

## 6 Mental health

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## 6.1 About this chapter

This chapter includes the population needs of mental health needs of adults. Information about other population groups can be found in the chapters:

- Children and young people
- Older people: for information about dementia, however, early onset dementia is discussed in this chapter
- Learning disabilities and autism: the population assessment has highlighted the way people current service divisions may not work for people on the autistic spectrum.
- Carers

For information about substance misuse please see the Area Planning Board needs assessment.

### What is meant by the term mental health?

The World Health Organisation (2014) has defined mental health as:

“a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”

The Mental Health (Wales) Measure 2010 includes four different ways people may need help:

- Local primary mental health support services: services accessed through a GP referral.
- Care coordination and care and treatment planning: for people who have mental health problems which require more specialised support (provided in hospital or in the community), overseen by a professional ‘Care Coordinator’ such as a psychiatrist, psychologist, nurse or social worker.
- People who have used specialist mental health services before: can request reassessment from the mental health service.
- Independent Mental Health Advocacy: For people receiving secondary care.

The Mental Capacity Act 2005 covers people in England and Wales who can’t make some or all decisions for themselves. The ability to understand and make a decision is called ‘mental capacity’. The Mental Capacity Act requires care co-ordinators to assume that a person *has* capacity, it also makes provision for Independent Mental Capacity Advocates and /or ‘Best Interest Assessors’ to support decision making for people who lack mental capacity.

## **How will the Social Services and Well-being (Wales) Act 2014 change things?**

The principles of the Social Services and Well-being (Wales) Act 2014 are similar to those already adopted by mental health services in North Wales. Regional work is taking place to make sure documentation is compliant with the act and that care and treatment plans required under the Mental Health Measure fit with the assessment requirements under the new act. For more information about the act please see <http://www.ccwales.org.uk/getting-in-on-the-act-hub/>

For more information about the legislation and guidance relating to mental health please see appendix 6a.

### **Safeguarding**

The safeguarding issues for adults with mental health needs are similar to those of the general adult population. People who lack the capacity to make decisions as to where they live and about their care planning arrangements need to be assessed for a Deprivation of Liberty Safeguards (DoLS). The aim of the safeguards are to ensure that the most vulnerable people in our society are given a 'voice' so that their needs, wishes and feelings are taken into account and listened to when important decisions are taken about them.

There is a new definition of 'adult at risk', a duty for relevant partners to report adults at risk and a duty for local authorities to make enquiries which should help to safeguard adults at risk, including those with mental health support needs.

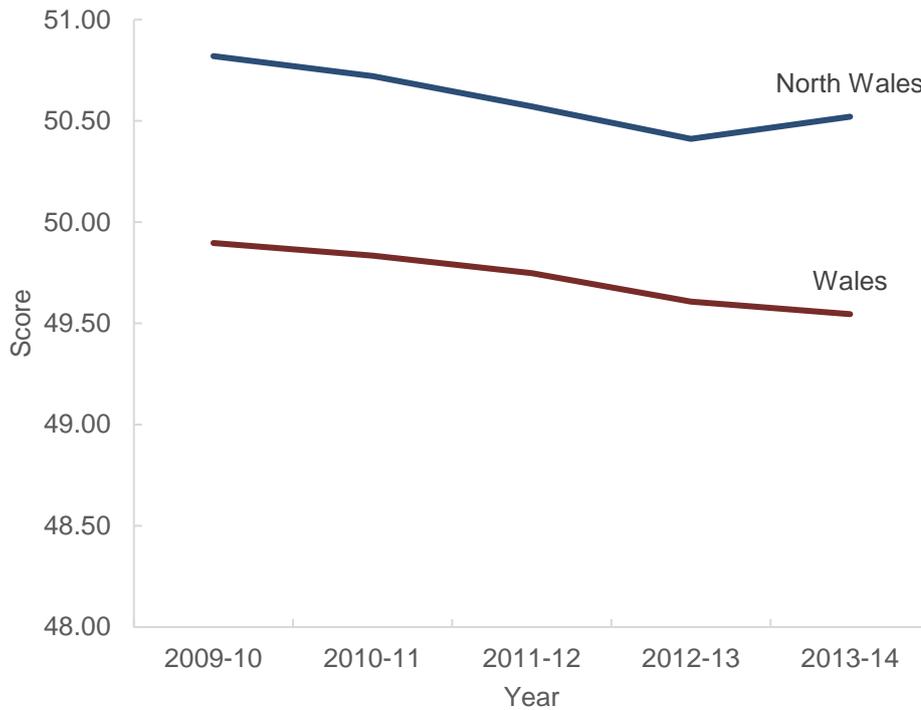
## **6.2 What do we know about the population**

An estimated 1 in 4 people in the UK will experience a mental health problem each year (Mind, 2016), which could include anxiety or depression. In the Welsh Health Survey 13% of respondents reported being treated for a mental illness, which is a slight increase since the survey started in 2003/4 (Welsh Government, 2015b).

### **People in North Wales report slightly better mental health than in Wales as a whole**

Figure 6.1 shows how respondents reported their mental health using the mental component summary score where higher scores indicate better health. This shows that people in North Wales report slightly better mental health than the population of Wales as a whole and that there has been a slight drop (worsening) in scores for mental wellbeing since 2009-10.

**Figure 6.1** Mental component summary score (higher scores indicate better health)



Source: Welsh Health Survey (observed)

Table 6.1 shows the mental component summary score for each county. The differences between the counties are quite small and there is variation between them from year to year. Overall, Wrexham has the lowest scores and Gwynedd and Anglesey have the highest, with a difference of 2 points between the scores.

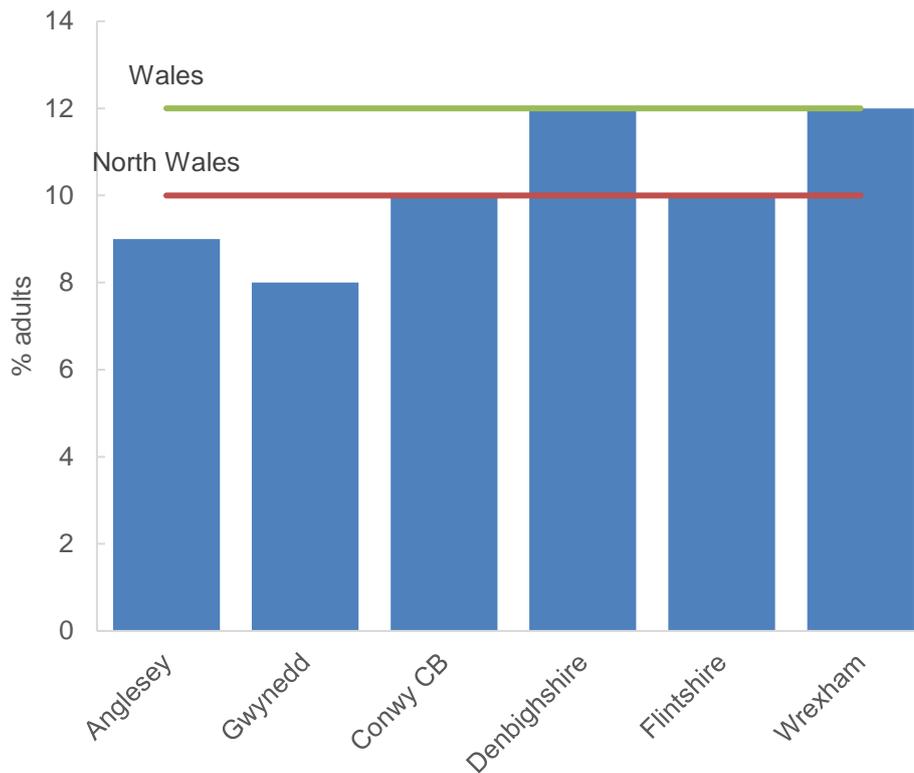
**Table 6.1** Mental component summary score (higher scores indicate better health)

	2009-10	2010-11	2011-12	2012-13	2013-14
Anglesey	50.8	51.0	51.5	51.4	51.1
Gwynedd	50.9	51.3	51.3	51.1	51.4
Conwy CB	51.1	50.3	50.2	50.3	50.6
Denbighshire	50.6	50.9	50.5	50.1	50.5
Flintshire	51.3	50.6	50.4	50.7	50.3
Wrexham	50.2	50.4	50.0	49.3	49.6
North Wales	50.8	50.7	50.6	50.4	50.5

Source: Welsh Government (Welsh Health Survey, observed)

Figure 6.2 shows the percentage of adults who report being treated for a mental illness.

**Figure 6.2** Percentage of adults (16 years and over) reporting being currently treated for a mental illness.

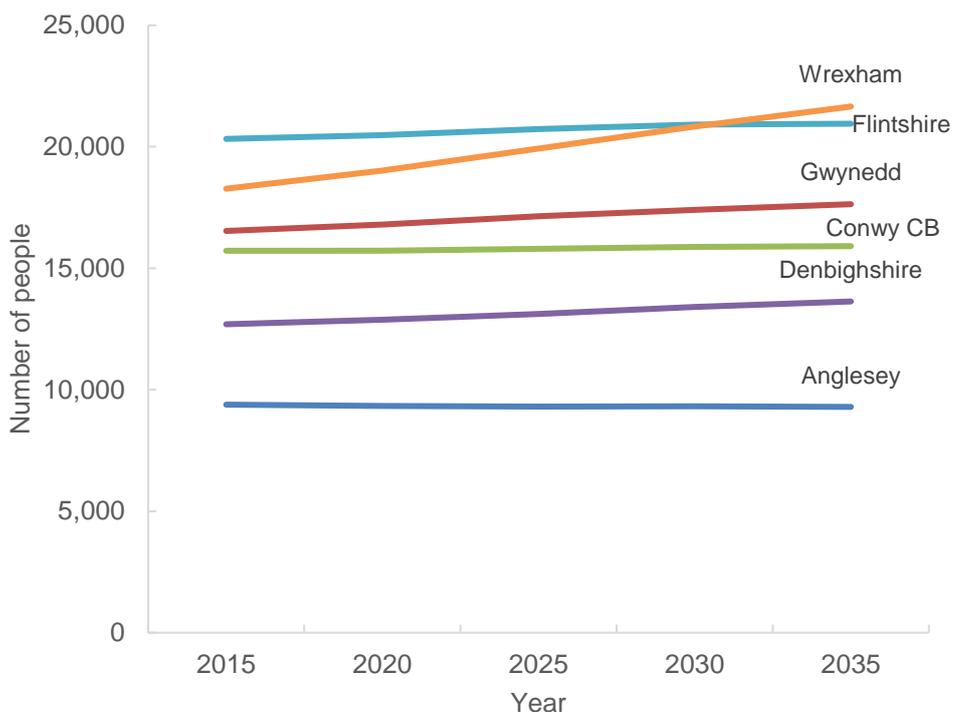


Source: Welsh Government (Welsh Health Survey)

**The number of people with mental health problems is likely to increase**

Data from the Welsh Health Survey can be used to see how numbers change over time. Figure 6.3 and Table 6.2 were generated from prevalence rates from the Welsh Health Survey and applied to population projections to 2035. It shows that the number of adults in North Wales with a common mental health problem is predicted to increase from 93,000 to around 99,000 by 2035. The numbers may increase further if there is also a rise in risk factors for poor mental health such as unemployment; lower income; debt; violence; stressful life events; and inadequate housing.

**Figure 6.3** Number of people aged 16 and over predicted to have a common mental health problem, North Wales, 2015 to 2035



Source: Welsh Government, Daffodil

**Table 6.2** Number of people aged 16 and over predicted to have a common mental health problem, North Wales 2015 to 2035

	2015	2020	2025	2030	2035
Angleseey	9,400	9,300	9,300	9,300	9,300
Gwynedd	17,000	17,000	17,000	17,000	18,000
Conwy CB	16,000	16,000	16,000	16,000	16,000
Denbighshire	13,000	13,000	13,000	13,000	14,000
Flintshire	20,000	20,000	21,000	21,000	21,000
Wrexham	18,000	19,000	20,000	21,000	22,000
North Wales	93,000	94,000	96,000	98,000	99,000

*Numbers have been rounded so may not sum*

Source: Welsh Government, Daffodil

### The most common mental illnesses reported are anxiety and depression

Mental health teams support people with a wide range of mental illnesses as well as people with psychological, emotional and complex social issues such as hoarding, eating disorders and Post Traumatic Stress Disorder (PTSD).

The Quality and Outcomes Framework (QoF) - information from GP records - can provide very rough estimates of the prevalence of some psychiatric disorders. This data is likely to underestimate the true prevalence because it relies on the patient presenting to a General Practitioner (GP) for treatment, receiving a diagnosis from the GP, and being entered onto a disease register.

Table 6.3 shows the number of patients in North Wales on relevant QoF disease registers.

**Table 6.3** Number of people on QoF disease registers in North Wales

Condition	Number on register
Depression	37,000
Dementia	4,600
Severe mental illness (Schizophrenia, bipolar affective disorder and other psychoses)	5,800

*Numbers have been rounded so may not sum*

Source: Quality and Outcomes Framework

Another way to estimate the number of people with common psychiatric disorders is to use the prevalence rates from the Adult Psychiatric Morbidity Survey 2007 and apply them to the 2013 mid-year population estimates for North Wales for those aged 16 and above. The findings are shown in Table 6.4 below.

**Table 6.4** Estimated numbers of adults in North Wales affected by mental health problems

Condition	Estimated prevalence (%)	Estimated number of people affected
At least one of the common mental disorders	16.2	92,000
Mixed anxiety and depressive disorder	9.0	51,000
Generalised anxiety disorder	4.4	25,000
Major depressive episode	2.3	13,000
Phobias	1.4	8,000
Obsessive Compulsive Disorder	1.1	6,000
Panic disorder	1.1	6,000

*Numbers have been rounded so may not sum*

Source: Adult Psychiatric Morbidity Survey 2007; ONS, Mid-Year-Estimates 2013

### Early onset dementia

Services for people with dementia tend to be provided as part of older people's services (see Older People's Chapter for more information). This may not meet the needs of younger people with early onset dementia. Mental health services often support people with Korsakoff Syndrome, a form of dementia most commonly caused by alcohol misuse. Substance misuse services are also likely to be involved with a person with Korsakoff Syndrome, focussing on the drug and alcohol issues, while mental health services can provide support for symptoms.

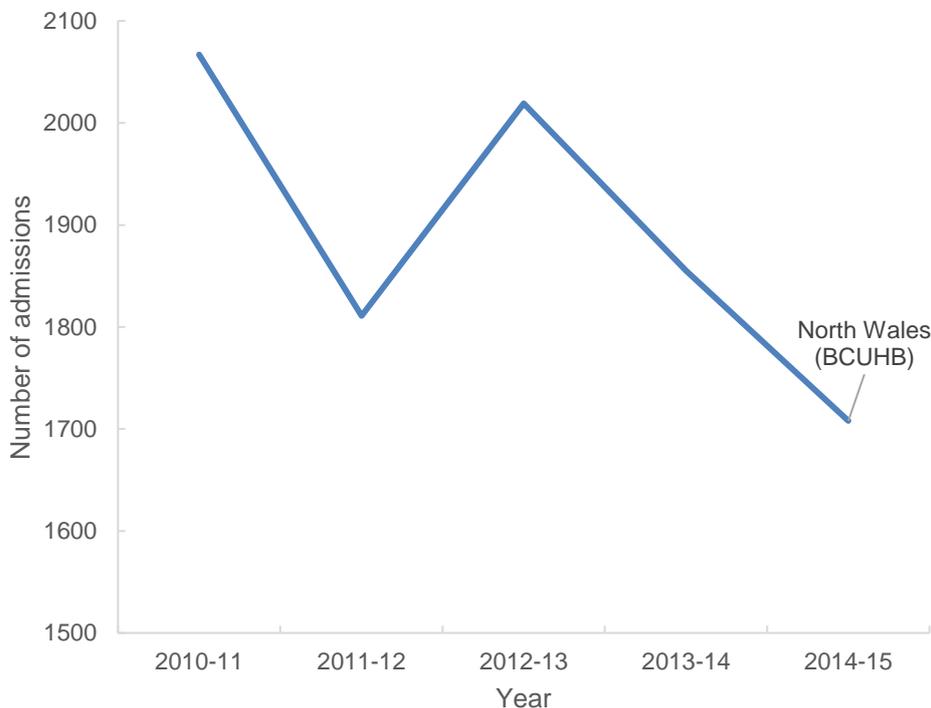
## Research suggests a high number of people with mental health problems do not seek help

The estimated prevalence of mental health problems generated by the Adult Psychiatric Morbidity Survey and the Welsh Health Survey is over twice the estimate of people who report being treated for a mental health problem. This suggests that there could be many affected people in the population who are not seeking help for various reasons.

## The number of admissions to mental health facilities is reducing

Figure 6.4 shows admissions to mental health facilities. This shows a decline in the number of admissions but it is not possible to tell from this data whether that decline is due to a reduction in demand or a reduction in the availability of acute mental health beds. Consultation for the population assessment identified people being placed out of the region, including examples of placements as far away as London and the South Coast. However, BCUHB do have home treatment teams to try to avoid hospital admission.

**Figure 6.4** Number of admissions to mental health facilities



Source: Welsh Government, admissions, changes in status and detentions under the Mental Health Act 1983 data collection (KP90)

## The number of people with more complex needs is increasing

Services report an increase in more complex issues as a consequence of deprivation, adverse childhood experiences and substance misuse.

They also report increases in:

- the number of people with diagnosis of personality disorder but it's not clear whether this is an increase due to social reasons or a change in the way the disorder is diagnosed.
- severity in patients presenting with anorexia nervosa compared with a few years ago, which is concerning as this client group often don't seek help voluntarily.
- the number of people with Autism Spectrum Disorders needing support

### **People with mental health problems are more likely to have poor physical health**

Mental ill health is associated with physical ill health, reduced life expectancy and vice versa (Royal College of Psychiatrists, 2010). Poor mental health is also associated with increased risk-taking behaviour and unhealthy life-style behaviours such as smoking, hazardous alcohol consumption, drug misuse and lower levels of physical activity (Welsh Government, 2012).

For example, current research suggests that smoking 20 cigarettes a day can decrease life expectancy by an average of ten years. While the prevalence of smoking in the total population is about 25 to 30 percent, the prevalence among people with schizophrenia is approximately three times as high - or almost 90%, and approximately 60% to 70% for people who have bipolar disorder. Mortality rates for people with Schizophrenia and bipolar disorder show a decrease in life expectancy of 25 years, largely because of physical health problems (Royal College of Psychiatrists, 2010). Obesity, poor diet, an inactive lifestyle and the long term use of medication are also contributory factors associated with severe mental illness and poor physical health.

Services identify high rates of Chronic Obstructive Pulmonary Disease (COPD: due to heavy smoking), diabetes and heart problems, though these needs are often overshadowed by the seriousness of mental health issues. This is an area councils have been developing for example, by using nurses to support individuals with long term mental health conditions to improve their physical health.

### **Inequality is one of the key drivers of mental health and mental ill health leads to further inequality**

Mental health problems can start early in life, often as a result of deprivation including poverty, insecure attachments, trauma, loss or abuse (Welsh Government, 2012). Risk factors for poor mental health in adulthood include unemployment; lower income; debt; violence; stressful life events; and inadequate housing (Royal College of Psychiatrists, 2010).

In Wales, 24% of those who are long-term unemployed or have never worked report a mental health condition compared with 9% of adults in managerial and professional groups. A recent study found more patients who died by suicide were reported as having economic problems, including homelessness, unemployment and debt (Centre for Mental Health and Safety, 2016).

Risk factors for poor mental health disproportionately affect people from higher risk and marginalised groups. Higher risk groups include looked-after children; children who experienced abuse; black and ethnic minority individuals; those with intellectual disability; homeless people; new mothers; lesbian, gay, bisexual and transgender people; refugees and asylum seekers and prisoners (Joint commissioning panel for mental health, 2013).

Having a wide support network, good housing, high standard of living, good schools, opportunities for valued social roles and a range of sport and leisure activities can protect people's mental health (Department of Education, 2016).

## **Suicide**

It is difficult to draw conclusions from the available data on suicide in North Wales due to the small number of cases and other caveats. The average annual suicides of people aged 15 and over in North Wales decreased from around 82 between 2002 and 2004 to 69 between 2011 and 2014 although there is variation year on year. None of the local council areas in North Wales have suicide rates for those aged 15 years and over which are statistically significantly higher than the Wales average (Jones *et al.*, 2016). Suicide numbers are more than three times higher in men than women (Office for National Statistics, 2014).

The causes of suicide are complex (Jones *et al.*, 2016). There are a number of factors associated with an increased risk of suicide including gender (male); age (15 to 44 year olds); socio-economic deprivation; psychiatric illness including major depression; bipolar disorder; anxiety disorders; physical illness such as cancer; a history of self-harm and family history of suicide (Price *et al.*, 2010). There are a number of ways in which mental health care is safer for patients, and services can reduce risk with: safer wards; early follow-up on discharge, no out-of-area admissions; 24 hour crisis teams; dual diagnosis service; family involvement in 'learning lessons'; guidance on depression; personalised risk management; low staff turnover (Centre for Mental Health and Safety, 2016). Many people who die by suicide have a history of drug or alcohol misuse, but few were in contact with specialist substance misuse services. Access to these specialist services should be more widely available, and they should work closely with mental health services (Centre for Mental Health and Safety, 2016).

Farmers are identified as a high risk occupational group, with increased knowledge of and ready access to means (also doctors, nurses and other agricultural workers). Certain factors have been identified as particularly creating risk and stress to people living in rural areas over and above the suicide risk factors affecting general populations: isolation, declining incomes, being different within the rural context; heightened stigma associated with mental health issues; barriers to accessing appropriate care (culture of self-reliance, poor service provision) poor social networks; social fragmentation; availability of some means of suicide (firearm ownership); and high risk occupational groups such as farmers and vets (Welsh Government, 2015a).

The Welsh Government suicide and self-harm prevention strategy is *Talk to me 2* (Welsh Government, 2015a) and there is a North Wales group that coordinates work on suicide prevention.

## 6.3 What are people telling us?

### Feedback from organisations

The organisations surveyed for the population assessment highlighted the following issues:

- Not enough support available for low level depression and anxiety.
- Many services available only over the phone which can make them difficult for people in mental health crisis to access, it would be helpful to have alternative methods such as email or texting. If a phone call is necessary, then the person from the contacted organisation should make it clear when the distressed person can expect a call so they are mentally prepared for it.
- There should be as much support for mental illness as for physical illnesses.
- It can be difficult for people with mental health problems to get back into employment
- More mental health practitioners are needed.
- It would be very useful to be able to have the opportunity for a practitioner to do a home visit, particularly for the initial assessment in a familiar setting.
- Delays with individuals receiving mental health assessments causes real problems.
- Support needs to be flexible.

More information about the survey is available in appendix 1.

Feedback from service managers in response to the survey supported the findings around employment difficulties and the need for more mental health practitioners. They also highlighted the following.

- BCUHB have commissioned Parabl to provide low level support.

- Recognise the advantage of home visits as they can give more information about how someone is coping at home. However, it's often not possible due to need to work efficiently and a shortage of staff. Also, some people would prefer to have a service outside of the home environment.
- Need to consider issues around digital inclusion when looking at alternative ways of providing support and communicating with people.

### **Feedback from people who use mental health services**

The workshops and surveys carried out for the population assessment highlighted the following issues:

- Transport: restricts access to local amenities and services as taxi costs are expensive, more community transport is required and better bus services.
- Cost also restricts access to activities in the local community, it would be good to have more affordable activities and more information about activities available.
- Friendships and social networks are very important to this group. Many wouldn't ask family or friends for support, as they don't want to burden them. They tend to keep things to themselves as they feel others don't understand them, including GPs. One individual said:  
"I would rather go into hospital than let my local community know I have a mental health problem, especially schizophrenia".
- Participants valued the support available: family, Mental Health Teams, Crisis Team, Drop ins, Social Links, Mind, advocacy and courses in learning for recovery and wellbeing programme.
- Drop in sessions were valued by those who attended, as one person said:  
"these drop ins help me feel connected and supported by staff and friends, which sets me up for the week. I don't feel on my own".
- Very important to feel supported otherwise would not have the motivation or confidence to do different things and would stay at home with no social interaction.
- Individuals need someone to contact in an emergency. If a member of staff or a professional is not available, it is not good enough to be called back the next day. If an individual is in crisis they need help immediately.
- Help at home would be welcomed, as individuals feel safer and are in control of things.
- Lack of a key worker/ care coordinator if under a Psychiatrist, as currently unable to contact them when needed.
- Barriers that get in the way of progress include: worry, stress, no spark (with staff/ friends) and tiredness/fatigue.

### **Feedback from staff and partner organisations**

Evidence from the consultation found that people often present to other services with mental health needs and that there is a need for better understanding of how to support a person presenting with multiple needs.

For example, housing associations commented that they identify people with mental health support needs but then don't know where to go for help. They find they are passed between GPs, other health board services, social services and third sector services. Respondents commented that it would be useful to have more information and advice about how to support people or where to signpost people. For example, trying to support someone with debt and money management while they have depression.

A major need identified is in support for adults with autism who don't have a learning disability and might be profiled as having Asperger syndrome or higher functioning autism. It can be a lengthy process to assess an individual. Some commented that people were being passed between learning disability and mental health/vulnerable people services (see Learning Disability and Autism Chapter for more information)

Other needs identified were:

- Increase in number of referrals to the Local Primary Mental Health Support Service
- Increasing number of referrals to Local Primary Mental Health Support Service with social stresses rather than mental health problems, these are harder to support and medication isn't an answer. Examples included domestic violence and relationship conflict.
- Increase in more complex cases and finding threshold for support has risen over the years
- Transition between children and adults mental health services
- Recovery focussed support
- Transport and accessing community facilities.
- Waiting lists for psychology support are too long.
- Support needed pre-diagnosis were also identified as needs.

Suggestions for how to improve services included:

- An overarching strategy with better coordination between housing, benefits, education and so on. One group gave an example where a family was working with three different teams within a local council's social services department.
- More capacity within mental health teams.
- Considering models that involve family and friends such as Community Reinforcement and Family Training (CRAFT) and Social Behaviour and Network Therapy (SBNT).
- Providing services outside of 9 to 5.

- Making better use of Dewis Cymru to share information about third sector services.
- Health services and housing partners need to work collaboratively and ensure the best outcomes for people who use services and to influence the future strategic planning of accommodation, both supported housing and general needs in the community.

### **Welsh language**

The consultation and engagement identified concerns that there may not be enough psychiatrists and psychologists who speak Welsh to provide a service that meet the needs of Welsh speakers in North Wales. This may affect people's ability to get an accurate diagnosis as well as to access services such as counselling. This is an area we need to investigate further.

See Welsh language profile for more information.

### **Housing needs and homelessness**

Housing support for people with mental health needs is largely funded through the Supporting People grant across North Wales and mental health services work in partnership with housing strategy teams and housing associations.

Consultation identified a shortage of suitable 'move on' accommodation, single person accommodation and emergency night time accommodation. The benefits system is causing difficulties for some people, including the 'bedroom tax'. Even where people are able to save for private rental accommodation there is a stigma by some not to take on tenants who are on benefits. There are concerns that accommodation offered is in flats in areas with high levels of anti-social behaviour and substance misuse which is really unhelpful for people coming out of hospital or who have substance misuse issues themselves. This also puts them at risk of exploitation. There can also be difficulty in finding accommodation for men in secondary mental health services due to the behaviours they can present.

Housing and mental health services are working collaboratively to improve access to appropriate housing for service users leaving acute settings and placements. Housing is a significant partner and more work is being undertaken to understand the roles for each agency and how we can work more effectively to produce the best outcomes.

There is a regional collaborative group working in this area, the Mental Health Rehab and Accommodation group who have considered both appropriate models for delivery and written a Commissioning Statement (2015) for the region. This group has representatives from all localities, BCUHB and third sector partners.

BCUHB has also created a Development Manager post for Supported Housing, who chairs the regional group and also works with acute settings, specialist services, rehabs and community services to ensure people in need of housing services are placed appropriately.

Homeless housing providers try to ensure equal access for mental health service users and enable those in need to also access health services and move on.

## 6.4 Review of services currently provided

Mental health services are provided through inpatient facilities and community mental health teams who support patients outside of the hospital environment. Local councils and the health board provide care and support for people with mental illnesses in the community. Residential care, day services and outreach teams are an important part of psychiatric care.

### Prevention and well-being

Investing to increase access to early intervention mental health services could lead to considerable savings for other public services (Public Health Wales, 2016)

Public mental health focuses on the wider prevention of mental illness and the promotion of mental health for people of all ages. Cost effective interventions exist to both prevent mental illness and to promote wider population mental health (Royal College of Psychiatrists 2010).

Actions to promote mental wellbeing include promoting inclusion, belonging and connectedness, increasing individual resilience and developing life skills, building and supporting parenting skills, strengthening communities and improving wellbeing at work.

The “Five Ways to Wellbeing” is a set of evidence based public health messages aimed at improving the mental health and wellbeing of the whole population. The five actions people can take to improve their well-being are summarised as follows: *connect, be active, take notice, keep learning and give*. The messages underline the existence of mental health as a positive and desirable state and can be used in many different ways from supporting individuals to informing policy development. Mental Health First Aid and promotion of mental health literacy can help to counter mental illness, as well as support for self-help and self-management, for example, through Books on Prescription.

The OPUS programme is a European funded programme for people aged 25 and over that are economically inactive and long term unemployed. It supports people with a mental health problem, people with a learning disability, from a workless household, carers and people aged 54 and over.

The project supports people to get closer to work by offering a number of different options from 1 to 1 support; group support and flexible support to meet the needs of individuals. The funding will come to an end in August 2019.

### **Mental health services**

In Anglesey the focus of services is around community mental health teams, with a comprehensive support work service including 1:1 support, group work, drop in and community based support. Third sector partners also provide a lot of support including Mind, Hafal (including support for mental health carers) and Agro Initiatives. The local council also provide supported accommodation.

Gwynedd support is provided through the Community Mental Health Team. Gwynedd Council provide Support Workers to work intensively with patients and to work within the recovery model. The Gwynedd team work closely with third sector partners in order to provide support (these include 3 Mental Health Resource Centres across the county, Hafal, Cais). Group work is provided through the teams and our third sector partners. The team works closely with the Home Treatment Team.

The provision in Conwy is similar in structure to that in Anglesey, with two co-located health and social care Community Mental Health Teams in the east and west of the county. The Third Sector provision is commissioned to support carers of those with mental health issues (Hafal) and a key new development entitled 'Recovery Compass', which offers a variety of interventions for individuals to navigate their way to appropriate points on their recovery journey with their own aspirations or destinations as their focus or outcome. The Compass is delivered by Aberconwy Mind and the future aim is for service users to transition from statutory services with a Wellness Recovery Action Plan (WRAP) and to extend the pathway of support into sustainable and service user focused support.

Denbighshire have two multi-disciplinary community mental health teams (CMHT) provided in partnership with health: Hafod based in Rhyl and Tim Dyffryn Clwyd based in Denbigh. Services are based on a four tier approach with the CMHT supporting tier 1 (assessments, information and advice for people who have been seen by their GP) and tier 2 (services for people considered to have a serious mental illness or disorder). Mental Health Services are focused on the Recovery Model to support service users to regain or improve their mental health and achieve a better quality of life.

In Flintshire support is provided through community mental health teams. The local council services include an Intensive Support Team, Community Living and Medium Support Team and Occupation and Support team (Flintshire County Council, 2016). Third sector partners also provide a lot of support including MIND, Hafal, KIM Inspire, AsNEw (advocacy service).

There is a good training partnership between the local council and third sector organisations to deliver training programme to people with mental health issues and their carers, which has been recognised as good practice and shared with other counties.

Wrexham's first point of contact for people in the community is through the mental health Single Point of Access. People then access either the Primary Care Team or Community Mental Health Team depending on the level and complexity of their needs. Both of the above teams are joint multidisciplinary teams between Adult Social Care and Betsi Cadwaladr University Health Board (BCUHB). People coming through treatment are supported by the Community Rehabilitation Team, a multidisciplinary BCUHB team. People needing support to move onto independent living in the community may access the Adult Social Care Recovery Service or the Hafal Recovery Housing; these are registered home care services providing support into independent accommodation or accommodation with a registered social landlord. This service is primarily funded by Supporting People, with joint funding also from Adult Social Care and BCUBH. Low level prevention and recovery service is provided from Advance Brighter Futures: lifestyle coaching, talking therapies and promoting awareness and resilience, and Hafal's Community Link Service. Support for Carers is commissioned from the Hafal Family and Carers Support Service.

### **Recovery model**

The recovery model is about supporting personal recovery and a move away from a focus on treating illness (clinical recovery) towards promoting wellbeing (Slade, 2009). Personal recovery can be defined as:

*A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).*

This is an approach that local councils have been working towards. Consultation with staff highlighted it's similarities with a social model rather than a medical model which health services have struggled with. The principles of the Social Services and Well-being (Wales) Act is considered to be in line with the recovery model - being person centred, with an emphasis on direct payments and control, equal/coaching relationship between practitioner and patient.

Integrated health and social care teams work together to ensure individuals in service have care plans with recovery outcomes and clarity around individual responsibility and who can/will help to achieve goals towards independence.

**Betsi Cadwaladr University Health Board**

A fifth of the NHS expenditure for Wales is on mental health services. A large proportion of attendances to Emergency Departments and general admissions to hospital are related to mental health problems.

## 6.5 Conclusion and recommendations

**Key messages**

- People in North Wales report slightly better mental health than in Wales as a whole
- The number of people with mental health problems is likely to increase
- The most common mental illnesses reported are anxiety and depression
- Research suggests a high number of people with mental health problems are not seeking help
- The number of admissions to mental health facilities is reducing
- The number of people with more complex needs is increasing
- People with mental health problems are more likely to have poor physical health

The numbers of patients seeking admission to hospital has increased across the region. Feedback from staff suggests the limited number of admissions may be due to bed pressures- influenced by Delayed Transfers Of Care (DTC) and lack of appropriate placements, where needed. This has led to the use of acute beds outside North Wales, which is far from ideal for patients, their carer's and families.

Common principles shared by the local councils and the health board include service user and carer involvement and participation; community advocacy; carers support and role of learning and work opportunities in recovery; joint working between agencies.

There needs to be a clear pathway from acute services into community based services. There should be more work around the preventative agenda to prevent needs escalating to hospital and reduce demand on other public services. Examples include home support and wraparound services as well as interventions and policies to support parents and young children, lifestyle changes, improve workplaces, provide social support and environmental improvements that support communities (Public Health Wales, 2016). Joint working with the third sector and social enterprises could provide this.

Local councils and health need to manage increase in demand for services with reducing budgets.

**Gaps in service / support**

- Support for people with ASD was consistently highlighted as a gap in the consultation

- There's a gap in befriending opportunities (need to be empowering and not encourage dependency) to support people to access existing social activities.
- Poverty and welfare reform were highlighted as risks for service users, as the drive to get people back to work can cause additional stress for vulnerable people. This can be particularly difficult for younger people with housing benefit issues.
- There needs to be sufficient supply of accommodation to support people to step down from residential care to community resources.
- We need to develop public mental health in North Wales and promote mental well-being to prevent mental ill-health. Public mental health should form part of the Betsi Cadwaladr University Health Board mental health strategy.

### **Data development agenda / suggestions for future research**

- Needs of vulnerable people without a diagnosis and best practice for providing support
- Investigate concerns raised about a lack of Welsh language provision in mental health services
- Find out more about the reasons for the reducing number of admissions to mental health facilities.

### **Our response**

The next phase of the project will be to discuss the information in these reports and agree an approach to addressing the issues raised. This may include carrying out further research in an area, local or regional actions.

### **Equality and human rights issues**

This chapter raises a number of issues on how risk factors for mental health needs disproportionately affect people from marginalised groups. These include many who share protected characteristics – for example, BAME groups; LGBTQ people; people with physical disability, sensory impairments or long term health conditions; refugees and asylum seekers.

The core protective factors that influence mental well-being include promotion of social inclusion. It is known that groups who share the protected characteristics are more likely to experience social exclusion and this will need to be factored into the assessments for individuals.

More information regarding care and support needs of these groups can be found in other chapters of this population assessment.

There may be other issues affecting groups of people who share protected characteristics which have not picked up by this assessment. We would

welcome any further specific evidence which may help inform the final assessment. This could be addressed in future population assessment reviews, in the development of the area plan which will follow this assessment, or in the services developed or changed in response to the plan

Services for people with mental health needs must take a person-centred approach that takes into account the different needs of people with protected characteristics. The move towards the recovery model, which shifts the focus from treatment of illness towards promotion of well-being, should support the identification of and appropriate response to address barriers being experienced by individual.

## **Appendix 6a: Summary of mental health legislation and policy**

- Mental Health Act 1983: covers the assessment, treatment and rights of people with a mental health disorder.
- Mental Health (Wales) Measure. The Measure has 4 main parts:
  - part 1 of the Measure ensures 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.
- Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales (2012) The Welsh Government strategy and delivery plan which aims to work towards a single, seamless, comprehensive system for addressing all mental health needs irrespective of age. Its priority is to take the next step, closing gaps in provision where they exist, improving consistency of quality and making connections across government, recognising the links between mental health and housing, income, employment and education.
- Together for Mental Health: Delivery Plan: 2016-19
- Findings from the Wales Audit Office follow up review in Adult Mental Health Services 2011 included the recommendation 'Strengthen arrangements for involving service users in planning and managing their care'.
- Mental Capacity Act 2005

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