Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar anghydraddoldebau iechyd meddwl

This response was submitted to the Health and Social Care Committee consultation on mental health inequalities

MHI 56

Ymateb gan: | Response from: Llamau

Llamau

Imagine a World Without Homelessness

Llamau Response to Mental Health Inequalities Consultation

About Llamau

Llamau is Wales' leading homelessness charity.

Our support is flexible and tailored to individual need; underlined through strong values and culture and a psychologically and trauma informed response.

Llamau is daring to imagine a world without homelessness. We are determined to create a Wales where no young person or woman ever has to be homeless.

We focus our support in three key areas in order to bring about an end to homelessness.

1) Early Intervention and Prevention: this means preventing homelessness before it happens and not waiting until people reach crisis point before they get the support they need. This involves going 'upstream' of the issue and in the long-run is a much more cost-effective way of tackling homelessness.
2) Safe Accommodation: this means providing homely and safe supported accommodation and refuges, and not institutional hostels. These are places that people can genuinely call home and which give people a safe platform from which to rebuild their futures.
3) Support to Move On: this means recognising that with the right support everyone can move on to live independently in their communities. We focus on supporting people with mental and physical health issues which have developed from the traumas they have experienced and on supporting people into education and training so they are able to move into sustainable jobs which allow them to move on from homelessness for good.

1. Which groups of people are disproportionately affected by poor mental health in Wales? What factors contribute to worse mental health within these groups?

- Trauma and abuse, particularly chronic situations, or during childhood (ACE's)
- Those experiencing domestic abuse situations / VAWDASV
- LGBTQ+ people, particularly young people
- Looked after children and young people
- Teenagers (important to reference this covers pre and post 18 & is compounded by neurological development & transition from child to adult services)
- Those with learning difficulties and disabilities, including neurodevelopmental concerns
- People living with ongoing stress levels e.g. poverty
- People at risk of / experiencing homelessness, or housed in temporary / substandard accommodation i.e. without a safe place to call home.

Reasons why/factors

- Abuse or prejudice leading to lack of trust in people - means that people are more reluctant to ask for help, or if they do, the help needs to be more mindful, engaging and empathic to these needs.
- Cultural understanding / trust in services and models
- Lack of easily accessible support services at both prevention and crisis points, meaning an absolute requirement of distress, or risk to health / life before services might be available.
- Long waiting lists for services i.e. not available at the point / time at which people are motivated to engage in them.
- Medical understanding of mental health in society and particularly in services – this means people are often afraid of asking for help, believing there is something 'wrong' with them – stigma and shame can be felt.
- Knowledge of and understanding of how to access and 'get' services
- Social isolation, particularly due to COVID, but also bullying, friendship issues, being out of work.
- Often more difficulties in education due to other stress in their lives impacting on ability to learn – which in turn can lead to less engagement in learning, lower outcomes and reduced career opportunities.
- Peer pressure to fit in – links to social media
- Multiple caregivers and workers / changes in placements and workers – leading to a loss of stable emotional relationships
- The above experiences mean missed emotional learning, e.g. how to regulate your emotions, think through consequences of situations etc – executive functioning skills.
- Potential for higher exposure to drugs / alcohol
- Less opportunities for education, activity, etc which promotes wellbeing – e.g. access to sports clubs, learning and fun activities due to cost/someone to take them etc. / moving around.
- If the first time someone tries to access support is a negative experience (it often is), people avoid trying again until things have escalated to crisis.

2. For the groups identified, what are the barriers to accessing mental health services? How effectively can existing services meet their needs, and how could their experience of using mental health services be improved?

Factors contributing to problems

- Lack of timely available services
- Previous negative experiences, e.g.:
    - Someone actively contemplating suicide being told to cheer up and look at a website will not make them confident in accessing services again.
    - Another young person found out a previous MH professional had labelled them with a disorder and not told them. This was on their notes for others to see but was unknown to the individual until they asked to see their case notes.

- Long waiting lists
- Difficulty in getting accepted by services and feeling 'judged' (e.g. we can't help you until you stop taking drugs…. Lack of comprehension of root cause).
- Being rejected by services as not fitting into service set ups, even when severely at risk
- Lack of outreach support which is meaningful and tailored to person
- Lack of longer term support services – trauma is not a six session model – people need to often dip in and out and build up trust, and have responsive services when needs get triggered (often at short notice)
- Services being built around the medical model of illness, rather than of need, so diagnosis leads the intervention, rather than getting to know the human individual need.
- Services being built upon the idea of 'weakness and problem' rather than strengths of the individual and their network
- Lack of joining up between mental health services and wider agencies in a supportive way rather than pushing back for these services to support people alone. (Mental health services not valuing partnerships and the intelligence and support that other agencies / workers can provide for a holistic assessment of someone's needs, rather than relying solely on what they can get from the person themselves).
- In many cases, a culture within some staff in these services to push people away and a response which is not respectful, empathic or engaging, meaning that people will not go back to seek help again, due to very negative experiences when they first tried.
- Access points – restrictive – through GP, and often through groups first before individual would be offered – many people in the list above are not able to trust or attend groups.
- A model of setting the service and fitting the client to what is available rather than more creative bespoke models. E.g. you must attend an anxiety group even if you don't trust people and are suicidal, before we can offer anything else.
- Transitions into adult MH services, where the 'gateposts' are set higher and offer less flexibility. E.g. someone missing an appointment because they are in crisis and can't leave the house, being taken off the list.
- Not listening to individual stories and experiences at the time of assessment. Not taking time to create a feeling of trust and safety during assessments, so how someone is really feeling is not shared.
- Mixed qualifications and experience at the time of assessment can impact the type of formulation and response – seeming to be linked to lack of training or experience in how to conduct these thoroughly – e.g. if someone presents as suicidal, a safety plan should be done, or if someone says they cant cope with groups, groups should not be the only service offered.

How can this be improved?

- Increased transparency

- Increased access, including a 'no wrong door' approach being implemented in adult MH services. Ensuring people get to the right type of support/approach at the right time.
- Extensive training and implementation of learning processes for all mental health staff in engagement, respect, listening, formulation and safeguarding
- Clear menus of support offerings rather than restrictive pathways of options
- Extensive outreach support flexible in terms of type and length
- Residential options with a psychological model of mental health available as alternative to medical model inpatient which exists
- A strength based culture
- Meaningful partnership working with existing agencies
- A clear suicide protocol to include safety planning
- A trauma informed model to underpin the new culture, and willingness and process that allow a more individualised care response, to improve outcomes – it's not just doing. Most current services diagnose the problem with the individual not looking at the trauma that's happened to someone.
- Where there are 'dual diagnosis' issues e.g. mental health & substance misuse – stop refusing to support with mental health until substance use is ceased. See the whole picture, rather than a silo focus, and work with other specialist agencies to support all of it in tandem. Substance use is often and symptom / consequence of poor mental health.
- Wales needs more acute mental health hospital beds – too often people are not admitted, despite us being told they meet the threshold, due to a lack of available beds. Or sent hundreds of miles away to access a bed, particularly if there is a 'specialist need' e.g. child placement, or complex needs.
- Discharge planning needs to be improved to include all agencies involved, and wider networks, particularly if discharge is intended to be back to family, or to a supported accommodation project, taking into account any risks to other vulnerable people who might also be sharing that environment, and/or the staff often lone working in those placements.

3. To what extent does Welsh Government policy recognise and address the mental health needs of these groups? Where are the policy gaps?

- A number of recent policies and PHW programmes do reference what is needed and how we understand mental health in Wales – the gap seems to be in implementing this learning into the key central mental health services
- Over the years there have been a number of positives in policy, or implied direction of travel from senior Government / Health management structures. Seem to have resulted in no real change on the frontline / for people in distress.

4. What further action is needed, by whom/where, to improve mental health and outcomes for the groups of people identified and reduce mental health inequalities in Wales?

- People need to have easy and timely access to a wide range of choice of services, at different levels.
- Stigma needs to be reduced and people need to continue to be educated about trauma – in services but also at a society level
- Access to support re mental health at a basic primary level should be available in a range of services not just via GP in health, and ideally with people who already have established relationships, or can link via those relationships
- An understanding that 'relationships heal trauma' and this takes time, empathy and needs to be at the pace of the individual
- A culture shift in adult mental health services from a medical to trauma informed model, from a deficits to strengths based model, from a doing to , to a doing with model, which respects the origins and personal stories which contribute to mental health, and is creative in its bespoke responding, from a range of evidence based techniques.

Notes from Feedback with Llamau Colleagues with Senedd Committee officials

Llamau operational colleagues fed back on their own experiences and of those they support.
[NB. People supported by Llamau are feeding back their views to Senedd committee officials on Monday 28th February]

Key questions asked;

1. What are the factors that are contributing to your poor mental health?

2. What are some of the key issues you have faced in accessing Mental Health support and how effectively can existing services meet your needs?

3. How could your experience of using mental health services be improved

- Lockdown and Covid has contributed to poor mental health. Lack of community provisions, constant changes to rules, lack of opportunities to socialise and engage with others has put more pressure on families. Young people have heightened anxiety and have become more withdrawn. Social integration and coping with lots of people has become difficult.
- Greater need for fun and engaging opportunities for young people
- The pandemic has meant that we have had to continuously deal with the unknown, leading to an increased pressure to look after ourselves as well as supporting others.
- Rural areas have seen a huge decrease in the number of community groups available - leading to isolation and lack of opportunities to socialise with others.
- Aces and experiences make it difficult for young people to sustain relationships. They often find it difficult to have trusting relationships with other professionals.

- Factors like family breakdown, financial difficulties including getting sanctioned have be exasperated by the pandemic.
- Use of social media has increased to a level where people are addicted
- Lack of consistency with support does not help long term for people experiencing mental health issues
- Parents not beings supportive or not having the skills or knowledge to know how to support their children
- Lack of support in schools, teachers and school staff are not always trained to deal with mental health issues.
- Increase in substance misuse – often used as a coping mechanism for mental health issues. Young people are more open about their substance misuse and illegal drugs are easily accessible with people advertising drugs on social media.
- When people are in crisis and access hospital, once they leave there is no follow up or after care.
- Young people are expected to know and have the confidence to call their GP but often lack the confidence.
- Online forms for access GP appointment or repeat prescriptions are often inaccessible and young people and families struggle to understand how to complete them.
- When accessing support services, if they are having a good day or miss an appointment they are quickly struck off the list.
- If they don't meet the threshold to be accepted into services (like CAMHS) there isn't anything else for them to be referred to for support.
- Emergency services have been called out to someone suicidal but have taken hours to get there and have explained that they need to be 2-1 for suicidal individuals.
- Often services push back on support workers and don't seem to take responsibility for the welfare of the individual. This puts pressure on support staff who are not mental health specialists.
- Young people often know where to go for support, however, waiting lists are long and they often do not have the confidence to contact services themselves.
- Police have responded to a situation where a person was suicidal and sent about 8 officers and 3 vehicles, this frightened the young person and didn't help with their mental health crisis.
- People do not know that social prescribing is an option to explore with GP.
- In Cardiff, there is a single access point contact number, which is fantastic but needs to be shared more widely
- Young people known to services or those who access services regularly seem to have stigma attached to them. Sometimes it feels that they are not taken seriously as they are 'known' to the service and staff.
- Often people are discharged from mental health support before they are ready with little follow up or support available.
- Education – the curriculum should enable children and young people to develop strategies to be more resilient
- The benefit trap doesn't help. Those in supported accommodation find it difficult to gain employment as their benefits stop and they will be no better off

financially or sometimes even worse off. A provision in place to allow them to work and doesn't penalise someone seeking benefits.

- Stigma around mental health needs to be removed – we should see mental health just the same as physical health.