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, 15 Ebrill 2008
Tuesday, 15 April 2008

Cynnwys
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National Assembly for Wales (Legislative Competence) (No. 6) Order 2008 (Relating to Provision of Mental Health Services)

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.
These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Janice Gregory	Llafur Labour
Bethan Jenkins	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
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

Dr Val Anness	Chair, Royal College of Psychiatrists (Welsh Division) Cadeirydd, Coleg Brenhinol y Seiciatryddion (Is-adran Cymru)
Lee McCabe	Defnyddiwr Gwasanaeth, Hafal Service User, Hafal
Bill Walden-Jones	Prif Weithredwr, Hafal Chief Executive, Hafal

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

Anna Daniel	Clerc Clerk
Gwyn Griffiths	Cynghorydd Cyfreithiol Legal Advisor
Olga Lewis	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.33 a.m.
The meeting began at 9.33 a.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

[1] **David Melding:** Good morning, and welcome to this meeting of the Proposed Provision of Mental Health Services LCO Committee. I welcome everyone to our evidence-gathering session. I will make the usual formal housekeeping announcements. We do not anticipate a fire drill this morning, so if we hear the fire alarm, please follow the instructions of the ushers on how to leave the building safely. Please switch off completely all electronic devices—that means that you cannot leave phones in silent mode—because they interfere with our recording equipment. These proceedings will be conducted in English and Welsh, and when Welsh is spoken, a translation will be available via the headsets on channel 1. If you are hard of hearing, you can amplify our proceedings by switching to channel 0.

9.34 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)

[2] **David Melding:** I welcome the two organisations that have representatives giving evidence here today—Hafal and the Royal College of Psychiatrists. We will start with Hafal. Our proceedings are intended to explore the written evidence that you have submitted, and to discuss the principle of this LCO. We have a series of prepared questions to put to you. I hope that the discussion will develop appropriately, but at the end, if you feel that there is something pertinent that has not been discussed, you will have an opportunity to add at that point.

[3] We will move on, therefore, to questions. I welcome Bill and Lee to our meeting this morning. We greatly appreciate the fact that we will get the perspective of Hafal as an organisation. Bill, of course, has been before various Assembly committees over the years and we welcome his expertise, and having Lee here this morning to add the direct perspective of a service user is also a great help. We realise that attending committee is not a terribly easy procedure, and we are grateful for your generosity in coming to talk about your experience and about how the matter before us may be developed. I will ask the first question, but I am not sure, Bill, how you will want to split up the answers.

[4] **Mr Walden-Jones:** Perhaps I could field them to Lee, as appropriate.

[5] **David Melding:** Exactly, or if you want to say something, Lee, just indicate to me and I will bring you in. We will try to be as informal as possible. We have a series of questions, and we will drill down to the detail, but could you first give us a short introduction about why you think this Order would be beneficial—if you do think that—and how it would allow effective Measures to be developed by the Assembly to help those people whom you represent, support and campaign for?

[6] **Mr Walden-Jones:** Lee, do you want to start with that?

[7] **Mr McCabe:** Okay. Hafal's general view is that the LCO could lead to Welsh law that changes for the better the relationship between the patients—the service users—and the service providers in the mental health system.

[8] **Mr Walden-Jones:** I will just add to that, Chair. Everyone recognises that the scope of the LCO is relatively narrow, but, for all that, we think that there is potential here, as Lee says, to get a sea change in how the patient relates to mental health services, and, in a sense, to the state, namely the Government. We suggest that that is so in two ways. Symbolically, to date, the assumption has always been that patients have no specific legal rights beyond some degree of protection once they are subject to compulsion, and that the state applies compulsion at a certain point—and we agree that this is necessary—although that is overwhelming, in the sense that it overwhelms someone's human rights. Symbolically, therefore, it would be immensely significant if a balance could be struck between the right of the state to intervene at a certain point and the rights of patients. We think that it is more than symbolic; we think that if the right Measure could be devised—and we think it possible—practical changes could be made to benefit patients in that critical period between an illness becoming pretty serious and its becoming so serious that compulsion is necessary. We think that those big changes could relate to the timeliness and level of treatment and support, but also in the approach to treatment and care, and we have set out some ideas for that. There would be some prescription of the nature of the treatment and care, which could change it from being too much about addressing symptoms to being more about treating patients as

human beings.

[9] **David Melding:** Thank you. That is very clear. As one of the principal voluntary organisations in this field, with a solid record of work, do you think that the type of legislation that this LCO might allow would buttress the position of the voluntary sector and allow you to work more effectively for those whom you represent?

[10] **Mr Walden-Jones:** I do not think that a Measure arising from the LCO would have something direct and specific to offer the voluntary sector, and I do not think that those in the voluntary sector who have supported an LCO and a future Measure have done so for that reason. I am pretty clear that it is a direct response to the needs of service users and their families. However, the voluntary sector will have some responsibilities, both in the delivery of services, which could be prescribed by the ensuing Measure and regulations, and in the provision of advocacy. However, essentially, this is not about something that supports the voluntary sector particularly.

9.40 a.m.

[11] **Janice Gregory:** In your written evidence and the explanatory memorandum, reference is made to the Scottish mental health legislation. Do you think that Wales could use the Scottish system as a model?

[12] **Mr Walden-Jones:** I have spent some time talking to service user groups and others in Scotland, and I have found that the Mental Health (Care and Treatment) (Scotland) Act 2003, which established modest rights to assessment, has made a huge difference to the relationship between the Scottish Government and patients. There was a real sense that patients wanted to work with the Government and with service providers to get things right. However, at the same time, we must be honest and say—and the Scottish Government itself would probably agree—that the rights that were established were pretty modest and lightweight. They had to be, because they are universal rights; in essence, anybody can make a demand using that right, but the right itself is lightweight. So, it is the symbolism of it that is important. It will have some practical value for people in unusual circumstances, when they just cannot get an answer, or when they first say, ‘Look, I think that there might be something wrong with me’. However, we would be deeply disappointed if we were not able to create something more complex in Wales, which would give more substantial rights to a smaller group of patients, even though that might be more difficult to achieve.

[13] **Janice Gregory:** That was to be my supplementary question, but you have been quite clear on that in your answer. Do you think that we should do something differently from the Scottish system, or better?

[14] **Mr Walden-Jones:** I do. There is quite a strong case for bringing in something like the Scottish right to assessment as a relatively small part of a Measure, because it has that wide, symbolic value, and would offer a small amount of practical help to the small number of people who are left out when they first raise an issue. We think that, with care, there could be a way of integrating this with the kind of gatekeeping that is already used in Wales for identifying people with a high level of need. Crudely speaking, that means people who cannot be sufficiently managed with primary care and associated care such as counselling, so people who need specialist mental health services, and people who experience psychosis or a very serious mental illness that requires a lot of care. If a Measure were carefully drafted, we think that it could integrate with that gatekeeping and therefore identify a much smaller group of patients, namely people who could become subject to compulsion if their illness gets worse. The key would be to identify that much smaller group of patients, and then to build modest but practical and valuable rights for them, by way of care plans and rights to advocacy.

[15] **Janice Gregory:** Do you think that there is a real chance of finding a middle ground between the Scottish approach and our current approach in Wales?

[16] **Mr Walden-Jones:** There would be nothing inconsistent in having both. You could have the modest, fairly light duty that is applied by the Scottish model, as well as a stronger duty for a much smaller group of patients. To be clear about this, some strong gatekeeping would be needed to identify that group of patients. In an ideal world, we would like to see everyone having a right to the best treatment, but, in our view, that could not be arranged straightforwardly by self-referral; a realistic process of assessment would be needed before including someone in the defined group in question. It is important that that process is the same as the assessment process that patients go through before treatment. In other words, there should not be a wholly separate legal process to identify a particular group of patients. That would be folly, it would be expensive, and it would be disruptive to the patient.

[17] **David Melding:** I think that you have covered question 3 as well with that answer. It followed on quite naturally.

[18] **Janice Gregory:** Yes, it has been covered.

[19] **Jenny Randerson:** Can you explain why you support the exclusion of those who are subject to compulsory treatment under the Mental Health Act 1983 from the scope of the legislative competence Order?

[20] **Mr Walden-Jones:** As you will know here, Hafal has lots to say about the rights that should apply to people while they are subject to compulsory treatment. We would certainly like to see improved rights for people in those circumstances, and improvements to the range of rights in legislation as it applies to compulsion. It may be wise not to go into that territory for two reasons. First, although we have much to say about the Mental Health Act 2007—and there is much in it that is insufficient, as far as we are concerned—it is coherent enough. However, if you try to bolt on other rights to that, it will cause difficulty. In other words, if that were to be reformed—and we are hoping that, one day, it will be, whether on a UK-wide or a Wales-only basis—it would need to be reformed wholesale.

[21] The second reason is that, as a campaigning organisation, we are realists. We think it unlikely that the Assembly will persuade Parliament to reform the 2007 Act so shortly after it went to the trouble—as it would see it—of creating it; it would be perceived as interference. Please do not mistake that as our being comfortable with all the processes that arise from the point of compulsion onwards, however.

[22] One other point on this, which is important, is that the Assembly has control over an important element of the 2007 Act, namely the code of practice. I think that the Minister will soon be putting forward a draft code of practice, which has now been consulted upon. We have campaigned vigorously for some prescriptive ideas on truly holistic and humane care planning to be prescribed in the code of practice. It will come as no surprise to you to learn that the things that we said should be prescribed in the care plan are the same things we suggest be prescribed in the regulations of a future Measure. It makes sense for there to be consistency between the standard of care that the Measure gives people a right to, and the standard of care that the Assembly has control over in the care plans for the process of compulsion. So, there is a way of linking those up, and we hope that Assembly Members will look carefully at the code of practice and ensure that it does that job for patients.

[23] **Jenny Randerson:** On a different issue, the Order covers assessment, treatment and independent advocacy. Are there any other areas of service provision that you would like to see included in the proposed Order?

[24] **Mr Walden-Jones:** We are not lawyers, so we are not absolutely sure about this, but our reading of it, and our advice, is that it would cover what needs to be covered. There are issues with the definition of 'treatment', which we have touched on, and we are just saying that the definition needs to pass the test and be broad enough in scope, which is really a matter for your lawyers. However, essentially, we think that it is sufficient.

[25] **Val Lloyd:** I want to concentrate on something that you said in your written evidence. You raised issues about the providers of assessment and treatment, and you told us that you think that the duty should not fall just on the health service, but on the wider social care sector. Why do you believe that that statutory duty should be placed on other bodies, and what should those duties be?

[26] **Mr Walden-Jones:** I think that Lee may have something to say about that, from his opening remarks.

[27] **Mr McCabe:** Yes, because treatment needs to be for—pardon me. Because treatment needs to be for self—

[28] **Mr Walden-Jones:** Shall I jump in, Lee?

[29] **Mr McCabe:** Yes, if you will.

[30] **Mr Walden-Jones:** Forgive me. Going back to the last question, if 'treatment' is to be seen as something much wider than the prescription of medication, as we believe it must be, and as is defined in the 2007 Act, it must include aspects of social care. From a user's perspective, that is what social workers do for them, and they are often the care co-ordinators and the lead person in making sure that a plan for treatment and care is taken forward. So, we think it right that it would extend to local government, and existing legislation—such as the Scottish legislation and its equivalent, the National Health Service and Community Care Act 1990—also applies to local government. That seems to make sense to us.

9.50 a.m.

[31] **David Melding:** Lee, I do not know whether you would be able to respond to that. Can you give your views? Presumably, the medical treatment that you receive is only a small part of getting better. What you do in the day, whether you can work or do a bit of training, is as important, perhaps.

[32] **Mr McCabe:** Yes, occupational therapy helps. You can be on a psychiatric ward from weeks to months, and, basically, you just sit around dwelling on your problems. There is no structure to your life or sense of getting better when you are in a psychiatric unit. My feeling was that, the more time I spent on the wards, particularly when I was first being assessed, the more I was alienating myself from the real world and society. I could have been receiving occupational therapy instead, which would have given my life a structure. In all that time, I was seeing psychiatrists for only about five or 10 minutes once a week—and there were ward nurses and so on. It was fairly difficult and long and upsetting; it also strange, because, when you go in, you see that these service users are people with mental illnesses, and that alone is hard to cope with. I did not find spending that amount of time living on wards to be very therapeutic; it does not do anyone any favours in recovery as a method of early intervention.

[33] **David Melding:** I think that the argument is that many therapeutic services creep towards social care or employment to supported employment and so on so that, if you are looking at earlier intervention while still dealing with quite vulnerable people, that balance must be struck. We are hearing evidence that points in that direction.

[34] Sorry, Val—I carried on with that.

[35] **Val Lloyd:** Not at all. Thank you for taking it forward.

[36] Do you think that the specification of the bodies that should be responsible for providing mental health services should be left to precise Measures?

[37] **Mr Walden-Jones:** I had not thought of it in those terms, but I guess that that might be right. As I understand it, the Measure can include sub-definitions anyway, but it needs to work within the context of the LCO. So, if that were perceived to be acceptable to define who the duties would be placed on, I guess that that would make sense.

[38] **Val Lloyd:** We have mentioned the additional bodies, and we have obviously said that the health service and local authorities should have the statutory duty placed on them. Can you think of any others that you would like to put forward for consideration?

[39] **Mr Walden-Jones:** The nuance that I would put on this would be that, if the duty is clearly on local authorities in their widest sense, then that would cover matters sufficiently. In the context of a Welsh Measure, I am guessing that it is probably not possible to place duties on bodies such as criminal justice agencies on which one would like to place some duty with regard to these matters.

[40] **Val Lloyd:** Turning to the subject of advocacy, as an organisation, Hafal has a great deal of experience of advocacy on behalf of people and their carers. The proposed Order does not place a duty to make provision for independent advocacy on a particular body. Are you satisfied with that provision for independent advocacy as laid out in the current Order?

[41] **Mr Walden-Jones:** As I understand it, the Assembly, when it creates a Measure, can dictate the nature of the advocacy, and it is probably appropriate that it is left to the Assembly to work that out.

[42] **Bethan Jenkins:** You mention in your evidence that the phrase, 'may be mentally disordered' as the definition of people with mental disabilities may be too open-ended. Why do you believe that your suggestion of 'persons who are or appear to be mentally disordered' would be better?

[43] **Mr Walden-Jones:** It was based on some legal advice. My understanding is that, if you say 'may be', that could be anyone; 'appear to be' is needed because you do not want duties being evaded on the basis that someone has to prove that they have a mental illness. My understanding from the lawyers is that 'appear to be' is fair ground for saying that you do not have to prove that you are, but that you merely need to show that that was the appearance of things. Therefore, it is trying to judge what the right middle ground is; we thought that 'may be' was extremely wide.

[44] **Bethan Jenkins:** Jonathan Morgan's argument, in his evidence to us last week, was that they needed to keep it as wide as possible, but you believe that trying to define it in this way would perhaps help us rather than restrict us?

[45] **Mr Walden-Jones:** It is more about what Parliament would think about it. If it were wider, I do not believe that that would make too much difference, provided that it was acceptable. However, our whole argument is that these duties would in any case be confined specifically to a much smaller group, so the real issue is how you define the much smaller group. If I understand how the LCO works, you are looking for a general power, but the likely intention of the Assembly is to create something for a much more defined group. If you were

to go for the general duty, as in the Scottish legislation, I believe that that would still be covered by 'appear to be'. However, in the end, this is a nice legal point—'may be' just looks extremely wide.

[46] **David Melding:** We can ask our legal team to look at this and at what the implications are.

[47] **Bethan Jenkins:** The other area that you touched on earlier was the definition of the term 'treatment'. Can you explain your concerns about the fact that this LCO does not define 'treatment' clearly, from your organisation's perspective?

[48] **Mr Walden-Jones:** Again, this is probably something for your lawyers. Our concern is to ensure that it is seen as sufficiently wide. Our understanding is that reference points for definition, if it is not further defined, would be things such as the Mental Health Act 2007, where it is widely defined. In other words, we could all be comfortable with it being left as it is. Therefore, our concern is not to narrow it down, but to ensure that it is seen as sufficiently wide. If it is sufficiently wide left as it is, that is fine. However, if there is any ambiguity about that, in particular going back to the point about social care intervention, we just need to be sure that that is addressed. It is interesting to note that the RCP shares our view, but has approached it from the other direction, by saying, 'Do not define it more closely—make sure that it is open.'. That is the same point that we are making; the only reason that we would want to add to it would be to ensure that it was seen as being very open.

[49] **Bethan Jenkins:** Following on from that, in your paper you suggest adding 'care' to 'treatment' in the text of the proposed Order. Why is that?

[50] **Mr Walden-Jones:** Again, it is about ensuring that the understanding of what support to a patient would be is sufficiently wide. Again, this may be a caution too far, because my understanding is that the definition of treatment is probably wide, or would be perceived as such, in law. It worries those of us who are not lawyers, because it sounds narrower than would be understood elsewhere. If we can all be reassured that it has an especially wide meaning, then people would be content with that.

10.00 a.m.

[51] **David Melding:** I suppose that this is still on the same point. The Scottish Act gives a definition of treatment that includes nursing; care; psychological intervention; habilitation, which includes education, training in work and social independent living skills; and rehabilitation. Am I right in saying that you think that 'care and treatment' would capture all of that.

[52] **Mr Walden-Jones:** That definition sounds pretty good. If adding something of that sort would remove doubts and the potential challenge in future that people are evading their duty when the intention was to include that more holistic vision, then add further definition. However, I do not feel qualified to judge that.

[53] **David Melding:** As I understand it, you hope that this will deliver a more holistic system, so the language needs to capture the many aspects that you may need to provide an appropriate package of care. However, you want to focus on those who are most ill and most vulnerable to suffer compulsion at some point. There is a balance to be struck because, having wide rights, which everyone accesses or that a large group would seek to access, dilutes the value of the intervention considerably. You have talked a little about the vulnerable people who could be treated in a way that does not require compulsion. However, from what you have said so far, I infer that you think that it is a fairly small group. Of the number of people who are under compulsion at any one time, or who are in acute care because they may not

always be compelled, what sort of proportion would you say is that key group that we could help? I ask because it seems to be the intention of this LCO to help that key group of people about whom you sometimes read in the newspapers—people who, after some unfortunate event, asked for treatment, but did not get it.

[54] **Mr Walden-Jones:** You could scope that from a number of directions, but a helpful way of scoping it is to observe that people will be familiar with the statistic that 1 in 3 figure people will seek help during their lifetime for a minor mental health problem. According a significant level of legal rights to all of those people, which superficially sounds desirable, would be folly and impossible to deliver. It might be helpful to say that around 1 in 30 people, at some point in their lives—and not all of the time—will experience a serious mental illness. Around one in 100 are diagnosed with schizophrenia and one in 100 are diagnosed with bipolar disorder, and there are other variations on that theme. So, that begins to give a scope of a different and much smaller proportion. I hasten to add that those who need specialist services at any one time in their lives represent a much smaller proportion. That is why we would scope this more narrowly and say that a Measure should try to get alongside best practice quite outside any legal rights. Best practice is about referral by primary care to specialist services, and there is an existing, although sometimes flawed, system—the care programme approach—that is a deliberate assessment and gatekeeping function to let people through into specialist, high-level mental health services.

[55] The care programme approach is due to be reviewed; in England, they have reached some conclusions about that. I am not necessarily saying that Wales should go in the same direction, but if the CPA and its gatekeeping function and the special arrangements for care planning for people with serious illness need to be reviewed in Wales, why not do that alongside the creation of a Measure? In that way, those two things would be fully integrated and there would not be two processes—one for getting specialist mental healthcare and the other about acquiring rights. That would surely be folly and we must marry the two things together. That will create an already recognised group of people with serious problems.

[56] **David Melding:** That would then take us away from the perversity of people wanting specialist treatment and having to go to an acute care setting at some point because otherwise, they could not access the treatment. That is something of a problem at such a level that we should perhaps seek a remedy through a Measure.

[57] **Mr Walden-Jones:** Yes. If the definition of acquiring the rights was made the same as the process of going through the CPA assessment and being assessed as needing a CPA plan—that is the gate-keeping point—then that would be a much narrower group of people. However, it includes many people being treated in the community, not just in acute care. Those are precisely the people for whom things go wrong and for whom there being some practicable duties in a holistic sense to look after their needs—having a duty in place—could make a real difference. It could be quite closely targeted.

[58] **David Melding:** I have one other follow-up point from the evidence that you gave on independent advocacy. The Member proposing this LCO, Jonathan Morgan, appeared before the committee last week. He saw great benefit in being able to access advocacy before you are under provisions of compulsion, and to move that one step back for those who need it. Obviously, I am not saying that this should be the case for everyone, because it would dilute it to the point where it would essentially not be a meaningful right, at the end of the day. You seem quite trusting that the Assembly would come up with guidance on advocacy that would cover the point of creating credible and independent advocacy services. Do you think that it should be more explicitly spelled out in the legislation that the service provider should not also be providing advocacy?

[59] **Mr Walden-Jones:** I suppose, Chair, that this is all new to everyone, but we are

trying to respond to the spirit of the Government of Wales Act 2006, which says that you look for a general area of legislation—this is already quite narrow in scope—and leave the options with the Assembly. We accept the detail of all of this and the real negotiation for patients will come when the Measure is created.

[60] **David Melding:** Okay, thank you very much. Would Members like to make any other general points? I think that we have covered the ground that we agreed to examine. Lee and Bill, you may feel that there are things that we have not touched upon—there may not be, so do not feel under pressure to invent something, but if there is something that you would like to bring to our attention, now is the time to do so.

[61] **Mr Walden-Jones:** No, thank you.

[62] **David Melding:** That concludes the first part of our evidence session this morning. I thank Lee McCabe, the service user, for speaking about his experiences. It is always a very difficult thing to do, but it often provides the best quality evidence that we hear, because we can be very remote and technical if we are not careful. I also thank Bill Walden-Jones, the chief executive of Hafal, for his expertise. We will be putting questions to a second organisation, and you are welcome to stay at the table. Should you wish to add something towards the end of the session, please indicate to me that you would like to do so.

[63] I welcome our second witness, Dr Val Anness, who is the chair of the Welsh division of the Royal College of Psychiatrists. You have obviously heard the way in which we conducted the first half of this morning's evidence session; this is very much what we intend to do now with the set of questions that we will put to you. As I said, if we need to cover any ground at the end that you feel has not been drawn out in the evidence session, then that is the time to do so.

[64] I will ask the first question, which will be a general question about what the royal college thinks about this legislative competence being transferred to the Assembly and what that might do. We will then drill down to greater detail. Are you broadly happy that the Assembly should seek such powers?

10.10 a.m.

[65] **Dr Anness:** Yes, indeed. As you know from my evidence, as a college, we are members of the Mental Health Alliance, which had many concerns about the 1983 amended Act. We are supportive of ensuring that people have earlier access to services to prevent them from becoming subject to the Act. We have some concerns in that respect, in that giving these rights before people are compelled to have treatment must be carefully balanced; we would not want to see those rights being extensive. In line with what we heard from Hafal, I think that that would be so broad as to be utterly meaningless. The group to which this legislation might be applied would have to be carefully defined. However, as I said, there are also ways to look more specifically at specific elements of legislation that are not necessarily to do with compulsion, but that could enable other elements of mental health services to be developed, for example, eating disorders and, as in Scotland, perinatal mental health services. We would see it as being narrow, but we also see the potential in a broad LCO to give new elements to services in Wales, which would not necessarily impinge upon the Act.

[66] **David Melding:** Thank you for those introductory remarks. We will now go through some of the detail. I do not find anything that contradicts the evidence that we have heard previously on the point that there is a risk of diluting the effectiveness of any particular Measure, if it is extended to such a broad population. We are looking at a particular group that could be helped by improving the system that we have for mental health care. Bethan Jenkins has the next question.

[67] **Bethan Jenkins:** You state in your written evidence that the royal college is supportive of legislation that addresses a balance between rights and compulsion. Do you believe that, if the LCO is passed, the Measure will be able to sufficiently deal with this, and put the balance in favour of the rights of patients?

[68] **Dr Anness:** I think that I largely addressed that in my opening remarks. We wish to see opportunities for people to receive earlier treatment, but, as I said, balanced by the need that that be gatekept. A huge number of people have mental health problems and they are largely dealt with within primary care services. There is a lot of room for improvement there as well, but, again, that requires there to be sustained development for mental health services in Wales.

[69] **Bethan Jenkins:** What is your experience of non-compulsory treatment in Wales at present for those suffering from mental illnesses?

[70] **Dr Anness:** There are concerns that many of the newer, more validated treatments, for example some of the psychological treatments, are not available in Wales. We would like to see the development of psychological treatments more broadly in Wales. That is not necessarily related to this, of course, but it would be part and parcel of improving community services for all.

[71] **Bethan Jenkins:** Could that be done through the Measures following this LCO going through Westminster?

[72] **Dr Anness:** I think that it could if it was also supported by financial developments. As you know, the English Government is ploughing huge amounts of money into psychological treatments at the moment.

[73] **Bethan Jenkins:** You mentioned Scottish legislation and best practice with regard to postnatal depression, for example. How can we learn from what is being done in Scotland and what we can do to emulate best practice there?

[74] **Dr Anness:** I would echo some what Hafal has already mentioned. The Act in Scotland is specifically about those who are detained and there is only a relatively small element about the right to assessment in the first instance. Regardless of whether it is symbolic or not, it is certainly a relatively small part. Interestingly enough, as you are probably aware, Scotland is already reviewing the Act because of difficulties about the numbers of interim orders. However, you could, if the LCO were sufficiently broad, look at very specific Measures around creating, as I have mentioned, improvements in perinatal services so that there were specific services there, for example. We have minimal provision in eating disorder services, as I have already mentioned, and you could subsequently look at identifying those specifically. I suppose that, in that sense, I am not really aware of how the LCO works in terms of how you could then utilise it, but, if it is sufficiently broad, you could subsequently bring in specific Measures in addition to those that you are considering at present.

[75] **David Melding:** I think that that is precisely how the process is designed to work. I think that we can move on. Val Lloyd is next.

[76] **Val Lloyd:** In your evidence, you tell us that modern mental health services are usually delivered jointly by health and local authority services in association with the voluntary sector. In your view, how effective will the proposed Order be if it only places statutory duties on the health service?

[77] **Dr Anness:** Again—I am sorry, this is a bit like 'Groundhog Day'—if you are going to provide a broad range of treatments and opportunities for people who have serious mental disorders, our local authority colleagues have to be included in terms of the opportunities for care following in-patient treatment and so forth. All modern teams are joint teams; they are not single teams.

[78] **David Melding:** Do not be afraid of repeating points that have been brought up in earlier evidence, because sometimes witnesses are unaware of who spoke before, and it is very important that we gather the evidence and see how many people subscribe to the view. Whether there should be some extension to cover local authorities is one of the key areas that we are looking at, so it is helpful to have your views.

[79] **Dr Anness:** To expand on that, then, an awful lot of people are in hospital unnecessarily, because they cannot leave as the provision, which is largely provided by our local authority colleagues, is not available for them. So, if we are placing duties on care and treatment, there has to be a seamless approach that addresses people's needs early on and, hopefully, prevents—although it is not necessarily always the case—a hospital admission and looks to enable people to move on, into step-down accommodation, and then to provide services to help keep them well.

[80] **Val Lloyd:** What role do you see for voluntary services?

[81] **Dr Anness:** There is the advocacy role, obviously, but we know that, in addition, the voluntary sector team provides a lot of supportive services for people.

[82] **Val Lloyd:** Your views on that are quite clear.

[83] I will move on to something else that you raised in your written evidence, which is that not all mental disorders will deteriorate to such an extent that compulsory treatment is required and that services could be inappropriately diverted towards assessment. The proposed Order seeks to allow Measures to be passed giving those who are or may be—and I stress the words 'may be'—mentally disordered the right to an assessment. Do you think that, taking that forward, the provisions in the proposed Order allowing future Measures to provide the right to assessments may be too broad?

[84] **Dr Anness:** This is again a question about how you interpret it in the Measures. Keeping a broad perspective initially and then producing something that is more specific and tailored is entirely appropriate.

[85] **David Melding:** You referred to the Scottish experience in that Scotland seems to have ended up with a system that allows for too much assessment in the community. Was that in terms of the interim assessments? I believe that that is how you referred to them. What is your understanding?

10.20 a.m.

[86] **Dr Anness:** I am specifically talking about the detention orders, where people have an interim order and then they have to go to a tribunal to continue the order. I understand that there are some specific concerns about that. That is specifically about detention orders.

[87] **David Melding:** I apologise; I misunderstood. Thank you for clarifying that.

[88] **Jenny Randerson:** In your evidence, you said that you believe it appropriate to exclude those subject to compulsory treatment from the scope of the proposed Order. What circumstances could lead you to support extending the legislative competence to encompass

people subject to compulsory treatment? There may be none.

[89] **Dr Anness:** I am not sure that there are at the moment, in the sense that the borders between England and Wales are very open in terms of the use of compulsory elements of the Act. For example, with regard to the criminal justice parts of the Act, if we were to try to create a completely new law, you would have to think about how that would work within the criminal justice settings. Also, people who are detained may well have their treatment in hospitals outside Wales, for example, and I think that it would make it quite unworkable, as things stand.

[90] **Jenny Randerson:** Thank you. That deals with my supplementary question. In your written evidence, you also state that, as we are all aware, the Mental Health Act 2007 does not come into force until October this year, so we do not know what impact it will have on services. Do you think, therefore, that there is a case for delaying this proposed Order until we know that impact?

[91] **Dr Anness:** Again, I would have to leave that with you in the sense that, if there was work to be done on a Measure, this would take some time. Hopefully, by then, we would be able to see how the Act was affecting people. There are dangers in trying to bring in too much legislation at any particular time. For example, I also refer to the deprivation of liberties safeguards, which we are expecting to be implemented in about a year from now. That could have a dramatic effect upon certain service provision because of the amount of assessments that might need to be undertaken. So, there are dangers in trying to do too much too quickly.

[92] **Jenny Randerson:** But you think that, in terms of timescale, it would fit reasonably well together, do you?

[93] **Dr Anness:** I think that I would like to see them dovetailing, but I do not think we should try to bring in legislation that would upset the current balance, as it were. We have to try to take things sequentially and see how the new Act works for us.

[94] **Janice Gregory:** With regard to compulsory treatments, you mentioned earlier the complex cross-border issues and your written evidence says—I paraphrase—that there could be, and would be, complex cross-border issues. Can you foresee any other cross-border issues, whether they are complex or not? I specifically mention the Welsh language, which would be an issue that would need to be addressed, particularly if you have Welsh-speaking patients who reside in Wales but need treatment in England. Will you expand a bit more on your written evidence on this, although you did not mention the Welsh language in your written evidence?

[95] **Dr Anness:** Are you asking me specifically about the Mental Health Act 2007, or about the LCO?

[96] **Janice Gregory:** Both. It is tied in with the compulsory treatment and the cross-border issues between England and Wales.

[97] **Dr Anness:** As I understand it, the LCO will not relate to compulsory treatment. However, in respect of the Act, as I have already indicated, particularly the criminal justice elements in Part 3 of the Act, many people are treated outside Wales because of the need for secure care and so on. That obviously would be one of the key reasons for not trying to specifically amend elements of the Mental Health Act 2007 with the LCO. The interesting thing in terms of the LCO would be that there is quite a lot of cross-border provision at a different level—not only for those subject to compulsion under the Act—so there are quite a lot of people who leave Wales for specific sorts of treatment, but there are also quite a lot of, largely private, facilities in Wales that provide services for people from England. I think that

that is going to be an interesting element to look at in terms of the LCO—the right to assessment and treatment within those contexts.

[98] **Janice Gregory:** Are there any other cross-border issues that you can think of? I have mentioned the Welsh language.

[99] **Dr Anness:** I do not think that I have any particular comment to make on that.

[100] **David Melding:** I presume that the system would be able to cope if there were particular rights generated by Welsh legislation that would then have to be addressed by English bodies because that is where the service is accessed. At the moment, there would be protocols for dealing with patients from other jurisdictions or other parts of the health system. What we are trying to tease out is whether there would be any real structural problems with a separate approach, not at the compulsory level, but still at a fairly specialist level, further back in the system.

[101] **Dr Anness:** I think that it was raised in Hafal's report, that—dear me, I have lost my thread of thought. I have completely lost it, I am afraid; I will have to come back to that. It is middle age.

[102] **David Melding:** It seems to me that there is currently an element of cross-trading between England and Wales, certainly at a specialist level, but even sometimes at the community and primary-healthcare levels in some areas that are directly on the border. There are protocols to deal with that now and it seems to me that a different legal approach is something that the system would be able to respond to. Presumably, we would not be talking about such differences that it would be like living in Russia instead of Britain. It would be within certain bounds, would it not?

[103] **Dr Anness:** The point that was made was that if you have a good care plan, it has to be followed through by any service that is being commissioned to provide that service. I think that the interesting thing would be in the other direction, which would be that if there were services in Wales that were providing something that we perhaps felt did not meet the requirements of the LCO, but were being commissioned from elsewhere.

[104] **David Melding:** We had not thought of that one. That is an interesting point.

[105] **Bethan Jenkins:** I have a question on definitions and terminology. The proposed Order makes provision for future Measures to require that assessment and independent advocacy services are made available to persons who are or may be mentally disordered. Do you believe that the expression 'persons who are or may be mentally disordered' provides sufficient scope to enable future Measures to provide mental health services to those who need them?

[106] **Dr Anness:** Yes. Again, I think that this is a question of having a broad definition that you can then subsequently define with actual Measures. It may be dancing on the head of a pin to decide whether you are going to say that it should be 'appear' or 'may be'. I think that we are trying to talk about people with serious problems, who would then require a coherent service. I think that, in a sense, the wording is not so important, as long as it captures a group of people who we would subsequently redefine as those who are the most needy.

10.30 a.m.

[107] **Janice Gregory:** Going on from that, mentally disordered persons are defined in the proposed Order as 'persons having any disorder or disability of the mind'. I have a similar question to Bethan's question, namely would this definition be sufficiently broad to

encompass those persons that any future legislation would seek to help, or should this be left to future Measures?

[108] **Dr Anness:** It needs to be addressed in the Measures—the definition is sufficiently broad but not too broad. It also fits in with the general terminology in use, which people would understand.

[109] **Janice Gregory:** Thank you. We looked at the definitions when Jonathan came before the committee, but is there an alternative definition of 'mentally disordered persons' that you could suggest to the committee, or are you happy with the term as it is?

[110] **Dr Anness:** You must recognise that the legislation and services are not simply about people with mental illnesses. Mental disorder is a much broader concept; you must include the needs of people with learning disabilities and older people, for example. So, I think that keeping the definition in a broad context is reasonable.

[111] **David Melding:** The final question that we want to put to you is the same as the one that I put to Hafal earlier, and is about the Scottish Act, which spells out what treatment might be. We have covered the question of whether we should say 'care and treatment' and extend it explicitly to cover local authorities, which you have done. Do you see any particular merit in being very explicit, as they have been in Scotland, or would keeping it fairly open and just saying 'care and treatment' suffice?

[112] **Dr Anness:** Although it is explicit in Scottish legislation, terms such as 'rehabilitation', 'habilitation' and 'care' can be broadly interpreted; nursing care is a given when people need that specifically. The rest is broadly worded and I presume that it is intended to be open to that interpretation. I am not entirely sure that you would want to bring it into a much tighter definition, because you would exclude the elements that help people towards recovery. Lee's description of being in hospital and not having anything to do while he was there was a clear failure of the health service, if that was the case. Having useful occupation, opportunities to go back to college or any type of learning, and work-related opportunities, is important.

[113] **David Melding:** Thank you; I think that that covers all of the areas that we wanted to examine. If there is anything that you wish to add or that we have not discussed, you now have an opportunity to say so. However, do not feel pressurised into thinking about three things off the top of your head.

[114] **Dr Anness:** I should mention that there is quite a degree of concern among members of the college in Wales that this will force services to diversify to a greater extent, as we have already mentioned, so that the 'worried well'—to use an unpleasant phrase—would be included in legislation that is intended to help those who are more seriously ill. That is a point that I should raise. Also, we would like to see services that are equitable for all people with mental disorders.

[115] **Jenny Randerson:** Is that concern based on the Scottish experience?

[116] **Dr Anness:** No, I think that we just wish to see that services are available to those people who need them.

[117] **Jenny Randerson:** You talked of concern about diversification.

[118] **Dr Anness:** No, I do not think that it is. I do not think that the Scottish Act, as I understand it, is bringing huge numbers of people in for assessment, diverting people away from the core business.

[119] **Jenny Randerson:** Thank you.

[120] **David Melding:** Thank you. I think that that concludes the session. I thank Dr Val Anness from the Royal College of Psychiatrists for joining us this morning and for giving her evidence, and I thank the two witnesses who were here from Hafal earlier. We have covered some useful ground, and you have added greatly to our deliberations. We will send you a transcript of the proceedings, and, if you feel that there has been an error in what was reported, you will have the chance to check the Record. You cannot change the substance of what was said, because what was said is what was said, but that is just in case something was misattributed. However, the main thing to say is that I am sure that your evidence will help us with the report that we will lay before the Assembly on the merits or otherwise of this particular LCO. Thank you again. We are well aware of how difficult it is to come to give evidence in this type of session, but you have done very well this morning, and we are very grateful.

[121] All that remains for me to do is remind Members that we will next meet on 22 April, which is a week today, and the only papers to note are the formal minutes of our last meeting. That concludes our proceedings this morning.

Daeth y cyfarfod i ben am 10.36 a.m.
The meeting ended at 10.36 a.m.