

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#)
ar [anhydraddoldebau iechyd meddwl](#)

This response was submitted to the [Health and Social Care](#)
[Committee](#) consultation on [mental health inequalities](#)

MHI 79

Ymateb gan: | Response from: Platform



Re: Consultation response on Mental Health Inequalities

Platform is the charity for mental health and social change.

We are a platform for connection, transformation and social change. We're driven by the belief that a strengths-based approach is the foundation to sustainable wellbeing for everyone. We do not believe that people or communities are "broken" or in need of fixing.

Our work takes a trauma informed approach to understanding mental health and emotional distress, and we see the current mental health, and wider health, social care and public sector systems as no longer fit for purpose. Based on illness and deficit models, they deny people the hope and agency to heal.

Our response to the consultation is as follows:

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

The groups disproportionately affected by MH are predictable and obvious. Poverty, racism, lack of access to green spaces, poor housing etc are all factors linked to MH. This is well-documented and the committee should already be aware of this.

Factors that can worsen MH within these groups include poverty, racism and other forms of collective trauma. However, it would be worthwhile for the committee to consider the effects of re-traumatising systems within public services. Examples of such re-traumatising includes:

- The DWP and in particular the culture of sanctions, conditionality, and the requiring people to undertake tests that have the intention of seeking to reduce entitlements such as the work capability test.
- Institutional racism, particularly in services that have the power to control and institutionalise people such as the criminal justice system, psychiatric units, and social care.
- Excessive and intrusive rules that prohibit people making choices and having control over their situation. For example, professionals assuming they know best and not working with people to find out what they want.
- Lack of services and resources that create lack of choice.
- Deficit based labelling of people and writing them off.
- Poor equalities practices that exclude people from accessing services and facilities.

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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?

The inverse care law is already understood and accepted within the Health service, but remains an important concept in explaining the barriers to support. In practice, it means a lack of choice for people accessing MH support, with medication over-relied upon because long waiting lists for talking therapy make meaningful choice unrealistic. The reality is that people who can afford to pay for counselling will not wait long, and people who are unable to pay for counselling will wait for a long period of time, often beyond the point at which it would have made a significant difference.

There are also specific shortages in counsellors able to provide counselling through the medium of Welsh, British Sign Language, or able to support people with neuro-diverse needs.

But there are also additional barriers that can be created following somebody being given a psychiatric diagnosis. Many services are risk adverse and will exclude people who receive such a diagnosis. This is illustrated well in support services for people who have experienced violence and abuse. We are aware of many occasions where women who have experienced abuse and violence have received psychiatric diagnosis of “borderline personality disorder” (BPD) or “emotionally unstable personality disorder”. We would question the suitability of such diagnosis, instead noting that the common symptoms associated with such a diagnosis are actually normal responses to a traumatic situation.

This is not a trivial matter. The over-reliance on medical models of mental health in the criminal justice system is a factor in how that system can re-traumatise people. It is used as a weapon by perpetrators of abuse to throw doubt on their stories, make the survivor feel they are at fault for experiencing abuse, and perpetuates gaslighting. In the family courts system, the use of the BPD label can potentially be used in custody battles, which has a subsequent effect on children. That’s why we are calling on the Welsh Government to commission a review of the use of BPD and its suitability when it comes to women who have experienced violence and abuse. We would also note that perpetrators of abuse can often choose their victims precisely because of their vulnerability, knowing that the person will not be believed because they have a psychiatric diagnosis.

This is not the only example of where people can be re-traumatised because of the over-medicalisation of trauma. People can also be excluded from support services such as refuges and counselling services with such a diagnosis, or if there are other responses to trauma such as substance use. There are lots of

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services that are very risk averse and will exclude people considered to be too “complex”. This is not trauma-informed, yet is still occurring.

We would therefore emphasise that one barrier to people accessing Mental Health services is the over-reliance on medical models and labels that have the effect of excluding people from other essential public services. This would be an interesting avenue for the committee to explore.

Another barrier is the climate in which staff within public services operate. Sometimes staff in public services can also experience trauma and burnout which increases the likelihood of a service not being trauma informed. Staff themselves can often find their professional judgement sub-ordinated to bureaucratic processes, meaningless targets, or micro-management of their activities. This can create compassion fatigue and increase the chances of labelling and viewing people they are working with as cogs in a machine.

This can have an enormous negative effect on staff members, shaping and reconstructing identity from ‘I am a compassionate, caring person who is here to help others’ to ‘Just get me through one more day’. Using power to manage extreme behaviours can cause service users to fear and distrust staff, resulting in poor engagement and thus potentially frustrated and dissatisfied staff who rely even more heavily on power and control.¹

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

Current WG policy acknowledges the inequalities in MH and -unlike the Westminster government - appears to be increasingly aware of the impact on MH that racism and structural inequalities cause.

However, there are a few gaps we wish to highlight:

- (1) A major gap is the lack of acknowledgement that an overly medicalised approach within MH services needs to be addressed, and choice expanded. We would like to see a focus on more alternatives to institutionalisation (such as Platform’s crisis homes in Cardiff and Newport) for people experiencing a crisis, and a greater range and availability of talking therapies and coaching. We would also like to see the asset/PTS and other asset based coaching styles of working with people (asset based rather than deficit based) expanded and more

¹ See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6088388/>

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awareness of this approach within the NHS and the advantages it offers over other approaches.

- (2) Linked to this is that the Policy response underplays the importance of non-medicalised ways of supporting and maintaining recovery. For example: Practitioners need to consider how to tackle loneliness and isolation, encourage people to participate in social activities (arts, culture, community etc). This has been difficult to do so within the context of the pandemic as many community and cultural activities have been unable to go ahead, but has always been a neglected factor within the Policy response.
- (3) As part of the covid recovery plan, the Welsh Government needs to acknowledge the collective trauma that has been experienced as a result of the pandemic (albeit an experience that has impacted poorer and marginalised groups more than others). It is not suitable to adopt a medical model of Mental Health for these circumstances and neither is it appropriate to deny there is a problem that requires a skilled and differentiated response that listens to people rather than makes assumptions about the cause of the problems. We would suggest learning from the disaster recovery framework about collective trauma and recovery from such trauma, noting that in cases such as Hillsborough and the Grenfell fire, a failure to be honest or transparent over mistakes can exacerbate the trauma.

We would welcome the opportunity to discuss further.

Yours Sincerely

James Radcliffe
Head of Public Affairs and Influence