



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

**Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government
Committee**

**Dydd Iau, 26 Chwefror 2009
Thursday, 26 February 2009**

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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynndi 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

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Alun Cairns	Ceidwadwyr Cymreig Welsh Conservatives
Ann Jones	Llafur Labour
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Jonathan Morgan	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Collette Dawkin	Defnyddiwr Gwasanaethau Service User
Lindsay Foyster	Cyfarwyddwr, Mind Cymru Director, Mind Cymru
Lee McCabe	Defnyddiwr Gwasanaethau Service User
Lynn Roberts	Gwasanaeth Eirioli Iechyd Meddwl Sir y Fflint Flintshire Mental Health Advocacy Service
Paul Roberts	Cadeirydd, Pwyllgor Cymru Chair, Pwyllgor Cymru
Alun Thomas	Dirprwy Prif Weithredwr, Hafal Deputy Chief Executive, Hafal

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

Steve Boyce	Gwasanaeth Ymchwil yr Aelodau Members Research Service
Steve George	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 9 a.m.
The meeting began at 9 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Jonathan Morgan:** I welcome members of the Health, Wellbeing and Local Government Committee and our colleagues from Hafal, who are here to give evidence in the first part of this morning's committee session. I remind members of the committee and

members of the public to switch off mobile phones, pagers and BlackBerrys. I also remind colleagues that the committee operates bilingually, so headsets are available for translation. I have not been advised of any fire drill planned for this morning, so, if the fire alarm sounds, please follow the advice of the ushers. I also advise Members that the microphones operate automatically, so there is no need to fiddle with the buttons.

[2] We have received an apology this morning from Irene James, and I understand that Alun Cairns will be slightly late. We have received no notification of a substitution for Irene. Are there any declarations of interest under Standing Order No. 31.6? I see that there are none.

9.01 a.m.

Ymchwiliad y Pwyllgor i Wasanaethau Iechyd Meddwl Cymunedol—Tystiolaeth gan Hafal
Committee Inquiry into Community Mental Health Services—Evidence from Hafal

[3] **Jonathan Morgan:** I am delighted to welcome Alun Thomas, the deputy chief executive of Hafal, and Collette Dawkin and Lee McCabe, who are service users. I know that Lee has attended the Health, Wellbeing and Local Government Committee in the past. It is a great pleasure to welcome the three of you this morning. Thank you for the written information and notes, which Members have read in advance. We will proceed with our questions.

[4] Alun, in various parts of the paper that you submitted, you talk about some of the gaps and weaknesses in the provision of community mental health services across Wales. What particular gaps and weaknesses exist? Are they more prevalent in certain parts of Wales than in others?

[5] **Mr Thomas:** There are a few issues there. There are gaps around certain ages within services: there are significant gaps with 16 to 18-year-olds. We have just been successful with a proposal for funding from the Pfizer UK Foundation for a pilot scheme in Neath Port Talbot to try to examine and explore that and find out what the reasons are for those gaps. We have some suspicions already, which are around the fact that young people do not often get a diagnosis. If you do not get a diagnosis, many of our services will not provide you with a service, because you do not tick a box.

[6] In addition, I have had meetings with the Neath Port Talbot children and young people's service, which is keen to be involved with us, but it has so many different strands of teams working in young people's services that there are questions about how teams make these referrals and which is the right team to take on the referrals—is it the adult team or is it the child and adolescent mental health service team? What happens to people who are aged 17 but who are not in full-time education? We are hoping that, over the course of the next year, we will be able to scope that a little and come up with a report that will identify where the gaps are and what the best practice models would be. Rather than suggesting that there should simply be an influx of funding to those areas, at the moment, we think that it should be scoped and quantified. That again can vary. In Cardiff, for example, Barnardo's is providing services for those aged up to 18, which are quite successful, but service provision is patchy and we have areas, particularly in rural Wales, where there is little in the way of service provision for adults of working age, never mind younger people.

[7] **Jonathan Morgan:** Looking at the national service framework for adult mental health services and bearing in mind that a strong strategic direction has been set out by the

Assembly Government, why are services still so patchy?

[8] **Mr Thomas:** In existing services, we have an inheritance of disinvestment in hospitals and money has gone out to community services without focusing on what is needed. It has gone to services because that is what professionals believe would benefit clients and service users, rather than services that service users want. Collette and Lee have experiences of mental health services in Wales before the care programme approach was introduced—Collette has received services for over 35 years—and it was only in 2005, when Collette had a CPA co-ordinator, that her care totally changed. She now uses services that she wants rather than being sent to whichever services exist. The same can be said for Lee. Lee had his diagnosis in 1994 but it was not until 2000 that he had a care co-ordinator. Lee has now been working for two and a half years. He has structure to his life and has what he wants rather than just what can be offered to him.

[9] We still have too many clients having to fit into existing day services rather than getting an individual, person-centred approach. There is still a failure to recognise the fact that secondary mental health services are for people with secondary mental health care needs. We still have this one-size-fits-all approach: if someone goes to their GP for support with an anxiety disorder perhaps or mild depression, primary care does not cover that and so they get sent off to secondary care services with everyone else. Many of these people should never enter mental health services; it is damaging to their self-esteem. We have talked to the Assembly Government and to individual Members about the discrimination issues. For someone with an illness such as schizophrenia or bipolar disorder, receiving secondary mental health services is one of the crosses that they have to bear and that we have to work with. The last thing that someone who does not have a serious mental illness needs is a service delivered by mental health teams. We should consider it as being more about the wellbeing agenda, which is delivered through primary and general social care.

[10] We are also looking at the idea of having 22 different commissioners. I know that we are now moving in the right direction—

[11] **Jonathan Morgan:** I will come to the structure later, but I want to bring Dai Lloyd in on this point.

[12] **David Lloyd:** Building on your answer, Alun, you have mentioned that provision in Wales is service-driven rather than needs-driven. To elaborate on your earlier answer, how do you think that services can be redesigned to meet individual need?

[13] **Mr Thomas:** It has to follow what service users want, and I have circulated some packs on this. We have published a document called ‘New Values—New Practice’, which is still with the printers. We went back to service users and asked them to tell us what services should be provided and what they wanted in their contact with community mental health services. That leads us to the point that services should be reviewed and reconfigured based on the needs assessed using the care programme approach. In that way, if a number of clients within a local authority area say, ‘Actually, what I want is to get into employment and training’, the local commissioner should look at the existing day service, which might provide a drop-in facility, for example, and see that it needs to be remodelled. The only way to do that is to involve the people who are the recipients of the service, by talking to them and asking for their views. We have already done a lot of that work. Lee was talking about his experience with the day service originally.

[14] **Mr McCabe:** Yes. When I was diagnosed, training and education projects such as Hafal were not established as they are today, so I spent a lot of my time in day services or drop-in centres, where you would just sit around, more or less dwelling on things and feeling sorry for yourself from 9 a.m. until 3 p.m. five days a week. Once I had a community

psychiatric nurse and a care plan, I found places such as NSF Cymru, as Hafal was then known, and I started to get a structure to my life.

[15] **David Lloyd:** So, in your view, the key to shifting things around is to take the care programme approach and to get commissioners listening to that.

[16] **Mr McCabe:** Yes.

[17] **Mr Thomas:** It is very much a case of using that to identify need. At the moment, we have gone through that transition with the CPA. With the first plans, we would say, 'We will fit you into that service'. We now need to look at the personalisation of care, and we feel strongly about that agenda.

[18] **David Lloyd:** To move on to the issues that you talked about at the start, and the problems that young people aged over 16 have in accessing suitable mental health services, can you spell out some of the problems faced by the average 16-year-old?

9.10 a.m.

[19] **Mr Thomas:** That is the sort of age at which a first episode of schizophrenia occurs. These young people may be seen as the odd kid at school. They may have started dropping out of school, having problems with relationships, becoming entangled with the criminal justice system, becoming withdrawn, perhaps using cannabis and so on, and those are seen as problems rather than as symptoms of an underlying condition. They end up receiving less support rather than more, because, in our education system, if someone is not turning up for school, they are not getting support from the school. Child and adolescent mental health services are focused on delivering services to young people in education, which means that, if someone is not turning up to school or college, they are not getting that engagement. Adult mental health services tend not to engage with under-18s because those people should be dealt with by the CAMHS team.

[20] **David Lloyd:** What is the best way of addressing that problem?

[21] **Mr Thomas:** We are trying to scope some further causes but, initially, there needs to be a local protocol for dealing with people who are not in school, to ensure that CAMHS are still responsible for them unless they have specific needs that the adult team could support. We should not base it on the diagnosis but on the symptoms. It is easy to say that we will not come up with a diagnosis although we know that a person is experiencing psychosis, so we should start dealing with that. These young people also need a multi-agency approach. How do we address that? By getting them a care co-ordinator, who will look at all aspects of their life and take a holistic approach. It may be that the underlying problem is a family relationship issue, or an educational issue that means that the person cannot cope in a formal education environment. However, they would benefit from having someone to draw together all aspects of education, training, health and social care, and that should be the responsibility of a single agency.

[22] **David Lloyd:** Are you talking about some kind of key worker for that individual?

[23] **Mr Thomas:** We call them care co-ordinators—we already have the language in the CPA. We promote the CPA and our recovery model to carers, because they often have issues as well. How do you best address those? By dealing with them systematically and getting someone to work with you. With young people, it needs to be someone who is sensitive to their issues, but what tends to happen is that there is a referral from one team to another, another team will refer on, and no-one follows that through. However, if you had a nominated person responsible for that individual, they would have to get results or someone would be

held accountable.

[24] **David Lloyd:** Right. Moving on, there is a pilot project in Neath Port Talbot to employ a young people's mental health officer—and I take it that that is the feeling behind making that appointment. Could you expand on how the needs of young people with mental health problems will be met by that approach in your pilot project?

[25] **Mr Thomas:** We are looking at a multistrand approach. We will try to establish why young people are falling through the gaps by looking at it from one county's perspective for the moment, as it is too big an issue to look at on an all-Wales basis at the moment. We know that there are good-quality services for young people in Neath Port Talbot, but the question is how to tie them in. We will also use that context to identify a group of 10 to 15 young people who are in need of those services, and we will deliver a direct service to them through this young person's worker, identifying and establishing what is beneficial for them, how that fits with other services, and whether it can be accommodated within existing services. That is not necessarily a way of saying that an extra £100,000 per county is needed; it may be that we already have the facilities or staff and we just need to remodel. However, we want to get the views of young people, to understand why they have not approached mental health services or their GP, and to see what the barriers are to their accessing existing services.

[26] **Mr McCabe:** May I add to that? In Merthyr, we are looking into a pilot with 16 to 25-year-olds, and we have been in discussions with CAMHS, Barnardo's, and so on. I have been surprised by how much help and support the youngsters in that age group need.

[27] **Val Lloyd:** You suggest in your paper that the resources for specialist mental health services are being used to provide services for people with lower levels of need to the detriment of people with a serious mental illness. How should that be rectified?

[28] **Mr Thomas:** The Assembly Government has already shown some commitment to working with GPs to renegotiate the primary care deal, because the UK-wide GP contract opened up the possibility of less support being provided in primary care for non-secondary care clients. Therefore, local health boards are having to find some way to deal with what they are calling an 'intermediate care group'. We struggle to see that there is an intermediate care group: people either need secondary mental health care services or they do not.

[29] We think that specialist community mental health services should be provided only to people who pass the threshold of needing a CPA programme. If someone has an issue that can be dealt with in primary care that does not require a multi-agency plan to identify how they will move forward, they should be dealt with in the non-specialist services. The specialist services should be focused on those people who might otherwise need hospitalisation or who would become economically inactive for long periods. That would avoid the one-size-fits-all approach of having a drop-in centre on a main street of a town to which anyone can go, whether they are experiencing mild anxiety or having paranoid thoughts. Focus the money on where it is needed.

[30] We think that education and leisure departments within local authorities have responsibilities in this regard. We are holding a conference in May to look at education and training in Wales. A specialist disability discrimination lawyer will be attending, because if people with physical needs were treated in the same way as people with mental illness, an awful lot of claims would be made against local authorities. We can build ramps, install hoists and provide people to assist physically disabled people, but what do leisure and education departments in local authorities do to assist people with mental illness? You do not hear about groups being run to help people with anxiety or mild depression issues to get involved with local leisure activities. That is a concern to us. That would represent a truly inclusive society. We should be supporting those people to access mainstream non-mental-health resources to

improve their quality of life. That would allow us to focus on those people whose lives are wrecked by mental illness, to help them to get their lives back together and to make changes.

[31] **Val Lloyd:** You may have gone some way towards answering my next question. What key community-based services make the greatest contribution to reducing hospital admissions and delayed transfers of care?

[32] **Mr Thomas:** This goes back to my first point that it must be about what the service user wants. We were chatting earlier, and Collette said that she has been admitted over the years, and when she was last admitted to hospital she had a care co-ordinator. Perhaps you would like to give the example of your housing, Collette.

[33] **Ms Dawkin:** Prior to 2005, the only help that I was given was in the form of medication, but when I had a CPN and a care plan, my nurse went against the consultant's wishes that I move into shared accommodation. She found me a flat, and I now live independently. I have recovered really well with her support. Before that, I would not have questioned the consultant.

[34] **Mr Thomas:** It is more about empowering and supporting individuals than having a building with a service within it. It is very much a case of having a meaningful care programme approach. If a county did not have any buildings or facilities through which to deliver mental health services, but had a group of staff to help individuals to develop what they wanted to, we would achieve greater success. The other thing that we must look at if we are to reduce hospital admissions is how to keep people healthy in their homes when they have a known serious mental illness. Anecdotal evidence shows that the introduction of Supporting People was hugely successful initially in preventing delayed transfers of care and hospital readmissions. It was almost up for grabs: if you identified individuals, the programme would get them onto transitional housing benefit and they could have as many hours of support as they needed. We were supporting people in the community for 35 hours a week based on the housing benefit side. That has been reduced over the past few years to an average of perhaps four hours per individual per week. Those people are now starting to go back into hospital care and need greater levels of support.

9.20 a.m.

[35] What they need is somebody who is just going to help them when a bill arrives; they need somebody who is going to go along to an appointment with them. Even at 35 hours a week, you were talking about perhaps £500 or £600 a week to support an individual. If you put them into an acute care bed, you are probably looking at £2,500 a week, and you have to start that all over again. We have reduced our community support. When Supporting People was introduced, the community care teams reduced because Supporting People took over. Supporting People is now dropping off, but community care has not filled that up, and we are lacking those support workers that have time to spend with individuals to find out what their ambitions are and what they want to do and to see how they can work that through with them. We have time to do it in the voluntary sector because our funding is based more on an ethos of recovery than the delivery of statutory requirements. However, those two things have to go hand in hand. There have to be performance indicators right across the voluntary sector to demonstrate how that prevents readmission and delayed transfers of care, but the services also have to be based on what that individual service user requires from each organisation.

[36] **Val Lloyd:** I would like to hear a bit more about the Ceredigion project, but I do not know whether we have time to go down that route.

[37] **Jonathan Morgan:** If you want to pursue that, you certainly may.

[38] **Val Lloyd:** On page 5, you talk about the model used by Ceredigion social services. Could you highlight the main issues with that?

[39] **Mr Thomas:** We are looking to replicate that project across Wales. The key point there was that all the partner agencies got together, and we decided that, whatever the obstacles were, we would get over them and that health and social services would split the cost 50:50. Once that decision was made, the service could develop. That service provides high-quality accommodation. We have had this habit of putting people with mental illness into the poorer accommodation, because nobody else wants it. When they are put into the poorer accommodation, they become more vulnerable to people trying to sell them illicit substances, and they are detached from the rest of the community. This model is a block of flats in the centre of Aberystwyth, where rental costs are probably at the top end of the scale. They are all self-contained flats; they are not bed-sits. They are well-furnished flats of a nice quality. That takes us some of the way.

[40] The other part of the model is that there are two members of staff available 24 hours a day for seven clients. Those clients have either come from private, out-of-county placements or have come through from delayed transfers of care on wards. One client had been waiting six years on the ward for a suitable place, because that person did not want to go out of county, but there was nothing available within the county. We have been running now for three years. Of the first seven clients that came to us, all of whom were long-term, high-cost clients, four have moved on. One is earning and is working as a support worker in another housing project, one has moved out with his girlfriend and is living an independent life with minimal support, and another two have moved on and are just receiving long-arm support. It used to cost anything up to £250,000 a year for their care placement. They came to us, and we work very intensively with them. It is a very structured day. Our Care Standards Inspectorate for Wales report said that the clients appreciated what we were doing but wanted to move on because they could now get on, taking a less structured approach. That is one of the drives. If you want to recover, you have to accept that structure—having to get up and do things—is important. We do not make people do that, but we agree with them that if that is how they want to recover, that is the plan and the way forward. It is about taking responsibility for general living activities, dealing with issues as they arise, and working on the recovery approach. It is up to them; they have to commit themselves to that recovery. Including rental costs, it works out at about £55,000 a year per place, but if we are moving people on within three years, compared with the cost of a £250,000 placement, the local authority and local health board will save about £0.5 million or £0.75 million a year just by setting up one project.

[41] We do not employ nurses in the project because the trusts and the community mental teams do that. Why should we duplicate what they do? So, we have full access to assertive outreach services. We can refer straight on to the ward; we do not have to wait and go through the GP. If somebody becomes unwell, they go straight to the ward, where they are re-assessed. We have had people who have gone into crisis and have needed to go to the casualty department, and they have come back to us, because we offer the most therapeutic level of support for that individual. It is all about understanding what we do and what we can offer. Ceredigion took a big leap. I think that it had to cover somewhere in the region of £150,000 in the hope that it would work the following year. All of a sudden, it snowballed. That has dealt with the people who are out of county, which means that they can have people in their own wards a little bit longer, so they do not have to send them out of county. We are moving people through from that into the next level of housing support, then out to floating support, and they will then not need any support at all. So, from a £250,000 per year care package, within three or four years, someone is not costing anything and is contributing to society. If you left those individuals with a private care provider, there is no incentive to move them on. If you are going to receive £250,000 per year for as long as you care for that individual, where is your incentive to work on a recovery ethos?

[42] **Jonathan Morgan:** Peter, would you like to raise something in relation to this point before we move on?

[43] **Peter Black:** I would like to go back to Supporting People. The use of transitional housing benefit was fairly patchy throughout Wales, so I am interested to know how variable the use of Supporting People funds are throughout Wales and how that impacts on different parts of Wales.

[44] **Mr Thomas:** Initially, we operated in Wrexham, Ceredigion and Pembrokeshire with transitional housing benefit, because we thought that it was too good to be true. We have seen that being halved over the last few years. We know that some local authorities have used it well. Swansea has been particularly successful in developing solid projects that became longstanding. Bridgend used it to set up projects and is now looking at refocusing. We struggle more in the rural areas. Gwynedd and Powys have such dispersed communities, it is difficult to get any sort of high needs scheme going. In the south-east Wales area, counties such as Merthyr and Blaenau Gwent are small entities to commission large-scale schemes. You end up with duplication from county to county, you cannot invest as much as you want to in it, and there are not enough clients to make the scheme as successful as it could be. These are things that should be commissioned on a multicounty basis. They are specialist and there can be quite a high level of need. We then have neither one nor the other. We have a lot more of the floating support services, which have their place, but all they are doing is keeping things ticking over. We need to be able to start bringing people back in from outside Wales, out of area, repatriating that money and using it to reinvest in making a difference.

[45] **Peter Black:** You referred to the reduction in Supporting People funds. Was this a result of projects coming to an end, or was it a conscious decision by local authorities or the Welsh Assembly Government to refocus and move that money to other priorities?

[46] **Mr Thomas:** We understood that the original estimate from the Westminster Government was that Supporting People would cost around £700 million per year. Transitional housing benefit came to around £2.1 billion in the first year, because it was the maximising the pot year. Over the last few years, that has been scaled down to try to bring it back into line. For example, in Ceredigion, we were providing £400,000 worth of services when it started; we are now down to just under £200,000 for exactly the same service. It has meant that individuals, instead of having 15 or 20 hours per week, can have only four hours per week. Local authorities have not had the money because it has been drawn back in. I do not know whether that has been reallocated across Wales or whether Westminster has made it clear that there is no more money in that pot.

[47] **Ann Jones:** You started to touch on the issues that I want to raise. I want to ask you, Alun, about the extent to which health and social services are currently configured. How do you think they are able to respond in a co-ordinated way to the needs of people with severe mental illness?

[48] **Mr Thomas:** There are some good examples. Conwy and Denbighshire have joined together to have health, social care and wellbeing all working to the same objectives. It means that organisations such as ours do not have to deal with five or six different bodies when we want to discuss an idea. The larger counties are able to commission on a larger scale for themselves. However, with the sort of project that we have in Aberystwyth, very few counties are able to commit £500,000 or £600,000 at a time because they do not have that sort of resource.

9.30 a.m.

[49] The other thing is that we are not seeing the sharing of best practice. We know that the situation will change and we are positive about the change, but there are currently 44 different commissioners—one for each local authority, one for each local health board—to whom you have to demonstrate why it works. There is not a good method of sharing best practice in Wales. The National Leadership and Innovation Agency for Healthcare produced a guide three years ago on models of best practice in mental health in which the Ceredigion scheme was listed, as was the recovery programme. However, following that, other local authorities commissioned their own recovery programmes instead of acknowledging that one was already available and being offered for nothing to any local authority that wanted it. Some local authorities have paid consultants to develop a model. So, there need to be clear guidelines to say that if an organisation such as NLIAH is developing a textbook of best practice models, it should be used as a first resource.

[50] There is a need to consider local issues, but someone with a serious mental illness in Gwynedd will have the same core needs as someone with a serious mental illness in Monmouthshire or Pembrokeshire. There is a need to look at the entire person, including their physical health needs, their medication and their treatment therapies. It is not about every area having a fixed employment project. Those local commissioners need to be cleverer about how they deliver the same type of services. It may be that a rural county cannot do that from a fixed base and somewhere such as Cardiff may be able to have two fixed bases because the transport infrastructure is much better in Cardiff than it is in Ceredigion, for example.

[51] **Ann Jones:** Moving on to the commissioning of mental health services, you started to touch on the fact that people should consider models that are already available and share them. Therefore, is that the only way in which commissioning mental health services should be undertaken in order to get co-ordinated, high-quality services across Wales?

[52] **Mr Thomas:** Something that concerns us at the moment is the development of the new seven health economies. No-one has individual responsibility for mental health. The Minister talked about the vice chair being responsible for mental health and primary care, but primary care will always win, so there needs to be a director who is responsible for mental health—that is the director's remit and he or she ensures that mental health is delivered. By doing that, you will get expertise in that post and you will have seven directors who can then look at strategic commissioning across Wales. We need a lead from the Assembly Government. The original lead was provided by the national service framework and nothing was ever done about that. There was an implementation advisory group to drive aspiration, but no-one ever said, 'Actually, you are not delivering what the national service framework outlines, so we are going to do something about it'. It is still left to local commissioners to make priorities. If mental health is to be a priority for the Assembly Government, it needs to say that this is the new NSF—namely the one that is currently in development—and that this is what it expects to see and that people will be held to account on that.

[53] The seven new health economies would be the ideal places to hold people to account. They will have significantly more money and a greater ability to commission. They have to commission based on what you decide are the strategic goals for the country.

[54] **Lorraine Barrett:** You have touched on the role of the care co-ordinator in your paper, and you state that you think that care planning should form the basis of services for people with a serious mental illness. How would such an arrangement involving the care co-ordinator help to improve the co-ordination of health and social services?

[55] **Mr Thomas:** This is not going to happen overnight. We have got what we have got and rather than simply pulling the rug out from under the feet of existing services, the care co-ordinators need to feed back into the commissioning cycle. In many counties where we have good relationships with commissioners, those commissioners seek the views of the

community mental health teams when they come around to reviewing contracts and to writing new service level agreements. We have then tweaked services based on the feedback that we have had from the care co-ordinators. The sort of activities provided would change along with the location of sites. The quality of projects would also change based on that feedback. There has to be a joined-up approach. Local authorities employ people who assess the need for care and the same person writes the care plan, but a different department then buys in that care. If those departments are not talking to each other, we will never get any change. I know that commissioning is changing and that it will not be done on the purchaser/provider basis, but unless the people responsible for the care programme approach are totally involved in the commissioning and development of services, we will not meet those needs.

[56] **Lorraine Barrett:** To what extent are service users involved in the development of the new mental health national service framework?

[57] **Mr Thomas:** The Minister has her implementation advisory group, and there is service user involvement on that. We and Mind Cymru are currently conducting some research for the Assembly into how service users and carers should be involved in any service development consultations. That is a good question to ask, because you can have local involvement, organisational involvement, or a national panel, and it is on these and others that we are seeking service users' views, to find out what they want and how they feel they could feed in to the process.

[58] We have to be careful locally that we do not end up with what is almost a professional service user. We tend to see tokenism with one service user sitting on a panel, but that is not consultation; it is having somebody to rubber-stamp decisions. If you have one or two service users, it is a concern that they might have their own agendas, and, based on the services that people have received over the years, I would probably be much the same: I would want to get what I needed. So, with regard to how service user care or participation officers are used in the various areas, and with regard to service user organisation involvement in implementation advisory group, what needs to happen is for the information to be sent out, consulted on, and for us to get the results back in.

[59] We are getting a fairly clear message that service users want what is right for them rather than what is cost-effective, local and so on. It is not about being service-driven; it is all about the personalisation of care. We have talked about direct payments and so on in the past, but they have never been funded to a reasonable enough level for people to commission the work properly themselves. We talk about a personalisation agenda in which people might have individual budgets but if, in doing that, the same people who do the assessing and managing also provide the bulk of the services, it will never work. There is almost a need to separate the people who assess the money and the people who deliver the service.

[60] **Lorraine Barrett:** I am glad to hear your remarks about ensuring that you get to as many service users as you can—and I hate that expression, but I will have to use it until we come up with another one—rather than relying solely on the professional types. That happens in any community, and not just in the mental health arena: whenever there is consultation, you always find the usual suspects, if you like. So, it is really good to hear that.

[61] **Jonathan Morgan:** In your paper, Alun, you say that the experience of your clients is that we are nowhere near having an inclusive mental health service framework in Wales. You also note the particular experiences of those from black and minority ethnic groups. What ought the Assembly Government be doing to ensure that the service is more inclusive, so that people's experience of it is better than that of those you mentioned?

[62] **Mr Thomas:** From the black and minority ethnic service user's perspective, there is a national organisation that works with people from that community, Awetu, and it is only in

the last couple of years that it has really received any funding from the Assembly Government. The level of funding that Awetu receives makes it difficult for it to do much outside Cardiff. Money is needed to follow any commitment with that.

[63] For service users to feel any benefit and to feel part of the services, it comes back to the care plan approach. Unless somebody is directing their own care, they will feel as though they are receiving or being given care. Collette has recognised the fact that she has never challenged her consultant. You have never had any sort of psychological therapies in 35 years, have you, Collette? Unless Collette asked for it, nobody was going to offer it.

[64] Within the Mental Health Act 1983 code of practice, the Assembly Government has taken a big step forward and come up with a requirement that anybody receiving care under that Act must have a fully comprehensive care plan based on the nine components. We have taken on board the ninth component of the whole-person approach and remodelled ours, because we think that perhaps we missed the issue of caring and parental responsibilities the first time around. However, if you were to make it a requirement that anybody who receives secondary mental health services should have a comprehensive care plan based on their needs, services users would start to believe that the care plan and the care that they receive are based on their needs, rather than someone ticking a box to say 'We provide what is said'.

9.40 a.m.

[65] **Jonathan Morgan:** Does that problem in part explain why people from black and minority ethnic groups are three or four times more likely on average to be admitted as an in-patient?

[66] **Mr Thomas:** There is still a failure to understand the needs of different communities. Mental health is trapped into thinking that, for example, young men from Jamaican backgrounds will behave in a certain way, but that is the stereotype coming in. Education is important for the practitioners. Collette and Lee have been involved in this area; Collette has done some teaching recently with the Gwent Healthcare NHS Trust early intervention team to get it to understand how service users want their recovery to be taken forward. We do not see very much feedback from services for the BME community because the funding is not there.

[67] We also have to recognise that there is no one-size-fits-all solution because someone may come from a Jamaican or Somali community. Again, it is the individualisation or personalisation of care that is needed. They need to be able to express what their needs are. It may mean that the workers in those communities need different skills and have to recognise the cultural sensitivities required when addressing certain matters. One of our clients said that no-one in medical records would dream of sending out an appointment for Christmas day, but they probably do not know what the other religious festivals are. They would not look at someone's notes to see whether Christmas day was an appropriate date for an appointment. There is no sensitivity built into the system, and the attitude seems to be, 'If we can provide some cultural sensitivity, we will, but you will just have to fit in with this service'. It goes back to the point about it being service-driven.

[68] **Jonathan Morgan:** Going back to the issue that you raise in the paper that individuals from black and minority ethnic groups are three or four times more likely to be admitted as an in-patient on average, that is a substantial proportion in comparison with people who are not from those communities. Is that a language issue more than a cultural issue? Is it due to a lack of understanding of what someone is trying to say to a clinician?

[69] **Mr Thomas:** There are some language issues, but the services have become better at identifying translation services and using local communities. Part of the problem is that there are very few specific services for people from those communities. In domestic abuse cases,

the organisation Women's Aid would deliver specific services for women to assist them through those times, and we work closely with groups in the Somali community and the Welsh Refugee Council. They have services for people from ethnic backgrounds but not the mental health expertise, while we are the other way around; we have the mental health expertise but not an understanding of the cultural differences of all groups. There is not sufficient funding to develop services that would work for those groups. We talk about ethnic minorities in Wales, and there is a black and ethnic minority population, but it is not being reached by services that are suitable to its needs and suitable for that community. That is why we see a disproportionate impact on that community. Those people reach crisis point more often than people from a white, European background. Perhaps they will have more difficulties with the criminal justice service. We hear a lot about the criminal justice service changing its views and attitudes, but stop-and-search powers are still focused very much on particular groups of society. We know what some of the causes might be, but we are not investing money into delivering services specifically for that client group.

[70] **Alun Cairns:** Are you aware of other equality issues such as gender, sexuality or language that have an impact on the experiences of mental health service users?

[71] **Mr Thomas:** We have recently been involved in a survey with Stonewall Cymru, which has not yet reported, on the impact of sexuality on mental health, and how the stigma of mental health may also have an impact on people's sexuality.

[72] We also work closely with Women's Aid in different areas, and women-specific service providers—and, sorry, but their names have completely left my head—have recently come in and trained our staff on identifying some of the issues around that.

[73] What tends to happen in domestic violence cases, for example, is that women would be supported by Women's Aid, which provides a range of services. However, if they need a specialist in mental health, the service needs to be joined up with a mental health provider. We could have an office two doors down from Women's Aid, but not have female staff based there. Those are the sorts of difficulties involved. I do not necessarily see it as discrimination in the services; it is just a lack of investment that means that people's needs are not being fulfilled.

[74] **Alun Cairns:** However, is the outcome discrimination?

[75] **Mr Thomas:** It could be indirect discrimination. We have just had funding for work with women prisoners in Eastwood Park Prison and Styal Prison, for example. For a start, we do not have a women's prison in Wales, so women are not provided with services locally. Visitors end up having to travel anything up to 200 miles—the family left behind in Wales, even young children. Women often go to prison for failure to pay council tax and other similar heinous crimes. There are far better outcomes if community services are provided to support those individuals to maintain their family needs.

[76] The system does not recognise the individual needs of women or of groups based on sexuality. It is almost as though, because there is not enough money to go around to provide the core services, we can offer only a token to those other groups. We do not accept that, which is why we are working with other organisations to change it. To do that requires the joining up of local authorities, and, between them, Swansea, Neath Port Talbot, Bridgend and Carmarthenshire could probably identify a group that would benefit. Why not pool the money to develop a service available across those four areas? As individual counties, they probably cannot afford to do that. It is all about being more rational with the commissioning.

[77] **Peter Black:** You state that you welcome the current NHS restructuring, and I think that you referred earlier to the need for a strengthening of the representation for community

mental health services on the boards. What opportunities does the restructuring present to improve community mental health services, apart from that top level representation?

[78] **Mr Thomas:** It is more a case that the general commissioning of services would become easier. I always find it interesting that, when you drive along the Heads of the Valleys road, you go through four counties in about five minutes, but each of those four counties may have their own specialist employment project or counselling service. There are economies of scale; by using those economies of scale and remodelling services, you should be able to free up money to deliver other broader objectives.

[79] The other issue is that we are a small country and we have expected to be able to find 44 experts in commissioning mental health services. We work quite closely with the local commissioners, but there are people who have mental health, substance misuse and learning difficulties within their remit. They cannot devote all their time to this. By having seven health economies, each of those could justify having a single person responsible for mental health who would be able to build up the knowledge and expertise, consult with service users and get out there to meet with the organisations. However, if that person is spending only one day a week in a county on mental health issues, it is not going to be a priority.

[80] A more shared understanding will also start to develop. If there are, say, four or five counties within the same health economy, examples that work well in one county can be considered for others. There are more opportunities to bring money in from out-of-county placements. Rather than setting up their own units, four counties could group together and, between the four of them, develop one unit. That way, they would save, probably, between half and three quarters of the money they are currently spending. What we want to see is ring-fencing of mental health money, so that it does not get chipped off to other issues that may be well deserving, but not our priority within the community care services.

9.50 a.m.

[81] **Peter Black:** Yet there are still the 22 local authorities, all with mental health services as part of that. Although economies of scale exist at the health level, they do not exist at the social services level—there are perhaps more difficulties when it comes to working together.

[82] **Mr Thomas:** It is not perfect. We were, as an organisation, keen on the IMC paper—the Michael Williams paper. It would have led to a single commissioner for mental health, social care and health services, dealing with a lot of the problems. We do have the example of the Conwy and Denbighshire partnership, where health and social care are together across the two counties. They have worked out how to do that and deliver the right things. It can be done without having huge restructuring, but that is for the Assembly to consider. If local areas do not do that voluntarily, does some kind of imposition need to be made?

[83] **Jonathan Morgan:** Thank you. Are there any further supplementary questions? I see not. Alun, thank you for coming in; I am also grateful to Collette and Lee. Thank you for your time.

9.52 a.m.

Ymchwiliad y Pwyllgor i Wasanaethau Iechyd Meddwl Cymunedol—Tystiolaeth gan Mind Cymru
Committee Inquiry into Community Mental Health Services—Evidence from Mind Cymru

[84] **Jonathan Morgan:** I am delighted to welcome Mind Cymru. Lindsay Foyster, the

director, is joined by Paul Roberts and Lynn Roberts. Thank you for the written memorandum provided. If it is okay with you, we will proceed with the questions.

[85] **Ms Foyster:** That is fine. May I request that, when answering questions, I am able to draw in my colleagues Paul and Lynn? They are the experts here through experience, and I would be delighted if you could hear from them.

[86] **Jonathan Morgan:** We will direct the questions to you, Lindsay. You can decide who is best placed to answer.

[87] I have two questions to start with, deriving from Peter's final question to Hafal in the earlier session, looking at funding. In your paper, you say that mental health services are underfunded in Wales. First, I am curious to know why you draw that conclusion. What comparison do you make with other health systems where the mental health services are funded in a different and perhaps better way?

[88] You mention the consideration that should be given to ring-fencing mental health funding. Would that encompass both health and social services? Why do you believe that ring-fencing would somehow make the system better? Are there examples where the NHS has not been putting resources into mental health, but perhaps taking resources out of it? I am wondering why you think that ring-fencing is needed. I suppose that there are three parts to the question.

[89] **Ms Foyster:** There are a number of points there, as you have highlighted. One of the areas for which we have evidence regards the ability to track expenditure in mental health services in the first place. We are very concerned; I know that Assembly Members and Ministers have shared that concern in the past, about being unable to track fully the expenditure going from the National Assembly into mental health, and how that is translated into service provision. A report done through a local health board in Wales recently identified that as a current problem, where the investment from the local health board does not appear to translate into the provision of services on the ground. There seems to be a gap between money that is intended for mental health services and money that is being invested, as well as the services being delivered.

[90] **Jonathan Morgan:** Why do you think there is a gap? We have the national service framework for older people, and the child and adolescent mental health services strategy. It is clear that the Assembly Government has what it sees as the strategic framework in place. Why is it that local health boards have not been providing the resources to commission the sorts of services that need providing?

[91] **Ms Foyster:** I think that the particular local health board in question was providing the resources; it was the trust that was not, in turn, translating it into mental health. The concern remains that money going into trusts does not necessarily get into mental health provision. I think that that concern has been around for some time. The recent local study in Wales is indicative that the problem is still there. That study looked at a comparative situation in England, for the area or population there, and identified that there was, indeed, relatively less investment in Wales than in England.

[92] **Ms Roberts:** I was going to say the same. In my experience, trusts do not like parting with money—certainly not for aspects such as service user involvement and the voluntary sector services.

[93] **Jonathan Morgan:** Perhaps the trusts should be reminded that it is not their money. There is clearly a role for them to play in providing services. If the strategic direction says that they should be providing X, Y and Z services, there is an expectation that they should do

so.

[94] **Ms Roberts:** I have never understood the national service framework. I have read it and been involved with it, but how do you make them implement it? With the best will in the world, you can write down what is supposed to happen, but how do you enforce it? That is the way that trusts look at it—the Government cannot force them to do it.

[95] **Jonathan Morgan:** I suppose that that is one of the reasons why I am pursuing a legislative competence Order.

[96] **Ms Foyster:** I think that that was part of the question that you asked—why is it not happening at a local level when there is a clear national service framework in place? When the previous national service framework was launched, one of the concerns was that there was a delay of 18 months or so before there was commissioning guidance to back it up. It is important that we learn the lessons from that, and that, moving into the development of a new national service framework, we are very clear about expectations and monitoring that can be put in place through the regional offices with the new seven health economies.

[97] On local authorities, there is still concern that money that should be invested in mental health services will get drawn into other emergency or high-risk areas and, therefore, taken away from mental health. If there are reports identifying a crisis in adult care services, local authorities, which have limited budgets, will draw money from wherever they have to in response to what is perceived as emergency need.

[98] **Jonathan Morgan:** Moving onto a different subject area, you express concern in the paper about the delays in implementing community mental health advocacy targets—they were to be met by December 2005, but that timeframe has now shifted to March 2010. What progress, if any, has been made on attempting to meet that new target? Do you know of any reasons why that original target of December 2005 was difficult to reach?

[99] **Ms Foyster:** I will answer that part, and Lynn can talk about her local experiences, as somebody who works for the Flintshire mental health advocacy service. The initial national service framework identified the 2005 target. I think that it was recognised that was ambitious, and a priority was given to looking at developing hospital-based advocacy services in relation to mental health. That was not sufficiently in place across Wales at that point to start resourcing community-based mental health advocacy. The priority is still not given to community-based mental health advocacy. If we are looking to move towards prevention and early intervention for the mental health promotion and wellbeing agenda, community-based advocacy is absolutely crucial to help people to stay out of hospital, to stay in the community and to access community services.

[100] It is not only to do with advocacy relating to mental health services. It involves enabling people to deal with everyday living—how to deal with debt, your landlord and coping with everyday life. That is why, in our view, community-based advocacy is such a vital part of the way forward. If you are going to look at the state of community mental health services, community mental health advocacy must be an integral part of that.

[101] **Ms Roberts:** After spending a long time in services, I was fortunate enough to get paid employment with Flintshire mental health advocacy service, which is unique in north Wales. It will provide advocacy for anybody who wants to use its service. By self-definition, a diagnosis is not needed. However, the other services across north Wales work for people who are known to mental health services.

10.00 am

[102] We are a team of eight people, five of whom are part-time advocates. Last year, we helped over 600 people, with a budget of £49,000 from the local health authority and £49,000 from the local health board. That is not a lot of money to help that many people, but we get good results and also work with mental health services.

[103] Advocacy is so necessary in mental health and it should be available to everyone, whether you are with a team and suffering from serious mental health issues, or whether you are anxious because you are about to lose your home, or your children are going into care and so on. People need support at that time in order to stop them becoming seriously mentally ill.

[104] **Mr Roberts:** On mental health advocacy in south Wales, it is non-existent. I have tried for the last four months—I have approached Swansea Mind, Hafal, Cefn Coed advocacy service, south Wales advocacy network and the UK Advocacy Network, but no-one can point to any support that would be provided. Essentially, I now refuse to engage with services, because the experience has been so horrific over the last three years. I am not going to do it by myself. I refuse to continue to go through it.

[105] I have pointed out several times that, through becoming very unwell, I was likely to fail my university course and faced eviction because I had not kept on top of things. Nobody listens—there is no interface on the social care side of things. It is absolutely fundamental that people get that support for all the reasons already outlined. It is not there and this needs to be addressed. As for its coming on in 2010, somebody raised concerns that the training will not start till 2011, so this is questionable and is obviously problematic.

[106] **Jonathan Morgan:** Thank you Paul. That was very useful.

[107] **Val Lloyd:** You say on page five of your paper that the focus on serious mental health issues ultimately results in increased demand on acute services, as those with less serious problems are overlooked. Could you tell me how you feel the needs of those with serious mental health problems should be met in the community, and how the reliance on in-patient services can be reduced?

[108] **Ms Foyster:** It is very important that the needs of people with serious mental health problems are addressed. Our concern has been that, if this is the only focus—and when resources are tight, people understandably try to prioritise—then the prevention and early intervention is overlooked. The cycle of people needing to have additional support, such as through acute in-patient services, cannot be prevented and the cycle continues. It is very important that we all—local Mind associations, Hafal and other local voluntary sector and statutory services—look at providing support for people with severe and enduring mental health problems.

[109] It is important that we look at how the needs of people who are beginning to experience serious problems, or perceive themselves as being on that journey, are supported and that we are able to intervene more readily. There are what I might term as perverse incentives, in that you have to be ill enough to access a service. At times, this is very detrimental. People are their own best judge and they know when it is the right time for care, support and intervention. If people do not get it at that point because they are not ill enough, they then have to go through a crisis to access the support and care that they need. Clearly, this is not good for the individual and the economic burden on the NHS and social care services is greater.

[110] **Val Lloyd:** You are talking about some sort of balance, so neither part of the service is predominant but that you are meeting the needs of individuals.

[111] **Ms Foyster:** Yes. You need to meet individual needs.

[112] **Val Lloyd:** Could you give some examples of earlier intervention by the community mental health services for people with mild to moderate needs, as well as the particular benefits? I think that you touched on that.

[113] **Ms Foyster:** What we gather more than anything at Mind Cymru is that people ask for support and help at the point that they perceive they need it. It is our understanding that, all too often, that perception is not shared by the professionals. They are deemed not to have reached a threshold. This means that, whether it is by seeing the GP or a community mental health team, if they are already linked into that service, if they try to get a hospital assessment those professionals do not perceive the person as having reached a stage of crisis at which they can access care.

[114] We give examples in our evidence particularly in primary care, but also—and more worryingly—in secondary care where, in talking to the professional, whether it is a consultant or a GP, they are not aware of the kinds of services available to which they could signpost people or refer them into. We were given evidence by one service user where she spent the time with her psychiatrist bringing them up to speed on the services available in her local area. He recommended that she try to find a women's group, and in fact she was the person who helped to facilitate and set one up because the area had no other provision.

[115] Knowledge and awareness of the services that are out there is important, so that it is not just about people asking for support and help only to be told that they can either have medication or go to a community mental health team. Access to advocacy services or local support services—not even necessarily in mental health, but in appropriate settings—should also be available.

[116] It is good to see different initiatives taking place, such as the book prescription service, where people can be referred into accessing library services and self-help. We need to take a wider look at how people with a mental health issue can be supported. The distress that people experience with that is not just about a medical problem; it is about enabling them to cope with other aspects of their lives.

[117] **Jonathan Morgan:** Looking at your paper, you talk about the problems in rural areas. You allude to three rural counties where there are particular concerns. In some areas, you said that there is no assertive outreach service, no crisis resolution home treatment service and a limited out-of-hours service. Given the acute problems in rural areas, particularly around transport, why have these sorts of issues not been addressed by the national health service, bearing in mind that the delivery of a service in a rural part of Wales is fundamentally different to the delivery in urban areas?

[118] **Ms Foyster:** Perhaps you need to ask the national health service why it has not been able to deliver that. Clearly that research was fairly recent, but it identified what we believed were the issues already. There is an expense in that regard. There are still services provided where there are centres of population without due regard given to how people can access those services.

[119] On the transport issue, that is not only about rural areas. If you take the south-east Valleys, getting to where the services are can be very problematic. The rural nature of Wales—whether it is in the Valleys or in more scattered areas of population—is an issue. I do not know if you have anything to add.

[120] **Ms Roberts:** I know from experience, because I must live in one of the smallest villages in the hills. Without a car you have nothing. A lot of service users could not get on a bus even if there was a service available, because their illness is such that they cannot leave

their home. It is about the cost—I know it all comes back to money—because most service users are on benefits that just give you enough to live on. If you have to go to visit your community mental health team every week, and have to choose between paying £5 for that or £5 for your electricity, what are you going to do? I know that it sounds basic but these are things people are coming up against. Whether there is transport or not, there are other issues around local services.

10.10 am

[121] **Ann Jones:** In your written evidence, you highlight the lack of appropriate services for young people over the age of 16—I suppose that that is the transition from being 16 years old to using adult services. What services are needed and how are these best provided for this transition period?

[122] **Ms Foyster:** When we look at the services needed, it is about ensuring that, when somebody is 16, they are not just told, ‘From tomorrow, you will have to start using a very different service’. It is necessary to look at the particular needs of the individual. Again, it is about individual-based services. A 16-year-old will have very different needs from someone who is 20 or 21, if we look at that transition period.

[123] There is a need for services specific to that age group that identify the support that they require as they move from adolescence to adulthood. It is about ensuring that that is mirrored in service provision. It might be about more intensive support to enable someone to become familiar with the adult services that they would receive, and to enable them to make that transition with support from somebody that they have been used to in the service that they were receiving when they were younger. If they move from services that they have been familiar with up to the age of 16, there is some concern about how well they will engage with services from that point on. Some people may then be lost because services are not appropriate to meet their needs at that point.

[124] **Ann Jones:** You talk about a model of working that has been piloted in four areas of Wales, called Team Around the Child. Can you give us more information about that?

[125] **Ms Foyster:** What I can do is make sure that we provide you with that information. I am aware that the site in Wrexham—which was not a pilot site; it was through the Inspire project and joint-working in the Wrexham area—decided to follow the Team Around the Child model. It is obviously, from the title, about a person-centred approach. I have information about the Inspire project, which decided that it would follow that approach. It has proved very successful and, again, it is an area of good practice in this field.

[126] **Val Lloyd:** What developments and improvements to community mental health services are needed to reduce hospital admission and delay transfers of care?

[127] **Ms Foyster:** In community mental health services?

[128] **Val Lloyd:** Yes.

[129] **Ms Foyster:** We have covered some of those points in that people need to have the support of advocates if they do not feel able to express their own needs themselves, so that they can access the right and appropriate service. There needs to be a wider range of services available more consistently in all parts of Wales, so that the capacity is there within services for people not to be admitted or to be discharged in a timely fashion. That is clearly important. Capacity has to have a bearing. Co-ordination between health and social care has to have a bearing on that as well. I would include co-ordination that involves the voluntary sector, which is one of the key providers of community mental health services, and a major

service provider through local Mind associations and independent voluntary organisations, such as Hafal and other national organisations.

[130] We frequently find a lack of involvement around discharge planning. Clearly, that can also lead to delayed transfers of care. It is crucial that the services understand and know what is out there in the community to support people. When somebody says that they are ready to move back into the community, if the staff in the in-patient setting are not aware of the support available that would meet their needs in the community, that is clearly going to delay people being able to be discharged. Advocacy is crucial in that as well.

[131] **Val Lloyd:** Do you think that it is the lack of discharge planning that accounts for such a large proportion of patients experiencing delayed transfers of care in this area of the service?

[132] **Ms Foyster:** I think that capacity within the service is probably the largest factor. Good discharge planning will be part of that. Our evidence shows that there are staff vacancies in various settings and that community mental health teams and crisis intervention teams identify staffing difficulties. I am not saying that those are vacancies, but they can be high levels of sickness absence and staff shortages in general, which mean there is not the capacity necessary to take people who need to use those services. There is a range of issues, therefore.

[133] **Peter Black:** You state in your evidence that there is conflict of ethos between the voluntary sector empowerment and independence model and the rescue and dependency culture in statutory services. What are the strengths of the voluntary sector model and how could this inform the future development of community mental health services across all sectors?

[134] **Ms Foyster:** We look at how individuals can be supported to recognise their own strengths and their own coping strategies to be their own experts by experience and to know for themselves when they need support and care and where to get that from. As I said earlier, when people approach support services, whether that is through health or social care, and they are told they are not ill enough, they have to reach a point of crisis. That is why we say statutory services perpetuate an ethos that is based on dependency—that they are needed when you are desperate—and that there is not as much done in the statutory sector around enabling people to make judgments about their own level of need.

[135] **Peter Black:** I am not sure whether this applies to the mental health sector but there are some models where the voluntary sector is commissioned to deliver statutory services. How would that work in this respect? Would you have a different culture if that happened?

[136] **Ms Foyster:** All the services are commissioned by the statutory sector. Voluntary sector services can be commissioned by local health boards or local authorities. That is still provided within an environment that is about looking at the needs of the individual and, certainly within local Mind associations, looking at how people can develop and have an input and inform the support that is provided to them and not, for instance, seeing that they are not compliant with their care as an issue, but working out what the issue is and how their needs would be better met. I would like to think therefore—although I cannot say this would be upheld across all voluntary sector services—that, as the voluntary sector is so much more rooted in the community, that enables that approach to be taken even for services that are commissioned by the statutory sector. There are issues there but the voluntary sector is becoming more competent at negotiating, for example, service-level agreements and contracts to specify the way in which we want to provide the service, so that it comes from that value base within the voluntary sector.

[137] **Peter Black:** Do you need more support in that negotiation process to assert yourselves better?

[138] **Ms Foyster:** As I said, some groups have become very competent at doing that. The new commissioning structure, however, raises concerns. I know that Lynn will want to say something about this. It raises concerns for the smaller groups about how they will continue to get their services commissioned. At the moment, small, locally based services that are appropriate to the community have mechanisms by which they can be commissioned. The move to the new seven health economies raises the concern that they will want to respond to agencies that can provide services across the whole of their area. That will undermine the creative community-based responses that are in place.

[139] Lynn, I know that you want to say something about that.

[140] **Ms Roberts:** Yes, exactly. At a meeting last week I was told the health boards were being restructured. When I asked about funding for the voluntary sector I was told that service-level agreements would be honoured but once they had run out the boards would probably be looking at commissioning across north Wales. That makes a mockery of community services.

[141] **Alun Cairns:** In the evidence, you state that service co-ordination is hampered by problems with the care programme approach and unified health and social services care assessments. Are the two systems compatible and what changes to them are needed to improve the co-ordination of health and social care services?

10.20 a.m.

[142] **Ms Foyster:** There is evidence that the systems are not always used in a way that is compatible. We looked at the recent Health Inspectorate Wales report, which identified, particularly for reviews of homicides, which it has to do, an 'immaturity' in the way in which the care programme approach and unified assessments were being used. There are issues, therefore, around the way that people understand how to make those work together.

[143] **Alun Cairns:** Thank you.

[144] **Val Lloyd:** Your paper points to the variability in partnership working. You tell us that there are very good examples of joined-up services, but that that is happening on an ad hoc basis and lacks resources and co-ordination. How should the Welsh Assembly Government support and encourage partnership working in mental health services?

[145] **Ms Foyster:** First and foremost you have to listen to what service users have to say. We often talk to the people responsible within the statutory services. We could talk to local health board commissioners and local authorities and they could tell us that everything is working very well in their area and that there is good joint planning and joint working in place. We have to then look to see whether that matches the experience of people on the ground. It would benefit the Assembly to better understand the experience of people in receipt of services. We need to be able to identify where there is good practice and that that is the experience of people in receipt of services and to be able to promote those models around Wales. The Assembly has a role in being able to do that.

[146] **Val Lloyd:** Do you think local service boards might have a role in that co-ordination?

[147] **Ms Foyster:** The role of local service boards is unclear. When the suicide prevention action plan was developed, a key role was identified for local service boards and they queried that themselves. There needs to be discussion around the role of local service boards. They

could have a crucial role, but it needs to be better understood.

[148] **Jonathan Morgan:** Val, before we move on to the next point, is there a difference of opinion between your approach and the approach outlined by Hafal? Earlier when we were looking at what services are provided, which groups of people should be accessing services and where they access them, Hafal was very clear that there is a category of individuals who would perhaps have anxiety or a variety of forms of depression who are, in a sense, inappropriately accessing services—they are accessing services that they should not be accessing, which are the sort of mental health services that we need for the more severely mentally ill. Is that your experience? With regard to the structure of the services, I know that Hafal was strongly in favour of an all-Wales mental health service trust, which the Minister has now shied away from, which is why we have the seven boards. Going back to the point that Lynn made about how we get the right sort of services in the area the size of north Wales, I wonder what your view is on the structure.

[149] **Ms Roberts:** I will say something, as I feel passionately about this. I have sat at a table with the trust and social services, and in Flintshire the CMHTs are multidisciplinary. They work together. CPA is probably 100 per cent; I do not know anyone who does not have CPA. In that respect it works. In my experience, however, although trust representatives listen while they are sat round the table with you, they then go off and do what they want to do anyway. They are very autocratic. They want your input but, once you have given it, you discover that the plan already exists anyway. It is just a case of rubber stamping it. I am just telling it like it is. I am not a politician; all I know is what I know. I know that Wrexham and Conwy and Denbighshire NHS trusts have merged, but now Gwynedd is being brought in as well. The thought of having one trust across the whole of north Wales scares the hell out of me. Mental health services will be run by psychiatrists, and the social focus will be lost. I need assurance that there will be checks and balances to ensure that that cannot happen. I am afraid that a monster is being created—it will be unstoppable. The social agenda and social inclusion will just go.

[150] **Ms Foyster:** With regard to your first point, about the different types of services that are required to meet different needs, Mind Cymru is looking at what it means to be able to address the wellbeing needs of the general population, as well as those of people with serious mental health problems, because everyone has wellbeing needs. Local Mind associations are moving towards services that are far more accessible to everybody. Some are quite advanced and some are looking at how this can work in their area. That is about meeting the needs of people with serious mental health problems—they are what you might call the traditional client group of local Mind associations—and also about being able to develop a better relationship with the community. That should enable the barriers of stigma and discrimination in the community to be addressed by ensuring that you do not provide all of the services in your local Mind association service but that most of your service is focused on enabling people to get out and do what they would want to do in their community. The Active Community initiative is a really good approach to taking this forward, in breaking down discrimination and also enabling people to live fulfilled lives—the kind of lives that anybody would want to live.

[151] So, I do not think that in the community setting those services have to be mutually exclusive. I understand that meeting the particular needs of people who are in the middle of an acute or chronic experience of severe mental illness is different from meeting the needs of somebody who is experiencing mild anxiety or depression that could run into being more serious at a later state. That, again, is about having a service that looks at and responds to people's individual needs. We would welcome, and we are looking to pilot, an approach that is about anybody being able to access, whether through a GP referral or off the street, a service that helps them understand how best to manage their lives, and to develop resilience and coping strategies so that they can cope with what life throws at them. A lot of anxiety and

mild depression would be addressed through that approach. Quite often it is about practical issues. It is about how to cope with everyday events and advocacy becomes a critical part of that. I do not know whether you want to add to that, Paul.

[152] **Mr Roberts:** Any mental health diagnosis is a very dangerous thing. You quickly become your label—that is what you are. These things are dealt with in a very regimented structure. It is not holistic—there is no consideration given to everything. I first presented 13 years ago with mild anxiety and over the last 13 years each diagnosis keeps getting worse. Nobody has ever addressed those issues, because you are just bounced back and forth between people. It is difficult.

[153] **Ms Foyster:** On the second point about the difference between an all-Wales approach to commissioning and the system that we are going to have, as part of the Wales Alliance of Mental Health we share Hafal's preference for something distinct for mental health. One of our main concerns is that, while mental health remains within general acute commissioning, it will be lost.

[154] **Jonathan Morgan:** Has not the Minister addressed that by saying the vice-chair of each board will have mental health services as one of his or her responsibilities?

10.30 a.m.

[155] **Ms Foyster:** We would share Hafal's concern about that, which Alun expressed earlier. We would want it to be on a par with all the other areas of healthcare. Alun said that should sit with one of the directors, so that there is an equal level of responsibility. There is still concern about the safeguards, just because, in the past, evidence in England, Wales and elsewhere has shown that mental health comes off as the poor relation in an acute health setting. So, that remains our concern, and I also understand Lynn's concerns. We need mental health expertise in both the commissioning and service provision, and the voice of the service user must be heard better if we are to provide the service that is needed.

[156] **Val Lloyd:** I had a question about the provision of services in the voluntary sector, but I think that that was answered fully in response to Peter's question. I will move on to a more specific question about the mental health problems among the BME groups. You highlighted in your evidence the specific problems experienced by those groups and by asylum seekers. How can capacity issues in the voluntary sector be addressed to improve services for these groups? Are you aware of any examples of good practice?

[157] **Ms Foyster:** It is difficult to look at the capacity issues of the voluntary sector in isolation. Concern about access to support and services for people from black and minority ethnic communities is a broader issue, although the voluntary sector has a critical role to play. We need more awareness and understanding among existing staff, whether in the voluntary sector or elsewhere, about the specific cultural needs of these individuals, and the impact of discrimination upon them.

[158] In our written evidence, we were not able to mention the Chinese mental health conference that took place on Wednesday, but we would be happy to provide an additional note on that. In talking to delegates and getting feedback on that event, we heard that interpretation services are often not enough. In addition to the evidence from Hafal, we also heard that there can be problems if you just have a verbatim translation of what someone told you, as that is not always enough for the care professional. Understanding the cultural context is important to know whether we should be worried about what someone has said, given their cultural context. It might sound worrying to us and suggest a high risk, but in the cultural context it may not be so significant. So, we need to understand that more fully. Not many staff working on a day-to-day basis, whether in in-patient or community-based settings, have

that level of understanding or knowledge. We need awareness training that covers all the relevant issues. The view of the Chinese mental health community is that it needs access to interpreters across the board. That would enable it to access advocacy services, which it is not particularly able to do at the moment. In Swansea, there is a Chinese mental health co-operative service, run purely by volunteers. They do all of that work, but they are not getting paid, which seems inappropriate. We need to build that into the system.

[159] Hafal spoke eloquently about the needs of the black and minority ethnic communities, particularly Awetu's work with Afro-Caribbean communities, and the need for further resourcing there. Local voluntary sector services need to look at how they build relationships with the non-mental-health aspects of BME communities, because, culturally, mental health is not necessarily dealt with separately and is still significantly taboo. That is true to a degree in mainstream white communities, but it is significantly taboo in black and minority ethnic communities. We need to build relationships with more mainstream community resources, to enable a sharing of skills and understanding between organisations. Like Hafal, we work on a national level with organisations such as Awetu, the Chinese mental health community, and the Islamic Social Services Association, to look at how our expertise in mental health can complement their expertise about their own communities. It is important that we learn from each other how we can meet the needs of groups whose voices are simply not heard.

[160] **Peter Black:** In your paper, you talk about the need for staff training to address a range of equality issues experienced by users of mental health services. Can you elaborate on how that staff training will be delivered? What sort of staff training would you be looking to provide?

[161] **Ms Foyster:** It is difficult to say exactly how the training would be delivered. There is a view that general equalities training only touches the surface. People who have been involved in providing that kind of training over the years recognise that it does not change personal attitudes; it enables people to understand the professional framework within which they must work. For instance, taking nursing staff as an example—and I am not saying that nursing staff are any more discriminatory than anyone else—they must understand the professional expectations of them. What they say to each other in the pub after work will not necessarily be changed through equality and discrimination training. Therefore, we must be clear about what we can achieve through training.

[162] On awareness-raising of certain issues, research that Mind undertook some years ago about the needs of lesbian, gay and bisexual people within mental health services identified that a hugely disproportionate number of people on acute wards identified themselves as being lesbian, gay or bisexual. There is a greater level of misunderstanding and discrimination around sexuality because of the legacy of the time when it was believed that anyone who was anything other than heterosexual was mentally ill. There is still that attitude in the service, which itself is discriminatory when it comes to those issues. It can be an extremely difficult experience for someone not only to have a mental health issue, but to have it seen as being related to their sexuality when, most often, it is not.

[163] **Jonathan Morgan:** I see that there are no further supplementary questions from Members. I was going to ask a question about the NHS restructuring, but you have answered that in a sense with your points about the proposed structure. Thank you for joining us this morning. We are very grateful to you all.

10.37 a.m.

Y Diweddaraf gan Lywodraeth Cynulliad Cymru ar Weithredu Argymhellion y cyn-Bwyllgor Iechyd a Gwasanaethau Cymdeithasol ynghylch yr ymchwiliad i'r

Rhyng-gysylltiad rhwng Iechyd a Gofal Cymdeithasol
Update from the Welsh Assembly Government on the Implementation of the
Recommendations made by the former Health and Social Services Committee as
part of its Inquiry into the Interface between Health and Social Care

[164] **Jonathan Morgan:** The Minister has provided us with paper 3, but, as Chair of the committee, I have to say that I think that the update is a little on the weak side, having gone through it and compared it with the recommendations made in the former Health and Social Services Committee's report. On that committee, we were very clear that we wanted to see a greater degree of working between health and social care and that the mechanisms for joint planning and the provision of services should be examined. There were recommendations on issues of accountability, such as the role of health and social services in promoting the independence of patients. It is an interesting list of strategies and some joint working, but I do not really see what the impact is on a practical level. If you were to talk to the people delivering the services, they would probably say that very little has changed. I am not sure of the views of other Members, but I did not think that it demonstrated much of a substantial leap forward from the point at which the committee was reporting originally. Are there any views on the paper?

[165] **Peter Black:** The problem is that the context is changing. In a sense, the context of the original report was that we had 22 local health authorities, the NHS trusts and local health authorities. We are now moving towards having seven local health boards, and it is difficult to see how these new strategies will fit into that context. Perhaps this needs to be revisited more thoroughly, rather than our relying on the recommendations of the previous paper.

[166] **Jonathan Morgan:** That is probably a good idea. The new structure kicks in around October, so x number of months beyond that, it might be useful for the committee to have another look at it. Are there any further views on that? I see not, so we will just note that report and keep it to one side for when we want to revisit the issue in future.

10.39 a.m.

Cynnig Trefniadol
Procedural Motion

[167] **Jonathan Morgan:** I will now propose a motion to exclude the public to allow the committee to discuss in private the draft report of its inquiry into local government scrutiny. I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[168] Are there any objections? I see that there are not. We will now move into private session.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.39 a.m.
The public part of the meeting ended at 10.39 a.m.