Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Pwyllgor Deddfwriaeth Rhif 3
Legislation Committee No. 3

Dydd Iau, 13 Mai 2010
Thursday, 13 May 2010

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Christine Chapman	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)

Eraill yn bresennol
Others in attendance

Mary Burrows	Prif Swyddog Gweithredol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Chief Executive Officer, Betsi Cadwaladr University Local Health Board
Beverlea Frowen	Cyfarwyddwr Iechyd a Gofal Cymdeithasol, Cymdeithas Llywodraeth Leol Cymru Director of Health and Social Care, Welsh Local Government Association
Stewart Greenwell	Cyfarwyddwr Gwasanaethau Cymdeithasol Casnewydd a Chyfarwyddwr Arweiniol Iechyd Meddwl Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru Director of Social Services Newport and Association of Directors for Social Services Cymru Lead Director on Mental Health
Rob Merrill	Cyfarwyddwr Eiriolaeth Iechyd Meddwl De Cymru ac Ymddiriedolwr i Eiriolaeth Cymru Director of South Wales Mental Health Advocacy and Trustee for Advocacy Wales
Dr Lyndon Miles	Is-gadeirydd Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Vice-chair, Betsi Cadwaladr University Local Health Board

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Stephen Boyce	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Ruth Hatton	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Cynghorydd Cyfreithiol Legal Adviser
Carys Jones	Clerc Clerk

Dechreuodd y cyfarfod am 8.58 a.m.
The meeting began at 8.58 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **David Lloyd:** Croesawaf fy nghyd-Aelodau, swyddogion ac aelodau o'r cyhoedd i gyfarfod Pwyllgor Deddfwriaeth Rhif 3 Cynulliad Cenedlaethol Cymru. Bydd ein gwesteion cyntaf yn cysylltu gyda ni drwy fideo-gynadledda o'r gogledd—mwy amdanynt yn y man.

David Lloyd: I welcome my fellow Members, officials and members of the public to this meeting of the National Assembly for Wales's Legislation Committee No. 3. Our first guests will be communicating with us from north Wales through video-conferencing—more on them later.

[2] Yr ydym wedi derbyn ymddiheuriadau oddi wrth Joyce Watson.

We have received apologies from Joyce Watson.

[3] Mae gennyf rai sylwadau agoriadol i'w gwneud. Os bydd y larwm tân yn canu, dylid gadael yr ystafell drwy'r allanfeydd tân gan ddilyn cyfarwyddiadau'r tywyswyr a'r staff. Nid ydym yn disgwyl prawf y bore yma, na thân ychwaith. Dylai pawb ddiffodd eu ffonau symudol, eu galwyr a'u 'mwyar duon', gan eu bod yn amharu ar yr offer darlledu.

I have some opening remarks to make. If the fire alarm sounds, we should leave the room through the fire exits, following the instructions of the ushers and staff. We are not expecting a test, or a fire, this morning. Everyone should switch off their mobile phones, pagers and BlackBerrys, as they interfere with broadcasting equipment.

[4] Mae Cynulliad Cenedlaethol Cymru yn gweithredu'n ddwyieithog. Mae clustffonau ar gael i glywed cyfieithiad ar y pryd, a gellir eu defnyddio i addasu lefel y sain os ydych yn drwm eich clyw. Peidiwch â chyffwrdd â'r botymau ar y meicroffonau, oherwydd gall hynny amharu ar y system ddarlledu. Sicrhewch fod y golau coch yn disgleirio cyn dechrau siarad. Mae cyfieithiad ar y pryd ar gael ar sianel 1, ac mae darllediad gair am air a chwyddleisio'r sain ar gael ar sianel 0.

The National Assembly for Wales operates bilingually. Headphones are provided for simultaneous translation, and they can be used to adjust the sound volume if you are hard of hearing. Do not touch the buttons on the microphones, as that can interfere with the broadcasting system. Please ensure that the red light is showing before you begin to speak. Simultaneous translation is available on channel 1, while the verbatim broadcast and sound amplification is on channel 0.

9.00 a.m.

Mesur Arfaethedig Iechyd Meddwl (Cymru)—Sesiwn Dystiolaeth 4
The Proposed Mental Health (Wales) Measure—Evidence Session 4

[5] **David Lloyd:** Yn gefndir i hyn, byddwch yn ymwybodol mai swyddogaeth y pwyllgor hwn yw ystyried egwyddorion cyffredinol Mesur Arfaethedig Iechyd Meddwl (Cymru) a gyflwynwyd ar 22 Mawrth gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol, Mrs Edwina Hart, a chyflwyno adroddiad arnynt. Fel pwyllgor, mae'n rhaid inni gwblhau ein gwaith a gosod adroddiad gerbron y Cynulliad erbyn 2 Gorffennaf eleni. Dyma'r bedwaredd sesiwn dystiolaeth mewn

David Lloyd: As a background to this, you will be aware that the committee's role is to consider the general principles of the Proposed Mental Health (Wales) Measure, which was tabled on 22 March by the Minister for Health and Social Services, Mrs Edwina Hart, and to produce a report on them. As a committee, we must complete our work and present a report to the Assembly by 2 July of this year. This is the fourth evidence session in relation to the proposed mental health Measure. We have already taken cysylltiad â'r Mesur iechyd meddwl arfaethedig. Yr ydym eisoes wedi clywed tystiolaeth gan amrywiaeth o randdeiliad a hefyd y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol. Daw ein hymgynghoriad ysgrifenedig i ben ddiwedd yr wythnos hon, sef yfory, ddydd Gwener, 14 Mai. Gwelir manylion pellach am hyn ar wefan y pwyllgor.

evidence from a variety of stakeholders and from the Minister for Health and Social Services. Our written consultation concludes at the end of the week, namely tomorrow, Friday, 14 May. Further details about this can be found on the committee's website.

[6] Diben cyfarfod heddiw yw clywed rhagor o dystiolaeth ar lafar mewn cysylltiad â Mesur Arfaethedig Iechyd Meddwl (Cymru). Caiff y sesiwn ei hollti'n dair rhan. Yn y rhan gyntaf, bydd tystiolaeth gan fyrddau iechyd lleol. Yn yr ail ran, ceir tystiolaeth gan Eiriolaeth Cymru, ac yn olaf, tystiolaeth gan Gymdeithas Llywodraeth Leol Cymru a Chymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol. Fel y cyhoeddais eisoes, bydd y tystion cyntaf yn cyflwyno tystiolaeth drwy gynhadledd fideo. Felly, hoffwn groesawu Mary Burrows, prif swyddog gweithredol Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr, a Dr Lyndon Miles, is-gadeirydd Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr. Croeso twymgalon i chi'ch dau.

The purpose of today's meeting is to hear more oral evidence in relation to the Proposed Mental Health (Wales) Measure. The session will be divided into three parts. The firs session will be evidence from local health boards, the second part will be evidence from Advocacy Wales, and finally from the Welsh Local Government Association and the Association of Directors for Social Services. As I have already announced, the first witnesses will give evidence by video conference. Therefore, I welcome Mary Burrows, chief executive officer of Betsi Cadwaladr University Local Health Board, and Dr Lyndon Miles, vice-chair of Betsi Cadwaladr University Local Health Board. A warm welcome to you both.

[7] **Dr Miles:** Thank you.

[8] **Ms Burrows:** Thank you. Bore da.

[9] **David Lloyd:** Diolch ichi ymlaen llaw am eich tystiolaeth ysgrifenedig. Gan fod amser braidd yn dynn, a chan fod yr Aelodau wedi darllen eich papur, awn felly yn syth i holi cwestiynau, os yw hynny'n iawn gyda chi.

David Lloyd: Thank you in advance for your written evidence. As time is rather tight, and given that the Members have read your paper, we will go straight into questions, if that is okay with you.

[10] **Ms Burrows:** Yes, that is fine; thank you.

[11] **David Lloyd:** Yn ôl ein harfer, dechreuaf gyda'r cwestiynau cyffredinol cyntaf ar y Mesur arfaethedig. A ydych yn cefnogi amcanion cyffredinol y Mesur iechyd meddwl arfaethedig hwn? Gofynnaf i Mary ateb yn gyntaf.

David Lloyd: As is our way, I will begin with the first general questions on the proposed Measure. Do you support this proposed Measure's general objectives? I will ask Mary to answer first.

[12] **Ms Burrows:** If the overall aim of the proposed Measure is to improve access to mental health and early diagnosis for our citizens, then we support its aims in that regard.

[13] **David Lloyd:** Symudwn ymlaen i gwestiwn tebyg. A ydych yn credu y gellid cyflawni amcanion y Mesur arfaethedig drwy

David Lloyd: We will move on to a similar question. Do you believe that the proposed Measure's objectives can be achieved using ddefnyddio deddfwriaeth sydd eisoes mewn bodolaeth? Y rheswm yr wyf yn gofyn y cwestiwn hwnnw yw ein bod wedi clywed tystiolaeth yn barod y gellid cyflawni amcanion y Mesur arfaethedig pe bai polisïau a strategaethau presennol y Llywodraeth, megis y fframwaith gwasanaeth iechyd meddwl genedlaethol, yn cael eu gweithredu'n llawn. Beth yw eich barn ar y gosodiad hwnnw?

existing legislation? The reason why I am asking that question is because we have already heard evidence that the proposed Measure's objectives could be achieved if the Government's current policies and strategies, such as the national mental health service framework, were implemented fully. What is your opinion of that statement?

[14] **Ms Burrows:** I will start and, if you are happy to allow it, I would like Dr Miles to add his comments. In reading the background documents, and as the chair of the all-Wales adult mental health programme board with local government that is taking on some of the issues for dementia that the Minister recently announced, I know that some of the issues related to mental health at a time when we had 35 NHS bodies, and we now have only seven. So, there is an issue about scale and the ability to influence and improve access with fewer bodies, more peer review and direct performance management by the Minister and citizens than we had before. That is an issue that I would like the committee to consider. It could be seen as an indictment that we are seeking to use legislation for services that we should already be providing, and I accept the issues around that. However, the committee needs to take account of the NHS reforms that the Minister has implemented, which we have rightly supported and welcomed, and there is an opportunity for us to do so.

[15] The second point that I would like to make is that, in hindsight, nationally—by which I mean the United Kingdom—we lost an opportunity in the use of the general medical services contract to improve access to primary general practice services for mental health. It is a remedy that we could still apply, either within Wales or across the United Kingdom, to improve access in that regard.

[16] **Dr Miles:** The priorities and aims of the proposed Measure may be achievable under the existing legislation and performance management framework. However, we have endeavoured to improve mental health services for some years, and the advantage of the proposed Measure is that it will provide us with priority and focus—it will make it a 'must do', and a higher priority. Therefore, in that sense, I very much welcome the proposed Measure.

[17] **Ms Burrows:** I support those comments. The issue will be that, in supporting that approach, we will need to look at the implications of a legislative framework above that, in the Health Act 2009, and the implications of this kind of legislation for the NHS.

[18] **David Lloyd:** Yn eich papur, yr ydych yn mynegi pryderon ynghylch gosod gofyniad cyfreithiol ar fyrddau iechyd ac eraill, oherwydd,

David Lloyd: The question follows on from that, and is based on the paper that you submitted, where you expressed concern about placing a legal duty on health boards and others, since,

[19] 'It sets these aspects of service delivery aside from many other aspects of mental health service delivery and indeed the wider care responsibilities of the NHS in Wales.'

Yr ydych yn dweud bod risg o ddatblygu gofal gwasgaredig ac *'a prescribed model of care'* yr ydych yn honni y gall fod yn niweidiol i wasanaethau iechyd meddwl. A allwch esbonio eich pryderon, ac a oes ffordd

You say that there is a risk of developing fragmented care and 'a prescribed model of care', which you claim could be detrimental to mental health services. Can you explain your concerns, and, in your opinion, can the o wella'r Mesur arfaethedig, yn eich tyb chi, i osgoi'r fath bryderon yr ydych wedi'u hamlinellu yn eich papur?

proposed Measure be amended in any way to avert the kind of concerns that you have outlined in your paper?

[20] **Ms Burrows:** The issue for me is this: if you prescribe something, and you stick rigidly to it—and we have seen this in some guidance—you make it difficult within the service to change the model of care. For example, if new ways of working, further integration, or working with social services or the third sector were proposed, and you are in the situation of having your funding routine or other aspects of your work heavily prescribed, you cannot add to the service or change it because, in this case, you would be in breach of the law. Therefore, if we are going to have a legislative framework, we need to ensure that it is flexible to allow clinicians, service users and those involved in the partnership to meet need, but not so heavily prescribed that they are constantly looking to ensure that they not in breach of the law. The last thing we want to do is to create a defensive mechanism where clinicians in particular—by which I mean doctors—are looking to the Medical Defence Union to see whether they are going to be sued or face judicial review under a legislative framework of this kind.

[21] **Mr Miles:** I would like to explain the duty component of the issue. The National Health Service (Wales) Act 2006 places a duty on Ministers to promote NHS services, and that is then delegated to local health boards through directives, regulations, targets, and so on. Local health boards then have a duty to balance resources across the system and to provide services in a reasonable way. The process is open to consultation and engagement, as well as to performance review by Ministers. However, if there were a direct legal duty on health boards to provide, for example, the primary mental health support service in every general practice building, but we were for some reason unable to comply—due to sickness, staff shortage or an inability to recruit—we would become legally culpable and open to legal challenge. The risk is that in agreeing a local mental health scheme, the mental health partners will have to consider the services that they can guarantee to provide. Although we hope to improve these services, and we are determined to do so, the risk may be that, because of the legal duty issue, mental health partners have to consider the minimum that can be guaranteed. As a result, I have some concerns that the local scheme will be less ambitious than it otherwise might be.

9.10 a.m.

[22] **David Lloyd:** Mae cwestiwn atodol gan Helen Mary Jones.

David Lloyd: Helen Mary Jones has a supplementary question.

[23] **Helen Mary Jones:** I am not sure that I fully understand what you are saying. Dr Miles, you said earlier that one of the arguments for legislation was that we have been trying to drive up the quality and availability of mental health services for at least 10 years, and for various reasons that has not been successful; it has been patchy. Is that not an argument for a basic legal safety net below which local health boards and local provision cannot fall? I am not sure that I understand why that basic safety net would prevent local health boards from doing more or doing better. Forgive me if I have misunderstood the implication of what you were saying, but it sounded to me that what you were saying is that the legal duty to do some things might prevent you from doing others.

[24] **Dr Miles:** There is a difference between a duty to develop a plan, for example, and a duty to provide a service. This proposed Measure would put a duty on mental health partners to provide the services that they have agreed in the local plan. The duty to develop a local scheme is fine; the issue is the duty to provide the local primary mental health services that may be in the scheme. If we say that we will provide primary mental health assessors to make assessments, that is fine, but if we start quantifying what we do in terms of the number of

assessors or the types of services that we might ask them to provide, then that is a different legal framework to that we currently work in under the NHS (Wales) Act 2006.

[25] **Ms Burrows:** It would be an issue of constantly coming up against judicial review in that circumstance. If it is so heavily prescribed that we do not have flexibility, then the health service would be constantly subject to judicial review on mental health services, which I do not think is the aim of the proposed Measure. It would defeat what we are trying to do. It will all be in the construct, interpretation and application of the law.

[26] **David Lloyd:** Symudwn ymlaen i'r cwestiynau nesaf sydd dan ofal William Graham.

David Lloyd: We move on the next questions, from William Graham.

[27] **William Graham:** Could we turn to some of the definitions? Sections 1 and 5 provide definitions of 'local mental health partners' and 'support services'. Similarly, sections 11 and 12 provide definitions of 'relevant patients' and 'secondary mental health service providers'. Are you content that these definitions encompass all relevant parties?

[28] **Ms Burrows:** I will ask Lyndon to start on this one. There is an issue about confusion on definitions.

[29] **Dr Miles:** I am content with the definitions in sections 1, 5 and 12. My query is about section 11, with regard to the co-ordination of care planning, secondary mental health service users and the meaning of a 'relevant patient'. A relevant patient is someone who receives secondary mental health services. The definition of 'secondary mental health services' then goes back to the NHS (Wales) Act 2006. In essence, secondary mental health services are those provided by the NHS but excluding the various categories of general practitioner services, or section 117 of the Mental Health Act 2007, or indeed Schedule 1 to the NHS (Wales) Act 2006. In essence, it means all of the NHS services apart from general practitioner services. Unfortunately, I think that the term 'secondary mental health services' and the general term 'secondary care' are not helpful for the direction that the NHS is going in. We are trying to pull down the wall between what happens in primary care, what happens with traditional community mental health services and what happens within hospitals. With regard to Part 2, which is about co-ordination, the critical issue is that patients who are currently using mental health services actually need a co-ordinator. Our view is that most patients going through the system currently have a key worker and the co-ordinating role will strengthen that key worker's role. However, there are some patients who will attend community mental health services, that is, secondary mental health services, perhaps only on one occasion, who will have an assessment and be signposted to other services. That may be their only contact with secondary mental health services. Therefore, with regard to the meaning of 'relevant patient', we do not think that those patients who have a one-off contact need a case co-ordinator.

[30] **William Graham:** On the issue of the scope of the proposed Measure, witnesses from the voluntary sector have suggested that time frames should have been included on the face of the proposed Measure specifying a maximum period of 30 days between referral by a GP for assessment and the making of that assessment, and 60 days between qualifying as a patient under Part 2 and the completion of a care plan. Do you agree, given that the current annual operating framework targets are significantly longer?

[31] **Ms Burrows:** In essence, no. The reason for that has to do with the comments that we made earlier about prescription, and you have to look at the behaviours. The aim, through the annual operating framework, would be that we should bring those waiting times down. The issue is that if you specify a time and we do not meet that, we would be in breach of the law and therefore, again, subject to whatever the penalties would be. As Dr Miles outlined, if

somebody is sick and unable to attend, and you cannot provide cover for them on that day, that could mean that you fall outside the maximum period of 30 days. What would the consequences of that be for the individual, the service and the NHS? I think that we should use guidance, performance management and peer pressure, and I think that we should use the seven local health boards to do that. However, by specifying, you would be prescribing very tightly and I would avoid that in a legislative framework such as this and try to achieve it in a different way. That is my personal and professional view.

[32] **David Lloyd:** Diolch yn fawr. Mae’r cwestiynau nesaf dan ofal Peter Black.

David Lloyd: Thank you. The next questions are from Peter Black.

[33] **Peter Black:** The Assembly has competence to legislate in this area to ensure provision across all ages, but, in the main, the proposed Measure is confined to adults. In your evidence, you suggest that there is a need to provide for early intervention in the case of children with mental health problems. What is the case for extending the proposed Measure to encompass people under 18 years of age?

[34] **Ms Burrows:** Again, in terms of our trying to put our review together and look at the issue of equity, the question was posed as to whether we should be looking at children. Our advice would be that, because we have the comprehensive Children Act 2004, we should look at adults. If the legislation works, I would look to extend it to cover children. However, I would start with adults. We have a much more comprehensive framework around children and there are various measures for seeing children through early diagnosis and assessment through the child and adolescent mental health services and what we do on safeguarding children. Therefore, I would prefer to take it on in stages, rather than trying to deal with the services from cradle to grave in one piece of legislation.

[35] **Dr Miles:** I would agree with that.

[36] **Peter Black:** That is an interesting point of view, given that there has been constant criticism from the children’s commissioner and many others of child and adolescent mental health services. Clearly, there is a big issue about access to those services, particularly for those aged between 16 and 18. If you legislate for adults only, are you not in danger of widening the gap?

[37] **Helen Mary Jones:** May I just add to that? You will be aware of the work that the Health, Wellbeing and Local Government Committee did on community mental health services. One of the biggest issues was transition between children and adult services. Is there not a risk that if we enshrine that difference between children and adult services in the law, we perpetuate those difficulties with transition?

9.20 a.m.

[38] **Dr Miles:** I think that the intention and the principle behind what you say are very real and we would strongly support them. On dealing with children with mental health problems, and children’s care in general, with the legislation and guidance that we have already, it is everyone’s business. Speaking as a GP and primary care practitioner, when I see children with mental health problems, they require a service with a different skills set than that set out in the proposed Measure for adults that is before us today.

[39] It is true that we have had problems with the child and adolescent mental health service. There is a lot of work going on to improve access and we certainly need to improve CAMHS tiers 1 and 2. That is a major priority for us, but it is difficult, from a primary care perspective, to see that bolted on to the adult service at this stage because that service is provided by another vehicle.

[40] The issue of integration is crucial. Clearly because of transition, the services that provide for children and for adults have to work well together and we have to deal with that, but, like Mary, I am a little bit worried that if we try to bolt on children's services at this stage, that might undermine the good work done by CAMHS and the fact that children's work is everybody's business.

[41] **Peter Black:** Are we not in danger of confusing the provision of the service with the legislative framework under which that service operates? I understand that there is a different skills set involved in providing mental health services for young people as opposed to adults, but this proposed Measure is setting out the framework and putting in place rights and entitlements that should apply across the age range.

[42] **Ms Burrows:** I agree with that, but you are also specifying, to a certain extent, what the construct of those services should be and the scheme. So, my view would be that if it works well, then there is no reason why the Assembly could not extend that to cover children. It is six of one and half a dozen of the other. It depends on whether we can get the legislation framework right so that that will meet all of the needs. Again, this brings us back to my earlier point and to Dr Miles's point about prescription within the legislative framework.

[43] **Peter Black:** Moving on, the proposed Measure allows, but does not require, local mental health partners to include patients within the schemes that are not registered with a GP. Should local schemes be required to include non-registered patients to ensure that groups such as homeless people are not excluded, or is flexibility needed to tailor schemes for local needs?

[44] **Ms Burrows:** Again, Lyndon will give you a view as a general practitioner, but I would probably argue that there is a human rights issue here and that if you are in Wales, why should you be denied a service if you are not registered with a GP? Our view is that if we are going to provide services, we should provide for all of our citizens, whether or not they are registered with a GP.

[45] **Dr Miles:** I think, to a degree, that the point may become slightly academic if one considers the access points to the primary mental health service. As I understand it, those access points are through general practitioners or selected secondary care staff. As a GP, if I see a patient, that patient becomes registered as my patient, be that temporarily on an immediately necessary basis, or as a fully registered patient. In that sense, I see no difference at all. If I see a patient in front of me, that patient is my patient. On referrals from secondary care, I agree with Mary, in that I think that we need to open this up to all patients in the NHS.

[46] **Peter Black:** However, you would accept that there is a group of people who do not tend to be registered with GPs—an example that springs to mind immediately is homeless people.

[47] **Ms Burrows:** The other issue would be people who are on holiday, who may be registered with a GP in England.

[48] **Dr Miles:** On access, if a homeless person wants to access the primary mental health service, how would that person get into the service? As I understand it, we are considering that that person would go to the general practitioner or to secondary care services. If we were thinking of a route in apart from those two, it would be important to think that through. However, at the moment, because we are trying to get these services located in general practices, I think that those patients would attend a practice and become de facto patients of those doctors, and would consequently get access to a mental health service.

[49] **Ms Burrows:** For example, if someone arrives in an accident and emergency department who is homeless, who may have substance misuse problems and a mental health problem, do we provide a service for them or not, if they are not registered? My answer would be that we have a duty of care and a moral obligation to provide a service to them.

[50] **Peter Black:** If anyone presents, they will get a service—I accept that—but if they are outside of that, do not present and are on the streets, and if outreach workers approach them and try to deal with them, the fact that they are not registered could become a problem.

[51] **Dr Miles:** Yes, that is absolutely correct and we need to address that. However, in reality, I suspect that what might happen is that those outreach workers would communicate with the practice where the service was provided and those patients would become patients of that practice.

[52] **Peter Black:** Okay. What contribution could the proposed Measure make to the support and treatment of people with dementia in community settings? What issues do meeting the needs of this group raise for the implementation of the proposed Measure?

[53] **Ms Burrows:** That is a very relevant and important topic given that one in five of us will probably have dementia, and given our demographic profile of an ageing population. It is a real issue that we need to address. There is an issue around support in the community and support in general hospitals. If we look at people over the age of 65 in a general hospital ward setting, for example, over 60 per cent of them will probably have dementia. So, we need to think very carefully about the implications of the proposed Measure, and not only for the ability to provide the support service in terms of assessment, which would be their right, because there is also an issue about advocacy, which we will come on to later. So, the proposed Measure will support this, but there will be implications and an impact to take account of in the community and the hospital setting.

[54] **Christine Chapman:** Good morning to you both. You point out that social services' eligibility criteria tend to focus services on those with the most complex needs, which may be more restrictive than primary care mental health services. How should this issue be addressed by the proposed Measure?

[55] **Dr Miles:** This is a challenge. We need to integrate services as much as we are able to and provide a holistic service for patients. It will be the case that patients with lower-level mental health needs may have their wellbeing affected by poor housing provision, for example. Consequently, they may be referred for consideration to be re-housed. The receiving authority—the housing providers—will have to consider whether they are in a place to provide that housing. I suspect that the concerns are that, in many cases, they will not be able to provide because their threshold for provision will mean that they will have to focus on those with greater needs. It is very difficult for the proposed Measure to address that problem.

[56] **Ms Burrows:** This is where we probably come across the rub of it, which is that social services' provision is based on a needs assessment and the NHS is free at the point of delivery. It will be for the 22 local authorities, through the development of a scheme, to look at how they will resource that. Eligibility criteria are often a method of looking at how you scale that in terms of the services that you provide.

[57] On whether the proposed Measure could do anything legislatively to try to address some of those issues, I am not a lawyer so I do not have the skills to give an opinion on that, but it is something that will need to be addressed. We have tried to express today and in our written response that the development of a scheme in each of 22 local authority areas could lead to 22 different eligibility criteria, with the health service trying to provide a standardised level of access. I hope that that makes sense.

9.30 a.m.

[58] **Christine Chapman:** We are also taking evidence from the Welsh Local Government Association. On primary mental health assessments, you say:

[59] ‘The proposed Measure refers only to the requirement to provide assessments’,

[60] and that, for patients referred on to other services,

[61] ‘an effective response to the identified need is not necessarily guaranteed’.

[62] There is also no requirement to produce a care or treatment plan. Should the proposed Measure be strengthened in these respects?

[63] **Dr Miles:** This refers back to the issue of the duty of provision, which I understand is a complicated issue. Having a duty to make plans, to work in partnership and to develop a strategy—just as we have a duty to provide health, social care and wellbeing plans—is something that we welcome. Clearly, when we develop those plans, we must put in performance-management measures to ensure that we do the best that we can to deliver them. The problem is that, if we enshrine in law the duty of provision, it brings in a distortion, because the organisations have to deliver. I am sorry; I cannot remember what the substance of your question was.

[64] **Ms Burrows:** I will pick it up from here. We can do a plan and the assessment; it does not guarantee that there is going to be the sort of outcome, necessarily, that the aims of the proposed Measure are trying to get at. It is like saying that you can be ISO 9000 registered because you have gone through a process, but it does not mean that the quality of your product has improved.

[65] **Dr Miles:** I have regained my train of thought; the issue is that we can have a duty on mental health partners, but if there is a need for a referral to another agency, that agency will be operating within its own resource constraints and legal framework. In essence, mental health becomes everybody’s business; we cannot solve the difficulties that society has just through this proposed Measure. To my mind, each of those receiving organisations needs to operate within the parameters that they have, and I do not think that this proposed Measure can put a duty on those other organisations to deliver if they do not have the resources to do so.

[66] **Christine Chapman:** I will move on to Part 2, on the co-ordination of, and care planning for, secondary mental health service users. You say in your written evidence that the proposed Measure could make an important contribution to improving care planning, including clarifying the relationship between the care planning approach and unified assessments. How can these potential benefits be maximised?

[67] **Ms Burrows:** Again, this is where we get different directions in policies, so the unified assessment is across both health and social care; if you have mental health needs you will have an unified assessment, and you will also have another care programme approach. We are calling for some simplification and rationalisation in trying to marry the two systems, in order to give the best benefit that we can to the individual and their family. There will be issues with the administrative burden that some of this may cause because it is law—there will be a question of how it is audited and regulated—and we would make a plea for some unification and simplification of a range of different requirements if we are to meet the stated aims of this; that is what that comment is trying to get at. We are being governed by different things, and are required to provide different assessments using different forms, but the patient

is the same. You can imagine that, if it is confusing for the patient and the family, it is hugely confusing for the practitioners who are involved, and also introduces an element of risk because information is not shared or is lost in the process.

[68] **Helen Mary Jones:** I have a further question in relation to assessment and access to services. You welcome the provision in the proposed Measure to allow former users of secondary mental health services to re-refer themselves, but you also argue that a distinction is needed between those who have had brief contact with community mental health teams and those who have had a limited engagement. What are your reasons for making that distinction, and how should the proposed Measure reflect it?

[69] **Dr Miles:** It is a question of utilisation of services. This reflects some of the comments that were made earlier about case co-ordinators. We welcome the ability of those patients with significant mental health problems, who have been through hospital care, longer-term counselling and other treatment in the community mental health teams, to have access back into the service for a period of time. It is done in other parts of the service at the moment. For example, children who are discharged from hospital often have access back into the system quickly without having to go through the GP. The problem might come in that many patients have limited needs from community mental health services. They may go in for an assessment and may be signposted or have reassurance, but many will have lower mental health needs; we might call them ‘worried less ill’. If there is an enshrined right for them to access the service again, there are some concerns that these patients, because they feel that they need the service, might seek access back into the system. That will tie up some capacity that ought to be expended on those people who are more seriously ill.

[70] **Ms Burrows:** If we believe that the foundation of the NHS is built on the GP as the co-ordinator of our care, there is an issue about going around the GP. While I accept that people should be able to self-refer, we do not want to remove GPs from their important role, on which the NHS was founded. That is what is underlying some of this. We still need the GP to be involved in the co-ordination of care for people who have just had limited access, rather than going around them. Does that make sense?

[71] **Helen Mary Jones:** Kind of, although I think that one of the issues that the proposed Measure is seeking to address is the difficulty of getting GPs to see people and do the referrals, which is part of the point of people having a right to self-refer. Can we explore that a bit further?

[72] **Ms Burrows:** It comes back to the point that I made about the GMS contract and how we use it to ensure the quality and outcomes framework, for example, which I argued nationally many years ago should have been much more heavily weighted on mental health. Lyndon may have a view on that, but you are right that there are mechanisms that we can use to strengthen that element.

[73] **Dr Miles:** I do not want to contradict what Mary said. GPs currently have to make judgments on patients and try to predict the thresholds that are currently used by community mental health teams for treatment. Any reluctance to refer may, in part, reflect a perception among GPs that the community mental health teams do not have the capacity to deal with the problem at hand. With this proposed Measure, and with primary mental health services available in practice, the threshold for referral will come down. I do not think that there will be a problem with referrals from GPs.

[74] **David Lloyd:** There are four questions left and six minutes in which to answer them, so the questions and answers need to be focused.

[75] **Helen Mary Jones:** I have some questions on advocacy services. In your written

evidence, you state that absolute clarity is required regarding the provision of support to patients on general wards. Do you believe that advocacy services should be available to these patients and, if so, what are the likely challenges of implementing such a requirement?

[76] **Ms Burrows:** The moral imperative is ‘yes’. The issue is that, if you get admitted at 2 a.m., you will be sectioned, assessed, and released at breakfast time, so should you have an advocate? The issue is about how you operate that, and whether it is right. There is also an issue of capacity, which may be transient; we do not want to take away someone’s human rights. It is a measure of balance.

[77] **Helen Mary Jones:** Should the duty to provide advocacy services be extended to all users of mental health services, including those in community settings, or is that, again, a question of priority and capacity?

[78] **Dr Miles:** It is difficult to define patients with mental health problems. A huge number of the population will have mental health problems at certain times. Defining that for in-patients is a challenge. For example, there may be patients on general medical wards in varyingly confusional states. They are there because of a mental disorder, but are having a physical assessment. Providing advocacy for all patients with mental health problems would be an enormous challenge.

9.40 a.m.

[79] **David Lloyd:** Mae’r cwestiynau olaf dan law William Graham.

David Lloyd: William Graham has the final questions.

[80] **William Graham:** You will know that there are 17 provisions under which Welsh Ministers will be able to make subordinate legislation. Do you think that the powers to make regulations achieve the correct balance between powers on the face of the proposed Measure and powers given to Welsh Ministers?

[81] **Ms Burrows:** To be honest, having looked at it, I am not sure. However, in relation to the form of delegated powers that I have noticed under some of the information provided, it needs to be sufficient to prevent the need to change the legislation frequently. It is necessary to ensure flexibility, however that is done.

[82] **William Graham:** Does the regulatory impact assessment make a realistic assessment of the financial implications of the proposed Measure? If not, what are the shortcomings?

[83] **Ms Burrows:** No, it does not. I spent a lot of time going through it, and I believe that the costs are understated, which is recognised. The cost of non-compliance for a breach of the law has not been accounted for. Option 3 does not provide robust arguments, because it does not take account of NHS reform, so it leaves you with only option 2. The regulatory impact assessment needs further work.

[84] **William Graham:** Do you have any idea how much?

[85] **Ms Burrows:** How much further work it needs?

[86] **William Graham:** Yes.

[87] **David Lloyd:** How much money?

[88] **William Graham:** Yes, extra money, really.

[89] **Ms Burrows:** I think that £5 million is very much on the low side. It would be difficult for me to put a figure on it. I was doing the mathematics last night. I looked at the population figures of north Wales and then added dementia onto that and added advocacy for all of those, and I stopped at about £8 million. However, once again, those are rough figures. We need to look at the evidence and use international benchmarks to ensure that we get it right. The last thing that we and you want to do is to put in a really good Measure that we cannot deliver. That would be the worst of all worlds for everyone, particularly the individuals affected.

[90] **Peter Black:** Is that £8 million for north Wales or for the whole of Wales?

[91] **Ms Burrows:** I think that it is for the whole of Wales. I am sorry. [*Laughter.*]

[92] **Peter Black:** I was just checking. It was the way that you phrased it.

[93] **Ms Burrows:** I probably should have said that it was for north Wales, should I not?

[94] **David Lloyd:** Dyna ddiwedd y cwestiynau swyddogol ar gyfer y sesiwn hon. A oes gan y tystion unrhyw sylwadau terfynol cyn inni gloi?

David Lloyd: That is the end of the formal questioning for this session. Do the witnesses have any comments before we close?

[95] **Dr Miles:** I have only one comment to make. I did not intervene right at the start, but I would like to say that I greatly support the proposed Measure and I am really proud that we are taking this action and producing a Measure for Wales. We want it to work and it is just a matter of doing our best to ensure that no unintended consequences result from the proposed Measure. I warmly welcome and support it.

[96] **Ms Burrows:** I wholly support that view as well.

[97] **David Lloyd:** Diolch yn fawr am eich cyfraniadau'r bore yma. Bydd y clerc yn anfon trawsgrifiad drafft o'r trafodion atoch er mwyn ichi ei gywiro os bydd angen cyn iddo gael ei gyhoeddi yn derfynol. Diolch yn fawr am eich cyfraniad drwy fideo-gynadledda.

David Lloyd: Thank you for your contributions this morning. The clerk will send you a draft transcript of the proceedings in order for you to correct it if necessary before the final version is published. Thank you for your contribution via videolink.

[98] Symudwn ymlaen at ail sesiwn dystiolaeth y bore yma. Yn y sesiwn hon, byddwn yn holi Eiriolaeth Cymru. Galwaf ar Rob Merrill, cyfarwyddwr eiriolaeth iechyd meddwl de Cymru ac ymddiriedolwr i Eiriolaeth Cymru, at y bwrdd. Croeso ichi, Rob. Byddwch wedi clywed sut y mae'r pwyllgor yn gweithio. Yr ydym wedi derbyn eich tystiolaeth ysgrifenedig, felly gofynnwn gwestiynau sy'n seiliedig ar eich papur.

We will move on to the second evidence session this morning. In this session, we will be questioning Advocacy Wales. I call Rob Merrill, director of south Wales mental health advocacy and trustee for Advocacy Wales, to the table. Welcome, Rob. You will have seen how the committee operates. We have received your written evidence, so we will ask questions based on your paper.

[99] Mae'r cwestiwn cyntaf dan fy ngofal i—un o'r rhinweddau o fod yn Gadeirydd. A ydych yn cefnogi amcanion cyffredinol y Mesur arfaethedig ar iechyd meddwl?

I will ask the first question—that is one of the benefits of being the Chair. Do you support the overall aims of the proposed Measure on mental health?

[100] **Mr Merrill:** The main thrust of my contribution will be on the advocacy provisions, obviously. To give you some background briefly, Advocacy Wales is a small organisation that tries to provide an advocacy network for all sectors of advocacy provision in Wales. I cannot say that we are a comprehensive organisation, but we have about 20 members across the advocacy spectrum, for learning disability, mental health and so on.

[101] Advocacy Wales warmly supports the proposed Measure. We think that advocacy is important. It empowers vulnerable people, and I would suggest that there are no more vulnerable people in the country than people who have been sectioned under the Mental Health Act 1983 or who are in difficult situations informally on in-patient wards. We very much support the thrust of the proposed Measure's advocacy provisions, which are an add-on to the original independent mental health advocate proposals, but we have some reservations as a sector. As is often the case, the devil is in the detail. However, when it comes to increasing the empowerment of individuals and the status of advocacy in Wales, we are very much in favour of what is proposed.

[102] **David Lloyd:** Byddwn yn mynd i mewn i fanylion yr eiriolaeth wrth i'r cwestiynu fynd yn ei flaen, felly cewch digon o gyfle i wyntyllu eich pryderon amdanynt. Yn dilyn y cwestiwn cyntaf, a ydych yn credu y gellid cyflawni amcanion y Mesur arfaethedig drwy ddefnyddio deddfwriaeth sydd eisoes mewn bodolaeth, neu a oes wir angen y Mesur arfaethedig ychwanegol hwn?

David Lloyd: We will go into the detail of the advocacy as the questioning advances, so you will have plenty of opportunity to air your concerns about the detail. On the back of that first question, do you think that the aims of the proposed Measure could be achieved by using the existing legislative framework, or is there a real need for this additional proposed Measure?

[103] **Mr Merrill:** I think that we need the proposed Measure. I will jump to the informal patients. There are advocacy schemes that encompass pretty much all in-patient units in Wales at the moment, but they are informal, ad hoc and often underfunded. Above all, they do not have the punch of a legislative framework. My day job is director of South Wales Mental Health Advocacy, which is the biggest provider of IMHA services in Wales. That sounds quite dramatic but, in fact, we are talking about fewer than seven members of staff. Since the IMHA service has come in, we have found that the balance of power and the dynamics between patients and services have changed with the help of advocates. We are only facilitators in the process, but we find that a great deal more is done and that clients' views are recognised as a result of the statutory provision that is proposed in this.

[104] **William Graham:** You state in your written evidence that Advocacy Wales members believe that there will need to be a clear definition of 'in-patient' in the proposed Measure. Would you like to enlarge on that?

[105] **Mr Merrill:** Yes. That has not come from my organisation, but some members are concerned about definitions. First of all, on informal patients, some informal patients are on the books of an in-patient unit but may not be there for weeks on end. They are registered, but they are not there. So, if they come into the unit only once every few weeks, but are registered there, do they qualify as an in-patient or as a community patient? That sort of issue needs to be clarified.

[106] The other issue, which I think will be touched on this morning, is what counts as an in-patient on general wards, where there are surgical as well as mental health issues? Not only will advocates or advocacy organisations need to know what they are expected to do and what the legal requirements are, but service providers will, too, and there are thousands of them. All a trust's staff will need to be clear on when a person is an in-patient and therefore qualifies for advocacy. We are looking for the proposed Measure to pin that down clearly.

[107] **William Graham:** Could I draw you on some of the definitions? Sections 1 and 5 provide definitions of 'local mental health partners' and 'support services', and similarly, sections 11 and 12 provide definitions of 'relevant patients' and 'secondary mental health service providers'. Are you content that those definitions encompass all relevant parties?

[108] **Mr Merrill:** Yes. It is not an area on which I am an expert, but our feeling is that they are sufficient for the purpose and provide enough flexibility. I am not a lawyer and I am not a mental health professional, as such, but I see no problems with those definitions. They are pretty much all-encompassing.

[109] 9.50 a.m.

[110] **William Graham:** On the age range, the Assembly has competence to legislate in this area to ensure provision across all ages, but the proposed Measure, in the main, is confined to adults. Witnesses have argued that it should be extended to include children and young people. What is your view?

[111] **Mr Merrill:** The advocacy provision will encompass children and young people, as the current IMHA service does. From an advocacy perspective, I do not see a problem. I am not expert enough to talk about primary care issues, and perhaps others have come here on that basis, but in respect of advocacy, it is as we are. As an IMHA service, we currently deal with people of all ages, and I assume that the proposed Measure will continue with that definition.

[112] **Peter Black:** From the point of view of an advocate, if different age groups have different entitlements to a different framework, will that cause a problem advocating on their behalf?

[113] **Mr Merrill:** You need the specialism, without a doubt. There is an advocacy qualification, for instance, which has a specialism in children's advocacy, and there is no doubt that mental health advocacy organisations will need to upskill on this and specialise. So, we envisage there being a specialist children's advocate, as it is a slightly different skill set.

[114] **Peter Black:** So, although the advocacy provisions here are not age-specific, the fact that other parts of the proposed Measure are could cause issues for you, as advocates, in respect of what different people are entitled to.

[115] **Mr Merrill:** We would need specialist input into that. There are special skill sets for advocacy. Is that what you are getting at, about how we would approach the various—

[116] **Peter Black:** I am getting at the fact that the rest of the proposed Measure, apart from the advocacy provision, relates entirely to adults, which means that it is setting down particular entitlements and a framework under which adult mental health services can be provided, which does not apply to those under the age of 18.

[117] **Mr Merrill:** No, but, as IMHAs, we already work in child and adolescent mental health units, so we understand the different frameworks under which children's advocacy operates. We would need to upskill on that to make sure that we have the capacity and expertise to deal specifically with children's advocacy issues.

[118] **Peter Black:** Fair enough. Members of Advocacy Wales have expressed concerns about the role of advocates in supporting patients who qualify under short-term and emergency powers. What more can you tell us about those issues and how they might be addressed?

[119] **Mr Merrill:** There are two issues that emerge. Most of the IMHA services of Wales—I think that it is six out of seven—are members of Advocacy Wales. The feedback on this has clearly come less from the general advocacy sector and more from the specific IMHA service. I have been talking to colleagues over the past couple of weeks about these provisions. It is to do with cost versus benefit, in one sense. It is a question of what we would need to do to be available for these short-term sections, for instance by extending hours of work. That is the first thing. At present, advocacy services tend to be 9 a.m. to 5 p.m. Monday to Friday, and are not an emergency service, but the talk, originally, was almost of provision for 24 hours a day, seven days a week. I made a very unfunny joke that I was busy costing up the price of two helicopters to get my staff from one end of the country to the other to hit the deadlines for these things. However, I think that that has moved on slightly to the idea of having five-day-a-week provision, possibly with an on-call system, very much like the crisis community mental health teams. That is to get to short-term section clients as soon as is practicable, which might be the next working day. Even the cost of an on-call system is considerable.

[120] Turning to short-term or emergency sections, and particularly the police section, which is of most concern, people on short-term sections are, by definition, very ill. Would they want us to play our role? Will they understand our role? Risk management is also a concern. If social workers and psychiatrists concern themselves with risk management in a police station in respect of a client who is in difficult circumstances, why should advocates be any bolder in treading into that area? The ability to engage is therefore questioned. Even if we were to engage, what can we tell people on short-term sections? They have no rights, so what can we say? We could say, ‘We are an advocate and if you move on to a longer-term section, if you are discharged, or if you come in as a formal patient, then we can support you’, but they have very few rights on the short-term sections.

[121] This is not the universal view. At least one of my colleagues has said that that would be the start, and that engagement on the short-term section would be a continuum. If an informal patient has been sectioned under the nursing section, it is quite likely that they will have seen an advocate before, because the second part of the advocacy provision allows them to do so, and so they may know about advocacy. However, we worry about how good a job we can do at that point and what we, as advocates, can really do.

[122] I know that one of my colleagues in the IMHA service has submitted evidence asking whether it is an advocacy role at all. There is the role of the appropriate adult in the police station, so could that person fulfil this role, too? There are sometimes nurses in police stations these days. So, what is the purpose of an advocate? I was in London yesterday talking to the chief executive of Action for Advocacy, which is Advocacy Wales’s big brother in England, and the chief exec said that that job might well be done by a closed-circuit television camera, if you are looking to protect the person’s human rights. What can an advocate offer in those circumstances? Those are the sorts of issues that have come up. That view is not universal, and one of my colleagues is adamant that that is an opportunity to develop advocacy and to develop this as a continuum. Advocacy may have happened before, and it may happen afterwards. That is not a universal view, but there are concerns about the costs and benefits of putting so many resources into short-term sections.

[123] **David Lloyd:** That is a very full answer, and I think that it has taken care of about three of your questions, Peter.

[124] **Mr Merrill:** I am sorry about that.

[125] **David Lloyd:** Do not be. It is very helpful. In fact, I see that you have covered them all. Excellent. Let us move onto Helen Mary Jones.

[126] **Helen Mary Jones:** That took me a bit by surprise, Chair.

[127] Your members have expressed concerns about the impact on existing advocacy services of making new statutory provision, for example with regard to the status of non-mental-health advocacy. How do you see the new duties fitting in with the existing advocacy framework, and how would you like to see those concerns addressed in the proposed Measure?

[128] **Mr Merrill:** Our non-IMHA and particularly our non-independent mental capacity advocate colleagues are very jealous of the IMHA service. People look at IMHA and IMCA and see them as the top of the tree, because they are statutory advocacy services. Other services tend to be ad hoc and limited, and many of them are based on grants from the lottery or Lloyds TSB, through the trust. Others are based on grants from local authorities, and are fairly short term. Advocacy provision in Wales is all a little ad hoc. The proposed Measure is pushing for a statutory service, and statutory services tend to rise to the top of the pile. It is just a worry that that sort of downgrades the prestige that is given to the IMHA service—and that prestige is welcome—which could psychologically downgrade other forms of advocacy. I do not really know how to address that in the context of the proposed Measure. We just need to be careful that this money does not push out existing funding from the advocacy sector as a whole.

[129] **Helen Mary Jones:** That is fair point. It is probably not a matter for this committee, but more for the policy and resources of different Government departments.

[130] Do you think that the proposed Measure should be strengthened to ensure that service users have a choice of advocacy provider, or is that unrealistic, given the resources?

[131] **Mr Merrill:** Given how it is commissioned, there would be only one IMHA in an area for them to choose. The area in which my organisation works encompasses 10 local authorities in south-east Wales, and there are other advocacy organisations, and the service users might be able to choose an informal, generic advocate, but that advocate will not have the legal back-up of an IMHA. There is no choice between equals. That is, there is no choice between two IMHA services at the moment, although we look for choice.

[132] The other issue is funding. If the service is seen to be funded, under statute, who will fund non-statutory services in an area? If all the ground is covered, where does the second layer of advocacy come from? Organisations are likely to fold, and it will reduce choice in that sense. There is no easy answer to that question, but it is likely to reduce choice for clients, as a couple of my colleagues have mentioned.

[133] **Helen Mary Jones:** I suppose there is always a balance to be struck. Having access for everyone may mean that there is less choice for a few, and the Government will have to consider that.

10.00 a.m.

[134] Looking at the independence of advocacy services, your written evidence states that providers of statutory advocacy services could be compromised by commissioning arrangements and find it harder to meet the independent standards in the national A4A standards. Is there evidence that this is currently an issue for the providers of statutory advocacy services? If so, how should the proposed Measure, or regulations and guidance, address the issue?

[135] **Mr Merrill:** I have not come across it in my organisation but, anecdotally, colleagues

have told me about a couple of situations. In one, an advocacy organisation was clearly told to back off by a service provider—told that they should not pursue the issue in question. Another was at a difficult meeting where funding options were being discussed, and the client was looking at the more expensive option while the provider wanted a less expensive one, and there was a bit of acrimony, and my colleague was pointedly asked, ‘Do we fund your organisation?’. That was clearly a pointed question. In fact, they were not the funders, so it was not an issue, but you can see where these are coming from. Advocacy is an odd profession, in that the more successful and effective we are, the more people we upset. That is an issue that we have to live with. That is why we are fixated on independence and on not being swayed by external factors, in particular funding.

[136] The other issue is that this kind of funding would become overwhelming. If you take my organisation as an example, at the moment some 25 per cent of our income comes from the independent mental health advocacy service, and the rest comes from seven or eight local authorities and the local health boards—the former NHS trusts—as well as some private contracts. If the proposed Measure comes into force and we become part of these new funding arrangements, they will provide something like 70 or 80 per cent of our funding, or even more, plus the [*Inaudible.*]. You can see where the danger lies. Moreover, when we were funded at arm’s length, there was a provider-commissioner split, but that is no longer there. We go into LHB-run units on a regular basis, and we upset staff—not deliberately, but on behalf of clients, to empower them. Somewhere in the hierarchy of the local health board is the person who makes a decision about the service and who is to fund it, because it does not have to be done by us.

[137] **Helen Mary Jones:** You have made a good case. Would you want us to suggest that the regulations and guidance should set out a separate funding arrangement for advocacy services? Just speculating, I wonder if that could be similar to funding for the children’s national advocacy unit, where the unit is separate—would you want to see the funding split from the local health boards?

[138] **Mr Merrill:** That is a radical proposal that I had not thought of. I would not want to see a national advocacy service, but in terms of how the money comes to us—

[139] **Helen Mary Jones:** In terms of where the money comes from.

[140] **Mr Merrill:** That would help greatly. It would develop independence in advocacy standards. The other way of doing it, although it is less radical, is to ensure that our contracts reflect the guidance in the proposed Measure and the commissioning documents, so that the commissioners recognise advocacy quality standards and the importance of independence. If they sign up to that, and we sign up to that, in any dispute we can point to the contract and say that they have signed up to it and agreed to our independence, irrespective of how much difficulty we might be causing individual trust staff. That is a safeguard that you might look at. Direct funding is a stronger safeguard, and an interesting idea. It is hard for me to say, because this is new to me, but I would suggest that the IMHA providers would welcome that approach.

[141] **Helen Mary Jones:** On a slightly different tack, it has been suggested that the framework for advocacy should be flexible enough to allow family and friends to provide formal representation. I will be truthful and say that I have some concerns about that, but does Advocacy Wales have a view? Should the framework be flexible enough to allow that?

[142] **Mr Merrill:** Could you clarify what you mean? Is it that they would have a formal right to be involved in an advocacy process?

[143] **Helen Mary Jones:** Yes, that they could be nominated as the formal advocate.

[144] **Mr Merrill:** That is fundamentally opposite to the principles of advocacy. We work for the client, and if the client wishes, and gives us permission in writing, to involve carers, friends and family, then we do so. Otherwise, we do not involve them, and there are good reasons for that. Even in the best of relationships, their agenda will be different from that of the client, and in the worst cases—and I hate to say it—the carers and those around the client can be part of the problem rather than the solution. It does not happen often, but we can find that that is a major issue with our clients. That is why we focus on the wishes of the client and no-one else's.

[145] **Christine Chapman:** I want to ask you some questions about community advocacy. In your evidence, you suggest that the absence of proposals for statutory community advocacy is a weakness of the proposed Measure. What is the case for including duties around community advocacy?

[146] **Mr Merrill:** We are slightly frustrated in reading the proposed Measure because two of the first three proposals dealing with primary care are crying out for the inclusion of advocacy. It is almost as though the absence of the term 'advocacy' is a typographical error. When we are talking about accessing services in primary care and secondary services, yes, the right to look to access services is there, but it is not a statutory right to receive them, and that is a huge advocacy role. I did a quick calculation and found that there is already community mental health advocacy provision in 17 of the 22 local authority areas; there is no professional paid advocacy in the other five. Where there is provision, we know that it makes a difference. We know that it supports clients and that it can certainly delay, and sometimes prevent, people's having to move into secondary services. We know this. This is about nipping issues in the bud with support from advocates. We provide community advocacy as an organisation in three areas of south-east Wales. We know, anecdotally and from our figures, that it makes a great difference to our clients. Given that the thrust of the proposed Measure is about keeping people in the community and supporting them at an early stage, we ask why on earth advocacy is not part of the support mechanism.

[147] **William Graham:** I am sorry, but could we go back to the question about having a friend provide formal representation? It is a question that we also asked the Deputy Minister. Where someone has severe dementia or other severe mental problems, how are they able to differentiate and give you that consent?

[148] **Mr Merrill:** I am talking specifically about people who have the capacity to instruct us. There is a different issue with people who lack that capacity, and our engagement with them is much less. In those cases it is to do with keeping a watching brief on legal rights. We cannot second-guess their needs. That is an entirely different area of operation.

[149] **Christine Chapman:** Is the proposed Measure likely to create any capacity issues for the independent advocacy sector? If so, how should they be addressed?

[150] **Mr Merrill:** In terms of building capacity?

[151] **Christine Chapman:** Yes.

[152] **Mr Merrill:** It is a huge ask to develop it. We talk about an independent mental health advocacy service, but we need to get an idea of how limited the scale is. The IMHA service in the whole of Wales is currently being provided by not many more people than are sitting in this room. There are 15 full-time equivalents, I think. For all organisations to develop that by some 250 per cent, which is what I think we are looking at over two years with these funding proposals, to develop the capacity to recruit and train people, and to develop core funding and infrastructure is a lot to ask. As I said, my organisation is the largest

IMHA service in Wales at present. We have just under seven full-time equivalent advocates working on IMHA and another five, six or seven working on other projects. So, we have 15 advocates and we are, by far, the biggest independent mental health advocacy charity in Wales. In Powys, there are two part-time independent mental health advocates for the whole of the county working for the community health council, so you can see what the capacity issues are for developing the sort of services that we are talking about rolling out not only to emergency sectors, but to large numbers of informal clients. They are starting from an extremely low base, and I think that there will be support issues. I know that some pre-implementation money is available. Careful thought needs to be given to how that will be used to develop capacity in smaller organisations.

10.10 a.m.

[153] **Christine Chapman:** And travelling, by the sounds of it, what with there being so few advocates.

[154] **Mr Merrill:** Absolutely.

[155] **Christine Chapman:** Moving on to funding arrangements, the regulatory impact assessment for the proposed Measure indicates that local health boards will be provided with an initial £0.25 million and £1 million in recurring funding for advocacy services for informal patients. Will this arrangement ensure that independent advocacy providers can meet demand for these services, and does the regulatory impact assessment make a realistic assessment of the financial implications of the proposed Measure? If not, what are the shortcomings?

[156] **Mr Merrill:** In terms of the advocacy proposal?

[157] **Christine Chapman:** Yes.

[158] **Mr Merrill:** Again, my colleagues are in dispute on this. In some areas, especially in the north where current provision is quite thin, and there are rurality and language issues, some people are quite concerned about the amounts. On the short-term sections, it very much depends on what is expected of us. We will not be able to provide a 24/7 advocacy call-out service—nothing like it—but if it is a more limited service, then these issues have been discussed with the Welsh Assembly Government officials who are concerned with the proposed Measure. They have been very robust about it. I must say that the engagement of the Welsh Assembly Government with the advocacy service has been exemplary—we have been included in what has been discussed.

[159] At the end of the day, this very much depends on what is expected of the service. Clearly, it is not going to be a full-blown emergency service in the short-term sections. From my perspective, it is doable; it is not generous, but according to my organisation's submission, it is adequate for purpose and that is also true for the informal patients. What we are worried about is dementia issues and the fact that it takes a lot longer to engage with someone who is elderly and mentally ill than it does with someone younger. That is perhaps too general a point, but I am talking about people noticing the service and becoming comfortable with discussing issues.

[160] The other point is how the issues in terms of the general wards pan out and what is expected of us when getting to non-mental-health units to see people who clearly have mental health issues. That comes back to the definition of 'in-patient'. Given all of those factors, it is a bit of an unknown quantity. One thing that we would hope to do would be to revisit this in a year or 18 months and have honest discussions with commissioners and say, 'Yes, it has been fine', or 'Sorry, these issues have come up'. There may be unintended consequences, as I mentioned this morning, and we may need to revisit it. I do not think that this could be set in

stone; we would have to monitor the situation.

[161] **David Lloyd:** Mae gan William Graham y cwestiwn olaf.

David Lloyd: William Graham has the final question.

[162] **William Graham:** On powers to make subordinate legislation, a number of sub-sections in the proposed Measure give Welsh Ministers the power to make regulations. Do you think that the proposed Measure achieves the correct balance between the powers on its face and the powers to be given to Welsh Ministers to make regulations?

[163] **Mr Merrill:** It is not an area that I am familiar with. Our gut feeling is that whatever provides most flexibility, allows for any changes or developments and provides that balance is probably the best approach.

[164] **David Lloyd:** Dyna ddiwedd y cwestiynau swyddogol. Diolch, Mr Merrill, am eich cyfraniad y bore yma. A oes gennych sylw terfynol cyn inni gloi'r sesiwn?

David Lloyd: That is the end of the official questions. Thank you, Mr Merrill, for you contribution this morning. Do you have a final comment to make before we close the session?

[165] **Mr Merrill:** My organisation is grateful for the opportunity to present to you this morning. Thank you all very much.

[166] **David Lloyd:** Bydd y clerc yn anfon trawsgrifiad drafft o drafodion y bore yma atoch i'w cywiro os bydd angen. Diolch ichi unwaith eto. Dyna ddiwedd y rhan hon o'r sesiwn.

David Lloyd: The clerk will send you a draft transcript of this morning's proceedings for you to correct if necessary. Thank you again. That is the end of this part of the session.

[167] Cawn egwyl fer am 10 munud cyn ailddechrau gyda'r drydedd rhan o'r sesiwn yn holi Cymdeithas Llywodraeth Leol Cymru a Chymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol.

We will now have a short break of 10 minutes before we start the third session when we will ask questions of the Welsh Local Government Association and the Association of Directors of Social Services.

Gohiriwyd y cyfarfod rhwng 10.14 a.m. a 10.30 a.m.
The meeting adjourned between 10.14 a.m. and 10.30 a.m.

[168] **David Lloyd:** Hoffwn eich croesawu i gyd yn ôl i'r drydedd sesiwn dystiolaeth lafar y bore yma. Hoffwn groesawu i'r sesiwn gwestiynu nesaf—sef yr un olaf y bore hwn—Beverlea Frowen, cyfarwyddwr iechyd a gofal cymdeithasol Cymdeithas Llywodraeth Leol Cymru a Stewart Greenwell, cyfarwyddwr gwasanaethau cymdeithasol Casnewydd a chyfarwyddwr arweiniol ar iechyd meddwl Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru. Dyna un o'r teitlau hiraf mewn bodolaeth, yr wyf yn credu. Croeso i'r ddau ohonoch.

David Lloyd: I would like to welcome you back to the third oral evidence session this morning. I would like to welcome to the next questions session—which is the last session of the morning—Beverlea Frowen, director of health and social care for the Welsh Local Government Association, and Stewart Greenwell, director of Newport social services and the Association of Directors for Social Services Cymru's lead director on mental health. That is one of the longest titles in existence, I believe. Welcome to you both.

[169] Yr ydym wedi cael eich papur ysgrifenedig, felly, yn ôl ein trefn arferol awn

We have received your written evidence, therefore, as is our usual practice, we will go yn syth at y cwestiynau, os yw hynny'n iawn gennych. Byddaf yn gofyn y cwestiwn cyntaf. Dyna un o rinweddau bod yn Gadeirydd y pwyllgor hwn; yr wyf yn cael dechrau gofyn y cwestiynau cyffredinol. A ydych yn cefnogi amcanion cyffredinol y Mesur arfaethedig ar iechyd meddwl?

straight to questions, if that is okay with you. I will ask the first question. That is one of the merits of being Chair of this committee; I get to ask the first of the general questions. Do you support the overall aims of the proposed Measure on mental health?

[170] **Mr Greenwell:** The simple answer is 'yes'.

[171] **David Lloyd:** Great, that is the kind of answer that we like. [*Laughter*.]

[172] **Ms Frowen:** Would you like me to qualify that?

[173] **David Lloyd:** Yes.

[174] **Ms Frowen:** We support the principle, as we have said in our evidence, but, as we go through this morning's evidence session, I will be a bit like a broken gramophone record in repeating that we are extremely worried about the funding implications and the capacity to do this.

[175] **David Lloyd:** Fine. There will be specific questions later on those issues, so do not worry.

[176] Hoffwn ofyn cwestiwn cyffredinol arall: a ydych yn credu y gellid cyflawni amcanion y Mesur arfaethedig drwy ddefnyddio deddfwriaeth sydd eisoes mewn bodolaeth?

I would like to ask another general question: do you believe that the aims of the proposed Measure can be achieved using existing legislation?

[177] Stewart, perhaps you can give a longer answer this time; I will not stop you.

[178] **Mr Greenwell:** I will certainly try to do so. Within the existing legislation, the danger is that the focus is on people who have been formally admitted into the system. Our concern would be to extend the eligibility for a service much wider than that, and we therefore support the proposed Measure.

[179] **Ms Frowen:** We all recognise that if we intervene earlier and have better, adequately resourced preventative services, we prevent an awful lot of problems later on. It is a general statement. We would love to be doing that with all services. This has been around for many years; it is not new. We have struggled with making primary care fit for lower, mild, moderate and early intervention categories. With those caveats, yes, we would like to extend the service.

[180] **William Graham:** Sections 1 and 5 provide definitions of 'local mental health partners' and 'support services'. Sections 11 and 12 provide definitions of 'relevant patients' and 'secondary mental health service providers'. Are you content that these definitions encompass all relevant parties?

[181] **Mr Greenwell:** The simple answer is 'no'. I will expand on that. The legislation needs to recognise that the health service and local government commission a considerable number of services from other bodies. The legislation needs to make it clear that those parties would be affected by the legislation, in the sense that they carry out the statutory responsibilities of both the health service and local government.

[182] **William Graham:** Witnesses from the voluntary sector have suggested that time frames should be included on the face of the Measure, specifying a maximum period of 30 days between referral by GP for assessment and the making of the assessment, and 60 days between qualifying as a patient in part 2 and the completions of a care plan. Do you agree, given that current annual operating framework targets are significantly longer?

[183] **Mr Greenwell:** The targets could be challenging but, in principle, it is good to have targets to discover whether they improve the services for people. Anyone experiencing a mental health problem should not have to wait a long time for an assessment following referral; that is the overriding principle. For those individuals experiencing a serious mental health disorder, a delay of up to a month could result in deterioration and enormous risks. So, setting the targets is a good principle. They bring challenges with them in terms of analysing whether or not we have the capacity in the system to meet those targets, the capacity being the people, such as community psychiatric nurses, psychiatrists and social workers.

[184] **Christine Chapman:** There have been differences of opinion about the balance between the time frame and the quality of care. Can you say anything about that, as we have had different views on this?

[185] **Mr Greenwell:** These timescales should not interfere with quality at all. It would be helpful, if they were introduced, to look at them over the first year to see whether quality had improved and whether people had got access to services quicker as a result. There is some evidence that says that the sooner that you get to people, particularly people with the early signs of mental disorder, the better the position that you are in to provide a whole range of services, which may not simply lead to someone going into hospital.

[186] **Christine Chapman:** On that, even at the lower end of the spectrum, if there is a target of 30 days it will take 30 days, when it could take five days. Do you think that people will just work to the target? Is that a danger?

[187] **Mr Greenwell:** On the other side, if you do not have a target, the danger is that it might take even longer. My concern would be that those targets in themselves are still challenging in terms of having the resources to meet them. The majority of mental health professionals would recognise that when someone needs help, you need to get it to them very quickly—five days is often too long.

[188] **Helen Mary Jones:** I am inclined to agree that targets are necessary. Some of the witnesses from the voluntary sector want to see those on the face of the proposed Measure. The problem then is that changing the target becomes quite a complex process, because you must propose a formal amendment that has to go through all of these processes. Given that you are clear that targets are needed—whether or not these are exactly the right ones—should they be on the face of the proposed Measure, or would guidance and regulation be a better place for them?

[189] **Mr Greenwell:** In my view, the best place is in guidance.

[190] **Ms Frowen:** Absolutely. That should be underpinned by really good ongoing evaluation, linked to outcomes, people’s perceptions of the service and all the things that we have. You are a hostage to fortune if you start to prescribe targets in legislation.

[191] **William Graham:** You state in your evidence that the proposed Measure is inconsistent in that it provides for assessment, but that there is no actual duty to treat. Should such a duty be included in the proposed Measure?

[192] **Mr Greenwell:** We believe that a duty to assess without a duty to treat is almost

worthless. That is why we have said what we have said in the written evidence. Without a duty to treat, particularly given the difference in the eligibility criteria between local authorities that people need to meet to access the services, people with mild to moderate symptoms could fall out of the system altogether, and that is what we want to avoid. In a sense, it is what the proposed Measure is trying to avoid as well.

[193] **Ms Frowen:** However, if you start putting in duties to treat but there are not the resources and capacity to treat, you are still doing the individual an injustice. All you will then have is people playing around with the system, whereby you will wait longer to receive care. You will not be refused care, but it will be rationed in all sorts of ways and so that is a tricky issue.

10.40 a.m.

[194] We all want this to work; we do not want to set up something that fails. We do not want to be promising things to an individual that we cannot deliver and nor do we want to put extra strain on professionals. So, this is about getting that thorough understanding of whether the capacity is in the system so that when we start to say that we will do something for someone, we can actually do it.

[195] **Mr Greenwell:** It is important that treatment is not just seen as hospital admission, and that might require a redefinition of 'treatment'. Following assessment, the service provided—and I would prefer to describe it as a service that might need to be provided to someone—might have nothing to do with a hospital admission, but the duty to provide it is equally as important.

[196] **Ms Frowen:** We get around that quite adequately by talking about care and support. Some of the language used is very medical and not the kind of words and phrases that we would use, while accepting that healthcare treatment is a necessary part of this. However, generally, we are talking more and more about care and support in a more holistic, global way. That is so important for this particular client group.

[197] **Peter Black:** Following on from that, on the duty to treat, for the professions that would be doing the treating, whether they are social workers, GPs or doctors, there are professional bodies that monitor and regulate what they do. In terms of local government, for example, there is the ombudsman and so on. So, if you assessed someone and failed to treat them, is there not already a professional duty on you, effectively?

[198] **Mr Greenwell:** Again, the simple answer is, 'yes', but it is about somehow acknowledging that a duty to assess without a concomitant duty to offer a service could leave someone stranded. That is our concern.

[199] **Peter Black:** I was just thinking about the fact that there are already duties in terms of offering a service.

[200] **Mr Greenwell:** Sure.

[201] **Peter Black:** The Assembly has competence to legislate in this area to ensure provision across all ages, but the proposed Measure, in the main, is confined to adults. You state that although this may be a missed opportunity to improve CAMHS, you would caution against arbitrary extension of the proposed Measure to cover children and young people. How should this issue be addressed by the proposed Measure?

[202] **Mr Greenwell:** In our evidence as the WLGA and ADSS Cymru, we said that we felt that simply including children and young people in the proposed Measure, because it seems to

make sense without a proper consideration, could prove helpful except in relation to advocacy, where there is probably a stronger case for children to have a statutory right to advocates in the mental health system than for adults, if only because normally adults speak on behalf of children and a child having an advocate of his or her own would certainly add something to that sense of feeling that the child's views are being represented properly and authentically. However, the culture of CAMHS is generally very different to the culture in adult services. To assume that simply by bringing them both into the proposed Measure you will tackle that issue is being very optimistic and falsely so.

[203] It feels, to us, that a considerable amount of further work needs to be done to better understand how mental health services for children and adolescents can be brought into the loop. In some ways, what we find is that services for children and young people offer more access to what we could call 'talking therapies'. In a sense, they may well be in advance of a lot of adult services in that respect. So, what one would want to do is preserve the really good things that go on in children's services rather than simply assuming that putting them all together will make everything okay, when, actually, I am not sure that that is the case.

[204] **Peter Black:** You are not talking about merging the services, but about the legislative framework, but you could turn your argument on its head and say that, if the legislation is not going to improve child and adolescent mental health services, it is not going to improve adult services either.

[205] **Mr Greenwell:** It is about going for the highest common denominator rather than the lowest, and aspects of children's services are very complex. One thing that we concluded from the work that I have done previously on looking at mental health services across Wales was that chronological age was one of the least helpful markers of the need to change to a new service, so that has to be given some attention.

[206] **Peter Black:** In evidence from the Royal College of Psychiatrists, Dr Helen Matthews told us that 50 per cent of mental disorders were evident by the age of 16, with 75 per cent evident by the age of 25. It seems to me that having a proper legal framework for child and adolescent mental health services would be particularly helpful in that regard. What are your thoughts on that?

[207] **Mr Greenwell:** Dr Matthews is absolutely right; it would be helpful. I do not mean this disparagingly, but I wonder whether just throwing children and young people into this proposed Measure is the answer. That is our question.

[208] **Helen Mary Jones:** You make a good point that chronological age is one of the least useful ways of determining when a person should move from one set of services to another. Is there not a risk that, if you have a piece of legislation that enshrines a certain set of rights for adult services, you end up unintentionally perpetuating that artificial split between adult services and children's services, for which there is not an automatic right to gain access to, or to be assessed for, and so on? I take your point about not including children in the proposed Measure in a bolt-on manner, and it is right to say that, when children can get access to services, they often get access to better services, such as talking therapies, but it is also true that it is still very difficult for them to access services at all in some places. Could we not be perpetuating the divide if we legislate for adults and not for children—except in regard to advocacy—and could that not unintentionally perpetuate the difficulties with transition that you have so accurately identified, especially considering Beverlea's point on resources?

[209] **Mr Greenwell:** That is the danger. There are unintended consequences to taking action or not, and a judgment has to be made. Our plea is to think this through carefully. We have stressed our belief that advocacy should be equally accessible to children and young people as to adults. We have also said that the right to reassessment outlined in Part 3 of the

proposed Measure should look back far enough so that the treatment or a service that an adult has as a child counts towards the right to a reassessment. That would be very helpful, but we were nervous about saying that you should just stick them in.

[210] **Helen Mary Jones:** However, you are not saying that we should leave them out.

[211] **Mr Greenwell:** Not at all.

[212] **Helen Mary Jones:** You are saying that, if they are to be included, it needs to be done carefully and not as a kind of bolt-on amendment.

[213] **Mr Greenwell:** Yes, that is what we are saying.

[214] **Ms Frowen:** That is an excellent point, and is one that I want to reinforce by saying that there are unintended consequences to singling out people in a population by age. Our overall view is that this is very good in theory, but there are a lot of issues to be worked through before its enactment, to be clear that the consequences can be mitigated, defended against or addressed in subsequent years.

[215] **Peter Black:** On the other end of the scale, you state that the proposed Measure has not paid due regard to the mental health needs of older people. What are your reasons for stating that, and how should the proposed Measure be amended to accommodate that group?

[216] **Mr Greenwell:** Spot the contradiction. [*Laughter.*] I thought that you might ask about that.

[217] **Helen Mary Jones:** You are saying do not include children, but do include older people.

10.50 a.m.

[218] **Mr Greenwell:** We are talking particularly about older people with dementia there. This is not about a service governed by chronological age, because we are increasingly working with a large number people in their early 50s, with early onset dementia. Ageism interferes with the outcomes of services for older people: at its worst, people will ask, ‘Well, what do you expect at your age?’ Older people still get that kind of response. Older people with dementia have distinctive needs, which a number of psychiatrists would describe as relating to the physiological breakdown of the brain rather than a psychiatric condition. Taking that approach is different from seeing people as having a psychiatric illness. We are making the same argument in relation to children. We need to think this through carefully and not simply lump older people with dementia together. Older people, who have had a depressive condition or anxiety in their earlier life still need the kind of services that would have been successful for them earlier on in their life. Having a condition at the age of 75 is no different from having it at 45. Older people with dementia have different issues and distinctive needs. Our plea is to do as much as we can to recognise the difference and not lump people together.

[219] **David Lloyd:** Before we move on, I want to go back to the earlier point about children, to flesh out a recommendation for the committee. Would you advocate children being accommodated within this proposed Measure, taking into account all the caveats, or should children be subject to a separate Measure?

[220] **Mr Greenwell:** There is a lot to be gained from children having access to assessment and advocacy and the reassessment in Part 3. However, there is more work to be done, which may require a separate Measure. We said earlier that some things can be unpicked in the

guidance, and it will be interesting to see how the guidance could be put together to recognise that this is not lumping groups of people together unhelpfully but is identifying the strands of the proposed Measure that will contribute to the care and support that we offer to children, as well as adults.

[221] **William Graham:** I have a question on the point about physical degenerative dementia and that the medical aspect diminishes because nothing can be done. Should there be something stronger in the proposed Measure to ensure adequate support at that time? That is really your part of it, rather than the medical part of it. The assessment has taken place—

[222] **Mr Greenwell:** It goes back to our earlier point about the use of the word 'treatment', recognising that it is not just older people with dementia who have needs that are met outside of what is traditionally seen as treatment, but a whole lot of people who have mental health problems. That needs to be embraced within the definition of 'treatment' in the proposed Measure.

[223] **William Graham:** So, there needs to be something stronger on that, do you think?

[224] **Mr Greenwell:** Yes.

[225] **Christine Chapman:** I have some questions about the local primary mental health support services. In your evidence, you say that local authorities' eligibility criteria for services are generally set at 'critical and substantial need', which may be more restrictive than primary care mental health services. How is that likely to affect the services provided for in the proposed Measure and how should the issue be addressed?

[226] **Mr Greenwell:** This is tricky. That may or may not be helpful, but it exposes two systems that are desperately trying to come together.

[227] **David Lloyd:** Others have said that.

[228] **Mr Greenwell:** The argument that we put is for shared responsibility, so that we could at least agree to undertake assessments within primary care, rather than setting up colleagues who work in primary care to fail. That could be achieved, we believe.

[229] There is evidence from some parts of Wales of social workers and community psychiatric nurses being located within GP practices. In some ways, it is worth piloting that again, but there is a lot of evidence from the past 30 years that, when you put professionals together with a shared objective—not just co-locating them—you get to people quicker, and you have different conversations between professionals and with the people who are struggling. We believe that such shared responsibility is much better than, if you like, dumping on each other, which is often what happens because many local authorities set their eligibility criteria quite high. It is unhelpful when we tell health colleagues, 'Sorry, but that person does not meet our criteria'. It is playing with words, which is enormously unhelpful.

[230] **Christine Chapman:** It is about getting everyone around the table, then, really.

[231] **Mr Greenwell:** Absolutely. Before Beverlea comes in, I want to discuss the duty to treat, which we think is important, with 'treat' meaning 'provide a service to'. That could also offer some incentive around shared responsibility, rather than separating the two worlds of local government and the NHS.

[232] **Ms Frowen:** This will increasingly expose the two different systems and the pressures on them. This is not unique. The work that is going on in relation to the integrated family support teams will tease out all this. No-one will argue against the view that that model

is what we should be doing. It makes sense on so many levels. However, we already know that many of the families that will be dealt with through that model will not get a service from social services, and never have, because they do not meet the eligibility criteria. Somewhere along the line, whether in relation to mental health, the frail elderly, or vulnerable children, we really need to find a way around this. In the uncertain times that we face, it will be exposed even more, because the pressure on budgets within local authorities means that social services are at breaking point now.

[233] **William Graham:** We have talked about eligibility criteria. As a regional Member, I find that it differs from authority to authority. Is that recognised by the WLGA? Could you set more standards?

[234] **Ms Frowen:** In fairness, it varies but it is not that variable. Stewart might say more about this because he is involved in setting them. The question is whether we are content for such a huge number of people who have a need to be excluded. Are we content to say now, when we know the value of social care and so on, as a joint service, that we have to set such high levels? That is the fundamental question, not whether Torfaen is on 'critical' and Blaenau Gwent at another level. Are we happy with both of those? Will we be happy, in the next four to five years, to see that even more? That is the fundamental question. Services of this kind tease that out. We just keep coming up against that all the time.

[235] **Peter Black:** We are all aware of the reasons why local authorities work on the basis of 'critical' and 'substantial' need. It is largely resource led. Some authorities put more resources into mental health services than others. In effect, mental health services tend to be the poor relation compared with children's services and others, in which local authorities have far greater statutory responsibilities. You were arguing earlier about the duty to treat but, if that duty to treat came in, would that mean that local authorities would have to find substantially more resources, because they would find that they had to deal with not just those with critical and substantial need, but anyone who has a need?

11.00 a.m.

[236] **Mr Greenwell:** Again, that is not the point that I was going to make, but the simple answer is 'yes'.

[237] The point that I was going to make in relation to both the follow-up questions was that we are certain that we will not get a massive amount of additional resources over the next three to five years. So, the answer to the increasing demand is to work differently. The advantage of the proposed Measure is that if the whole sense of shared responsibility is reinforced, it requires the NHS and local government to work together to avoid the duplication that exists at times, so that we can, at the very least, make the best use of the resources that we have, rather than running around trying to check whether the psychiatric nurse, social worker or GP is doing it. The helpful part of the proposed Measure is saying that shared responsibility is the foundational answer.

[238] **Christine Chapman:** Do you want to say any more on this? How do you envisage the requirement for primary mental health assessments in the proposed Measure interacting with the duty on local authorities to assess in the National Health Service and Community Care Act 1990?

[239] **Mr Greenwell:** I think that I have answered that. It is by exploring the opportunities for much closer links between those people who, at the moment, would say that they are providing care and support and those people who would say that they are providing treatment. When we get rid of those distinctions and say, 'This is about providing a service', we will be able to overcome some of the professional and organisational boundaries that you identified.

The people who suffer most as a result of those organisational boundaries are not the professionals, but the people who are caught in between one approach by the NHS and another approach by the local authority. We should do pilot work or look at the success of some of the work that is already taking place where social workers or psychiatric nurses are already in GP surgeries, and ask whether something different is happening there and, if it is, we should do more of it.

[240] **Helen Mary Jones:** This builds on the area that you have just explored with Chris. In your written evidence, you state that the requirement for partnership working and joint accountability between local authorities and the NHS ‘could be stronger in the drafting’. You have made a clear case for that partnership working being crucial, but do you have any further thoughts on how the proposed Measure ought to address that and how it could be strengthened to fortify the requirement to work together?

[241] **Mr Greenwell:** It is now well accepted that there are three conditions for an integrated service: a single manager, a single information system and a single budget. Those are generally accepted as the three critical characteristics of an integrated service. It would be helpful if the proposed Measure or the guidance highlighted those as the key indicators that services would be expected to pursue.

[242] **Helen Mary Jones:** Given how critical they are, do you have a view on whether they should be on the face of the proposed Measure or whether regulations could deal with that? Should that be included in something slightly stronger than guidance?

[243] **Mr Greenwell:** It would be the view of ADSS Cymru that the more that we can strengthen the understanding of what an integrated service means, the better. It is now well accepted that those three characteristics bring integration. Often, in the past, and I have been part of it, we have brought professionals together in one place so that they are co-located, but they are still operating two or three information systems, there are three or four files per service user, with two or three managers and four different budgets, which is crazy—that is not a technical term.

[244] **Ms Frowen:** The WLGA has lots of different evidence, particularly around safeguarding children, in which all the reports continually cite good shared information management and systems and care plans. However, when you try to implement that, there are significant costs, and it is not as easy; if it was, we would do it. It is a long-term strategy, and we continue to argue that any new information strategies or initiatives, particularly if they are focused on health, should stop, and be re-focused on health and social services, or health and local government. It was a shame that, five or six years ago, when we had ‘Informing Healthcare’ as a national strategy for information, we actually had ‘Informing Social Care’ as well, but suddenly the social care part disappeared. There has since been considerable investment in the NHS without that holistic approach. The general public would ask what is going on with all these separate systems. It is not easy, and that is why I would be hesitant about prescribing this in legislation as opposed to taking a strong line in guidance that you expect these things to evolve over time. There are discussions about moving to shared systems, but to prescribe that kind of thing in a Measure is a very different thing.

[245] **Helen Mary Jones:** You have touched on this, but I will put the question to see if there is anything further that you would like to add. In your view, does the proposed Measure recognise the distinctive role and contribution of social services in supporting people with mental health problems? You have touched on that, but how would you like to see it amended?

[246] **Mr Greenwell:** I would like a close look at the language in the Measure, so that it is made clear that this is not directed at clinicians. The danger is that the more that you use

words like ‘treatment’, the more you end up thinking, ‘That’s nothing to do with social services, then’.

[247] **Helen Mary Jones:** So, it is about services rather than treatment in isolation. That makes sense.

[248] **Mr Greenwell:** The danger is that that is seen as only words, but we all know how powerful words are. The more professional groups and associations that recognise that this is part of their business, the better.

[249] **Helen Mary Jones:** I will move on to assessments, and the right of former service users to be reassessed. Again, we have touched on this with regard to children and young people. You say in your written evidence that there is a need for greater clarity on the arrangements for people regaining access to services. You mentioned that one of the things that needs to be cleared up is the situation where someone who received a service as a child or young person then needs to refer themselves for another assessment as an adult. You said that that should be included. Is there anything else that you feel needs to be done to clarify that?

[250] **Mr Greenwell:** It goes back to the issue about eligibility criteria, and whether having previously been a recipient of the service would kind of shoves you up the list, even though your current condition and circumstances, on their own, may not suggest that you meet the criteria. My view is that it would be helpful to say that the duty to reassess is a duty, and the fact that the person has previously had a service would deem them to be in substantial need.

[251] **Helen Mary Jones:** If I may, Chair, I will ask a supplementary question, because I think that it is quite important. It has been put to us that the proposed Measure should make provision for carers and family members to make referrals to secondary services. Would you have a view about that?

[252] **Mr Greenwell:** Our view is that the information that carers have is intelligence that is as important as anything, when it comes to understanding how you best meet the needs of someone with a mental health problem, to be perfectly honest. Those who live with someone with mental health problems need to be listened to, because they are with that person many more hours a day than professionals. Hence, the carers should have the right to make a referral.

11.10 a.m.

[253] It is always tricky to balance the human rights of the individual who is being talked about with the human rights of the person whose life is possibly being seriously damaged by that person’s behaviour. However, I guess that the test is whether we are all acting in the interests of the person who is struggling. Provided that we apply that test every time we encounter that dilemma, we ought to be able to convince everybody that people have been acting in good faith. I do not think that you should ever ignore information from a carer. That is the bottom line.

[254] **Peter Black:** Moving on to the issue of advocacy services, should the duty to provide advocacy services be extended to cover all users of mental health services, including those in primary care?

[255] **Mr Greenwell:** In a way, it depends on the role of the advocate. If their role is to support, in addition to representing a person’s views—rather than just representing a person’s views—that could be very helpful. My guess is that the focus has often been on those people who have been compulsorily detained—those people in secondary care services. I do not think we have really understood the contribution that advocates could make to the lives of

people who are in receipt of services, but who are outside traditional treatment. However, I think that we have some experience now of the value that advocates bring. I do not wish to make an unhelpful comparison between people with mental health problems and people with learning disabilities, but the contribution that advocates have made to the ability of people with learning disabilities to lead ordinary lives has shown that, when people are either the target of unhelpful behaviour from others or easily ignored, having access to an advocate is more, rather than less, helpful. That is a lot of words that probably mean that the answer is, 'Yes, it would be quite helpful if the proposed Measure were extended'.

[256] **Peter Black:** Moving on to the regulatory impact assessment, which is the bottom line really, what capacity and resource issues does the proposed Measure raise for local authority services, and how should they be addressed?

[257] **Mr Greenwell:** We have not got all day. [*Laughter.*]

[258] **Ms Frowen:** In a nutshell, we are where we are and we know what we are facing. It is significant, is it not, to look at how this can be set up not to fail? There is also an anxiety in the system that money will be moved around and that we will take money from other parts of the system—which is already creaking—such as community mental health teams. You hear people make the simplistic argument that, 'Well, we just need to intervene earlier, don't we?' Well, yes, but the reality is that we have significant need in our system at the moment. Are you just going to stop dealing with that? Of course you are not. So, there needs to be that transition, and we know that there are significant pressures in all parts of our system. That is a particular anxiety—that we will take our eye off the ball with regard to people in community mental health teams and in the service further up the continuum. We could be making a good case today for those people to receive more. So, we face a dilemma in that, although we all want to do things differently and we all want to intervene earlier, there is not enough money to go around.

[259] **Mr Greenwell:** The impact assessment poses a question and, for me, it makes the statement that we cannot simply do more of the same. The proposed Measure is very helpful, and it poses some serious questions about the need to do things differently. In doing things differently, we have to identify how we can make the best possible use of the resources that we already have, as well as identifying the additional resources that we need. None of us in the public sector now can simply argue for more resources; we first have to demonstrate that we are making the best use of what we have. We can only do that if we work hard to remove those barriers that have prevented us from looking at the whole system. For people with mental health problems, the whole system is the NHS and it is local government in all its guises, rather than just social services. It includes housing, leisure, education and so on.

[260] There is also a growing sector that is providing services on behalf of the NHS and local government, namely the third sector. There is also the commercial world, and some for-profit organisations are providing some of the best care. They might be providing some of the worst as well, but they are providing some of the best. We ignore them at our peril. For voluntary sector organisations in particular, the professional constraints are not the same. Service users will say that the difference between going to Mind, for example, and going to the local authority is that no-one in Mind says, 'That is not my job'. They say, 'Right, you want someone to come with you to have a look at some furniture because you are moving into a flat. Okay, we can do that'. The danger in local government is that we might say, 'That is not our job'.

[261] **Peter Black:** The regulatory impact assessment has put a figure of £5 million on the additional amount that will go into this. Do you think that it is a realistic assessment? Do you think that there is an understanding that local authorities should get a share of that money?

[262] **Mr Greenwell:** We do not think that it is realistic. Could you just ask that second part of the question again? [*Laughter.*]

[263] **David Lloyd:** That is not scripted.

[264] **Peter Black:** Do you think that there is an understanding in the assessment that local authorities will also bear costs, and that they should therefore have a share of that money?

[265] **Mr Greenwell:** I suppose that my answer to the first part of the question, that we do not think that it is realistic, could suggest that the assessment of where the resources are needed has been a fairly narrow. Our view would be that that is an unrealistic assessment of the cost even for the NHS, and it is certainly unrealistic if it is an assessment of the cost across the whole system. I will not say that we have worked out a figure; I would say through the committee that ADSS Cymru and the WLGA would be willing and keen to work with those officials who, in working up the guidance, might need to do more work on the financial consequences, so that we do not have something dumped on us, as it were, at a point when there cannot be any negotiation.

[266] **Ms Frowen:** We have some models now for trying to get out of this dilemma, in that everything is unsustainable and we do not have enough money but we need to do things differently. I mentioned earlier the integrated family support teams. I think that they are fundamental to what they are trying to achieve. This, however, is the first time that we are piloting, with some dedicated cash, a whole new way of working, on the understanding that it has to be properly evaluated and that is has to release energy in the system. We would argue that the financial estimates, even for that, were not as good as they could have been, and we are concerned about that. So, there are examples that we could look at, but any discussions about who has the share will just force us back where we always seem to end up.

[267] **Christine Chapman:** A number of sub-sections in the proposed Measure give Welsh Ministers powers to make regulations. Do you think that the proposed Measure achieves the correct balance between having powers on its face and giving powers to Welsh Ministers to make regulations?

[268] **Ms Frowen:** To be honest, we have not considered that in depth. We would want more time to give a more detailed answer on that.

[269] **Mr Greenwell:** It is related to my last comment about offering our time and support in developing the regulations, rather than facing the regulations when they have been sorted. Therefore, we would welcome involvement.

11.20 a.m.

[270] **David Lloyd:** Teimlwch yn rhydd i ysgrifennu atom gyda’r ateb, neu os oes gennych unrhyw fanylion pellach ynglŷn â’r pwynt hwnnw. Nid oes angen ichi ateb popeth heddiw.	**David Lloyd:** Please feel free to write to us with your response, or if you have any further details on that point. You do not have to answer everything today.
[271] Yr ydym wedi dod at ddiwedd y cwestiynau swyddogol, felly, diolch yn fawr iawn ichi am eich cyfraniadau. A oes gennych unrhyw sylwadau terfynol i’w gwneud, ynteu a ydych yn hapus â sut y mae pethau wedi mynd? A ydych yn dymuno gorffen gyda sylw terfynol ar y Mesur	We have come to the end of the official questions, therefore, thank you very much for your contributions. Do you have any final comments to make; or are you happy with how things have gone? Do you wish to finish with a final comment on the proposed Measure?

arfaethedig?

[272] **Mr Greenwell:** No. I am very happy.

[273] **David Lloyd:** Diolch yn fawr iawn ichi. Bydd y clerc yn anfon atoch drawsgrifiad drafft o drafodion heddiw iddynt gael eu cywiro, os bydd angen gwneud hynny. Fel rheol, mae pethau'n gweithio'n berffaith yma, ond teimlwch yn rhydd i geisio cywiro pethau. Diolch yn fawr am eich cyflwyniadau.

David Lloyd: Thank you very much. The clerk will send you a draft transcript of today's proceedings so that they may be corrected, if necessary, of course. As a rule, things work perfectly here, but feel free to try to correct things. Thank you very much for your presentations.

[274] Cynhelir y cyfarfod nesaf ddydd Iau nesaf. Gyda hynny, hoffwn ddiolch i bawb am y cyfraniadau y bore yma. Diolch am gefnogaeth y swyddogion ac am y gwasanaeth cyfieithu. Mae'r cyfarfod hwn yn awr ar ben.

The next meeting will be held next Thursday. With that, I wish to thank everyone for their contributions this morning. Thank you for the support provided by the officials and for the interpretation. The meeting is now closed.

Daeth y cyfarfod i ben am 11.21 a.m.
The meeting ended at 11.21 a.m.