

London Assembly Health Committee – 12 January 2017

Transcript of Item 5 – Mental Health and Disabled and Deaf People

Dr Onkar Sahota AM (Chair): That brings us to the main discussion this afternoon. Can I please welcome Roger Hewitt, who is the General Secretary and Chief Executive Officer of the British Society for Mental Health and Deafness (BSMHD); Alessandro Storer, Equality Improvement Manager for Mind; Joan Hutton, representing the Association of Directors of Adult Social Services; and Richard Holmes, the Policy and Campaigns Manager for the Royal National Institute of Blind People. Thank you very much for coming this afternoon.

There are five Committee members and we will all ask one main question, but if you feel that there is anything you want to contribute – a question may have been asked to one of the guests – please feel free to contribute whenever you wish to do so.

First of all, I just want to start setting the framework in broad terms and look at the overview, so perhaps if I could start with you, Alessandro. Could you give us an overview of how common mental ill-health is in disabled and Deaf people, and what are the most common mental health concerns for these groups?

Alessandro Storer (Equality Improvement Manager, Mind): Thank you very much for having me today. I just want to start by saying that this is not an area where Mind has huge expertise in terms of supporting people that have physical or sensory, cognitive impairment or learning disabilities with their mental health. It is an area that has been of growing interest since 2012, when we identified a number of key groups that we knew were at high risk of developing mental health problems. Disabled people were one of them, and I want to clarify from the beginning in terms of the use of language, though “disability” as a legal definition includes mental health issues, the way that Mind talks about disability, we try to look at the wellbeing, so the wider issues that define the social determinants of wellbeing of all people, including people with mental health problems as well as other disabilities and impairment groups.

When it comes specifically to a narrow definition of people with physical, sensory or cognitive impairments and learning disabilities, we have done some research in collaboration with a number of disability organisations that started from looking specifically at autism as one particular group. Through that research, we found that 70% of people that are on the autistic spectrum will suffer at some point in their lives from anxiety, severe anxiety or depression. That is prevalent in people with autism. More recently, we have partnered with Inclusion London and Shaping Our Lives [National Network of Service Users and Disabled People] to conduct broader research and consultations through service user engagement around other impairment groups. We have also identified other groups that are at high risk of developing mental health problems, and particularly those with sensory impairment, and deafness came up as a particularly acute area in which Deaf people suffer acute isolation, and that has a really negative impact on their wellbeing. Also people with learning disabilities more generally [are affected], again with a 40% chance that people who are either Deaf or have a learning disability will suffer a mental health problem in their lives. These are the statistics that we have.

What I would like to add on top of it is that these are generic statistics that cover all disabled people, the average that we could identify also through national research, but when it comes to looking at multiple layers of disadvantage, when we start looking, for example, at the experience of black and minority ethnic (BAME) community disabled people, those statistics become much, much higher. For example, in terms of poverty and unemployment, the statistic for BAME disabled people is much higher than the average when we look at the

entire population and then we compare it with the entire group of disabled people in the United Kingdom (UK). One of the things that I would like the Committee to address is the issue of intersectionality and multiple disadvantage and multiple discrimination because I think that is where services, especially mental health services, are failing people. I speak for Mind in terms of what we are offering, and we are pretty good at supporting people that are able to advocate for themselves and are quite educated and they articulate their problems, and that is stereotyping a bit, but, broadly speaking, middle-class, white British people, even when they are disabled. When they come with more complex problems, when they come from a different background or they have additional challenges that may be linked to their sexuality or again ethnicity or religion, that is when services feel much less confident in addressing those issues. I would like to see that dimension explored a bit more today.

Dr Onkar Sahota AM (Chair): Are you able to comment on any trends in the last ten years?

Alessandro Storer (Equality Improvement Manager, Mind): Probably I am not the best placed to comment on the last ten years, but what I can say is that in the last four to five years, the changes in the social care funding and some of the cuts in terms of local funding and commissioning, especially to social care, has had an impact on the capacity of disabled people to live independently, including of course the closure of the Independent Living Fund (ILF). This has had an impact on all disabled people including both people that we work specifically with, people with mental health problems, as well as other impairment groups.

The one thing that I would mention about that is again about independent living. The fact that, for example, in terms of social care, many disabled people have lost their dedicated social worker, so the community psychiatric nurse (CPN) or the mental health nurses that were working in the community to help them effectively access a number of different services that they needed, from employment to housing, disability support and mental health. With that being much more difficult to access now, people become much more isolated and their problems in terms of wellbeing and mental health become more acute.

Dr Onkar Sahota AM (Chair): Thank you. Richard, the question was: can you give an overview of how common mental illness is among disabled and Deaf people, and if you have seen any trends evolving over the last ten years?

Richard Holmes (Policy and Campaign Manager, Royal National Institute of Blind People): Thank you very much, Chair, for the opportunity. I would like to explore the need for support for existing services to try to prevent visually-impaired people entering the system later on, reporting with a mental health condition. There is a lot of statutory support available from local authorities. Alessandro has mentioned social care. Within aspects of social care, we were very aware of increased pressures on support for blind and partially-sighted people such as mobility support, for example. The reduction in that service inevitably means an increased sense of isolation, lack of independence, loss of independence, and an inability for them to get out safely and confidently. That is one of the angles I would like to look at to try to prevent people reporting back later on into a system that is already creaking, as we know, with a secondary condition, rather than their primary, initial condition of vision impairment being addressed. That starts from the point that their condition is diagnosed in an eye hospital and how that should then be referred on to their local authority and the support they should then receive. There are gaps. We have noticed increasing gaps in terms of how people are referred on from the eye clinic to local authorities and then how quickly they are assessed and their needs become addressed through a care plan. That is one area. It is often referred to as the eye care or eye health pathway. I do not particularly like the phrase but I have not come up with a better one, so I will use it until I think of a better one later on.

At the point that a person is told they have glaucoma, for example, but it is OK because you can be referred to a local authority, you can be registered: what on earth does glaucoma mean? What are the implications of glaucoma? Will I go blind overnight, next week, next year? What support can I receive? Will I have to give up my job? All those are questions that a person would ask, which the medical profession are not able, and frankly do not have time to answer, but a non-medical person located in an eye clinic could help to answer some of those questions and, crucially, could give some information as to how that person could be referred on to support they can get from their local authority.

We have also noted an increase in the levels of unemployment in the last decade or so among visually-impaired people. The rates of employment were not particularly high to start with, but we are now looking at around 27% of people who are blind and partially-sighted in work at the moment, which is a decline from where we were in the last piece of research in 2001. A series of very alarming trends which, on their own, could be expected to increase a person's stress, anxiety etc, but add them all together and there are bigger problems further on from a person not having their condition initially addressed and properly dealt with.

Dr Onkar Sahota AM (Chair): Thank you, Richard. Can I ask the same question to Roger?

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): Thank you, Chair. I have to say that both the previous speakers have covered things pretty fairly well. I think Deaf people have similar problems, like, for example, somebody who perhaps loses their hearing very suddenly, and it can happen. You can lose your hearing overnight. You can imagine how the person has difficulty coping with that, and there can be a danger of acquiring serious mental health problems. Basically, it should be a question of making sure that these people have the right support and also, maybe more importantly, the right knowledge. As you have probably heard, earlier this week there was a message sent out by the Prime Minister [Rt Hon Theresa May MP] about mental health first aid. The British Society has been promoting mental health first aid courses and delivering them to the Deaf community around the country, with a Deaf instructor, and that has been quite successful, meaning that more Deaf people are identified that they have mental health issues which they had not been aware of previously.

The main issue, as has already been mentioned by Richard [Holmes], is in terms of unemployment. In the last ten years there has been a slight improvement in the number of Deaf people who have been in work, but the latest research shows 33% out of work. I am talking about British Sign Language (BSL) users specifically, which is only one part of the spectrum of deafness. As you have already mentioned, the biggest issues are with communication and lack of access to information. Community mental health teams are often not aware of what Deaf services are available. There are services available in London, specifically in south west London, South West London and St George's Mental Health National Health Trust in Tooting, but people are not always referred there. What tends to happen is that Deaf people who go to their general practitioner (GP) get referred to a generic counselling service with interpreters. It is all very well, but the latest research, which has not yet been published, shows that Deaf people have a much better recovery rate with peer-to-peer support because there are Deaf counsellors available. At the same time, we would expect it to be more cost-effective, but it just so happens, the way the clinical commissioning groups (CCGs) work and their budgets and their system, they have a budget for communication support but not for external counsellors, which seems a bit ridiculous.

Also with regard to approved mental health professionals, they have no deaf awareness training that I am aware of, which is quite appalling because it must be ten years ago now that the Department of Health published a report that we call the TEA report, which stands for *Towards Equal Access*, and there were 26 recommendations in that report, one of which was health professionals should have Deaf awareness

training. Now, it does vary between trust and trust. Some are very good about it. Others do not want to spend the money.

Andrew Boff AM: Can I just ask? You have said that there was no budget for external counsellors. Sorry, whose budget were we talking about? Is this the CCGs?

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): The CCGs.

Andrew Boff AM: They are specifically prevented from using external counsellors, is that correct?

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): Yes. That is our understanding. I am not an expert on that particular area. It should be SignHealth [Deaf health charity] you approach over that because they have something called BSL Healthy Minds [psychological therapy service for Deaf people], and it is historical that we have been involved as the BSMHD. The British Society received £107,000 from the Department of Health to train Deaf people to become counsellors, and there were 19 counsellors who were trained from the whole of England. They moved on to become psychological wellbeing practitioners (PWP), and they went to John Moores University, of which 17 Deaf counsellors or PWP became qualified, and they were located in different primary care trusts (PCTs), as they were then. They were then funded by the PCTs, but when they changed to CCGs, a lot of that service was lost, although the money was supposed to be 'ring-fenced' and now there are only a few CCGs that actually pay for these PWP. Other PWP have been made redundant, which is a shame because there is a fantastic resource there.

If I can give you just a simple, straightforward example, a profoundly Deaf person wanted counselling, and they went to their GP. The GP referred them to a counsellor with an interpreter, and after ten sessions the GP was tearing his hair out because there had been no progress. The Deaf person said, "What about going to BSL Healthy Minds?" The GP said they would find the money, and after two sessions with a Deaf counsellor the person started recovery and was in recovery.

Just one other thing I would like to mention. Helplines, including the Samaritans [charity for people in emotional distress] and Crisis [charity for single homeless people], do not have immediate accessible services. For example, yes, Samaritans do have a text number, but you are lucky if it gets answered within two hours. Emails are 24 hours, which is no good for somebody who is in crisis. Thank you, Chair.

Joan Hutton (Association of Directors of Adult Social Services): A lot of points have been covered by members of this panel, but I think that one of the really important issues is that access to mental health services is predominantly via GPs. One of the areas of concern I believe for most disabled people and people who have sensory impairment is about that access, about not getting a good diagnosis. We have heard from some of the evidence today about the barriers to communication for some of those groups of disabled people - people with sensory impairment, people with a learning disability - who may also need a specific communication support. I do believe that is an area that needs some further exploration because that is the gateway into mental health services.

Things have been raised today about social care and the role that social care takes in terms of supporting disabled people, people with sensory impairment, and indeed the changes that have taken place in terms of the Care Act, in terms of the efficiencies and savings that are hitting all of the public services, as you will know. The focus is to support people to be self-reliant, and I think there is a risk of some people with disabilities or mental health problems falling through that net, not finding the right thing to help them be self-reliant. There

have been some very good things over the last ten years, just picking up on a further question - technology has advanced, there are more things to help and promote self-management, exposure to better information, etc - but that in itself is not enough. Some good things have happened I believe, but essentially there is more to be done to support people with mental health issues from that point of prevention and [provide] links to employment. It is well evidenced that support into employment is of benefit to those people who have a mental health concern, particularly those that relate to depression, low mood etc, and all types of mental illness, it is true to say, but particular in that cohort of people that perhaps could be supported more effectively if there were more opportunities.

In terms of people with sensory impairment, data is very poor. There are registers that local authorities keep in terms of disabled people and people with sensory impairment, but there is not anything aggregated across with health that would - I do not know - help us understand. Some organisations focus on this and try to use this to promote the needs of those groups of people, but there is something about finding more evidence and data that would be important.

Dr Onkar Sahota AM (Chair): Thank you for that, Joan.

Shaun Bailey AM (Deputy Chair): I shall address my question to Joan, and then everybody please jump in following what Joan says? For those of us outside of this arena, I would like to ask: how does housing and crime and hate crime affect disabled people? What effects do we see from a lack of housing, employment etc in this community?

Joan Hutton (Association of Directors of Adult Social Services): Again, I think that there is a lack of data to give a comprehensive view of that and a good understanding of that, but we know that very often those disabled people are affected by lack of housing or hate crime. We know from safeguarding, for example, that when there is a safeguarding incident, we look at how many of those people are disabled in any way. I do not think that any of that [data] is collected. One thing that may be interesting to look at is from the safeguarding data that is collected by every safeguarding partnership board. How much of that relates to people who are disabled or have a sensory disability? That would then link to certainly hate crime.

Shaun Bailey AM (Deputy Chair): Are you saying there is not enough data across the board? There is some there, but we are not aggregating that data, we are not interrogating it enough?

Joan Hutton (Association of Directors of Adult Social Services): There is some there, yes. I think local authorities in their own right may do that. It may be something to ask Safeguarding Boards to do, but it is interesting. I am just thinking about hate crime in particular. In terms of housing, that would not come to the Safeguarding Boards, but is there data that people who have housing needs do register their disability? Is any of that aggregated, and where does it go? I am afraid I am not sure, but that would be worth looking at.

Shaun Bailey AM (Deputy Chair): I am going to circle back around slightly under the Mayor's powers to housing, but just to talk about social isolation, is that prevalent for people who have disabilities? How impactful is that? Is that something that we look at and understand?

Joan Hutton (Association of Directors of Adult Social Services): I think it is prevalent with people who have mental health problems. Very often people who have mental health problems withdraw and are isolated. Unless they are referred by a GP or access their GP and the GP knows about it, they may well not be known by anybody unless they have networks of support. It is very prevalent.

Shaun Bailey AM (Deputy Chair): One of the things that strikes me when you are in Health Committee - I am sure Dr Sahota will tell me if I am wrong - everything seems to go through the GP from housing to mental health. Do other organisations try to support GPs in any way, provide a buffer or provide a service that can advocate for them?

Joan Hutton (Association of Directors of Adult Social Services): Just to come back to your first point, not everything goes through the GP. People can access the local authority housing department and social care independently of a GP and their issues are looked at. The GP is the gateway to mental health services very often, referrals from a GP, unless of course someone is in crisis and there is an approach under the Mental Health Act. Then obviously the GP comes in later.

In answer to your second point, there is an approach whereby local authorities, social care and health are expected to work in a more collaborative way - this is a requirement - and to work closer with GPs. Local authorities are in different stages in implementing this, but there are closer arrangements with GPs and social care, housing and health, so all of those services coming together, which is going to be a better option.

Shaun Bailey AM (Deputy Chair): Are you saying that is beginning to happen and it is improving?

Joan Hutton (Association of Directors of Adult Social Services): Yes. It is in differing stages in differing parts of the country, but that is a national approach to that integration across health and social care and linking in with housing and mental health, with different models of how that is done across the country. There is certainly that close working with the GPs to provide people with more information, with more advice, with more opportunities for self-management, more opportunities for preventative services, and services that are brought together, joint-funded, to support people after and through an episode of mental illness, for example.

Andrew Boff AM: Just very quickly on that particular point, do you think it would help if social workers, for example, could take some of that load off the GPs and were able to prescribe certain services for individuals? Social workers at the moment, as you say, only tend to see people under stress, but is it worth considering allowing those mental health services to be prescribed by somebody other than a GP?

Joan Hutton (Association of Directors of Adult Social Services): Yes. I think that happens in certain areas better than in others, but the generic social workers, the non-mental-health social workers, are working closely with their GP, and the mental health trusts and GPs are coming into that alliance. It is a whole-system approach to integration. Yes, I think that is helpful.

Andrew Boff AM: That would be helpful.

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): It has been mentioned earlier about the changes that have been made in the last ten years. One of the things is that some boroughs have done away with their specialist social workers. From our point of view, the social workers for the Deaf are fantastic because often they are a pathway into housing, even jobs. Now they have been done away with, Deaf people are expected to go to a generic social worker who is not aware of the specific issues that Deaf people have. I am not saying all of them, but many of them. Now there is some pressure on voluntary organisations to take on the load without the funding, so it is becoming more and more difficult not only for the voluntary organisations but for the Deaf people themselves. Sometimes Deaf people are floundering. Again, some GP practices are very good about providing interpreters for patient consultations, but others do not want to know. In the same way as Joan [Hutton] says, there is technology available but not all health professionals will take it on. A good example is something called SignVideo, where

you can have an interpreter on your mobile phone, at a very reasonable cost compared to bringing in a face-to-face live interpreter. It is very good for particular consultations but not for all, and it is also cost-effective, but some GPs will not take it on board.

Andrew Boff AM: Thank you very much.

Alessandro Storer (Equality Improvement Manager, Mind): Can we come back to a couple of points that were made just really quickly on data? Especially around employment, there is quite a lot of data out there that is collected by Jobcentres, some that is collected through the census and other ordinance systems, and a lot of research that the voluntary sector has been funded to do. Sometimes local authorities ask for more data just as a way of delaying intervening and delaying acknowledging that there is a problem. Around employment, we know that less than half of the disabled people in the UK are employed; so it is 49% in the latest statistics that we are collating from the latest census. 49% of disabled people; and it goes down 14% for people with learning disabilities who have a mental health problem. We know that there is a problem in terms of the employment gap, and we know that a lot of it has to do with the way that support is commissioned locally. I strongly agree with the point that was made about cutting specialist provision, because although not everything goes through the GP, often it is the GP that has to spot the additional needs that somebody who presents with a mental health problem or condition might have in relation to their employment, debt or housing, and unless they are able to signpost people to specialist services that are available locally, the patient themselves will not access them. They can, they are available, and the local authority offers them, but people need to be able to be, again, informed about them and advocate for themselves and be able to access them. Often it is the GP that is in the best position to make sure that the person accesses the support they need to access their particular agency, for example, around employment or housing.

There has been increasing collaboration between GPs and especially the voluntary sector in that space, in that grey area, especially when people are waiting to access counselling, for example. If the Committee wanted to look into some of the good practice around it, there is something that Mind is piloting called Active Monitoring, which is exactly about supporting people as they wait to be formally seen by a counsellor so that we can help them sort out all of the additional social aspects of their wellbeing which may have to do with their housing, employment, debt advice and so on.

Richard Holmes (Policy and Campaign Manager, Royal National Institute of Blind People): I just wanted to pick up on your question about housing. It is a really, really very significant one for people who are blind or partially-sighted, particularly if they find themselves homeless and in a position to accept an offer of accommodation. There is not enough flexibility given to that person's impairment, so the chances are that they will be extremely well advised to accept any offer because not to do so can have significant implications. The likelihood is that that property would be in a different part of the borough or even outside of that borough. That fits back in with what I was saying initially around mobility and rehabilitation support because that person will have become familiar with their initial area and being independent within that area, but then will be moved to another area where support systems are all taken away. They will need to wait to have further mobility support. Therefore, if they are fortunate, they will rely on family members or friends to offer that level of help, but that in itself has implications because that means that they are on someone else's timetable and go when that person has time, go to the place that that person wishes to go. Therefore, anything else they would wish to do is on top of that, and that can cause considerable stress and anxiety within families. That obviously increases mental ill-health.

The other side of it is the person may well think it is too much pressure on the family: "So I won't go out. I will remain at home and wait until some point when I will be able to go back into the system and get some more support from social services to have the increased levels of mobility support". That is an issue around housing.

There certainly are examples we have become aware of in relation to where people have been moved as the victims of hate crime, which obviously further reduces their confidence, rather than the perpetrator's, which is an obstruction for the reasons that I have mentioned. Housing is a real, significant problem.

I was speaking with someone last week who has moved across his borough to a fifth-floor flat without any of the support I have mentioned, and he was exactly having some of these problems, relying on his partner so much more to go out without any of the statutory support that should be available and he should be able to opt back in, so they were very, very much under pressure.

Shaun Bailey AM (Deputy Chair): The Mayor offers support for specialist housing development, and we are beginning to hear signals that that is not always used, it is not always part of the development package, etc. Do you have any experience or any knowledge, statistically or anecdotally, of that pot of money not being spent? One of the things the Committee will do afterwards is go back and look at whether all that money is spent and how it is spent. I wonder what it looks like on the ground. Have you any knowledge of the Mayor's financial power being used to provide specialist housing in all the new developments across London?

Richard Holmes (Policy and Campaign Manager, Royal National Institute of Blind People): There was a very useful report put together by our colleagues at Leonard Cheshire Disability [UK charity for disabled people] on this issue, which I think is well worth taking a look at because it precisely raises these points, that you have the paradox that we are aware there is not enough specialist accommodation, there is potential to improve the situation, but for whatever reason that is not happening. I think that is a document well worth visiting. We ourselves are not particularly aware of that as an issue. As I say, the issue is more in terms of general provision of services for independence as a whole, rather than specialist accommodation and accessible accommodation in particular.

Dr Onkar Sahota AM (Chair): Thank you. Joan, I just want to pick this up. It is a pity that we do not have a GP who can speak from a neutral position, rather than me, but there has been a decline in the number of dedicated social workers. Are there dedicated social workers available to people with disabilities and with learning needs as well, or are they all dealt with on an emergency basis?

Joan Hutton (Association of Directors of Adult Social Services): The mental health trusts that are commissioned by the CCGs have an arrangement of social workers that are often seconded from the local authority, and they are specialist social workers for mental health, and they are approved mental health practitioners who are able to assess and support people in accordance with the Mental Health Act. Then, in addition, there are social workers within the social services in the council that are generically trained social workers for adults and for children. Of these social workers, there are fewer specialist social workers. Taking on Roger's [Hewitt] point, the numbers of specialist social workers for people who are Deaf, it is true to say, seems to be reducing. Where many local authorities had a specialist team that worked with people who were Deaf or sensory-impaired, for example, that seems to be eroding and there is a greater approach to generic teams working in geographical patches with their health colleagues, but with a wider generalist understanding of disability and sensory impairment. It is there, but there are not the kernels of specialism that perhaps there once were, it seems.

Dr Onkar Sahota AM (Chair): The other thing is access to counselling services. We hear that people should be able to access them correctly, and not necessarily through a GP, but there is no availability of those counsellors. That is another problem, that people need counselling and they need it today or tomorrow, but they go to the GP, who unfortunately does not have access to those services, and there is another problem.

The other thing that ends up with GPs is people who have housing problems. It has nothing to do with a doctor technically, but the clerical officer or housing officer sitting there says, "If you go to your GP and get a letter from them, they will put you higher up in priority". We know where the letter goes. It goes to a filing cabinet under the table, called the bin. That is what is happening increasingly.

Also what I am seeing is that people who have disabilities, can some of them still walk? Can some of them still feed themselves? But there are strict questions asked of them in the disabilities assessment. They often get rejected as beneficiaries, and they then end up at the doctor's. Are you finding that increasingly happening?

Alessandro Storer (Equality Improvement Manager, Mind): Absolutely, yes.

Dr Onkar Sahota AM (Chair): I am forever writing reports for appeals of cases of these people who are disabled, who have a lot of mental illnesses, and yet they have passed the test to return to work. I am seeing this increases the pressure on me. Is this just my practice or is this happening right across London?

Alessandro Storer (Equality Improvement Manager, Mind): I can speak for east London and [the London Borough of] Newham in particular, the borough where I am from. I am part of the Healthwatch in Newham. We have seen a reduction in the specialist support that was offered in terms of counselling, and local authority teams that used to have dedicated support workers for disabled people and people with sensory impairment having been amalgamated into one generic team. That support is gone, effectively.

In terms of people being signposted back to their GP so that their housing support will be increased or they will be more likely, that keeps happening, and it is certainly a way - as far as I can say, this is more of a personal opinion - again of delaying that offer in terms of turning people away and making them hope that if they go back to the GP they will have better chances when they come back. What we have been calling for is to have many more friends or advocates that go with people to meetings, especially housing, employment and debt, before they are referred back to the GPs so that the advocate can say, "This is not right. You are not going to send this person back to the GP because we know this is not going to do any good". Housing is not an issue the GP should be dealing with. The advocacy support has been something that again is not ideal because it is often by the voluntary sector instead of having the direct specialist support in the local authorities, but it has somehow been filling that gap of the absence of specialist support so when people try to access support independently, at least they have an advocate with them and they feel more empowered to say, "This is not what I am going to do because it is not going to help me". It has been increasingly happening.

Richard Holmes (Policy and Campaign Manager, Royal National Institute of Blind People): It is becoming an issue that we are more and more aware of, and there certainly seems to be an increase in either waiting time from seeing the GP, to being able to be referred on to a service, so people either wait and their condition deteriorates, or they take out some private counselling sessions. A lady I worked with went down that route and happily got very good support, but it is obviously, as with a lot of services, still a bit too piecemeal to be relied on. We are finding that there is that longer period between having the evaluation of the GP, but then the GP being aware, which must be so frustrating because the GPs are aware that they will not be able to refer someone on as quickly as that person needs to be referred on. It could be because of the great pressures on the service, which is precisely why we as an organisation want to look at services and service enhancements earlier on to avoid these delays and, therefore, a person becoming depressed or increasing their levels of anxiety through not having an appropriate assessment, whether that is initially a vision impairment or when they do have a mental health condition, that not being assessed quickly enough and dealt with quickly enough either. It is almost like a danger of two issues coming together but neither being addressed as quickly and efficiently as it needs to be done.

There is also another issue for us as well around the ability of services to be able to work with and understand someone who has a mental health condition but also has another impairment as well, so they would be very good at the mental health side but would not necessarily know how to deal with someone who has glaucoma or macular degeneration, for example. We have terrible evidence of someone who was receiving support but some days she would not eat her food, because it was just left there, and the staff assumed it was part of her mental condition why she was not eating it, but she was not aware of the food that was being left in front of her to actually eat, and most of it, she was not aware of what she was eating anyhow because she was not communicated with. There are essential communication issues that visually-impaired people would need that are separate to the mental health condition which they are being treated for, rather than dually, as it were.

Andrew Boff AM: Would anyone like to say what are the main barriers for Deaf and disabled people trying to access mental health support?

Alessandro Storer (Equality Improvement Manager, Mind): Building on what Richard [Holmes] was just saying about the lack of understanding that mental health services have of other impairment. We constantly face the challenge of people being referred by the GP to a local Mind because the waiting lists for the Improving Access to Psychological Therapies (IAPT) programme, for example, are too long. They present other needs that come with, for example, a particular impairment group, and our staff often do not feel confident or comfortable about engaging with that particular individual because they are just afraid they will use the wrong language. They have not been trained --

Andrew Boff AM: Would you say it is a more sensitive referral or a more accurate referral?

Alessandro Storer (Equality Improvement Manager, Mind): In that case I am speaking particularly about mental health services not being equipped with the right knowledge and skills to confidently support people that come not only with the mental health problems but also with other disabilities. This is where we started in terms of understanding that there was a gap in our skills in terms of how we were supporting people. From the data that we were collecting, we realised that though there is an acute need in terms of mental health among disabled people, disabled people were not accessing our services. When we did a bit of investigation we found out that the reason why that was not happening was because when they were first approaching Mind and other mental health services, including statutory services, their first experience from the receptionist or on the phone was quite negative, and the main issue was the lack of confidence that our staff had in terms of addressing disability and talking about that disability.

Andrew Boff AM: What you have described sounds relatively easy to fix. Forgive me if I have got the wrong end of the stick. It would require training programmes for those who are responsible for referrals, which does not sound like an enormous job to me. Perhaps I am wrong.

Alessandro Storer (Equality Improvement Manager, Mind): Unfortunately the funding for that kind of specialist training is being cut consistently. There is a recent report that was done on London CCGs, looking at the level of funding that was going into specialist training, that very training that would enable better signposting, better referrals, and that is being constantly cut. Not only are the services that are offering specialist provision being cut, but also the training that would enable generic services to be more accessible is also being cut.

Andrew Boff AM: This is an example of a cut that is taking place that is going to cost us more in the long run.

Alessandro Storer (Equality Improvement Manager, Mind): Absolutely. I give east London as an example, where the majority of the population is from a black or Asian background, and there are 194 languages spoken. If you do not have the specialist provision in place and you cut the training that would enable mainstream services to understand how to support that kind of diversity, by definition people will not access early prevention and early intervention services and they will only access hospital care. They will end up in crisis, and that is so much more expensive. That is the kind of issue that probably the Mayor could look at. You are right; it is a fairly straightforward solution. Unfortunately, because it is devolved – I do not know the exact word – to the CCG in terms of the final decision where the money goes, from their point of view it seems better to invest in front line services, so they are saying, “We are increasing the number of mental health nurses”. However, if they are not trained properly, those that come with multiple needs and those that have always been excluded by services are going to be even more excluded now because there is nothing for them. Voluntary sector services are closing, specialist provision is being reduced, training is not there, so those people are simply going to be excluded.

Andrew Boff AM: You may not be able to answer this but I am going to try anyway, because everybody thinks everybody should be trained more, to the point where you could spend your entire professional career in training rather than doing the job. How much training do you think it would require for those people who are referring to be sensitive to the requirements of disabled people when referring for mental health services? What amount of training is a reasonable amount, do you think?

Alessandro Storer (Equality Improvement Manager, Mind): Yes, I think that is a good point because the training needs will be different from the point of referral and the point of service provision, and Inclusion London [Deaf and disabled charity] does amazing work in terms of, for example, training – with the right level of training – Transport for London (TfL) staff. TfL staff only need a very limited amount of information in order to know what kind of support they might need to provide to somebody who has limited mobility or is partially blind, and there is no point for them to go through full disability equality training, which is the one that actually service providers should go through, and this is the one that Mind is piloting, which is a couple of days, which is delivered by disabled people, and it is about service provision. There are others though: at point of referral, for example, there is half-day training, and there are even modules for GPs that are recommended and are being developed as an online offer that take a couple of hours, just to give the basic information. You can strip it out, but there needs to be a foundation --

Andrew Boff AM: I am dubious about online training.

Alessandro Storer (Equality Improvement Manager, Mind): I know, but at least they could do that as a compulsory starting point. They do not do that either. That would be one starting point.

The risk with that is that it still excludes people who have more complex needs. On the point of housing, for example, just to give you a statistic that came out of a national study that the Equalities National Council did, 44% of BAME disabled people live in poverty, basically, compared to 17% of the population. When you look at that group, 44% of BAME disabled people, that kind of training is not going to be enough because the understanding that is required to really understand the issues that are relevant for that particular part of the population require more specialist training or more specialist interventions. Training is an answer but not the answer to everything. It needs to be combined with specialist advocacy, outreach, and investment in local services that are much better positioned to understand people’s needs and support them.

Andrew Boff AM: What you have said seems to take on what Mr Holmes was saying about early support for people with diagnoses of visual problems. It says here in our briefing note that only 17% of registered blind

and partially-sighted people were offered any form of emotional support at the time of diagnosis. Mr Holmes, is that a figure you would recognise?

Richard Holmes (Policy and Campaign Manager, Royal National Institute of Blind People): Yes, it is, sadly. It is a crucial area to look at because, as you mentioned, not doing so only stores up greater costs later on. To have emotional support at the point a person receives their diagnosis, ideally from someone who has been through that themselves - so ideally from a visually-impaired person but that's not essential - helps, but I think it also helps with training as well, to make it more relevant, but specifically talking about the emotional support. It is a crucial part. Too many people have told us that they were given their diagnosis and told, "Off you go". In that situation some people will manage, because people always manage. Some people will manage a bit. Too many people will just fall out of the system and, like I said, come back some years later on without their eye condition being dealt with, but with a mental health condition on top of it as well. They have been coming into the wrong part of the system, which is already overstretched, as we have discussed, but still not having the initial eye condition dealt with. Emotional support in its essence in terms of people being given basic information is crucial, but also crucial is the information that a person can receive from that and what services they can get from that, because chances are a person would not know what to ask for and would not know what services are available because you do not know until you need something generally.

One of our big campaigns is getting more of what we call 'sight loss advisers' into eye clinics and hospitals to precisely provide that service and that support that a person can then go back to, maybe not seeing them on the particular day they have received a diagnosis, but at least being aware that that support is available, someone outside of the medical profession who can provide practical and basic information and awareness. It is crucial, and we do need more sight loss advisers in hospitals. They are proven to be successful in terms of the benefit people receive from them, but also they are beneficial in the broader sense as well because statutory services are picked up and awareness of them is picked up. As I also said, potential future problems are also diminished with the increased level of support and emotional support a person receives at the point of their diagnosis.

Andrew Boff AM: Can you possibly - any other members as well of the panel - cite any particular barriers that there may be for Deaf and disabled people to access mental health support, any specific ones? I am very pleased that you have come up with one. It sounds like early, accurate referral is a very key one here. Are there any issues?

Joan Hutton (Association of Directors of Adult Social Services): Certainly, for people who are sign language users, BSL, the lack of available interpreters is an issue and can be a barrier to accessing mental health and ongoing treatment through a programme of mental health support. That support is not going to be as effective as it needs to be without communication in the person's preferred communication medium.

Andrew Boff AM: Yes. I did a rapporteurship about access to the health services for Deaf people, and I certainly found that a shortage of professional BSL interpreters and the technology to enable Deaf people to access those services was a real issue. I do not know if we can just bring that forward from that rapporteurship.

Joan Hutton (Association of Directors of Adult Social Services): Could I elaborate a little further, please, on that very point?

Andrew Boff AM: Yes, please.

Joan Hutton (Association of Directors of Adult Social Services): It is interesting, because over the course of the last, let us say, ten years, there are far more people trained as interpreters. From a personal point

of view, I trained as a sign language interpreter in 1991 and there were six or seven. There are far more interpreters, but what is lacking is the funding at a rate for those interpreters to accept work. Contracts are let to interpreting agencies that are very generic and cover a whole range of languages and BSL is a part of that. Therefore, what are often sourced are practitioners who are not at an adequate level, so money comes into this, not quality.

In terms of mental health, this is an area where it is absolutely essential that the person concerned has access. It is a complex issue: somebody who is prelingually profoundly Deaf, their communication will be slightly different to somebody who has lost their hearing after they have developed spoken language. It is not one size fits all; it is complex. It is true to say that those complexities are not easily met, but I believe that that is a real barrier to good preventative - and indeed ongoing - support through a mental health episode.

Andrew Boff AM: That would be something that mental health service providers themselves should do. Is there anything else that the mental health service providers should do in order to make themselves more accessible to Deaf people?

Joan Hutton (Association of Directors of Adult Social Services): I would say that there are national services that specialise in mental health in Deafness and there is something about GPs and locally people being more aware of that provision. There is something about CCGs commissioning together, rather than for 33 London boroughs. What about CCGs thinking across the geographical boundary and commissioning together? There are very often a few people in a borough but more people across several boroughs, and therefore it would make it more cost-effective.

Andrew Boff AM: That would be a great thing. Certainly the Committee in the past has called on the Mayor to use his convening powers to get that kind of operation working.

Jennette Arnold OBE AM: I just wonder, Joan, if you could go back, because I wanted a little bit more clarity. We have a lack of available interpreters and you are saying that is because of the specialities that need to be addressed, because the variation is so wide, basically it is almost like we are in a realm of having to have somebody who is so skilled that it is almost a personalised service --

Joan Hutton (Association of Directors of Adult Social Services): Absolutely.

Jennette Arnold OBE AM: -- or that that person is skilled - I do not know enough - in a particular area. Is it then even though they are so skilled, they are more likely to be working in a sort of generalised area when you want them and so that is one of the real difficulties? It is like a beehive, is it not? It is so complex, is it not?

Joan Hutton (Association of Directors of Adult Social Services): Yes, but if we liken this to a foreign language, if I could speak French fluently and English fluently, but you ask me to interpret very complex technical --

Jennette Arnold OBE AM: Yes, in a local dialect.

Joan Hutton (Association of Directors of Adult Social Services): Exactly. It would be a challenge, and we have to see it in that very way.

Jennette Arnold OBE AM: It would be a challenge. I can come to you, Roger [Hewitt]. Given you belong to the organisation and in order to deliver the care, the buck stops with you, what measures have you taken?

This is not new. You may well be getting new areas, but you have known for as many years that there is this need of this particular group of people.

Joan Hutton (Association of Directors of Adult Social Services): The social services' statutory responsibility is not to provide interpreting or commission interpreting services generically. If mental health services work with somebody who needs an interpreter, then they have to commission that interpreter to support the person they are working with.

Jennette Arnold OBE AM: How can social workers do their job if they do not have interpreters?

Joan Hutton (Association of Directors of Adult Social Services): Most local authorities and CCGs have contracts with interpreting organisations. My point is that the rates that are being paid have to be sufficient to pay the interpreters and the quality issue has to be considered.

Andrew Boff AM: I think during our rapporteurship we found that there was a variable interpretation of what "adequate interpretation" was, so it would differ from CCG to CCG. Actually, the qualification levels of BSL can be quite confusing when applied to things like interpreting medical diagnoses, for example, which is a special skill. There is an issue there. I should not be giving evidence; I should be asking.

Jennette Arnold OBE AM: We can make reference back to your work, definitely, Andrew. It just struck me that this is an area where we found other areas where it is so easy to just keep passing the buck and to say it is so complex, it is so challenging. It is like you make a little bit of an inbreak and then it defaults back to being, "Oh, this is so difficult".

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): Some interpreters do specialise in the mental health area, but one of the problems they have is they could possibly acquire mental health issues themselves because it is a very, very stressful area and situation to work in. That is why a lot of interpreters will not agree to work in the mental health field. If I can give you just a brief description of what happened recently - not in London, fortunately - in one CCG in the north, they put out a tender for a new interpreting service for Deaf people with a cut of one-third in what they were paying. As a result of that, a lot of interpreters have just quit from providing that National Health Service service. Unfortunately, this is common, so that leads again to a lack of interpreters.

So far we have talked about the need for interpreters, but also there is a need for mental health services to make sure that their written information, for example, is accessible, because quite often Deaf people are given a leaflet which is in English which they cannot follow. Again, the charity SignHealth, have produced a number of clips in sign language explaining about the different forms of mental health. The question is this: why should a charity be doing this voluntarily with no funding when it should be something that the mental health services should be providing?

Andrew Boff AM: Can I just move on to something about where there hopefully may be good practice in London and further afield? Are there examples of practices that perhaps CCGs and we could copy and also that we could recommend to the Mayor to take up? I do hope there is some response to good practice. There must be some somewhere.

Jennette Arnold OBE AM: You must have found some.

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): As I said earlier about South West London, St George's Mental Health Trust has a very good

service, but it is a question of ensuring that the GPs and the CCGs are referring Deaf people to that service and it is not always happening. As we have been mentioning, people are being left floundering for weeks and weeks and weeks without support, when it is possible they could be referred to this service in Tooting almost immediately. There are other services; for example, children's services I believe are referred to Maidstone. It is a long way away for parents to have to take their children. I am not aware - maybe you are, Joan [Hutton] - of any other children's services in London specifically.

Andrew Boff AM: Can I just ask, Mr Hewitt, what it is that they are doing that makes them a good service? What are the actions they take that makes them recommendable?

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): The fact that they are meeting Deaf people's specific needs, like communication, access to information and so on with, in many cases, Deaf professionals as well, because what we have found is peer-to-peer support makes a massive difference.

Andrew Boff AM: Are there any other examples of good practice that we can follow up on?

Alessandro Storer (Equality Improvement Manager, Mind): I can give a few. This links back to the question of barriers, because I think one barrier that we have not fully addressed, I guess, is the attitudinal barriers. We talked about communication, information, we talked about physical and environmental barriers, but the attitudes of staff and professionals towards disability is a big, big issue. It often comes because of lack of understanding and knowledge, but also just lack of exposure sometimes, not having worked with disabled people before and so on. A lot of the good practice that I can mention is about partnership work that has been funded through combining budgets that come from local authorities and CCGs, where they understood that they had to look at clinical as well as social interventions so that different local agencies - mostly voluntary sector, but sometimes a combination of statutory and voluntary - come together to offer different levels of support to the same person.

Andrew Boff AM: Where is that?

Alessandro Storer (Equality Improvement Manager, Mind): Again, East London is a good example because there is so much diversity to deal with that, by definition, local authorities have to be a bit more creative. There are services like the Equalities National Council that support specifically BAME disabled people working in collaboration with the local authority as far as the specialist provision is concerned. For example, when disabled people need interpretation, local authorities will provide emergency budgets for them to access that specialist interpretation when the CCG contracts do not have enough money. However, the whole system is designed for the person to access one point of contact that then is already linked with other agencies that have to do with employment, debt advice, housing and then what in Newham is called social prescribing, so access to other activities. A lot have to do with peer support, for example. They will provide emotional support to people, either because of early diagnosis of a disability that they have to kind of make sense of, or ongoing mental health problems.

Combining the kind of clinical interventions with advice and support as well as social prescribing is an example of that kind of more emotional support that takes into consideration the social determinants of health. However, it can only happen if at the source funding is pooled together so that it enables funding for both clinical and social interventions, which is often the problem. That line between clinical interventions funded by the CCG and more public health prevention and interventions funded by the local authority is very blurred. It is easy to just keep passing the buck and saying, "This is not my responsibility". However, if local authorities and CCGs pool budgets together and then are willing to fund services that are generally holistic, so they look at all

the spectrum of people's needs, that is where you can see improvements in people's wellbeing and the quality of the support that disabled people receive.

Andrew Boff AM: There is some hope that the health services may actually start to be reorganised along those lines. The jury is still out, is it not? We are waiting for an announcement, so there is some hope there.

Unmesh Desai AM: Sorry, yes. Chair, I think at this stage I should declare a non-pecuniary interest. I am a Newham Councillor.

This is not a subject that I have much knowledge of, but I think once we have all the evidence it would be good to get a response from you, particularly the point you make about the emergency budget. I suspect - and I say this with some trepidation because I do not have the full facts at my disposal - the issue will come up about cuts and budgets and so on.

Alessandro Storer (Equality Improvement Manager, Mind): That is part of social care.

Unmesh Desai AM: I am not going to say anything much more than that because I do not have the information. It would be good, just for an all-round perspective - it could be any other authority, Conservative or Labour or whatever, it is not party political - to get a response from you. We will put it to you later in correspondence.

Andrew Boff AM: They have all had to make cuts. My last point, unless anybody else wants to come in on that, just very quickly, Mr Storer, you did mention TfL. Of course the Committee did some work regarding TfL's role in promoting health in London. What role can TfL play in promoting awareness and tackling accessibility of positive mental wellbeing for London's Deaf and disabled people?

Alessandro Storer (Equality Improvement Manager, Mind): This is an area where the expertise comes mostly from Inclusion London, so what I am going to say is mostly coming through their work with TfL. TfL seems to be a good example in terms of staff attitudes and approaches towards disability, thanks to the training that has been paid for by TfL for their staff, station staff especially. People there are supposed to help people as they are using the service. They have been trained in something that is very specific and it is called Disability Equality Training (DET), which is something that is only delivered by disabled people, so that gives staff a chance to actually interact with disabled people and understand their needs in terms of mobility, but also attitudes and behaviours, that we might unconsciously discriminate because of language or because of our prejudice or misunderstandings around disability.

By busting those myths as people will not admit they have a gap in their knowledge and by giving people the space to ask the questions that they are often uncomfortable to ask, this particular training is much more about the relation and the attitudes than the knowledge seems to be very effective in putting front line staff in a position where they feel confident and comfortable engaging with disabled people and supporting them in the right way.

Andrew Boff AM: What seems to be key there is that training is delivered by people with disabilities.

Alessandro Storer (Equality Improvement Manager, Mind): Yes. It can only work if it is delivered by disabled people.

The less positive story about TfL is obviously that - I have information here - only 66, as per 2016, of the 260 Underground stations have step-free access. Obviously, it is great to improve attitudes and behaviours of staff, but if people cannot get into the stations, then that is another problem.

Andrew Boff AM: You are reaching to the choir.

Richard Holmes (Policy and Campaigns Manager, Royal National Institute of Blind People): I would just like to add a couple of things, if I may. The ability to be able to turn up and travel on the Underground is phenomenally important and massively, massively appreciated by visually-impaired people. Sadly, it contrasts with services on Mainline trains, where often they require 24 or 48 hours' notice of a person wishing to make a journey. You can get a brilliant service on the Underground, but maybe you arrive at a Mainline station, and if you have not booked, you may have to be punished by waiting a while and potentially missing the train. There is a great service on the Underground and I would confidently say that the ability of visually-impaired people to travel around London is greatly enhanced by that, by the iBus information on the buses, which all have audio announcements.

One of the areas which I think it would be useful in terms of people's confidence and wellbeing, if the Committee could consider it, is in their own areas around the built environments. A couple of things: to encourage their boroughs not to deviate from guidance at crossings, ie laying the appropriate tactile paving in the appropriate colour; make sure crossings have audible and tactile indicators on them. Some boroughs like to deviate from that and have grey bubble paving in a grey background for aesthetic purposes, but the whole point is if it blends in, it is not providing its purpose properly, reducing therefore a person's independence and confidence to be independent. That is one area that TfL can themselves be a useful means to try to influence boroughs, but also you, obviously as Committee members, could look at that as well in your own area. That is another area.

Also to try to resist changes to the public realm in general, in particular to our old friend, shared space, and to try to resist shared space, again for the same reason, that they diminish independence, diminish confidence and a person's wellbeing. Whether or not that person has had the mobility training initially to be able to navigate in a shared-space environment, which sadly are becoming quite popular, is very difficult, because there are no lines to follow, no kerb edge, so a person is completely unable to navigate in the area and there is no delineation between where motorists should go and where pedestrians should go. The choice is a stark one: go through a shared space or do not go into certain parts of your own area, and I would say neither is an ideal option.

Jennette Arnold OBE AM: My question area is about the concerns over cuts to social care. Joan, can I ask you, what impact has the reduction in the social care budget had on the mental wellbeing of disabled and Deaf Londoners?

Joan Hutton (Association of Directors of Adult Social Services): That is a difficult question to answer, Chair. Clearly we all know that the cuts are having a profound impact on social care public services. Most local authorities' approach is to minimise that impact and do their utmost to minimise that impact, so all cuts have equality impact assessments undertaken to look at what the likely impact will be. That is not to say there will be no impact, but it is just to put to this forum that there is very detailed consideration on any cuts that are proposed by any local authority.

Jennette Arnold OBE AM: We would appreciate and respect that, but let me see if we can just get deeper into this. If I read from my briefing to you:

“Research by the disability charity, Scope, has shown that disabled people have been heavily affected by cuts to the social care budget. A recent survey found that over half of disabled people using social care, 55%, can’t get the support they need to live independently, with knock-on effects on their mental health. Examples of lack of service include people waiting 14 hours to go to the toilet [so that means they have been to the toilet many times where they are sitting or lying or sleeping], sleeping in their clothes, being able to wash, eat and left socially isolated.”

Now, because your members are at the front face of this, would you say that that is a reasonable account; that it is even worse than that? Can you give us some sense that you would be supportive of the survey carried out by Scope?

Joan Hutton (Association of Directors of Adult Social Services): I am not aware of that survey, I am afraid, but I would say that everybody that requires an assessment is certainly allowed to have an assessment of need. Some of the changes may be because the approach to assessment has changed and that an assessment will look at what somebody can do for themselves as well as what they may need to have to support them. That change has been very difficult. There should not be a situation where people are waiting 14 hours to --

Jennette Arnold OBE AM: There should not be, but there is, from Scope’s survey.

Joan Hutton (Association of Directors of Adult Social Services): There should not be that situation. The cuts, from my understanding and from what I know from the Association of Directors of Adult Social Services (ADASS), that would not be a standard that they would want to have in place. The cuts have to come in some way, but in a way that does not have that sort of impact.

Jennette Arnold OBE AM: Can I read to you then what your Association is saying? They welcome the Government’s recent announcement to allow councils to raise Council Tax by up to 3% to provide funding for adult social care, but they said that they had concerns because this would raise issues around some areas getting that increase, but those areas would not necessarily be the areas of greatest need. Even then, what would happen in the areas of greatest need, that 3% would then actually not make [the greatest --

Joan Hutton (Association of Directors of Adult Social Services): Not enough to--

Jennette Arnold OBE AM: They were concerned. Do you concur with that? Is our briefing correct?

Joan Hutton (Association of Directors of Adult Social Services): I think there is a great concern that the precept, the increase or the proposal to increase to 3%, will not be enough in certain areas to cover the gap in funding, which there clearly is. This is a real cause of concern, that there is such a funding gap in terms of what is available. Most local authorities are in deficit, are running with overspends for adult social care, but have a statutory duty to provide that care and support to people, so that tension is very profound for each and every local authority.

Jennette Arnold OBE AM: Would it be fair to say that if there is no money in the pot, the service cannot be provided and therefore you lose the ability to then be able to speak of the degree of need? Then what happens is that those individuals, if they are lucky, may well receive support from the voluntary sector or from charities. What happens is that statutory agencies, where your members and your association are about, then are away from really where the crisis is.

Joan Hutton (Association of Directors of Adult Social Services): I do not think we are away from where the crisis is. I think that ADASS is very aware of the crisis and is proactively escalating that crisis to Government. I believe that ADASS is doing all it can to support people, to ensure that people still receive the support that they need. As I have said earlier, the way that we look at how we support people considers what they already can do, but certainly on an individual basis the intention is to ensure that that support is available. The London Living Wage for most local authorities in London is paid to the providers, who are the people who come in and do that care and support, so that there is sufficient quality and a good standard of care for people at the right time and at a time that is suitable for those individuals that are in receipt of it.

Jennette Arnold OBE AM: Thank you. I think we are not going to touch today on the carers, because that is a whole can of worms, is it not?

I just wanted to lastly say, what impact is this having on the staff, your members? Because surely you are now into this awful cycle, where your members are under more and more pressure and are being asked to really do the impossible, now they are being asked to assess and do a job, knowing it cannot be delivered?

Joan Hutton (Association of Directors of Adult Social Services): The intention is that the job can be delivered and that there is good care and provision in place and that it is paid for at a rate that secures that provision. The London Living Wage certainly for many authorities is what is paid, good commissioning arrangements and support for those care agencies and care homes that provide that support. I am talking outside of mental health and more generic in terms of a response to this issue, if I may. However, it is true to say that the staff within social care are under a great deal of stress. That is from the staff that undertake the assessment to the people that are commissioned to provide the care, who may have five people to see within a period of time. There is monitoring and quality assurance of that provision to make sure that people are not overstretched etc, but it is a service that is creaking. There are no two ways about that.

Alessandro Storer (Equality Improvement Manager, Mind): Can I quickly come in just to say that looking at the original question, I think there is something that needs to be said about the cut to the ILF and the fact that that has taken away a lot of the support that was enabling people to live independently, which included having nominated or assigned mental health nurses or social workers, CPNs, that enabled them to navigate the sort of service that they needed.

Also, as Joan [Hutton] said, the reason I focus on what disabled people can do for themselves in our opinion means that there is greater pressure on agencies to look at employment. I do not want to say forcing or pushing, but there is greater emphasis on how disabled people can be enabled to go back into employment. That reassessment is proving very stressful for disabled people. Especially, I speak for people with mental health problems, but across the board in terms of people that have an experience of disability, seeing that their benefit or their support is being taken away and they are being put under a system of reassessment to really make sure that they are not fit for work, and until that is completed they will not have access to their benefit, that is putting a lot of pressure on people. Because of the lack of ongoing emotional support, because there is not a system that supports people through that process, many people's mental health and wellbeing worsens considerably in that process of reassessment.

Richard Holmes (Policy and Campaigns Manager, Royal National Institute of Blind People): One of the things I wanted to say was that in the era of ever-increasing cuts, one area I think that could help in terms of how a service is delivered is something that Joan [Hutton] mentioned almost at the beginning is the register that local authorities have of visually-impaired people. It probably has not had anything done to it for years, so half the people are either deceased or have moved out of the borough. In that sense, how can you plan a service when you do not really know accurately how many people you are delivering that service to?

Perhaps a way to help in the allocation of ever-diminishing resources is to look at the register, to work through it, to prune, to have a more accurate idea of the numbers and then think about how you deliver the service. At the moment it seems to be too much is based on an out-of-date system and, therefore, a service being delivered on the basis of that, rather than awareness of numbers and how you deliver a service to those people. You get almost a double situation, where a service, vision rehabilitation, is being diminished but it is not actually any relation to how many people, potential recipients, that there may be. There may be more, there may be fewer, but no one actually knows. In terms of delivering a service, how can that be accurately delivered until that initial part of the process is undertaken?

To go back to something we talked about earlier on, it is another thumbs-up for south west London, because the London Borough of Merton have handed over the register to the local society, Merton Vision [visual impairment charity]. Merton Vision have worked through that. They deliver the rehab and they take all the referrals, which seems to me an extremely useful means of delivering services, from the point of diagnosis that a person might receive at St George's [Hospital] in Tooting, where there is a sight loss adviser in the clinic, to that being referred on to the evaluation of need and that service being delivered. That seems to be a pretty good model to me, where they know the numbers, and therefore they can more accurately evaluate. I think Merton as a council deserves some congratulations on acknowledging that situation - and the local society also - in terms of being to deliver that service in a more accurate, efficient and beneficial way.

Jennette Arnold OBE AM: Richard, thank you for that. You have put your finger on it: if you cannot count it and you do not know it, then you are not responsible for it. It is a political policy ploy. You choose not to know, because then you do not have to respond. Thank you for the example. If I can look through to you, Chair, that we actually get some information about that to flag up that there is good practice out there. It does not deal though with the fact that unless you can then have that replicated everywhere, it is still seen then as, "Oh well, that is good for you, Merton, you get on with it", but Merton, if you were looking at boroughs, is one borough out of 32 and we do not have a clue what the national situation is like. Thank you for bringing that up.

Richard Holmes (Policy and Campaigns Manager, Royal National Institute of Blind People): That is an extremely important point in terms of our big campaign called See, Plan and Provide, because we are trying to meet and discuss with boroughs in terms of how they deliver their service and highlight, where we can, good practice, but try to make that good practice relevant. For example, trying to refer boroughs that are similar, so maybe Richmond with Bromley, Lewisham with Hackney or Haringey to try to keep the relevance of it. As you say, the danger is that most people say, "Oh, Merton, that is very different. That is a relatively affluent borough" although it is actually more diverse than people probably think and does not have much relevance to perhaps Croydon or Lewisham.

Nonetheless, in terms of what they are able to deliver, it is always useful to have a model that you can then refer others to. I think that it would be helpful if Members were to look at what provision there is in terms of vision rehabilitation in their own area and to look at how that is delivered and whether it is delivered by full-time trained officers or if it is delivered by agency staff to try to fire-fight, to stop the build-up of referrals taking place, as we see in some areas. I think that would be an extremely useful exercise in terms of the impact of cuts, but also how services are being delivered and to what level they are being delivered.

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): I just wanted quickly to add, just so that you are aware, the change from the Disability Living Allowance (DLA) to Personal Independence Payment (PIP). I am aware of a number of Deaf people who have

lost their PIP, which means they become even more isolated and they are not able to pay for services that they would like to receive. I think it is important to include that as well, please.

Unmesh Desai AM: Would it be a useful exercise as part of our evidence-gathering, Chair and other colleagues, if we asked our officers to write to 32 London authorities to see whether they maintain such a register and where they are with it?

Jennette Arnold OBE AM: That would be good.

Dr Onkar Sahota AM (Chair): Yes, we can do that.

Unmesh Desai AM: I suspect many Members probably would not even know that there is such a register.

Shaun Bailey AM (Deputy Chair): We have just been talking about the cuts, and obviously local authorities country-wide are having to reduce their budgets in many a strange way because of what is going on, but it just strikes me, is this not an opportunity for some change as well? There are lots of work practices that have built over a number of years that are not efficient; people do operate in bunkers. The lack of budget sometimes forces a different way of thinking on the ground. I think this is why the word “efficiencies” is used so much, but apart from the sort of cynical use of the word “efficiencies”, do you see things that can change now that the change is going on? There is going to be change anyway. Do you see certain best practices that could now come to the fore that would benefit people’s mental health?

Joan Hutton (Association of Directors of Adult Social Services): I think there is an opportunity now. I think the local authorities are thinking more about cross-borough working, which I think is very helpful, particularly as we think about disability and mental health, where you are not perhaps looking at huge numbers of people that have a specific area of disability or mental health, but they are there and their needs are very bespoke, if you like. I think there is an opportunity to be gained from some of that cross-borough thinking. That is happening in places.

Alessandro Storer (Equality Improvement Manager, Mind): Just building on that, I think the opportunity that comes with it is an efficient use of personalised budgets, because again many local authorities - and CCGs especially - do not enable disabled people to use personalised budgets to the full extent in terms of what kind of support and social sort of aspect of their life the personal budget could enable them to access. They are still used for a very medicalised kind of approach. Disabled people can use the personal budget only for very limited things and it is still very much linked to the care plans and having to be assessed by their GPs or their community practice nurse and so on. Whereas if people were empowered, with guidance and information, to use that personalised budget in the way that they feel is best for them, that would create savings, in a way, because there is a much less bureaucratic system, where people have control over their budgets rather than somebody else having to decide what to do with that budget. The individual is empowered and then they can access services in the way that they feel is best for them. CCGs especially need to let go of that control and trust people that they, with the correct guidance, advocacy and the correct support systems and information, will be able to understand what is best for them.

Unmesh Desai AM: This is the role of the Mayor in preventing mental ill-health. I have two very specific questions. What can the Mayor do to promote better mental health for and improve engagement with disabled and Deaf Londoners?

Joan Hutton (Association of Directors of Adult Social Services): I think by playing a co-ordinating role to raise the profile of disability and mental health within London.

Richard Holmes (Policy and Campaigns Manager, Royal National Institute of Blind People): Where there are areas of good practice, to promote that and encourage other boroughs to look at the way they deliver their services compared with the areas of good practice. Perhaps to have a criteria for how and what a good service looks like, which I think would be much more clearly understood by both boroughs and also recipients of the service, and to be able to try to influence a more consistent service across London, rather than the sort of more piecemeal approach that we see at the moment, where some boroughs do particularly well in the way they deliver services; other boroughs have much greater problems, fewer staff, perhaps agency staff delivering the disabled service, so it cannot be delivered to the same level. I think that would be a useful pan-London approach, to have set down key criteria and find out how boroughs are doing and to encourage them to do better.

I think that that fits in with the previous point as well about boroughs delivering services together. I think that is particularly going to be beneficial where one borough that perhaps is not doing so well links up with a borough that is meeting particular standards. One hopes the movement is up rather than towards the middle and that the borough that is not doing so well has increased resource to be able to come up to the standard of the borough that it is going to work with.

Alessandro Storer (Equality Improvement Manager, Mind): Yes, I would quickly add to that supporting user-led local organisations, so through different opportunities and funding that they may have access to, especially again around the areas of employment - the Back to Work schemes and all of it - so that they are tailored and designed in a way that is relevant and effective in meeting the needs of people where they are. Promoting collaborations, definitely, and I think that has to include better integration in funding, so the Mayor highlighting good practice and recommending ways in which funding can be used more effectively. One of those is looking at funding requirements. A lot of our frustration is around how CCGs are contracting services without requiring the agencies that win those contracts to demonstrate how they address equality dimensions, for example, without requiring that specialist training is received if they are winning a contract around disability, or similarly around cultural competency if they are winning a contract around supporting a particular ethnic group, so that those contracts are not just driven by efficiencies and savings, but also look at exclusion and they will promote a funding cycle that looks at how services can meet everyone, especially those that are most in need, and then again disseminating best practice.

I think there are a couple of things that we have submitted in terms of checklists and things that every borough and every service provider can do to demonstrate that they are thinking about accessibility and inclusion. By the weight and the profile that the Mayor has, if they recommend similar processes to every local authority, if they recommend similar processes to contractors that deliver services for the London Assembly, that kind of profile will start becoming much more visible. The understanding of why issues around disability and multiple needs are so important and how they link to people's wellbeing becomes much better articulated and much better understood by both providers and individuals.

Joan Hutton (Association of Directors of Adult Social Services): Could I just add that in 2018 there is a World Congress on Mental Health and Deafness that I believe is due to take part in London. It may well be worth the Mayor being mindful of this. I know that the organisers are looking for sponsorship and a way of promoting what is a very important event of learning from services across the world that provide services to people who are Deaf.

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): A conflict of interest: I am one of the organisers. You are correct, the dates are 6 to 8 March near St Paul's [Cathedral]. It is 2018, so you have 12 months to plan.

Dr Onkar Sahota AM (Chair): You should write to the Mayor's Office.

Unmesh Desai AM: We have external relations people here, so I am sure they will make a note of the date.

Dr Onkar Sahota AM (Chair): We recommend you write to the Mayor's Office.

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): Actually, the Mayor has already been asked and I understand initially he turned down the request, but we are going to try again. We thought it might be a good opportunity to launch your report.

Andrew Boff AM: Hang on, turned down a request to what?

Dr Onkar Sahota AM (Chair): The Mayor has turned it down?

Roger Hewitt (General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness): Just to attend the conference. We have not said anything about sponsorship, but we thought it might be a good opportunity for the Mayor or yourselves to launch your report.

Dr Onkar Sahota AM (Chair): We recommend that you write to the Mayor again. The recommendation of this Health Committee is that you write to the Mayor, and we shall also recommend to the Mayor that he attends this very important event.

Unmesh Desai AM: Alessandro, you talked about employment. That was the second question, but I would like to hear more about engagement with disabled and Deaf Londoners. Are there any specific suggestions: any models, any ideas?

Joan Hutton (Association of Directors of Adult Social Services): Somebody has suggested to me that once the Mayor had a Disabled and Deaf Adviser role - I do not know - and the idea of this role coming back.

Unmesh Desai AM: That is something we can make a note of. Unless there are any other specific suggestions, moving on to my second and final question - and you touched upon this, Alessandro - in terms of employment, the Mayor is due to take greater control of adult skills and Back to Work programmes in London from 2019/20. What are the key things he should consider to ensure this programme supports mental wellbeing for disabled and Deaf people?

Alessandro Storer (Equality Improvement Manager, Mind): I am going to quickly come in. Linked both in terms of engagement and effective delivery of this new programme, it needs to be designed in a way that involves smaller user-led organisations rather than being big contracts that are won by agencies because of their efficiencies in terms of savings and costs, because otherwise those that have more complex needs will be excluded. I would hope that the way the programme will be set up will be very localised and will be very mindful of the need to both engage meaningfully - that means having the budget and thinking about the type of outreach and the type of specialised professionals that you need to make that outreach happen in an effective way - but also the advocacy aspect of things. It is great to have a programme of funding and support that enables people to go back to work and to access adult skills and so on, but if people do not know their rights and they are not able to access it at the beginning because they do not have the right support in terms of advocacy and information, then it is all for nothing. I would definitely say meaningful engagement through user-led organisations and meaningful outreach combined with strong advocacy support so that people can access that new programme of work.

Joan Hutton (Association of Directors of Adult Social Services): If I may say so, Chair, there is something about also linking the opportunities that have been touched on during this discussion, as we have identified the fact that very often advocacy and peer support from people with disabilities or sensory impairment is of crucial importance. Here we have opportunities for employment, so just not losing sight that disabled people and people with sensory impairment can be very effective contributors to the improvements in mental health and wellbeing services.

Andrew Boff AM: Could I just ask, in the context of what Ms Hutton said about a Disabled and Deaf Adviser role, you have got to be very careful with these positions. I am not coming down on either side, but we have a substantial equalities team at the GLA. Do you think that in addition to that equalities team we need to define an adviser for disabled and Deaf people? There is always an argument that you kind of ghettoise the subject if you give it to one person.

Joan Hutton (Association of Directors of Adult Social Services): Absolutely.

Andrew Boff AM: Do you still think there is a strong argument for that? I am agnostic on it.

Joan Hutton (Association of Directors of Adult Social Services): I put the questions out to disabled and Deaf people and that was what came back.

Andrew Boff AM: That came back? Great, so that is what has come back.

Joan Hutton (Association of Directors of Adult Social Services): That was what came back.

Andrew Boff AM: Thank you.

Alessandro Storer (Equality Improvement Manager, Mind): I think it has to do with the issue of profile and visibility, because it is great to have a strong equality dimension that looks at all of the nine characteristics and all of the legislation around it, but sometimes there is the risk that it is very much policy- and legislation-driven and less about people, engagement, outreach. The adviser role, the way I understand it, it is a bit like the Night Tsar, it is a bit like somebody that would have a very visible role in terms of stating that this is an important priority for the Mayor. I work in equalities and I do not see the GLA's equalities team as very visible in terms of their engagement with the wider third sector and statutory sector around equality issues.

When it comes to mental health specifically, we know, as one of the leading mental health charities, that there are a few minorities, a few groups in society that are acutely concerned by this problem. Disabled people are one of them; ethnic minorities and lesbian, gay, bisexual, and transgender people. Those are issues that the Mayor should have some sort of advisers or some sort of representatives that can be more visible in terms of how they engage with wider third-sector organisations.

Richard Holmes (Policy and Campaigns Manager, Royal National Institute of Blind People): I think one area definitely to become involved in, if not already, is with the excellent apprenticeship programme that the Government are rolling out. That is something that I think could be extremely beneficial to people within our sector. Also I think wherever possible to exert influence over employers about, as Joan [Hutton] said, the employment of disabled people. Why is it that we have had such a great increase in technology in the last ten years, yet no discernible rise in the level of employment among groups who would benefit most from that? Visually-impaired people benefit massively from the increase in technology, the ability to be able to use a computer and a smartphone, and yet the rate of employment has gone down in the same time. Why is that

paradox ongoing? What are employers afraid of about employing a visually-impaired person? I think one of the answers will be that it will be expensive. That is one of the frustrations, because it would not be expensive. There is a Government scheme which takes on the cost of any additional equipment.

However, if employers are not given that level of awareness and influence, if the Mayor has some influence and even can convene an event with some of the main employers, that I think would be a starting point to try to overcome some of these barriers. Without that, I do not think there is any reason to necessarily think things will improve employment-wise, because they have not in the last decade, where technology has leapt forward. Why would they improve in the next decade unless someone steps in and actually takes responsibility and takes a lead in this area?

Andrew Boff AM: Can I just ask on that, Mr Holmes? The previous two Mayors had a fairly good record of encouraging employers - more and more employers - to pay the London Living Wage and they used more carrot than stick. Do you think that is something that the Mayor could do with regard to the number of people specifically large employers are employing, the number of Deaf and disabled people that are being employed? Do you think that is something he could do?

Richard Holmes (Policy and Campaigns Manager, Royal National Institute of Blind People): I think it would be useful if many people of influence talk about the schemes and support that is available to get people into work. That would hopefully have some influence. The London Living Wage is a really good point, because that highlights some of the issues that I think impact upon visually-impaired people. It is the inability to be able to get short-term casual type of work compared with non-disabled peers. You cannot just turn up and work in a bar or work in a restaurant or do some temping work without the support that I have mentioned, so gaps build up on the curriculum vitae (CV). As I know only too well from personal experience, employers do not like gaps on CVs, so I think that employers, wherever possible, need to be aware of the support that is available and perhaps organisations who they can speak with for advice, because probably a lot of this comes down to lack of perception, lack of awareness.

I suspect when a person in human resources receives an application from someone who has declared themselves as visually impaired, that person closes their eyes and thinks, "Well, there is no way I could do this job, so how on earth could this person come in and do a job?" because they are not aware of the support that is available. I think there are a couple of things that could be very usefully done, hopefully not using too much stick, but I think with equality legislation, it is always useful. The velvet glove can come off, if necessary, and there is that recourse to a legal route, but I think ideally a less confrontational initial approach is probably the right one, while being mindful of other options should that not yield the outcome we are looking for.

Andrew Boff AM: Speak softly and carry a big stick!

Dr Onkar Sahota AM (Chair): Thank you very much to all the witnesses who have come this afternoon. If you feel that you have forgotten to say something and you want to write to us, we are still open to taking your evidence. If you feel there is someone else who should write us, you can also let them know too. We are still open to taking evidence. Thank you very much for coming.