

Y Pwyllgor Deddfwriaeth Rhif 3

The Legislation Committee No. 3

Dydd Mawrth, 4 Mai 2010
Tuesday, 4 May 2010

Cynnwys

Contents

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

Mesur Arfaethedig Iechyd Meddwl (Cymru)—Sesiwn Dystiolaeth 3
The Proposed Mental Health (Wales) Measure—Evidence Session 3

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
Janice Gregory	Llafur Labour
David Lloyd	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)

Eraill yn bresennol

Others in attendance

Dr Victor Aziz	Cymdeithas Feddygol Prydain British Medical Association
Dr Andrew Dearden	Cymdeithas Feddygol Prydain British Medical Association
Yr Athro Phil Fennell	Ysgol y Gyfraith Caerdydd Cardiff Law School
Dr Helen Matthews	Coleg Brenhinol y Seiciatryddion Royal College of Psychiatrists

Martin Semple	Coleg Brenhinol y Nyrsys Royal College of Nursing
Dave Williams	Coleg Brenhinol y Nyrsys Royal College of Nursing

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 8.56 a.m.
The meeting began at 8.56 a.m."

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions

David Lloyd: Croeso i gyfarfod Pwyllgor Deddfwriaeth Rhif 3 Cynulliad Cenedlaethol Cymru. Croesawaf fy nghyd-Aelodau, a hefyd yr Athro Phil Fennell; byddwn yn clywed mwy ganddo yn y man.	David Lloyd: Welcome to the meeting of the National Assembly for Wales's Legislation Committee No. 3. I welcome my fellow Members and Professor Phil Fennell; we will be hearing more from him later.
Yr ydym wedi derbyn ymddiheuriadau oddi wrth Helen Mary Jones.	We have received apologies from Helen Mary Jones.
Os bydd y larwm tân yn canu, dylid gadael yr ystafell drwy'r allanfeydd tân gan ddilyn cyfarwyddiadau'r tywyswyr a'r staff. Dylai pawb ddiffodd eu ffonau symudol, eu galwyr a'u 'mwyar duon' yn llwyr, gan eu bod yn amharu ar yr offer darlledu.	If the fire alarm sounds, we should leave the room through the fire exits, following the instructions of the ushers and staff. Everyone should completely switch off their mobile phones, pagers and BlackBerrys, as they interfere with broadcasting equipment.
Mae Cynulliad Cenedlaethol Cymru yn gweithredu'n ddwyieithog. Mae clustffonau ar gael i glywed cyfieithiad ar y pryd, a gellir eu defnyddio i addasu'r 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 ymlaen cyn dechrau siarad. Mae'r cyfieithiad ar y pryd ar gael ar sianel 1, ac mae'r darllediad gair am air, i glywed y sain yn well, 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 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 on before speaking. Simultaneous translation is available on channel 1, and the verbatim broadcast, to amplify the sound, is available on channel 0.

8.58 a.m.

Mesur Arfaethedig Iechyd Meddwl (Cymru)—Sesiwn Dystiolaeth 3

The Proposed Mental Health (Wales) Measure—Evidence Session 3

<p>David Lloyd: Fel y byddwch yn gwybod eisoes, rôl y pwyllgor yw ystyried egwyddorion cyffredinol Mesur Arfaethedig Iechyd Meddwl (Cymru) fel y'i cyflwynwyd gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol ar 22 Mawrth 2010, a chyflwyno adroddiad ar hynny. Mae'n rhaid i'r pwyllgor gwblhau ei waith a chyflwyno adroddiad i'r Cynulliad erbyn 2 Gorffennaf eleni. Dyma ein trydydd sesiwn dystiolaeth. Yr ydym eisoes wedi clywed tystiolaeth gan elusennau iechyd meddwl, gan Jonathan Morgan, Aelod Cynulliad, a chan Edwina Hart, y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol, sef yr Aelod sy'n gyfrifol am y Mesur arfaethedig. Mae ein hymgynghoriad yn dal i fynd yn ei flaen, a cheir manylion amdano ar wefan y pwyllgor. Y dyddiad cau ar gyfer derbyn cyfraniadau ysgrifenedig yw dydd Gwener, 14 Mai.</p>	<p>David Lloyd: As you will be aware, the committee's role is to consider and to present a report on the general principles of the Proposed Mental Health (Wales) Measure as laid by the Minister for Health and Social Services on 22 March 2010. The committee has to complete its work and present a report to the Assembly by 2 July of this year. This is our third evidence session. We have already heard evidence from mental health charities, from Jonathan Morgan, Assembly Member, and from Edwina Hart, the Minister for Health and Social Services, who is the Member responsible for the proposed Measure. Our consultation is ongoing, and details on it can be found on the committee's website. The closing date for any contributions is Friday 14 May.</p>
<p>Diben y cyfarfod yw clywed tystiolaeth lafar bellach mewn cysylltiad â'r Mesur arfaethedig. Caiff y sesiwn ei rhannu'n ddau. Yn gyntaf, bydd yr Athro Phil Fennell yn cyflwyno tystiolaeth. Yna, rhoddir tystiolaeth gan banel a fydd yn cynnwys cynrychiolwyr o Gymdeithas Feddygol Prydain, Coleg Brenhinol y Nyrsys, a Choleg Brenhinol y Seiciatryddion.</p>	<p>The purpose of the meeting is to hear further oral evidence in relation to the proposed Measure. The session will be split into two parts. First, Professor Phil Fennell will give evidence. Following that, a panel that will include representatives from the British Medical Association, the Royal College of Nursing and the Royal College of Psychiatrists, will give evidence.</p>
<p>Croesawaf yr Athro Phil Fennell, sy'n athro yn y gyfraith yn Ysgol y Gyfraith Caerdydd. Yr ydym wedi derbyn eich papur, ac wedi'i ddarllen. Y drefn arferol yw y byddwn yn gofyn rhes o gwestiynau sydd yn seiliedig ar eich tystiolaeth ysgrifenedig. Symudwn yn syth at y cwestiynau; mae oddeutu 18 i'w hateb mewn 40 munud. Felly, efallai y bydd angen cadw rhai o'r atebion a rhai o'r cwestiynau yn gryno. Dechreuaf gyda rhai cwestiynau cyffredinol. Yr Athro Fennell, a ydych yn cefnogi amcanion cyffredinol y Mesur arfaethedig ar iechyd meddwl?</p>	<p>I welcome Professor Phil Fennell, who is a professor of law at Cardiff Law School. We have received your paper and have had an opportunity to read it. As usual, we will ask a series of questions that are based on your written evidence. We will go straight into questions; there are about 18 to answer in 40 minutes. Therefore, we may need to keep some of the answers and some of the questions short. I will start with some general questions. Professor Fennell, do you support the overall aims of the proposed Measure on mental health?</p>

9.00 a.m.

Professor Fennell: Yes, I support the aim of providing early intervention for people who have mental health problems. My concern is that I do not think that this proposed Measure will achieve that. My belief is that the best way to achieve this type of early intervention is to have crisis intervention centres that people can approach when they have experienced mental distress, rather than this legislative framework, which seems a very complex and lengthy way of achieving this aim.

David Lloyd: We will come on to your thoughts as we go through the questions.

Yr ydych yn dweud yn eich tystiolaeth ysgrifenedig nad oes angen y Mesur arfaethedig hwn achos bod gwasanaethau eisoes ar gael i gleifion a'u teuluoedd. Beth yw eich rhesymau dros ddweud hyn?

You say in your written evidence that this proposed Measure is not needed because services are already available to patients and their families. What are your reasons for saying this?

Professor Fennell: I do not think that I said that services are already available; what I was saying is that there are already legal duties on social services authorities to carry out community care assessments of people who appear to them to be in need of community care services. The case law clearly shows that there should be a low threshold of need, particularly when someone has a mental disorder. Many people with mental disorder, or those who appear to have mental disorder, should almost automatically be considered to be in need of community care services under the National Health Service and Community Care Act 1990. That is the point that I am making. I am willing to accept the evidence of service users and the charities that they have tried to access services and have not been able to do so. I do not think that that is because of an absence of law. I think that it is because of an absence of service.

David Lloyd: Diolch am hynny. Felly, i gadarnhau, a all amcanion y Mesur arfaethedig ar iechyd meddwl gael eu cyflawni drwy ddefnyddio deddfwriaeth sydd eisoes mewn bodolaeth?

David Lloyd: Thank you for that. So, to confirm, can the objectives of the proposed Measure on mental health be achieved by using existing legislation?

Professor Fennell: I think so. Although services in England are equally patchy, they have the legislative framework that we currently have. I am no health economist, but from what I can gather, England's per capita spend on mental health is higher than ours. That may have more to do with it than the legal framework. What this proposed Measure does is to say that when the partners carry out an assessment, they must decide whether some services might alleviate or prevent deterioration in the person's condition. Between the two of them, they have to decide which services ought to be provided and whether any services are called for. So, there is a two stage assessment, just as there is under the National Health Service and Community Care Act 1990, in that you assess the person's needs and then you decide which of those needs call for the provision of services. That is a local authority duty, and health is supposed to co-operate. Directions have been issued in England to get health to co-operate. The proposed Measure appears to be setting up legislation in parallel with section 47 of the National Health Service and Community Care Act 1990. I am worried that there will be all these duties and that further confusion will arise.

The problem identified with the care programme approach—which is what the proposed Measure legislates for, namely that everyone should have a care co-ordinator, a reviewed care plan and all the rest of it—is bureaucracy, according to the research commissioned by the Assembly Government. That has been the big problem. What the proposed Measure does is to give that bureaucracy a legal form. It says that there will be a duty to have a care co-ordinator, that regulations will state who those care co-ordinators will be, and that regulations will state what must go into a care plan. A lot of it is left to regulation. This 50-section proposed Measure will increase the size of the Mental Health Act 2007 by a factor of another quarter—that is, 50 sections will be added to the 160 or however many there are now. There are something like 17 or 18 rule-making powers in the proposed Measure, so further rules would be made under this. We are in danger of micromanaging by legislation. It would be a costly exercise, too, what with the appointment of national and local leads and the training. This was all supposed to have been made available by March of last year, but it has not been. Having a law will merely defer implementation until, I believe, 2013, which is four years after Welsh service users were supposed to be getting all of this under the national service framework.

Having been a lawyer all my life, I have less faith than many in the power of law to deliver these good quality services. There is a noble motive behind this proposed Measure—it is vital to develop good mental health services for people in Wales—but there are problems. The problems partly come from Wales's geographical features—its geo-population; that is, where everyone is. That is clearly part of the difficulty. The other part of the difficulty is funding, and I am worried that funding will be diverted into implementing the legislation and the strategy, when it could be used to pay for an improvement in primary care services.

David Lloyd: Diolch am yr ateb llawn hwnnw. Yr ydych wedi ateb nifer o'r cwestiynau sydd i ddod, felly efallai bydd rhaid ichi ailadrodd rhai o'r pwyntiau hynny yn nes ymlaen. Yr ydych yn dweud yn eich papur a hefyd yn awr ar lafar bod y Mesur arfaethedig hwn yn drwsogl a hynod gymhleth. A all amcanion y Mesur arfaethedig hwn gael eu cyflawni gan Fesur byrrach a symlach?

David Lloyd: Thank you for that full answer. You have answered many of the questions that are to come, therefore you may need to repeat some of the points that you made. You state in your paper and also now verbally that the proposed Measure is cumbersome and unduly complex. Can the aims of the proposed Measure be achieved by a shorter and simpler Measure?

Professor Fennell: Yes, I believe that they could, although I hope that you will not ask me to write such a Measure down for you now. The Scots have two sections in their Mental Health (Care and Treatment) (Scotland) Act 2003, which perform a similar function to this assessment and care provision decision. They also have three or four pages on it in their code of practice. The reason why I say that this proposed Measure is cumbersome is because there are so many areas where regulations will come into force. Given that the people who are subject to mental health law may have some difficulty in understanding these complex documents, I think the simpler it can be, the better. This proposed Measure is complex; I would defy anyone to understand what right they have to an assessment from reading this proposed Measure. It is supposed to be a right based on an idea of entitlement, but a lot is left to the scheme that is agreed by the partners and to regulations. So, for example, if I have been discharged from the secondary mental health service and I want an assessment, I would have to look in regulations to see during what period after my discharge I would be entitled to that assessment, because the Minister makes the regulations that state how long after your discharge you continue to have this right to access services. There is no time limit on the assessments.

9.10 a.m.

In Scotland, there is a time limit. Admittedly, it is 14 days, but here, it is as soon as is reasonably practicable. There could be many factors that might make it not reasonably practicable to conduct an assessment quickly. From that point of view, I think that it could be clearer. If we do want to give people a right, we need to do it more clearly.

David Lloyd: Diolch yn fawr. Mae'r cwestiynau nesaf dan law William Graham.

David Lloyd: Thank you. The next questions are in the care of William Graham.

William Graham: I wish to draw you out on 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. Do you think that these definitions encompass all relevant parties?

Professor Fennell: It is my understanding that they encompass health, social services, voluntary organisations and housing authorities. That is my understanding of who is encompassed in the provision of services. I do not see much of a problem there, but I do see a problem in the definition of 'patient' used in section 5, which states that a patient is an adult who has, or may have, a mental disorder. That is different from the general definition in the Mental Health Act. I know that it is only supposed to apply to the sections in this proposed Measure, but I think that it would be confusing to differ from the definition that is in the 1983 Act, which is perfectly okay and states that a patient is a person who suffers, or appears to suffer, from a mental disorder. With that, there has to be some outward manifestation that the person is suffering from a mental disorder, by their evidence from family, carers or whatever, but something that makes it appear that the person suffers from a mental disorder. I may have a mental disorder, and with great respect to everyone in this room, so may all of you. However, it is only when we actually appear to be manifesting some sign that we have a mental disorder that we would become a patient. That should be consistent throughout the Mental Health Act and all of its provisions.

I am a little worried that the definition of 'carer' is quite widely drawn. How much involvement must the members of the families of patients, and the friends of patients who are involved in their care, have? A carer under carer legislation is someone who provides substantial care on a regular basis. My concern is that you would need to think about the busybody member of the family when you are thinking of who is eligible to ask for these kinds of assessments.

William Graham: I now refer back to your previous answers about timescale. Witnesses from the voluntary sector have suggested that timeframes should be included on the face of the proposed Measure specifying a maximum period of 30 days between referral for an assessment by a GP and the making of the assessment, and 60 days between qualifying as a patient under Part 2 and the completion of a care plan. Do you think that that is suitable?

Professor Fennell: I am wondering. If you have a severe mental health problem, 30 days is a long time to be suffering; it is a long time to wait for an assessment. In Scotland, if you ask for an assessment, the authorities have 14 days in which to carry it out. I was a legal adviser to the scrutiny committee on the 2004 version of the Mental Health Bill and then, with the 2006 version of the Mental Health Bill, I worked for the Joint Committee on Human Rights. Some of the cases that came before those committees, where arguments were being made for this kind of power, involved people who went to places that were supposed to be 24/7 crisis intervention centres. There is a poignant story of a man in west Wales who went to one of these centres, found that it was shut when he needed it, broke into it, wrote on the floor in sugar, and was later arrested for burglary. The problem there was a lack of a 24/7 service, not something that you could access within 30 days. It is like the old hymn:

'A thousand ages in Thy sight
Are like an evening gone'.

A mental health episode is traumatic, and we are looking for rapid response services. If I break my leg, I can go to casualty, but if I am in acute mental distress, my family may not know where to go. That is the problem, not a lack of strategies or of policy documents. We have 'Raising the Standard', and 'Working Together', and this legislation will mean more documentation, more policies and strategies and schemes, but what we need is more service, with more of a rapid response.

Peter Black: May I take you back to the definition of 'patient'? I got the impression that your objection to that was that people are classed as patients when they exhibit mental health disorders, but we could all have such a disorder and people should not have to wait until it has been exhibited before being able to receive treatment. The other part of that definition refers specifically to adults as opposed to a person generally, and a number of witnesses have said that that, in effect, excludes children and adolescents, as defined in other legislation. Is that a problem?

Professor Fennell: The incidence of child mental health problems is dramatically on the increase, and parents will often present their children and ask for assessments. I cannot generalise about this, but if you are to give a right to access help and advice to the family members of adults who have mental health problems, it would appear that you should give the same right to children. My concern is that this proposed Measure does not do that, so there is a need to develop child and adolescent intervention.

Peter Black: So, you would agree with previous witnesses that there should be a catch-all provision, as opposed to one specifically for adults.

Professor Fennell: I think so. Children are detainable under mental health legislation, so they should also be entitled to whatever benefits are available under that.

Peter Black: You say that the need to provide local schemes and to ascertain entitlement according to what the schemes say will in all probability lead to continued local variation in provision. Should the proposed Measure be more prescriptive about the contents of local schemes to reduce the likelihood of variation?

Professor Fennell: Regulations allow for some prescription. There are a lot of regulatory powers under the Act, and I cannot remember this precisely, but I think that there is some permission for prescription. What I would say is that you cannot tell from this proposed Measure who will be eligible. Sometimes, eligibility for these assessments will be based on whether you are of a class of patient mentioned in the scheme, but we have not seen the scheme, and we do not know whether regulations will prescribe entitlement under the scheme. Quite a lot remains a mystery, and quite a lot depends on what is in the local schemes or in the regulations that are made later.

Peter Black: Is that not the nature of all legislation nowadays?

9.20 a.m.

Professor Fennell: It is relatively straightforward. As I said, the Scots have done it in two sections and in two pages of a code of practice. With so many regulatory powers, there will have to be a team of people in the Assembly Government drafting all the regulations, and teams of people in local health boards and social services authorities meeting to agree schemes, and only then will we know who will be entitled to what.

David Lloyd: We will stay with local primary mental health support services, Professor Fennell. You have touched on these few issues already in your full answers thus far. With reference to section 10 of the proposed Measure, which is on action following a primary mental health assessment, you state in your written evidence that

'We may ask what this does that is not already done by the National Health Service and Community Care Act 1990'.

May I just press you further on that? Is it not the case that the duty under section 10 of the proposed Measure is wider than that in the 1990 Act, given that it includes services provided by general practitioners and secondary mental health services, as well as community services?

Professor Fennell: We must first decide which partner is responsible. That is my understanding of this. A partner must consider itself to be the responsible authority. The duty to decide whether any of the assessed services are called for is similar to that in the NHS and Community Care Act 1990. Section 47 of that Act states that the district health authority may be invited to assist, and that directions can be made to get the co-operation of local health services if it is the local authority that is doing the assessing. There may be some slight broadening here, in the sense that a primary local health board may be the responsible body, when social services would be primarily responsible under the NHS and Community Care Act. This could all be resolved with directions or with a deeming provision, as in the Scottish legislation, which states that if a mental health officer says that someone should have an assessment, that person gets an assessment. If a person, their carer or any nominated person asks for an assessment, the reasons must be given if they do not get one within 14 days. Those are two quite tight duties, and they are not complicated to understand, but I find this quite difficult to follow.

David Lloyd: Is there a risk of creating uncertainty over whether an assessment is needed under the NHS and Community Care Act 1990 and under the proposed Measure?

Professor Fennell: Yes. At the moment, local authorities and social services know that they have this duty. The problem is with getting health and housing on board. That problem could be solved by directions or by other legislation amending the National Health Service (Wales) Act 2006 and amending the NHS and Community Care Act. However, this proposed Measure amends the Mental Health Act 1983 in a way that people will find confusing.

David Lloyd: You touched on the care programme approach earlier. Could the proposed Measure be amended to ensure that the bureaucracy surrounding that is not increased? I take on board what you have already said about the bureaucracy.

Professor Fennell: Under the care programme approach, everyone should have a care co-ordinator. The proposed Measure creates a statutory duty to provide a care co-ordinator, and then goes on to say who can be a care co-ordinator. That is the current care programme approach—and if you want to call that bureaucracy, you can. You have to review the care plan at regular intervals, and if you want to amend it, people have to be consulted, and so on. All that will now go into the law and into regulations, so we can move away from calling it bureaucracy. However, I predict that a report down the line will tell you that excessive legalism is the problem with the care programme approach. There is too much regulation, too many rules and too much of a training need to educate our people about these rules.

David Lloyd: Point taken.

Christine Chapman: I have a few questions about Part 3, on the assessment of former users of secondary mental health services. Will the provision in the proposed Measure for the self-referral of former users of secondary mental health services improve services for them? If so, is this drafted in such a way as to secure that improvement?

Professor Fennell: When people have been in secondary mental health services, that usually means that they have been in hospital. It may not necessarily mean that, but it certainly means that they have been referred to a consultant psychiatrist under the current service in Wales. The problem comes after discharge. When you have a mental health problem, you need continuing support in the community until you have the problem under control, but, as I think I mentioned earlier, there is no time limit in the proposed Measure, and no clarity about how long after discharge you will get those services. That, to me, is the problem—that this proposed Measure will not pin anyone down to provide an assessment within a specified time.

David Lloyd: We have eight minutes left for this session, and we have five questions.

Christine Chapman: Okay. Let me just move on to—

David Lloyd: It is not that I wish to curtail the discussion, obviously, but I think that there needs to be some focus.

Christine Chapman: Right. On the advocacy part of this proposal, you state that the problem is the shortage of suitably qualified advocates and the resources to employ them, not the absence of a legal duty to provide them. What are the current legal duties to provide advocacy to users of mental health services, and how could they be used to better effect?

Professor Fennell: The current ones are under the Mental Health Act 1983, in the new sections from 130A to whatever it is—I cannot remember the numbers off the top of my head. Those are for people who are subject to compulsion under the longer-term provisions. They do not apply to people under the 72-hour provisions, and they do not apply to people who are informal patients. I applaud the intent behind this; it is just that we should have had it by March last year. The reason we did not have it was not because there was a new duty to provide for compulsory patients, but because this is a skilled activity, and training people up to do this takes time. You do not just magic suitable people out of the air to do this. You need a lead-in time to train people, to get enough people and to provide enough contracted hours to enable those advocates to provide effective advocacy support.

9.30 a.m.

Christine Chapman: Thanks. Should the duty to provide advocacy services be extended so that provision covers all users of mental health services, including those in primary care, as some witnesses have suggested?

Professor Fennell: There is a question of the resources that you have and of whether you create a duty that you will not be able to fulfil within a reasonable timescale. I note from the plans that this advocacy part will come into force straight away, as soon as Royal Approval is given to the proposed Measure. So, a lot of lead-in work and training of advocates are needed to ensure that we are not creating yet another expectation that we will not be able to meet.

Christine Chapman: On the regulations, there are a number of subsections in the proposed Measure that give Welsh Ministers the power to make regulations. Does the proposed Measure achieve the correct balance between the powers that it contains and the powers given to Welsh Ministers to make regulations?

Professor Fennell: As you have no doubt heard in the ministerial evidence, flexibility is needed to respond to changing circumstances. That is the argument. However, the other side of that is that a great deal of the detail remains mysterious. A great deal of it will be in regulations. For how long after you have been discharged will you be entitled to continue asking for an assessment? What professions will care co-ordinators come from? There are something like 18 powers. Two of them require affirmative resolution, and the others require only the negative procedure. I think that that balance is wrong, to be honest. There is too much that is being left to regulation and not enough on the face of the proposed Measure.

Joyce Watson: Good morning. It has been fascinating listening to you and reading your paper. Thank you for that. I will move on to the issue of the regulatory impact assessment. Do you think that it makes a realistic assessment of the financial implications of the proposed Measure? If not, could you outline some of the shortcomings?

Professor Fennell: I have had a look at it. As I said, I am not an economist, but these are the things that struck me about it. First, there is £0.5 million for a lead. I am not sure whether that will cover the leads in the local health boards as well or whether local health boards will be paying for those. Then, it says that it will cost £5 million up to year 3, as I think it is referred to in the assessment, which is 2012-13. When it starts up, there will be £3 million extra a year going into primary mental health services. What is not clear to me is how much of that £5 million is the cost of implementation, drafting, and guidance and training. If that £5 million is all to do with implementing the legislation, I would rather see the £3 million a year starting next year and no legislation than all of this detail. That is my concern. It is not clear to me what the cost of doing this will be. It is not crystal clear what the £5 million will cover.

Joyce Watson: Looking at the other side of that, some witnesses have said that the proposed Measure could achieve savings by reducing the reliance on long-term and more specialist interventions. Do you agree with that?

Professor Fennell: Yes, I do. Intuitively, it seems right. However, the question is how you quantify that. We can quantify cost, and we can say quite blithely that there will be an injection of £3 million a year into primary care services, but on Thursday we will start the process of a new Government, and we are told that any new Government will have an agenda of cutting expenditure, rather than of increasing it. So, those promises can be made in all honesty and sincerity now, but whether they can be delivered in three years' time is another matter.

David Lloyd: Joyce, I think that the last question about Scotland has been answered.

Joyce Watson: Mostly, yes. Unless you think that there is anything specific that we can learn from Scotland.

Professor Fennell: Scotland, as I say, has these two duties in sections 227 and 228 of its Act. It has a code of practice that states how local authorities are to implement this and what health bodies are to do to co-operate, and it has directions that it has issued to mental health officers, who are the people who will be implementing all of this. I have copies of all of those and can easily leave them with the committee. However, there is much less regulation and much less legal volume. I tried to find out what the impact had been, and I phoned various people whom I know in Scotland, who said that there is no real clear evidence. Its mental health Act has been recently reviewed, but this bit was not reviewed. It was mainly the tribunal and other things that were looked closely at.

<p>David Lloyd: Diolch yn fawr iawn. Dyna ddiwedd y rhan hon o'r cyfarfod. Diolchaf yn fawr i'r Athro Phil Fennell am ei gyfraniad arbennig y bore yma. Fe'i hysbysaf y bydd y clerc yn danfon trawsgrifiad drafft o drafodion y bore yma ato i gael eu cywiro cyn eu cyhoeddi'n derfynol. Diolch yn fawr iawn i chi am eich cyfraniad y bore yma.</p>	<p>David Lloyd: Thank you very much. That is the end of this part of the meeting. I thank Professor Phil Fennell very much for his special contribution this morning. I inform him that the clerk will send him a draft transcript of today's proceedings for correction before it is finally published. Thank you very much for your contribution this morning.</p>
<p>Dechreuwn yr ail sesiwn yn syth. Croesawaf i'r bwrdd gyfeillion o Gymdeithas Feddygol Prydain, sef Dr Andrew Dearden, cadeirydd Cymdeithas Feddygol Prydain, a Dr Victor Aziz, sy'n seiciatrydd ymgynghorol. Hefyd, o Goleg Brenhinol y Nyrsys, croesawaf Dave Williams, yr is-gadeirydd, a Martin Semple, cyfarwyddwr cyswllt Coleg Brenhinol y Nyrsys. Hefyd, o Goleg Brenhinol y Seiciatryddion, croesawaf Dr Helen Matthews, cadeirydd is-adran Cymru. Croeso i bawb. Yr ydym wedi derbyn eich papurau ysgrifenedig, a diolch yn fawr amdanynt. Mae ystod o gwestiynau wedi'u paratoi ar eich cyfer, sy'n seiliedig ar eich papurau chi. Diolch yn fawr am eich gwaith caled hyd yn hyn. Mae'r cwestiynau yn cwmpasu ystod eang y Mesur arfaethedig hwn, ac mae cryn dipyn ohonynt—rhyw 20—ac mae gyda ni rhyw awr i'w hateb. Felly, gofynnaf i'm cyd-Aelodau gadw'r cwestiynau'n gryno, gan obeithio felly y bydd hynny'n ysbrydoli atebion cryno hefyd. Deallwn hefyd fod bwysau amser ac y bydd rhai Aelodau efallai yn gorfod mynd a dod yn ystod y sesiwn dystiolaeth. Derbyniwn hefyd y bydd angen efallai i Dr Andrew Dearden ein gadael ar un adeg. Deallwn hynny'n iawn.</p>	<p>We will start the second session immediately. I welcome to the table colleagues from the British Medical Association, namely Dr Andrew Dearden, chair of the British Medical Association, and Dr Victor Aziz, who is a consultant psychiatrist. Also, from the Royal College of Nursing, I welcome Dave Williams, the vice chair, and Martin Semple, associate director of the Royal College of Nursing. Also, from the Royal College of Psychiatrists, I welcome Dr Helen Matthews, chair of the Wales division. Welcome to you all. We have received your written papers, and thank you very much for them. We have a range of questions prepared for you, which are based on your submissions. Thank you very much for your hard work so far. The questions cover the broad range of this proposed Measure, and there are quite a few of them—around 20—and we have around an hour to answer them. Therefore, I ask my fellow Assembly Members to keep their questions succinct, which will, hopefully, also inspire succinct answers. We are also aware of time constraints and that some Members may have to come and go during the evidence session. We are also aware that Dr Andrew Dearden may have to leave us at some point. We understand that completely.</p>
<p>Awn yn syth at y cwestiynau, felly. Dechreuaf gyda rhai cwestiynau cyffredinol. Nid oes rhaid i bawb ateb bob cwestiwn. Os ydych yn credu bod rhywun wedi rhoi ateb arbennig, medrwyh gytuno â'r ateb ac fe symudwn ymlaen, neu efallai y byddwn yma drwy'r dydd. Mae'r cwestiwn cyntaf yn un cyffredinol i bawb. A ydych yn cefnogi amcanion cyffredinol y Mesur arfaethedig hwn ar iechyd meddwl?</p>	<p>We will go straight to questions, therefore. I will start with some general questions. You do not all need to answer every question. If you feel that someone has given a great answer, you may agree with it and we will move on, or we may be here all day. The first question is a general one to all of you. Do you support the overall aims of this proposed Measure on mental health?</p>
<p>Dr Matthews: Diolch yn fawr. Mi siaradaf yn Saesneg, neu mae gennyf ofn y byddaf yn siarad Wenglish wrth drafod materion mwy technegol.</p>	<p>Dr Matthews: Thank you very much. I will speak in English, or I am afraid I will turn to speaking Wenglish when discussing more technical matters.</p>

Thank you for the invitation. In broad terms, the college would support the objectives of the Measure and welcomes the approach to preventative and public health mental health in this area.

Dr Deardon: The British Medical Association is certainly supportive of the actual aims of the proposed Measure. Our only concerns are those things that tend to limit all good intentions, which tend to be funding, resources and manpower.

9.40 a.m.

Mr Williams: The Royal College of Nursing was a strong supporter of the legislative competence Order on mental health and we welcome the development of the proposed Measure.

David Lloyd: A ydych yn credu y gall amcanion y Mesur arfaethedig ar iechyd meddwl gael eu cyflawni drwy ddefnyddio deddfwriaeth sydd eisoes mewn bodolaeth? Ni wn pwy yw'r arbenigwyr cyfreithiol yma.

David Lloyd: Do you believe that the aims of the proposed Measure on mental health could be achieved by using the existing legislative framework? I do not know who the legal experts are here.

Dr Matthews: As we have expanded upon in our written evidence, it seems that we could be using a number of what could be thought of as sticks to try to achieve what should have been achieved through many initiatives over the years. The discussions of our membership tried to explore the barriers to implementing many of the changes that have already been supported in a range of guidance. I suggest that, in Wales, we have been slow to apply sufficient rigour to our evaluation of various initiatives over the years. We would seek to have incremental change rather than using a stick for some measures and using the energies in the proposed Measure to explore some of the reasons why some systems have not operated.

David Lloyd: What is the BMA's view?

Dr Dearden: One of the difficulties in using legislation to force good practice is that it rarely looks at the reasons why good practice is not automatically implemented. One of the dangers of this is a target mentality that says, 'We will do this regardless', which tends to deviate funds, personnel and so on from other worthy areas. One question that you need to address is why good practice has not been implemented when everyone accepted it as such. Those barriers need to be addressed before saying, 'You now must do this'. What we do not know, because we almost never look at this in impact assessments, is the clinical impact of targets or legislation on other parts of mental health services.

David Lloyd: Does the Royal College of Nursing think that we could do this within existing legislation?

Mr Williams: No, and I do not think that we can do it with the existing level of staff.

William Graham: To go on to 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 the relevant parties?

Dr Matthews: There are elements that have not been acknowledged in the explanatory memorandum that are key providers of mental health services. I suspect that it is because they are outside the legal competence of the National Assembly for Wales. The most notable is the National Offender Management Service, which provides mental health services for people on probation and in the prison service. An additional area is the treatment of substance misuse, which overlaps with the Ministry of Justice. I do not see those areas even acknowledged in the explanatory memorandum, which is potentially a serious deficit.

As regards the definitions in sections 11 and 12, in our written evidence we have talked at some length about definitions of who is in secondary mental healthcare. Some of the developments proposed in the proposed Measure have been met to an extent because the barriers between primary and secondary care have been broken down. A concrete example would be where one would place crisis resolution teams. Are they in primary or secondary care? If all service users who use crisis resolution services or are seen by liaison services in district general hospitals were considered in the proposed Measure, it would be a very significant number of the population.

The second area is the definition of a mental health service provider. Again, I echo the comments that I made earlier. I would also suggest that more should have been made of section 16, where there is a duty to co-ordinate the provision of mental health services. Perhaps sufficient regard has not been paid to that whole issue in the explanatory memorandum.

David Lloyd: Does the BMA have a view on that?

Dr Aziz: Dr Matthews and I have spoken about this, and it is important to look at the whole picture. One example is GP liaison, because plenty of the time secondary mental health services are provided for patients in GP surgeries, which makes the boundaries bigger, and we need to tighten up those boundaries.

David Lloyd: What is the Royal College of Nursing's point of view on the definitions?

Mr Williams: My view is that the boundaries are being broken down, and that secondary services are moving into surgeries. I am a nurse practitioner in the community, and the only problem that I have is with discharging patients from secondary care into primary care. Rather than bedblocking, we have delayed discharges through that. So, the sooner we become one entity, the better it will be for the service user.

David Lloyd: Do you wish to add anything, Andrew?

Dr Dearden: I will just make a short contribution. One concern if we stick to the definitions of 'primary' and 'secondary' is that that will take us away from the patient and the severity of their condition. The assumption is that the very severe must be in secondary care and the very mild must be in primary care, but, in fact, many patients prefer to be in primary care so that they are not seen as secondary care patients. So, perhaps over time, we might make the move and change the terms that we use, which define patients. Perhaps we should be defining the patient according to their condition, how severe it is, and what they need, as opposed to where they receive treatment. Perhaps it is a philosophical point, but it is one that we should move towards.

William Graham: On the timescales, witnesses from the voluntary sector have suggested that time frames should be 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 the assessment, and 60 days between qualifying as a patient under Part 2 and the completion of a care plan. Do you agree?

Dr Matthews: In principle, I would totally agree with getting access to services as quickly as possible. I would urge caution, however, because that would bring the targets forwards significantly as compared with the targets that the services are working towards currently. For example, within the annual operating framework for local health boards, clinicians work to a 10-week waiting time and, in children's services, they work to a 16-week waiting time. I do not have the detail of the statistics on how those targets are looking, and it may be appropriate for the committee to consider approaching the national statistics and analysis unit for a current update on those targets, and specifically the mental health areas, to see how they are being met. That could provide a rich vein of information on the practicality of achieving such aims.

David Lloyd: Would the BMA like to respond?

Dr Dearden: The difficulty that we have is that, whenever we are not reaching a target, we have to go back to the causes. We have to ask what is causing that—is it that we do not have enough manpower or resources? If everyone is meeting the 10-week target, suddenly to ask them to achieve that within a shorter period of time assumes that more can be done with the same number of personnel. Earlier, there was a question about advocacy. Advocacy needs three skill bases: advocates need to understand mental health and mental health services, which are two completely different knowledge sets, and they also need to have advocacy skills. If the people who have all three are now working at full pace, and you suddenly say, 'You now need to take on more people', you will actually be asking a great deal of them. Look at the time and money spent dealing with waiting lists in hospitals. That should give some indication of what is required to achieve shorter waiting lists, and yet this would require the same amount of investment. So, simply to say, 'You will do it by this date' would place a strain on resources. As I said in my initial statement, the problem lies with where you take those resources from. You tend to take them from an untargeted, unmeasured, but no less important area. In other words, people will make sure that they achieve whatever it is that you make important to measure.

9.50 a.m.

Mr Williams: It is an area of consistent concern for service users and carers. The review of the care programme approach in Wales has revealed a very disappointing level of compliance within the service. It is essential for there to be clearly planned care delivered in a collaborative manner. That would require a step change by all in the approach to service users' involvement and to develop staff to support their ability to deliver.

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. Other witnesses have argued that it should be extended to include children and young people, and I would be grateful for your views on that.

David Lloyd: Dr Matthews, you are in the frame.

Dr Matthews: We would totally support that. If we are genuinely going to go for a preventative strategy, the proposed Measure will have to cover children and young adults. Allow me to give you some bald statistics: 50 per cent of mental disorders will have started by the time a person is aged 16, and 75 per cent by the age of 25. The early phases of certain serious mental illnesses also begin at that age, including anorexia and other eating disorders, early onset schizophrenia and bipolar disorder. However, equally important are the developmental disorders such as attention deficit hyperactivity disorder and autism, on which the Welsh Assembly Government currently has a strategy. There is also the whole area of young offenders, because the majority of young offenders will have started offending before the age of 18. That is also true of people with substance misuse issues.

Dr Dearden: This comes down to a basic tenet surrounding the word 'not'. If the legislation says that it does not support the extension of this to a certain age group, it would have to have a very good reason for not doing so. If there is no good reason, that group should be included. If this is good enough for a 21-year-old, why not for an 18-year-old or a 15 year-old? If you cannot 'not' support it, perhaps you should.

Mr Williams: I have a problem with young children being thrown into the mix with the adults, for example, placing a 16-year-old on a ward with 30, 40 or 50-year-olds who are long-term mentally ill. The time to catch them is when they are young, to identify the first episode of mental ill health, whether it be psychosis, eating disorders or substance misuse.

Dr Dearden: I apologise if we did not present our view clearly enough. We are not talking about lumping the age groups together, but about having the same level of service provision adapted to their age. That is what we would want: the same level of care regardless of age, related to the severity of the illness.

Peter Black: I was just going to clarify the question along those lines, so thank you. Section 2 of the proposed Measure provides for joint mental health primary care schemes to be agreed by the local mental health partners. Should more detail on the contents of such schemes be included on the face of the proposed Measure? Perhaps the BMA should start on this one.

Dr Dearden: Simply put, we would support a lot more services being available for patients, certainly in community care. One challenge that primary care often faces is that, as the increased workload has hit both primary and secondary care, the latter has quite rightly focused on the more severe end of the scale. The difficulty then is that primary care—and let us call them general practitioners for the moment—have always done what general practitioners do, namely slowly expand into the mild to moderate group. However, there is a group of people in the middle, who are perhaps not quite severe enough to warrant an urgent assessment, but who are too severe to be left where they are. We talk about the separation of the two services and I am speaking now from a primary care point of view.

A simple example is that a GP colleague of mine tried to contact the local health team at 5.30 p.m. on a Friday only to find that it had closed at 4 p.m.. That same GP then contacted the crisis team, but was told that they were busy and was asked to ring back in an hour, by which time the patient had left the surgery and was uncontactable over the weekend. So, there is this middle ground—and you might call them 'intermediate' services—for which much more is required. That is not to criticise either primary or secondary care; it is simply to recognise that the more severe the patient, the more likely it is for those who are experts in the severe end to tackle that. There is a real gap in the middle for simple counselling services. Many practices now have a counsellor on site. I have one, and I would say that she is as valuable as any GP who works in the surgery, because of what she can do and how she can help. However, there is that increasing gap, so we would be happy to do anything that we can to support people in that moderate group and, hopefully, stop them from getting into it. To go back to that example, the person I was speaking about had an urgent assessment query for sectioning on the following Tuesday, because they had deteriorated over those three or four days. For that time, they were not quite there and there was difficulty finding something suitable for that intermediate part. So, we would be fully supportive of anything that we can do, especially on the more preventative side. We will not prevent all cases, but we can prevent some from progressing to the point at which they need in-patient treatment or even sectioning.

Dr Aziz: The biggest problem that we have is not primary or secondary care; it is options. Whether it is in the middle of the day or the middle of night, you are stuck with a patient whose needs you want to meet, but there are no options in the community. We need to strengthen and widen the options, whether they are in intermediate care, rehabilitation or liaison, because unless you have options, you are stuck with the problem.

Mr Williams: I agree totally, but in some pockets in Wales there is a 24-hour service, so we need consistency across Wales. Another area over which I have concerns is specialist teams. We need specialist teams, but sometimes they have become so elitist that we cannot access them.

Dr Matthews: An additional point is that the proposed Measure potentially allows a revaluation of what we call 'primary' care, by acknowledging that we do not have primary health care and primary social care, but that they are integrated. If one were to take this proposed Measure seriously, one should consider having that integration more forcibly at the front end. When people go to their GP, as Dr Dearden mentioned in his scenario, it may be that they desperately need time in a supported residential setting or additional support over the weekend, which may traditionally have been interpreted as a social care element. So, it is vital for that integration to happen genuinely at the interface of primary care.

Peter Black: This question is specifically addressed to the Royal College of Psychiatrists. You say in your evidence that it is unclear in the proposed Measure whether local mental health partners would be required to plan and provide any or all treatments recommended in assessments, or whether this requirement could be interpreted in a more limited fashion. Can you explain your reasons for those concerns?

Dr Matthews: We took note of the content of the explanatory memorandum, which made the concept of treatment extremely wide—even to the extent of acting as a resource service and specifically offering some very complex areas of psychological treatment. Additionally, because this proposed Measure is very much conceived as a bill of rights, many people who currently do not feel eligible for secondary mental health services would come to this new enhanced service. Therefore, there could be quite a significant heterogeneous population coming along with an expectation of getting treatment at primary care level, be it in respect of psychosocial interventions or more traditional pharmacological and biological approaches. Unless there is some concept of how wide that remit is, the expectations raised could be really quite untenable. We could not find a clear recognition anywhere of the fact that some needs could go unmet, and there is no process for acknowledging and strategically harnessing needs that are unmet.

David Lloyd: Moving on, my next question is to the BMA. The proposed Measure allows but does not require local mental health partners to include within their schemes patients who are not registered with a GP. Could this result in the exclusion of some people who have mental health needs, or is flexibility needed to tailor schemes to local needs? Your paper talks about your concerns about how the mental health needs of ex-prisoners and ex-service personnel are met. Will the proposed Measure help to address those sorts of issues for people who are not registered with a GP?

10.00 a.m.

Dr Dearden: One of the great difficulties that we have is with that group of people whose needs we do not know. They include people who are registered with a GP, because many people register with a GP but do not come when they should. So, there are many proxy measures of need. However, there are large population groups that tend not to register with GPs: the homeless, for example, who have an extremely high level of mental health needs; travelling populations; and, the transient population who might have to move around because of the nature of their job, and so on. Students are another example. If you look at the number of students in Cardiff, we estimate that half or less are registered with a GP in the local area. It is quite possible to seriously underestimate the mental health needs of the population.

With the broadening of the health service, there are now several ways and points at which you can access mental health services. The gatekeeper role of the GP has been broadened, as is perfectly reasonable, but there are many other avenues for people to access mental health services, so simply using the numbers registered with a GP to plan services could result in a serious underestimation. I only have to point you to accident and emergency departments, for example, which is the commonest way for people to present with mental health problems. Another way is through the police. You can talk about social groups and the refugee council, and there are many other avenues that people might use. I was rung the other day by a university, commenting on someone living in my area who was not registered with me, asking what it could do, and how it could help. The danger is that you may seriously underestimate the level of services that you require, and if those services are needed, you would find yourself with a significant shortage.

David Lloyd: I have a related question, which applies to both the BMA and the Royal College of Psychiatrists: how effectively will the proposed Measure help to secure better services for people with multiple needs, such as those with learning disabilities and substance misuse problems in addition to their mental health needs? Should the proposed Measure be amended to specifically address these needs, which Dr Matthews touched on earlier?

Dr Matthews: The test of this proposed Measure, to an extent, would be whether it could improve services for these groups of people who often have complex and enduring needs, and genuinely require services to be provided in a new fashion, with a new value base. When we talk of a proposed Measure integrating health and social care, we are really talking about forming a new system of care. I would suggest that it may be useful for this committee to consider evidence from the new integrated family support teams, which are really coming into play following the Children and Families (Wales) Measure 2010, where similar concepts are being worked with. There are a number of overlaps that flag up that one really needs to think about quite differently integrated systems of care for the long term, rather than the possibly simplistic view that secondary care is an episodic element.

David Lloyd: Do the representatives of the BMA have anything to say about whether the proposed Measure will improve the service for those with complex needs?

Dr Aziz: It is important to look at this in a holistic way. There is a lot of integration between child learning disabilities and adult and old age learning disabilities. However, there are lots of gaps around perinatal psychiatry, substance misuse, forensic services and probation services. One of the most obvious examples is intermediate care or rehabilitation. Lots of patients are blocking beds in hospitals and we cannot discharge them because there are no available places. That is important. Unless we provide all of these services, and look at whether these services are available in Wales, integration will be nominal rather than clinical and practical.

Dr Dearden: To add one small point, we should not just look at the integration of services, but also the services for those who create the demand. You have the Crown Prosecution Service, the legal service and the probation service, all of which could impact on this. We were talking earlier about the difference where, for example, if a court in England made a determination about someone who was then either housed in or moved to Wales, how would the legal requirements of that court be translated into a different country's mental health system? It is not just integration of health services, but all the bodies involved with these groups, including the Home Office, the courts, and so on. We need to consider those as well as mental health services.

Christine Chapman: I have two questions for all of you. First, what challenges to primary care services do the provisions in the proposed Measure make, for example with regard to capacity to meet the new requirements? My second question is linked to the first: what is likely to be the impact on demand for secondary mental health services of the development of primary mental health schemes and assessments?

David Lloyd: Who wants to kick off on these questions? Perhaps the Royal College of Nursing can start; you have been quiet for a while.

Mr Williams: The insufficient number of healthcare professionals employed to provide an appropriate service is causing unacceptable delays in the treatment of patients in Wales. The lack of staff is not entirely due to the ability to recruit. In many cases, local health boards have not created a sufficient number of posts to respond to patient need. The Royal College of Nursing calls for a clear workforce planning strategy for mental health nurses in Wales, which will meet the future mental health needs of the people of Wales, whether they are children or adults.

Mr Semple: The challenge with regard to resources, both human and financial, may be significant, but there is also the potential for the creation of a demand that does not currently exist. The focus on prevention is clearly a welcome step forward, but it may encourage people who do not currently suffer mental health problems to explore services to maintain mental health wellbeing. All of the publicity about the effectiveness of programmes to prevent physical illness has now been transferred to the mental health community. So, it is not unreasonable to expect people to demand wellbeing services. Counselling has already been mentioned and we know from the literature that the public wants more psychological services, rather than psychiatric services. So, there may be an unseen demand that has been created by the focus on prevention.

Dr Matthews: There will be demands in primary care with regard to capacity and competency. A particular issue in Wales—I am talking specifically about medicine—is that we are not translating that many of the undergraduates from our medical schools into doctors who will carry on working in Wales. After people qualify, they spend their first two years in what are called foundation years—foundation years 1 and 2—within which they sometimes experience the NHS in Wales, which does not have particular models to integrate mental health and physical care. So, anything that they may have encountered at undergraduate level is perhaps more emphasised within their foundation years. I will give concrete examples: how many pain and stroke services in Wales have experience of what are called traditional mental health and physical health practitioners working together? How well have we developed liaison psychiatry services working at both primary and secondary care levels? These are critical times, when people are being trained in the early years after they graduate. We probably have the lowest number of foundation posts for mental health services in the UK.

We were reflecting only last Friday in the psychiatric school, which is the deanery structure for organising mental health training for doctors in Wales, on the more specialist levels for both general practice and psychiatry. We are not the only area, but we are still, unfortunately, at one end of the spectrum in the UK of having a paucity of psychological training opportunities for doctors. So, it is in that context that we are trying to bring in a proposed Measure. It is something that we desperately need, given that it is in the fundamental area of how we provide psychosocial interventions. One reason why some people leave Wales to receive higher training in psychiatry is because it is perceived that there are some opportunities that they cannot get here that they could get in England, which does not put them in such an advantageous position.

Dr Dearden: To follow up on Helen's point, we must understand where we are starting from. With regard to GP numbers per head of population, Wales has between six and seven GPs per 10,000 people, and England has between seven and eight. The number of junior doctor vacancies in Wales, as a percentage of posts, exceeds that in most parts of England. So, we are already starting from a lower level of training and in terms of the number of people present.

10.10 a.m.

I am sure that if you talked to the health visitors, district nurses, and GPs about health visitors and district nurses, you would find that they would tell you the same thing. We seemed to have more in the past, but we are struggling for those now. We are now talking about a whole new group that we want to bring in and to cover. As I said before, we are recruiting from a very small skill base in Wales in terms of population, but also in terms of opportunity. I will give you an example. I realise that this will be recorded; therefore, I will tell you that it is a personal example. I wanted cognitive behavioural therapy training. As a GP, many of my patients were talking about it and I was fairly unfamiliar with it. I searched around for a training programme that I could attend that could tell me about it. I ended up in WHSmith, buying the idiot's guide to CBT because that was the quickest thing that I could get to read or go to, where I could actually work out CBT. As a GP, and as chairman of the BMA in Wales, I could not find an appropriate CBT training programme that was available or would accept me, if I might make that subtle point. Therefore, I ended up in WHSmith.

David Lloyd: Did they accept you?

Dr Dearden: They certainly accepted my money. The book itself was extremely helpful and I have lent it to three patients. Unfortunately, the third patient did not bring it back. It was very simple and helpful, but although I know my way around the health service I could not find the appropriate training. Therefore, if I was a junior doctor, flat out in work, for me to try to find a programme that I could go to and receive one or two days of updating would be nigh on impossible.

David Lloyd: Gan symud ymlaen, mae'r cwestiynau nesaf yn nwylo Joyce Watson.

David Lloyd: To move on, the next questions are from Joyce Watson.

Joyce Watson: Good morning to you all. I am going to ask some questions on Part 2, the co-ordination of and care planning for secondary mental health service users. Do you support the introduction of the duty in the proposed Measure on mental health care providers to appoint a care co-ordinator who will draw up a care plan for each patient?

Dr Matthews: In principle, yes. Again, it is a recurring theme to ask, 'What have been the barriers to us doing that already?' We have had the care programme approach, which has been subject to annual operating framework targets. I used the term 'stick' earlier. It is about as tough a stick as you can have within services. I do not think that it is not within the will of services to do it; I think that we really need to be exploring some of those barriers, some of which we could hypothesise around. I would also like us to echo the concept of who is in secondary mental health services. The real concern of the membership is that what has been totally laudable and are aims that we totally support has become overwhelmed by bureaucratic processes, for the care programme approach, but also for the unified assessment process. Both of these processes seem to have taken on—to use a colloquialism—a life of their own, which seem to be quite divorced from everyday practice.

Dr Dearden: Sometimes the process becomes the aim. If the process is a good one, and that means measurable paper trails and so on, somehow we feel that we are doing it. We do not always measure the results, benefits and blocks to that, but I will just echo everything that Helen said. One of the great difficulties that we have—and I will try to say this sensitively—is that those who are not always directly involved in patient care focus on the process of the care, as opposed to the care itself, which can be extremely distracting because we have to feed the process rather than care for the patient.

Dr Aziz: I have just a simple comment. In the SaFF targets, there is an old age liaison, but that target has not been met anywhere because of resource issues. It is very important to look at resources and training. There are revalidation appraisals and many things that are now interfering with simple targets.

Mr Williams: I am in total agreement with having a care planner and a care co-ordinator. First and foremost, how can you formulate and implement a plan without having some co-ordinator there to arrange all of this? I totally agree with it.

Joyce Watson: This is a question for the Royal College of Psychiatrists. You state that the introduction of compulsory care planning may have unintended consequences. What more would you like to tell us about that and how it should be addressed?

Dr Matthews: The introduction of the care programme approach was associated with a number of community mental health teams discharging people back into primary care—people who might have been perceived to be at the softer end of secondary care—because of the demands made. In some ways, that could have been totally laudable, because a six-month wait for an appointment with a junior doctor is not the most effective way of meeting healthcare needs. However, if there were to be more stringent areas of compulsion, picking up Andrew's earlier point, people would then say 'If I've got to do all of this paperwork and follow all of these new systems' and more people could be precipitously discharged from secondary care, because they would not be subject to those stringent conditions.

The other point is rather more philosophical and ethical. Why have we brought in a legislative framework for the co-ordination of care for people with mental health needs? Why are they different to people who have had a devastating stroke or people with a complex oncology condition? What is so ethically different? Our real philosophical concern is whether this could be perceived as yet another way of setting up a barrier or a perception that mental healthcare is entirely different and for the people in that system to be so negatively perceived that they need a legal framework for their care planning. We have stigma among the general population, but let us not forget that some of the greatest stigma, unfortunately, is within health and social care organisations. You would not want the perception to be 'That's the mental health patient; they've got one of those Measure-type care plans'.

David Lloyd: Dr Dearden has a point on this.

Dr Dearden: To follow on in support, there are two things that I sometimes see happening when you introduce a new measure of whatever kind. First, if that measure or assessment qualifies you for certain benefits or services, more people will apply for it, because they will see the benefit of going through the process and having those things. Secondly, if the person doing the assessment knows that they only have three places, they will make the assessment tougher so that only three people will get through, and because of that, as was mentioned, others are allowed to go somewhere else. So, there is a need to ensure that assessments are not done in the context of 'We can only let three people pass', because what happens to person No. 4, who, if there were four places, would have passed? There is a real issue about ensuring that what you agree that a person needs is in place, otherwise, the next time that we meet, you will be legislating for the things that the assessment said that they should have, but they did not have. There are knock-on consequences; it is all well and good to say 'I need a car', but if there is no car for sale, I will still need one.

Joyce Watson: My final question is to the RCN and the RCP about the care programme approach. You have both expressed concerns about the existing care programme approach. To what extent will the provision of the proposed Measure around service co-ordination and care planning in secondary mental health services help, in your opinion, to address those issues?

Dr Matthews: At the risk of echoing some of my comments, there are ongoing reservations about what has stopped us from doing things to date. There could be prioritised services, but you could be looking at something like the system in England at the moment, where there has been a change in the care programme approach and secondary mental health services have a group of people who are subject to the care programme approach and another group who are not, but still have to have care plans. So, you could end up with a fudge. It may be worthwhile for the committee to consider the evidence about this revision of the CPA in England in 2009 to see what the impact has been of having people in the CPA and outside the CPA in secondary mental health services.

Mr Williams: It is a way of formalising what we already do. In this day and age, everything needs evidence. This is a good way of showing, not only discharges, but what treatment is needed, why you do not get it and how you access it. It is a good paper trail and it gives a good sense of the whole package and what the whole client needs.

10.20 a.m.

Mr Semple: One of the challenges of the care programmes approach was the degree to which so many clients were non-compliant with treatment. There are obviously other parts of the service where compliance is high, so what criteria increase compliance? The question for this proposed Measure is: is the role of the co-ordinator the necessary missing link? There are examples across Wales of excellent mental health care practices, which put the patient with mental health problems right at the centre of the service. It is not just about the service. Let us look at what existing services we have. I recently saw a fantastic example of a personality disorder service where the clients themselves ran the service with facilitative input only from some mental health experts, which is a really unusual way of approaching things. Compliance within that group with the care plans that have been agreed is fantastic. It seemed to me that the key there was agreement. To what extent, in some other systems, is there prescription of a plan, rather than agreement of a plan? Is that one of the criteria that leads to compliance?

Mr Williams: The care plan is carried out in collaboration with the individual, the carer and whoever else who feels fit to be part of it.

William Graham: In terms of Part 3, assessment of former users of secondary mental health services, what do you believe would be the benefit of providing for self-referral of former users of secondary mental health services? Do you have concerns about this requirement?

Dr Matthews: The advantages potentially could be that people could receive the appropriate level of care as quickly as possible, and back to the same group of people. Going back to the comments made earlier, some of the difficulties may be around what currently constitutes secondary care. Is one to perceive that everyone who had had contact with what is now traditionally called secondary care, be it an accident and emergency assessment by a liaison psychiatric service, perhaps some outreach work into a general practice surgery from secondary care, possibly as part of a court diversion system. How you define secondary care could be extremely difficult, because the person themselves might perceive that they have been in secondary care. There is then the whole area of more transitory populations, such as in university towns, the homeless, as we have said already, and people who are in residential colleges. How do you define whether people are eligible for such a scheme? Would all the people who have had contact with secondary mental health services as a child be eligible? The population that could potentially be referred back in, or would perceive that they had a right to come back in, could be significant. It may be more appropriate to intertwine this with better implementation of the care programme approach, if that is the route that we are to follow, to say that it is at the termination of a programme under that aegis that one would allow re-entry.

Dr Aziz: I believe that I am talking now as a psychiatrist as well.

David Lloyd: It is a very difficult challenge, but I am sure that you are up to it.

Dr Aziz: It is very important for services to be accessible and available, so we fully agree on that principle. The problem is that it is also a problem of resources, because, on the other hand, you need staff, training and resources to direct people where it is appropriate. Most of the time, we see plenty of people who just have grief reaction and there are no counselling services there. With plenty of the people we see in a functional clinic, rather than with regard to anxiety or depression, there is only one person involved, in an out-patient clinic or with the consultant. So, a care plan there is about being seen, followed by agreeing a treatment and then receiving the treatment. This is also the definition of a care plan and what we mean by it and the available resources everywhere else. As we said, the holistic approach is very important.

Peter Black: Moving on to advocacy, Part 4 would extend the provision of independent mental health advocates to Welsh qualifying compulsory patients and Welsh qualifying informal patients. Do you believe that this would benefit the users of secondary mental health services?

Dr Matthews: Undoubtedly. I would really like to echo the comments that I overheard earlier from Professor Fennell. There have been provisions for doing this for ages. It is about seeing how one can actually provide the services. This is to do with resources, because mental health services have a strong tradition of championing advocacy. Certainly, the royal college has a strong tradition of employing advocacy—and all its different models. In that way, we would have no difficulty. It is really about the practicalities: are we going to put resources around such a wide group of people, particularly as one would have to consider that, for all areas, we would really be talking about 24-hour advocacy, 365 days a year? It would mean acknowledging that some of the most complex advocacy one would ever have to do would be for people in acute situations, looking, for example, at sections 5(2) and 136.

Mr Williams: This expansion of advocacy entitlements will require investment in the support and development of advocates specifically trained for and educated on this complex field. If I may, I would like to go back briefly to the last question about the entitlement to an assessment when you have been discharged.

David Lloyd: Yes; you are talking about self-referral.

Mr Williams: Yes. This is perhaps the boldest change, circumventing the traditional patterns of referral and empowering service users to reassess the services that they need. This clearly has implications for the secondary services, which would require the capacity to screen and assess referrals that would normally be handled by a GP. When I discharge somebody, the letter states that they can ring the secondary services directly.

Dr Aziz: I think that Andrew answered this question earlier by referring to three very important points. There must be knowledge of mental health, knowledge of mental health services, and there must be advocacy skills. You need these three things to be available before we can say that everyone is entitled to an advocate. The other very important point with regard to the proposed Measure is that a doctor/patient relationship is triangular, because it involves the families and carers, who form a very important group of advocates, because these people know the patients and service users very well. We do not want to ignore them.

Peter Black: Of course, the legislation excludes family members acting as advocates, as the Minister made clear last week. Should our duty to provide advocacy services be extended so that it includes all users of mental health services, including those in primary care?

Dr Aziz: It should be everywhere. As Dr Helen Matthews said, in district general hospitals, it is very common for us to see patients who have suffered a stroke. We see plenty of patients in an acute confusional state. It should not just be about mental health patients; it should be available for everyone.

Dr Matthews: This may be an auxiliary response to your other question, but my understanding of the proposed Measure is that this is a provision for all people admitted with a mental disorder. That would be the greatest challenge, and, potentially, it would be the greatest change in terms of outcomes. For example, talking about the 1000 Lives campaign, we should look at advocacy for people in secondary physical care settings. You must remember that, of the people aged over 70, some 40 per cent of them will have some element of dementia. Are we really saying that we are potentially going to have advocates for all of those people within the district general hospital setting? Is that what we really mean? Perhaps the load would be very light. What we know of that 40 per cent of people over the age of 70 in district general hospitals is that only about half of them are recognised by their caring physicians as having dementia, so those people would not be referred for advocacy. So, you must look at some quite fundamental values within our health and social care services at this time.

Peter Black: Dave, should advocacy be extended to all in primary care? That would be everyone, basically.

Mr Williams: Yes. Everyone should be entitled to it. Obviously, there must be criteria. Otherwise, it would be diluted too much.

Peter Black: Dr Matthews said that you would have to be recognised as having dementia before you are entitled to access advocacy services. How do you square that circle?

10.30 a.m.

Dr Matthews: A particular hobby-horse of mine is that we are perhaps not an emotionally minded health service and I think that there is a lack of recognition across all professional groups in health and social care of mental disorder and integrating care planning, treatment and support and of recognising people's mental and physical health. I am sorry that I came back and responded rather fully on the secondary care element of people being admitted to district general hospitals, but if you really want to use definitions, you will find that one in four people have a mental health problem in the various epidemiological surveys. Are we really saying that one in four people will have an advocate to help them negotiate our health systems? Are our health services so poor that one in four of us needs an advocate to negotiate them? Is it perhaps that we need to look at the system? I suggest that rather than invest in advocacy, we perhaps need to invest in changing the systems through which people are receiving their health and social care.

Mr Sample: Only now are we learning lessons from the independent mental capacity advocates about the skills that they need. I agree with the points made earlier, that the knowledge skills that are needed are significant and they take time and investment to develop. I would like to come back to the point made earlier by the Royal College of Psychiatrists—it is indeed the case that if we are taking a preventative approach, there are people who may feel sad and feel that they have a mental health disorder. The definitions are so important and yet they have so many blurred and unclear boundaries. I have not made any comments on resource issues, but this is a really important issue, because we know the efforts that the IMCAs put in are huge and that this group has access to a much wider range of the population, so we need to think about this very carefully.

Peter Black: I am going to take all of the concerns about capacity and ask you to think like accountants. The regulatory impact assessment has set the total cost of extending advocacy services as £1.5 million a year, plus initial one-off funding of £500,000. Is that enough?

David Lloyd: A 'yes' or 'no' will do; we do not need a breakdown of figures.

Peter Black: You can give me another figure, if you want. ["Laughter".]

Dr Matthews: From the flavour or tenor of my earlier comments, I would say that if one were going to be genuinely all-encompassing, as the proposed Measure seems to imply, it would not be enough and then one would need an army of advocacy systems within our district general hospitals and primary care settings. However, let us not be pessimistic and lose the flavour of this proposed Measure. Is it perhaps that we need to think about our primary care settings being quite genuine resource settings? I noted from last week's transcript of the evidence that you took from carers and people who had experienced mental disorders that they felt that there were particular deficits in terms of getting good information. There is a wealth of available information, leaflets and sources, but we are not particularly good at bringing that information to the forefront for people. We have spent a lot of energy on trying to get such things as unified assessment processes. If we tried to simplify things and got unified assessment processes happening alongside primary care physicians, that could make a significant difference quite quickly.

Mr Williams: I think that this comes down to capacity again. That is a major issue. If the funding is not capped, it will run into billions, never mind millions.

Dr Aziz: Before we came here, we made calculations of this. If you look at how many people you can employ for £1 million or £500,000, if you are going to employ someone for £15,000 or £20,000 you need to add at least one third again for that person's pension, national insurance contribution and everything else, so you are looking at appointing 50 people in Wales. So, if you are going to appoint 50 people, what is the capacity of each one? It is perhaps 20. So we are looking at a small number in terms of capacity for that amount of money when you consider the population of Wales. So, it is an underestimation.

David Lloyd: Yr ydym yn dod tuag at y diwedd. Dim ond tri chwestiwn sydd ar ôl ac y mae'r ddau gwestiwn nesaf o dan ofal Christine Chapman.

David Lloyd: We are coming to the end. We only have three questions left and the next two are from Christine Chapman.

Christine Chapman: To further explore the cost implications, first, are you content that the regulatory impact assessment makes a realistic assessment of the financial implications of the proposed Measure? For example, would the proposed Measure result in extra costs in meeting new staffing requirements?

Mr Williams: You will find in all health boards that everyone is cutting things to the bone, and that there is no money to play with. There would definitely be a cost.

Mr Semple: There will clearly be a need for a lot of extra resource. This legislation runs alongside 'Designed for Life', which aims to shift many other secondary care services into the primary care sector. To what extent are we blurring the boundaries with this huge shift from secondary to primary care?

The second point is that it is not just about staffing costs. We are talking about a workforce, as you said earlier, which is very poorly informed about mental health problems, the solutions and the advocacy needed to achieve those solutions. So, all that training and continuing professional development is needed to go alongside staff that we do not currently have. So, the costs are significant. I am not a calculator man and I do not feel qualified to say what numbers of zeros are needed to meet that need.

Christine Chapman: Some witnesses have said that the proposed Measure could produce savings by reducing reliance on long term and more specialist interventions. Do you agree with that? Could those savings offset the extra costs? That is also a question to the other witnesses.

Mr Semple: My honest response is that I do not feel qualified enough to know how much would be saved from secondary care settings that would enable new primary care developments. I am fairly confident that the engagement with local authorities has the opportunity to de-stigmatise some of the mental health issues. On the example that I gave earlier of the personality disorder measure, the clinic was run in a university, which was considered to be the centre of the local community. So, there is much potential there, but I cannot calculate the costs versus the savings.

David Lloyd: Dr Matthews, will you comment on whether early intervention saves money in the long term? That is the balance that we are trying to advance.

Dr Matthews: It does in the long term, but there are qualifications to that. For example, there have been recent papers about the treatment of chronic fatigue syndrome, which is a core type of disorder that could be supported in this way to prevent major devastating disabilities for individuals and their families. What is coming through is that unless one gets the correct combination of therapists—it is not just about offering a form of graded exercise and cognitive behavioural therapy, but about having the individual therapists with the right set of skills at the right time in the patient's illness journey—you do not get the evidence that is shown at one year. Otherwise, there is a risk that people will have therapy and see initial improvements that are not sustained at one year. I do not want to sound pessimistic, but there is no nice neat response to these cost-effectiveness type of programmes. However, perhaps we need to be a little more rigorous in evaluating what we do.

I also wish to bring to the committee's attention that I suspect that by raising expectations the proposed Measure will tap into a whole group of people whose mental health needs are not met. You referred earlier to some of the disadvantaged groups. I suspect that there will be significant numbers of additional referrals to secondary mental health care for some areas of practice. I can only reflect on the fact that the Royal College of Psychiatrists' experience is that the autism spectrum disorder strategy has raised expectations already and a number of areas are getting increased referrals of people with autism spectrum disorders. That is very appropriate, but are we struggling to meet those needs at the moment.

Dr Aziz: The concern is a cut in resources everywhere. We have gone through a period of reconfiguration in Wales, and there is a single budget in the local health board between primary and secondary care and the concern that we have is that there will be a shift of resources, because we do not have adequate resources available at the moment to carry out the proposed Measure, so resources will have to be shifted from somewhere else. Mental health care, both in primary and secondary care, is already suffering from a lack of resources and from competing for resources with everyone else. By adding the proposed Measure, you will be adding to the competition. Whatever happens, somewhere else will suffer.

10.40 a.m.

David Lloyd: Yr ydym wedi cyrraedd y cwestiwn olaf a bydd Joyce Watson yn ei ofyn.	David Lloyd: We have reached the final question and Joyce Watson will ask it.
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Joyce Watson: This question is specifically about the powers to make subordinate legislation. The proposed Measure contains 17 provisions under which Welsh Ministers will be able to make subordinate legislation. A number of subsections in the proposed Measure give Welsh Ministers the powers to make regulations. Do you think that the correct balance is achieved between powers on the face of the proposed Measure and powers given to Ministers to make regulations?

Dr Matthews: I do not profess to be a legal expert, but I would urge you to think about incremental change in Wales. Whereas, in many ways, I totally applaud an increased emphasis on the areas in the proposed Measure, perhaps using regulations would be more appropriate, because I suspect that for the proposed Measure to have any success there will need to be an incremental approach, which might best be achieved by a series of regulations to allow flexibility. I have reservations about doing that, but it may afford greater benefits in the longer term. If I may add an additional point, the proposed Measure is very much talking about new integrated systems of working in primary care. I have already alluded to the issue of children's teams in the Children and Families (Wales) Measure 2010. What seems to be possibly an anomaly is that the proposed Measure does not integrate secondary mental health care to the same degree—we have already talked about the struggle to define a secondary mental health care. So, the proposed Measure could have perverse, unintended consequences.

Dr Aziz: It is important to have flexibility, but, at the same time, you need to see the overall picture. You may start with something, but if you have flexibility and find that you need to change everything, you will end up with something completely different. The boundaries of the power need to be clear in the proposed Measure—that is, which areas will have the flexibility to change—otherwise you will end up with something completely different.

David Lloyd: Â'r gair olaf i Goleg Brenhinol y Nyrsys.	David Lloyd: The final word goes to the Royal College of Nurses.
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Mr Semple: Flexibility is important and there is a need to be able to respond to local need. The proposed Measure seems to imply that it extends down to the individual, which to me seems rather strange, but perhaps I have misunderstood what I have read. I would have thought that it would be the clinicians who would make the decisions about what was needed for particular individuals. I am referring to the ability to make different provisions for different cases or classes of cases. I was a little nervous about the degree to which that applies right down to an individual client.

David Lloyd: Dyna ddiwedd ein sesiwn cwestiynau ffurfiol. A oes gan unrhyw un sylwadau terfynol? A oes rhywbeth nad ydym wedi trafod neu rhywbeth ychwanegol yr ydych eisiau ei ddweud cyn inni ddwyn y trafodion i ben?	David Lloyd: That brings us to the end of our formal questioning session. Does anyone have any final comments to make? Is there something that we have not covered or something additional that you wish to raise before we bring the discussions to a close?
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Dr Matthews: I have a suggestion, which is that it may be helpful for you to consider asking the National Offender Management Service for its observations, particularly on some of the evidence that we have given to date. The college has been very involved with the secure services review and its action planning, which teases that out right down into the primary care level of practice in health and social care. I would urge you to consider taking evidence from representatives of those areas that are responsible for the treatment of drug and alcohol misuse. I would also urge you to take evidence formally from the Royal College of General Practitioners. I fully appreciate that Dr Dearden represents the BMA, but informal contact with professional leaders in that specialty suggests that they have not fully appreciated the breadth of the proposed Measure. Their observations could be timely if one is to engage genuinely with primary care.

David Lloyd: Diolch am hynny, Dr Matthews. A yw pawb arall yn hapus?	David Lloyd: Thank you for that, Dr Matthews. Is everyone else happy?
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Dr Aziz: I have to mention that the court system is applicable to England and Wales, as is the prison system. So, there is a wider implication, and you might need to take their views and those of the Home Office.

The issue of what will happen if needs go unmet and if a patient does not engage was mentioned briefly. You may have the best care plan in the world and all the necessary resources, but if we cannot engage the patients, are we going to resort to the Mental Health Act and to the Mental Capacity Act 2005? To do that would defeat the object of early intervention and detection. So, there will be a wider implication as well.

David Lloyd: Diolch yn fawr. A yw Coleg Brenhinol y Nyrsys eisiau ychwanegu rhywbeth?

David Lloyd: Thank you. Would the Royal College of Nursing like to add anything?

Mr Williams: We talk a lot about the therapies—cognitive behaviour therapy, dialectical behaviour therapy, and others—and I would welcome clarification on how we can meet the growing expectation regarding the receipt of psychological services. There is now a waiting list of between six and 18 months for psychological therapy, if you are lucky. The psychological skills within the workforce, among nurses, doctors and so on, are underutilised at present. Maybe we should use them a little bit more.

David Lloyd: Diolch yn fawr, yr ydym wedi cael cyflwyniadau graenus y bore yma. Diolch ichi am ateb y cwestiynau mewn ffordd mor drwyadl. Bydd y clerc yn anfon trawsgrifiad drafft o drafodion y bore yma atoch er mwyn iddo gael ei gywiro, os bydd angen, cyn i'r fersiwn derfynol gael ei chyhoeddi. Diolch yn fawr am eich presenoldeb, eich gwaith ac am y papurau y gwnaethoch baratoi ymlaen llaw.

David Lloyd: Thank you, we have had some fine contributions this morning. Thank you for answering the questions so thoroughly. The clerk will send you a draft transcript of this morning's proceedings for you to correct, if necessary, before the final version is published. Thank you for your attendance, your work and the papers that you prepared beforehand.

Hoffwn gloi'r cyfarfod drwy hysbysu fy nghyd-Aelodau y cynhelir y cyfarfod nesaf ar ddydd Iau 13 Mai. Diolch i bawb am ei bresenoldeb, a diolch i'r cyfieithwyr. Deuaf â'r cyfarfod i ben.

I will conclude the meeting by informing my fellow Members that the next meeting will be held on Thursday 13 May. I thank everyone for their attendance, and I thank the interpreters. I draw the meeting to a close.

" Daeth y cyfarfod i ben am 10.48 a.m.
The meeting ended at 10.48 a.m. "