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Ymchwiliad i'r Adolygiad Blaenoriaethau ar gyfer y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Inquiry into the Priorities for the Health, Social Care and Sport Committee
Ymateb gan: Coleg Brenhinol y Seicatryddion
Response from: Royal College of Psychiatrists

Royal College of Psychiatrists in Wales

Consultation Response

DATE:	**5 September 2016**
RESPONSE OF:	**THE ROYAL COLLEGE OF PSYCHIATRISTS in WALES**
RESPONSE TO:	**The Health, Social Care and Sport Committee Future Programme for the Fifth Assembly**

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

The College aims to improve the outcomes of people with mental illness, 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 is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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Dr. Dai Lloyd AM,
Health, Social Care & Sport Committee,
National Assembly for Wales,
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5 September 2016

Dear Dr Lloyd, AM

Re: The Health, Social Care and Sport Committee Future Programme for the Fifth Assembly

Thank you for giving us the opportunity to comment on the Committee's proposed forward work plan for 2016-2017.

We are pleased that the Committee has prioritised areas that directly relate to mental illness, specifically work on gambling addiction, isolation and loneliness in the elderly, and the use of antipsychotic medication in care homes. The College in Wales considers these as high priority areas and we therefore strongly support the Committee including these in their forward work programme.

The other areas proposed are also important and commendable. If any of these are to be included in the forward work programme, we would strongly suggest that the work include a mental health aspect. Mental health and physical health are inextricably linked.

We provide detailed comments overleaf.

Yours Sincerely,

Professor Keith Lloyd

Chair, Royal College of Psychiatrists

Integration of health and social care services

This is a very important area for the College and other health and social care organisations, and it is one which all political parties have pledged to address. Plaid and Labour have begun to conduct a parliamentary style review into integration of health and social care. It is unclear to us at this point what shape this Review will take or how it would tie in to work of the Committee.

If the Committee were to proceed with this piece of work, it would have to be clear on what it means by 'integration'. Would it include integration within health and social care; for example between primary, secondary and tertiary services? Being clear on the definition could narrow the scope of what is potentially a large-scale project.

Mental health services rely on multidisciplinary working and as such can be seen as the forefront of integration. We use the Whole Systems Approach in planning and delivering care, in hospitals but largely in the community, to achieve patient-centred care. Mental Health service models involve multi-disciplinary teams covering a range of services in social services, education, and health and the level of success of the service provided is often dependent on how well it is integrated.

A model that is structured on integration can still be broken if it is not supported by individuals. It is therefore important not to just look at policies and legislation but to focus on cultural environments than enable integration.

Waiting Times

Waiting times are generally longer in Wales than in other UK countries so we believe that the Committee should examine this issue to understand why this is the case. RCPsych in Wales is particularly concerned around waiting times for psychiatric appointments in CMHTs and the availability of psychological therapies, timely ASD diagnoses, and appropriate referrals to CAMHS.

It is important that the Committee focuses on quality of care alongside the length of waiting times and how or if Welsh Government is meeting its targets.

Efficiency within the NHS and modern management practices

We questions whether this could form part of the forward work programme of the Assembly's Public Accounts Committee.

Although not directly connected, the HSCS Committee could scrutinise the success of Welsh Government's Prudent Healthcare agenda of co-production, treating those with greatest need first, do only what is necessary, and reduce inappropriate variation.

Neonatal services

We question whether it would seem sensible for the current CYPE Committee to undertake this review.

Use of antipsychotic medication in care homes

RCPsych in Wales has called for a cycle of national and a local audits of prescribing antipsychotics in care homes to patients with dementia to improve clinical practice. We have worked closely with the Commissioner on this issue and we are in partnership with

the Royal Pharmaceutical Society in Wales, campaigning for an end to routine prescribing and a reduction in the time and dosage where antipsychotics are required.

The use of antipsychotics results in a number of side effects, such as drowsiness, nausea and constipation. The longer term use of antipsychotics increases the risk of fatal conditions such as stroke.

The College would ask the Committee to focus on the use of *inappropriate* prescribing of antipsychotics. This fits into the Government's Prudent Healthcare Agenda.

Ambulance Services

We welcome the new clinical model for measuring Ambulance services with a focus on quality and not just the speed of delivery. If the Committee were to examine this area, we would like it to focus on ambulance responses to those patients with dementia. We worry that the ambulance services may be reluctant to transfer patients who lack capacity to A&E, hospital wards or care homes. Section 6 of the Mental Capacity Act states that they are allowed to do so, including the use of appropriate force. There are also concerns that sometimes section 135 of Mental Health Act is used inappropriately to transfer those patients without capacity

Loneliness and isolation among older people

According to Age Concern Cymru, 75,000 over-65s in Wales describe themselves as 'always or often lonely', equating to nearly half of the elderly population. The Committee is right to consider this area for further investigation as studies show that isolation and loneliness have a significant impact on a person's health and wellbeing. Recent studies have shown loneliness to have twice the health impact as obesity, and can cause premature death in older people by up to 14%.[1]

If the Committee were to examine this area, we would like it to look at the connection between isolation and alcohol misuse. In recent years, we have seen an increase in the number of elderly people drinking above 'safe limits' (20% in men and 10% in women). Boredom, isolation, loneliness, bereavement, retirement, depression are psychosocial factors that are associated with the onset of alcohol misuse. If the Committee decides to look further into the area of loneliness and isolation in the elderly, we would suggest including the growing trend of elderly people and excessive drinking.

Gambling addiction

We are very pleased to see that this issue has made the list of Committee proposals. There needs to be a better understanding of problem gambling and more funding in treating those who suffer with this addiction. People with gambling problems will only seek help when they reach the point of crisis, or if they are seeking help for alcohol or drug addictions. Most will go untreated.

Given the ease of gambling in today's culture, we are unprepared to treat those who are predisposed to problem gambling. The repercussions of problem gambling are serious for the individual and their families. We must treat problem gambling as any other addiction and begin to tackle the stigma attached to it.

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[1] Presentation by John Cacioppo, Professor of Psychology at the University of Chicago to the American Association for the Advancement of Science (February 2014).

We must also makes steps to understand the seriousness and scale of the problem. There is a lack of data on the prevalence of problem gambling. The gambling industry is the main provider of treatments for those with serious addiction and they do not divulge the scale of the problem. It is unclear how many are affected or in need of treatment. There is only one NHS Treatment service for gamblers, which is part funded by the Responsible Gambling Authority.

A Committee inquiry into gambling may begin to address these issues. There has, to date, been only one debate in the Assembly around gambling and we feel much more attention needs to be given to this area.

Sport and public health

It is clear that regular exercise improves a person's health and wellbeing. The Committee needs to examine why, despite overwhelming evidence, we are still struggling as a nation to become healthier.

We also know that a number of factors play a part, such as disability, physical and/or mental illness, chronic pain, and so on. For example, a recent international study into psychosis and activity shows that men with psychosis are twice as likely as those without the illness to miss global activity targets. The reasons for this are often due to impairments associated with the illness, such as depression, chronic pain, cognitive impairments and mobility problems.[2] For many with a learning disability it is often a case of access.

Also, those less likely to exercise are females, the elderly, and those in deprived areas. For some, physical activity is not seen as a priority or there isn't enough time for exercise.

Promotional messages must be tailored to address a variety of groups and these messages must be appropriately targeted. We must avoid developing a single message that is designed to address the population as a whole.

RCPsych in Wales would like to recommend other areas which the Committee may wish to examine either now or during the Assembly's 5th term:

Learning Disabilities and healthcare provision

People with learning disabilities are often predisposed to certain physical and mental illnesses. There is a much higher prevalence of a range of diagnosed psychiatric disorder in people with a learning disability compared with those without. They are also more likely to experience health inequalities and suffer from poor physical health. Once in the healthcare system, many will face barriers to receiving good care, such as difficulties in communication, diagnostic overshadowing, challenging behaviour, attitudes among professionals, and poorly developed links between specialist learning disability and general hospital services.

There is no baseline audit on learning disabilities in Wales. Professor Dame Sue Bailey, a world renowned Child Forensic Psychiatrist, past president of the Royal College of Psychiatrists and current President of the Academy of Medical Royal Colleges, said at the Faculty meeting in Wales, "Having a baseline audit puts you on the map; it says that you actually matter".

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[2] http://schizophreniabulletin.oxfordjournals.org/content/early/2016/08/19/schbul.sbw111.abstract

The Committee could look in to specific issues around the Learning Disability Strategy for Wales (1983) and why this has been updated only piecemeal over the years, despite a shift from treatments in institutional settings to community-based services.

Eating Disorders and Disordered Eating

The current level of service provision for people with eating disorders is inadequate and cannot appropriately address the psychiatric and psychological needs of the population.

Eating disorders are on the increase in the population and expansion of Welsh universities brings at risk population of young adults creating additional pressures on eating disorder services and CMHTs.

Patients with the most severe cases who require hospitalisation are transferred out of area to the NHS and increasingly to private clinics in Bristol, Marlborough, or London where they can stay for up to one year. Teams have to deal with multiple care providers and lack of continuation of care. As a result of commissioning services for local populations in England, Welsh patients have to wait for beds for up to several months.

Tragically, those most likely to be affected by eating disorders are young adults. There is a common misconception that, because many are young girls, the disorder is brought on through vanity. The reality is that most people with an eating disorder have psychiatric co-morbidity such as complex trauma, personality disorder, depression, or anxiety and are using their eating disorder as a means to control the only aspect of their lives, namely what they eat.

A patient is identified as having a need for treatment dependent on their Body Mass Index (BMI), not if he or she has a mental illness resulting in an eating disorder.

Wales remains the only country in the UK, where patients with severe eating disorders are seen by general psychiatrists and by multiple teams with resulting lack of medical leadership. We feel that a dedicated service providing a seamless care for inpatients and outpatients is needed in Wales and that Welsh patients should be treated locally in a dedicated in patient unit.

Disordered Eating is common in the elderly, in particular with those suffering from dementia or those with co-morbidities, including those who have difficulty in swallowing. Their diet and nutrition is severely impacted. (This could also form part of an examination into Dementia, which we outline below.)

Out of Area Placements

There are a large number of people in Wales who must be placed out of area to receive the treatment they need.

People receiving treatment for mental health conditions are often placed out of area where they can be seen by specialists. Almost all patients with eating disorders are treated in England; for young adults this leads to loss of support from peers and families and educational underperforming. Patients with gender dysphoria are all referred to London; lack of funding for local services results in excess spent and waits of over a year. Patients requiring specialist inpatient learning disability services are also often transferred out of area when beds are available. There are no prisons for women in Wales. Prisoners have

the highest proportion of mental health conditions compared with most other populations. Again, this group of people rely on treatment from English services.

We would suggest that the Committee look into the human and financial costs.

Primary Care Mental Health Support

The College believes that more focus should be placed on prevention and early intervention where possible and primary care should be equipped to deliver this. The Mental Health (Wales) Measure was passed recently to better support primary care mental health provision; however, a report by Gofal shows that patient satisfaction has not improved since the law was implemented. A survey of GPs conducted by Wales and Mental Health in Primary Care (WaMH in PC) showed that 50% of respondents said that they are spending 20% of their workload on helping people with mental health issues. This group felt that there should be a rebalancing of priorities within the Local Primary Mental Health Support Services (LPMHSS) to provide better support to the primary care workforce.

The Health Committee held an inquiry on the post-legislative scrutiny of the Mental Health (Wales) Measure and we understand that there are no plans to undertake another review.

Dementia

Welsh Government is currently developing Wales' first Dementia Strategy for Wales as outlined by the *Together for Mental Health Delivery Plan*. The Strategy will be published by the end of 2016. The Committee could examine the progress of the Strategy in due course.

We feel the Committee could look specifically at early onset dementia. To date, there are no services that are able to best treat this cohort of people. The patient is often inappropriately referred to Old Age services. We feel a national assessment, diagnostic and supported service for Wales is needed.

It is important to note that depression accounts for 40% of Old Age Psychiatry workload. It is highly prevalent in early onset dementia patients where frequently a diagnosis of dementia can trigger depression. We would ask the committee to look at the level of training in identifying and treating depression in patients with dementia. This aspect could also be included in work on isolation and loneliness in the elderly.

Gender dysphoria

According to the Gender Variance Report (2009)[3] there is a continuing increase in cases presenting with gender dysphoria as a result of increasing public acceptance and overcoming stigma associated with the condition. Welsh patients with gender dysphoria have no local service provision. Expert assessment and treatments such as hormone therapy are well established and relatively inexpensive and could easily be provided in Wales.

Currently treatments for Gender Dysphoria are only provided in London and Welsh patients must endure lengthy waits. If you take into account the long wait for routine psychiatric assessments in CMHTs, followed by a long wait for assessment out of area, often patients will wait for two years with their lives on hold. This again is often a problem affecting

[3] Reed, Bernard. et. al. (2009) Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution. Gires.

young adults and leads to unnecessary suffering and occupational underperformance of this vulnerable group.

The Committee could consider the benefits of having a local gender clinic in Wales.