National Assembly for Wales
Legislation Committee No. 3

Proposed Mental Health (Wales) Measure

Stage 1 Committee Report
July 2010

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Legislation Committee No.3
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The Committee was established on 9 December 2008 as one of the Assembly's legislation Committees. Its powers are set out in the National Assembly for Wales' Standing Orders, particularly SO10, 22 and 23. These are available at www.assemblywales.org

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Committee Member	*Party*	*Constituency or Region*
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Peter Black	Welsh Liberal Democrats	South Wales West
Christine Chapman	Labour	Cynon Valley
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Relevant Reports published by a Legislation Committee

Report title	*Date of publication*
Proposed Provision of Mental Health Services LCO Committee Report on the National Assembly for Wales (Legislative Competence) (No.6) Order 2008	June 2008

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The Committee's Recommendations

Our conclusions and recommendations are listed below, in the order that they appear in this report. Please refer to the relevant paragraphs of the report to see the supporting evidence.

General principles and the need for legislation

Based on the majority of the views we have received, we support the general principles of the proposed Measure and the need for legislation, to guarantee earlier intervention for those with mental health problems, and to deliver effective, consistent mental health services in Wales. (Paragraph 40)

Should the Minister accept our recommendations relating to the scope of the proposed Measure it is our expectation that the Minister will bring forward consequential amendments at the next stage to amend the relevant Sections of the proposed Measure accordingly. (Paragraph 44)

Scope of the proposed Measure: Age

We consider that legislating for the provision of mental health services for children and young people will help to improve service provision, and the assessment and treatment of young people with mental health problems in Wales. (Paragraph 73)

We recommend the scope of Parts 1 to 3 of this proposed Measure should be extended to include children and young people. This should not be left to a separate Measure at a later date. (Paragraph 74)

We recommend that the Minister explores ways of extending the scope of the proposed Measure in order to include children and young people, and we seek assurance at the earliest opportunity that this work is progressing. (Paragraph 75)

We recommend that the Minister brings forward appropriate amendments to extend the scope of the proposed Measure. (Paragraph 76)

Timescales

We agree with a number of health professionals and service providers regarding the risk of unintended consequences that might arise if prescriptive timescales were included in the proposed Measure. We consider that the prioritisation of services should be based on the clinical needs of the patient, and not dictated by targets. (Paragraph 93)

We do not consider that it would be appropriate to include specific timescales on the face of the proposed Measure. (Paragraph 94)

Prisoners

We are concerned at the lack of clarity relating to prisoners and consider that this could lead to difficulties for service providers in planning for the needs of patients. We note the Minister's assurances that she will address this issue, and recommend that the Minister ensures that the proposed Measure and accompanying Explanatory Memorandum clarifies the provisions contained in Parts 1 to 4 of the proposed Measure in respect of prisoners. This also applies to any explanatory information that will accompany the Measure as passed. (Paragraph 105)

Resources

The Finance Committee will consider the financial implications of the proposed Measure in detail. We wish to highlight the need for adequate resources to be made available to develop the skills and capacity required to successfully implement the proposed Measure. (Paragraph 121)

Part 1

We consider that making statutory provision for earlier intervention through enhanced support at primary care level could help prevent further deterioration in patients' mental well-being. Overall, therefore, we are content with the general principles of Part 1 and its aims. (Paragraph 129)

Section 1 – Meaning of 'Local Mental Health Partners'

Section 1 provides a clear definition of 'local mental health partners', and the inclusion of both the Local Health Boards and Local Authorities

is welcomed. Therefore, we are content with the definition contained in Section 1. (Paragraph 136)

We welcome the provisions within Section 42 that will enable mental health partners to undertake regional approaches within a relevant local health board's area. (Paragraph 137)

Section 2: Joint schemes for the provision of local primary mental health support services

The Minister has assured us that a National Service Model will be developed, which will be flexible so that partners can respond to local need, but will secure parity of services across Wales. We welcome the Minister's aims in developing the National Service Model. (Paragraph 149)

Given the importance placed upon the National Service Model, and its role in securing parity of primary mental health services across Wales, we recommend that the Explanatory Memorandum be amended to provide more information on the National Service Model, and that any explanatory guidance accompanying the Measure as passed also includes this information. (Paragraph 150)

We recommend that criteria for determining eligibility for mental health services be made explicit in guidance. (Paragraph 151)

Section 2(4) – making provision in the scheme for patients not registered with a GP

We recommend that Section 2(4) be amended to require local mental health schemes to include service provision for those who are not registered with a GP. (Paragraph 162)

Section 3: Duty to provide local primary mental health support services

We are content that the provisions in Section 3, along with the provisions in Section 5, establish a clear duty to treat. (Paragraph 169)

Section 5: Meaning of 'local primary mental health support services'

We are content that the definition of 'patients' is appropriate. We are also content with the definition of 'carers', and agree with the evidence

that this definition is sufficiently broad to capture the range of individuals that may be involved in a patient's care. (Paragraph 184)

The definition of 'community care services' is particularly complex because it derives from a number of legislative instruments. Whilst this definition is clear from a legal perspective, it may be unclear to service users or their carers, and could lead to difficulties for those individuals in understanding their rights. We recommend that it be clarified within the Explanatory Memorandum, and any explanatory information that will accompany the Measure, as passed. (Paragraph 185)

We recommend that the importance of signposting patients and their carers to those support services provided by the voluntary sector be clearly set out in guidance. (Paragraph 186)

Section 9: Conduct of primary mental health assessments

We recommend that the importance of holistic assessments in ensuring services for patients are based on the Recovery Model be emphasised in the Explanatory Memorandum, guidance and any explanatory information that will accompany the Measure as passed. (Paragraph 198)

We reiterate our concern that the definition of 'community care services' is particularly complex and may be unclear to the service user because it is derived from a number of legislative instruments. We therefore recommend that this be clarified within the Explanatory Memorandum and any explanatory information that will accompany the Measure as passed. (Paragraph 199)

Section 10: Action following a primary mental health assessment

We are content that professionals should make decisions on service provision based on clinical need and are therefore content with the provisions of Section 10. (Paragraph 205)

Part 2

We agree with the need to make statutory provision for care and treatment planning for those in receipt of secondary mental health services. We therefore agree with the general principles of Part 2. (Paragraph 211)

Section 11: Meaning of 'relevant patient'

The proposed Measure defines any adults in receipt of secondary mental health services as a 'relevant patient', without any requirement for a qualifying level of contact that the patient would need to have with secondary services for a care coordinator to be appointed. However, we consider that it would be inappropriate to define this level of contact on the face of the proposed Measure. We are therefore content with the provisions of Section 11. (Paragraph 222)

We reiterate our view that the planning of a patient's care must be driven by clinical need. The appointment of a care coordinator should therefore be based on clinical need, and be proportional. We consider that this should be clarified in guidance, to manage the expectations of patients, and to reassure service providers. (Paragraph 223)

Section 12: Meaning of 'mental health service provider'

We note that witnesses were content with the definitions contained in Section 12. We are also content, and consider that it is appropriate that services be defined in legislation in this way. (Paragraph 228)

We reiterate our concerns that there is a need for clear guidance on the level of contact a patient would need to have with secondary mental health service providers to be eligible for the provisions within Part 2 of the proposed Measure, and that this should be proportional, and driven by clinical need. (Paragraph 229)

Sections 13 - 15: Appointment of care coordinators

We are concerned at the lack of clarity regarding the dispute resolution process in instances where a secondary service could be provided by both a health board and a local authority, but there is disagreement. (Paragraph 235)

We recommend that such disputes should be quickly resolved by Welsh Ministers, and that this should be clearly set out in the regulations made under Section 14(4). (Paragraph 237)

Section 16: Duty to coordinate provision of mental health services

We do not consider there is a need to amend Section 16(2) and (3) to require the provider of services to seek the advice of the care coordinator with regards to the discharging of its duty under Section

16(1). Individual circumstances will dictate whether this is necessary, and we are therefore content that the provisions of Section 16(2) and (3) will allow for this. (Paragraph 243)

We welcome the reference in the proposed Measure to 'any services related to mental health provided for the patient by a voluntary organisation', and consider that this provides a clear indication that the service providers must coordinate care with that of the voluntary sector. We are therefore content with the provisions contained in Section 16. (Paragraph 244)

Section 17: Functions of a care coordinator

We welcome the provisions of Section 17, which we believe clearly set out the functions of a care coordinator and the approach to a care plan. (Paragraph 253)

We consider that the form and content of care and treatment plans, to be made by regulation under Section 17(8), should not simply be administrative. We consider that the care plans should reflect the Recovery Model, taking into consideration other contextual information that can assist a patient's recovery and should be patient-led. We recommend that this be reflected in the regulations. (Paragraph 254)

Given the importance of the care and treatment plans in supporting a patient's recovery, and the need for clarity regarding the aims of care plans, we recommend that the first set of regulations made under Section 17(8) be made using the affirmative procedure. (Paragraph 256)

Part 3

We note the broad support for Part 3 of the proposed Measure, which provides patients discharged from secondary services with a rapid route back to services if required. It is our view that these provisions will empower patients and support their recovery. We therefore support the general principles of Part 3 of the proposed Measure. (Paragraph 264)

Section 21 - 23: Assessment entitlements

We note the concern of witnesses regarding the eligibility of patients requesting re-referral, the importance of ensuring patients understand that there is no guarantee of treatment if it is not considered to be clinically necessary, and the lack of a definition of qualifying level of previous contact with services. We consider that parameters will need to be defined, and endorse the Minister's intention to amend the proposed Measure accordingly. (Paragraph 277)

We consider that the provision contained in Section 21(1)(d), which gives service providers the discretion to consider whether a request for an assessment is vexatious or frivolous, is appropriate and allows for decisions to be based on clinical judgment. However, we recommend that clear guidance is developed to manage the expectations of patients and support the decisions of service providers. (Paragraph 278)

We are concerned at the lack of clarity regarding the discharge period, and the eligibility of patients who have previously accessed Child and Adolescent Mental Health Services to the provisions of Part 3. Should the Minister reject our recommendations regarding the need for the proposed Measure to be 'age blind', we recommend that the regulations made under Section 22, which will define the relevant discharge period, should clarify the eligibility of previous users of Child and Adolescent Mental Health Services. (Paragraph 289)

We recommend that the regulations made under Section 22 establishing the length of time following discharge for which a previous service user would remain eligible for reassessment under Section 21 should follow the affirmative procedure. (Paragraph 280)

Part 4

We agree with the aim of Part 4 of the proposed Measure and are therefore content with the general principles of Part 4. (Paragraph 292)

We do not believe that universal access to statutory advocacy services is appropriate at this time. (Paragraph 293)

Section 29: independent mental health advocates: Wales

We consider that the principle of independence for statutory mental health advocates should be retained, and are therefore content that the provisions inserted into the *Mental Health Act 1983* by Section 29 of the proposed Measure retain this independence. (Paragraph 302)

Sections 30 – 31: Further provision about independent mental health advocacy for Welsh qualifying compulsory and informal patients

We believe the new Sections 130F and 130G to the *Mental Health Act 1983* (inserted by Sections 30 and 31 of the proposed Measure) are appropriate, and provide clear definitions of the roles of the Independent Mental Health Advocates in respect of both Welsh qualifying compulsory and informal patients. We call for clear guidance on the roles of the Independent Mental Health Advocates in respect of the new categories of Welsh qualifying patients. (Paragraph 307)

Section 32: Independent Mental Health Advocates – supplementary powers and duties

We note that under Section 130E of the *Mental Health Act 1983* (inserted by Section 29 of the proposed Measure) Welsh Ministers are under a duty to make arrangements to make Independent Mental Health Advocates available to qualifying compulsory and informal patient, and assume that this confers an on-going right for the patient. On the basis that this assumption is correct, we are content that the patient is not included in the list of those who can request a visit from an Independent Mental Health Advocate in Section 130H of the *Mental Health Act 1983* (inserted by Section 32 of the proposed Measure). We recommend that the Minister confirms this position. If this is not the case, we recommend that the patient be added to the list of those who can request a visit from an Independent Mental Health Advocate. (Paragraph 316)

Support workers should also be able to request a visit from an advocate on behalf of both compulsory and informal patients, and therefore should be included in the lists of those who can make such requests in Section 130H of the *Mental Health Act 1983* (inserted by Section 32 of the proposed Measure). We recommend that the Minister clarifies whether, similar to the provision enabling hospital managers to delegate the ability to make a formal request for an advocate to

hospital staff, social workers will be able to delegate this to support workers. (Paragraph 317)

Section 33: Welsh qualifying compulsory patients

We are content that the definition of Welsh qualifying compulsory patients contained in Section 130I of the *Mental Health Act 1983* (inserted by Section 33 of the proposed Measure) is appropriate. (Paragraph 329)

Section 34: Welsh qualifying informal patients

We are content with the definition of 'Welsh qualifying informal patients' in Section 130J of the *Mental Health Act 1983* (inserted by Section 34 of the proposed Measure), but consider that this should be clarified in accompanying guidance and relevant regulations. (Paragraph 335)

Section 35: Duty to give information about independent mental health advocates to Welsh qualifying compulsory patients

We are content that Section 130K in its entirety is within the legislative competence of the National Assembly for Wales and are therefore content with new Section 130K of the *Mental Health Act 1983*, as inserted by Section 35 of the proposed Measure. (Paragraph 341)

Part 4: Subordinate Legislation Provisions

The *Mental Health Act 1983* currently provides that regulations relating to advocacy will be subject to annulment (negative procedure). In light of the policy developments to be implemented by these regulations it is our view that the affirmative procedure would be more appropriate. We recommend that a suitable amendment be brought forward to secure the relevant amendment to the *Mental Health Act 1983*. We are, however, prepared to concede that the affirmative procedure should apply only to the first regulations made under the new provisions. (Paragraph 343)

1. Introduction

1. On 22 March 2010, the Minister for Health and Social Services, Edwina Hart AM (hereafter referred to as 'the Minister'), introduced the Proposed Mental Health (Wales) Measure1 and accompanying Explanatory Memorandum.2 The Minister made a statement in plenary3 the following day.[4]

2. At its meeting on 9 February, the National Assembly for Wales' Business Committee agreed to refer the proposed Measure to Legislation Committee No.3 for consideration of the general principles (Stage 1), in accordance with Standing Order 23.21. The Business Committee agreed that the Legislation Committee No. 3 must report on the proposed Measure no later than 2 July 2010.

Terms of scrutiny

3. We agreed the following framework for scrutiny of the general principles of the proposed Measure.

To consider:

- the need for a proposed Measure to deliver the intended effects (see paragraph 10);
- whether the proposed Measure achieves its stated objectives;
- the key provisions set out in the proposed Measure and whether they are appropriate for delivering its objectives;
- potential barriers to the implementation of the key provisions and whether the proposed Measure takes account of them;
- the views of stakeholders who will be affected by the new arrangements.

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[1] *Proposed Mental Health (Wales) Measure*: http://www.assemblywales.org/bus-home/bus-guide-docs-pub/bus-business-documents/bus-business-documents-doc-laid.htm?act=dis&id=173835&ds=3/2010

[2] Welsh government, *Explanatory Memorandum to the proposed Mental Health (Wales) Measure*, March 2010: http://www.assemblywales.org/bus-home/bus-guide-docs-pub/bus-business-documents/bus-business-documents-doc-laid.htm?act=dis&id=173836&ds=3/2010

[3] A full meeting of the National Assembly for Wales

[4] RoP, 23 March 2010, available at: http://www.assemblywales.org/bus-home/bus-chamber/bus-chamber-third-assembly-rop.htm?act=dis&id=174417&ds=3/2010#datdeddf

The Committee's approach

4. We issued a call for evidence and a range of interested groups, primarily from the health and social care sectors, were invited to submit written evidence to inform our work. We received a large number of responses, details of which can be found at the end of this report.

5. We also took oral evidence from a number of witnesses over 6 meetings, details of which can be found at the end of this report.

6. The following report represents the conclusions and recommendations we have reached based on the evidence we received during our inquiry. We would like to thank all those who have contributed.

2. Background

The legislative competence

7. The principal powers that enable the National Assembly for Wales to make a Measure in relation to mental health are contained in Section 93 of the *Government of Wales Act 2006*.[5] Section 93 gives the National Assembly the power to make Assembly Measures in relation to 'matters' listed in Field 9 (Health and Health Services), and Field 15 (Social Welfare) of Part 1 of Schedule 5 of that Act. Specifically these are matters 9.2 and 15.10, detailed below:

"Matter 9.2

Assessment of mental health and treatment of mental disorder.

This matter does not include any of the following –

(a) subjecting patients to-

(i) compulsory attendance at any place for the purposes of assessment or treatment,

(ii)compulsory supervision, or

(iii) guardianship;

(b) consent to assessment or treatment;

(c) restraint;

(d) detention.

For the purposes of the matter, "treatment of mental disorder" means treatment to alleviate, or prevent a worsening of, a mental disorder or one or more of its symptoms or manifestations; and it includes (but is not limited to) nursing, psychological intervention, habilitation, rehabilitation and care."

"Matter 15.10

Social Care services connected to mental health.

This matter does not include the independent mental capacity advocacy services established by Part 1 of the Mental Capacity Act 2005."

[5] *Government of Wales Act 2006*
http://www.opsi.gov.uk/acts/acts2006/ukpga_20060032_en_1

8. The competence to legislate in this area was conferred by the National Assembly for Wales (Legislative Competence) (Health and Health Services and Social Welfare Order 2010,[6] and the National Assembly for Wales (Legislative Competence) (Social Welfare and Other Fields) Order 2008.[7]

The Explanatory Memorandum

9. The Explanatory Memorandum that accompanies the proposed Measure explains that purpose of the proposed Measure is to:

- provide local primary mental health support services at an earlier stage than is currently the case for individuals experiencing mental health problems, the aim being to lessen the risk of further decline in mental health, and in some cases, to reduce the need for subsequent inpatient treatment and possible compulsory detention;
- ensure that all individuals accepted into secondary mental health services in Wales have a dedicated care coordinator and receive a care and treatment plan, and that service users discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extend the categories of patients qualifying for statutory mental health advocacy provision beyond that which is currently required.[8]

10. According to the Explanatory Memorandum, the intended effect of the proposed Measure will be achieved through five policy objectives:

- to provide assessment of an individual's mental health and, where appropriate, provide treatment of an individual's mental disorder within primary care, by establishing a duty for Local Health Boards and local authorities to deliver primary mental health support services across Wales;
- to establish statutory requirements around care and treatment planning and care coordination within secondary mental health services;

[6] Explanatory Memorandum, Paragraphs 2 - 9
[7] Ibid
[8] Ibid, Paragraph 17

- to require that secondary mental health services have in place arrangements to ensure the provision of timely access to assessment for previous service users;
- to extend the group of 'qualifying patients' under the *Mental Health Act 1983* entitled to receive support from an Independent Mental Health Advocate, so that all patients subject to the formal powers of that Act can receive support from an Independent Mental Health Advocate, if required;
- to enable all patients receiving care and treatment for mental disorder in hospital to have access to independent and professional specialist mental health advocacy.[9]

11. The Welsh government's intended timescale for commencement and implementation of the proposed Measure is outlined in the Explanatory Memorandum:

> "Most provisions of the proposed Measure will be commenced at such times as the Welsh Ministers think appropriate or expedient. This recognises that some Local Health Boards and local authorities will be required to enhance existing services, or perhaps develop new services, to meet their obligations under this legislation.
>
> The current intentions are therefore to stage implementation of the various aspects of the proposed Measure, whilst still ensuring that the benefits expected to arise from the new arrangements are achieved as quickly as possible. The overall timescale is three years to achieve full implementation.
>
> On this basis (and subject to the proposed Measure being made in the financial year 2010/11) it is expected that:
>
> - "local primary mental health support services will come into full effect in Year 3 (2012/13). Development work will take place in Years 1 and 2 ahead of commencement;
> - care planning for secondary mental health services will come into full effect in 2011;
> - secondary mental health assessments will also come into full effect in 2011;

[9] Explanatory Memorandum, Paragraph 18

- mental health advocacy in respect of compulsory patients (i.e. for those sections of the 1983 Act not currently supported by advocacy) will come into full effect in 2011;
- mental health advocacy in respect of informal inpatients (i.e. for those not subject to compulsion under the 1983 Act) will come into full effect in 2011/12." [10]

[10] Explanatory Memorandum, Paragraphs 63 - 64

3. General principles and the need for legislation

Background

12. The following paragraphs provide a summary of Parts 1 to 4 of the proposed Measure. We did not receive evidence on Parts 5 and 6, which contain technical provisions.

13. In relation to Part 1of the proposed Measure, 'Local Primary Mental Health Support Services', the Explanatory Memorandum states:

> "The aim of this policy objective is that throughout Wales there will be local primary care mental health support services and that these will be delivered by Local Health Boards and local authorities, in partnership.
>
> "These services will offer assessment of an individual's mental health and provide advice and/or treatment of an individual's mental disorder within primary care.
>
> "These services are not intended to be part of the existing General Medical Services regime provided (in the main) by General Practitioners (GPs) but are intended to act as a bridge between GP provision and secondary mental health services."[11]

14. For the 'Coordination of and Care Planning for Secondary Mental Health Service Users', Part 2 of the proposed Measure, the Explanatory Memorandum explains that all individuals throughout Wales will have a care and treatment plan that is reviewed regularly.[12]

15. The Explanatory Memorandum goes on to say:

> "The proposed Measure will place duties on service providers (Local Health Boards and local authorities) to act in a coordinated manner to improve the effectiveness of the mental health services provided to an individual. There will be:
>
> - a care and treatment plan for all service users aged 18 and over who have been assessed as requiring care and treatment within secondary mental health services;

[11] Explanatory Memorandum, Paragraph 19
[12] Ibid, Paragraph 28

- the plan will be developed by a care coordinator in consultation with the service user (so far as practicable, taking into account their capacity and cooperation), and overseen by the care coordinator;
- the plan will outline the expected outcomes of services, and how those outcomes are to be achieved. This process will be informed by a needs assessment and a risk assessment;
- the plan will be in writing;
- the plan will be subject to periodic review and variation to reflect any changes in the type of care and treatment which may be required by the service user over time."[13]

16. In relation to Part 3 of the proposed Measure, 'Assessments of Former Users of Secondary Mental Health Services', the Explanatory Memorandum states:

> "The aim of this policy is to enable individuals who have been discharged from secondary mental health services, but who subsequently believe that their mental health is deteriorating to such a point as to require specialist intervention again, to refer themselves back to secondary services directly, without necessarily needing to first go to their general practitioner or elsewhere for a referral."[14]

17. The Explanatory Memorandum continues:

> "This policy therefore aims to encourage safe and effective discharge, by providing individuals with a mechanism to swiftly re-access services should these be required again at a later stage."[15]

18. Part 4 of the proposed Measure contains provisions to amend the *Mental Health Act 1983* in relation to Independent Mental Health Advocacy. The Explanatory Memorandum explains:

> "This proposed Measure provides for an expanded statutory scheme of independent mental health advocacy, both for patients subject to the compulsion under the *Mental Health Act*

[13] Explanatory Memorandum, Paragraph 32
[14] Ibid, Paragraph 36
[15] Ibid, Paragraph 39

1983, and those in hospital informally (i.e. not under compulsion)."[16]

19. In relation to statutory advocacy for patients compulsorily detained under the *Mental Health Act 1983,* the Explanatory Memorandum states:

> "The policy objective in this proposed Measure is to extend the group of Welsh qualifying patients who are entitled under the 1983 Act to receive the support of an [Independent Mental Health Advocate] to include patients subject to the emergency short-term sections of that Act who do not currently attract such support, namely individuals who are subject to sections 4, 5(2), 5(4), 135(1), 135(2) and 136 of the 1983 Act."[17]

20. In relation to informal patients, a new category of patients that will qualify for statutory advocacy, the Explanatory Memorandum states:

> "The intention of the proposed Measure in relation to informal patients is to ensure that independent advocacy is available to all inpatients who are receiving treatment for mental disorder (including those in non-mental health settings)."[18]

21. The Explanatory Memorandum explains the rationale for these provisions:

> "By expanding statutory advocacy services to ensure that access is available to all inpatients receiving treatment for mental ill-health, whether subject to compulsion or not, the proposed Measure seeks to ensure that the rights of this often vulnerable group of patients are safeguarded. Statutory advocacy will assist inpatients in making informed decisions about their care and treatment, and support them in getting their voices heard."[19]

Evidence from Witnesses

22. There was broad support for the proposed Measure, and agreement with the need for legislation to provide earlier intervention for those with mental health problems.

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[16] Explanatory Memorandum, paragraph 47
[17] Ibid, paragraph 52
[18] Ibid, paragraph 57
[19] Ibid, paragraph 61

23. Gofal Cymru told us that the proposed Measure has the "potential to make a very real difference to the lives of people who are experiencing mental ill health."[20] This view was echoed by a number of witnesses, including the Royal College of GPs, who told us that the implementation of the Measure would result in quicker access to services for patients:

> "There is evidence that early intervention in mental health problems produces better outcomes for individuals whether this is for episodes of psychosis or less serious illness. Primary care already offers early access for initial assessment by a general practitioner but the Measure may help speed access to other more appropriate care."[21]

24. We also heard that introducing legislation would address the gaps in policy implementation, and help to ensure that earlier intervention would be provided for services users across all parts of Wales. Mind Cymru told us that at present, service provision can differ depending on the location of the service user:

> "We would say that there is a need for the proposed Measure. We know that, for many years, mental health services in Wales have been patchy. People have a completely different experience depending on where they live."[22]

25. Some respondents believed that the proposed Measure "signals sign up from the highest level to delivering" the mental health agenda, which:

> "… brings together the whole system approach to mental health taking into account the range of needs within our communities without discrimination."[23]

26. A number of witnesses supported the principles of joint responsibility to deliver enhanced primary mental health care as outlined in the proposed Measure. Public Health Wales, for example. told us:

> "Enhanced primary mental healthcare may further help break down barriers between primary and secondary healthcare

[20] RoP, paragraph 123, 22 April 2010
[21] Written Evidence, MH 37
[22] RoP, paragraph 55, 22 April 2010
[23] Written Evidence, MH 9

> providers and impact positively on improving communication and skills across boundaries. There is still a perceived stigma regarding mental health issues and greater awareness and improved access may go some way to address this issue in Wales."[24]

27. This view was supported by the Hywel Dda Health Board, who explained that requiring earlier intervention through partnership working could significantly decrease the likelihood of further patient decline:

> "We are already working very closely with our local authority colleagues but this Measure will strengthen joint working in various ways and assist in pool funding for targeted areas. We feel that **clinically** there is a strong case to make such an assumption (that is to say it will reduce the risk of further decline and ultimately reduce the need for admission let alone compulsory detention)."[25]

28. In contrast, we heard evidence from Professor Phil Fennell that existing legislation, policy and guidance should be delivering a higher standard of services and earlier intervention. However, in practice this is not the case. In oral evidence, he questioned whether further legislation was necessary, stating that:

> "I am willing to accept the evidence of service users and the charities that they have tried to access services and have not been able to do so. I do not think that that is because of an absence of law. I think it is because of an absence of service."[26]

29. Several other witnesses agreed that "despite the strategies, National Service Framework and other guidance, service improvement has been slow."[27] However, many also believed that this provided a rationale for further legislation:

> "… as a result, legislation is required to make improvement a reality."[28]

30. The Royal College of GPs, in particular, emphasised this point stating that:

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[24] Written Evidence, MH 49
[25] Written Evidence, MH 56
[26] RoP, paragraph 11, 4 May 2010
[27] Written Evidence, MH 57
[28] Ibid

"The current mental health framework has failed to address many of the significant mental health issues in Wales."[29]

31. Whilst supporting the general principles of the proposed Measure and the need for the legislation, the Local Health Boards explained the need for flexibility in the legislative framework so that services can be developed around clinical need. They stated:

> "If we are going to have a legislative framework, we need to ensure that it is flexible to allow clinicians, service users and those involved in the partnership to meet need, but not so heavily prescribed that they are constantly looking to ensure that they are not in breach of the law.
>
> "(…) If it is so heavily prescribed that we do not have flexibility, then the health service would be constantly subject to judicial review on mental health services, which I do not think is the aim of the proposed Measure."[30]

32. Despite supporting the aims of the proposed Measure, the Royal College of Psychiatrists raised concerns that the proposed Measure could increase the stigma associated with mental health. They stated:

> "Our real philosophical concern is whether this could be perceived as yet another way of setting up a barrier or a perception that mental healthcare is entirely different and for the people in that system to be so negatively perceived that they need a legal framework for their care planning. We have stigma among the general population, but let us not forget that some of the greatest stigma, unfortunately, is within health and social care organisations. You would not want the perception to be 'that's the mental health patient; they've got one of those Measure-type care plans'."[31]

33. This view was shared by Professor Peter Lepping who stated:

> "I also hope that the Assembly take into account the consequences of this measure for other medical disciplines. It would be a travesty if this measure caused increased stigma by being reserved for psychiatric patients only."[32]

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[29] Written Evidence, MH 37
[30] RoP, paragraph 25, 13 May 2010
[31] RoP, paragraph 131, 4 May 2010
[32] Written Evidence, MH 10

Evidence from the Minister

34. When asked whether there was a need for the legislation, the Minister stated:

> "We must recognise that the existing mental health legislation, the *Mental Health Act 1983*, deals predominantly with matters of compulsory detention and treatment. There is no law to make specific provision for early detection and treatment of mental health problems before they reach a point at which compulsory treatment or detention is required. We have seen a real need emerging from the sector and mental health charities for different services in this regard."[33]

35. The Minister went on to explain:

> "I have the national service framework targets and policy implementation guidance to help me in this area. However, looking at this more widely, I also have powers available to me, as a Welsh Minister, to insist that Local Health Boards provide these services. However, I think that the proposed Measure would be better at achieving those aims than if I were to give directions. We also need to recognise that creating specific mental health legislation for Wales has wide-ranging support among the users and campaigning organisations. It is key for us, as the National Assembly for Wales, to welcome this. We have the support of mental health professions and service providers. I think that it is important that I go for a proposed Measure, because it would be more satisfactory than any directions that I can give, as I do usually."[34]

36. In further evidence to the Committee, the Minister explained that:

> "…much of the proposed Measure is aimed at ensuring that interventions are available at much earlier points for individuals, to reduce the impacts of mental illness as much as possible and to aid recovery wherever possible. So, that aim has been central to the development of the proposed Measure. Early intervention is key and reducing the impact of mental

[33] RoP, paragraph 85, 29 April 2010
[34] RoP, paragraph 86, 29 April 2010

illness will continue to be central as we develop the guidance in this area."[35]

Our View

37. **We note that the majority of witnesses are in favour of the principles of and need for the proposed Measure. The Minister aims to provide parity of services for those with mental health problems across Wales, and to provide a legislative framework for earlier intervention.**

38. **We acknowledge the evidence provided in support of the proposed Measure's emphasis on joint working and enhanced primary care. We too support this approach.**

39. **We note the strength of evidence that there are still gaps in service provision despite the existing policy framework, and agree that the proposed Measure can help improve this. .**

40. **Based on the majority of the views we have received, we support the general principles of the proposed Measure and the need for legislation, to guarantee earlier intervention for those with mental health problems, and to deliver effective, consistent mental health services in Wales.**

41. We have commented in detail on specific sections of the proposed Measure. Our views on specific sections are set out in Section 5 of this report.

[35] RoP, paragraph 12, 27 May 2010

4. Themes

42. Several crosscutting themes emerged during our scrutiny of the proposed Measure. We have set out our views on these key themes at the outset, so that our recommendations are clear, and to indicate how our conclusions and recommendations will impact on detailed sections of the proposed Measure.

43. It should be noted that the conclusions and recommendations for these themes are not cross referenced within the detailed discussion in subsequent parts of this report.

44. **Should the Minister accept our recommendations relating to the scope of the proposed Measure, it is our expectation that the Minister will bring forward consequential amendments at the next stage to amend the relevant Sections of the proposed Measure accordingly.**

Scope of the proposed Measure: Age

Background

45. The provisions contained in Parts 1 to 3 of the proposed Measure apply only to adults.

46. The Explanatory Memorandum explains that in relation to local primary mental health support services (Part 1) "services are aimed at individuals aged 18 or over."[36]

47. For Part 2, the coordination of and care planning for secondary mental health service users, the Explanatory Memorandum states that the proposed Measure will establish duties for "a care and treatment plan for all service users aged 18 or over."[37]

48. The right to self re-referral and assessments of former users of secondary mental health services, detailed in Part 3 of the proposed Measure, applies to "eligible persons … aged 18 or over."[38]

49. However, Part 4, Mental Health Advocacy, currently extends to "hospital inpatients of all ages that are being assessed or given

[36] Explanatory Memorandum, paragraph 26
[37] Explanatory Memorandum, paragraph 32
[38] Explanatory Memorandum, paragraph 41

treatment for a mental disorder."[39] The provisions of Part 4, therefore, apply to those under the age of 18.

50. The legislative competence conferred as a result of *the National Assembly for Wales (Legislative Competence) (Health and Health Services and Social Welfare) Order 2010* (the LCO), enables the Assembly to legislate on the assessment of mental health and treatment of mental disorder in respect of individuals of **all ages**.

Evidence from witnesses

51. The majority of witnesses who provided us with evidence expressed concerns that Parts 1 to 3 do not extend to children and young people. The evidence is outlined below.

Services

52. Jonathan Morgan AM[40] explained why legislative competence was sought in respect of all ages.

> "The LCO was drafted to ignore a person's age and focus on the individual. The EM accompanying the Order stated at paragraph 7.14 that competence will allow such duties to be imposed in respect of all individuals, and this was re-emphasised by the Minister in the evidence she gave to the Proposed Provision of Mental Health Services LCO Committee.[41] Therefore with those pre-requisites came an expectation that any subsequent Measure would not be age specific."[42]

53. Jonathan Morgan AM, also told us that he was disappointed that the proposed Measure is not as ambitious as the LCO had anticipated:

> "It is vital that the proposed Measure is as seamless and comprehensive as possible. We need to provide a service for individuals. This should not be about trying to cherry-pick people, either because of their age, their condition, or perhaps the setting within which they receive services."[43]

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[39] Explanatory Memorandum, paragraph 58
[40] Member in Charge of the *National Assembly for Wales (Legislative Competence) (Health and Health Services and Social Welfare) Order 2010*, which gave the National Assembly legislative competence in this area
[41] RoP, paragraph 56, 6 May 2008, *Proposed Provision of Mental Health Services LCO* Committee
[42] Written Evidence, MH 12
[43] ROP, paragraph 12, 29 April 2010

Transition from child to adult services

54. Witnesses from mental health charities called for consistent services, to protect those moving from children's to adult mental health services. Hafal, for example, told us that there was a:

> "… need to consider that children should not be coming out of children's services, having to go through a referral process again (…) There needs to be consistency for all ages through the process."[44]

55. Evidence from the Welsh Branch of the British Psychological Society explained that there are many cases of individuals between the ages of 16 and 18 who are unable to access support:

> "Child and Adolescent Mental Health Services provide services (only for those with discrete psychiatric diagnoses) for those up to age 16, leaving those from 16 – 18yrs without robust services at a primary care level. This runs a risk of deterioration in their mental health and social functioning, with potential future costs to the NHS and other agencies in Wales."[45]

56. This view was echoed by Mind Cymru, who told us that these individuals are often extremely vulnerable, and a lack of services can have a significant impact on their lives:

> "These children are most at risk of falling out of the education system at around 15, and they fall into a gap because they are too young for adult services and are not in employment, education or training, and so they do not fall under Child and Adolescent Mental Health Services. They fall into this big gap in the middle, and that can have a lasting impact on the person and their family."[46]

Mental Health in adolescence

57. A number of witnesses explained that mental health problems often become apparent during adolescence. Hafal told us:

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[44] RoP, paragraph 14, 22 April 2010
[45] Written Evidence, MH 45
[46] RoP, paragraph 67, 22 April 2010

> "When we think about mental health, we should be considering people from the ages of five to 50. Papers have been published that say that you need to be age blind. We have service users under the age of 18 who are married with children."[47]

58. The Royal College of Psychiatrists agreed that the proposed Measure "will have to cover children and young adults,"[48] because of the way in which mental disorders can often start affecting people during adolescence:

> "50 per cent of mental disorders will have started by the time a person is aged 16, and 75 per cent by the age of 25. The early phases of certain serious mental illnesses also begin at that age, including anorexia and other eating disorders, early onset schizophrenia and bipolar disorder. However, equally important are the developmental disorders such as attention deficit hyperactivity disorder and autism."[49]

Terminology and definitions

59. The Association of Directors of Social Services expressed caution about the difference in the 'culture' of child and adult services, and the need for further work to understand how legislation should underpin children's mental health services. The Association of Directors of Social Services also told us about the diversity of services available to children and young people, many of which are not available to adults:

> "In some ways, what we find is that services for children and young people offer more access to what we could call 'talking therapies'. In a sense, they may well be in advance of a lot of adult services in that respect. So, what one would want to do is preserve the really good things that go on in children's services rather than simply assuming that putting them all together will make everything okay, when, actually, I am not sure that that is the case."[50]

60. A number of witnesses raised concerns about the different terminology used to define mental health services for adults (primary

[47] RoP, paragraph14, 22 April 2010
[48] RoP, Paragraph 93, 4 May 2010
[49] Ibid
[50] RoP, paragraph 203, 13 May 2010

and secondary) and children (tiers),[51] and felt that legislating for this could be difficult. We asked a number of witnesses whether this was likely to act as a barrier to extending the scope of the proposed Measure to children and young people. Representatives from children and young people's charities[52] offered a solution to this potential problem, to illustrate their view that this was not the case, and that it was simply a matter of adopting different 'language':

> "In England … 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."[53]

61. The Children's Commissioner for Wales agreed that different terminology was not a "sufficient reason not to include people under 18."[54]

Separate legislation for children and young people

62. Whilst many witnesses believed that the scope of the proposed Measure should be extended to cover all ages, others believed that there was merit in evaluating the impact and success of the proposed Measure on adult mental health services first.

63. Representatives of the Local Health Boards, for example, suggested that a second Measure to encompass the needs of children and young people could be introduced at a later date. They believed that there was a comprehensive legislative framework for children already:

> "Our advice would be that, because we have the comprehensive *Children Act 2004*, we should look at adults. If the legislation works, I would look to extend it to cover children. However, I would start with adults. We have a much more comprehensive

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[51] Information on the CAMHS Tiers can be found at the following link http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/mentalhealthissues/camhs/fourtierstrategicframework/fourtierstrategicframework/

[52] Children's NGO Policy Officers Mental Health Sub Group, represented by NSPCC Cymru, Barnardo's Cymru and Tros Gynnal

[53] RoP, paragraph 144, 20 May 2010

[54] RoP, paragraph 58, 20 May 2010

framework around children and there are various measures for seeing children through early diagnosis and assessment through the child and adolescent mental health services and what we do on safeguarding children. Therefore, I would prefer to take it on in stages, rather than trying to deal with the services from cradle to grave in one piece of legislation."[55]

64. However, this view was not shared by the majority of witnesses. The Children's Commissioner for Wales, for example, explained:

> "I cannot really see any rationale for their exclusion (…) 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."[56]

65. Jonathan Morgan AM agreed, reiterating the need to address the problems faced by those making the transition from child to adult services.

> "One of the difficulties of introducing a separate piece of legislation for those under the age of 18 is the potential for those people to fall between the gaps of any framework for the under 18s compared with a framework provided for the over 18s. So, it would be far better for this piece of legislation to be amended in a way that takes into account those who are under the age of 18."[57]

Timing of the proposed Measure

66. Representatives from children and young people's charities informed us that the time was right to legislate for mental health services for those under 18:

> "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

[55] RoP, paragraph 34, 13 May 2010
[56] RoP, paragraph 58, 20 May 2010
[57] RoP, paragraph 23, 29 April 2010

people a far more coherent and directed mental health service."[58]

67. The Children's Commissioner for Wales agreed with this view, highlighting the policy failures which could be addressed by legislation:

> "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."[59]

Evidence from the Minister

68. In explaining why Parts 1 – 3 of the proposed Measure apply only to adults, the Minister stated:

> "We looked at it from the point of view that we already have primary care and care planning services for under-18s within [Child and Adolescent Mental Health Services] … I look forward to seeing what emerges from your evidence-gathering sessions, to see whether I should look at seamless proposals with regards to under-18s as well. I have an open mind on this matter, and I look forward to receiving the evidence gathered by the committee."[60]

69. The Minister also acknowledged "the very strong evidence that the Committee has received" in respect of extending the provisions of the proposed Measure to include children and young people.[61]

70. We sought the Minister's view on whether or not it might be appropriate to introduce a separate Measure dealing specifically with children and young people. The Minister stated:

> "I do not see an appetite out there for a separate Measure in respect of children and young people. However, I will be guided by the Committee's report in this regard."[62]

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[58] RoP, paragraph 141, 20 May 2010
[59] RoP, paragraph 50, 20 May 2010
[60] RoP, paragraph 93, 29 April 2010
[61] RoP, paragraph 19, 27 May 2010

71. In response to concerns raised in relation to the compatibility of terminology between children and adult mental health services, the Minister assured us that she did "not think that would be a problem at all."[63]

Our view

72. We have heard overwhelming evidence calling for extension of the scope of Parts 1 – 3 of the proposed Measure, to include children and young people.

73. Witnesses have told us that at present many young people are unable to access services during their transition from child to adult services**.** There is a risk that by not extending the scope of the proposed Measure to those under 18 would exacerbate this problem. **We consider that legislating for the provision of mental health services for children and young people will help to improve service provision, and the assessment and treatment of young people with mental health problems in Wales.**

74. **We note the evidence received about the timeliness of legislating for children's mental health services. We recommend the scope of Parts 1 to 3 of this proposed Measure should be extended to include children and young people. This should not be left to a separate Measure at a later date.**

75. **We recommend that the Minister explores ways of extending the scope of the proposed Measure in order to include children and young people, and we seek assurance at the earliest opportunity that this work is progressing**.

76. In light of the above, **we recommend that the Minister brings forward appropriate amendments to extend the scope of the proposed Measure**.

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[62] RoP, paragraph 19, 27 May 2010
[63] RoP, paragraph 21, 27 May 2010

Timescales

Background

77. The proposed Measure contains a number of provisions requiring local mental health partners to perform specific duties, for example in relation to the assessment of patients, or the completion of a care plan. The proposed Measure, as drafted, contains no timescales within which these duties should be undertaken.

Evidence from witnesses

78. We received written evidence from a number of witnesses who were concerned that "a number of the duties within the proposed Measure do not have timescales attached to them."[64] The majority of these suggested that timescales should be included in relation to:

- the assessments undertaken by local primary mental health support services in Part 1; and
- between qualifying as a patient and the completion of a care plan in Part 2.

79. There was a difference of views regarding the most appropriate way of including these timescales, with some believing they should be set out on the face of the proposed Measure, whilst other thought they would be best dealt with by regulations.

80. Hafal suggested that 30 days should be the maximum period between a referral by a GP for assessment and the making of the assessment in Part 1 of the proposed Measure.[65]

81. In relation to Part 2 of the proposed Measure, Hafal suggested that the maximum period between qualifying as a patient and the completion of a care plan should be 60 days.[66] Hafal explained:

> "We feel that a maximum deadline would really benefit people because it is such a crucial time. If you get an early intervention –a referral – very quickly, the outcomes are far more positive. We have heard of people who have presented to GPs with a

[64] Written Evidence, MH 31
[65] Written Evidence, MH 6
[66] Ibid

serious mental illness being referred and sometimes it is eight months, maybe longer, before they are seen."[67]

82. Hafal also suggested that the timescales should be included on the face of the proposed Measure, adding:

> "If it is not and is in regulations, it will be open to different interpretations by different professionals and we will still probably get delays."[68]

83. Mind Cymru raised similar concerns. Responding to Hafal's suggested timescales of 30 days in Part 1 and 60 days in Part 2, they stated:

> "Putting a target to get a patient seen by the local primary mental health support services within 30 days and then getting a care plan designed within perhaps 60 days may be quite tricky if it is not on the face of the proposed Measure. However, it should certainly be there somewhere, whether that is on the face of the proposed Measure, in regulation, guidance or in the annual operating framework."[69]

84. This was also the view of Age Cymru whose response supported the inclusion of clear timescales, attached to duties, to ensure patients receive timely assessments and treatment.[70]

85. Cymorth Cymru believed that providing assessment within a:

> "… set period of time … to achieve the objective of earlier intervention, assessment and access needs to happen within a relatively short period of time."[71]

86. Professor Phil Fennell told us he believed the lack of timescales could lead to a lack of clarity for service users:

> "… a lot is left to the scheme that is agreed by the partners and to regulations. So, for example, if I have been discharged from the secondary mental health service and I want an assessment, I would have to look in regulations to see during what period

[67] RoP, paragraph 24, 22 April 2010
[68] RoP, paragraph 34, 22 April 2010
[69] RoP, paragraph 44, 22 April 2010
[70] Written Evidence, MH 61
[71] Written Evidence, MH 57

> after my discharge I would be entitled to that assessment … There is no time limit on the assessments."[72]

87. The Chartered Society of Physiotherapy drew attention to the role targets and timescales might play in evaluating the impact of the proposed Measure:

> "The National Assembly and partners will scrutinise the implementation, but it must be made clear for service providers, service users and their families what the timescales for achievement are for delivery post implementation – and what the consequences are/will be for failure to meet obligations."[73]

88. Many health professionals, however, did not believe timescales proposed by Hafal in relation to Parts 1 and 2 were necessary. The Royal College of Psychiatrists stated:

> "In principle, I would totally agree with getting access to services as quickly as possible. I would urge caution, however, because that would bring the targets forward significantly as compared with the targets that the services are working towards currently."[74]

89. The British Medical Association also urged caution. They explained timescales could result in priority being given to mental health services, resulting in resources being taken from untargeted areas.[75] Whilst agreeing in principle, the Association of Directors of Social Services disagreed with the need for timescales in relation to Parts 1 and 2 of the proposed Measure. They were concerned that "timescales should not interfere with quality at all."[76]

90. Representatives of Local Health Boards also disagreed with the need for timescales, reiterating the view that this could have a detrimental effect on the delivery of services and could have significant consequences in instances of failure:

> "The issue is that if you specify a time and we do not meet that, we would be in breach of the law and therefore, again, subject to whatever the penalties would be (…) if somebody is sick and

[72] RoP, paragraph 17, 4 May 2010
[73] Written Evidence, MH 57
[74] RoP, paragraph 87, 4 May 2010
[75] RoP, paragraph 89, 4 May 2010
[76] RoP, paragraph 185, 13 May 2010

unable to attend, and you cannot provide cover for them on that day, that could mean that you fall outside the maximum period of 30 days. What would the consequences of that be for the individual, the service and the NHS? I think that we should use guidance, performance management and peer pressure, and I think that we should use the seven local health boards to do that. However, by specifying, you would be prescribing very tightly and I would avoid that in a legislative framework such as this and try to achieve it in a different way."[77]

Evidence from the Minister

91. In considering the evidence we received on timescales, the Minister explained that, whilst she was willing to recognise the concerns expressed by witnesses, she believed that the speed of decisions on the care and treatment of patients should be based on clinical need:

> "Assessments should always be based on clinical need, not on legally based time limits, and that is an important matter that we have recognised within the proposed Measure. In the NHS, we have always tried to prioritise according to clinical need, because that ensures basic fairness and equity for all users of the NHS. I attach importance to clinical need in the proposed Measure, not legally based time limits. That could be quite perverse in a way, because people marching towards time limits are not looking at the clinical needs of the patients, which is why the proposed Measure is focused in the way that it is."[78]

Our view

92. We received different views regarding the need for certain duties introduced by the proposed Measure to be undertaken within a set time. We note the views of those who emphasised the need to ensure patients do not experience unnecessary delays in receiving treatment, assessment or care from service providers. We believe that timely access to services will be a key factor in ensuring the success of the proposed Measure.

[77] RoP, paragraph 31, 13 May 2010
[78] RoP, paragraph 124, 29 April 2010

93. However, **we agree with a number of health professionals and service providers regarding the risk of unintended consequences that might arise if prescriptive timescales were included in the proposed Measure. We consider that the prioritisation of services should be based on the clinical needs of the patient, and not dictated by targets**.

94. **We note the Minister's evidence regarding the need for and speed of any assessment, treatment, care and service provision to be based on clinical need. We also welcome the Minister's assurances that the proposed Measure is focused in a way to ensure that services are prioritised, based on clinical need. We therefore do not consider that it would be appropriate to include specific timescales on the face of the proposed Measure.**

Prisoners

Background

95. The proposed Measure aims to provide a legislative framework for mental health services for adults in Wales. However, it is unclear how the proposed Measure will relate to prisoners.

96. Responsibility for the prison healthcare service was transferred from the prison service to the NHS under Section 23 of the *NHS Reform and Healthcare Professions Act 2006*. Nevertheless, there remains a combination of devolved and non-devolved responsibility with regards to healthcare for prisoners. Local Health Boards are responsible for commissioning healthcare for public sector prisons in their areas, whilst the prison governor remains responsible for the overall health and welfare of prisoners and ensuring health services are developed within the security framework of the prison.

97. The prison service, in conjunction with the NHS, must ensure that prisoners have access to health services that are broadly equivalent to the services the general public receive from the NHS.

98. A written response from the National Offender Management Service confirmed the arrangements for the provision of primary mental health services for those in prison:

> "As the provision of healthcare services is a devolved matter, the planning and provision of mental health services is undertaken by the relevant Local Health Board, in partnership with the prison establishments in its area … for prisons … this would comprise both GP and registered mental health nurse input; with support from other relevant disciplines within the establishment."[79]

Evidence from Witnesses

99. We received evidence that the proposed Measure and accompanying Explanatory Memorandum, as drafted, are insufficiently clear in relation to the provision of mental health services for prisoners and offenders. The Royal College of Psychiatrists told us:

[79] Written Evidence, MH 64

> "There are elements that have not been acknowledged in the explanatory memorandum that are key providers of mental health services. I suspect that it is because they are outside the legal competence of the National Assembly for Wales. The most notable is the National Offender Management Service, which provides mental health services for people on probation and in the prison service."[80]

100. Witnesses also raised a number of issues in relation to specific Sections of the proposed Measure, which are summarised below:

- there is a lack of clarity regarding the way the primary mental health schemes would need to reflect the provision of services to prisoners;[81]
- offenders and other people in contact with the criminal justice system have a range of complex needs which can include mental health needs. In some instances the "missing ingredients are early intervention and access to primary mental health services;[82]
- many primary mental health services are only accessible via a GP. However, many offenders are not registered with a GP, or their health needs only become available when they are in contact with the criminal justice system. Evidence from the National Association for the Care and Resettlement of Offenders (NACRO) called for primary mental health services to be "available to those held in prisons either on remand or under sentence … currently many prisoners only have access to secondary mental health care."[83]

Evidence from the Minister

101. We asked the Minister to respond to comments about the lack of clarity within the proposed Measure regarding prisoners. The Minister acknowledged these concerns and made specific reference to the confusion regarding women prisoners, and the ability of offenders from Wales held in England to qualify for services under Part 3 of the

[80] RoP, paragraph 77, 4 May 2010
[81] Ibid
[82] Written Evidence, MH 54
[83] Ibid

proposed Measure. [84] An official accompanying the Minister confirmed:

> " … the schemes that have to be set up under Part 1 of the proposed Measure will need to ensure that they provide local primary and mental health support services to prisoners in Wales. The present position is that Local Health Boards provide these services and that they have been directed to view prisoners in public prisons in Wales being ordinarily resident at the prison address."[85]

102. The Minister assured us that she would clarify this issue. [86]

103. We also sought clarification from the Minister with regards to the eligibility of prisoners for advocacy services under Section 130I of the *Mental Health Act 1983* (inserted by Section 33 of the proposed Measure). The Minister explained:

> "The current advocacy scheme under the 1983 Act is available for persons transferred to hospital under sections 40, 47 and 48. The proposed Measure maintains that position, which is important, and there is no question of prisoners transferring from Wales to a hospital in England ceasing to be eligible for those services under the 1983 Act."[87]

104. Explaining this issue further, the Minister's official told us:

> "When the proposed Measure comes into effect, Section 130C(2)a would only apply in England, but the new section 130I(2)(a) would apply to Wales, giving you the same groups of people in view of sections 47 and 48, so that transferred prisoners are still eligible for IMHS."[88]

Our view

105. **We are concerned at the lack of clarity relating to prisoners and consider that this could lead to difficulties for service providers in planning for the needs of patients. We note the Minister's assurances that she will address this issue and recommend that the Minister ensures that the proposed Measure**

[84] There are currently no prison places in Wales for women
[85] RoP, paragraph 53, 27 May 2010
[86] Ibid Para 78
[87] Ibid
[88] Ibid Para 79

and accompanying Explanatory Memorandum clarifies the provisions contained in Parts 1 to 4 of the proposed Measure in respect of prisoners. This also applies to any explanatory information that will accompany the Measure as passed.

106. We wish to highlight the following areas of particular concern that require clarification within the proposed Measure:

- Provision of primary mental health services for prisoners and inclusion within the schemes in Part 1;
- Eligibility of prisoners for the provisions within Parts 1to 3;
- Prisoners usually resident in Wales who are detained in England and their eligibility under the proposed Measure. This is particularly relevant to women prisoners, given that currently there is no women's prison in Wales;
- Prisoners usually resident in England who are detained in Wales;
- Whether the provisions in relation to Independent Mental Health Advocates under Part 4 will still be available to a Welsh prisoner transferred to a facility in England, or whether they would only be entitled to the provisions under the scheme operating in England in such circumstances;
- Eligibility of prisoners held in private sector facilities in Wales for the provisions of the proposed Measure.

Resources

Background

107. The Regulatory Impact Assessment provides an estimate of the financial resources needed to meet the requirements of the proposed Measure. The Explanatory Memorandum explains that the Welsh government intends to stage the implementation of the proposed Measure over a period of three years.[89]

108. A summary of the headline figures is provided below:

- the cost of the changes to primary mental health services: £3.0 million per year recurring costs and £0.5 million leadership and capacity development costs for each of the first two years;
- coordination of, and care planning for, secondary mental health services: no additional funding beyond an initial allocation of £0.75 million;
- assessment of former users of secondary mental health services: no significant extra costs;
- mental health advocacy for compulsory patients: an additional £0.5 million annually and additional one-off funding of £0.25 million to Local Health Boards to allow service development;
- mental health advocacy for informal patients: an additional £1 million of recurring funding and an additional one-off £0.25 million for preparatory work by Local Health Boards.[90]

109. Once steady state is reached (year 3) it is believed that the ongoing cost of the proposed Measure will be approximately £5 million per year.[91]

110. The Explanatory Memorandum includes a summary of the Welsh government's implementation plans which gives details of the guidance and support that will be issued to service providers to underpin the proposed Measure's implementation. The Explanatory

[89] Explanatory Memorandum, Regulatory Impact Assessment
[90] Ibid
[91] Ibid

Memorandum also highlights the need for skills development within health and social services, specifically referring to capacity building, training, advice and support.[92]

Evidence from Witnesses: financial implications

111. Most respondents believed that the proposed Measure will create significant additional costs for providers, for example in relation to extra staffing costs and the cost of training staff. Evidence from Conwy County Borough Council, highlighted there would be:

> "… significant financial pressures in implementing the measures to the full. Additional staffing will be required to undertake the more detailed work with individuals, and to pick up increased demand."[93]

112. Witnesses highlighted the enhanced services within primary care as one area that would need additional funding for staff development.[94] The increased statutory provision of advocacy services was another area that many witnesses believed would require additional resources, particularly in view of the costs of providing services to people detained on short-term sections.[95]

113. Whilst welcoming the proposed extra funding identified in the Regulatory Impact Assessment, the majority of those who commented on the financial aspects of the proposed Measure expressed concerns about the accuracy of the estimated costs.[96]

114. Despite this, many respondents told us that, if successfully implemented, the proposed Measure could save money in the longer term by reducing the number of people referred to secondary services, although there may be shorter term additional costs.[97]

115. Witnesses also commented on the financial pressures that public service providers will face in the coming years, with many questioning whether, against this backdrop, making statutory provision for mental health services would result in resources being diverted from non-statutory areas. However, the Association of Social Services Directors

[92] Explanatory Memorandum, Consultation
[93] Written Evidence, MH 39
[94] Written Evidence, MH 59
[95] Written Evidence MH 10, MH 19, MH 15
[96] Written Evidence MH 22, MH 47, MH 53, MH 59
[97] Written Evidence MH 40, MH 54, MH 57, MH 61, MH 41, MH 49

believed that the solution was for service providers to work differently and that the proposed Measure provides an opportunity to do this:

> "We are certain that we will not get a massive amount of additional resources over the next three to five years. So, the answer to the increasing demand is to work differently. The advantage of the proposed Measure is that if the whole sense of shared responsibility is reinforced, it requires the NHS and local government to work together to avoid the duplication that exists at times [and] make the best use of the resources that we have."[98]

Evidence from Witnesses: skills and capacity

116. Concern was evident from a large number of witnesses regarding the capacity to provide enhanced service provision within primary and secondary care in the absence of substantial additional resources. Witnesses also believed there was a need for skills to be developed and that there was a need to recognise that this would not be resolved in a short space of time. For example, Cymorth Cymru's submission stated:

> "The primary barrier to effective implementation is resources. It is crucial that enough well trained staff are appointed for the effective fulfilment of the proposals outlined within the Measure."[99]

117. Some witnesses highlighted specific problems with the capacity and expertise of GPs in relation to mental health in primary care,[100] with many referring to need to carefully manage the "increase in workload, specialist skills and physical space requirements."[101]

118. Staff training and the availability of suitably qualified staff to meet the new requirements for assessment and advocacy were generally perceived to be potential problems.[102] Many commented on the potential problems around recruitment and capacity building, and

[98] RoP paragraph 237, 13 May 2010
[99] Written Evidence, MH 31
[100] Written Evidence, MH 29
[101] Written Evidence, MH 42
[102] Written Evidence, MH 31

the need for staff appointed to be of a sufficient grade to undertake the work.[103]

Our view

119. Successful implementation of the proposed Measure and achievement of the stated aims will require time and resources. We note the specific concerns of witnesses with regards to skills and capacity, and the need for the Welsh government to ensure training programmes are in place. We recognise that time will be needed to develop capacity and expertise.

120. We also note the concerns many witnesses have raised regarding the impact of increased demand for services resulting from the proposed Measure. However, we believe that, as outlined in evidence to our Committee, the requirements for partnership and accountability within the proposed Measure provide opportunities for service providers to eliminate duplication and develop new ways of delivering services together.

121. **The Finance Committee will consider the financial implications of the proposed Measure in detail. However, we wish to highlight the need for adequate resources to be made available to develop the skills and capacity required to successfully implement the proposed Measure.**

[103] Written Evidence, MH 40, MH 41, MH 42

5. Comments on specific sections of the proposed Measure

122. The following provides a detailed discussion of specific Sections of the proposed Measure, and outlines our views and recommendations. We did not receive any evidence on the contents of Parts 5 and 6 therefore our comments are limited to Parts 1 to 4.

Part 1: Overview

123. Part 1 of the proposed Measure places a statutory duty on Local Health Boards and Local Authorities to work in partnership to deliver local primary mental health support services throughout Wales.

124. The aim is to secure earlier intervention in a patient's care by providing enhanced support and treatment at primary care level for those with mental health problems.

Evidence from Witnesses

125. The majority of witnesses recognised the need for, and value of, earlier intervention through enhanced service provision in primary mental health services, delivered through assessments and information, including for older people and those with dementia.[104]

126. Many witnesses welcomed the proposals for partnership working. Evidence from the Abertawe Bro Morgannwg University Health Board, for example, highlighted the fact that, in requiring that services be delivered jointly by both Local Authorities and Health Boards, the proposed Measure recognises the need for "a holistic service that encompasses social, psychological, medical, physical and emotional approaches" when addressing the needs of those with mental health problems.[105]

127. Many witnesses believed that the proposed Measure could secure more equitable primary mental health service provision across Wales. Evidence from Merthyr Tydfil Country Borough Council stated:

[104] Written Evidence, MH 61
[105] Written Evidence, MH 60

> "The proposed Measure will provide a regulatory requirement in relation to the development of local primary mental health services. This should ensure that these services are developed for all areas within Wales rather than reliance on local practice."[106]

128. Witnesses also told us that earlier intervention would reduce pressure on secondary care, with some suggesting that many of the people who would benefit from the provisions of the proposed Measure might not progress to secondary care. The Cardiff and Vale University Health Board told us that:

> "Access to high quality, timely local mental health support services is key to reducing referrals to secondary care and avoiding inappropriate hospital admissions. These services also reduce the possibility of re-admission, and help address the problem of delayed transfers of care."[107]

Our view

129. **The aim of securing earlier intervention for people with mental health problems was welcomed by most of those who provided us with evidence. We note that witnesses supported the partnership approach to the provision of primary mental health services. We consider that partnership working is necessary to secure a holistic approach to patients' recovery, and that making statutory provision for earlier intervention through enhanced support at primary care level could help prevent further deterioration in patients' mental well-being. Overall, therefore, we are content with the general principles of Part 1 and its aims**.

[106] Written Evidence, MH 52
[107] Written Evidence, MH 42

Section 1: Meaning of 'local mental health partners'

Background

130. Section 1 of the proposed Measure defines the 'local mental health partners' required to develop primary mental health schemes for their area, and deliver the services contained within the schemes. For the purposes of the proposed Measure, the partners are defined as the Local Health Boards established under Section 11 of the *National Health Service (Wales) Act 2006,* and Local Authorities.

131. The Explanatory Memorandum explains that, given that Local Health Board areas are wider than local authority areas, Local Health Boards will be local mental health partners in multiple areas, but with a different partner in each local authority area. The proposed Measure allows for regional approaches, which will enable groups of local authorities to work together within a Local Health Board area. This is provided for by Section 42.

Evidence from Witnesses

132. In general, witnesses were content with the definition of local mental health partners contained in Section 1. Representatives from Gofal Cymru believed that the inclusion of both Local Authorities and Local Health Boards was to be welcomed, because "[it] helps us to move away from this idea of it just being a medical issue."[108]

133. Jonathan Morgan AM agreed, stating:

> "It is right for the Assembly Government to stipulate that we anticipate that local authorities and local health boards will be identified jointly as the partners. This is the clearest indication from the Assembly Government that it wants organisations to work together in securing the services that people need in order to secure an assessment and to provide a package of care and treatment to enable individuals to live with the effects of mental ill health."[109]

134. However, we heard from the Association of Social Services Directors that the proposed Measure, as drafted, does not:

[108] RoP, paragraph 129, 22 April 2010
[109] RoP paragraph 14, 29 April 2010

> "… recognise that the health service and local government commission a considerable number of services from other bodies. The legislation needs to make it clear that those parties would be affected by the legislation, in the sense that they carry out the statutory responsibilities of both the health service and local government."[110]

Evidence from the Minister

135. The Explanatory Memorandum states:

> "By requiring that local primary mental health support services are established, the proposed Measure will place statutory obligations on health and social care bodies which are consistent with current mental health policy."[111]

Our view

136. We note the comments of the Association of Directors of Social Services regarding the need to recognise that the health service and local government commission services from other bodies, and that many of these provide mental health services. However, we also note that the majority of witnesses told us that **Section 1 provides a clear definition of 'local mental health partners', and that the inclusion of both the Local Health Boards and Local Authorities is welcomed to ensure joint delivery of and accountability for local primary mental health services. Therefore, we are content with the definition contained in Section 1.**

137. **We also welcome the provisions within Section 42 that will enable mental health partners to undertake regional approaches within a relevant local health board's area.**

Section 2: Joint schemes for the provision of local primary mental health support services

Background

138. Section 2 requires the local mental health partners to develop a scheme for their area for the provision of primary mental health services. The schemes will set out the arrangements for the services,

[110] RoP, Paragraph 181, 13 May 2010
[111] Explanatory Memorandum, Paragraph 27

including the type and extent of the local primary mental health treatment that will be made available, and will identify which partner is responsible for delivering different aspects of the service.

Evidence from Witnesses

139. Some witnesses were concerned at the lack of detail in Section 2 regarding the types of services that partners will be required to deliver under their primary mental health schemes. Furthermore, a number of witnesses believed Section 2 should be more prescriptive, to guarantee that certain types of services would be provided, and that this level of detail should be on the face of the proposed Measure or in Regulations.[112]

140. Gofal Cymru believed there was a risk that the proposed Measure, without prescriptive details in Section 2, could result in a continued variation in services across Wales, stating:

> "We were quite shocked that there is so little in the proposed Measure that will dictate what [the schemes] should contain. So much is left to the discretion of the local health boards and local authorities that, as a result, you could see and increase in the postcode lottery … rather than a decrease."[113]

141. Professor Phil Fennell agreed, but expressed concern that whilst regulations would allow for some prescription for the contents of the schemes, "quite a lot remains a mystery, and quite a lot depends on what is in the local schemes, or in the regulations that are made later."[114]

142. The Betsi Cadwaladr University Health Board were concerned that schemes would be negatively influenced by resources and capacity:

> "The risk is that in agreeing a local mental health scheme, the mental health partners will have to consider the services that they can guarantee to provide. Although we hope to improve these services, and we are determined to do so, the risk may be that, because of the legal duty issue, mental health partners have to consider the minimum that can be guaranteed. As a

[112] Written Evidence, MH 5
[113] RoP, paragraph 143, 22 April 2010
[114] RoP, paragraph 33, 4 May 2010

result, I have some concerns that the local scheme will be less ambitious than it otherwise might be."[115]

143. The Association of Directors of Social Services told us that agreeing and delivering schemes could be difficult for the partners, because of the variation in the criteria used to assess eligibility for services by local authorities and local primary health services. However, they gave examples of social services providers working within GP practices, demonstrating that such cooperation can provide positive outcomes for patients. Specifically, the Association of Directors of Social Services stated:

> "The argument that we put is for shared responsibility (…) We believe that such shared responsibility is much better than, if you like, dumping on each other, which is often what happens because many local authorities set their eligibility criteria quite high. It is unhelpful when we tell health colleagues, 'sorry, but that that person does not meet our criteria."[116]

Evidence from the Minister

144. In commenting on the views of those who called for Section 2 to be more prescriptive, the Minister explained that she believed flexibility was needed so that schemes could respond to local needs. However, to guarantee standards across Wales, the Minister told us that a National Service Model would be developed, and that this would set out what each of the schemes must deliver. The Minister stated:

> "The key is that we want flexibility not variability (…) I would not necessarily want to put treatment and delivery on the face of the proposed Measure."[117]

145. An official accompanying the Minister went on to explain:

> "That level of detail is more appropriately based on a clinical judgment, and that needs to come out of the National Service Model."[118]

146. When we questioned the Minister on this issue a second time, she maintained the view that flexibility is necessary, and disagreed

[115] RoP, paragraph 21, 13 May 2010
[116] RoP, Paragraph 229,13 May 2010
[117] RoP, paragraph 100, 29 April 2010
[118] RoP, paragraph 101, 19 April 2010

with witnesses regarding the risks associated with flexibility.[119] The Minister reiterated the fact that the National Service Model would play a central role in setting out how the schemes should be developed, taking account of best practice.[120]

147. Responding to the comments made by the Association of Directors of Social Services with regards to the fact that the proposed Measure would require local authorities and Local Health Boards to work differently, and the risk that different eligibility criteria across local authority services compared with those of primary healthcare services could have a negative impact on the delivery of the schemes, the Minister stated:

> "We were very much taken by [the Association of Directors of Social Services] comments on this, which put that evidence into context … about the opportunities for working together … about shared responsibility being the foundational answer, and I believe that the proposed Measure dealt with that. My officials will develop guidance that will support the operation of Part 1of the proposed Measure."[121]

Our View

148. We note the views of witnesses regarding the need for detail on the face of the proposed Measure to guide the development of the joint schemes under Section 2. We also note concerns regarding the risk that, without such detail, the current patchy provision of primary mental health services across Wales will continue in spite of the new legislative framework.

149. The Minister has assured us that a National Service Model will be developed ,which will be flexible so that partners can respond to local need but will secure parity of services across Wales. We welcome the Minister's aims in developing the National Service Model.

150. However, we note that the references to National Service Model in the Explanatory Memorandum accompanying the proposed Measure are limited to the Regulatory Impact Assessment. **Given the importance placed upon the National Service Model, and its role in securing parity of primary mental health services across Wales, we**

[119] RoP, paragraph 42, 27 May 2010
[120] RoP, paragraph 46, 27 May 2010
[121] RoP, paragraph 68, 27 May 2010

recommend that the Explanatory Memorandum be amended to provide more information on the National Service Model, and that any explanatory guidance accompanying the Measure as passed also includes this information.

151. **We are concerned that, as a result of the variation in the criteria used to determine patient eligibility for services, local mental health partners could experience problems in delivering schemes for their areas. We therefore recommend that criteria for determining eligibility for mental health services be made explicit in guidance**.

Section 2(4) – making provision in the scheme for patients not registered with a GP

Background

152. Section 2(4) (c) allows, but does not require, the local mental health partners to make provision within their schemes for adults who are not registered patients.

Evidence from Witnesses

153. Witnesses told us that there are large groups of the population who tend not to register with a GP, and that these groups are often made up of individuals from a range of backgrounds. Some witnesses expressed concern about the risk of excluding such groups from primary mental health schemes.[122] We also heard that individuals within these groups often have significant mental health needs. The British Medical Association illustrated this point:

> "There are large population groups that tend not to register with GPs: the homeless, for example, who have an extremely high level of mental health needs; travelling populations; and, the transient population who might have to move around because of the nature of their job, and so on. Students are another example." [123]

154. Whilst recognising that these individuals patients may not be registered with a GP, the Betsi Cadwaladr University Local Health Board, told us that, in practice, any patient with mental health

[122] Written Evidence, MH22, MH55
[123] RoP, paragraph 106, 4 May 2010

problems who required medical attention was likely to receive care from a clinician because the medical profession has "a duty of care and a moral obligation to provide a service to them."[124]

155. Given that such individuals would receive care from primary care providers despite not being registered with a GP, the British Medical Association representative explained why it was important to try and plan for such demand:

> "The danger is that you may seriously underestimate the level of services that you require, and if those services are needed, you would find yourself with a significant shortage."[125]

156. We also explored whether this issue was likely to be problematic if outreach or support workers were trying to help individuals who were not registered with a GP to access services in primary care. We were told by the Betsi Cadwaladr University Local Health Board that:

> "In reality, I suspect that what might happen is that those outreach workers would communicate with the practice where the service was provided and those patients would become patients of the practice."[126]

Evidence from the Minister

157. The Minister told us that the flexibility that was contained in the proposed Measure in relation to the schemes would enable local partners to develop schemes that reflected the needs of their local populations. The Minister told us:

> "We want to capture those groups who are at risk and are hard to reach, such as the homeless. Given the levels of mental illness within those groups and the related issues, this proposed Measure should try to capture as many of those people as possible."[127]

158. However, an official accompanying the Minister stated:

> "We do not anticipate that all of the schemes will need to make provision for some of these groups … However, where an area has a homeless centre, for example, it would be appropriate for

[124] RoP, paragraph 49, 13 May 2010
[125] RoP, paragraph 106, 4 May 2010
[126] RoP, paragraph 51, 13 May 2010
[127] RoP, paragraph 119, 29 April 2010

the scheme to include provision for people in those hard-to-reach groups."[128]

159. The Minister's official also confirmed that Section 2(4) gives the schemes the flexibility to deal with local needs, but there is no requirement in the proposed Measure, as currently drafted, for services to be planned for those who are not registered with a GP.[129]

160. When questioned whether she had considered amending this provision to require schemes to include people who are not registered with GPs, the Minister confirmed that she would "look at issues around this."[130]

Our view

161. The Minister told us that flexibility is necessary to ensure that local primary mental health schemes can meet the specific needs of local populations. We have also heard that the duty of care placed upon the medical profession would mean that, in practice, those requiring attention would receive it whether or not they were registered with a GP.

162. Nevertheless, **we consider that by not requiring local primary mental health schemes to make provision for those who are not registered with a GP, there is a risk that insufficient provision will be made for vulnerable groups with high levels of mental health needs. We consider that requiring the schemes to make provision for those not registered with a GP will enable mental health partners to plan for the demands of those patients. We therefore recommend that Section 2(4) be amended to require local mental health schemes to include service provision for those who are not registered with a GP.**

Section 3: Duty to provide local primary mental health support services

Background

163. Section 3 places a duty on local mental health partners to provide primary mental health support services, in accordance with their agreed scheme.

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[128] RoP, paragraph 110, 29 April 2010
[129] RoP, paragraph 114, 29 April 2010
[130] RoP paragraph 57, 27 May 2010

164. Section 5(1)(b) places a duty on the local primary mental health partners to provide patients with the treatment identified by the assessment which might improve or prevent a deterioration in the patient's mental health.

Evidence from Witnesses

165. Representatives of Local Health Boards were concerned at the impact of this duty on their ability to provide adequate services, and the possibility of repercussions for service providers that were unable to fulfil the duty. They told us that:

> "If there were a direct legal duty on health boards to provide, for example, the primary mental health support service in every general practice building, but we were for some reason unable to comply—due to sickness, staff shortage or an inability to recruit—we would become legally culpable and open to legal challenge."[131]

166. Some witnesses felt that whilst the proposed Measure contained a duty to assess, it lacked a 'duty to treat':[132]

> "We believe that a duty to assess without a duty to treat is almost worthless (…) Without a duty to treat, particularly given the difference in the eligibility criteria between local authorities that people need to meet to access the services, people with mild to moderate symptoms could fall out of the system altogether, and that is what we want to avoid."[133]

Evidence from the Minister

167. During our meetings with the Minister, we queried whether there was a 'duty to treat' within the proposed Measure. The Minster responded as follows:

> "I am happy to confirm that Section 3 of the proposed Measure establishes a duty to treat (…) The proposed Measure does establish a duty to provide primary healthcare treatment. It is

[131] RoP, paragraph 21, 13 May 2010
[132] Written Evidence, MH-15, MH-40, MH-41, MH-51
[133] RoP, paragraph 192, 13 May 2010

not limited to admission to hospital, as some witnesses have said."[134]

168. The Minister's official went on to explain that:

> "Section 5 sets out the services that the schemes cover. Those include local primary mental health treatment at Section 5(1)(b), so the proposed Measure establishes a duty to provide treatment in accordance with the schemes established under Section 2."[135]

Our view

169. **We acknowledge the concerns of witnesses regarding the clarity of the 'duty to treat' in the proposed Measure. However, based on the assurance given by the Minister, we are content that the provisions in Section 3, along with the provisions in Section 5, establish a clear duty to treat.**

Section 5: Meaning of 'local primary mental health support services'

Background

170. Section 5 describes the services that local primary mental health partners must provide within the schemes required under Section 2. The services listed in paragraphs (a) to (e) of Section 5(1) include:

- the carrying out of primary mental health assessments;
- the provision of the treatment identified by the assessment;
- the making of referrals concerning other services which could be of relevance;
- the provision of information, advice and other assistance to primary care providers to meet the providers requirements for such services for the purpose of improving the services they provide or arrange;
- the provision of information and advice for patients and their carers about the services available to them.

[134] RoP, paragraph 60, 27 May 2010
[135] RoP, paragraph 61, 27 May 2010

171. Section 5(2) provides a definition of those services about which information and advice is to be given to patients and their carers under Section 5(1)(e). These are:

- secondary mental health services;
- community care services (which are not secondary mental health services);
- housing and welfare services.

172. Section 5(2) also provides definitions of the 'carers' and 'patients', to whom information and advice about the services available would be given under Section 5 (1)(e).

173. The definition of community care services is taken from several legislative instruments. For ease of reference, an explanation of community care services is provided below:

- Section 47 of the proposed Measure defines 'community care services' as having the same meaning as set out in Section 46 of the *NHS and Community Care Act 1990*.
- Section 46 of the 1990 Act defines community care services as services which a local authority may provide or arrange to be provided under the following provision:
    a) Part 3 of the *National Assistance Act 1948* (provision of residential accommodation (for adults) who by reason of age, illness or disability or other circumstances are in need of care and attention which is not otherwise available to them);
    b) Section 45 of the *National Health Services and Public Health Act 1968* (promotion of welfare of older people);
    c) Section 192 of and Schedule 15 to the *National Health Service (Wales) Act 2006* (care of mothers; prevention, care and after-care; and home help and laundry services); and
    d) Section 117 of the *Mental Health Act 1983* (after-care services for persons previously detained under Section 3, or admitted to hospital under Section 37, or transferred to a hospital under a transfer order).

Evidence from Witnesses: definition of 'services' under Section 5(1)(e)

174. Some witnesses felt that the list of 'services' included in Section 5(1) was unclear. A representative from Hafal was concerned that this lack of clarity could lead to Section 5 being open to "different interpretations", leading to a continued variation in the services provided across different parts of Wales.[136]

175. Representatives from Gofal Cymru felt that the related definition of the services contained in the list provided by Section 5(2) should also include voluntary sector services:

> "… they play an important role in supporting people who experience mental ill health. They offer that balance with statutory services, which is quite important when taking a holistic view."[137]

176. Evidence from the Welsh Local Government Association and the Association of Social Services Directors referred to the 'language used' in the proposed Measure. These organisations were concerned that the language:

> "… appears to target clinicians in the NHS. For example, local authorities do not provide 'treatment'."[138]

Evidence from Witnesses: definitions of 'patients' and 'carers' in Section 5(2)

177. In his evidence, Professor Phil Fennell explained his concerns regarding the definition of 'patients' contained in Section 5(2), which states that a 'patient' is 'an adult who has, or may have, a mental disorder'. He was concerned that this definition differs from that used in the *Mental Health Act 1983*:

> "I think it would be confusing to differ from the definition that is in the 1983 Act, which is perfectly okay and states that a patient is a person who suffers, or appears to suffer, from a mental disorder. With [the 1983 Act], there has to be some outward manifestation that the person is suffering from a mental disorder, by their evidence from family, carers or

[136] RoP, paragraph 8, 22 April 2010
[137] RoP, paragraph 129, 22 April 2010
[138] Written evidence, MH 25

whatever, but something that makes it appear that the person suffers from a mental disorder."[139]

178. Professor Fennell also commented on the definition of 'carers' in Section 5(2), which defines 'carers' as 'members of the families of patients, and friends of patients, who are involved in their care'. Professor Fennell believed that this definition of 'carers' is too widely drawn, explaining that:

> "A carer under carer legislation is someone who provides substantial care on a regular basis."[140]

179. However, the Children's Commissioner for Wales told us that he was content with the broad definition of carers because it would capture young carers, and called for the information needs of young carers to be met.[141]

Evidence from the Minister

180. In evidence, the Minister acknowledged the concerns of the voluntary sector:

> "We must not underestimate the important role of other services in dealing with issues, and I strongly support the work of the voluntary sector. I am sure if anything further comes out of this, we will look at the proposed Measure to see what more can be done in terms of signposting." [142]

181. Responding to the concerns about the definition of 'patients', the Minister told us that she did not think this was problematic, and was merely a difference in drafting styles between Assembly and Westminster legislation.[143]

182. The Minister explained the definition of 'carers':

> "We made a deliberate decision to have a wider definition of a carer in the context of this legislation … the Children's Commissioner for Wales concurred with the wider definition of carers we have used in this context."[144]

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[139] RoP, paragraph 22, 4 May
[140] RoP, paragraph 23, 4 May 2010
[141] RoP, paragraph 89, 20 May 2010
[142] RoP, paragraph 120, 29 April 2010
[143] RoP, paragraph 38, 27 May 2010
[144] RoP, paragraph 27, May 2010

183. Commenting on the evidence regarding the 'language' of the proposed Measure being geared towards health services, the Minister explained that she is of the view that the proposed Measure gives a clear indication that 'treatment' is wider than just medical treatment and hospital admissions.[145]

Our view

184. **We have considered the concerns of witnesses in relation to both the definitions of 'patients' and 'carers' in Section 5(2). We are content that the definition of 'patients' is appropriate. We are also content with the definition of 'carers', and agree with the evidence that this definition is sufficiently broad to capture the range of individuals that may be involved in a patient's care, including young carers.**

185. Section 5(2) also provides a definition of the services about which information and advice would be made available to patients and their carers under the provisions in Section 5(1)(e). **The definition of 'community care services' is particularly complex because it derives from a number of legislative instruments. Whilst this definition is clear from a legal perspective, it may be unclear to service users or their carers, and could lead to difficulties for those individuals in understanding their rights. We note the evidence from witnesses regarding the complexity of this definition and therefore recommend that it be clarified within the Explanatory Memorandum, and any explanatory information that will accompany the Measure, as passed.**

186. We discussed whether it would be appropriate to include voluntary sector services in the definition of 'services about which information would be given to patients and their carer'. We have concluded that it would be inappropriate for this to be included on the face of the proposed Measure. However, **we recommend that the importance of signposting patients and their carers to those support services provided by the voluntary sector be clearly set out in guidance.**

[145] RoP, paragraph 63, 27 May 2010

Sections 6 – 8: Duties to carry out primary mental health assessments

187. Section 6 of the proposed Measure places a duty on primary mental health partners to undertake an assessment of adults referred to them by the GP with whom the individual is registered. Section 7 makes a similar provision for GPs to make referrals for those who not registered with them, if this is provided for by the local scheme (see our comments on Section 2(4).

188. Under Section 8, if a scheme established under Section 2 allows, referrals may also be made in respect of patients from within secondary mental health services.

Our View

189. The majority of the evidence we received in relation to Sections 6 – 8 relate to the timescales within which individuals should be assessed once they have been referred by the GP. We have responded to this issue in detail in our comments on timescales.

190. We also received evidence questioning whether the proposed Measure establishes a duty to treat as a result of the duty to assess. We have dealt with this issue in our comments on Section 3. **We are** therefore **content with the provisions of Sections 6 to 8, as drafted.**

Section 9: Conduct of primary mental health assessments

191. Section 9 makes provisions for the way primary mental health assessments should be undertaken, and by whom. This section also explains the role of the primary mental health assessment (Section 9(1)(a) and (b)), which is to:

- identify the treatment which might improve or prevent a deterioration in the adult's mental health (any treatment identified must be provided in accordance with Sections 3 and 5);
- identify 'other services' which might improve or prevent a deterioration in the adult's mental health.

192. 'Other services' are defined in Section 9(3) as:

- secondary mental health services;

- services of a type that are not normally provided by primary care providers;
- community care services (not being secondary mental health services).

193. An explanation of 'community care services' is provided in our comments on Section 5.

Evidence from Witnesses

194. Gofal Cymru told us that any primary mental health assessments should be:

> "… as holistic as possible, and so should include consideration of a wider range of services (including housing and employment) which may 'improve or prevent a deterioration in the adult's mental health'."[146]

195. The need for a holistic approach was also highlighted in the evidence we received regarding Part 2 of the proposed Measure, but these comments are also relevant here in relation to Section 9. Witnesses from mental health charities, for example, explained the importance of taking a holistic approach to mental health services, that considered all elements could have an impact of a patient's life, and could affect recovery. Mind Cymru told us that:

> "The care and treatment planning process should be person-centred and needs-led (…) Contextual information such as the degree of social exclusion (homelessness, poverty, and access to support networks for example) also needs to be considered within the proposed model".[147]

Evidence from the Minister

196. In response to this issue, the Minister told us that she would consider the concerns of the Mental Health charities regarding the need for a holistic approach to the provision of services which may 'improve or prevent a deterioration in the adult's mental health'. However, the Minister did confirm:

> "Assessments are and will be holistic, because that is the clinical good practice at present (...) This proposed Measure

[146] Written Evidence, MH 4
[147] Written Evidence, MH 5

does not seek to overturn any of that, but to enforce it through to operation."[148]

Our view

197. Mental health assessments conducted in primary care will play an important role in identifying the aspects of a patient's life that could impact on their mental well-being. Section 9(1)(b) refers specifically to the need for assessments to identify 'other services' the patient should access which might improve or prevent a deterioration in the individual's mental health. In light of the evidence we received, we agree that the consideration of 'other services' should be holistic, reflecting the Recovery Model. However, **based on the Minister's assurance that assessments 'are and will be holistic', we are content that the definition of 'other services' provided in Section 9 allows for this.**

198. However, **we recommend that the importance of holistic assessments in ensuring services for patients are based on the Recovery Model be emphasised in the Explanatory Memorandum, guidance and any explanatory information that will accompany the Measure as passed.**

199. **We reiterate our concern that the definition of 'community care services' is particularly complex and may be unclear to the service user because it is derived from a number of legislative instruments. We therefore recommend that this be clarified within the Explanatory Memorandum and any explanatory information that will accompany the Measure as passed.**

Section 10: Action following a primary mental health assessment

200. Section 10 deals with the actions to be taken following a mental health assessment if that assessment has identified services, other than local primary mental health treatment, that might benefit the individual, but might not necessarily be provided by the local primary mental health partner.

201. Section 10(1)(a) gives the relevant mental health partner the discretion to decide whether the service identified by the assessment is needed.

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[148] RoP, paragraph 129, 29 April

202. If the partner considers that it would not be the service provider, they must make a referral to the relevant responsible authority (Section 10(1)(b)). Section 10(3) requires the person to whom a referral has been made under these circumstances to decide whether any of the services are called for.

Evidence from Witnesses

203. We did not receive any specific evidence on the provisions contained in Section 10. However some witnesses did make specific comments on the difficulties that could arise as a result of the Local Authorities and Local Health Boards adopting different criteria to assess eligibility for services. The Association of Directors of Social Services was concerned that this could lead to service providers:

> "… dumping on each other, which is often what happens because many local authorities set their eligibility criteria quite high. It is unhelpful when we tell health colleagues, 'sorry, but that that person does not meet our criteria."[149]

Evidence from the Minister

204. We sought clarification from the Minister regarding the provisions within Section 10(1)(a) and 10(3), which give discretion to responsible authorities over whether or not to provider 'other services' identified by the primary mental health assessment. The Minister explained the need for flexibility, which would allow professionals to exercise judgement on the appropriate levels of treatment required by the patient.[150]

Our view

205. Our views on the provisions within Section 10, which give service providers the discretion to decide whether services identified by an assessment are necessary, reflect our views on timescales. **We are content that professionals should make decisions on service provision based on clinical need and are therefore content with the provisions of Section 10.**

206. However, we note the concerns of witnesses regarding the use of different criteria by local authorities and health boards when

[149] RoP, paragraph 229, 13 May 2010
[150] RoP, paragraph 131, 29 April 2010

assessing eligibility for services, and the impact this could have on service provision. We have commented on this in detail in our response to Section 2.

Part 2: Overview

207. Part 2 of the proposed Measure makes statutory provision for care and treatment planning for those individuals receiving secondary mental health care.

Evidence from Witnesses

208. In general, witnesses welcomed the provisions in Part 2 of the proposed Measure. Some felt that the framework for this approach existed already, through the Care Programme Approach. However, the proposed Measure was welcomed as a means of securing consistent provision across Wales and guaranteeing the implementation of care plans.[151]

209. Some witnesses believed that making care planning and care coordination a statutory obligation under the framework of the proposed Measure would only be legislating for "what organisations are required to do under guidance already", and were concerned that legislation would not allow sufficient flexibility to deal with patients according to their clinical need.[152]

210. Other witnesses, however, saw the introduction of the proposed Measure as an opportunity to address the failings of the Care Programme Approach in delivering on its aim of providing individuals accepted into secondary mental health services with a dedicated care coordinator and care and treatment plan. Monmouthshire Mental Health Strategic Planning Group, for example, told us that the failings of the Care Programme Approach identified by a recent review provided a "requirement for the Measure to deliver this aim."[153]

Our view

211. **We note the broad support for the aims of Part 2 of the proposed Measure. We agree with the need to make statutory provision for care and treatment planning for those in receipt of secondary mental health services. We therefore agree with the general principles of Part 2.**

[151] Written Evidence, MH 63, MH 15 MH 9, MH 39, MH 63
[152] Written Evidence, MH 24
[153] Written Evidence, MH 47

Section 11: Meaning of 'relevant patient'

212. Section 11 provides a definition of 'relevant patient' for the purposes of this part of the proposed Measure. A 'relevant patient' is defined as an adult in receipt of secondary mental health services by a mental health service provider. Definitions of 'Secondary Mental Health Service Providers' are dealt with in Section 12, with 'Secondary Mental Health Services' defined in Section 45 of the proposed Measure.

213. This Section identifies those patients for whom a care coordinator will be appointed, and in respect of whom the duties relating to care and treatment planning and cooperation of service provision will apply.

Evidence from witnesses

214. Hafal believed that the proposed Measure was insufficiently clear on how it addresses those unwilling to engage with secondary services, and whether or not this would mean such individuals were a 'relevant patient':

> "Although it is acknowledged that it is often difficult to draw up a care plan in these circumstances, this can be very important for this often vulnerable group of patients, for example by giving assistance to carers and family members whom the patient may be prepared to engage with even though they will not engage for the time being with secondary mental health services."[154]

215. Age Cymru also stressed the value of care plans for those who refuse treatment.[155]

216. The Betsi Cadwaladr University Health Board queried the definition of 'relevant patient'. Dr Miles explained that he was concerned that, as 'secondary mental health services' (see Section 12) were "in essence … all of the NHS services apart from general practitioner services", the definition of relevant patient would also encompass those who had only had very brief contact with secondary services: [156]

[154] Written Evidence, MH-6
[155] Written Evidence, MH-61
[156] RoP, paragraph 29, 13 May 2010

> "There are some patients who will attend community mental health services, that is, secondary mental health services, perhaps only on one occasion, who will have an assessment and are signposted to other services. That may be their only contact with secondary mental health services. Therefore, with regard to the meaning of 'relevant patient', we do not think that those patients who have one-off contact need a care co-ordinator."[157]

217. Some witnesses highlighted the diverse needs of patients with psychiatric problems in secondary care and questioned the value of care planning in all cases:

> "The requirement that they should have a Care and Treatment Plan, a Care Co-ordinator, Needs Assessment and Risk Assessment in all cases is unnecessary, in my view, for patients who will be seen once or twice only, or for some, brief interventions over 5 sessions."[158]

Evidence from the Minister

218. We received assurances from the Minister and her officials that Sections 17(3), 17(4) and 17(5) (these deal with the functions of a care coordinator) will capture those individuals who are unwilling to engage with secondary services. The Minister's official told us that these sections make provision for the development of a care and treatment plan if those involved in making arrangements for secondary services for a relevant patient, including the patient, are unable to reach an agreement, giving:

> "…the ability to make care plans where people do not agree with outcomes and so on."[159]

219. The Minister and her officials also told us that this often happens under the current arrangements, and that the intention of the proposed Measure is to guarantee patient choice and autonomy.[160]

220. The Explanatory Memorandum explains that the policy objective is that:

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[157] RoP, paragraph 29, 13 May 2010
[158] Written Evidence, MH 22
[159] RoP, paragraph 72, 27 May 2010
[160] Ibid

> "… throughout Wales, **all** individuals accepted into secondary mental health services for treatment will have a care and treatment plan prepared and regularly reviewed by a care coordinator."[161] [Emphasis added].

Our view

221. We have considered the concerns of witnesses regarding the need for the proposed Measure to allow for care plans to be drawn up for those patients unwilling to engage with secondary services, but who would be willing to engage with their carers. In light of the Minister's comments with regards to the provisions in Section 17 (functions of a care coordinator), **we are content that there is sufficient provision within the proposed Measure to ensure such patients can benefit from a care plan where this is appropriate.**

222. **We note the concerns raised in evidence that the proposed Measure defines any adults in receipt of secondary mental health services as a 'relevant patient', without any requirement for a qualifying level of contact that the patient would need to have with secondary services for a care coordinator to be appointed. However, we consider that it would be inappropriate to define this level of contact on the face of the proposed Measure. We are therefore content with the provisions of Section 11.**

223. **We reiterate our view that the planning of a patient's care must be driven by clinical need. The appointment of a care coordinator should therefore be based on clinical need, and be proportional. We consider that this should be clarified in guidance, to manage the expectations of patients and to reassure service providers.**

Section 12: Meaning of 'mental health service provider'

224. Section 12 of the proposed Measure defines secondary mental health service providers as Welsh Ministers, Local Health Boards and local authorities in Wales.

Evidence from Witnesses

225. Witnesses were broadly content with the definition of secondary mental health service providers.

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[161] Explanatory Memorandum, paragraph 28

226. However, the Royal College of Psychiatrists, the Royal College of Nurses and the British Medical Association were concerned that, whilst professionals recognised the need to define services in this way, there was a move towards a more integrated delivery of services across primary and secondary care. As a result, it may not be clear to the patient whether their care had been provided by a primary or secondary service provider:

> "Some of the developments proposed in the proposed Measure have been met to an extent because the barriers between primary and secondary care have been broken down. A concrete example would be where one would place crisis resolution teams. Are they in primary or secondary care?"[162]

227. The British Medical Association added:

> "One concern if we stick to the definitions of 'primary' and 'secondary' is that it will take us away from the patient and the severity of their condition. The assumption is that the very severe must be in secondary care and the very mild must be in primary care, but, in fact, many patients prefer to be in primary care so that they are not seen as secondary care patients."[163]

Our view

228. **We note the concern of witnesses that the boundaries between primary and secondary services are becoming less visible as services become increasingly integrated. However, we also note that despite this, witnesses were content with the definitions contained in Section 12. We are also content, and consider that it is appropriate that services be defined in legislation in this way.**

229. **However, we reiterate our concerns that there is a need for clear guidance on the level of contact a patient would need to have with secondary mental health service providers to be eligible for the provisions within Part 2 of the proposed Measure, and that this should be proportional, and driven by clinical need.**

[162] RoP, paragraph 78, 4 May 2010
[163] Ibid, paragraph 85

Sections 13 - 15: Appointment of care coordinators

230. These sections deal with the duty placed on service providers to: appoint a care coordinator for a relevant patient (Section 13); and set out a mechanism for identifying the providers with a duty to appoint a care coordinator (Sections 14 and 15).

231. According to the Explanatory Notes that accompany the proposed Measure:

> "The Measure … recognises that over time the care coordinator for an individual may change, perhaps to reflect the changing needs of the person receiving services, and where this happens the duty to appoint a care coordinator continues.
>
> (…) Care and treatment provision within secondary mental health services is often undertaken by a range of different professionals, and via a number of agencies, reflecting the complex and sometimes enduring needs that users of those services may have. This complexity of provision is recognised in the Measure."[164]

232. Section 14(4) provides that, where both the Local Health Board and the local authority provide a secondary mental health service for a relevant patient, the service provider is to be identified in accordance with regulations made by Welsh Ministers. The regulations may provide for determination of disputes with their operation to be determined by Welsh Ministers. However, it is unclear whether this is to be by way of a formal process or by Ministerial decision.

Evidence from Witnesses

233. Mind Cymru were concerned that the language in this part of the proposed Measure is insufficiently strong, and could result in uncertainty with regards to the rights of patients if there were disputes about the responsibility for service delivery. They called for the process for dispute and dispute resolution in Section 14 to be "robust, independent, sensitive and timely."[165]

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[164] Explanatory Memorandum, Annex A
[165] Written Evidence, MH 5

Our view

234. **It is our view that in the main, the provisions contained in sections 13 – 15 of the proposed Measure are appropriate.**

235. However, we are concerned at the lack of clarity regarding the dispute resolution process in instances where a secondary service could be provided by both a health board and a local authority, but there is disagreement.

236. **It is our view that any process for the resolution of disputes, to be made by regulations, should be timely. Developing a formal process for dispute in such circumstances could delay the provision of care and have a detrimental effect on a patient's mental well-being.**

237. **We therefore recommend that such disputes should be quickly resolved by Welsh Ministers, and that this should be clearly set out in the regulations made under Section 14(4).**

Section 16: Duty to coordinate provision of mental health services

238. Section 16 places a duty on the relevant service provider to coordinate mental health services, and ensure effective provision. The service provider is also under a duty to coordinate its services with those of other mental health service providers, including the voluntary sector.

239. The proposed Measure defines the mental health services that must be coordinated as: secondary mental health services (which include certain community care services); services under Part 1 of the Measure; and, where applicable, the exercise of the local authority's powers in relation to guardianship under the *Mental Health Act 1983*.

Evidence from Witnesses

240. Section 16 (2) and (3) enable, but do not require, the care coordinator to give advice to the service providers regarding the coordination of services. Mind Cymru believed that the language in these subsections should be strengthened to guarantee the involvement of the care coordinator in all aspects of the patient's care.

241. Mind Cymru were also concerned that in the past, support workers, who may have supported patients prior to admission, were often excluded from any discharge or service planning groups. They called for the care coordinator:

> "To be sufficiently involved with the service user to ensure all relevant individuals and organisations are fully involved in the care planning and review process, with the permission of the service user."[166]

242. On this issue, Gofal Cymru said:

> "We … hope that the duty to coordinate the provision of mental health services will lead to a more joined up approach between health, social services and voluntary sector providers in the interest of the individual receiving treatment from them."[167]

Our view

243. We note the concerns of many witnesses regarding the need for the care coordinator's involvement in every aspect of a patient's care. However, **we do not consider there is a need to amend Section 16(2) and (3) to require the provider of services to seek the advice of the care coordinator with regards to the discharging of its duty under Section 16(1). Individual circumstances will dictate whether this is necessary, and we are therefore content that the provisions of Section 16(2) and (3) will allow for this.**

244. We also note the important role of the voluntary sector in providing support to those with mental health problems, and in many instances in providing mental health services. **We welcome the reference in the proposed Measure to 'any services related to mental health provided for the patient by a voluntary organisation', and consider that this provides a clear indication that the service providers must coordinate care with that of the voluntary sector. We are therefore content with the provisions contained in Section 16.**

[166] Written Evidence, MH 5
[167] Written Evidence, MH 6

Section 17: Functions of a care coordinator

245. According to the Explanatory Notes:

> "The importance of a collaborative approach to care planning is enshrined in Section 17 of the proposed Measure."[168]

246. Section 17 requires the care coordinator to work with the patient and the service provider(s) to agree the outcomes of the care, and the mechanisms for achieving those outcomes. These matters are to be recorded in a treatment plan, the form and content of which is to be prescribed in regulations (Section 17(8)).

247. Section 17(10) requires mental health service providers to make services available to the relevant patient in accordance with the care and treatment plan 'so far as it is reasonably practical to do so'.

Evidence from Witnesses:

248. The majority of witnesses believed the approach to care planning outlined in Section 17, which provides a legislative framework for the Care Programme Approach, was to be welcomed.

249. In calling for a similar approach for child and adolescent mental health services, Barnado's Cymru welcomed the care planning approach set out in Section 17, explaining that it "very usefully describes the function of a care coordinator" and makes:

> "… significant points … in relation to the participation of the patient in the planning of their care."[169]

250. Witnesses from mental health charities believed that care plans should be holistic, adopting an approach that considers all aspects that could have an impact on a patient's life, and could affect their recovery. Mind Cymru told us that:

> "The care and treatment planning process should be person-centred and needs-led (…) Contextual information such as the degree of social exclusion (homelessness, poverty, and access to support networks for example, also needs to be considered within the proposed model."[170]

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[168] Explanatory Memorandum, Annex A
[169] RoP, paragraph 18, 20 May 2010
[170] Written Evidence, MH 5

251. Hafal held a similar view, and called for each care plan to cover:

> "… the nine areas of life identified in the current Welsh Code of Practice for the Mental Health Act, that is:
>
> - finance and money;
> - accommodation;
> - personal care and physical wellbeing;
> - training and education;
> - work and occupation;
> - parenting or caring relationships;
> - social, cultural and spiritual;
> - medical treatment;
> - other forms of treatment including psychological interventions."[171]

252. Care plans will be dealt with by regulations, under Section 17(8). Hafal called for the Measure itself, rather than regulations, to prescribe how the care plans should be delivered.[172] As drafted, the proposed Measure would provide for regulations to be made by negative procedure. Gofal Cymru stated that:

> "… getting these regulations right will be extremely important."[173]

Our View

253. We welcome the provisions of Section 17, which we believe clearly set out the functions of a care coordinator and the approach to a care plan.

254. In light of the evidence we have received, **we consider that the form and content of care and treatment plans, to be made by regulation under Section 17(8), should not simply be administrative. We consider that the care plans should reflect the Recovery Model, taking into consideration other contextual information that can assist a patient's recovery and should be**

[171] Written Evidence, MH 4
[172] Ibid
[173] Written Evidence, MH 6

patient-led. We recommend that this be reflected in the regulations.

255. Whilst we recognise the need for proportionality in relation to care and treatment planning, we are concerned that requiring service providers to make the services identified by the care and treatment plan available 'so far as it is reasonably practicable to do so' (Section 17(10)) could result in this process being driven by the availability of resources. We reiterate our view that care planning should be holistic and should reflect the Recovery Model.

256. **Given the importance of the care and treatment plans in supporting a patient's recovery, and the need for clarity regarding the aims of care plans, we recommend that the first set of regulations made under Section 17(8) be made using the affirmative procedure.**

Part 3: Overview

257. Part 3 of the Measure enables individuals discharged from secondary mental health services to refer themselves back to secondary services directly, without needing to go to their GP for a referral.

Evidence from Witnesses

258. Most witnesses welcomed this part of the proposed Measure, with many making reference to the positive impact this could have by empowering former users of secondary mental health services. Gofal Cymru stated:

> "Having previously been in receipt of such services, individuals will often be more aware than anyone else when they are in need of such support again and we hope that this aspect of the proposed Measure … will result in timelier access to support when people first find themselves becoming unwell."[174]

259. A number of witnesses echoed this view, with some highlighting the fact that allowing rapid re-entry to secondary care services might encourage earlier discharge, as patients and clinicians would be confident of re-access to services if necessary. Evidence from Conwy County Borough Council referred to the way in which this would empower patients, stating that it:

> "… fits well with the recovery model and restores some of the balance between client and professional in determining when they may need assistance again."[175]

260. However, the Royal College of Psychiatrists told us that there could be unintended consequences as a result of the provisions in Part 3:

> "Statutory prioritisation may also carry clinical risk. Some self-referred individuals may have lower levels of risk and need than unknown individuals, yet they may be arbitrarily prioritised".[176]

[174] Written Evidence, MH 6
[175] Written Evidence, MH 39
[176] Written Evidence, MH 14

261. Other respondents were concerned with the capacity of secondary services to meet increased demand from former service users,[177] and the need to ensure that those re-engaging with services can benefit from them.[178] There were suggestions that a qualifying level of previous contact with services should be defined so as to exclude those with only minimal involvement,[179] or that self re-referral should be confined to those on the Care Programme Approach[180] or to those on the Enhanced Care Programme Approach.[181]

262. Witnesses also highlighted the need to manage the expectations of patients and provide clarity regarding the fact that treatment would not be guaranteed if it wasn't required.[182] Some respondents felt that clarity would also be needed to ensure patients understood that:

> "… the right to an assessment does not guarantee the right to health, social, housing or welfare services."[183]

Evidence from the Minister

263. In evidence, the Minister told us:

> "The aim of this part of the proposed Measure is to enable former service users to have control over the opportunities to access secondary services. It is anticipated that this will support safe and effective discharge from services (…) It is important as it will support recovery, which is an important aspect of the proposed Measure."[184]

Our view

264. **We note the broad support for Part 3 of the proposed Measure which provides patients discharged from secondary services with a rapid route back to services if required. It is our view that these provisions will empower patients and support their recovery. We therefore support the general principles of Part 3 of the proposed Measure.**

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[177] Written Evidence, MH 57, MH 10
[178] Written Evidence, MH 10
[179] Written Evidence, MH 15
[180] Written Evidence, MH 10
[181] Written Evidence, MH 2
[182] Written Evidence, MH 15
[183] Written Evidence, MH 42
[184] RoP, paragraph 139, 22 April 2010

265. **However, we note the concerns of witnesses regarding the prioritisation of patients and the need for service providers to carefully manage demand. We believe that clear information will be required to manage the expectations of patients and ensure their entitlements are understood.** We have provided detailed comments on eligibility and entitlements in relations to Section 21 – 23.

Section 21 - 23: Assessment entitlements

266. Section 21 sets out the conditions a former user of secondary mental health services would need to meet to be entitled to an assessment under Part 3. Section 21(1)(d) enables the service provide to make a decision regarding whether or not the request is 'vexatious or frivolous'.

267. Section 22 makes provision for a 'relevant discharge period' during which former secondary mental health service users would be entitled to a reassessment. The discharge period would be stated in regulations under Section 22(2), made using the negative procedure.

268. Under Section 23, a duty will be placed on the relevant local health board or local authority to provide written information about the assessment arrangements, and the entitlement to assessment under Part 3.

Evidence from Witnesses: entitlement

269. Whilst Part 3 of the proposed Measure was welcomed by the vast majority of witnesses, some were concerned that the entitlement to self re-referral would lead to confusion and difficulties for some patients, and believed the entitlement should be clearly defined under Sections 21 and 22. The Royal College of Psychiatrists, for example, highlighted concerns regarding to the definitions of 'secondary' and 'primary' care, and the understanding patients might have of their entitlements as a result:

> "Some of the difficulties may be around what currently constitutes secondary care (…) How you define secondary care could be extremely difficult because the person themselves might perceive that they have been in secondary care."[185]

[185] RoP, paragraph 140, 4 May 2010

270. Echoing the comments in written evidence on restricting self re-referral to users who had participated in the Care Programme Approach, the Betsi Cadwaladr University Health Board told us that clear definitions of those patients who could re-engage with services were required, to ensure that the prioritisation of services was based on clinical need:

> "We welcome the ability of those patients with significant mental health problems, who have been through hospital care, longer-term counselling and other treatment in the community mental health teams, to have access back into the service for a period of time (…) the problem might come in that many patients have limited needs from community mental health services. They may go in for an assessment and may be signposted or have reassurance, but many will have lower mental health needs (…) If there is an enshrined right for these to access the service again, there are some concerns that these patients, because they feel that the need to service, might seek access back into the system. That will tie up capacity that ought to be expended on those people who are more seriously ill."[186]

271. The Royal College of Psychiatrists highlighted a similar point, and were also concerned that this would have an impact on the prioritisation of services:

> "Prompt access to secondary mental health services should be a universal entitlement not restricted to those who have previous contact. This Measure may act as a perverse incentive to prioritise this group with a statutory entitlement over others, either those with no previous contact or those discharged outside of the relevant discharge period."[187]

272. The joint submission from the Welsh Local Government Association and the Association from Social Services Directors raised concerns about the lack of a provision for a 'carer' or 'next of kin' to re-refer to secondary care services, in order to support the individual being cared for.[188] The Association from Social Services Directors expanded on this point:

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[186] RoP, paragraph 69, 13 May 2010
[187] Written Evidence, MH 14
[188] Written Evidence, MH 25

> "Those who live with someone with mental health problems need to be listened to, because they are with that person many more hours a day than professionals. Hence, the carers should have the right to make a referral."[189]

Evidence from Witnesses: the relevant discharge period

273. Several witnesses welcomed the inclusion of a 'relevant discharge period' within which requests could be made, but stated that this needed to be clearly defined (Section 22). Professor Phil Fennell raised concerns regarding the lack of a:

> "… time limit in the proposed Measure, and no clarity about how long after discharge you will get those services."[190]

274. The Association from Social Services Directors believed that entitlement under Part 3 of the proposed Measure should:

> "… look back far enough so that the treatment or a service that and adult has as a child counts towards the right to a reassessment."[191]

Evidence from the Minister

275. The Minister told us that she was mindful of the comments made in relation to eligibility under Sections 21 to 23, and assured us that she had asked officials to look at this matter again to:

> "… explore an amendment to the proposed Measure to ensure that the boundaries are appropriately drawn."[192]

276. With reference to the need for the discharge period to take into consideration any services received by an adult previously under Child and Adolescent Mental Health Services, the Minister's official explained:

> "If a young person has received Child and Adolescent Mental Health Services, and they reach their eighteenth birthday, they will be covered from that birthday until the end of the relevant period, whatever its duration. For example, if a person was discharged from [Child and Adolescent Mental Health Services]

[189] RoP, paragraph 252, 13 May 2010
[190] RoP, paragraph 46, 4 May 2010
[191] RoP, paragraph 209, 13 May 2010
[192] RoP, paragraph 74, 27 May 2010

at 17, the relevant discharge period is three years, and then from the eighteenth birthday, for the remainder of the two years left, they would be covered."[193]

Our view

277. We **note the concern of witnesses regarding the eligibility of patients requesting re-referral, and the importance of ensuring patients understand that there is no guarantee of treatment if it is not considered to be clinically necessary. We also note the comments regarding the lack of a definition of qualifying level of previous contact with services, to ensure services are targeted towards those with the greatest need. We consider that parameters will need to be defined, and endorse the Minister's intention to amend the proposed Measure accordingly.**

278. **We consider that the provision contained in Section 21(1)(d), which gives service providers the discretion to consider whether a request for an assessment is vexatious or frivolous, is appropriate and allows for decisions to be based on clinical judgment. However, we recommend that clear guidance is developed to manage the expectations of patients and support the decisions of service providers.**

279. Despite the explanation provided by the Minister, we are concerned at the lack of clarity regarding the discharge period, and the eligibility of patients who have previously accessed Child and Adolescent Mental Health Services to the provisions of Part 3. **Should the Minister reject our recommendations regarding the need for the proposed Measure to be 'age blind', we recommend that the regulations made under Section 22, which will define the relevant discharge period, should clarify the eligibility of previous users of Child and Adolescent Mental Health Services.**

280. **We recommend that the regulations made under Section 22 establishing the length of time following discharge for which a previous service user would remain eligible for reassessment under Section 21 should follow the affirmative procedure.**

[193] RoP, paragraph 76, 27 May 2010

Part 4: Overview

281. Part 4 of the Proposed Measure amends the *Mental Health Act 1983* (the 1983 Act) in respect of Independent Mental Health Advocacy. New Sections are inserted into the 1983 Act which provide for a statutory scheme of independent advocacy in Wales which is wider than the statutory provision currently provided in accordance with the 1983 Act. Independent advocacy will, therefore, be available to both patients subject to compulsion under the 1983 Act, and those in hospital informally (not subject to compulsion). A wider range of compulsory patients would qualify for independent advocacy; the proposed Measure aims to include those subject to emergency short-term sections who are not currently entitled to receive the support of an independent advocate.

282. Sections 29 to 36 of the proposed Measure insert new Sections 130E to 130L to the 1983 Act. Section 37 of the proposed Measure amends Section 118 of the 1983 Act (application of the *Mental Health Act 1983* code of practice) in respect of Independent Mental Health Advocates in Wales.

Evidence from Witnesses

283. We received overwhelming evidence supporting the role of the Independent Mental Health Advocates and emphasising the importance of their work in representing patients with mental health needs. The Welsh Local Government Association and the Association of Social Service Directors told us that:

> "Advocacy is not a panacea for ensuring that individuals receive care and support with respect and dignity, and if people are to have advocates, then the arrangements must ensure that the provision of such a service is fit for purpose; that is, advocacy gives people experiencing mental health problems a voice in the decision making process."[194]

284. There was general support for the aims of the proposed Measure in relation to statutory advocacy services, particularly with regards to the extension of services to informal patients. However, there were some reservations around the practical implications of supporting some patients subject to short-term compulsory powers under the

[194] Written Evidence, MH 25

Mental Health Act 1983, and the resource issues related to this.[195] One respondent commented:

> "… those involved in advocacy are concerned that it would be difficult to ensure access to advocacy in this short period. This would be exacerbated in rural areas."[196]

285. We have discussed this issue further in our comments on Section 33.

286. A number of witnesses believed that the benefits of advocacy services should be extended to all patients accessing mental health services across primary and secondary care. Witnesses from Hafal explained the rationale for this suggestion:

> "When people first present as mentally ill … very often they have no idea what their rights are and what information is available. Therefore, advocacy services can only enhance people's ability to take control of their own lives and to start taking responsibility from the outset (…) Advocacy services are vital to represent people and encourage them to learn about what is going on."[197]

287. Mind Cymru told us that there have been efforts to extend advocacy provisions to community settings, but that this has not been successful despite the targets already in place. Mind Cymru also highlighted the fact that a lack of advocacy for all could have implications for the successful implementation of the provisions of Part 3 of the proposed Measure, which enables previous users to re-engage with secondary services, because: "if there is no recourse to community advocacy to support that person, there are people who will not ask for it."[198]

288. Mind Cymru also believed that, in practice, it was likely that few people would want to take up the provision, as long as there was sufficient information available.[199] Gofal agreed, stating that for many, having access to good, independent information and advice regarding their rights would be of benefit:

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[195] Witten Evidence, MH 10
[196] Written Evidence, MH 51
[197] RoP, paragraph 47, 22 April 2010
[198] RoP, paragraph 99, 22 April 2010
[199] RoP, paragraph 100, 22 April 2010

> "Some people need advocacy, but some just need recourse to their rights being upheld, or duties not being upheld."[200]

289. Some witnesses expressed the view that the provisions for extending advocacy did not go far enough, leaving some vulnerable groups excluded.[201] This includes those in community settings and with complex needs supported by crisis and home intervention teams,[202] people in care homes,[203] and those on leave from compulsory detention as part of discharge planning.[204] One witness pointed out that the number of people using these services is increasing, emphasising the need to provide advocacy support for them."[205]

Evidence from the Minister

290. The Minister explained why she had chosen not to extend statutory advocacy to all those in receipt of primary and secondary mental health care:

> "I think that advocacy will continue to grow and develop. We might want to look at future legislation that pays specific consideration to community advocacy."[206]

291. The Minister also explained that the extension of statutory advocacy provision was limited because:

> "A range of non-statutory advocacy is currently available across Wales [which] currently supports primary care as well as community care services."[207]

Our view

292. **We have received substantial evidence supporting the provisions within Part 4 of the proposed Measure that extend statutory advocacy provisions available in Wales under the *Mental Heath Act 1983.* We agree with the aim of Part 4 of the proposed Measure and are therefore content with the general principles of Part 4.**

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[200] RoP, paragraph 155, 22 April 2010
[201] Written Evidence, MH-37
[202] Written Evidence, MH-21, MH-35, MH-56, MH-59
[203] Written Evidence, MH-61
[204] Written EvidenceMH42, MH51
[205] RoP, paragraph 154, 29 April 2010
[206] RoP, paragraph 147, 22 April 2010
[207] RoP, paragraph 146, 29 April 2010

293. Witnesses have told us that many benefits would result from universal access to advocacy services, and have suggested that all patients in receipt of mental health services, across both primary and secondary care should have a right to an advocate. Whilst we agree that there would be significant benefits for some patients in primary care and community settings in receiving support from an independent advocate, we do not believe that universal access to statutory advocacy services is appropriate at this time.

Section 29: independent mental health advocates: Wales

294. Section 29 inserts a new Section 130E to the *Mental Health Act 1983*.

295. Specifically, Section 130E of the *Mental Health Act 1983* places a duty on Welsh Ministers to make arrangements for the assistance to be provided by the Independent Mental Health Advocates Such help will be available to two client groups: Welsh qualifying compulsory patients (see Section 33); and Welsh qualifying informal patients (see Section 34).

296. Section 130E establishes a principle of independence for advocates and enables the Minister to make regulations setting out the standards and qualifications that will need to be met by any individual seeking qualification as an Independent Mental Health Advocate. Section 130E(4) contains the power for the Minister to make regulations setting out from whom the Independent Mental Health Advocates should be independent.

Evidence from witnesses

297. Most witnesses welcomed the extension of statutory advocacy provided for by the duty placed on Welsh Ministers in Section 130E(1). Evidence from South Wales Mental Health Advocacy, for example, stated:

> "The proposal to extend the current arrangements to informal patients is once again welcome. Experience shows that informal patients require the same support as those detained and in reality most informal patients are subject to the same restrictions as those who are detained."[208]

[208] Written Evidence, MH 21

298. Jonathan Morgan AM raised concerns about the scope of the proposed Measure in Section 130E(4) of the *Mental Health Act 1983* (inserted by Section 29 of the proposed Measure), and argued for allowing close friends, carers or members of a patient's family to act as advocates:

> "I would be concerned if we were saying to patients that an advocate has to be someone who has undertaken training or someone working for one of the mental health charities, and that it could not be someone who is a close friend, a carer, or a member of your family (…) We all know of situations … where a family member understands the patient extremely well, where a family members understands the condition of that person, and they understand the nature of the treatment and what works well for that person."[209]

299. When questioned on the appropriateness of this suggestion, Advocacy Wales told us that the formal involvement of friends or family in the advocacy process would be "fundamentally opposite to the principles of advocacy."[210]

300. The regulations in operation at present (under the *Mental Health Act 1983*) establish a principle of independence. This is carried through in new section 130E(4) of the 1983 Act.

Evidence from the Minister

301. In response to questions about the possibility of extending those who can become advocates to include family and friends, the Minister's official told us that:

> "The regulations will follow the pattern of those that work now; that level of independence and professionalism is important so we intend to continue on that basis …the regulations do currently preclude [family and friends from acting as an advocate]; you can only be an advocate if you are approved by the board."[211]

[209]RoP, paragraph 51, 29 April 2010
[210] RoP, paragraph 144, 13 May 2010
[211] RoP, Paragraph 166 & 168, April 29 2010

Our view

302. The independence of mental health advocates is essential in ensuring that patients receive fair representation. **We consider that the principle of independence for statutory mental health advocates should be retained, and are therefore content that the provisions inserted into the *Mental Health Act 1983* by Section 29 of the proposed Measure retain this independence.**

Sections 30 – 31: Further provision about independent mental health advocacy for Welsh qualifying compulsory and informal patients

303. Sections 30 and 31 insert new Sections 130F and 130G to the *Mental Health Act 1983*. These sections define the role of Independent Mental Health Advocates, and enable Welsh Ministers to prescribe the type of help and advice which may be given by an Independent Mental Health Advocates to compulsory (Section 130F of the 1983 Act) and informal (Section 130G if the 1983 Act) patients.

304. For Welsh qualifying compulsory patients, the Independent Mental Health Advocates will be able to provide information and help regarding the provisions and application of the 1983 Act; the patient's treatment; the patient's rights; and any other services which may be available to the patient.

305. For Welsh Qualifying Informal Patients, the Independent Mental Health Advocates will be able to provide information and help relating to treatment.

Evidence from Witnesses

306. In their submission, the Welsh Local Government Association and Association of Social Services Directors called for "clear guidance … on the 'role' of advocates, particularly for informal patients."[212]

Our view

307. **We believe the new Sections 130F and 130G to the *Mental Health Act 1983* (inserted by Sections 30 and 31 of the proposed Measure) are appropriate and provide clear definitions of the roles of the Independent Mental Health Advocates in respect of both**

[212] Written Evidence, MH25

Welsh qualifying compulsory and informal patients. Given that the roles of the Independent Mental Health Advocates in Wales will be expanding, we call for clear guidance on the roles of the Independent Mental Health Advocates in respect of the new categories of Welsh qualifying patients.

Section 32: Independent Mental Health Advocates – supplementary powers and duties

308. Section 32 inserts a new section 130H into the *Mental Health Act 1983*. This section applies to both compulsory and informal patients and makes supplementary provision for the powers and duties of Independent Mental Health Advocates. For example, the Independent Mental Health Advocates will be able to meet patients in private, and visit and interview anyone professionally concerned with the patient's medical treatment.

309. Under Section 130H of the 1983 Act, an Independent Mental Health Advocate must meet with a Welsh qualifying compulsory and informal patient on the reasonable request of the persons referred to for each category of patient.

310. Section 130H(3) provides a list of those who can reasonably request a visit from an Independent Mental Health Advocate for qualifying compulsory patients. The list includes:

- the nearest relative;
- responsible clinician;
- approved mental health professional;
- registered social worker professionally concerned with the patient's care, treatment or assessment;
- managers of the hospital or establishment where a patient is liable to be detained;
- the patient's donee or deputy.

311. For informal patients, this list is not as extensive (Section 130H (4)). Those included are:

    - the managers of the hospital or establishment in which the patient is an in-patient;
- any person appearing to the advocate to be the patient's carer;

- the patient's donee or deputy;
- a registered social worker professionally concerned with the patient's care, treatment or assessment.

Evidence from Witnesses

312. In general, witnesses were content that the supplementary powers and duties contained in Section 130H of the *Mental Health Act 1983*, inserted by Section 32 of the proposed Measure, were appropriate.

313. However, Gofal Cymru suggested that the list of those who can reasonably request a visit from an Independent Mental Health Advocate for Welsh qualifying compulsory patients (Section 130H(3)) should be expanded to include:

> "… all those who are professionally involved in that person's care including (for example) support workers. It also doesn't mention that the patient themselves can request a visit from an advocate, and we think it's extremely important to include them in that list."[213]

Evidence from the Minister

314. The Minister and her officials explained that the provisions contained in Section 130H of the 1983 Act (inserted by section 32 of the proposed Measure) in relation to informal patients (Section 130H (4)) are new, whilst those for compulsory patients (Section 130H(3)) extend the current provisions contained within the *Mental Health Act 1983*:

> "For patients who currently qualify, there are provisions on who can make a reasonable request and we have extended those: for compulsory patients, and not just the new compulsory patients, we have included registered social workers, hospital managers, and donees and deputies.
>
> "(…) All the provisions about who can make an informal request are entirely new. We have included donees and deputies and carers—we have not limited it to the nearest relative, as would be the case for patients detained under the Act. I know that the inclusion of nearest relatives as those who would be able to

[213] Written Evidence, MH 6

make an informal request was considered, but we have taken it much wider by including carers.

"Crucially, we have added hospital managers for both groups. When we have met advocacy providers, they have indicated that the majority of their referrals come from nursing and ward staff. So, by including hospital managers, we have clarified the legal position for them, because hospital managers can delegate that to professionals, and that is where a lot of the professionals that you may have been referring to will come from, namely those working in a hospital. It is now quite a rounded provision."[214]

Our view

315. We note the views of witnesses regarding the importance of Independent Mental Health Advocates in supporting patients and helping them to understand their rights, treatment and the services available to them. We also note the concern of witnesses regarding the exclusion of the patients themselves from the list of those who can request a visit from an advocate, both in relation to Welsh qualifying compulsory and informal patients.

316. We note that **under Section 130E of the *Mental Health Act 1983* (inserted by Section 29 of the proposed Measure) Welsh Ministers are under a duty to make arrangements to make Independent Mental Health Advocates available to qualifying compulsory and informal patient and assume that this confers an on-going right for the patient. On the basis that this assumption is correct, we are content that the patient is not included in the list of those who can request a visit from an Independent Mental Health Advocate in Section 130H of the *Mental Health Act 1983* (inserted by Section 32 of the proposed Measure). We recommend that the Minister confirms this position. If this is not the case, we recommend that the patient be added to the list of those who can request a visit from an Independent Mental Health Advocate.**

317. We have heard of the role of support workers in assisting the recovery of patients. **We agree with witnesses who have suggested that support workers should also be able to request a visit from an advocate on behalf of both compulsory and informal patients,**

[214] RoP, paragraph 154, 29 April 2010

and therefore should be included in the lists of those who can make such requests in Section 130H of the *Mental Health Act 1983* (inserted by Section 32 of the proposed Measure). We recommend that the Minister clarifies whether, similar to the provision enabling hospital managers to delegate the ability to make a formal request for an advocate to hospital staff, social workers will be able to delegate this to support workers.

Section 33: Welsh qualifying compulsory patients

318. This section inserts a new Section 130I into the *Mental Health Act 1983*. The Explanatory Memorandum provides the following information:

> "The policy objective in this proposed Measure is to extend the group of Welsh qualifying patients who are entitled under the 1983 Act to receive the support of an [Independent Mental Health Advocate] to include patients subject to the emergency short-term sections of that Act who do not currently attract such support, namely individuals who are subject to sections 4, 5(2), 5(4), 135(1), 135(2) and 136 of the 1983 Act.
>
> "Section 4 is an emergency order that lasts up to 72 hours; it is made by an approved mental health professional based on one medical recommendation. Section 5(2) is referred to as the holding power of a doctor or approved clinician; it can only be used in respect of an inpatient who wishes to leave the hospital, but whom the doctor or approved clinician considers needs to be detained for assessment or treatment. The power lasts up to 72 hours. Section 5(4) is a similar power which may only be instigated by certain qualified nurses, and lasts for a maximum duration of 6 hours.
>
> "Section 135 is a warrant made by a magistrate and provides a police officer with the power to enter an individual's residence, remove them and take them to a place of safety if they are suspected of being mentally disordered. Further assessment will take place at a place of safety, which may result in discharge or informal or formal admission to a hospital. Section 136 provides that a police officer may remove a person found in a public place, who they consider to be mentally disordered and in immediate need of care and control, to a place of safety. Further assessment will take place at a place of safety, which

may result in discharge or informal or formal admission to hospital."[215]

Evidence from Witnesses

319. Witnesses welcomed the provisions within the proposed Measure to widen the criteria for those Welsh qualifying compulsory patients that will receive statutory advocacy. However, a number of witnesses felt that there may be challenges in applying these provisions in practice, and that providing this level of advocacy support would have resource implications.

320. Evidence from South Wales Mental Health Advocacy, for example, stated:

> "Currently [Independent Mental Health Advocacy] services are required to see clients 'within a reasonable time' – this is considered by our commissioners to be within 5 working days. The new provisions will require a far shorter response time (although not an instant one) for clients held on emergency sections of the Mental Health Act. This will, as currently proposed, require the implementation of 7 day or 10 or 12 hour response service in order to receive and assess referrals and achieve a same day (or next day) response."[216]

321. Advocacy Wales expanded on this, telling us that there would need to be changes in working patterns to ensure that advocates could respond to the needs of those on emergency short term sections, but emphasised that the aim would be "to get to short-term section clients as soon as is practicable."[217]

322. The Royal College of Psychiatrists commented along similar lines:

> "It is really about the practicalities: are we going to put resources around such a wide group of people, particularly as one would have to consider that, for all areas, we would really be talking about 24-hour advocacy, 365 days a year."[218]

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[215] Explanatory Memorandum, Paragraph 52
[216] Written Evidence, MH 20
[217] RoP, paragraph 119, 13 May 2010
[218] RoP, paragraph 145, 4 May 2010

323. Other witnesses questioned the practicality and value of advocacy to these patients, particularly those subject to 6-hour sections. Some stated that there is no evidence of a need for advocacy in these circumstances[219] and that approved Mental Health Professionals already have a duty to explain to patients their rights under these sections of the *Mental Health Act 1983.*[220] Some suggested that arranging advocacy within such short timeframes could even delay the assessment process.[221]

324. There is risk, according to some respondents, that confidence in independent advocacy services could be undermined by a perceived association with statutory mental health services."[222]

325. Nevertheless, it was felt that introducing such patients to advocates at this stage might be a helpful way of laying the foundations of a longer term relationship, perhaps by providing information on advocacy services."[223]

Evidence from the Minister

326. We sought confirmation from the Minister on the extent of the advocacy provision for those in secondary care. With reference to compulsory patients, the Minister told us:

> "It covers short-term sectioned patients and those in in-patient settings… to reiterate, there are already statutory community advocates for individuals under Section 17 of the 1983 Act. The proposed Measure retains that position."[224]

327. In addition, the Minister's official explained that those under community treatment orders and guardianship orders are all currently eligible, and that this would be maintained, but that:

> "… other community services that are non statutory provision are not covered by this proposed Measure."[225]

[219] Written Evidence, MH 10, MH 28
[220] Written Evidence, MH 28
[221] Written Evidence, MH 10
[222] Written Evidence, MH 19, MH 35, MH 46, MH 63
[223] Written Evidence, MH 58, MH 40
[224] RoP, paragraph 100, 27 May 2010
[225] RoP, paragraph 101, 27 May 2010

Our view

328. We note the concerns of witnesses regarding the practical implications of providing Independent Mental Health Advocates for those on short term and emergency sections. However, we do not consider that such issues should act as a barrier to extending the right to statutory advocacy to such categories of compulsory patients.

329. **We are content that the definition of Welsh qualifying compulsory patients contained in Section 130I (inserted by Section 33 of the proposed Measure) is appropriate.**

Section 34: Welsh qualifying informal patients

330. Section 34 inserts Section 130J into the *Mental Health Act 1983* and provides a definition of Welsh qualifying informal patient. According to Section 130J(2):

> "A patient is a Welsh qualifying informal patient if he is admitted as an in-patient for treatment for, or assessment in relation to, mental disorder to a hospital or registered establishment situated in Wales (whether or not the patient is also admitted for any other purpose) without any application, order, direction or report rendering him liable to be detained under this Act."

Evidence from Witnesses

331. Witnesses welcomed the provisions within the proposed Measure to extend advocacy provision to informal patients. South Wales Mental Health Advocacy told us:

> "The proposal to extend current arrangements to informal patients is once again welcome. Experience shows that informal patients require the same support as those detained, and in reality most informal patients are subject to the same restrictions as those who are detained. Some Local Health Boards already provide the extended services covered in the proposed Measure, but there are areas where this is not the case, so the Measure will ensure an equitable service."[226]

[226] Written Evidence, MH 21

332. There was broad support for the extension of advocacy to informal patients with some highlighting the benefits for people with dementia, many of whom are in hospital.[227] However, some believed that further clarity and guidance would be needed on extending advocacy to people in general wards whose primary diagnosis may not be for a mental health problem.[228]

Evidence from the Minister

333. In evidence, the Minister recognised that:

> "There seems to be a great deal of uncertainty about the description of qualifying informal patients (…) I have asked my officials to look at this again."[229]

334. As discussed previously, in confirming which services would be covered by the advocacy provisions, the Minister's official stated that:

> "… community services that are non statutory provision are not covered by this proposed Measure."[230]

Our view

335. Mental health services are increasingly being delivered in community settings. As such, **the definition of an informal patient as contained in the proposed Measure could lead to a lack of clarity with regards to those would qualify for an Independent Mental Health Advocates. We are content with the definition of 'Welsh qualifying informal patients' in Section 130J of the *Mental Health Act 1983* (inserted by Section 34 of the proposed Measure), but consider that this should be clarified in accompanying guidance and relevant regulations.**

Section 35: Duty to give information about independent mental health advocates to Welsh qualifying compulsory patients

336. Section 35 of the proposed Measure inserts Section 130K into the *Mental Health Act 1983*.

[227] Written Evidence, MH 52, MH 60, MH 63
[228] Written Evidence, MH 46, MH 52
[229] RoP, paragraph 101, 27 May 2010
[230] Ibid

337. Section 130K contains provisions that place a duty on certain categories of 'responsible person' to give information to the patient about the independent advocacy available to them. The definition of relevant 'responsible person' in relation to a Welsh compulsory patient depends on where the patient is detained.

338. Where a person is detained in a place of safety, section 130K(2)(c) provides that the 'responsible person' is:

- where the place of safety is a hospital, the managers of the hospital;
- where the place of safety is an independent hospital or care home, the person registered as the provider of the home under Part II of the *Care Standards Act 2000*;
- where the place of safety is residential accommodation provided by a local social services authority under Part III of the *National Assistance Act 1948* (other than accommodation which is a care home), the authority;
- where the place of safety is a police station, the relevant custody officer;
- where the place of safety is any other suitable place, the occupier of which is willing temporarily to receive the patient, the occupier.

Evidence from Witnesses

339. The Association of Chief Police Officers Cymru raised concerns about the duty contained in Section 130K of the *Mental Health Act 1983* (inserted by Section 35 of the proposed Measure) being imposed on the 'relevant custody officer' and the power of the National Assembly to impose duties on police officers. Furthermore, the Association of Chief Police Officers Cymru, stated that the Police Authorities 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."[231]

[231] Rop, paragraph 37, 20 May 2010

Evidence from the Minister

340. We received legal advice to the effect that such a provision was within the legislative competence of the National Assembly. The Minister concurred.[232]

Our view

341. **We are content that Section 130K in its entirety is within the legislative competence of the National Assembly for Wales and are therefore content with new Section 130K of the *Mental Health Act 1983*, as inserted by Section 35 of the proposed Measure.**

Part 4: Subordinate Legislation Provisions

342. The subordinate legislation provisions within Part 4 of the proposed Measure are as follows:

- Section 130E(2) of the *Mental Health Act 1983* (inserted by Section 29 of the proposed Measure) enables Welsh Ministers to make regulations for the appointment of persons as Independent Mental Health Advocates.
- Section 130E(4) of the *Mental Health Act 1983* (inserted by Section 29 of the proposed Measure) establishes a principle of independence for advocates and enables Welsh Ministers to describe the persons from whom the Independent Mental Health Advocates should be independent.
- Sections 130F(2) and 130G(2) of the *Mental Health Act 1983* (inserted by Sections 30 and 31 of the proposed Measure) enables Welsh Ministers to prescribe further forms of help and advice which may be given by an Independent Mental Health Advocates in addition to those set out in Sections 130F(1) and 130 G(1).
- Section 130H(1) of the *Mental Health Act 1983* (inserted by Section 32 of the proposed Measure) allows Welsh Ministers to set out persons, in addition to those professionally concerned with the patient, who the Independent Mental Health Advocates may visit and interview in connection with their functions under the *1983 Act*.

[232] RoP, paragraph 102, 21 May 2010

Our view

343. **The *Mental Health Act 1983* currently provides that regulations relating to advocacy will be subject to annulment (negative procedure). In light of the policy developments to be implemented by these regulations it is our view that the affirmative procedure would be more appropriate. We recommend that a suitable amendment be brought forward to secure the relevant amendment to the *Mental Health Act 1983*. We are, however, prepared to concede that the affirmative procedure should apply only to the first regulations made under the new provisions.**

Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at http://www.assemblywales.org/bus-home/bus-committees/bus-committees-perm-leg/bus-committees-third-lc3-agendas.htm

22 April 2010

Sue Barnes	Hafal
Lee McCabe	Hafal
Ruth Coombs	Mind Cymru
Lyn Richards	Mind Cymru
Ewan Hilton	Gofal Cymru
Alexandra McMillan	Gofal Cymru

29 April 2010

Jonathan Morgan AM	*Member in Charge of the* National Assembly for Wales (Legislative Competence) (Health and Health Services and Social Welfare) Order 2010
Edwina Hart AM	Minister for Health and Social Services

4 May 2010

Professor Phil Fennell	Cardiff Law School
Dr Andrew Dearden	British Medical Association
Dr Victor Aziz	British Medical Association
Dave Williams	Royal College of Nurses
Martin Semple	Royal College of Nurses

Dr Helen Matthews	Royal College of Psychiatrists

13 May 2010

Mary Burrows	Betsi Cadwaladr University Health Board
Dr Lyndon Miles	Betsi Cadwaladr University Health Board
Rob Merrill	Advocacy Wales
Beverlea Frowen	Welsh Local Government Association
Stewart Greenwell	Association of Directors of Social Services

20 May 2010

Sally Burke	Association of Chief Police Officers
Dean Piper	Association of Chief Police Officers
Keith Towler	Children's Commissioner for Wales
Nia Lloyd	NSPCC
Menna Thomas	Barnardo's Cymru
Jackie Murphy	Tros Gynnal

27 May 2010

Edwina Hart AM	Minister for Health and Social Services

List of written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at http://www.assemblywales.org/bus-home/bus-legislation/bus-leg-measures/business-legislation-measures-mhs-2/lc3_3__mentalhealth_consultationresponses-2.htm

Name	*Organisation*	*Reference*
Paul Bettridge	Individual Response	MH 1
Ian Hughes	Cardiff and Vale NHS	MH 2
Joy Lock	Individual Response	MH 3
	Gofal Cymru	MH 4
	Mind Cymru	MH 5
	Hafal	MH 6
Anonymous		MH 7
Liz Davies	WCVA	MH 8
Carol Tunnicliffe	Individual Response	MH 9
	Betsi Cadwaladr University Health Board	MH 10
	Royal College of Nursing	MH 11
Jonathan Morgan AM		MH 12
	Cardiff University	MH 13
	Royal College of Psychiatrists	MH 14
	Aneurin Bevan Health Board	MH 15

Janet Howell	Individual Response	MH 16
	British Medical Association	MH 17
	The Police Federation	MH 18
	Mental Health Advocacy Scheme	MH 19
	Advocacy Wales	MH 20
	South Wales Mental Health Advocacy	MH 21
Dr S Davies	Individual Response	MH 22
	The Chief Fire Officers Association	MH 23
	Local Health Boards	MH 24
	Welsh Local Government Association and Association of Directors of Social Services Cymru	MH 25
	College of Occupational Therapists	MH 26
	Velindre NHS Trust	MH 27
T McClatchey	Individual Response	MH 28
Professor Vivienne Harpwood	Individual Response	MH 29
	NSPCC	MH 30
	Cymorth Cymru	MH 31
	Tros Gynnal	MH 32
	National Deaf Children's Society	MH 33

	Barnardos Cymru	MH 34
	Flintshire Mental Health Advocacy	MH 35
	Crossroads	MH 36
	Royal College of GPs	MH 37
	Association of Chief Police Officers	MH 38
	Conwy County Borough Council	MH 39
	Cwm Taf Local Health Board	MH 40
	Merthyr and Rhondda Mental Health Joint Planning Group	MH 41
	Cardiff and Vale University Health Board	MH 42
	Children's Commissioner for Wales	MH 43
	Comic Relief	MH 44
	British Psychological Society	MH 45
	Conwy and Denbighshire Advocacy	MH 46
	Monmouthshire Mental Health Group	MH 47
Bryan Williams	Individual Response	MH 48
	Public Health Board Wales	MH 49
	British Association for counselling and Psychotherapy	MH 50

South East Wales Voluntary Sector	MH 51
Merthyr Tydfil County Borough Council	MH 52
Betsi Cadwaladr University Health Board	MH 53
Nacro	MH 54
Stonewall Cymru	MH 55
Hywel Dda Health Board	MH 56
Chartered Society of Physiotherapy	MH 57
Map	MH 58
Abertawe Bro Morgannwg	MH 59
Alzheimer's Society	MH 60
Age Cymru	MH 61
Welsh Language Board	MH 62
City and County of Swansea	MH 63
National Offender Management Service	MH 64