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Executive Summary

Mental health services in Cwm Taf are currently attempting to respond to a large pool of the population whose wellbeing is poor. The lack of alternative services is one reason behind the high rates of antidepressant prescribing in Cwm Taf. This is an unsustainable model of service.

This feasibility study assesses whether an alternative approach would lead to a reduction in antidepressant prescribing, create costs savings and better meet local need. It is based on a literature review, key informant interviews with potential stakeholders from public and third sector bodies, workshops and interviews, and an economic evaluation.

The development of a new model of additional services for people with poor wellbeing is recommended. This model has the potential for great benefit to society across a range of factors (reducing sickness, improving employment readiness etc). The model’s strength lies not only in the comprehensive nature of the alternative services offered but also the partnership that is created between the statutory bodies and the Third sector. This provides opportunities to access social investment funds that can deliver new innovative and effective solutions. A special purpose vehicle established as a joint venture is the most suitable option for the delivery of this project.

Setting the outcomes of the project and the measurable indicators that drive the investment is a very important part of the development process and needs to involve all stakeholders fully. The indicators need to monitor performance and activity and value for money of savings made. Comparable sources of information are needed to ensure realistic and ambitious goals.

Our review of the evidence suggests that CBT and mindfulness are the two most effective approaches underlying high volume low intensity courses aimed at improving wellbeing or supporting people with mild and clinically sub-threshold anxiety and depression. In addition Bibliotherapy and activities that promote social interaction and physical health are well evidenced effective interventions.

Mindfulness and talking therapies provide an essential building block of low-intensity support. These are based on the ‘social model’ of mental health which ‘normalises’ rather than ‘pathologises’, is based in a community setting, and aims to remove the stigma of ‘mental health’ through a focus on wellbeing.

It is important that these additional services are seen as part of a range of activities undertaken by many agencies working in a strong partnership. Activities to promote well-being, build social connections, and improve individual coping skills and resilience are everyone’s responsibility and everyone’s priority. Whilst this is recognised by the key stakeholders in their joint plans, it is not always evident from our mapping exercise where delivery can often appear disconnected, when collaboration would be much easier.
There are a variety of models of similar services operating across the UK from which much can be learned. Key features these services share are a strong focus on collaboration and easily accessible way for people to self-refer into the service.

Most critical of the many success factors is the engagement of GPs and the support given to practices to adopt the full use of the alternative interventions. For whilst there will always be a key role for high quality prescribing of antidepressants, the increasing volume of patients on long term repeat prescriptions is not sustainable. Cwm Taf currently has the highest volume of antidepressants per Prescribing Unit in the UK and not making improvement is not a sustainable option. There are a range of interventions that have been shown to improve prescribing quality. These include software support systems, education, clear guidance and awareness-raising but there must also be specific action and support to improve the frequency of medication reviews.

Critical to the feasibility of pursuing this new model of service under the terms of the Social Bond investment, is reversing the current trend in the high volume of antidepressants prescribed. It is considered that in taking effective action in accordance with the recommendations, it is possible to achieve that goal. However, subject to the terms of any proposed investment, it is estimated that the target requirement is a 20% reduction over a 5 year period, which would be the equivalent of reaching the current Welsh average usage.

In conclusion, therefore, the development of a comprehensive and integrated service, offering early interventions in mental health and aimed at improving the emotional wellbeing of Cwm Taf is considered to be a feasible project and that its delivery is best pursued through a partnership approach using the social investment from the Wales Wellbeing Bond.

**Recommendations**

1. The University Health Board, the local authorities and other stakeholders must acknowledge their collective responsibility for promoting the wellbeing of their community and must work together within the strategic frameworks, such as Together for Health, the Single Integrated Plan and Communities First programme, to address the wellbeing needs of the population.

2. Priority should be given to more clearly defining and tackling the needs of the ‘Tier 0’ population. Effective interventions reduce the risk of people developing more severe forms of depression and anxiety and are likely to reduce the number of people moving into Tier 1 and Tier 2 services. Additional services focused on wellbeing and mild anxiety or depression will also prevent the inappropriate use of Tier 1 services. These additional services will enable people to play a greater part in the community and also provide an effective alternative to anti-depressant prescribing.

3. Every encouragement should be given to GPs to enhance their perception of clinically effective and sustainable alternatives to anti-depressant prescribing, acknowledging that
they have a key role in diagnosing and referring their patients and that they will be a key
driver in the success of a STEPS type model.

4. A partnership model should be developed to create a programme of interventions which
should have the following characteristics:
   a. Clear entry point via website and telephone
   b. Services clearly explained and defined
   c. Strong branding to ensure credibility and community outreach
   d. A means of addressing barriers to access (e.g. disability, cost, confidence, location
      and language)
   e. Quality assurance, clinical governance, confidentiality, safeguarding
   f. Partnership built on trust with buy in from GPs, the community, individuals, other
      statutory and voluntary organisations
   g. An integrated service with clear interface with other services – e.g. maternal
      mental health, substance misuse, youth services
   h. A means of targeting and accessing the hard to reach without stigma
   i. A means of delivering services to vulnerable, excluded and ‘equality’ groups
      which ensure their safety
   j. Appropriate therapies that focus on people’s living skills and mental resilience
      (e.g. mindfulness, Bibliotherapy, CBT)
   k. Use of computerised interventions with telephone support to reach target groups
   l. Procurement / commissioning that allows the partnership to embrace the broad
      range of issues that can affect well-being – e.g. debt counselling, tenancy and
      unemployment issues – as well as delivery of therapeutic interventions
   m. Common standards and outcome measures to provide the basis for
      commissioning and procurement
   n. Strategic underpinning through shared programmes (e.g. Five Ways to Wellbeing)
   o. Simple measures that are meaningful and commonly understood

5. Outcomes of and impact of new model should be considered in its broadest sense – e.g.
in terms of the population having the living skills to manage their lives. The following
possible outcomes should be considered:
   a. Lower anti-depressant prescribing – this is a key driver for this project
   b. More appropriate visits to the GP – i.e. fewer patients attending with problems of
      low mood, freeing up GPs time to review existing patients within the system
   c. Shorter waiting times within the LPMHSS and capacity to target services to those
      needing them
   d. More activity focused on wellbeing and less on mental health, leading to reduced
      stigma, less benefits dependency
   e. More engagement with the third sector leading to more community self-help, active
      citizenship and participation
   f. Co-production leading to a diversity of activity at different levels within the brand
g. Added critical mass through the partnership to enhance participation from parts that the LHB / NHS alone would not reach

h. Added opportunities to support improvements in the wider social welfare and economic prosperity agenda

i. People in the community feeling better, expressing greater levels of self-esteem, having greater confidence (e.g. as measured through WEMWBS)

6. An appropriate structure for the development of a legal entity and its governance should be developed. It should have a Board of Directors encompassing all key stakeholders and could involve a series of interlinking committees, (e.g. to develop and implement a business and strategic planning, to focus on clinical standards, procurement and delivery protocols, and to focus on user engagement). The partnership needs to respect and trust each other and follow good practice in working together.

7. The agreed Outcomes of the project and the measurable indicators of these drive the financial transactions of the Social Bond model and ensure effective service delivery. A group to develop outcomes and measurable indicators should be established. This should include GP representation. The outcomes should include measures of performance (including clinical effect), necessary activity (e.g. prescribing rates) and clear triggers for financial transactions and project review.

8. The Outcomes will need to include actions taken and data collected not only directly by the new ‘Valley STEPS’ agency but also by other departments of the Health Board, contracted service providers and other partners. The governance and success of the Valley STEPS project must be understood as a wider function than the performance management of the interventions directly provided by the ‘Valley Steps’ agency.

9. The development of the ‘Valley STEPS’ project should learn from similar projects established elsewhere in the UK. In particular the IAPT experience in England is useful for:
   a. Assessing value for money against costs
   b. Developing Outcomes and Indicators
   c. Developing and delivering high volume low intensity interventions
   d. Training practitioners to deliver such intervention

10. There are significant variations in the type of anti-depressant prescribed. Much of this will be for clinical reasons and should be justified. However in the Cynon and Merthyr valleys, the greater use of Duloxetine is questionable given that its use elsewhere is much more limited. Given its much higher cost action should be taken to reduce its usage and possibly apply the saving to help sustain the Valley STEPS project.
11. Action to ensure better practice and reduce variation in anti-depressant prescribing is both desirable and essential to the establishment of the Valley STEPS project. This action should encompass the following:

a. The development of a computer support app or ‘reminder’ for GPs at the point of diagnosis or prescribing
b. Dissemination of Clinical Guidance (in suitable forms such as poster presentation, summary checklist etc) supported by education and professionally led discussion
c. A Cwm Taf ‘campaign’ in primary care with circulation of prescribing rates and links to guidance and support
d. Additional support to practices through Pharmacy advisers to conduct medication reviews of those on antidepressant medication. This activity needs monitoring and to be linked to the key indicators of the project.

12. The level of investment made by the Health Board and Local Authorities into Voluntary services is not inconsiderable. It is not known whether these services are delivering the levels of service as required or commissioned, nor is it known whether these services deliver the benefits considered necessary. In the light of developing the Tier 0 STEPS model, action should be taken to review these commissioned services and introduce measures to monitor status and performance.

13. From the financial evaluation, the options of doing nothing and providing a modest expansion to the existing Tier 0 services are not sustainable in the long term. Action is needed and it is considered that the Valley STEPS model does offer a realistic prospect of stopping and possibly reversing the current trend. However its capacity to deliver the requirements of the Social Bond will depend on the achievement of the critical success factors and the delivery of a 20% reduction in anti-depressant usage.

14. The Valleys STEPS model is feasible for development within the framework of the Wales Wellbeing bond and is a more sustainable approach for the LHB because it cannot afford the status quo and needs to secure buy in from the other stakeholders in well-being, which this model can provide.

15. If successful the established project should consider extending the service to Children and Young People as a ‘second wave’ development.
Chapter One - Introduction

1.1 The Brief

This Mental Health Early Intervention Feasibility Study was commissioned by Interlink 2013, Cwm Taf University Health Board, Voluntary Action Merthyr Tydfil, and Wales Council for Voluntary Action. It was designed to explore the viability of investing in early intervention mental health initiatives which would improve patients’ wellbeing and make a saving in Cwm Taf University Health Board’s prescription costs for anti-depressants.

The study was specifically required to assess the following:

- how access to psychological therapies in primary care and Tier 0 could be improved
- how inappropriate initial and long term antidepressant prescribing could be avoided
- how admissions to Tier 2 services could be reduced
- the nature and scope of alternative services that would be required to achieve these goals, taking into account changes in statutory services, and
- the economic feasibility of new alternative services.

The study was expected to involve:

- identifying and assessing similar models of alternative provision to antidepressant prescribing
- consultation with key personal in primary and secondary care, other service providers and third sector organisations
- an economic (financial) analysis of cost savings
- identification of critical success factors,
- an appraisal of options
- assessment of risks, management systems, clinical governance, ethical and equality criteria, and
- recommending the most effective delivery options.

Following the Inception Meeting in July 2013, the key aims of the study were agreed as follows:

- to explore the viability of investing in early intervention mental health initiatives to improve patients’ wellbeing with particular regard to the Glasgow Steps model
- investigate whether this course of action make a saving in Cwm Taf Local Health Board’s prescription costs for anti-depressants
- assess whether this project would be a suitable pilot for the Wales Wellbeing Bond

1.2 Methodology

Three broad sources of evidence have been considered in the production for this report. The first, underlying the report, is an overview of the clinical evidence available. The
National Institute for Health and Care Excellence is internationally recognised for the rigorous process by which it produces its guidance on technology and clinical pathways taking into account the best available evidence. The NICE guidance on areas relating to poor wellbeing and common mental health disorders forms a foundation for our recommendations in this area. Other academic and peer-reviewed sources of evidence are also referred to when appropriate.

Authoritative evaluations of projects, sources of statistical evidence, administrative data and policy studies have been considered as secondary sources. These are referenced in the text and a full list is provided at the end of the report.

Interviews with Health Board managers and clinical leads, GPs and managers of third sector provision have been undertaken and group discussions have been held with service-users and third sector providers. These have informed our assessment of the actions needed and feasibility of the mode. Where confidentiality permits, these contributors are gratefully acknowledged in Appendix 5.

1.3 Outline of the Feasibility Study Content

The remainder of Chapter 1 provides an overview of the national policy context in which this study takes places and also introduces some of hazards of confusing terms or concepts in early intervention in mental health. The difference between wellbeing and mild common mental health disorders is discussed.

In Chapter 2 a summary is provided of current services and mental health in the Cwm Taf area. Only by understanding the current picture can we consider the feasibility of moving to alternative arrangements. In particular current patterns of antidepressant prescribing in Cwm Taf which appear high are considered. This chapter ends, as do all subsequent chapters with a ‘findings & conclusions’ section summarising the narrative so far.

Chapter 3 examines the evidence base for successful clinical interventions for mild common mental health disorders and poor wellbeing. CBT and Mindfulness are found to be suitable evidenced based high volume low intensity interventions. Bibliotherapy and the promotion of social activity are also well evidenced as having a beneficial impact. Measures to ensure best practice in prescribing are also considered.

In Chapter 4 a number of mental health projects are discussed including the national experience of IAPT in England and Glasgow Steps. The aim of this chapter is to outline similarities and differences in project aim, interventions, evidence base and outcomes. The chapter is based on secondary sources as an independent evaluation of each of the projects is beyond the scope of this study.
Chapter 5 provides a potential model of the Cwm Taf Mental Health Early Intervention or ‘Valley Steps’ project and assesses its potential impact on patient flows and other services. Critical success factors are reviewed and a financial analysis of the potential costs and benefits of the model with differing input assumptions is made, which provides the basis of an options appraisal.

In conclusion, Chapter 6 examines the feasibility of investment in this model from the Wales Wellbeing Bond. It provides an overview of comparable developments in England and the lessons to be learned from this experience. It also examines the governance, management and performance delivery requirements and the setting of outcomes and measurable indicators.

1.4 National Policy Context

The aims of the Mental Health Early Intervention Feasibility Study emerge from, and contribute to, three areas of significant national policy development.

The first is the emphasis on developing preventative health services: identified as a strategic priority in the Wanless Report of 2003 this ambition has been most recently articulated in the Welsh Government’s 2012 Together for Health strategy. Within mental health policy this coincides with a renewed holistic focus on wellbeing and the resulting interest on services that seek to prevent, minimise and manage the acuity of mental health conditions. This is articulated in the Welsh Government’s 2012 strategy Together for Mental Health. In addition recent legislation has echoed this focus: Part 1 of the Mental Health Measure of 2010 created new statutory duties for authorities to extend primary mental health care.

The second is the need for policy to reflect the austerity of possible public spending. The implications for Welsh public spending are grave and have most recently and clearly laid out in the Institute for Fiscal Studies Report Scenarios for the Welsh Government Budget to 2025-26. This has led to an emphasis on evidence of benefit against cost and on efficacy and efficiency in public spending. This includes the area of medicines management where highly visible cost pressures coincide with the emergence of accessible and evidenced based advice on best prescribing practice. The development of a new service model must also consider the cost and benefits of providing an alternative service and the negative effects of not doing so.

The third strand is the social investment strategy launched in England by the UK Government (Cabinet Office 2011) and designed to break up public sector monopoly suppliers, encourage a wider diversity of providers, and give more choice and control to service user. The UK Government has set up (for England) a £20m Social Outcomes Fund, a £10m Innovation Fund and a £10m Investment and Contract Readiness Fund. All of these relate to the development and establishment of Social Impact Bonds as a method of financing and delivering public services. In addition the Big Lottery Fund (in England) has
established a £40m Commissioning Better Outcomes Fund and a £10m Social Incubator Fund to support the development of more innovative approaches to improving social outcomes. The UK Government now estimates that the social investment market in England reached £202m in 2011-12 ([www.gov.uk/social-impact-bonds](http://www.gov.uk/social-impact-bonds)).

In 2012 the Wales Council for Voluntary Action launched the Wales Wellbeing Bond. The WCVA (2012) set this development in the context of pressure on public service finance and specifically that programmes to be funded through this mechanism would be new models of service delivery that are preventative in nature and will reduce demand on public services and generate savings that will repay the initial investment.

1.5 Defining Mental Health, Wellbeing and Early Intervention

The potential services this study is concerned with are aimed at mild forms of commonly preventable mental health disorders (such as anxiety and depression) alongside wellbeing.

In her 2013 report the Director of Public Health for Cwm Taf included the following diagram from Keyes 2002 showing the relationship between mental illness and the broader concept of wellbeing. This was also referenced by Dr Jim White in his presentation to Cwm Taf Health Board (September 2013) as one of the underlying concepts of the Glasgow Steps Project (discussed in chapter 4).

**Figure 1: Dual Continuum of Mental Health (Director of Public Health for Cwm Taf)**

The nature of good and poor mental health and its relationship to environmental (e.g. the experience of chaotic childhood or a negative life event such as sudden redundancy in adulthood) and physical factors (e.g. genetic, or biochemical) is not fully understood.
although we also know that factors such as poverty, unemployment, poor physical health impact negatively on mental health and wellbeing. There is a clear relationship between poor mental health and poor feelings of wellbeing, which is usefully laid out in the National Survey for Wales, Measuring National Wellbeing (ONS, 2012).

Services in mental health are commonly understood (by providers and practitioners if not service-users) as existing in four tiers. Welsh Government (2010) The Role of Community Mental Health Teams in Delivering Community Mental Health Services defines these as follows:

**Tier 1** – primary mental health care [The identification, assessment and treatment of common mental health problems, such as anxiety and mild to moderate depression, and monitoring the physical and mental healthcare needs of people with a severe and enduring mental health problem, along with the provision of good quality information and sign posting services].

**Tier 2** – secondary mental health care

**Tier 3** – specialist services, including specialist inpatient services

**Tier 4** – highly specialist inpatient, secure and residential services

The specification for this feasibility study asks whether “it would be viable to develop a service that delivers a range of preventative non-stigmatising interventions to improve patients’ wellbeing, develop their resilience, and better manage their emotional wellbeing in the future” (emphasis added). The specification also explicitly references the concept of creating a ‘Tier 0’ service which is defined as “resources that are accessible prior to presentation to statutory primary care services that are freely accessible to the population”.

Glasgow Steps defined Tier 0 as “people who are demoralised, demotivated, anxious, stressed and who may also exhibit associated behaviours (substance misuse, domestic abuse, co-morbidity), but not have a mental illness requiring a psychiatric assessment.”

‘Tier 0’ therefore, while a useful shorthand expression for healthcare professionals, is **not a clinically defined target group in that a person unknown to mental health services could be clinically in need of a variety of services or none.** Furthermore there is no evidence that interventions can ‘prevent’ poor mental health at a later date. Whilst low intensity interventions may reduce the risk, prevalence or severity of poor mental health by building resilience, macro-economic, societal or personal factors will continue to impact on the population’s wellbeing and cause depression and anxiety at any time.
Chapter Two – Mental Health & Current Services in Cwm Taf

This chapter is designed to provide a factual context for the feasibility study. It describes the population and geography; assesses needs and concerns; observes current practice; identifies potential stakeholders; and develops key issues for further consideration. It is based on secondary sources, 12 key informant interviews; a telephone survey of 25 provider organisations; workshops involving over 50 participants from the third sector; and a recent focus group of service users run by Interlink.

2.1 Geography & Demography of Cwm Taf

Key indicators

By comparison with the Wales average and other local health boards, the population of Cwm Taf has the worst profile in terms of:

- economic deprivation and poverty
- economic inactivity
- premature deaths
- premature morbidity
- numbers of people without qualifications, jobs or training, and
- the proportion of people affected by mental health issues (24%)

The population of Cwm Taf University Health Board at the 2011 Census was 293,200 of which Rhondda Cynon Taff was 234,400 and Merthyr Tydfil 58,800 (Public Health Wales Observatory, 2013 and 2011 Census). Historically the population was administered in four localities – Merthyr Tydfil, Cynon Valley, Rhondda Valleys, and the former Taff Ely.

Geographically based deprivation measures (Lower Super Output Areas) show the significant areas of deprivation in the post industrial areas of Rhondda and Cynon Valleys and Merthyr Tydfil. 73 of the 188 LSOAs are amongst the most deprived fifth in Wales (39%) with only 17 LSOAs (9%) being in the least deprived fifth.

Whilst life expectancy rates are below the Wales average for both males and females, geographical variations account for differences in mortality and ‘life to years’ (i.e. years in good health). For example, in RCT life expectancy can vary by around 7 years between the most affluent and most deprived areas and living with good health can vary by over 15 years (Single Integrated Plan needs assessment for RCT, 2013). In Merthyr Tydfil healthy life expectancy ranges from 56.6 years in the Gurnos to 66.3 years in Vaynor less than 5 miles away (Single Integrated Plan for Merthyr Tydfil, 2013). Cwm Taff has the highest rate of premature mortality (deaths before the age of 75 years) amongst all LHBs in Wales, with deaths occurring as a result of smoking and deprivation.
Limiting long term illness (illness, health problems or disability that limits people’s daily activities or the work they do) was 27% in Rhondda Cynon Taf and 26.9% in Merthyr Tydfil (compared with 19% for England and Wales, Census 2011). This, together with high numbers of people without qualifications, has meant relatively high levels of economic inactivity, high levels of deprivation, child poverty and mental illness. DWP statistics suggest that 40% of all claimants of Incapacity Benefit / Employment Support Allowance were unable to work because of a mild to moderate mental health problem.

Tackling these problems is a challenge for all providers because of their widespread and entrenched nature, their concentration, frequency, and because the wider environment has little capacity to encourage change. Poor health and poor mental health in particular, is both a cause and a consequence of deprivation. The community surveys we have undertaken cite lack of job opportunities, lack of resources, poor transport, and the erosion of the community infrastructure as barriers to improved wellbeing. The public health surveys show that economic and social inactivity leads to stress, poverty, and poor mental health. The map below shows the geographical distribution of deprivation in Cwm Taf.

**Figure 2: Deprivation in Cwm Taf**
2.2 Mental Health in Cwm Taf: Strategic Planning

The key strategies for Mental Health in Cwm Taf are set out in the following documents:

(1) Cwm Taf Five Year Strategy for Mental Health 2011-16
(2) Together for Mental Health, the Welsh Government strategy (2012)
(3) The Mental Health (Wales) Measure (2012)
(4) Focus on Wellbeing in Cwm Taf (2013)

Adult mental health services for people of working age have been redesigned, and a Recovery Model has been introduced to deliver higher quality and more sustainable services. In-patient services have been relocated on a single site, and new community posts in assertive outreach, home treatment and crisis intervention have been introduced. – All this relates to the Cwm Taf 5 year strategy and was completed before the introduction of the Measure.

(1) Cwm Taf Five Year Strategy for Mental Health 2011-16 (2011)

This 5 year Strategy for Adult Mental Health Services in Rhondda Cynon Taf and Merthyr Tydfil has been developed by Cwm Taf Health Board in partnership with Public Health Wales, Rhondda Cynon Taf County Borough Council, Merthyr Tydfil County Borough Council, the third sector, mental health service users and carers. Its scope is the promotion of mental health and wellbeing in the whole population and provision of mental health services to adults of all ages. This comprises initial contact in the community and primary care through to specialist community and inpatient care and support and includes services for older adults and child and adolescent mental health. The Strategy seeks to develop a single model of service delivery to address service gaps and modernisation needs, meeting NICE guidelines and delivering a timely, high quality service across the board.

On the basis of the Office for National Statistics 2007 Survey in England, the prevalence of mental health problems in Cwm Taf were estimated as follows:

**Figure 3: Prevalence of Mental Health Problems in Cwm Taf**

<table>
<thead>
<tr>
<th>Estimated numbers of adults aged 18 to 74 with one of these disorders in the previous three months in Cwm Taf (rounded to nearest 100)</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety &amp; depressive disorder</td>
<td>13,200</td>
<td>7,800</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>6,000</td>
<td>4,700</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>4,600</td>
<td>3,300</td>
</tr>
<tr>
<td>All phobias</td>
<td>3,200</td>
<td>1,300</td>
</tr>
<tr>
<td>OCD</td>
<td>2,700</td>
<td>1,000</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>Figure awaited</td>
<td>1,100</td>
</tr>
<tr>
<td><strong>Any neurotic disorder</strong></td>
<td><strong>29,700</strong></td>
<td><strong>19,200</strong></td>
</tr>
</tbody>
</table>
The Cwm Taf Strategic plan has four components:

a) To promote and improve the mental health and emotional wellbeing of the local population: This means working with others to promote the factors associated with good emotional health, such as social networks, decent income, being active and having a meaningful purpose to life, and addressing the factors that impact negatively on mental health such as physical inactivity, poor physical health, social exclusion, fear of crime, deprivation, unemployment, experience of violence or abuse, poor housing or homelessness.

b) To provide prompt and effective assessment and access to services within primary care and the wider community, that help people to manage their mental health needs, with an emphasis on early intervention, self-care, peer and carer support: This is supported by the Mental Health (Wales) Measure, which places a statutory duty on Health Boards and Local Authorities to deliver local primary mental health support services offering assessment and, where appropriate, treatment for people of any age with mental ill-health.

c) To provide timely and integrated interventions as close to home as possible for people needing to access specialist mental health support, and to prevent and respond to crises; to ensure appropriate support in places of safety

d) To provide local services that promote rehabilitation, recovery, independence and social inclusion, and that challenge stigma.

(2) Together for Mental Health (2012) Welsh Government

This points to the value of improving well-being at three different levels: supporting the individual, investment in the community, and addressing barriers to wellbeing through education, meaningful employment etc. It emphasises the need:

- To promote better mental wellbeing amongst the whole population
- To ensure that the needs of vulnerable people with mental health problems receive the appropriate priority
- To adopt a recovery and enablement approach to improve the lives of services users and their families
- To work in partnership, acknowledging that no single body or sector can transform mental health in Wales.
Part 1 of the Mental Health (Wales) Measure (2010)
This Measure, implemented in 2012, has led to the reorganisation and strategic redesign of mental health services in Cwm Taf. Part 1 of the Mental Health Measure places a statutory obligation on Health Boards to develop a scheme outlining arrangements for primary care mental health services and the delivery of new Local Primary Care Mental Health Support Services (LPMHSS) which are present in all GP practices. It offers assessment, interventions information and advice for patients and carers; supports GPs and practice staff to promote mental health through a stepped range of intervention. Examples of these steps are:

- Interventions – Bibliotherapy (prescribed therapeutic reading), Psycho-educational CBT/Mindfulness based Courses, Group therapies and Individual Counselling and CBT;
- Social prescriptions - welfare and debt advice, exercise referral and housing advice and
- Onward referral – to specific counselling services, Education for Patients Programme, peer support, and 3rd Sector projects.


This report points to the huge cost of poor mental health (through costs of health and social care, losses to the economy, and the human cost of a poorer quality of life) and explains the importance and value of preventing mental illness and promoting well-being. Mental health issues affect 24% of the population and cost an estimated £7.2 billion a year in Wales in 2007/08 (Friedli L and Parsonage M (2009) Promoting mental health and preventing mental illness: the economic case for investment in Wales. All Wales Mental Health Promotion Network, Cardiff)

The Annual Report stresses the importance of actions to support people’s wellbeing from the cradle to the grave, with actions at all stages in life. It points to the need to address the wider poverty agenda. People with long term conditions and co-morbid mental health problems live disproportionately in deprived areas and have access to fewer resources of all kinds. Communities First clusters in these areas have developed plans focused on tackling poverty. The recession has exacerbated poor mental health, by creating rising unemployment rates, increased job insecurity, the loss of social role, increased anxiety, financial strain, and the stigma of being unemployed. The impact of the Welfare Reform Act will exacerbate this, increasing the demands on health, housing, and social services.

The report stresses the need for the wellbeing agenda to be adopted by everyone. For the University Health Board, the primary aim must be to keep the population well and outside the downward spiral of severe and enduring mental illness. For the local authorities, the priority is to mobilise and activate the population away from the dependency of chronic morbidity and social exclusion. Communities First clusters have targets to improve prosperity, health, and learning. Housing providers are motivated to ensure that their tenants and residents can manage and enjoy their tenancy and live independent lives. The
Department of Work and Pensions have an interest in addressing the large numbers of people who are chronically sick and economically inactive because of low to moderate mental health issues. Schools, parenting and older people’s services alike have a role to play in ensuring the best outcomes for their client groups. The Third Sector provides an important vehicle with huge capacity for investing in the well-being agenda.

The Public Health Report also refers to the report, *Building Resilient Communities* (2013), published by the Mental Health Strategic Partnership, with funding from the Department of Health. This coincides with the transfer of primary responsibility for wellbeing from health to local authorities (April 2013). The report makes a convincing economic case for investment in public mental health, in building community resilience and in future proofing wellbeing. It identifies key factors to promote resilience as follows:

- Activities that promote wellbeing (feeling good and functioning well) – using the New Economics Foundation’s Five Ways to Wellbeing.
- Building social capital – social connections, peer support, community groups and investment
- Developing psychological coping skills – education, CBT-based skills for stress management to reduce stress and anxiety at key stages.

The report stresses the importance of developing mental health awareness, providing comprehensive information, a closely integrated network of service providers and making services accessible, non-discriminatory and non-stigmatised.

*Focus on Wellbeing in Cwm Taf* also indicates the important role that urban regeneration can have on mental health (e.g. through the provision of accessible facilities, improving/creation of open spaces and good design). A community outreach direct access model would require accessible venues for stress-busting or mindfulness courses, for local learning, volunteering and connecting with others. However, community venues (e.g. libraries and community centres) are currently being threatened with closure.

As the Director of Public Health in Cwm Taf suggests, an effective strategy for achieving wellbeing will need a whole community approach, with strong leadership, joint working, co-production of services, trust and an understanding of the relationship between factors like social connectedness, physical activity, volunteering and mental health through a common agenda and common measures of impact and outcomes.
2.3 Current Services provided by the Health Board

Local Primary Care Mental Health Support Service

*Services for patients suffering with mild or moderate depression*

Before the implementation of the Mental Health Measure 2010 (June 2012 for Secondary Care and October 2012 for Primary Care), all GP referrals for mental health services would go to a single point of entry (SPE) at the Community Mental Health Team (CMHT). GPs would usually have tried other approaches, including medication, prior to this referral.

At this time some GP surgeries in Taf Ely and Rhondda had counsellors available so patients could be referred there if their symptoms did not warrant psychiatric interventions. This service was heavily over-subscribed and waiting lists were long so that many patients with milder difficulties did not receive timely help at all. In Merthyr and Cynon there were Primary Care Liaison Workers (usually Community Psychiatric Nurses -CPNs) who worked with GP surgeries. These would often offer advice as to the best way forward and undertake some short term interventions themselves.

The CMHT comprised Consultant Psychiatrists, CPNs, Social Workers and a psychologist with patients being prescribed medication by the psychiatrist to be administered via the GP. Other support to the CMHTs was through Resource Centres that were staffed mainly by CPNs, and which offered some group interventions as well as 1:1 support. Referrals to psychologists were made by members of the CMHT. This too was heavily over-subscribed with long waits.

After October 2012, patients who consulted their GP were usually referred to the new LPMHSS, although GPs could still refer patients with more severe symptoms directly to the CMHT. There were four teams serving each of the four localities in Cwm Taf, working alongside the GP practice at Tier 1 level. Most of the staff in these teams were drawn from existing Community based and Resource Centre staff, but additional staff have been funded from recurring monies amounting to £0.267m p.a. made available by the Assembly Government. This measure has started to offer a more cohesive and timely pathway for patients with emotional distress and the greater opportunity for non-pharmacological treatments.

*Non-pharmacological treatments*

The following are Tier 1 to non-pharmacological interventions, to which GPs and LPMHSS can now refer their patients:
Mindfulness - Tier 1: Operating since 2004, this service is delivered mainly in health care premises (Keir Hardie in Merthyr; Mountain Ash Hospital in Cynon; Trealaw in Porth and the Maritime in Pontypridd). Each of the four teams offers a course of 7 x 1 hour sessions over 3 weeks. In 2012 – 13 there were 53 courses, 20 in the North and 33 in the South including 2 put on in the evening. Each course took an average of 10 people with around 90% finishing the course.

Attendees are offered a single 1:1 follow-up following the course in case they have not worked out how to apply it to their situation. Various outcome questionnaires have been used over time but since it is lifetime skills that are taught these often do not reflect a great change after only three weeks. An open questionnaire asking for comments is overall positive but it is difficult to judge as people are not required to answer all questions.

First Steps - Tier 1: This is similar to Mindfulness but is based on a traditional CBT approach in that patients are taught to challenge their thoughts. It is again offered in each of the areas lasting 6 x 1.5 hour weekly sessions taking around 10 patients. A formal questionnaire is being developed, but informal feedback is positive.

Positive Focus - Tier 1: This is offered as a follow up to Mindfulness/First Steps courses and looks to build self-esteem. It is currently only run in Rhondda and Cynon, although patients from other areas may be referred. It is more of a group therapy approach during which patients are expected to speak so it only involves small numbers.

Emotional Coping Skills (ECS) - Tier 1: This is a course broadly based on DBT principles (Dialectic Behaviour Therapy) which uses Mindfulness skills to cope with negative feelings. This is only currently available in Merthyr with up to 12 attendees. When capacity permits it is hoped to extend this to other areas.

Baby Blues - Tier 1: This is a group intervention specifically for women who have low mood following childbirth and is undertaken by an LPMHSS Practitioner along with Health Visitors in Merthyr and Rhondda.

Thermostat - Tier 1: This is designed to help control anger issues. It is available in the Maritime at Pontypridd over a 4 to 6 week period for up to 6 people.

Chill Skills - Tier 1: This is a flexible intervention delivered by Health Care Assistants and aimed at those people whose anxiety about being amongst others or doing something new, prevents them from attending other courses. They are taught a variety of relaxation techniques both to use when anxious as well as others to apply on an ongoing basis to reduce their general anxiety levels. Sometimes this is delivered on a 1:1 basis but preferably in small groups of 2 or 3. After attending Chill Skills many patients are able to join other mainstream courses on offer.
**ACT (Acceptance and Commitment Therapy) - Tier 1:** This is a follow-on for some of those who have previously attended the Mindfulness course. ACT therapy is comprised of the three basic components of Mindfulness plus three others. It is for those who require further focused techniques for consolidating what they have learnt already. It is done in groups of about 12 people.

**Forthcoming services to be provided by the Local Primary Care Mental Health Support Service from January 2014**

In response to the growing waiting list and the need to offer courses on a self-referral basis, the Mindfulness courses will be opened up and expanded and Stress Control courses will be introduced. It has been found that many attendees at existing basic psycho-educational courses afterwards want to promote this to friends and relatives. This can only be beneficial in the long term because the more people who become psychologically aware, the more resilience will be built up. Friends and relatives have a very powerful effect on those with problems so it is helpful if they too give the same message. It may also encourage some reluctant attendees to attend if they can bring a friend. Courses will be taken by LPMHSS staff.

**Mindfulness – Tier 0:** The course is being rewritten to cater for larger numbers and will start in January 2014, using sports halls or similar venues in each of the four areas. There will be 6 x 1.5 hour weekly sessions, catering for 50-60 people. It is envisaged that 12 courses will be held over the year with 50% held in the evening (i.e. provision for 500-600 new spaces).

**Stress Control – Tier 0:** Based on Glasgow STEPS, but similar to the CBT First Steps course, this will be held in sports centres and other venues catering for 50 – 60 people. There will be 12 courses of 6 x 1.5 hour weekly sessions, catering for 600 to 720 people over the year. The only extra cost of the course will be hiring the venues and printing of publicity and course material. It is expected that the administration will be undertaken by the third sector.

**Local Primary Care Mental Health Support Services and reducing anti-depressant use**

Much of the attention since the introduction of 2010 Measure is to manage in a timely fashion the assessments and onward referrals of new patients. The review of existing patients will be a real challenge given the pressure to manage the new patients. If existing patients are stable then it is unlikely that there will any urgency for GPs to review. Also, where existing patients are claiming benefits, they may be resistant to changing their health status if it means losing those benefits. There is a need to act on the most recent cases where the individual may be more receptive to considering alternatives. The Measure has meant that Secondary Services will now work with patients who require Care and Treatment
Plans to meet complex needs and those not requiring this level of care planning are discharged into the care of their GP.

**Suicides**

The National Confidential Inquiry into Suicide and Homicide published its most recent report in July 2013 covering the period 2001 to 2011. There were 3450 suicides in Wales between 2001 and 2011 of which 802 (or 23%) had been in contact with Mental Health Services in the previous 12 months. Those at highest risk of suicide are males aged 35-44 who are socially and economically disadvantaged, live alone and abuse alcohol. This demographic group is likely to have had no contact with mental health services and is over represented in the Cwm Taf population. The advent of primary care and Tier 0 services should offer an opportunity to encourage engagement of high risk individuals who might not otherwise come into contact with services and who suffer from socially determined emotional distress.

**2.4 Current trends in anti-depressant prescribing in Cwm Taf**

The use of anti-depressants remains the major component of the treatment given to patients experiencing emotional distress and therefore a key factor when considering the feasibility of introducing alternative therapies and the potential financial benefits from reducing the dependency on medication. From the National Prescribing Indicators (All Wales Medicines Strategy Group, 2012/13), Cwm Taf has the highest DDD (defined daily dosage) of anti-depressants per 1000 PU in England and Wales.

The graph below (taken from data prepared by the Medicines Management Prescribing Unit in Cwm Taf Health Board) shows the increasing trend in anti-depressant usage comparing Cwm Taf with the Welsh average.

**Figure 4:**

Antidepressant prescribing – items/1000PU, Cwm Taf Health Board

![Graph showing increasing trend in anti-depressant usage](source: Medicines Management Prescribing Unit, Cwm Taf Health Board)

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1 Data in this section is sourced from unpublished report (2013) by Dr Huw Griffiths and Dr Paul Davies, Directorate of Primary Care, Community and Mental Health, Cwm Taf LHB
The table below (taken from the same source) summarises the anti-depressant usage over the last three years. The Prescribing Unit (PU) is the standard way of counting the relevant population to aid comparison.

**Figure 5: Antidepressant usage**

<table>
<thead>
<tr>
<th>Cwm Taf Health Board</th>
<th>Year 1 2010/11</th>
<th>Year 2 2011/12</th>
<th>Year 3 2012/13</th>
<th>% Change +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of items</td>
<td>417k</td>
<td>452k</td>
<td>479k</td>
<td>+14.8</td>
</tr>
<tr>
<td>Cost per item</td>
<td>£5.11</td>
<td>£4.52</td>
<td>£3.80</td>
<td>(25.0)</td>
</tr>
<tr>
<td>Overall cost</td>
<td>£2.1m</td>
<td>£2.0m</td>
<td>£1.8m</td>
<td>(14.2)</td>
</tr>
<tr>
<td>Cost/ 1000 Pus</td>
<td>£5.3k</td>
<td>£5.0k</td>
<td>£4.4k</td>
<td>(16.9)</td>
</tr>
<tr>
<td>Welsh Average Cost/ 1000 PUs</td>
<td>£4.0k</td>
<td>£4.1k</td>
<td>£3.55k</td>
<td>(11.0)</td>
</tr>
</tbody>
</table>

Whilst the costs have come down as a result of price reduction, this has been as a result of drugs coming off patent and being available generically and is not sustainable. It can be seen that the volume of anti-depressants as measured by the number of items prescribed has continued to increase by around 7% pa. This steady increase is due partly to the number of new patients prescribed medication but mainly due to existing patients remaining on the drugs for a long time with some 90% of all patients on anti-depressants staying on repeat prescriptions for over a year or more.

The impact of long term repeat prescriptions in increasing the volume of anti-depressants is supported by the research carried out in Scotland by Lockhart and Guthrie (2011) into the nature of anti-depressant prescribing over a number of years. This study shows that “over the period 1995/1996 to 2006/2007, the increase was initially driven by a combination of large increases in patients prescribed and increases in the duration of treatment, but latterly more by increases in duration of treatment and the mean dose prescribed.”

Comparison with the Welsh average in the last year shows that Cwm Taf has an additional cost of £850 per 1000 PU. Given that Cwm Taf had 411,000 PUs in 2012/13, the overall additional cost is £0.350m pa.

Over the last three years prices have come down as a result of an influx of generic drugs following the lapse of patents, particularly for the SSRI anti-depressants. In 2012/13 despite the increase in volumes, the overall cost had come down from £2.1m to £1.8m. However as a result of shortages in supply in the last six months up to June 2013, the latest prices have increased the annual cost to around £2.4m. These uncontrollable price fluctuations prevent any meaningful comparisons and for the purpose of the feasibility study the key indicator
will be the volume of items prescribed. Eventually this will be by DDD as this will be more accurate but that indicator is not yet readily available.

The anti-depressant usage in 2012/13 for each of the seven Health Boards in Wales is shown in the table below. (Data supplied by the Medicines Prescribing Unit, Cwm Taf)

Figure 6: Table showing Antidepressant Usage by Health Board

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Items per 1000 PUs</th>
<th>% above Welsh Average</th>
<th>Cost per 1000 PUs</th>
<th>% above Welsh Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cwm Taf</strong></td>
<td>1.170</td>
<td>+24%</td>
<td>£4,451K</td>
<td>+24%</td>
</tr>
<tr>
<td><strong>Aneurin Bevan</strong></td>
<td>1.076</td>
<td>+14%</td>
<td>£4,234K</td>
<td>+18%</td>
</tr>
<tr>
<td><strong>Abertawe Bro Morgannwg</strong></td>
<td>1.046</td>
<td>+11%</td>
<td>£3,785K</td>
<td>+6%</td>
</tr>
<tr>
<td><strong>Wales</strong></td>
<td>0.940</td>
<td>0</td>
<td>£3,577K</td>
<td>0</td>
</tr>
<tr>
<td><strong>Cardiff and Vale</strong></td>
<td>0.868</td>
<td>-8%</td>
<td>£3,507K</td>
<td>-2%</td>
</tr>
<tr>
<td><strong>Betsi Cadwaladr</strong></td>
<td>0.830</td>
<td>-12%</td>
<td>£2.866K</td>
<td>-20%</td>
</tr>
<tr>
<td><strong>Hywel Dda</strong></td>
<td>0.807</td>
<td>-14%</td>
<td>£3,138K</td>
<td>-12%</td>
</tr>
<tr>
<td><strong>Powys</strong></td>
<td>0.708</td>
<td>-25%</td>
<td>£3,248K</td>
<td>-9%</td>
</tr>
</tbody>
</table>

It can be seen that Cwm Taf has the highest item usage and cost of the Health Boards in Wales, closely followed by Aneurin Bevan and Abertawe Bro Morgannwg. All three Health Boards include the South Wales valley communities. A graph of the usage from the table above is shown below. This shows the variations either side of the Welsh average.

Figure 7: Graph showing antidepressant usage by Health Board
An analysis has been undertaken of the four primary care areas within Cwm Taf.

**Figure 8: Prescribing within Cwm Taf**

<table>
<thead>
<tr>
<th>Area</th>
<th>Items per 1000 PUs</th>
<th>% above Welsh Average</th>
<th>Cost per 1000 PUs</th>
<th>% above Welsh Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cwm Taf</td>
<td>1.170</td>
<td>+24%</td>
<td>£4,451k</td>
<td>+24%</td>
</tr>
<tr>
<td>Cynon</td>
<td>1.209</td>
<td>+28%</td>
<td>£5,564k</td>
<td>+55%</td>
</tr>
<tr>
<td>Merthyr</td>
<td>1.140</td>
<td>+21%</td>
<td>£5,460k</td>
<td>+52%</td>
</tr>
<tr>
<td>Rhondda</td>
<td>1.290</td>
<td>+37%</td>
<td>£3,807k</td>
<td>+6%</td>
</tr>
<tr>
<td>Taf Ely</td>
<td>1.054</td>
<td>+12%</td>
<td>£3,665k</td>
<td>+2%</td>
</tr>
</tbody>
</table>

Interestingly, Rhondda whilst having the highest usage per 1000 PU does not have the highest cost. Cynon and Merthyr have the highest cost by some margin, due to the use of more expensive anti-depressants prescribed.

**Figure 9: Cost of antidepressant medication**

The drug that has the most impact of the cost profile of each area is Duloxetine which only makes up 4% of the volume of items but represents 31% of the total cost.

There appears to be a legacy of usage of this drug in the Cynon and Merthyr areas which stems from the clinical preference of some Consultant Psychiatrists. The “excess” cost amounts to £0.320m pa and it is understood that this will be an area for review and action for pharmacy advisers and the Mental Health Directorate working with GPs.
Figure 10: An AWMSG audit of GP practice data showed the following results in each of the four areas

<table>
<thead>
<tr>
<th></th>
<th>Merthyr Tydfil</th>
<th>Cynon Valley</th>
<th>Rhondda Valley</th>
<th>Taff Ely</th>
</tr>
</thead>
<tbody>
<tr>
<td>List size</td>
<td>44972</td>
<td>36920</td>
<td>80550</td>
<td>103426</td>
</tr>
<tr>
<td>Repeat antidepressants</td>
<td>5329</td>
<td>5479</td>
<td>9845</td>
<td>7661</td>
</tr>
<tr>
<td>% of list (range)</td>
<td>12% (7.9-20.2)</td>
<td>15% (8.4-20.3)</td>
<td>12% (10.7-21.6)</td>
<td>7% (8.8-14.2)</td>
</tr>
<tr>
<td>Treatment &gt;12 months</td>
<td>4661</td>
<td>4828</td>
<td>8822</td>
<td>6881</td>
</tr>
<tr>
<td>% of repeats &gt;12 months (range)</td>
<td>87% (84-91)</td>
<td>88% (83-95)</td>
<td>89% (85-99)</td>
<td>90% (89-95)</td>
</tr>
</tbody>
</table>

This information confirms the high level of anti-depressant prescriptions in the Valley communities and also the high level of repeat prescriptions across all areas.

An examination of prescribing at an individual practice level reveals some wide variations. The table below shows examples of variations in each area of the proportion of patients on anti-depressants which are either as a result of a different prescribing practice or in the make-up of the practice populations.

Figure 11: variation by practice

<table>
<thead>
<tr>
<th>GP practice</th>
<th>Higher levels</th>
<th>Lower levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cynon</td>
<td>Abercynon</td>
<td>1 in 5</td>
</tr>
<tr>
<td></td>
<td>Abercwmboi</td>
<td>1 in 8</td>
</tr>
<tr>
<td>Merthyr</td>
<td>Treharris</td>
<td>1 in 6</td>
</tr>
<tr>
<td></td>
<td>Dowlais</td>
<td>1 in 12</td>
</tr>
<tr>
<td>Rhondda</td>
<td>Gilfach Goch</td>
<td>1 in 5</td>
</tr>
<tr>
<td></td>
<td>Tylerstown</td>
<td>1 in 9</td>
</tr>
<tr>
<td>Taff Ely</td>
<td>Taff Vale</td>
<td>1 in 7</td>
</tr>
<tr>
<td></td>
<td>Ashgrove</td>
<td>1 in 12</td>
</tr>
</tbody>
</table>
These figures coincide with the areas of greatest deprivation in Cwm Taf.

In preparing this report the authors interviewed leading GPs as ‘key informants’ to assess their views of current practice in antidepressant prescribing. Most expressed concern about the high volume of cases of depression they saw and the resulting antidepressant prescribing. They linked a high rate of antidepressant prescribing to a lack of suitable alternative provision, although some had experience of Bibliotherapy and Exercise Prescriptions. They welcomed the prospect of alternative psychological therapies. Chapter Three explores their views in more depth and discusses the pursuit of high quality prescribing as a means of addressing the trends outlined above.

2.5 Current Services In Cwm Taf – Provision By Other Stakeholders

It was agreed to assess what the whole community had to offer this project. This was based on a series of workshops, interviews, and secondary sources of information provided very helpfully by all the stakeholders. Further details are set out in Appendix 2.

Services provided by the voluntary sector for people with serious and enduring mental health problems

Gofal and Hafal, Bipolar UK, Venture Out, MATV Mind, Journeys and New Horizons all provide services for people with serious, chronic and enduring mental health issues. MATV Mind, Journeys and New Horizons also provide an extensive range of support activities within the community for people who might be regarded as ‘Tier 0’. They would welcome a Tier 0 service so that their clients can progress to other services as an exit strategy or at times of remission. There is also the opportunity for Tier 0 clients to be referred from other interventions into their services.

Depression busting

These courses have been commissioned by partners including the Health Board, Public Health and Rhondda Cynon Taf (RCT) Communities First grant funding over the last 5 years. Together partners have worked with Journeys to provide Depression Busting courses together with local peer support groups. The Depression Busting Course developed by Journeys provides individuals with the tools they need to self-manage their condition and improve their wellbeing. Course participants have gone on to undertake Mental Health First Aid and Train the Trainers courses and are able to share their learning and experience with new members of the peer support groups. The pilot peer support group in Maerdy (MASH) has been extended to five other communities.

Some services are core funded by the LHB for their core work, but also have the skills, systems of supervision and quality assured services to offer clients at Tier 0. There are
concerns here about the interface / level playing field with the Community Mental Health Teams and about their own sustainability and there is certainly a sense that between them, they could provide many of the services that it is intended for STEPs to provide.

**Housing providers**

Many of the services delivered by housing providers and voluntary organisations are similar services to the statutory bodies, but they have the advantage of being more open to change and flexibility. The focus of the work is about living skills, making tenants more work-ready and socially integrated, improving well-being and fostering volunteering and engagement. In future, many housing providers will be less able to provide direct hands on support and will have to focus more on their core services. All projects are running to the limits of their capacity/ funding. All recognise that intervention needs to be medium to long term. However, none of the projects are certain about their own long term sustainability.

- **Adref** provides support for homeless people, most of whom have mental health, substance misuse or alcohol problems and is funded largely by the LA’s Supporting People budgets.
- **Gofal** provides supported housing and tenancy support and advice for people with anyone with mental health issues. They are commissioned to support people at risk of becoming homeless via Supporting People funding, they also provide a Housing Advice Service in the community and a Hospital to Home service to in-patients at risk of homelessness. Gofal also deliver ‘Routes to Recovery’ a self-management course for mental health service users.
- **RCT Homes, Merthyr Tydfil Homes, Cynon Taf Housing Association** have established a three year Community Well-being coaches scheme established with a Big Lottery grant that has run for 18 months. Community Wellbeing Coaches work with individuals to create their own personal health and well-being plan.
- **Rhondda Housing Association** has a Lottery Funded Project providing 1-1 services, peer support groups and vocational training.
- **RCT Women’s Aid** provides emergency refuge accommodation, floating support and drop in support for women victims of domestic abuse, 90% of whom have mental health issues, alcohol abuse and substance misuse issues.

**Substance misuse providers**

**Drug Aid**, the **Substance Misuse RCT team** and **TEDS** provide a wide range of services for people affected by SM and alcohol, many of whom also suffer from mental health issues. The manager of TEDS stressed the importance of joint working, particularly in training, cross referrals and in co-production of services.
**Young people**

- The *Amber Project* provides services for young people with a focus on reducing self-harm and suicides, through music workshops, theatre projects, and 1-1 counselling.
- *Barnardos* provides services for 69 care leavers aged under 25, offering services to enhance confidence, build relationships, and improve well-being; care leavers experience particularly high levels of anxiety and depression.
- *SNAP Cymru* supports parents and carers of young people with educational issues resulting from a mental health issue.
- *Eye to Eye* provide the Schools Counselling Service in RCT, a community based counselling service for young people and a similar dedicated service for the LPCMHSS.

All organisations stressed the importance and cost-effectiveness of interventions with children and especially with adolescents. This is because if mental health problems hit young people at adolescence, the ramifications can affect them for the rest of their lives. It is therefore important for services to develop ways of providing de-stigmatised community support for young people to ensure that they do not become socially excluded or held back.

**Older People**

It is recognised that older people, especially those who are socially isolated, who have significant caring responsibilities or suffer from dementia, can suffer from varying degrees of anxiety and depression. *Age Concern Morgannwg, Alzheimer’s Society* and *RSVP* provide befriending services and access to volunteering opportunities and signpost people to activities in the community, e.g. choirs and crafts, and provides benefit advice and support. The *50 + Forums* run social activities to support the well-being of their client groups and could act as referral points if called upon to do so.

**People with learning difficulties**

Many people with physical and learning difficulties are victims of bullying and social exclusion and a high % also suffer from low to moderate mental health issues. The following organisations were interviewed:

- *Ategi* offers supported living in the home, visiting respite support, a fostering project and volunteering and social activities for adults with learning difficulties, 80% of whom have a mental health problem.
- *Drive UK* supports people with physical and learning difficulties to live a normal life in the community, but have just taken on 2 projects, providing support in 32 units of self-contained accommodation owned by RCT Homes for people with mental health issues.
**Victims and Offenders**

A very high % of victims and offenders have mental health problems. *New Pathways*, funded by Police, Probation and Forensic Services, provide services to 1000 victims of rape and sexual abuse and will be assessing the impact of their counselling service on medication, including anti-depressants. With Ministry of Justice Funding, *Platform 51 Cymru* provides 12-16 weeks intervention to 20 women who have offended or at risk of offending and who have a mental health problem. *RCT Women’s Aid* provides services through Supporting People to victims of domestic abuse. All welcomed the prospect of a Tier 0 service in the community because of the limitations of their own service and the need to be able to move people on to self-help and community support.

**Peer Support groups**

There are 6 peer support groups all within RCT. Five of these evolved from a grant funded project in Maerdy, which has continued *(M.A.S.H)* and now also includes *New Beginnings* (Glyncoch), *Brighter Journeys* (Capel Farm), *Positive Steps* (Darren Las), *Footsteps* (Ferndale). These groups were initially supported by Communities First grant funding and are now individually constituted and supported by RCT’s Independent Living Service (on which the sustainability of these groups still depends). *Rhondda Listening Friends* (Ton Pentre) established following a withdrawal of a local voluntary sector day service is also a peer support group which is self-funding and sustained by the group itself.

Peer Support groups are a great concept. They tick the boxes for community engagement and active citizenship, volunteering, rising to the challenge and social inclusion. They give their members comfort, maintain their well-being and sometimes help them to move on. However, they rely on development support, which is a scarce and dwindling resource.

**Communities First**

The Communities First Programme is charged with developing the resilience of their communities through three strands: prosperous communities, healthier communities and learning communities.

Communities First teams in each local authority area have been developing action plans to achieve demonstrable and measurable outcomes for each strand. Mental health / well-being / resilience is one of the sub-strands of most of the ‘Healthier communities’ strand, although clearly well-being has a part to play in each of the strands. Action to tackle worklessness, learn new skills, develop confidence and self-esteem, and address financial illiteracy all play a part in achieving personal and community well-being.
Workshops held to discuss a strategy to support mental health within the RCT and MT were held in October 2013 as part of this study. The key problems in each area were similar and include the following:

- ‘Low mood’, stress, anxiety, and lack of motivation a normal state not identified as needing to be addressed
- Problems with debt, drink, drugs, etc endemic in communities
- Social isolation
- Lack of employment, anxiety about benefit changes, and becoming job ready.

Communities First workers are sign-posters and enablers. Their role is to bring in interventions and expertise into their area and ensure that there is local take-up resulting in improvements. In both Cluster Groups there was huge enthusiasm for a STEPs type initiative in which Communities First clusters could contribute the following:

- Identifying people and targeting families who might benefit
- Linking other community development activities to add value to STEPs
- Building on referrals from GPs and practice nurses.

In achieving optimal outcomes for STEPs and for Communities First, they would need to know what’s out there – well-branded information, phone numbers etc and a good website and a means of measuring their contribution and performance within a social model (e.g. Warwickshire and Edinburgh Measure of Wellbeing Score – WEMWBS – see Appendix 4)

**Job Centre Plus**

The DWP is an important stakeholder in being able to refer, support and help people into work. They also have a broader holistic role (e.g. they can advise people about volunteering, engage the business sector, give talks at community sessions and promote the Five Ways to Wellbeing).

Job Centre Plus (part of the Department of Work and Pensions) has a crucial role in addressing the barriers to wellbeing created by economic inactivity. In RCT alone, there are 17,500 people receiving Incapacity Benefit / Employment and Support allowance of which 40% receive the allowance because of mild to moderate mental health needs (around 7,000 people). This depends on a GP who will identify people with a mental health need (and often prescribing medication to address these needs). It should be noted that people with mild to moderate mental health needs may also be part of the employed population on long term sickness / statutory sick pay or self-managing their condition and still attending work.

Job Centre Plus has a number of schemes to keep people in work or to enhance their employability – for example, the Access to Work Scheme, (which helps someone to gain new employment if they have a disability or health need, by providing an intervention such as counselling to employee at no cost to employer/ee. There is also a help-line for employers)
The ESF funded Want to Work Programme will finish in 2015 and seeks to tackle barriers to employment. Advisors are based in community outreach venues - in Bridgend they are based in GP surgeries.

2.6 Volunteer Organisations and Service User Feedback

Service users provide important insights into how the service might be shaped and delivered. As part of the study, we held two workshops, one of the Mental Health Forum’s November 2013 meeting and the other at Interlink’s AGM, involving a mixed group of service providers and users and carers: a total of 50 people were consulted. We also relied on ‘Get Involved in Mental Health!’ workshops to discuss services for people with mild mental health issues run by Interlink in November 2013, which were attended by a total of 44 service users.

The workshops identified the following gaps and shortcomings in services:

- **Lack of information**: Information about services was felt to be insufficiently available or accessible, was not provided in appropriate formats (e.g. a trailer at cinemas), and was not available where people needed it (e.g. youth clubs, leisure centres, GP practices, libraries). Services were not promoted to make them visible and pathways / access to support were unclear. This meant that even if services existed, people did not know how to access them.

- **The role of GPs**: More provision was needed at the GP surgery: a generic place within the surgery for people to drop in; CPN provision; information about what else is available. A few people felt that GPs needed education about available alternatives to prescribing anti-depressants and listen better to their patients.

- **Lack of services**: Inadequate capacity prevented services responding in a timely way; assessments were delayed; lack of counselling services meant long waiting lists. It also meant that services did not always capture people when they needed help. Gaps between CAHMS and PCMH were said to exist and the service was insufficiently responsive and flexible to enable joined up services and other types of support (e.g. forums, apps, chat rooms and social media) to help people when they need it.

- **Stigma**: Employers’ attitudes to mental health issues were mentioned as a barrier to people getting help; managers did not always access mental health awareness and training. It was also noted that people who are working and high risk groups, (e.g. middle aged men, older people) needed to be able to access support without a fear of being stigmatised.

- **Young people**: More services for young people and more training for youth workers are needed

- **Poor partnership working**: The lack of trust between health professionals and third sector has exacerbated capacity gaps. There also needs to be a recognition that the
voluntary sector (by providing opportunities for people to connect through volunteering and aspire to join in and integrate) can be part of the solution, and therefore needs to be part of the partnership.

**Preventative agenda:** It was widely felt that a service based on the Five Ways to Wellbeing it would be more preventative, less reactive, and more joined up.

**Lack of resources:** More resources were thought to be needed to deal with socio-economic issues that exacerbate mental health issues – poverty, illiteracy, poor physical health and immobility, lack of money, problems of accessing services, lack of confidence and resilience.

Service users also suggested the following changes and improvements:

- Alternatives to medication and improving access to psychological interventions
- To be listened to by consultants with better people skills
- Better information about the different types of mental health support available locally e.g. groups, organisations, websites etc.
- Improved awareness of mental health by health and social care workers
- Shorter waiting times and improvements to appointment systems
- Challenging stigma and discrimination
- New opportunities e.g. sport, creativity
- Improved relationships between service users and service providers
- Better integrated service delivery based on coproduction

### 2.7 Findings & Conclusions

- The findings from this section demonstrate the strain on the community mental health service resulting from being expected to deal with a large pool of the population whose wellbeing is poor. As a result, GP’s surgeries become clogged up with patients who are quickly sucked into medication, without being subsequently monitored or reviewed. There are also long waits for assessments and alternative therapies within the CMHT. There is recognition that the service cannot be sustained in this way.

- The continual increase in the volume of anti-depressants prescribed confirms the inadequacy of alternative interventions both for new patients but of more concern is the high level of repeat prescribing for existing patients. Cwm Taf is not alone in prescribing high levels of medication, with the neighbouring Health Boards who are also responsible for Valley communities exhibiting similar levels. There are also variations in the use of different anti-depressants which is difficult to justify in clinical terms and given the additional cost, it does warrant action by the Health Board.

- We started this feasibility study with a definition of Tier 0 - people who are demoralised, demotivated, anxious, stressed and who may also exhibit associated behaviours
(substance misuse, domestic abuse, co-morbidity), but not have a mental illness requiring a psychiatric assessment. We also considered how provision for this cohort might be suitably branded and packaged, made more accessible and inclusive, de-stigmatised and non-medicalised, and also embrace key stakeholders. The Wellbeing Agenda (and, particularly, the Five Ways to Wellbeing) was mentioned widely and could provide the common currency for co-production of the interventions needed at Tier 0.

- Activities to promote well-being, build social connections, and improve individual coping skills and resilience are everyone’s responsibility and everyone’s priority (e.g. they are a priority for the Single Integrated Plan, Communities First, amongst voluntary organisations, Job Centre Plus and the University Health Board). However, the mapping exercise has shown that many key stakeholders are working in virtual isolation and are competing for scarce resources, when collaboration would be much easier. There are some shining examples of joint working, which should be built upon. As the Director of Public Health in Cwm Taf suggests, an effective strategy for achieving wellbeing will need a whole community approach, with strong leadership, joint working, co-production of services, trust and an understanding of the relationship between factors like social connectedness, physical activity, volunteering and mental health through a common agenda and common measures of impact and outcomes.

- The Director of Public Health’s Report indicates the important role that urban regeneration can have on mental health (e.g. through the provision of accessible facilities, improving/creation of open spaces and good design). A community outreach direct access model would require accessible venues for stress-busting or mindfulness courses, for local learning, volunteering and connecting with others. This depends on community venues being available.

- Funding cuts in the public sector have led to many activities that used to be funded now no longer existing in Cwm Taf. Some community buildings are occupied on a limited basis. Some agencies listed in the Mental Health Services Directory have withdrawn their services from the area and many retain only a small core staff. It appears that, if needed, additional capacity could be found (e.g. by bringing in counselling and supervision on a sessional basis, or providing accommodation), but only if added resources were made available.

- Improving the mental wellbeing of the population is an important element of the Single Integrated Plan in both local authorities. Despite cuts in funding, the local authority remains a strategic player in any Tier 0 provision. They fund a number of the voluntary sector projects (e.g. through Supporting People) and they host Communities First, covering the most vulnerable communities with the poorest health and wellbeing.
• Housing providers interviewed clearly were settling into a new regime where innovative community based work can no longer be delivered without grants. However, they seem to work well in partnership and to bring in grant funding for time limited projects.

• Interviews with GPs have revealed that one of the reasons why they do not refer their patients to third sector support is that they do not know what is available. To address this problem, a Directory of Mental Health Services was developed. We remain unconvinced about the benefit of giving GPs more detailed information (to be trawled through within the 6 minute appointment). We suggest instead a single point of contact at a one stop shop, available at the press of a button or at the end of a phone call.

• The Directory provided the basis for the voluntary organisation survey which was undertaken as part of this feasibility study. Having a Directory of services is a good idea, but its format (listing organisations alphabetically and not by function) limited its value for someone who did not know the sector, and also it was found to be out of date. There is a need for a means of signposting, but in addition, more thought also needs to be given to the format of this information, which needs to be instantly and electronically available (e.g. via an app). This could be of value to patients wanting to find out on a 24/7 basis what is available for them.

• Cwm Taf currently funds the core costs of some of the specialist mental health services in the third sector. This has allowed them to survive. They maintain the flexibility and diversity of the sector through a combination of collaboration and competition, by identifying new gaps and opportunities, and generating new and innovative projects to fill them. There are concerns that introducing a new model to deliver services targeted to ‘Tier 0’ clients will affect this.

• Much has been discussed of the value of physical activity, of volunteering, and making the connections. All too often services are perceived in terms of ‘doing something to’ service users instead of getting them to take action themselves. A lot more of this model needs to be about getting volunteers involved (e.g. in running self-help groups and in supporting events and training). Interlink’s Volunteer Co-ordinator could help to develop this.

• Voluntary sector organisations are keen to ensure that they too will be able to contribute to the model alongside other providers. Whilst concerns have been mentioned about quality assurance, clinical governance, competence, and supervision etc, it is clear that many voluntary sector organisations are already heavily regulated. Furthermore, all grant funded projects and most organisations have output, outcome and impact measures. It makes sense for any new service to develop a single system for measuring outcome and success, even though this means that most contractors/service providers would have to keep dual records. It is thought that the Warwick-Edinburgh
Mental Wellbeing Scale would be suitable in providing meaningful, easy to use and relevant measures.
Chapter Three – Examining effective early interventions

3.1 Achieving high quality antidepressant prescribing for mild and sub-threshold anxiety and depression

The requirement for this feasibility study was to specifically examine whether a reduction in antidepressant prescribing could be made and whether an alternative provision of therapies to promote wellbeing and tackle mild common mental health disorders would in itself result in a reduction in antidepressant prescribing.

The underlying assumption was that currently, without any alternative provision, GPs were forced into relying too heavily on the option of antidepressant prescribing. Chapter 2 outlined not only the wide variation in prescribing practice within Cwm Taf but also that the prescribing of antidepressants is far higher than other Health Boards in Wales.

In preparing this report the authors interviewed leading GPs as key informants to assess their views of current practice in antidepressant prescribing. This provided a useful insight into the views of practitioners. Concern was expressed about the high volume of common mental health disorders and the consequent high levels of antidepressant prescribing (although few were aware that Cwm Taf as an area was an outlier in this field). This was linked to a lack of suitable alternative provision and access to psychological therapies would be welcome as a suitable alternative to medication.

The National Institute for Health and Care Excellence (NICE) has examined the best available evidence on effective interventions in mental health. Generalised Anxiety Disorder and Depression are the two most common mental health disorders that people present with to their GP. NICE not only make very specific recommendations on the care pathway and stepped treatment that should be made available for patients with mild disorders but also those ‘sub-threshold’ that Tier 0 services are designed to serve.

**Tier 1:** NICE guidance recommends that once a diagnosis of anxiety has been made and patients are regarded as having mild to moderate level of the condition (Tier One) low intensity options are offered such as individual non-facilitated self-help, individual guided self-help and psycho-educational groups. It is only after these options have been trialled and failed that a drug treatment should be considered alongside the option of an individual high-intensity psychological intervention. The choice of treatment at this stage should depend on the person’s preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better.

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2 Sub-threshold refers to people who do not meet the diagnostic criteria for depression but have a number of symptoms for a number of months
**Tier 0:** For people with persistent sub-threshold depressive symptoms or mild to moderate depression NICE recommend: individual guided self-help based on the principles of cognitive behavioural therapy computerised cognitive behavioural therapy or a structured group physical activity programme. Antidepressants should not be routinely used to treat persistent sub-threshold depressive symptoms or mild depression. This recognises the potentially disabling effects of sub-threshold depression and the poor risk–benefit ratio.

NICE recommends that anti-depressants are considered for people with: a past history of moderate or severe depression or initial presentation of sub-threshold depressive symptoms that have been present for a long period (typically at least 2 years) or sub-threshold depressive symptoms or mild depression that persist(s) after other interventions NICE do not recommend the use of antidepressants for children and young people with sub-threshold or mild depression.

There are many complex interrelated factors that make-up ‘good prescribing’ such as effectiveness of treatment, cost, patient choice and minimising risk. Achieving high quality ‘good’ antidepressant prescribing for mild and sub-threshold anxiety and depression must be the goal for Cwm Taf rather than simply reducing the volume of antidepressant prescriptions.

There is a view among stakeholders that presenting patients would want an antidepressant prescription. Research such as Britten et al (2000) and Dollman et al (2003) has shown a consistent overestimation by GPs of patient’s desire for medication, particularly in relation to repeat prescriptions. This is also a concern of service users (see user survey responses in chapter 2).

The need to undertake medicine reviews of patients already on antidepressant prescriptions was identified as a serious problem. GPs felt they did not possess the capacity in their practice to undertake these reviews as best practice recommends. This is especially significant if a GP is writing a prescription for a year’s supply at one time – which could then become a repeat prescription.

Interviews with GPs also revealed that one of the reasons why they do not refer their patients to third sector support is that they do not know what is available. To address this problem, a Directory of Mental Health Services was developed and is available on a website. However, it provides an alphabetical list of organisations rather than by service, its format is cumbersome and we discovered that the information was outdated. GPs would prefer instead some form of software prescribing support that would provide onscreen direct details of the services which could be an alternative to an antidepressant prescription. There have been numerous reviews and studies of the impact of electronic based support tools for clinical decision-making such as Pearson et al (2009) Bryan C and Boren SA (2008). The consensus is in their favour although more research into type of impact and effectiveness factors is called for.
All GPs interviewed expressed an interest in opportunities such as educational seminars or collective discussions that would allow them to learn more about alternatives to antidepressant prescription and related issues. Clinical Guidelines and other tools can make a difference as part of concerted campaigns changing the behaviour of healthcare professionals. Rix et al (1999) conducted a useful analysis the English ‘Defeat Depression’ Campaign on GP education and highlighted in particular the impact of clear guidance a point echoed by Mitchie and Johnston (2004).

Previous local initiatives in Cwm Taf demonstrate that it is possible to make a significant change in practice in a relatively short timeframe. A poster by Sugden and Tyrell (2013) summarise the measures and successful impact taken by Cwm Taf Health Board to improve prescribing of Non-Steroidal Anti-Inflammatory Drugs and reduce pre-mature cardiovascular events by selecting safer NSAID choices for patients. There are other examples in the last year in Cwm Taf of joint working between Mental Health, Primary Care and Primary Care pharmacists in undertaking wholesale change in prescribing practice with significant cost savings e.g. switching existing patients for long acting Venlafaxine (an antidepressant) to a much cheaper short acting form and guidance on Gabapentin dosage avoiding high cost dosage combinations. The pharmacy department of Cwm Taf Health Board have also developed guidelines on for the Pharmacological Treatment of Chronic Non-malignant Pain to influence the practice of healthcare professionals.

The launch of ‘Valleys Steps’ provides an ideal and necessary opportunity to collectively improve antidepressant prescribing in Cwm Taf.

3.2 Bibliotherapy

NICE emphasis the value of educational resources to help patients understand their condition and treatment options. Traditionally this type of information was used to supplement practitioner information and aid discussion of consent and compliance with the treatment option. However, the medical model of action is increasingly being challenged by a model of health coproduction between the professional and service-user. As decision-making becomes seen as at least a shared process, access to information for service-users has become a priority.

Bibliotherapy is a widely acclaimed alternative way of making psychotherapy available to people with mild to moderate health problems. The first Books on Prescription Scheme was set up in Cardiff, based on the work of psychologist Dr Neil Frude. Individual books are prescribed by GPs or mental health practitioner and the prescription is filled in the library. According to Frude (2004), Bibliotherapy has the following advantages over medication:

- Higher patient acceptability
- More immediate effects than some medication
- No rebound effect at the end of treatment
• Tendency to continued improvement over time
• Lower relapse rates
• No appreciable adverse side effects / reaction with medication
• No danger of overdose.

Bibliotherapy is sustainable because all the stakeholders are committed to making it work. It works because:

• It is acknowledged as a clinically effective treatment for mental health conditions, which has adds value, is cost effective, and can demonstrate health benefits

• It is a treatment, with clinicians controlling the treatment and libraries acting as an intermediary to deliver the books, rather than ‘self-management’, with libraries providing advice and guidance to the client selecting the materials.

• Because it is clinically effective GPs and medical practitioners are committed to using libraries to help achieve the required outcomes

• There is an accredited list of books, which does not require library staff to have the medical skills or clinical judgement needed to consistently be able to select appropriate materials

NICE has recommended Bibliotherapy as a first line treatment option for bulimia since 2004 and guidelines have been produced for anxiety disorders. NICE concluded that high quality CBT-based bibliography is often effective for the treatment of generalised anxiety disorder and mild and moderate depression. These type of materials provide techniques that need to be actively adopted by the user. A trained practitioner therefore reviews progress via a face-to-face intervention or a short telephone call. These interventions might also be possible to be delivered via e-mail, text or larger group meeting. Possible barriers might include poor literacy rates and reliance on accessibility a physical library network which may be difficult to maintain in an era of severe cuts to public funding.

3.3 Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is a mainstream psychotherapeutic technique that draws on cognitive and behavioural concepts. The role of the therapist is directive and aim of the process to teach techniques that will correct current negative patterns of thought, emotion and behaviour. Cognitive skills are developed through techniques such as rehearsal and exposure. The therapy is goal orientated and to succeed the patient must be an active participant.

There is a well-established evidence base demonstrating the beneficial impact of CBT in the treatment of anxiety and depression. NICE are clear in their recommendation of CBT for both these conditions citing results in randomised control trials of 50% of individuals
experiencing clinical significant improvement in depression, a rate comparable to that of patients on antidepressants.

However in its original one-to-one practitioner to patient delivered model CBT is expensive in its use of trained staff time. For example, NICE recommends 6-8 individual sessions of CBT over 10 to 12 weeks for mild to moderate depression. For moderate to severe depression, up to 20 sessions over 9 months are recommended. For anxiety the optimal range of duration of CBT is between 7 and 14 hours.

3.4 Computerised Cognitive Behavioural Therapy

An evidenced-based method of disseminating CBT techniques to much wider groups is the use of computerised CBT or CCBT. CCBT packages are delivered via CD-ROM for use by the patient at home or alternatively on computers set up for this purpose (perhaps in clinical setting such as a GP surgery or group setting) and are designed to be accessed over the Internet. Practitioner support might include telephone, e-mail or face-to-face contact.

NICE Technological Appraisal 51 (2013) recommends this method of delivering CBT for mild to moderate depression and anxiety and persistent sub-threshold symptoms as an equally effective alternative to the traditional face to face model. It notes however that different commercially available products may vary in content and quality and also in the cost of the license per-user. Hammond et al (2013) compare over the telephone methods of delivery to face to face and found them equally beneficial in terms of outcomes for mild and moderate conditions.

Costs would also vary depending on the ability of the Health Board to develop an in-house model to suit local need. Computer developed materials if designed with animation, audio and graphics may require a lower level of literacy and focused attention span (as they can be ‘paused’) than a more traditional teaching approach of talk and written accompanying hand-outs. Alongside access to an interactive or reflective teaching module it is certainly worth considering the materials that could be made available via a website or mobile phone app.

It may be feared that such as delivery method would be likely to fail, as access to the Internet, personal computers or digital literacy could be lacking in the target population. The 2011 Welsh Government report on Digital Inclusion showed that Rhondda Cynon Taf and Merthyr Tydfil are amongst the four lowest local authorities for digital access, but 61% and 58% of the population respectively do use the internet regularly; this could be a cost-effective tool.
3.5 Mindfulness

Mindfulness as a therapeutic technique is derived from a meditative discipline of Buddhism which seeks to bring awareness to the present moment without judgement. In therapy the skills taught are to recognise current and habitual patterns of thought and emotion without judgement leading to the ability to create new ways of dealing with situations. Mindfulness-based stress reduction (MBSR) is a structured group program designed to alleviate suffering associated with physical, psychosomatic and psychiatric disorders. The program seeks to develop awareness of moment-to-moment experience of perceptible mental processes. People enrolled in a MBSR program practice various meditation techniques, including those focussed on breathing and body awareness. Studies such as Grossman et al (2004) have shown benefits in helping people cope. A useful overview of recent evidence can be found in Lang (2013). NICE guidance specifically refers to mindfulness based cognitive therapy as effective in the treatment of depression.

3.6 High Volume Low Intensity Courses

In the introduction to this report the increased emphasis of mental health services on the reduction of the risk of mental illness, promoting resilience and management of mental health and wellbeing was discussed. This has led to health services promoting a plethora of shorter courses, often designed for a larger group audience, sometimes based on the principles on mindfulness and CBT and aimed at the Tier 0 population. This ‘Tier 0’ population, as discussed in the earlier section, would cover both people who might not define themselves as ‘depressed’ or ‘mentally unwell’ but might be prepared to seek or benefit from advice delivered in non-medicalised language and also those who be described as having sub-threshold symptoms of common mental ailments (the two groups overlap but are not necessarily identical).
These short courses are targeted at popular understanding of mental wellbeing. Anger management and stress control are the most prevalent. Clinical effectiveness is difficult to evaluate because long-term self-assessments of the outcome are highly unlikely to be obtainable, although some measures of benefit might be secured through WEMWBS.

Assessments of anger-management courses based on mindfulness principles (Wright 2009) and CBT (Naemer 2010 and Bradbury 2007) have been done and individual stress control programmes based on mindfulness and CBT been undertaken and found to be effective, e.g. van Son (2013) who looked at the impact on diabetes patients and Lynch (2011) who examined university students. It is recommended therefore that the development of courses should specifically follow a theoretical base of mindfulness or CBT.

3.7 Social Activity

The link between social isolation and an increased risk of mental illness and conversely the role of active social networks in promoting resilience and wellbeing is well established. ‘Access to play, sports and friends; social, cultural or spiritual needs’ is one of the ‘8 Areas of Life’ used in Care and Treatment Planning.

Social activity as ‘prescribed’ by a mental health service could be structured around a group or condition (e.g. young mothers, diabetes), befriending (by trained volunteers), activity based (dancing, singing, creative writing etc), or volunteering. NICE specifically recommend self-help groups and befriending as services for common mental health disorders.

NICE also emphasise the significance of social activity for older people’s wellbeing. Social activities, ‘getting out and about’ and family contact are among the factors most frequently mentioned by older people as important to their mental wellbeing (Audit Commission 2004).

Howlett (2004) examined the benefits of volunteering in relation to mental health. It showed that wellbeing in the over-65s improved with volunteering. This finding was echoed in Age Concern in 2010. An Institute of Volunteering Research Report in 2003 found that volunteers with mental health conditions reported improvements in their wellbeing. This finding was also demonstrated by a 2008 Community Service Volunteers Report.
Figure 13: Examples of Evidenced Based Social interventions

Reading
The Readers Association (University of Liverpool) have introduced Reading Aloud groups in Libraries. A year-long study in 2011 concluded that shared reading groups helped patients suffering from depression in terms of their social, mental, emotional and psychological well-being. It also identified factors conducive to success. Monmouthshire County Council piloted a programme in 2011-12 in public libraries and residential homes with the befriending service.

Arts
In 2004 the Arts Council for England published a comprehensive review of medical literature demonstrating the evidence of the beneficial impact of art. In Cwm Taf MIND and New Horizons can both point to the value of the work they have done to support people with a mental health problem through arts and complementary therapies (e.g. music, drama and art therapy at www.mind.org/uk).

Singing
Tenovus Sing for Life Choir and the Alzheimer’s Society Singing for the Brain are examples of interventions for people to address mental health problems. There is anecdotal evidence of singing’s therapeutic benefits. Tenovus recently secured £1m to roll-out the project across Wales, based on Cardiff University’s evaluation of a pilot in 2009. The study showed that over a 3 month period the choir brought about statistically significant improvements in social function, mental health and even a reduction in perceived pain in the choristers. It also reduced depression and anxiety in those that reported suffering from these conditions prior to taking part in the choir.

3.8 Physical Wellbeing: Exercise

The presence of chronic conditions and illness and their associated conditions of pain, social adjustment and disability will impact on mental wellbeing. NICE Clinical Guidance 91: Depression in adults with a chronic physical health problem (2009) ‘chronic physical health problems can greatly increase the risk of depression in people with physical illness, and depression can also exacerbate the pain and distress associated with physical illnesses and adversely affect outcomes, including shortening life expectancy. Furthermore, depression can be a risk factor in the development of a range of physical illnesses, such as cardiovascular disease.’
Antidepressants are not recommended as a routine treatment of sub-threshold depressive symptoms or mild depression in patients with a chronic physical health problem. Instead structured group physical activity and group-based peer support are suggested. Physical activity and exercise can assist in sleep management or in boosting feelings of individual empowerment. It can be a useful displacement activity as strategy for constructively responding to stress, anger etc.

It is important to distinguish exercise as improvement to wellbeing for which there is a great deal of evidence e.g. NICE (2008) Public Health Guidance 16: Mental wellbeing and older people and exercise as a treatment for mental health disorders even at mild or sub-threshold symptom level for which there is a great deal less evidence of benefit (see for example Cooney et al 2013).

It is also worth considering linking exercise into mindfulness and CBT based courses, courses around cooking, healthy eating, smoking cessation and exercise. This smorgasbord of healthy living support is a useful means of minimising any perceived stigma or assumptions about ‘mental health’. Good examples of interactive support can be seen on the Live Well pages on NHS Choices.

3.9 Alcohol Misuse

Alcohol misuse has a close relationship with the common mental health disorders of anxiety and depression. Alcohol misuse may be an attempt to self-medicate and may exacerbate the condition and in addition heavy alcohol misuse causes the development of mental health disorders. NICE Clinical Guidance 115: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence recommends that in cases of mild dependency, where medical assistance with cessation is not thought required, that specific alcohol misuse courses based on principles of CBT and self-help are deployed.

It also recommended that alcohol misuse is tackled first as co-morbid mental health disorders may also cease within a month of alcohol cessation. However if the symptoms of depression etc continue without the presence of alcohol then the care pathway for these may be applied. Thus we can see that any model of service based on self-referral and signposting to a selection of CBT/mindfulness based course should usefully include one targeted at mild alcohol misuse/dependency and that in addition awareness and identification of alcohol misuse (as oppose to appropriate alcohol use see for example Bellos 2013) as a factor is necessary to those delivering the more general courses.
3.10 Equality Considerations

**Gender issues**
Women are more likely to have been treated for a mental health problem than men 29% compared to 17% (Better or Worse: A Longitudinal Study of the Mental Health of Adults in Great Britain, National Statistics, 2003). Depression is more common in women than men. 1 in 4 women will require treatment for depression at some time, compared to 1 in 10 men. Women are also twice as likely to experience anxiety as men and may also experience post natal depression. Men however are far more likely than women to commit suicide and misuse substances and they form most of the veterans with mental health problems.

**BME issues**
The BME communities in Rhondda Cynon Taf and Merthyr Tydfil are 2.6% and 2.4% of the local authority populations respectively. Using the 13% figure of people in Cwm Taf receiving mental health treatment as a guide this would indicate a BME population in need of such services as 960 persons.

**Older people**
Despite the lower numbers of people over 65 (18% of the local authority population) it is of course important to consider that older people may be more vulnerable to depression and anxiety as a result of factor such as social isolation, poverty etc. The UK Inquiry into Mental Health and Well-being in Later Life in 2006 found that 40% of older people attending GP surgeries, and 60% of those living in residential institutions were reported to have 'poor mental health'.

**Welsh and language issues**
The Welsh Speaking population of Rhondda Cynon Taf and Merthyr Tydfil is 12% and 9% of the local authority populations respectively. Using the 13% figure of people in Cwm Taf receiving mental health treatment as a guide this would indicate a Welsh Speaking population in need of such services as 4265 persons. More than just Words, the strategic framework for the development of health and social care services in the Welsh Language (Welsh Government 2012) demonstrates that services not delivered in Welsh formed a barrier to service users and undermined their effectiveness. NICE guidance is also recommends that therapies and accompanying materials are delivered in the language of need, particularly where there are significant communities.
3.11 Findings & Conclusions

- There are a range of interventions that have been shown to improve prescribing quality. These include software support systems, education, clear guidance and awareness-raising.

- The best available evidence currently indicates that CBT and mindfulness are the two most effective approaches underlying high volume low intensity courses aimed at improving wellbeing or supporting people with mild and clinically sub-threshold anxiety and depression.

- Bibliotherapy is a well evidenced effective intervention

- Computerised CBT is a useful approach to consider

- Activities that promote social interaction and physical health improve feelings of wellbeing.

- It is important to monitor and improve accessibility to services through an equality framework. Age, gender and language are significant factors.
Chapter Four – Examining alternative models of delivery

In this chapter we examine models of delivery in England and Scotland. Our evidence is based on secondary sources of IAPT projects in England, on a workshop with and subsequent cross examination of Dr Jim White from Glasgow STEPS, and on community consultation workshops held in Cwm Taf in Autumn 2013.

4.1 Learning from the IAPT experience in England

Improving Access to Psychological Therapies (IAPT) is the name of a nation-wide programme coordinating the delivery of mental health services across England within a national framework. The programme has been operating since 2007 and the first three years have recently been evaluated.

The IAPT model arose out of a desire to ensure the NHS in England was able to put into operation the recommendations of best evidenced based practice in treating common mental health conditions, and to create better access and referral arrangements via GPs.

The IAPT service is designed to meet the needs of those with moderate and severe mental health conditions who might benefit from talking therapies as well as those with milder conditions. It was originally envisaged as a predominantly high-intensity service with 1:1 therapy with referrals from the GP. The IAPT service used additional funding to ensure that sufficient therapists (drawn from professions such as clinical psychology and nursing) were trained and available to deliver high and low intensity interventions. In practice, many local mental health services operating under the national ‘umbrella’ of IAPT have developed educational programmes and self-referral as a main form of access.

Of particular interest to Cwm Taf may be the role of the Psychological Wellbeing Practitioner (IAPT: 2012) developed to specifically deliver low intensity but high volume interventions and provide face-to-face, computerised and telephone support etc. These roles are Band 4 to 6 on the Agenda for Change scale.

The programme is seeking to ensure that the 15% of the adult population who have a diagnosable condition of clinical depression, anxiety disorder or similar condition will have access to IAPT services by 2015. The three year report on IAPT (Department of Health: 2012) states that: ‘this is based on the assumption that in any given population, of 100 people with depression and/or anxiety, only 50 will seek treatment; of those, only 25 will be diagnosed and equally distributed between anxiety and depression; and of those, 80% with anxiety and 68% with depression, or around 18 patients, will opt for psychological therapy. The figure of 15% therefore allows for a degree of local variation in performance and patient preference.” (Department of Health: 2012, p.12)
By 2012 9.7% of this population were accessing these services. However, meeting the target through “dramatically increased referrals” meant that “significant waiting lists have built up in a number of areas as the limited number of service providers struggle to keep pace with demand” (Department of Health: 2012: p.1).

NICE guidance that a course of between 6 and 12 sessions is recommended for the best outcomes. The KPI for completion of treatment was 66%. Although reached in 2001, 2012 figures show a completion rate of 60%. Recovery rates, defined as moving from ‘caseness’, (when the outcome score exceeds the accepted threshold for a standardised measure of symptoms) for 2011/12 are 45.6%.

A national programme of data collection and analysis has provided invaluable high quality data (also available at a local level) on access rates, completion rates, and clinical outcomes for the individuals receiving treatment alongside detailed information on organisational costs (materials, training, payroll etc.). This information programme in itself provides significant learning points on how delivery and commissioning organisations should agree at the outset the need for easily accessible performance data on both activity and outcome and how benefit and cost will be assessed. Outcome data also allows for clinical oversight of the delivery programme.

IAPT was created as a programme that would at minimum save the same amount of money invested in it and indeed would recoup financial investment.

The Depression Report produced by the Centre for Economic Performance’s Mental Health Policy Group (2006) was an influential article in the formation of IAPT. The simple argument was that the cost of therapy for one individual could be estimated at £750. Using the evidence provided by NICE of a 50% success rate for CBT, and an assumption that people receiving the treatment were not currently in work but would return to work after a successful treatment, the report estimated that 12 months free of depression would result in 2 extra months of work. One month of incapacity benefit and lost tax receipts cost £750. Two months of extra work meant the treatment paid for itself.

In 2008 The King’s Fund published a paper on the economic costs of mental health, Paying the Price which broadly agreed with the modelling above. It argued that treating the currently untreated population with anxiety and depression would increase service costs but make bring economic benefits with employment.

In 2011 the Department of Health prepared for the continued expansion of talking therapies. The Impact Assessment (Department of Health 2011) illustrates the financial assumptions, potential costs and likely benefits.

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3 For example cited as such in IAPT three-year report (Department of Health 2012)
It lays out the evidence for a direct benefit on the NHS from a reduced burden of service use. This does not distinguish between mild and moderate anxiety/depression:

**Figure 14: Impact on Healthcare services according to 2011 Department of health Impact Assessment**

<table>
<thead>
<tr>
<th></th>
<th>Reductions in healthcare usage per person</th>
<th>National average unit cost</th>
<th>Annual savings per recoverer</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP consultations</td>
<td>1.59</td>
<td>£38</td>
<td>£60</td>
</tr>
<tr>
<td>Inpatient bed nights</td>
<td>0.36</td>
<td>£533</td>
<td>£387</td>
</tr>
<tr>
<td>Outpatient procedures</td>
<td>0.73</td>
<td>£200</td>
<td>£72</td>
</tr>
</tbody>
</table>

**Saving per person completing treatment = £519** [total saving as shown in table above] x 2 [over years] x (48% - 18%)[average recovery rate from IAPT CBT course – natural recovery rate] = £311

It also estimates **Savings per person treated for mild anxiety/depression = £12,935** [Exchequer savings from benefits/tax] x 2 [extra working months gained] x (48% - 18%) [average recovery rate from IAPT CBT course – natural recovery rate] x 4.3% [expected employment rate] = £334

This demonstrates the importance of savings outside the NHS. It is significant that neither the Kings Fund’s report nor the Department of Health assumes a reduction in inappropriate antidepressant prescribing as a likely financial saving (because the IAPT programme is concerned with treatment for people with moderate to severe mental health conditions for whom antidepressant prescription (potentially combined with a talking therapy) would be an appropriate treatment).

However, some local areas within the IAPT programme have assessed the impact on medication e.g. a 2010 evaluation of the service in Poole (Corporate Research Team, Borough of Poole: 2010) showed that 52% (462 people) of those at the first session were on antidepressant medication and of those that completed treatment 26% (i.e. 96 people) were no longer on an antidepressant prescription. This needs further study.

**Figure 15: Learning from IAPT**

- Although it was targeted at ‘Tier 1’, it became drawn into providing interventions to people with milder conditions
- It recognised that high-intensity services were not appropriate for the wider population
- It demonstrated that savings should be assessed holistically, in terms of getting people back to work, enjoying a better quality of life, and reducing the burden on health services.
4.2 2gether NHS Foundation Gloucestershire

This model provides an example of what can be achieved through the greater flexibility of a NHS Foundation Trust. All the information here has been drawn from its website http://www.talk2gether.nhs.uk

2gether NHS Foundation Trust provides mental and social health care services to Gloucestershire and Herefordshire, a combined population of 761,000 people. As a NHS Foundation Trust, it is part of the NHS and treats NHS patients according to NHS principles and standards, but is run locally by a board of trustees. This helps to ensure local ownership, accountability and control. The trust is able to develop services in a way that best suits the needs of the local community. It has more flexibility of funding, greater freedom to set up new types of partnership, and opportunities to work innovatively. The Trust currently has 14 members, drawn from all walks of life, and geographical representation is assured by recruitment through the participating district councils. The public is encouraged to take up free membership and to volunteer.

*Making Life Better* provides integrated mental and social health care within the community. Services include: assertive outreach, hospital liaison, primary mental health service, recovery, one stop team, psychiatric liaison, and learning disability. Provision for children and young people, eating disorders, dementia, psychoses, and self-harm is integrated within this service. It has a well-designed website, created by a local company, which provides an easily navigable route to online information and signposts to conditions and services.

One of its strands is “*Let’s Talk – Improving Access to Psychological Therapy*” (an IAPT service) which provides

1. **Information and guidance** on: gaining control, wellbeing, work and wellbeing, books on prescription, anxiety and depression checks.

2. **Access to courses** on:
   - Mindfulness Based Stress Reduction (MBSR)
   - Mindfulness-based Cognitive Therapy (MBCT)
   - Let’s Talk Emotional Wellbeing
   - Let’s Talk Low Mood
   - Let’s Talk Panic (see below)
   - Let’s Talk Low Self Esteem
   - Let’s Talk Stress and Anxiety
   - Let’s Talk Anger
   - Let’s Talk Sleep
The target audience for 2gether services is different (this is a more affluent part of the UK, with a greater tradition of self-help) and the geography is different (predominantly rural and based on market towns). Nevertheless, it is clear from website that the service is well used (e.g. some of courses advertised for two months ahead were nearly full). Courses are available throughout all the (eight) main towns in the area. Below is an example of one of the course advertisements:

**Figure 17: Course advertisement for Mindfulness Based Stress Reduction**

**Mindfulness Based Stress Reduction (MBSR)**

Mindfulness-based Stress Reduction (MBSR) is a group-based programme for people with a wide range of physical and mental health problems. The evidence base for MBSR shows significant positive effects for participants with long-term medical conditions, stress and anxiety. The programme is taught in 8 weekly sessions and involves intensive training in mindfulness meditation together with discussion on stress and life skills. Participants are given CDs and are asked to practice the meditations daily whilst carrying out informal practice in their day to day activities. Mindfulness can help us to work directly with our distress and this can improve the quality of our life.

After registering your interest we will contact you for a discussion to see if this course is the best course to suit your needs. Your place will not be confirmed until we have spoken to you.

This is a psychological / educational course run within a group setting. Group sizes are usually between 5 and 20. There will be some group discussions, however, it is up to you how much or how little you choose to say in front of the group. It is structured as a 8 week course with sessions of 2 hours. We offer a variety of day and evening opportunities to attend across the county involves meditation practice within the session and at home. We offer a variety of day and evening opportunities to attend cross the county.

Number of spaces available:  

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**Reading Well Books on Prescription** scheme is a national reading list for England delivered by The Reading Agency and the Society of Chief Librarians with funding from Arts Council England [www.readingagency.org.uk/readingwell](http://www.readingagency.org.uk/readingwell). The scheme helps people to manage their own health and well-being through recommended self-help books. Books on the list have been carefully selected and are designed to cover a range of mild to moderate mental health problems including stress, anxiety, anger, phobias and depression amongst others. Books can be borrowed on prescription or directly accessed through the library.
4.3 Sandwell: A Primary Care approach to Mental Health and Wellbeing

Sandwell and West Birmingham Clinical Commissioning Group is a membership organisation involving 110 GP practices serving around 530,000 patients. The area has a diverse, rapidly changing population that was historically from an industrial background, but has more recently seen the growth of ethnic minority groups. This case study describes the approach taken by Sandwell PCT (now Sandwell and West Birmingham Clinical Commissioning Group) in response to specific inequalities in health. It has been selected because of its collaborative approach at a primary care level and its measurable success in drawing people into its Tier 0-1 services. All the material in this section has been collected through the NHS Confederation (2012) Case Study Report: A Primary Care Approach to Mental Health and Wellbeing Julie Das.

Sandwell is the 14th most deprived local authority in England, with high unemployment/low economic activity rates, poor housing, and a large BME population. As well as socio-economic deprivation, there are poor levels of mental and physical health, poor access to low intensity community mental health and wellbeing services and heavy use of secondary mental health services.

In 2006, Sandwell PCT undertook a mental health profiling assessment. This showed that mental health problems existed predominantly in wards with high deprivation. It focussed on these areas and mapped its community services – (e.g. local libraries and children and family services), reviewed its workforce capacity, introduced a new clinical outcome measure (Clinical Outcomes in Routine Evaluation Information Management System – COREIMS), and adopted a starfish networking system with potential partners to develop a strategic vision.

The collaborative care model that was developed works on the principles of co-location, integration and collaboration. It upholds strong values around co-production – pragmatism, listening and responding to feedback from patients, clinicians, professionals, and a search for continuous improvement. This approach is underpinned by having two steering groups:

- **A primary care mental health clinical steering group**: to lead the development and implementation of the model; this has representation from clinician and local authority interests e.g. GPs, primary care, public health, drug and alcohol services, pharmacy, adult and children’s mental health

- **Unique People** – service user group with 12 core members of voluntary and other organisations who have a specialist knowledge about services and the needs of wider service users; they are involved in educating GPs about service user perspectives, lobby for patients’ rights locally, and provide the ‘human face’ of the service
Patients are managed in a primary care setting (which reduces stigma and improves adherence to treatment). Services are integrated (to include acute, primary and secondary healthcare, well-being and social care services) and there is collaboration through gateway workers. Steps have been taken to address the needs of people who traditionally have fallen through the net: the LGBT population, those with hearing disability, young people (under 16s), carers and South Asian population.

Sandwell has created a Hub, a single referral point, through which a wellbeing co-ordinator acts as a gateway and takes on responsibility for low-intensity referrals, ensuring that there is follow-up and no one gets lost.

There are 4 distinct levels of service starting with Tier 0 to 1, which provides a Confidence and Wellbeing service based on prevention and self-help. This tier is open to all, but is targeted for those identified by the needs analysis. It provides low-level interventions through programmes and courses that cope with conditions including mild depression, obesity, and anxiety: these courses are provided by Sandwell Mind, the Accord Housing Group, Murray Hall Community Trust and Black Country Housing Group. The service has core staffing including five self-help coaches, two community development workers, and a management lead. The aim of Step 0-1 is: “to support people to become less reliant on NHS services, to lift the mood of the population, to empower residents to seek support, have choice, and help themselves, and to respond to low-level issues before they go to primary care”

Low intensity therapy services include:
- Counselling (bereavement, confidence and relationship difficulties)
- Fit for work (dealing with return for work or stress at work)
- Listening and guidance (through chaplains for wellbeing)
- Trauma / post-traumatic stress disorder, emotional distress and depression
- Cognitive behavioural therapy and talking therapies
- An esteem team for complex needs and maternal mental health.

Early outcomes are promising. Between February 2011 and July 2012 over 4,000 people had completed prevention, wellbeing and health improvement programmes (which Commissioners estimate equates to a saving of £800,000 in prevention costs) and 3,000 have accessed talking therapies (which on the same basis suggests a saving of around £600,000). In terms of outcomes, initial results suggest reduction in lengths of stay and hospital stays, as well as wider social benefits. Sandwell uses the WEMWBS measures (see Appendix 3) to demonstrate outcomes from courses.
Figure 18: Sandwell Course Outcomes using WEMWBS Measures

Figure 19: Learning from Sandwell

- The importance of basing the model on a needs assessment, mapping community services and workforce capacity and developing a network of stakeholders (including local authorities) to develop a strategic vision
- Having effective partnership arrangements, including governance structures which allow for non-clinical input through a third sector committee
- The clearly defined vision for Step 0-1 provision, with a package of services with its own support team
- Working with and commissioning of services to partners (e.g. housing, community trust, and voluntary sector)
- Outcome measures using WEMWBS, which is simple to use and a clear focus on identifying savings to Tier 2 and above

4.4 Glasgow STEPS

The Steering Group was particularly interested in the Glasgow STEPS model. This description is based on a presentation (September 2013) from and subsequent correspondence with Dr Jim White, who developed this model and contextual material drawn from Scotland’s Wellbeing (mental health) website [www.wellscotland.info].

**Background**

STEPS was established in 2005 in South East Glasgow, a hugely deprived, densely populated area of 130,000 people of which 11% are Pakistani Muslim. Within the community are high levels of stress, anxiety and depression caused by lack of work, social connections, hope and
‘life-style issues’ (e.g. lack of exercise, stimulation, poor diet). STEPS has seen 17% of the adult population. Its clients’ average age is 34 years.

STEPS was established to do ‘something’ about the huge hidden social, economic, health and personal costs of poor mental health and wellbeing:

- People with ‘sub-clinical’ and clinical mental health problems are more likely to die from Cardio Vascular Disease (CVD) or cancers;
- Young people experiencing MH problems are disadvantaged by this throughout their lives; some 49% adult mental health problems develop before the age of 14 years and 74% by the age of 21 years;
- Intervention to prevent suicides is often non-existent or too late.

**Model**

The STEPS concept addresses mental health and well-being ‘in the round’ looking at the wider dimensions of people’s lives. For many people the ‘grim reality of daily living’ is the problem; they may be just unhappy or unable to manage their current situation, rather than suffer from a mental health issue. There is a confusion between good and poor well-being and good and poor mental health: people with serious mental health issues may still experience high wellbeing; whilst people may have poor wellbeing without having a mental illness.

Historically, mental health services have emphasised depression and not on anxiety, insomnia or other related symptoms of deprivation and poverty. In most deprived communities, a typical MH patient is demoralised, demotivated and co-morbid not psychologically ill, but having a label of poor mental health can justify sickness benefits, removing incentives to get better.

The model is based on low intensity intervention with universal access. The traditional approach, focussed on 1-1 interventions, which aimed at ‘curing’ people, required significant patient engagement as well as significant professional time. This meant long waiting lists, a rationing of services and lack of reach. It carried with it a stigma, which resulted in around 50% of the population (especially working age men) not going to their GP to get help.

The STEPS approach It focuses on people’s strengths, wellbeing and recovery and on their being able to self-manage their circumstances in a sustainable way. It relies on a social model of mental health. It seeks to provide open access to a choice of therapies for people and thereby de-clutter the blockages at the points of entry to the service; to engage and inform people in user-friendly ways; to respond rather than simply reacting to people’s needs; and to deliver a non-stigmatised, social model of intervention through community engagement, awareness raising, and education and developing personal motivation.
**Access to services**

Significant energy has gone into making STEPS inclusive and easy to access, raising, working with other groups and organisations, and access through word of mouth and self-referrals; a travelling road show which includes use of DVDs with stand-up comics giving a humorous insight to the way people can feel; information stalls at local shopping centres, betting shops or on beer mats in pubs; and a website which signposts services offered. Participants can self-refer and access the service via advice centres or by phone / e-mail with rapid callback (within 8 hours) and online booking for courses.

A dedicated team\(^4\) focus on stress control and other stress-busting activities, rather than addressing ‘depression’. Service users can select from a menu of therapies; classes (e.g. classes on baby blues, anger management, first steps, step into shape and workshops on self-esteem); and social activities (e.g. healthy reading, singing, walking, debt management; housing advice; help with literacy). 1:1 assessments are available if wanted, but only one third take this up;

**Figure 20: Example of Stress Control Sessions**

**Stress control:** typically provided through six sessions of CBT in a community venue, with 1 teacher, and easily understood booklets. Around 30-50 people attend sessions during the day and 80-140 attend evening sessions. There is no attendance list and no assessments except once a year, for evaluation. It is well attended, especially by men and results are good for the ‘usual suspects’. There remain concerns about reaching the hard to reach.

STEPS is delivered in community settings throughout the catchment areas and services are tailored to local needs. New initiatives include a Life Gym project - a Wellness Recovery Action Plan – has involved developing life skills, which is being delivered by the Glasgow Association of Mental Health within the ‘Jeely Piece Club’, with sponsorship and support from the Celtic Football Club. The programme is built on a 5 a day (Five Ways to Well-being) approach. The project has been successful in bringing in the business sector, e.g. Celtic Football Club, to fund specific initiatives.

Glasgow STEPS costs £450,000 p.a. Health managers continue to fund the project because it is effective and GPs rate the service highly. The role and behaviour of GPs is critical to the success of the STEPs approach – both in terms of their willingness to refer to good, rapidly accessed alternatives and decisions not to prescribe. Although, STEPS had only anecdotal evidence of providing an alternative to anti-depressant prescribing, a massive **89% of GPs**

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\(^4\) Team includes: 2 clinical psychologists; 1.8 CBT therapists; 0.6 MH practitioner (counsellor); 1 assistant psychologist; 1.5 admin; 1 peer supporter; 1 exercise trainer
questioned said they were able to withdraw or not initiate anti-depressant medication prescribing because of Stress Control / STEPS.

In terms of partnership working, there are no formal arrangements for working with the third sector, but informally work does take place, e.g. through joint events, provision of materials, training in signposting, etc.

The experience of Glasgow STEPS is that while services have to prove they work in the traditional way (e.g. engagement and participation, numbers completing sessions etc) there are dangers of over-measuring outcomes and impact. Many participants are simply trying to keep their heads above water; decreasing scores on questionnaires may not be an appropriate measure, in a situation where what the service needs to do is to keep clients coming along each week.

**Figure 21: Learning from Glasgow STEPS**

- It recognised the need to target the hard to reach, demoralised, demotivated co-morbid population, using outreach activities and communication methods that met their needs (e.g. easy to read information and word of mouth at pubs). Furthermore, its focus on community engagement, awareness raising, working with other groups and organisations, using a travelling road-show, use of materials and drama, and website / social media have all been effective in reaching people.

- Its ‘brand’, focusing on wellbeing and recovery, has effectively de-stigmatised ‘mental health’ issues and enabled at risk groups who traditionally do not seek help (e.g. the working population and middle aged men)

- It clarified the confusion that widely exists between good and poor well-being and good and poor mental health. The Glasgow STEPS model focuses on people with poor well-being, whether or not they also have an underlying mental illness.

- It recognised the benefits of and barriers to partnership working: (1) the benefits of added capacity, diversity, engagement of service users, creation of new opportunities and innovative solutions; (2) the barriers to joint working include working at different rates, different cultures, ‘baggage and ‘sensitivities’.

- It has shown that it is possible to deliver low intensity interventions (e.g. stress busting and mindfulness) to large groups and thus reduce the number of people who are waiting in limbo

- It recognised the importance of investing in GPs (e.g. in supporting some training, providing information, an easy access service they can refer their patients to, and making them confident in the quality of alternative provision)

- It also has demonstrated the importance of strategic buy in within the Scottish Wellbeing agenda and the need to broaden the agenda from primary care to public health.
4.5 A partnership approach

Using the information from the STEPS and other models, and in discussion with the Steering Group we were able to develop some ‘sought after’ outcomes from introducing a STEPS type model in Cwm Taf. This approach builds on the assumption that the wellbeing agenda is everyone’s responsibility and needs to be adopted by everyone. We used these to start a discussion with the wider stakeholders – statutory partners, Communities First, community and self-help groups, housing organisations and the voluntary sector. We sought to find out through interviews, presentations, workshops and meetings what each of the potential stakeholders perceived should be the vision for STEPS, how it would benefit their own agendas and performance requirements, what they could contribute to making the service both viable and sustainable, and where they thought the risks and concerns might be. We needed to gauge the strength of support from key players as well as understand their capacity. The detailed responses from stakeholders are summarised in Appendix 3.

Figure 22: Possible outcomes from a partnership model

- Lower anti-depressant prescribing – a key driver for this project
- More appropriate visits to GPs – e.g. lower numbers attending GPs with problems of low mood, GPs more able to signpost to self-help or community based solutions
- Shorter waiting times within the LPCMHSS and capacity to target services to those needing them
- More capacity to give those people who need it a ‘good experience’ of treatment and a positive outcome of treatment
- More activity outside the ‘MH service’ leading to reduced stigma and benefits dependency
- More engagement with third sector leading to more community self-help/active citizenship and 3rd sector partnerships and participation at a strategic level
- More engagement with other sectors – e.g. workplaces, Job Centre Plus, libraries and local authorities to reduce mental ill-health as a cause of chronic economic inactivity
- Added resources to allow innovative solutions / more efficient approaches, e.g. stress control classes for large groups of people in anonymous settings
- More flexibility of delivery – e.g. MH team / training orgs to support enhanced, quality assured capacity of practitioners for CBT, stress control and alternative therapies
- Easy access for people with low mood to appropriate and effective services in which they are confident
- Greater levels of self-esteem expressed by individuals
- All solutions must be Quality Assured/Evidence based and it must fit in with the requirements of the Mental Health Measure
- Solutions must find a way of addressing the wider social welfare infrastructure – currently weighed in favour of people being labelled as mentally ill.
The Valleys STEPS concept is about providing appropriate interventions for people who have poor wellbeing, thus enabling GPs, the CMHT and LPCMHSS to better manage their services, with improved outcomes of people who also have mental illness. There is wide recognition by all the stakeholders that this large pool of people are not only the responsibility of the LHB and that provision needs to come from the wider statutory, community, voluntary and business sectors all working together.

These stakeholders provide significant added value which would enhance the value of a Valleys STEPS service and contribute significantly to its viability and sustainability and secure additional buy in and political support. Whilst the contribution of each organisation is not huge, the whole is much greater than the sum of the parts e.g.:

- Communities First can signpost, encourage, support and find local venues
- Public Health can support the strategic underpinning and evidence base
- Health Improvement can support the Five Ways to Wellbeing activities and training
- Job Centre Plus can ensure participation and support journeys into work
- Local Authorities can tailor their priorities to delivering the outcomes for wellbeing outlined in the Single Integrated Plan, provide physical venues and a community infrastructure through libraries, and leisure centres and support community organisations such as OAP and church halls
- The Voluntary sector can provide opportunities for volunteering, engage service users, signpost, and deliver therapeutic activities
- Housing providers can provide targeted support to their tenants, e.g. through debt counselling, sessions with CABx, links with credit unions, and tenants and residents associations
- The business sector can contribute to healthier, less stressful workplaces
- The schools and youth sectors can work with the pre-16 age group.

One of the benefits of working in partnership is to create the sense of a self-standing resource, which gives service users opportunities to help themselves and make choices. Inclusion of a range of organisations can change the culture from a service that ‘does to’ people to provision on a ‘can do’ basis. A key factor in this is providing opportunities for volunteering as a way of improving wellbeing.

To maximise the benefit of the service requires drawing on the resources of a large number of players, none of which has significant spare capacity, and all of which have their own agendas, targets and outcome measures to deliver. This will require resources and skills to ensure a common vision and ethos, common ways of working and a common understanding of outcomes. Partners need to be able to trust each other.

There is widespread recognition of the role that GPs play as gatekeepers to Employment and Support Allowance, to anti-depressants and to Community Mental Health Services and of the need to make STEPS work for GPs and their patients.
Good communications are vital to a successful project. There is a huge amount of work to be done in appropriately branding a non-stigmatised, open access, generic service.

Although the study focused on ‘generic’ needs, the population with poor wellbeing encapsulates a widely varying range of circumstances (e.g. old and young, male and female, victims and offenders, people with learning, sensory, and physical disabilities, minority groups etc.) and once the service is established it needs to reach out to all these groups.

Most aspects of the service operate on a shoestring with annual funding and this makes it difficult for them to contribute flexibly to a new service, without worrying about what will happen to their own identity and sustainability. Most of the existing players recognise that they are competing for scarce resources and that new players may come onto the scene with the demands of a new service.

It is important for a partnership activity to recognise and measure all the added benefits that it can provide in a holistic way. The sought for outcomes of STEPS are not just about lower anti-depressant prescribing or shorter waiting times within the CMHT or even about improving the GP experience. They also include ensuring that people who need help having timely and appropriate support, about providing innovative solutions to help people to help themselves, and having sufficient capacity to provide flexible solutions to improve people’s wellbeing.

Finally, the feedback gave a clear idea of the importance of the wider social, community and economic infrastructure for individual and family wellbeing. It does matter that people have somewhere to go to address their isolation, that they are able to resolve their debt problems, eat healthily and manage their tenancies, and that they can engage and become (physically and mentally active). For as long as there is a vast pool of people who have low aspirations, low expectations, and low opportunities, managing their problems of low mood, anxiety, and distress will remain unaffordable for the LHB. A STEPS type approach is important because it provides an opportunity for vital buy-in from a whole partnership of stakeholders.

4.6 Findings and Conclusions

- The English models in particular have a strong focus on collaboration and have developed a relationship with the community / local authority setting in supporting community outreach and co-location of services. They also have a strong vision, strategic buy in, and governance arrangements which allow for all stakeholders to contribute.

- Successful models have a key point of entry into their services – a telephone helpline and easy to navigate website are essential to bring in the high volume needed to demonstrate the value of the health promotion agenda. Services were clearly explained
and defined, organisations had a robust profile, strong branding, and credibility and community outreach to target hard to reach people.

- All the successful models have a clear understanding of the need for and purpose of Tier 0 services – to support wellbeing, provide low intensity services, promote good health and tackle low-level issues before they become (stigmatised) ‘mental health’ problems.

- There is a strong focus on choice and reliance on self-help in all the models and resources are allocated to make this work (e.g. the information contained in the Glasgow STEPS packs and website; the easy to use Gloucestershire 2gether website; the use of community development workers in Sandwell).

- All the services recognise the pivotal role of the GP, the need to provide support around GPs, and the value of educating GPs about interventions and support that could help their clients and provide an alternative to prescribed medication.

- Services that work well have integrated a broad range of themes, including maternal mental health, bereavement, eating disorders, alcohol and substance misuse, youth and dementia.

- All services recognise the difficulties of identifying and reaching the hard to reach; those that appear to work most effectively use non-health channels to reach these people.

- Mindfulness and talking therapies provide an essential building block of low-intensity support. These are based on the ‘social model’ of mental health which ‘normalises’ rather than ‘pathologises’, is based in a community setting, and aims to remove the stigma of ‘mental health’ through a focus on wellbeing.

- The Five Ways to Wellbeing and WEMWBS scoring of improved wellbeing appear to provide a common thread in terms of measuring impact and outcomes. The aim is not to ‘create a perfect life’ but to create living skills enable people to manage and keep going within the constraints of their circumstances.

We can draw from this some Critical Success Factors for a model for a Tier 0-1 service.
A service based on a needs assessment, mapping of community services and capacity, workforce capacity, and resources available from all stakeholders (i.e. to use what is already available and to strengthen what can be built upon)

A clearly defined vision of what Tier 0 (Step 0-1) is, its purpose, interventions and access to it – and what it will NOT do

A recognition of the pivotal role of GPs in driving forward this service and the need to gain GP confidence and buy in to the service

A recognition that wellbeing is everyone’s responsibility and must be tackled at different levels, from different perspectives, and through joint working

Having appropriate links to the wider political agenda (e.g. through the Single Integrated Plans) to ensure that the importance of and priority for mental health and wellbeing is fully acknowledged in the context of prosperous and sustainable communities

Partnership working supported through governance arrangements

Using commissioning and procurement to buy in services through other sectors (e.g. voluntary, community or housing) as a way of enhancing synergy of provision and ensuring diversity of co-production

Open recruitment of paid staff and volunteers

Common standards, practices, values and protocols (e.g. on clinical governance, data protection, protection of children and vulnerable adults, upholding equalities, dealing with discrimination)

Strong branding, marketing and communications to underpin the focus on individual choice and self-help and remove the stigma of ‘mental’ health and dependency

Resources to target the hard to reach, whilst providing for the broader population

Flexibility in the model to embrace the broad range of issues that can affect wellbeing – maternal health, substance misuse, youth and older people’s health, unemployment, housing, personal finance, inactivity – within a service covering all ages and all groups

Accessibility for clients (addressing psychological, physical, sensory, and locational barriers) with services at appropriate times

An appropriate range of psychological interventions and social activities to support wellbeing (see chapter 3)

Having appropriate outcome measures which are easy to use by all stakeholders and reflect the aims of a Tier 0 service (WEMWBS measure linked to Five Ways to Wellbeing is one option).
Chapter Five – Appraising the Valley Steps Model

In response to the revised brief it was agreed to consider the feasibility of establishing a Valley STEPS model adopting the principles of the Glasgow STEPS service, described in Chapter 4. This model will be appraised in its impact both in service and financial terms comparing it with doing nothing and pursuing the current service plus plan.

5.1 Current Service Plus

Unlike many physical conditions where patients can often take a passive role in their treatment by taking medication, in the case of mental health there is a need for patients to take control by understanding more about their condition, how their mind works and learning the life skills available to take back that control. In Cwm Taf there has been some attempt to introduce a number of psycho educational courses run both by the Health Board and the Third sector to help patients take control.

Since the establishment of the LPMHSS teams in 2012, there has been increasing demand for these courses which has led to the decision to increase their capacity but also importantly making them available at Tier 0 to the general public. From 2014 therefore Mindfulness and a new course on Stress control will be offered to the general public.

The introduction of these new and expanded courses will be a modest step up from the existing service and will test the value of the course particularly in considering the impact on the general public.

Mindfulness – Tier 0
The course is being rewritten to cater for larger numbers and will start in January 2014, using sports halls or similar venues in each of the four areas. There will be 6 x 1.5 hour weekly sessions, catering for 50-60 people. It is envisaged that 12 courses will be held over the year with 50% held in the evening (i.e. provision for 600-700 places).

Stress Control – Tier 0
Based on Glasgow STEPS, but similar to the CBT First Steps course, this will be held in sports centres and other venues catering for 50 – 60 people. There will be 12 courses of 6 x 1.5 hour weekly sessions, catering for 600 to 700 people over the year.

Additional resources required
The courses will be run by existing staff from the LPMHSS teams and the only extra cost of the course will be hiring the venues and printing of course material. It is expected that the administration will be undertaken by the Third sector. Financially the extra cost would be minimal and will be met by the Health Board. It is not considered that the additional capacity in itself will have any significant bearing on the volume of anti-depressants.
dispensed simply because it will remain part of an under developed, fragmented Tier 0 service.

5.2 Valley STEPS – A new model

Valley STEPS is a new Tier 0 model which seeks to create a comprehensive and integrated service for the people who experience emotional distress that looks to break down social barriers and foster opportunities to access non-pharmacological interventions and provide the means for recovery. However whilst the new model is considered essential in helping to break the current cycle of the growing numbers of Cwm Taf adults being prescribed repeat doses of anti-depressants as their first and only intervention, it is important that the main factors of deprivation and economic disadvantage are tackled at the same time so as to reduce the risk of poor mental health.

Key features

De-stigmatisation and branding

Essential to the success of the model is the branding of Valley STEPS so it becomes part of day to day life thus removing the stigma of shame and guilt that is often associated with mental ill health. In the Glasgow STEPS model these barriers were broken down by portraying many of the conditions such as stress, anger and anxiety in a comic way on DVDs using well known personalities. In Wales the well-known personalities of Rob Brydon, Rod Gilbert, Roy Noble and Boyd Clack would be ideal as their line of comedy and manner would easily fit into the Valley’s culture.

Profile

To raise awareness and the profile of Valley STEPS there will be the need for a standardised logo applied to all promotional literature. This will be used on adverts placed on buses, trains and in local newspapers as well as local radio. Posters and information booklets will be placed in GP surgeries, libraries and other community centres. Taking an idea from Glasgow STEPS the use of specially printed beer mats and leaflets will be placed in pubs and clubs. This will all seek to promote Valley STEPS detailing its purpose and key features amongst the general public.

Access to Information

The Valley STEPS would have its own website detailing the services in an easy to read format with access to printable booklets, DVDs, self-help literature and through social media access viral films and messages and stories that can help change behaviour. The website would provide up to date detail on courses, events, news items and drop in services covering all
the partners who provide such services. Also key telephone / email contacts in each area that can provide advice and support when needed.

**Community Investment Company – CIC**

The Valley STEPS will be established as a Community Investment Company limited by guarantee. This will enable access to funds in the form of the Social Bond, the details of which are provided in Chapter 6. This will provide the necessary start-up funds to establish the model and begin harnessing the strength of the existing partners and their relevant services. As a CIC it will also have the opportunity to attract other funds from a variety of sources that will allow it to grow in the direction chosen by its governing body. This includes access to grants; potentially deriving income from activities and obtaining donated income from corporate business partners and the general public with the added benefit of gift aid.

**Main services**

Valley STEPS will create an integrated model providing a comprehensive service at Tier 0 for people who need help to cope with emotional distress. It is not designed to manage patients who have potentially mental ill health conditions that require medical interventions at Tier 1 and Tier 2 levels. The model brings together the key strands of the different service sectors that can provide an effective range of Bio-Psycho-Social interventions as set below. It becomes the ‘one stop shop’ that links the relevant services to offer prompt and simple access for the general public and GPs to refer/signpost their patients.

**Figure 24 Services of Valley Steps Model**

![Services Diagram](#)

**Therapeutic interventions**

The service would deliver a drop in service for a minimum of one day per week in each locality (could move around the valley on alternate weeks) and telephone call back service on at least 4 days of the week.
• **Psycho-education courses**
  Under Valley STEPS the two courses, Mindfulness and Stress Control will be expanded still further to take account of the socio-economic backgrounds, educational preferences and preferred locations and times. They will provide capacity for at least 3,800 places p.a. and will be provided by STEPS with the support of the LPMHSS, for example, providing psychological input for ongoing development of courses and supervision for counsellor/psychotherapists could be provided by the psychologist within this service.

• **Psychological assessments and therapy**
  STEPS will provide a timely telephone information service and a weekly “drop in” service in each locality to receive peer support and professional help.

**Social prescriptions**

Many of the problems that can lead to emotional stress stem from issues associated with unemployment, accommodation and debt. Getting people engaged and actively addressing their problems is an important therapy in itself. The New Economics Foundation’s Five Steps to Well-being (*Connect, Be Active, Take Notice, Keep Learning* and *Give*) provides a basis for social prescribing. It is envisaged that Valleys STEPS will provide the initial contact point, through its website, social media, e-mail or telephone contact and that Valleys STEPS will inform, explain, signpost, and reassure.

There is already a robust programme of social support in Cwm Taf, although there are concerns that there is not enough up-to-date information about what is available and where at the places where people go to and when they need the help. Valleys STEPS, as the first port of call for people with emotional distress, is ideally placed to improve matters. Here are some examples of who they might refer to:

- LHB runs an Education for Patients Programme which gives participants the opportunity to address their needs through peer support.
- Communities First has a remit to support healthier, more prosperous, learning communities and can signpost local residents to local activities and local support.
- Providers of social housing will do what they can to maintain tenancies and a number of them are engaged in projects to support their tenants and, as well as advice and mentoring projects, they offer gardening, walking and exercise activities.
- Job Centre Plus will advise its clients on how to access job related training and employment opportunities and can support employees of private companies in addressing their mental health as a means of keeping their job.
- Libraries hold Bibliotherapy books for prescribed therapeutic reading and provide a range of activities to support people’s well-being.
- Credit unions have an important role to play in helping households manage their budget and CABx provide debt counselling.
Third Sector services

From the audit undertaken, as part of the study, there are many different interventions provided by a host of Third Sector providers. These provide invaluable help and support for individuals, families and communities throughout Cwm Taf. They depend on financial support from many sources including some who receive core funding directly from the Health Board and/or Local Authorities whilst others obtain financial support from Housing Associations, corporate sponsors and grants.

Not all of the Third sector services would be appropriate for users of Valley STEPS, recognising that many of their services are relevant to people who have an enduring mental health conditions. However there are many services which would be essential in providing suitable and effective interventions for people with emotional distress.

The interventions include:-

- Psycho-educational courses covering stress control, depression busting, mindfulness, CBT and anger management provided by Merthyr and the Valleys Mind, Journeys, TEDS
- Outdoor activities including walking and gardening (allotments) provided by Hafal, Cynon Walking Group, Cyfartha Park greenhouse and volunteer project, Merthyr and the Valleys Mind and Venture Out (Mentro Allan).
- Complementary therapies provided by New Horizons and Merthyr and the Valleys Mind
- Healthy eating, cookery and weightwatchers offered by Venture out and Communities First
- Singing/music therapy by Merthyr and the Valleys Mind and New Horizons.
- Community networks, befriending schemes and peer support are integral activities to most of the Third sector partners.

The key features of the relationship between Valley STEPS and the Third sectors providers are:

- Funding is becoming more difficult in this time of economic hardship and even more creative ways are needed to obtain sufficient funds. Working with the Valley STEPS will provide greater focus and scrutiny and more evidenced support to access funds.
- The Third sector providers depend to a large degree on volunteers, which is both invaluable to the organisation and also often to the volunteers themselves, as it offers a vital source of employment and valued activity, albeit unpaid, for many who themselves have experienced mental ill health. This resource is an important component in Valley STEPS model and hopefully even more volunteers will be encouraged to come forward as a result of its creation.

Management and delivery arrangements

One of most important factors in the success of Valley STEPS is the management and delivery arrangements to be put in place. The creation of the new model that becomes the
focus for Tier 0 services needs to have the right scrutiny and empowerment arrangements to maximise the opportunities and outcomes available for service users and at the same exploit the skills and experiences of its many partners.

There will be a need for a Governing group comprising high level representatives from the key bodies that will set objectives, formalise the strategic and operational plan, engage with the service users, monitor performance and evaluate outcomes. Responsibility for the operational delivery will be undertaken by the Valley STEPS Service Manager who will ensure that Valley STEPS provides high quality and effective services. The Service Manager will be supported by a Business Manager responsible for securing funding, engaging with partners to agree Service Level Agreements on the services to be delivered, auditing activity and outcomes, setting contracts with external agencies and making grants applications.

There is a need for a Communications/information officer who will maintain the website, promote activities, market events, ensure that information about what is available is up to date, create good case studies and perhaps digital stories, support audit and maintain links with partners.

There should be a volunteer co-ordinator who is responsible for recruiting, supporting, training, retaining volunteers. There are grants available for this post (e.g. Volunteering in Wales Fund, but it needs to be sustainable)

Administrative staff needs to be employed to arrange room bookings, deal with correspondence, production of materials and answer telephone.

Professional team comprising 4 FT staff running psycho educational courses – there will be 3 courses running weekly for 6 weeks, 4 times per year (one in the afternoon and one in the evening) in each of the 4 localities. The professional team will also answer the helpline / respond to individual enquiries and attend the “drop in” service.

The service will have a central base to accommodate the main functions together with four drop in centres with access to venues for the educational sessions. There will be a need for materials to support the advertising campaigns and educational courses.

5.3 Potential impact on GPs, LPMHSS, CMHT

To understand the potential impact of Valley STEPS on the existing services, it is important to understand the changing nature of current flows of patients who experience symptoms of emotional distress. A diagrammatic view of the linkages between the community, existing Tier 1 services and the proposed Tier 0 services headed by Valley STEPS is shown below.
Diagram showing the existing flows (→) and those proposed (←→)

**Figure 25:** A diagrammatic view of the linkages between the community, existing Tier 1 services and the proposed Tier 0 services headed by Valley STEPS

- **Community**
- **Valley Steps, Tier 0**
  - Citizens given confidence to self-refer to Valley Steps
  - Partners including third sector Tier 0
- **GP, Tier 1**
- **LPMHSS, Tier 1**
- **CMHT, Tier 2**
- **Medication, Anti-depressants**

- Those who consult their GP

Detailed explanations:
- **Community**
  - Individuals, families and communities to have support to build the capacity to improve health and sustain their wellbeing
- **Valley Steps, Tier 0**
  - GP/LPMHSS Refers or signpost patient Valley Steps
- **GP, Tier 1**
  - Refers or signpost patient Valley Steps
- **LPMHSS, Tier 1**
  - Partners including third sector Tier 0
- **CMHT, Tier 2**
  - Medication, Anti-depressants
Existing flows to Tiers 1 and 2

The triangle represents the community made up of individuals and families who traditionally (shown by solid red arrow lines) have consulted their GP for symptoms of emotional distress, anxiety and stress. The GP would often prescribe medication and/or refer to the newly formed LPMHSS in Tier 1 or the CMHT in Tier 2.

New flows to Tier 0

The introduction of Valley STEPS is aimed at finally changing the dynamic in the current system with a Tier 0 model that can offer with the support of Partners and the Third sector a ‘one stop shop’ which will give confidence to the public to self-refer themselves to Valley STEPS to obtain the necessary help and for GPs and the LPMHSS to refer/signpost patients to potentially avoid the medicalization pathway of their condition.

To understand the potential impact of the Valley STEPS on the existing services it is necessary to understand the existing flows. The Mental Health Measure 2010 required a detailed collection of information about the newly created LPMHSS teams and their activities. The table below summarises the capacity and throughput of the newly established LPMHSS teams in Cwm Taf for the first year up to September 2013.

Figure 26: Key indicators of LPMHSS

<table>
<thead>
<tr>
<th>Key indicators of LPMHSS</th>
<th>12 months to Sept. 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of practitioners as at the end date</td>
<td>29.8 WTE</td>
</tr>
<tr>
<td>No. of referrals</td>
<td>6558</td>
</tr>
<tr>
<td>No. of assessments</td>
<td>5010</td>
</tr>
<tr>
<td>No. of completed therapeutic interventions</td>
<td>1900</td>
</tr>
<tr>
<td>No. signposted to Tier 0 services</td>
<td>1248</td>
</tr>
<tr>
<td>No. referred to secondary care</td>
<td>120</td>
</tr>
<tr>
<td>No. waiting for assessment – up to 28 days</td>
<td>210</td>
</tr>
<tr>
<td>No. waiting for assessment – up to 56 days</td>
<td>93</td>
</tr>
<tr>
<td>No. waiting for assessment – over 56 days</td>
<td>1</td>
</tr>
</tbody>
</table>

It shows that significant numbers of patients, over 6000 per annum are referred by the GP to the LPMHSS, the majority of which would be experiencing emotional distress. It is considered from discussions with Health Board staff that another 3000 patients would have been seen by the GP and not referred. Of the 9000 patients seen by the GP, it has been assessed (see financial evaluation in section 5.5.3) that some 6000 patients would have received new prescriptions for anti-depressants. Following referral to the LPMHSS patients are either therapeutically treated; signposted to Tier 0 services or referred to Tier 2 secondary care. It can be seen that the teams remain under pressure with the numbers...
waiting for assessments exceeding the statutory maximum limit of 28 days and even the short term maximum allowance of 56 days.

Following the introduction of Valley STEPS, it is necessary to analyse the potential impact of the new services on existing flows, examining the flows at each point on the patient pathway and ultimately on the numbers of patients taking anti-depressants. To enable this assessment a number of assumptions have to be made based on the evidence available.

- From the Glasgow STEPS model, whilst there is no information on the impact of the numbers continuing to take anti-depressants, there is widespread take in the non-medical interventions, with 89% of GPs stating that it offered a real alternative.
- There is a great deal of evidence that non-medical interventions are effective with many patients who have suffered emotional distress making an adequate recovery that avoids repeat prescriptions.
- Cwm Taf has the highest use of anti-depressants in the UK and we know that this is attributable largely to the levels of deprivation. However from interviews undertaken with GPs it is felt that there is little in the way of easy to access adequate alternatives.
- Despite the high levels of deprivation in many parts of Cwm Taf, there are notable variations amongst GP practices in similarly deprived areas, where the rates of anti-depressant use varies between 8% and 21% of the practice list.
- It would be appropriate to gain recognition by GPs that their practice is sub optimal by prescribing more than neighbouring practices.
- Valley STEPS would offer GPs and patients a suitable alternative if they wish to pursue it.
- Publicity campaigns with Communities First and in workplaces and schools to promote ‘5 ways to wellbeing’
- GPs being confident that their patients will be cared for in a service that will be consistent, regulated and quality assured.

From the above supporting evidence it is assumed that Valley STEPS would have an impact on patient flows and eventually on the anti-depressant prescription rate from the current rate of 15.5% of the adult population to 14% (10% reduction) to equate with the neighbouring Health Boards with valley populations and 12.5% (20% reduction) to equate to the Welsh average which is the desired target of Health Board professionals.

The table below examines and estimates each part of the annual flow, comparing the existing service with the current service plus (see section 5.1 above) and with the Valley STEPS service reflecting (1) a 10% reduction in anti-depressants and (2) a 20% reduction as set above.
### Figure: 27: Estimated Annual Flows

<table>
<thead>
<tr>
<th></th>
<th>Existing Service</th>
<th>Current Service Plus</th>
<th>Valley STEPS (1) 10%</th>
<th>Valley STEPS (2) 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of Patients self-refer to Tier 0</td>
<td>0</td>
<td>0</td>
<td>3600</td>
<td>4800</td>
</tr>
<tr>
<td>No of patients seen by GP</td>
<td>9000</td>
<td>9000</td>
<td>8500</td>
<td>8000</td>
</tr>
<tr>
<td>No of patients referred/signposted to Tier 0 by GP</td>
<td>0</td>
<td>600</td>
<td>1000</td>
<td>1500</td>
</tr>
<tr>
<td>No of patients referred to LPMHSS</td>
<td>6500*</td>
<td>6500</td>
<td>5500</td>
<td>5000</td>
</tr>
<tr>
<td>No of patients seen by LPMHSS</td>
<td>5000*</td>
<td>4800</td>
<td>4400</td>
<td>4000</td>
</tr>
<tr>
<td>No of patients treated by LPMHSS</td>
<td>1900*</td>
<td>1700</td>
<td>1500</td>
<td>1200</td>
</tr>
<tr>
<td>No of patients referred/signposted to Tier 0 by LPMHSS</td>
<td>1200*</td>
<td>2000</td>
<td>2700</td>
<td>2800</td>
</tr>
<tr>
<td>No of Patients referred to Tier 2</td>
<td>120*</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>No of patients attending Tier 0</td>
<td>1200</td>
<td>3400</td>
<td>6800</td>
<td>8600</td>
</tr>
<tr>
<td>No of new Patients prescribed anti-depressants</td>
<td>8400</td>
<td>8400</td>
<td>7130</td>
<td>5630</td>
</tr>
<tr>
<td>No of exist Patients ceasing to use anti-depressants</td>
<td>3700</td>
<td>3700</td>
<td>7830*1</td>
<td>7030*1</td>
</tr>
<tr>
<td>Total no of adult population on anti-depressants</td>
<td>37000</td>
<td>37000</td>
<td>33500</td>
<td>30000</td>
</tr>
</tbody>
</table>

*Actual data     *1 Patients actively reviewed

The table reflects the three phases of development:

- Starting with the existing service following the introduction the Measure 2010 and the establishment of the LPMHSS in October 2012. This provides the first hard data on patient flows.
- The planned expansion of the Mindfulness and Stress control courses in 2014 with the opportunity to offer more frequent sessions which are open to the public.
- The proposed development of Valley STEPS with its integrated programme of educational, therapeutic and social interventions targeted at the public. This is split between a potential 10% reduction and a 20% reduction in the numbers taking anti-depressants.

Under the current service plus option, it is considered that much of the increased capacity will largely be taken up the Tier 1 referrals from the LPMHSS to ease pressure on waiting times. Whilst there will be some self-referrals, it is unlikely to make significant difference to the populations wellbeing.

Under Valley STEPS it shows the anticipated change in flows based partly on the much expanded capacity, planned change in GP behaviour and through the publicity campaign a greater response from the public to take up the alternative methods of treatment.
The change in flows is expected to show a reduction in
(1) the number of patients seeking a consultation with the GP;
(2) the number referred to Tier 1 and Tier 2 services
(3) those being initially prescribed anti-depressants

On the other hand there is an expectation to see an increase in
(4) the number of self-referrals to Tier 0
(5) the number of patients referred or signposted to Tier 0
(6) the number of patients ceasing to use anti-depressants

Ultimately it is planned that the overall volume of anti-depressants prescribed will fall
caused partly by new patients being offered interventions and existing patients after being
reviewed by the GP/LPMHSS to consider more appropriate long term solutions. The result is
net reduction over the 5 evaluation period of 700 per annum at 10% a 1400 per annum at
20%, leading to the overall totals of 33,500 and 30,000 respectively.

The schematic below illustrates the anticipated change in flows under the Valley STEPS model.

**Figure 28: The Valleys Steps Model**
Clinical Governance

Clinical governance is ‘a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’. (Scally and Donaldson 1998, p.61) Ensuring the clinical effectiveness of the interventions offered is a priority. To ensure that therapeutic interventions are consistently delivered to required standards, the competencies of practitioners involved in delivery need to be clearly established. Continuous Professional Development and clinical supervision needs to be provided to these practitioners, irrespective of whether these interventions are delivered directly by the NHS, by Valleys Steps, or a third sector agency. Clinical Governance and the transparency it promotes should inspire confidence by commissioners, health care professionals, service users and the public and in the healthcare professionals who will be working closely with the new arrangements.

Opportunities and Risks

The success or otherwise of Valley STEPS will depend on a number of factors which are set below highlighting the

- key opportunities and benefits
- concerns and limitations and
- threats and risks

Opportunities and benefits

**Improved access to appropriate help:** Currently when people encounter low level mental health problems, there is very little available to help them in Cwm Taf, other than waiting to see their GP and probably being prescribed medication. Valleys STEPS will instead provide open-access, community based therapies in each locality, and enable people to try bio-social solutions, that make them feel good, rather than medication. This should enable GPs and the Primary Care Mental Health Support Service more time to focus on those people who really need their care.

**A non-stigmatised approach:** By branding Valleys STEPS as a wellbeing organisation (linked to the Five Ways to Wellbeing), rather than a mental health body, the service can be inclusive to the whole community. The service could give people the opportunity to address some of the problems that cause low mood – social isolation, inactivity – without the stigma of having a ‘mental illness’ label. This is particularly important for the working population, whose employers may be unsympathetic.

**Partnership working:** By having strategic leadership for the management of a Tier 0 service, it should become easier for voluntary sector organisations to collaborate in delivering the
agreed outputs, rather than competing for scarce resources in a fragmented arena. Awareness of provision should be increased and signposting should be easier.

**Encouraging people to move on:** The aim of Valleys STEPS is to treat people and encourage them to move on (although this may take varying lengths of time, depending on individual circumstances). This is in contrast to the current approach for many voluntary organisations, where their clients remain with them over several months or years. This creates a culture of dependency. There is also some evidence to suggest that social therapies lose their impact unless over long periods and without variation, so there is much to be said for providing a mixture of therapies.

**A broader menu of provision:** Valleys STEPS should be able to deliver a broader range of interventions through co-production of delivery. A more flexible, inclusive approach to well-being with a broader range of stakeholders should encourage the delivery of new interventions, access to best practice better attendance at prominent events, etc. At its best, Valleys STEPS will be able to secure funding to bring in new activities (e.g. drama groups or music therapies). Partnership working could also engage new groups, particularly hard to reach groups who currently fall through the net. New approaches to marketing and communications will support this.

**Enhancing the capacity of GPs:** The proposals are likely to take pressure off GPs with much clearer pathways that will hopefully encourage them to use anti-depressants less and community services more.

**Concerns and limitations**

**The need for a home-grown, needs-led model**

There were concerns that the model would be ‘bought in’ and not shaped by the third sector or by local needs (e.g. children’s and young people’s needs were going to be dealt with ‘later’). The aims and scope of the new organisation need to be absolutely clear: (e.g. Is it to improve motivation, focus on well-being and therapeutic activities?)

**Concerns about the client group**

Whilst welcoming an open service and opportunities for empowerment and choice, there were concerns that people would slip through the net – e.g. because of their own illiteracy/ lack of access to Information / IT / and communications, or because of underlying mental health issues. There were concerns that clients might turn to Valleys STEPS rather than their GP when they really needed GP help.

There were also concerns that 8 weeks of sessions would not be adequate to turn people around and that it would not work for people with chronic mental health conditions. This underlines confusion about who the ‘client’ is and the distinction between poor wellbeing and mental illness.
There were also concerns that the benefits system would act as a brake to the STEPS model (i.e. is it going to affect my benefits? will it be used against me?). It was felt that changes in benefits will act as a driver for people designated as well-enough to work to address their mental health needs and become work-ready. The partnership with Job Centre Plus, housing providers and Communities First needs to support people without frightening, embarrassing or stigmatising them.

**Access barriers**

There are many barriers for service users in taking the initiative to address their mental health problems. There is a need for people to admit that there is a problem and coming along and having the confidence to become engaged. Many people are the victims of social isolation after school, at weekends & school holidays. There is a need to reach people who are housebound, people who would have gone to day centres, and to address the needs of carer groups and childcare.

People feel more comfortable in their own localities: “People are locally organised and territorial; they don’t have access to transport or communications, which make access difficult; some will not pick up the telephone and need peer support / services to help them do this.”

Many voluntary organisations have experience of physical difficulties of delivering outreach services experiences across the valleys – e.g. having to accommodate their services to the barriers posed by poor or expensive public transport – which effectively limits provision to the main centres, as the most geographically accessible locations.

**Threats and Risks**

**Will it work?**

Valleys STEPS is a hugely exciting idea. The idea of providing easily accessible and timely life skills education to anyone who feels they need it (as a way of investing in the wellbeing of the community and prevent people from becoming ill) is both innovative and refreshing. However, there were concerns that it was too ambitious, that people needing help would not come forward, that it would not address the needs of people with more severe problems, or that people needing additional intervention (e.g. Tier 1 or 2 services) would not be signposted on for further help. One of the reasons for having an experienced, qualified professional team delivering educational courses in the community and running the advice-line is to ensure that the needs of people with more enduring or serious mental health issues get the help they need, but also to avoid having those that do not need such interventions getting sucked into services they do not need, because there isn’t anything else for them. Furthermore, this feasibility study has explored as far as possible whether there is clinical evidence to justify the use of these particular interventions.
Will it stifle innovation?

Although Valleys STEPS is primarily designed to target clients with poor mental wellbeing (Tier 0), whereas most third sector services support Tier 1, it is difficult to imagine that Valleys STEPS will have no effect on the Third Sector. By providing both a driver and a framework for Tier 0 provision, Valleys STEPS is likely to ‘regularise’ some of the arrangements for Tier 0 and make it necessary for the Third Sector to sign up to this agenda – a ‘top down’ model which may cut across their ethos, their innovative approaches to project development, and processes of client participation and engagement. While this may be painful for some organisations, it should also open up new opportunities and introduce new approaches to co-production, and by encouraging collaboration can remove barriers to innovation. However, this will require more transparency and accountability by all players.

Partnerships

Whilst the potential benefits of partnership working and the prospect of complementary activities was welcomed, many questions arose concerning the nature of the partnership and how it would work. There are many barriers to effective partnership – it relies on trust, on all partners being transparent about their own agendas, and on willingness to share resources. If none of the partners has spare capacity, there is nothing for the partnership to share. There were concerns about the difficulties of addressing gaps, short term funding, the need to draw in specialist activities, whether the partnership could be used to broaden the range of provision (e.g. sports and outdoor activities) and the importance of engaging with other sectors (e.g. drug and alcohol services).

Lack of capacity

Concerns exist that there will not be enough finance to deliver a whole range of services sustainably and that there would not be enough capacity within the service to address long waits for services (e.g. counselling). It was felt that fragmentation of and gaps in services were threats to sustainability. It was hoped that volunteers would be trained to help to support groups and provide services. All stakeholders needed to work together to address capacity issues and considers what they could contribute (e.g. Communities First could contribute signposting and local venues).

Governance and management

It is one thing to recognise that the Valleys STEPS service could be feasible; quite another to ensure its viability and sustainability. There is a need to build up confidence in the new model. Some service users stated that their poor experiences of mental health services had exacerbated their insecurity and lack of confidence in provision. There is a need for proper co-ordination, strong governance and partnership agreements, clarity of funding streams and roles, and for effective referrals / good process of signposting. Ensuring ‘buy in’ also depends on appropriate engagement of service users, friendly, approachable marketing, and an appropriate quality assurance framework, with clear quality thresholds and protocols about who is allowed to provide the service. Outcome measures need to be
agreed and there is also a need to look at boundaries and rules – transparency, confidentiality and data protection within a community setting.

**GPs**
Concerns centred on poor, irrelevant or less than useful information at GP surgeries, difficulties of accessing GP appointments, and lack of incentives for GPs to reduce anti-depressant prescribing. It was acknowledged that there is a culture of ‘I’m under the doctor’, which was reinforced by the benefits system, and led to the medicalization of the Tier 0 condition. A need for GP training was noted as was the need for more information and appropriate websites for GPs to tap into. All these issues needed to be addressed if the new service was to succeed.

**Sustainability of voluntary organisations**
Voluntary organisations recognised that the proposals would change the way they delivered their services. There were concerns that there could be long term funding issues, that they might struggle to keep their own branding and identity, and that their own sustainability would be threatened.

> “There is an expectation that we will deliver collaboratively and deliver within one model; this will change commissioning and the face of small organisations and it may reduce the diversity of provision.”

**Addressing stigma**
The ethos of wellbeing within Valleys STEPS (as distinct from ‘mental’ health) is very important. Whilst co-production and peer support could win over doubters, there was nevertheless a concern that confidence in the new model needs to be built. Having open access, inclusive provision (rather than services accessed via the GP) would contribute to de-stigmatising the service, but there was still a risk that the hard to reach groups would not take up the service (this is especially true of young people and middle-aged men.)

**Addressing workforce needs**
One of the real benefits of addressing Tier 0 mental health needs is the potential contribution it will make to the wider economy and prosperity of the community. There are huge difficulties in providing support for the working population: information and support needs to be available where people are; employers need to be part of the scheme and support their workforce in using it; services also need to be available in the evenings and weekends as well as during the day. Concerns exist amongst employees – “is my mental health going to affect my employment?” If the service is to work effectively, it will need to encourage employees to use the service when problems arise rather than waiting until their health problems become unmanageable. Proactive work will need to be done within Valleys STEPS to ensure that this happens.
5.6 The Financial Analysis

The financial analysis examines the estimated cost and potential savings arising from the different options in the development of the Tier 0 services. This is undertaken in line with the brief and the plan to consider funding from the Social Bond. There are many wider economic and social costs and savings, as illustrated in the IAPT model implemented in NHS England; however no attempt has been made to assess these other potential consequences which will apply to the community at large.

**Key indicator - Volume of anti-depressants dispensed**

The key financial indicator to assess the savings will be the volume of anti-depressants dispensed. This is the main cost which can be measured and reflects the potential savings attributable to the Health Board. All the evidence suggests that the present pathway of patients experiencing symptoms of emotional distress will lead to increased numbers consulting their GPs with the result in even more patients being prescribed anti-depressants. This trend is exacerbated by the fact that the majority of patients remain on anti-depressants for a long time and therefore the overall volume will continue to rise.

**Figure 29: Cwm Taf Volume of Anti-depressants by items prescribed**

As the graph above shows the volume of anti-depressants prescribed in Cwm Taf underlines the present service trend and ultimately the cost in so many ways. In 2012/13, 479,000 items (one item typically refers to 4 weeks supply of medication) were prescribed costing £1.8m
This cycle of a steady 7% annual increase in the volume of anti-depressants prescribed makes Cwm Taf the highest prescribing Health Board in England and Wales, with an estimated 15.5% (1: 6.5 adults) of the total adult population on anti-depressants. Information from the Medicines Prescribing Unit based on the last six month to September 2013 shows that Cwm Taf will prescribe over 500,000 items this year.

The annual increase is £94,000, based on 2012/13 prices, and amounts to a total cost of £1.8m in 2012/13 and is projected to be some £2.4m in the current financial year.

Options

The financial evaluation of Valley STEPS is therefore set against a background of increasing demand fuelled by the economic downturn and increased financial hardship; a predominant dependency on repeat medication and the lack of suitable alternative interventions.

Consideration is given to three options, including

- Doing nothing which will be seen is not considered an acceptable or a sustainable way forward.
- Extending the current service to maximise the educational courses from 2014 within existing resources.
- Consider the opportunity of establishing a Valley STEPS model with additional investment to deliver a more integrated Bio-Psycho-Social approach amongst the statutory and third sector organisations.

The central question is what option has the effective means to stop and possibly reverse the current trend of anti-depressant prescribing.

Financial Evaluation

The financial evaluation comprises three elements:-

- The estimated level of additional investment required to establish Valley STEPS recognising the multi-agency approach.
- The potential positive impact on the wider community and the consequential reduction in the number of additional patients consulting their GP and being offered non pharmacological interventions
- The potential for reducing the number of existing patients on anti-depressants by offering suitable alternatives to those patients who are receptive to seeking a change from repeat prescriptions

There are some basic assumptions made in the evaluation which are that:-

- All costs are based on the current costs of the last financial year, 2012/13.
The costs and savings are considered over a five year period, recognising the phased nature of the development with set up in year 1 and the subsequent resultant savings both in terms of cost avoidance and real savings.

The change in the numbers of new and existing patients is based on targets considered reasonable but assumes a 10% and 20% reduction in patients taking antidepressants.

The ultimate savings are subject to many factors, some of which are outside the control of the parties involved.

**Additional investment**

There will be a need to provide additional investment to establish the Valley STEPS recognising both recurrent and non-recurrent costs over the assumed time frame. Account needs to be taken of the existing staff resources both with the Health Board, Local Authorities and the Third sector. For example there are already 29 WTEs in the newly established LPMHSS teams who already provide some alternative interventions at a Tier 1 level and plan to deliver expanded educational courses at Tier 0 in the 2014. In addition there are some skilled paid and volunteered resources with the other partners including the Third sector.

**Staffing requirements**

Assuming support from LPMHSS, for example psychological input for ongoing development of courses and supervision for counsellor/psychotherapists, the new service could be staffed with the input of an additional 9 WTEs as follows:

1 x WTE Band 7 Service Manager who will lead the new service in ensuring its operational delivery and where possibly when necessary contribute to the provision of telephone services, drop ins and delivery of courses.

1 x WTE Band 5 Business manager responsible for securing funding, engaging with partners to agree Service Level Agreements on the services to be delivered, auditing activity and outcomes, setting contracts with external agencies and making grants applications.

4 x Band 5 Project Support / Low Intensity Workers (community psychiatric nurse, occupational therapist or psychology assistant) to coordinate and support delivery of courses; provide telephone advice and support and staff the ‘drop in’ centres.

1 x Band 3 Communication and Information officer, who will maintain the website, promote activities, market events, ensure that information about what is available is up to date, create good case studies and perhaps digital stories, support audit and maintain links with partners.

2 x Administrative support workers to undertake administrative tasks required to support the service and assist in delivery of courses, telephone service and ‘drop in’ centres.
A volunteer co-ordinator, who will be responsible for recruiting, supporting, training, retaining suitable volunteers. There are grants available for this post (e.g. Volunteering in Wales Fund, but it needs to be sustainable) so will not be included in the costs.

**Figure 30: Additional Staffing Costs**

<table>
<thead>
<tr>
<th>Post</th>
<th>WTE/ Band</th>
<th>Cost pa (inc “on costs”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Manager</td>
<td>1.0 WTE Band 7</td>
<td>£49,000</td>
</tr>
<tr>
<td>Business Manager</td>
<td>1.0 WTE Band 5</td>
<td>£35,000</td>
</tr>
<tr>
<td>Project support</td>
<td>4.0 WTE Band 5</td>
<td>£140,000</td>
</tr>
<tr>
<td>Comms/Information</td>
<td>1.0 PT Band 4</td>
<td>£15,000</td>
</tr>
<tr>
<td>Admin support</td>
<td>2.0 WTE Band 2/3</td>
<td>£30,000</td>
</tr>
<tr>
<td>Total</td>
<td>9.0 WTE</td>
<td>£269,000</td>
</tr>
</tbody>
</table>

The costs have initially been assessed using NHS bandings but the actual cost will be subject to the way the posts are eventually filled.

There would be both set up and routine running costs as set out in the following table. It is assumed that the set up costs would apply in Year 1, with the running costs applying to following four years.

**Figure 31: Non Pay requirements**

<table>
<thead>
<tr>
<th>Service/item</th>
<th>Set up cost</th>
<th>Running pa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web site</td>
<td>£8,000</td>
<td>£1,500</td>
</tr>
<tr>
<td>Posters/Leaflets/Beer mats</td>
<td>£2,500</td>
<td>£1,500</td>
</tr>
<tr>
<td>Advertising-radio, buses</td>
<td>£5,000</td>
<td>£2,000</td>
</tr>
<tr>
<td>Venues</td>
<td>£8,000</td>
<td>£8,000</td>
</tr>
<tr>
<td>Staff Travelling expenses</td>
<td>£6,000</td>
<td>£6,000</td>
</tr>
<tr>
<td>Administration</td>
<td>£5,000</td>
<td>£5,000</td>
</tr>
<tr>
<td>Course materials</td>
<td>£5,000</td>
<td>£3,000</td>
</tr>
<tr>
<td>Training of GPs/other staff</td>
<td>£6,500</td>
<td>£5,000</td>
</tr>
<tr>
<td>Premises</td>
<td>£6,000</td>
<td>£2,000</td>
</tr>
<tr>
<td>Total</td>
<td>£52,000</td>
<td>£34,000</td>
</tr>
</tbody>
</table>

Key to the success of Valley STEPS is the widespread publicity and promotion to create the right non-stigmatising branding for the new service. There will be a specific website designed to capture the key messages and information about the service.

Quality posters and leaflets will be distributed throughout the four areas to engage with as many individuals and groups as possible. The administrative centre will be managed from existing premises but will require appropriate IT and communication links.
Venues will be chosen for size and ease of access but will include sport centres and other community based premises. There will be course materials including information booklets and DVDs.

Finally there will the cost of training, particularly GPs about the alternative interventions and the manner in which referrals or signposting can be made to Valley STEPS. Training will be needed for other staff and volunteers who will be engaged in the new service.

**Third Sector support**

Valley STEPS is an integrated model which brings together the Therapeutic interventions, Social prescriptions and the Third sector services. It is considered that it will be necessary to review and enhance existing Third sector services to ensure that they can properly support the increased demand from the public and caring professionals. There is already financial support made available to the Third sector which will need to be reviewed as part of the necessary realignment to meet the needs of the new service. There may be additional commissioning requirements for which the Health Board/Local Authorities will be responsible.

**Figure 32: A summary of the additional investment costs**

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>£269,000</td>
<td>£269,000</td>
<td>£269,000</td>
<td>£269,000</td>
<td>£269,000</td>
</tr>
<tr>
<td>Non staff</td>
<td>£52,000</td>
<td>£34,000</td>
<td>£34,000</td>
<td>£34,000</td>
<td>£34,000</td>
</tr>
<tr>
<td>Total</td>
<td>£321,000</td>
<td>£303,000</td>
<td>£303,000</td>
<td>£303,000</td>
<td>£303,000</td>
</tr>
</tbody>
</table>

**Additional Patients**

It is expected that the number of new patients likely to be prescribed anti-depressants will reduce as Valley STEPS becomes a realistic choice for GPs and patients and therefore a better alternative. The exact number of new patients prescribed anti-depressants is not known. However based on the number of additional items prescribed per year over last three years, this would provide a reasonable indicator of the net number of new patients.

Given that the annual increase is some 31k items and that the on average each item is prescribed on a 28 day basis (13 times per year), the number of additional patients would be 4680, assuming an even spread of new patients throughout the year. However this is a net increase which would include those existing patients no longer taking anti-depressants. Again this number is not known, but based on the fact that 90% currently stay on the drug, with 10% appearing to cease usage within a year, then with a total number taking anti-depressants of 37,000 (Total volume of items 479k divided by 13) it is assumed that 3,700 would cease use.
The gross number of new patients would therefore be around 8380 (3,700 ceasing plus 4680 net increase). This number is broadly supported by the number of seen by GPs and referrals made to the LPMHSS.

Based on the average cost of medication for each new patient (taking the part year 2012/13 cost, discounted by the “duloxetine” element) of £20 p.a., the total additional net cost of new patients is some £94K (4680 new patients X £20).

Based on the potential success of Valley STEPS and using the 10% and 20% reduction scenarios, it is assumed that:

1. **Under the 10% scenario**, the net number of additional patients would reduce by 200 in the first two years, 250 in the third and 300 per year in the subsequent 2 year period and that no new patient would remain on the anti-depressant over a year. This process would slow the increase in volume as follows:-

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patients</td>
<td>8180</td>
<td>7980</td>
<td>7730</td>
<td>7430</td>
</tr>
<tr>
<td>Exist patients</td>
<td>(3700)</td>
<td>(3700)</td>
<td>(3700)</td>
<td>(3700)</td>
</tr>
<tr>
<td>Add’l patients</td>
<td>4480</td>
<td>4280</td>
<td>4030</td>
<td>3720</td>
</tr>
<tr>
<td>Cost @ £20 each</td>
<td>£91k</td>
<td>£87k</td>
<td>£82k</td>
<td>£76k</td>
</tr>
<tr>
<td>Cost avoidance</td>
<td>£4k</td>
<td>£8k</td>
<td>£13k</td>
<td>£19k</td>
</tr>
</tbody>
</table>

2. **Under the 20% scenario**, the net number of additional patients would reduce by 350 in the first year and 600 per year over the subsequent 4 year period and that no new patient would remain on the anti-depressant over a year. This process would slow the increase in volume as follows:-

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patients</td>
<td>8030</td>
<td>7430</td>
<td>6830</td>
<td>6230</td>
</tr>
<tr>
<td>Exist patients</td>
<td>(3700)</td>
<td>(3700)</td>
<td>(3700)</td>
<td>(3700)</td>
</tr>
<tr>
<td>Add’l patients</td>
<td>4330</td>
<td>3730</td>
<td>3130</td>
<td>2530</td>
</tr>
<tr>
<td>Cost @ £20 each</td>
<td>£88k</td>
<td>£76k</td>
<td>£64k</td>
<td>£52k</td>
</tr>
<tr>
<td>Cost avoidance</td>
<td>£7k</td>
<td>£19k</td>
<td>£31k</td>
<td>£43k</td>
</tr>
</tbody>
</table>

**Existing patients**

It is assumed that the numbers of existing patients who are currently taking medication would reduce as realistic alternative interventions became available. Again this assumption would need to be tested, but this opportunity offers the only major potential financial gain but also the presents the greatest barrier, especially from those patients who have been on anti-depressants for a considerably period of time.
It is not known how many existing patients are on medication but based on the previous assumptions of 13 items per year, then 479k items would equate broadly to 37k existing patients i.e. 15.5% of the existing adult population of 238k. This figure appears plausible given that it accords with the information gleaned from GP records.

The reduction in the number of patients taking medication would depend on the GPs change in behaviour in encouraging patients to take an alternative approach. The GP would have the support of the LPMHSS team who in turn may have more time, given the reduction in new patients, to identify existing patients who were seeking help to cease use of the medication, particularly those newly prescribed the anti-depressants.

Again for the purpose of the evaluation, it is assumed that there would two scenarios:

(1) **10% reduction** which would represent a reduction to 431k items per annum from the current 479k, equating 3,500 patients over say 5 years. It is assumed that the reduction in Year 1 would be 50% of what is achieved thereafter, i.e. 300, and an extra 800 would cease usage in Years 2 to 5. The application of £40 unit cost reflects the full year cost.

This would produce the following saving:

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing patients</td>
<td>36,700</td>
<td>35,900</td>
<td>35,100</td>
<td>34,300</td>
<td>33,500</td>
</tr>
<tr>
<td>Saving @ £40 each</td>
<td>£12k</td>
<td>£44k</td>
<td>£76k</td>
<td>£108k</td>
<td>£140k</td>
</tr>
</tbody>
</table>

(2) **20% reduction** which assumes that there is a steady reduction in the number taking medication. For Cwm Taf this would represent a 20% reduction to 386k items per annum from the current 479k, equating 7,000 patients over say 5 years. It is assumed that the reduction in Year 1 would be 50% of what is achieved thereafter, i.e. 800, and an extra 1,550 would cease usage in Years 2 to 5.

This would produce the following saving:

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing patients</td>
<td>36,200</td>
<td>34,650</td>
<td>33100</td>
<td>31,550</td>
<td>30000</td>
</tr>
<tr>
<td>Saving @ £40 each</td>
<td>£32k</td>
<td>£94k</td>
<td>£156k</td>
<td>£218k</td>
<td>£280k</td>
</tr>
</tbody>
</table>
Summary of financial evaluation

A summary of the financial effects of introducing Valley STEPS and also compared to the other options is given in the table below. Each of the assumptions in the new Valley STEPS model needs to be tested against the potential risks, barriers and opportunities. At present the plan assumes two scenarios:

(1) 10% reduction

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valley STEPS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment</td>
<td>£321k</td>
<td>£303k</td>
<td>£303k</td>
<td>£303k</td>
<td>£303k</td>
<td>£1,533k</td>
</tr>
<tr>
<td>Add’l Patients</td>
<td>(£4k)</td>
<td>(£8k)</td>
<td>(£13k)</td>
<td>(£19k)</td>
<td>(£25k)</td>
<td>(£69k)</td>
</tr>
<tr>
<td>Existing Patients</td>
<td>(£12k)</td>
<td>(£44k)</td>
<td>(£76k)</td>
<td>(£108k)</td>
<td>(£140k)</td>
<td>(£380k)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£305k</td>
<td>£251k</td>
<td>£214k</td>
<td>£176k</td>
<td>£138k</td>
<td>£1,084k</td>
</tr>
<tr>
<td><strong>Extended service</strong></td>
<td>£95k</td>
<td>£190k</td>
<td>£285k</td>
<td>£380k</td>
<td>£475k</td>
<td>£1,425k</td>
</tr>
<tr>
<td><strong>Existing service</strong></td>
<td>£95k</td>
<td>£190k</td>
<td>£285k</td>
<td>£380k</td>
<td>£475k</td>
<td>£1,425k</td>
</tr>
</tbody>
</table>

Under the 10% reduction, the net cost does reduce but by Year 5 which is time period for the duration of the Social Bond, there is still an annual cost of £138,000 which would have to be found from other sources and there is little prospect that the Social Bond would be repaid. Having given that bleak assessment, consideration will need to be given to the fact that compared to doing nothing or sticking with the current service plus plan, there will be a saving over the 5 years of some £0.341m.

(2) 20% reduction

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valley STEPS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment</td>
<td>£321k</td>
<td>£303k</td>
<td>£303k</td>
<td>£303k</td>
<td>£303k</td>
<td>£1,533k</td>
</tr>
<tr>
<td>Add’l Patients</td>
<td>(£7k)</td>
<td>(£19k)</td>
<td>(£31k)</td>
<td>(£43k)</td>
<td>(£55k)</td>
<td>(£155k)</td>
</tr>
<tr>
<td>Existing Patients</td>
<td>(32k)</td>
<td>(£94k)</td>
<td>(£156k)</td>
<td>(£218k)</td>
<td>(£280k)</td>
<td>(£780k)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£282k</td>
<td>£190k</td>
<td>£116k</td>
<td>£42k</td>
<td>(£32k)</td>
<td>£598k</td>
</tr>
<tr>
<td><strong>Extended service</strong></td>
<td>£95k</td>
<td>£190k</td>
<td>£285k</td>
<td>£380k</td>
<td>£475k</td>
<td>£1,425k</td>
</tr>
<tr>
<td><strong>Existing service</strong></td>
<td>£95k</td>
<td>£190k</td>
<td>£285k</td>
<td>£380k</td>
<td>£475k</td>
<td>£1,425k</td>
</tr>
</tbody>
</table>

It will be seen based on the assumptions made for Valley STEPS that whilst there is there is a need to invest some £1.533m over the 5 years, there are potential savings of up to £0.935m over the same period by reducing the number of additional and existing patients on antidepressants. The net additional cost is £0.598m which would be sought from the Social
Bond would provide the necessary start-up costs, with the potential for the scheme to become both self-sufficient in after Year 4 and produce a modest saving of £32,000 in Year 5. To repay the bond assuming that no further reductions were made would take a further 18 years.

The new Valley STEPS model is also considered from the comparative viewpoint of the extended service planned for 2014 and staying with the existing service. In the option of staying with the existing service, the drugs costs will continue to rise by around £0.1m each year, reaching an additional £0.475m p.a. by the end of evaluation period, and a cumulative total of £1.425m, which is almost equivalent to the new investment made.

It is considered that whilst the extended service will offer some additional benefits by providing GPs and patients with a greater range of alternative interventions, it is thought unlikely that this will lead to a reversal of the present trend and therefore the same projections are used as for the existing service.

In considering this conclusion three other issues should be taken into account, namely

(a) Whilst the financial evaluation excludes the “duloxetine” cost of £0.32m from the use of expensive drugs, the switch to more cost effective medicines would eliminate this net cost and if applied to paying off the Social Bond, this could be achieved within 2 years.

(b) The cost base applied in the evaluation assumes 2012/13 levels and ignores the subsequent price fluctuations. If however the price increases in the first half of 2013/14 equivalent to 30%, were to remain over the period of the evaluation then the overall savings on prescriptions would increase by some £0.25m. Again this would enable the Social Bond to be repaid within 2 to 3 years.

(c) There will be other benefits arising from the introduction of Valley STEPS that stem from the wider economic, health and social viewpoint. It is acknowledged for example that where improvements can be made in the health and well-being of individuals, there is much stronger chance of seeking and gaining employment. Likewise patients who suffer from chronic physical conditions may experience improvements where their emotional well-being is improved and thus avoid hospital admission.

5.7 Findings and Conclusions

- The introduction of the Welsh Government’s Measure 2010 has improved the level of accurate data in the number and flow of patients through the clinical pathway. This promotes better understanding of the inputs and outputs of the clinical model and potential to assess the outcomes of the relevant interventions and benefits of new models such as Valley STEPS. It will be necessary to extend the use of data capture on
the flows of patients through the clinical pathway including Tier 0 services, to better understand the changes in flows and make corrections as necessary.

- There are significant variations in the type of anti-depressant prescribed. Much of this will be for clinical reasons and should be justified. However, in the Cynon and Merthyr valleys, the greater use of Duloxetine is questionable given its more limited use elsewhere. Given its much higher cost which represents a total “excess” cost of £0.32m p.a. compared to equivalent drugs then action should be taken to reduce its usage.

- There are significant variations in the level of anti-depressants prescribed amongst GP practices. Some may be associated with the nature of the population served particularly in deprived communities. However there are examples especially in areas of deprivation where usage is significantly lower. Further investigations should take place into the work of number of GP practices where the level of anti-depressant prescribing is lower than expected. The actions of GP’s will be a crucial factor in reducing the need for long term repeat prescriptions.

- The level of investment made by the Health Board into Voluntary services is considerable. It is not known whether these services are delivering the levels of service as required or commissioned, nor is not known whether these services deliver the benefits considered necessary. Each service therefore needs to be reviewed comparing what was commissioned and what is being delivered and to introduce basic performance measures to monitor status.

- There is insufficient research data to definitively conclude the impact of the Tier 0 Valley STEPS model on the level of anti-depressant prescribing. The Glasgow STEPS has limited information other than the evidence of 89% of GPs who consider it a significant factor in being able to review and reduce anti-depressant prescribing. Given the limited evidence it is necessary to introduce pragmatic targets to monitor performance and through appropriate means measure benefits.

- It is clear that doing nothing is neither acceptable nor sustainable. The cost to the human lives of individuals, families and communities whilst not measurable is enormous and requires action. The extended service whilst offering some benefits with increased capacity, the impact on reversing the current trend in the use of anti-depressants is limited.

- It is considered that Valley STEPS would mark a significant change from the current service model and based on the assumptions would provide an opportunity to offer interventions that would radically improve the health and well-being of people in Cwm Taf.
- Under the 10% reduction scenario, equivalent to the neighbouring Health Boards, the Valley STEPS would not be self-sufficient over the 5 year period and without additional resource would not be able to continue. Compared however to doing nothing, there would a net saving of £0.341m after 5 years.

- Under the 20% reduction scenario, equivalent to the Welsh average, the Valley STEPS would be self-sufficient within the 5 year period and yield a small saving providing a pay back over 18 years. This could be shortened quite considerably if the savings from the use of duloxetine was made available, albeit that savings is not directly attributable to Valley STEPS.
Chapter Six – Feasibility of the Wales Wellbeing Bond

6.1 The Development of Social Impact Bonds in England

In 2011 the UK Cabinet Office launched the strategy Growing the Social Investment Market signalling their determination to ensure this market would develop into a significant source of investment for services in the broad field of social care. Its ideological context is to reduce state provided services and move control of these services initially from state to local authority level and ultimately into citizen control.

Social Impact Bonds (SIBs) are seen by the UK Government as vehicle for growth of social investment. Initial funding is paid for by investors to cover the costs of the project. Payment is by results and the ‘bonds’ carry equity-like risk. This model is not primarily about making savings. The Cabinet Office\(^5\) provides useful policy context: “Social impact bonds (SIBs) are designed to help reform public service delivery. SIBs improve the social outcomes of publicly funded services by making funding conditional on achieving results.”

The UK Government has ensured that considerable funding is available to support SIBs in England. The Department of Work and Pensions has a £30m (over three years from 2012) Innovation Fund. The Cabinet Office has a further £20m set aside in its Social Outcomes Fund and also the Investment and Contract Readiness Fund, the Mutuals Support Programme and the Social Incubator Fund (each with £10m funding).

In addition to Government funding the Big Lottery has established a £40m Commissioning Better Outcomes Fund\(^6\) and in 2012 Big Society Capital\(^7\) (the social investment bank) was launched with equity investments of £600m. Organisations such as Social Finance\(^8\) have sprung up providing both advisory and direct organisational support in managing Social Impact Bonds and other forms of social investment. The Cabinet Office (2013) estimated that the size of the social investment market in the UK was over £200m.

Despite this, there are only 13 Social Impact Bonds operating in England, with the oldest in operation for less than 3 years. Information on their activities and performance is difficult to find in the public domain and no independent evaluations of their impact have been published.

\(^5\) Available at https://www.gov.uk/social-impact-bonds
\(^6\) Available at http://www.biglotteryfund.org.uk/global-content/programmes/england/commissioning-better-outcomes-and-social-outcomes-fund
\(^7\) Available at http://www.bigsocietycapital.com It is worth noting that of all the funding sources listed Big Society Capital is a UK wide rather than England only source.
\(^8\) Available at http://socialfinance.org.uk/about/vision
Figure 33: Examples of the use of Social Impact Bonds

**Peterborough One Service** ([www.onesib.org](http://www.onesib.org)): Intensive support to 3,000 short-term prisoners over a six year period, both inside prison and after release, to help them resettle into the community. If this initiative reduces reoffending by 7.5% or more, investors will receive from Government a share of the long term savings. Investors will receive an increasing return, the greater the social impact achieved, up to a maximum of 13%.

**Example SIB – Essex Vulnerable Children (LGA 2013):** This provides multi-systemic therapy to 11-16 year olds on the edge of care or custody in Essex. Outcome payments depend on the saving in aggregate care placement days for each MST cohort, benchmarked against a historical comparison group.

### 6.2 The Wales Wellbeing Bond

The Wales Council for Voluntary Action (WCVA) promote social investment schemes in Wales through the Communities Investment Fund. In partnership with Finance Wales and Unity Trust Bank, WCVA now has a social investment portfolio where organisations can access finance ranging from £1,000 to £5 million. In 2012 the WCVA launched the Wales Wellbeing Bond. This Fund aims to gather investment from several funding sources to specifically promote the development of social impact bonds in Wales.

The WCVA (2012) set this development in the context of pressure on public service finance and sought to ensure that the SIB mechanism is used to develop new models of service delivery that are preventative in nature, will reduce demand on public services and will generate savings that will repay the initial investment. This means that the new model must deliver agreed outcomes and produce future cost reductions and cashable savings.

### 6.3 The Delivery & Governance Model


1. An ‘investor Social Impact Bond Delivery Agency’ in which a Special Purpose Vehicle (SPV) sources the investment capital required, acts as the co-ordinator of the contracts, and sub-contracts service provision.
2. A partnership of investors and providers establish a Social Impact Bond delivery agency (SPV).
3. The Social Impact Bond Delivery Agency is established as a Joint Venture between existing public service providers and investors.
Models of delivery and governance from England are likely to more complex than would be required for the Cwm Taf project. Often a number of contracts and sub-contracts are required for service provision owing to the nature of the market. Another point to consider is that social impact bonds in England have so far been focused on service delivery outside the direct health or NHS field. Where health provision is considered the expertise needed to deliver and manage the service may lie wholly or partially in the NHS; this may necessitate a slightly different approach to designing the SPV.

A crucial principle of the Social Bond model is that social investors are attracted by the opportunity to deliver new services in innovative ways which in turn rewards the statutory sector. Governing Boards in England seek to balance the interests of investors with those of service providers and commissioners. As the Health Board is a commissioner and a service provider, it is important that the SPV operates as a new partnership body with a governing board representing social investors, the public sector and the third sector.

**Figure 34: Essex SIB Governance model (adapted from LGA 2011)**

It is important to consider the relationship between the SPV and services provided by the statutory sector. Social Finance (2011) recommends that outcomes-based contracts for the new service ‘wrap around’ existing statutory provision (which continues to be funded through traditional means). They also suggest developing a hybrid outcome and activity based payments approach where activity is specified by statute.

Other important areas to consider in establishing the SPV are procurement and public sector budgeting. Health services are generally regarded as falling under ‘Part B’ services under EU law but for the purposes of procurement still need to adhere to rules around transparency, fairness and competition, particularly relevant if the SPV is also the service provider. Social Finance (2011) also flag public sector budgeting as a potential issue. SPVs that are joint ventures with the public sector or SPVs with a controlling public sector interest may be regarded as public sector organisations in terms of legal rules for financial accountability. Given the different legal framework within Wales this would be appropriate
for the Welsh Government Department of Health to advise on during the designing of a detailed delivery model.

Performance management should also be considered at the design stage. In section 5.2 we have theorised a potential staffing structure for the SPV for cost estimation purposes. The roles included a Business Manager and Services Manager. Social Finance (2013) describes the role of a Contract Manager and a Performance Manager which are similar to our vision of a Business Manager. Both roles are separate from operational delivery. The Contract Manager focuses on review of contract performance and the wider policy context. The Performance Manager focuses on data analysis and liaison with key stakeholders including investors, and has a role to understand and communicate the lessons learned from the activity and outcomes and thus strengthen delivery and investor confidence. Social Finance (2013)

**Figure 35: Example SIB Governance Structure (from Social Finance 2013)**

In the Wellbeing Bond prospectus (2012) WCVA identify four potential delivery models, reflecting the differing policy context and goals of this particular Bond.

1. A Special Purpose Vehicle established as a joint venture (described earlier)
2. A consortium approach
3. A third sector stand-alone model and
4. A pure Payment by Results approach.

Having considered the various models available, our recommended model is presented below. A joint venture SPV seems the most desirable and is the favoured model of the WCVA, the prospective funders. It allows the active participation of the public sector (NHS) which possesses much of the expertise in delivery and management. It also allows for a fresh partnership approach with the third sector which as outlined in section 4.5 will benefit from a new mature approach to service delivery based on an outcome model and participation in design of services.
6.4 Outcomes and Measures

Since repayment to the investors in a social bond is dependent on successful achievement of outcomes the setting of intended outcomes and the measurable indicators is essential. The outcomes are the working mechanism of the social bond. As the measurable indicators of these outcomes reach certain levels over time, actions (such as payment, release of funding or re-examination of the parameters of the project) are prompted.

This must be done in a considered way that brings together all the stakeholders.

Figure 22 on page 58 provides a possible list of intended outcomes for the project. These need to be discussed by the whole partnership – GPs, service providers, community stakeholders, voluntary sector organisations and service users.

Chapter 3 identifies some of the anticipated outcomes from particular interventions. It cites variations in clinical effectiveness between interventions. It notes that many of the interventions provide support to people, who may require sustained ongoing help, or who may want a one off course to improve their emotional resilience never to return.

Chapter 4 looks in more detail at the outcomes of some of the models that have been developed. The IAPT approach, with its focus on Tier 1 and above, has been able to holistic impact of its interventions – reduction in the number of people unfit for work, requiring high levels of support from the NHS, or simply not enjoying life. The Sandwell Primary Care service used WEMWBS to measure its outcomes. Glasgow STEPS cautioned against over-measuring: it monitored its community penetration regularly, but its impact only annually.

Before considering how to demonstrate the clinical benefit of the intervention, the target population of the project should be more specifically identified. This is difficult with the sub-threshold Tier 0 population, since (as shown in chapter 1, page 13), this is not a group
with defined symptoms, but a number of miscellaneous individuals unknown to mental health services, who could be clinically in need of a variety of services over a short or sustained period or who could need none.

Indicators chosen must be considered for their ease of use and integration into service procedures, as otherwise the burden of extra administrative data collection will antagonise partners and reduce the impact of the service. They will need to assess the visibility and access to the service, the impact on GP services and practice, service users engagement with the service and satisfaction with it, whether it reaches all age groups and the hard to reach etc.

GP s need to be recognised as significant stakeholders in the design of the outcomes and accompanying data set and represented as such in the process. Sandwell PCT provides an example of how this might be achieved.

The measurable indicators fall into three broad groups each having a differing purpose. Performance data are used for clinical governance, improving commissioning and service delivery etc. Activity data measure services delivered and used. Both these are used to calculate the financial measures that trigger activity and transfer of funds.

**Figure 37: Outcomes and measures**

Finally in designing measureable indicators it might be helpful to consider comparable or benchmark indicators. Suggestions for this group could be Welsh national population levels, Cwm Taf population levels or a ‘twinning’ arrangement with a similar English authority.

It is also important to consider the impact of the service against the impact of doing nothing or an alternative intervention. This is particularly significant in calculating financial impact / value for money (Department of Health 2011). These are the types of comparable data that will be needed to assess the success of otherwise of the Valley Steps project.
6.5 Findings & Conclusions

- The development of social impact bonds in England provides a useful base of evidence for the Cwm Taf project. This includes the governance and contractual arrangements and management of the delivery model.

- A special purpose vehicle established as a joint venture is probably the most suitable option for the delivery of this project.

- Setting the outcomes of the project and the measurable indicators that drive the investment is a very important part of the development process and needs to involve all stakeholders fully. The indicators need to monitor performance and activity and value for money of savings made. Comparable sources of information are needed to ensure realistic and ambitious goals.
Chapter Seven - Recommendations

1. The University Health Board, the local authorities and other stakeholders must acknowledge their collective responsibility for promoting the wellbeing of their community and must work together within the strategic frameworks, such as Together for Health, the Single Integrated Plan and Communities First programme to address the wellbeing needs of the population.

2. Priority should be given to more clearly defining and tackling the needs of the ‘Tier 0’ population. Effective interventions reduce the risk of people developing more severe forms of depression and anxiety and are likely to reduce the number of people moving into Tier 1 and Tier 2 services. Additional services focused on wellbeing and mild anxiety or depression will also prevent the inappropriate use of Tier 1 services. These services will enable people to play a greater part in the community and also provide an effective alternative to anti-depressant prescribing.

3. Every encouragement should be given to GPs to enhance their perception of clinically effective and sustainable alternatives to anti-depressant prescribing, acknowledging that they have a key role in diagnosing and referring their patients and that they will be a key driver in the success of a STEPS type model.

4. A partnership model should be developed to create a programme of interventions which should have the following characteristics:
   a. Clear entry point via website and telephone
   b. Services clearly explained and defined
   c. Strong branding to ensure credibility and community outreach
   d. A means of addressing barriers to access (e.g. disability, cost, confidence, location and language)
   e. Quality assurance, clinical governance, confidentiality, safeguarding
   f. Partnership built on trust with buy in from GPs, the community, individuals, other statutory and voluntary organisations
   g. An integrated service with clear interface with other services – e.g. maternal mental health, substance misuse, youth services
   h. A means of targeting and accessing the hard to reach without stigma
   i. A means of delivering services to vulnerable, excluded and ‘equality’ groups which ensure their safety
   j. Appropriate therapies that focus on people’s living skills and mental resilience (e.g. mindfulness, Bibliotherapy, CBT)
   k. Use of computerised interventions with telephone support to reach target groups
   l. Procurement / commissioning that allows the partnership to embrace the broad range of issues that can affect well-being – e.g. debt counselling, tenancy and unemployment issues – as well as delivery of therapeutic interventions
   m. Common standards and outcome measures would provide the basis for commissioning and procurement
n. Strategic underpinning through shared programmes (e.g. Five Ways to Wellbeing)
o. Simple measures that are meaningful and commonly understood

5. Outcomes of and impact of new model should be considered in its broadest sense – e.g. in terms of the population having the living skills to manage their lives. The following possible outcomes should be considered

a. Lower anti-depressant prescribing – this is a key driver for this project  
b. More appropriate visits to the GP – i.e. fewer patients attending with problems of low mood, freeing up GPs time to review existing patients within the system  
c. Shorter waiting times within the LPMHSS and capacity to target services to those needing them  
d. More activity focused on wellbeing and less on mental health, leading to reduced stigma, less benefits dependency  
e. More engagement with the third sector leading to more community self-help, active citizenship and participation  
f. Co-production leading to a diversity of activity at different levels within the brand  
g. Added critical mass through the partnership to enhance participation from parts that the LHB / NHS alone would not reach  
h. Added opportunities to support improvements in the wider social welfare and economic prosperity agenda  
i. People in the community feeling better, expressing greater levels of self-esteem, having greater confidence (e.g. as measured through WEMWBS)

6. An appropriate structure for the development of a legal entity and its governance should be developed. It should have a Board of Directors encompassing all key stakeholders and could involve a series of interlinking committees, (e.g. to develop and implement a business and strategic planning, to focus on clinical standards, procurement and delivery protocols, and to focus on user engagement). The partnership needs to respect and trust each other and follow good practice in working together.

7. The agreed Outcomes of the project and the measurable indicators of these drive the financial transactions of the Social Bond model and ensure effective service delivery. A group to develop outcomes and measurable indicators should be established. This should include GP representation. The outcomes should include measures of performance (including clinical effect), necessary activity (e.g. prescribing rates) and clear triggers for financial transactions and project review.

8. The Outcomes will need to include actions taken and data collected not only directly by the new ‘Valley STEPS’ agency but also by other departments of the Health Board, contracted service providers and other partners. The governance and success of the
Valley STEPS project must be understood as a wider function than the performance management of the interventions directly provided by the ‘Valley Steps’ agency.

9. The development of the ‘Valley STEPS’ project should learn from similar projects established elsewhere in the UK. In particular the IAPT experience in England is useful for:

   a. Assessing value for money against costs
   b. Developing Outcomes and Indicators
   c. Developing and delivering high volume low intensity interventions
   d. Training practitioners to deliver such intervention

10. There are significant variations in the type of anti-depressant prescribed. Much of this will be for clinical reasons and should be justified. However in the Cynon and Merthyr valleys, the greater use of Duloxetine is questionable given that its use elsewhere is much more limited. Given its much higher cost action should be taken to reduce its usage and possibly apply the saving to help sustain the Valley STEPS project.

11. Action to ensure better practice and reduce variation in anti-depressant prescribing is both desirable and essential to the establishment of the Valley STEPS project. This action should encompass the following:

   a. The development of a computer support app or ‘reminder’ for GPs at the point of diagnosis or prescribing
   b. Dissemination of Clinical Guidance (in suitable forms such as poster presentation, summary checklist etc) supported by education and professionally led discussion
   c. A Cwm Taf ‘campaign’ in primary care with circulation of prescribing rates and links to guidance and support
   d. Additional support to practices through Pharmacy advisers to conduct medication reviews of those on antidepressant medication. This activity needs monitoring and to be linked to the key indicators of the project

12. The level of investment made by the Health Board and Local Authorities into Voluntary services is not inconsiderable. It is not known whether these services are delivering the levels of service as required or commissioned, nor is it known whether these services deliver the benefits considered necessary. In the light of developing the Tier 0 STEPS model, action should be taken to review these commissioned services and introduce measures to monitor status and performance.

13. From the financial evaluation, the options of doing nothing and providing a modest expansion to the existing Tier 0 services are not sustainable in the long term. Action
is needed and it is considered that the Valley STEPS model does offer a realistic prospect of stopping and possibly reversing the current trend. However its capacity to deliver the requirements of the Social Bond will depend on the achievement of the critical success factors and the delivery of a 20% reduction in anti-depressant usage.

14. The Valleys STEPS model is feasible for development within the framework of the Wales Wellbeing bond and is a more sustainable approach for the LHB because it cannot afford the status quo and needs to secure buy in from the other stakeholders in well-being, which this model can provide.

15. If successful the established project should consider extending the service to Children and Young People as a ‘second wave’ development.
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Appendix 2  Selective Glossary

Tier 0  “People who are demoralised, demotivated, anxious, stressed and who may also exhibit associated behaviours (substance misuse, domestic abuse, co-morbidity), but not have a mental illness requiring a psychiatric assessment.”  [Glasgow Steps] It includes people unknown to mental health services, who could be clinically in need of a variety of services or none. ‘Tier 0’ services are “resources that are accessible prior to presentation to statutory primary care services that are freely accessible to the population”.

Tier 1  People needing Tier 1 mental health services experience common mental health problems, such as anxiety and mild to moderate depression. ‘Tier 1’ services identify, assess and treat these problems within the primary mental health care service, monitor the physical and mental healthcare needs of people with severe and enduring mental health problems, and signpost other services.

Tier 2  Secondary mental health care

Tier 3  Specialist services, including specialist inpatient services

Tier 4  Highly specialist inpatient, secure and residential services

CMHT  Community Mental Health Team

LPMHSS  Local Primary Mental Health Support Service

PCMHT  Primary Care Mental Health Team

WEMWBS  The Warwick-Edinburgh Mental Well-being Scale
## Appendix 3 Checklist for community audit

Information provided by: MATV Mind, New Horizons, Age Concern Morgannwg, Gofal, Venture Out, Journeys and Interlink. August/September 2013

<table>
<thead>
<tr>
<th>Type of intervention</th>
<th>Organisation that provides / refers / would know more</th>
</tr>
</thead>
</table>
| Stress control courses | Gofal provide Routes to Recovery courses at the New horizons resource centres in Aberdare and the Rhondda  
Merthyr and the Valleys Mind  
Journeys provide Depression Busting(DB) courses at the two New Horizons resource centres and have developed a youth DB course for the New Horizons’ youth project. |
| CBT or mindfulness educational courses | Merthyr and the Valleys Mind offer Living Life to the Full & a range of Agored Cymru accredited workbooks  
Counselling is provided by Eye to Eye Youth Counselling  
Statutory services provide these services |
| Depression Busting | Journeys provides this for all the peer support groups |
| Complementary therapies | Merthyr and the Valleys Mind  
New Horizons offers Reflexology (led by a trained volunteer) at the Apple Tree Stores resource centre in the Rhondda.  
Primary Care run relaxation classes |
| Anger management courses | Merthyr and the Valleys Mind  
Journeys piloting 2013/14  
TEDS provide courses in anger management for people with alcohol and substance misuse issues  
New Pathways also offer this training for staff in their training brochure |
| Therapeutic creative writing, creative arts, social interventions | Merthyr and the Valleys Mind provides a range of social and creative interventions  
Pontypridd Resource Centre –  
New Horizons offers creative interventions in the resource centres run with specialist partner organisations eg RCT Art in Community run art and craft courses at the New Horizons resource centres in Aberdare and the Rhondda. Volunteers also support one another to learn new art and craft skills.  
New Horizons has an ebay project that supports the sale of art and craft items on ebay-this helps to develop IT and photography skills.  
E3 have also held graffiti art classes for the New Horizons youth project  
There have been volunteer led creative writing classes at the New Horizons Aberdare resource centre which have been very popular. A poetry book was also produced a few years ago for fundraising and there are poems on the Mental Health Support website that New Horizons manages [http://www.mentalhealthsupport.co.uk/](http://www.mentalhealthsupport.co.uk/) |
| Access to physical fitness | Venture Out – MTCBC – Learn through the Outdoors  
New Horizons – there is a Nintendo Wii available for individuals and groups (physical health activities).  
Staff support and signpost service users to leisure facilities provided by partner agencies as identified through the STAR project. |
| Walking, gardening/ allotments and | Hafal - Merthyr Tydfil  
NH Service users are signposted to the Cynon Walking Group (formally Mentro Allan) and activities provided by local Communities First groups |
| Other outdoor projects | Cyfarthfa Park greenhouse & volunteer project  
Merthyr and the Valleys Mind offers Gardening project – Agored learning in horticulture at Pontypridd Resource Centre |
| Healthy eating, cookery / weightwatchers | Family and community learning offered by Venture Out  
New Horizons Staff link up with and signpost to local Communities First activities  
Merthyr and the Valleys Mind offer a weekly cookery group – Agored learning in food preparation in the Pontypridd Resource Centre |
| Singing/music therapy | Age Concern Morgannwg, supports people to access community groups  
Merthyr and the Valleys Mind offers a music group at the Pontypridd Resource Centre – submitted funding application to make a CD  
New Horizons has an active music group that meets once a week in the Aberdare Resource centre |
| Telephone or IT based support | Merthyr and the Valleys Mind offers IT learning  
At the two New Horizons resource centres there is access to developing and expanding IT skills through internal and external training e.g. Communities 2.0 and WEA. There is access to an internet cafe at both centres  
New Horizons manages the [http://www.mentalhealthsupport.co.uk/](http://www.mentalhealthsupport.co.uk/) website and as part of this there is a service users and volunteer focus group which involves service users as volunteers on the project and to also give feedback on the items covered |
| Support to access Benefits/Welfare advice | Age Concern Morgannwg provides Benefit Advice and support  
Merthyr and the Valleys Mind offers advocacy support for people needing financial advice/access to benefits  
Bridges into Work support workers  
New Horizons signpost service users to CAB and to the Merthyr and the Valleys’ Mind advocacy service  
New Horizons is working in partnership with DWP and can signpost people to their visiting and disability teams. |
| Housing advice | Gofal and RCT Supporting People teams provide housing advice and support  
Merthyr and the Valleys Mind offers generic community based advocacy. |
| Advice about how to access training and employment services | Merthyr and the Valleys Mind offers Get Well, Get Work Project – partnership with DWP Flexible Support Fund – limited funding  
NH works with partner agencies e.g. WEA/Remploy to provide information and advice on support to return to work. Barclays are also proving support and training to the New Horizons youth project. NH eBay project is helping people to develop IT skills to help them return to work |
| Community networks / bespoke support (e.g. chronic conditions) | Journeys currently supports 7 depression peer support groups  
New Horizons works in partnership with Interlink-EPP and has worked with Stroke Association and the British Heart Foundation (training)  
The local Diabetes peer support group offer a monthly support group at the New Horizons resource centre in Aberdare  
New Horizons is working with B-eat Cymru to start a volunteer led eating disorder support group at the Aberdare resource centre working alongside the youth project |
| Befriending schemes | Age Concern Morgannwg provides a volunteer based befriending scheme  
Merthyr and the Valleys Mind have a befriending scheme |
<p>| Support with substance | New Horizons work in partnership with TEDS and a local charity called ‘Seven’. |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</table>
| Peer Mentoring                   | Merthyr and the Valleys Mind offer peer mentors  
This has always been an integral part of the work of New Horizons—there are peer support group meetings held on a regular basis |
| Signposting to regular local activities/groups | Age Concern Morgannwg supports and signposts people to appropriate group/activities  
Merthyr and the Valleys Mind offer signposting to other services through its information and advice centre  
This is an integral part of the work of New Horizons. This is identified through the 1:1 support provided by the STAR project. New Horizons can make referrals to Team Around the Family |
| Support to access volunteering opportunities | Age Concern Morgannwg supports volunteering  
Merthyr and the Valleys Mind  
This is an integral part of the work of New Horizons both in house and signposting people to volunteering opportunities in the community  
Cyfarthfa Park volunteer project. Get Merthyr Tydfil online |
| Bibliotherapy                    | Provided through library service                                                                                                                                                                    |
Appendix 4  Perceptions from partners about their role and contribution to a steps type partnership approach

A survey of 30 organisations operating in Cwm Taff was undertaken to establish what the third sector might have to offer STEPS. Other stakeholders were also interviewed. Using short prearranged telephone interviews with questions e-mailed in advance, we established from each organisation:

- the range of services offered
- sources of funding
- services provided now and capacity for the future (depending on resources)
- what activities were offered
- impact (e.g. on prescribing / GP contact)
- how they measure success
- whether they employed clinically qualified staff
- its interest in STEPS.

Local Authorities
The Single Integrated Plan in both local authorities gives high priority to addressing mental health and emotional well-being. This suggests that attention, if not resources, will be devoted to this aim, that training and awareness raising of staff will be provided, that partnership working will be explored. Local authorities provide excellent support to Tier 0 clients through the (Bibliotherapy) Book Prescription Scheme, they support the wellbeing agenda and the Exercise on Referral Scheme, through leisure centres. Interviews held with two development workers in RCT and MT Social Services, both developing and providing support to Peer Support groups highlighted the necessity of devoting resources to such groups, but raised the question of their sustainability.

The context of the Building Resilient Communities Work in England also needs to be considered. One of the things that local authorities traditionally did best was to create local facilities, resources and services to support people – e.g. they invested in day centres, libraries, village halls and leisure centres. However, the current dismantling of the community infrastructure through partial or full closure of these facilities may limit opportunities for a STEPS type approach to outreach to local communities.

Communities First
Many of the factors of low to moderate mental health issues, anxiety, low mood, and poor well-being lie within the poverty agenda that is the core business of Communities First. The programme has a series of targets designed to engage communities in improving health, learning and prosperity – all of which can improve well-being. Communities First can offer energy to a STEPS type model and CF staff and volunteers can help to signpost, provide support for people within their community, offer accessible community venues, and provide supporting activities (e.g. helping with financial literacy, healthy eating on a budget, and supporting social interaction and volunteering). Their unique contribution is their intimate knowledge of their communities and community networks, and being able to foster confidence in the service. In order to be effective partners, CF need up-to-date information about what’s available and how the various parts of the service work. It was encouraging that all the teams we spoke appreciated the extent and intractability of low to moderate mental health issues in their area and the long lasting and often chronic effects of
medication. They were hugely enthusiastic at the prospect of something constructive being done to help them, and hoped to develop constructive working relationships with primary care practitioners as well as at a strategic level.

**Public Health**

The role of public health is to provide the evidence to underpin action. As its name suggests, improving the wellbeing of the community is a key priority for Public Health. Public Health can bring to the table a variety of attributes:

- Strategic underpinning – e.g. maintaining a strategic focus on Our Healthy Future, Fairer Outcomes for All, Together for Mental Health, National-Coproduction Implementation Plan
- Evidence of need and the efficacy of interventions – e.g. through reports such as the Public Health Annual Report for Cwm Taf
- Drawing on best practice – e.g. Hywel Dda Local Health Board is leading on developing the national mental health measure
- Advising on appropriate outcome measures- e.g. the use of the Warwickshire & Edinburgh Mental Well Being Score vs Recovery Star

Public Health is very keen to ensure that a STEPS model is closely linked to the Five Ways to Wellbeing agenda, as this is a widely understood approach which can be driven through subsidiary agendas like Health Schools and Corporate Health Standards and be used alike by the Primary Care Mental Health Team, Job Centre Plus, GPs and the Third Sector. It provides an effective branding for de-stigmatising ‘mental health’ and effectively drawing a distinction from mental illness.

A small health improvement team provides the ‘implementation arm’ of the public health agenda. Its primary aim is to achieve targets for smoking, obesity, mobility, substance misuse and mental health. It could support STEPS through:

- ‘training the trainer’ activities – it has a small training grant which could be used for Mental Health Wellbeing Training and Mental Health First Aid (training, and access to training will be an issue for STEPS)
- engaging with the business community (e.g. through Corporate Health Standards)
- providing well-being materials and toolkits to support local community and self-help groups (e.g. in helping non-health trained community development staff in following NICE guidelines on weight management)
- providing a link with outdoor activities (e.g. walking groups and gardening clubs) and/or
- ensuring that all players link in with strategic and local priorities (e.g. through the Single Integrated Plan).

**Job Centre Plus**

Job Centre Plus is able to provide a range of initiatives to help people into work. They can engage the business and the third sectors, advise people about volunteering, and promote the Five Ways to Wellbeing. Their involvement in a STEPS initiative is important because unemployment and economic inactivity are significant contributors to poor well-being and poor mental health. Also, with the replacement of Incapacity Benefit with a more stringent Employment and Support Allowance, it has more than just an enabling role.
**The Voluntary Sector**

There is much evidence of the value of volunteering to individuals and the community. For individuals, volunteering is fun and sociable, a way of addressing low self-esteem, loneliness, mental health issues, a way of gaining new experiences and interests or giving back to the community, and a pathway to employment or training. It can help people to become engaged and in harmony with their community and it can give them a voice. For the wider social economy, volunteering can generate a more cost-effective way of delivering services. Salaries and overhead costs within the voluntary sector tend to be lower than in the statutory sector. There is a wealth of voluntary organisations and social enterprises offering therapeutic and supportive activities to people with low to moderate mental health problems, as well as people with severe and enduring mental illness. Engaging with the voluntary sector also changes the culture of organisations. It ensures that they have a ‘human face’, embraces service users, and provides a different focus on building capacity, creating social capital, encouraging self-help, and encouraging innovation and flexibility in delivery.

**The Business Sector**

Having a mentally well workforce, which does not lose time through stress, is very important to the business sector. Whilst Corporate Health Standards and the Five Ways to Wellbeing Programmes underpin efforts by businesses to keep their workforce healthy, an organisation like Valleys STEPS is likely to be helpful to their staff. This could provide a source of income as the organisation develops and matures.

**Schools and youth services**

We did not explore the potential of extending the service to the pre-16 age group, but most of the people we spoke to felt that this would be a ‘very important’ element of the service, and would support the wellbeing component of Healthy Schools.

**Working in partnership**

The third sector is keen to establish the opportunities for real collaboration and investment. There was a real sense that the voluntary sector had a genuine contribution to make in the provision of services to ‘Tier 0’ and that many of the solutions lay within the community that they serve. The third sector has experience of working in partnership with a wide range of statutory providers like the police, fire-service, schools and colleges. They can help to make linkages between services and their users and clients and, like housing agencies that straddle sectors, they can reach parts of the community that others cannot reach and introduce added depth and dimension to the service. Finally, the voluntary sector, being grounded in the community, can ensure that the reformulation of a STEPS model into a Valleys STEPS can reflect the needs and interests of the locality.

**Signposting**

Like everyone else, voluntary sector providers state the value of being able to move clients on, give them some variety, and reduce their dependency on one organisation. Third sector organisations supporting clients with mental health needs are many and varied and they would benefit from opportunities to cross refer, collaborate, raise awareness of their own and other services. Word of mouth is very important, and existing groups can help to generate confidence in a STEPS model.
**Marketing and promotion**
The voluntary sector is used to marketing its services, using case studies and live experiences to demonstrate good practice. New Horizons has developed skills in social media; they and a number of organisations could support website, Facebook and Twitter and promote STEPS to a wide network of people who would prefer to use social media and informal systems of communication than formal sources. The voluntary sector is also experienced in producing colourful and user-friendly leaflets.

**Reaching the hard to reach**
Third sector organisations, and especially Communities First, have a knowledge of their client group, know how to market services in their locality, and work in partnership with other agencies to reach their hard to reach clients. They could use their networks to promote the service within their own networks and communities and suggest ways of reaching a wider audience (e.g. trailers in cinemas, twitter, texting, etc) and in venues such as food banks, supermarkets, hospitals, post offices, libraries and town centres. The third sector has experience of engaging service users and clients and making them appreciate their role in shaping delivery. The point was also made that there needs to be a different model of communication with young people, adults and older people and of the importance of engaging with youth in the community.

**Working with GPs**
Some organisations, such as MTAV Mind, Hafal and New Horizons have referrals from GPs. If one of the aims of STEPS is to give GPs an alternative to anti-depressants when considering the best ways of managing their clients, the voluntary sector is certainly willing to be at the receiving end of referrals. There were suggestions that more use could be made of the Directory of Mental Health Service and the website, but there are issues which need to be addressed in order to make it more easy to use.

**Extending the range of services available**
Discussion at Interlink’s AGM highlighted a wide range of activities used by the voluntary sector to foster well-being and thus potentially support people with Tier 0 mental health needs. These included using sport as a vehicle to engage with young people (Game On); using arts and creative activities in a community setting; creating digital stories; using volunteers to befriend and pass on information; using drama to help people express themselves (Spectacle Theatre). The Third Sector has successfully developed training and/or train the trainer programmes (e.g. Journeys and MTAV, Drug Aid and Eye to Eye all provide this).

**Barriers**
There was a sense that the voluntary sector was regarded as less ‘professional’ than the statutory sector, with less robust standards, expertise and confidentiality. One problem, of course, is that the ‘voluntary sector’ is not an integrated brand, which delivers consistently across the piece. The impression this creates is diversity, fragmentation, and lack of unity, which makes it difficult for the sector to guarantee to work as one in synergy with other partners. Participants also mentioned difficulties of being able to offer their service at pharmacists and GPs as well as problems with transport and funding.
## Appendix 5  The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts.
Please tick the box that best describes your experience of each over the last 2 weeks

<table>
<thead>
<tr>
<th>STATEMENTS</th>
<th>None of the time</th>
<th>Rarely</th>
<th>Some of the time</th>
<th>Often</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’ve been feeling optimistic about the future</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling useful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling relaxed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling interested in other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve had energy to spare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been dealing with problems well</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been thinking clearly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling good about myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>I’ve been feeling close to other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>I’ve been feeling confident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>I’ve been able to make up my own mind about things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling loved</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been interested in new things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling cheerful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
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The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)
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Appendix 6  Mental Health Early Intervention Study: Individual Interviews

As part of the feasibility study it was agreed to provide a mapping exercise of provision by the voluntary and community sector. This is the result of telephone interviews carried out with 22 voluntary organisations and the co-ordinators of 7 self-help mental health groups in November 2013.

SPECIALIST PROVISION FOR PEOPLE WITH MENTAL HEALTH ISSUES

<table>
<thead>
<tr>
<th>Journeys - Jacqui Rafferty - <a href="mailto:jacquir@journeysonline.org.uk">jacquir@journeysonline.org.uk</a></th>
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</thead>
<tbody>
<tr>
<td><strong>Range of services offered</strong></td>
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<tr>
<td><strong>Funding received from LHB / others</strong></td>
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<tr>
<td><strong>Services provided now &amp; in future</strong></td>
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<tr>
<td><strong>Interventions with clients / contact frequency</strong></td>
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<tr>
<td><strong>Impact on prescribing / GP/</strong></td>
</tr>
<tr>
<td><strong>How measure success?</strong></td>
</tr>
<tr>
<td><strong>Employ clinically qualified staff?</strong></td>
</tr>
<tr>
<td><strong>How kept informed?</strong></td>
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<thead>
<tr>
<th>Merthyr and Valleys Mind Debra Roberts / Julian John</th>
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<tbody>
<tr>
<td><strong>Range of services offered</strong></td>
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<tr>
<td><strong>Funding received from LHB / others</strong></td>
</tr>
<tr>
<td><strong>Level of services provided now &amp; in future</strong></td>
</tr>
<tr>
<td><strong>Interventions with clients /</strong></td>
</tr>
<tr>
<td><strong>Impact on prescribing / GP/</strong></td>
</tr>
</tbody>
</table>
How measure success? | Each activity measured differently – KPI’s, specific counsellor outcome measure, Mental Health Recovery Star Outcome Model, Work Star (Agored Learning), number of individuals gaining a qualification
---|---
Employ clinically qualified staff? | We have clinical supervision and trained counsellors – but they need to be paid.
How kept informed? | Very interested and could contribute to management.

Other issues | Clinicians need to trust the 3rd sector. The third sector and clinicians need to agree on an appropriate measure of effectiveness, impact and quality. Need to spend resources as widely as possible – voluntary sector has the skills to draw in other sources of funding that statutory sector cannot reach. Not just about the money – more about the partnership working & style; lack of stigma; finding pathways out of mental health for clients/moving clients on. Need to maintain the diversity of the sector and innovative solutions.

New Horizons, Janet Whiteman - janet.whiteman@newhorizons-mentalhealth.co.uk

Range of services offered | NH used to run an open door policy with services on 6 days a week, but because of funding cuts now run restricted services on 4 days per week. Old building had 16 agencies delivering a range of services, training and outreach in communities. Caters for all ages. Work with people with long term issues – older age group have more condition. Used to work with Bryncynon HLC. Facilitate courses run by Journeys. Work with adults 18+, 1333 attendances per 3 months (15-20 per day)
---|---
Funding received from LHB / others | LHB core funding has enabled NH to draw in project funding from RCT CBC (for managing the MHS website); Lloyds TSB-youth project pilot Interlink for the youth project to work with Spectacle Theatre; RCT-SEWCED for development of NH2 as a social enterprise.
Level of services provided now & in future | Provide training, arts and crafts, social activity and volunteering. There is 1-1 support using the Recovery star. No cut off point but 3/6/9 monthly reviews. People do move on. No capacity to increase recovery star model; but some capacity to increase the numbers attending classes. There is a small waiting list. Would need added resources to go into the community at weekends or evenings
Interventions with clients / contact frequency | People can refer themselves / be referred. Youth project for 18-25 year olds has been piloted with funding from Lloyds TSB to provide 1 session per week with tailored social provision for up to 6 months. Now LHB commissioned – have a group in Rhondda and will go to Taff in New Year. This project uses Spectacle Theatre to engage y/p. CMHT assess impact. Many similarities with Recovery Star.
Impact on prescribing / GP/ | No
How measure success? | Measure well-being using Lamplight scoring system, which measures outputs from Recovery Star. Results Based Accounting includes access to services, numbers coming through, progress through recovery star.
Employ clinically qualified staff? | 1 staff member is a Psychiatric Nurse
How kept informed? / How interested? | Need some certainty of funding – through 3 year funding. Services need to be in bigger centres to de-stigmatise services / make people more anonymous. Likes consultation approach through forum. Interested to know about ages, genders, school involvement, and the potential of using social media to engage people. Had 88,000 visits to the website between July and September 2013.
Other issues | Until 2011 we had an open door policy where anyone with a mental health issue could access training/activities/signposting to partner agencies/opportunities for volunteering and leisure & social opportunities (a one stop shop model of service with 16 partner agencies providing a range of services each week under one roof). Centre open evenings, week-ends, bank holidays, etc for 40-50 people per day. Services need to be in the town centres.
<table>
<thead>
<tr>
<th><strong>Venture Out – Ryan Stokes – <a href="mailto:ryan.stokes@merthyr.gov.uk">ryan.stokes@merthyr.gov.uk</a></strong></th>
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<tr>
<td><strong>Range of services offered</strong></td>
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<td><strong>Funding received from LHB / others</strong></td>
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<td><strong>How measure success?</strong></td>
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<td><strong>Employ clinically qualified staff?</strong></td>
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<tr>
<td><strong>How kept informed? / How interested?</strong></td>
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<thead>
<tr>
<th><strong>HOUSING /HOUSING RELATED SERVICES</strong></th>
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<tr>
<td><strong>Adref – Dave Jones – organisation operated for 24 years</strong></td>
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<tr>
<td><strong>Range of services offered</strong></td>
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<td><strong>Funding received from LHB / others</strong></td>
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<td><strong>How measure success?</strong></td>
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<td><strong>Employ clinically qualified staff?</strong></td>
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<td><strong>How kept informed? / How interested?</strong></td>
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<tr>
<td><strong><a href="mailto:Dave.jones@adref.org.uk">Dave.jones@adref.org.uk</a></strong></td>
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<tr>
<th><strong>Ategi – Karen Thomas – <a href="mailto:karent@ategi.co.uk">karent@ategi.co.uk</a>  Rachel Lapham – <a href="mailto:rachell@ategi.co.uk">rachell@ategi.co.uk</a></strong></th>
</tr>
</thead>
</table>
| **Range of services offered** | - Supported living in the home;  
- Targeted respite (visiting support) 2-3 hours per week  
- Shared lives (living in someone’s home) / fostering  
- Volunteering and social activities |
| **Funding received from LHB / others** | None – have had Henry Smith / Lloyds TSB / Lottery etc, local businesses, but mostly rely on Cardiff CBC /Supporting People |
| **Services provided now & in future** | Had a contract with RCT – 2 supported houses, but not any more. All work restricted to Cardiff. Scheme was predominantly learning difficulties – but now 8 out of 10 clients have a mental health problem. Provide drama (e.g. Hýlynx. Project in Cardiff supports just over 100 people with 1 staff member, 35 volunteers. Huge
How measure success? Supported People Outcome model: volunteer retention, word of mouth, feedback, progression, 9 month waiting list, and ability to identify and refer on problems (e.g. financial abuse)

How kept informed? / How interested? Experienced in dealing with people with mental health issues and in training / supporting ‘Five Steps to Well-being’. Could contribute to project, but would need resources. Ategi’s schemes currently not accessible to people with mental health issues. Problems in RCT mostly concerned access and ability to deliver on a dispersed basis.

Cynon Taff HA – Colette Williams /Kayleigh Jones  Kayleigh@wellbeingcoaches.com

Range of services offered Community Wellbeing Coaches is a CIC, providing a free personal service to motivate, encourage and support people to better health and well-being, reduced social isolation, tackling smoking, obesity, domestic abuse, rent arrears and depression

Funding received from LHB / others Working Links, Merthyr Valley Homes, RCT Homes and CT HA. There may also be funding from Merthyr Housing and Rhondda Housing.

Level of services provided now & in future 26 clients – all CTHA’s tenants – referred from housing officers or maintenance teams – aim to maintain their tenancies. Working at full capacity with a waiting list of 20

Interventions with clients / contact frequency Some clients have interventions for 6 weeks. Others for 6 months. We help people in their homes and take them to activities.

How measure success? Questionnaire at the beginning and an initial assessment repeated at quarterly intervals. Also outcome monitoring.

Employ clinically qualified staff? Refer on to Cruise and Mind and other organisations qualified to help.

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How measure success? Questionnaire at the beginning and an initial assessment repeated at quarterly intervals. Also outcome monitoring.

Employ clinically qualified staff? Refer on to Cruise and Mind and other organisations qualified to help.

How kept informed? / How interested? EXPERIENCED IN DEALING WITH PEOPLE WITH MENTAL HEALTH ISSUES AND IN TRAINING / SUPPORTING ‘FIVE STEPS TO WELL-BEING’. COULD CONTRIBUTE TO PROJECT, BUT WOULD NEED RESOURCES. ATEGI’S SCHEMES CURRENTLY NOT ACCESSIBLE TO PEOPLE WITH MENTAL HEALTH ISSUES. PROBLEMS IN RCT MOSTLY CONCERNED ACCESS AND ABILITY TO DELIVER ON A DISPERSED BASIS.

Gofal, Hazel Yates hazelyates@gofal.org.uk / enquiries@gofal.org.uk

Range of services offered Supported housing & tenancy support – two schemes 1 providing 24 support and the others for 5 hours a week. Clients are 16+ from across Cwm Taf. Routes to Recovery for homeless people.

Funding received from LHB / others 50% from health and 50% from social services (Supporting People) for the R2R project

Level of services provided now & in future 30 in supported housing; 70 with floating support. Routes to Recovery for homeless people – support to 300 homeless people – recruited from RGH acute psychiatric wards for people who are homeless or at risk of homelessness. A lot of people suffer anxiety and depression because of their housing situation. It is harder to get quick solutions because of lack of access to the private sector.

Interventions with clients / contact frequency R2R involves a 13 week self-management course for 1 day a week, which helps people to understand mental health, the triggers and solutions, people’s personal resilience tools, and management tools for the future. Volunteering is an outcome.

Impact on prescribing / GP/ Impact is measured by Recovery Star

How measure success? Measures include prevention of homelessness and of a mental health crisis

Employ clinically qualified staff? No

How kept informed? / How interested? THROUGH MENTAL HEALTH FORUM AND ALSO REGULAR UPDATES.
### Hafal RCT (RCT /MT) Hafal RCT (RCT /MT) rcttower@hafal.org

**Range of services offered**  
Employment education resource centre with structured activities between 9 am and 3 pm (e.g. woodcraft, walking, arts and crafts, allotment, essential skills, money management & IT) 5 days per week. Have referrals from PMH Teams and GPs. Provide for people with severe mental illness. Based Aberaman and provide for whole of RCT – people come to us – hope eventually to disperse activities.

**Funding received from LHB / others**  
Solely LHB funded plus rents. Pay for 2 paid staff.

**Level of services provided now & in future**  
Current SLA is 10 per day 5 days p/week. Some days it’s more. Could take more people and broaden activities to more training and skills and less practical/social activity

**Interventions with clients / contact frequency**  
Max is 4 days per week. 20% come for 2 days per week. Most long term and don’t really taper down. Focus on Recovery Star. Each client has a care, treatment and recovery plan. Aim to move them on.

**Impact on prescribing / GP/**  
No measures on prescribing but hope to reduce crisis hospitalisation / acute admissions.

**How measure success?**  
Hafal determines outcome measures nationally; we keep standard database.

**Employ clinically qualified staff?**  
No. Generic staff. Rely on clinical staff to do appraisal and assessment

**How kept informed? / How interested?**  
By e-mail. Need to work flexibly, broaden our remit and look positively at the benefits. There is a need to do more for younger people – in last 18 months more people in 20s/30s have come to us – traditionally it was people aged 45+. Need to do more work in schools as part of Time to Change.

### Hafal MT (RCT /MT) Hafal MT (RCT /MT) Gill Bundy - merthyr@hafal.org

**Range of services offered**  
Project for people with serious mental illnesses, bipolar disorder. Trying to build up Carers Family Support, Carers’ Break and Carers’ Transport Scheme. Services for ages 18-65 years. Located at Pant Industrial Estate in Dowlais.

**Level of services provided now & in future**  
Have around 10 clients per day – operating at 50% of capacity because of staff changes.

**Interventions with clients / contact frequency**  
People attend 1 – 5 days per week on gardening, woodwork, gardening and arts & crafts projects. People stay from 3 months to a couple of years, depending on condition. Some employed on the scheme following recovery.

**Impact on prescribing / GP/**  
Knowing that people have improved

**Employ clinically qualified staff?**  
No – most Hafal projects do not. We do not have a CPN, and would need to refer onto clinical services.

**How kept informed? / How interested?**  
By word of mouth / through forum. Very important for have STEPs as a back-up for people to move on from here – somewhere to go to boost their mood especially in winter.

### Rhondda Housing – Simone Deverett - Support Project simone@rhondda.org

**Range of services offered**  
Project supports people with mental health needs through (1) 1-1 visits (2) establishing peer support groups (3) vocational training. Around 70 clients aged 16-65.

**Funding received from LHB / others**  
Project Lottery funded. Hope that groups will be sustainable, but STEPs would be needed. Use Community premises – Pontygwaith, Ystrad, RHA’s Tenant Room, Llanharan Drop in Centre – we could provide for about 10 people.

**Services provided now & in future**  
Project works with Want 2 Work, Journeys, Art is Community. Numbers could be increased to 100 people, but if there were 150+ more staff would be needed.

**Interventions with clients / contact frequency**  
Some use service regularly; some irregularly; and some have left. We don’t have a plan for clients, who are assessed at the beginning and after 6 months. There used to be a 16 week block but it wasn’t long enough – people not work-ready.

**Impact on prescribing / GP/**  
Sometimes we work with people who have let their health seriously deteriorate, but we encourage them to have more control of their health so less likely to be in crisis and more in
### Rhondda Housing: Strategic issues

**Shelagh Iles**

**Shelagh@rhondda.org**

**Main issues**

- Many of the services delivered by Housing Associations and voluntary organisations are similar services to the statutory bodies but they are not as open to change or flexibility.
- HA’s will need to focus more on core services (renting homes) and enabling rather than delivery of services
- Needs are labelled as mental health – but they’re about living skills
- Some tenants will never be work ready and need help with managing their well-being and social integration within the community

**Main benefits**

- A STEPs model is innovative and will help with community regeneration as other sources of funding dry up and move to the 3rd sector

**Can contribute**

- We have volunteer champions to address the problem of people being weary of interventions that don’t really change their lives.

### SERVICES SUPPORTING YOUNG PEOPLE

**Amber project Cardiff (Caryl)**

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Provide services for young people with a focus on reducing self-harm and suicides. Case load for schools in Cardiff and the Vale is overwhelming. Open access plus referrals from GPs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding received from LHB / others</td>
<td>No statutory funding – grants from trusts</td>
</tr>
<tr>
<td>Services provided now &amp; in future</td>
<td>40 clients per week – work with 2 theatre groups. Three staff and a volunteer team. Waiting list for volunteers and training provided. Excellent clinical supervision for volunteers.</td>
</tr>
<tr>
<td>Interventions with clients / contact frequency</td>
<td>Run music workshops and theatre projects, 1-1 counselling. Community based social model – not medical model.</td>
</tr>
<tr>
<td>Impact on prescribing / GP /</td>
<td>D/K</td>
</tr>
<tr>
<td>How measure success?</td>
<td>Don’t assess impact but people do return to school again after they have dropped out and only 1 suicide in the 10 years of operation. Y/P’s confidence gained quickly through theatre activities</td>
</tr>
<tr>
<td>Employ clinically qualified staff?</td>
<td>Counselling is clinically assessed using Richter system</td>
</tr>
<tr>
<td>How kept informed? / How interested?</td>
<td>Caryl, Project Co-ordinator lives in Rhondda Fawr – very aware of needs there. Project should involve schools very early on and address problems for young people.</td>
</tr>
</tbody>
</table>

**Barnardos – Marion.hewitt@barnardos.org.uk**

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Provide services for 69 care leavers 16-24/ 25; support for 24 young people managing their own tenancies; activities for 80 young carers aged 1-18; and a Flying Start service in MT. There is also a Leaving Care Services with Flying Start.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding received from LHB / others</td>
<td>Nothing from LHB – Y/P in care not in school do not have services.</td>
</tr>
<tr>
<td>Level of services provided now &amp; in future</td>
<td>Capacity to provide more is limited by resources and also by training. Very interested in CMHT’s Mindfulness training. Staff would like to be able to do 1-1s. Barnardos has taken on 2 x 400 placements for Level 5 H &amp; S Care students. Capacity limited by resources – could provide a little more training.</td>
</tr>
<tr>
<td>Interventions with clients / contact frequency</td>
<td>Much of the work is about confidence building. LA has put on CBT training. We provide 1-1 support, targeted on developing a pathway plan – about relationships, housing, activity, health and well-being. Some clients need daily help and others need less.</td>
</tr>
<tr>
<td>Impact on prescribing / GP/</td>
<td>We actively encourage people to look after their health care and go to GP – clients often DNA appointments, and want instant solutions.</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>How measure success?</td>
<td>We have own outcomes measures – if clients reach a level where they could manage, we should withdraw, but by law are responsible. Don’t measure distance travelled and had to adapt Outcomes Star because it did not match Pathway Plan. It would be difficult for us to have to work to another measure as it would mean doing the work twice.</td>
</tr>
<tr>
<td>Employ clinically qualified staff?</td>
<td>No – would refer on if there was a need.</td>
</tr>
<tr>
<td>How kept informed? / How interested?</td>
<td>Through e-mail especially about training. Would be interested in contributing to governance / steering group.</td>
</tr>
</tbody>
</table>

**Eye to Eye – Young People’s Counselling - Elizabeth Owen**

| Range of services offered | Work with 8 comprehensives and 27 primaries in RCT – 44% referred from school; 34% self-referred; 20% others. Ran 5407 counselling sessions in schools in 2012-13. |

**SNAP Cymru – nicola.white@snapcymru.org**

| Range of services offered | Support parents and carers of young people with educational issues resulting from a mental health problem – e.g. ADHT, problems of bullying. Services for people aged 0-25 all education based. Linked with Careers Wales and covers MT/RCT. |
| How kept informed? / How interested? | We would be happy to signpost and welcome referrals to the new service. |

**SUPPORT FOR PEOPLE WITH A DIAGNOSIS OF MENTAL ILLNESS**

**Bipolar UK, Newport**

| Range of services offered | 16 self-help groups across Wales - e-community and discussion groups for people with Bipolar diagnosis. Also a link mentoring project – volunteer linked with someone in the community by phone providing support for 1 hour per week. 45 mentors. Both mentor and mentee have bipolar diagnosis. |
| How kept informed? / How interested? | We could publicise, inform self-help groups and support with word of mouth and cascading information. Would be good for carers to have support. Would expand portfolio of activities and projects in the community and would help with networking. No accommodation, but can see many benefits. |

**SUPPORT FOR OLDER PEOPLE / CARERS**

**Carers Trust Karen Chantry 01443 480484**

| Range of services offered | Deliver support to carers through Cwm Taf Crossroads Care. Saw no relevance of this project to their work. |

**Fifty Plus Forum – Lowri.rees@merthyr.gov.uk**

| Range of services offered | Provide administrative support to maintain a forum for people aged over 50 to engage in well-being activities. Forum is inclusive and there may be members with mental health and dementia issues, but this is not its main function. Could refer and take referrals if a project arose. |

**COMMUNITY PROJECTS**

**Arts Factory, Ferndale**

| Range of services offered | Used to provide community based activities, workshops, social learning activities and 1-1 support, but no longer because of funding. |
| Funding received from LHB / others | None – currently have only 4 core staff plus 40 volunteers. |
| Services provided | Not providing anything. |
| How kept informed? / How interested? | Could provide accommodation for stress-busting course for up to 50 people on a weekly basis – contact lisa@artsfactory.org |
## Bryncynon Revival Strategy – Lee Meredith healthylivingcentre@bryncynonstrategy.org.uk

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Used to have groups supporting mental health, but now mothering is provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding received from LHB / others</td>
<td>None – and there is only core provision managing the building and healthy living café / social enterprise catering.</td>
</tr>
<tr>
<td>How kept informed? / How interested?</td>
<td>Could signpost and receive referrals. We could accommodate activities and may not always charge. We know our community and have experience of running a HLC. Have links with RCT Homes and could link with other housing providers. No links with GPs of CMHT currently.</td>
</tr>
</tbody>
</table>

## Gellideg and Treharris Healthy Living Centre – Colette Watkins

| Range of services offered | It was not possible to speak to the Co-ordinator, but the centre in Gellideg offers a range of activities (e.g. dancing) to support well-being. |

## SPECIALIST SERVICES FOR PEOPLE WITH LEARNING DIFFICULTIES

### Drive UK – Claire Jones – clairejones@driveltd.org.uk

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Support people with physical and learning difficulties to live a ‘normal’ life in the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding received from LHB / others</td>
<td>Supported living</td>
</tr>
<tr>
<td>Level of services provided now &amp; in future</td>
<td>Taken over 2 projects in 2013 – self-contained accommodation for people with mental health issues – 15 units in Pontypridd and 17 in Tonyandy Units owned by RCT Homes.</td>
</tr>
<tr>
<td>Interventions with clients / contact frequency</td>
<td>Floating support and a warden scheme. There is accommodation that could be used – e.g. for stress busting or mindfulness within the community.</td>
</tr>
<tr>
<td>How kept informed?</td>
<td>Keep informed.</td>
</tr>
</tbody>
</table>

## SPECIALIST SERVICES – ABUSE / OFFENDING BEHAIOUR

### New Pathways – Debbie Woodruff - Debbie@newpathways.org.uk

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Provide counselling for adult victims of rape and sexual abuse and children under 18 years with any trauma; provide police interview room and examination rooms; counselling project for offenders who have experienced sexual abuse; services for victims of human trafficking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding received from LHB / others</td>
<td>Police / Probation / Forensic Services</td>
</tr>
<tr>
<td>Services provided now &amp; in future</td>
<td>Have 50 staff and 50 volunteers and provide counselling to 1000 people 100 people are referred to Sexual Assault Referral Centres across Wales. Could do more but would need more resources. Have a therapy room, which in Merthyr.</td>
</tr>
<tr>
<td>Impact</td>
<td>We’re about to start assessing medication prior to counselling and post counselling and data should be available in 12 months.</td>
</tr>
<tr>
<td>How kept informed? / How interested?</td>
<td>Would refer and would actively seek referrals from STEPS. This could be helpful ongoing support for many clients. Would help with governance.</td>
</tr>
</tbody>
</table>

### Platform 51 Cymru – Kathryn Hobbs – kathryn.hobbs@platform51.org

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Provides 12-16 week intervention to 20 women per quarter who have offended or are at risk of offending, criteria for inclusion is that mental health is a factor in their offending. Aims to stabilise their lives through group work and through 1-1 support in the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding received from LHB / others</td>
<td>Ministry of Justice – short term contracts</td>
</tr>
<tr>
<td>Services provided now &amp; in future</td>
<td>Could have additional capacity.</td>
</tr>
<tr>
<td>Interventions with clients / contact frequency</td>
<td>Work with GP, Mind, CMHT. Group work is done in probation. 1-1 work is done in community to raise self-esteem, self-confidence and alleviate social exclusion</td>
</tr>
<tr>
<td>Impact on prescribing / How measure success?</td>
<td>Don’t measure</td>
</tr>
</tbody>
</table>
outcome measures would be difficult

Employ clinically qualified staff?
Offer clinical supervision of project workers – staff have community based skills – we don’t offer CBT

How kept informed? / How interested?
Real benefit is ability to refer and signpost and get more referrals especially at community level – especially from LHB. We have a wider network of people with SM / MH issues. Please keep in loop.

**RCT Women’s Aid – Alyson Shmylo - info@wa-rct.ofg.uk (alysonshmylo@wa-rct.org.uk)**

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Emergency refuge accommodation and floating support for women in the community – tenancy, emotional, advocacy, financial and children. Drop in and crisis accommodation. More formal support through activities to increase confidence and self-esteem, life skills, legal surgery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>None from LHB / Supporting People funding</td>
</tr>
<tr>
<td>Services provided now &amp; in future</td>
<td>Last quarter: 43 referrals to refuge; 28 to floating support; 60 referrals to Safe Project providing a lower level of support. No limit to who we see. No waiting list. We’d find a way of managing worker time.</td>
</tr>
<tr>
<td>Interventions with clients / contact frequency</td>
<td>1 night &gt; 3 -4 months in refuge 2 months .2 yrs floating support Safe project – could be longer term – dealing with SM / alcohol abuse</td>
</tr>
<tr>
<td>Impact on prescribing / GP /</td>
<td>90% of referrals have depression and most take anti-depressants. We don’t help as we try to maintain the status quo and ensure clients take their medication.</td>
</tr>
<tr>
<td>How measure success?</td>
<td>Women whose needs are met, don’t return, get re-housed, and who maintain their tenancies</td>
</tr>
<tr>
<td>Employ clinically qualified staff?</td>
<td>No</td>
</tr>
<tr>
<td>How kept informed? / How interested?</td>
<td>This would be VERY keen on this service. We’re very limited in what we can do. Waiting lists for CMHT / GP too long and most services overwhelmed. We’d definitely refer if services were safe and a risk assessment was done for our clients. Could help with governance.</td>
</tr>
</tbody>
</table>

**SPECIALIST SERVICES DEALING WITH SUBSTANCE MISUSE**

**Drugaid Cymru (RCT /MT)** [katherine.griffiths@drugaidcymru.com](mailto:katherine.griffiths@drugaidcymru.com)

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Was unable to make contact. Other members of the team were unable to answer questions.</th>
</tr>
</thead>
</table>

**TEDS – Jean Harrington – jean@teds.org.uk**

<table>
<thead>
<tr>
<th>Range of services offered</th>
<th>Work with anyone affected by SM / alcohol, providing holistic packages of care based on care plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding received from LHB / others</td>
<td>By LHB and others – can draw in other funding.</td>
</tr>
<tr>
<td>Services provided now &amp; in future</td>
<td>Support 2000 people – very little spare capacity</td>
</tr>
<tr>
<td>Interventions with clients / contact frequency</td>
<td>Main care is client led and open ended, recovery based and leads to harm reduction.</td>
</tr>
<tr>
<td>How measure success?</td>
<td>Treatment outcome profile will seek reductions in drug use (esp illicit drugs), prescription drugs and anti-depressants</td>
</tr>
<tr>
<td>Employ clinically qualified staff?</td>
<td>2 CPNs and xx social workers, 1 nurse is CBT trained. Team of counsellors provide CBT.</td>
</tr>
<tr>
<td>How kept informed? / How interested?</td>
<td>Interface between MH and SM MUST operate better. Synergy with some individuals works well. TEDS access to CMHT is difficult (e.g. needs to go through GP and alcoholics are barred), but access from mental health to TEDS is open. Need joint teams, joint training, and cross-referrals. Issues of who should take responsibility for this co-production. SM team must be on steering group (could help here).</td>
</tr>
</tbody>
</table>

**PEER SUPPORT GROUPS**

**Footsteps – Sian Seymour - sian.t.seymour@rctcbc.gov.uk**
| Range of services offered | Self-help group for around 12 members with moderate MH needs in Ferndale. Has been running for 1 year. Meets weekly. Some people clinically depressed; others with low mood – problems lack of work, SM/alcohol abuse, apathy, boredom, low confidence, and new benefits system. Sarah supports this group, which faces problems because its ‘free’ building will be closed. Group has occasional outings (e.g. visit to college for therapy day) as well as weekly meetings. |
| Funding received from LHB / others | Small pots of money. Funding from Journeys, CF provides staff time. |
| Services provided now & in future | Group could be bigger, but difficult to attract new people and some stigma attached. |
| How kept informed? | This would go down really well. We’d use word of mouth and knowledge of our communities. Encourage people to go and put transport on. |

**M.A.S.H. – Sian Seymour - sian.t.seymour@rctcbc.gov.uk**

| Range of services offered | Self-help group for around 20 members with moderate MH needs in Maerdy. Has been running for 6 years. Meets weekly. Some people are clinically depressed; others with low mood – problems lack of work, SM/alcohol abuse, apathy, boredom, low confidence, and new benefits system. |
| Funding received from LHB / others | Small pots of money. Funding from Journeys. Sian from CF provides support. |
| Services provided now & in future | Group could be bigger, but difficult to attract new people/ stigma attached. |
| Interventions with clients / contact frequency | Occasional outings (e.g. visit to college for therapy day) as well as weekly meetings. |
| How kept informed? / How interested? | This would go down really well. We could use word of mouth and knowledge of our communities. Encourage people to go and put transport on. |

**New Beginnings, Positive Steps, Brighter Journeys - Sara Davies – 01443 424350**

| New Beginnings – Glyncoch | Run from Glyncoch Community Centre every Friday morning for 3 hours. Follows the MASH model. Social Services put in an Outcomes bid for Journeys to deliver Depression Busting followed up by self-help peer support groups. CF and Sarah set them up, helped them constitute. Grant was for 18 months and it was envisaged that Sarah’s role would finish after 1 year. This has not happened: the group has been going for 4 years and needs ongoing help. |
| Positive Steps – Darren Las | Run from Daren Las Community Centre 12.30 – 3 pm. Has been going for 4 years and is dependent on Sarah’s ongoing support. |
| Brighter Journeys – Capel Farm | Started 4 years ago and at one stage finished, but it was re-constituted and reinstated. Runs Tuesdays 10.30 am – 12.30 pm and it also is dependent on Sarah’s ongoing support. |
| Issues relating to self-help groups | If self-help groups are to be developed further, there needs to be a worker to support this or a trained volunteer. There is not enough outcome, and indeed there needs to be more of an exit strategy following the 6-8 stress-busting sessions. Some people will be very far from resolving their issues after this period and there needs to be follow-up. Within the groups some people are there from the start, the group gives them comfort and they don’t move on. It maintains their wellbeing and does them good. If stress-busting courses are delivered in smaller groups, members of the self-help groups could talk about how it works for them. |

**Rhondda Listening Friends - Sara Davies – 01443 424350**

| Services offered | Set up 5 years ago when New Horizons pulled their services and people were very disgruntled. Initially it was led by NH staff, with a drop in. They now hire a church hall in Ton Pentre every Monday from 11 am – 3 pm. There are 30 members and 15 is the average attendance |
| Funding | They had a grant of £500 to establish from LA Mental Health Service and £500 from the LHB which helped with costs of hiring the venue. They have raised their own funds through raffles |
and table top sales, and secured funding from the Co-op and Greggs. They have 1 year’s reserves.

How organised
Everyone takes turns to become an officer. They have a partnership agreement and terms of reference. They get different speakers in – e.g. from Council, Interlink, Benefits advice. Every two months an officers’ meeting is held to maintain good practice.

Measures of success
No formal measures of success, but impact could be measured by the group remaining well / moving to paid employment or other activities. Formal measures would put extra pressures on the group.

**VOLUNTEERING**

<table>
<thead>
<tr>
<th>Interlink – Thomas Prichett Volunteering Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Range of services offered</strong></td>
</tr>
<tr>
<td><strong>How kept informed? / How interested?</strong></td>
</tr>
</tbody>
</table>
Appendix 7 Acknowledgments

The team would like the following people for their contribution to the report:

Members of the steering group

James McMahon Mental Health Development Manager, Cwm Taf UHB
Huw Griffiths Consultant Psychologist, Senior Clinical Lead Service Development, Cwm Taf UHB
Sue Breton Consultant Clinical Psychologist, Cwm Taf UHB
Ann Unitt Principal Public Health Specialist, Cwm Taf Public Health Team
Gareth Coles Public Service Delivery Officer, Wales Council for Voluntary Action
Simon James Chief Executive, Interlink

The team would also like to thank Professor Richard Williams for his advice

The following individuals, organisations and forums for providing the opportunity for group discussions or for taking part in interviews

Communities First Merthyr Tydfil, Les Dobson and other members of the team
Communities First Rhondda Cynon Taff, Nicola Lewis and other members of the team
Cwm Taf Mental Health Forum
Interlink AGM 2013
Kate Walker Chief Pharmacist Taf Ely, Cwm Taf UHB
Howard Rowe, Clinical Director, Head of Medicines Management, Cwm Taf UHB
Key informants GPs
Job Centre Plus, Department of Work and Pensions, Kevin Morgan, Local Partnership Manager
Shian Neale, Adult Services (Mental Health), Merthyr Tydfil CBC
Interlink Mental Health Co-ordinator for Cwm Taf – Maria Abson
Claire Williams, Health Improvement Officer, Cwm Taf
Sara Davies, Adult Services (Mental Health), Rhondda Cynon Taf CBC

The following organisations responded to telephone interviews:

Adref
Amber Project Cardiff
Arts Factory, Ferndale
Ategi –
Barnados
Bipolar UK, Newport
Bryncynon Revival Strategy
Bipolar UK, Newport
Bryncynon Revival Strategy
Cynon Taff HA
Drive UK
Fifty Plus Forum
Gofal
Hafal RCT

Hafal MT
Interlink
Journeys
Merthyr and Valleys Mind
New Horizons
New Pathways
Peer Support Groups
Platform 51 Cymru
RCT Women’s Aid
Rhondda Housing
SNAP Cymru
TEDS
Venture Out
References


Age Concern (2006) UK Inquiry into Mental Health and Well-Being in Later Life

All Wales Medicines Strategy Group for Wales (2012) Towards More Appropriate Management of Depression in a Primary Care Setting

All Wales Medicines Strategy Group for Wales (2008) A MEDICINES STRATEGY FOR WALES

All Wales Veterans Health & Wellbeing Service available at http://www.veteranswales.co.uk

Audit Commission (2004) Older people, independence and well-being


Cabinet Office (2013) Guidance on the template contract for social impact bonds and payment by results


Community Service Volunteers (2008) *Mental health, volunteering and social exclusion CSV*


Corporate Research Team, Borough of Poole (2010) *Improving Access to Psychological Therapies*

Corrigan, P. (2011) *A new way to invest in better healthcare* Social Finance

Curtis L, Netten A (2006) *Unit Costs of Health and Social Care 2006* Personal Social Services Research Unit, University of Kent


Cwm Taf Health Board (2012) *Mental Health (Wales) Measure 2010: Part 1 Scheme ‘Local Primary Mental Health Support Services’ for Cwm Taf Local Health Board and Partner Local Authority areas of Merthyr Tydfil and Rhondda Cynon Taf*

Cwm Taf Health Board (2011) *Cwm Taf Five Year Strategy for Mental Health 2011-16*


Department of Health (2012) *IAPT three-year report: The first million patients*

Department of Health (2011) *Impact Assessment of the expansion of talking therapies services in as set out in the Mental Health Strategy*


Foroughani, Pooria; Schneider, Justine; Assareh, Neda (2011). "Meta-review of the effectiveness of computerised CBT in treating depression". *BMC Psychiatry* 11: 131. PMC 3180363. PMID 21838902

Friedli L and Parsonage M (2009) *Promoting mental health and preventing mental illness: the economic case for investment in Wales.* All Wales Mental Health Promotion Network, Cardiff

Frude NJ (2004) Bibilotherapy as a Means of delivering Psychological Therapy, *Clinical Psychology* (39) 8-10


Glasgow Steps at http://glasgowspcmh.org.uk

Grant, A. Sullivan, F and Dowell J. (2013) ‘An ethnographic exploration of influences on prescribing in general practice: why is there variation in prescribing practices?’ *Implementation Science* 2013, 8:72 doi:10.1186/1748-5908-8-72 The electronic version of this article is the complete one and can be found online at: http://www.implementationscience.com/content/8/1/72


Health and Social Care Information Centre (2013) Improving Access to Psychological Therapies, Key Performance Indicators (IAPT KPIs) - Final Q4 2012-13


IAPT (2012) Psychological Wellbeing Practitioners

IAPT (2011) The IAPT Data Handbook version 2.0.1


Interlink (2013) INVITATION TO TENDER: Mental Health Early Intervention Feasibility Study


The Knowledge Box (2013) available at http://data.gov.uk/sib_knowledge_box


Liverpool Health Inequalities Research Institute (2011) An investigation into the therapeutic benefits of reading in relation to depression and well-being University of Liverpool & Liverpool NHS Primary Care Trust


Local Government Association (2013) An introduction to social investment


127


NHS Confederation (2012) Case Study Report: A Primary Care Approach to Mental Health and Wellbeing


NICE (2013) Review of Technology Appraisal 51: Computerised cognitive behaviour therapy for depression and anxiety

NICE (2012) NICE Public Health Guidance 41: Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation

NICE (2011) NICE Clinical Guidance 113: Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults


NICE (2011) NICE Clinical Guidance 123: Common mental health disorders

NICE (2009) NICE Clinical Guidance 90: Depression in adults

NICE (2009) NICE Clinical Guidance 91: Depression in adults with a chronic physical health problem

NICE (2008) NICE Public Health Guidance 16: Mental wellbeing and older people


NICE (2005) NICE Clinical Guidance 28: Depression in children and young people


Reading Agency: [www.readingagency.org.uk/readingwell](http://www.readingagency.org.uk/readingwell) (Books on Prescription)


Rhondda Cynon Taff Local Services Board (2013) *Single Integrated Plan*


Social Finance (2013) *A TECHNICAL GUIDE TO DEVELOPING SOCIAL IMPACT BONDS*

Social Finance (2011) *A TECHNICAL GUIDE TO COMMISSIONING SOCIAL IMPACT BONDS*


Sugden, N and Tyrell G (2013) ‘An integrated approach to improve the safe and rational prescribing of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) across an LHB’ Poster by Cwm Taf Local Health Board

[http://www.talk2gether.nhs.uk](http://www.talk2gether.nhs.uk). Website of the 2gether Foundation Trust, Gloucestershire


van Son, Jenny et al ‘The Effects of a Mindfulness-Based Intervention on Emotional Distress, Quality of Life, and HbA1c in Outpatients With Diabetes (DiaMind): A randomized controlled trial’ *Diabetes care* yr:2013 vol:36 iss:4 pg:823


WCVA (2012) *Wales Wellbeing Bond*

Wellbeing Scotland website: [www.wellscotland.info](http://www.wellscotland.info)

Welsh Government (2013) *Review of access to, and implementation of, psychological therapy treatments in Wales*

Welsh Government (2012) *Together for Health A Five Year Vision for the NHS in Wales*

Welsh Government (2012) *Together for Mental Health*

Welsh Government (2013) *More Than Just Words*

Welsh Government (2012) *Welsh Health Survey 2012*

Welsh Government (2011) *Digital Inclusion: Analysis Package*

Welsh Government (2010) *The Role Of Community Mental Health Teams In Delivering Community Mental Health Services*

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