**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [anghydraddoldebau iechyd meddwl](#)**

**This response was submitted to the [Health and Social Care Committee](#) consultation on [mental health inequalities](#)**

**MHI 43**

**Ymateb gan: | Response from: Canolfan ar Gyfer Iechyd Meddwl a Chymdeithas | Centre for Mental Health & Society**

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**Senedd Consultation on Mental Health Inequalities**

The role of the social determinants of mental health has attracted an increasing level of attention over the past 10 years, particularly with respect to psychosis. Robin Murray, FRS, is an international expert on schizophrenia whose research has had a strong biological emphasis, but he has acknowledged that social factors are far more significant than has previously been recognised. Evidence of significant social causation opens the possibility of policies that promote primary and secondary prevention of mental ill health across the full spectrum of severity.

**General comments on the impact of inequality**

Inequality has a broad adverse effect on societal wellbeing, as has been demonstrated across a range of measures, including health, life expectancy, crime, and mental health amongst others. Inequality has an impact on society as a whole, and not just on discrete disadvantaged groups.

The consultation document implies that inequality can be seen to impact on categorical disadvantaged groups, but instead inequality should be seen rather as a continuous variable. All sectors of society would experience tangible benefits from reductions in inequality.

Contrary to the rhetoric of the current Westminster government, inequality cannot be reduced through so-called levelling up. Wealthier sections of society will have to give up some resources and privileges. Julian Tudor-Hart, a South Wales GP, argued in 1971 that funding for social and health care varied inversely with the needs of the population being served. The Inverse Care Law still applies and tackling inequality means that funding will have to be reallocated to disadvantaged areas from those that are currently relatively advantaged.

**General comments on targeting**

Universalist policies are preferable to those targeted at specific groups for several reasons:

- First, the social gradient in risk of physical and mental illness means that increased risk is not confined to those at the bottom. A population attributable risk perspective implies

that we should be aiming to reduce risk across the whole social gradient. Targeting only those at highest risk misses much of the problem.

- Second, targeting implies labelling with all of the attendant hazards of stigma.

- Third, individual level preventative interventions put too much focus on individual autonomy, failing to recognise the interactions between broader social inequities that affect personal choices and which are a key factor leading to high rates of severe mental health problems amongst the Black population and those living in urban poverty.

- Fourth, a health service for the poor is a poor health service; an education service for the poor represents poor education. In Britain, most of the population have a stake in the National Health Service, which is a universal service. Were there to be a special health service for the poor, the middle classes would have less interest in it, and its quality would suffer. Experience of the impact of austerity policies in England has shown that the mental health projects that were targeted at deprived populations under New Labour were the first to be cut when budgets tightened.

- Fifth, targeting through First Episode Psychosis and Early Intervention services, whilst effective for those who meet their criteria, has the perverse effect of neglecting those with long-term and chronic conditions, who now experience poorer clinical and social outcomes than was the case 20 years ago.

Overall, targeting is likely to be counter-productive in achieving primary and secondary prevention. We acknowledge that people at high risk may indeed need special attention, but this is best achieved through proportionate universalism—universal programmes and services with resources distributed in proportion to need. There is a need rather to focus on what Marmot has referred to as "the causes of the causes" of health inequalities, such as housing, infrastructure and education. A further advantage of a population approach is a reduction in medicalisation. It is important to recognise that, in general, the greatest population benefits are seen from interventions aimed at reducing the risk of the whole population rather those targeting high-risk individuals. The same principles apply to reduction of population rates of mental illness as was successfully applied to the reduction of population rates of tuberculosis.

## Experiences of people who are disproportionately affected

In recent times, there has been some improvement in effective and productive engagement with service users and carers. In order to fully address their needs, and their current difficulties in accessing appropriate care, more engagement and capacity building is needed, including in the domains of policy-making, research, and the co-production of care and treatment.

In addition to the limitations that arise from thinking exclusively in terms of the disadvantaged, as we have indicated in the sections above, it is important to note that so-called disadvantaged groups experience multiple intersecting disadvantages, commonly referred to as intersectionality. For example, members of ethnic minorities experience

racism, less advantageous employment, poor quality housing, worse physical health, and so on.

We note that not all disadvantaged groups have been identified in the consultation document, with one conspicuous omission being people involved in substance misuse, who are known to be at high risk of mental illness and death from suicide and overdose. Substance misuse provides an illustrative example of some of the key issues that need to be considered. These include the complex relationship with other disadvantages, the frequent impenetrable barriers to care as individuals are bounced between services, and the interactions with issues of appropriate prescribing. They are also a key exemplar of the way in which those who are most at risk are often regarded as undeserving or responsible for their own situation.

**Barriers to access**

**Geography**

Rural areas in Wales are associated with significant barriers to access, due to a scarcity of statutory services, scarcity of Third Sector organisations, inadequate housing, limited internet connectivity, and difficulties with transport. The farming community experiences particularly high rates of suicide, and the degree of isolation amongst rural communities is known to affect suicide rates.

**Access to Primary care and Third Sector organisations:**

The majority of mental health problems are managed within primary care, but Wales as a whole, and North Wales in particular, are experiencing significant difficulties. Some practices in North Wales only have locum medical cover, which means that services can be unreliable and lack continuity of care. These conditions militate against adequate services for people with common mental health problems. Historically, training for GPs in the recognition and treatment of mental health problems has been imperfect, and this remains a problem.

Third sector services are based in urban hubs, and not in rural communities. This creates barriers for access, and leads to inadequate links with local communities, carers, and service users. Some groups are evidently reluctant to use third sector facilities, and not enough is understood about the reasons.

**Primary care and Secondary care interface**

There are referral criteria in place that restrict referrals from primary care to secondary care, and this remains an important barrier to access. There is a widespread perception that such criteria have become more restrictive as an unintended consequence of the Welsh Mental Health Measure.

**Barriers to care despite being within the service**

Functionalised models of care are a major barrier to accessing appropriate care. They create multiple service interfaces with associated rigorous policing of boundaries, the continual

"bouncing" of patients between services, and encouragement of attitudes around the notion of "this is the wrong kind of patient for us". These problems disproportionately affect patients with multiple problems, who are more likely to belong to marginalised and deprived populations.

The interface between mental health and social services has deteriorated over recent years. Mental health teams often have no dedicated social care members, and there is evidence of the withdrawal of social workers and social services staff from mental health settings. Tight budgets have exacerbated these problems. This fact militates against integrated care plans that deal with social and mental health problems in a single individualised care strategy.
The situation exacerbates a lack of understanding across different services, as to what each service can provide. At the level of individual staff members, it leads to a lack of joint working across services.

**Factors affecting the sustainability and quality of services**

There is fragmentation of overarching care provision, with an over-emphasis on health care. There has been recognition for many years that tackling the needs of deprived populations demands a greater emphasis on Local Authority, Health, Third Sector and Police co-working and joint planning, especially in order to develop better approaches to mental health and welfare crises, but there is limited progress.

Funding models make it difficult to plan ahead for service development, especially in Third Sector organisations. This impacts on developing and training staff, and hence on retaining them. We see little or no evidence that competition between third sector organisations for funds is helpful. On the contrary, it appears to be disruptive and counterproductive. There is a lack of joint commission, and most crisis care funding goes to health, which leads to hospital based crisis services, when the population most at risk would benefit from community based services.

There are substantial problems with mental health staff recruitment and retention in Wales. Staff often feel disempowered, for a variety of reasons, including a pervasive top-down approach throughout services, a culture of blame, and managerial defensiveness. There is a long-standing problem related to the lack of training opportunities for staff. Training and staff development, including involvement in research, are early casualties when services are under pressure, as has been the case during the Covid pandemic. However, these are often the times when staff skills need to be upgraded.

Services need to do more to the measure the quality of care and treatment provided. The only measure that seems to be assessed regularly is whether the Care and Treatment Plan has been completed on time. There is insufficient attention paid to the content of the plan, whether it was delivered, and what the outcome was.

Finally, there is a lack of sharing of good practice across different sectors.

**Leaving the service**

NHS mental health services collect insufficient information about social circumstances on assessment, and neglect social outcomes and social inclusion, as opposed to symptomatic recovery, in relation to current service provision. Hence, the social aspects of service users' lives are neglected both at the assessment and follow-up stages. In contrast, service users place the highest priority on social outcomes such as employment, finances and leisure activity, exactly those parameters that are most neglected by statutory services.

There is insufficient access to employment and training opportunities for service users with mental health problems.

**Further Reading**

*Causal role of social factors in mental illness*

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*Impact of the political economy on outcomes of schizophrenia*

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**About CFMHAS**

The Centre for Mental Health and Society is a research centre within Bangor University. It is co-directed by a social scientist (Peter Huxley) and a psychiatrist (Rob Poole). It has a substantial portfolio of research focusing in social justice and clinical issues affected deprived and marginalised populations. It draws an associate membership from a wide range of other universities and health organisations. Website: https://cfmhas.org.uk/