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National Assembly for Wales

Health and Social Care Committee

Post-legislative scrutiny of the Mental Health (Wales) Measure 2010

Evidence from Royal College of General Practitioners – MHM 07

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA.

11 September 2014

RE: Post-Legislative Scrutiny to Assess the Implementation and Operation of the Mental Health (Wales) Measure 2010

Please find attached comments from Wales Mental Health in Primary Care (WaMH in PC) regarding post legislative scrutiny to assess the implementation and operation of the Mental Health (Wales) measure 2010.

The Wales Mental Health in Primary Care Network (WaMH in PC) was established in 2003 to help promote and improve primary mental health care across Wales. It is a working sub-group of RCGP Wales. The Network brings primary care mental health practitioners, professionals, agencies, organisations, carers, service users, and their friends and family together to help improve mental health services across Wales.

The responses to the questions are collated from a wide variety of sources including GP's third sector organisations, those concerned with the provision of services, the results of our recently held survey of primary care (to be published soon), and others. Rather than give one view we have decided to give you all the views expressed as this will best represent the range of views from our highly diverse core group. This means some of the answers may seem on the surface slightly contradictory but this reflects the honestly held views of our members. Perhaps the best summary is that whilst we welcome the introduction of the measure, and in particular Part One, we feel that the service as a whole has not yet grown to fit the expectations of primary care and in particular there are frustrations about continuing barriers to access, the lack of psychological therapies to help primary care to manage

common mental health problems in line with best practice, and concerns about CAMHS services
Yours Sincerely

Mark Boulter
Chair, WaMH in PC

Theme 1 (achievement of stated objectives):
The Measure was implemented during 2012. Please answer any of the following questions in relation to the impact of the Measure on which you feel able to comment.

a) Do primary mental health services now provide better and earlier access to assessment and treatment for people of all ages? Are there any barriers to achieving this?

The mental health measure has moved the bottle neck, rather than remove it. Now I am finding it is quicker and easier to refer directly to the CMHT than to the PCMHSS. I find the PCMHSS assessments usually recommend treatments that I already suggest to my patients i.e. computerised CBT (www.llttf.com) book prescriptions and the psychoeducation courses (Stress Control Course, ACTion for Living etc) and so has little additional value. There is no improvement in accessing the services we need: high quality one-to-one CBT, specialist advice on medication management and tertiary services (trauma focussed services, eating disorders, support for personality disorders in particular)

Reports from primary care staff suggest that more assessment is taking place but with regards treatment specifically with psychological therapies the key barrier to access is lack of provision. In the recent 2014 WaMH in PC survey 'lack of timely access to psychological therapies' was the most significant barrier to access with some 85% of respondents identifying this barrier.

There is a central hub for adult referrals now that has streamlined the process and has meant that people are assessed quicker than the old system. However, rather than having any treatment, they are likely to be signposted to other services. Our practice has had difficulty with urgent referrals not being dealt with as quickly as we would like and, in those situations, not being certain that the referral had been received, as it is done electronically.

Despite referring patients for assessment, patients are still contacted and asked to confirm that they still want to be assessed which can be an additional unnecessary barrier for some vulnerable patients. Some colleagues now refer patients directly to the third sector for counselling.

The CAMHS service locally has not been able to work to the standards set by the Mental Health Measure and there is still a long wait for patients to be seen for assessment and treatment.

No.

It seems that in many areas there has been an improvement in the ability of Primary Care to get their patients assessed but the treatment aims of the measure have not been achieved with patients being sign-posted to other services and not getting appropriate access to meaningful psychological therapies. It seems the services have not matured into one which

can provide quick access to professional assessment and also treat patients with common mental health problems.

GPs – Service received still very much dependent on the individual GP, their confidence and interest in mental health. Where services are good/excellent this is still the case. Where services need improvement they do not believe that their experiences over the last two years have significantly improved. There still appears to be a lack of information and understanding of what the Measure is seeking to do. We have concerns that without knowledge neither patients nor primary practices can get the best out what is considered a good piece of legislation.
We have also been told that GPs are sometimes prescribing anti-depressants because of waiting lists for talking treatments, not wanting to leave their patients "with nothing" in the meantime. Talking treatments through the medium of Welsh a particular concern – this is an equalities issue. CMHTs etc., concerns about waiting times even for urgent referrals, when hospitalisation is being seriously considered people are waiting 5 days to see CMHT, only to be told there is nothing they can do.
Also services are under pressure leading to CPNs for example doing their own role and trying to also do the role of support workers or support volunteers. E.g. trips to garden centre for coffee and also trying to have as client meeting at the same time.
The social model of disability should underpin the Measure, but there is reliance on the medical model.

Only patients under the care of a consultant can re-enter the service without re-referral. In contrast, patients in primary care mental health services or CAMHS need to be re-referred. Given many patients DNA their assessment, re-referral is common, time consuming and an unnecessary extra burden. A lot of pressure is applied not to refer patients as 'urgent' to services because of the outcome measures currently used. This impacts on patient safety and generates unnecessary stress for GPs. Many patients' problems are complex and signposting without discussion with the referring GP or limited and inappropriate therapy intervention has a negative impact on outcomes. The waiting times for psychological therapies remain at 2 to 3 years and are considered inaccessible and not a practical option.

Part 1 of the Measure appears to be having some impact on patient experiences but there is still some way to go to achieve the intended outcomes. The first two years of implementation should be viewed as a step in the journey towards better mental health services. It is therefore important that there continues to be a political focus on the impact of this legislation and improving patient outcomes.

b) What has been the impact of the Measure on outcomes for people using primary mental health services?

Another tier has been added in between primary care and secondary care by part one of the measure which has created a further separation of both. I don't think it has improved access. In fact, most people using primary care mental health services find it distressing repeating the same questions over and over again. To have to explain your symptoms and social situation to your GP, and PCMHS worker and to an ongoing practitioner (e.g. a counsellor/member of the CMHT) adds to the distress.

Feedback from patients suggests that patients have found the session with the Primary Care Mental Health Worker helpful.

It is common for patients with mental health problems to have attachment problems and issues with trust and safety. However, many are referred for group work that is not suitable

and they become more distressed and DNA appointments. Some diagnoses are not acknowledged with a focus on co-morbid problems such anxiety or depression missing the primary problem. Avoidant patients who fail to attend for assessment are discharged and need to be re-referred leading to repeat consultations and referrals for reasons given in (a)

Our in-practice CAMHs facility whereby families could be booked into surgeries with access to practice IT systems has been closed. An award winning early intervention team of counselors in training to support parents of children in CAMHS has also been closed.

Some patients may be referred appropriately to Community Mental Health, but by the time they are seen the acute symptoms have been helped by treatment received in General Practice so they are then referred to Primary Care Mental Health Support Services, which in some areas have several month waiting times. Often when patients are seen they are then referred on to other third party agencies which have long waiting times. GPs are now managing increasingly more difficult mental health problems, which 10 years ago were supported by Mental Health. Introduction of the measure has delayed access to care for some Mental Health conditions.

Some patients, when are seen by Primary Care Mental Health Support Services, are offered get additional support that was not previously available. For some, particularly the elderly and disabled, may be difficult or expensive for them to access. There may not be local and may have difficult or no public transport links. We have seen patients who fear attending group sessions, which seem to be the commonest form of support offered and so opt out of treatment. Some patients with mental health have fluctuating conditions so when they arrive at the assessment, they do not fit that services criteria and then they get bounced back to different services or back to the GP with out having any help or support. Some of them have an unstable life style and move frequently so appointments are not received or they have moved to different catchment areas. Either of these scenarios mean that care is not opium and they affect the self esteem of the patient seeking care and reinforce the idea that no one cares. They also increase GP work load in managing and supporting patients, who previously would have been monitored by CPNs from Mental Health. There is also increased administration both in general practice and secondary care associated with repeat referrals.

c) What has been the impact of the Measure on care planning and support for people in secondary mental health services?

I don’t see a significant change in the care planning system from the previous CPA system. Most care plans are still made in secondary care with little involvement of the primary care team.

Not noticed much of a change.

Care and treatment plan may be available in secondary care, but often patients are not aware of the details and the information is not translated into comprehensive information available to GPs, who often manage the patients between visits to secondary care. There is often lack of transfer of care across different divisions of secondary mental health care e.g. mental health ward, crisis unit, liaison psychiatry, community mental health, substance abuse.

d) Has there been a change to the way in which service users in secondary mental health services are involved in their care and treatment?

I don’t think this has improved.

I don't think so

e) What impact has the Measure had on service users' ability to re-access secondary services? Are there any barriers to achieving this?

I don't think this has made a noticeable difference. I expect the right to a reassessment has created more assessments but, without improvement in the available services (i.e. greater investment in crisis teams, assertive outreach services, psychological therapies, inpatient services and access to specialist or special-interest GP services in GP surgeries) more assessment has not led to improved access.

Although patients are made aware of being able to refer themselves back in to secondary care, on the one time this has happened, the secondary care team would not accept the referral without a GP referral even though this was clearly in the Patient's Care Plan. After a few phone calls, this was rectified, but it did cause unnecessary distress to the family.

Re access to services can be different for patients as there are often no clear guidelines or criteria and delays are often experienced due to patients being in different catchment areas or being unaware how they can self refer. The arrangements for children and young people to them or their families/ carers or even their GP, especially if they become adults during the process. The arrangements for referral need to be made part discharge summary and this information **must** be sent to the GP and available to the patient. This can result in additional delays to care.

f) To what extent has the Measure improved outcomes for people using secondary mental health services?

It have improved people rights to access, but has not resourced the services they can access. It is akin to NICE guidance: it tells us what *should* be happening, but does not make it happen.

Sadly the introduction of Primary Care Support Services in some areas was very slow and has now resulted in a split Mental Health Service, which means that patients can experience delays in actually getting support and treatment as well as assessment.

g) To what extent has access to independent mental health advocacy been extended by the Measure, and what impact has this had on outcomes for service users? Are there any barriers to extending access to independent mental health advocacy?

As a primary care professional, I have no comment.

Access to advocacy services can be limited and requires awareness of the system, which may be limited outside mental health units. There is come confusion about the mental health and mental incapacity advocates and this needs additional clarification. Some patients lack capacity and also have mental health problems so there may be benefit in review the separation of these 2 roles.

h) What impact has the Measure had on access to mental health services for particular groups, for example, children and young people, older people, 'hard to reach' groups?

Speaking for my community, we continue to have difficulty with access for our non-white British communities and the homeless, particularly those with a mixture of substance misuse and mental health problems. The measure does not address the lack of culturally-appropriate mental health services or bridge the gap between general adult and substance misuse services.

There are large concerns across Wales from our survey which describe issues around access to CAMHS services which often are not able to accept referrals from GP's who themselves do not feel they have the skills, support or knowledge to care for these patients and their families

Transfer from adolescent service to adult services can be difficult as often equivalent management pathways are not available e.g. ADHD.
Limited information is available about learning disability. It is still noted that it is difficult to have support for some of these patients especially if the have mental health problems and / or are diagnosed as having learning disability as adults rather than as children

i) To what extent has the Measure helped to raise the profile of mental health issues within health services and the development of services that are more sensitive to the needs of people with mental health problems?

It has added more discussion to the agenda but has not come up with more solutions.

There is a sense that the expectation among GPs was that the Measure (part one) would enable more access to therapies. Given there remains much more demand than can be met by the current workforce, the existence and expectation of the Measure has raised the profile and priority of the need to improve provision of therapies in NHS Wales.

I think it has raised the status of mental health problems generally but I can see no evidence of greater support for patients with mental health problems at a Health Authority level. I read in my local newspaper that total funding for mental health services among all Wales' health boards fell by 3.7% from 2011/12 to 2012/13.

Having the measure as legislation has meant that people now have to look at mental health seriously and consider how services need to be developed. This is the first time that primary care mental health has been considered when looking at developing mental health services and this is to be welcomed as 90% of all mental health care is provided in Primary Care with a work force that is under immense pressure and is often not supported or skilled to look after the complex cases that come in on a daily basis. Most GP's say that they spend over 20% of their working day dealing with mental health problems (WaMH in PC 2014 survey)

The Measure appears to have raised the profile of mental health issues within the health service, but in the context of competing priorities this can only be consolidated through additional funding. While some professionals have been extremely receptive to the potential of the Measure, others continue to demonstrate poor understanding and empathy towards people with mental health problems, which needs to be addressed.

j) To what extent has the implementation of the Measure been consistent across Local Health Board areas?

I cannot speak beyond Cardiff. However, without increased funding for mental health services or the redirection of funding allocated to physical health services to achieve parity between physical and mental health services, I cannot see how the measure can be properly implemented anywhere.

The implementation of the Measure has been varied across Wales and in general probably has improved Mental Health Care of population

k)Overall, has the Measure led to any changes in the quality and delivery of services, and if so, how?

It has set a very high bar but has not assisted services to reach it.

The only difference I can see is that patients can now be assessed within a certain timeframe. There has been no change in the long wait for psychotherapy-over 18 months in my area, which is wholly inadequate. Patients are often directed to group therapies rather than the one-to one therapies they need. Patients are often offered counselling sessions with trainee counsellors who will not have the necessary experience and expertise.

Not. Please see (a)

Theme 2 (lessons from the making and implementation of the legislation): The proposed Measure was scrutinised by the Assembly during 2010 and implemented during 2012. Please answer any of the following questions in relation to the making and implementation of the Measure on which you feel able to comment.

a)During scrutiny the scope of the Measure was widened from adult services to include services for children and young people. What, if any, implications has this had for the implementation of the policy intentions set out in the Measure as it was proposed, and as it was passed by the Assembly?

I welcome the attempts to improve the transition from CAMHS services to adult services. CAMHS services remain difficult to access and provide comprehensive care once children are in the service, which rapidly disappears when they reach adulthood. The measure has not changed this.

We understand that the financial envelope for the measure was agreed before the addition of CAMHS services and this has led to un-necessary budgetary pressures on implementing the measure across Wales. This should be rectified by further cash injections to improve primary care services and in particular access to CAMHS for primary care teams

b)How effective were the consultation arrangements with stakeholders and service users during the development, scrutiny and implementation of the Measure?

There has been a great deal of consultation but the main issue (parity of esteem and funding for mental health services cf. physical health services to provide appropriate high quality treatments including psychological therapy and inpatient services) was not addressed.

WaMH in PC experience has been positive in engaging on all levels.

Having attended several consultation events I found them well run, informative and very positive

c)How effective were the consultation arrangements with stakeholders and service users during the development, making and implementation of the associated subordinate legislation and guidance?

As above

d)Has sufficient, accessible information been made available to service users and providers about the Measure and its implementation?

Yes

e)How effective was the support and guidance given to service providers in relation to the implementation of the Measure, for example in relation to transition timescales, targets, staff programmes etc?

Poor. There was a great deal of information of what should change but not enough help to do so.

f)Did any unforeseen issues arise during the implementation of the Measure? If so, were they responded to effectively?

The main unforeseen issue was the recruitment of the PMCSS workers. It was anticipated these would be well versed in primary care and operate within primary care teams. Instead, they are secondary care trained and operate separately from both primary and secondary care teams.

The new primary care workers had issues around access to suitable rooms in primary care. Many practices do not have spare rooms and there are huge problems with the primary care estate as there are demands from teaching (under and post graduate), consulting, other services/outreach.
Many of the new support workers did not have the skills at the outset to assess and treat patients

g)Are there any lessons which could be learned, or good practice which should be shared, for the development and implementation of other legislation?
Primarily, legislation is only as good as the resources that move with it.

Theme 3 (value for money):
The Welsh Government prepared and laid an Explanatory Memorandum to accompany the proposed Measure when it was introduced, including a Regulatory Impact Assessment. Please answer any of the following questions on which you feel able to comment.

a)Were assumptions made in the Regulatory Impact Assessment about the demand for services accurate? Were there any unforeseen costs, or savings?
Not at all. The measure drastically underestimated what was needed considering current spending on mental health services to be the baseline without considering the extent to which mental health services have been chronically underfunded for decades. Far, far more resources are needed to achieve parity between mental and physical health problems. Also the benefits of good quality mental health care on physical health conditions, such as the improvement in diabetic control and reduction in cardiovascular morbidity, and on the economy was grossly underestimated.

We feel there was little understanding of the huge mental health workload in Primary Care and how large the demand would be when a new service was set up. Without adequate resources and suitably trained staff the new service was starting at a huge disadvantage. We would hope though that as the service does develop and if the demands on secondary care reduce then more resources can be directed to tier zero and one services

b)Have sufficient resources been allocated to secure the effective implementation of the Measure?
Absolutely not.

Not at all.

The ambitions of the measure are not achievable under current financial constraints and service model. A 'push' model for primary care mental health continues that works against the 'pull' system advocated for chronic physical conditions. A central focus and directive on improved outcomes rather than cost cutting is also required.

If the Measure is successfully implemented, it should deliver future savings as more people benefit from early intervention through improved access to primary mental health services. However we believe that further resources are required to support the implementation of the Measure to ensure that it meets the intended objectives and delivers long term savings. Welsh spending on mental health is approximately 11% yet is estimated to make up 20% of the overall disease burden. Investment in mental health services would therefore need to be increased in order to deliver parity of esteem with physical health.

c)What has been the impact of the Welsh Government's policy of ring-fencing the mental health budget on the development of services under the Measure?

It was the right decision not to cut mental health services but patients have still seen a deterioration in relative access to services as the degree of psychiatric morbidity increases due to the recession, increasing demand whilst services remain at a chronically underfunded level. The ring-fencing of resources is not enough to prevent mental health service reaching a tipping point where under-recruitment and under-retention of staff, lack of funding and beds creates an untenable situation.

According to the information that was published in my local newspaper, it appears that the only funding that is ring fenced by the Welsh Government is the minimum amount of money a health board should spend on mental health. In actual fact, the spending on mental health among Wales' Health Boards fell by 3.7% from 2011/12 to 2012/13.

d)What work has been done to assess the costs of implementing the Measure, and to assess the benefits accruing from the Measure?

I am aware of some cost-benefit analysis but I don't believe it addresses the wider costs of chronic underfunding and the long term benefits of improved physical health (particularly in preventable non-communicable disease) and on the economy of reduced unemployment,

e) Does the Measure represent value for money, particularly in the broader economic context? What evidence do you have to support your view?

No. Much more needs to be done. I don't think the achievements of the measure go anywhere near addressing the funding gap in mental health services, the lack of psychological therapies, the under recruitment and under retention of mental health staff, the communication between primary care practices and attached mental health support workers, or access to timely acute crisis care, assertive outreach or inpatient services.

Investing in mental health is an investment in all health because 'there is no health without mental health'. The Measure is a positive step and Wales needs more initiatives designed to promote good mental health if it is to prevent avoidable physical disease (costly to the economy and human suffering) and truly deliver on the prudent healthcare agenda.

The Measure has merely started the process. Much more investment is needed to provide psychological support for patients in a timely manner to allow them to keep working and sustain their lives and their families' lives and wellbeing. At the moment it seems to be too little, too late to prevent the downward spiral for patients who do not respond to the care and support. that is provided by GPs and the Primary Health Care Team.