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, 22 Ebrill 2008
Tuesday, 22 April 2008

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

14 Dyddiad y Cyfarfod Nesaf
Date of the Next Meeting

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

Stewart Greenwell	Is-lywydd Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol, Gofal Cymdeithasol a Thai, Cyngor Bwrdeistref Sirol Tor-faen Vice-President of Association of Directors of Social Services, Chief Officer, Social Care and Housing, Torfaen County Borough Council
Liz Majer	Cyfarwyddwr Cynorthwyol Gwasanaethau Cymdeithasol, Cyngor Bwrdeistref Sirol Blaenau Gwent Assistant Director of Social Services, Blaenau Gwent County Borough Council

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

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

Dechreuodd y cyfarfod am 9.35 a.m.
The meeting began at 9.35 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **David Melding:** Good morning, and welcome to this meeting of the Proposed Provision of Mental Health Services LCO Committee. I must make the usual housekeeping announcements. These proceedings may be conducted in Welsh and English, and, when Welsh is spoken, the translation is available on channel 1. Should you be hard of hearing, you can amplify the proceedings on channel 0. Please turn off all electronic equipment completely, such as BlackBerrys, mobile phones and so on, because if they are left on silent mode, they will interfere with our broadcasting system. We do not anticipate a fire drill this morning, so, should we hear one, please follow the instructions of the ushers to leave the building safely.

9.36 a.m.

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

[2] **David Melding:** We are pleased to be receiving evidence from the Association of Directors of Social Services this morning. I welcome Stewart Greenwell, who is the chief officer of social care and housing in Torfaen County Borough Council, and a vice-president of the Association of Directors of Social Services, and Liz Majer, who is assistant director of social services at Blaenau Gwent County Borough Council. Welcome to you both. As I said, we value this opportunity to receive evidence from you.

[3] I will start with a general question, so please do not feel compelled to give a comprehensive and detailed answer. This initial approach is a general one, but we will then drill down to the detail with a series of questions that other Members will put to you about the legislative competence Order. The proposed Order seeks to allow Measures to be passed in the future by the Assembly for the provision of assessment, treatment and independent advocacy for mentally disordered persons. I would like your general response to that. Do you think that this is an appropriate area for the Assembly to have competence for, and do you welcome it?

[4] **Mr Greenwell:** I will respond to that. As an association, we believe that this is the right direction to be heading in. In our minds, there is a question as to whether the intention is to work with the people who currently have mental health problems and are being worked with, and so to get to them earlier, or to reach a much wider group of people. Our preference would be the latter—to use any future Measures to reach a wider group of people—although getting to people earlier will also be beneficial.

[5] **David Melding:** That is an interesting and helpful observation, and one that has been hinted at in other evidence, although not raised quite as directly as that. However, we will reflect on it.

[6] **Val Lloyd:** Good morning. I want to focus on the limitations of the current legislative and policy framework. The health service and local authorities already have certain duties to provide services to people who have a mental disorder, and you note in your evidence that it could be argued that the health service and local authorities have certain obligations to provide those assessments. Within the current legislative and policy framework, do ADSS Cymru members feel able to provide effective services to mentally disordered persons and to deliver the standards set out in the national service framework for people with mental health problems?

9.40 a.m.

[7] **Mr Greenwell:** It is probably just as well to say that the ADSS position generally is that current legislation does provide the opportunity to offer services to people. The constraints and limitations of current legislation have more to do with inviting the organisations that have a statutory responsibility, within local government and the national health service, to focus on those people who fall within the remit of Acts of Parliament than issuing what could be seen as no more than a moral obligation to give consideration to people who are in the early stages of developing and displaying mental health problems—and I will avoid the term 'mental illness'. However, it is at that stage that some form of intervention could prevent people from becoming eligible for the services that come within our statutory

responsibilities. The limitations are in the prescription associated with legislative responsibilities at the moment.

[8] **Val Lloyd:** Do you feel that the existing legislation and policy framework provide scope to improve assessment, treatment and advocacy services to people who have a mental disorder, or are our proposed Order and any subsequent Measures essential if those services are to improve?

[9] **David Melding:** We are focusing on those who are not detained.

[10] **Mr Greenwell:** The current legislation does not prevent those services being made available to a much wider group of people. It is our view that the national service framework, if implemented fully in Wales, would provide a strong foundation for best practice to people in the early stages of mental health problems as well as people who are in a chronic condition. Perhaps Liz would like to comment on that.

[11] **Ms Majer:** The legislation gives you opportunities, but, to be honest about this, the public sector is working within limited resources, so we have to prioritise according to the legislation. The legislation on detention is a lot clearer than it is on what you can provide for other people. If the LCO were to broaden the scope, it would focus more on the opportunities to provide services at an earlier stage.

[12] **Bethan Jenkins:** Mae eich tystiolaeth a'r memorandwm esboniadol yn sôn am brofiadau'r Alban. A ydych fel mudiad yn meddwl bod agweddau ar system yr Alban y gallwn ddysgu ohonynt, hynny yw, pethau effeithiol y gellid eu cynnwys yn y Gorchymyn?

Bethan Jenkins: Your evidence and the explanatory memorandum mention the Scottish experience. Do you as an organisation think that there are any aspects of the Scottish system that we could learn from, that is, effective measures that could be included in the LCO?

[13] **Ms Majer:** Not having worked in Scotland, I can speak only on the information that we have read. However, the association and I were impressed by the way the legislation was drafted in Scotland, because it is based on principles, and is focused on the needs of the individual and the expectations on all public sector bodies to work together to provide services for people who have mental health problems. It is based on a set of principles that talk about 'least restrictive', and, from our point of view, it is helpful to bring together mental capacity and mental health issues in one Act, because you look immediately at an individual's capacity and needs.

[14] There is a standard of reciprocity. If society expects certain people to undergo treatment, society is expected in return to ensure that those people have the services that they require to live fulfilled lives in the community, as well as their medical treatment. That was a very important aspect.

[15] The right to assessment within 14 days includes health and social care assessments, so we are not talking purely about medical treatment. We recognise the fact that people have needs that must be dealt with by other services—as we stated in our response to you—such as education, housing and employment. Those are all important aspects, and there are opportunities here to include in the LCO what is not in current legislation. There is an issue about informal care and the right to treatment without compulsion. That goes back to the previous answers about the current legislation, which is very much focused on compulsion and on treatment from that point of view.

[16] So, we need a community treatment Order rather than a compulsory community treatment Order. There is an essential difference there: we are not looking at hospital

treatment, but focusing on providing people with treatment in the community, with preventative services and compulsory treatment being given equal weight. There is a considerable amount in the Scottish legislation that we could learn from. How it works in practice is a different matter, and I have not yet been able to establish how well the Scottish legislation is working in practice, but I certainly feel that ADSS would agree with the principles of that legislation.

[17] **Bethan Jenkins:** A oes unrhyw beth yr ydym yn gallu ei wneud yn wahanol i beth sy'n digwydd yn yr Alban? Yr ydym wedi derbyn tystiolaeth yn dweud bod asesiadau yn gallu digwydd yn yr Alban ond bod dim hawl ar gyfer triniaeth. Felly, tybed beth yw eich barn chi ar yr elfen honno.

Bethan Jenkins: Is there anything that we could do differently to Scotland? We have received evidence that assessments can take place in Scotland but that there is no right to treatment. So, I was wondering what your opinion was of that element.

[18] **Ms Majer:** That would certainly be covered by this LCO, and yes, it is all very well to have an assessment, but if you do not have a right to support afterwards, that assessment is probably fairly meaningless. So, I would agree that we could learn from that.

[19] **Janice Gregory:** In a previous answer, you touched upon the issue that I want to ask you about—namely, early intervention. You note in your written evidence that the current focus of mental health provision is on the relatively small number of people suffering from mental health problems who are classed as seriously mentally ill. Do you think that the proposed Order as currently drafted will ensure that those with less serious mental disorders will be able to access services at an early stage of their illness?

[20] **Mr Greenwell:** I would certainly hope so. In many ways, there is no better rationale for a piece of legislation than widening access to services for people at a much earlier stage of distress so that they can make decisions for themselves. The most important thing for us to recognise is that between 85 and 90 per cent of people with mental health problems deal with those problems through their general practitioner—and deal with them adequately. However, to raise a point that we may want to make in relation to a later question, the legislation should somehow help to avoid the over-medicalisation of mental health problems. This LCO has the potential to create an environment in which mental health services are not mental illness services; at the moment, that is what they are. 'Mental health services' is a misnomer. The majority of mental health services are targeted at people with serious mental health problems, rather than helping people to understand why they are experiencing distress and to find ways of dealing with it.

[21] General practitioners and primary care services are immensely important but, even so, the danger is that a prescription of chemicals is too often seen as the answer. Members may not know that I recently co-chaired a review of mental health services in Wales with Mary Burrows, the chief executive of the North East Wales NHS Trust. We met with a large number of service users, including a small group in Torfaen, a member of which had been receiving antidepressants for 30 years. Fortunately, she moved away from them because, one day, when she went to collect her repeat prescription, her general practitioner was on leave and she saw a locum general practitioner who said, 'What are we doing to you?'. That brought about a fundamental change in her life; all of a sudden someone said, 'What are we doing, continuing to prescribe antidepressants after 30 years?'. The locum GP even asked the question, 'Are you depressed?', and she actually was not sure any more. You probably would be depressed if you had been on antidepressants for 30 years. While that is only one example, it is a powerful example of what can happen with the over-medicalisation of people's mental health problems.

9.50 a.m.

[22] **Janice Gregory:** Having given that comprehensive and interesting answer, do you think that the proposed Order would be too broad in its provisions, therefore, allowing future Measures to provide access to services for 'those who are or may be mentally disordered'?

[23] **David Melding:** I should say that the microphones operate automatically. There is a slight delay, but the technicians operate them.

[24] **Mr Greenwell:** I assumed that they worked as they do in our council chamber. I beg your pardon.

[25] Could you please ask your question again?

[26] **Janice Gregory:** You have given us a comprehensive answer. Do you think that the proposed Order is too broad, so that, for future Measures, there may be an issue regarding providing access to services for people 'who are or may be mentally disordered'? Do you think that there is an issue about how broad the Order is?

[27] **Mr Greenwell:** Our view is that it is not too broad and that there is a wonderful opportunity to embed in the legislation a statutory responsibility to promote prevention.

[28] **Janice Gregory:** So you would not want it restricted in any way, and you would think that it would be better for it to be this broad?

[29] **Mr Greenwell:** In answer to the second question about the current legislation, one of its limitations is that, in a sense, it forces a concentration on one's statutory responsibilities and that, when one is faced with limited resources, surprise, surprise, that is what gets attention. If prevention were a statutory responsibility, there would be justification for giving those preventative services considerable attention even within those limited resources.

[30] **Janice Gregory:** You talked about the moral obligation as well as the statutory obligation.

[31] **Mr Greenwell:** Yes. Absolutely.

[32] **Jenny Randerson:** In this proposed legislative competence Order, the restriction is that the duty is on health services. You say in your evidence that that duty should be widened to include other public sector bodies, including local government. Why do you believe that a duty placed only on the health service in isolation would be insufficient?

[33] **Mr Greenwell:** I will start the answer, but we both have things to say on this. Essentially, if there is no acceptance of a shared responsibility between the NHS and local government, what you get is a partial response and a partial service. For example, Conwy and Denbighshire in north Wales have an arrangement, which is a firmly embedded partnership between local government and the NHS—between two local health boards, two local authorities and an NHS trust. What is interesting is that NHS colleagues in that partnership are now saying that they have started to learn that the NHS on its own is no good at recovery. By that, they do not mean that the NHS cannot get people over the symptoms that they are displaying and the distress that they are experiencing, but that, if you want to focus on recovery, we must look at ourselves and ask what has an impact on our lives and gives us a sense of wellbeing. They are the things that we dangerously take for granted when things are going well, such as good housing, income, feeling safe in the neighbourhood in which you live and having access to a range of cultural and leisure activities. These are things that can easily trip off the tongue when we think about what matters to us and what makes us feel okay in our lives.

[34] My view is that a recovery model for people with mental health problems must include organisations that have access to a range of services that meet those needs, as well as, to put it rather crudely, organisations that get people better. If it does not, what you end up with is the NHS doing the job that it is good at and, three months later, that person returning to get more NHS treatment. Liz might want to add something on that.

[35] **Ms Majer:** I think that you have probably summed it all up. When it comes down to it, we all work to the duty that we have under legislation. We all have joint planning arrangements, so local authorities and local health boards get together to plan services, but, without a joint duty to undertake those services, there is a tendency to work separately in many cases. There are areas of good practice and that has been brought out in the Wales Audit Office report on the baseline of services for mental health, in the national service framework, and certainly in the report that Stewart has been referring to. There is a great deal of good practice, but it is disjointed and, unless you have that joint responsibility, it will not happen.

[36] **Jenny Randerson:** For the record, can you summarise what services local authorities provide to people with mental health problems?

[37] **Mr Greenwell:** We co-operate with NHS colleagues in providing treatment—the kind of treatment that involves working with people at the extremes of their condition. That means doing some very close therapeutic work with people. Alongside that, the local authority will provide access to decent and supportive housing, often by working with housing associations and care and support providers of those services. Many local authorities have a range of day activities for people with mental health problems and, increasingly, we are moving away from day centres and ensuring that people with mental health problems have opportunities to regain skills that could put them in a position where they could regain employment. Being employed gives you purpose, it gives you money, and it gives you identity. If you take those things away from people with mental health problems—if you take them away from anybody in fact—you will leave them feeling devalued, and there is therefore limited potential for recovery.

[38] What the local authority does—and at its best, it does it with the NHS—is ensure that all of those things that will make a difference to a person’s life and ensure their recovery, rather than a temporary improvement, are in place. Those must be sustained, often over a number of years. Both councils are working with people with whom we have been involved for several years. Often, it is a very unglamorous and ordinary kind of contact with people that ensures that they know that there is somebody whom they can turn to. It may not require a doctor or a nurse, although a number of community psychiatric nurses are carrying out the very same task—being around for people as and when they need them. Often, people with mental health problems have become very isolated, often from their families and friends, and as a consequence the role of the professional is not to be a friend, but a source of support and, often, a facilitator that helps them to access a much wider range of support than is ordinarily available to them.

[39] **Jenny Randerson:** With regard to amending the LCO, you simply want a duty placed on local authorities. We could just insert the words ‘local authorities’.

[40] **Mr Greenwell:** Yes. At the broad level, we think that that would be helpful. It might be that the Assembly would then want to consider Measures underneath that broad outline that would identify where the expectations should lie. However, we believe that the fundamental principle is a shared responsibility between the NHS and local government—and it is local government, not social services.

10.00 a.m.

[41] **Jenny Randerson:** What about the reference that you make to other public sector bodies? What role would other public sector bodies or the voluntary sector have in terms of Measures that we might pass in future with regard to people with mental health problems?

[42] **Mr Greenwell:** I will let Liz give some examples of the way in which voluntary sector organisations make a significant contribution. On other public sector bodies, education in its broadest sense, not just schools for children and young people, but colleges of further education and higher education institutions, have a part to play, as do the police, because of the danger associated with people being quickly labelled as a result of inappropriate behaviour that brings them into contact with the criminal justice system. Once someone has gone down that road, it is almost impossible to escape from the label of being a mentally disordered offender, which is not a label that many people would want to have attached to them. Liz might want to say something about the role of voluntary organisations.

[43] **Ms Majer:** I would also add organisations such as Jobcentre Plus, because employment is a major aspect of providing services to people with mental health problems. As far as the voluntary sector is concerned, it is a major player in working with people with mental health problems, particularly people with what we may call the lower levels of mental health problems, who do not come into services. The voluntary sector is the provider of advocacy services—which we will probably talk about later—but it is an important player in that respect. It also provides services such as drop-in centres and information centres. There are major voluntary organisations who work across Wales, but there are also local groups that are service-user-led or carer-led and are funded through local authorities or various other funding streams. So, the voluntary sector needs to be included, because, as I said, it is a major player in that regard.

[44] **Janice Gregory:** Moving on to the impact of the Mental Health Act 2007, in your written evidence you stated that ADSS Cymru supports the exclusion of those subject to compulsory treatment under the Mental Health Act 1983 on the basis that they already have access to the services that are likely to be provided by future Measures. Of course, the Mental Health Act 2007 will introduce amendments to the Mental Health Act 1983 from October of this year. Would there be benefits in delaying the proposed Order or any future Measures, so that the impact of the amendments made by the 2007 Act can be assessed?

[45] **Ms Majer:** We do not think that it would be a good idea to delay it. This is an opportunity to widen the scope and that legislation will still restrict services, effectively, to those that receive services under the 1983 Act. We feel that this is the opportunity and that we should take it.

[46] **Janice Gregory:** So, that is a firm ‘no’, then. Thank you.

[47] **David Melding:** That was a clear and succinct answer.

[48] **Bethan Jenkins:** Mae’r Gorchymyn hwn yn cyfyngu asesiadau i driniaeth mewn gwasanaethau iechyd yng Nghymru, ond mae eich tystiolaeth yn egluro bod materion trawsffiniol o ran pobl o Gymru yn cael triniaeth yn Lloegr. A wnewch esbonio mwy am eich barn ar hynny? Pam ydych o’r farn nad oes angen deddfwriaeth yn yr ardal hon, a pham y dylem ganolbwyntio mwy ar wasanaethau yn y gymuned, yn hytrach na

Bethan Jenkins: This Order limits assessments to treatment in health services in Wales, but your evidence makes it clear that there are cross-border issues in terms of people from Wales being treated in England. Can you explain more about your opinion on that? Why do you think that legislation is not necessary in this area, and why should we concentrate more on providing services in the community, rather than looking at legislative

newid deddfwriaethol eto ar gyfer y dyfodol yn y maes hwn?

change again in the future in this area?

[49] **Mr Greenwell:** I am happy to comment on this. Our view is that the objective for all people in Wales should be local and safe services. Inevitably, there will be specialist services that cannot be made available locally. There is a real tension when it comes to saying that everyone in Wales has a right to receive their services in Wales. For example, if you live in Wrexham, there is a question as to whether you should have to travel 160 miles to access services in Wales when you can travel 30 miles to access services in England. 'One Wales' makes the Assembly Government's objective clear, but is it sensible to impose that extra journey on someone simply so that they access services in Wales? It also builds on current practice. Our view is that there is not much to be gained from trying to enshrine the cross-border issues in legislation. In Scotland, it appears that it is done through careful negotiation and then on an individual case basis, so without taking the broad-brush approach that everyone will get services in Scotland. For people who live in the borders, for example in Dumfries and Galloway, there are occasions when it is highly appropriate for them to access services in England.

[50] If you look at primary care services and GPs in particular, in Monmouthshire, GPs have patients who live in England and patients who live in Wales. For someone who lives in Chepstow, accessing a service at Gloucestershire Royal Hospital makes considerably more sense than it does to have to drive to Swansea for specialist services. So, we need to apply common sense to cross-border issues. We do not believe that legislation can necessarily provide the framework for decent negotiation to deal with cross-border issues. I will repeat what I said at the start: we believe that the objective should be to provide local and safe services. Sometimes you cannot provide specialist services locally and safely. Therefore, people have to travel and, increasingly, when that is explained to people, they understand that.

[51] **Bethan Jenkins:** Felly, yr ydych o'r farn ei fod yn anghywir i hyd yn oed crybwyll y cysyniad o gynnwys rhywbeth mewn deddfwriaeth. Efallai y gallem wneud yr un peth â'r Alban, ond cynnwys yn y ddeddfwriaeth yr egwyddor o ddarparu gwasanaethau i bobl yng Nghymru oherwydd eu bod yn teimlo'n fwy cysurus o fewn eu milltir sgwâr a chael gwasanaethau arbenigol yng Nghymru yn help mawr iddynt ac i'w teuluoedd.

Bethan Jenkins: Therefore, you are of the opinion that it is wrong even to mention the concept of having something included in legislation. Perhaps we could do the same as Scotland, but enshrine in legislation the principle of providing services for people in Wales because they feel more comfortable in their own communities and having specialist services in Wales would be of great help to them and to their families.

[52] **Mr Greenwell:** Again, the simple answer is 'yes'. It would make considerable sense to have at the very least the objective of local and safe services enshrined in the legislation. However, people should not be disadvantaged by the pursuit of that objective so that they—and I have already used the example of Wrexham—are not forced to travel 150 miles to access services instead of 50 miles or less. It might be 10 miles; I cannot remember the distance between Wrexham and Chester, but it is near. You made a point about services being sensitive. Services in Wales should be sensitive to the needs of Welsh people. Therefore, the person in Wrexham should make the decision on where he or she receives treatment, particularly in the case of a specialist service. People should not have imposed on them a service that is 150 miles away simply because it is in Wales.

[53] **Bethan Jenkins:** Yr ydych hefyd y sôn yn eich tystiolaeth bod ardaloedd o weithredu effeithiol yn rhan o'r gwasanaethau hyn ond nad yw hwn yn glir

Bethan Jenkins: You also mention in your evidence that there are areas of effective practice in some of these services, but that it is not clear across the entire spectrum. Do

dros y sbectrwm cyfan. A oes barn gennych ynglŷn â sut byddai'r Gorchymyn hwn yn gallu helpu'r sefyllfa i wella fel bod gwasanaethau yn effeithiol ledled Cymru?

you have an opinion on how this Order could help to improve this situation so that services are effective across Wales?

10.10 a.m.

[54] **Mr Greenwell:** We have made reference in a few of our answers to the national service framework for people with mental health problems. Our view, which is a view that was taken in the review of mental health services that I co-chaired, is that no-one has to do any rewriting of the national service framework; it provides probably as good a foundation for best practice as there is. There is an interesting comparison between the approach that has been taken in England on the implementation of the NSF and the approach that has been taken in Wales. In England, there are 117 local implementation action groups. In Wales, there is one advisory group: a national advisory group on the NSF.

[55] The NSF is in the performance objectives of every trust and local health board. The local implementation action teams in England are all held accountable for whether they are delivering the implementation of the NSF. That seems to carry clout. There has been a recent review of mental health services in England: this was a joint review between the Healthcare Commission and the Commission for Social Care Inspection, so there was shared responsibility between the NHS and local government. The review had no problem in identifying poor performers. One can argue about whether that is a good thing to do: perhaps we ought to be identifying the best performers as a way of promoting best practice. However, in identifying the poor performers, the review was saying that it is not good enough. There is something important about saying that the national service framework is as good a foundation for best practice as we have and that we should use it and promote it. We should insist on its implementation. On whether enshrining it in legislation is the best way forward, it certainly needs to have clout. If the Assembly Government felt that that was the best way to give it clout, then the Association of Directors of Social Services would certainly not object to it. However, we believe that the answer is more about winning the hearts and minds of all of the professionals involved in delivering services to people with mental health problems.

[56] Some of the detail in the NSF is quite fundamental. For example, one of the requirements of the NSF is that, when someone is prescribed a treatment, they should first be offered an explanation—particularly if it is a prescription of drugs, they should be given an explanation of the side effects of those drugs—and they should also be given an alternative to that, whether that is alternative drugs or an alternative treatment without drugs. If that was pushed, it would start to give the person with mental health problems the opportunity to choose. It is very difficult, because at the point of deepest crisis, you are probably not in a condition to be able to make sensible choices. That comes back to the Mental Capacity Act 2005 and people's capacity to make sound decisions. However, even at the point of immense crisis, there is more opportunity than we believe there to be to give people the opportunity to choose. Again, it is a principle in the NSF, which is not about more money; it is about a principle that you pursue through the words that you use with people.

[57] **Val Lloyd:** I have some questions on independent advocacy. As it stands, the proposed Order does not place a duty to make provision for independent advocacy on any particular body. Do you feel that this duty should be placed on specific bodies, or should it be left for a future Measure? You touched on it when you talked about the role of voluntary bodies, pan-Wales, and local groups.

[58] **Ms Majer:** It is about the provision and the commissioning. At present, services are usually commissioned by the LHBs or by local authorities; the decisions made depend on the circumstances of the individual areas. On the Mental Capacity Act 2005, the responsibility for

the Independent Mental Capacity Advocate Service is with the LHBs. However, to take the example of south-east Wales and Gwent, where we work, several organisations have got together on a consortium basis—so that is local authorities and LHBs—and we commission that service across south-east Wales. That is very effective, because there you have the economies of scale that you need and the ability to develop skills within an organisation, so we have an organisation that is able to provide across, I believe, seven health authorities and LHBs. At present, that seems to be very effective.

[59] The provision needs to be independent. The voluntary sector is the best place for it, because it has the expertise and is separate from the statutory agencies, so it can give that independent voice that service users need.

[60] **Val Lloyd:** That has answered my supplementary question quite clearly—thank you. However, your written evidence also suggests that there could be a substantial demand for independent advocacy services. Therefore, would you seek to introduce eligibility criteria?

[61] **Ms Majer:** That is a difficult one, because, if you want to open up services to everyone who needs them and if you want to give people the choice at the time—Stewart was talking about the choice of treatments, and so on, and giving people the opportunities to be able to access those services—you should make advocacy open to everyone who needs it. Therefore, it would be very much an open referral system, which it is in many cases at present. The advocacy services that I know of across Wales are not restricted to people in hospital, but they tend to be prioritised for those people because of the nature of the resources; you do not have enough advocates out there to provide a service to everyone who may need it.

[62] The difficulty is that we do not know how many people would need to access an advocacy service. However, if you restrict it too much at the beginning, you will not have that opportunity to allow people to access the services that you want them to be able to. Therefore, I cannot give you an answer to that one I am afraid, but once you start putting eligibility criteria in, you are going to restrict that service, so it depends on how you want this service to be provided to people.

[63] **Val Lloyd:** You have made your views clear. However, should any reference to this be included in the proposed Order, or should it be left to the Measure?

[64] **Ms Majer:** I like what is in the Scottish legislation; it makes it available to the people who need it because they have a mental disorder. That is how I would see it being defined here.

[65] **Val Lloyd:** Thank you.

[66] **Jenny Randerson:** I want to turn to definitions. You have outlined a broad approach to treatment and what you believe should be the treatment for people with mental illness. Do you believe that the term ‘treatment’ in the proposed Order could be interpreted in too narrowly a medical sense? Would you want a more specific definition that included care in the definition of treatment?

10.20 a.m.

[67] **Mr Greenwell:** Yes. We would argue that we—and you—should avoid too narrow a definition of treatment, particularly a definition of treatment that is located solely in the provision of services within and by the NHS. Widening the definition introduces complexity, but there is a part of me that says, ‘tough’, because it is complex, and there is no neat definition of treatment. If activities are contributing towards someone’s recovery, for me, that

counts as treatment. We have described in our answers a whole range of activities, including ensuring that people have access to good and supported housing; providing access to activities that lead people back into employment and/or purposeful activity; and helping people to feel safe, which is often about helping people to look after themselves so that they do not put themselves in danger. Those are activities that are not clearly defined as taking place in a clinic, with someone being seen once a week or once a month at an out-patients clinic. Those activities are much looser, but nevertheless have as much impact, and therefore, in my view, if treatment is to be taken seriously, it must be defined in such a way as to embrace that range of activities rather than the narrow medical definition that I mentioned earlier.

[68] Anything that we can do together to avoid the over-medicalisation of people's problems will be welcome, and it will be welcomed by many people in the NHS who recognise that there are limits to the impact that medicine can have on someone's life. This is not just about helping them to get better—getting better is not the same as recovery, and that is the thrust of our argument on this. I cannot give you a clever and smart definition of a broader range of treatment, but, as an organisation, we would be happy to make a contribution on that.

[69] **David Melding:** You have anticipated the final question. You are not the first witnesses to say that a phrase such as 'treatment and care' would be a better construction, and we will certainly take legal advice on that. The Scottish Act defines 'treatment'—probably in order to capture the scope beyond the medical model—and I wonder whether you think that a similar definition would be appropriate in our Order, or in any future Measure. The Scottish legislation states that 'treatment' includes

[70] 'nursing; care; psychological intervention; habilitation (including education, and training in work, social and independent living skills); and rehabilitation'.

[71] That is fairly exhaustive and comprehensive, I would say, but I do not know whether you have any views on whether we should be as explicit as the Scottish model.

[72] **Mr Greenwell:** I think that it would be helpful. The important thing about the Scottish definition is that it is designed to include things rather than exclude them. That is the real advantage of that definition; it is able to include all of those activities that can, dangerously, be described as nothing to do with the NHS or nothing to do with dealing with mental illness. People with mental illness, people with mental health problems, or people who have been on a journey through mental health problems, often graphically describe how the things that got them through were the things that the rest of us take for granted.

[73] **David Melding:** That is a very eloquent way to finish the series of questions from us. We give witnesses an opportunity to add anything that we might have neglected to raise, but that is very pertinent. Most witnesses have not raised anything, but I think that it is appropriate that we give you a chance in case there is anything that you want to say at this stage that we have not covered.

[74] **Mr Greenwell:** Just one, then: we have avoided mentioning the issue of resources, because my guess is that Assembly committees such as this one are often told that increased resources is the answer to everything. Our view is that the answer to improving services lies as much in changes in professional behaviour as it does in resources. Let us suppose that the NHS in Wales was to spend the same proportion of its budget on mental health services as the NHS in England spends. In 2005-06, the NHS in England spent 12.2 per cent of its total budget on mental health services. The same year, the NHS in Wales spent 11.9 per cent of its budget. When you say it as a percentage, you think, 'Well, we are almost there in Wales.', but it is actually a difference of £11 million. That small shift in the percentage of resources allocated could make a significant difference, and I would like to leave you with that.

[75] **David Melding:** On behalf of the committee, I thank you both for attending this morning and for giving of your valuable time. You gave us very clear evidence and focused, succinct answers. That is very helpful, and we are most grateful. We will send you a transcript of the proceedings. The transcript is not to be changed just because you feel that you should not have said something, but if something has not been transcribed correctly, you will have the opportunity to correct it. It will be sent to you in due course. Thank you both very much indeed.

10.26 a.m.

Dyddiad y Cyfarfod Nesaf
Date of the Next Meeting

[76] **David Melding:** All that is left now is for us to confirm the date of the next meeting, which will be a week today, on 29 April. That concludes our business this morning. I thank everyone for attending. The meeting is closed.

Daeth y cyfarfod i ben am 10.26 a.m.
The meeting ended at 10.26 a.m.