

Iechyd Meddwl Cymru IMC

A Well Being and Mental Health Service Fit for Wales

Comments by the Welsh Division of the Royal College of Psychiatrists

Introduction

1. The Division welcomes the opportunity to comment on the strategic development of improving the Mental Health of Welsh people.
2. The comments made are in the spirit of responding to a discussion document rather than providing detailed reports on individual items.
3. Divisional Officers welcomed the opportunity to meet with the Minister of Health and Social Services on the 17th July. As recommended from that meeting an appendix is provided identifying some of the current barriers to delivery of service to meet the Welsh populations Mental Health needs. The appendix includes consideration of barriers at these different levels:
 - Issues for the whole population across the lifespan;
 - Issues for specialist mental health services;
 - Issues for the medical workforce and specifically psychiatryThe appendix does not comment specifically on the barriers within organisational structures.
4. The comments below are a response to the proposal to establish Iechyd Meddwl Cymru. The provision of an easy read version and consultation events allowed a clearer understanding of the proposals.

Strengths

5. A proactive public Mental Health structure is strongly supported with clear aims for prevention and proactive early intervention. Additionally, the recognition that the public health agenda is far wider than specialist Mental Health Services.
6. A clear cycle between establishing population needs, planning, commissioning and delivering services is welcomed. The Division does not support the maintenance of the current LHB and HCW structure which has not resulted in efficient and effective strategic service or individual commissioning.
7. Strengthening of arrangements with Social Services and the third sector appears essential to take forward and meet all health care needs. To date progress on shared/joint commissioning and service provision has been slow, requiring significant energies for only modest results.
8. We recognise that merely remaining in integrated Trusts will not ensure service improvements. There have been long standing concerns about the low profile of Mental Health services within

- Trusts, the operational and financial pressure of competing demands, (e.g. waiting lists) and the reporting of governance being very limited, e.g. only serious incident reporting.
9. The Division would strongly support a National Framework with clear clinical and financial accountability. The clinical accountability should include data on the delivery of specific programmes be they in Mental Health promotion or direct service delivery. The infrastructure to design, commission, monitor and evaluate a network of programmes should not be underestimated.
 10. The creation of formal links with educational structures is strongly supported. In Wales, Deanery structures are already within Cardiff University, perhaps such approaches could be extended and opportunities maximised?

Weaknesses

11. There is an implication that there are two populations – those with and those without mental disorders. Those with would have many of their health and social needs met by IMC. This would seriously increase the stigma and discrimination experienced by people with such needs, their families and carers’.
12. There are areas of confusion in the paper around the areas of developmental disorders. People with learning disabilities have campaigned hard to develop services which support integration. People with learning disability and difficulties require support to lead more independent lifestyles.
13. The paper fails to specify the need for assessment and intervention services for developmental needs across the age and intellectual profile of the whole population.
14. There is no recognition that people with learning disability and difficulties have increased emotional and mental health needs.
15. The proposed time scale for effecting change is unrealistic. The Trusts established in April 2008 have still not all appointed full Boards.
16. There would be concerns if there was piecemeal integration with only limited aspects of social services. There would be potential for local authorities to neglect aspects controlled centrally with enhanced support of initiatives under local democratic control.
17. Many of the interface issues are within speciality Mental Health Services, these could be amplified on a National basis with retreat into subspecialties.
18. Divisional members perceived that there was a stance implying that the ‘medical’ model was wrong. Medical models have always included bio-psychosocial issues. Indeed, psychiatry within medicine has probably been the most innovative and rigorous proponent of this approach.

Threats

19. The managerial and leadership capacity within Wales appears limited to undertake major organisational change.
20. Structural re-organisation of planning and managing other NHS services will start prior to decisions on Mental Health.

21. No amount of service reconfiguration will change basic attitudes. However, if generic services perceive there may be separate services, they will withdraw or restrict input to integrate services, e.g. joint units for elderly people, joint Mental Health/Paediatric consultations, A&E initiatives for management of self-harm, primary care health checks for people with severe mental illness and learning disability.
22. If Welsh services are very different to those in the rest of the UK this could further deter local, UK and International recruitment.
23. Senior and middle management reorganisation in secondary Mental Health services would divert sparse energies from developing genuinely capable clinical teams. Such individuals are required across all Mental Health care for genuine implementation of the Care Programme Approach and bio-psychosocial model.

Opportunities

24. The next NHS structural reorganisation consultation round needs to include proposals for people with mental health and developmental disorders. There needs to be an opportunity to comment on the whole proposal.
25. To allow genuine clinical and financial accountability, mental health needs must have designated senior appointments at central Boards, and at the Boards of any proposed regional structures.
26. The evidence base for changing attitudes needs to be employed at least within the training and development of staff within Statutory services e.g. NHS, Social Services, Education.
27. There is careful consideration to provide integration opportunities between the NPHS, educational bodies, professional groups and services. Perhaps consideration of some University Affiliated Programmes?

Barriers to Delivery of Welsh Mental Health Services

1. Issues for the Whole Population
2. Issues for Specialist Mental Health Services
3. Issues for the medical workforce and specifically psychiatry

1. Issues for the Whole Population

- 1.1 There is lack of cohesion in the planning and delivery of services for people with developmental disorders; services should include screening, diagnosis, treatment and intervention.
- 1.2 Wales has an enviable genetics research pedigree. Pre and perinatal medicine is making rapid advances with increasingly improved survival of babies born after surviving difficulties during pregnancy and significantly pre term. Such babies are vulnerable to developmental disorders which do not fully emerge in the very early months and years. Robust linkage between genetics, maternity and paediatric medicine could yield significant opportunities for early intervention.
- 1.3 There is a lack of network of evidence based services to assess, diagnose and intervene with children suspected of having a developmental disorder. Waiting until they have entered education is too late for some approaches to have maximum impact to prevent further developmental delay. Additionally, children are all too often only referred when they 'fail' conventional education.
- 1.4 WAG has recently provided guidance on services for people with autism. The lessons learnt from the generation of this guidance needs to be incorporated into future planning. The implementation team's experiences need to be complimentary and integrated into approaches for the whole population.
- 1.5 There has been no strategic development of services for adults to screen, diagnose, treat and provide intervention for developmental disorders. All too often developmental needs are not recognised until late adolescence. Symptoms of this deficit include:
 - The use of 'out of area' residential colleges
 - The high number of adolescents and young adults with learning difficulties in secure care and prisons
 - The rate of people with learning disability going into 'out of area' residential care.
- 1.6 People with developmental disorders have higher rates of emotional and mental health needs right across the lifespan, this is frequently not recognised within service planning and delivery. The situation is particularly difficult for adults with developmental disorders without learning disability (mental retardation).

- 1.7 There is a fracture line within many services at adolescence/young adult, the peak time for emergence of complex mental health needs.
- 1.8 Unscheduled care planning has neglected the presentation of people with emotional needs e.g. self harm. Such presentations are frequently to out of hours GP, social services and A&E departments. Across Wales liaison services if developed, function between the hours of 9 – 5. In many areas the only service available is a junior doctor in the very early years of training.
- 1.9 The development of an out of hours GP practices within, or coterminous with A&E departments is welcomed. However, the high number of hospitals in Wales (each with its own A&E department) makes service design especially challenging.
- 1.10 People present in advanced distressed states, often after abuse of alcohol or drugs. The presentation frequently includes issues of self harm or harm to others. Currently there are no facilities to support the individual and allow safe assessment of needs. There have been developments in some English services of 'Treatment Centres' to try to meet the needs of this population. Currently these individuals are victims of cross-service disputes and arguments. Police cells, A&E departments and acute psychiatric inpatient units do not provide an appropriate environment.
- 1.11 Lack of recognition that substance misuse is a major aetiological factor in the presentation of individuals to health services. There are lost opportunities for timely intervention most notably A&E, trauma, orthopaedics and acute medical units.
- 1.12 People with complex mental health needs have high rates of unmet physical health needs, not meeting such needs impedes complete recovery.
- 1.13 People with long term enduring disorders often have associated emotional needs which are not recognised. Not meeting such needs leads to increased disability with enhanced personal and service costs.
E.g.
 - slow rehabilitation from a fractured femur
 - poor compliance with an obesity programme.
- 1.14 There are clear service gaps in disorders which clearly bridge the physical and mental health services.
E.g.
 - epilepsy
 - stroke
 - head injury.
- 1.15 There is a lack of provision for people with major behavioural challenges within secondary general health services. People with these disorders have high rates of morbidity and mortality. They frequently present with aroused disinhibited behaviours or withdrawal. Situations associated with such presentations include people with:
 - an infection and dementia
 - learning disability and infection

- post head injury, stroke
 - post surgery for major laceration with ongoing self harm
 - post operatively with previous heavy alcohol use
- 1.16 People in contact or at risk of contact with the criminal justice system have higher rates of mental disorders. There is a need for significant competency in a range of front line staff e.g. police, youth teams, prison staff and probation.
- 1.17 Prisons are organised on an England and Wales level. There are no prisons in Wales for women. A number of Welsh people spend considerable time in English prisons.
- 1.18 The planning and commissioning of specialist day and residential services for people with complex mental health needs does not include sufficient emphasis on meeting service users' emotional needs. Such services would include some people with severe mental illness, learning disability and dementia, such settings often have little competency and capacity for using evidence based behavioural and psychological approaches. Registration and regulatory structures do not robustly act as drivers to improve the situation.

2. Issues for Specialist Mental Health Services

- 2.1 Issues of stigma and discrimination have not been addressed by being in integrated Trust structures. Unfortunately, some of the most deeply prejudiced views are held by NHS staff.
- 2.2 Unfortunately, the closure programme of campus institutions has not resulted in the development of integrated general and mental health services. Even units within district general hospitals are marginalised. E.g. not part of Hospital at Night initiatives. The ongoing use of some campus sites perpetuates the negative image of mental health services.
- 2.3 The failure to develop liaison services in many areas results in loss of appreciation of mental health perspectives.
- 2.4 The ongoing separation of physical and mental health means that few professionals within secondary mental health care have an understanding and basic competency in physical health care.
- 2.5 General Practitioners trained prior to the last decade would have little experience of community based mental health services. During their training there were significantly higher rates of admission and retention of people within secondary mental health care. The competency and capacity issues within primary care have not been fully addressed during this transition.
- 2.6 There is lack of recognition that complex mental health needs frequently arise because of more than one diagnostic category. E.g. Schizophrenia and substance misuse, depression and personality disorder, anxiety and autism, psychosis and dementia. Development of teams for distinct diagnostic categories or treatment approaches needs careful consideration

- of internal mental health service interfaces. It relies on provision of particularly sophisticated care co-ordination.
- 2.7 Implementation of CPA is still at an early stage within Wales. In adult generic mental health services, care co-ordinators have only developed to a very limited degree, an ability to commission individual packages. In many cases they act as mediators of services currently available. More expert care co-ordination and case management has not really developed for people with mental health needs at transition from Children's services, with learning disabilities, substance misuse and forensic needs.
 - 2.8 There are no structures to draw together the needs identified by case managers for local or National Strategic Planning. Local partnership arrangements have failed to build cohesive service networks. Commissioners have concentrated (or retreated?) to individual patient contracting from mainly established services.
 - 2.9 There is a lack of recognition in the varying skills required to work at different tiers. There is sometimes a simplistic assumption that fewer skills are required at primary than higher levels of service delivery. The skills required are different but equally challenging and should have equal investment in targeted training.
 - 2.10 There is a lack of fidelity to evidence based models. For example, Crisis Resolution Teams, assertive outreach, personality disorder teams have been established across many areas of Wales but few are genuinely multi-disciplinary and multi-agency.
 - 2.11 Many professionals within secondary mental health services are involved across a range of agencies in training and education. Few have this fully recognised within their job specifications and there is scant attention to their needs for training as educators.
 - 2.12 Secondary mental health services are made up of a number of subspecialties. Whilst this has allowed some development of highly specialist expertise it leaves increasing numbers of interfaces for service users to fall through. Adult generic mental health has increasingly focused on only supporting people with some severe mental illnesses notably schizophrenia and mood disorders, consequences include a better ability to develop initiatives for early intervention in psychosis and assertive outreach but no real development of other areas e.g. adults with anorexia, adult survivors of abuse and adults with ADHD.
 - 2.13 There is a lack of counselling and innovative psychological support within communities thus putting pressure on secondary mental health services.
 - 2.14 There has been a lack of development of mental health services for 'vulnerable adults'. Currently, primary care services feel they lack the competency to meet their needs often arising out of factors such as abuse, educational limitations, unemployment, drug abuse, contact with criminal justice or child protection. They become subject to disputes between services and frequently present in crisis (cross ref 1.8).

- 2.15 Integrated mental health teams with social services and the third sector have not really developed. Many so called integrated teams work with professionals working to different management systems, different clinical infrastructure systems, different eligibility etc.
- 2.16 There is a lack of clarity if secondary mental health services should provide all diagnostic and intervention services for people with mental disorders or only be providing the services for additional mental health needs. This is particularly relevant to substance misuse, learning disability and dementia services.
- 2.17 There has been confusion over the provision of intensive psychiatric care with units variously described e.g. high dependency (HDU), psychiatric intensive care units (PICU). Such units have varying levels of environmental security, staff competency and capacity. There is a lack of clarity in arrangements for the emergency provision of secure care.
- 2.18 Some areas of Wales have police surgeons with only limited expertise in assessing mental health needs. LHB's have difficulties in establishing 24 hour, Section 12 doctor availability. This puts additional pressure on secondary mental health services.
- 2.19 Considerable travelling is required between the different sites currently designated as places of safety (Section 136 Mental Health Act). Only a minority of current 'places of safety' will have easy access to a psychiatric intensive care bed.
- 2.20 There are insufficient low secure and 24 hour staffed placements resulting in delayed transfers of care or transfer to care of a higher security than required.
- 2.21 Complex psychological assessments and treatment are only available in forensic or specialist settings leading to referral into secure settings and difficulties in a return to local services.
- 2.22 The relationship of NHS secondary mental health services, social services and private & voluntary sectors in service delivery is sometimes unclear. If an establishment is a designated mental health nursing home, they usually can function with clinical independence. However, social services and other sectors may set up structures with insufficient regard for their clinical infrastructure need which can result in significant pressures on local services and more importantly an inadequate service.
- 2.23 Specialist services for people with personality disorders are at an early stage in development. Unrealistic and poorly managed expectations may put individual patients at risk and sabotage future progress.
- 2.24 Forensic community mental health services expertise lacks capacity and infrastructure. Lessons can probably be learnt from the past development and demise of MDO groups.
- 2.25 Service innovation has frequently relied on internal Trust reallocation of clinical and financial resources. Such reallocation can be skewed and may further fragment services received by the individual.

3. Issues for the Medical Workforce and Specifically Psychiatry

- 3.1 Wales has a poor record in producing psychiatrists. There needs to be consideration of selection of applicants with an aptitude for holistic care which should improve the whole potential medical workforce and enhance the possibility of choosing psychiatry.
- 3.2 There need to be role models for medical undergraduates within academic appropriate and clinical settings.
- 3.3 Issues such as stigma and discrimination need to be proactively addressed within the undergraduate curriculum.
- 3.4 Psychiatry across the UK has significant recruitment issues which are partly masked by the continuing appeal of the UK training to international graduates. Continuing issues include the marginalisation of psychiatry from the rest of medical practice and within mental health teams. The term medical model is often used in a pejorative fashion. The medical model has always included drawing together biological, psychological and social factors to give an understanding of a persons current difficulties.
- 3.5 Recruitment to postgraduate medical training programmes in Wales has had difficulties. Fuller Deanery analysis of 2008 is awaited. Concerns expressed by trainees have included Welsh recruitment rounds being later than other Deaneries, concerns about the potential wide geographical spread of posts, working in different legislative frameworks.
- 3.6 No opportunities for joint training with other specialties (note in the past a significant minority of psychiatric trainees had had their first experience in general practice).
- 3.7 Current psychiatric workforce is working in the sub specialty silos mentioned above. Significant energies are required to establish a cohesive psychiatric and mental health workforce.
- 3.8 The opportunities afforded by job planning and appraisal systems have not been fully exploited. Statements are made about wanting doctors involved in designing, evaluating and operationally managing services, as well as focussed assessment and treatment of people with complex needs.
- 3.9 The development of new legal frameworks, notably the Mental Capacity Act and Deprivation of Liberty Safeguards require specialist assessments. There is already an expectation of increased psychiatric input whilst the MCA is in its early implementation phase. This input is in addition to that required for the assessment and treatment of mental health needs. In some cases, psychiatric input is solely required for advice on capacity, consent and ethical issues. This new area of work has its own training requirements. To function effectively in these developing areas psychiatrists require a different supportive infrastructure beyond mainstream current clinical practice.