

National Assembly for Wales
Health and Social Care Committee

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

Evidence from Mind Cymru – MHM 11



Mind Cymru Evidence to Health and Social Care Committee of Inquiry into the Implementation of the Mental Health (Wales) Measure 2010

Theme 1 (achievement of stated objectives)

Primary Care

Our beneficiaries report that primary care services are still inconsistent across Wales. General practice experiences are still dependent on the confidence, knowledge and interest of practitioners in mental health. Where people have had good or excellent experiences, this hasn't changed, where service improvement is needed the Measure has not led to a rapid upskilling or raising of confidence.

Some local Minds are able to provide advice, guidance and support at GP practices, and good relationships have been established through partnership working. However this is limited by the inability of GPs to fund such arrangements. Where local Minds have the capacity to this within existing resource it has worked well.

Some GPs report prescribing anti-depressants due to the waiting times for talking treatments as they feel they cannot leave patients with no intervention whilst on waiting lists. However some are becoming much more aware of the role of the voluntary sector and are referring clients to local Minds and other organisations.

Access to talking treatments continues to be of great concern with both primary practice and voluntary sector waiting lists getting longer. There is also a particular concern with regards to the availability of Welsh language services, which leads to people waiting longer, travelling great distances or accessing a service in English to reduce delays. This is an equalities matter.

Some primary care teams (PCTs) are trying hard to engage with local third sector organisations, looking to them to provide solutions when the PCT can't meet targets with few or no additional resources. Often clients are referred when they find it difficult to engage with very large group interventions being run by PCTs.

However this evidence elsewhere of PCTs withdrawing into their own services and not using local voluntary sector services when this would be more appropriate, reducing the effectiveness and quality of the service to the individual. As public sector resources are shrinking this is becoming more prevalent.

There is evidence that there is still a lack of joined up strategic planning across health and social care, public and voluntary sectors, which negatively impacts on implementation of the Measure at all levels. This also in some parts of Wales leads to duplication of services and confusion for service users.

Community Mental Health Teams

Again the picture is mixed, but evidence suggests services under pressure with diminishing resources. In some areas of Wales Community Psychiatric Nurses (CPNs) are trying to undertake their own role, whilst also doing social inclusion work more suited to Support Workers, such as visiting garden centres, having coffee etc. Important work but not best placed with CPNs.

We know of midwives who are trying to seek appointments for women at risk, but appointments are repeatedly cancelled due to pressure on services.

We know of one person with post natal depression who upon visiting the GP on a Wednesday and after very serious consideration being given to hospitalisation, was instead referred as an urgent case to the CMHT. She was seen the following Monday and told there was nothing they could do for her.

Similarly a person who seriously self-harms has been given no attention by the CMHT and the GP doesn't know what to do. There are other examples including the response to a referral to a CMHT in January being a letter in October asking the person to get in touch if they want to be seen. A person with suicidal thoughts being seen for five minutes and then told they would get another visit in two weeks. This is clearly not what the Measure intended, and is unacceptable.

We also have reports of very good experiences, within the same Health Board, where a person has had the same CPN for over ten years and has good support from the Crisis Resolution and Home Treatment Team when needed.

A common picture is people being supported in larger and larger groups and then being referred to local Minds due to being resistant to treatment, when the issue is not unwillingness to engage, but inability to engage in a large group setting.

Secondary Care and Hospital Treatment

Again there is some good and some poor practice. The Measure does not appear to have brought standards up to good or excellent across Wales. There are still hospitals and units where there is little or no therapeutic activity, lack of engagement with patients and frankly some that are not clean. It still appears that standards for mental health units are much lower than would be expected for general or community hospitals.

We have evidence of good practice, which is a result of the Measure with joint planning around discharge, with local Mind providing support whilst the person is in hospital, to prepare them for discharge, so that the person is familiar with those who will be providing support on discharge. This did not happen before and is due at least in part, to a developing confidence and understanding of the third sector as partners. However this is not universal.

We know of one older person who was considered disengaged when in hospital. He had witnessed bullying of other patients and what was assumed as being a disinclination to engage was built on his fear after seeing how others were being treated. He also felt disempowered by the assumption from staff that as he lacked

some capacity he would be unable to control his diabetes and so staff took total control of insulin. There was no encouragement to self-manage medication and diet, something that is second nature to him. This was also true of other patients with diabetes that he came into contact with.

Other examples of disempowerment include having a room where you can make tea and toast but patients have to rely on staff to do it, when they would choose to do it themselves, with staff support as appropriate.

Care Plans

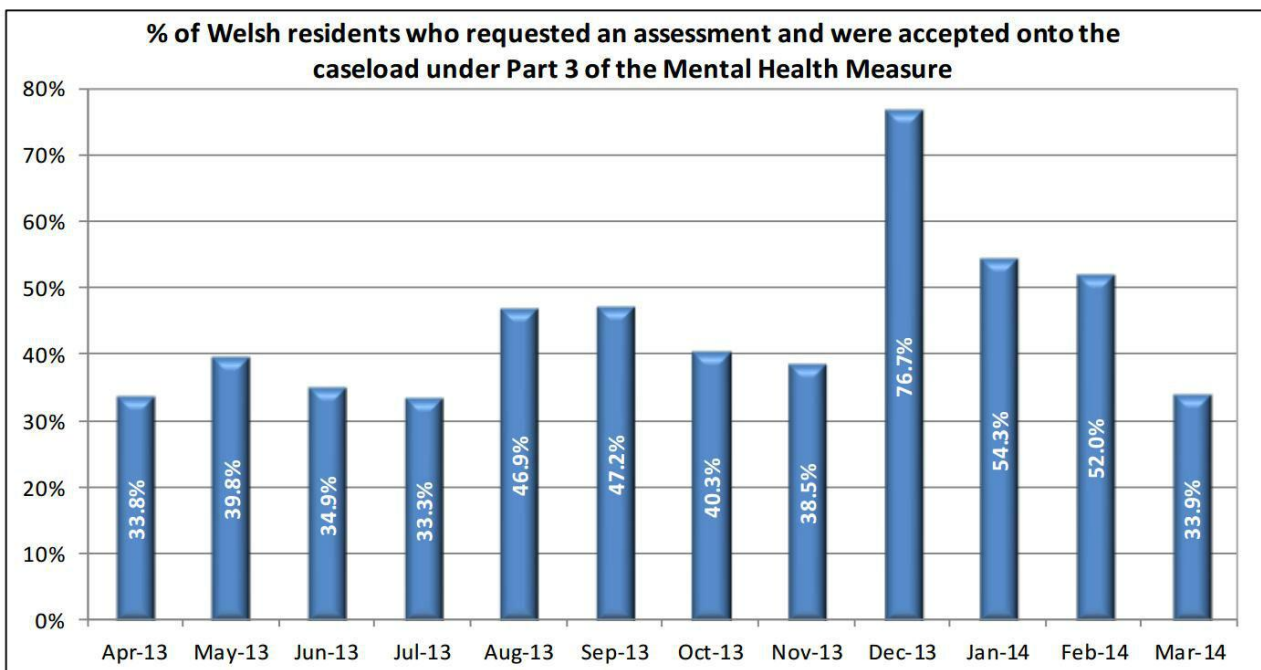
Although 80% of people entitled to a Care Plan now receive one, we know that both the quality and the practice used to develop them varies; and many are poor. We know that some domains are less likely to be completed than others, for example Domain 7 Social, Cultural and Spiritual Needs is poorly recorded, despite over 50% of participants in our recent survey of over 200 inpatients identifying as having a specific faith¹. Others particularly those around the medical model of care and treatment are most frequently completed.

The individual is not always involved in the development of the Care Plan and carers are also excluded. Assumptions are made that family members can care for their loved one and, for example provide regular meals on discharge during the day, with no consideration of their work or other commitments. We also still hear of people getting their Care Plan in the post for them to sign and send back.

In our survey 58.4% of in-patients were not given a copy of their Care and Treatment Plan, with a further 5.6% unsure if they had been given a copy.

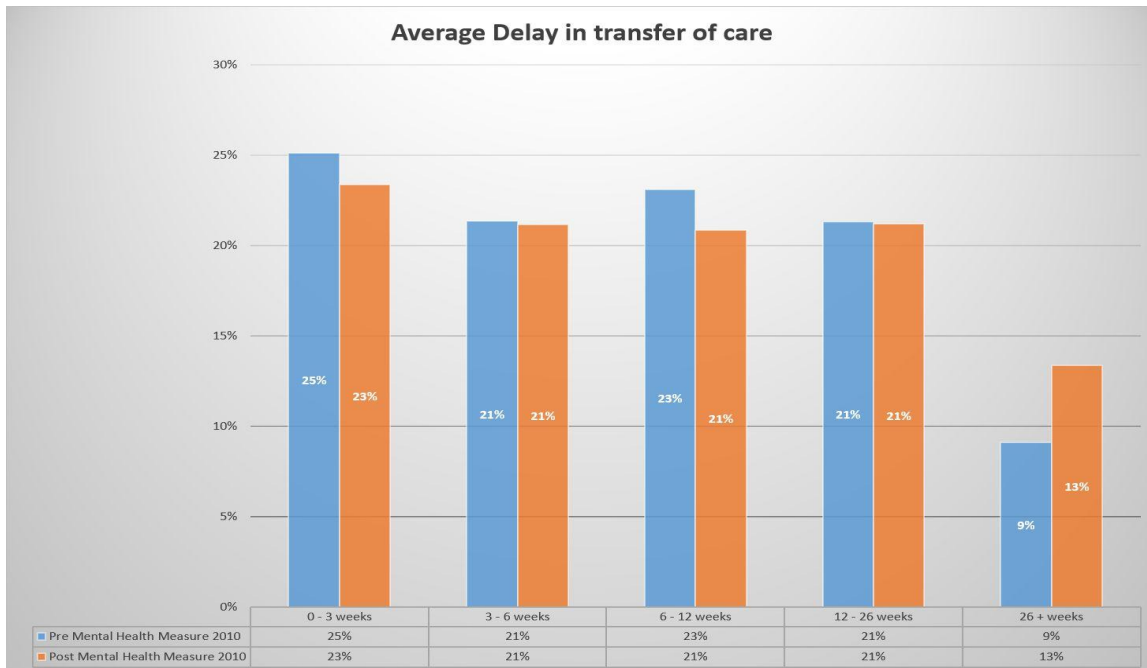
Secondary Services

There are concerns at local level with regard to the number of people being discharged back into primary care services and the pressure that is putting on the service. We know that individuals are using the Measure to seek to re-engage with secondary services, but do not know how successful this is. We know of people who are finding it difficult to get consideration and of others that are turned away and signposted to their local Mind, for example Mind Triage services. We also know that the numbers of people being accepted onto caseload under Part Three is consistently well below the numbers requesting assessment, with an average of 44.3% over the twelve months April 2013 to March 2014².



Delays in Transfers of Care

Evidence shows that there have not been significant reductions in delays of transfers of care post implementation of the Measure, with percentages staying fairly static except for those of twenty six weeks and over, which have increased from 9% (average October 2009 to December 2011) to 13% (average January 2012 to June 2014). In the same period non-mental health delays of twenty six weeks and over reduced from 4% to 2%³.



Part 4 Advocacy

Mind Cymru has recently completed a survey of patient experience of Part 4 of the Measure⁴. Adult mental health units and hospitals in each of the 7 Health Boards in Wales were visited. An online version of the survey was available during the same period. Over 200 patients were engaged. We will forward the report to the Committee on completion, however some key findings include:

- 58.4% of participants had not used or tried to access inpatient advocacy during the past year. Many people lacked information about what an advocate does, and their entitlement to advocacy.
- Of those who did access an advocate only 50% were provided with IMHA on admission. The modal waiting time was three days, however 42 participants waited more than seven days before they were introduced to an IMHA.
- 36.9% of participants were not provided with IMHA on formal admission to hospital.
- 34.4% of participants were on informal admission when they accessed advocacy, the rest were detained.
- The quality of advocacy was reported as good or excellent with 64.3% of participants believing the advocate made a significant difference to their care, treatment, information and support.

³ Compiled from monthly delayed transfers of care reports 2009-14, Stats Wales

⁴ Mind Cymru National IMHA Evaluation 2014

More work needs to be done to ensure that all patients receive accessible information about advocacy when they are admitted to hospital, using a variety of approaches. This also needs to be revisited regularly throughout the in-patient stay.

There is also a significant gap in legislation with regard to community advocacy. There is no right to advocacy for those people who have been discharged from secondary care and who wish to exercise their right to re-referral within three years and no right to advocacy for those seeking a first assessment. It is possible that this might contribute to the low percentage of those accepted onto caseload compared to the numbers seeking assessment.

We have concerns that the Measure does not take into consideration the increase in demand for services as a result of external factors, such as Welfare Benefit Reform, the inertia of the Welsh economy and high levels of unemployment, all of which impact on the mental health and wellbeing of individuals, families and communities.

Theme 2 (Lessons from Making and Implementing)

Making the legislation all age was meant to reduce the gaps and challenges of transition between children's services and adult services. However the challenges and shortcomings reported by the children's sector does not appear to bear this out. With regard to consultation, particularly with regard to the Code of Practice we would have liked to have seen a similar level of engagement as with the Code of Practice for Wales for the Mental Health Act (as amended 2007), where Mind Cymru was commissioned to consult in community, hospital, secure and prison settings across Wales.

There is a lack of communication and accessible information at all levels, between service providers and for people with mental health problems and their carers. Support for carers is extremely weak across Wales, with many of our local Minds reporting no services available at all. Carer services are being withdrawn with no regard for consequences. For example a service costing £17,000 per year has been withdrawn, leaving the carers of the four clients most at risk of hospitalisation without any respite. The cost of hospital treatment in that area is £2,500 per week.

Value for Money

Our local Minds report inequalities in service provision as a result of poor funding allocation. There was insufficient funding for mental health to begin with and due in part to poor communication and a lack of joined up planning resources are not directed to maximise benefit. Systems have been developed that don't result in the right people the right resources to deliver effective services. There is also a lack of transparency in reporting on the ring fence.

The evidence above is an overview of our experience of the implementation of the Measure and we would welcome the opportunity to give oral evidence to the Committee in due course.

Ruth Coombs, Manager for Influence and Change

