estimate) it would mean that:

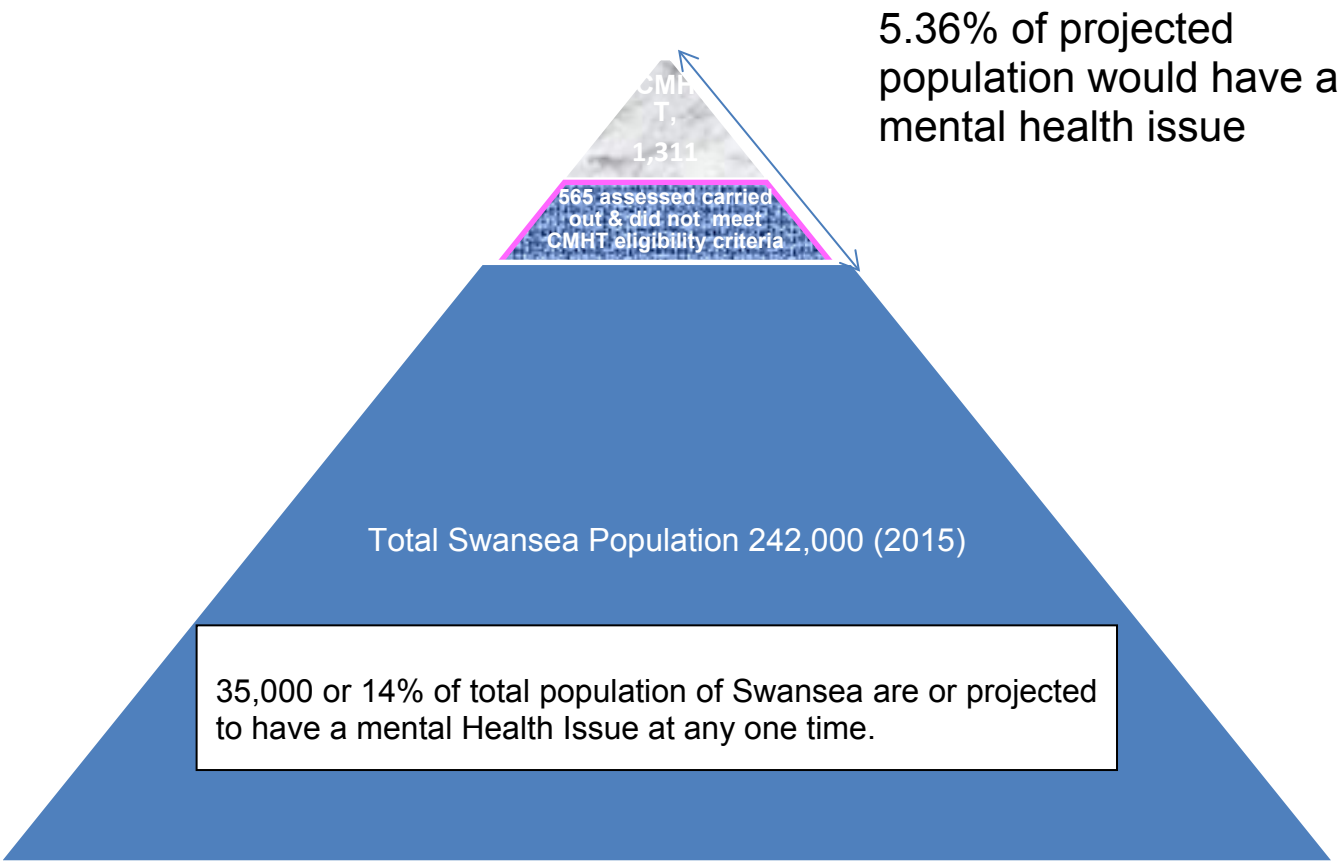
- About 60,000 people in Swansea are likely to experience some form of mental health issue during their lifetime.
- About 40,333 are likely to be currently experiencing a mental health issue.
- About 31,460 are likely to have an awareness of and are actively engaging in treatment for a mental health issue.

- The Welsh Government Daffodil System for predicting social care needs for Swansea indicated for 2016 there would be around 35,000 adults who would have a mental health issue and this would likely rise 35,767 in 2019. A 2.1% increase.

Appendix 1

City & County of Swansea Data April 2015 to March 2016

Relative proportions of population and where they are supported



Community Mental Health Teams

Within the Community Mental Health teams are professionals from Health and Social care e.g. Social Workers and Care Management Officers. Currently Adult Social Service only have contact with those being assessed and have an involvement in formally managing the care those that meet the eligibility for a social care service only. The diagram shows that this is a small proportion of those who are predicated to have a mental health issue in Swansea. Social Services commissions one Mental Health day opportunity which can be accessed by those who have not met the CMHT eligibility criteria.

City & County of Swansea Data April 2015 to March 2016

- Number of assessments undertaken by the CMHT's was 1763
- Of those assessments the number identified as not eligible for secondary mental health services 565 (32% of assessments)
- There were 526 (30%) individuals who were new to secondary Mental Health CMHT.

- An average of 19 new cases each month. (Jan 2013 to Dec 2013 15.5cases)
- An average of 19.3 cases were discharged each month (Jan 2013 to Dec 2013 17.4)
- There was an average of 1311 individuals supported each month and based on the Daffodil projection of 35000 for 2015 that is approximately 3.7% of the population with a mental health issue.

Those remaining individuals receive support through primary health care and others services. During the engagement event individuals were asked where they received support from

Tier 1	**Tier 2**
Family/Friends Carers colleagues (peers). Each other kindness of strangers Befriending Peer Support Self Help Groups. Animals (Therapeutic). Work/Employer Schemes Colleagues (work) Trade Unions Media Private Counselling Services internet/ Apps Stress Packs Online. TV Online / Physical Forums Universal – things that people can access themselves/ Spiritual Centres and facilities/Church/Libraries/ Leisure Centres/women's institute /Workers Institute/pub Third Sector. Community groups – Singing for the Mind, Red Café, Belly Dancing Education/Student wellbeing services and all establishments/Higher / Further ED Support Services, schools colleges, universities Directories.	Occupational Health, ABMU Wellbeing Services - stress control, Activate your life, Information and Advice Leaflets, Self- help information electronically Primary care / GP's/Primary Liaison Police/Probation/Criminal Justice Services Statutory Day Care Provision/ Cwmbwrla Day Services. Community Connectors / Local Area Co-ordination Citizen's Advice Homelessness Services /Housing. Community based groups, Voluntary Sector e.g. mind, SCVS, Volunteering, befriending, Hafal, Alzheimer's Society, Age Cymru, Domestic Abuse/Hafan Cymru/Carers Trust /Carers Centre EVST/Transcend Swansea

Tier 3	**Tier 4**
Team PLT (Health fund). Hospitals and rehab Secondary -CMHT SW, CPNs, OTs, Doctors, physiologist, Nurse Therapist. Assertive outreach. services/Emergency departments/ Counselling A&E (general hospital), Crisis Team – home treatment for hospital and crisis. Day Services/ Connect/ Mind /Hafal SP funded Supported Living /Llanfair /Gofal/WISH Tenancy Support. SM Services, coat, sands, WCADA.	Hospital/In-patient care / crisis resolution H treatment Forensic services Nursing Care/Res Care/Low secure units

Conclusion

There has been a decrease in the number of hospital beds available and a corresponding decrease in hospitalised patients. Three quarters of patients were discharged following 1 month stay. Therefore, more individuals with a mental heal issue are living in the community and therefore need to access to care and support service in the community. People are less likely to be admitted to hospital than in the past and stay they will say for shorter periods. Those who are admitted are getting older and there is an increase in formal admissions as a percentage of the total admissions.

What we know is that due to lack of awareness and stigma associated with seeking help and declaring you have a mental health issues the prevalence is under represented in the data collected and available.

There are efforts being made nationally and locally to challenge the stigma and get people talking about mental health issues in a similar way that physical health issues are https://www.time-to-change.org.uk/about-us/about-our-campaign/time-to-talk. The conclusion is there is likely to be an increase in the incidence of mental health issues reported over the coming years possibly beyond current predictions and a corresponding increase in demand for information and advice and care and support in the community as a result of people positively seeking help.

What are the specific mental health risk factor's.

There are a number of risk factors for individuals and areas which can affect the prevalence of mental health issues. This section outlines the particular risk factors that may increase the level of mental health issues in relation to the Wales average.

Risk factors indicate whether an individual, community or population is particularly vulnerable to mental health issues and suicide, and exist at various levels. Factors may relate to the individual and could be social or contextual in nature, and can exist at multiple interaction points. Where risk factors are present there is also a greater risk and likelihood of suicidal behaviours.

Prevention efforts should focus on at risk groups while simultaneously focusing on the entire population in order to mitigate risk at the individual level. The following table – although not exhaustive – lists a number of known risk factors.

Links to Deprivation

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

Common mental health problems such as depression and anxiety are distributed according to a gradient of economic disadvantage across society with the poorer and more disadvantaged disproportionately affected from "common mental health problems" and their adverse consequence

The Wales Index Multiple deprivation (WIMD) indicates Swansea has:

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

Secure Estate

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

Mental Health links to Physical Health

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

Premature mortality is a well-known phenomenon among people with severe mental health problems, with an average reduction in life expectancy of 10-25 years (15 years for women, 20 years for men) compared to the general population. Although

suicide is a factor, most of these deaths are due to chronic physical medical conditions (e.g. cardiovascular, respiratory and infectious diseases), and socio-economic and healthcare risk factors. People experiencing mental health problems are less likely to be managing the physical health and wellbeing.

Mental Health & Long Term Illness Benefits
At a national level the DWP analysis (published on Daffodil) indicates among adults on long-term benefits as a result of ill-health, 43% suffer primarily from a mental health problems.

- A 43% rate would be approximately 5,400 individuals with a mental Health issues on DLA or PIP in Swansea.
- Apply the percentage to the Employment Support Allowance (ESA) benefit data for Swansea as at May 2015 there would be further 9,300 individuals on ESA with a mental health issue.

It is estimated that in 2015 approximately 45% the predicted population of Swansea with a mental health issue (Daffodil =35,000) were on out of work benefits. That is about 15,000 people.

DWP welfare reforms and review of ESA are resulting in individuals loosing entitlement to ESA. However, local information indicates a significant proportion are successful on appeal. It is reported anecdotally by agencies which support individuals with benefit appeals that this process is in itself adding to the stress for those individuals many of which are already experiencing mental health issues.

Suicides & Gender, Suicidal Behaviours & Self harm
Talk to me 2. A Suicide and self-harm prevention strategy for Wales 2015-2020.
http://gov.wales/topics/health/publications/health/reports/talk2/?skip=1&lang=en

There were 247 suicides in people aged 10 and over in Wales in 2014 (199 male, 48 female suicides); this is a decrease of 146 deaths since 2013. This is the lowest suicide rate observed since the beginning of our time series in 1981. Similar trends were seen in males and females in Wales. However, the figures show that the risk of suicide for males in Wales is still significantly higher than females.

Suicide is usually in response to a complex series of factors that are both personal and related to wider social and community influences. There is therefore no single reason why someone may try to take their own life. Suicide is best understood by looking at each individual, their life and circumstances.

It is however important to remember suicide and self-harm are largely preventable, if risk factors at the individual, group or population level are effectively addressed.

This requires a public health approach, broader than focussing on services for mental health service delivery, and which demands collective action by individuals, communities, services, organisations, government and society. This means no single organisation or department can take sole responsibility: suicide and self-harm reduction must be cross-governmental, cross-sectoral and collaborative, with shared responsibility at all levels of the community, if it is to have a chance of success.

Men are around three times more likely to die by suicide than women. Women are more likely to engage in non-fatal suicidal behaviours that require hospital admission. Many people may have thoughts of suicide. Up to 19 people in every 100 will have thoughts of suicide at some point in their life 9. These thoughts are distressing and can further isolate an individual, creating additional barriers to seeking help. Only a very small number of those who harm themselves or who think about suicide will actually die in this way.

Among both males and females there is an association between suicide and area of residence based deprivation. Rates are higher in our more deprived communities and this gap appears to be widening in Wales. This is consistent with existing literature and highlights that suicide prevention should address inequalities that exist in society.

Families and friends bereaved by suicide are at greater risk of mental health and emotional problems and may be at higher risk of suicide themselves. Timely effective support will be facilitated by having effective local responses to the aftermath of suicide in place.

In 2010 there were 4,450 individuals admitted to inpatient care following self -harm in Wales. Some individuals are admitted more than once in any year. There are approximately 5,500 admissions for self -harm in Wales each year. This gives an indication of the burden of self -harm on services but does not take into account those assessed in A&E departments who do not require admission, or the many more who do not attend following an incident of self -harm. The age and pattern of self -harm shows that young women aged 15-19 have the highest prevalence with some evidence of an increase in males over 85.

Suicidal Risk Factors

INDIVIDUAL	SITUATIONAL	SOCIO-CULTURAL
Male sex	Job and financial losses	Exposure to suicidal behaviours
Low socio-economic status	Stressful life events (including divorce/ separation)	Stigma associated with poor help seeking behaviour
Restricted educational achievement	Relational or social losses or discord	Barriers to accessing healthcare, particularly mental health and substance misuse treatment
Previous suicide attempt(s)	Easy access to lethal means	
Mental disorder (including those unrecognised or untreated)	Clusters of suicide have an element of contagion	
Major physical or chronic illnesses including chronic pain		
Alcohol or substance misuse		
Family history of suicide		
History of trauma, abuse or neglect		
Sense of isolation		
Hopelessness		
Impulsiveness		
Admission to prison / engagement with criminal justice system		
Victimisation, bullying and stigma.		

The patterns of suicide and self -harm in Wales have not always been as we see them today and will continue to change. The challenges these changes present for prevention are considerable. There should be ongoing systematic collection of and access to data on suicide and self -harm to enable the identification of priority people and places for action and to monitor and evaluate the impact of intervention.

Prevention & Wellbeing - Protective factors

As equally important as risk factors are protective factors which help reduce a person's risk of developing mental health issues & vulnerability to suicidal behaviours. Protective factors will increase an individual's capacity to cope with particularly difficult circumstances.

The Five Ways to Wellbeing are a wellbeing equivalent of 'five fruit and vegetables a day'. It is recommended that individuals build the Five Ways into their daily lives to improve their wellbeing. http://www.wales.nhs.uk/sitesplus/863/page/47545

The Five Ways to Wellbeing are taken from the Foresight Project Mental Capital and Wellbeing published in October 2008. The project commissioned the centre for wellbeing at nef (New Economics Foundation) to develop the 'Five ways to Wellbeing': a set of evidence based actions to improve personal wellbeing. For more information visit http://www.neweconomics.org/

The NHS has nationally adopted these issuing self-help guides
Self Help http://www.selfhelpguides.ntw.nhs.uk/abmu/SelfHelp

Protective Factors *(Suicide Prevention Strategy*)
Strong connection to family and community support i.e. social connectedness
Skills in problem solving, conflict resolution and non-violent handling of disputes
Seeking help and easy access to quality care for mental and physical illness
Personal, social, cultural and religious/ spiritual beliefs that support the self
Restricted access to the means of suicide

Issues for commissioning from the Population Assessment
• Increase in numbers of people with a mental health need in line with population increases and demographic trends particularly more older people, dementia, complex needs/co-occurring substance misuse and learning disability. • Significant social stigma, isolation, discrimination which needs tackling • Lack of awareness of mental health issues • Lack of information on protective factors for mental wellbeing and early intervention help • More people will be seeking help with their mental health need as awareness improves and stigma and fear of discrimination reduces • Assessing and meeting carers own support needs • Health inequality needs addressing by improving access to health & social care services to giving regard to the population and individual risk factors to mental wellbeing • Need a better understanding of the needs within the BME community in Swansea better than we do currently • Supporting people to maintain or return to work and enabling access to meaningful work related activity • Develop an outcomes framework to capture what matters to people and support people to do more of what matters e.g. choice and control • Facilitating change to develop new models of support

Section 2 – Current Service Provision

Existing Provision presented by the Adult Services Model by Tier.

<table>
<tr><th colspan="3">City & County of Swansea - Adult Services Interventions</th></tr>
<tr><td rowspan="3">Tier 1 – universal services to support wellbeing</td><td colspan="2">The role of universal services is to ensure that adults are able to have a good quality of life. This includes support to keep active, stay healthy, avoid loneliness and isolation, keep informed and remain connected to their local community. We will expect these services to take an active role to identify and support those people who might be at risk of future health or wellbeing problems, and ensure that they are engaged and supported effectively.</td></tr>
<tr><td>Provided by the City & County of Swansea</td><td>Commissioned by the City & County of Swansea</td></tr>
<tr><td></td><td>Local Area Coordination</td></tr>
<tr><td rowspan="3">Tier 2 – prevention and early intervention</td><td colspan="2">These services help people avoid risks to their health, wellbeing and independence. When people do have difficulties, they will be supported to recover their independence as quickly and effectively as possible. Such services will focus on helping those most likely to need complex support if they do not get early help.</td></tr>
<tr><td>Provided by the City & County of Swansea</td><td>Commissioned by the City & County of Swansea</td></tr>
<tr><td>TSU - In House Community Care Group</td><td>Day Centres
Connect Day Centre- Caer Las (also for LD)
MIND Service (Carers Grant)
Hafal Service (Carers Grant)

Prevention of Homelessness
Housing Related Support
• Floating Support by Gofal</td></tr>
<tr><td rowspan="2">Tier 3 – managed support for identified needs</td><td colspan="2">When health and wellbeing issues threaten someone’s independence, care services will provide a targeted response to identify and reduce risks as soon as possible. These services will focus on supporting people to retain or regain as much independence as possible, even where a health or wellbeing issue is complex or long-term. A period of intensive support within Tier 3 may enable someone to move back to Tier 2 support.</td></tr>
<tr><td>Provided by the City & County of Swansea *</td><td>Commissioned by the City & County of Swansea *</td></tr>
</table>

	Social Workers & Care Management Officers within Integrated Community Mental Health Teams **Day Centre** Crest ***Temporary Supported Living*** In house 24hr Shared supported .	***OASIS*** **Floating Support Service Model** Gofal Gwalia Care & Support ***OASIS*** ***Temporary Supported Living*** Wish 24hr (FHA) Women only project (FHA) Wish dispersed shared.(FHA) Self- contained 24hour supported (Caer Las) N.M Shared Supported (Caer Las) ***OASIS*** ***Permanent Supported Living*** • WISH – Family Housing (FH) • E. Supported Housing Ltd • G.H. Ltd • K.H. Ltd • P.Y.W • Over 50 yrs. (FHA)
Tier 4 – specialist support for high level or complex needs	These services will meet the needs of those who cannot manage without specialist care and support. We will ensure that such services are high quality, designed and delivered in a way that promotes as much independence as possible. Where possible, care will be provided within or close to someone's local community. People will be supported to retain their dignity and exercise as much choice and control as they wish.	
	Provided by the City & County of Swansea	Commissioned by the City & County of Swansea
		Residential without nursing Spot Purchase Placements for Individuals • A and EA Scott (Cross ref. learning disability) • TRACS Ltd

		• Aston Care Ltd (W & L.H.) • H.S • C. G • T.Y.A.L • L.G • B.H RC • T.N (Integra) • A.C (Wellchime Ltd) **Residential with nursing care** Spot Purchase Placements for Individuals • M.H Sure Plan Homes Ltd • T.V, Sure Plan Homes Ltd • B.Hl. NH • L. NH • A.y.M. NH • Apex Care Homes (A) • C.F NH

** Abbreviations used to protect anonymity of addresses.*

How well are current services (across the four tiers) delivering these outcomes?

Commissioning and Service provision have moved to an increasingly outcome focused way of working and systems and processes are being developed to support this way of working. Some of our contracts are outcome focused and performance is measured against the delivery of outcomes (particularly in Supporting People).

Development of a Supported Living Framework will set out clear expectations of an outcome focused, co-productive approach and performance will be measured against outcomes at an individual and strategic level. However, this is not currently routine and our systems and processes are changing to re-focus on a clear specification of outcomes and outcome based performance management approaches. It is therefore difficult currently to be certain about how well current services are delivering outcomes when they are neither expressly specified nor measured across the piece.

We therefore asked people who access services, family carers, providers and commissioners how well current arrangements were delivering outcomes for people with mental health needs. The following was an overview of what people thought.

STRENGTHS	**WEAKNESSES**
Stigma reducing / more acceptable to ask for help around MH. Celebrities speaking out. Information more readily available. Recognition 'we need to change'. Willingness to change and become co-productive. **National Health Service (free at the point of use).** Free prescriptions / delivery service. Developments and progress with meds and therapies. Primary care MH Service. Primary care funding (but still not enough). **Social Services influence Health with a social model of understanding mental health & stress.** Positive goal setting – equality. Allowing individual personalities to develop. Integrated working. Co-location. Joint records. Response from CMHTs very	**Stigma still exists** • Public have negative perceptions of MH. Even MH stigma experienced within general health & social care settings. • Poor relationship/communication between MH and General Health Services. **Lack of Information/**People not aware about mental health conditions. Information not accessible to everyone about services and needs regular updating. **Staffing Issues** • High turnover/reorganisation of staff at strategic Planning level impacts negatively on progress. • Short term funding (third sector). Changes of operational worker including volunteer's results in erratic Services.

good. Joint commissioning of services. Multi-disciplinary teams.

A good range of support services relatively well provided for in Swansea compared to other areas within ABMU.

Seems different to OAP – close down cases.

Staff

Consistency of operational staff in some MH – known people for 20 years.

- Skilled/ trained/ Training Committed/Experienced with right attitude. Non- judgemental.
- Not so high turnover - Stable CMHT. It's for you – tend to stay until retire e.g. some staff know you well.
- Service users see less professionals.

Informal carers – can look after them better.

Prevention Services highlighted.

- Provision of MH specialist non MH services such as Tenancy Support. Helps maintain MH.
- LAC's.
- Advocacy.

Co-production and utilising Service User skills and experience to deliver activities etc.

Third Sector

- A supported (funded) Third Sector which is responsive, flexible, innovative.
- Good established partnership working arrangements.
- Opportunities for Networking.
- Service user wants, service user led. Partnership Utilising and sharing of good practice.
- Stress on staff due to caseloads & demand

Service user engagement carer / lack of involvement – planning / developing

Eligibility & Access

- Segregation between primary and secondary care has a negative effect on eligibility.
- Not all services are accessible to everyone, different criteria's. Increasing thresholds for accessing services.
- Bureaucracy of referral & assessment for LA funded services inefficient as compared to universal services are much simpler. No-one needs a referral and assessment just walk in when need it.
- Lack of clear pathways.
- Better accessibility and clearer criteria needed.
- Sustainability of services and consistency.

Gaps In Services

A good range of support services but not enough capacity. Pressure of numbers and lack of turnover. Caseloads too high.

- Getting advice Counselling.
- Lack of respite – impact on individuals and Carers.
- Lack of move on from supported housing
- Res Care – not enough between acute support
- Gap weakness for Dom Care speciality for understanding MH. Do not understand MH e.g. TIA exam triggers, meds, impact.
- postcode lottery
- Gender specific, (PRAMS, child care).
- Everything seems to be OAP focused
- Community Connectors and Local Area Coordination about older people not about MH.

• Skills / attributes of local communities. • Volunteering (but not replacing skilled workforce) **OASIS** Single referral point. Mixed range / variety of accommodation based services. Allowing different levels of projects to meet different levels of need. Appropriate technology	• Should be age blind – issue what can we offer? • No service from CAHMS, as primary care workers attached to GPS are in overload. • Transitional period child / adult. *We need proper, adequate transitions. • Not enough 1 – 1 working. Prevention, no system around sorting 'me' out! **In Crisis and urgent need** • Crisis only in hospitals. • Shortage of beds – necessitates police intervention.GP – CPN – MH Staff (G and B). • Mental Health Hospital Discharge – big problem. • Services not available at times when most needed e.g. evenings & weekends. Lack of flexible working. • Flexible services when service users and carers received it (only 9-5). **Joint commissioning – not always effective** • Service delivery hampered by funding agreements/lack of agreement. • Decision making debate while we wait. Arguments over funding between Health and Social Care due to budget pressures. • Pass the buck culture between physical health and MH or LD and MH dual diagnosis. • Uncoordinated and inconsistent funding postcode lottery. **Transport** • Travelling across ABMU. Rurality – transport issues. • Transportation use of ambulance services. Travelling out of Swansea area. • Need 1:1 transport for 1 – 1 work. Need better partnership working between disciplines! (Social Services, ABMU and Third Sector). Lack of integration to

	address stagnation / lack of innovation and Talking not doing.

Issues for Commissioning
• Coproduce an evaluation of each of the specific LA delivered and commissioned services within each tiers is delivering the outcomes • Build on the strength existing assets • Tackling health inequalities for people with mental health problems • Tackling stigma in general health & social care settings • Tackling stigma in universal services. • Delivering improvement in information about positive protective factors for mental wellbeing • Delivering improvement in information about access service for those experiencing mental health problems • Delivering accessible and responsive crisis support 24/7 • Delivering improved and effective partnership and joint commissioning • Eliminating barriers caused by transport issues

The next stage will be to evaluate each of the services within each of the tiers against the Outcomes established.

What do we spend?

City & County of Swansea expenditure Budget on MH

Social Services Revenue	14/15	15/16	16/17
Create	327,576	221,009	509,425
Community Mental Health Team 1	287,911	324,800	303,966
Community Mental Health Team 2	340,309	858,241	415,404
Community Mental Health Team 3	494,917	*0	517,569
Crisis Resolution & Home Treatment	96,423	99,804	104,524
C M&A Central Management (MH)	35,134	0	0
Mental Capacity Grant	12,992	12,550	12,550
DEL MH Residential Care	1,976,373	2,174,091	2,679,071
Direct Payments Wag Grant	168,877	280,885	425,146
C M&A Service & Staff Dev (MH)	67,932	67,462	61,734
L.A. Supported Housing	515,154	455,383	*812,332
Total Expenditure	4,323,598	4,494,226	5,841,721

*CMHT 2 & 3 co-located and budget combined.

*L.A – increased income toward budget from rents & service charges

Commissioning Arrangements

We have developed new co-productive commissioning arrangements and ensured clear governance arrangements both within the LA, Western Bay and other key partnerships.

This new Local Authority Strategic Commissioning Group will oversee and manage the development and implementation of the new local commissioning action plan that will be developed to deliver the strategic outcomes for people with a Mental Health need.

We aim to commission and deliver services on the basis of outcomes, co-production and social value. This will entail working collaboratively with local citizens and services to maximise value for money, promote wellbeing and encourage prevention. We will do this by:

- Recognising people as assets
- Building on people's strengths
- Fostering mutual; and reciprocal relationships
- Strengthening peer support networks
- Breaking down barriers
- Facilitating rather than delivering
- Developing insight
- Planning effectively, and
- Improving delivery

Section 3 - Engagement

The context of the engagement was set out as follows:

What needs to change?

Changes identified will need to be delivered in the context of:

- Meeting increasing levels of need
- Delivering a new model of support
- Manage reducing resources

Shifting resources

We will manage a shift of resources away from tiers 3 and 4 towards tiers 1 and 2 of 5% over the next three years in Adult Services.

The Western Bay Population Assessment sets out the following priorities:

- Effective management of transition
- Better redistribution of respite resources across the region
- Look at the potential of assistive technology within supported living

A key challenge in Swansea will be to continue our approach to support people in community settings as opposed to residential care, however, we need to support people to progress and move on, not get stuck in supported living options.

Co-production with Citizens

In January 2016, the City & County of Swansea began engaging with citizens to inform the Local Authority on what and how it should use its resources on to support people with mental wellbeing within its roles and responsibilities. A range of methods was used;

An all-day event at the Einon Centre where about 150 people attended. The session was held with individuals with experience of mental health issues, their carer's and health and social care professionals were asked a series of questions
A questionnaire sent to providers to support individuals who could not/or did not want to attend to give their views.
A series of smaller coproduction groups also took place through the year. The key question which was asked was "What does good look like?" Below are the summarised responses for the stakeholders.

What does a good life look like?

- Being worth something (having role, a reason to get up in it the morning/contributing /being respected)
- Being Safe/secure
- Somewhere to live (or closely associated with somewhere to live)
- having support when it's needed
- Having social support networks (opportunities to see and make family & friends love & care, emotional wellbeing)
- Security/stable/Financial income
- Be healthy physically and mentally
- Choices /Freedom to make decisions
- Everyone having an awareness of mental health, being understood & not to be discriminated against 5/8
- Being listened to
- Having/knowing information
- Having control (Not controlled by bad habits/addiction)
- Having aspirations
- Managing
- Achieving
- Laughter/Joy
- Stability/managing limiting stress and anxiety

The group were then asked what outcomes do we want to achieve?

- To stay alive and have a good reason to live,
- A reason to get up, to have meaningful occupation.
- Recovery, to be as well as I can be, be well, stay well and not need services
- To have my medication.
- To have my physical health needs met and reduce health inequalities.
- Self-management of symptoms, to be as independent and free of stat services as possible.
- MH fluctuates - so have support that fluctuates as it is needed.

- Sustainability and security from support services. Peer support opportunities.
- Overcome loneliness and isolation which magnifies mental ill health. Opportunities to meet others. Feel Needed- Part of community Living in the community
- To thrive, Must have joy / success in their life. I want to feel good about myself. Being able to achieve aspirations the things that made a good life to the individual.
- Developing skills – starting with the strengths of the people. What they can do rather than cannot do.
- Have choices, - Listened to and heard. Positive risk taking.
- Safeguarding, People being safe and feeling safe.
- Financially secure –Maximise/ income improvement. Transparent welfare system- Positive changes i.e. permitted work.
- A society which understands MH and how it affects people, which allows integration & achieved e.g. through Education involvement).
- Appropriate and timely Open referral / Access services to the individual need. Consistent/stability of flexible Services that continue to meet service user's needs and are personal centred. Reduce long term support. Centralising referrals (one stop shop).
- Appropriate and safe accommodation.
  Information, accurate, accessible, up to date. Access to IT (digital).

The group were then were asked to tell us "What support do people need to live a good life?". The following were the areas identified.

Support to challenge stigma and inform wider community and professionals
Stigma and fear of being unable to speak about their MH was still felt to be a massive issue. People need to be able to speak about the mental health to get help. Therefore need awareness raising in society and develop champions and role models.

Health campaigns should always focus on MH as well as physical health.
E.g. Health 5 a day, how does that improve MH. Need to train the general nursing staff.

Support the carers/family and community and professionals with information on what signs to look out for when mental health is deteriorating and what to do. Sometimes family networks & community opportunities are the only contacts which can spot early signs of Mental Health deterioration and trigger an early intervention response otherwise there is no early intervention. Carers / family need support recognise the "signs" and know what can be done to managing symptoms. . Older peoples support networks reduce mental health issues with bereavement services.

Accessible information and advice
Information on all services and where to get help when things go wrong. Greater knowledge of what to do when you experience mental health issues, what's available, how to access to where to go.

Early, responsive practical help (not which eligibility criteria you miss or meet) which is simple to access when you are becoming unwell.
We need to have services that help when people are first unwell. Accessible practical and emotional support when I need it!. Help is there without jumping through hoops to get it. Tailored package of support around frequency, intensity, needs and wants. Access to prevention services without needing to access a specific diagnosis and without having care management. If relapse get support when need it without going back to the start – simple re-access to support / services. Access to universal services is simplified, to attend a normal community club in the community there are no forms or assessments etc. Practical support e.g. tenancy support that will help my Mental Health. Help to get stability again.

Access to services outside normal office hours
Services that are available that meet needs of individuals at different times during recovery. Increased availability (beyond 9-5 Mon-Fri) for support in a crisis. When it's needed, not when "they" can provide, if at all. Easier access and able to attend when you need to.

A choice from a range of services
A range of services no matter what their age or disability. Services with flexibility built in.

Staff with the right qualities, skills and knowledge
Staff with right attitude (qualified and trained). Experienced, motivated and enthusiastic people who believe in what they are doing. Someone to trust and to speak to / be listened to. Not disillusioned and worn out. Staff who stay approachable passionate and focussed. Good morale of staff. Multi-disciplinary. Support from one person, consistency and informed support staff.

Support for the range of individuals who have Mental Health Issues (1in 6 people at any time). Across age and gender and with other needs such as homeless, substance misuse and physical illness.
Worried that services are gaining focus on younger people. Need to include older people. Complex needs with non-engagement, often compounded with Substance Misuse and Homelessness. Dual diagnosis and problems with pigeon holing when present to Council. Links between homelessness and poor MH / worsening mental health. Nido Therapy. Adults in the secure estate. Impact SSWBA14.

To overcome loneliness
Lonely no contact. Company and companionship?? It's the softer elements e.g. confidence, people understanding mental health, feeling self-conscious. It's all the softer side. Need to be individual. Focus on what people are good at. Confidence – support from networks.

To take part in meaningful occupation.
Breaking down barriers around trust, motivation, confidence, stigma to enable access to universal & specialist. Having a building good support networks formal / informal. Small steps, as too traumatic for some suffering anxiety. Communities supporting but cannot force people to get involved. Community connections/ Local area coordination may be used to access other interests. These widen interests. Need to support to link with Community/friends / neighbours / local figures. Joined up approach of services – take ownership and trust each other and not duplicate assessment process. Fear of illness constant fight to attend/ take part/keep work.

Geographically financially affordable Services
Some costs are prohibited. Attendance drops when bus lost. Late evenings buses home. Transport – catching a bus £10. Organising / very expensive. It's never free. Better use of community based existing LA buildings, break down the barriers. Intimidating being on own in taxi or on service bus in evening.

Be realistic – managing expectations and those of the advocates. You need to take risks.

Co-productive services. Self- help groups – third sector groups which prevent crisis / or need to access services.

The group were then asked "What do we know about Mental Health future needs?"

It's always going to be there.

- There will be changes in attitudes and understanding of Mental Health.
- There may be increased diagnosis and treatments.
- It is becoming more acceptable to ask for help. This which is likely to mean demands will increase for information and advice, people will have more complex lifestyles and higher expectations.
- Everyone's journey is different. No-one size service fits all.
- More people living longer with their Mental Health issues and increase in Dementia sufferers. There may be more isolation. Should not look at older people as one homogenous group. More older carer's as well as younger carers.
- People will have physical health needs and as the population ages so these needs are likely to increase too e.g. obesity and diabetes etc
- Impact of Substance Misuse (Legal Highs Particularly) on diagnosis, complexity of care & support needs and complexity of delivery.
- Mental Health issue high amongst people in secure estate.
- Prioritising groups of needs e.g. High and complex needs. Drugs, legal highs and alcohol increasing abuse. Alcohol related dementia.
- Transition to Adult Provision. Younger people accessing Mental Health service with substance misuse issues. SM "messed up" young people entering services for life. Younger carers.
- With Substance misuse recovery takes longer if at all and is interdependent with Substance Misuse treatment responses and services.
- Changes in the approach to service delivery Enhanced primary care services to decreased impact on secondary mental health services.
- Reorganisation of statutory organisation structures.
- Impacts of Welfare Reform on incomes, particularly for under 35 and difficulties for those not working to access affordable good quality housing
- Impact of private MH hospitals may increase on demand locally with patients from out of area with placements not known to CCS until the placement breaks down. No control measures.
- **r**epatriation of individuals placed outside of Swansea / Wales (where appropriate).
- Limited number of specialist providers in market limits competition.
- Not enough accommodation for the critical few.
- Intensive services are out of area in private sector more expensive
- Commissioners seeking further efficiencies, do more with less not financially viable for some providers.
- Staff on statutory minimum pay dealing with challenging, complex needs, but we need high skill / experience staff. Staff look for easier work in Tesco.
- Millions extra needed to maintain service level

The group was then asked to consider where individuals get support now and these sources were grouped by them into informal and formal support.

Informal	**Formal**
Family/Friends Carers colleagues (peers). Each other kindness of strangers Befriending Peer Support Self Help Groups. Animals (Therapeutic). Work/Employer Schemes Occupational Health, Colleagues (work) Trade Unions Media internet/ Apps Stress Packs Online. TV Online / Physical Forums Universal – things that people can access themselves/ Spiritual Centres and facilities/Church/Libraries/ Leisure Centres/women's institute /Workers Institute/pub Third Sector. Community groups – Singing for the Mind, Red Café, Belly Dancing Private Counselling Services	ABMU Wellbeing Services - stress control, Activate your life, Information and Advice Leaflets, Self- help information electronically. Primary care / GP's/Primary Liaison Team PLT (Health fund). Hospitals and rehab services/Emergency departments/ Counselling A&E (hosp) Crisis Team – home treatment for hospital and crisis. Secondary -CMHT SW, CPNs, OTs, Doctors, physiologist, Nurse Therapist. Assertive outreach. Hospital/In-patient care / crisis resolution H treatment Police/Probation/Criminal Justice Services Forensic services Statutory Day Care Provision/ Cwmbwrla Day Services. Day Services/ Connect/ Mind /Hafal Community Connectors / Local Area Co-ordination Nursing Care/Res Care/Low secure units Citizen's Advice Homelessness Services /Housing. SP funded Supported Living /Llanfair /Gofal/WISH Tenancy Support. SM Services, coat, sands, WCADA. Community based groups, Voluntary Sector e.g. mind, SCVS, Volunteering, befriending, Hafal, Alzheimer's Society, Age Cymru, Domestic Abuse/Hafan Cymru/Carers Trust /Carers Centre EVST/Transcend Swansea Education/Student wellbeing services and all establishments/Higher / Further ED Support Services, schools colleges, universities Directories.

The Group were asked to consider what they felt were the strengths and weaknesses.

STRENGTHS	**WEAKNESSES**
Stigma reducing / more acceptable to ask for help around MH. Celebrities speaking out. Information more readily available.	**Stigma still exists** • Public have negative perceptions of MH. Even MH stigma experienced within general health settings.

Recognition 'we need to change'. Willingness to change and become co-productive.

National Health Service (free at the point of use). Free prescriptions / delivery service. Developments and progress with meds and therapies. Primary care MH Service. Primary care funding (but still not enough).

Social Services influence Health with a social model of understanding mental health & stress. Positive goal setting – equality. Allowing individual personalities to develop.

Integrated working. Co-location. Joint records. Response from CMHTs very good. Joint commissioning of services. Multi-disciplinary teams.

A good range of support services relatively well provided for in Swansea compared to other areas within ABMU.

Seems different to OAP – close down cases.

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Consistency of operational staff in some MH – known people for 20 years.

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Lack of Information/People not aware about mental health conditions. Information not accessible to everyone about services and needs regular updating.

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- Skills / attributes of local communities.
- Volunteering (but not replacing skilled workforce)

OASIS

Single referral point. Mixed range / variety of accommodation based services. Allowing different levels of projects to meet different levels of need.

Appropriate technology

- Getting advice Counselling.
- Lack of respite – impact on individuals and Carers.
- Lack of move on from supported housing
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- Transitional period child / adult. *We need proper, adequate transitions.
- Not enough 1 – 1 working.

Prevention, no system around sorting 'me' out!

In Crisis and urgent need

- Crisis only in hospitals.
- Shortage of beds – necessitates police intervention.GP – CPN – MH Staff (G and B).
- Discharge – big problem.
- Services not available at times when most needed e.g. evenings & weekends. Lack of flexible working.
- Flexible services when service users and carers received it (only 9-5).

Joint commissioning – not always effective

- Service delivery hampered by funding agreements.
- Decision making debate while we wait. Arguments over funding between Health and Social Care due to budget pressures.

	• Pass the buck culture between physical health and MH or LD and MH duel diagnosis. • Uncoordinated and inconsistent funding postcode lottery. **Transport** • Travelling across ABMU. Rurality – transport issues. • Transportation use of ambulance services. Travelling out of Swansea area. • Need 1:1 transport for 1 – 1 work. Need better partnership working between disciplines! (Social Services, ABMU and Third Sector). Lack of integration to address stagnation / lack of innovation and Talking not doing.

Section 4 - Outcomes

Attendees at the event in January were asked "What outcomes do we want to achieve?".

- To stay alive and have a good reason to live,
- A reason to get up, to have meaningful occupation.
- Recovery, to be as well as I can be, be well, stay well and not need services
- To have my medication.
- To have my physical health needs met and reduce health inequalities.
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- Appropriate and safe accommodation.
  Information, accurate, accessible, up to date. Access to IT (digital).

The Mental Health Coproduction Group workshop in another meeting was asked to look at the Nation Social Service and Wellbeing Act outcomes and consider whether they wished to amend them to be locally and mental health specific. They were informed that the outcomes would be used to measure service provision against going forward. Some outcomes were easier than other to relate to Mental Health with much debate about the language and assumptions.

The table below represents the comments from both groups to make a specific Mental Health set of outcomes.

Appendix 1

What well – being means	National well-being outcomes	Mental Health City & County of Swansea variations & additions to the National wellbeing outcomes. To be used to review commissioned services against.
• Securing rights and entitlements • Also for adults control over day to day life	• I can access the right information, when I need it in the way I want it and use it to manage and improve my wellbeing. • I am treated with dignity and respect and treat other the same. • My voice is heard and listened to. • My individual circumstances are considered. • I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me.	• I know and understand what care and support and opportunities are available and use these to help me achieve my mental and physical well-being • I know my financial rights and entitlements and get support when I need it to access them. • I am treated with dignity, respect without fear of discrimination and treat others the same. • My voice is heard and listened to. • My individual circumstances are considered. • I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me.
• Physical and mental health and emotional well-being. • Also for children: Physical intellectual, emotional, social and behavioural development.	• I am safe and protected from abuse and neglect. • I am supported to protect the people that matter to me and from abuse and neglect. • I am informed about how to make my concerns known.	• Information & advice is equally available about supporting mental health and emotional wellbeing, as is that for physical wellbeing. • I am supported to stay alive and have a good reason to live. • I am supported to recover and self -manage my mental wellbeing towards a life fee of services. • I am supported to have my physical health needs met with understanding and consideration of my mental health needs. • I can have my medication • I am supported to take positive risks. • I am safe and protected from abuse and neglect.

Appendix 1

What well – being means	National well-being outcomes	Mental Health City & County of Swansea variations & additions to the National wellbeing outcomes. To be used to review commissioned services against.
		• I am supported to protect the people that matter to me and from abuse and neglect. • I am informed about how to make my concerns known.
Education, training and recreation.	• I can learn and develop to my full potential. • I do the things that matter to me	• I have opportunities to learn and achieve and develop to my full potential that are suitable for people with fluctuating mental health issues. • I do the things that matter to me
Domestic, family and personal relationships	• I belong. • I contribute to and enjoy safe and healthy relationships.	• I do not feel lonely or isolated and am supported to overcome it when I do. • I contribute to and enjoy safe and healthy relationships.
Contribution made to society	• I engage and contribute to my community.	• I am supported to do things that matter to me and make me feel worthwhile. • I can engage with opportunities which contributes to a society, which understands Mental Health, and how it affects people.
Social and economic well-being Also for adults: Participation in work	• I contribute towards my social life and can be with the people I choose. • I do not live in poverty. • I am supported to work.	• I am supported to maintain my existing employment/ or have suitable work opportunities with employers who understand and are supportive to people with fluctuating mental health issues.

What well – being means	National well-being outcomes	Mental Health City & County of Swansea variations & additions to the National wellbeing outcomes. To be used to review commissioned services against.
	• I get the help I need to grow up and be independent. I get care and support through the Welsh Language if I want it	• I get the help I need to grow up and be able to identify and reduce the risks to my mental wellbeing and to live free from services. • I get care and support through the Welsh Language if I want it. • I contribute towards my social life and can be with the people I choose. • I do not live in poverty
Suitability of living accommodation.	• I live in a home that best supports me to achieve my well-being.	• I have choices to make on where I live, in communities and with housing providers who understand and do not discriminate and support my mental wellbeing.

Section 5 - Priorities

Within the engagement event individuals were asked to identify their top 3 priorities which are set out in the table below.

Top Priorities	
Breakdown stigma – value everybody. Educate, integrate and motivate.	Developing services to achieve self-management through encouragement. The Recovery Model.
Meaningful assessment and robust outcome based review process with individual at the centre.	Development and strengthening of primary care services. More resource into prevention and primary care.
Range of flexible services– one size does not fit all	Investment has to be shifted to prevention but needs to be flexible.
Commissioning process to include Co-production. People who use services and their carers being involved at every stage of this process (Commissioning and Reviewing).	No further cuts to secondary care – consider extra resource
Timely response in a crisis.	Care before profit.
Improved delivery of outcomes for individuals to enable achievement – with all stakeholders working together to achieve.	Focus on meeting the LA's statutory responsibilities – prioritise what works well and what is important to the patient
Mixed market of providers – competition / partnership ensure reasonableness.	Better partnership working around dual diagnosis.
Simpler Access to services	Integration of Health & Social Care across ABMU area.
Access to services – simplified and consistent – focus on Early Intervention & Prevention.	Need to integrate current research treatments into current practice. Other therapies of the medical model.
Maximise the full potential of current services ensuring services meet the need	Increase flexibility into services across all pathways.
Good staff recruitment and support. Production in designing and providing services.	Greater efficient and effective services – co-production especially service user carers.
Sustainable – consistently there and accessible.	Review if we have sustainability and adequate current resource for provision of existing service in a safe way.

This feedback was significantly summarised to bring out the Big Issues in one power point slide and used to test and challenge and coproduce a summary of the Big Issues with a smaller group of stakeholders some of which were at the original event.

They were asked to look as the "Big Issues" and consider the following questions:

Do you agree these are the important issues? Are we missing anything?	All agreed these were important issues but more detail/emphasis in some areas: • Need to emphasise demands are increasing for secondary mental health services. E.g. Higher caseloads CMHT for Social workers & CPN's plus additional responsibilities for SW dols and AMP. Consequently it's more difficult to get a Care & Treatment Plan which reflects all the principles of the act and the measure due to time. • No mention of the principles of recovery model. Need to developing an assessment and practice framework based on the principles of recovery that everyone has agreed to, is embedded and everyone works towards. • Wider description of groups within MH needed e.g. complex needs, dementia & acquired brain injury. • It was felt clarity was needed on the range of services referred to which planning care & support applied. • Must note peoples mental health is not stable includes recovery & relapse. Need to have care & treatment plans that describe how people move in and out & through degrees of support & care. Should be part of the. How will/can this happen. Start the exit strategy on day one. Must inform commissioning. • The list feels like what's wrong with secondary mental health not emphasising prevention and early intervention areas. • More detail should be identified what was meant by lack of crisis support for who and when and where are they. • Emphasis a need for a less risk averse culture so that people can challenge themselves. **Missing** • What will future model look like. Need to recognise what good practice will need to look like to deliver a recovery based model. E.g. positive risk taking recovery approach, getting work supported, normalising. • Need to be flexible to allow for experimental approach without a blame culture. E.g. the person cut themselves because they wanted to not because someone did not do something. • Asset based approach building areas of strength not continually focusing in what wrong with you. A new practice model. • A gap is there is not enough clear information accessible around options for how to get back into work and support and permitted work part time work. We need supported and sympathetic employers. Support around finding work should not be portrayed as a negative. There is a culture of change needed as it is a positive approach and impact on a person's quality of life and being part of recovery. Support

	seems to be targeted at how not to work and stay on benefits which is not always in the best interest long term. • Respite services are not in the scoping doc for the review was raised as a gap. However, day service provision gives respite both to the family carer and cared for. **Other comments** • Individual CTP 1:1 conversations must be reflected from CTP and must be used in pop needs assessment at a strategic level as a commissioning tool. • Currently good performance looks like holding on to someone and does not drive progression/moving on. If safe and well given no formal time and progression stops. If problems much time is given. • Social isolation a lack of diversity in day to day reinforcing isolation. Drop in models of structured support • Include a test & challenge/sense check session across the other client groups LD & PD. • Produce a MH asset map. • E.g. front loading support is high initial support to achieve outcomes used in Bridgend.
Think of a time when you have received support or given support to someone – what made it good and why?	• Positive relationship's leads to positive outcomes. There are a range of relationships which may be important to the person and the CTP should to identify and be explicit what the role is of the CTP to support identification and sustain them and creation. • A person is able to cope & succeeds in spite of limits and suggestions they would not. • Where a person knows what's on offer and there is a shared understanding of the purpose of the intervention/service and the outcome everyone is trying to work towards. • A good stable structure to facilitate ongoing conversations. Regular contact/relationships serviced which define issues and work together to resolve. Good partnership behaviour. In relation commissioning compliant with the law flexibility responsiveness. • Always has the principle of reflecting on our own experiences of accessing service e.g. a GP service then we ensure we are grounded in what it look like to everyone/ourselves people who need the service. • When you have a crisis someone is there listening to reassure and give advice (answering the phone! Can save a life in Mental Health.) Listening & talking is a service and is important. • Knowing when it's the right time for the right type of conversation. Sometimes it's not best when someone is the most unwell. There should be time for a conversation when they are not in crisis and have insight. • When people come to us they tell us what they want. We should listen. • There should be a contingency plan in place as part of the CTP. • We must remember that information & advice on line is not accessible for all and we should use a range of formats. • Medication - having choices /options which can be discussed.

	• Being creative what is possible to achieve jointly agreed outcomes with trust & risk factors considered. • Build on what people want don't waste time and money on what they don't want.
How can we continue to work with this group?	• This group to get back together regularly but must have the appropriate decision makers. • Add some key people like Local Area Coordinators • Must have service user/carers feedback to shape. • The conversation must continue, Adult co-pro project Local info must link clearly to WB commissioning board and develop their thinking. Needs a consistent structure and personnel to achieve the continued conversation. • What's working and we need to keep identify these areas • Focus on topics/thematic approach going forward to work the detail in the co-pro groups.
What advice do you have for us about engaging more widely?	• Need a consistent structure to have a corporate memory of activity and not restart each time staff or council changes. It stops progress • Wider group of those with MH issues. How do we get primary MH users involves? • More care managers must be involved if we want to change culture. • Need to take a broader look at who the strategic partners are: 1. Education courses by staff who are sensitive to MH needs and input into the recovery model , not set it back 2. Support general universal services to be sensitive contribute to recovery. • Local Area coordinators – What can they do and what information do they get from the community.

Appendix 1

Engagement with citizens and their carer's with mental health issues identified the following priority areas for action. A lot of detail was given in some areas by people about what they felt was happening now, what good would look like and what actions to undertake to make the changes. It was felt that each of the "need to change priorities" would need a coproduction group working on that area to make the change. Some areas are not the direct responsibility of the Council to do but we have a shared responsibility under the Social Services & Wellbeing Act to work with partners such as health and support people to have voice choice and control.

Draft - Swansea Mental Health Strategic Commissioning Strategy Action Plan				
What Needs to Change to deliver the Outcomes?	**What is happening already?**	**What would success look like?**	**Draft Actions**	**Person Responsible &Timescale**
Stigma and discrimination still exists • From public • From general health settings	LA Developing Advise and Information services (DEWIS)	• Discrimination is eliminated • People no longer feel stigma from the public and in general health settings	Develop a LA corporate plan to contribute to raising public awareness of Mental health issues and protective preventative factors Review the balance of output from Information and Advice services in relation to physical and mental wellbeing.	
*Strengthening and development of **additional** **primary care services.***	*General Practitioners act as a gateway to primary care services. Services*	*There is access to an increased range of primary care interventions. Waiting times are reduced and*		

Predicted future increase in demand for support in the community.	*are accessible via GP referrals*	*intervention times are evidenced as effective.*		
No further cuts to secondary care	*A Western Bay Commissioning Board has been established* *City & County of Swansea undertaking a commissioning review.*	*An appropriate range of financially sustainable .services are in place.*	Target levering in extra resources including linking to existing community assets. Exploring new models of provision Lambeth Council as an example.	
Simplified eligibility & access to sustainable services which focus on prevention early intervention, and recovery.	Segregation between primary and secondary care has a negative effect on eligibility and access. Not all services are accessible to everyone. Single point of access for all to access Mental Health Services Bureaucracy of referral & assessment for LA services compared to universal services		Review LA commissioned services for effectiveness. by Tier 1 Tier 2 Tier 3 Tier 4	

	No-one needs a referral or assessment just walk in when you need it.			
An appropriate and timely response when someone is in a mental health crisis or has an urgent need through flexible services available when service users and carers need it. A perceived lack of respite has been identified as an issue of concern by stakeholders linked with managing crisis.	Crisis support too frequently equates to hospital admission. A shortage of acute beds – necessitates police intervention. Early discharge from Mental health Hospital is perceived as a problem. Barry Shier innovative example	Make support for people in crisis available when needed e.g. in evenings & weekends. Increase flexible working by services. Have a range of options to provide support to those in a mental health crisis Increase acute beds for crisis Ensure there are appropriate respite options for people with Mental Health and their carer's. .	Ensure LA services are flexibility to respond to crisis and urgent need. For Individuals For their carers Increase our understanding of need for "respite" in a Mental Health context Increase our understanding of mental health hospital discharge issues problems	
Meaningful assessment and robust outcome based review process with individual at the centre.	Development and implementation of a new practice framework for adult services.		Develop a less risk adverse culture so that people can challenge themselves.	

Developing services to achieve self- management through encouragement.	Living Well programme evaluation The Recovery Model	New and innovative treatments are introduced into current practice. E.g. talking therapies rather than the medical model.	Establish a research group to identify new models of support focusing on early intervention and the recovery model.	
Shift resources to prevention but needs to be flexible.		Prevention services also focus on younger adults with Mental Health. They are not just looking at older persons.		
Reduce the waiting time for Counselling and increase the length of intervention.	Waiting times are long and support period is too short. CBT only 6 sessions. Counselling is one element of talking therapy.	Access to the range of formal and informal counselling services is rapid delivering on early intervention and prevention	Increase our understanding of mental health hospital discharge issues problems. Increase understanding of evidence (analyse data) for the appropriate format of talking therapies, access time and for the optimum period for effectiveness. (is it formal counselling or other)	
Lack of move on within and from supported housing.	Move On Strategy exists from temporary accommodation into	I have choices to make on where I live, in communities and with	• Linking to Housing for build & access. • Age appropriate	

Many Homeless or people threatened with homeless have mental health issues.	Social Housing and private rented Social Lettings Agency. General rehousing application process in place. A new Homelessness Strategy being developed.	housing providers who understand and do not discriminate and support my mental wellbeing.	• Gender appropriate options • More options to tackle loneliness and isolation with low level floating support • sharing opportunities	
Res Care – not enough specialist provision between acute support and supported living. Limited availability of specialist sustainable provision within the City & County of Swansea	Western Bay Brokerage for those above cost threshold E.g. Robense House, which is a high relational 24-hour supported living project, is an alternative accommodation option to residential care.	Mixed market of providers – competition / partnership ensure reasonableness. Care before profit. There is a range of specialist sustainable residential care or alternative provision within the City & County of Swansea or Western Bay area.	Explore alternative models to residential care Explore Joint commissioning with Western Bay partners Engage with the local private sector market & consider role of internal services.	
Need for a Dom Care speciality for understanding MH and co-occurring physical health needs		Support to people with Mental Health when delivered by Domiciliary care agencies has the necessary specialism e.g.	Link to Domiciliary care commissioning review and procurement.	

		understanding of TIA triggers, meds and their impacts and can provide seamless hands on personal care in this context.	Link to review of internal provision.	
Provision for parents with Mental Health issues ,	(PRAMS) child care			
Need good Transition to Adult services from children's service.	CAHMS No services, as primary care workers attached to GPS are in overload.	Transition from children is to age appropriate adult services. Prompt access to, appropriate preventative, and crisis support for children and young people.		
Support to continue/return to or become work ready. Too much, focus on how not to work and staying on benefits and not always in the best interest long term.		Clear information on options for how to get back into work. Access to support to do so and information on permitted work/ part time work. Supported and sympathetic informed employers. A culture of change showing work as positive impact on a person's		

		quality of life and being part of recovery.		
Commissioning process to be Co-productive. People who use services and their carers being involved at every stage of process Staff to be involved in coproduction in designing and providing services.	Limited to date, should be at all stages of the commissioning cycle.	More effective commissioning decisions leading to improved delivery of outcomes for individuals stakeholders working together.		
• Improve staff recruitment and retention. • High turnover/reorganisation of staff at strategic planning level affects negatively on progress. • Short term funding (third sector). Changes of operational worker including volunteer's results in erratic Services. • Stress on staff due to caseloads & demand		Sustainable services are in place. A stable well-trained, informed and supported staff resource is in place**.**		
Better partnership working specifically around dual diagnosis. Uncoordinated and inconsistent funding postcode lottery. Decision-making debates while the person waits.		Seamless and sustainable services Better partnership working between Social Services, ABMU and Third Sector.		

➢ Shift the responsibility culture between physical health and MH or LD and MH duel diagnosis. ➢ Arguments over funding between Health and Social Care due to budget pressures. ➢ Service delivery hampered by funding agreements.				
Transport issues Traveling across county and out of county to access ABMU services. Added difficulties for those in rural communities. Appropriate transport for those who need 1:1 support.				