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Thank you for the opportunity to contribute to the Committee's deliberations.

We would very much endorse the principle of the Assembly having the power to legislate in the area of Mental Health. The general aim of enabling people experiencing mental distress to access appropriate treatments and advocacy at an early stage, avoiding deterioration in their condition and the possible later use of compulsion is one we would strongly support. Compulsory treatment and detention tends to result in much greater stigma and discrimination for people experiencing mental distress, particularly in small communities. It also carries with it a much greater likelihood of family breakdown and makes a return to work much less likely than early and voluntary treatment.

Our greatest area of expertise in this response is in Independent Mental Health Advocacy though we do make some contribution to other aspects of the order.

In answer to the questions asked:

Would the terms of the proposed Order confer the appropriate powers on the National Assembly for Wales to allow for the implementation of the policy proposals outlined in the Explanatory Memorandum?

It appears to do so, but this is a legal question, outside our area of expertise.

Is the scope of the proposed Order appropriate, too narrow or too broad to allow the Assembly to bring forward the Measures to address issues you believe should be addressed via legislation in the field of Mental Health in Wales? If necessary, how should the proposed Order be re-drafted and why?

Again, this is outside our area of expertise, but it may be too narrow, since it leaves different legislation applying to detained and voluntary patients. We believe that this may be confusing in practice, and would ask for as 'seamless' and clearly understandable set of rights as possible, which can be communicated and understood by service users, carers, and for those working with the mentally distressed.

The way in which the law currently deals with 'mentally disordered persons' as a group in society whose rights can be curtailed, and who are subject to compulsion contributes in great measure to the stigma and discrimination people experience. Clear and well understood rights, making emphasis on the right to treatment and support, and making it clear that compulsion is a last resort would help break down these barriers to recovery.

The proposal is to impose duties on the Health Service to provide assessment of and treatment for mentally disordered persons. Should it cover duties on other bodies?

We welcome this proposal, but would point out that in Wales; we have been working towards a holistic service that means all those involved with a persons care have a duty to work together using the Care Programme Approach. It has been recognised that mental wellbeing is not solely a health problem. We would like local authorities and others to share the obligation to provide the services which people may need to facilitate their inclusion in society, for instance tenancy support, personal care, support in accessing public services during a period of mental distress. In many cases, a period of mental distress results in a loss of home, family, work and social networks which are difficult to regain during recovery. In many cases, this is not an issue of health care so much as one of disability access and discrimination.

We also believe that individuals should have the right to a range of treatment which is appropriate and acceptable to them. The aim must be to enable the mentally disordered individual to be treated as an individual with the capacity to be a full partner in their own treatment and recovery, and to exercise choice and autonomy as far as possible. The right to treatment should specifically include talking treatments, proven self-help methods, bibliotherapy, ecotherapy and support to address lifestyle issues, including personal problem solving.

It should be clarified that mental disorder includes addiction issues, and the right to treatment extended to people who suffer from these. Currently people with 'dual diagnoses of mental distress and addiction can fall between two stools, having difficulty in accessing either addiction treatment or mental health services.

The parts of the proposed Matter which relate to assessment and treatment (paragraphs (a) and (b)) are limited to "the health service in Wales". Would this deal appropriately with any cross-border issues?

If it possible to achieve, we believe the rights should apply to patients resident in Wales as many people on or close to the borders of Wales receive their service or part of it; from services in England. There are also many patients in specialist services in England too that

are or cannot currently be provided in Wales. Commissioners should have the responsibility to arrange access to advocacy for patients normally resident in their area, even when they are using services in England, or are in (for instance) a secure unit in England. This service already exists in some places, for instance, the Powys Advocacy Service and Patients Council provide advocacy services for people from Powys in Shelton Hospital in Shrewsbury.

In relation to assessment of persons and advocacy services, the matter applies to persons "who are or may be mentally disordered". What are your views on this?

We believe these services need to be available to all people who experience mental distress. Our experience is that advocacy at an early stage helps people access the most appropriate treatments, engage in them in a way that supports their personal empowerment and recovery, and can help people to avoid compulsory admission and the collapse of their lives.

It is vital that mental health advocacy be provided by organisations which are truly independent and are not also service providers, either statutory or voluntary. Advocates need to be appropriately experienced, supported and resourced.

Independent advocacy services should be open to self-referral from people who feel they need assistance to negotiate appropriate treatment. They should have the capacity to enable people to access advocacy to deal with issues such as social care and housing as well as medical care. In Pembrokeshire, MAP has 7 advocates to serve a population of 113,000. It is fully taken up and generally does not receive self-referrals from all who would benefit from the service.

Work has still to be done to establish the desirable number of advocates per head of population, and therefore the cost of providing a full service, and we would request this work to be commissioned. CYMAR raised this issue and carried out some work in 2004, but there is no up to date picture of the current provision of advocacy in Wales, or an agreement as to how best it should be arranged.

Mental Health Advocacy in Wales is patchy in provision and insecure in its funding. We would like to see a service which is nationally co-ordinated, of high quality, and locally provided. It needs to be provided in ways that are accessible to all, and are culturally appropriate. For instance, we are aware from 'Siawns Teg' that people from migrant communities are having difficulty accessing mental health services, particularly where they are unable to speak English. People with hearing impairments and people from BME communities have a particularly poor experience of using mental health services, and need specialist advocacy.

Currently, there is no co-ordination of mental health advocacy in Wales, and people are reliant on whatever is locally able to gain funding. Access to (for instance) an advocate with appropriate language skills, an advocate specialising in children, or of the person's own gender may not be available. We would like to see mental health advocacy remain as a specialist area of expertise and delivery, but be better co-ordinated with other services, and across the country.

Is it appropriate to limit legislative competence to exclude persons detained under the Mental Health Act 1983?

We understand this question to be asking whether the Assembly should be asking for the power to provide services differently for detained patients to the way services will be provided in England.

In terms of the right to advocacy, we believe people should have a right to advocacy as required. Early and free access to advocacy is often effective in helping people retain and regain control over their lives and supports recovery. In terms of its delivery, we believe that the important thing is that there are not different services for detained and non-detained patients. We would like to see the advocacy services integrated, ideally so that people can have an ongoing relationship with an advocate, whilst they are detained or otherwise. Again, it is important that the advocate is independent, and of the person's own choice, not provided as 'part of the service'. It is our understanding that this may need different arrangements in Wales to those planned at present and possibly additional legislative competence for the Assembly.

Is the definition of "mentally disordered persons" in the proposed Order appropriate? If not, how should the definition be re-drafted and why?

We are not sure there is a clear definition of 'mentally disordered'. It is a stigmatising term and implies a permanent ill health condition. We would prefer it to read 'who are or may be mentally distressed'. An alternative would be 'experiencing or recovering from mental distress'. This reflects that most people have periods of wellness during which they may be able to manage their affairs effectively perhaps with more use of direct payments for those in need of long term care.

Rather than attempting to use a definition to limit the right to service, we would like to see the right to assessment and advocacy cast as widely as possible, to anyone who believes themselves in need of it, in order to expedite early treatment and assessment, and avoid problems such as loss of employment, home and family, and avoid compulsory treatment. Where this approach is effective great savings can be made when compared to the cost of ongoing and intensive care deriving from an individual's deterioration.

It is important that advocacy and the right to assessment continue during the recovery period, which for most people continues throughout life.

Should the term "treatment" also be defined within the matter?

Yes, as expressed above, treatment should not be regarded as confined to the medical model. Many non-drug therapies have been proven as effective in treating and relieving mental distress, and promoting sustained recovery. We would like people to have the right to these interventions, and treatment to be defined as widely as possible. In particular, it should include a right to talking therapies. The service in Wales is developing in these directions, and the matter should reflect this.