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Dros iechyd meddwl a newid cymdeithasol

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Platfform response to Draft Mental Health and Wellbeing Strategy

Introduction

The Draft Mental Health Strategy published by the Welsh Government marks a significant shift in how we understand mental health, and how the levers of government could be used to shift the wider social determinants that can lead to distress, trauma and harm across our communities. The overall focus is one that we are pleased to see, and it offers the chance to build a firm foundation for action by multiple stakeholders.

We are particularly pleased to see the importance being placed on connection, communities, and early years, as these are the most significant ways in which we can change the reality for people both now, and for future generations. By recognising these areas as being pivotal in making change, we have the opportunity to shift into a more preventative approach, and it can offer hope to people throughout our country.

We are also pleased to see a focus on shifting the culture towards one of preventing and reducing harm.

Despite that, however, there are some real missed opportunities in the strategy, where the clear vision for mental health – and what it means for our communities – is not followed up with a commitment to cross-Government action. As well, despite the welcome consideration of harm in the system, the action committed to falls short of what we believe is needed. The harm that is often caused by the system needs to be explicitly named, and a clear plan committed to, with specific actions, that will help address this harm. This is particularly important when it comes to the commitment to increase access to the mental health system, for people experiencing mental health challenges from diverse communities. We argue that this is not as simple: access alone does not recognise the differential, and often more harmful, interactions that different communities have with mental health services.

Our summary of the Draft Mental Health and Wellbeing strategy is that it is a positive start, and an example of a *transitional* strategy, without being fully *transformational*. We would want to see a commitment to review this strategy once the delivery plan has had time to make progress. We believe that if the Welsh Government is genuinely committed to shifting our focus to a social determinants model, significant structural change will be needed. On that basis,

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although welcoming the strategy in principle, we believe it will need to be rewritten in five years.

That also, for us, matches with our ambition to see big changes made to our mental health system. A strategy is helpful, but we will also be pushing Welsh Government to lay the groundwork for a national mission on mental health – and to lay the foundations for a Mental Health Reform (Wales) Act that could help our country lead the world in our response to poverty, trauma and distress, leaving the medicalised, coercive legacy of decades of mental health policy and legislation behind.

Key themes:

Building in WHO/UN Guidance principles

The recent WHO/UN report, *Mental Health, Human Rights and Legislation: Guidance and Practice* (WHO/UN, 2023) articulates a powerful and compelling vision for mental health services across the world. This document could provide a guide for reform of our mental health services across Wales. At the very minimum, we should see the commitment to a rights-based, informed-choice, least-restrictive system. A lot of this is reflected in the strategy already, but the hugely impactful vision from the WHO/UN has not been fully included in this strategy.

Being open about the foundations of our mental health system

Whilst it is tough to face up to, it is important that our mental health system – and all professionals within it – understand the foundations of the system we operate in. This is not an observation to create shame or blame, but to start an open-hearted, reflective conversation about how almost 150 years of mental health legislation and policy have left a legacy that we have still not fully unpicked. If we are to create a truly trauma-informed, person-led system in Wales, we need to understand that the building blocks themselves are flawed, and we need a national conversation that reckons with this troubled history and offers a hopeful way forward.

Challenging the reliance on ‘prudent healthcare’

We are concerned about the reliance on the concept of ‘prudent healthcare’, in the strategy. Whilst people taking ownership for their own health (and mental health) is important, we are concerned that its inclusion in the strategy undermines the central point that we continue to make at Platfform. This point is clear, and simple: our conditions play a significant role in determining our mental health, and when we grow up around poverty, trauma, discrimination and inequality, it is much harder for us to regulate and build positive connections. If our local communities are struggling too, then we grow up without the same

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experiences as others in wealthier areas. For example, people in areas of poverty will have fewer green spaces, less public transport, schools that are struggling, police that refuse to engage with the community, a hostile media, cutting of welfare, poor quality housing – the list goes on.

The extent to which people surrounded by such inequality and structural distress, can take ownership for their own mental health, is limited – and we would want this to be reflected in the final strategy much more clearly.

Equality of access cannot be the only approach.

We welcome the Welsh Government commitment to ensuring wider access to mental health services, particularly for specific groups such as with minoritised communities. However, our significant concern remains that often, the services themselves can be more harmful than a lack of access. We need to ensure that our approach to equalities in mental health system is as much about the experiences people have, as access. For example, women survivors of domestic abuse are more likely to be given a diagnosis of personality disorder; or black men are more likely to be physically restrained within services. These are significant challenges that we need to address across Wales.

Challenging stigma *inside* the mental health system

We welcome the Welsh Government commitment to tackling the stigma around mental health diagnosis, but we are also concerned about the stigma, or overshadowing, *within* services. All too often, particularly for people with diagnoses that are considered serious (personality disorder, for example), they can find themselves infantilised, institutionalised, or experiencing direct harm, because of not being listened to, or being seen as “just” their diagnosis. This can make it harder for people to receive the support they need, because the stigma that is sometimes held against them can put up barriers within services to a person-led, trauma-informed response.

Reliance on diagnosis can inhibit choice

We recognise that for some people, being given a diagnosis is important and helps them access the support they need. However, we are also very clear that use of diagnosis, has questions of validity to answer, given the shifting history of the mental health system, the changes to what is classed as a disorder, and the lack of clear empirical evidence for diagnosis. We also are clear that being given a diagnosis can be harmful, particularly for people who do not wish to access support with that label attached.

Our concern is that this strategy does not create a second pathway for people who would benefit from non-medicalised interventions, that are attached to their experiences of distress, and are meeting their needs in the way they want. We would ideally want to see a commitment to explore how this could be implemented in the future.

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Challenges with primary mental health offers

We would want to see a different approach to primary mental health explored. We understand that often it is the relationship between a practitioner and someone needing support, that matters most – and that the 'type' of mental health intervention has less of an impact. For this reason, we would want to see primary mental health services focus more on building relationships with people they support and ensuring that time is given to that (for example, removing often arbitrary session limits). Additionally, we would want to see more open access primary mental health services within communities – but following community-building principles, seeking to understand what communities need and want, and basing practitioners in communities that face the greatest barriers.

We need a national mission of transformation.

If we are going to change the lives of people across Wales, who are living in situations of distress, poverty, and isolation, we need a sea change in how we talk about mental health, deliver support, and ultimately how we structure our society. We need to ensure that the mental health strategy is the *start* of a conversation across Wales about our mental health, and that we keep a focus on how we can reimagine our public services, the health of our communities, and the conditions we create. Only when we are all engaged in this national mission, will we see the structural changes that we need.

About Platfform

Platfform was born in 2019 from Gofal, a mental health charity established in Wales in the late 1980s. Through decades of working across housing and mental health, we gained real insight into the reality of mental health in society, the impact of trauma, and the causes of distress. That work led us to change our focus and become Platfform, the charity for mental health and social change.

Today we work with over 9,000 people a year. We support people of all ages, across urban and rural communities, in people's homes and alongside other services. Our work spans inpatient settings, crisis services, community wellbeing, supported housing and homelessness, businesses, employment, counselling, schools and youth centres.

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Consultation questions

Question 1: How much do you agree that the following statement sets out an overall vision that is right for Wales?

> ***"People in Wales will live in communities which promote, support and empower them to improve their mental health and wellbeing, and will be free from stigma and discrimination. We will take a rights-based approach to ensuring that everyone has the best mental health possible. There will be a connected system of support across health, social care, third sector and wider, where people can access the right service, at the right time, and in the right place. Care and support will be person-centred, compassionate and recovery-focused, with an emphasis on improving quality, safety and access. Care and support will be delivered by a workforce that feels supported and has the capacity, competence and confidence to meet the diverse needs of the people of Wales."***

We are pleased with this overall vision – we believe it captures what the people we support want from their support, whilst also understanding that the longer-term, generational change needs to take place at a community level. We will explore the details in later questions, but the element that is currently missing is a clear statement that some communities do not have the conditions in which to thrive, and that the systems we oversee at Welsh and UK levels, do not allow for promoting, supporting or empowering actions.

To reflect that, we would recommend the following change in wording, so that from the outset it is clear the mental health strategy requires a societal shift and more targeted work at a community level with our poorest communities.

> "…will live in communities that have the resources and capacity to promote, support and…"

Question 1a: What are your reasons for your answer to Question 1?

Across Wales and the UK there is a growing understanding and realisation that the determinants of mental health are complex – but that our social determinants play a more significant role. Being born, and growing up, in an area of poverty or deprivation, is a significant risk factor for poor mental health (Knifton and Inglis, 2020), and it is also clear that the system responses to this are mixed, with the poorest areas of the UK seeing greater prescription of anti-depressants than other areas (Read et al, 2020). This can extend beyond depression as well, with

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long-standing research demonstrating the links between poverty and psychosis – there is a temptation to see a link between poverty and depression, or poverty and anxiety, and to draw a line between that and more 'serious' conditions. A thirty-year longitudinal study (Hastings et al, 2019) found that cases of bi-polar and schizophrenia for example, double in poorer areas. Our argument is clear: if poor mental health is more prevalent in areas of poverty, then the response cannot be a purely medical one. In short, you cannot medicate yourself out of poverty.

Increasing evidence is demonstrating that it is the quality of our relationships and connections that has the biggest impact on our mental health – our "connectedness" or "relational health" is the best predictor of our mental health (Perry and Winfrey, 2021). It is harder to establish – or maintain - those quality connections when in stressful or overwhelming situations. For that reason, any mental health strategy for Wales needs to prioritise, to a greater extent than previously, the relational capacity and health of our communities.

In the same way, we are also developing our understanding of the impact of trauma on our mental health, with people who have experienced trauma more likely to experience poor mental health (Magruder et al, 2017). We would go further, and adopt an approach advocated by the WHO/UN guidance (2023), which makes it clear that the link between trauma and mental health is a critical one that mental health systems need to adapt to. Our current system has its roots in a parochial, patriarchal, Victorian structure (Taylor, 2024) if not before (Scull, 2015), and despite best efforts, it remains extremely difficult to build a trauma-informed, relational culture into the current structure. The commitment from the Welsh Government, to shift to a rights-based approach is the first step towards this work.

In this context, we would draw on the experience of the learning-disabled sector, and the admirable journey professionals have undertaken over recent decades. The parallels with the mental health sector are significant: both were included in the initial legislation in the 19th Century, and system approaches to both groups were consistent for much of the 20th Century as well. This approach involved the use of asylums or institutions, and it wasn't until the late 20th Century that campaigns for LD liberation resulted in significant system change. Nowadays, although imperfect, the understanding that people with learning disabilities can live on their own, do not need to be medicalised or institutionalised, is well-established and difficult to argue against, quite rightly. The Welsh Government were instrumental in making this shift within learning disability services and could be again with mental health services.

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This same journey is well overdue within the mental health system, and we all bear the responsibility to be open-hearted and reflective in considering our respective roles in that. For additional context, the Mental Deficiency Act 1913 further locked in a values-judgement into our mental health system: each local authority had a “Mental Deficiency Committee”, which recommended, amongst other reasons, for the detention of single mothers with young children. This moralising foundation has continued throughout the history of our mental health system, including (but not limited to) the use of hysteria against Suffragettes (Hooper, 2019), schizophrenia against black civil rights activists in the 60s (Metzl, 2010), and of course the idea of homosexuality as a mental disorder, only removed in the late 70s from the DSM (Baughey-Gill, 2011) – and only from the ICD in 1990.

This is not to say that practitioners within the mental health system take this same approach – but it is important to recognise, that the systems and structures that our mental health system are built on, have their foundations in this uncomfortable history.

It is this awareness of our shared history of the mental health system, that leads us to celebrate the inclusion of the rights-based approach, but also the commitment to improving quality and safety. Further in this response, we will explore how we could protect people from harm and ensure that a rights-based approach to mental health can be adopted. It is also important to note that although there is historical harm, there is also contemporary harm. Our recent Truth Project (Platfform, 2024), that seeks to hear from people who have been given the diagnosis of personality disorder, demonstrates that our mental health system can still be coercive, harmful and can cause lasting harm. This is not an isolated issue: recent advocacy by Alexis Quinn (Sky News, 2024) has demonstrated significant weaknesses in the system, where patient safety has been failed in many ways. It is our view that in a system where coercion is the default setting, and patient rights are hard to enforce, the culture becomes one where harm can be overlooked or excused away.

Question 2: In the introduction, we have set out ten principles that are the building blocks of the new Mental Health and Wellbeing Strategy. Do you agree these principles are the right ones?

We agree that these principles are helpful building blocks for the new strategy. We applaud Welsh Government for committing explicitly to a rights-based principle, which will help pave the way for real, impactful change. Once the system is considered through a rights-based lens, it will be harder to justify aspects of the way support can be delivered. We are also pleased to see that

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there is commitment to a wider determinants' health understanding, and that the trauma-informed context, especially the Trauma Informed Wales Framework, is explicitly referenced.

We are also pleased to see a commitment to equity of access, experience and outcomes – all too often the debate around equity is focused on access, so ensuring that we focus too on the experiences of people once they reach the system is underpinning this work.

We would like to propose the inclusion of four additional principles, that will help guide the strategy, especially when it comes to the delivery stage. These are:

1) **Inclusive of lived experience:** to ensure that the views of people within the mental health system are explicitly included in the principles at all stages. Whilst it is implicit in other principles, it is not directly referenced and so there is a risk that it is seen as less of a priority.
2) **Focus on reducing restrictive practice:** again, aspects of this principle are implicit in the principles around rights-based approaches, but including this as a clear principle will help support a much-needed shift away from restrictive practice as a too-often default response within services.
3) **Community-informed:** We want to see this included as a principle in the strategy, again to focus minds and action on the need to work with wider communities, and the conditions around them, rather than treating mental health as a problem facing individuals in isolation.
4) **Poverty-informed:** We want to ensure that the awareness of poverty's impact on mental health runs throughout the entire strategy, and any future delivery plan. Without addressing and tackling poverty, and the impact of poverty on our mental health, we will not be able to make the progress we want to see on changing the system and tackling mental distress in Wales.

Question 2a: What are your reasons for your answer to question 2?

Our reasons for this perspective are covered substantially in our response to Question 1. For Platfform, it is imperative that the foundations of our mental health system are understood, and that the harm they have caused is actively addressed. Additionally, we need to see our mental health system as part of a wider society that inhibits choice, maintains communities where distress and poverty are endemic, and focuses instead on changing the way services work, rather than undertaking wholescale system change. By adopting the principles outlined in the strategy, new foundations can be laid for a positive future.

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Question 3: Vision statement 1 is that people have the knowledge, confidence and opportunities to protect and improve mental health and wellbeing. Do you agree that this section sets out the direction to achieve this?

We welcome this vision statement, and in particular, the inclusion of 'opportunities' in this statement. We have stated above that different communities across Wales will have different conditions that make action easier or harder to take to protect and improve mental health – and that in some cases, it will be extremely difficult. For example, it would be hard to envisage how someone who has been homeless and is placed in a flat with damp and mould, and who is struggling with poverty, can easily take action to improve their mental health without the right conditions. It is also the case that in areas of significant poverty and distress, whole community approaches are needed.

We would like to add to the vision statement, to make this even clearer, with the following amendment:

> "…mental health and wellbeing – and that the conditions around them are created to make this possible."

Question 3a: What are your reasons for your answer to question 3?

At Platfform, we have significant concerns in the approach being taken in the name of 'prudent healthcare'. Whilst in principle, it is a helpful way of articulating the need for personal action and responsibility, there is a risk that in practice, it can be used to abscond public services of a shared responsibility to intervene where there is significant poverty or distress. This is one of the reasons why it is so important that the idea of 'opportunity' is included in the Vision Statement, as it has been. But we also believe that it should be more explicit, so that the clear principles espoused at the opening of the strategy are maintained.

In our conversations with people using services, one of the pieces of feedback was that they welcome the open access resources for self-help – but that they also need specialist services and a more connected system to help when they are in crisis. This reflects our long-held experience at Platfform, that people need a whole range of support structures in place, to create a sense of safety where reflection and change becomes possible.

To put this more directly: at Platfform we are seeing more and more people in higher levels of distress, in levels of crisis that we have not seen before. It is not

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realistic, or helpful, to expect people to be able to protect and improve their mental health in a vacuum, and without significant work to stabilise emotions and improve regulation. This also applies to wider communities, and there is a need to embrace a trauma-informed community development approach across Wales, to help create the right conditions for personal responsibility.

We are also concerned about the language on page 19, which implies that mental health problems are inevitable, or impact everyone equally. We are curious about the statement that “some mental health conditions are unavoidable”, as well as that “we are all susceptible to poor mental health”. Whilst both statements have an element of truth to them, the reality is much more complex.

There used to be a similar argument within homelessness services, that all of us are just two pay cheques away from homelessness – but this was thoroughly debunked (Bramley and Fitzpatrick, 2017), as it did not consider the different conditions that faced people. The vast majority of homelessness is linked to poverty and trauma, in much the same way as with mental health. Well-meaning narratives that suggest mental health can impact all of us equally, can result in obscuring the reality for people within services and across Wales.

The point we are making about inevitability here is crucial to get right in the Wales as part of the strategy. This section rightly draws attention to disabled people and neurodivergent people being at “particular risk” of experiencing poor mental health and wellbeing. However, the way this is presented, implies that the disability, or neurodivergence, causes the mental health problem. There is a very real risk here, that this presentation undermines the decades-long struggle for the social model. Disability does not cause mental health problems, any more than neurodivergence does. The higher prevalence of poverty, discrimination, the co-morbidity with experiences of trauma, the social isolation and the unsuitability of our society that cannot meet our needs, are all contributing much more to mental health problems than the existence of a disability or other additional need / identity.

The paragraph below this section, where attention is drawn to the *experiences* of different communities, is much more in line with the principles set out at the start of this strategy – and more in line with the wider approaches taken by the Welsh Government across Wales in recent years.

We would therefore recommend rewording this section, and we have suggested a form of words below:

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From:

> “Some mental health conditions are unavoidable and we are all susceptible to poor mental health. There are factors that can increase our susceptibility. For instance, people living with long-term physical health conditions are two to three times more likely to experience mental health conditions than the general population. We also know that disabled people and neurodivergent people are at particular risk of experiencing poor mental health and wellbeing.

To:

> “Some mental health conditions result from embedded, long-term and structural factors, and can often seem unavoidable at an individual level. It is important that any mental health system understands that there are factors that make it more likely we will experience poor mental health. For instance, people living with long-term physical health conditions are two to three times more likely to experience mental health conditions than the general population. We also know that disabled people and neurodivergent people are at particular risk of experiencing poor mental health and wellbeing, often due to discrimination, inequality and poverty that disproportionately impacts these communities.

We are pleased that the strategy under Vision Statement 1, is clear about the importance of communities – although we believe that it could be stronger. Community and connection are two of the critical interventions in our mental health across Wales and should not be seen as incidental. They are foundational, and this part of the strategy document felt defeatist – that it was accepting that communities would lose assets and we were powerless to prevent that. We cannot accept that in Wales, we should be passive while communities lose assets and capacity to thrive. We would make an amendment to the following paragraph (page 22):

From:

> “A full range of sustainable community assets is crucial. However, it is inevitable that these will vary across localities and may grow and decline depending on funding, demand and changing needs.”

To:

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> "A full range of sustainable community assets is crucial. It is important that all stakeholders across Wales work to protect these assets actively, in the face of declining funding."

Whilst our comments on this section might seem critical – we do want to acknowledge that overall, this is a helpful, progressive section that will help provide the understanding we need to shift our system further towards the person-centred, rights-based approaches we know we all want to see. In particular as well, we want to pay tribute to the clear commitment to early years, and the whole life cycle, as described in this chapter. That is critical to get right, if we are to make real change for future generations.

Question 3b: We've included a number of high-level actions for vision statement 1 in the strategy. Do you agree with these actions?

We broadly agree with these actions identified in the strategy and have suggested clarifications or provided additional support for these actions in the following question.

Question 3c: Are there any changes you would like to see made to these actions?

VS1.1:

We are pleased to see this action – particularly the aspect that commits to identifying and listening to under-served groups. This is an area that Platfform is working on actively, trying to offer alternatives to clinic-based interventions in communities that face barriers to engagement with mental health services. This can be seen through our joint project with Save the Children, "Embrace", which is based in Bettws in Newport. In this project, we worked to provide access to knowledge, skills and understanding around how we experience distress and overwhelm, bringing knowledge normally held one-to-one in a clinic-based intervention, to a group based in the local community. This was not a group-based CBT intervention, which has not been as thoroughly researched as individual CBT (Whitfield, 2018), but instead offers person-led, holistic psychosocial education that can help people understand their own reactions to stress and challenging situations. We would encourage a future delivery plan to explore similar models and approaches at working with underserved communities.

VS1.2:

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Again, this is a helpful action to commit to – but we would challenge that this will only be as helpful as the accuracy of the advice being given. For example, we need to see leadership from NHS Wales, on the information being given to people across Wales about mental health interventions such as anti-depressants. With over 80% (Moncrieff et al, 2022) of people still believing that mental health is caused by a "chemical imbalance", it is imperative that accurate, evidence-based information is communicated to the public so they can make informed decisions about their own care.

VS1.3:

We are concerned about this action, based on our above comments on the inherent risks in applying a 'prudent healthcare' approach to a mental health system. Mental health is exacerbated as we know by societal disconnection – poverty, discrimination, loneliness, inequality – and so opening a national conversation focused on individual actions runs the risk of privileging people with wealth and opportunities and introduces further shame into the system. Whilst we are not opposed to this national conversation, we hope that the execution of this holds that tension in mind. We would encourage a change in wording to:

> "…take positive steps to protect and improve their mental health and wellbeing, and to consider how we can work collectively across our communities to tackle the social determinants of mental health and create the conditions for connection."

VS1.4:

We wholeheartedly support this action, to address stigma. However, we would also push this further, to ensure that education addressing stigma is also extended to the impact that diagnoses have on perceptions of people in situations of distress. The over-reliance on diagnosis for access to services has created a culture that too often sees people as the diagnosis they have been given, and not as an individual. To achieve the person-led strategy that we know the Welsh Government wants, we need to create a space to interrogate and question the use of diagnoses. Stigma is not limited to overall mental health, but also applies to the concept of diagnostic overshadowing (for example, someone who has been given a diagnosis of EUPD being seen as manipulative or controlling, rather than having their genuine complaints taken seriously by services) and can have a direct negative impact on people's lives (Nieuwenhuizen, 2012).

This was a perspective echoed in part by one of the people we support:

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> *"Stigmatisation against mental illnesses - especially personality disorder. Lack of resources offered - no therapies or interventions even when asked. No support or help offered unless you are at immediate crisis point / high risk of taking your life. Lack of medication reviews or assessments."*

VS1.5:

We fully agree with this action – but it is also important to ensure that commissioning and funding arrangements across Wales allow the space for organisations across Wales to provide reflective practice and quality supervision capacity. Otherwise, it runs the risk of being a positive ambition that cannot be met in practice.

VS1.6:

We also agree with this action. Social prescribing has a positive role to play across Wales and our public services. The proposed principles behind the planned National Framework for Social Prescribing are a positive start. Again, we are concerned that it obscures the lack of options available to poorer communities, and it runs the risk of privileging communities with more resources. We would want to see this framework implemented alongside a wider review of community assets and resources and how they can support our mental health. There is also a wider comment to make here, about how social prescribing is a system response to a lack of community connection and to disconnected (and disconnect*ing* services). We need to be careful that our approach to social prescribing is not seeking to fill in the gaps left by a diminishing, under-funded public service network.

VS1.7:

We welcome this action – but are concerned that again, it runs the risk of entrenching inequality, or prompting disconnection and lack of hope from poorer communities. If people are living in an area with reduced public transport, where few services operate, where there are no green spaces, where housing quality is poor, there is no level of promotion that will address that entrenched inequality. More helpful in this, would be to commit to promoting community assets, whilst also completing a community asset mapping exercise across Wales (as articulated above), to identify areas lacking resources – which will closely match those areas most at risk of poverty and distress.

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VS1.8:

We warmly welcome this commitment and would encourage this action to begin with a nation-wide mapping exercise (as above), building on the excellent work by Building Communities Trust (2023) on developing a Community Asset Index, and encapsulating the approach from the Belonging Forum (2024).

VS1.9:

We warmly welcome this commitment – it will have a significant impact on the generational nature of our mental health and reflects a sea change in Welsh Government policy. If we can get our early years approach right, we will begin reducing the prevalence of distress in the years to come. Our key caution here, comes in needing to face the reality that with entrenched poverty and inequality, this will not happen quickly or easily, and we will need concerted effort from the Welsh Government over the next twenty – thirty years to start seeing the generational change we want to see.

Question 4: Vision statement 2 is that there is cross government action to protect good mental health and wellbeing. Do you agree that this section sets out the direction to achieve this?

We were pleased to see the recognition that mental health cannot be addressed by a single department in Welsh Government, and clearly needs cross-government work. We also wanted to commend the Welsh Government for placing the impact of poverty front-and-centre in this section, and for drawing attention to other areas of policy that impact on our mental health.

Question 4a: What are your reasons for your answer to question 4?

Overall, we welcome this Vision Statement. This is an area that is only increasing in importance. With economic hardship through cost-of-living, announcements such as with uncertainty around Port Talbot and other industry, and growing climate chaos, our policy levers absolutely must take into account the impact on our citizens' mental health. Every decision made at government level has the chance to impact significantly on the health and wellbeing of our communities.

We are clear, that addressing the challenge of mental health has to be a national mission: Wales has to tackle community poverty and disconnection; consider the whole life-cycle, including the first 1000 days, early years, school, FE and HE;

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economic growth that is not extractive and damaging, built on good, fulfilling jobs that pay well, and many more policy areas besides. We also need to see the further devolution of criminal justice and welfare, so that Wales as a country can make decisions in a holistic way, in a way that improves lives in communities, and in a way that will ultimately improve our mental health.

The difficult truth to face, is this: whilst we can make changes in our mental health system, and whilst they might make an impact, we cannot achieve the sea change in healthy, well communities that can support each other with their mental health, without a significant policy and societal shift. The current system is not working, distress is increasing every year, and people's needs are not being met, and there is very little that politicians, policymakers, or professionals can do to change that if we only focus on the narrow scope of what takes place within or around mental health services. This might seem like a recipe for despair, but we know there are brilliant things happening across Wales, the UK and wider across the world we can draw inspiration and hope from.

The strategies across Government that are shared in this draft strategy are an excellent start – but we want to see that there will be cross-governmental progress reports, specifically drawing out how work is impacting our mental health and wellbeing in Wales.

Question 4b: Is there anything else that mental health policy can do to ensure that work across Government improves mental health outcomes?

One specific area we would encourage clarity on, is the accountability of these commitments for cross-government action. We absolutely welcome the inclusion of Health Impact Assessments (page 26), and the reference to "public bodies". In the most recent consultation document on the Health Impact Assessments, it was proposed that the definition of "public bodies" shift from the Public Health (Wales) Act 2017, to include the list defined in the Wellbeing of Future Generations (Wales) Act 2015. This list includes "Welsh Ministers", as the Welsh Government stated in its response to the Senedd report (2023), *Connecting the Dots: tackling mental health inequalities in Wales* (2022), but we would advise that a sector-wide engagement exercise is undertaken to find ways of establishing an effective assessment approach.

We also want to draw attention to the suggestions in the debate in the Senedd, on the Welsh Government response to *Connecting the Dots*, that "ministerial advice submissions" be used to further ensure that decisions made by Ministers, are made with the consideration of mental health in mind.

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Overall, mental health and the way in which it impacts on policy, and vice versa, needs to be given Cabinet-level attention, cross-Ministerial portfolio. Whilst every policy area could argue this, we would suggest that mental health, similar to climate change, should have a dedicated Minister (which we currently have), but who also has a Cabinet-level responsibility to scrutinise and hold other Ministers to account. We understand that this is a political decision that would need to be made by the First Minister, but it is important that we put this in writing – we believe it is one part of what is needed to change the way we think about mental health. Once our thinking has changed, we can begin to change the outcomes for people across Wales.

Question 4c: There is lots of work happening across Government that could improve mental health outcomes. Is there any work we have missed that you think we should include?

Our perspective is set out above – it is not possible to capture the complexity of the mental health system in one strategy, and it is much more important that the principles captured are the right ones, and that there is high-level cross-government commitment to making policy and delivering system change. That is how we will shift the mental health and wellbeing of Wales forward.

Question 4d: We've identified a number of high-level actions for vision statement 2 in the strategy, do you agree with them?

We broadly agree with these actions identified in the strategy and have suggested clarifications or provided additional support for these actions in the following question.

Question 4e: Are there any changes you would like to see made to these actions?

VS2.1:

We welcome this position fully – whilst reiterating our call for there to be additional, high-level Cabinet scrutiny of mental health policy (its impact on departments, and other department impacts on *it*).

VS2.2:

Again, we welcome this position and would encourage the impact assessment approach to be co-produced with the mental health sector to ensure the specific

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impacts are considered (they can at times be subsumed into physical health assessment approaches).

VS2.3:

We welcome this – again, with the caution that these indicators need to capture the holistic, complex nature of mental health.

VS2.4:

We welcome this – and would encourage further development work to consider how to apply NYTH/NEST Framework to the adult population within mental health services.

VS2.5:

We welcome this – but we would encourage a wider conversation about what qualifies as best practice for care and treatment planning. There is little point in producing best practice on how to work within harmful, traumatising settings (except as a matter of last resort), and instead our care and treatment planning should prioritise best practice that reduces harm, offers informed choice, and protects our rights. As just one illustrative example of this, we would consider the area of electroconvulsive therapy, and how within this context, any level of best practice is still inherently flawed as it is a treatment that is difficult to give truly informed consent to, where the evidence of harm is growing, and where there is limited public conversation about the practice. We would want there to be clear principles underpinning any sharing of best practice.

Additionally, Platfform has concerns about the structures of the mental health system, which traditionally rely on diagnosis to access support. It means that people who do not wish to receive a diagnosis, or treatment predicated on that conception, cannot access support. In short, the current pathways within the NHS, and the current care and treatment plan approaches, do not allow patient choice. We would also want to see a review of best practice where care and treatment is undertaken without a diagnosis – and if this does not exist, then work begun to establish a body of emergent practice in this area. We also are concerned that care and treatment plans are set, typically, post-discharge, or in the context of multi-disciplinary teams, and often organised around suggested diagnoses. This can set in motion a medicalised approach, which in turn influences care and treatment plans. Essentially, even if the plans are created in the most co-productive way, the parameters and boundaries of the plan have been created without involving the person. Again, if that person wishes to access

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support that is not predicated on a diagnosis, it becomes very difficult to do so within the current structures.

One of our case workers fed back with a sense of despair about the current system, which demonstrated for us the need to review the way we approach our mental health system, both in primary care, with care and treatment planning, and more. They said, in response to a question on current challenges:

> *I have experience of GPs refusing to refer people to the community mental health team, I can't get through to the CMHTs via phone, Psychiatrists have cancelled appointments and leading to another few months on the waiting list. Lack of female psychiatrists, crisis teams are not following up with people in crisis, waiting lists are endless for therapy or counselling.*

The challenges facing people we support, on discharge to community, was shared loud and clear, and is reflected in this feedback:

> *When crisis services discharge patients to community, they go unseen and unsupported for months. People sectioned when it isn't always necessary - too restrictive. Overall neglect. People calling asking for help and being turned away. Playing yo-yo between GP and mental health teams, both telling patients to go to the other. Strict criteria to get into therapy or interventions. Experience of staff with no compassion or empathy. It took me making a formal complaint to just get a medication assessment/review and an appointment to do crisis planning."*

Question 5: Vision statement 3 is that there is a connected system where all people will receive the appropriate level of support wherever they reach out for help. Do you agree that this section sets out the direction to achieve this?

We agree fully with this statement, and welcome the commitment to creating a connected system, from Welsh Government.

Question 5a What are you reasons for your answer to question 5?

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At Platfform, for some time, we have been advocated for a ‘whole systems approach’. Siloing services and responses to distress based on arbitrary funding arrangements does not make sense for the people who need support and help. In a modern Wales, where we have some people who are hyper-connected and others who are desperately isolated and disconnected, we need to have responsive services that meet the needs of people who come to us for help. That means moving away from 20th Century command-and-control service bureaucracy, rationing of help, and gatekeeping, and instead shifting culturally, practically and crucially, *financially*, to a preventative, person-led, “No Wrong Door” approach.

This shift will not be easy, and it will mean making decisions and setting ambitions that traditional services and structures will struggle with. It means working in partnership with a range of stakeholders, and asking the difficult questions about where responsibility sits. There has been a great deal of focus about personal responsibility in the strategy, for people experiencing poor mental health and wellbeing – we would like to see clearer accountability and responsibility for services at all levels. If citizens across Wales are expected to be prudent, and preventative, then that same duty and expectation must be extended to our traditional structures across Wales: from Welsh Government to the NHS, local authorities, and service providers. If we are going to address the growing levels of distress in Wales, it needs to be a national mission, and all partners need to show humility, and consider what role we can play respectively in creating solutions together.

One concrete example of the need for this shift can be seen in the language around voluntary sector (page 43), which inadvertently creates the sense that this sector (as well as preventative work and community work) is a nice-to-have, although we are also pleased to see the honesty here, that this work still needs to be understood. We would recommend a change in wording.

From:

> “Understand and value other interventions (including preventative, community and voluntary sector work)”

To:

> “Develop understanding of preventative, community and voluntary sector work, and ensure they continue to play a key role in coordinating support, connecting services and holding people in distress.”

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The point about the third sector / voluntary sector is one to explore further. If we want to shift to a connected sector, we need to better understand where people go to for help, where the highest quality relationships are built, and which parts of the system have a tradition of coordinating and connecting with others.

One of our case workers, in response to the strategy, said:

> *"It is noticeable that when third sector services are supporting an individual statutory services often fall away."*

Another paid tribute to the preventative impact of third sector support:

> *"I feel the support offered by services in Wales is reducing pressure on centralised mental health teams. There is an identified collaborative approach that requires continued and increased funding to best support those with mental health difficulties."*

We also, with gentle honesty, would suggest that the weaknesses in the mental health system, that we laid out at the start (a coercive, controlling history and foundation, with power held at the centre by experts) mean that professionals in this setting will need to be open and show humility about whether traditional service approaches (and their roles) are best placed to guide and lead this change. This needs to be a wider conversation, and we would encourage this to be a focus of Welsh Government work to deliver this strategy. Our service and system culture needs to change, and we need to be reflective and honest if we are to do that.

Another colleague responded to say they were concerned with just that – how to ensure their professional expertise and knowledge of the people they support was recognised and understood, particularly when people had been sectioned. They were increasingly worried about:

> *…how we support people who are under a section. There have been cases where we are repeatedly informing key teams of someone's behaviour, and they are not taking it seriously when we have concern for them.*

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There are significant positives to take from the direction of travel laid out in the Welsh Government strategy. The development of trauma-informed approaches, and the explicit reference to the Trauma-Informed Wales Framework, is to be welcomed, although the work that needs to be done to make this a reality should not be underestimated.

This challenge to implement change can be seen with the continued challenges around dual diagnosis, and the consistent feedback that despite significant work from Welsh Government to tackle this injustice in care, people still struggle to get the support they need. People we support in Platfform, and others who work across housing, homelessness, substance use and mental health services, consistently report that mental health professionals have refused to work with them whilst they are still dependent on substances. Our contention is that the reliance in the *Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem* (Welsh Government, 2015), on the idea that adult mental health services should be the 'lead' service in cases of "severe mental illness", is a significant stumbling block, and fails to recognise the reality that substance use is often a coping mechanism for experiences of trauma and disconnection – it is a way to seek regulation in situations of overwhelm. If an individual does not qualify for a definition of "severe mental illness", the experience on the ground is they are expected to work on their substance use without expert mental health support. This has not changed significantly or consistently in the nine years since this framework was published, and it serves as a humbling reminder to all of us that change is slow and should act as a caution about ensuring this strategy focuses on achieving change however we can.

Question 5b: We've identified a number of high-level actions for vision statement 3 in the strategy, do you agree with them?

We broadly agree with these actions identified in the strategy and have suggested clarifications or provided additional support for these actions in the following question.

Question 5c: Are there any changes you would like to see made to these actions?

VS3.1:

We broadly agree with this action – with a caution about the nature of the advice given to people working in services. If that advice is given purely from a traditional perspective, the risk is that it will continue to enforce a dynamic where

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people's rights are not prioritised, and their choices and safety are potentially diminished.

VS3.2:

We broadly agree with this action – we would want Welsh Government to ensure that our earlier point that talks about the need for a second pathway through mental health services is acted on, as it is often the fear of a system that does not listen to people, that doesn't give choice, and at times can cause harm, that prevents people from engaging, and makes them feel inaccessible. It is not as simple as reaching out to diverse communities and making changes to accessibility, we need to consider what we are offering to people as part of that, and whether they want it at all.

VS3.3:

Our comments on VS3.2 would also apply to this action.

VS3.4:

We fully welcome this point – the Trauma Informed Wales Framework could, if implemented across Wales in all services, with genuine honesty and openness about preventing trauma, be revolutionary in the difference it makes. We need to ensure that all parts of the Welsh policy system are aware of the framework and using it to inform the way they work. It is also critical however, that this way of working informs commissioning and policy making too. We would want to see training for Welsh Government officials, and possibly even Ministers, on this framework, to demonstrate leadership from the very top of government.

VS3.5:

We fully welcome this point – the NYTH/NEST Framework is a helpful way to ensure the system has an overview on how everyone and everything works together. As we have mentioned previously, we would want to see an exploration of how this could be applied to adult mental health services as well. The same needs articulated so clearly in this Framework also apply to adults as well.

VS3.6, 7, 8, 9:

We fully welcome these points. However, we would also caution about the importance of resourcing this offer – whilst the impact of this would result in savings from crisis services, and also protect the emotional health of families

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and other groups (resulting in further savings in future years), those savings will not be realised immediately. This is the classic catch-22 of preventative working, and the delivery plan will need to consider, clearly, how this can be addressed.

VS3.10:

We fully welcome this commitment. However, as per previous comments in this response, we are concerned that we need to address the harm that is disproportionately caused *to* ethnic minority people *by* our mental health system. If we limit this conversation to access alone, then we will limit the potential for anti-racist action and system change.

VS3.11:

We welcome this commitment – but we would also offer the caution around substance use treatment frameworks, as we have seen that previous frameworks have not achieved the change we need to see in the way we approach substance use.

We would also encourage that this is amended to include a review of the adult service framework that we noted above, to ensure that it is updated and having an impact. The challenges around dual diagnosis and treatment have not gone away, and the need for action remains.

Question 6: Vision statement 4 is that people experience seamless mental health pathways – person-centred, needs led and guided to the right support first time without delay. Do you agree that this section sets out the direction to achieve this?

We agree that this section sets out the start of a direction to achieve this, within the context of where the mental health system is currently situated. In future years, we would want to see our mental health system move away from services/interventions geared towards conditions and/or diagnoses, and instead offering interventions based on meeting the needs of people experiencing distress, trauma, disconnection – a holistic view of mental health. The language around conditions, and diagnoses, are ubiquitous across the mental health system, and can inadvertently lead people to self-select, or self-censor, based on perceptions of whether their mental health is “severe/enduring” enough.

More broadly, this language can also remove hope. The idea that mental health illness is “enduring”, can lead to people accepting living situations that they otherwise wouldn’t, because their distress has been attributed to a condition or a

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diagnosis. Examples of this can be seen throughout Wales, but particularly salient are examples of survivors in the Violence Against Women, Domestic Abuse and Sexual Violence sector, who are often more likely to be given diagnoses of personality disorder (Sansone, 2007). This becomes particularly relevant in terms of the mental health system, as a BPD/EUPD diagnosis could play out either after they have fled abuse (therefore medicalising distress), or during abusive situations (potentially invalidating genuine survival instincts and introducing doubt about their actions).

We are also concerned that a focus on conditions / diagnosis can give specific and potentially unaccountable power to a specific part of the mental health system, and risks reinforcing the same coercive foundations that we have previously referenced in this response. We believe that whilst people can, at times, and in specific ways, find diagnoses helpful, as a whole-system phenomenon, they can invalidate distress, excuse circumstance and engender hopelessness and fatalism. We believe that the evidence base for diagnoses is flawed, but our current system has been structured around them for so long, any approach that is different is seen as impossible to consider.

For that reason, we need to be clear: we do not believe it is possible for this strategy, in today's context, to move away from this language. At this point in time, this way of thinking is too ingrained in how we consider mental health, but we would hope that this need to shift away from medicalised understandings of mental health can be considered in detail by the Welsh Government mental health team, in partnership with the sector, to challenge some long-established assumptions so that by the time the next strategy is considered, our language and approach to mental health is much more focused on the person, and on their reasonable reactions to distress, rather than arbitrary, unscientific diagnosis criteria.

The reason we have gone into detail on this point, is that we believe a focus on "conditions" (mild/moderate, or severe/enduring) does not enable a truly seamless system. Too much of what support people get, and when they get it, is dictated by a diagnosis. We do not see, across the system, a holistic assessment approach for example, that considers trauma and distress. Instead, as a system we still resort to diagnosis, before building a care and treatment from that position.

Despite our comments above, however, we welcome the content of this chapter – we believe that it will make a significant difference to people using services, if it can be effectively implemented in the systems, we have built around us.

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It is also critical to get right. We received feedback from people we support, that connections between services, and their ability access the support they need at the right time, and in the right way, remains a challenge. One person said:

> *In the past I was on a 2-year waiting list to receive counselling when I lived in Swansea I patiently waited the 2years to discover I had been removed from the waiting list. They told me I hadn't responded to a letter asking if I still wanted to be on the list. I hadn't received any such letter. I don't feel that sending people letters asking them if they wish to remain on a list is good practice. Many people with poor mental health find it difficult to open letters let alone respond to them. this practice may well help to reduce the waiting list but it is causing people to fall through the net and not receive the help they need*

Another person said:

> *Waiting lists. I am currently on waiting list to be assessed for ADHD I have been on this list since Jun 2021. I used to be able to phone to check that I am 1. still on the list 2. how much longer I will need to wait. However the adult ADHD service not longer answer the phone you get a recorded message telling you to email them. When you email them, you get an automated response telling you they don't man the emails and it gives you... their phone number. This is Hywel Dda. services in Swansea appear to be different, services need to be standardised to stop this post code lottery.*

Question 6a: What are you reasons for your answer to answer to question 6?

We believe that all our services (and, in fact, the wider systems that offer support across the life cycle, and more widely to our communities) should be seamless, without unnecessary bureaucracy and processes to follow. When people are in positions of distress or crisis, they will not be able to make sense of complex systems, they want help where they are, in the best way it can be delivered, promptly, and in a way that asks people what they want. The internal processes and bureaucracy is what we need to resolve as professionals.

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At Platfform we believe it is in the community, and in place-based services, where there is most scope for real change. Communities are where informal networks of support can build (if the conditions exist for this), where people face fewer barriers to access (with specific exceptions that would need to be considered from an equity and inclusion perspective), and where there is a space and opportunity for creative work, and less formalised, bureaucratic responses. But in order to harness the power of communities, and the organisations / people around them, we need to shift the focus of our mental health system so it is less focused on formal, clinic-based interventions led by traditional medical understandings – and more on shared power, sense-making in communities, and a true commitment to meeting people's needs as they see them, and not as we want them to be.

Ultimately, we see the actions in this chapter as critical to make progress – but we also see them as transitional. We must make these changes to even begin making the huge shift we need to see for the 21st Century challenges Wales will face, but even these transitional changes are challenging in and of themselves. In that context, the Welsh Government have our full support for the changes they have committed to, and we look forward to seeing how they will develop.

Question 6b: We've identified a number of high-level actions for vision statement 4 in the strategy, do you agree with them?

We broadly agree with these actions identified in the strategy and have suggested clarifications or provided additional support for these actions in the following question.

Question 6c Are there any changes you would like to see made to these actions?

VS4.1:

We welcome this commitment – we would want to see this incorporate the key elements of the Trauma-Informed Wales Framework, the WHO/UN Guidance on legislation and practice (specifically, the principles of rights-based, informed choice and least-restrictive), and other work that prioritises harm reduction within mental health services and systems.

VS4.2:

We welcome the commitment to action on equitable access, and also on co-occurring mental health needs, but our previous cautions on equitable access

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remain – we have to consider much more what experiences people have *within* mental health services and systems, rather than purely improving access. We would welcome clarity on co-occurring substance and mental health needs, but again, would caution that this clarity cannot come by focusing on the flawed concepts of "severe" mental illness. We hope that these quality statements will be open to public consultation, but also prior to that, worked with in a co-productive way with the sector.

VS4.3:

We welcome this action – although we would want to ensure that the concept of vulnerability is fully scrutinised. Our current mental health system does not handle issues of vulnerability, risk and safety, very well – and as enumerated many times above, there is the constant pull within mental health services back towards the coercive if not punitive interventions for individuals who do not conform to expectations of normality, or conceptions of what is "vulnerable".

On risk, and the way in which mental health services can approach it, one of our colleagues said they would want to see:

> *…a review of the risk management processes employed by health and social services, WARRN is cumbersome and not flexible in enabling healthy and acceptable risk taking. It is restrictive and deeply flawed in its approach to historical and predictive / active risks.*

VS4.4:

We welcome this action – a Mental Health Safety Programme is much needed, and we want to applaud the Welsh Government for committing to this, and for already setting these steps in motion. We would want this work to lean heavily on the WHO/UN Guidance on legislation and practice for mental health, that we have referenced throughout this response.

VS4.5:

We welcome this action – but also suggest that the way we approach primary mental health services needs to shift. We know that the most effective determinant of whether a mental health intervention is successful is influenced heavily by the relationship between participants, rather than simply just the mode of therapy or the model (Herman, 1998; Arnow et al, 2013). This makes the

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default approach we take within primary mental health services flawed from the outset. The gatekeeping/rationing mentality that the NHS adopts due to scarcity of resources and high demand, leads to strict interpretation of what types of services or support can be offered to people when they present in situations of distress – and for how long. The most effective method of working with people – to build a positive relationship, and establish a connection, which can take time – is in opposition to the systems we have created. This approach permeates our responses to distress throughout the primary care system in mental health, and it is no surprise that people struggle to get the care and support they need when they ask for it. This same issue faces professionals, feeling frustrated at what they can offer, or feeling stuck with limited or restricted modes of therapy or self-help. That feeling within primary mental health services, is also picked up elsewhere by Platfform colleagues.

One of our case workers had this to say about primary care, in their experience:

Access to primary mental health care is often too protracted leaving people to develop chronic conditions or crisis. Secondary health services are difficult to access and seem to be driven by a model that appears to say "keep out", rather than listen.

Another case worker said:

Let's try and prevent things from escalating rather than waiting until it's too late which causes detrimental effects on people and their families.

Even within community responses, the system needs to be open to challenge about the effectiveness of the work done. The temptation is to consider that by delivering primary mental health services in the community, something different is being offered. This might take the form of open-access groups that anyone can attend, which is a positive step forward – but our experience has been that these tend to be held in regular, and specific venues. What is not happening as a standard approach, is reaching out to specific communities, and taking the time to build the right relationships, understanding the challenges facing people there, and co-creating therapeutic spaces that are unique to place. That response, which is harder, and takes more time, would be a more helpful primary care intervention, because it considers the reality of people's lives, and does not follow a one-size-fits-all approach which is one of the consistent weaknesses of

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primary care (Purgato et al, 2021). We would want to see a renewed focus on a community-led, place-based approach that reimagines primary mental health as support that people can access where they need it, and not just through GP referrals. This will need a significant effort to deliver, and we know it will not be easy, but it is important to shift away from traditional primary mental health approaches, which we know are not working as we would want them to – despite phenomenal effort from mental health practitioners.

Question 7: We have identified some areas where action is needed to support the mental health system as a whole. These areas are:

- **digital and technology**
- **data capture and measurement of outcomes**
- **supporting the mental health workforce**
- **physical infrastructure (including the physical estate of services)**
- **science, research and innovation**
- **communications**

Do you agree these are the rights areas to focus on?

We agree that these are helpful areas for action, with the caveat that they must also be considered through the lens of the principles set out at the outset of the mental health strategy.

Question 7a: What are your reasons for your answer to question 7?

There are specific reasons that we believe these actions are helpful areas to prioritise, around the mental health strategy. Particularly around more robust data, this is crucial. We are specifically interested in data around restrictive practice and ensuring that we are capturing the real experiences of people within the mental health system. We would want to see a focus put on measuring restraint, use of ECT, levels of antidepressant prescriptions mapped against (for example) areas of multiple deprivation. These are not an exhaustive list, but a starter to consider some of the data we would want to be captured.

Additionally, we would want to see work on communication. Particularly on ensuring people can understand what support they are entitled to, and where to access it – but crucially, to support their ability to advocate for informed choice within the system. This would mean a concerted effort from the Welsh Government to ensure that up to date, relevant and evidence-based information is made available to the public.

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We believe that this all rests on the need to understand the reality of the mental health system, and that we need robust research and innovation to ensure we are responding to mental distress in a way that is in line with the latest evidence available.

Ultimately, we believe that the transitional nature of this strategy should be acknowledge as an excellent stepping stone towards something more transformational. We would want to see the Welsh Government commit publicly to legislating for a Mental Health Reform (Wales) Act once certain conditions have been reached (better data collection, wider public understanding, community-based interventions more widely available, restrictive practice starting to reduce), to offer a world-leading approach to mental health and wellbeing. Wales has the chance to do something very different and change the future of our country as a result.

Question 8: The high-level actions in the strategy will apply across the life of the strategy. They will be supported by delivery plans that provide detailed actions. These delivery plans will be updated regularly. Are there any detailed actions you would like to see included in our initial delivery plans?

We will want to comment on a full-scale delivery plan, as that is where the real impact of this mental health strategy will be seen. However, there were key points we made throughout this consultation, and we would like to see the delivery plan commit to them. This includes commitments to:

- a national conversation about our mental health system, with inclusion from the public, about embedded myths, medicalised approaches, and the need to understand the coercive foundations at the heart of our structures.
- exploring community-based primary care services, specifically exploring open-access approaches that build connections with communities that face barriers to engagement.
- working with NHS Wales, Public Health Wales, and other relevant bodies to deliver high-quality, evidence-based education that tackles out-dated information such as depression being linked to a chemical imbalance;
- working with relevant community partners, to develop a community asset-mapping exercise to understand where mental health community interventions (and others) might be most needed;
- working to explore how the NYTH/NEST framework could be applied to adult mental health structures and services;
- review the Service Framework for the Treatment of People with a Co-Occurring Mental Health and Substance Misuse Problem, with a focus on

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removing the requirement for “severe and enduring” mental health problems to be present before support is offered;
- exploring training for all levels of Welsh Government around the Trauma Informed Wales Framework;
- reviewing our current mental health structures and systems to understand the differential negative impacts facing people from minoritised communities of any kind;
- ensuring that the Mental Health Safety programme embeds the core principles of the WHO/UN Guidance on legislation and practice for mental health;
- explore, after the first years of implementing the strategy, how a Mental Health (Wales) Act could create a whole new approach and system for our country.

Question 9: This is an all-age strategy. Whenever we talk about our population, we are including babies, children, young people, adults and older adults in our plans. How much do you agree that the strategy is clear about how it delivers for all age groups?

We believe that this strategy is clear about how it would deliver for these groups, although we would want to ensure that the principles that are more easily applied to young people services are also applied to adult mental health services.

Question 9a: What are your reasons for your answer to question 9?

As above.

Question 10: We have prepared impact assessments to explain our thinking about how our strategy may impact Wales and the people who live in Wales. We have thought about positive and negative impacts. Is there anything missing from the impact assessments that you think we should include?

We do not have a specific view on this question, other than the need to keep these under regular review and ensure that stakeholders can recommend amendments over the lifetime of this strategy and delivery plan.

Question 11: We would like to know your views on the effects that the strategy could have on the Welsh language. How could we change the strategy to give people greater opportunities to use the Welsh language? How could we change the strategy to make sure that the Welsh language is treated as well as the English language?

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We do not have a specific view on this question.

Question 12: 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.

We have covered everything that we wanted to say, in the above questions.

Thank you

We are grateful for the opportunity to respond to the draft Mental health and wellbeing strategy for Wales. In our submission, we have been challenging and forthright, because we believe that in Wales we have the opportunity – with the levers that devolution provides – to make real, lasting and material change for people across our nation. We do believe that this strategy should be seen as the *start* of a change journey, and not a finished approach. There is a lot of work to be done, by all of us across Wales, to continue to shift our understanding of mental health and delivery of support closer to a modern, compassionate, rights-based approach.

We are also aware that this is a difficult time for people across Wales and the UK. Distress is increasing, we can see that ourselves through our services. Disconnection is growing, and there is a sense that our systems are no longer able to cope. In this context, the idea that people can take responsibility and ownership of their own mental health is hugely attractive, and whilst we welcome the focus on giving power to people, we absolutely must grapple with the lack of equality, and the poverty endemic in our communities, before we can legitimately argue for a prudent healthcare approach as an answer to mental distress.

Our robust response seeks to nudge the strategy further towards the widescale shift we need, and to encourage all of us in mental health services, and partners across Wales, to be open and humble about the foundations that we stand on. Only by facing up to these foundations can we begin to build something new.

We would conclude, however, by paying tribute to the Welsh Government for an excellent start on that journey. There has been huge thought, compassion and effort put into this strategy. We can see areas where significant progress has been made since the last strategy, and we know that the visions articulated will provide a powerful focus as we begin to work across Wales on implementing these ideas. Whilst we do see this as a transitional strategy, to lay the groundwork for a sea change in the future, we also applaud the Welsh

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Government for addressing many of the challenges the sector faces today. We look forward to working alongside the Welsh Government in the months to come, as this strategy is further developed with a focus on delivery.

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