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Y Pwyllgor Iechyd a Gofal Cymdeithasol

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Health and Social Care Committee

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Jayne Bryant MS
Chair, Children, Young People and Education Committee
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Chair, Equality and Social Justice Committee
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5 April 2022

Dear Jayne, Jenny and John

Health and Social Care Committee inquiry into mental health inequalities

Further to my letter of 14 December 2021 to the Children, Young People and Education Committee and the Equality and Social Justice Committee, I am writing to update you on the next steps for the Health and Social Care Committee's inquiry into mental health inequalities.

The evidence we have already heard clearly demonstrates the cross-cutting nature of the determinants of mental health inequalities, and the potential solutions. I was pleased that members of the CYPE and ESJ Committees were able to participate in some of the focus groups we arranged in February. I look forward to continuing to work with you and your Committees to identify areas of mutual interest and opportunities to work together.

Yours sincerely

Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Health and Social Care Committee inquiry into mental health inequalities: update

Work to date

The Health and Social Care Committee launched an inquiry into mental health inequalities in January 2022. The terms of reference were very broad, seeking to identify which groups were most likely to experience mental health inequalities, what barriers they face, whether Welsh Government policy does enough to recognise and address these groups' needs, and what more needs to be done.

So far, we have gathered evidence by:

- Launching an open call for written evidence, which received over 90 responses. A summary of the written evidence prepared for internal use by the HSC Committee is attached in confidence.
- Running a digital communication campaign to promote the inquiry and encourage people to share their views.
- Working with twelve partner organisations to arrange a series of thirteen focus groups and two in depth interviews with participants across Wales. In total 77 people from across Wales took part. The focus groups and interviews were facilitated by the Senedd's Citizen Engagement Team, and, where possible, attended by members of the HSC, CYPE and ESJ Committees. A report summarising the findings has been published.
- Holding oral evidence sessions on 24 March with the Centre for Mental Health, the Mental Health Foundation, the Children's Commissioner for Wales and the Older People's Commissioner for Wales.

Emerging themes

Having reflected on the evidence we have gathered so far, we now plan to explore four key emerging themes in greater detail:

1. Mental health and society: the wider determinants of mental health, and the role of society and communities in promoting and supporting mental health.
2. Community solutions: the role of communities in promoting and supporting mental health, and social prescribing.
3. The impact of mental health inequalities on people with neurodiverse conditions: we have heard significant concerns about this group in the evidence that we have gathered so far. This is also a diverse group, many of whom may also experience inequalities relating to their other characteristics. The evidence suggests that some of the barriers experienced by

this group—such as a lack of joined up services, limited awareness and training, and diagnostic overshadowing—may also be experienced by other groups and communities. Looking at the experience of people with neurodiverse conditions will therefore also help us to explore broader themes that affect other groups.

4. Role of the healthcare and wider workforce: including mental health and equality awareness across the whole workforce, training, joined up working within the health service and with other organisations, and the role of GPs as the 'front door' to mental health services.

We plan to gather evidence on these themes through a range of mechanisms, including formal oral evidence, visits and further engagement activity. This will help us to hear a wide range of voices, including people with professional and lived expertise and experience of the matters we are considering.

Welsh Government

We will hold an oral evidence session in the autumn with the Welsh Government. During this session we will draw on all of the evidence we have gathered during our inquiry, including issues raised in our initial focus groups and written evidence submissions, as well as the evidence we gather during the summer term in respect of our four emerging themes.

As previously agreed, we will also coordinate with the CYPE Committee to seek a written update from the Welsh Government on progress made on key recommendations made by Fifth Senedd committees in respect of mental health.

Advisory group

To ensure that lived experience is at the heart of our inquiry, we will establish an online advisory group. The group will include 10 to 15 people with lived experience of mental health inequalities, who will be asked to consider discussion topics at key milestones during the inquiry and provide us with summaries of their views. This is likely to include, for example, before and after the Ministerial evidence session, before we finalise our report, and before any Plenary debate on our report.

We'll be working with partner organisations to identify and support advisory group members, drawing where possible from the pool of people who took part in our initial focus groups, and taking account of characteristics such as geographical location, sex, age, and membership of specific communities such as neurodiversity, minority ethnic, sensory impairment, LGBTQ+ and unpaid carers.

Welsh Youth Parliament

As the Welsh Youth Parliament has identified 'Our mental health and wellbeing' as one of its priorities, we also plan to look for opportunities to work with WYPMs as appropriate.

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Mental health inequalities

Pwyllgor Iechyd a Gofal Cymdeithasol | 24 Mawrth 2022
Health and Social Care Committee | 24 March 2022

Reference: RS22/2284

Introduction

The **Centre for Mental Health** describes a 'triple barrier' of mental health inequality, which affects large numbers of people from different sections of the population:

i. Some groups of people are **disproportionately at risk of poor mental health**. This is often linked to inequalities in society.

ii. Groups with particularly high levels of poor mental health can have the most **difficulty accessing services**.

iii. When they do get support, their **experiences and outcomes are often poorer**.

During this **first phase of evidence gathering**, the Health and Social Care Committee issued an open call for evidence between 10 January – 24 February 2022. We received 92 written responses, from a wide range of individuals and organisations.

Our Citizen Engagement team also ran a series of focus groups to gather the lived experiences of diverse groups of people. A report on this engagement activity is included with the papers for today's meeting. Many of the issues highlighted reflect what stakeholders are telling us in their consultation responses.

Summary of consultation responses

Who is most at risk?

Stakeholders highlight a range of groups who may be at particular risk of mental ill health. These include:

- People from socioeconomically disadvantaged backgrounds
- Ethnic minority communities/racialised communities (communities subject to racial inequality), including gypsy and traveller communities
- Older people
- Children and young people (both as a broad, general group and also in relation to factors such as adverse childhood experiences (ACEs), experience of care, school exclusion, and protected characteristics)
- People with autism/other neurodivergent conditions including ADHD
- People with a learning disability
- People with sensory impairment/loss
- LGBTQ+ people
- Pregnant women/new mothers (the 'perinatal' period)
- Disabled people
- People living with a chronic health condition
- Carers (including those caring for someone with a chronic/terminal illness, and those supporting a family member with mental health difficulties)
- People with communication and speech and language difficulties
- People with substance misuse issues
- People with serious mental illness
- Women as a broad group
- Men, including young men, middle-aged men, unemployed men
- Refugees and asylum seekers
- People who've experienced trauma, including sexual violence/domestic abuse
- Homeless people
- Offenders
- People living in rural areas
- Agriculture and fishing communities
- Health and care workforce
- Education workforce

A key point is that the relationship between mental health and inequality is complex; the factors involved are interrelated and may be two-directional. For example, poverty can be both a cause and a consequence of mental ill health (for further information on this see Senedd Research's article: **Poverty and mental health**).

For many of the groups listed, common factors contributing to worse mental health include: impact of discrimination and fear; feelings of shame/humiliation; income uncertainty; loneliness and isolation; trauma (e.g. from abuse, violence, ACEs (adverse childhood experiences), and; lack of voice, choice and control.

There's a clear view that as well as identifying 'who', there must also be focus on 'why' - the circumstances that cause mental health inequality. The Centre for Mental Health and Society at Bangor University told us "Inequality has an impact on society as a whole, and not just on discrete disadvantaged groups. (…) All sectors of society would experience tangible benefits from reductions in inequality" (MHI43).

It was widely acknowledged that the COVID-19 pandemic has made existing inequalities worse. It has had an adverse impact on population mental health, and particularly those people already subject to mental health inequality.

Barriers to accessing effective mental health support

Responses highlight the following barrier to seeking and/or receiving appropriate, effective support:

- Stigma. Fear of being judged, losing existing support or being penalised (e.g. children being taken into care)
- Discrimination (e.g. age discrimination)
- Cultural barriers, language issues
- Lack of trust in services. Previous negative experiences, feeling not listened to/dismissed
- Not knowing what help is available or how to access it
- Lack of capacity within existing services, long waiting times and high thresholds for access
- Gaps/variability in provision, including lack of specialist services
- Services aren't flexible enough, there's a 'one size fits all' approach
- Being excluded from services, due to a focus on an individual's 'main' diagnosis
- Lack of clarity about referral processes/'restrictive' referral processes

- Geographic issues/rurality
- Digital exclusion

While some of the issues raised by stakeholders are more relevant to specific groups, many are common themes which apply more broadly.

Key themes

People struggle to access support appropriate to their needs

Responses describe a lack of provision across the spectrum of need, from early intervention through to specialist and crisis services. Long waiting times are a significant issue. Stakeholders highlight gaps in provision for certain groups (e.g. older people). Services need to be more accessible (e.g. for people with sensory loss), and better at recognising and meeting needs of ethnic minority communities for example. There's a lack of services in the Welsh language. NHS support is often time-limited (e.g. an offer of six counselling sessions only). There's a lack of follow-up/ongoing support.

Some stakeholders describe people being 'bounced' between services, including between primary and secondary care where an individual is "too ill for primary care/not ill enough for secondary care" (MHI92). People may be unable to access much-needed support because they don't fit into existing service set-ups. Llamau gives an example – "You must attend an anxiety group even if you don't trust people and are suicidal, before we can offer anything else" (MHI56).

Often people aren't aware of the support available or how to access it. There's a need for improved signposting and accessible/inclusive information about services. To reach a wider range of people, Care and Repair Cymru suggests that the Welsh Government work with organisations such as Welsh Water to include information on mental health support with their customer literature (MHI39).

We have an outdated, 'medical model' for mental health which fails to address broader needs

Mental health services tend to be based on a medical model of illness. The 'diagnosis' therefore leads the support/treatment provided, but the human needs underlying a person's mental health difficulties are often ignored or under-explored.

Current policy and practice doesn't adequately reflect a trauma-based understanding of people's needs. Psychologists for Social Change says "This perpetuates mental health inequity as it obscures the necessary solutions from

view" (MHI36). Many stakeholders agree we need a trauma-informed approach across all public services.

> Note: '**Trauma**' results from an event, series of events, or set of circumstances that an individual experiences as physically or emotionally harmful or life-threatening, and that has lasting, adverse effects on the individual's functioning and mental or physical wellbeing.
>
> 'Trauma-informed approaches' are ways of supporting people that recognise the impact of past or ongoing trauma, and the specific needs a person may have as a result.
>
> Stakeholders have previously described the impact of the pandemic as 'population-level trauma'.

Services need to be **person-centred**, with support designed around the needs of each individual, "rather than fitting people into a limited range of expected services" (MHI61). Stakeholders describe key features of a more person-centred approach to service provision, including:

- greater **flexibility** (in terms of how services are accessed, opening hours etc.);
- they are **co-produced** (designed and developed with service users and people with direct lived experience);
- there's a **'no wrong door'** approach to accessing support;
- services are **joined-up** and communicate effectively (e.g. so people don't have to repeat their story multiple times).

The Royal College of Psychiatrists provides an example of how a more holistic approach to meeting people's needs might work (MHI54):

> *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.*

A key concern raised by a number of respondents is an **over-reliance on medication,** often without discussion of talking therapies or other options. Limited availability of alternative options is also a clear factor here. Adferiad tells us that antidepressants are widely prescribed for problems which actually require

practical support (e.g. housing issues, unemployment, abusive relationships). "In some disadvantaged communities antidepressants are seen as the only "answer" to a poor quality of life, especially for women" (MHI62).

People with co-occurring conditions or 'dual diagnosis' are often denied support

This may be a particular issue for people with neurodivergent conditions or learning disabilities, people with dementia, and for people with substance misuse issues.

Parents Voices in Wales CIC says that mental health problems are regarded as an "inevitable consequence" of neurodivergence, and mental health referrals for people with such conditions are often declined (MHI08). Mencap agrees that a focus on an individual's 'primary diagnosis' can lead to people being denied mental health support. A person's behaviour, even when experiencing a mental health crisis, is seen as part of their learning disability/condition. (MHI32).

Substance misuse is often a symptom and a consequence of poor mental health, but siloed ways of working can mean that support for mental health is denied until substance misuse issues have been addressed. The Wallich tells us that treatment pathways for 'dual diagnosis' (i.e. problems with mental health and substance use) do exist but aren't working effectively across Wales (MHI60).

The mental health impact of living with a physical health condition is under-recognised

This includes where conditions are undiagnosed, involve long waits for treatment, or there's a lack of rehabilitation support.

RNIB Cymru says "While the emotional impact of sight loss is well documented, in practice it is often overlooked (…). Treatment and support is more focussed on the physical impacts" (MHI58). Endometriosis UK calls for mental health support to be incorporated into care pathways to improve access for those who need it, including prior to diagnosis (MHI19).

The wider, often hidden impacts of inadequately-supported health conditions were highlighted. Specsavers says that undiagnosed and/or untreated hearing loss can impair education, employment and social activities, leading to isolation, and physical and mental ill-health (MHI11). The ADHD Foundation describes the "unseen costs" of unmanaged ADHD for other areas of healthcare, education, social services, and the criminal justice system (MHI01).

Points made reflect evidence received during the Committee's 'waiting times' inquiry.

Greater awareness of equality issues among the healthcare and wider workforce is needed

A number of responses describe a lack of capacity in the mental health workforce. Recruitment and retention issues pre-date the COVID-19 pandemic, but staff are experiencing increased burnout and attracting staff to train and work in mental health is challenging.

There was significant comment about the need for more awareness and training among frontline staff, not just for mental health/healthcare staff, but across education, social services and other public-facing roles. Stakeholders highlighted a range of issues. Lack of understanding about autism/neurodiversity was a key area. Other training 'gaps' included the mental health needs of older people, people with sensory impairment/loss, personality disorders, carers' needs, the impact of grief, of women's health issues, and suicide prevention awareness. To address some of the barriers to effective mental health support, services and staff need to be culturally-sensitive, trauma-informed, and better at recognising signs of poor mental health and people's needs for support.

GPs are often the first port of call for someone struggling with a mental health issue, but a number of responses suggest this is a key professional group where improved training and awareness is needed, in relation to mental health generally and also equality issues. The Welsh Police Forces' submission says "Training for GP's needs to be increased as 1 in 3 persons who attend have hidden mental health issues which manifest in physical health symptoms" (MHI28). The Centre for Mental Health highlights that people from racialised communities are less likely to be referred for mental health support by their GP (but are more likely to come into contact with services via the police) (MHI80).

Respondents highlighted Healthcare Education and Improvement Wales and Social Care Wales' current consultation on a **mental health workforce plan** for health and social care, saying this provides a "real opportunity to remodel current provision and create sustainable services which ensure that all people in Wales can access appropriate mental health support" (MHI83).

The potential for more community solutions should be explored, including social prescribing schemes

There was significant comment about the need to invest in communities to promote and support good mental health, and build the capacity of local

voluntary/community groups to develop and deliver services. This includes improving access to community hubs.

The Welsh Local Government Association calls for the role of local government to feature more strongly in conversations about improving and delivering mental health support - "for example, broadening the use of parks and green space, championing wellbeing in new planning requirements, supporting adult learning, improving access to leisure centres and sports facilities, or improving community links with local artists and cultural events" (MHI55).

There's a need for stronger links between mental health services and wider community support. Platfform says "Practitioners need to consider how to tackle loneliness and isolation, encourage people to participate in social activities (arts, culture, community etc)". While this has been difficult to do during the pandemic, Platfform says this has always been a "neglected factor" (MHI79). Further responses describe the need to 'unlock the potential' of social prescribing schemes. Although schemes are in place in some parts of Wales, there are differences in approach and levels of service available (MHI75).

A significant number of responses raise the issue of short-term funding. Diverse Cymru for example tells us "Longer term funding of services, including services commissioned from third sector and community groups and organisations, is vital to ensuring that services can focus on meeting the needs of different groups and communities and developing specialist services, rather than winding up and down every 3 years" (MHI61).

More detailed data would give us a clearer understanding of where equalities lie

We don't have adequate data to understand the extent of mental ill health among the population in Wales, or how well different groups are able to access mental health services and have their needs met. Mind Cymru tells us "there is no routine, reliable and comparable measure of the prevalence (both treated and untreated) of mental health problems within the Welsh population. As a result, the true scale of mental health problems, inequalities between groups and changes overtime remains unclear (MHI47)

Stakeholders highlight limited availability of demographic data, including information on socio-economic disadvantage, ethnic minorities, lack of data on mental ill health in the older population, autistic people, and people with sensory impairment/loss. There also remains a focus on outputs rather than outcomes.

The development of a **mental health core dataset** in Wales is welcome, but there are concerns about delays to this work. Additionally, more data is needed about the long term impact of the COVID-19 pandemic on mental health.

Policy needs to be more joined-up and resources focused according to level of need

While a number of responses welcome the Welsh Government's vision and policy intent for improving mental health in Wales, a key concern is the **"translation of policy into practice"** (MHI85).

The Government's 'Together for mental health' strategy is being reviewed (the existing delivery plan ends this year), and stakeholders see this as an **opportunity to address the needs of a wider range of communities** who experience discrimination and/or disadvantage. Examples given of groups not specifically covered by the current delivery plan include older people, gypsies and travellers, and people living with chronic conditions. Any new strategy or delivery plan must be informed by **learning from the COVID-19 pandemic**, particularly "the entrenched and widening existing economic, social, cultural and environmental inequalities that have led to poorer mental health" (MHI55).

Stakeholders describe the need to **link together the various action plans/policies** in relation to mental health and different protected characteristics groups and communities who experience discrimination and disadvantage. A number of Royal Colleges are jointly calling for a **cross-government strategy** on health inequalities. The Royal College of Physicians says (MHI15):

> *The Welsh government should 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.*

Many responses highlight the need for increased **funding** for mental health, but we also need to look at **value for money** and what outcomes are being achieved (MHI28).

To tackle mental health inequalities, the Mental Health Foundation and others call for a **'proportionate universalism'** approach, which balances universal actions (for everyone) with targeted actions (for specific groups), and allocates resources according to level of need (MHI90).

Under this approach, action should be taken for everyone, but the scale and intensity of interventions should be proportionate to the level of disadvantage experienced.

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