



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

**Y Pwyllgor ar y Gorchymyn Arfaethedig ynghylch
Darparu Gwasanaethau Iechyd Meddwl
The Proposed Provision of Mental Health Services
LCO Committee**

**Dydd Mawrth, 29 Ebrill 2008
Tuesday, 29 April 2008**

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2008 (ynghylch Darparu Gwasanaethau Iechyd Meddwl)
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to Provision of Mental Health Services)
- 22 Dyddiad y Cyfarfod Nesaf
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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynndi yn y pwyllgor. Yn ogystal,
cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee.
In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Janice Gregory	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
David Melding	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Jenny Randerson	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Clare	Defnyddiwr Gwasanaeth, Mind Cymru Service User, Mind Cymru
Ruth Coombs	Rheolwr Dylanwad a Newid, Mind Cymru Manager for Influence and Change, Mind Cymru
Richard Cowley	Ymddiriedolwr, Eiriolaeth Iechyd Meddwl MAP Sir Benfro, Cymar Trustee, Mental Health Advocacy Pembrokeshire MAP, Cymar
Martyn Jenkins	Prif Swyddog, Cyngor Iechyd Cymuned Caerdydd Chief Officer, Cardiff Community Health Council
Peter Munn	Cyfarwyddwr Ymgynghori, Ffenics Ltd., Cymar Consultancy Director, Ffenics Ltd., Cymar
Bob Woodward	Aelod, Cyngor Iechyd Cymuned Caerdydd Member, Cardiff Community Health Council

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

Anna Daniel	Clerc Clerk
Gwyn Griffiths	Cynghorydd Cyfreithiol y Pwyllgor Legal Adviser to the Committee
Olga Lewis	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.37 a.m.
The meeting began at 9.37 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **David Melding:** Good morning. I welcome everyone to this meeting of the Proposed Provision of Mental Health Services LCO Committee. I have a few housekeeping announcements to make. Could people switch off all electronic equipment completely? That means off and not on 'silent' mode, as it can interfere with our recording equipment if the devices are left on, so please ensure that you do that. These proceedings will be conducted in Welsh and English. When Welsh is spoken, a translation is available via the headsets, on channel 1. If you are hard of hearing, you can amplify these proceedings by choosing channel 0.

[2] We do not anticipate a fire drill this morning, so if the alarm sounds, it is to be taken seriously. Please follow the instructions of the ushers to leave the building safely. I remind witnesses not to touch the microphones in front of you; everything will come on automatically—the technicians will see to that. We have also received an apology from Val Lloyd, who is unable to attend this morning's meeting.

9.38 a.m.

**Gorchymyn Cynulliad Cenedlaethol Cymru (Cymhwysedd Deddfwriaethol)
(Rhif 6) 2008 (ynghylch Darparu Gwasanaethau Iechyd Meddwl)
National Assembly for Wales (Legislative Competence) (No. 6) Order 2008
(Relating to Provision of Mental Health Services)**

[3] **David Melding:** I welcome the representatives of Mind Cymru, who are our first witnesses this morning. I welcome Ruth Coombs, who is Mind's director of support for people with severe mental illness and their carers. Her actual job title is Manager for Influence and Change. Ruth, you have brought Clare along with you, who is a service user. Clare does not want her surname to be used, and we will all respect that.

[4] I will start off today's evidence session by asking a general question about whether you welcome this LCO and the Assembly's getting this area of competence. We will drill down to more detail in questions, so please do not feel that you have to give an enormously comprehensive answer. This question is on the principle of the Order, and why we should seek these powers in respect of assessment, treatment and independent advocacy for what will currently be termed 'mentally disordered persons'. Ruth, I am sure that you will involve Clare as the evidence progresses. Clare, if you want to come in at other points, please indicate to me and I will bring you in, but we will try to let it flow naturally.

9.40 a.m.

[5] **Ms Coombs:** We welcome this opportunity for Wales. We have stated for some time, as you and others in the Assembly will know, that the context of Wales is different from other parts of the UK, for instance our geography is quite distinct and our population is diverse. There is a full range of diversity, but in different types of environments to other parts of the UK. We feel that the LCO reflects the ethos and the way that the Welsh Assembly Government and others want to work in the field of mental health, rather than narrowing it down to what you are entitled to legislatively and then having no other consistency. So we are pleased that this is going to be an early opportunity in the process.

[6] **Bethan Jenkins:** This is a question for you, Clare, more than anyone else. What services and support do people with mental health problems have and need, and do you believe that current provision is sufficient?

[7] **Clare:** I can talk only from my perspective. I was diagnosed with manic depression 15 years ago; a more favourable term is bipolar disorder. Over the past 15 years, I have been fortunate to have received a good range of services, but that is not the case for other people. Services that have been provided for me have included regular contact with a community psychiatric nurse and regular outpatient appointments with a consultant, but the problem is that, in the main, you see someone different every single time. I was fortunate to have the same consultant for two to three years, but that was a one-off. Quite a few years ago, I saw an employment psychologist. I was very lucky to have that service because I know that not many people have received that service. There are many factors—not just about your medical condition, but your whole life and how that has an impact.

[8] I was on incapacity benefit for five years, because I was not well enough to work. I needed to do things in stages, because it is not just black and white. For example, if you are well enough to come off benefits and pursue a college course, it does not mean that you are well enough to work. It does not work like that, and that needs to be recognised. People need to progress in their own time, taking small steps to reach their goals. I have also had contact with an occupational therapist, which was also to look into therapeutic opportunities, such as college courses, which would improve and help my recovery. I have been at crisis point and have been sectioned many times, and that has an impact all around really, particularly on your confidence and self belief. I have also had contact with a social worker to look into issues such as housing and daily living, but that is not the case for many people.

[9] **Bethan Jenkins:** So you believe that, at every stage of your illness, you have had someone there to support you, but that, from talking to other people that support is perhaps sporadic across Wales and that other people have not received the same amount or quality of treatment that you have.

[10] **Clare:** I think that because I got so ill so quickly and was sectioned, and because bipolar disease is classed as a serious condition, perhaps people from the lower spectrum of mental conditions, such as moderate depression and panic attacks, may not receive as much treatment. Sorry, what else did you ask?

[11] **Bethan Jenkins:** I just asked whether, in your experience, you had perhaps received more support than others that you are involved with through support networks.

[12] **Clare:** It also depends—and this should not be the case—on what area you live in and what community mental health team you come under, because each community mental health team offers different services. I come under the north-east Cardiff community mental health team, which provides quite a seamless service.

[13] **Jenny Randerson:** In your evidence, you suggest that the proposals relating to social care could complement the proposed Order and that a duty should be placed on local authorities. Can you explain why you have said that, and why you referred to local authorities in particular?

[14] **Ms Coombs:** This builds on what Clare has already said this morning. When you experience mental distress, it affects your whole life; it does not merely affect your health, as it also affects your social structure, your ability to work and your status in the community. We know that some people are ostracised within their communities because they have mental health problems and that some people have to move because they cannot remain living where they are. It is really important that the whole support network, which includes local authority support, is there. At the moment, in our experience, many senior staff in local authorities do not think that mental health is their problem—and they see it as a problem because they see it as a drain on resources.

[15] I have one example in Wales that we are trying to look into at the moment of someone who was taken into hospital—I will not say exactly where, but it was further north than Cardiff—and while she was there, her property was left unsecured. The local authority has not taken any responsibility for it and the house has fallen into disrepair. It is an insecure property and this has caused additional distress for this person and her relatives. No-one seems to be taking responsibility. Whose responsibility is it? If you go into hospital, you should be able to expect that someone, somewhere will make sure that your house is okay and that it is locked and secure and does not become an easy target for squatters or vandals. The dispute continues regarding this particular property and the deterioration continues, which is causing additional stress. The increased stress caused by such problems often leads to people

staying longer in hospital than would otherwise be the case. So, it is vital that all agencies that work with people have a responsibility and a duty that is over and above their thinking that if they think that it is their role they will do it, but if they do not, they will not.

[16] **Jenny Randerson:** That is a very interesting answer. Are you suggesting that the duty should go beyond local authorities and be placed on the police, for example?

[17] **Ms Coombs:** Duties are placed on the police when it comes to people being detained. If new duties are placed on the police, it is important that they carry them out in a supportive and helpful way. In a way, it does not matter who goes to check a property, but someone needs to be checking a checklist somewhere to ensure that the right people have been informed and that the property is secure, and to find out whether the person in hospital has other people whom they care for, such as children or older relatives, or whether they have a dog, for example. All these things are so important. Many people with mental health problems may not have family support networks, but they have other support networks. Many of them find comfort in having a pet, and issues such as kennel fees and so on also need to be considered. So, a wide range of people need to be involved in the process.

[18] **David Melding:** Are you going to ask the next question on the Mental Health Act 1983, Jenny?

9.50 a.m.

[19] **Jenny Randerson:** Sorry; I was so interested in that answer that I forgot that I was asking the next question. Patients who are subject to compulsory treatment under the 1983 Act will be excluded from future Measures that would be proposed to come from this. What case is there, if any, for delaying the proposed Order or any future Measures that would follow from it until the Mental Health Act 2007 is fully implemented?

[20] **Ms Coombs:** People who live in Wales have been waiting a very long time for therapeutic services that reflect the needs and the diversity of the population in Wales. We also know that many people from Wales are not currently treated in Wales. We think that anyone who lives in Wales should have the right to have therapeutic treatment as close to home as possible. Therefore, we would want to see the legislative competence Order and the Measures progressed in order to make life better for the wide range of people who experience mental distress. It will encompass far more than the small number of people who are detained, which is important. There may be issues in terms of people who fall under the Act. The Act comes under England and Wales, but for people who do not fall under the Act, it is up to Wales to deliver the best services that it can. We see the legislative competence Order and the Measures that will follow as a great step in the direction of providing appropriate therapeutic services for people in Wales, close to home and in a way that involves service users. We hope that you would want to involve service users in the development of how this looks. That is also important.

[21] **Jenny Randerson:** Do you think that the amendments to the Mental Health Act 1983 will have an impact upon the proposed Order or any future Measures?

[22] **Ms Coombs:** That is an interesting question. There would have to be careful scrutiny by legal experts, for example, which we have in Wales; we are lucky that we have legal expertise in mental health in Wales. This careful scrutiny would ensure that things become as seamless as possible; that there is not a gap in the services provided to someone who might be detained and no longer meet the criteria to be detained; and that there is not a gap in the service provided to people who are able to access treatment earlier and become ill enough to be considered for detention. We would expect and hope that the legislative competence Order and future Measures would ensure that people would get treatment much more quickly. We

all know that if you can intervene more quickly in any illness, you get a better prognosis, a quicker return to health and people are less likely to fall under the Act, which is why we welcome this earlier stage.

[23] **Clare:** Many people have been turned away for services in early intervention, which has resulted in them reaching crisis points. If intervention was considered early on, that person's condition would not have got so bad and they would not have to get worse.

[24] **Janice Gregory:** As an organisation, you have vast experience in providing advocacy on behalf of people with mental health problems and their carers. The proposed Order does not place a duty for commissioning or providing independent advocacy services on any particular body. Which bodies, do you think, should be responsible for this?

[25] **Ms Coombs:** Our concern is that independent mental health advocacy must be truly independent. There is a vast array of knowledge and expertise in the voluntary sector around mental health advocacy. It is mostly conducted by small organisations in small parts of Wales, but the expertise is there to be co-ordinated. If the commissioning for the procurement was done through a local authority or a local health board, for example, it would be important to try to maintain that independence. It must be transparent. Regardless of which commissioning structure goes forward, maintaining the independence of the service delivery is really important. The service users whom we have talked to have expressed concern over whether the service will be truly independent if the local health board is paying the wages. It depends on how distant that funding arrangement can be. We would want to see a co-ordinated, strategic service, rather than have to rely, as we do at the moment, on whatever happens to be available in the local area. That is the really important thing.

[26] It is also important to have a diverse range of advocacy across Wales so that you do not just have advocates who can work with particular black and minority ethnic communities in urban areas; they should also be available in rural areas. The other thing that I would like to say about advocacy is that, if you talk to independent mental health advocacy agencies, you will find that advocates often work in pairs. It is important that the costing reflects that. If you are working in a large area, such as Gwynedd, you cannot think in terms of one person travelling, because, often, two people will be travelling. The geographical vagaries of Wales also need to be taken into account.

[27] **Janice Gregory:** Your answer was very clear, but I would like you to comment on whether you feel, bearing in mind what you have said about their being truly independent, there would be any mileage in specifying the bodies responsible for independent advocacy within the Order or any future Measure?

[28] **Ms Coombs:** One benefit that you get from specification is that you know where the responsibility lies. With something like advocacy, it has to be co-ordinated and joined up. That is the important thing. I also think that it is important to take views and evidence from independent mental health advocates in this regard, as they are the real specialists working daily with clients on a one-to-one basis.

[29] **Bethan Jenkins:** The proposed Order would allow Measures to require the provision of assessment and independent advocacy services for

[30] 'persons who are or may be mentally disordered'.

[31] Is that broad enough in your opinion? Will it allow services to be provided to those who need them the most, including those who are recovering from mental disorders?

[32] **Ms Coombs:** We think that it does. It is important that you have some form of

definition. However, at this stage, we would want to see it being as broad as possible in order for there not to be any difficulties further down the line because we have forgotten something, as it were. This is a new process. So, we would not want to have something that was so narrow that it excluded different people or different circumstances. Therefore, we would want to see a broad definition at this stage.

[33] **Bethan Jenkins:** Staying with definitions, do you believe that the term ‘treatment’ in the LCO is adequate, or should it be expanded to shape the treatment that you would wish for your service users, so that they receive the relevant treatment across the board?

[34] **Ms Coombs:** Any treatment would have to be of therapeutic benefit. That is really important for us. We also see treatment in terms of care and treatment, because it is important that people have both, and that they have a wide range of different types of treatments. For example, talking treatments, and access to different things, because different things work for different people. Education opportunities for young people, for example, could be considered as part of the therapeutic treatment, because they are of therapeutic benefit. I know that Clare has talked about the different things that you need in the stages of your recovery. You might need different things at different times. So, it is important that is not just seen in terms of medical treatment, but is much broader than that, and that the care aspect is included.

10.00 a.m.

[35] **Bethan Jenkins:** So, do you believe that just putting in the word ‘treatment’ would not incorporate the other elements that you have described? Would you specifically like to include ‘treatment and care’ to ensure clarity and the diversity of services that you would wish to see?

[36] **Ms Coombs:** Yes, we would prefer that.

[37] **David Melding:** Before we move on from this particular section on definitions, what is Mind’s view of the term ‘mentally disordered’? Does that cause any difficulties in terms of the public perception of people with mental health difficulties, or is it a technical description that you could live with?

[38] **Ms Coombs:** When people talk about mental disorders, it tends to conjure up the severe end, and people who are compelled to have treatment. As the LCO will, hopefully, encompass and support people with a wider range of mental health problems, one of the terms that we prefer to use is ‘people with direct experience of mental distress’, because that covers the whole range of people with mental health problems. To talk about people as being ‘mentally disordered’ can sometimes, in some people’s minds, recall the term ‘mentally disordered offenders’, which brings up the idea that these people are dangerous, and that, obviously, needs to be dispelled, because, as you will probably know, according to the latest figures for this country, people with experience of mental distress are six times more likely to be the victims of violent crime than people who do not have a mental health problem. So, if it is possible to use a different definition more along those lines, which would encompass the broader spectrum, then we would support that, but we appreciate that that is not always possible.

[39] **Janice Gregory:** Within Scottish mental health legislation, there is quite an extensive list under the definition of treatment. For the purposes of the record, it is: nursing, care, psychological intervention, habilitation, including education and training in work, social and independent living skills, and rehabilitation. Do you think that this could be a suitable definition for the proposed Order or for any future Measures?

[40] **Ms Coombs:** It seems to work in Scotland, but we would like to see the definition

state that, while treatment includes that list, it is not exclusively confined to it. At the moment, the National Institute for Health and Clinical Excellence guidelines talk about different treatments that have been proven in different ways, but because new things come along quite frequently, we would not want to limit the legislation so that, if some new intervention became available, it would not be on the list and people could not access it.

[41] **Jenny Randerson:** Several witnesses have mentioned the role of carers. Do you think that the proposed Order should specifically allow us to pass future Measures to address the needs of carers? If so, in what areas of service provision?

[42] **Ms Coombs:** Carers are incredibly important for people with mental health problems. Some 90 per cent of carers are what are called ‘informal carers’. That is, they are unpaid. From our experience, we know how important their role is. One of the things welcomed in the proposed code of practice for Wales for the Mental Health Act 2007 was the fact that it included a chapter on carers for the first time. We would say that it is important that carers are part of it. We know that an LCO for carers is at a similar stage to this one, and it would be really helpful if the two joined up really well, so that a reference could be included in this LCO and that, if possible, it encompassed the rights of carers that are being embedded into the other LCO. I am not sure how that would work, because the system is new, but certainly the role of carers is incredibly important.

[43] **David Melding:** The logic of the LCO is that it is broad enough to allow future Measures across a wide range of issues. Over time, the Assembly may want to look at different areas, drawing on the power in the original LCO. The LCO defines that power in relation to ‘assessment’, ‘treatment’ and ‘advocacy’—do you think that those concepts provide a basis for a comprehensive view of mental health services?

[44] **Ms Coombs:** We have considered this quite carefully, and we think that they are the three areas that service users regard as needing additional support and attention. It is important that people have the right to assessment. At the moment, there is a right to assessment under the Mental Health Act 2007, but if you are feeling unwell, or you care for someone who feels unwell, it is comforting and supporting to know that you can ask for an assessment. It may be that not everyone would take up that right, but knowing that you can if you want to is incredibly important.

[45] As regards treatment, yes, people should be able to access a wide range of therapeutic treatments regardless of where they live. Clare has spoken eloquently about what she has found supportive, and about what she knows that other people have not had access to. On advocacy, it is so important that people have that right at various stages: when they want an assessment, and even before then. I can give you one example, involving a lady in south Wales who has experience of mental distress, is Asian, and does not speak very good English. Someone had somehow cloned her identity and run up a huge credit card bill. There is no way that she would be able to do that, for several reasons—first, it is not part of the culture in which she lives, and, secondly, she does not have sufficient command of English to fill out the forms, and so on. She desperately needs someone who can advocate on her behalf in a culturally sensitive manner, in the language of her choice, and interpret for her. She is incredibly distressed, as you can imagine, given the fact that she has problems with mental and physical health on top of the stress that anyone would feel in her situation—plus the difficulty of being able to make her voice heard. So, absolutely, people need access to advocacy before the stage at which they are detained under the Mental Health Act.

[46] **David Melding:** That concludes the range of questions that we wanted to put to you. You now have an opportunity to add anything that you want, but, please, if you do not have anything to add, do not feel that you have to invent anything. However, we have not talked much about the role of the voluntary sector, for instance, and whether that could be enhanced

in proposals that could spring from this LCO.

[47] **Ms Coombs:** It is important that voluntary sector colleagues, and, in particular, people with direct experience of mental distress and of using services, are engaged throughout the process. We need that evidence as to whether something has worked or not in practice—we need their input. The voluntary sector is able to offer a different perspective, but often comes to the table as something other than an equal partner. There is an opportunity here for the expertise in that sector to be recognised and drawn upon, in order to make future Measures as good as possible. We all want the same thing: for people in Wales with mental distress to have better lives than at present, and to be the best that they can. We want the services to reflect that, so that everyone gets at least the experience that Clare has had, and hopefully more, regardless of where they live and what language they speak, whether it be Welsh, English, Urdu or whatever. We want a situation where people in other countries say, ‘That is what we would like to do’, and to look to Wales as a leader in this field. There is a real opportunity for that, which is really exciting, so please involve us.

10.10 a.m.

[48] **David Melding:** Thank you. Bethan wants to come in on a final point.

[49] **Bethan Jenkins:** I have a quick question on the cross-border issues that you touched upon earlier. Is there a large percentage of patients not being treated in Wales who could be treated in Wales? Would this legislative competence Order help with that?

[50] **Ms Coombs:** There are people who are not being treated in Wales, because of the particular conditions that they have. The LCO is looking at earlier intervention and at providing appropriate therapeutic and supportive treatment, so, yes, that would have to be considered. We see this as an opportunity to bring the services to Wales rather than people having to go to the services.

[51] **David Melding:** Thank you. The committee has been greatly helped by the evidence from our witnesses this morning, Clare and Ruth from Mind Cymru. You will receive a transcript of our proceedings, which you can check for accuracy. You cannot change anything that you feel that you should not have said, but you will have a chance to correct anything that has been transcribed incorrectly. If you wish to stay, you can take seats at the back, and swap seats with the representatives of Cymar, which is the Welsh association of mental health patients’ councils and advocacy schemes.

[52] I now invite Peter Munn, consultancy director for Ffenics Ltd., and Richard Cowley, trustee of Mental Health Advocacy in Pembrokeshire, to join us at the table. You are most welcome. I think that you sat through the previous witness session, so you have an idea of how we run the proceedings. We have a range of questions and we want as frank an exchange as possible; if we raise issues to which you do not have a particular response, that is not a problem and we can move on. I will give you an opportunity at the end to raise anything that we have not raised ourselves.

[53] I will start off the questioning, again with a general question; do not feel that you have to give a comprehensive answer, because we will drill down to some of the details. The general principle of the LCO is to give the Assembly competence over these issues, particularly around assessment, treatment and advocacy; is it your general view that this is to be welcomed?

[54] **Mr Munn:** Yes, we feel that it is important to try to improve the scope of the Mental Health Act 2007. We feel that advocacy was included as a safeguard in the mental health Bill, and that using it as an after measure, rather than in a preventative way, is not particularly

helpful. So we would generally agree.

[55] **Janice Gregory:** Again, as an organisation with experience of advocacy, how do you think that the proposed Order and any future Measures could contribute to improving the advocacy services available to those with a mental disorder?

[56] **Mr Cowley:** We believe that independent advocacy services need to be provided locally, to reflect cultural needs, and co-ordinated nationally through a regular update of a user base. Funding needs to be independent of other service providers, and it needs to be secure and ongoing. It also needs to be subject to successful monitoring and scrutiny of service provision, as you would expect in any service that exists. We would like to note that, where local health boards are commissioners and not providers, a legitimate funding source could be found here. I am also aware that, under proposed provisions for full cost recovery, that could be a way forward for ensuring transparency and you could tender for what could be seen as Government services or responsibilities, in an open and transparent manner.

[57] **Janice Gregory:** Could you tell us what advocacy provision is currently available for people with a mental disorder?

[58] **Mr Cowley:** First, I could speak about my area.

[59] **David Melding:** Could you speak about your direct experience?

[60] **Mr Cowley:** I am a founder of an advocacy provider called Mental Health Advocacy in Pembrokeshire, which has existed for 10 years. We employ a number of advocates who provide, to the community generally in Pembrokeshire, adult advocacy and services for older and younger people. We have been able to reach this situation by having a diverse committee and by doing research. I have brought with me copies of research documents and so forth, which might be useful to the committee at a later stage. In doing that, we were able to show the need and access funding from different streams. Therefore, at the earliest concept of advocacy, we were able to provide a service inside the unit for sectioned patients. Once we were able to manage that successfully, we were able to provide for adult patients generally, including people in the community. We knew that there were gaps but, because we wanted equity, we were able to look at the researched material, and identify funding for advocacy in the older and younger person settings.

[61] More recently, working in partnership with another advocacy project called Eiriol in Carmarthenshire, we have been able to tender for what is called an independent mental capacity advocate service, which covers the whole area. Therefore, our structure has grown organically, but we have been very fortunate to be able to have the right people on board at the right time with the right expertise, and we all play a role.

[62] **David Melding:** Is Pembrokeshire particularly well served as a result? Is that typical?

[63] **Mr Munn:** No; I do not think that it is typical. I asked Richard to accompany me today because, like me, he has been involved in developing advocacy in other areas. Mental Health Advocacy in Pembrokeshire would be regarded as a flagship type of service. I still feel that that is not the case across Wales, in any shape or form. There are other services that might be comparable, such as the one in Flintshire. All of the services are insecure and dependent on a lot of work from the managers and the advocates in obtaining funding from all kinds of other sources. Therefore, that is certainly not the case. We agree with MIND Cymru that there is a need for some kind of co-ordination between those services that exist and there is a need to expand the services that people deliver. That cannot be done in the way that it is currently done.

10.20 a.m.

[64] **Jenny Randerson:** In your paper, you say that mental wellbeing is not solely a health problem, but the LCO, as currently drafted, only applies to health services. If it were only to provide assessment and treatment in relation to the health service, how might that affect the quality and effectiveness of service provision?

[65] **Mr Munn:** Again, due to budgets and so on, services would be limited to the provision that could be resourced. In any case, that is not how we have been working on developing the mental health service in Wales. I think that we have a better understanding of these matters than just talking about mental illness; we now talk about mental distress, which is something that we all experience. At times, any one of us might need to engage the services of an advocate. So, I do not feel that it would be good to limit these matters to the health service. Furthermore, there would be much conflict about the resources that were put into advocacy from all the other areas of health, which might find their service diminishing. So, it is not a good way forward in either case.

[66] **Jenny Randerson:** Can you suggest any other bodies that should be included in the scope of the LCO?

[67] **Mr Munn:** Yes. We have been trying, as I say, to develop a health service that is much more holistic. That means that the voluntary sector and other parts of the statutory sector, such as local authorities, are all responsible for delivering a service that helps to keep people well. We have a large problem in Wales. I hope that we are looking to tackle that and trying to prevent the problem from getting worse. So, it is largely a matter of resources, and that money needs to be identified independently to fund independent advocacy organisations to deliver a service.

[68] **Mr Cowley:** We have two types of care system in Wales. The first is a medical model, which is the traditional model, whereby mental health is treated medically, in general terms. That model is not necessarily always useful in mental health, because it deals with treating exhibiting symptoms of illness and does not generally or easily help the person who holds that exhibiting symptom to tackle the problems that generate it. So, I understand, from my own knowledge of 20 years inside our mental health system, that doctors, in particular, who administer the medical model have limited time to spend with people who are their patients at that stage. The expectations of people, sitting around this table and in our nation, are that doctors should have the answer to all ailments, but it is not like that in mental health. We have a mind, body, soul and spirit—that is what forms human kind—so, just addressing one aspect of a human being, which might be the exhibiting symptom, and not solving the problem, is not necessarily extremely helpful.

[69] It may keep the person maintained in an NHS-style system, but, surreptitiously, the patient is handing his or her life over to a system that deals with maintenance and illness. I would prefer to come at this from a health aspect, to promote healthy lifestyles, and advocacy is part of that. This is possibly the first road that many service users go down in looking at their personal issues, which could stop their exhibited symptoms from reoccurring—that is certainly true from my own point of view. This is available to everyone, but, on a personal basis, it always involves change, and that is not always easy.

[70] **David Melding:** Thank you for that eloquent expression of an holistic service, which chimes with a lot of the evidence that we have received.

[71] **Mr Munn:** That is true for Richard and me; both of us have been in receipt of services for many years, and only a small part of them comes from health. Social services, citizens' advice bureaux and housing have played their part. All those services have a

responsibility for everyone's mental wellbeing.

[72] **Mr Cowley:** As a former police officer and custody officer, I have been at the front line. People who exhibit symptoms of mental distress in the public arena are detained under the Mental Health Act 1983 by police officers, are brought to a place of safety, namely a police station, and are detained there until a form of assessment is carried out, which may take many hours. For some, that is not a place of safety but a place of death, because it is inappropriate. Mental health service users need consideration and care, and, if they are initially exhibiting extreme symptoms and need some sort of treatment, our psychiatric services need to be up to be speed to deal efficiently with that sort of incident, so that people are taken from police custody into psychiatric care at the earliest opportunity, and so that doctors and nurses can care for them in their distress, which is at an acute stage.

[73] **David Melding:** Question 4 has been answered. I will ask the next set of questions, which relate to what independent advocacy would be like if it were delivered within the best model. You have touched upon some of these themes, so please be patient as we are trying to draw out quite comprehensive evidence, and there will be a bit of repetition. Would it help if the legislative competence Order spelled out who should commission and provide advocacy? Would you want it to be spelled out or do you think that it should be addressed in detail in a subsequent Measure? I realise that that is a fairly technical question, and we would be grateful if you had something to say on that, but we can move on if you do not.

[74] **Mr Cowley:** Initially, independent advocacy should always be provided by a service that is independent of the statutory and voluntary sectors because, in our communities today, voluntary sector providers provide an increased service for people in care in the community. When I first went into mental health care, there might have been 1,500 people in one unit in Carmarthen, but now, in the same area, there are 16 adult beds in four different locations in the same south-west Wales community.

10.30 a.m.

[75] There are probably the same amount of mental health issues and much of that now is dealt with in the third sector—the voluntary sector—which is now the provider of services. That is an integral part of our overall health service. In this, our police forces provide a lot of health services as well by being the first point of contact, but they are not trained, and do not have the proper resources to do this, although they do their best. I may be a little lost now on this discussion.

[76] **Mr Munn:** We are thinking that we possibly need to extend our services to the police service as well. I think that that was mentioned earlier. The police have an important role to play. What we are saying is that, if we are to define it at all, we would say that there needs to be an independent advocacy organisation.

[77] **David Melding:** That is not linked to the service.

[78] **Mr Cowley:** That is right.

[79] **David Melding:** That is fine. We are pressed for time, so I will move this on. I think that what you have said is very clear.

[80] You state in your written evidence that independent advocacy should be open to self-referral. I can see why that is considered an ideal system, but are there practical problems with that approach? Would you want that embedded in the Order, or would you be comfortable leaving it to a future Measure that the Assembly might adopt?

[81] **Mr Cowley:** For people who have mental health issues, self-referral is a first step for them to engage with the system voluntarily, and that could assist them hugely in solving problems in their personal lives, which might prevent the exhibited symptoms. Self-referral in that way could be a beneficial way of moving forward with personal mental health.

[82] **David Melding:** I can see why it is desirable, but I suppose that what we are seeking may be further ahead of us than the current objectives, which could be achieved in the delivery of better mental health services. How integral is it in your mind to sound legislation, or should we work towards it in good practice eventually?

[83] **Mr Munn:** I think that you are right. It is a wish list of what we would like to see, and it may not be particularly relevant at this stage. However, if we could work towards that, it would be good.

[84] **David Melding:** From what you have said to us, it seems that self-referral is your ideal, but it is absolutely essential that advocacy is independent, and that the assessment process is robust.

[85] **Mr Cowley:** You should not discourage self-referral. Once a person comes through an acute stage and out of a psychiatric hospital, back into the community, that is the point at which they come into a well situation. However, they are frequently left to their own devices at that stage, when the services have let them go. Instead of making progress in their personal lives while they are lucid, have normal thoughts and reactions, could take on board a great deal and are looking to make personal progress, they are just left to resume bad habits, bad thoughts or different ways. That is when they come back into our loop—and I have done that myself.

[86] **Mr Munn:** It is all about problem solving. You can best do that when you are in the best state of mind.

[87] **Janice Gregory:** You stated in your written evidence that you would like to see an integrated, independent advocacy service that covers mentally disordered persons detained on a compulsory basis and those who are not detained. What problems could you foresee if there were separate arrangements?

[88] **Mr Munn:** We feel that the problem in this area is mostly to do with continuity, which service users talk about in relation to the whole of the service, particularly the psychiatric service. They may not get to see the same psychiatrist more than once, and so they have to explain their situation over and over to different people, which is not helpful. We also think that it is a ludicrous situation to engage and build a relationship with someone during quite a short period while under detention—and you need that as it is very important; it is similar to a counselling relationship in that you feel that someone will support you to speak for yourself and help you to move on—only to have to disengage with them completely and build a relationship with someone new.

[89] **Mr Cowley:** It is a waste of resource.

[90] **Mr Munn:** We hope that advocates are being skilled up to provide Mental Health Act advocacy so that they are capable of dealing with both situations. For us, that seems to be the obvious way forward.

[91] **David Melding:** I think that we understand why that would be a more seamless service.

[92] **Janice Gregory:** Do you think that the exclusion of those detained under the Mental

Health Act 1983 should be removed from the proposed Order? I am trying to find the part in your paper where you talked about that. I know that I have read it somewhere. Here it is; I had highlighted it.

[93] **David Melding:** At the moment, the Order would not cover those under compulsory detention, but should it?

[94] **Mr Munn:** We think so, yes. We are very worried about the delay until 2009 for the implementation of the Mental Health Act 2007, as we believe that people should have a right to advocacy as soon as possible.

[95] **David Melding:** We are going to press on. That was a very clear answer, which is why we will not follow it up with further discussion.

[96] **Bethan Jenkins:** You suggest in your written evidence that the term 'mentally disordered', as used in the Order, will stigmatise people, and you say that there are possible alternatives such as 'mentally distressed'. Can you elaborate on why you say that, and provide other alternatives?

[97] **Mr Cowley:** We found that the term 'mental disorder' implied mental illness. We have an illness model, and people frequently consider mental health issues as mental illness. 'Mental distress', which we thought was better terminology, is much wider. It does not necessarily mean mental illness, but it can mean people who experience the everyday things that can challenge our mental health and cause us distress. In that distressing situation, if you can address your issues using the definition of 'mental distress', it will prevent you from descending into mental illness proper. So, the wider definition will allow people to seek assistance at an earlier stage, and it is a preventative way of going forward, and could be more useful. 'Mental disorder', as the previous speakers said, implies other things, and there is enough stigma and misunderstanding about mental health as it is. 'Disorder' implies something serious. I once sat on a group that had 'mentally disordered offenders' in its title. How much more stigmatising could that be?

[98] **Mr Munn:** And when do you become 'mentally ordered'? [*Laughter.*]

[99] **David Melding:** The clock is causing me distress at the moment, which is why you may feel that I am moving this on. [*Laughter.*]

10.40 a.m.

[100] **Mr Munn:** I wonder if I could turn it around and ask a question of any of you. If you experienced or went through a period of distress, would you like to be labelled 'mentally disordered'?

[101] **David Melding:** It is an interesting area. This evidence session is the first time that this particular question has been raised and I am sure that we will look at it when we review our evidence. Bethan, you wanted to ask a follow-up question.

[102] **Bethan Jenkins:** I wanted to ask a question because you mentioned that you wanted to include people within the Mental Health Act. Do you think that there will be a clouding of differentiation or a clouding of definitions, if this is how the definition is at the end?

[103] **Mr Cowley:** The important thing, as far as I am concerned, as a person who uses services frequently, is how I regard myself. I do not think that I have a serious mental disorder. I have a condition, which some people might regard as a disorder or an illness, but I do not regard it as such: I regard it as a condition. If it was a disorder, I would be a patient or,

even worse, perhaps a prisoner, but if it is a condition, I have personal responsibility for my condition to make sure that it remains a condition and does not become a disorder. It is that way of thinking that works for me.

[104] **Mr Munn:** I think that people can also manage it better too if they look at it in that way. Generally, we would agree with MIND Cymru's approach that the definitions should be kept as broad as possible, so that, when these issues arise, people get the best rights.

[105] **Janice Gregory:** You spoke very comprehensively about the medical model. In your written evidence, in discussing the issue of treatment, you said that you believe that treatment should be defined as widely as possible. You also say:

[106] 'In particular, it should include a right to talking therapies'.

[107] Why do you believe that there should be a definition of treatment in the Order?

[108] **Mr Cowley:** I think that the definition should be as wide as possible because, on diagnosis by a medical expert, such as a doctor or a psychiatrist, the person who has that diagnosis—provided that they are not in an acute phase and posing a problem to society—should have a right to whatever treatment model is available in the world because, in other cultures, they treat the same problems differently. From my perception, sometimes I use aromatherapy and sometimes it involves Chinese medicine, seeking someone who will give me acupuncture and help me in other ways. So, I would like a full range of treatments to be available. This is not necessarily as astounding as it might sound; many of us know that the NHS already encompasses other thinking—they use acupuncture as pain relief in NHS hospitals. Why not look more widely at the treatments available and allow the person concerned to have some personal choice in the matter? Under the direct payment scheme, which does exist, but is not properly taken up in Wales for whatever reason, people who are under section 117 of the Mental Health Act, where there is a duty of care put on a local authority to provide services, could be empowered to take more personal responsibility and to access services—whatever they may be—that are suited to them, to aid them in their recovery.

[109] **David Melding:** We are out of time for the final question, but I think that we can infer an answer to that one as it has been covered earlier.

[110] **Janice Gregory:** I just wish to ask a very brief question. You have mentioned a range of treatments that I was not aware existed. Have you given any thought to how you would define treatment, given that there is such a huge range of treatments and that, as you mentioned, there are different treatments in different cultures as well?

[111] **Mr Cowley:** I would say that the principle is that treatments should be individually based and therapeutic, with a view to achieving improved outcomes for the person.

[112] **Mr Munn:** I came up with the word 'remedy' as a possible alternative to treatment. If I may quickly add that I am proud of what we have been doing in Wales to turn the service around to become much more tailored to the individual. If we are all different, we should listen to the individual and ask them what helps. That is why we need as broad an aspect of treatment as we can get.

[113] **David Melding:** That concludes the questions that we want to put to you this morning. If there is anything else that you think we should be looking at that has been omitted, now is your chance to bring it to our attention.

[114] **Mr Cowley:** I just wish to submit these documents for perusal.

[115] **David Melding:** Thank you for that. On behalf of the committee, I thank Cymar for giving evidence this morning. Peter and Richard have spoken eloquently and from direct experience, which we are always most grateful to hear, because of the difficulties involved. It is powerful testimony. A transcript of the session will be sent to you, so that you can check it. We are grateful for your help with the committee's work this morning. I now ask you to move to the back to allow our next witnesses to join us.

[116] I welcome the witnesses from Cardiff Community Health Council: Martyn Jenkins, the chief officer, and Bob Woodward, who is a member. I think that both of you, particularly Bob, are known to most of us. I am sure that you will have given evidence in the new building before, and on our old patch you were a regular participant. I think that you have heard the other sessions and how we run things, so I will not repeat any of that. I will start with a general question. In principle, do you welcome this Order and do you think that it will add to what we can do in terms of assessment, treatment and independent advocacy for people in Wales who may be suffering mental distress?

[117] **Mr Woodward:** We welcome this Order and endorse the comments made by previous witnesses. I do not think there is much point in repeating that, except to say that it helps balance some of the provisions of the Mental Health Act 2007, so this Order is an added bonus.

[118] **Mr Jenkins:** I would add that, as we move services out of hospitals to other providers in the community, this is really important. We are concerned that, as we move those services out, there will not be enough capacity to look after patients in a community setting as we would like to do.

[119] **David Melding:** You made the point in your written evidence that the legislative competence Order should not just focus on the health service and health bodies, but should be extended to local authorities, and this has come up frequently from other witnesses. I would like to hear what advantages you think adding local authorities would bring, and whether it should extend to other public bodies; mention has been made of the police, for instance, this morning.

[120] **Mr Woodward:** It seems to me that the legislative competence Order gives an important signal about how the Assembly views priorities and services. Quite apart from legislative implications, it is a message about priorities, is it not? It is also a priority for the Assembly to promote joint working and 'joined-upness', so, including local authorities as a joined-up measure sends an important signal, and that is quite apart from the role that local authorities play in mental health services.

10.50 a.m.

[121] I was looking at the figures in their budgets. In 2007, they spent about £60 million; that compares with about £530 million or £540 million on health. We recognise that health is a lead player in all this, but local authorities play an extremely important part in communities in combating issues such as stigma, and it is vital that you send a message that this should all be joined up.

[122] **Mr Jenkins:** I have been working with a lady on the care of her daughter since 2001. This lady's daughter had complex mental health needs; she had a personality disorder, an eating disorder, and a drug and substance misuse disorder. She required healthcare, help from social services and the police, and help with education and housing. In 2003, she was found dead in her bedsit, having overdosed on heroin. We have just had an independent review panel, IRP, on this, the report of which will be coming to the Assembly when it is finalised, and we are clear that this lady fell through all those gaps that we talked about earlier. It was

clear that social services, the local health board, housing, and so on, did not work as well as they should have done. Therefore, I believe that it should be even wider than what we have talked about here, and, having heard other people's evidence, we would support that now.

[123] **David Melding:** Thank you, that is clear. Bethan has the next questions.

[124] **Bethan Jenkins:** Helen Mary Jones, another Assembly Member, has proposed a legislative competence Order on providing rights for carers with regards to independent advocacy and so on. I note from your evidence that you have requested that the rights for carers be extended within this proposed Order. Can you expand on why you say this, and why it could not be included in the other Order, which is coming before the Assembly?

[125] **Mr Woodward:** As has been said, the bits need to be joined up. However, again, it is as much about the signals that are given about the importance of carers in different settings. I will give you an example of a case that we came across recently when we visited Whitchurch Hospital.

[126] There was a patient there whose daughter was concerned about his circumstances; he had been moved from Barry Hospital to Whitchurch, and he had particular communication needs, which were not being met, but which she regularly met. She had been able to visit him daily in Barry, but it was much harder for her to do that in Cardiff. The patient had been moved without reference to her; she did not know why the patient had been moved, she could not provide the services, and she was concerned about him deteriorating without the sort of support that she was able to give him. Therefore, I gave her details to the advocacy services—we as a community health council run an advocacy service—and they have been in touch with her, to help her understand what has happened to her father, and to help her make her case, which she was finding difficult.

[127] Therefore, I do not believe that I need to say any more about why carers need to be involved and have these rights within mental health services.

[128] **David Melding:** I believe that you are saying, if I understand you correctly that, in, I do not want to say 'medicine'—that is too medical a model—but in mental health, carers' involvement is particularly important because it is so deep and extended, and that that makes it a special case almost. Is that correct?

[129] **Mr Woodward:** Yes.

[130] **Mr Jenkins:** It is extremely important too with regard to mental health services for older people. We run carers' meetings at St David's for this group, purely because they felt that they were not being included and engaged with the care at that hospital and at Whitchurch Hospital. It really is important, because they are usually fairly elderly themselves and find it difficult to assert themselves on behalf of their loved one.

[131] **Jenny Randerson:** Why do you think, as you state in your evidence, that patients receiving compulsory treatment under the Mental Health Act 1983 should be brought within the scope of the Order?

[132] **Mr Woodward:** We have had some discussion on that already. I am not a technical expert on all of these issues relating to legislation. However, there is a point about continuity of care. People do not necessarily stay on orders for long periods. So, if they are dipping in and out of rights, it will create some serious difficulties in terms of consistency and sending a message about people's rights. As I said, I am not fully aware of the full legislative impact and why they should be excluded. However, speaking as a lay person, it does not seem to make sense.

[133] **Jenny Randerson:** Okay, thank you. In your written evidence, you suggest adding provisions for the management and planning of services to the text of the proposed Order. Why do you think that the current Order, as it is proposed, would not be adequate in that regard?

[134] **Mr Woodward:** Again, this may be a technical matter of interpretation, but it seems to me to be only about the delivery of the services overall to individuals rather than about the way in which agencies work together to plan and manage the services. I will give a specific example of where I think there are some problems in the planning and management of services. At the moment, we have some very good proposals going forward for the development of older people's mental health services, such as the long-overdue closure of wards in Whitchurch Hospital and the development of new units. I sit on the planning group and a number of other groups relating to that, so I have seen the proposals for the hospital services in that area, but I have not seen some of the detail about how community services will be provided around that. The proposed model of care is very different and very short term in the new unit, so it can work effectively only if it is seen as an overall package of services rather than as individual components. All I see at the moment are individual components. There needs to be something far more effective in relation to how the services come together. As we have said in the evidence, regrettably, the current framework of health, social care and wellbeing strategies do not provide the necessary detail to address the sort of issues that I have just highlighted.

[135] **David Melding:** Before we leave this issue of the 1983 Act, which deals with people under compulsion, it seems that the logic of this LCO and any Measures that it will then enable at a future date is to encourage and provide for significant intervention earlier in a person's history in terms of their health, before compulsion becomes necessary, and, in a way, to prevent compulsion. That is the assumption as to why it therefore excludes people who are at the point where they have been compelled. I sense that you are saying that that may be a misapprehension and that the systems could be complementary. Is that your view? Presumably, for those who come under the 1983 Act, in many ways the measures or procedures there will be rigorous and the entitlements will probably be greater than those people would get earlier in any episode of ill health. Is that your view? If they overlap and confuse the picture, the committee will need to know—that has been most of the evidence, to be frank, but you seem to have a different view.

11.00 a.m.

[136] **Mr Jenkins:** I think that the view would be that the service should be exactly the same for many aspects, whether you are detained under the Act or a voluntary patient. As we have said, people move in and out of the provisions of the Act as their problems ease and as they move on and so on. I fully support early assessment and treatment; it should be earlier than is currently the case. In Cardiff, our mental health teams are probably under-resourced and they have waiting lists. Many people are seen by their GPs, and GPs have different skills. Some GPs will be very good in their knowledge of mental health services and others will not be as good, and their patients cannot then access mental health teams.

[137] If we are going to move these services from hospital care, which is what everyone wants—although at least they are a fallback—it is important that our mental health teams have enough staff and the right staff skills to deal with these people as their condition moves up and down the spectrum, because the last thing that we want is for people to be in a crisis and to not be able to access services.

[138] **Mr Woodward:** My understanding is that legislation is there to provide a framework within which people will operate, unless it relates to specific circumstances, for example,

proposals for detention. It is about providing a context, and, within that, people interpret it flexibly. The more you draw lines around it, the more people will, potentially, not respond to that framework flexibly, if you see what I mean.

[139] **David Melding:** Yes, I think that that is clearly expressed.

[140] **Bethan Jenkins:** As was mentioned earlier, there has been some discussion as to the terminology and Cymar said that it would like to change the wording to 'mentally distressed'. You note in your evidence that you would like the term to be 'person with a mental illness or mental health problem'. Why do you take that particular view?

[141] **Mr Woodward:** There are others in user groups who would perhaps have stronger views on this, which one would wish to listen to, but I was always under the impression that the way to do it is to start with the word 'person' first, and then go on to the other attributes that that person had. So, that is why I emphasised putting 'person' first, rather than the mental disorder. The latter is potentially a more stigmatising approach. However, as I say, there are others who would have stronger views.

[142] **Bethan Jenkins:** Do you believe that provision should be made in the Order for those who are recovering from a mental illness?

[143] **Mr Jenkins:** Absolutely, because if they are recovering, that means that they could also go backwards and so they need to be covered.

[144] **David Melding:** That also addresses your point about flexibility. You state in your evidence that treatment, as a concept, perhaps inclines us too much towards a medical model and you would like some reference to services as well as treatment. Would 'care and treatment' or 'treatment and care' capture that, or do you have an alternative that you could suggest?

[145] **Mr Woodward:** To pick up a point that Mind Cymru raised about education, it said that education is part of treatment or care, but I do not think that it is. However, 'services' would include the notion of education. We have an issue that we are currently raising around education. You will be aware that the Harvey Jones Unit has transferred to Bridgend, and that children over the age of 16 at the unit are not receiving any education. Some of them are very vulnerable but also quite intelligent. A group of community health councils recently visited the unit, and we will be submitting a report about that. So there are issues about services rather than just care, but, again, it is a matter of terminology. This is always subject to debate in how legislation is then interpreted.

[146] **David Melding:** We have had a large number of witnesses saying that 'care' should be added, so it is interesting that you picked that up independently as well. It adds weight to the argument.

[147] **Mr Jenkins:** In our area of Cardiff, we have very much a medical model, and as we move services from hospitals into other areas, we need other services to be able to support patients. If there is an area that patients have to go out of Wales for, it is usually for those sort of services, such as psychotherapy, and so on.

[148] **Bethan Jenkins:** The Scottish mental health legislation provides a definition of treatment that includes nursing care, psychological intervention, habilitation, including education and training in work, and rehabilitation. Do you believe that this definition would be suitable for this Order or do you believe that it would be suitable for any future Measure that may come before this Assembly?

[149] **Mr Woodward:** I heard reference to the Scottish definition earlier. We would need to study that legislation, but, in principle, that sounds as though it would be useful.

[150] **Mr Jenkins:** It seems to me, as a patients' representative, that that includes a lot of what patients would be looking for and therefore I think that we would have to support that model.

[151] **Bethan Jenkins:** Would you believe, however, as we heard earlier, that perhaps we should not be excluding anything, and that we should leave it open, for more scope, so that if there are new therapies or any new developments they should be included within this definition?

[152] **Mr Jenkins:** Yes.

[153] **Mr Woodward:** Yes.

[154] **David Melding:** The Scottish definition is quite wide, but there is always the danger that it could still get outflanked. I sense that your evidence has been encouraging us to go in a flexible direction.

[155] That concludes the questions that we want to put to you. I would now like to give you an opportunity to raise any issues that you feel should be brought to our attention. You have heard the exchanges on advocacy and about how it should be independent, and I just wonder whether you have any particular reflections on that point, given your important role as a watchdog, if I can refer to you as such.

[156] **Mr Jenkins:** We have an independent advocacy service that tends to concentrate on the medical issues rather than on the other, wider issues that we talked about earlier. To find an advocate who can provide all of the services that a complex mental health patient would need would be very difficult. We deal with a number of mental health issues and they always consume huge amounts of time, which is extremely difficult because it is not like a patient who has a medical problem, which can be operated on and the problem is then solved; these things are much more complex. We work with the other mental health advocates when there is a need for our expertise. I would support what has been said in that advocacy needs to be independent, but to have one organisation providing that whole advocacy support would be very difficult and perhaps we need to have a system whereby the expertise of a range of advocates are used as and when appropriate.

[157] **David Melding:** So you would not want the Order to be prescriptive about the body that can provide advocacy, because of the need for that flexibility, and a variety of expertise?

11.10 a.m.

[158] **Mr Jenkins:** No, I do not believe that we would.

[159] **David Melding:** Is there anything else that you wish to bring to our attention?

[160] **Mr Woodward:** To give some weight to the point about planning services, we met last week with the person who oversees the development of community mental health teams in Cardiff. He told us that there had been no particular increase in resources allocated to the community mental health teams in Cardiff in the last few years. The current health, social care and wellbeing strategy just refers to an overall statement in this context, and no more detail about strengthening primary and community services, which I believe has been their intention for the last however many years it has been. One cannot see much change happening as a result of that statement. Therefore, there is a need to strengthen the planning of those

services. Thank you.

[161] **David Melding:** Thank you. The committee, again, has been greatly helped by your expert evidence. We have covered a range of issues, and you have brought some new issues to our attention, which is valuable. Therefore, I wish to put on record our thanks to the representatives of Cardiff Community Health Council, Martyn Jenkins and Bob Woodward. You will receive a transcript for you to check.

[162] **Mr Jenkins:** A cheque?

[163] **David Melding:** No, you will receive a transcript for you to check. There is no appearance fee—that would be a radical departure. [*Laughter.*] If you feel that anything has been mistranscribed, you will have a chance to correct that. Again, you leave with our profound thanks.

11.12 a.m.

Dyddiad y Cyfarfod Nesaf
Date of the Next Meeting

[164] **David Melding:** The date of our next meeting is 6 May. I thank Members for their patience. We have run over time, but we have received valuable evidence. We have had to perhaps take a bit more evidence than was ideal this morning, but I appreciate that you have remained vigilant throughout, so that our deliberations will benefit from this range of expertise. Thank you. That closes the meeting.

Daeth y cyfarfod i ben am 11.12 a.m.
The meeting ended at 11.12 a.m.