Annex 1

Consultation Response Form

Your Name:

Organisation (if applicable): British Medical Association Cymru Wales

e-mail / telephone number: 02920 2047 4646

Your address:
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Caspian Way
Cardiff Bay
Cardiff
CF10 4DQ

Are you responding as an individual or on behalf of an organisation. Please tick box.

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1. Are the outcomes the right outcomes? Please tick appropriate box

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Where you have ticked ‘No’ or partly? Please provide an explanation and alternative suggestions. Ideally referring to the relevant chapter.

Additional comments/Explanation:

While there are many worthy outcomes discussed, it would be beneficial to have more substance and detail on how they will be meaningfully delivered.

Chapter 2: Being better informed is important, but there is little detail on how this will be approached and how the support that an individual will need will be assessed. Further, how will the public be informed of what support is out there?
Chapter 3: While it is vital to deliver early access to psychological therapies, as this will be in line with NICE guidelines, the reality is that waiting lists are already too long and patients become either significantly more unwell or are more difficult to treat, and the delay has an effect on the person as a whole in terms of their mental health, lifestyle, and willingness to seek treatment.

Book Prescription Wales has worked well, but there may not be consistent use of it across Wales. There is free access to computerised Cognitive Behavioural Therapy (CBT) but this requires IT skills and access. Many patients need face to face or group therapy and these needs to be delivered quickly. There are gaps in provision for CBT for schizophrenics and little consistency for eating disorders. This chapter makes reference to addressing issues of inequalities of access, but there is no detail on how this will be done. We agree that it is essential for all service providers to work together.

Chapter 4: Cross-sector working to achieve sustainable services is a good approach, but it will require solid commitment. It can be difficult for service providers to commit to this given that there are so many competing demands for resources. Therefore mental health needs to be prioritised.

Overall, we feel that some of the outcomes are rather vague. Some are very important and warrant further consideration such as DTOC.

The focus on research and training is welcome.

2. Where we have indicated how we will deliver the vision, are the broad actions the right ones to achieve these outcomes?

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Where you have ticked ‘No’ please provide an explanation and suggested actions that may be taken by relevant partner organisations? Could you please refer to the relevant chapter?

Additional comments/Explanation:

Chapter 1: In order to break the cycle of inequalities and poverty, what resources will be available to support the most disadvantaged in our communities? With reference to helping older people plan their retirement, detail as to how this would be achieved would be beneficial. It would also be important to understand what the parameters for health checks on the population over the age of 50 would be; what support and resources would be used for this; and what the evidence is that this would be useful.
We are pleased to see that the high workload for GPs in regards to mental health issues is recognised in this chapter.

While the goals of community regeneration through new housing and residential developments being well-designed are important, many of the most deprived individuals in our communities will not be able to access these developments. A focus on community regeneration in current areas would be more helpful.

We are pleased with the reference to school-based counselling for teens and pre-teens as they may feel more comfortable talking about issues or problems identifiable in this setting. Bullying and its effects on mental health should also be specifically covered as it is a significant issue in school systems. It is important to establish good links to CAMHS and GPs where appropriate.

Chapter 3: We are also pleased to see the plan for services to be based on need and not age, but this plan is lacking in detail; specifically, how will services address the varying degrees of mental health to ensure that those on all ends of the spectrum are treated appropriately? We also agree with recognising the dual diagnosis of alcohol and drug misuse that can cause or be caused by mental health and should be managed by a cohesive mental health service. At this time, patients are often shifted from one service to another and issues are treated in isolation.

Chapter 4: In the condensed version of the consultation available online, GPs are solely referenced as the signposter to assist, however the main consultation document does clarify that several people are able to signpost individuals to advice. We would like to affirm that GPs should not be the only ones to signpost individuals to advice.

It would also be helpful to clarify how this information will be updated. Will individuals be signposted to a central directory?

Overall we feel that the strategy would benefit from further incorporation of dementia services – specifically the recovery model. As well as a greater focus on the needs of children and young people as well as older people.

3. Are the indicators appropriate to measure whether or not we have achieved the outcomes? (Please refer to technical annex 2)

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Where you have ticked ‘No’ please provide an explanation and any indicators you think we should include? Please make reference to technical annex 2 and any relevant chapters.

Additional comments/Explanation:

Priority Outcome 1: The measuring of prescribing rates needs to be placed in the context of population demographics, services available and patient preference, among others. Prescribing rates on their own are too crude to measure wellbeing.

Priority Outcome 2: We fail to see the connection between the number of children benefitting from Flying Start and people and communities being more resilient. For the percentage of children in Flying Start reaching development milestones at age 3, is there comparative evidence to show that they would not have done so if they were not involved in this scheme? What primary care data will be needed?

Priority Outcome 6: Who will be providing the care plans for mental health? Is this for all mental health patients or only those with significant mental health illnesses? This could be a large workload for one individual.

Priority Outcome 7: It is also unclear who is to do the carers assessments. We have also had reports from members that carers do not always fill in their assessment forms which could be a hindrance to measuring this outcome.

Priority Outcome 9: We have concerns about the crude referral numbers as per priority outcome #2 (above).

Priority Outcome 11: As with Priority Outcome #6, who would be responsible for the care and treatment plans?

With regards to the Life Area on personal care and physical wellbeing, how would primary care be audited?

The strategy is not very clear on implementation, we await further details on that.

Chapter 1: Promoting Better Mental Wellbeing and Preventing Mental Health Problems.

4. Are there other actions we should be taking to support the promotion of mental well-being?

Yes | No
---|---
| X

**Additional comments/Explanation:**

Mental health liaison services have not been covered in the strategy. These are currently poor across Wales.

We feel it is important to continue to raise awareness at any and all opportunities; to expand the places and modes of delivery of promotion of mental well-being; and to ensure a mix of written and multi-media delivery including information packs, highly visibly posters in multiple venues, social media, television, and websites.

Mental well-being needs to be promoted throughout life and the information targeted for specific age groups. Quite often, information for children is not sufficient, while at the other end of the spectrum, carers for patients with dementia need to have information on things such as support groups for varying stages of dementia, particularly as this information is difficult to find.

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5. **What more can we do to improve mental health and well-being?**

As mentioned above, a full-scale approach from childhood through education, carers (ensuring opportunities and support), benefits, retirement, growing older, and end of life care.

Training and awareness of general hospital staff, together with an effective and coordinated liaison psychiatry service, could work to improve awareness and reduce stigma.

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**Chapter 2: A New Partnership with the Public**

6. **What further action can we take to help reduce stigma and discrimination?**

One possibility would be to embed an education programme on mental health in legislation, and to robustly take action when a problem is identified.

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**Chapter 3: A Well Designed, Fully Integrated Network of Care**

7. **What additional actions do we need to improve access to Child and Adolescent Mental Health Services and address transition issues?**
One action would be to ensure that services are accessible from all avenues where patients may be such as schools, A&Es, GP surgeries, etc. Currently, referrals for attention deficit can only come from a school, even if a GP recognises the signs within the consulting room – this situation should be addressed. It is also important that GPs are kept informed and are regularly updated.

The coordination of adult ADHD and neurodevelopmental services would be a very worth while course of action.

If a referral is made and discussed at MDT and not accepted or downgraded, the referrer should always be informed.

Eligibility criteria and care pathways should be designed not just with service users in mind, but also with the clinicians who provide these services and must maintain cohesive records for the patient.

We are pleased to see that it is age that determines transition to adult services, as the previous policy of dependence on educational status caused many problems. The patient should be aware of whom they are being referred to next and an appointment with adult services should be given before they are discharged from CAMHS (and again, the GP should be kept informed of the arrangements).

Concerns have been raised regarding crisis intervention for children and access to in-patient beds; there is a lack of clarity around the services provided and how they can be accessed as this can vary from location to location. Consistency is needed in these circumstances.

Chapter 4: One System to Improve Mental Health

8. Does the strategy provide sufficient focus to children and young people, and older people? If not what can we further do to strengthen this?

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Where you have ticked ‘No’ please provide an explanation and alternative suggestions. Ideally referring to the relevant chapter.

Additional comments/Explanation:

The above responses sufficiently cover what we feel could be done to further strengthen the strategy.
9. How can we ensure that the needs of children and young people in the youth justice system are met?

The setting should not change the crux of the approach for meeting the mental health needs of children and young people. There should be timely access to treatment which meets an individual’s need irrespective of location.

Regardless of age in the justice system, there is also the issue surrounding Forensic Medical Practitioners working in custodial settings and the high proportion of individuals with mental ill health who find themselves in custody, many of which also have drug and alcohol related dependency. It is vital that these settings are closely aligned to local NHS services. The BMA has long called for forensic medicine in Wales to be provided on an all Wales basis and in collaboration with the NHS. The current arrangements are that each of the four police forces have their own arrangements for providing forensic medical services which results in a patchwork of services across Wales. Forensic Medical Practitioners are well placed to assess these individuals and divert them to appropriate settings of care and treatment.

10. Are there any other cross government issues not in the strategy that we should include?

It is important to ensure that private sector hospitals in Wales’ costs are not being borne by NHS Wales.

There are also some concerns regarding the quality of psychiatric care supervision given from geographically remote locations.

Also, patients who are “placed in care” in Wales from Local Authorities in England often have mental health issues and communication is managed remotely with the expectation that the local GP will prescribe based on this, which may not be appropriate. This could affect safeguarding the quality and safety of patient care.

We would suggest the following areas should be included in the strategy: Drug and alcohol dependence; the role of Forensic Medical Practitioners in diverting individuals to appropriate settings and the need to coordinate this with the NHS; and brain damage and neuropsychiatry services.

Chapter 5: Delivering for Mental Health

11. What else should we consider including in the strategy?
We are pleased to see that the consultation covers all ages but feel that greater focus should be placed on services for young people and older people, especially in secondary care settings. We are also pleased it is looking for an integrated approach covering the responsibilities of the individual, raising educational awareness, training in understanding and recognising mental health, and that it includes such issues as housing, employment, debt, financial issues, education, as well as more traditional health and social care sectors – as well as between health and social care.

It is also reassuring to see that this consultation recognises the impact and costs borne by the individual as well as the wider community and that it wants to improve outcomes for patients and families. However, greater consideration needs to be given to the integration of primary, secondary and community care.

There is reference to autistic spectrum disorders but it does not address adult ADHD as having very different provision across Wales.

Another gap is around relationships. There is reference to parental discord and investment in conciliation courses for parents, but psychosexual issues between couples can lead to significant mental health issues and this topic is very poorly provided for across Wales. It overlaps somewhat with gynaecology and urology, but should not be ignored in mental health.

There is also no reference to the need to review therapeutic and medication interventions, and in particular, the possible need to stop these interventions if they are ineffective. This information should be included in the section on information and education of service users, carers, and professionals as they need to understand that some interventions may need to be modified.

Finally a look at the IT infrastructure available to support the strategy and to collect outcomes data.

### Additional Questions

**12. Are issues relating to the Welsh language adequately covered? If not, what could be added or improved?**

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### Additional comments

Yes. Mental Health services should be available in the language that best meets individual needs.

We also agree that it is important to consider other languages as there is
evidence to say that patients whose first language is not English or Welsh have significant amounts of undetected mental ill-health.

13. We would welcome your views on the potential impact of the strategy on:

a) Disability
b) Race
c) Gender and gender reassignment
d) Age
e) Religion and belief and non-belief
f) Sexual orientation
g) Human Rights

a) Disability: The only two disabilities mentioned were deaf patients and those with acquired brain injury. It would be beneficial to discuss a wider breadth of disabilities.

b) Race: There is no reference to cultural issues, such as women who will only be seen by female professionals and the difficulties with consulting in the third person with a patient who does not speak English or Welsh. Some patients consult with their spouses before responding and therefore some information could be withheld.

c) Gender and gender reassignment: It is difficult to know what is available in Wales, and this issue would benefit from mapping.

d) Age: Please see the responses to previous questions.

e) Religion, belief, and non-belief: No response

f) Sexual orientation: No response

g) Human rights: The strategy sufficiently covers issues of equality, diversity, right to adequate housing, assessment and family life to ensure that there is a positive impact.

14. We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them, or attach further comments:

We are pleased with the direction of the consultation and of the mental health strategy. The consultation covers all ages and is looking for an integrated approach which covers the responsibilities of the individual, raising educational awareness, training in understanding and recognising mental health, and that it includes such issues as housing, employment, debt, financial issues, education,
as well as more traditional health and social care factors. It is also reassuring to see that this consultation recognises the impact and costs borne by the individual as well as the wider community and that it wants to improve outcomes for patients and families.

In addition to points made elsewhere, we would suggest the following additions and/or clarifications:

- Staffing issues need to be addressed. Recruitment and retention of suitably qualified psychiatrists is a major problem.

- Proposals to increase GP training in mental health are welcomed given that an increasing amount of mental health care is provided in primary care. In addition exposure to mental health services during general medical training and foundation posts improves recruitment to this area.

- It is important to ensure that there is ongoing funding available to support mental health services.

- While the Flying Start Scheme provides a good start for children, there are age limits and there are variable outcomes for children who transition out of the program in terms of an adequate handover. It is important that developing services in one area does not lead to dilution of service provision in another area, unless appropriate.

- There is a reference (p. 10) to integrated service provision between Local Authority and NHS increasingly becoming a feature of services. More information on this collaboration would be helpful. As well as other areas of integration (health and social care, and within health itself)

- Crisis teams should be available 24/7 and should be easily accessible. Sometimes a face-to-face consultation is not necessary so requiring the GP to see the patient before accessing this service interrupts access (p. 10).

- There is a reference to Public Health Wales’ review of the outcomes of “Talk to Me” service to assess its impact on suicide. The BMA would be interested to see this review when it is complete as it directly relevant to patient care (p. 18).

- The section on Improving Health references WG support of Stop Smoking Wales; there is also a smoking study being performed by pharmacies. It would be interesting to see their performance. Also, there could be a reference to QOF changes around patients known to be smoking; whether they have mental health issues or not, they should be offered smoking cessation advice. Specifically within the mental health part of QOF is a reference to having a holistic review of these patients and there is specific reference to smoking cessation, so the work of GPs in this area should be included (p. 19).

- With regards to the annual survey to assess how discrimination is being
reduced, how would this be measured (p. 24)?

- We are in agreement regarding the best interests’ statement on consent to share information. However, this does not seem to consider the autonomy of the individual and capacity of patients to refuse to share information (p. 25).

- We agree that GPs are vital in providing holistic, integrated care and aiding in early identification of problems. We need to understand further what is meant by ensuring that GPs co-ordinate services with partners and what the expectations surrounding this are (p. 30). It would also be good to reference the hard work of GPs with the learning disabilities directed enhanced services (p. 36).

- Regarding responses to referrals, timelines need to be agreed locally between primary and secondary care (p. 31).

- There is a suggestion that GPs and members of the Primary Care Team will develop up-to-date specialist skills in mental health, however, this is a difficult objective to achieve. Mental health is covered as a core curriculum item in GP training and GPs deal with vast amounts of mental health day to day without having specialised skills. GPs need a general level of knowledge, but clear knowledge on how to refer and to what services that are available. More detail on this section is necessary (p. 57).

- Combining effective medicines with effective prescribing will be difficult to amend without access to timely and accessible psychological therapies. For some patients, medication is the only avenue as it is all they will accept. We agree with the importance of ensuring safe and appropriate prescribing, but medics should not be responsible when the problem is really a lack of resources to provide alternatives. There are issues in challenging prescribing recommendations between primary and secondary care at times. Education of residential and care home staff is key too to ensuring they have the training and skills to calm down agitated patients and enable good sleeping patterns, among others (p. 62).

Responses to consultations may be made public – on the internet or in a report. If you would prefer your response to be kept confidential, please tick here: