Agenda - Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 5 - Tŷ Hywel
Dyddiad: Dydd Mercher, 6 Gorffennaf 2022
Amser: 09.00

I gael rhagor o wybodaeth cysylltwch a:
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Rhag-gyfarfod preifat (09.00-09.30)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

(09.30)

2 Anghydraddoldebau iechyd meddwl: sesiwn dystiolaeth gyda'r sector gofal sylfaenol

(09.30-10.30) (Tudalennau 1 - 26)

Dr Julie Keely, Cadeirydd, Cyfadran De-orllewin Cymru Coleg Brenhinol yr Ymarferwyr Cyffredinol a chynrychiolydd Coleg Brenhinol yr Ymarferwyr Cyffredinol ar Grŵp Cynghori Arbenigol Iechyd Meddwl Colegau Brenhinol
Yr Athro Euan Hails, Aelod Bwrdd Coleg Brenhinol Nyrsio Cymru
Lisa Turnbull, Rheolwr Materion Seneddol a Materion Cyhoeddus - Coleg Nyrsio Brenhinol Cymru

Briff ymchwil
Papur 1 - Coleg Brenhinol yr Ymarferwyr Cyffredinol Cymru
Papur 2 - Grŵp Cynghori Arbenigol Iechyd Meddwl Colegau Brenhinol Cymru

Egwyl (10.30-10.45)

3 Anghydraddoldebau iechyd meddwl: sesiwn dystiolaeth gyda'r sector gofal eilaidd

(10.45-11.45) (Tudalennau 27 - 39)

Yr Athro Keith Lloyd, Coleg Brenhinol y Seiciatryddion

Papur 3 - Cymdeithas Cwnsela a Seicotherapi Prydain

Papur 4 - Coleg Brenhinol y Seiciatryddion

4 Papurau i'w nodi

(11.45)

4.1 Llythyr gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol at y Llywydd ynghylch Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Ymwelwyr Tramor) (Diwygio) (Rhif 3) (Cymru) 2022 ("Rheoliadau 2022")

(Tudalennau 40 - 47)

5 Cynnig o dan Reol Sefydlog 17.42(ix) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

(11.45)

6 Anghydraddoldebau iechyd meddwl: trafod y dystiolaeth

(11.45-12.00) (Tudalennau 48 - 65)

Papur 5 - ymchwiliad i anghydraddoldebau iechyd meddwl: y camau nesaf

7 Blaenraglen Waith

(12.00-12.15) (Tudalennau 66 - 72)

Papur 6 - blaenraglen waith

Mae cyfyngiadau ar y ddogfen hon

Royal College of GPs Cymru Wales response to the HSCC inquiry into mental health inequalities

Introduction

The Royal College of GPs Cymru Wales is pleased to give evidence to this inquiry from the Health and Social Care committee. Our members note that due to a wide range of factors, from economic circumstance to geography to identity, mental health inequalities are prevalent in Wales. Following COVID-19 these inequalities have been exacerbated by already over-laden waiting lists and staff shortages. We urge the Welsh Government to take the below responses in conjunction with our calls for a detailed workforce plan and for further support following the increase in GP workload.

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

The following seven groups have been identified as being disproportionately affected by poor mental health. However, it is important that any strategy aimed at inclusion does not inadvertently lead to exclusion, there will be people who do not fit into the following categories, of those who can be invisible to the system such as someone living in poverty but in what is perceived as generally an affluent area. The categories provide an important steer but there must be flexibility.

1. Children and young people:

One in five children were experiencing poor mental health prior to COVID-19. [1]Poor mental health is more prevalent in girls, children from less affluent families or if the child did not identify as a boy or a girl.[2]

[1] https://www.cardiff.ac.uk/news/view/2509156-fifth-of-young-people-in-wales-were-experiencing-poor-mental-health-prior-to-covid-19,-report-shows
[2] https://www.cardiff.ac.uk/news/view/2509156-fifth-of-young-people-in-wales-were-experiencing-poor-mental-health-prior-to-covid-19,-report-shows

Children and young people with learning disabilities and autistic children were disproportionality affected by the pandemic due to the disruption of home life and schooling: consistency and a stable routine is vital to these young people. Children with long term conditions are more likely to develop mental health problems.

2. Those living in poverty

Those experiencing indicators of poverty are more likely to have poor mental health.[3] In Wales's most deprived areas, suicide rates are between two and three times higher compared to the most affluent areas.[4]

This also applies to children and young people. RCPHC's State of Child Health indicators reveal a widening gap between the health of children from wealthy and deprived backgrounds.[5]

3. Ethnic minority groups:

Those from ethnic minority groups are less likely to seek help for mental health issues. Of this segment, young African-Caribbean men are more likely to access mental healthcare in a crisis. Adults from South Asia are least likely to be referred to specialist services. Recovery rates following psychological therapies are higher among white British people compared to people of all other ethnicities.[6]

4. LBGTQ+ groups:

LGBTQ+ individuals are more likely to commit suicide and are also at risk of discrimination when accessing healthcare including for mental health. [7]

5. Older people:

The World Health Organisation (WHO) reported that approximately 20% of people aged 60 or over have a mental health illness. The two most common illnesses are depression (7%) and dementia (5%).[8]

[3] Welsh NHS Confed response to the WG consultation on the TFMH Delivery Plan 2019 2022 August 2019 PDF_1.pdf
[4] Socioeconomic_disadvantage_and_suicidal_behaviour_bilingual.pdf (samaritans.org)
[5] SOCH-WALES-02.03.20.pdf (rcpch.ac.uk)
[6] equality-action-plan---january-2021.pdf (rcpsych.ac.uk)
[7] equality-action-plan---january-2021.pdf (rcpsych.ac.uk)
[8] https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

6. Those who experience speech, language, and communication difficulties:

Research also highlights those children with a mental health disorder are five times more likely to have problems with speech and language (NHS Digital, 2018)[3]

7. Those with severe mental illness:

Approximately 1 in 50 people in Wales has a severe mental illness such as schizophrenia or bipolar disorder.[9]

People with SMI are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population.[10]

Patients with mental health problems are at greater risk of developing these issues due to a generally higher prevalence of smoking, side effects of antipsychotic drugs, and lack of engagement with screening problems.

In addition, this patient group traditionally has poorly engaged with healthcare services, especially cancer screening programmes and health promotion such as smoking cessation advice. Geography can also play a huge role in the inequity of access for these patients.

Provision of specialist services in mental health, such as psychotherapy and EMDR treatment, assessments for PTSD, eating disorders, autism diagnostic and management services, ADHD, and CAMHS provision is often inequitable and may not be available in a patient's local area and patients may be unable to travel sue to their mental health or another factor.

COVID-19 has affected the treatment of lower-level mental health conditions such as anxiety and depression.

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?

COVID-19 has presented a significant challenge throughout primary care and no less so the provision of care at this level for mental ill health. Staff shortages due to infection or long covid the resultant stress and fatigue on GPs and practice staff continues.

[9] together-for-mental-health-summary.pdf (gov.wales)
[10] People with severe mental illness experience worse physical health - GOV.UK (www.gov.uk)

However, even prior to the pandemic certain groups felt they could not seek help for mental ill health either because services do not exist in their area (as mentioned above) or due to fear of discrimination, as in the case of those in ethnic minority or LGBTQ+ groups.

In many areas there is limited support for low level mental health issues. Patients may not seek help from their GP as they doubt the likelihood of an onward referral. Initiatives, such as social prescribing, vary from area to area, while in some areas these provisions no longer exist due to COVID-19. There is a need for greater availability of social prescribing options and information as it can benefit patients and take some pressure away from mental health services and primary care.

Increasing access for support for lower-level mental health issues can also be improved through greater use of community pharmacists. By monitoring requests for over-the-counter medicines (e.g. anti-anxiety or sedative products) they are particularly well placed to identify early sign of mental health problems. However, at present, there is no formal mechanism in place for community pharmacists to act on their observations. Formal systems should therefore be introduced to enable pharmacists to directly refer patients to appropriate third sector services or health professional colleagues.

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

Recently we have seen an increase in investment for mental health. The budget for 2022/2023 provides an additional investment of £100 million for mental health services in Wales.[11] The College welcomes the introduction of the Whole School Approach.[12] The Whole School Approach has highlighted the need to support the emotional and mental health of children and young people.

The College supports the introduction of these such initiatives to improve mental health however we would urge the Welsh Government to review the remaining inequalities for those already suffering with severe mental health concerns, to ensure care is personalised and inclusionary of those with specific needs as well as general mental health.

[11] https://gov.wales/draft-budget-2022-2023
[12] https://gov.wales/sites/default/files/publications/2021-03/framework-on-embedding-a-whole-school-approach-to-emotional-and-mental-well-being.pdf

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

The College urges the Welsh Government to implement the designing of services which are both universal and targeted. Consideration should be given to general mental health and well as specific initiatives aimed at the groups above as well as those with existing severe mental health concerns. These services as well as any accompanying communications should be available in Welsh as well as English.

We accept that the many of the recommendations in the Mind Over Matter report,[13] the intention of which was to improve awareness of mental health services for children and young people,[14] may have been delayed due to COVID-19 however the College urges the Welsh Government to resume this programme now that all restrictions have been lifted to improve awareness of mental health services.[15]

Following the implementation, we would also ask the Welsh Government to improve links between all services for children and young people, which would lead to better communication between colleagues and greater efficiency.

As mentioned above and in previous publications by the College, urgent investment in the primary care workforce, including but not limited to GPs and social prescribers. Together with this investment training must also be given to all professionals working in primary care to better support people with mental health issues, including pharmacists.

To support all the above, further investment in the use of technology throughout primary care is crucial to ensure the increased service capacity and access that the above would entail.

[13] The Emotional and Mental Health of Children and Young People in Wales (senedd.wales)
[14] gen-ld11623-e.pdf (senedd.wales)
[15] gen-ld11623-e.pdf (senedd.wales)

Royal College Mental Health Expert Advisory Group response to the HSCC inquiry into mental health inequalities

Background

The Royal College Mental Health Expert Advisory Group (RCMHEAG) brings together partners from across health and social care services and acts as a source of independent and impartial, evidenced-based expert advice for policy and decision makers.

The group also aims to ensure a sharper focus and understanding on the current and necessary support for the people we collectively represent in social care and in primary, community, and secondary care mental health services.

The advisory group has established common work areas of Covid Recovery (including workforce wellbeing), the Mental Health Workforce Plan, and Community Mental Health Services as initial priorities. These priority areas intend to offer scrutiny and guidance to compliment areas of national focus.

However, this is not exhaustive, and the advisory group will be keen to develop and receive further areas of interest.

The current, full membership is made up of:

- Royal College of Psychiatrists Wales
- Royal College of Nursing Wales
- Royal College of Speech and Language Therapists
- Royal College of Occupational Therapists
- Royal College of General Practitioners Wales
- Royal College of Paediatrics and Child Health
- Royal College of Physicians Wales
- Royal College of Surgeons England
- Royal College of Surgeons Edinburgh
- The Royal Pharmaceutical Society
- Chartered Society of Physiotherapy
- British Psychological Society

Additionally, the Group works closely with other forums such as the Academy of Medical Royal Colleges on areas that can sometimes sit outside of typical mental health service discussion, but span across health and social care.

Each of the group's membership will have individual priorities and we would wish to draw the Committee's attention to these responses.

For further information please contact: Ollie John, RCPsych in Wales Manager:

Introduction

The Royal College Mental Health Expert Advisory Group welcomes this inquiry into mental health inequalities and is encouraged by this focus from the Health and Social Care Committee.

Mental health inequalities are the result of a myriad of factors and meaningful progress will require coherent efforts across all sectors. There are a number of opportunities to address mental health inequalities, including through embedding measures around this into the next iteration of the long-term strategy for mental health and through Health Education and Improvement Wales (HEIW) and Social Care Wales' Mental Health Workforce Strategy.

We also call on the Welsh government to take cross-government action to tackle mental health inequalities by pulling together a delivery plan that outlines the action being taken across all government departments, how success will be measured and evaluated, and how individual organisations should collaborate across Wales to reduce health inequalities and tackle the cost-of-living crisis. Our response also highlights a number of specific recommendations at the end of the document.

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

Covid has driven an increase in poor mental health.[1] This includes exacerbations of existing inequalities and health conditions and many new cases due to restrictions to lifestyle, loss of work and role, typical working environment and colleague support, loss of usual social support, and social isolation.

However, we know that there are groups of people who are disproportionately affected by poor mental health in Wales. Below we will give further detail on this and will highlight the factors that contribute to worse mental health within these groups.

Children and young people

Child health outcomes are the product of complex, inter-connected social, economic, personal and political factors. An individual child's health is inevitably influenced by the world and environment around them, not only by the quality of care they receive from the health system, but also by the services they are able to access and by their family's lifestyle.

[1] The Lancet, Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population, July 2020

Children are experiencing a high level of mental ill health. Research from Cardiff University found that 1 in 5 children were experiencing poor mental health prior to the COVID-19 pandemic.[2] The research further identified poor mental health was higher if:

- The child was a girl, with a significant gender difference by year 10,
- If the child was from a less affluent family,
- If the child did not identify as either a boy or a girl.[3]

A survey by Mind Cymru found that 75% of young people said their mental health had worsened in the early months of the pandemic. The survey also showed that a third of young people who tried to access mental health support were unable to do so.[4]

Certain groups of young people may be particularly vulnerable to poorer outcomes and require targeted support to ensure they have a healthy and happy childhood. Looked after children, children on the child protection register/ those who are known to social services and children with long term health conditions such as diabetes and neurodevelopmental conditions, experience higher levels of mental health issues but often have no additional resource to support them.[5]

Children and young people with long term conditions are more likely to develop mental health problems and may have poorer education outcomes. Young people with long term conditions should be empowered with self-management tools to control their health condition as they become adults. This is particularly important for young people as they navigate the transition from child to adult health services.

The RCPsych Wales Children and Adolescents faculty found that children and young people with learning disabilities as well as Autism Spectrum Disorders (ASD) were disproportionately affected by the pandemic and the disruption to home life and schooling, which negatively impacted their routine and activities of daily living. A predictable routine is central to the stability of this cohort of children, and as such the pandemic, with all the associated disruptions has been a source of increased anxiety. There's anecdotal evidence that this has presented in the clinic in the form of increased challenging behaviour (physical aggression towards their families, carers and environment and self-injurious behaviour) with a disruptive impact on the wider family environment.

[2] https://www.cardiff.ac.uk/news/view/2509156-fifth-of-young-people-in-wales-were-experiencing-poor-mental-health-prior-to-covid-19,-report-shows

[3] https://www.cardiff.ac.uk/news/view/2509156-fifth-of-young-people-in-wales-were-experiencing-poor-mental-health-prior-to-covid-19,-report-shows

[4] Mind Cymru (2020) The mental health emergency: how has the coronavirus pandemic impacted our mental health? Wales summary report. Cardiff: Mind Cymru. Accessed via: https://www.mind.org.uk/media-a/6176/the-mental-health-emergency-wales-summary-report-english-1.pdf

[5] https://stateofchildhealth.rcpch.ac.uk/wp-content/uploads/sites/2/2020/03/SOCH-WALES-02.03.20.pdf P27

Poverty

Mental health conditions interact with and include biological, psychological, environmental, economic and social elements. The clearest evidence of this is the well-established overlap between those who experience mental health conditions and indicators of poverty e.g. poor housing, low income and poor educational attainment.[6] In Wales' most deprived neighbourhoods, suicide rates are between two and three times higher compared to the most affluent.[7]

Gradients of social disadvantage also correlate to much poorer mental health outcomes in children and young people. Data consistently shows that poverty and inequality impact a child's whole life, affecting their education, housing and social environment and in turn impacting their health outcomes. RCPHC's State of Child Health indicators reveal a widening gap between the health of children from wealthy and deprived backgrounds.[8]

In order to reduce the prevalence of mental health issues, we need to address the social determinants. There is a significant amount of anecdotal evidence regarding work done by Allied Health Professionals (AHPs) to reduce health inequalities and influence the social determinants of health.[9] When considering how to re-shape and refocus activity to bring about change, planners and decision-makers need to consider what data would best inform them of service effectiveness and their positive impact.

Black, ethnic minority groups

It is now clear that experience of discrimination and inequality can increase the risk of developing mental illness. People who are subject to inequality go through life with higher levels of stress and mental distress, which places them at higher risk of attempted suicide and self-harm.

We know that people from ethnic minority groups are at increased risk of involuntary psychiatric detention:

- People of Black Caribbean and Black African heritage are all significantly more likely to be compulsorily admitted than White ethnic groups.
- Those from Black Caribbean backgrounds were also significantly more likely to be readmitted.
- South Asian and East Asian people are also significantly more likely to be compulsorily admitted than people from White British backgrounds.
- Migrants from all backgrounds are also significantly more likely to be compulsorily admitted.
- There is a growing body of research to suggest that those exposed to racism may be more likely to experience mental health problems such as psychosis and depression.

[6] Welsh NHS Confed response to the WG consultation on the TFMH Delivery Plan 2019 2022 August 2019 PDF_1.pdf
[7] Socioeconomic_disadvantage_and_suicidal_behaviour_bilingual.pdf (samaritans.org)
[8] SOCH-WALES-02.03.20.pdf (rcpch.ac.uk)
[9] Roots of recovery: Occupational therapy at the heart of health equity - RCOT

- Young African-Caribbean men are more likely to access mental healthcare in crisis and to be admitted via criminal justice routes.
- Adults from South Asia are least likely to be referred to specialist services, despite being frequent consulters of primary care. Research suggests this may be related to a lack of culturally appropriate services.
- Recovery rates following psychological therapies are higher among White British people compared to people of all other ethnicities.[10]

Much more needs to be done to shape the mental health services to meet the needs of a diverse population.

LGBTQ+ individuals

LGBTQ+ individuals have a higher risk of suicidality yet experience discrimination when accessing healthcare.[11] Among LGBTQ+ young people, 7 out of 10 girls and 6 out of 10 boys described having suicidal thoughts. They were around three times more likely than others to have made a suicide attempt at some point in their life.[12]

Older people

The World Health Organisation (WHO) reported that approximately 20% of people aged 60 or over have a mental health illness. The two most common illnesses are depression (7%) and dementia (5%).[13]

There have been a number of instances where older people's mental health has been neglected. The Ockenden report (2015), investigated patient safety in the older people mental health ward, Tawel Fan following significant concerns from families and staff. The report identified, among other things, that the ward had struggled to maintain appropriate staffing levels and subsequent patient safety.[14]

Children and adults with communication and speech and language difficulties

Research also highlights Children with a mental health disorder are five times more likely to have problems with speech and language (NHS Digital, 2018)[3] and 81% of children with social, emotional and mental health needs have significant unidentified language deficits (Hollo et al, 2014).[4] Adolescents and young adults with developmental language disorder (DLD) are more likely to experience anxiety and depression than their peers (Conti-Ramsden at al, 2008; Botting et al, 2016).

80% of adults with mental health disorders have impairment in language (Walsh et al, 2007) and over 60% have impairment in communication and discourse (Walsh et al, 2007). Likewise, over 30% of adults with mental health disorders have some impairment in swallowing (Walsh et al, 2007). There is a greater prevalence of dysphagia (swallowing difficulties) in acute and community mental health settings compared to the general population - 35% in an inpatient unit and 27% in

[10] equality-action-plan---january-2021.pdf (rcpsych.ac.uk)
[11] equality-action-plan---january-2021.pdf (rcpsych.ac.uk)
[12] equality-action-plan---january-2021.pdf (rcpsych.ac.uk)
[13] https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults
[14] https://bcuhb.nhs.wales/news/updates-and-developments/updates/archived-updates/tawel-fan/tawel-fan/full-hascas-report-may-2018/

those attending day hospital, which compares to 6% in the general population (Regan et al, 2006).

We also want to highlight the inequalities faced by people living with severe and enduring mental illnesses.

Severe mental illness (SMI): co-morbidities and life expectancy

Approximately 1 in 50 people in Wales has a severe mental illness such as schizophrenia or bipolar disorder.[15] The exact number of people experiencing severe and enduring mental illness is largely unknown as the Welsh Government do not gather this information centrally. What we do know is that there are 31,597 people registered as having a mental health illness on the GP Quality and Outcome Framework (QOF), although the breakdown is not provided.

Mental health problems can influence education, development, employment and physical health. People with SMI are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population.[16] It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented.[17] Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension. Patients with mental health problems are at greater risk of developing these issues due to a generally higher prevalence of smoking, side effects of antipsychotic drugs, and lack of engagement with screening programmes. In addition, this patient group traditionally has poorly engaged with healthcare services, especially cancer screening programmes and health promotion such as smoking cessation advice. As a result, it's crucial that routine physical health monitoring is available and accessible to people with SMI.

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 Covid pandemic has exacerbated challenges within mental health services, including staff shortages due to covid infection, isolation, staff illness and long covid. Staff stress, burnout, and early retirement have impacted workforce retention.

However, it was clear that even before the pandemic, barriers existed for a number of groups and individuals. As mentioned above, we know that reduced access exists for those in economically deprived communities, ethnic minority groups and LGBTQ+ groups. These groups of people still face discrimination and stigma, leading to a limited understanding of their needs.

Geography can also play a huge role in the inequity of access. Provision of specialist services in mental health, such as psychotherapy and EMDR treatment, assessments for PTSD, eating disorders, Autism diagnostic and management services, ADHD, and CAMHS provision is often inequitable. In many areas, services

[15] together-for-mental-health-summary.pdf (gov.wales)
[16] People with severe mental illness experience worse physical health - GOV.UK (www.gov.uk)
[17] (The Mental Health Taskforce, NHS England. 'Five Year Forward View for Mental Health' 2016).

have been merged so that patients need to travel greater distances for appointments. For patients with mental health issues who are anxious or agoraphobic, needing to use unfamiliar services is an additional challenge. This could also act as a barrier to people who find it physically difficult to attend appointments and access local community resources.

The availability of support for lower-level mental health issues such as anxiety and depression via social prescribing can also vary, and in many areas this option has completely disappeared due to Covid. There is a need for greater availability of social prescribing options and information as it can benefit patients and take some pressure away from mental health services and primary care.

Increasing access for support for lower-level mental health issues can also be improved through greater use of community pharmacists. By monitoring requests for over-the-counter medicines (e.g anti-anxiety or seductive products) they are particularly well placed to identify early signs of mental health problems. However, at present, there is no formal mechanism in place for community pharmacists to act on their observations. Formal systems should therefore be introduced to enable pharmacists to directly refer patients to appropriate third sector services or health professional colleagues.

For those with severe and enduring mental illness, the greatest barrier to timely and appropriate mental health support is the lack of NHS inpatient beds and waiting times backlog for those in acute crisis; those who require longer term specialist adult mental health services, and for those needing specialist Child and Adolescent Mental Health Services (CAMHS). Mental health services, in particular specialist CAMHS, are experiencing significant difficulties regarding waiting times.[18]

Access needs to be open, appropriate, and fair to population groups who have been known to experience reduced access to, and satisfaction with, health and care services. The implementation of digital throughout the health service is a long-term objective of 'A Healthier Wales' and is an enabler to aspirations for us all to work more sustainably. Digital innovation can support in offering services in different ways that ensure increased service capacity and access, and better outcomes for patients in light of increased demand. However, it's crucial that digital platforms and new technology are robustly evaluated to ensure no group is excluded and that everyone receives appropriate and timely care.

It's crucial that people can directly access the right expertise when needed, but for this to be inclusive, services need to proactively identify local population groups that are not currently reflected on caseloads, then work with them to co-create access points and services that accommodate their requirements and preferences.

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

There will always be individuals who have complex mental health problems that require care and treatment from health professionals in inpatient facilities. Individuals with severe and enduring mental ill heath may be vulnerable due to

[18] First appointment waiting times (gov.wales)

nature of their illness, but their vulnerability will have increased due to the lack of strategic focus and investment in the workforce and mental health estate.

In recent years there have been efforts by the Welsh Government to address mental ill health. The budget for 2022/2023 provides an additional investment of £100 million for mental health services in Wales.[19] There has also been a significant effort around wellbeing and low-level mental health support, including the introduction of the Whole School Approach.[20] The Whole School Approach has highlighted the need to support the emotional and mental health of children and young people.

Investing in overall mental health support for the general population is welcomed as it will aid in preventing some mental health problems from deteriorating, but it will not prevent people with severe and enduring mental ill health from needing support.

This has also unintentionally led to an inequality within mental health services and support for those with severe and enduring mental illness. There needs to be a greater understanding that care must be personalised, and that general mental health support will not meet the needs of people who will require specialist intervention. People who have been subjected to physical/sexual and emotional abuse often experience complex post-traumatic stress disorders which exacerbate existing mental health problems, resulting in the need for evidence based, trauma informed care and treatment. There will also always be a need for inpatient mental health services and a workforce available to provide complex clinical care, including CAMHS and services for children and young people.

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?

We call on the Welsh government to take cross-government action to tackle mental health inequalities by pulling together a delivery plan that outlines the action being taken across all government departments, how success will be measured and evaluated, and how individual organisations should collaborate across Wales to reduce health inequalities and tackle the cost-of-living crisis.

<u>Service design</u>

- To improve services in order to reduce these inequalities it is important that services are co-designed with the people the services are intended to support
- Services should be both universal across all aspects of life, and targeted, so that they are shaped and placed according to the needs of local population groups
- Where possible, people should be able to access mental health services in their preferred language, including the Welsh language.

[19] https://gov.wales/draft-budget-2022-2023

[20] https://gov.wales/sites/default/files/publications/2021-03/framework-on-embedding-a-whole-school-approach-to-emotional-and-mental-well-being.pdf

Severe and enduring mental illness

- The Welsh Government must invest in all secondary and specialist mental health services to reduce the stigma and inequalities experienced by people with severe and enduring mental illness
- The Welsh Government must review the pressures facing mental health services in Wales: this includes the interface with the Criminal Justice System, the increased use of the Mental Health Act (MHA), as well as inpatient services, out of area placements and the response to individuals in crisis
- It's crucial that individuals living with SMI and learning disabilities receive routine physical assessments to identify and treat physical co-morbidities and prevent early death
- As recommended in the National Clinical Audit of Psychosis, Welsh Government should expand the Individual Placement and Support (IPS) programme to a national offer, supporting people with severe and enduring mental illness into employment.[21]

Children and young people

- There is a need for increased awareness of mental health across all those working with children and young people, in line with recommendations made in the Mind Over Matter report[22] and accepted in principle by the Welsh Government to improve knowledge of signposting and services and to make sure there is quicker access to mental health services for those who need it.[23]
- We need to bolster CAMHS, as well as community delivered care for children and young people, by ensuring there is investment in both the specialist and wider mental health workforce (including paediatricians, children's nurses, health visitors, primary care and allied health professionals) and mental health estate, to ensure that services are integrated, responsive to need and meet recognised and agreed standards of service and care to children, young people and families.
- Ensure that the enablers are in place to ensure adequate integration across all services operating within the child and adolescent continuum of care to help realise the 'whole-system' approach ambitions. Improved integrations amongst these entities and institutions will lead to improved efficiency, utilisation of finite resources and improved health outcomes. This includes facilitating the systems and processes needed to improve co-working and communications.
- Place children and young people at the heart of decision making and service design initiatives to ensure optimal outcomes.

[21] ncap-spotlight-audit-report-on-employment-2021-(2).pdf (rcpsych.ac.uk)
[22] The Emotional and Mental Health of Children and Young People in Wales (senedd.wales)
[23] gen-ld11623-e.pdf (senedd.wales)

Workforce

- Services and workforces need to reflect and be shaped by the culture of the communities that they serve, with a shared understanding of the desired outcomes for the community and the service.
- To achieve this there needs to be urgent investment in the mental health workforce, to ensure an appropriate number of staff with an appropriate skill mix in a safe environment.

This group has identified the mental health workforce strategy as a priority at the outset of its establishment, and we will remain engaged as an independent collective voice and will scrutinise this ongoing work. We have a number of longstanding recommendations in this area:

- Call for the committee to scrutinise the mental health workforce plan to ensure it considers the immediate challenges as well as the long-term vision for the workforce
- Call for the committee to scrutinise the extent the plan will drive change and include a wide range of professions given recruitment and retention challenges in the traditional workforce
- Call for the committee to ensure specialist skills and training are valued across the MDT, and that a full specialist MDT is in place to support patients, this includes specialist mental health speech and language therapists and occupational therapists to aid recovery. All specialist MDTs should also include a specialist mental health pharmacist with responsibility for medicines optimisation and to support appropriate prescribing and deprescribing.

This response is endorsed by:

The British Psychological Society

Royal College of General Practitioners Wales

Royal College of Nursing Wales

Royal College of Occupational Therapists

Royal College of Paediatrics and Child Health

Royal College of Physicians Wales/ Cymru

Royal College of Psychiatrists Wales

Royal College of Speech and Language Therapists

The Royal Pharmaceutical Society

Senedd Health & Social Care Committee Inquiry – Mental health inequalities

Introduction

The British Association for Counselling and Psychotherapy (BACP) welcomes this important inquiry into mental health inequalities in Wales. BACP is the leading and largest professional body for counselling and psychotherapy in the UK, with over 60,000 members and over 2,441 in Wales, where our membership has grown by 32% in the last 5 years. BACP is committed to improving equality, diversity, and inclusion (EDI) by creating 'a profession for the future', addressing systemic barriers within the profession to improve access to psychological therapies for all who need them.

The COVID-19 pandemic and the social distancing restrictions resulting from it have taken an enormous toll on people's wellbeing and mental health. This represents an unprecedented challenge for the Welsh Government considering mental health is a key determinant of educational success, productivity, future earnings, and life expectancy (Layard, 2020).

Whilst inequalities in health and wellbeing have historically presented themselves within society, the Covid-19 pandemic has exacerbated and widened the gap, shining a light on inequalities in a way never seen before. Evidence has emerged on the disproportionate impact of Covid-19 on Black and Minority Ethnic communities; people with disabilities; older people; people from the LGBTQ+ community and various other sections of society. There is an urgent need to take a proactive stance and develop a preventative range of methods and long-term support systems that are individually relevant and suitable to people from these underrepresented communities.

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

For people within marginalised groups, the pandemic intensified the level of risk, the precariousness of maintaining good mental health, and difficulties accessing the right support at the right time. In testament to the pervasiveness of mental health inequalities, the people who have historically endured the biggest risks for poor mental health, and the worst access to and experiences of support, were those most exposed to the worst of the immediate shock of Covid-19. These same groups will also be the most vulnerable to mental health difficulties longer term, as the pandemic leaves behind an unequal legacy of complicated bereavement, trauma and economic repercussions.

Throughout the pandemic it has become evident that Black and Minority Ethnic communities have disproportionately been impacted. Analysis by the Office of National Statistics (ONS) found that Black people in England and Wales were

more than four times as likely to die as white people of the same age to die from Covid-19. The ONS adjusted its figures to filter out the effect of the region where people lived, deprivation, household composition, socioeconomic status, education, and health and disability. Once these factors were adjusted for, there were still disproportionate deaths among Black and Asian people. People of BAME backgrounds are more likely to be engaged in jobs such as public transport driving, cleaning, caring and Band 5 nursing, and all of these jobs cannot be done from home.

These factors have clearly had a detrimental effect on those from marginalised communities in Wales. For example, in June 2020, BAME individuals in Wales reported on average more than 4.1 problems associated with mental distress, whilst White British individuals reported 2.7, a difference of 55% in relative terms (Cardiff University, 2021)

The impacts of the pandemic on disabled people further shines light upon UK health inequalities. A 2021 study by the Health Foundation found that disabled people are more likely to report that COVID-19 restrictions have had a negative impact on their lives than those who did not identify as disabled. Similarly, disabled people are more likely to report that their medical treatment has been disrupted during the pandemic. This inequality is further highlighted through recent figures from the ONS, showing that disabled people had on average poorer well-being ratings than non-disabled people across all four well-being measures (life satisfaction, feeling that things done in life are worthwhile, happiness and anxiety). Furthermore, the explanation given that many Covid-19 deaths arise from 'underlying health conditions' – intended as a reassurance to the majority – unsurprisingly left many disabled people feeling frightened and othered (The Health Foundation, 2021)

Older people with pre-existing health conditions were some of the hardest hit by the pandemic, and those who were shielding were more likely again to be feeling more anxious since lockdown than those who were not (Age UK, 2020).
A report by Amnesty International says prolonged isolation from family and friends had a "devastating" impact on the physical and mental health of care home residents. This included loss of movement, reduced cognitive functions and appetite and loss of motivation.

The Covid-19 pandemic has also been found to disproportionately affect women, who are more vulnerable than men to socioeconomic inequalities, gender inequalities, domestic violence and economic insecurity (Roberton et al., 2020; WHO, 2020). Additionally, women face challenges to their sexual and reproductive health rights (Roberton et al., 2020; WHO, 2020). During the lockdown period(s), pregnant women and parents were unable to access their usual support network of family and friends, as well as the face-to-face contact from the professionals providing support during the prenatal period. Prenatal maternal distress can negatively impact the course of pregnancy, fetal development, offspring development, and later psychopathologies; signifying the need for more support for pregnant women during the pandemic. In Wales, women exhibited worsened levels of mental health after the onset of the pandemic, with the gap of reported wellbeing between men and women increasing from 9.9% to 14.1%.

This lack of access to social support during the pandemic has also been acutely felt by those within the LGBTQ+ community. Social support is known to be effective in reducing poor mental health in trans and gender diverse people (e.g., Pflum et al., 2015; Veale et al., 2017). More specifically, social support from family and friends has been identified as a predictor of quality of life (Davey et al., 2014), reduced depressive symptoms, suicidal ideation (Veale et al., 2017; Wilson et al., 2016) and increased mental wellbeing (Alanko & Lund, 2020). The near total absence of this important support network during the pandemic has led to worse mental health outcomes for LGBT+ populations, compared with before the COVID-19 pandemic or compared with heterosexual/cisgender populations, suggesting worsening health inequities (McGwoan et al, 2021).

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?**

The mental health needs of people from a wide range of communities are often unmet by available services and many people are still experiencing a 'triple barrier' of worsened health, reduced access to services, and poorer outcomes when services are accessed (Centre for Mental Health 2021). The Covid-19 pandemic has brought to greater attention the long-standing and enduring health inequalities across society and highlighted a need for action. People from marginalised and racialised community backgrounds and those with protected characteristics as defined in the 2010 Equality Act are less likely to seek help for their mental health; this may be due to cultural stigmas associated with help-seeking or people feeling that clinicians have a poor understanding of different cultural needs, and even expecting or experiencing racism within services.

The latest NHS Race & Health Observatory report found evidence to suggest clear barriers to seeking help for mental health problems rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare. One of the reasons cited for this lack of trust in health professionals and its subsequent impact on avoiding or delaying seeking help was patients' views that healthcare professionals (GPs and mental healthcare professionals) did not either 1) understand what racism was or 2) understand how racist experiences and other individual experiences impacted both their experiences of mental health services and the outcome of the receipt of services.

Moreover, the report cited a qualitative study of Pakistani service users in the UK, finding that mental health services were not meeting the needs of Pakistani people. A key reason for this was the lack of interpreters available to people who did not speak English.

Those from marginalised communities often struggle to access a wide choice of mental health services. A study into service users who self-identified as Chinese reported that participants felt disempowered due to a lack of choice in treatment, whilst a similar study into Black Caribbean and Black African service

users reported a similar narrow choice of medication, rather than any offering of counselling or talking therapies (Tang, 2017; Rabiee and Smith, 2013).
The Centre for Mental Health has reported that 'mainstream mental health services often fail to understand or provide services that are acceptable and accessible to non-white British communities and meet their particular cultural and other needs' (The Centre for Mental Health (2020) Mental health for All? – The Final Report of The Commission for Equality in Mental Health). Barriers to accessing the right support at the right time can be understood and overcome through engagement with diverse communities, and third sector organisations that have the trust of people from marginalised community background.

Evidence also suggests that there is a general under-provision of many services which could potentially be beneficial to disabled people in Wales including rehabilitation services and mental healthcare provision (Welsh Government, 2018). This was also highlighted in a survey of disabled people in Wales (DW December 2020); which said just 15% of respondents felt that their rights are enforced in health and social care, 56% of respondents did not think they are enforced and 29% did not think they are well enforced at all. Further evidence suggests a clear relationship between reductions and withdrawals in available social care during the pandemic and a negative impact on well-being among disabled people. Survey evidence from Mencap (August 2020) shows that people with a learning disability, for example, have experienced a negative impact on their mental health (69%), relationships (73%), physical health (54%) and independence (67%), according to family carers.

Similarly, The National LGBT Survey (2018) found that 24% of respondents had accessed mental health services in the last year, but a further 8% had tried to get help and failed. Long waiting lists and unsupportive response from GPs were cited as the key reasons for this. When LGBT+ people did have access to mental health services, they found mental health professionals often failed to deal with their experiences of trauma, and therefore were less likely to meet their needs (LGBT Foundation, 2020).

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

Whilst there is good recognition of these issues across a range of relevant strategies in Wales, including the Welsh Government's flagship Mental Health Strategy and Action Plan - *Together for Mental Health* and specific action plans for those from marginalised groups. The evidence shows that there is often a disconnect between policy rhetoric and the reality of local delivery.

The pandemic has increased demand for mental health services to a level where current plans are now out of step with the realities many people are facing across Wales, particularly marginalised communities. The proposed refresh of *Together for Mental Health in 2022-23* provides an important opportunity to re-evaluate and reflect this this the new strategy in light of Covid 19, ensuring adequate investment and provision of accessible and culturally sensitive mental health services, including counselling and psychotherapy

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?**

We know that a 'one-size-fits-all' approach is an ineffective strategy for meeting the needs of diverse populations (Mantovani et al., 2016). Thus, BACP believes that it is beneficial for the therapeutic relationship to offer clients full and informed choice when accessing mental health services and psychological therapies. This should include choice around therapists (for example based on those characteristics protected in the Equalities Act 2010 (HM Gov, 2010), as well as therapy type, appointment times and location of intervention.

A focus on understanding socio-cultural issues within the specific communities as well as recognising shared common features is likely to reduce the barriers faced by marginalised communities when accessing mental health services. For instance, improving awareness and understanding of cultural and religious influences which may affect access and referral to mental health services. In doing so, this will improve understanding on how these cultural interpretations may impact on potential access and may therefore decrease stigma.

In its 2019 report 'Racial disparities in Mental Health', the Race Equality Foundation calls upon policy makers and commissioners to provide better access to talking therapies according to local need, and engagement with black and minority ethnic communities to ensure the therapies are culturally appropriate and geographically accessible. The report encourages practitioners in all disciplines to increase understanding of cultural and faith beliefs of Black and minority ethnic communities and how this impacts on beliefs and behaviours around mental health. The report also recognises the importance of the role of the voluntary, community and social enterprise sectors in supporting people from BAME communities, filling the gap where statutory service is missing or inadequate to meet needs.

BACP is the professional body for 2,441 counsellors and psychotherapists across Wales. Our members are drawn from the various professional disciplines in the field of counselling and psychotherapy, working in a broad range of settings including education, private practice, healthcare, workplace support and within the third sector, as well as working with clients across all age-groups.

Our members are a capable, highly trained yet underutilised workforce. Our most recent Workforce Survey demonstrates that our members in Wales have capacity to undertake an average of 4.5 additional client hours per week, which amounts to almost 10,000 client hours per week, across our membership. This untapped resource could play a critical role in fixing gaps in the Mental Health system and ensure that vulnerable people across Wales get the support they most desperately need.

Contact details

Please contact Steve Mulligan, Four Nations Lead at BACP, if you would like to discuss our submission further.

RCPsych Wales response to the HSCC inquiry into mental health inequalities

About RCPsych Wales

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness and intellectual disabilities, and the mental health of individuals, their families and communities.

In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales represents more than 600 Consultant and Trainee Psychiatrists working in Wales.

For further information please contact: Ollie John, RCPsych in Wales Manager

Introduction

We welcome the opportunity to respond to the committee's consultation on mental health inequalities.

Mental health inequalities are complex and are the result of a myriad of factors, and we join a number of organisations in Wales in their call for coherent cross-sector and cross-government action to tackle them. This includes addressing the social determinants of mental health as well as the inequalities faced by individuals with severe and enduring mental illness.

There are also a number of strategic opportunities to address mental health inequalities, including through the next iteration of the long-term strategy for mental health and through Health Education and Improvement Wales (HEIW) and Social Care Wales' Mental Health Workforce Strategy.

It is well evidenced that existing inequalities have been exacerbated by the pandemic and that Covid has driven an increase in poor mental health.[1] However, we know that there are groups of people who are disproportionately affected by poor mental health in Wales. Below we will highlight the factors that contribute to worse mental health within these groups and will set out a number of recommendations.

Children and young people

At a global level, a recent report published by UNICEF estimates that more than 1 in 7 adolescents aged 10–19 live with a diagnosed mental disorder, with the report acknowledging significant gaps between mental health needs and mental health funding.[1] We know that the COVID-19 pandemic has caused tremendous challenges to the mental health of children and young people, causing disruption in their emotional, cognitive and social development.[2] In Wales, a survey by Mind Cymru found that 75% of young people said their mental health had worsened in the early months of the pandemic. The survey also showed that a third of young people who tried to access mental health support were unable to do so.[3]

Social isolation, socioeconomic challenges as well as bereavement played a major role, and children were isolated from their usual support systems, including friends, family members and school.

For children and young people, the barriers to accessing mental health services include patient factors, workforce, and service design factors. Patient factors include parental physical and mental illness and fear of contracting Covid. Workforce factors include pre-pandemic staff shortages which have been exacerbated due to staff burnout, sickness, absence and early retirement. Finally, service factors include access issues due to government pandemic restrictions, staff shortages resulting in scaling back services needed to meet the needs of children and young people and finally the sub-optimal collaboration between social services, CAMHS and Schools. Another barrier to access has mainly impacted children transitioning to adult mental health services. These patients have found themselves falling between the cracks between management at a primary care level and specialist adult mental health services.

[1] United Nations Children's Fund, The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health, UNICEF, New York, October 2021. Accessed via: https://www.unicef.org/media/114636/file/SOWC-2021-full-report-English.pdf

[2] UK Parliament. Children's mental health and the COVID-19 pandemic. Published Thursday, 09 September, 2021. Accessed via: https://post.parliament.uk/research-briefings/post-pn-0653/

[3] Mind Cymru (2020) The mental health emergency: how has the coronavirus pandemic impacted our mental health? Wales summary report. Cardiff: Mind Cymru. Accessed via: https://www.mind.org.uk/media-a/6176/the-mental-health-emergency-wales-summary-report-english-1.pdf

There has been a significant effort around wellbeing and low-level mental health support, and Mind over Matter (2018) acknowledged that 'education settings, including primary schools, secondary schools, colleges and universities, are key to promoting emotional well-being and good mental health'. The introduction of the Whole School Approach[4] was also central to the stepwise change needed to support the emotional and mental health of children and young people.

However, while we welcome investment in overall mental health support and early intervention for children and young people, it will not prevent those with severe and enduring mental ill health from needing support.

Existing services need to be horizontally equitable across Wales. CAMHS services in Wales desperately need increased funding and staff.[5] This requires equitable allocation of resources and staff across the whole of Wales to ensure we do not have regional discrepancy in access and mental health outcomes. This can include more investment in mental health support teams in schools to facilitate early detection, prevention and treatment, but also investment into sCAMHS.

Existing resources can be optimised through innovative ways of working that are cost effective. The use of health technologies such as telemedicine can help address patient access challenges through facilitating virtual appointments thereby overcoming regional coverage challenges with specialist mental health services. However, it's crucial that digital platforms and new technology are robustly evaluated to ensure no groups are excluded and are receiving appropriate and timely care. It is critical that the views of children and young people as well as wider set of stakeholders are integrated in the planning and design of any future service.

Poverty

Poverty increases the risk of mental health problems and can be both a causal factor and a consequence of mental ill health.[6] It's crucial to consider the social determinants of mental ill health, such as living in poverty, unemployment and unsafe or insecure housing.

The link between severe and enduring mental illness and socio-economic deprivation is also well evidenced. A study published in *The British Journal of Psychiatry*, indicated that although genetics are known to play a part in the development of mental illness, environment may also have a significant role to play. When researchers compared adults who had just been diagnosed with schizophrenia, they found that a significant number of them had been raised in

[4] https://gov.wales/sites/default/files/publications/2021-03/framework-on-embedding-a-whole-school-approach-to-emotional-and-mental-well-being.pdf

[5] Pledge to support youth with extra £9.4m investment in children and young people mental health services. 1st February 2021. Accessed via: https://gov.wales/pledge-support-youth-extra-ps94m-investment-children-and-young-people-mental-health-services

[6] Poverty and Mental Health.pdf

poverty.[7] The findings show that "indicators of social inequality at birth are associated with increased risk of adult-onset schizophrenia".[8]

Learning disabilities and Autism Spectrum Disorder

Children and adults with learning disabilities as well as Autism Spectrum Disorders (ASD) were disproportionately affected by the pandemic, and the disruption to home life, schooling, as well as cuts to social care have had a negative impact on their routine and activities of daily living. A predictable routine can be central to the stability of this cohort of children and adults, and as such the pandemic, with all the associated disruptions, has been a source of increased anxiety. Members have told us that they have seen this present in the clinic in the form of increased challenging behaviour (physical aggression towards their families, carers and environment and self-injurious behaviour) with a disruptive impact on the wider family environment. Likewise, a member of our Intellectual Disabilities faculty told us that one of their patients has lost 5 days a week at their day centre and is now only getting 6 hours of 1:1 support. Having occupation and purpose in life is essential and day centres are part of this, as are increased opportunities for employment/training.

Severe mental illness (SMI): co-morbidities and life expectancy

People with SMI are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population.[9] It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented.[10] Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension.

Last month, NHS England National Directors for Mental Health for Learning Disability and for Health Inequality wrote to mental health trusts throughout England to ensure and prioritise the delivery of physical health checks for people with severe mental illness and people with a learning disability. Within this correspondence there was acknowledgement of the stark health inequalities faced by people with SMI and people with a learning disability, and how the pandemic has served to further exacerbate these inequalities.

There exist a number of barriers for people with severe and enduring mental illness, including workforce shortages, a lack of NHS inpatient beds and waiting times backlog for those in acute crisis or who require longer term specialist mental health services.

Likewise, whilst understanding that for the majority of people, mental ill-health as presented at primary care will not need specialist intervention, for many it will. We need to ensure that services are available for all.

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[7] Association between schizophrenia and social inequality at birth: case–control study | The British Journal of Psychiatry | Cambridge Core

[8] Association between schizophrenia and social inequality at birth: case–control study | The British Journal of Psychiatry | Cambridge Core

[9] (DE Hert M and others. 'Physical illness in patients with severe mental disorders' World Psychiatry 2011: volume 10, issue 1, pages 52 to 77).

[10] People with severe mental illness experience worse physical health - GOV.UK (www.gov.uk)

We also can't forget the role of clinical prevention, we have lost the understanding that for many, it's clinical teams that prevent further deterioration and illness. The three kinds of interventions of promotion, prevention, and treatment are interrelated and complementary; however, they are somewhat different from one another. Psychiatrists are competent and specialist in prevention of mental illnesses and mental health promotion in various settings.

Health promotion mainly deals with the determinants of mental health and aims to keep people healthy or become even healthier. In other words, mental health promotion aims at enhancing individual's ability to achieve psychosocial wellbeing and at coping with adversity.

On the other hand, prevention of illnesses focuses on the causes of risk factors to avoid illness. There are three categories of prevention:

- Primary prevention focuses on various determinants in the whole population or in the high-risk group.
- Secondary prevention comprises early detection and intervention.
- Tertiary prevention targets for advanced recovery and reduction of relapse risk.

We must understand that for a significant number of vulnerable people a definition of prevention, best sits, as managing mental ill-health or mental illness.

We can support people living with mental health problems to stay well and prevent people from relapsing or reaching crisis point. Drawing focus and appreciation away from this understanding, serves to further disadvantage those who are vulnerable.

Black, ethnic minority groups

It is now clear that experience of discrimination and inequality can increase the risk of developing mental illness. People who are subject to inequality go through life with higher levels of stress and mental distress, which places them at higher risk of attempted suicide and self-harm.

We know that people from ethnic minority groups are at increased risk of involuntary psychiatric detention:

- People of Black Caribbean and Black African heritage are all significantly more likely to be compulsorily admitted than White ethnic groups.
- Those from Black Caribbean backgrounds were also significantly more likely to be readmitted.
- South Asian and East Asian people are also significantly more likely to be compulsorily admitted than people from White British backgrounds.
- Migrants from all backgrounds are also significantly more likely to be compulsorily admitted.
- There is a growing body of research to suggest that those exposed to racism may be more likely to experience mental health problems such as psychosis and depression.
- Young African-Caribbean men are more likely to access mental healthcare in crisis and to be admitted via criminal justice routes.

- Adults from South Asia are least likely to be referred to specialist services, despite being frequent consulters of primary care. Research suggests this may be related to a lack of culturally appropriate services.[11]
- Recovery rates following psychological therapies are higher among White British people compared to people of all other ethnicities

Much more needs to be done to shape the mental health service to meet the needs of a diverse population.

LGBTQ+ individuals

LGBTQ+ individuals have a higher risk of suicidality yet experience discrimination when accessing healthcare. Among LGBTQ+ young people, 7 out of 10 girls and 6 out of 10 boys described having suicidal thoughts.[12] They were around three times more likely than others to have made a suicide attempt at some point in their life.[13]

These groups of people still face discrimination and stigma, leading to a limited understanding of their needs.

We welcome the Welsh Governments Race Equality Action Plan and LGBTQ+ Action Plan, but they must ensure that they lead to services being targeted and co-designed with the people they are intended to support.

Older people

For older people, age discrimination is associated with worse psychological well-being and poorer physical health outcomes. Older people are less likely to be referred on to the most appropriate service, and there is a higher risk of their needs being overlooked. In some services, only 1 in 6 older people with depression receive any treatment, and whereas 50% of younger people with depression are referred to mental health services, only 6% of older people are.[14]

Likewise, older age mental health conditions are often associated with dementia due to preconceptions around someone's age, and other issues, such as issues around substance misuse for example, don't get the attention they should. Research shows that diagnoses and treatments given to the younger patient were more appropriate than those for the older patient. This pattern has been confirmed in a recent study that suggests old people who self-harm are less likely to be referred to specialist mental health services than younger adults, despite a higher risk of suicide in this group.[15]

Utility of Video Consultation and digital interventions

A mixed methods survey for remote mental health services in NHS Wales, published in the BMJ, presents real data gathered from operation of a national video consultation service. This data is around the use, value, benefits and

[11] equality-action-plan---january-2021.pdf (rcpsych.ac.uk)
[12] equality-action-plan---january-2021.pdf (rcpsych.ac.uk)
[13] equality-action-plan---january-2021.pdf (rcpsych.ac.uk)
[14] college-report-cr221.pdf (rcpsych.ac.uk)
[15] college-report-cr221.pdf (rcpsych.ac.uk)

challenges encountered by the patients and clinicians in mental health services in Wales.[16]

Consideration should be given to how video consultation impacts on socio-cultural factors, health inequalities, digital poverty and the need for reasonable adjustments. It will also be important to continue to measure key metrics such as equity of access, patient outcomes and experience measures for both patients and clinicians to compare their quality over time.

Recommendations

Children and young people

As mentioned above, to improve mental health and outcomes in children and adolescents and to reduce mental health inequalities in Wales, the government needs to:

- Increase investments in the Child and Adolescent Mental Health Services (CAMHS) across the full spectrum of services within the whole-system framework. These investments must be done in a way to ensure equity of access and outcomes across Wales and balance existing regional inequities.
- Ensure that the enablers are in place to ensure adequate integration across all services operating within the child and adolescent continuum of care to help realise the 'whole-system' approach ambitions. Improved integrations amongst these entities and institutions will lead to improved efficiency, utilisation of finite resources and improved health outcomes. This includes facilitating the systems and processes needed to improve co-working and communications.
- Place children and young people at the heart of decision making and service design initiatives to ensure optimal outcomes.

All adults with mental illness and learning disabilities

- The Welsh Government must invest in all secondary and specialist mental health services to reduce the stigma and inequalities experienced by people with severe and enduring mental illness
- It's crucial that individuals living with SMI and learning disabilities receive routine physical assessments to identify and treat physical co-morbidities and prevent early death
- As recommended in the National Clinical Audit of Psychosis, Welsh Government should expand the Individual Placement and Support (IPS) programme to a national offer, supporting people with severe and enduring mental illness into employment.[17]

Workforce

[16] Remote mental health services: a mixed-methods survey and interview study on the use, value, benefits and challenges of a national video consulting service in NHS Wales, UK | BMJ Open

[17] ncap-spotlight-audit-report-on-employment-2021-(2).pdf (rcpsych.ac.uk)

- Call for the committee to scrutinise the mental health workforce plan to ensure it considers the immediate challenges as well as the long-term vision for the workforce
- Call for the committee to highlight the importance of specialist roles are included in the design of the multidisciplinary team, and to ensure specialists can operate at the top of their licence
- Call for the committee to scrutinise the extent the mental health workforce plan engages and consults across service user and professional groups in its implementation
- Call to make working in the health service in Wales more attractive; This includes opportunities around remote working to make it easier for retired psychiatrists and those taking time off to care for children or relatives to return to work. Other opportunities include new credentials, bringing in support to enable psychiatrists to work to the top of their skill level.

<u>Social determinants of mental health</u>

- Advice services should be co-located in mental health settings, so that people with practical problems, such as financial and housing concerns, can receive the right support at the right time and the root cause of their problem can be dealt with appropriately
- There should be coherent cross-sector and cross-government action to tackle mental health inequalities, including addressing the social determinants of mental health.

Eitem 4.1

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-EM-2157-22

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29 Mehefin 2022

Annwyl Llywydd

Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Ymwelwyr Tramor) (Diwygio) (Rhif 3) (Cymru) 2022 ("Rheoliadau 2022")

Yn unol ag adran 11A(4) o Ddeddf Offerynnau Statudol 1946, rwy'n eich hysbysu y bydd yr offeryn statudol hwn yn dod i rym ar 1 Gorffennaf 2022, ymhen llai na 21 diwrnod i'r dyddiad y cafodd ei osod. Mae copi o'r offeryn a'r Memorandwm Esboniadol cysylltiedig ynghlwm, er gwybodaeth ichi.

Mae Rheoliadau 2022 yn diwygio Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Ymwelwyr Tramor) 1989 ("y Prif Reoliadau"). Mae'r Prif Reoliadau yn gosod y fframwaith ar gyfer codi ffioedd ar bersonau nad ydynt yn preswylio fel arfer yn y DU am driniaeth ysbyty a ddarperir yng Nghymru.

Mae Rheoliadau 2022 yn diwygio Atodlen 1 o'r Prif Reoliadau i gynnwys brech y mwncïod fel clefyd, y mae gwasanaethau i'w drin wedi'u hesemptio rhag ffioedd y GIG ar gyfer ymwelwyr tramor.

Mae Rheoliadau 2022 hefyd yn darparu pan ddarperir gwasanaethau i ymwelydd tramor ar gyfer trin brech y mwncïod, ar neu ar ôl 23 Mai 2022 ond cyn 1 Gorffennaf 2022 (sef y dyddiad y daw'r diwygiadau i rym), ni chaniateir i Fwrdd Iechyd Lleol neu Ymddiriedolaeth GIG godi ffioedd am y gwasanaethau hynny ac os ydynt eisoes wedi codi ffioedd yna ni chaniateir eu hadennill ac os ydynt eisoes wedi'u hadennill yna rhaid eu had-dalu. Y rheswm am hyn yw bod achosion o'r clefyd yng Nghymru eisoes, o ganlyniad i'r brigiad diweddaraf. Drwy ganslo taliadau a allai fod yn gymwys fel arall cyn y dyddiad dod i rym, y bwriad yw sicrhau na fydd ymwelwyr tramor yn peidio â cheisio triniaeth oherwydd pryderon ynghylch codi ffi. Bydd hefyd yn sicrhau bod y rhai sydd wedi cael triniaeth am frech y mwncïod cyn i'r Rheoliadau ddod i rym yn cael eu trin yn gyfartal â'r rhai sy'n cael triniaeth ar ôl i'r Rheoliadau ddod i rym.

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Er gwybodaeth, mae'r Adran Iechyd a Gofal Cymdeithasol (DHSC) wedi cynnwys darpariaeth debyg yn ei rheoliadau codi ffioedd, heblaw bod DHSC wedi dewis estyn yr eithriad rhag ffioedd am driniaeth a ddaparwyd i ymwelwyr tramor ar neu ar ôl 1 Mai 2022, yn hytrach na 23 Mai 2022. Mae hyn oherwydd bod yr achos cyntaf o frech y mwncïod wedi'i nodi yn Lloegr (ar 6 Mai 2022) yn gynharach nag yng Nghymru (ar 25 Mai 2022, ac wedi'i gadarnhau gan Iechyd Cyhoeddus Cymru ar 26 Mai 2022). Daeth y ddeddfwriaeth ddiwygio y rhoddwyd effaith iddi gan DHSC yn Lloegr i rym lai na 21 diwrnod ar ôl ei gosod, er mwyn lleihau unrhyw risg i iechyd y cyhoedd pe bai ymwelydd tramor yn peidio â cheisio triniaeth oherwydd y posibilrwydd y byddai ffi yn cael ei chodi arno.

Gwnaed Rheoliadau 2022 a'u gosod cyn gynted ag y bo'n ymarferol er mwyn galluogi brech y mwncïod i gael ei gynnwys yn y rhestr clefydau yn Atodlen 1 sy'n esempt rhag ffi gan y GIG (pan fo angen triniaeth i ddiogelu iechyd y cyhoedd yn ehangach).

Os cedwir at y confensiwn 21 diwrnod, mae perygl (fel y mae DHSC wedi'i nodi mewn perthynas a'i deddfwriaeth yn Lloegr) y bydd ymwelwyr tramor yn peidio â cheisio triniaeth oherwydd pryderon am ffioedd, a thrwy hynny yn dod yn risg iechyd y cyhoedd i'r gymuned ehangach.

Mae peidio â chadw at y confensiwn 21 diwrnod yn caniatáu i Reoliadau 2022 ddod i rym cyn gynted ag y bo'n ymarferol, a thrwy hynny leihau'r risg i iechyd y cyhoedd yn ehangach.

Rwy'n anfon copi o'r llythyr hwn at y Gweinidog Materion Gwledig a Gogledd Cymru, a'r Trefnydd, Huw Irranca-Davies AS, Cadeirydd y Pwyllgor Deddfwriaeth, Cyfiawnder a'r Cyfansoddiad, Siwan Davies, Cyfarwyddwr Busnes y Senedd, Sian Wilkins, Pennaeth Gwasanaeth y Siambr a Phwyllgorau a Julian Luke, Pennaeth Gwasanaeth y Pwyllgorau Polisi a Deddfwriaeth.

Yn gywir

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

OFFERYNNAU STATUDOL
CYMRU

2022 Rhif 715 (Cy. 158)

Y GWASANAETH IECHYD GWLADOL, CYMRU

Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Ymwelwyr Tramor) (Diwygio) (Rhif 3) (Cymru) 2022

NODYN ESBONIADOL

(Nid yw'r nodyn hwn yn rhan o'r Rheoliadau)

Mae'r Rheoliadau hyn yn diwygio Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Ymwelwyr Tramor) 1989 (O.S. 1989/306) ("y prif Reoliadau"), sy'n darparu ar gyfer codi ac adennill ffioedd am wasanaethau perthnasol a ddarperir o dan Ddeddf y Gwasanaeth Iechyd Gwladol (Cymru) 2006 (p. 42) i ymwelwyr tramor.

Mae rheoliad 2 yn diwygio'r prif Reoliadau i fewnosod "Monkeypox" yn Atodlen 1 (clefydau na chodir ffi am eu trin). Mae rheoliad 2(2)(b) yn darparu, o ran ffioedd yr aed iddynt mewn cysylltiad â gwasanaethau a ddarparwyd i ymwelydd tramor ar gyfer trin brech y mwncïod ar neu ar ôl 23 Mai 2022 ond cyn i'r Rheoliadau hyn ddod i rym—

- os nad ydynt wedi eu codi eto, na chaniateir eu codi,
- os ydynt wedi eu codi, na chaniateir eu hadennill, neu
- os ydynt wedi eu talu, fod rhaid eu had-dalu.

Ni chynhaliwyd asesiad effaith rheoleiddiol mewn perthynas â'r Rheoliadau hyn oherwydd bod angen eu rhoi yn eu lle ar frys i ymateb i'r achosion presennol o frech y mwncïod yn y Deyrnas Unedig.

O F F E R Y N N A U S T A T U D O L
C Y M R U

2022 Rhif 715 (Cy. 158)

Y GWASANAETH IECHYD GWLADOL, CYMRU

Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Ymwelwyr Tramor) (Diwygio) (Rhif 3) (Cymru) 2022

Gwnaed *28 Mehefin 2022*

Gosodwyd gerbron Senedd Cymru *29 Mehefin 2022*

Yn dod i rym *1 Gorffennaf 2022*

Mae Gweinidogion Cymru yn gwneud y Rheoliadau hyn drwy arfer y pwerau a roddir gan adrannau 124 a 203(9) a (10) o Ddeddf y Gwasanaeth Iechyd Gwladol (Cymru) 2006(**1**).

Enwi, cychwyn a dehongli

1.—(1) Enw'r Rheoliadau hyn yw Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Ymwelwyr Tramor) (Diwygio) (Rhif 3) (Cymru) 2022.

(2) Daw'r Rheoliadau hyn i rym ar 1 Gorffennaf 2022.

(3) Yn y Rheoliadau hyn, ystyr "y prif Reoliadau" yw Rheoliadau'r Gwasanaeth Iechyd Gwladol (Ffioedd Ymwelwyr Tramor) 1989(**2**).

(**1**) 2006 p. 42.

(**2**) O.S. 1989/306, a ddiwygiwyd gan O.S. 1991/438; O.S. 1994/1535; O.S. 2004/614; O.S. 2004/696; O.S. 2004/1433 (Cy. 146); O.S. 2008/2364 (Cy. 203); O.S. 2009/1175 (Cy. 102); O.S. 2009/1512 (Cy. 148); O.S. 2009/1824 (Cy. 165); O.S. 2009/3005 (Cy. 264); O.S. 2010/730 (Cy. 71); O.S. 2010/927 (Cy. 94); O.S. 2011/1043; O.S. 2011/2906 (Cy. 310); O.S. 2012/1809; O.S. 2014/1622 (Cy. 166); O.S. 2020/113 (Cy. 20); O.S. 2020/1607 (Cy. 334); O.S. 2021/221 (Cy. 55); O.S. 2022/89 (Cy. 30); O.S. 2022/402 (Cy. 99); mae offerynnau diwygio eraill ond nid yw'r un ohonynt yn berthnasol i'r Rheoliadau hyn.

Diwygio'r prif Reoliadau

2.—(1) Mae'r prif Reoliadau wedi eu diwygio fel a ganlyn.

(2) Yn rheoliad 3 (gwasanaethau sydd wedi eu hesemptio rhag ffioedd)—

(a) daw'r testun presennol yn baragraff (1);

(b) ar ôl y paragraff newydd (1), mewnosoder—

"(2) Services provided to an overseas visitor for the treatment of monkeypox on or after 23 May 2022 but before this paragraph came into force are to be treated for the purposes of these Regulations as if, at the time that the services were provided, they were relevant services in respect of which no charge may be made or recovered.

(3) Where paragraph (2) applies, a Local Health Board or NHS Trust—

(a) yet to make charges under regulation 2 (making and recovery of charges) must not make the charges;

(b) that made charges under regulation 2 but has yet to recover the charges, must not recover the charges; or

(c) that made charges under regulation 2 and received payment in respect of the charges, must repay any sum paid in respect of the charges in accordance with regulation 8 (repayments).".

(3) Yn Rhan 4 o Atodlen 1 (clefydau na chodir ffi am eu trin), yn y lle priodol yn nhrefn yr wyddor, mewnosoder "Monkeypox".

Eluned Morgan
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, un o Weinidogion Cymru
28 Mehefin 2022

Explanatory Memorandum to The National Health Service (Charges to Overseas Visitors) (Amendment) (No 3) (Wales) Regulations 2022

This Explanatory Memorandum has been prepared by the Health and Social Services Department and is laid before Senedd Cymru in conjunction with the above subordinate legislation and in accordance with Standing Order 27.1.

Minister Declaration

In my view, this Explanatory Memorandum gives a fair and reasonable view of the expected impact of The National Health Service (Charges to Overseas Visitors) (Amendment) (No 3) (Wales) Regulations 2022.

Eluned Morgan MS
Minister for Health and Social Services

29 June 2022

PART 1

1. Description

1.1 These Regulations amend the National Health Service (Charges to Overseas Visitors) Regulations 1989 (SI 1989/306) (the Principal Regulations).

1.2 The Principal Regulations require Local Health Boards and NHS Trusts in Wales to make and recover charges for relevant healthcare services that are provided to overseas visitors not ordinarily resident in the United Kingdom (UK), unless the overseas visitor or the service they receive falls within a charging exemption.

1.3 These Regulations are being made to:

- amend Schedule 1 of the Principal Regulations to include monkeypox as a disease, services for the treatment of which is exempt from NHS charges for overseas visitors; and
- amend the Principal Regulations such that where services were provided to an overseas visitor for the treatment of monkeypox on or after the 23 May 2022 but before these amendments come into force, a Local Health Board or NHS Trust:
    - yet to make charges, must not make the charges;
    - that made charges but has yet to recover them, must not recover the charges; and
    - that made charges and received payment, must repay any sum paid in respect of the charges.

2. Matters of special interest to the Legislation, Justice and Constitution Committee

2.1 In accordance with section 11A (4) of the Statutory Instruments Act 1946, the Llywydd has been informed that the Regulations are being made according to the negative procedure and will come into force less than 21 days after the instrument has been laid. The early commencement is necessary to respond to a public health emergency as well as removing a financial barrier to overseas visitors in Wales in presenting for NHS hospital treatment for monkeypox, therefore ensuring that the risk to public health from infected visitors is minimised.

2.2 As well as inserting monkeypox into the list of diseases exempt from charges, the amendments also provide that where services were provided to an overseas visitor for the treatment of monkeypox on or after 23 May 2022 but before these amendments are brought into force, a Local Health Board or NHS Trust must not charge for such services, and if charges have already been made then those charges must not be recovered or if they have already been recovered then they must be repaid. This is because as a result of the latest outbreak there are already monkeypox cases in Wales. The policy justification for this amendment is provided at paragraph 4.4 below.

2.3 The Regulations will come into force on 1 July 2022.

3. Legislative background

3.1 The instrument is being made under sections 124, 203(9) and 203(10) of the National Health Service (Wales) Act 2006 (the 2006 Act) which confers a power on the Welsh Ministers to make regulations for the making and recovery of charges from persons who are not “ordinarily resident” in the United Kingdom for NHS services. As required by Section 203(4) of the 2006 Act, these Regulations are being made under the negative resolution procedure.

4. Purpose and intended effect of the legislation

4.1 The Regulations amend the Principal Regulations and add monkeypox to Schedule 1 of those Regulations, which is a list of infectious diseases, services for the treatment of which are exempt from charge to all overseas visitors.

4.2 This is to remove a financial barrier to overseas visitors in Wales presenting for NHS hospital treatment for monkeypox, therefore ensuring that the risk to public health from infected visitors is minimised.

4.3 The Regulations also provide that where an overseas visitor who, on or after 23 May 2022 but before these Regulations are brought into force, was provided with services for the treatment of monkeypox, a Local Health Board or NHS Trust must not charge for those services and if charges have already been made then they must not be recovered and if they have already been recovered then they must be repaid.

4.4 It is intended, that by cancelling charges that might otherwise apply before the coming into force date, overseas visitors will not be deterred from presenting for treatment due to charging concerns. It will also ensure that those who have received treatment for monkeypox before the Regulations came into force are treated equally to those who receive treatment after the Regulations come into force.

5. Consultation

5.1 There is no statutory duty to consult prior to making the regulations. It is considered that the proposed amendments do not require consultation as they are an urgent amendment to the Principal Regulations to protect the wider public health by including monkeypox as a disease, services for the treatment of which is exempt from NHS charges for overseas visitors and thereby ensuring that the risk to public health from infected visitors is minimised.

5.2 Previous amendments to the 1989 Charging Regulations have not always been consulted on, this was in the case of the 2020 Coronavirus amendment which added SARS-CoV-2 to Schedule 1 of the Principal Regulations.

6. Regulatory Impact Assessment (RIA)

6.1 A regulatory impact assessment has not been prepared in relation to these Regulations due to the need to put them in place urgently to respond to the current outbreak of monkeypox in the UK.

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon