Report of the Health Impact Assessment of Proposed Changes to Mental Health Services in Cardiff and the Vale of Glamorgan

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Foreword

This report to the Cardiff and the Vale University Health Board (subsequently to be referred to as ‘the Board’) is the final report from the Health Impact Assessment undertaken by Cardiff Institute of Society and Health (CISHE), with the support of the Wales Health Impact Assessment Support Unit (WHIASU).

Health Impact Assessment (HIA) is a …combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within a population’ (WHO 1999). HIAs are an aid to decision-making for institutions and communities. They are systematic, flexible and participatory and can identify potential health benefits and potential deficits from proposed change.

The HIA was commissioned late in 2010, to coincide with the consultation period on changes to mental health services in Cardiff and the Vale. The time available, and the time of year meant that it was not possible to include perspectives from all stakeholders in the interim report, which was utilised by the Health Board in their decision making. In this report, additional material has been gathered to address the principal shortcoming of the interim report, the absence of the views of the local community in the parts of the area affected by changes proposed to hospital provision.

The sources of the additional information have included discussions at the Health Board meeting on January 18, 2011; a discussion with the Community Health Council Public Engagement Officer revealed little information about local community views of potential health impact, there was also little published literature concerning such impacts. Additional literature, particularly on the crucial process of the implementation of the recovery approach has been reviewed and included in the report.
Executive Summary and Recommendations

The Board inherited advanced plans for the redevelopment of mental health services and chose to review them once more. The revised plans include a significant change to the model of care for people with mental health problems. The model proposed (the recovery approach) has been described as a philosophy of care which emphasises the promotion of good mental health and well-being and the recovery from mental health problems when they occur. These changes are in line with current thinking about the optimum provision of mental health care.

The other major change, which flows from the adoption of the recovery approach, is a change in the location of hospital provision for people in acute mental distress. The closure of the current provision and its replacement with newly built facilities on another site is in line with the view that mental health care should be seen in the same light as other health care and is best provided on the site of a general hospital.

In general, the assessment of these changes is that they will improve the health of service users, particularly through the introduction of the recovery approach, however that there are practical problems which should be addressed to ensure that the move to Llandough is achieved successfully. These problems include access to the site, which is currently inadequate and access to normal services such as shopping, cafes and banking in Llandough.

Mental health service users, carers and mental health advocates took part in a participatory workshop in December 2010. The workshop included discussion around the proposals themselves as well as specific discussion of their impact on the determinants of health. The timing of the HIA and the event itself meant that participation was limited, so that some views may not have been represented, however those who attended showed a strong consensus in considering both the proposals and the determinants of health.

Notes from the consultation meetings have also been considered in the preparation of this report. These show a level of opposition from service users to the move as well as demonstrating a lack of confidence in the plans. Also considered in the preparation of this report are the policy context in Wales for the provision of mental health services and literature describing contemporary thinking concerning best practice in provision of services for people who experience mental health problems.

The workshop provides some information about the potential impact on service users and their carers, however little evidence has been found on the health impact of new mental health facilities on the communities where there are placed. It has also not been possible to gather evidence on the potential impact of the changes on inequalities in health.
Recommendations

1. There was significant support for the new approach to delivering mental health services among those attending the workshop. However there was concern about the detail of implementation. In other consultation events, service users expressed what was described as a ‘lack of trust’ in the Health Board. The confidence of those involved underpins the recovery approach, so that it is important that this be addressed by the Board. **The Board should work closely with a range of service user and carer groups throughout the process to ensure that they are fully involved.** There are a number of models of good practice in user and carer involvement which might be adopted by the Board, including involving service users in strategic planning groups, user focused monitoring, user forums and participation at Board meetings.

2. For some, access to the Llandough site is seen as a problem (particularly at weekends and in the evening). **The Board should make it a priority to initiate a constructive partnership with the local public transport provider to ensure that public transport meets a minimum standard of frequency and reliability.** This might be a standard developed or agreed with service users and carers.

3. For service users who attended the workshop, the recovery process was intertwined with social, economic and physical activity. **The Board should work with other agencies, professionals, service users and the local community to ensure that opportunity for leisure activity (including physical activity) and employment (including social enterprises developed on the site) are maximized at the new hospital.**

4. Location of the mental health inpatient unit at Llandough and the other development proposed for hospital site call for the Board to establish closer links with the Llandough community. **The Board should make early contact with the Llandough Community Council and discuss possible approaches to realizing the potential for mutual benefits**

5. The issue of stigma remains a real and important one for mental health service users and their carers. Integrating mental health services into general hospital services may help in that regard, but there is still considerable work to be done with professionals (including GPs), other staff in health and social services, the media and the general public. **The Board should actively commit itself to addressing the issue of stigma in mental health across its services and in the wider community.**
6. Participants at the workshop were unanimous in concluding that non-mental health and social care professionals, especially in primary care, were insufficiently informed of mental health or of related risks to physical health such as diabetes. This contributed to the growth of stigma as well as to poor access to and quality of care in physical health facilities. The Board should prioritize improving the mental health knowledge of GPs and other primary care workers, as well as all staff working within Llandough University Hospital. A skilled, trained and empathetic workforce, sensitive to mental health issues, is essential to full and successful implementation of the recovery approach.

7. The recovery approach is widely advocated, but there are few evaluative studies in the UK. The Board should work with academic colleagues and service users to ensure that a rigorous evaluation of the implementation of the recovery approach in Cardiff and the Vale is carried out.
Background

The Board was formed in 2008 following the reorganization of the NHS in Wales. It is responsible for an area which covers 471 sq kilometres, and a population of 445,000, making it the most densely populated Health Board in Wales. Most (321,000) of the population live in the City of Cardiff, with the remainder resident in the adjoining Vale of Glamorgan, which includes the towns of Barry, Penarth and Cowbridge.

The area includes some of the most disadvantaged, as well as some of the most affluent areas in Wales. There is a significant black and minority ethnic population in Cardiff. The black and minority ethnic proportion of the population of Cardiff is 8.4%, four times higher than the figure for Wales as a whole. Across the UK, people from black and minority ethnic communities are also overrepresented among mental health service users.

The Proposals

The Board sees their proposals as a new ‘vision’ for mental health services and focuses on the delivery of a recovery oriented model of care in a safe, modern environment. A detailed review, including consultations with service users and carers, clinicians and partners in the delivery of services to people with mental health problems informed the Board that their services were deficient in some areas and that there was variation in quality. It also revealed frustration that action had not yet been taken and that mental health still carried a stigma which made recovery more problematic.

Their analysis of what they needed to do identified seven areas for action:

- Strengthening service user involvement
- Strengthening planning to support equity of service provision
- Developing primary care services
- Developing community-based services
- Developing recovery focused hospital care
- Improving access to psychological therapies
- Refocusing housing policies

The proposals for achieving these are underpinned by the recovery approach, the strengthening of community services and early intervention strategies.

For hospital provision, the choice was between redevelopment of the Whitchurch Hospital and developing the site of the Llandough University Hospital. The latter, as a general hospital met the aim of minimising clinical risk, while also addressing the issue of stigma, by co-locating mental health services with general hospital services.

Whitchurch Hospital is in a Cardiff suburb, about three miles from the City Centre. The Hospital was built in the early years of the twentieth century as a psychiatric
hospital for Cardiff. It is located in easy reach of the City by road and rail, while Whitchurch itself has ample facilities and public transport links.

Llandough is a village to the northwest of Penarth, overlooking Cardiff. It is about five miles to the City Centre and 3 miles from the centre of Penarth. The hospital, known as University Hospital Llandough opened in 1933. As a General Hospital (currently with over 400 beds), it provides a full range of inpatient services. Although there are public transport links, they are slow, infrequent and limited. The village of Llandough has few local amenities at present. This issue is recognized in the consultation document, which featured to the development of a ‘concourse’ serving the hospital and improving access to amenities such as shops, cafes and banking services.

In September 2010, the Board concluded that the changes to mental health services should proceed, with the development of acute inpatient services taking place on a single site at Llandough. A period of consultation on the plans ensued, leading to a final decision taken at the Board meeting on January 18, 2011 to develop a new mental health inpatient unit at University Hospital Llandough and to proceed with plans to refocus mental health care on community services underpinned by a recovery approach.
Methodology

Health Impact Assessment

HIA uses a range of knowledge sources to assess the potential impact of plans, projects and policies on the health of a population and the distribution of effects within a population. It is intended to provide evidence based advice to decision-makers which will help to maximize benefits and minimize harm from the implementation of their decision.

HIA is a systematic, yet flexible process which proceeds from:

- Screening – to assess the appropriateness of an HIA to
- Scoping – when the focus and methods are identified and planned, to
- Assessment of impacts using different sources of information, to
- Reporting conclusions and making recommendations to decision-makers and finally
- To evaluation and reflection on the process.

HIA is also a participatory process, relying not only on published literature or data, but offering the opportunity for the involvement of stakeholders, providing their own experience and knowledge based perspectives on the proposed developments.

This interim report on the HIA of proposals for mental health changes in Cardiff and the Vale principally covers the assessment and reporting stages of the process.
Literature search strategy

The key issues for the HIA were the impacts from the introduction of that recovery approach and the health consequences for developing mental health services in a community. The time available meant that the preferred approach of a systematic review of the evidence was not possible, however a rapid review of evidence is often as effective in identifying key papers for consideration. Searches were carried out on a number of common databases, including PubMed, Psycinfo, CINAHL, Cochrane Reviews Database, with supplementary Google and Google Scholar searches. Using keywords including ‘recovery approach’, ‘mental health recovery’, ‘mental health development’, grey literature and policy papers were also included where appropriate, with a specific focus on Welsh and UK policy.

Abstracts of papers were reviewed and those relevant read in full. There was little published literature found discussing the impact of new mental health facilities on communities or community health, although some relevant papers were reviewed. The literature on the recovery approach was quite substantial, dating back to the 1990s (Peebles et al 2009) but with roots in the sixties and seventies (Johnson 2008). There were, however, few evaluations of its implementation or its impact on health and wellbeing, exceptions being Johnson (2008), Lucksted et al (2009), Cook et al (2009) and Whitley et al (2009) all of which were US based. There were also some papers (eg Frese et al 2001, Thornton 2010), offering a critical perspective although much of the literature supports recovery as a strategy with links to empowerment and social inclusion.
Policy Context and Literature Summary

Policy Context in Wales

In 2001, the Welsh Assembly Government (WAG) published a Mental Health Strategy Document entitled ‘Equity, Empowerment, Effectiveness, Efficiency’ (WAG 2001) which was intended to set the agenda for mental health services in Wales and to refocus mental health services towards enabling and empowering people who experience mental health problems so that they can participate in the community and realize their full potential. Its focus was on services to improve the quality of life for those who experienced mental health problems and it aimed that community based care should be at the heart of provision.

Service standards for mental health care in Wales were set out initially in 2002, before a revision in 2005 of the National Service Framework (NSF) for mental health services (WAG 2005). The NSF covered health and social services provision, aiming to eliminate inequities in provision through consistent guidance for service providers and the introduction of the care programme approach (CPA) across the country. In late 2010, the Assembly passed a Mental Health Measure (WAG 2010) which reiterated the intention that individual care and treatment plans should be universal as well as providing earlier access to mental health care for those in need and supporting more advocacy services.

People who suffer serious and often long term levels of mental distress have complex needs which require support services extending well beyond mainstream health and social care. Access to the housing support provided by programmes like ‘Supporting People’ (Aylward et al 2010) is important in stabilizing people’s lives in the community, as is access to employment through the Work Programme (DWP 2011) and social activity.

Recovery approach

The recovery approach emerged from the user/survivor movement in the 1970s and 1980s although its roots can be traced back much further. Survivors view the mental health system as oppressive and emphasise a social model of mental health (Wallcraft 2003). Recovery can be seen as offering an alternative to the biomedical model of treatment (Thornton & Lucas 2010), though it is increasingly endorsed by psychiatrists (SLAM/SWLSTG 2010). It is sometimes explained in terms of a personal ‘journey’ or a process of change for person who has suffered mental distress, which does not necessarily imply a return to a previous state, but to establish control over ones life. For people who experience ongoing mental health problems, this might mean learning to manage their condition. Although no one definition has been agreed, the National Institute for Mental Health in England offers several meanings (NIMHE 2004).

- A return to a state of wellness (e.g. following an episode of depression);
o Achievement of a quality of life acceptable to the person (e.g. following an episode of psychosis)

o A process or period of recovering (e.g. following trauma);

o A process of gaining or restoring something (e.g. one’s sobriety);

o An act of obtaining usable resources from apparently unusable sources (e.g. in prolonged psychosis);

o Recovering an optimum quality and satisfaction with life in disconnected circumstances (e.g. dementia).

Another view (Jacobsen & Greeley 2001) emphasizes four conditions necessary for recovery: hope, healing, empowerment and connection while the Centre for Mental Health calls recovery ‘a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness’. Recovery involves the development of a new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness’ (Centre for Mental Health 2010)

All of these alternatives place the impact on the determinants of health at the centre of the process and represent a transition within the mental health service to a social model of health. Some authors (Frese et al 2001) have concluded that while recovery may be appropriate for many, some people in extreme mental distress and those who have the most profound disabilities are better served by services which focus on biomedical treatment based on evidence. A clue to understanding this view may be in Velyvis (2010). He distinguishes between clinical recovery and personal recovery, a distinction also made by psychiatrists in South London (2010). Clinical recovery, according to these authors, refers to an alleviation of symptoms as assessed by a professional. Personal recovery on the other hand is more subjective, placing emphasis on personal knowledge, priorities and wellbeing and building on areas of strength. Both Velyvis (2010) and the South London psychiatrists (SLAM/SWLSTG 2010) advocate a model of recovery that incorporates clinical notions but is firmly based in personal recovery with the participation and empowerment of the individual and nurturing a positive attitude to the process of care seen as essential.

It has to be said that the recovery approach has not yet been through the same kind of trial-based testing that drug or other therapies have undergone, although in their review (Ramon 2009), the Centre for Mental Health Recovery found two examples. This is because recovery is less a template that can be measured than a process of change which is different for everyone who undertakes it. Although large scale evaluations of the implementation of a recovery approach remain rare, there are positive examples, particularly from the United States which use appropriate non-trial research methods (eg Cook et al 2009, Luksted et al 2009, Whitley et al 2009).
Participatory Workshop

Seventeen service users, carers and mental health advocates attended a participatory workshop held at the Scope Centre in Cardiff on December 10, 2010. The workshop included presentation of the proposals, followed by a detailed discussion of health impacts. It was facilitated by Michael Shepherd and Chloe Chadderton. Ann Unitt and Cerys Jones from the local public health team took notes throughout the meeting. The workshop offered an opportunity for people to discuss the Board’s proposals and to assess their impact on the social determinants of health.

A representative of the Board, Ian Wile presented the proposals, with participants enthusiastically contributing their views. There was a general welcome for the recovery approach, with many comments reiterating support. However participants were concerned that the implementation should be closely followed and offered concrete suggestions for the important features of the implementation:

- Psychotherapy provision was seen as poor and had become less valued as it was excluded from current performance measures. Access to psychological therapies in primary care is also poor and third sector providers are over subscribed, so that early intervention strategies are compromised.
- Crisis care is also an important deficiency, with different teams adopting different approaches and availability sporadic out of office hours.
- The issue of stigma runs through all considerations, whether it is in the re-location of services or the successful implementation of the recovery approach. For participants, staff attitudes are central – particularly the attitudes of staff not directly employed by mental health services including general nursing staff and primary care professionals. The advice of participants was that the Board needs to offer training to all staff and to primary care staff to improve understanding of mental health.
- The separation of facilities has created some of the stigma among staff working in general services, who were said to lack empathy with people who are in mental distress. The co-location of mental health hospital provision with general services was welcomed as one approach to tackling stigma among staff, it was seen as important but not sufficient.
- GPs in particular are central to early intervention, but have little knowledge or understanding of mental health so that diagnosis can be delayed. Similarly, those working in A&E may be the first contacts for people with mental health problems who present with a physical injury. A tendency for staff to treat only one (either the physical or the mental) was reported, with consequent problems in appropriate overall care.
- Co-morbidities are common among people who have continuing mental health needs. One which is a consequence of drug therapies is type 2 diabetes. For those affected there are issues around hospital mealtimes and availability of specific diets. Staff are poor at recognizing the links and lack appropriate expertise in addressing people’s needs. Hafod is currently working with WAG on research into the links between physical and mental health problems.
- Services in Cardiff and the Vale were said to be ‘stuck in the 1950s’, so that the advent of the recovery approach and the forthcoming launch of a ‘Recovery Charter’ which should address training issues were major steps forward.

- Whitchurch has good access, access to facilities and nice grounds, with a community that is used to the presence of the Hospital. If Llandough is to be acceptable, the Board has to commit itself to making it as good for people who may be there for a longer period. This means committing to improving access and providing or linking to facilities such as sports and leisure. Concourse development such as in the plans could provide opportunities for therapeutic work in shops and cafes which could be run by people who use mental health services.

- Access to Llandough is an important issue and while the proposals talk about improved bus services, there was no detail on how this might happen. Frequencies are poor at Llandough, especially on weekends. The Board needs to work closely with the bus service providers to ensure that frequency and reliability are improved.

**Social Determinants of Health**

Table 1 summarises the discussion of the social determinants of health. Throughout the discussion, there was a concentration on making the approach work, rather than on the building itself. There was also a consistent reference to the need to address stigma throughout services and in the community.

**Table 1: Assessment of Health Impacts**

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<th>Lifestyles</th>
<th>Positive</th>
<th>Negative</th>
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<tr>
<td>Diet</td>
<td>Potential for service user run café which could use fresh food grown on site or at Forest Farm (<em>need to maintain good access to Forest Farm through minibus service</em>). More flexibility in mealtimes and choices needed, particularly among people who have specific physical health problems such as diabetes. Need for culturally sensitivity in the provision of food and to ensure special diets are adhered to. More access to fresh water is needed. There is an issue of choice, which is linked to empowerment and recovery – equality of access to ‘treats’ for patients on section. (<em>Vending machine rules in hospitals have meant that they don’t have</em>).</td>
<td>Diet</td>
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Physical activity
Need for a mix of indoor and outdoor physical activity. Opportunity for integration between staff and patients and possibly local community. Outdoor walks and sports facilities currently available at Whitchurch are seen as important to recovery. Replicating them is essential.

Gardening and working at Forest Farm is beneficial and must be sustained.

Physical Activity
No sight of plans for recreational area at the new site

At the Whitchurch site there are 2 gyms and a recreational area (pool table, table tennis etc). Concern over whether these facilities will be at the new site too. Socially and physically very important.

<table>
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<tr>
<th>Positive</th>
<th>Negative</th>
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| **User led business**
Development of concourse for shops provides potential for service user led social enterprises such as cafe. There is also space for service user garden which could produce fresh vegetables to improve diet and supply cafe/kitchens. There might also be other opportunities to involve service users in activities on the ‘concourse’ |

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<tr>
<th>Stigma</th>
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<tr>
<td>The choice of Llandough may lead to a reduction in stigma as it is not just a mental health facility (Llandough will have a more rehabilitation focus). Change of culture across services with less focus on institutionalisation and more on a recovery approach. Attitudes of staff, doctors and nurses towards those with mental health issues needs to be addressed.</td>
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<th><strong>Stigma</strong></th>
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<tr>
<td>It is possible that stigma may be stronger in Llandough and that there may be opposition from the community about having the unit there (there are ways to break this down) People at the Llanfair unit have, in the past, been blamed for vandalism in the Llandough area</td>
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<th>Community integration</th>
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<tr>
<td>The Board will need to work hard to improve community integration at the new site. Development of ‘friends of the unit’ to build relationships and develop links within the hospital and with the local community. We need to bring the community in as well as going out into the community. There might also be events such as pub quizzes or sports events that could bring people from the mental health facilities into the local community. Possibility for park that can be used by all (including local</td>
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<th><strong>Community integration</strong></th>
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<tr>
<td>Local facilities in Whitchurch are better than those in Llandough, the Board will need to work hard to improve access to facilities, people need to access facilities for normal daily living.</td>
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Although there have been good relations with the community in Whitchurch, it was not always that way, the same process could apply at Llandough.

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<th>Positive</th>
<th>Negative</th>
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<tr>
<td>People want to remain part of society, not be in hospital for long periods. This is the philosophy of the recovery approach.</td>
<td>People now at Whitchurch may be unwilling to relocate – it might set back their recovery.</td>
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<tr>
<td>There is a need for training facilities within the new unit to facilitate service users being able to be employed within the mental health service (see access and quality of service)</td>
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<tr>
<td>New development will have single sex, single bed wards (unlike at Whitchurch)</td>
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<tr>
<td>There is potential for separate assessment ward to make things calmer on the other wards.</td>
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<tr>
<td>Siting of building in relationship to the main hospital – IW presentation outlined this.</td>
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<tr>
<td>Location of new unit should be better than that of the current Llanfair unit (which is at the bottom of a hill). (Llanfair unit is not held in high regard by service users, either in terms of building itself or the care provided within it)</td>
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<tr>
<td>Llanfair unit will be used for outpatient services</td>
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**Economic conditions**

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<th>Positive</th>
<th>Negative</th>
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<tr>
<td>Employment</td>
<td>Employment/stigma</td>
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<tr>
<td>There is potential to increase opportunities for voluntary work and</td>
<td>General and persistent issues around discrimination by employers towards those</td>
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routes into employment – this is consistent with the recovery approach. Employment, whether paid or voluntary is good for wellbeing and or economic stability.

It might be possible for there to be in-reach services such as regular job centre clinics to improve employment opportunities. People moving out of hospital need support through that transition into recovery.

There is also the potential to encourage that links with work are maintained whilst service users are in hospital (as there is then a better chance of them still being in employment when discharged)

There is also a need to recognise that people have different goals. Again, this is a strength of the person-centred approach of the recovery approach.

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<th>Access and quality of services</th>
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<tr>
<td><strong>Positive</strong></td>
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<tr>
<td>Access</td>
</tr>
<tr>
<td>Bus services to Llandough have been reduced due to lack of use. To be acceptable, there would need to be an increased frequency. These could be increased again. If need was identified. Improvements to Sunday services would also be beneficial. Assessment of infrastructure is needed.</td>
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<tr>
<td>Education</td>
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<tr>
<td>There is a need for support – be that in education or work. Working more closely with social services and the voluntary sector - joined up service and links. Service users could be offered training and employment opportunities within the mental health service.</td>
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<tr>
<td><strong>Co-morbidities</strong></td>
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<tr>
<td>Patients with mental and physical health issues receive a less than adequate provision of service. This issue requires further investigation and change of culture to look at people in a holistic way.</td>
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**Implementing the Recovery approach**
The recovery approach would be best supported by continuity of care and staffing. The full and measured implementation of the Care Programme Approach and for ‘lead’ and ‘backup’ key workers, so that service users are dealing with people familiar with their individual circumstances.
The Consultation Meetings

While few issues seem to have been raised in the consultation meetings that were not aired at the Participatory Workshop, the notes from the public and stakeholder meetings that took place as part of the consultation tend to offer a somewhat different perspective, particularly on the relationship between service users and the Board.

One issue that was not raised at the workshop was finance, but it became a relatively important issue in consultation meetings where there were questions about whether the funding for taking forward the developments was actually available. The assurance from the Board that it had been agreed by the Welsh Assembly Government, was not helped by the lack of financial data in the consultation papers.

At one of the meetings, someone is quoted as saying that there seemed to be a lack of trust between service users and carers and health board staff. Evidence for this can be seen in the questions over the reasons for the development of these proposals, the questioning of the process of consultation (views were that it had been hurried and poorly planned) and may lie at the root of concerns over available finance. The origins of this lack of trust appear to be in the experience of service users who commonly see their treatment in the mental health system as oppressive, as well as more specific changes to plans for mental health services over the course of the last several years. Trust is important in terms of the success of the recovery approach as it implies the absence of confidence in the service on the part of those who use it and the absence of a positive attitude to care. If the recovery approach is not successfully implemented by the Board, there are significant consequences for the health of people who experience mental distress in Cardiff and the Vale.

The Board may seek to mitigate this situation by seeking to build trust and by developing more comprehensive approach to user and carer participation, consistent with the commitment outlined in the draft ‘Recovery Charter’. If it is to be more than ‘just a buzz word’ as one participant in the consultation called it and to yield the potential health improvements, the Board must make serious steps to implement an inclusive approach. In other parts of the UK, there is a long history of successful participation, which has occurred in areas such as needs assessment, service planning (including joint planning with social care services), advocacy and quality monitoring.

A small example of how user voices may be silenced and trust diminished was in the refusal to allow participation in the Board Meeting on January 18, 2011. While the Chair offered to speak to the service user concerned after the meeting, to do so was to also sideline the user’s comments putting them both out of context and outside the decision process. It may be common practice to exclude all but ‘recognized’ voices in such meetings, however these are conventions which may not be known to people who attend such a meeting and the implication was that there was no place for service users’ direct voice at that level. Those service users in attendance were clearly angered by the Board’s position.
Assessment and Further Analysis

The overall health impact of the proposed changes to mental health services on those people who use them in Cardiff and the Vale is that it should lead to improvements. For the communities of Whitchurch and Llandough, impacts are less certain and are probably negligible. The reuse of the Whitchurch site may have positive economic impacts, while the same may be true of the improvements to amenities on the Llandough site.

The principle caveat for this assessment is that the recovery approach needs to be implemented fully and that the Board needs to invest in training and awareness raising for primary care staff and those who work in other specialties at the Llandough site. Previous proposals from the predecessor organizations have been criticized as being too buildings focused. This criticism still applies as plans for implementation of the approach to care are less well developed than those for the hospital. As the stakeholder workshop found, the most important issues for service users were not about location, but about the process of care.

South London psychiatrists conclude that the recovery approach represents a significant challenge for mental health professionals:

\'[to look beyond clinical recovery and to measure effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the individual service users and their family, ie personal recovery\'] (SLAM/SWLSTG 2010)

The embedding of recovery within clinical and management practice requires leadership from the top and an appropriate culture within the organization (Whitley et al 2009). It may for example change Board level practice, including recognizing the contribution of service users and carers to decision-making; and may mean that approaches to training and supervision are reviewed and remodelled.

Service user involvement also takes on a new importance, contributing to the planning, operation and monitoring of services and to research and training (SLAM/SWLSTG 2010), so that health is recognized as a process of co-production in which the individual’s contribution and goals are at least equally important as those of the service provider. Developing the role of service users is a complex task and may require close cooperation with the service user/survivors movement. Lewis (2009), for example found that despite feeling disempowered by their experiences with mental health services, service user participants still found it difficult to step outside the medically dominated framing of issues, to fully embrace a social model of mental health and a person focused recovery approach. None the less, Simpson and House (2001) in their review of service user involvement found positive benefits for a range of activities, including case management and advocacy (as employees of the service provider), training and quality monitoring (Forrest et al 2000; O’Donnell et al 1998; Simpson & House 2003; Weinstein 2006). These examples move beyond the ‘comfort zone’ of many services which sanction service user comment or involvement in choices about hospital
food, the ward environment and even staffing but not in choices about drug therapies or models of care (Goodwin et al 1999). Such change has been forthcoming through collective efforts of service users at national and international level, rather than the activities of local groups or individual users. The issue of trust arose in the consultation at several points, building trust is a long term process, however the recovery approach closely matches the view held by many years by service user organizations, so that its full and well supported implementation offers a route to improved levels of trust. Calnan and Rowe (2006) note a general shift towards new forms of trust relationships in health care. They suggest that the nurturing of trust at an institutional level might lead to increasing trust at the individual level and that in building trust, the confidence in shared values plays a part.

Shifting mental health care towards a more explicit community focus means that contacts with services outside of the NHS will be earlier and more extensive. The relationship with social care agencies such as housing, employment and community networks as well as social services, is vital to achieving the goals of recovery for a satisfying and contributing life (Centre for Mental Health 2010). It is also important for the Board in terms of good working relationships, agreed strategic directions, professional practice and shared philosophies of care.

The continuing stigmatization of people who suffer mental distress remains a real and important issue for mental health service users, their carers and families. In a recent piece in the Western Mail, Madeleine Brindley (2010) called for a change in attitudes to mental health, joining MIND Cymru in calling for an anti-stigma campaign in Wales. Stigma has been defined as:

“a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders - especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness… Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.” (President’s New Freedom Commission on Mental Health, 2003 p7)

This definition clearly illustrates how stigmatization can inhibit recovery through its impact on self-esteem and on social exclusion. Integrating mental health services into general hospital services and increasing the community focus of care are positive steps which may help change attitudes, but it is not enough and there is still considerable work to be done with professionals (including GPs), other staff in health and social services as well as the general public. According to the Office for National Statistics (2010), attitudes to mental illness are changing, though slowly. Their latest survey results indicate that there an increasingly tolerant view of mental health, with two-thirds of people believing they have ‘nothing to fear’ from people who suffer mental distress, however there remains a level of stigmatization, with one in five thinking that a mental health facility nearby would degrade their neighborhood. Some of the consultation
meetings noted a history of tensions between the existing Llanfair Unit at Llandough and local people. Other authors have studies public attitudes to mental illness, finding that much of the information generally available to the public is misleading. Nairn (1999) found that while professionals may present mental health issues positively, their opinions were undermined by journalists in search of a more newsworthy story, sometimes focusing on threat (Wahl 2003). Recent exceptions like Brindley’s piece in the Western Mail (2010) may be further evidence of changing attitudes, continuing the trend noted by Wahl (2003) and successive ONS Surveys (ONS 2010). The Board’s role in continuing to shift attitudes is important, particularly with the development of a new facility, and it can achieve change through its work with the media, the community as well as through service user and carer groups and the practice of its professionals and staff.

Many of these issues are taken up in the draft ‘Recovery Charter’, which will be adopted formally by the Board in February 2011. The preparation of the Charter is an example of how service user participation can enrich a policy process in mental health and can inject a service user perspective into service delivery, but there is no defined role for service users in monitoring its implementation. To ensure that it becomes a working document, it is important that the monitoring of practice involve all stakeholders. User focused monitoring is a process through which trained mental health service users evaluate the experience of other service users, putting users at the heart of the process to improve the quality of mental health service delivery (Rose, 2001).
Conclusions and Recommendations

Although most attention in the consultation process has been paid to the relocation of hospital services for people in acute mental distress, participants at the workshop were far more concerned with issues surrounding the implementation of the recovery approach of care. While issues of access to services were important, and the general view was that by moving to Llandough there would be a loss of access (both to health services and for those in the hospital to services in the local area), there was acceptance among participants that the recovery approach provides for a more acceptable approach to care for people with mental health problems.

By moving the main inpatient facility to Llandough, the Board is prioritizing the issue of access to health care services which complement mental health inpatient services and provide access to health care support. They are also assuming that by integrating mental health care into other health services, they will address issues of stigma. The issue of stigma is one that is very important to service users, to the implementation of the recovery approach and to the mental health system. It is also important to recognize that knowledge and understanding of mental health issues among health care professionals and staff from other disciplines is imperfect and may stigmatize people who suffer mental health problems. Participants at the HIA workshop were unanimous in concluding that professionals, especially in primary care, were insufficiently informed of mental health or of related risks to physical health such as diabetes, while they raised specific examples of stigmatizing attitudes among general health care staff.

Whereas in Whitchurch, community amenities are located outside of the hospital and provide an opportunity for service users to be included in local life, at Llandough the proposal for a ‘concourse’ within the hospital means that there will be a different relationship with the local area. Unless the development is managed quite carefully and draws people into the hospital precinct, the experience for service users will not be as inclusive. Related to this is the wider relationship with the Llandough community, which has not had significant input into the plans. It is likely that they will become increasingly interested in developments once work begins. This interest provides the opportunity for the Board to develop a relationship with the local community and address concerns that may emerge, including challenging stigma and assumptions about people who suffer mental distress.

The recovery approach is supported by most of the published literature, although some clinicians characterize it as lacking the evidence base available for drug or other therapies, others like the South London psychiatrists (SLAM/SWLSTG 2010) strongly support its widespread adoption. Service users, including those who attended the workshop support the concept strongly and it represents an approach which has been advocated by the service user and carer movement for many years. However the Board will need to consider carefully how the model is implemented. There is little evaluation of the model in the UK, so that promoting research into the implementation by commissioning an evaluation study will help in developing an evidence base.
Recommendations

- The Board should work closely with a range of service user and carer groups throughout the process to ensure that they are fully involved. There are a number of models of good practice in user and carer involvement which might be adopted by the Board, including involving service users in strategic planning groups, user focused monitoring, user forums and participation at Board meetings.

- Transport to Llandough is a key issue. The Board should make it a priority to initiate a constructive partnership with the local public transport provider to ensure that public transport meets a minimum standard of frequency and reliability. This might be a standard developed or agreed with service users and carers.

- Location of the inpatient unit at Llandough, in mental health as well as the other development happening at the hospital call for the Board to establish closer links with the Llandough community. The Board should make early contact with the Llandough Community Council and discuss possible approaches to realizing the potential for mutual benefits.

- The Board should work with professionals, service users and the local community to ensure that opportunity for leisure activity (including physical activity) and employment (including social enterprises developed on the site) are maximized at the new hospital.

- The Board should commit itself to addressing the issue of stigma in mental health across all services it provides. An action plan should be part of the plan for the implementation of the decision to move all inpatient services to Llandough.

- The Board should prioritize improving the mental health knowledge of GPs and other primary care workers, as well as all staff working within Llandough University Hospital. A skilled, trained and empathetic workforce, sensitive to mental health issues, is essential to full and successful implementation of the recovery approach.

- The Board should work with academic colleagues and service users to ensure that a rigorous evaluation of the implementation of the recovery approach in Cardiff and the Vale is carried out.
References


Brindley M (2010) Its time we changed our attitude to mental ill-health. Western Mail December 10, 2010


Rose, D. (2001), The Perspectives of Mental Health Service Users on Community and Hospital Care, Sainsbury Centre for Mental Health, London


Welsh Assembly Government (2001) Adult Mental Health Services for Wales: Equity, Empowerment, Effectiveness, Efficiency Cardiff, WAG.
Appendix

Evaluation of the Participatory Workshop

At the end of the workshop, participant were asked to complete an evaluation form. The results were are follows:

What did you learn during the workshop?

• Realise that mental health issues can affect any member of society
• Valuable insights from service users and their priorities
• There is a lot of strong feeling surrounding the issues
• What patients felt about certain things ie. access to site. Lack of info to them about services and changes.
• Improved my basic knowledge of HIA – knew very little about this before
• That Whitchurch should be closed, what ever the service users think or want
• Greater insight and understanding of proposals
• That most people we more concerned about the care than the building
• Not a great deal

What do you feel were the positive outcomes resulting from this workshop?

• Learned about the future for mental health services for South Wales
• Capturing some essential features of new services and role of new hospital
• Able to feed into the health boards on physical impact of changes to delivery of mental health in Cardiff and Vale
• Very lively discussion and a good learning process for all
• The main points to be sent to the UHB
• Being able to put point of view across. Being heard and listened to.
• Hope, for the future
• Some points to refer

What do you think worked and what didn’t?

• The first speaker could have raised his voice more. The flip chart was very well written and recorded important information.
• Lack of structure and focus on the proposals
• Plenty of time for discussion, very relaxed
• Thought the discussion went very well
• Good input and ideas from nearly all attended. Needed to be more disciplined on giving out views ie. hands up and not speaking all at once.
• The general discussion was good and quite heated at times! Should have set some ground rules at the start of the workshop to control the discussion better.
• Possible needed to split into smaller work groups than large brainstorming.
• Morning activity was incomplete as groups digressed too much.

What were your expectations prior to the session? Did the session meet them? (1=not at all, 10 = very much met them)

7: was not sure what to expect. Gave a valuable insight into mental health matters that directly affect me and my community.

Assess preferred option against others: 1. Judge present services so not fit for purpose: 8. The board is wrong to start from best way to deliver the service.

Any other comments you wish to make

• Would like to come to future meetings
• A very positive workshop. Facilitators willing to respond to participants rather than stick to rigid timetable.
• Did not have access to my email for map. Needed to state ‘Scope’ in actual car park of the Wharf pub. There is a wharf further up the road so caused hold up in attending.
• I think people should have introduced themselves at the start of the workshop. Thanks for a good lunch!
• This should have been done in two different sections e.g. one for carers and the other for service users as some of this workshop was put in a way difficult to understand.
• Future discussions should be aimed at service users in one session.
• Thank you. Nadolig Llawen.