Legislation Committee 3

LC3(3)-08-10 - Paper 3

Proposed Mental Health (Wales) Measure

Written Evidence Submitted by Welsh Local Government Association and the Association of Directors of Social Services

Introduction

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities, the three fire and rescue authorities, and four police authorities are associate members.

2. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

3. The Association of Directors of Social Services Cymru (ADSS Cymru) is the professional leadership organisation for Social Services in Wales. Its membership comprises the statutory Directors of Social Services and the Heads of Services for Adults, Children, and Business across the 22 local authorities in Wales. By working in partnership with the Welsh Assembly Government, and other key partner organisations in the public, independent and voluntary sectors, ADSS Cymru strives to ensure better outcomes for citizens and the Welsh Community.

4. We welcome the opportunity to present written submission for consideration of the Mental Health (Wales) Measure.

General Key Points

1. We broadly agree with the aims and proposals within the Mental Health (WALES) Measure, but we are concerned about the NHS and Local Government having the capacity to achieve all that is set out in the Measure, even where there is a strong commitment to work closely together. It is essential that the concerns set out below are considered.

2. Effective mental health services require strong collaborative commissioning and strategic planning of services to ensure that the recipients of the service experience good outcomes. Therefore mental health services must be a shared responsibility of the NHS and Local Government, and the interdependence of each party's role and contribution has to be visible to the professionals working within the service. In this context, we have always supported the concept of integrated delivery models which should contain a pooled budget, a single information database shared amongst the partners, and a single manager to oversee the service. We have excellent examples in Wales of this approach which can be built upon to inform the design of new joint services as proposed in this Measure so that we are working toward one level of service that also gives consistency and equity.

3. All new services and initiatives require resources and we refer to the long standing agreement between the Welsh Assembly Government and Local Government that adequate resources should be made available to support implementation and that detailed financial implications are a pre requisite for drafting regulations and new or revised guidance.

4. The Welsh Assembly Government has given some indication of costs but it is an unrealistic funding model, and there is an unrealistic expectation that "working smarter" will on its own deliver the efficiencies that could contribute to the costs of the proposals in the Measure. Both the NHS and Local Government accept the challenge of 'working smarter' in a time of unprecedented financial strain for the public sector, but find it difficult to see how the new Measure can be absorbed in the way envisaged.

5. Furthermore, it is anticipated that people with mild to moderate MH needs would be signposted to other organisations, mainly the Third Sector, but a considerable proportion of funding to voluntary organisations is provided through local authorities and Local Health Boards commissioning services. In the case of local authorities, eligibility criteria for receiving services is generally set at 'critical and substantial need', a level too high to provide services aimed at early intervention and prevention. We have consistently argued that the funding and priorities for WAG need to reflect intelligence from front-line services. More action needs to be taken earlier to reach a wider proportion of the population but financial constraints and priorities mean that only those with serious levels of need do actually receive an assessment.

Specific key points

6. Any targeting of resources at clinical posts without sufficient resources for a whole system approach, will inevitably mean that the contribution of Local Government is ignored. We would argue that there is a potential increase in the requirement for social work and other council services, notably housing, advice services and of course social care itself, if we are to offer 'recovery' as a real goal.

7. We support the principle that any one of the partners could be the budget holder, but no one partner takes the lead in allocation of funds. We propose a Section 33 agreement before money is allocated, and we propose that this view is enshrined in the guidance accompanying the proposed Measure.

8. We endorse the support for the Recovery model and the Recovery approach which will help individuals experiencing mental health

problems to aspire to and achieve a good quality of physical, mental and social well-being. We welcome the move towards more holistic, outcome focussed planning of mental health services. However, the proposed Measure does not demonstrate an understanding of the principles of 'Recovery', as shown in some inconsistencies in the Explanatory Memorandum.

9. The language in the Measure doesn't address the wider target audience - it appears to target clinicians in the NHS. For example, local authorities do not provide 'treatment', and there should be a clear distinction made between a 'secondary care' service and a 'mental health' service in the proposed Measure. If the partners are to accept shared responsibility, language has to refer to, and appeal to, both local government and NHS bodies.

10. A cultural shift in primary care services is required if the implementation of the Measure is to be successful. With no duty on General Practitioners to engage, we will depend on their 'good will'.

11. We have a commitment to support local social services find a way through unhelpful professional and organisational barriers between partners.

12. We believe that access to services of the appropriate nature, and at the right time is crucial into improving the lives of those who experience mental illness. As such we supported the LCO as a mechanism that did not use chronological age as the crucial factor in determining the nature of the service offered. However, the proposed Measure does not pay due regard to the mental health needs of Older People.

13. The current scope of the Measure is heavily biased towards treatment for adult patients, and makes no specific mention of the needs of children and young people or Children and Adolescent Mental Health services (CAMHs). We are concerned that this may present a missed opportunity in terms of making improvements to CAMHs services. However, having said that we would caution against arbitrary extension of the Measure to cover children and young people, without further significant consideration and consultation as to where duties need to be applied in order to achieve sustained improvements based on evidence derived from the NSF and the recent Welsh Audit Office /Health Inspectorate Wales report.

Response to the Consultation Questions

Question 1: Is there a need for a proposed Measure to deliver its aims?
a) Providing local primary mental health service at an early stage etc.
b) Ensure all individuals have a care co-ordinator and, a care & treatment plan, and Service users previously discharged from secondary MH can re-refer themselves.
c) Advocacy provision beyond current arrangements

14. We welcome the fact that the Measure requires both the NHS and Local Authorities to work in partnership and are jointly accountable for agreed local and national outcomes. We believe this could be stronger in the drafting and subsequent guidance so that we achieve a shared ownership and shared responsibility.

15. There is general support for a primary care mental health service for people with mild and moderate symptoms as described in the paper as there is presently a gap in the system between primary and secondary care. However, as stated earlier, we have reservations about the resources required to provide such a service. We support, in principle, that primary care may best serve the community as the single point of entry. This would require a cultural shift for General Practitioners, and some investment is necessary to build in training and staff development for both health and local authority staff. What will be the safeguards to ensure that everyone in the NHS can and will meet these expectations?

16. We welcome the strengthening of the CPA so users, carers and families are involved in the design of a care service that meets the needs of the individual. However, the CPA plan is not just a clinical plan as implied but incorporates the social model of recovery. It is a target and audited against AOF, however, CPA implementation is patchy across Wales, and having it enshrined in legislation will prioritise CPA. We acknowledge that the use of the CPA is a start to follow and promote good assessment, and potentially should not need extra resources.

17. The CPA approach appears not to fit the reality of EMI service users so in this area there is potentially a failure to meet measures regarding CPA.

18. We support the provision for Care Co-ordinators, and propose that they are qualified social workers or qualified specialist nurses.

19. There is general agreement to the principle that service users should be able to re-refer themselves for an assessment following discharge from secondary care as it would offer a planned re-entry in the event of a genuine relapse. However, a gap exists where in the event of a relapse the discharged individual does not re-refer for various reasons, and the Carer or Next of Kin does not have a clear route to the secondary care services in order to support the individual who is cared for.

20. We welcome the move for self-determination by individuals accessing support via a strengthened advocacy system, and the entitlement for assessment. Clear guidance will be required on the 'role' of advocates, particularly for informal patients. Funding to provide 24 hour advocacy is required.

Question 2. How will the proposed Measure change existing arrangements and what impact would this have?

Question 3: Are the sections of the proposed Measure appropriate in achieving the stated aims?

21. The provision of adequate resource is our biggest concern especially when the timing for implementation of the Measure may fall at the most difficult times for the public sector. We will not be able to divert resources from other areas of mental health provision in local authorities, nor do we suspect, from NHS secondary care services to fund new arrangements. Securing and deploying adequate financial resources is not the only risk. All agencies will need to ensure appropriately skilled staff are available, and the integrity of existing Community Mental Health Teams (CMHTSs) cannot be compromised.

22. We consider a need for greater clarity on arrangements for people regaining access to services.

23. There are several inconsistencies in the Measure. For example, individuals have a right to assessment but there is no actual duty to treat, and that needs to be considered, so that it is not left to chance - what happens then?

24. We consider that advocacy is not a panacea for ensuring that individuals receive care and support with respect and dignity, and if people are to have advocates, then the arrangements must ensure that the provision of such a service is fit for purpose; that is, advocacy gives people experiencing mental health problems a voice in the decision making process.

Question 4 What are the potential barriers to implementing the Measure?

25. A significant obstacle will be the lack of sufficient resources. We would wish to work alongside WAG to refine a feasible costing assessment prior to giving.

26. Staff and advocates need additional training and development to provide safe assessments and representation, and this will cost.

27. What are the thresholds for re-referral to the secondary care services?

28. Unrealistic timescales to achieve service changes.

29. The mental health needs of older people have not been considered in depth.

Conclusion

30. We broadly support the proposed measure on mental health. We are concerned about the lack of realistic funding assumptions for the new arrangements. We would welcome further dialogue to investigate what is feasible and can be jointly supported.

31. The Measure is focussed on adult services. Strong links need to be made to the inter dependency and impact onto other client groups.

32. We would argue for caution in the drive to add on CAMHS to the proposed Measure.. There is much work to do to reconfigure CAMHS so that there is a clear view of the future model of CAMHS which can be adequately incorporated into the existing proposed Measure.

33. We welcome the focus on the Recovery model, and we would emphasise that central is the role of social work and the wider local authority role in supporting people beyond clinical treatment of a mental health disorder. The Measure should reflect this principle.

34. Finally, we welcome further engagement through this process so that we can assist, jointly with health, to provide high quality services for the citizens and communities in Wales.

END / May 2010

Signed:

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