Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Pwyllgor Deddfwriaeth Rhif 3
Legislation Committee No. 3

Dydd Iau, 20 Mai 2010
Thursday, 20 May 2010

Cynnwys
Contents

3 Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies a Substitutions

4 Y Mesur Arfaethedig Iechyd Meddwl (Cymru)—Sesiwn Dystiolaeth 5
The Proposed Mental Health (Wales) Measure—Evidence Session 5

31 Cynnig Trefniadol
Procedural Motion

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
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Joyce Watson	Llafur Labour

Eraill yn bresennol
Others in attendance

Sally Burke	Prif Swyddog Cynorthwyol Dros Dro, Heddlu De Cymru Temporary Assistant Chief Police Officer, South Wales Police
Nia Lloyd	Swyddog Polisi, NSPCC Cymru Policy Officer, NSPCC Cymru
Jackie Murphy	Cyfarwyddwr Cynorthwyol, Tros Gynnal Assistant Director, Tros Gynnal
Menna Thomas	Swyddog Datblygu, Barnardo's Cymru Development Officer, Barnardo's Cymru
Dean Piper	Cymdeithas Prif Swyddogion yr Heddlu Cymru Association of Chief Police Officers of Wales
Keith Towler	Comisiynydd Plant Cymru Children's Commissioner for Wales

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 9.03 a.m.
The meeting began at 9.03 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies a Substitutions

[1] **David Lloyd:** Bore da a chroeso i gyfarfod diweddaraf Pwyllgor Deddfwriaeth Rhif 3. Yr wyf yn croesawu'r tystion ar gyfer y sesiwn dystiolaeth gyntaf. Dywedaf fwy amdanynt yn y man.

David Lloyd: Good morning and welcome to the latest meeting of Legislation Committee No. 3. I welcome the witnesses for the first evidence session. I will say a little more about them in a moment.

[2] Yr ydym wedi derbyn ymddiheuriadau gan Christine Chapman a

We have received apologies from Christine Chapman and William Graham. I state to

William Graham. Yr wyf yn datgan i bawb yma, gan gynnwys y cyhoedd a gwesteion, os bydd y larwm tân yn seinio, dylai pawb adael yr ystafell drwy'r allanfeydd tân a dilyn cyfarwyddiadau'r tywyswyr a'r staff. Nid ydym yn disgwyl prawf larwm tân y bore yma, ac nid ydym yn disgwyl tân ychwaith. Dylai pawb ddiffodd eu ffonau symudol, eu galwyr a'u 'mwyar duon', gan eu bod yn amharu ar yr offer darlledu. Fel mae pawb bellach yn gwybod, mae Cynulliad Cenedlaethol Cymru yn gweithredu'n ddwyieithog. Mae clustffonau ar gael i glywed cyfieithiad ar y pryd a gellir hefyd addasu'r sain arnynt gan bobl sy'n drwm eu clyw. Peidiwch â chyffwrdd â'r botymau ar y meicroffonau, oherwydd gall hynny amharu ar y system a sicrhewch fod golau coch yn disgleirio arnynt cyn cychwyn 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.

everyone here, including the public and guests, that if the fire alarm sounds, everyone should leave the room through the fire exits and follow the instructions of ushers and staff. We do not expect a fire alarm test this morning, and neither do we expect a fire. Everyone should switch off their mobile phones, pagers and BlackBerrys, because they interfere with the broadcasting equipment. As everyone will now be aware, the National Assembly for Wales operates bilingually. Headsets are available to listen to the interpretation and to amplify the sound for those who are hard of hearing. Please do not touch the buttons on the microphones, because that can disrupt the system, and please ensure that the red light is on before beginning to speak. Interpretation is available on channel 1 and the verbatim feed is on channel 0, for those who need the sound amplified.

9.05 a.m.

Y Mesur Arfaethedig Iechyd Meddwl (Cymru)—Sesiwn Dystiolaeth 5
The Proposed Mental Health (Wales) Measure—Evidence Session 5

[3] **David Lloyd:** Rhof ychydig o gefndir. Fel yr ydych yn ymwybodol, rôl y pwyllgor hwn yw ystyried a chyflwyno adroddiad ar egwyddorion cyffredinol y Mesur Arfaethedig Iechyd Meddwl (Cymru) a gyflwynwyd yn y Cynulliad ar 22 Mawrth gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol, Edwina Hart.

David Lloyd: I will give some background. As you are aware, the role of this committee is to consider and report on the general principles of the Proposed Mental Health (Wales) Measure, which was introduced in the Assembly on 22 March by the Minister for Health and Social Services, Edwina Hart.

[4] Rhaid i'r pwyllgor gwblhau ei waith a gosod adroddiad gerbron y Cynulliad erbyn 2 Gorffennaf eleni. Felly, fel arfer, mae'r amserlen yn dynn. Dyma ein pumed sesiwn dystiolaeth ar y Mesur arfaethedig hwn. Yr ydym wedi derbyn tystiolaeth eisoes gan nifer o randdeiliaid a'r Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol. Daeth ein hymgynghoriad i ben ar ddydd Gwener, 14 Mai ac mae'r manylion ar gael ar wefan y pwyllgor.

The committee must complete its work and present its report to the Assembly by 2 July this year. So, as usual, the schedule is tight. This is our fifth evidence session on this proposed Measure. We have already received evidence from a number of stakeholders and the Minister for Health and Social Services. Our consultation came to an end on Friday, 14 May and the details are available on the committee's website.

[5] Diben cyfarfod heddiw yw clywed tystiolaeth ar lafar ar y Mesur Arfaethedig Iechyd Meddwl (Cymru). Mae'r sesiwn wedi'i rhannu'n dair. Yn gyntaf, cawn dystiolaeth gan Gymdeithas Prif Swyddogion yr Heddlu; yn yr ail ran, cawn dystiolaeth gan

The purpose of today's meeting is to hear oral evidence on the Proposed Mental Health (Wales) Measure. The session will be divided into three parts. First, we will hear evidence from the Association of Chief Police Officers; in the second part, we will hear

Gomisiynydd Plant Cymru; ac, yn y drydedd rhan, cawn dystiolaeth gan is-grŵp iechyd meddwl swyddogion polisi cyrff anllywodraethol plant.

evidence from the Children's Commissioner for Wales; and, in the third part, we will hear evidence from the children's non-governmental organisations policy officers mental health sub-group.

[6] Croesawaf ein tystion cyntaf, Sally Burke a Dean Piper, sy'n cynrychioli Heddlu De Cymru. Yr ydym wedi derbyn eich tystiolaeth ysgrifenedig. Felly, os cytunwch, symudwn ymlaen i'r cwestiynau sydd wedi eu paratoi, sy'n ymwneud â phob agwedd o'r Mesur arfaethedig. Mae nifer o gwestiynau, felly gofynnaf i'm cyd-Aelodau i fod yn gryno a gobeithiaf y bydd yr atebion hefyd yn gryno.

I welcome our first witnesses, Sally Burke and Dean Piper, who are representing South Wales Police. We have received your written evidence. Therefore, if you are happy to do so, we will move straight on to questions that have been prepared, which cover all aspects of the proposed Measure. There are a number of questions, so I ask my fellow Members to be brief and I hope that the responses will also be brief.

[7] Dechreuaf gyda chwpwl o gwestiynau cyffredinol. A ydych yn cefnogi amcanion cyffredinol y Mesur arfaethedig hwn?

I will start with a couple of general questions. Do you support the overall aims of the proposed Measure?

[8] **Ms Burke:** Thank you for the opportunity to come here today. We, as a service, recognise that we come into contact with people with mental health problems in a variety of ways and that such people can feel vulnerable and isolated. We certainly feel that the proposed Measure gives such individuals a voice, an opportunity to be assessed and a clear care pathway. We fully support the proposed Measure.

[9] **David Lloyd:** A gredwch y gellir cyflawni amcanion y Mesur arfaethedig gan ddefnyddio deddfwriaeth sydd eisoes yn bodoli?

David Lloyd: Do you think that the aims of the proposed Measure can be achieved using existing legislation?

[10] **Ms Burke:** It is difficult for us to comment in-depth on certain aspects in Parts 1, 2 and 3. Looking at the documents that accompanied it, it appears that the care programme approach that was introduced in 2003 certainly provides some scope. However, it is fair to say that the implementation of the care programme approach has been varied. Our view is that the proposed Measure aims to improve that and to improve the efficiency of such care paths.

[11] In relation to the specific practical issues relating to sections 135 and 136 of the Mental Health Act 1983, we feel that there is no need for a duty to be imposed on the custody officer. That may raise some other issues in relation to the Home Office and non-devolved services and so on. There are also some potential issues in relation to the Police and Criminal Evidence Act 1984.

[12] The Association of Chief Police Officers is content to adopt that on a voluntary basis and to work with local health boards and independent mental health advocacy service providers to achieve the aims of the proposed Measure fully on a voluntary basis. We would feel much more comfortable with that approach.

[13] **David Lloyd:** We will turn to some specific questions now, the first of which relates to definitions in sections 1, 5, 11, and 12. Some of these may not apply to you, or you may not have a view, so feel free to express that as well. However, sections 1 and 5 provide definitions of 'local mental health partners' and 'local primary mental health support services'. Similarly, sections 11 and 12 provide definitions of a 'relevant patient' and a 'secondary mental health

service provider'. Are you content that these definitions encompass all relevant parties?

[14] **Ms Burke:** I will give a very concise answer. Yes, we are content with the definitions.

9.10 a.m.

[15] **David Lloyd:** Great. Those are the sorts of answers that we like.

[16] Mae'r cwestiynau nesaf dan ofal Peter Black. Peter Black will ask the next questions.

[17] **Peter Black:** On the scope of the proposed Measure, the Assembly has competence to legislate in this area to ensure provision across all ages but, in the main, the proposed Measure is confined to adults. I think that the advocacy part is the only exception to that. Witnesses have suggested that the proposed Measure should be extended to encompass people under the age of 18. Do you have a view on that?

[18] **Ms Burke:** Yes, I think that we do. We recognise that the proposed Measure is a positive starting point. Any opportunity to extend it to include people under 18 would be beneficial in our view. We are certainly aware of the joint Wales Audit Office and Healthcare Inspectorate Wales report—which looked at the issues around children and young people—and its recommendations. We think that an extension of the proposed Measure would be beneficial.

[19] **Peter Black:** The proposed Measure allows, but does not require, local mental health partners to include patients who are not registered with a GP in their schemes. However, some witnesses have argued that local schemes should be required to include non-registered patients to ensure that, for example, homeless people and other groups are not excluded. Do you have a view on that?

[20] **Ms Burke:** Yes, I think that that would be a good move. From a policing perspective, we recognise that members of the homeless community often have complex mental health problems. We see that first-hand, and we would support the recommendation to extend schemes to include people who are not registered with GPs. There may be some practical issues around the logistics of how that is managed, but we support the principle.

[21] **Peter Black:** In your evidence, you state that you strongly support access to primary care services at an early stage and swift access to secondary services to ensure that individuals do not deteriorate into crisis while awaiting referral. Are you satisfied that the proposed Measure will address these needs? If not, how should it be amended?

[22] **Ms Burke:** From the discussions that we have had with colleagues and briefings that we have attended in relation to the proposed Measure, we certainly think that it will go some way to addressing those needs. However, in all honesty, healthcare professionals are probably in the best position to give you an informed answer on that one.

[23] **Peter Black:** What do you anticipate the impact on police forces would be of the implementation of these provisions with regard to your involvement with people with mental health problems?

[24] **Ms Burke:** Generally, I do not think that there would be a significant impact, if you are talking about the proposed Measure as a whole and its impact on policing services. The requirement on the custody officers is not an onerous one, which is why we think that we can do it voluntarily and manage that process. In a custody environment, we already observe

rights, and we are comfortable with that. In principle, we do not have any issues with it.

[25] **Peter Black:** 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 have a view on that?

[26] **Ms Burke:** In relation to any timescales, we would look for any service or assessment to be based on individual need and for the provision of such support to be timely. With regard to the appropriateness of the number of days proposed, they seem appropriate, but I am sure that healthcare professionals would have a better view on that. In our experience, in a policing environment, when you set a maximum period it tends to become the norm. So, my only concern is that it should be clear that that would be the maximum rather than the norm. I know from our service that that could tend to be the case, so there probably needs to be some clarity on that. However, they seem appropriate given the circumstances.

[27] **David Lloyd:** Mae'r cwestiynau nesaf dan ofal Helen Mary Jones.

David Lloyd: Helen Mary Jones will ask the next questions.

[28] **Helen Mary Jones:** Good morning. In your written evidence, you suggest that some individuals who have left, or who have never received, secondary care could be helped by a referral to assessment by 'responsible concerned third parties', to use your phrase. Could you tell us more about what you mean by that and how that might be accommodated in the proposed Measure?

[29] **Ms Burke:** It is clear to us that, sometimes, people suffering with mental health issues recognise that they are deteriorating and need additional support, and need to go back to secondary services. We also come across individuals who do not recognise that their mental health is deteriorating, and we often find that family members, friends and contacts have recognised that deterioration, and it is an opportunity for them to be able to seek some support for that individual. The role of the care co-ordinator provides an opportunity for a point of referral, and that would be a good way of managing that with secondary services. We probably accept that it is slightly more difficult with primary mental health care arrangements, but there are some real opportunities for crime prevention in being able to access stress counselling, anger management and so on that would really support that. Although we think that it might be difficult to manage, it is certainly worthy of consideration.

[30] **Helen Mary Jones:** That is helpful. Building on that, you say in your written evidence that it would seem appropriate that information used to develop the care and treatment plan should be cognisant of intelligence from the police service, family members and other services. How should that exchange of information with the police service be facilitated, and should that be done through the proposed Measure—including, if necessary, the primary care level?

[31] **Ms Burke:** Any opportunity to share information in these sorts of circumstances, certainly in our experience, given the contact that we have with people with mental health issues, would be beneficial. It is important to say that we recognise that not every person with a mental health issue has an offending history or contact with the police, and that is important to get across. However, a very small minority of people do have such a history and when we have some information or intelligence to share, we would manage that through contact with the care co-ordinator. That would be quite simple in terms of a point of contact and similar to the kinds of arrangements that we have under the multi-agency public protection arrangements and the multi-agency risk assessment conference within public protection. They work very effectively, and often with many of the same partners. All that we would be

looking for would be some practical extensions of existing information-sharing agreements or protocols to facilitate that exchange of information, recognising that it may not be necessary on every occasion. However, when something adds value to the development of a care plan, that would be a way to facilitate that.

[32] **Helen Mary Jones:** In your view, are there issues with regard to confidentiality and the individual's right not to have everyone know that they have been arrested for a minor offence, or whatever it may be?

[33] **Ms Burke:** There may well be, and they would have to be taken into consideration, but that is not in any way different from some of the considerations that we currently take into account around disclosure and public protection issues. The principles are similar—each case would need to be considered on its merits, but as long as those issues are taken into consideration, they are not insurmountable. It is a matter of looking at individual cases and making the decision based on risk, the rights of the individuals, and those sorts of things. Those safeguards are already in place, to some degree, and it is about providing that overall support and care for the individual.

[34] **David Lloyd:** Mae'r cwestiynau olaf yn y sesiwn hon o dan ofal Joyce Watson.

David Lloyd: Joyce Watson has the last questions in this session.

[35] **Joyce Watson:** My question is about mental health advocacy. I know that you said at the beginning that you did not think that it was right to impose a legal duty on custody officers through the proposed Measure, because you felt that it was outside our powers. However, for the record, could you tell us more about the issue and how you think that it should be resolved?

[36] **Ms Burke:** It is important that I reinforce, at the outset, the ACPO Cymru perspective: that we are fully supportive of the aims of the proposed Measure. It is also worth noting that policing services fall outside the devolved settlement, and we recognise that. We have some responsibility to the Home Office, and we are compared with forces in England in terms of performance. That aside, it is a complex legal issue and I do not pretend to understand all of the detail of the advice that lawyers give. However, our lawyers take the view that the National Assembly for Wales does not have the power to impose a duty on the custody officer. I think that the National Assembly for Wales's lawyers take a contrary view. I understand that this is not the first time that this has occurred; it happened as recently as last year with regard to the Local Government (Wales) Measure 2009. It is a matter of principle more than anything else. I would not want it to be seen as anything other than that.

9.20 a.m.

[37] This is important for us in that the custody officer is regulated by the Police and Criminal Evidence Act 1984 and the related codes of practice. We feel that if a duty were imposed it might necessitate some consideration of primary legislation around the Police and Criminal Evidence Act 1984 and some amendment of the codes of practice, as they apply to Wales. That would be our view. Having said that, we maintain, as we always have, that a police place of safety should very much be the last resort. The message that I would like to deliver to you is that a custody suite can be a quite demanding environment on different days, particularly at certain times, and that some very challenging people are dealt with in that environment. If the committee wanted to take the opportunity to visit a custody suite—I could suggest one 60-cell complex locally that is a nice, brand new facility—and have a chat with some custody officers to understand the demands made of them, it might give you an insight into some of the challenges. At the outset, our stance is that we would look to deliver the full aims of the proposed Measure voluntarily, and we do not feel that there is a requirement to impose a duty on the custody officer to do that.

[38] **Joyce Watson:** On the same theme, the proposed Measure would also provide Welsh Ministers with the power to make regulations setting out the people involved with patients whom the independent mental health advocate may interview. This could include the police officer who removed the patient from a public place to a place of safety. Do you have any comments on that?

[39] **Ms Burke:** It is perfectly logical to expect that someone who is planning a response to the circumstances would expect to have a full understanding of them. To a police officer, an interview means certain things, and is a very formal thing. I am sure that is not what we are talking about, and that we are talking about a discussion of the circumstances under which the individual came to be at a place of safety. We would have no issue with that. We anticipate that those instances would probably be fairly rare. For a person in a police place of safety, in particular, it would be fully documented on the custody record and would be available in written form. We would support that. I do not think that there would be an issue with that. The only time when there might be an issue is if there was an ongoing independent investigation. Again, however, the circumstances would still need to be communicated to the advocate, so he or she could provide the necessary support beyond that.

[40] **Joyce Watson:** Okay, that is fine. I now turn to my final question. Do you think that the duty to provide advocacy services could be extended to all users of mental health services, including those in community settings?

[41] **Ms Burke:** Yes, I do. I would support any extension of the proposed Measure to improve our responses in Wales to people with mental health issues.

[42] **David Lloyd:** Dyna ddiwedd y cwestiynau swyddogol. A oes gennych unrhyw sylwadau terfynol ar y Mesur arfaethedig hwn i gloi?

David Lloyd: That brings the official questions to an end. Do you have any final comments to make on this proposed Measure?

[43] **Ms Burke:** No, other than to say thank you very much for the opportunity to come here today. I am very grateful.

[44] **David Lloyd:** Diolch yn fawr iawn i chithau, hefyd. Diolch, felly, i Sally Burke, Prif Swyddog Cynorthwyol Dros Dro, Heddlu De Cymru, a diolch hefyd i Dean Piper o Gymdeithas Prif Swyddogion yr Heddlu Cymru. Bydd y clerc yn anfon trawsgrifiad drafft o drafodaethau heddiw atoch er mwyn ichi ei ddarllen a'i gywiro, lle bo angen, cyn iddo gael ei gyhoeddi yn derfynol. Diolch yn fawr iawn ichi.

David Lloyd: Thank you very much, too. Thank you, therefore, to Sally Burke, Temporary Assistant Chief Police Officer, South Wales Police, and also to Dean Piper from the Association of Chief Police Officers of Wales. The clerk will send you a draft transcript of today's discussions so that you can read it and correct it, if necessary, before the final version is published. Thank you very much.

[45] Yn awr, galwaf y tyst nesaf i'r bwrdd ar gyfer ail sesiwn y cyfarfod hwn. Mae'r tyst nesaf yn hen ffrind i'r Cynulliad erbyn hyn, gan ei fod yma bron bob diwrnod yn rhoi tystiolaeth i ryw bwyllgor o'r Cynulliad: Keith Towler, Comisiynydd Plant Cymru. Diolch am eich tystiolaeth ysgrifenedig ar Fesur Arfaethedig Iechyd Meddwl (Cymru). Yr ydych yn ymwybodol o'r drefn: yr ydym i gyd wedi darllen y papur ac mae cwestiynau

I now call the next witness to the table for the next session of this meeting. The next witness is an old friend of the Assembly's by now, given that he is here nearly every day giving evidence to some Assembly committee or other: Keith Towler, the Children's Commissioner for Wales. Thank you for your written evidence on the Proposed Mental Health (Wales) Measure. You are aware of how things work: we have already read the

wedi eu paratoi. Awn yn syth atynt os yw hynny'n iawn gyda chi.

paper and questions have been prepared. We will turn to them immediately, if that is okay with you.

[46] **Mr Towler:** Yes, indeed.

[47] **David Lloyd:** Dechreuaf gyda rhai the cwestiynau cyffredinol. A ydych yn cefnogi amcanion cyffredinol y Mesur arfaethedig?

David Lloyd: I will start with some general questions. Do you support the overall aims of the proposed Measure?

[48] **Mr Towler:** Yes, I do, although there is a theme to what I want to say to you today, which is that I want to see under-18s included in the proposed Measure.

[49] **David Lloyd:** You will have plenty of scope to enlarge on that.

[50] **Mr Towler:** Early intervention is important and we have a big opportunity to address some of the substantive issues that members of this committee and I have spoken about in various committee meetings for some time. It is timely for issues around child and adolescent mental health services to be addressed, particularly since it is 10 years since 'Everybody's Business' was published. The national service framework is due for a review, yet we still know that there is quite a big gap between what we all want to see happening for children and young people in this area and what is being delivered on the ground. So, I support the proposed Measure, but I want it to be extended to under-18s.

[51] **David Lloyd:** Eto ar faterion cyffredinol, yr ydych yn cydnabod yn eich papur fod y fframwaith deddfwriaethol sydd eisoes mewn bodolaeth yn gallu cyflawni llawer o amcanion y Mesur arfaethedig a bod hynny hefyd yn wir ynglŷn â phlant a phobl ifanc. A allwch ymhelaethu ar yr achos dros gyflwyno deddfwriaeth ychwanegol fel hyn?

David Lloyd: Again on general issues, you acknowledge in your submission that there is a legislative framework in place that could deliver much of the proposed Measure's objectives and that that is also the case for children and young people. Can you expand on the case for introducing this additional legislation?

[52] **Mr Towler:** Broadly speaking, it is the failure of implementation so far. I know that that sounds brutal, but my position on that is well known. The bottom line is that the current framework is not delivering. Practitioners are as frustrated as we are that the framework does not deliver. If it brought under-18s in, the proposed Measure would afford an opportunity for a robust route to ensure that children and young people's issues are addressed. The concept of 'Everybody's Business' is absolutely right. Somehow, there has been a lack of a consistent approach in relation to 'Everybody's Business', because it is not being delivered in the way that we would want it to be. So, this could provide focus. Professionals in the field appear to welcome the idea that the proposed Measure should be extended to under-18s. I can see no reason why that should not be the case. The current failure to deliver is reason enough for me. Something has to happen; we have to sort this out. Frankly, I am fed up of talking about it. So, we have to get on with it.

[53] **David Lloyd:** We are not fed up of hearing you, however. We will drill down to some of the details now. First of all, as regards definitions, sections 1 and 5 of the proposed Measure 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 those definitions encompass all relevant parties?

[54] **Mr Towler:** Broadly, I am. When we talk about local authorities and when we think about the messages in the recent Care and Social Services Inspectorate Wales report in

relation to safeguarding, we find a similar principle at work. The inspectorate is saying that there is too much reliance on children's services in relation to safeguarding. When we are talking about a local authority, we are talking about the variety of services that that local authority provides. So, we are talking about social services, housing and education—that concept of this being everybody's business. We would not want that to be siloed in a local authority. There are also some questions about youth justice and the place of the youth offending services within this, and also, no doubt, with regard to the criminal justice system for adults, which you have just been hearing about. That applies equally. So, it is comprehensive enough.

9.30 a.m.

[55] I would say that some of those services, particularly the support services, going beyond that, rest in the third or voluntary sector, and, at the moment, the voluntary sector is under huge pressure—so much so that some voluntary organisations are contracting or closing. Those so-called soft support services, which children and young people actually rely on very heavily, are under some pressure. Our calling those services 'soft' is a bit of a contradiction. We need to recognise that, because it is the voluntary sector that delivers lots of tier 1 services. So, there is a big issue there for me. With regard to the words 'relevant patient', provided that that covers people under 18, I am content.

[56] **David Lloyd:** Funnily enough, we are going to drill down on age now.

[57] **Joyce Watson:** 'Age range and scope' is the broad heading for the questions that I will be asking, just to give you an idea of what to expect. The Assembly has competence to legislate in this area to ensure provision across all ages, but, in the main, the proposed Measure is confined to adults. You do not need me to tell you that. Why should the proposed Measure be extended to cover children and young people?

[58] **Mr Towler:** I cannot really see any rationale for their exclusion. I have heard some arguments about the different language or jargon that we use. For example, with adults, we talk about primary and secondary services; with CAMHS, we talk about tiers. I do not think that that is sufficient reason not to include people under 18. I have kept up to date with your evidence sessions so far, and I am not looking for a bolt-on in relation to age, but a rewrite that ensures that people under 18 are fully included in the scope of the proposed Measure. We should do it correctly. Although the issues are quite complex, and I would not pretend to understand all the complexities, I have yet to hear a counter argument that we cannot surmount the issues. So, I think that we must absolutely ensure that that happens. I would counter the argument that we should contemplate a separate Measure for children and young people, because all that would do is build in further delay. Children and young people are being failed at the moment, frankly, and we need to find a way to sort that out. I cannot see why people under 18 should be precluded from these statutory rights. Does that help?

[59] **Joyce Watson:** That does help, but I am going to probe a bit further because previous witnesses have suggested that it may be preferable to assess the impact of the proposed Measure on adult mental health services before developing separate legislation for children and young people.

[60] **Mr Towler:** So, the idea is that we should test it on adults first to see whether it works?

[61] **Joyce Watson:** Something like that, yes.

[62] **Mr Towler:** With regard to seeing whether it makes any difference, I could be prepared to be persuaded on that but, to be honest, at the moment, nothing is really making a

difference for children and young people, so it seems that that is just a reason for delay, which I cannot possibly support. I have talked before about the need for people to focus their minds on what needs to be delivered for children and young people. The fact that mental health services are currently not being made available for children and young people is scandalous and we have to sort it out, so I do not buy that.

[63] **Joyce Watson:** My other prepared question has been answered, Chair.

[64] **David Lloyd:** Yes, it has already been answered very well indeed.

[65] **Peter Black:** Previous witnesses have argued for the inclusion in the proposed Measure of set timescales between referral by a GP for assessment and the making of the assessment and between qualifying as a patient under Part 2 and the completion of a care plan. Other witnesses have raised concerns that a prescriptive approach of this nature would lead to a target-driven approach rather than a patient-led approach. Do you have a view on that?

[66] **Mr Towler:** This is quite tricky. There are very often unintended consequences of target setting. Of course, what we are all trying to ensure happens is that the best interest of the child or patient prevails. The Minister has been pretty clear in how she has been talking about this—she sees clinical need coming first, and I sympathise with that. This is where it gets a bit tricky: there are complexities with the national service framework for children, which includes some timescales that apply. My reading of this—and I am not a lawyer, of course, which I keep repeating—is that, if the NSF were incorporated into that care programme approach model, the timescales in the NSF should apply. I know that they do not work at the moment, but in terms of timescales, we have a pretty good NSF; if we only implemented it, we would not be sitting here discussing it all the time. That is an issue. There are timescales in the NSF; what is the extent to which those timescales, if incorporated in the care programme approach, would work? That would answer the question about the proposed Measure's timescales and the best-interests principle, because the NSF is built on that principle.

[67] **Peter Black:** You have already said that the proposed Measure is needed because existing provision is not working.

[68] **Mr Towler:** That is why I say that it is a tricky one. [*Laughter.*]

[69] **Peter Black:** Moving on, section 2 of the proposed Measure provides for joint mental health primary care schemes to be agreed by the local mental health partners. What would be the benefits of requiring these schemes to cover children and young people?

[70] **Mr Towler:** It would provide appropriate gateways for children and young people. It would be less stigmatised. I know that these are early days, but introducing school-based counselling services in our secondary schools appears to have been an unbridled success from the way in which young people are approaching counselling services. My understanding—this is anecdotal, based on what I am hearing from headteachers—is that there are queues of young people wanting to make appointments with school-based counsellors. That is a good indication that, if we provide enough gateways to help and support, young people will access them. The key, and one of the worries that we had about school-based counselling, is whether it would be stigmatised in itself. Actually, what appears to be happening, because teachers and counsellors are approaching this in a sensible way, is that there is no stigma, and it is opening up opportunity. I am really pleased to see that school-based counselling has been extended a bit, but when you think about how young people are accessing that service, it screams that everything that we have been talking about in various committees is coming home now. There is an opportunity to extend that.

[71] On early intervention in CAMHS, that would benefit the whole mental health system. Adults are so affected by what happens in their childhoods. All of us as adults can remember things that happened to us as children that were defining experiences. If extended, we would find more opportunity for children and young people to access support, and there is an opportunity for that to be less stigmatised. In other words, you would have the confidence of children and young people, and they might use the service.

[72] **Peter Black:** Might the proposed Measure have any beneficial impact on the transitional period between child and adolescent mental health services and adult mental health services?

[73] **Mr Towler:** Transition is the biggest issue for me. I think that there is potential for that. It is probably one of the biggest areas that I would want the proposed Measure to deliver on, because the whole area around transition is currently so flawed.

[74] **Helen Mary Jones:** Without wishing to put words into your mouth—she says, as she tries to put words into his mouth—

[75] **Mr Towler:** Yes, I agree. [*Laughter.*]

[76] **Helen Mary Jones:** Other witnesses have suggested that, if you exclude children and young people from this proposed Measure, you potentially perpetuate the problems that we have with transition. Adults would have a set of rights around mental health services that do not apply for children. Picking up on the point that you just made to Peter, would that be one of your concerns—that we make transition more difficult if we say that a law applies after 18, but not before?

[77] **Mr Towler:** Absolutely.

[78] **Helen Mary Jones:** I did it again—I put words in your mouth.

[79] **Mr Towler:** You did, but I am very happy to have those words put in my mouth. Transition is one of the key areas. In a variety of committees, we have talked about those major failings. I have identified it in annual reports, as did my predecessor. It is a key area.

9.40 a.m.

[80] **Peter Black:** On a related issue, if the scope of the proposed Measure was extended to cover children and young people, how should section 5 reflect the age-specific services that should be available for children and young people?

[81] **Mr Towler:** Apart from the obvious wording difference—maybe you could take out the word 'adult'; that would help—my feeling is that the regulation would need to ensure age-specific provision. We would need to be very clear about that and how it was delivered, but I do not see that as being a major problem. There is not enough there to think that it is beyond our wit to sort it out, although we need to be very clear about age-specific intervention, age-specific support, how information and services are made known to children and young people, the language that is used and all those kinds of things. However, we have enough intelligence, knowledge and expertise in Wales to sort that out.

[82] **Peter Black:** Given that CAMHS is a specific discipline with different requirements to adult mental health, would you, within the definition of local primary mental health support services, need a specific reference to that service?

[83] **Mr Towler:** Yes, I think so.

[84] **Peter Black:** Just to make sure that that is all covered.

[85] **Mr Towler:** Yes.

[86] **Peter Black:** I am putting words in your mouth now.

[87] **Mr Towler:** Please feel free. [*Laughter*.] I will stop you when you put bad words in my mouth.

[88] **Peter Black:** Finally, before we move on, your submission raises some concerns about the information needs of young carers under section 5(1)(e). How should the proposed Measure reflect the specific needs of this group?

[89] **Mr Towler:** My understanding is that the broad definition of 'carers' would cover young carers. We have had a debate about the proposed carers Measure, and I have since had reassurance from the Deputy Minister for Social Services about definitions of carers, which I am pleased about. You will be aware that I did some work with young carers and recently published a report, the key message from which is that young carers are at risk of being disengaged from services and support by the very nature of the work that they do. As part of that, they become disempowered.

[90] So, information must be appropriate and we need to find a way to ensure that support packages are based around the needs of the whole family, and not just the patient. You capture what young carers are doing when you take a whole family approach. I do not know whether you saw it, but I was recently involved in a television programme on BBC Wales about attention-deficit hyperactivity disorder involving a little boy. The critical issue was not that that child or family could not access services but that they did not know that the services and support were available. They had no way of finding them. It took phone calls from the children's commissioner and a helpful headteacher to find that support. It should not be that way. So, in terms of information, it is about thinking about the whole family and the way that services respond so that, when you have a patient in front of you, you are thinking about the family circumstances of that patient and how we should respond, within the principles set in 'Everybody's Business' on what support services can do for young carers. That is the kind of cultural approach that we need to spread.

[91] **Peter Black:** If we were to make the proposed Measure non-age-specific, we would have to give considerable thought to definitions, particularly around the primary mental health support services and how that section is drafted.

[92] **Mr Towler:** Absolutely.

[93] **Helen Mary Jones:** Your submission suggests that by not stipulating even minimum levels of services that should be ensured, there is a risk that the proposed Measure will not address the issue of variability of services provision, which is a huge issue that has been highlighted repeatedly. What safeguards should be put in place to eliminate this risk, and how should this be applied to child and adolescent mental health services? Would you wish to see minimum levels of service stipulated in the proposed Measure, or should it be in regulation and guidance?

[94] **Mr Towler:** Regulation is probably the place for that. Again, it feels very similar to debates that we have had recently about what is in a list and what is not. When there are prescriptions about what should be in, you focus immediately on worrying about what is not covered, and that is not a helpful way of progressing this. So, the services that are available

could, potentially, be diluted in that respect.

[95] Another thing that is interesting is the concept of the added value that some services and support bring. When we think about commissioning services and being very specific about what we want, commissioners sometimes lose sight of the added value of the service that is already in place. In relation to the previous example, that was certainly a key issue that young carers would talk about; they were very concerned about having a tight and prescriptive way of saying 'This is how you will support a young carer'. What then happens to the other stuff in relation to that is a big issue. So, it is probably for guidance, but, again, the issue for me is that I do not like the concept of lists, because there are so many unintended consequences.

[96] **Helen Mary Jones:** I think that my next question has more or less been answered by that, so I will move on to question 25, Chair. How should Part 1 of the proposed Measure address the transition issue that we have talked about? Is it, again, a question of not addressing it in a specific way because of the risk associated with having a list, namely that if you put certain things in the proposed Measure, or in guidance or regulation, you might leave things out? Conversely, should there be something on the face of the proposed Measure that is specifically about those transition issues? I have conflicting views about that .

[97] **Mr Towler:** Again, I find myself on the horns of a dilemma about this. There is a real lack of clarity in everyone's minds, and I have not heard persuasive arguments either way. With regard to issues such as learning difficulties, challenging or managing difficult behaviour, the NEETs agenda—although I hate using that phrase—and so on, you immediately put your finger on what the issues are in relation to transition. We need to provide for a holistic and comprehensive service that places the need of the patient or the child at the centre of that approach. That is the only way to approach it. If the care programme model delivers that, and applies to children and adults, the issues regarding transition should be key and central to it.

[98] **Helen Mary Jones:** Again, you have more or less answered my next question. You are very supportive of the care planning approach and would like to see that extended to children and young people. Could you tell us a little more about what evidence there is, in your experience, that extending that approach to children and young people could improve the current situation?

[99] **Mr Towler:** One of the big things in that respect relates to levels of accountability, what organisations and individuals are committing themselves to do, and how children and young people understand that. If you think about that in a rights-based framework, children and young people are very clear on what they can expect, who will deliver it and when it will be delivered. So, to me, accountability is a big attraction in relation to that approach, because that will deliver some understanding on the part of the child or young person about the level of service that they can expect, when it will be delivered and how. At the moment it is such a grey area; every time that I speak to children and young people about this, they are really quite confused about what is happening and why it is happening. So, accountability is probably a key area.

[100] **Helen Mary Jones:** That is helpful, thank you.

[101] **Joyce Watson:** I will now move on to the issue of assessments of former users of secondary mental health services. In your evidence, you highlight potential unintended consequences that could arise as a result of the provision in Part 3 for those who have previously received a secondary mental health service. Do you want to elaborate on that?

9.50 a.m.

[102] **Mr Towler:** I was sympathetic to the issues that were raised in Barnardo's submission to you, because I think that it put its finger on a number of issues. On readmission, from personal experience of talking to children and young people about this, the consistency of approach and the consistency of a relationship between a child or young person and a practitioner is one of the key issues. That is where children and young people feel respected and where trust can be built. I concur with the Barnardo's evidence on that. I do not have much else to add. I found myself feeling comfortable with what it had to say.

[103] **Joyce Watson:** Do you agree with other witnesses who have suggested that the discharge period should allow any treatment received by adult patients during adolescence to be taken into consideration when assessing an individual's entitlement to re-engage with services?

[104] **Mr Towler:** Yes, but the discharge period is what needs to be looked at closely. That relates to the conversations that we had about transition. Again, I do not feel best placed to comment on the detail. I just know from the work that my office has done and from what young people have raised that that is another area of some confusion. There is confusion about the discharge period, how that works and what the expectations are. Children may feel completely alone at the point at which they are discharged and have no idea about whether they can go back. We should consider whether they understand and if they do go back and ask a question, whether they can expect an answer. Children are quite confused about all of those things. Sometimes, they will get in touch with the children's commissioner and raise those issues about re-engagement and what is happening to them now. It is quite interesting when they come to me or to another advocacy provider and ask what is happening to them, because the service provider should have been very clear about what is happening and why.

[105] **David Lloyd:** Mae'r cwestiynau olaf yn y sesiwn hon dan ofal Peter Black.

David Lloyd: The final questions in this session are from Peter Black.

[106] **Peter Black:** On advocacy, what impact would extending the scope of the proposed Measure have on advocacy services, for example, in relation to the entitlements of children and young people under Parts 1 and 2?

[107] **Mr Towler:** I would welcome this because it would be an addition in terms of advocacy, although, under the Children Act 2004 and the assessment of children in need, it is hard to imagine—again, it is about the failure of current implementation—where advocacy would not be provided for a child who had been identified as being in need, notwithstanding the Welsh Government's very clear move that all children should be eligible for an advocate.

[108] On mental health provision, the issue is that independent mental health advocacy requires some skills and experience that are very specific. So, if that addition is being introduced, I would welcome it. Although, broadly in relation to advocacy, we need to look closely at how it is all working.

[109] **Peter Black:** In your submission, you say that the proposed Measure is introducing a threshold for advocacy that runs contrary to other children's legislation. Could you elaborate on that?

[110] **Mr Towler:** I suppose that it relates to the universal entitlement for advocacy for children that we have a clear commitment to provide in Wales.

[111] **Helen Mary Jones:** In the course of this discussion, you have been clear with us that you think that the legislation needs to apply to children and adults. That case is well made, but on advocacy, we have this commitment to universal advocacy for children. However, we

would not want that provision for adults; or would we? Is it a complication that the proposed Measure sets that threshold where advocacy kicks in for adults? I suppose that the assumption behind that is that most adults are able to advocate for themselves and we have to define the circumstances in which they are not. Given children's lack of legal capacity and so on, the Welsh Government's approach, which is supported across the Assembly, has been that any child, at any time, could be in circumstances where they might need an independent advocate. Is that a complicating factor when we talk about legislation around the rights for advocacy?

[112] **Mr Towler:** Possibly. There are so many elements of this where I find myself tricked in terms of trying to think through what implications there may be. You find yourself saying immediately in relation to independent mental health advocacy for children and young people, 'Surely, that must be a good thing', but when you start to think through the implications of that for children and young people in terms of universal entitlement and transition, all of a sudden, you are asking why you need it in the first place. In relation to the proposed Measure, I constantly find myself, initially, being comfortable and saying, 'I agree with that; that's a really good addition', but then asking myself why we need some of this if some of the other work that this place has done has worked. The NSF is the obvious example of that. We must not find ourselves putting plasters and patches over things that should be delivering, at their core, now. That is a dilemma for you and for me, but for a child or young person, what we are trying to deliver is completely confusing, because it does not make much sense if you at the receiving end.

[113] **Helen Mary Jones:** If the proposed Measure were extended to children and young people, it would have consequences for things that have been policy for 10 years and have not delivered. There would then be legal recourse for the child or young person. Heaven forbid that it should happen, as none of us wants anyone to be in that position, but 10 years down the line—I am putting words into his mouth again, Dai. Is one of the reasons why we need to extend this to children and young people so that there are consequences if services are not delivered?

[114] **Mr Towler:** Yes, absolutely. This is related to my points about accountability, setting things in the standards and recognising children as rights holders and their ability to complain, to ask questions and to expect answers to get things moving and for things to happen. The answer to that is 'yes'. We have talked before, in this committee and in others, about the extent to which legislation focuses people's minds on what they have to do. That is what we really need. Enough is enough; we have to sort this out for children.

[115] **Helen Mary Jones:** Is there a risk that if this legislation were to apply to adults, but not children, the focus of services would make people think, 'We have a legal duty to do this for adults', and the focus for children and young people would be lost?

[116] **Mr Towler:** There is the will among practitioners who would work hard to ensure that that does not happen, but the bottom line is that, when you are looking at competing economic constraints and priorities, the thought of what they are legally required to do is what makes people act.

[117] **David Lloyd:** Peter has the final question.

[118] **Peter Black:** This is a bit of a technical question.

[119] **Mr Towler:** I am really rubbish at technical questions, as you know.

[120] **Peter Black:** A number of sub-sections in the proposed Measure give Welsh Ministers the power to make regulations. Do you think that the proposed Measure gets the balance right between powers on the face of the proposed Measure and powers that are given

to Welsh Ministers to make those regulations?

[121] **Mr Towler:** No, there is too much reliance on ministerial guidance. There is a strong argument that initial guidance, at least, should be subject to your affirmative procedure; in other words, there should be a proper consultation, at least on the initial guidance. On some of the concepts that we have been talking about, such as whether we need minimum standards or not, it would be good to have a proper discussion about that. We could also do with a proper discussion of the issues around timescales, the overlap with the NSF and the accountability issues. This is too good an opportunity, it seems to me, not to get this absolutely right. If I was to use a technical question to pull your emotional heartstrings, I would say, 'Don't let the children down'. We need to ensure that we get this right, so some discussion and open transparency about how to make this work is what is required.

10.00 a.m.

[122] **Peter Black:** Dredging my memory now, I think that there are 17 different sets of regulations.

[123] **Mr Towler:** I look forward to reading all of those. [*Laughter.*]

[124] **Helen Mary Jones:** We, as backbenchers, love the affirmative procedure, because it lets us potch. [*Laughter.*]

[125] **David Lloyd:** Dyna ddiwedd ar y cwestiynau swyddogol; diolch yn fawr i chi am eich atebion. A oes gennych chi unrhyw sylwadau terfynol i'w gwneud cyn cloi'r sesiwn hwn? Gwelaf nad oes; mae popeth wedi'i ddweud. Diolch, Keith.

David Lloyd: That brings the official questions to an end; thank you very much for your answers. Do you have any closing remarks to make before we close this session? I see that you do not; everything has been said. Thank you, Keith.

[126] Bydd y clerc yn anfon trawsgrifiad o drafodaethau y bore yma atoch er mwyn i chi eu cywiro, os bydd angen, cyn iddynt gael eu cyhoeddi'n swyddogol. Diolch yn fawr iawn.

The clerk will send a transcript of this morning's discussions to you so that you can correct them, if necessary, before they are officially published. Thank you very much.

[127] Croesawaf i'r bwrdd ein tystion nesaf a'r olaf am heddiw. Mae'r tystion nesaf ar ffurf panel sy'n cynrychioli is-grŵp iechyd meddwl swyddogion polisi cyrff anllywodraethol plant, sy'n un o'r teitlau hwyaf mewn bodolaeth. Estynnaf groeso swyddogol i Nia Lloyd, swyddog polisi NSPCC Cymru a chadeirydd is-grŵp gwasanaethau iechyd meddwl plant a'r glasoed, Menna Thomas, swyddog datblygu Barnardo's Cymru, a Jackie Murphy, cyfarwyddwr cynorthwyol Tros Gynnal.

I welcome to the table our next and final witnesses for today. The next witnesses appear as a panel representing the children's NGO policy officers' mental health sub-group, which is one of the longest titles in existence. I extend an official welcome to Nia Lloyd, NSPCC Wales policy officer and chair of the child and adolescent mental health services sub-group, Menna Thomas, development officer with Barnardo's Cymru, and Jackie Murphy, assistant director with For Maintenance.

[128] Yr ydym wedi derbyn eich papurau ysgrifenedig unigol, ac, yn naturiol, yr ydym oll wedi'u darllen. Mae cwestiynau wedi'u paratoi ar yr ystod eang o bethau sydd yn gynwysedig yn y Mesur arfaethedig ac o'r pwyntiau sy'n codi o'ch papurau ysgrifenedig. Wrth inni ofyn cwestiynau i

We have received your individual papers, and, naturally, we have all read them. Questions have been prepared on the wide range of things that are included in the proposed Measure and on the points raised in your written papers. When we ask you questions, all three of you may answer, or

chi, gall y tair ohonoch eu hateb, neu ddim ond un. A bod yn blaen, nid oes gennym drwy'r dydd, felly os credwch fod rhywun eisoes wedi ateb y cwestiwn, ac os nad oes gennych bwyntiau ychwanegol, nid oes rhaid ichi deimlo bod rhaid ichi ddweud rhywbeth. Gan fod amser yn pwyso arnom, gofynnaf yn garedig i'm cyd-Aelodau hefyd fod yn gryno wrth ofyn eu cwestiynau.

only one of you. To be frank, we do not have all day, so if you think that someone has already answered the question, and you do not have any additional points to make, please do not feel that you have to contribute. As time is against us, I kindly ask my fellow Members to be concise in their questions.

[129] Gyda hynny o ragymadrodd, dechreuaf â chwestiwn cyffredinol. A ydych yn cefnogi amcanion cyffredinol Mesur Arfaethedig Iechyd Meddwl (Cymru)?

With those introductory remarks, I will start with a general question. Do you support the general objectives of the Proposed Mental Health (Wales) Measure?

[130] **Ms Lloyd:** Diolch, Gadeirydd, am y cyfle i ddod yma heddiw i gynrychioli plant a phobl ifanc sy'n defnyddio'n gwasanaethau, ac sydd hefyd yn gweithio gyda ni, fel mudiadau anllywodraethol yng Nghymru, i geisio datblygu polisi ac effeithio ar ymarfer.

Ms Lloyd: Thank you, Chair, for the opportunity to come here today to represent children and young people who use our services, and who also work with us, as non-governmental organisations in Wales, to try to develop policy and to influence practice.

[131] In answer to your first question, yes, we agree with the overall aims of the proposed Measure as it stands. However, we are aware that not all of the proposals will have an effect on children and young people, and that is what we would like to have an influence on and allow the committee to consider whether it should be expanded to children and young people. However, we agree with the overall aims of the proposed Measure.

[132] **David Lloyd:** Soniasoch am oedran ac ati; mae'r cwestiynau ar y materion dyrys hynny o dan ofal Helen Mary Jones.

David Lloyd: You mentioned age and so on; the questions on those difficult issues are in the hands of Helen Mary Jones

[133] **Helen Mary Jones:** Mae gan y Cynulliad bwerau i ddeddfu ym maes oedolion a phlant. Yr ydych chi, fel mudiadau, yn glir eich barn y dylai'r Mesur arfaethedig gael ei ymestyn i gynnwys plant a phobl ifanc. Pam y credwch fod hynny'n bwysig?

Helen Mary Jones: The Assembly has powers to legislate in relation to adults and children. You, as organisations, are firmly of the opinion that the proposed Measure should be extended to include children and young people. Why do you think that that is important?

[134] **Ms Lloyd:** Ultimately, our opinion is that it is a rights-based issue for children and young people, around their rights to health and appropriate services to tackle their mental health issues. Many articles of the United Nations Convention on the Rights of the Child allow children to take up their rights. Ultimately, the proposed Measure could go some way towards ensuring that those rights are in place. However, we know that there is an implementation gap in practice. The children's commissioner, in his annual report, has consistently highlighted this. Research undertaken by each of our organisations has shown that there is a real gap in service delivery.

[135] So, we believe that the proposed Measure could consolidate the policy and the current guidance in relation to child and adolescent mental health services. That could then be applied within the current planning frameworks. We think that it could strengthen the national service framework targets for children and young people who are experiencing mental health problems. It could also strengthen the case for more specialist independent mental health advocacy for children and young people.

[136] **Helen Mary Jones:** Mae'r Llywodraeth ac eraill wedi awgrymu nad oes angen cynnwys plant yn y ddeddfwriaeth hon gan fod gennym gyfraith yn barod sy'n amddiffyn plant a phobl ifanc yn y cyd-destun hwn. A ydych yn cytuno, neu a ydych yn credu nad yw hynny'n iawn?

Helen Mary Jones: The Government and others have suggested that there is no need to include children in this legislation because there is already a law in place that protects children and young people in this context. Do you agree, or do you think that that is not right?

[137] **Ms Lloyd:** We have considered whether it would be more appropriate to go along the road of the proposed Measure looking predominantly at adult services and then look, perhaps, at drawing up another Measure specifically for children and young people. We do not think that that is a good thing and we would argue that children and young people ought to have been considered in the proposed Measure at the outset. Had that been the case, we would not necessarily be in this position now. Nonetheless, we are in this position and children and young people ought to be considered now.

[138] Our understanding is that the existing legislation framework is the Mental Health Act 1983, the Children Act 1989, and the Children Act 2004. However, that framework would not allow for the same proposals as those in the proposed Measure. That is our case for including children and young people now.

[139] **Helen Mary Jones:** That is helpful. I think I know the answer to my next question to you, but I will ask it for the record anyway. A previous witness has suggested to us that it might be preferable to assess the impact of the proposed Measure in relation to adults and then, in the light of the impact of that legislation, potentially develop separate legislation along the same lines for children and young people. I think that I have an idea of what your view on that might be, but, for the record, can you tell us your view?

[140] **Ms Thomas:** The proposed Measure should be age-blind and it should include children and young people. We can see that a lot of work has been carried out on the proposed Measure; it is well developed and quite adult-focused. However, the underlying principles of the proposed Measure would apply to CAMHS. There is currently a lot of activity and opportunity in the field of CAMHS in the Welsh Assembly Government. We are expecting its action plan at the end of June in response to the Healthcare Inspectorate Wales and Wales Audit Office review of CAMHS.

[141] The national service framework is up for review and the children and young people's plans have reached the end of their three-year cycle. It is an opportune moment to tie a number of different policies and pieces of guidance together to ensure that the next three years deliver for children and young people a far more coherent and directed mental health service. The Healthcare Inspectorate Wales and Wales Audit Office review makes it clear that that is an incredibly important thing to be thinking about at this time. So, despite the amount of work that has happened on the proposed Measure already, we believe that consideration should be given to making it applicable for children and young people.

[142] **Ms Murphy:** I would like to reiterate the comments made by the children's commissioner and say that it would be a lost opportunity if it was not included.

[143] **Joyce Watson:** 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 secondary 'mental health service providers'. Are you content that these definitions encompass all relevant parties?

10.10 a.m.

[144] **Ms Thomas:** We think that section 1 is fine and that it could be applied to children and young people. We need to consider that, with children and young people, the mental health system is described in tiers. Therefore, the language needs to be adapted from primary and secondary. We need to find different language. In England—I read a document recently which provided guidance to commissioners on commissioning early intervention support services—they have decided to use the word 'universal' to describe tier 1 services, which are services that are universal to all children and young people, and 'targeted services' to describe services to all those children and young people accessing tiers 2, 3 and 4. We could do something similar, or we could simply use 'primary' and 'secondary' and put tiers 2, 3 and 4 into secondary, in which case, section 5 becomes an incredibly useful description of what a primary mental health service should look like. It lays out the need for assessment, identification of treatment, referral, and that information should be provided to service users and service providers, which adds to and enhances the guidance that is already available through the NSF for CAMHS. The language issue comes up once more at the bottom, as the proposed Measure refers again to secondary mental health services, and to community care services. These terms are not used in the fields of children and families.

[145] Regarding section 11, maybe we have not done our research properly. We thought that subsection (1) would be applicable, assuming that tiers 2, 3 and 4 were considered as secondary mental health services. We were unclear about subsection (2) because we were unclear about the implications of the term 'guardianship'. We wondered whether guardianship would be the same as corporate parenting, in which case, it says that,

[146] 'An adult who does not fall within subsection (1) is also a relevant patient if the adult is under the guardianship of a local authority in Wales.'

[147] Not all children of a corporate parent can be considered as mental health patients. Therefore, that would not fit if that is what guardianship implies. However, we are not entirely clear about what guardianship implies.

[148] **Joyce Watson:** So, are you happy—you have partly answered this—that, with those changes, the definitions will encompass all relevant parties if the scope of the proposed Measure was extended to cover children and young people?

[149] **Ms Thomas:** We think that there is a strong chance that it would be sufficient.

[150] **Joyce Watson:** Witnesses from the voluntary sector, such as yourselves, have suggested that timeframes 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, and if so, what timescales do you think are appropriate for children and young people?

[151] **Ms Thomas:** The NSF clarifies a number of different timescales at the different tiers. Many of them are quite detailed and prescriptive. Tier 4, for example, says that routine cases should be seen within three weeks, urgent cases within two weeks, and emergency cases within six hours. Therefore, much of that detail has been clearly thought through, and although it is very relevant, it is too much to put on the face of the proposed Measure.

[152] On referrals, the timescales for tier 1 refer to tier 1 staff requesting consultation from tier 2 staff. Tier 2 staff, for example, can request an assessment from a primary mental health worker. If that is a routine request, the timescale is four weeks, and three days if it is an emergency request. That would need to be included somewhere in the proposed Measure, if it is to apply to children and young people.

[153] The second point is about a care plan, as there is not in fact a care plan as such. There are not really guidelines for care planning as such for CAMHS patients. The NSF states that a multi-agency team needs to work around the child at tier 3. That is inevitable, because that child would have quite complicated needs, so there would be a multi-agency approach. However, there are no guidelines about care planning. At tier 4, which is when young people go into in-patient units or hospitals, a nominated lead practitioner needs to be identified to co-ordinate admission, care and discharge. The only clear description of care planning that we have in the NSF is in relation to transition, and that sits inside the disability section. Children and young people with quite established mental health illnesses would, therefore, come under the transition planning in that section, and that involves identifying a care co-ordinator and putting together a much more formal multi-agency plan. The patient care plan aspect can only serve to improve the situation for children and young people, because it simply describes a process for care planning that is much needed in the child and adolescent mental health services sector.

[154] **Ms Murphy:** I will add that there would need to be some consultation on this. You have already received some evidence that says that children experience timeframes differently. It is not unusual for young people to wait 12 weeks for a referral to CAMHS. That is a long time for an 8-year-old; it is a long time for 14, 15 or 16-year-olds, at a time when they are trying to get on with their exams. Twelve weeks is a term—a third of a school year—so I think that some work needs to be done on deciding what reasonable timeframes are for children and young people.

[155] **Ms Lloyd:** It would be too complicated to specify those sorts of details, which can often differ for the individual child or young person, on the face of the proposed Measure; we were uncertain about that.

[156] **Joyce Watson:** Moving on, section 2 of the proposed Measure provides for joint mental health primary care schemes to be agreed by local mental health partners. What do you think would be the benefits of requiring those schemes to cover children and young people?

[157] **Ms Lloyd:** We think that the benefits for children and young people are considerable. As the children's commissioner has mentioned, early intervention is key. Primary mental health services could be vital to safeguard a child or young person who is experiencing mental-health issues from prolonging their experiences of those issues, and that is why we strongly believe that this proposed Measure should be expanded to cover children and young people. We often find that tiers 1 and 2 of CAMHS can be less stigmatising for children and young people, so if this proposed Message would allow in statute for that service to be provided, children and young people would be far more engaged with the service, as they would be able to access it, and any further unnecessary barriers to that provision could, ultimately, be avoided.

[158] A child's emotional and psychological wellbeing can be affected by maltreatment and the experience of abuse. From the NSPCC's point of view, if we can have timely identification and assessment of need, followed by appropriate treatment, it allows us to help children and young people to overcome that experience far more quickly. It can also, ultimately, avoid the escalation of the problem and having to access the higher tiers of CAMHS, which can be quite costly, not only for the child or young person, but in terms of financial resources, too. I do not know whether it is helpful, but I have brought a case study from one of our services. It puts meat on the bones and shows that issues could be nipped in the bud if primary health services were available for children and young people. Robert is eight, and he was sexually abused by an older boy, who was a neighbour. The school was worried about him, and he had angry outbursts. Social services had been involved, but as this

case did not go to court, and because the mother could ensure that this would not happen again, they closed the case. The school asked the NSPCC to see Robert, and he attended 15 weekly sessions of play work. He did not want to talk about what had happened, but through the play sessions he worked out some of his difficulties and his behaviour in school improved. He said on his feedback form that he loved coming to the NSPCC, the worker that saw him was very kind and that she listened to him. He said that he was not angry anymore, and therefore Robert was not referred to CAMHS and was able to refer back to our service if necessary. Robert and his family knew that that option was available to him.

10.20 a.m.

[159] The point that I would like to make is that these are classed as primary care services. Robert was assessed and was able to access a voluntary sector service, which was probably deemed as tier 2. That is not always the case, and children like Robert cannot always access services like that. We would like to see the proposed Measure being expanded to include children and young people, particularly in relation to primary mental health services. It would allow for more children and young people to overcome their experiences sooner rather than later.

[160] **Ms Murphy:** May I give an example? There has been a very good take-up of school counselling. In adult primary care, there has been extremely good take-up of GP practice counselling, which is very useful, but young people cannot access that. We had a case of a young woman who was 16 years of age and attending a technical college who started experiencing depression and having some very frightening thoughts. She had to be referred to CAMHS, but there is a 12-week waiting list. If she could go to see a GP practice counsellor, she could be seen very quickly. The GP would be able to discuss it with the counsellor, they could look at medication, and it would be a very quick process and could possibly avoid a referral to CAMHS. As Menna says, the service is timely, available to everyone and is accessible.

[161] **Joyce Watson:** That makes it very clear.

[162] **David Lloyd:** Mae'r cwestiynau nesaf dan ofal Helen Mary Jones.

David Lloyd: Helen Mary Jones will ask the next questions.

[163] **Helen Mary Jones:** Referring again to the local schemes that the proposed Measure would require, are there any considerations that would need to be taken into account to ensure that the schemes reflect the distinctive needs of children and young people, if they were included in the scope of the proposed Measure?

[164] **Ms Murphy:** What we have been told by children and young people time and again, and the review of CAMHS undertaken by the Directorate-General of Health and Social Services reiterated the point, is that they do not want the adult clinic model. They do not want to go to hospital. They want to see someone who does not stigmatise them, who is very accessible and to whom they do not have to go to in school time so that their friends are not aware that they are going to see a psychiatrist. Many young people have grown up in communities where hospitals are seen as very scary places, are spoken about in colloquial language in a way that is very frightening to them. Many voluntary organisations provide very good services, such as the one that Nia talked about, which the NSPCC provides for children and young people who have been sexually abused, the Taith project that Barnardo's provides for young people who sexually harm, and the projects that Action for Children provides. These services are not always seen as being within the family of health service provision, and they are not resourced properly—they are usually funded from charitable contributions. We need to look at the broader picture and have more accessible services. That is the only thing that I would say on that.

[165] **Ms Thomas:** When we were going through section 4, we noticed that if there is a failure locally to agree a scheme, it falls to the local health board to deliver a primary health scheme. With regard to CAMHS, that might not be applicable because most children at tier 1 access services such as schools and parenting. It is far more appropriate to look at primary care services in a slightly different light for children and young people.

[166] **Helen Mary Jones:** May I just unpick that a bit? Part of the point of legislating is that someone has to carry the can. We have had really good national policy for eight or nine years on child and adolescent mental health services, but as the children's commissioner keeps telling us, that good policy is not delivering consistently. If it is not the local health board that carries the can if the scheme is not agreed—and this is potentially one of the reasons why the Government has not included children and young people, because it is complicated—then someone has to say, 'Okay, this is the scheme'. There has to be statutory responsibility for that. If it is not the local health board that does that for children and young people, who should do it, and does the proposed Measure need to reflect that?

[167] **Ms Thomas:** I suppose that I was thinking more in terms of the services that children receive. Primary mental health services, particularly with the advent of school counselling, would be delivered through schools. So, my assumption was that if you were putting a plan together locally, the education department would be a key player alongside the health department. However, I agree with you that if you have to just say, 'Right; somebody has to pick up'—

[168] **Helen Mary Jones:** So, somebody has to be in trouble to get it done.

[169] **Ms Thomas:** Somebody has to pick up the responsibility for that. Somebody needs to be accountable. Would it be possible to have the education department and the health department jointly responsible? Is that feasible? Is it practical?

[170] **Helen Mary Jones:** I do not know. We would need to find that out.

[171] **Ms Murphy:** May I just mention something that might help? There has been a lot of partnership working. The thing about CAMHS is that it a cross-organisation service; it involves tiers 1, 2, 3 and 4, but it also involves education, health and social services. One of the points that was made about 'Everybody's Business' was that everyone should work together. That has been achieved through a lot of goodwill, and what I have found in delivering services, particularly advocacy services, is that if there is not a statutory requirement, they will not come up with the funding. That is how it should also work with the health boards. Social services have a statutory requirement to provide certain services, as does education, but up until now, health boards have not. This is an opportunity to tie them in, so that they will engage more in partnership working to provide those services for children and young people in a more child-friendly way. Does that help?

[172] **Helen Mary Jones:** Yes, that is helpful. One of the issues that has been put to us by other witnesses is that the transition from adolescent to adult services is difficult for a lot of young people already. One of the risks, if we do not include children and young people in the proposed Measure, is that that gets worse. Do you have a view about how Part 1 of the proposed Measure should address the needs of those moving from child and adolescent services into adult services?

[173] **Ms Murphy:** We have provided a good example in our written evidence—a case study of a young woman. We chose that example not because it was unusual, but because it was typical. When it becomes a statutory requirement for health boards to ensure that the transition is seamless, it will happen. It is about having an age-blind Measure, as Menna said.

That would make it much easier for them to think across the piste and provide those services and ensure that children and young people are not falling through the gap.

[174] **Peter Black:** Moving on to secondary mental health service users, what would be the benefits of extending the provisions contained in Part 2 of the proposed Measure to children and young people?

[175] **Ms Thomas:** We have referred to the lack of availability of planning around child and adolescent mental health services, and we think that this Part would be particularly beneficial and useful to support and develop that aspect of the work. The NSF, as I have described, makes a number of references to transition, and refers to 'Everybody's Business' in the context of the case-management aspect of care planning. 'Everybody's Business' contains just two suggestions: one is that the framework for assessment is used for children in need, and the other is that the principles of the underlying approach, 'Together We Stand', be considered by local authorities when they are planning CAMHS. Ultimately, there is no clear guidance. Currently, this legislation would ensure that all children and young people accessing services at tier 2 and above, which are described as the secondary mental health service, would have a dedicated care co-ordinator, which would be a major improvement on the situation as it stands.

[176] **Ms Murphy:** I think that this is key. The proposed Measure looks at care co-ordinators when people become in-patients and then when they leave; I think that that co-ordination needs to start much sooner, helping young people and their families to understand the system. We set up a project called The Maze, and the reason that we called it that was because it is so confusing for families, and even more so for children and young people.

10.30 a.m.

[177] That care co-ordinating role is a key one. It needs to be someone who meets with the young person, builds a relationship with them and sees them through, because young people will move fluidly through the tiers because they are at that stage in their development. In some ways, that is more significant for young people than for adults who can understand the systems better.

[178] **Peter Black:** What provisions would need to be put in place to guarantee that the care needs of children and young people are carefully planned for and delivered jointly by the relevant agencies? We have already talked about the interaction between social care and healthcare.

[179] **Ms Thomas:** We went through Part 2, which describes the care planning approach. The legislative language is quite dense and difficult to understand sometimes. Section 13 suggests that a care co-ordinator needs to be appointed, which is applicable to CAMHS. Section 14 seems to be addressing the need to identify the service provider, which, again, is straightforward.

[180] Section 15 makes a very important point, which is that, once you have identified your care co-ordinator, even if your service provider changes, your care co-ordinator will not. That is particularly important for children and young people because it is that consistency and that holding of the organisational planning around them that is key. As the commissioner said earlier, it is currently a missing aspect of care planning. Section 16 refers to the co-ordination of the provision of mental health services, which implies that a number of different services come together around the child, which is certainly the case at tier 3, and sometimes at tier 2.

[181] Section 17 very usefully describes the function of the care co-ordinator. There are some very significant points made here in relation to the participation of the patient in the

planning of their care. The joint report from Healthcare Inspectorate Wales and the Wales Audit Office flagged up the fact that it would be a very positive development for children and young people to be involved with a known care co-ordinator who was familiar with them and their needs. Having someone thinking with them about how the systems were working around them would be incredibly useful. There is a requirement for a protocol to review the care plan to be put in place, which, again, is a key element. The plan is to be recorded and there is guidance on dissemination of the plan.

[182] That was a very rough summary. There is a great deal of detail that is difficult to understand, speaking as someone who does not read legislation that often. However, it seems as though the bones of an extremely coherent plan are in place, which can only benefit children and young people if it is applied to them. So, we fully support the bones of Part 2 being applied to CAMHS.

[183] **Helen Mary Jones:** I am looking at the right to reassessment for former users of services. You are pretty clear in your evidence—and the WLGA and ADSS agree—that, if a person has been in receipt of services as a young person, they should have the right to be re-referred even if they have crossed the threshold of 18 years. In other words, the right to reassessment should not have to start again when you turn 18. Do you have a take on what level of demand there might be for entitlement under Part 3 of the proposed Measure if that right to re-referral were extended to children and young people?

[184] **Ms Lloyd:** In principle, we agree that this should be made available to children and young people in practice. In our written response, we make reference to the fact that children and young people who access our services are able to re-refer up to the age of 25. There may be a few more difficulties in practice, which we might touch on, but, in principle, that should be available for children and young people. Generally, only a small number of children and young people will be re-referred, so we do not expect that there would be a considerable demand on that Part of the proposed Measure. Nonetheless, that is an important Part, and we have found from our experience with children and young people that it can help their therapeutic process if they understand that they are able to re-refer, and their families are aware of that as well. Only a small number of young people re-refer, and often that is because a young person who has experienced abuse may have gone through the therapeutic process and felt considerably better, but then, life experiences such as having a baby, or their first relationship, can trigger the past trauma. It is often the case that those young people will come back, and any other intervention that we provide would be specific to an issue that they had identified. We do not think that there would be a considerable demand; nonetheless, we think that it is important and should be in place for children and young people.

[185] **Helen Mary Jones:** So, you would not expect that that right to re-refer would have a negative effect on people who were currently waiting to get into secondary mental health services? The fear that has been raised is that if you have an open door for people who have accessed the service in the past, you might exclude those who have not got through the door in the first place. You said that you did not think that that would have a major impact.

[186] **Ms Murphy:** No. Our experience is that a re-referral can be triggered by something very simple, such as people starting to feel unwell again; it could be hormonal, or it could be to do with exam pressures, or whatever. Sometimes it is just about going back to the consultant psychiatrist or psychologist and tweaking the patient's medication. That can be enough to get them back on track. Going through a referral to an adult specialist can be a lengthy process with re-assessments, which means that they will get more and more unwell. That can mean a hospital admission that is expensive and unnecessary. That is what we feel.

[187] **Ms Thomas:** With young children who have become involved in therapeutic work with mental health practitioners, it might be unwise to suggest that they can re-refer. Young

children experience therapeutic relationships in a personal way, so they would expect to go back to see the person with whom they had been working. Bear in mind the fact that CAMHS are under a huge amount of pressure, with huge demand for specialist CAMHS. It is difficult for the service to cope with the referrals that it has currently. The idea of being able to offer the same resource on a re-referral basis to all patients is just setting children up for a disappointment. It is unrealistic. If a child who has had an intensive therapeutic relationship with a member of mental health staff is re-referred, finds themselves re-assessed by someone else, and is given someone different to relate to, some clinical thought needs to happen around that. I do not think that it is straightforward, and it can have a negative impact and undo the benefits of the work that has already taken place. I do not think that you can assume that children who enter CAMHS at tiers 2, 3, and 4 necessarily have a concept of adults being on their side, being safe and consistent, and sometimes of making a mistake and getting things wrong. They do not come in to the services with those concepts in place, and that is why they need therapy—they need to develop an idea of a good, positive safe base, a safe relationship, and from that, get some emotional security. It needs to be discussed in a clinical setting and thought through carefully. I do not think that we should take the risk of setting young, fragile children up for a disappointment.

[188] **Helen Mary Jones:** That is really interesting, Menna, because you have just argued for this legislation not to be applied to children. If you say that it should be applied to a 16-year-old, would the legislation need to prescribe the point of transition? I completely agree with what you said about children going back into the service and expecting to see the same nurse, psychologist, play worker or whoever it was, but we cannot guarantee that.

10.40 a.m.

[189] **Ms Thomas:** If you are an adolescent, I think that your cognitive abilities are more developed, by then you will have a greater sense of autonomy and independence, and you will have a peer group and a more adult experience of the world, and so that is an entirely different position from which to come at this. A re-referral process for those young people can be potentially very useful. It would be more possible for those young people to cope with a different worker. For very young children, however, I am not entirely convinced that it would be in their best interests.

[190] **Helen Mary Jones:** How should we suggest that the Government define that right? At what point does that right kick in? At the moment, partly for some of the reasons that you suggest, the Government says that it cannot extend this to people under the age of 18. However, you are saying that 10 or older might be different from less than 10; it is very difficult to define that in legislation, is it not? You could have a seven-year-old who could cope with it, and a 13-year-old who could not, because of their cognitive ability and their development.

[191] **Ms Thomas:** Yes, that is right.

[192] **Helen Mary Jones:** I am trying to unpick this. If we are to make this recommendation to the Government, this is the response that may come back at us, so we need to try to unpick it.

[193] **Ms Murphy:** In some cases, people ask for a change of professional.

[194] **Ms Thomas:** That is why it is so difficult to come in so late in the day on this. There have been a lot of in-depth discussions on issues such as this, in relation to adults. It is unfair, really, to ask us to take all these issues on board at this late date. I do not know whether it might be possible to create some more time for those discussions to happen and for that thinking to take place. The detail of this proposed Measure is important.

[195] **Ms Lloyd:** This is so timely for children and young people. Given the length of time that the committee has had to look at all this and get evidence, it would be very disappointing if it recommended that, in this case, the proposed Measure should not be extended to children and young people. Time allowing, conversations and discussions could be held to try to iron out those intricacies before any clear 'yes' or 'no' decision was made.

[196] **Helen Mary Jones:** That is helpful, thank you. I think that my next question has been covered by what the witnesses have said.

[197] **Joyce Watson:** I will move on now to ask you about advocacy. Should the duty to provide advocacy services be extended to all users of mental health services, in your opinion, including those in primary care?

[198] **Ms Murphy:** Yes, definitely. You should expect that answer, really, from Tros Gynnal. I do not want to repeat myself, but I would say that children and young people move quite fluidly through the four tiers. For us, it is about having that provision, not just for in-patients but for people before they become in-patients. Advocacy can help, and we have know of experiences and case studies in which it has helped to prevent admissions. It can also prevent bounce-back. If young people can get an advocate and the proper services that they need to support them in the community, they may not need to be readmitted to an in-patient unit, which is an expensive process.

[199] We also have experience of a young person accessing advocacy when she was in the community. She then moved in to a unit and moved very quickly through a succession of two or three units, while they tried to find which one best met her needs. In one of the units, she experienced quite frightening incidents, as she was physically restrained. She had been physically restrained in other units before, but in this instance, she had three men sitting on her chest and another member of staff holding her head for what she felt was an overly lengthy period. They were not talking her down. She was extremely upset and distressed by that. She then contacted us because she had known an advocate when she was in the community, and asked us to help her to make a complaint about the way in which she had been restrained. That is significant in showing how advocacy can help young people. As she had a good relationship with the advocate, she also used the advocate to discuss matters with her new doctors and to explain how she felt was the best way to restrain and manage her condition when needed. Advocacy is therefore crucial for children and young people, particularly as some of the units that they move around might not be managed by the health service. That particular unit was an educational establishment.

[200] **Joyce Watson:** To what extent does the proposed Measure provide for the needs-led advocacy service?

[201] **Ms Murphy:** The proposed Measure looks mainly at in-patient advocacy, so there needs to be consideration of children and young people. Again, that does not require a huge resource. They do not overly use it; they use when they need it. To answer your question, I do not think that it does provide for that, because it relates to in-patients, and it would need to give consideration to children and young people across the four tiers of CAMHS. Young people have come to us to ask us to advocate on their behalf, as they have been excluded from school because of their mental health issues, and that cannot happen. They had been excluded until their next CAMHS appointment, which was eight or nine weeks away. That went against their right to have an education, but the situation was easily resolved with an advocate.

[202] **Joyce Watson:** What impact would extending the scope of the proposed Measure have on advocacy services, for example in relation to the entitlements of children and young people under Parts 1 and 2?

[203] **Ms Murphy:** I might be jumping ahead, but it is all tied up with the other initiatives for extending the universal advocacy service. If it is a requirement for the health boards to provide advocacy, they will engage with the partnerships and will provide that service in the community. It has to be their responsibility as well to provide advocacy in the in-patient units, as they would do with adults. For me, the power of the proposed Measure comes from the fact that it gives them that responsibility, but I am sure that advocacy services could respond. I do not think that it will be a huge capacity issue.

[204] **Ms Thomas:** On Part 2, having specialist mental health advocacy services included in the care plan is extremely important for some young people. The level of advocacy that those involved in the Maze project in Cardiff, which is a Tros Gynnal project, deliver to children and young people who have mental health problems is really quite impressive. They work on a number of levels with those young people. They create a relationship with them, give them the language with which to express their thoughts and feelings, and enable them to untangle their own relationships from the situations that they are in. So, on the one hand, they work closely on a one-to-one basis with those children and help them to express themselves, and, on the other, they are co-ordinating and thinking about the different organisations that the children are interacting with, helping them to understand what is going on and how to hold their position in relation to those different organisations. We would think of that as being quite a specialist form of mental health advocacy, and to have that available to children who are involved in secondary services is invaluable.

[205] **Ms Murphy:** Thank you for reminding me about that, Menna. It is an idea that works day in, day out. The work that we have done on our project, the Maze—and I have got a copy of a report on it here—has been helped by advice from Eddy Street, a clinical psychologist, and Dr Mike Shooter. There is a quote by Dr Mike Shooter about how he cannot conceive of mental health services being delivered to children and young people without advocacy. The issue is of helping young people to develop that language and trust in the advocate, and being able to put across their point of view and understand services, what they mean and how they can best use them. Savings can be made by making sure that CAMHS services and any mental health services are used more appropriately. It can help young people to avoid primary mental health services. We have done an awful lot of work with primary mental health teams, and they have been revolutionary. However, the primary mental health teams are there to work with teachers and professionals; they are not working directly with children and young people.

10.50 a.m.

[206] What we also do with the Maze project is provide an active outreach programme. A lot of young people do not attend their appointments, which can be quite expensive. Even those people working in CAMHS think that, if they had someone who could sort out the practicalities, advocate on housing, go to the schools to discuss the children's education or sit down with their parents to explain these things, it would be so beneficial and possibly help us with the therapeutic process. The advocates can provide that active outreach. When young people want to refer back to the advocates, when they are in different mental health settings, they can also do that. Key to this, when the young people come out of the in-patient units, is ensuring that those services are mobilised and co-ordinated, that those young people understand what they are entitled to and that we advocate again to the other organisations relating to education and to social services and housing on their behalf. That is the invaluable thing that can be achieved.

[207] **Peter Black:** The children's commissioner raised concerns about the advocacy provisions in the proposed Measure, suggesting that the proposed Measure is introducing a threshold for advocacy, which runs contrary to other children's legislation. Do you agree?

[208] **Ms Murphy:** I agree. I thought that he covered that quite well. Again, this is about the in-patent services covered in the proposed Measure. You have to be aware that it is about the four tiers and the different organisations and about making health boards accountable for their responsibility. That is what the proposed Measure could do here.

[209] **Peter Black:** How would you put it right?

[210] **Ms Murphy:** If you tailor the proposed Measure to young people and say that they have a right to advocacy, health boards will take that on board and probably engage with the partnership approach and the joint commissioning approach. At the moment, they do not feel that it is their responsibility to provide advocacy services for children and young people with mental health issues, so they do not provide them. They have had opportunities to do so; we have tried. Some health boards have embraced it, but others, through partnerships, have been asked to fund such a service to which the principle of economies of scale would apply, but they have not chosen to do so because they felt that they did not have to.

[211] **Helen Mary Jones:** I want to try to unpick whether the right thing to do is to include children and young people in this proposed Measure or to look for a separate Measure. The provision for universal advocacy for children and young people is made because children need help to express their voice. We would not want to extend a universal right to state-funded advocacy to every adult, would we? So, you have to have a threshold for adults. Whether that threshold is set in the right place is something on which different witnesses have given us different advice and we will have to consider what advice we give to the Government, but one would not want to dilute the universal right for all children to receive advocacy support by putting a threshold in mental health. It is complicated if it is the same piece of legislation and you have a threshold for adults, but no threshold for children or a different threshold for children.

[212] **Ms Murphy:** At the moment, there is no threshold for children in in-patient care. There is very little right to advocacy for children and young people on children's units or when they are placed on adult wards. Again, it is about that service being appropriate for children and young people because they need that specialist service, as we have said. At the very least, the proposed Measure will provide that right to advocacy when they are in-patients.

[213] **Ms Lloyd:** The children's commissioner's paper states that, despite the contradiction, if it focuses minds and allows children and young people that right when they become secondary mental health service users, that can only be a good thing, and we would support that.

[214] **David Lloyd:** Dyna ddiwedd y cwestiynau swyddogol. Diolch ichi am eich cyfraniadau a'ch atebion bendigedig y bore yma. A oes gennych unrhyw sylwadau terfynol ynteu a ydych yn hapus?

David Lloyd: That is the end of the official questions. Thank you for your wonderful contributions and answers this morning. Do you have any final comments or are you happy?

[215] **Ms Thomas:** Thinking back to the re-referral process, set within the context of a coherent care plan, it might be possible to incorporate that. With a care plan, there would be a group of organisations and people working with the child. With younger children, you would ensure that there were other people in that group able to pick up issues were they to crop up later. It is a shame that we have not had more time to think through these complex details, but that would be worth pursuing as an idea.

[216] **Ms Lloyd:** These are very vulnerable children and young people, and it would be

really disappointing if the proposed Measure did not address all those issues that we are aware of in terms of access to CAMHS. It would be really disappointing if we did not attempt to tackle those for children and young people.

[217] **Ms Murphy:** The children's commissioner mentioned earlier that children in need would have a right to advocacy in any case, but children with mental health problems would not necessarily be assessed as children in need, and that might not be helpful for them. So, they would not access advocacy through that provision. To reiterate, there needs to be in-patient advocacy for these young people.

[218] **David Lloyd:** Diolch yn fawr. Bydd y clerc yn anfon trawsgrifiad drafft o drafodaethau'r bore yma atoch er mwyn ichi gael ei gywiro os bydd angen—nid oes angen fel rheol, ond o leiaf byddwch wedi gweld y trawsgrifiad cyn iddo gael ei gyhoeddi'n derfynol. Diolch yn fawr ichi am eich presenoldeb.

David Lloyd: Thank you. The clerk will send you a draft transcript of this morning's proceedings so that you can correct it if necessary—there is usually no need to do so, but at least you will have seen the transcript before it is finally published. Thank you for your attendance.

10.57 a.m.

Cynnig Trefniadol
Procedural Motion

[219] **David Lloyd:** Cynhelir cyfarfod nesaf y pwyllgor ddydd Iau nesaf, 27 Mai. Byddwn yn dechrau am 10 a.m. er mwyn ystyried y dystiolaeth a gawsom hyd yma. Bydd y Gweinidog yn dod i'r cyfarfod i ateb cwestiynau am 11 a.m. ac fe gawn sesiwn breifat arall wedi hynny. Gan y byddwn yn dechrau cyfarfod yr wythnos nesaf drwy ystyried y themâu sy'n datblygu ar gyfer ein hadroddiad, byddai'n well inni gytuno i gynnal sesiwn breifat i wneud hynny.

David Lloyd: The next committee meeting will be held next Thursday, 27 May. We will begin at 10 a.m. to consider the evidence received to date. The Minister will attend the meeting to answer questions at 11 a.m. and there will be another private session following that. As we will begin next week's meeting by considering the developing themes for our report, it would be best if we were to agree to do so in private session.

[220] Cynigiaf fod

I move that

y pwyllgor yn penderfynu gwahardd y cyhoedd o ddechrau'r cyfarfod nesaf, a phob cyfarfod yn y dyfodol lle byddwn yn trafod materion allweddol i'n hadroddiad, yn unol â Rheol Sefydlog Rhif 10.37(vi).

the committee resolves to exclude the public from the beginning of the next meeting, and every subsequent meeting when we discuss key matters for our report, in accordance with Standing Order No. 10.37(vi).

[221] Gwelaf fod y pwyllgor yn gytûn. Diolch am eich presenoldeb ac am bob cefnogaeth gan swyddogion. Diolch am y cyfieithu. Mae'r cyfarfod ar ben.

I see that the committee is in agreement. Thank you for your attendance and thanks for all support from officials. Thank you for the translation. The meeting is closed.

Derbyniwyd y cynnig.
Motion agreed.

Daeth y cyfarfod i ben am 10.58 a.m.
The meeting ended at 10.58 a.m.