Verbatim from 2011 WaMHinPC Survey

Q2. Setting aside issues of funding, resources or service quality, what factors contribute to making the management of mental health more challenging in primary care? Please tick all that apply and rank by importance. If other please specify

- "stress" is the new back pain. Young patients with no mental illness get tagged with a mental health label because they want to claim benefits. Perhaps this is "stress" : these young people are ill equiped to deal with entering an adult world. This is a failing of society but I can not tell if it is lack of parentimg or schooling.
- All of above
- breakdown of families
- consultation time
- Cultural perceptions held by the public about the need to be referred on to an 'expert'
- enormous difficulty with young people who are not quite adults and fall between services. Social expectations of young women with children
- Fear of impact of diagnosis on employers and therefore fear of job loss. Fear of lack of support from friends and family if diagnosis made.
- I am concerned about the number of middle aged people devoting their life to looking after demented parents and how they will cope when the parents die.
- lack of resources and investment in primary care
- Lack of support for primary care services, many deemed "not ill enough" to warrant a CMHT input. CAHMS services leave a lot to be desired
- Low level of services locally. Unavailability of support. Patients discharged from CMHT while still acknowledged to be unwell.
- mental health issues should be reveiwed and monitered at mental health units when a problem occurs in primary care you cannot contact anyone in mental health units to deal with the problem immediatly
- Poor availability of cunselling services makes it difficult for short term problems
- poor drug and alcohol services and lack of recognition by secondary care that comorbid with significant mental health issues. poor employment opportunities and fear of job loss reduce likelihood of admission of problem. fear of involvement of solicitors / social services reduce patient admission of problems if also marital issues / legal issues and children involved. time constraints on assessing patient fully for problems. lack of good quality training in mental health at primary care level and support
- poor knowledge of staff that work in GP surgeries about mental health and stigmatisation of clients
- primary care providers needs their own counsellors .the exisisting counselling service is very poor inaccessable to pt when they need.
- Skills Experience & Training within Primary Care Practices to recognise, support & treat using a range of holistic therapies, which include, but not exclusively, medication. Lack of knowledge re range & variety of support serivces available, including voluntary sector.
- Some people live in Rural settings and have difficulties accessing services. Cultural differances with some people trying to access service provision. Local services (i.e a rehab centre) which takes people out of area who then settle within the local community and then put pressure on service provision for the existing client population.
- Substance Misuse and Mental Health problems
- Support from secondary care when referred to support primary care diagnosis
- time
- We find that a number of people with an urgent need (suicidal) are simply rejected by Community Mental Health Teams because they have no "diagnosis". Leaving them to be supported in an ad-hoc manner by third sector organisations and thier GP.
- Why exclude funding, resources and service provision as these are way above number one in

the list

- you have set aside the major factors

Q3. Which of the following do you feel affects the successful delivery of improvements to primary care mental health services in Wales? Please tick all that apply

- Ability of secondary care service to ignore GP referrals
- Alot of people are classed as having 'untreatable mental illness' and we are to direct them to MIND. Can Mind cope with all these people. It is a charity. How long will it last? Feels like people are being dumped elsewhere by psychiatrists and result in coming to gp again and agian and what are we to do with these vulnerable needy people?
- CMT/secondary care unresposnive and unilaterally place restrictions on referrals without consutlatiosn and often without appropriate advice or alternative solutions
- Difficult to get hold of secondary care especially after 4pm
- I don't even understand the question.
- inadequate support leads to chronic mental illness.missed oppertunity
- inconsistency of decision making by strategic "bods"! most mental health care is done in promary care but the resources are in secondary care so if you want to increase primary care management with cmht'sthen its not rocket science to work out the funding.also 24 hour care needs to be available to avoid inappropriate admissions and deteriorations in patient with severe mental illness-this needs to be provided by cpn's/specialist workers who can liaise with primary care or in case of severe mental health problems secondary care on call
- increasing restrictions on referrals, lack of availability to CBT
- Local CPN having strict referral guidelines that require filling out a PHQ or similar prior to being seen, as opposed to in the past reciving a referral letter. In addition have been refusing to see patients with 'anger management ' problems, and also with patients who have no depression but simply anxiety.
- Not having the support from mental health services to manage these patients effectively and timely at home
- Post code lottery of availability of psychological support. CBT availability free at point of contact
- prevalence of drug and alcohol problems; their lifelong nature for many people.
- primary care is a busy area mental health issues require more than 10 minutes which is the time allowed for gp/nurse appointments
- Primary care Mental health service is ineffective as the wait is so long. Patients keep returning to GP and feel let down by the service
- Problems with access to counselling which patients are kwwn to have but no service available locally
- Shortage of staff within Primary Care services to deliver the service. Variation in the service model provisions across the various Trusts. Too much bureaucracy and paper work getting in the way of delivering a quality service
- some referal bounce between in house councillors and CHMT team. In house councillors work needs to be looked at in terms of no of Patients seen/ session cancellations and feed back from the patients annomously for it to be cost effective. All of us are having our work scrutinised how about other therapists.
- staffing levels and lack of interaction with social services
- The varying knowledge base of G.P's some of whom miss diagnosis Mental Health problems when they do not exist, and others who persistantly sent in referrals as urgent or in Crisis when this is not the case. This highlights a training need among some GP's and presently relects on their anxieties.
- time constraints / lack of well trained manpower
- Too much being bounced back into primary care, and the sectorisation of secondary care provision makes referral difficult, e.g. drugs / alcohol / mental illness all having separate specialists

- Very poor primary care / secondary care communication pathways. Secondary care seems to have its own ideas and rules that only applly to a small proportion of a GP's patients. Ther is little help there when things start to go wrong.
- We have no counselling service to refer to. the contract is no incentive to improving care; I would rather talk to my patient than fill in a phq9 or HADS.
- We're continually blocked and fobbed off by First Access, whom we call 'First Refusal' and often the only help we get is when catastrophe finally strikes.

Q8. Do you think that the language needs of your Welsh speaking patients are being met?

If no in what ways can these needs be met?

- All patients in my area are bilingual (Welsh & English)
- Difficulf for older people who have trouble with English
- I am not welsh speaking
- I do not know of any places to refer them that will consult in Welsh, locally.
- inc welsh speakers at all levels
- Insufficient welsh speaking practitioners in mental health field generally, subsidised training, recognition that language plays an important part of treatment.
- Lack of Welsh speaking health professionals in Primary and especially Secondary care
- Need to recruit & retain Welsh speaking professionals, from Welsh speaking communities, with an understanding & empathy with Welsh culture & language. Offer enhancements to Welsh speaking professionals to aid recruitment & retention. Increased training opportunities for second language Welsh & to learn Welsh.
- no less than non welsh speakers
- Not many Mental Health workers in my immediate area who are first language Welsh speakers
- there is no local welsh speaking counsellor. We have had no complaints about this.
- Very little Welsh spoken as first language in my area of Wales
- We have few welsh speakers trained in Mental Health First aid - our need is more generally for Polish.
- welsh speaking service but also what about the deaf community and BSL??
- Yes by me but little literature available in Welsh and lack of Welsh speaking counsellors

If yes in what ways are these needs being met?

- all also speak english
- All are bilingual , while it would be nice to offer services in welsh I feel that the money to do this would be spent better on other areas
- Although some have welsh as a first language, they are all bilingual.
- availablility of welsh language signs, dr, reception staff. however no welsh speaking nursing staff, letters from the surgery are all in english
- bilingual information
- Bilingual population.
- dr's who speak welsh, written info can be given in welsh
- Easy to translate or converse. Much harder for growing Polish community.
- I am a welsh speaker
- I am assuming that I have some Welsh-speaking patients, but all my UK-born patients are happy to consult in English.
- I can speak Welsh to them, other areas not fluent - probably more im-portant with the elderly
- i have never had a patient ask me to converse in welsh or to conduct a consultation in welsh,if i

did then that would be problematical initially until i could solve the problem

- in our area Welsh is usually 2nd language . we have access to intepreter if nescessary
- It is very rare that the patient cannot speak english well enough to be able to communicate with me in english
- Language doesn't present a barrier to the consultation as I am happy to consult in the preferred language of the patient
- Lead doctor speaks welsh and so do I.
- Luckily our practice has two out of the five partners that are native Welsh and speak fluent Welsh.
- most speak english also.we have first language welsh speaking gps in the surgery.
- No monoglot patients and I have never been in the position of being unable to connect with and understand a patient that I know can speak Welsh
- No monolingual patients
- Not aware of any only Welsh language speakers so all happy to use English
- one of our partners is a fluent natural welsh speaker. I have a welsh A level and can say enough to manage in a bilingual conversation
- One of the GP partners is Welsh speaking
- One partner welsh speaking
- Patients have access to bi-lingual information if requested although no-body ever has in my 17 years in the practice
- patients speak english as too
- PRACTICE HAS WELSH SPEAKING DOCTORS
- Probably as very few indeed as all speak en glish fluently
- reception and clinical assistant staff speak welsh, information from WAG can be bilingual as are many other information leaflets.
- some doctors in the surgery speak welsh and there are welsh speaking members of the CMHT
- some welsh speaking GPs / staff. majority of patients bilingual. carers / family often help to translate in difficult cases. would not be feasable to train all staff to speak fluent welsh in order to provide ideal scenario care at all times
- there are welsh speaking members of staff
- They are all willing & able to converse in English as well
- They can all speak English as well so I do not think that additional resources should be wasted on prviding a multilingual service
- They can all speak English fluently
- they can speak english
- they can speak english as well
- they can speak english!!
- We have many welsh speaking health professionals working in the paractice
- we have no first language welsh speakers , all fluent english first language patients
- welsh speakers within Practice.Written info can be given
- Welsh speaking GP and reception staff available
- Welsh speaking partner with psychiatric training availableand other welsh speaking professionals in primary and secondary care
- WELSH SPEAKING STAFF ALWAYS ON HAND
- Welsh speaking therapists
- x2 gp's ist language is welsh
- Yes, but I find neigh on all patients are perfectly adept at consultations in English

Q12. If you were responsible for improving the overall mental health provision in your area, which aspects of care would you address as a priority to achieve the greatest benefit? Please rank your top 5 priorities. If other please specify

- There is no easy access to secondary care services in this locality.
- access to counselling service
- CAB
- I would like better access to talking therapies, and that the local 'first access' scheme would stop returning referrals, especially those that the local psychiatrists have recommended we send to them!
- improved sevices needed for child and adolescents and especially 16-18 year olds.
- Improved talking therapies in primary care. Urgently needed- does not mean secondary care coming into primary care but means primary care developing this important service themselves.
- investment in primary care teams akin to District Nurse models
- needs support staff
- Outreach services must be practice attached to ensure trust & continuity Referral systems must be agreed & not imposed; there is an increasing tendency for secondary care to design "hoops" that are difficult to jump through when GPs are genuinely concerned
- recognition by patients and carers of limitationsof health professionals/services to "cure" effects of individual lifestyle choices adn relationship difficulties-in particualr management of alcohol and drug abuse
- The only area of concern is in children's problems.
- We have a vast wokload in Primary CAre, yet our numbers have barely increased in the past 15 years. We do not have the capacity at present to undertake a lot of support work, yet we see CMHT's increasing in personnel, but reducing the patients that they are prepared to deal with.
- We would like appropriate referral pathways for people presenting as suicidal. At present we signpost to GP or A and E. GP signpost to CMHT they reject them and they finish up back in our reception. A and E discharge and we see them again the following day. The major factor is lack of access to accomodation, tenancy support and MH and drug and alcohol services.

Q13. Please rank the overall importance of these factors in determining mental well-being for the population in general. Please rank your top 5. If other please specify

- For our client group - its basic - accomodation, access to support and services.
- expectations of society. I see many young women who are in the catch 22 situation where they need to work for money to support their lifestyle, but the work available is poor quality and conflicts with their availability to look after their children. Latch key kids / social breakdown. Overtired / stressed / TATT /mums. Poor marital relationships. Family breakdown. Society breakdown. Debt / alcohol / poverty.
- drug and alcohol abuse
- Also the state of the local drug culture & access to drugs of addiction
- Trying to rank all these is a bit silly. It is easy to argue that they all have high priority!
- expectations in life

Q15. If you have heard of WaMHinPC before, please confirm how. If other please specifiy

- Attendance at a conferance
- presented at conference
- Attended conference in June 2010
- Newsletter
- PTLS meeting
- RCGP Welsh Council
- can't remember

- attended conference
- personal knowledge of development

Q19. WaMHinPC is developing quality standards to encourage improvements in the following areas. What other areas would you focus on? And why?

- Carers are very important and i would look after them as much as i would look after the patient
- Services for people with Personality disorders and Adults with ADHD. No service provision in our area, lack of training and skills among existing staff, no back up sercices for GP's and a big demand on existing services made on a regular basis
- Links to housing
- Adult ADHD
- Depression - extremely common and often poorly managed - important overlap with physical wellbeing
- The service has deteriorated over the apst 5 years. It needs a thorough overhaul
- berevment, can lead to lonelyness depression
- Support for counselling in Primary CAre
- Personality disorder - as this diagnosis becoming more common.
- There is a lack of provision for patients with moderately severe mental health problems who fall outside the psychotic range
- clinical psychology -it is a seriously under developed service
- Learning disabilities. Much care has devolved to general practice. Puerpural conditions. No specialist service in Wales. Psychological Therapies. Major proven benefit for depression, anxiety disorders, OCD. Grossly deficient provision with stupid waiting list times.

Q22. What improvements to primary care practice would you wish to see as a result of the implementation of Part 1 of the Measure?

- proper use of the gateway workers to liase between primary and secondry care
- Access to advice / acceptance of ownership of problems
- don't know
- easier, quicker access
- Enough skilled and approriately trained staff available to implement these measures. A reduction in the huge amount of paperwork presently required. A health educator at every surgery to assist and support clients in taking responsibilty for improvement in their over all physical health which significantly impacts on their Mental Health
- Greater capacity, skills, time & knowledge to support people with more complex needs in primary care, including those with severe but stable mental illness & those with mild-moderate symptoms, eg, depression & anxiety.
- more self help and resilience
- Cannot comment - see above, need to research first.
- Provision of a CPN to support each GP practice
- all mental health patients seen by RMH nurses/doctors
- Much greater access and capacity in wellbeing services for people with emotional and psychological conditions and difficulties
- Better services for GP's to signpost into - especially for suicidal patients.
- Medium to longer term counselling available
- dont know anything about it
- better access to services especially primary/secondary interface

- shorter waiting times
- Improved liaison with community services
- na
- not aware
- primary care based services - actually seeing patients in primary care and interacting with primary care physicians
- I would wish the nonsense being talked about improvements through the mental health measures to stop. To supply just an extra 4 posts, for 150,000, principally to hand out leaflets or run a database is extremely poor value for money. My receptionists could do this. Why not spend the money on more clinical encounters?
- better community support
- Access to fellow professionals when needed
- Support in pathways for referral
- Having a keyworker & improved patient access & choice. However, how this is to be delivered with no additional resources is beyond me.
- More money to facilitate health promotion
- Better access to Counselling and support for patients with mental helath
- More outreach mental health services
- Better support in primary care
- closer engagement with services and much more structured support
- Quick easy acess to counselling services, pt should be seen no less than two wks from presentation
- improved confidence and a greater capacity to manage mental health problems in primary care. Quicker assessment and intervention for patients and more support for doctors and patients
- Greater availability of 'talking therapies' - CBT/anger management/relaxation etc
- Quicker access to primary mentah health care team and back up from community mental health team services
- closer integration between primary care and menatl health services such as working within gp practices
- bettercommunication between primary and secondary care, better access support services
- Improved training and knowledge in GP clinical staff resulting in increased confidence
- one call / referral and the team to assess what's appropriate. Named person assuming responsibility as a case manager
- improved practice based community mental health care
- Shorter wait for input from Primary Care Cpn
- I would like to see mental health workers working regularly in primary care. At present we only have a gateway worker once a week who does not take part in any treatment. They only make an initial assessment.
- better interface with mental health services
- need to have general practice attached members of the mental health team to enable mutual trust & confidence to be established. More combined training & the recognition that some apparently minor mental health problems do need consultant psychiatrist input on occasions
- gateway workers; access to groups eg anger management, stress etc
- Improved interface and access to secondary care. Better integration. Community Mental Health Teams are too stringent in their acceptance criteria, miss a vast population of mentally ill people because they defend against treating moderately ill but unstable patients. This allows them to adopt a lazy approach to treat few patients, leaving a large number of mentally ill patients to be dealt with in primary care, beyond the expertise of most GPs.
- Access to CBT and CPN support for patients
- long term support for people who have chronic mh issues
- Not aware of what this is
- Easy accesibility of practice-based counselling

Q24. What key improvements would help you manage patients with dementia? If other please specify

- This is an area of Specialism within our locality and therefore my knowledge base and understanding of this particular illness is very limited
- Support for the carers
- we have very good services locally consultant led,please dont fiddle and change them now but sadly chiefs of staff who seem to be dictator like in their decision making are cahnging things when they feel like wothout consulting people who look after these patietns,secondary care sees but a smidgeon of the patients with mental health issues in the broad sense
- respite/ support for carers
- early diagnosis
- especially in younger patients
- help for carers
- Diagnosis isn't a problem here, long term care and management is.
- the service locally is excellent and I don't want it changed
- medication training and advice
- more community support
- At present we have very good dementia servicesin this area.
- better carer support and more EMI placements.
- i think we have a good local service for confirmation of diagnosis

Q25. In the case of Black and Minority Ethnic patients, do you consider their cultural background?

If yes how

- I have very few Bme patients , would generally look up as and when needed
- language and gendre specific counselling
- very little if any.
- none
- none
- linguists, information sheets in their own language
- Dependant on their 1st language, a languge translation and interpretor service.Other than this our facilities within the area are very limited.
- help with translation..
- we have v feew BME patients, translation is the main issue
- female health professionals
- articles in the pref language, aware of religious customs
- awareness of culture
- None
- none
- interpretation service
- not aware of anything specific
- There are none locally that I know off, we have very few BME patients, but I sensitive to their needs having worked in areas with large BME populations.
- their family support is oiften better
- none-they should be treated same as host population
- None at present.
- No known local support services
- religious beliefs,family values
- Culturally sensitive consultations. Regard for the ways that communities try to deal with mental

health issues themselves without involving primary care or statutory services.

- Awetu
- none
- language issues are a problem, we try language line, but not always successful nad time consuming++

Q29. Your professional background if not GP or practice nurse

- community psychiatric nurse. gateway worker
- primary care mental health liaison nurse
- counsellor
- Primary Nurse Practitioner in Adult Mental Health
- Commissioning Manager
- ANP
- Vol Org
- counsellor in general practice
- Third sector manager (Health and social care support services)
- specialist nurse in psychiatry working in primary care setting
- Counsellor in GP practice
- advanced practitioner
- Practice Manager
- Practice Manager
- Practice Manager
- gp registrar
- GP background but presently psychiatrist
- PRACTICE MANAGER

Q32. Do you have any specific qualifications in mental health? If yes please specify

- RMN
- rmn
- counselling quals
- RMN Dip.N Community Practitioners Certificate in Mental Health
- PG Dip Psychological Counselling Relate Certificate
- Undertaken Mental Health First Aid course.
- rmn. BSc in health studies,(rgn, onc)
- Higher Diploma in Counselling
- section 12(2) approved
- RNMH, Cert in Counselling..
- Dip Subs Misuse
- Diploma in Clinical Psychiatry (Ireland)
- I am Section 12 approved
- psychoanalyst
- I did post graduate course in Liverpool "postgraduate certificate"
- section 12 approved

- FRCPsych RCGP Cert. Management of Substance Misuse

Q33. Any other comments?

- work with local s/ help group through " Journeys "org ; local group in town THE LIGHTHOUSE.
- I have Counselling experience as a member of the Institute of Psychosexual Medicine and these skills are transferrable for managing Mental Health problems. "Minor" mental health problems is a concept of Psychatric services and it makes it very difficult for GPs to obtain help for patients who may need more that GP skills of services to manage their condition.
- Question No. 25 is not very clear. is this a % or number of clients treated? and if so over what time period. I assumed it was the number of clients I have seen this year to date!
- There needs to be imporved emergency services for people who are suicidal, with improved support services - ie housing, soical support etc.
- proper consultation by BCU lhb is essential,the cpg is secondary care dominated and led by them yet they do the smallest quantity of work but do look after the more severely mentallyill but to reduce this primary care needs to lead and be consulted.chiefs of staff also should be answerable to GP's and attend lmc but dont! to explain their vision for mental health but they dont pay any attention.the advent of the new lhb's has been a major retrograde step for mental health completely alienating gp's again unlike the previous smaller lhb's who engaged with primary and secondary care,
- The Old Age psychiatric services locally(bridgend) are very good. The rest of the service is poor to bad.
- occasionally see patients with mental health problems. usually monitored by the G.P,s.
- Many of my patients are women who are struglling to balance ageing parents / children / husbands and work. Often the precipitating factor is debt - peer pressure on children to confirm with 'dress code', latest ipod, plasma screen yc etc. Many women juggle several jobs at once to pay bills and they can't cope. Often then start drinking and can fall into a spiral of alcohol fuelled misery. About 25% of my patients have mental health issues. I regularly empty the tissue box during a surgery and one medical student said my surgeries were 'burdensome'. Often the social issues stretch the imagination and 10 minutes is never long enough. CPN is available and helpful, when at work computer generated tick box questionnaires are not.
- Improving availability to counselling services is of paramount importatnce. A pt should be seen no more than tw wks from initial presentation, because presentation to services usually happens wks, months or maybe even years into the situation, as pts usually delay presentation due to fear, shame or other issues. If a pt requests counselling or agrees to the suggestion of counselling there should be the infrastructure in place to ensure professionals are able to treat the situation with a greater sense of urgency, than the current system allows.
- really poor service for accessing mental health service personnel locally means long waits and difficulties with increasing mental health issues during waiting perio
- not a very good survey!! questions possibly weighted to get a result that suggests "low knowldge/expertise of GP's"
- Fairly recently qualified as a GP. I didn't do Psychiatry as part of my rotation, which was very frustrating. More frustrated by poor access to psychologicla services-I feel I';m forced to prescribe antidepressants when other forms of intervention would probably be prefered (counselling etc).
- i work in a deprived area and the access to mental health services for my patients is very difficult. The services for drug abuse are inflexible and would be better based in primary care.
- in Q1 should difficult/ quite difficult be the other way around? I would have thought quite difficult is less difficult than difficult.
- wamh-pc fact sheets are far far too simple and uninformative -good housing is related to good mental health as is useful employment -"duh"
- lthough i do not have a specific interest in mh i seem to attract it
- This was a complicated survey !

- We have terrible trouble getting patients seen by a doctor yet there seem to be dopzens of them in clinic and on the wards. What do they do all day. WHen we ask for help, we're fobbed off with social workers in First access offering leaflets or are told that the psychitic patient you want them to see should wait until after the weekend to see a social worker! The frustration with the local service is extreme and will, I have no doubt, lead to a stinking cock-up and recriminations before long.