



**Cynulliad Cenedlaethol Cymru
The National Assembly for Wales**

**Pwyllgor Deddfwriaeth Rhif 3
Legislation Committee No. 3**

**Dydd Iau, 22 Ebrill 2010
Thursday, 22 April 2010**

Cynnwys
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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
Joyce Watson	Llafur Labour
Mohammad Ashgar	Ceidwadwyr Cymreig Welsh Conservatives
David Lloyd	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)

Eraill yn bresennol
Others in attendance

Sue Barnes	Hafal Hafal
Ruth Coombs	Rheolwr Dylanwadu a Newid, Mind Cymru Manager for Influence and Change, Mind Cymru
Ewan Hilton	Prif Weithredwr, Gofal Cymru Chief Executive, Gofal Cymru
Lee McCabe	Hafal Hafal
Alexandra McMillan	Rheolwr Materion Cyhoeddus, Gofal Cymru Public Affairs Manager, Gofal Cymru
Lyn Richards	Mind Cymru Mind Cymru

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 9.30 a.m.
The meeting began at 9.30 a.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

[1] **David Lloyd:** Croeso i chi gyd i gyfarfod Pwyllgor Deddfwriaeth Rhif 3. Yr ydym yma i drafod y Mesur Arfaethedig Iechyd Meddwl (Cymru). Dyma'r sesiwn dystiolaeth gyntaf. Yr wyf yn falch o weld y tystion cyntaf o'n blaenau, ond mwy am hynny yn y man. Gwnaf sylwadau agoriadol

David Lloyd: Welcome to you all to this meeting of Legislation Committee No. 3. We are here to discuss the Proposed Mental Health (Wales) Measure. This is the first evidence session. I am pleased to see that the first witnesses are before us, but more on that in a moment. I will make some opening

wrth groesawu fy nghyd-Aelodau, Peter Black, Mohammad Asghar a Joyce Watson. Os bydd larwm tân, dylai pawb adael yr ystafell drwy'r allanfeydd tân penodol a dilyn cyfarwyddiadau'r tywyswyr a'r staff. Nid ydym yn disgwyl prawf ar y larwm na tân heddiw. Dylai pawb ddiffodd eu ffonau symudol, eu galwyr a'u 'mwyar duon', gan eu bod yn amharu ar yr offer darlledu. Fel y mae pawb yn gwybod, mae Cynulliad Cenedlaethol Cymru yn gweithredu'n ddwyieithog. Mae clustffonau ar gael ar gyfer clywed cyfieithiad ar y pryd, a gellir hefyd addasu'r sain arnynt ar gyfer pobl sy'n drwm eu clyw. Peidiwch â chyffwrdd â'r botymau ar y microffonau, oherwydd gall hynny amharu ar y system hefyd, a sicrhewch fod golau coch yn disgleirio cyn cychwyn siarad. Mae cyfieithiad ar y pryd ar gael ar sianel 1 a darllediad gair am air i glywed y sain yn well ar sianel 0.

remarks in welcoming my fellow Members, Peter Black, Mohammad Asghar and Joyce Watson. If a fire alarm should sound, everyone should leave the room via the marked fire exits and follow the instructions of ushers and staff. We are not expecting a test or a fire today. Everyone should switch off their mobile phones, pagers and BlackBerry's because they interfere with the broadcasting equipment. As you will all be aware, the National Assembly for Wales operates bilingually. Headphones are available to receive simultaneous translation and the sound can also be amplified for those who are hard of hearing. Do not touch the buttons on the microphones, as that can also interfere with the system, and please ensure that the red light is showing before you start to speak. Simultaneous translation is available on channel 1 and a verbatim feed to amplify the sound is available on channel 0.

9.31 a.m.

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

[2] **David Lloyd:** Diben y cyfarfod hwn heddiw yw clywed tystiolaeth lafar mewn cysylltiad â'r Mesur arfaethedig hwn, a byddwn yn clywed tystiolaeth gan Hafal, Mind Cymru a Gofal Cymru; caiff y sesiwn ei rhannu'n dair. Hefyd, fel cefndir i'r drafodaeth, cyflwynwyd y Mesur Arfaethedig Iechyd Meddwl (Cymru) ar 22 Mawrth eleni. Lanswyd ymgynghoriad y pwyllgor hwn ar 29 Mawrth. Dyddiad cau'r ymgynghoriad yw 14 Mai a byddwn yn craffu ar y Mesur arfaethedig hwn dros yr wythnosau nesaf ac yn adrodd yn ôl cyn diwedd tymor yr haf.

David Lloyd: The purpose of today's meeting is to take oral evidence on the proposed Measure, and we will hear evidence from Hafal, Mind Cymru and Gofal Cymru; the session will be divided in three. Also, as background information to the discussion, the Proposed Mental Health (Wales) Measure was laid before the Assembly on 22 March this year. This committee's consultation was launched on 29 March. The closing date of the consultation is 14 May and we will be scrutinising this proposed Measure over the next few weeks and reporting back before the end of the summer term.

[3] Felly, gyda chymaint â hynny o ragarweiniad, hoffwn groesawu'n ffurfiol Sue Barnes a Lee McCabe o Hafal i roi tystiolaeth gerbron y pwyllgor y bore yma. Croeso i chi'ch dau. Yr ydym wedi derbyn papur tystiolaeth gan Hafal, ac mae gennym restr o gwestiynau i'w gofyn sydd wedi'u paratoi o flaen llaw. Felly, gyda'ch caniatâd, symudwn ymlaen yn syth at y cwestiynau. Gofynnaf y ddau gwestiwn cyntaf. Yn eich tyb chi, a oes angen am y Mesur arfaethedig hwn, ac a ydych yn cefnogi ei amcanion?

Therefore, with that by way of introduction, I formally welcome our witnesses, Sue Barnes and Lee McCabe from Hafal, to give evidence to the committee today. Welcome to you both. We have received an evidence paper from Hafal and we have a list of questions to ask that have been prepared beforehand. So, with your permission, we shall proceed directly to the questions. I will ask the first two questions. In your opinion, is there a need for this proposed Measure, and do you support its overall aims?

[4] **Ms Barnes:** Good morning, everyone. I am sorry, but I will be speaking in English this morning. Yes, there is a need for this proposed Measure. Eighty per cent of service users in Wales are leading chaotic lives and receiving inconsistent services across Wales. We feel that this proposed Measure is important as it imposes a legal requirement to improve the quality of life for those people and their families.

[5] **David Lloyd:** Yn dilyn o hynny, a allai amcanion y Mesur arfaethedig hwn gael eu cyflawni wrth ddefnyddio'r fframwaith deddfwriaethol sydd gennym yn barod, neu a oes angen y Mesur arfaethedig hwn? **David Lloyd:** Following on from that, do you believe that the aims of this proposed Measure could be achieved by using the existing legislative framework, or do we need this proposed Measure?

[6] **Ms Barnes:** Current legislation does not meet the requirements of people with a serious mental illness. However, this proposed Measure will, to an extent. There are some pieces missing from it that, if they were put in it, could improve people's lives, for example, timescales and quality care plans, which we have mentioned in our written evidence. On the whole, we think that it is a good proposed Measure, but it needs to be tightened up in places.

[7] **Peter Black:** We will move on to some very difficult definitions now, if that is all right. Sections 1 and 5 provide definitions of local mental health partners and support services, and similarly, sections 11 and 12 provide definitions of relevant patients and secondary mental health service providers. Are you content that these definitions encompass all the relevant parties?

[8] **Ms Barnes:** On the whole, yes; I think that they are quite clear about who these people are. Perhaps the definition of support services needs clarification in some areas because it could be open to different interpretations: support services could vary from as little as befriending someone and having a cup of tea with them, to quite intensive daily support from services such as ours within our projects.

[9] **Peter Black:** In your written evidence, you state that the definition of a relevant patient should be extended to include patients who may be unwilling to engage with secondary mental health services. What would be the benefits of such an amendment and how would it work in practice without the use of compulsion?

[10] **Ms Barnes:** It is important for people who are not engaging with services to have a care plan, which will enable us to keep in contact with them, although we obviously cannot force people, as it would go against our ethos as care workers. That plan would enable families and carers to have some support and would facilitate contact, which would encourage that person to consider the support that is available should they wish to come back. They are probably the most vulnerable group in terms of their wellbeing and the wellbeing of others within the community.

[11] **Peter Black:** Could you do that care plan if they are not willing to engage?

[12] **Ms Barnes:** Absolutely. A designated care co-ordinator who has that person's history, with the assistance of family members who can provide information, can prepare a quality care plan and it does work, if you are fortunate enough to have one for people who do not want to engage with services.

[13] **Peter Black:** You state in your evidence that all aspects of the proposed Measure should be extended to include people under the age of 18. What is the case for extending its scope to include children and young people?

[14] **Ms Barnes:** When we think about mental health, we should be considering people

from the ages of five to 50. Papers have been published that say that you need to be age blind. We have service users under the age of 18 who are married with children. You have to consider those people too. When young people present with serious mental illness, they may be 15 years of age and they progress through services from 15 to 18, to 19 and beyond. There needs to be a consistent service, so you need to consider that children should not be coming out of children's services, having to go through a referral process again and being back in a black hole. There needs to be consistency for all ages through the process.

[15] **Peter Black:** There is no doubt that we will ask the Minister about this next week, but do you think that the best way to do this would be by extending the existing proposed Measure or by introducing a new proposed Measure aimed at children and adolescents?

[16] **Ms Barnes:** I think that it needs to be included in the proposed Measure to ensure that there are no gaps and that no-one gets lost as they progress from childhood to adulthood. You sometimes need to have separate laws for children and adults, but mental health services have been so patchy, so many children get lost in the system when they come into adulthood, and they are such a vulnerable group, that we really believe that it needs to be in the proposed Measure.

[17] **Peter Black:** You also state in your paper that the requirement in the proposed Measure to produce primary care mental health schemes should be extended to incorporate secondary mental health services. What are your reasons for suggesting that?

[18] **Ms Barnes:** Are you talking about advocacy? Are you referring to advocacy in particular?

[19] **Peter Black:** Yes.

[20] **Ms Barnes:** That is my interpretation. We suggested that because those people who are in secondary services are probably more in need of advocacy. If people are sectioned to a mental health ward, they are probably more desperate for those advocacy services before they are sectioned. That is the time when they have more need for advocacy than people in primary care. Does that make sense?

[21] **Peter Black:** Yes, that is fine. This is my last question. You state that there should be a requirement on the face of the proposed Measure of a maximum period of 30 days,

[22] 'between referral by a GP for assessment for secondary mental health services and the undertaking of that assessment.'

[23] What benefits would that offer service users?

[24] **Ms Barnes:** I am speaking from personal and professional experience and on the basis of information that we have received from our 1,000 members. Certainly, we feel that a maximum deadline would really benefit people because it is such a crucial time. If you get an early intervention—a referral—very quickly, the outcomes are far more positive for people. We have heard of people who have presented to GPs with serious mental illness being referred and sometimes it is eight months, maybe longer, before they are seen.

9.40 a.m.

[25] In my experience, I was very lucky when I presented as ill, as the GP had just done a rotation on an acute ward and she recognised quite quickly that I was seriously ill. She made a phone call, because she knew someone on that ward, I got in and I was seen within a few days and I recovered. It took me two to three years to get back into work and to recover fully. My

colleague had a completely different experience. Do you want to talk about that, Lee?

[26] **Mr McCabe:** I went along to a GP and I told him about my experiences. I was suffering from paranoia. I was sent from the GP surgery, and caught the bus to Prince Charles Hospital, where I was taken aside into a cubicle and where I sat for about two hours, with a nurse popping her head in every now and then. Then I was told that I was going to a psychiatric ward at St Tydfil's Hospital, and was taken there by ambulance. I was taken on to the ward, and I was seen by a psychiatrist. I spent about 10 minutes in the room and he asked me a few questions. He diagnosed me with paranoid schizophrenia. I was taken to a ward where I spent about six weeks, taking medication, which neither I or my mother knew anything about. Nothing was explained to us. As I said, I was on the ward for six weeks and I was then released. Within three weeks, I was back on the ward, having had a relapse. I was quite scared about going back out into the community, and I was sectioned into a psychiatric ward a week after having returned. I was there for six months, and felt institutionalised. The thought of going out into the community was quite horrendous, and for all that period neither I nor my family had a support worker or key worker. My mother was not given any information—she had no joy in that—and, as I said, I was on the ward for six months, until I had a support worker, which helped me and my mother quite a lot. However, for a good 10 years, it was a case of trial and error with medication and so on. I did not receive a care plan or anything.

[27] **Ms Barnes:** It was 10 years before a quality care plan was in place, which is horrific, really. Lee has obviously recovered now and is working full-time. Once that care plan was in place, the recovery was quite quick. That is just the evidence of one person. Across the board, I would say that as soon as a care plan was in place that covered all the nine areas of someone's life, about 80 per cent of our 1,000 members were able to recover and make progress, and many of those people are back in education or employment, whether part-time or full-time.

[28] **Peter Black:** If you had a 30-day maximum period between referral and assessment, what implications would that have for the service providers?

[29] **Ms Barnes:** There would be implications—I imagine that there will be talk of resources and how, practically, they will put this in place. However, if we can meet this target, which we feel is essential, it will cut the demand on resources in the long term, because you will not have people in long-term hospital settings and you will not have people relapsing and needing intensive daily support from support workers and community practice nurses, as is the case at the moment. At the moment, we have support workers and community practice nurses visiting people every day just to do the basic things that we take for granted, such as shopping. So, in the long term, it will cut the demand on resources hugely. We know that there will be those implications, but that is not for me to worry about, thankfully.

[30] **David Lloyd:** Still on the care plans and, in particular, secondary mental health services, Oscar has the next questions.

[31] **Mohammad Asghar:** You have already answered my question in part in the response that you gave to my colleague, Peter. You state in your written evidence that timescales for a care plan for users of secondary mental health services must be drawn up, with a maximum timescale of 60 days. What would be the benefit of that?

[32] **Ms Barnes:** Again, as we have said, the difference is in the quality of care provided. That is not just true of those two examples, but across the board. When a quality care plan is in place quickly, the outcomes for people are hugely improved. People are not just returning to a good quality of life, but managing their mental illness themselves. They learn quickly that they can manage their medication and their lives, and get back into work. That is in contrast

to the delays that currently exist, which are horrendous. You would not believe what can sometimes happen. People will present to a GP, particularly young people, with a severe mental illness, possibly schizophrenia or paranoid schizophrenia, and a referral is made. Sometimes, they are seen quickly, but sometimes they are not. Some people have told us that they have waited up to eight or nine months for an appointment. Those people are in the community, they are chaotic and their families are suffering. On the impact on families, I am talking about children being removed into care, for example; irreparable damage can be done to families. Research shows that those people's outcomes are nowhere near as good as those of people who have a quality care plan in place quickly. Lee's experience and my experience is proof of that. I was recovered and was back in full-time employment within a short time for someone with a serious mental illness. It was 10 years before Lee had a care plan, but, as soon as it was in place, things improved. Lee is now working full-time, self-managing and recovered.

[33] **Mohammad Asghar:** Should the requirement of a timescale be included in regulations or on the face of the proposed Measure?

[34] **Ms Barnes:** It should absolutely be on the face of the proposed Measure. If it is not and is in regulations, it will be open to different interpretation by different professionals and we will still probably get delays. So, it absolutely needs to be a legal requirement. People will be anxious about that in relation to resources and will worry about that, but we have to start somewhere. There are lots of different laws and we have come a long way. We need to make this a legal requirement, so that people start to think, when people present with a serious mental illness, that they need timely intervention and need a quality care plan quickly.

[35] **Mohammad Asghar:** Why do you believe that the proposed Measure, rather than the regulations, should set out how the care plan provided for in Part 2 should be delivered and the nine areas of life in the Welsh code of practice for the Mental Health Act are covered?

[36] **Ms Barnes:** We need to consider all aspects of someone's life. To give a brief example, you can counsel people and medicate them until the cows come home, but if they have other problems going on in their lives, such as being at risk of losing their home, having financial worries, living in isolation, their relationships have broken down or there is domestic violence going on, which are all related to their mental illness, with all those things going pear-shaped, they will not recover. We need to take a holistic approach to people's lives. In our organisation, we have proven that taking that approach—we played a part in the inclusion of those nine areas in the code of practice—means that people's chances of recovery are much greater.

[37] **Mohammad Asghar:** Why do you believe that the format of a care plan should be set out in regulations?

[38] **Ms Barnes:** That is an issue that we feel strongly about. Our organisation covers the 22 counties of Wales, and there is a lot of bureaucracy involved in these plans—some plans can be up to 83 pages long. I know that our original recovery plan was four pages and it was successful. It covered the nine areas, but it was succinct. The service users planned their goals and we put in the support to get them to where they wanted to go. Some people's care plans are 83 pages of bureaucracy. A prescribed format is needed that gets to the heart of the problem. The plan should incorporate the nine areas, but be succinct, asking, 'What are the difficulties?' and 'What are we going to do about them?' It should give responsibility to service users and patients: these are their illnesses and lives. It needs to be consistent across Wales.

[39] **David Lloyd:** Mae'r cwestiynau **David Lloyd:** The next questions are from nesaf gan Joyce Watson. Joyce Watson.

[40] **Joyce Watson:** Good morning and thank you for the paper and for sharing your experiences; it cannot be easy. You state that the duty to provide advocacy services in section 32(3) should be extended to all relevant patients under Part 3. Which group of patients are you referring to and why do you believe that that is particularly important?

9.50 a.m.

[41] **Ms Barnes:** Which section did you refer to?

[42] **Joyce Watson:** Section 32(3), under Part 4, which is mental health advocacy. In the written evidence, you argue that the right to advocacy should be extended to ‘all relevant patients’ under Part 3 of the proposed Measure.

[43] **Ms Barnes:** I think that a similar question was asked earlier. Advocacy is important for all people who are seriously mentally ill, but more so for patients pre sectioning. They are the people who need advocacy more than others.

[44] **Joyce Watson:** Thank you. If you had that, what would the implications be for service providers?

[45] **Ms Barnes:** It goes back to resources again. There are many good advocacy services out there; it is a matter of either rearranging the ones that we have or funding new ones to cover demand and to meet the needs of those who need representation.

[46] **Joyce Watson:** I know that you have answered the question, but I want to probe a little further, because I want this on record. You say that the provision in the proposed Measure relating to advocacy should extend to a general duty on local authorities and the NHS to provide advocacy at primary care level. What would be the benefits of that further advocacy provision?

[47] **Ms Barnes:** When people first present as mentally ill—and this applies to people from all walks of life—very often they have no idea what their rights are and what information is available. Therefore, advocacy services can only enhance people’s ability to take control of their own lives and to start taking responsibility from the outset, and they can be provided with that information. It can be daunting speaking to psychiatrists or general practitioners, particularly when you are frightened. The term ‘mental illness’ carries a stigma, so advocacy services are vital to represent people and encourage them to learn about what is going on.

[48] **Joyce Watson:** I will now move onto the regulatory impact assessment. Does the regulatory impact assessment make a realistic assessment of the financial implications of the proposed Measure? If it does not, what are the shortcomings?

[49] **Ms Barnes:** We are talking about costs here, and, as we said in our written evidence, successful implementation requires major investment. We need to consider the indirect costs, to ensure that we are not just talking about money for implementing the proposed Measure. We also need to consider how we are going to deliver the services, so those costs really need to be taken into consideration. I am glad that it is not me who has to do that. *[Laughter.]*

[50] **David Lloyd:** Dyna ddiwedd y cwestiynau swyddogol. A oes gennych rywbeth yr hoffech ei ychwanegu at y dystiolaeth, neu a gredwch fod y cwestiynau wedi bod yn ddigon cynhwysfawr? **David Lloyd:** That is the last of the official questions. Is there anything else that you would like to add to the evidence, or do you believe that the questions have been sufficiently comprehensive?

[51] **Ms Barnes:** I hope that we have answered all of the questions; I know that we got stuck on one or two. You have our written evidence, and all we—myself, as someone with experience of mental illness and as a professional working with people, Lee, with his experience, and our 1,000 members—need to reinforce is the 30-day maximum to receive services and the 60 days to have a quality care plan, because there is proof that the outcomes would be much better as a result. If that can be achieved, we believe that this proposed Measure can improve the quality of life for those suffering from serious mental illness.

[52] **David Lloyd:** Diolch i'r ddau ohonoch am ateb y cwestiynau mewn modd bendigedig. Fe'ch hysbysaf y bydd y clerck yn anfon trawsgrifiad drafft o'r drafodaeth atoch i'w gywiro os bydd angen. Gyda hynny o eiriau o ddiolch, symudwn ymlaen at y grŵp nesaf o dystion. Diolch yn fawr iawn, Lee a Sue.

David Lloyd: I thank both of you for answering the questions so well. I remind you that the clerk will send a draft transcript of the discussion to you for correction if needs be. With those words of thanks, we will now move on to the next groups of witnesses. Thank you, Lee and Sue.

[53] **Ms Barnes:** Thank you for giving us the opportunity.

[54] **David Lloyd:** Hoffwn groesawu'r tystion nesaf yn awr. Bore da i Ruth Coombs, rheolwr dylanwad a newid Mind Cymru, a Lyn Richards, sydd hefyd o Mind Cymru. Byddwch wedi gweld sut mae'r cyfarfod yn gweithio. Mae gennym restr o gwestiynau wedi'u paratoi, sydd wedi'u selio ar y dystiolaeth ysgrifenedig yr ydym wedi'i derbyn. Felly, symudwn yn syth ymlaen at y cwestiynau, os yw hynny'n iawn gennych. Mae'r ddau gwestiwn cyntaf yn fy ngofal i. Fel yr wyf wedi'i ofyn i eraill, a oes angen am y Mesur arfaethedig hwn ac a ydych yn cefnogi ei amcanion?

David Lloyd: I would now like to welcome the next witnesses. Good morning to Ruth Coombs, manager for influence and change at Mind Cymru, and Lyn Richards, who is also from Mind Cymru. You will have seen how the meeting works. We have a list of prepared questions, which are based on the written evidence that we have received. Therefore, we will proceed straight to the questions, if you are content to do so. I will ask the first two questions. As I asked the others, do you think that there is a need for this proposed Measure and do you support its aims?

[55] **Ms Coombs:** We would say that there is a need for the proposed Measure. We know that, for many years, mental health services in Wales have been patchy. People have a completely different experience depending on where they live. The experience that Lyn's family had demonstrates the need for this. Do you want to say a few things about that, Lyn?

[56] **Ms Richards:** Would you like me to give a brief overview of my experience?

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

[58] **Ms Richards:** I am talking about my son, a 43-year-old man who became ill two years ago and would not recognise or accept that he had a problem. We tried to seek advice through the doctor, from whom we had little co-operation, because it was an area that was difficult to understand. To cut a long story short, the only alternative, despite all sorts of interaction with different organisations, was to have him sectioned. I fought against that continually, because I knew that it was not the answer, but that was the conclusion that was given: be sectioned, or else. It happened, but it was an absolute disaster and, two years later, we have today a young, 43-year-old man who lies in bed and looks at the ceiling but is not so mentally ill as not to know what is happening. However, he is mentally ill and will not accept help. That is my predicament. I am the mother but nobody will talk to me. No-one will discuss anything with me, because my son is 43 and is capable of answering questions. I go

for advice but am told to do so through my son. I seek guidance and am told ‘no’. I cannot get past it. There is no care plan and no follow up, and I do not want to waste your time, but I cannot get anywhere, and all that is happening is that a very fit and well man is lying in bed, looking at the ceiling. He is not washing—but I will not go into all the details.

[59] **Ms Coombs:** There is also a sense that he blames you, is there not?

[60] **Ms Richards:** I am totally to blame. It is all my fault. He says, ‘If you had not interfered and called in the mental health people, and if I had not been put in hospital, I would be well’. So, now, everything is my fault. Even if I try to take further action, I am told to mind my own business. When I go to the doctor to ask for help, I am told, ‘No, we cannot discuss it with you’. I go for guidance through other people, and I am told, ‘No, we cannot talk’. Where do I go? What do I do? Until something absolutely catastrophic happens, nothing will be done.

[61] **David Lloyd:** Diolch am y dystiolaeth honno, sy’n bwerus iawn ac yn ateb nifer o’r cwestiynau, felly byddwn yn dod yn ôl ati wrth i’r sesiwn hon fynd yn ei blaen. Hoffwn ofyn cwestiwn atodol i hynny, sef a allai amcanion y Mesur arfaethedig gael eu cyflawni drwy ddefnyddio’r fframwaith deddfwriaethol sydd gennym eisoes? Ruth, a ydych chi mewn sefyllfa i ateb y cwestiwn hwn?
David Lloyd: Thank you for that evidence, which is very powerful and answers a number of our questions, so we will come back to it as we proceed with this session. I would like to ask a supplementary question to that, namely could the aims of the proposed Measure be achieved by using the existing legislative framework that we have? Ruth, are you in a position to answer that question?

[62] We have existing legislation, so could we not just use that?

[63] **Ms Coombs:** No, we do not think that current legislative practices are strong enough. We have a situation in Wales whereby if something is in statute, it happens. However, we know from the example of the national service framework that, where things fall outside of legislation, they are widely open to interpretation. If we look at raising the standard and the revised timescales attached to the revision of the national service framework for adult mental health, we see that the standards are still not being met. So, the legislation is certainly not strong enough to move the system on in Wales.

10.00 a.m.

[64] **Peter Black:** My questions are about definitions and the scope of the proposed Measure. On definitions first, sections 1 and 5 provide definitions of ‘local mental health partners’ and ‘support services’. Similarly, sections 11 and 12 provide definitions of ‘relevant patient’ and ‘mental health service provider’. Are you content that those definitions encompass all the relevant parties?

[65] **Ms Coombs:** Overall, we are content that the majority of partners are included. There will always be exceptions, and I am not sure that the catch-all ‘and other interested relevant parties’ would strengthen it, because someone with a particular need is not quite the same as the mainstream, and there might be someone in a partnership group whom you would not necessarily think of, because people’s needs are so different and so complex. Overall, we are fairly content with the definitions, and we were pleased to see that the definition of ‘relevant patient’ includes sub-definitions, because people use different terminology and jargon, and might refer to patients as service users, recipients or clients. The strong definition makes it clear that the proposed Measure is trying to encompass as many people as possible, including voluntary sector providers as well as statutory providers, which is important.

[66] **Peter Black:** You state in your evidence that consideration should be given to expanding the proposed Measure to include provision for those under the age of 18. What is the case for extending its scope to include children and young people?

[67] **Ms Coombs:** There have been several reviews of children's services over the past couple of years, and huge gaps in practice have been highlighted there. For example, the report by the Wales Audit Office and Healthcare Inspectorate Wales published in November 2009 clearly stated that there were huge gaps, and we have also identified gaps through talking with young people and those who work with them. I get phone calls at home in the evenings from people who have a 17-year-old son, say, who do not know what to do or where to go, so there is definitely a gap there. There are recommendations in 'Everybody's Business', and, if they were a part of the proposed Measure, it would be strengthened. We believe that that would give vulnerable young people much more protection, and there would be a seamless flow of support, because the other thing that tends to happen—and I have a lot of experience of this through working with child and adolescent mental health teams, and family support teams, with young children—is that these children are most at risk of falling out of the education system at around 15, and they fall into a gap because they are too young for adult services and are not in employment, education or training, and so they do not fall under child and adolescent mental health services. They fall into this big gap in the middle, and that can have a lasting impact on the person and their family.

[68] **Peter Black:** When the Health, Wellbeing and Local Government Committee looked at mental health services and identified that gap, particularly for 15, 16, 17 and 18-year-olds, it made recommendations around that. There is still a distinction between child and adolescent mental health services and adult mental health services, and the problem seems to be when someone switches from one to the other. This proposed Measure is largely about adult mental health services, and if you argue that it should be extended to include CAMHS as well, does that mean that we want to do away with that distinction and just have a service going all the way through from the age of five, or do you want to keep that distinction but try to reconcile those problems through the proposed Measure?

[69] **Ms Coombs:** I firmly believe that, if you start with a person-centred approach and you build the services around the person, their families and carers as appropriate, regardless of what you call the system, that person will receive the very best care. If that is the purpose of the proposed Measure—that the people of Wales receive the best care possible—that is where we need to start. Talking with colleagues—for example, we work quite closely with Barnardo's Cymru around transition—we know that the children's charities in Wales firmly support the proposed Measure's encompassing children as well as adults.

[70] **Peter Black:** I take it that you would prefer to have it all in this proposed Measure rather than have a separate Measure for children and adolescents.

[71] **Ms Coombs:** The difficulty with having a separate Measure is that you always get somebody falling through the gap in the interface. When that is a vulnerable young person, that impact can last for the rest of their life.

[72] **Peter Black:** That is very clear. Thank you.

[73] **Mohammad Asghar:** Ruth, maybe you could make a few notes. We have had just had evidence from Hafal, and my questions will probably be along the same lines: the timescale for implementing the provisions in the proposed Measure. You express concern in your paper that the proposed Measure does not set out timescales for the provision of assessment, treatment and care. How could that affect services, and how should it be addressed by the proposed Measure? That is the first part.

[74] Secondly, evidence that we had not long ago from Hafal suggests that there should be a requirement on the face of the proposed Measure of a maximum period of 30 days between referral by a GP for assessment for secondary mental health services and the undertaking of that assessment. What is your view on the merits of that? Hafal also suggested imposing a maximum period of 60 days for the period between qualifying as a patient under Part 2 and the completion of a care plan. Do you agree?

[75] **Ms Coombs:** There should certainly be timescales in the proposed Measure; otherwise, it would become a toothless tiger, and we would not want to see that. This is a huge opportunity to get things right for Wales and to be at the forefront of mental health service development. On the period of 30 days, I noted that colleagues from Hafal stressed that that should be a maximum. I know that Lyn has a view, based on her own experience, on the length of time that would have been helpful for her.

[76] **Mohammad Asghar:** [*Inaudible.*]

[77] **Ms Richards:** No, I am not trying to be negative; I am trying to be positive about this. This is about the frustration that I felt because I could not get anything done. I am two years down the line, and I still have not had an assessment for my son; there has been no title given or diagnosis of whatever is the matter. Thirty days, you say? Fine, put that in, because surely some decision could be made in 30 days, but I do not know about leaving it for 60 days. If you say that it takes 60 days to make a care plan, does that mean that people will think, 'Oh, I have 60 days and then I will do it'? I would like to see something along the lines of: within those 60 days, strategies and plans should be put in place, and there should be ideas, suggestions and communication between the patient and the carer. That would be great. However, what do you do when the patient does not talk, or when the patient says that there is nothing wrong? Who talks about those plans? The plan has to be put in place, and in a much shorter period than 30 days.

[78] **Ms Coombs:** In our view, we would want the norm to be much shorter than that. We are not saying that it should be done overnight, but we need to consider a scenario in which somebody is at serious risk of becoming ill—and if you are referring someone for a secondary service assessment, there will be people who are in danger of becoming very ill. People can become very ill very quickly, and so we would not want the 30 days to lead to a perverse incentive to detain people so that they get an assessment more quickly. So, if this was an absolute maximum, we would say, 'Yes, there needs to be an absolute maximum'. However, we would want to see that qualified by a norm, with that norm being within 15 days. People should be able to get an assessment within two working weeks. The 30 days would then be a catch-all, so that if an assessment in two working weeks was not possible in some circumstances, it should take absolutely no more than 30 days. We would not want people thinking, 'Oh, we have 29 days', which could cause issues. So, yes, there need to be timescales, and we would want to see the norm shorter than 30 days, with the latter being a failsafe.

[79] As for having 60 days for a care plan, I absolutely echo Lyn's view that those should be 60 days of intense activity, working in partnership with the service user or patient and those around them—their informal or other carers—and with the voluntary sector, statutory sector or independent sector, if they are involved in that person's care. That time should be spent looking at the holistic picture. If we think about Maslow's hierarchy of needs, we know what needs to be included so that people do not think, 'I've got 60 days, so I don't need to think about it for the next 40 days', but instead use that time for active development, so that the care plan is in a good shape at the end of that period. It certainly should not take longer.

10.10 a.m.

[80] **Mohammad Asghar:** My final question is: should the requirement for a timescale be included in regulations or on the face of the proposed Measure?

[81] **Ms Coombs:** We would agree with our colleagues that that has to be on the face of the proposed Measure, because we know what happens when things are in guidance or regulations—the system does not get consistently enforced. If it is on the face of the proposed Measure, it will be front-loaded. If it is in regulations, the danger is that it will be back-loaded, which means that it will be a scramble in the last few days to get things done, and we want to avoid that.

[82] **David Lloyd:** Mae'r cwestiynau **David Lloyd:** Joyce Watson has the next nesaf dan ofal Joyce Watson. questions.

[83] **Joyce Watson:** Good morning and thank you for sharing your personal experience, because it cannot be easy to do that. Moving on to local primary mental health services, you state that,

[84] 'Primary Mental Health Schemes have no standards and no measures prescribed within the proposed Measure'.

[85] What kinds of standards and measures are needed, in your opinion, and how should they be applied by the proposed Measure?

[86] **Ms Coombs:** There need to be mechanisms in the proposed Measure that give a little more detail about content. It is not sufficient to say that the plan needs to be in writing because you can have two written paragraphs that do not say anything. The plan has to say something. Person-centred measures have to be attached to it, so that, on an individual basis, there are measures that affect me and my needs. What impact has it all had on me? It needs to be demonstrated that a measure has had a beneficial impact on the recipient of the services, so those measures need to be person-centred. We would suggest, with respect, that there is evidence from other parts of the world that could be looked at. We would like to see the committee looking at what sorts of person-centred measures are applied in other places and at best practice, and for the committee to work up some ideas that could go out to consultation to organisations such as ours, and to service users and carers, so that we can see what the practice is in the other places and what works. We know that there is good practice in Scotland, New Zealand and parts of Scandinavia. There are lots of different places that take a person-centred approach, which is the important thing. It cannot be service driven. Things must be built around the individual and their particular circumstances. I do not know whether you have anything to add to that.

[87] **Ms Richards:** It is about having a meaningful description of what is best for that person—we are not all the same. However, it has to be followed through and it has to address the specific needs and requirements of that person.

[88] **Joyce Watson:** If there is evidence that might assist us, could you send it to us?

[89] **Ms Coombs:** Yes, we can certainly provide you with some signposting for that.

[90] **Joyce Watson:** Moving on to the language, you say that the language used with reference to care co-ordinators in subsections 16(2) and (3) is too weak and needs to be strengthened. Can you explain why you feel that that is necessary?

[91] **Ms Coombs:** That was one example. There are some other examples where the word 'may' has been used. We believe that, at the very least, the word should be 'should', not 'may'. I know that Lyn has a strong view about what will happen if 'may' is left in the

proposed Measure, because if you say ‘may’, the implication is that you may not.

[92] **Ms Richards:** It is about the interpretation of the word ‘may’: you may do it, you may not. It should say, ‘It has to be done’. It should not be a case of, ‘Shall we or shan’t we?’. It should be, ‘It has to be done’. You cannot leave it weak any more; it has to be done.

[93] **Joyce Watson:** You also expressed concern about the process and the lack of a timescale for dispute resolution in the proposed Measure. What more can you tell us about those concerns and how you think that they might be addressed?

[94] **Ms Coombs:** We know that if you look at other areas of NHS activity, other Acts and other dispute procedures, you will see that they all have timescales and timeframes. If you were asking local authorities and health boards to work together to build up joint plans, there needs to be a reasonable amount of time attached to that. However, what you cannot do is not put a maximum timescale on an activity, because the danger there, particularly with reorganisation, is that it gets put off, or they think, ‘We’re in the process of doing it, but this is not important; if it is a priority, put a timescale on it’. That timescale indicates to service deliverers and planners that it is a priority. Mental health is meant to be a top-three priority. If you put timescales on it, it becomes a priority in reality for the people working on those plans. If we took three months to provide evidence to committees, or if we took four or five months to do things for our clients, service users and networks, it would not be good enough and I think that you should apply the same thing to the proposed Measure, that it is not good enough to say, ‘We are working on it indefinitely’.

[95] **David Lloyd:** Turning to advocacy, Oscar has some more questions.

[96] **Mohammad Asghar:** As the Chair mentioned, I have a question on advocacy. You state that section 32(3) of the proposed Measure should be broadened to include a general duty to provide an independent community mental health advocacy service. What are your reasons for that?

[97] **Ms Coombs:** One of the things that we would like to start with is Lyn’s experience of advocacy, and then I would like to firm up some of the reasoning behind that.

[98] **Ms Richards:** I am sorry to be very blunt, but there was none. There was no guidance or advice, and I consider that I am quite capable of asking questions and finding out. I did pursue issues and I did ask, and I got nowhere. There was no guidance, and if it was not available for me, as someone who is quite prepared to ask questions, what about the people who cannot, or who are ill and suffering and are unable? My son could not do it. He is totally incapable of asking questions because he does not want to. I am very capable, but I did not get anywhere. There was nothing, absolutely nothing.

[99] **Ms Coombs:** So, we would want to see advocacy expanded into community advocacy. We know that other mechanisms for trying to move that on have not worked—they have failed completely. The regulatory impact assessment talks about the targets in the national service framework for in-patient advocacy. There are also targets for community advocacy that have not been met. They slipped six years between the first NSF and the revision of the NSF, and they keep slipping. One of the dangers of neglecting community advocacy is that if there is a right to re-referral for someone who has been in the system and has come out of it, if there is no recourse to community advocacy to support that person, there are people who will not ask for it.

[100] We want to see a general duty on the new local health boards and local authorities to provide advocacy for all. We want to see that coupled with a much richer information flow, because the estimates in the regulatory impact assessment are that around 50 per cent of

people who have a right to advocacy might take it up. In that wider community setting, you would probably have fewer people wanting to take it up, provided that good quality information was available to people at all times. Part of that information would be to say, 'If you want to discuss this further, if you feel that you need the services of an advocate, we can provide that if necessary.' We do not feel that there would be a huge cost to it, but the benefit would be huge, because the majority of people would benefit from the increased information, and some people require a bit more support and someone to help them to articulate their views. We know that people with experience of mental distress living in the community often do not have the social networks that other people have. They do not have the benefit of friends who are able to support them. If you say, 'I have depression', people with whom you have been friendly for a long time are suddenly not your friends any more, so you do not have someone there and you need someone. We firmly believe that that is where the proposed Measure falls short.

10.20 a.m.

[101] **Mohammad Asghar:** What would be the implications of that for service providers?

[102] **Ms Coombs:** With regard to service providers, they would have to improve their information and communication flows, but I do not see that as having a particularly high cost. That is about giving people the information that they are supposed to give them, and having it available in a variety of formats. For example, if you go to the doctor and are told that you are suffering from stress, they will tell you to try to step back from your work and so on. This happened to my daughter last week. She said that the doctor was great, and gave some suggestions about what to do. However, if they then give some information that goes alongside that, that helps to reinforce the message. If you help to reinforce the message, fewer people will need the services of someone else because they will have had the information in an appropriate format for them at the time. It is about saying it, doing it, showing it, giving it, and giving support to those people who need the additional support.

[103] **Mohammad Asghar:** You say that a broadened advocacy duty 'should be implemented alongside much wider and more thorough access to information'. How should this requirement be reflected in the proposed Measure?

[104] **Ms Coombs:** It should be on the face of the proposed Measure. There is very little about information and communication flow on the face of the proposed Measure at the moment. If it was on the face of the proposed Measure, it would be done. It does not have a huge impact. I will give a simple example. We have run five focus groups over the last four months around what people would like to see at a GP practice, in primary care. There is a lot of emphasis on primary care in the proposed Measure, and rightly so. People were saying, 'If there was an information board and information in the waiting room, people could get what they need without asking specifically.' If you go to see the nurse because you are going on holiday to South Africa, the nurse will print a great wodge of information off the internet and give it to you. If that can be done for holiday information, why can it not be done for other information? My father was fortunate when he was diagnosed with a medical condition of which one of the side effects is depression, as he was given an information leaflet, which he took home and shared with my mum. They then understood the implications, what to look for and how to tackle it. They did not need anyone else to do it because they could work it out for themselves, because they had the information. If you get the information and you need more help, you can go and ask for more help. Give the information in a variety of ways so that people can say, 'That is what I need.'

[105] If you go into a doctor's surgery and are told that you have a mental health problem, like with a lot of other illnesses, everything goes out of your head because you think, 'I was not expecting that. What does that mean?' A lot of the verbal advice that is given to you at

that point gets lost, so it should be backed up with information in a simple format. We know from our work in prisons that the people who are there with mental health problems say the same thing, that is, that they need information in an easy-read version. It would enrich the experience and would help to support the implementation of the proposed Measure.

[106] **David Lloyd:** Mae'r grŵp olaf o **David Lloyd:** Joyce Watson will ask the last gwestiynau yn yr adran hon o dan ofal Joyce group of questions in this section. Watson.

[107] **Joyce Watson:** I am going to ask you questions initially about the cost of the regulatory impact assessments. In your opinion, does the regulatory impact assessment make a realistic assessment of the financial implications of the proposed Measure? If you think that it does not, what are its shortcomings?

[108] **Ms Coombs:** Overall, as it stands, it looks reasonable. The costings look reasonable on the basis that they were costed, that is, on a status-quo basis—I cannot remember the exact term; it has gone out of my head. One thing that we would expect to be revisited is the provision of advocacy because if there were to be an extension to the provision of advocacy, that would have a financial impact. However, we do not believe that that financial impact would be huge, because we would want the proposed Measure to ensure that something that should have been planned by health boards and local authorities under the national service framework—which is coming to an end—is implemented, as this has not happened as yet. It is about putting a statutory requirement for guidance onto a framework that should already have been implemented. Yes, there will be an increase in the cost, but it is a cost that should have been accounted for in the first place.

[109] We believe that the approximations for population levels that have been used are probably as good as you can get at this time. I would qualify that by adding that, in a couple of places, the regulatory impact assessment said that some further work needs to be done. We support the observation that more work needs to be done in some areas.

[110] **Joyce Watson:** You also state that resources need to be in place to ensure effective staffing levels to implement the proposed Measure. Does the financial information in the regulatory impact assessment make allowances for that?

[111] **Ms Coombs:** Again, the information on population levels seems to be as accurate as possible at the moment. One of the things that will need to be taken into account is upskilling and ongoing professional development. I do not believe that the proposed Measure should increase continuing professional development costs. In practice, that might happen, because we anticipate that it might identify staff development needs that are currently hidden. It might be that people need additional training and support, but they need that anyway. So, that should be costed in the health boards' professional development plans and in the local authorities' development plans. It is important to note that, because of the impact of the recession on the public sector, one of the first things to go is training and development. We would absolutely reiterate that that cannot happen for mental health, because things move fairly quickly, things change, and people need the skills to be able to implement a care plan in the here and now, not a care plan as it was five years ago. However, these are things that people should have been doing anyway.

[112] **Joyce Watson:** You say that the proposed Measure is likely to reduce reliance in the long term on more specialist interventions, resulting in some savings. How would that work in practice? Could you give some brief examples?

[113] **Ms Coombs:** In practice, there is likely to be a time lag. You have to invest to reap the benefit. We know that early intervention works. In Lyn's case, there is a strong belief that

that would have made a difference.

[114] **Ms Richards:** If we had had earlier intervention, earlier involvement and earlier knowledge, for my son and for me, we could have put things in place in a different way, rather an ultimatum being given and being told, ‘This has not worked; we will section you’. There was nothing in between; it was like a gap in the middle through which things fall. If there were facilities—or whatever word you want to use—that could have been put in place right at the beginning, perhaps we would not be where we are now, two years later. Perhaps he would have been better. Perhaps he will get better, but that is a different journey. I like to believe that early and holistic intervention would have made a big difference, and I think that it would for others as well.

[115] **Ms Coombs:** The average hospital stay for an acute patient in a physical environment is around three or four days, whereas in a psychiatric environment, it is three months. If you have earlier intervention, people could be treated in the community and they could be kept well. They can stay at home, and they may stay in work, which would bring an economic benefit to Wales, as well as lessening the impact on the health service and social care services. Some people would still require hospital care at some point, but the numbers would be much smaller and the stays shorter. We know that earlier intervention in all aspects of this work means that people get better quicker and often do not become a ‘revolving door’ patient.

10.30 a.m.

[116] **Joyce Watson:** You have raised concerns about equality for users of mental health services on grounds of, for example, ethnicity, gender and sexuality. Will the proposed Measure, as currently drafted, address those issues? If you do not think that it will, can you make any recommendations for its redrafting?

[117] **Ms Coombs:** It appears that equality is blind at present, and that is not sufficient. If you are from an ethnic group, that puts you at a disadvantage. For instance, if you are a black African who is gay and you have a mental health problem, you could face three levels of discrimination, one on top of the other. We know of people who had to flee their home country because of such discrimination. That evidence is very powerful and real. If you look at Stonewall Cymru’s recent research, to which we contributed, you will see the double impact of sexuality and mental health. There needs to be a specific reference to mental health service providers and to schemes that ascertain the specific equalities and diversity needs of their areas and address them appropriately. That includes rural issues, because diversity is not just in urban areas. The whole of Wales reflects that diversity. Plans need to take account of that, otherwise, what can happen in rural areas, for example, is that the diverse needs of certain sections of the community are missed, because they are not well represented numerically. So, there needs to be a specific reference to that.

[118] **David Lloyd:** Dyna ddiwedd y cwestiynau swyddogol. A oes gennych sylwadau i gloi? Yr ydym wedi gofyn y cwestiynau yr oeddem eisiau eu gofyn, ond os oes gennych rywbeth i’w ychwanegu, dyma’r amser i wneud hynny. **David Lloyd:** That is the end of the official questions. Do you have any closing comments? We have asked the questions that we wanted to ask, but if you have anything to add, now is the time to do so.

[119] **Ms Coombs:** We just want to reiterate that this is such a positive opportunity, and we want to be involved, as would other organisations, along the way, to have the opportunity to be part of the consultation on any regulations, standards and measures that are to be put in place when it gets to that stage. We reinforce the plea that advocacy be considered more broadly because of the benefit that it has to the person and to the carers of that person.

[120] **Ms Richards:** Thank you for the opportunity to speak. I just hope that other people will not have to experience the hurdles and obstacles that are still present. I hope that these measures will be put in place so that people can benefit from them. I am optimistic that, someday, somehow, there will be a different attitude to the usual 'You're ill; we'll section you' attitude, because there is a gap in between. Resources can be put in place, and things can happen.

[121] **David Lloyd:** Diolch yn fawr i'r ddwy ohonoch am ateb y cwestiynau mor fendigedig. Fe'ch hysbysaf y bydd y clerch yn anfon trawsgrifiad drafft o'r drafodaeth ar gyfer unrhyw gywiriadau. Ni fedrwnch mynd i'r afael â'r hanes, ond gallwnch gywiro unrhyw fân gamgymeriadau, er fy mod yn siŵr na fydd rhai. Dyna ddiwedd yr adran dystiolaeth hon.

David Lloyd: Thank you both very much for answering the questions so splendidly. It remains to inform you that the clerk will send you a draft transcript of the discussion for any corrections. You cannot change the course of history, but you can correct any minor errors, although I am sure that there will not be any. That concludes that part of the evidence session.

[122] Hoffwn groesawu cynrychiolwyr Gofal Cymru, sef Ewan Hilton, y prif weithredwr, ac Alexandra MacMillan, rheolwr materion cyhoeddus Gofal Cymru. Yr ydym wedi derbyn tystiolaeth ysgrifenedig eisoes gan Gofal Cymru, a hefyd gan Hafal a Mind Cymru, fel y dywedais. Byddwnch wedi clywed ac wedi gweld y drefn y bore yma. Mae cwestiynau wedi cael eu ffurfio sy'n seiliedig ar eich papur. Felly, os ydych yn hapus i fynd ymlaen, symudwn at y cwestiynau. Byddwnch wedi clywed y ddau gwestiwn cyntaf o'r blaen, oherwydd ein bod yn dilyn patrwm sy'n tueddu i ailadrodd ei hun ychydig. Dechreuaf fi. A oes angen am y Mesur arfaethedig, ac a ydych yn cefnogi ei amcanion?

I welcome representatives from Gofal Cymru, namely Ewan Hilton, the chief executive, and Alexandra MacMillan, the public affairs manager for Gofal Cymru. We have already received written evidence from Gofal Cymru, as well as from Hafal and Mind Cymru, as I have said. You will have heard and seen the order of proceedings this morning. Questions have been formed based on your paper. Therefore, if you are happy to continue, we will move on to the questions. You will have already heard the first two questions, because we are following a set pattern that tends to repeat itself. I will start. Is there a need for the proposed Measure, and do you support its overall aims?

[123] **Ms McMillan:** Yes, we welcome the introduction of the proposed Measure. We have been part of its development since Jonathan Morgan laid his proposed LCO, several years ago now. We therefore very much welcome it and think that it has the potential to make a very real difference to the lives of people who are experiencing mental ill health.

[124] **Mr Hilton:** I concur with that. We work with around 2,000 people every year. Some use secondary mental health services and many, increasingly, are in need of primary care services. At the risk of repeating what our colleagues have said, services are patchy across Wales and people have varying experiences. It is not that long ago since we sat in this committee room to give evidence to the health committee, which was looking into mental health services in Wales. In addition, we have contributed to the third consecutive Wales Audit Office review of mental health services, and all are very clear that the current system that we have, even for implementing strategy, such as the NSF, is not delivering. I would stress that we are in support of the need for a Measure in this area. This is a fantastic opportunity for mental health services in Wales.

[125] **David Lloyd:** Yn dilyn hynny, yn eich tyb chi, a allai amcanion y Mesur arfaethedig gael eu cyflawni wrth

David Lloyd: Following on from that, in your opinion, could the aims of the proposed Measure be achieved using the existing

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presennol?

[126] **Ms McMillan:** No, we do not believe that they could. The Mental Health Act 2007 covers the small number of people who are most severely unwell, but there is a distinct gap in the legislative framework in respect of the majority of people who experience mental ill health. There have been attempts to do many of the things that are contained in the proposed Measure, through mechanisms such as the national service framework and guidance. They have consistently failed to produce the improvements in mental health services that they intended for. They have not been implemented fully, which has resulted in real inequality in Wales. So, we feel that the only way to ensure that everyone has access to the level of services that they would rightly expect is through legislation.

[127] **David Lloyd:** Symudwn ymlaen at y **David Lloyd:** We shall move on to the next set of questions, which will come from Oscar.
cwestiynau nesaf, sydd dan ofal Oscar.

[128] **Mohammad Asghar:** My first question is on definitions. Sections 1 and 5 provide definitions of 'local mental health partners' and 'support services'. Similarly, sections 11 and 12 provide a definition of 'relevant patients' and 'secondary mental health service providers'. Are you content that these definitions encompass all relevant parties?

[129] **Ms McMillan:** In some respects, we are quite pleased with the definitions that are contained in the proposed Measure. For example, the fact that the proposed Measure refers to 'local mental health partners' explicitly as local authorities as well as health boards helps to move us away from this idea of it just being a medical issue. However, we do have some concerns. We have heard from previous witnesses about the need for a holistic approach to mental health and so, for example, under section 9 we would want the mental health assessments to include things like housing and employment services, which are not contained in the current definition. Equally, under section 5, which lists the different services that patients and carers should receive information about, we think that voluntary sector services should be included, because they play an important role in supporting people who experience mental ill health. They offer that balance with statutory services, which is quite important when taking a holistic view.

10.40 a.m.

[130] **Mr Hilton:** Just to add to that, our experience working across Wales is very much the same as that described by Hafal. It is rare for us to work with someone with a single issue of mental ill health; very often there are complications around housing, or even homelessness, or problems with peer relationships, debt or finance, so the role of the voluntary sector and the additionality that can be provided by other sectors would be significant.

[131] **Mohammad Asghar:** My second question is on the scope of the proposed Measure. You state in your evidence that section 1(3) of the proposed Measure should include children and young people as well as adults. What is the case for extending the scope in this way?

[132] **Ms McMillan:** We believe that the proposed Measure should extend to people of all ages. We know that the children's non-governmental organisations support that extension. They know an awful lot more about CAMHS than we do, and I would strongly advise that you listen to their evidence, which I know they will be presenting to you. We think that it should be extended. We know that child and adolescent mental health services are no better than adult services, and there is a need for the same sort of improvements that you would expect in adult services.

[133] **Mohammad Asghar:** In addition to that, is there a case for introducing separate legislation to address the distinctive mental health needs of children and young people? Or would that be better dealt with by extending the scope of this proposed Measure?

[134] **Ms McMillan:** I would agree with our colleagues from Mind Cymru, from whom you just heard: the danger of two separate Measures is that they do not adequately join up, and people could fall through the gaps. Therefore, my inclination would be to have it all under one Measure, but recognising that the way that CAMHS is currently designed is not the same as adult services, so the terminology that is used would have to be different in order to ensure that the Measure is applicable to children's services. Having it all in one Measure would be beneficial.

[135] **David Lloyd:** Symudwn ymlaen. **David Lloyd:** We move on. The next Mae'r cwestiynau nesaf ar amserlenni o dan questions on timescales are from Joyce ofal Joyce Watson. Watson.

[136] **Joyce Watson:** Good morning. As the Chair said, I am asking questions on timescales for provision in the proposed Measure. You state in your written evidence that few of the new duties contained in the proposed Measure have timescales attached to them. How could this affect services, and how should this be addressed by the proposed Measure?

[137] **Mr Hilton:** Timescales are critical. We are the third organisation to say the same thing—there is no point in legislation without teeth. Timely, early intervention—which is certainly what this proposed Measure is all about—is critical to supporting the mental wellbeing of the population of Wales. I would agree with what has been said previously: there should be a maximum of 30 days for assessment for secondary care services, and 60 days for an initial care plan. On top of that, there needs to be accountability for delivering. One of the problems that we have at the moment with the national service framework, for example, is that there are a lot of good words in there, but the levels of accountability just do not exist in terms of implementation. So, timescales are critical, but I am also aware that they lead to perverse incentives, just in terms of getting people to places in the system where the regulations say that they need to be. Hard targets need to be balanced with outcomes and outputs based on that individual's need, and services actually being delivered. We need to also take that back to primary care, and if this is accepted as needing to form part of the secondary care service, it needs to occur in a similar format in primary care services. The primary care element is what will keep people out of secondary care services and keep the vast majority of people in this country who are experiencing mental distress well. I am not saying that the vast majority of people in this country are experiencing mental distress, but that is the wider catchment. If that is working and providing high-quality interventions early on that are accountable through legislation, you will see the cost benefit.

[138] **Ms McMillan:** I would emphasise the need for the timescales to apply to the primary care aspects of the proposed Measure. We know that in some areas there are what are called gateway or liaison workers already operating, who have a similar role to some of the services described in Part 1. In some areas, they are working well, but in other areas, the waiting list to see that professional is extremely long and is therefore becoming a barrier to people getting the support that they need, rather than acting as a conduit in the way that is necessary. Therefore, those timescales are important.

[139] **Joyce Watson:** For the record, should the requirement for timescales be included in regulation or on the face of the proposed Measure?

[140] **Mr Hilton:** It should absolutely be on the face of the proposed Measure.

[141] **David Lloyd:** Symudwn ymlaen. **David Lloyd:** We will move on; Oscar is

Oscar sydd nesaf.

next.

[142] **Mohammad Asghar:** You expressed concern in your paper that the proposed Measure does not stipulate what the primary care mental health schemes will be required to include. What would be the benefits of prescribing the contents of the mental health schemes and how should this be addressed by the proposed Measure?

[143] **Ms McMillan:** This was one of our main concerns when reading through the proposed Measure. The primary mental health schemes are the documents that will detail the treatment that can be provided in an area and, in some cases, who is eligible to receive that treatment. So, it is absolutely fundamental to how the proposed Measure will work. To be honest, we were quite shocked that there is so little in the proposed Measure that will dictate what they should contain. So much is left to the discretion of local health boards and local authorities that, as a result, you could see an increase in the postcode lottery—for want of a better phrase—rather than a decrease. For example, the proposed Measure would allow some areas to say ‘If you are not registered with a GP, if you receive secondary services, we’ll still incorporate you into our primary mental health schemes’, but a neighbouring authority might decide that you were not eligible. That is left up to local authorities and local health boards. We would like to see the Assembly Government taking more of a lead on this in the proposed Measure by making clear what services it expects LHBs and local authorities to provide. We also think that the scheme should be subject to approval by Welsh Ministers and that there is some level of scrutiny.

[144] The explanatory memorandum proposes appointing an all-Wales primary mental health lead who would work, in the first 18 months, to identify what gaps exist in areas that they need to address to meet the requirements of the proposed Measure. That seems like a good opportunity to say that that advice cannot go nowhere, but that it has to be incorporated into the schemes.

[145] **Mohammad Asghar:** Secondly, you also state that there are no detailed requirements beyond actual provision of the primary mental health assessment in the proposed Measure. What further requirements would you like to see in the proposed Measure?

[146] **Ms McMillan:** Is that with regard to the assessment process?

[147] **Mohammad Asghar:** Yes.

[148] **Ms McMillan:** Again, it is about having a greater level of detail. We welcome these proposals, but we want to see their potential fulfilled. So, for example, we talked about timeframes for having assessments in the first place, which is important. The people who will be delivering those assessments are important and who they are is left to regulations, which might or might not be the right approach, but either way, who delivers those assessments will be important. In addition, some kind of written documentation should come out of the assessment. Where the proposed Measure deals with secondary care, it talks about care planning; this does not necessarily need to be as detailed a format as that, but there needs to be a requirement that the result of an assessment is that the individual who has had that assessment comes away with a piece of paper that says ‘I am entitled to receive this treatment’. It is important that we ensure that that piece of paper exists.

10.50 a.m.

[149] **Mr Hilton:** In the primary care setting, it is not just treatment. What Ruth was talking about, in terms of information giving quality and real signposting to support people to get to the places that they need to be to receive the interventions, is a fundamental part of this working in a primary care setting. So, we need to be careful not to think that strengthening

this will be massively resource-intensive or even require many more professionals; it is about using GP surgeries better and enabling them to get people to where they need to be in terms of many existing resources.

[150] **Mohammad Asghar:** You have partly answered my next question, but you can fill in the blanks. How should the proposed Measure ensure that primary mental health assessments are holistic and include, for example, consideration of housing and employment?

[151] **Mr Hilton:** The proposed Measure needs to be specific about that. There needs to be accountability within the legislation, which is why we are keen that something akin to the care plan exists in the primary care setting. To be able to evaluate the quality of what we are delivering under legislation, we need to be able track it. We feel that it falls down at the point that you may get an assessment and then you may get treatment. That needs to be much more specific. So, we would be looking at a similar model to the recovery model, which looks at relationships, social networks, employment, housing, debt. A medical approach to managing the mental health social model should exist in the primary care setting as well, with someone accountable for developing that with the individual and delivering it. However, we recognise that it could be much more flexible, it could be much smaller in many cases and that it could happen much more quickly, because we are looking at a very low level. That should be specifically outlined in the proposed Measure so that we are accountable for delivering it.

[152] **David Lloyd:** Gan Joyce Watson **David Lloyd:** Joyce Watson has the final mae'r cwestiynau olaf. questions.

[153] **Joyce Watson:** I will move on to some questions around advocacy. You state that you believe that the list of people able to request advocacy services in section 32(3) should be broadened. What are your reasons for that statement?

[154] **Ms McMillan:** In effect, the proposed Measure will give people many additional rights. I know that it is termed as 'duties', but it is essentially similar. What is really important is that people are able to benefit from the things that the proposed Measure will bring. Not everyone is able to advocate for themselves, especially if they are unwell, and it is important that no-one misses out because of that. We want everyone to benefit from this.

[155] **Mr Hilton:** When we were looking at this issue, we were thinking whether this was all just advocacy or if some of it was about access to independent advice and support that we use in Wales to uphold other areas of legislation, such as housing and homelessness legislation. There is free-at-the-point-of-entry access to advice and support across Wales for people threatened with and experiencing homelessness to ensure that local authorities uphold their duties. That watchdog approach is critical. So, when we discussed advocacy, although I cannot give you the specifics, we began to explore the idea that some people need advocacy, but some people just need recourse to their rights not being upheld, or duties not being upheld. We wish to see if that type of idea can be explored somewhere in the proposed Measure.

[156] **Joyce Watson:** You also say that the provision relating to advocacy does not go far enough, and you gave an example of that. What further provision in the proposed Measure would you like to see in relation to advocacy?

[157] **Mr Hilton:** In terms of advocacy, our colleagues from Mind gave a comprehensive answer, and we have nothing to add to that.

[158] **Joyce Watson:** Moving on to the cost of regulatory impact assessments, does the regulatory impact assessment make a realistic assessment of the financial implications of the proposed Measure? If not, what are the shortcomings?

[159] **Mr Hilton:** It looks okay on the face of it, but depending on how the evidence that has been given to the committee during this meeting is taken forward, it means that further work needs to be done. We are asking for the introduction of timescales, and we are asking for greater definition of the primary care schemes, services and treatments available. Depending on how that influences the proposed Measure, further financial impact assessments will need to be done. However, I would draw attention to the fact that I believe that we will be missing a trick with this if we do not develop—prior to this proposed Measure being implemented—more robust and cost-efficient ways of measuring the wider impact of mental health issues in Wales.

[160] A report was launched recently stating that mental health issues in Wales cost £7 billion. That is partly to do with treatment and care, but it is also to do with loss of earnings, costs to the economy and so on. If we really believe that this proposed Measure is about improving the mental wellbeing of Wales, and that that in itself will make Wales a more economically active and better place, I think that we will be missing a trick with this quite significant piece of legislation if we do not measure more than how quickly it takes somebody to get an assessment, and we do not make links to see whether it is having an impact on the economy, such as from workdays lost through sickness.

[161] Then, we also start to talk about the spend-to-save notion. There might be some additional costs. We are not necessarily assuming that they need to be significant as, hopefully, we can eliminate some bureaucracy within existing services just by getting things moving quickly. You talked about people being in and out of secondary services for a long time just because they did not get an assessment and a good care plan. Clearly, that would be one area in which eliminating bureaucracy would save money. We run the only crisis house in Wales. People stay there for seven days as an alternative to in-patient admission. The average stay of an in-patient is three months. There is clearly a saving to be made there. Our challenge, in implementing this, will be to deliver flexible, fast-moving, responsive, and high-quality services, and doing it in a way that has a benefit to Wales.

[162] **Joyce Watson:** You also say that the proposed Measure could reduce reliance on long-term and more specialist interventions—and you just outlined some of that. How could it work in practice? You have given some examples, but this is the last question, so if you want to give another, now is your chance. [*Laughter.*]

[163] **Ms McMillan:** If this proposed Measure delivers on its potential, it will result in people receiving the support that they need more quickly. The implication of that is that people would become less unwell and recover more quickly. Hopefully, that means that they would not need higher-level services in the first place, or that, if they would need them, they would need them for a shorter period of time, so there would be a saving there for the NHS. It also means that they would be able to stay in work or return to work more quickly, and there is widely recognised benefit in that. There is also a wider societal benefit from people being healthier.

[164] So, there are a number of different possibilities for saving money and, as Ewan mentioned, it is really important that those savings be captured in a robust way and that any money saved be put back into mental health services or other services that promote mental wellbeing. The proposals in this proposed Measure would represent a great opportunity for saving money in the long run, but it would be a shame to lose that money to other areas. There is a long way to go with mental health services and other opportunities that promote mental wellbeing. It is really important that the money be reinvested and not lost.

[165] **David Lloyd:** Dyna ddiwedd y **David Lloyd:** That brings us to the end of the sesiwn gwestiynau swyddogol. Wrth ddirwyn official questioning session. To close, do you

i ben, a oes gennych unrhyw sylwadau have any further comments?
pellach?

[166] **Ms McMillan:** I would just add that we absolutely welcome this proposed Measure. We think that it has huge potential. Our concern is about those areas in which things are not overly specific, or where a lot of stuff is left to regulations. Although the fact that the explanatory memorandum outlines how things are expected to happen is very welcome, there is no guarantee that it will happen. That is our concern, I guess. We want all those things that are promised to be delivered.

[167] **Mr Hilton:** I have nothing further to add.

[168] **David Lloyd:** Diolch yn fawr iawn ichi am eich tystiolaeth. Mae'r atebion wedi bod o safon arbennig drwy'r bore, a dweud y gwir, yn ogystal â'r dystiolaeth ysgrifenedig. Felly, diolch yn fawr iawn ichi oll.

David Lloyd: Thank you very much for your evidence. The answers have been of an exceptional standard all morning, in all honesty, as well as the written evidence. Therefore, thank you very much, everyone.

[169] Bydd y clerch yn anfon trawsgrifiad drafft o drafodaethau heddiw atoch er mwyn ei gywiro, os bydd angen, cyn i'r fersiwn derfynol gael ei chyhoeddi. Dyna ddiwedd y sesiwn ac, yn wir, y cyfarfod. Wrth ddirwyn i ben, hysbysaf fy nghyd-Aelodau y cynhelir cyfarfod nesaf Pwyllgor Deddfwriaeth Rhif 3 ddydd Iau nesaf, sef 29 Ebrill. Gallaf ddatgan, felly, fod y cyfarfod ar ben. Diolch yn fawr iawn ichi am eich presenoldeb a diolch i'r cyfieithwyr.

The clerk will send you a draft transcript of today's proceedings so that it can be corrected, if necessary, before the final version is published. That brings the session and, indeed, the meeting to a close. In closing, I inform my fellow Members that the next meeting of Legislation Committee No. 3 will be held next Thursday, on 29 April. I declare, therefore, that the meeting is over. Thank you very much for your attendance and I also thank the translators.

*Daeth y cyfarfod i ben am 11 a.m.
The meeting ended at 11 a.m.*