# 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, 13 Mai 2008**
**Tuesday, 13 May 2008**

**Cynnwys**
**Contents**

**Aelodau'r pwyllgor yn bresennol**
**Committee members in attendance**

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

**Eraill yn bresennol**
**Others in attendance**

| | |
|---|---|
| Yr Athro/ Professor Phil Fennel | Cymdeithas y Cyfreithwyr<br>The Law Society |
| Ewan Hilton | Gofal Cymru<br>Gofal Cymru |
| Ian Hulatt | Coleg Brenhinol y Nyrsys Cymru<br>The Royal College of Nursing Wales |
| Alexandra McMillan | Gofal Cymru<br>Gofal Cymru |
| Kay Powell | Cymdeithas y Cyfreithwyr<br>The Law Society |
| Lisa Turnbull | Coleg Brenhinol y Nyrsys Cymru<br>The Royal College of Nursing Wales |

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

| | |
|---|---|
| Anna Daniel | Clerc<br>Clerk |
| Olga Lewis | Dirprwy Glerc<br>Deputy Clerk |

*Dechreuodd y cyfarfod am 9.32 a.m.*
*The meeting began at 9.32 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 will start with the usual housekeeping announcements. These proceedings will be conducted in Welsh and English; when Welsh is spoken, a translation is available on channel 1. Should you need to have these proceedings amplified, you can press channel 0, and hear the proceedings amplified through the headphones. Please switch off all electronic equipment completely—that means 'off' and not just on silent, because even on silent it interferes with our recording equipment. We do not anticipate a fire drill this morning, so if we hear the alarm, please pay great attention to what the ushers tell you, and leave the building under their instruction.

9.33 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 am pleased to welcome our first set of witnesses this morning. We have Alexandra McMillan, who is the policy and information officer for Gofal Cymru, and Ewan Hilton, who is the executive director of Gofal Cymru. Good morning and welcome—we are pleased that you are able to join us this morning to help us with our evidence gathering. Members have a range of questions for you, and I will start the questioning.

[3] Can you give us your general view about whether the Assembly should have this legislative competence, which may then lead to a range of things that the Assembly might choose to do in various Measures in the future? Why do you believe the Assembly would benefit from having legislative competence in this area?

[4] **Mr Hilton:** Thank you for inviting us—it is good to be here. We have been working with our colleagues in the mental health voluntary sector for several months now, and we are also working closely with the cross-party group in the Assembly. It is good that there is such widespread support and understanding. We believe that the Mental Health Act 2007 is very much written from the criminal perspective—the public protection angle—and we feel that it misses a large part, namely the welfare of the individual, and somewhat conflicts with the values of our organisation and, it seems, with the values of everyone who we have been working with and talking to. The legislative competence Order would enable us to balance the legislation more appropriately—to balance the right to early assessment and advocacy treatment against the compulsion element. A great deal of what we would have said today has already been said, so I am not going to repeat the comments of our colleagues. However, we feel very excited about this, and we think that this could give us world-class mental health services in Wales—something that we could be proud of.

[5] **David Melding:** We will now look at the some of these issues in specific detail, but thank you for the general response.

[6] **Jenny Randerson:** In your evidence, you say that you hope that a statutory right to treatment will lead to more and different services being available. Could the proposed Order enable future Measures to establish a statutory right to treatment, rather than just placing duties on the health service to provide treatment?

[7] **Mr Hilton:** I think that this is where my lack of legal expertise could become apparent. We were wondering whether this was almost an issue of semantics. One almost counteracts the other; if there is a duty to assess and treat, it is my understanding is that that means that an individual would have right to that assessment and treatment. Certainly Jonathan Morgan was saying that the basis of his proposal was to enshrine in law patient rights and that we should legislate to provide the right to assessment and treatment. Therefore, we feel that they almost mean the same.

[8] **Val Lloyd:** You say in your evidence that mental health may require a range of services and not just those provided by the health service. In what ways could future Measures be more effective if they were allowed to place duties on bodies in addition to the health service? That being the case, which bodies should those duties be placed upon?

[9] **Mr Hilton:** This has been talked about by a number of our colleagues in mental health organisations—certainly by Mind Cymru, the Royal College of Psychiatrists, and, probably most notably, the Association of Directors of Social Services. Like them, we feel that social care needs to be involved in this LCO. Clear pathways of treatment, care and support are crucial to an individual's mental wellbeing, and social care plays a critical part in that. However, I guess that what we are saying throughout is that we do not want to stretch this LCO too far and jeopardise the chance to devolve some powers to Wales. Everything that we and Ministers do needs to be done in close consultation with Westminster, and we need to be clear that we are not going to stretch this too far and end up with nothing. However, I do not think that that is the case with the social care element, and we would strongly support our colleagues' view that that must form part of the LCO.

[10] **David Melding:** Are there any other bodies that you would like to see this extended to? You mentioned local authorities.

[11] **Mr Hilton:** No, not at this point. I think that anything further may well jeopardise this.

[12] **David Melding:** So local authorities are the most important?

[13] **Mr Hilton:** Yes, I think so.

[14] **Janice Gregory:** On service provision, do you think that the proposed Order addresses the main issues of concern identified by you—assessment, treatment and independent advocacy—for service users and their carers?

[15] **Mr Hilton:** The short answer to that is 'yes'. We want the LCO to be as wide as possible, and we do not want future law-making to be fettered, which I believe is an issue raised by the Law Society, from which you will take evidence later. We think that assessment, treatment and advocacy are addressed appropriately.

[16] **Bethan Jenkins:** As you are no doubt aware, at the moment, this LCO does not cover those who receive compulsory treatment under the Mental Health Act. Some people have said that they want to introduce an integrated advocacy system. Do you believe that any difficulties would arise if we combined the two elements of the voluntary service sector and people under compulsion to receive treatment?

[17] **Mr Hilton:** Much as we would like to rewrite the Mental Health Act, criminal justice is not devolved, and trying to incorporate those elements of the Act into the LCO may jeopardise its success. Our feeling about advocacy is that it needs to be available, consistent, of a high quality and equitable. The delivery of advocacy really needs to come afterwards, in terms of how it is structured. I think that there is a perverse incentive under the Act for it to come under the compulsion element because that is where the advocacy resources are directed at the moment. So, there is almost a perverse incentive to seek advocacy through that route. That needs to be redressed. I do not believe that we should seek to include the compulsion element.

9.40 a.m.

[18] **Bethan Jenkins:** You do not believe that people would be falling in and out of the system; you believe that the care pathway would be sufficient as it stands?

[19] **Mr Hilton:** I believe that it should be, if the right to advocacy is enshrined within Measures when we successfully get the LCO.

[20] **Ms McMillan:** We understand that the Minister, when she came to give evidence, mentioned that some concerns had been raised that if those detained under the Act were not included in this LCO and future Measures around advocacy, it would lead to a two-tier advocacy system. We would be really interested to see what the Minister and her officials come up with on that because, obviously, that is something that we would not want to see. However, I do not really see how we can include those detained under the Act within this LCO.

[21] **Bethan Jenkins:** I will now move on to independent advocacy; your organisation provides many such services. Who do you believe should be responsible for commissioning independent advocacy? Do you think that the responsible body should be named or made clearer in the LCO or do you think that it is sufficient as it stands?

[22] **Mr Hilton:** The commissioning issue is a difficult one at the moment, in the light of the consultations that are out on the structure of the NHS, and the possibility of having a mental health trust in Wales. If there was a mental health trust, there would be a strong argument for that to be a potential commissioner. Our belief is that advocacy needs to be truly independent and it needs to be commissioned in a way that enables that. However, at this point, it is quite difficult to talk about how commissioning structures might work in Wales because we do not know what the health structures will be in 12 months' time.

[23] **Val Lloyd:** We have taken evidence from a number of organisations and individuals and many of them have mentioned the role of carers. Do you think that the proposed Order should specifically allow future Measures to address the needs of carers and, if so, in respect of what areas of service provision?

[24] **Ms McMillan:** The rights to assessment, treatment and advocacy that are talked about in this LCO will bring benefits, not only to the individuals experiencing mental ill health, but to their families, friends and carers. I am not sure, however, that it is necessary to include carers explicitly in this LCO. We are very excited about Helen Mary Jones's LCO that is coming through on carers. It could lead to some confusion and to a muddle if carers were explicitly included in this LCO.

[25] **Janice Gregory:** You state in the written evidence that 'treatment' should not just mean medical treatment and suggest 'care and support' or 'services' as more appropriate terms. Can you explain to the committee why you believe that the proposed Order should refer to 'care and support' or 'services' rather than to 'treatment'?

[26] **Mr Hilton:** Having read MIND Cymru's evidence, I believe that it is a similar definition—'treatment and care' or 'treatment and support'. 'Treatment' is very medical. One of the things that we are very excited about is the potential for Measures around early assessment and early treatment. You will see, in other areas of our evidence, that we talk about 'mental distress' rather than 'mental disorder'. While what we are looking at is an LCO that will give us the widest spectrum to deliver brilliant services in future, it will all be subject to Measures. We work from a social model; we believe that employment, talking therapies, physical activity and many other non-medical interventions support people's recovery and enable people to stay mentally well. That is why we are looking at a broader meaning and are certainly not looking to define 'treatment' too narrowly within the LCO.

[27] **Jenny Randerson:** You mentioned 'mental distress' as an alternative phrase in your evidence and say that 'mental disorder' has negative connotations. Can you explain your objection to the term 'mental disorder'?

[28] **Mr Hilton:** Yes. I would say that to use the phrase 'negative connotations' is slightly

missing the point. My feeling is that it is a very legal definition and we would like to see a broader definition that encompasses broader mental wellbeing to enable us, in future, to deliver Measures that provide real, early interventions that may not simply be focused on a mental health diagnosis because we believe that if you can get in there early enough in a primary care setting, you can make a difference to people's lives, and the earlier the intervention, the more possible that is.

[29] **Ms McMillan:** Just to add to that, the term 'mental disorder' comes from previous legislation and there is always the temptation to use the words that legislation has used in the past. However, you do not have to carry on using those same terms. We noticed that the Assembly Government's LCO on additional needs deliberately used a different definition to what had been used in past legislation, so there is no need for this committee to feel that it needs to use the same terminology as has been used in previous legislation.

[30] **Jenny Randerson:** That is a very interesting answer because what you are clearly saying—and this is something that the other witnesses who have suggested 'mental distress' have not made as clear—is that by using a different term, we would include a whole range of additional people. For clarity, is the term 'mental distress' used by clinicians for people who are in what you have almost described as a pre-mental disorder state?

[31] **Mr Hilton:** It can be, yes.

[32] **Jenny Randerson:** That is something, Chair, on which we might take some additional written evidence. As a final follow-up question, would you prefer the term 'person with a mental disorder' to 'a mentally disordered person'? Is there a difference?

[33] **Mr Hilton:** Not to my mind. We are looking at the breadth of the LCO and at being able to deliver real, early intervention. We understand the resource implications and the change that it would mean, but what we are very clear about is that this is an LCO, not a Measure, and what we want is the potential to deliver things differently in the future and to be able to plan for that.

[34] **David Melding:** Some witnesses have said that if the definition is too wide, it would lead to problems, in that we would not be able to focus on those who are most in need of care even if they do not require compulsion. However, if you want something like 'mental wellbeing' in the definition, is that so that a broader line of work, say promoting mental health, could be undertaken, which may not have huge resource implications and may impact on a large part of the population who are not currently in a state of any mental distress?

[35] **Mr Hilton:** We believe that that would, potentially, enable that to happen.

[36] **David Melding:** Okay. That is very helpful. That concludes the questions that we want to put to you. This is one of our last evidence-taking sessions. We have been very focused and much less discursive than earlier in the process, and you are one of the last witnesses to come to us. Also, your answers were unambiguous, focused and helpful. We have not pursued points when we have felt that you have answered the question very directly. However, if there is something that you want to raise with us now, which has not been covered in these questions—I do not want to invite you to invent something on the spot, but I do not want you to go away feeling that you would have liked to have said a or b in addition—now is your opportunity to do it.

[37] **Mr McMillan:** I would just like to add a quick point because I know that, in some of the written evidence, and possibly with regard to some of the people who have come in to talk to you, there has been concern as to whether children and young people would be covered by this LCO. Having read it, we believe that 'persons' means everyone—old people and young

people—but if that is not the case, we would certainly want to see it broadened so that it would include children and older people. This should encompass everyone, regardless of age.

[38] **Mr Hilton:** I absolutely concur with that. Those are two areas where you see quite big gaps and difficulties with mental health service delivery, so it is crucial that those age groups are included.

[39] **David Melding:** I thank you both. We can tell, from the cross-referencing to the other evidence that we have already received, that you have done your homework and it is very helpful that you have taken the trouble to do that. You are welcome to stay in the committee room, but you will have to move to the back seats, or you can leave the Assembly or go up to the gallery. Thank you again. We will send a transcript of this evidence session, so if there are any inaccuracies, you can correct them. You cannot change what you have said, but if something has been wrongly transcribed, you will have an opportunity to put it right.

9.50 a.m.

[40] I ask the Royal College of Nursing to come forward. I am pleased to welcome Lisa Turnbull, the Royal College of Nursing policy adviser in Wales, and Ian Hulatt, who is the Royal College of Nursing adviser on mental health. Welcome to you both. I think that you were present for most of the previous session; we will conduct this session along similar lines. We have a range of questions to put you. We would like to be as focused as possible, so there is no need to go into long answers when you have something direct to say. If there is an issue on which you do not have a view, we will move on. That will not be a problem, because we are not here to examine you and you are here to help us gather evidence for this proposed LCO. Right at the end, I will give you an opportunity to add anything that you feel has not been raised.

[41] I will start, again, with a general question: do you believe that it would be helpful for the Assembly to have this general legislative competence and, if so, why?

[42] **Ms Turnbull:** Thank you for this opportunity. I intend to allow my colleague Ian, as the expert, to answer most of the questions, but I will begin by saying that we very much welcome this proposed Order. We feel that it is an opportunity to create legislation that will promote people's wellbeing in a different way and will answer their needs, and legislation that, importantly, will be workable. We have made the point in our answer to the first question that work on policy, guidance and the workforce will need to be done to deliver the intentions of the legislation. Legislation by itself is not everything, but we very much support this legislation.

[43] **Val Lloyd:** Good morning. In your written evidence, you mentioned some examples of non-medical services provided to those with a mental disorder, including those related to housing and criminal justice. What would be the advantages of extending the scope of the proposed Order to cover services delivered by bodies other than the health service?

[44] **Mr Hulatt:** As the previous speakers have alluded to, the breadth of need with regard to mental health services is not just at the very acute end, when an individual may require detention. There is a continuum here from wellbeing to distress to disorder, and people manifest these problems in a whole range of settings; it is not exclusive to health. That is why we felt that it was appropriate to include other settings too.

[45] **David Melding:** We have heard people say that local authorities are the other key player, but they are not the only other key player. How broad do you think we should go, or do you think that we would just end up listing lots of bodies?

[46] **Mr Hulatt:** That is the risk, is it not? You would list lots of bodies that provide services to individuals, but we felt that it had to be seen as a broad canvas.

[47] **Janice Gregory:** I am sure that you will be aware that several witnesses have mentioned the role of carers. Do you think that the proposed Order will specifically allow future Measures to address the needs of carers, and if so, in respect of which areas of service provision?

[48] **Mr Hulatt:** I agree with that. It must be remembered that carers provide an awful lot of support and care to people for a lot of time when health professionals are not involved. It can be an arduous and draining task, and it can result in a situation where the carer becomes unwell. They should not be in a position where they are isolated and under-resourced and become unwell. So, I welcome the idea that carers would similarly receive support in their task and in their care of individuals, which they do very competently.

[49] **Janice Gregory:** I understand what you are saying about the broad thrust of it, and I am sure that everyone would agree that carers need to be appropriately catered for, for the want of a better term, but can you think of any areas where you would specifically like carers to receive support?

[50] **Mr Hulatt:** In a focused way, carers need support in accessing the services that they require, and are entitled to receive, and also that the person that they are caring for needs. Therefore, they need assistance in navigating through what can sometimes seem complex systems, in order to continue in their care, as well as information and support, and places that are safe and appropriate for them to talk about the caring process. We have to be mindful that, when we are not around, care is given by family members.

[51] **David Melding:** You are saying that a good care system would recognise the role of carers and try to support them. Lisa may be in a better position to answer this—I sense that your members are not telling you that this LCO needs to mention carers. That is not because they are indifferent about carers, but that they do not believe that this legislative route has to mention them.

[52] **Ms Turnbull:** When we first considered the possibilities, I believe that we were naturally quite focused on the specifics of the health professional relationship and the individual. However, given that the question has been raised, I do not believe that it is something that we would be averse to. There might potentially be the opportunity for specific Measures that are related to mental health, as opposed to general Measures around carers. If there is that possibility, it is not something that we would be averse to in any way.

[53] **Jenny Randerson:** The Order would exclude from future Measures people who are subject to compulsory treatment. We have had evidence that suggests that there should be an integrated system of advocacy covering voluntary service users and those detained under the Act. Should the advocacy provisions within the Order cover both sets of people?

[54] **Mr Hulatt:** Yes, I believe that they should. There is a false division being raised here, between individuals who are receiving compulsory services and require advocacy, and people who are not receiving compulsory services. The nature of mental illness, or mental distress, or mental disorder—the terms are interchangeable—is such that these are often relapsing illnesses. Therefore, during their lifetime, an individual may move frequently in and out of statutory services under compulsion, and it seems perverse that their advocate at that point would stop working with them. Would the advocate not follow the individual in their pathway, or their trajectory, through their illness? It seems plausible and right to do that, and that an individual would not be handed over.

[55] I will not digress, but receiving compulsory treatment, and being detained, is an extremely unpleasant process, no matter how you attempt to ameliorate it as a professional—this is someone having their civil liberties removed and being detained. It is possibly an isolating experience, and certainly a scary one, so I believe that it makes good, humane sense that an advocate would be able to follow that individual through.

[56] **Jenny Randerson:** Thank you—that is helpful. On continuity, you say in your evidence that if, following an assessment, a person is not found to have a mental disorder they should still have a right to access services that have been identified during that assessment of their needs. Why do you believe the proposed Order should give rights to those who do not have a mental disorder?

[57] **Mr Hulatt:** When we discussed this we were trying to think of it from a personal experience, of being assessed, of going through that process, of being advised of why that was occurring, and then, because certain criteria were not met, you did not enter into the opportunity to receive certain services. That seems harsh—it raises an expectation, and then denies it to the individual. An individual may not require certain services, but if we go back to this idea of a continuum from distress to formal disorder, people may require light-touch support at an early stage, and we felt that it was inhumane to deny an individual of support after they had been assessed. I think that I will leave it there.

10.00 a.m.

[58] **David Melding:** That earlier stage, is that more the wellbeing end—strategies to build up psychological health and resilience?

[59] **Mr Hulatt:** Yes.

[60] **David Melding:** Interventions at the earlier stage tend to be more about public health and health promotion, do they not? Those strategies are not so expensive, to be frank.

[61] **Mr Hulatt:** Possibly not to the individual, but there are an awful lot of people who may receive such a wellbeing service, so there is an issue of scale. However, with an individual who has been detained and found disordered, the objective is to return them to a place of wellbeing through a process of recovery. At that stage, perhaps they would use those services—the light, maintenance-type approach.

[62] **Bethan Jenkins:** To move on to definitions, and you have already touched upon this, you provided in your evidence an alternative to the term ‘mentally disordered persons’, namely ‘persons who have any disorder or disability of brain or mind’. Can you explain why you believe that the current definition in the LCO is inadequate?

[63] **Mr Hulatt:** Definitions are extremely fraught with difficulty, as the past seven years with the Mental Health Act have demonstrated. We added ‘brain’ to the term ‘disability of mind’ because the mind does not exist independently of the brain. There may be individuals who have physical or organic illnesses that cause them to become periodically disordered, and we would not want to see their being excluded from receiving services.

[64] **Bethan Jenkins:** Do you think that there may be some confusion in that case with physical problems if you include the word ‘brain’? Might it cloud the definition with regard to addressing mental health?

[65] **Mr Hulatt:** There is that potential. As I said, this is fraught with difficulty, and people can exercise a great deal of energy on definitions. However, they are critical in legislation because they can exclude people from receiving whatever the legislation exists to

provide. Therefore, we would go for a more inclusive definition. At the same time, we are very aware that this is a subject that can take a great deal of debate—it is not fixed easily.

[66] **Bethan Jenkins:** Following on from that, other organisations have provided alternatives, but I notice that you mentioned a continuum from distress to disorder. Do you therefore believe that there could be multi-component definitions, from distress at an earlier stage to a disorder at a later stage? Would that fit together in this LCO, or would that come into play at the Measure stage?

[67] **Mr Hulatt:** I think that it could fit together in the LCO. It has been alluded to at the wellbeing end that there is an opportunity to engage in mental health promotion, which, I would argue, is a relatively ignored or under-resourced area. Therefore, there is an opportunity to include that if you take a broader view.

[68] **Val Lloyd:** You tell us that the term 'treatment' requires further definition, and that it should not simply mean medical treatment. Can you suggest an alternative definition? Should this definition be contained in the proposed Order or in any future Measures?

[69] **Mr Hulatt:** Again, definitions of the term 'treatment' are fraught with difficulty, because this is where disciplines engage in what disciplines do. However, the whole purpose of treatment is to improve or ameliorate the distress or disorder of the individual concerned. We felt that it would be appropriate to acknowledge that treatment is given in a very broad sense by very many different disciplines and in different ways. All the disciplines would agree on the purpose of it, but it can be provided in a wide range of ways. At the distress end of the spectrum, it may be that exercise is an appropriate treatment for an individual who is low in mood. Therefore, it is a broad concept, and the Royal College of Nursing is keen to advocate the fact that our members are in the places and positions and have the skills to offer treatment.

[70] **Val Lloyd:** Thank you. That leads nicely into my next question. A section of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of treatment that includes nursing, care, psychological interventions, habilitation and rehabilitation and so on—I am sure that you know it far better than I—and the amended Mental Health Act 1983 contains a similar definition. Do you think that that would be helpful to us in the Order or in a Measure?

[71] **Mr Hulatt:** Yes, it would be very helpful.

[72] **Val Lloyd:** That was a direct answer, thank you.

[73] **Ms Turnbull:** I will just add a minor point to that about the broader definition of treatment. This is not the first piece of draft legislation that I have seen that restricts itself very tightly to a medical model and the concept of the doctor providing treatment. It is a point that we have had to raise quite a few times before, namely that definitions need to be broader to encompass the health professional giving the treatment. I just want to flag up that I do not think that point of drafting is specific to this LCO.

[74] **David Melding:** That completes the range of questions that we want to put to you, but I said that I would give you the opportunity to add anything that you think would be valuable to our evidence gathering.

[75] **Mr Hulatt:** There is one issue that we would encourage you to consider, namely the issue of the principles that would be argued to underpin the LCO—principles about its intent and the means by which it is delivered. That would include notions such as the least restrictive alternative, which is, as you alluded, used in the Scottish Act, and which is

seriously worth considering. We would encourage that.

[76] **David Melding:** Thank you. That was very helpful, clear and direct evidence, which allowed us to deal with the range of questions in a very timely fashion. We will send you a transcript so that you are able to check the accuracy of your evidence; you cannot change what you said, but it is just in case anything has been mistranscribed. We appreciate the effort that you have taken in giving us evidence in writing and orally this morning.

[77] The next witnesses are from the Law Society. While they are making themselves comfortable at the table, I will introduce them. Kay Powell is a solicitor and policy adviser for the Law Society and Professor Phil Fennel, from Cardiff Law School, is a member of the Law Society committee on mental health and disability; he is known to several of us who worked in the previous Assembly on mental health reforms and their likely effect on Wales. As you arrived during the course of our earlier proceedings, I will inform you that these proceedings can be conducted in English or Welsh; when Welsh is spoken, a translation is provided on channel 1 of the headsets. If you are hard of hearing, you can amplify proceedings on channel 0. If you have any electronic equipment, please ensure that it is switched off completely, and not just left on silent, as that interferes with our recording equipment.

[78] We have a range of questions to put to you and I will give you an opportunity at the end to add anything that you wish to say, if you feel that we have not captured all the evidence that you can validly give us this morning. If, on particular questions, you do not have anything relevant to say, we can just move on. This is not an exam viva; you are here to help with our evidence, so I hope that it is as relaxed as these necessarily formal proceedings can be.

[79] I will ask the first question, which is very general. Why do you think that this legislative competence Order would be valuable to the Assembly so that it could introduce, in the future, Measures relating to mental health?

[80] **Professor Fennel:** I will begin our response. The question is asking whether we agree with the general principles behind this legislative competence Order. The answer is that we see the sense in having such an Order, because when the various Westminster parliamentary scrutiny committees looked at the mental health bills that did not eventually emerge to become the Mental Health Act 2007, one of the things that came very clearly through the evidence was that people often approached mental health services for assessment and did not get the assessment that they should have received. They ended up getting their assessment as a result of having committed a criminal offence or having to be sectioned under the Mental Health Act. So, if the intention is to enable the users of psychiatric services, carers and the families of service users to get access to an early assessment before they or their loved ones end up in the criminal justice system, I think that this is a jolly good idea.

10.10 a.m.

[81] The first provision in connection with the assessment of persons who are or who may be mentally disordered persons has the potential to be a very good idea, as long as it is kept limited. It would worry me if there were provision for others to request assessments, such as neighbours who have suddenly decided that their next-door neighbour may have a mental disorder, or if somebody were to come to the attention of the police. If somebody is found in a public place, the police can already ask for an assessment under section 136 of the Mental Health Act. Therefore, the Law Society would like the people who can request an assessment to be limited to those who have a legitimate interest, namely service users, carers and the person who would be the nearest relative if someone were detained under the Mental Health Act.

[82] As for duties, we agree with the general principle, but we also think that it needs to be remembered that there is already a duty on social services authorities under section 47 of the National Health Service and Community Care Act 1990 to provide an assessment of a person's need for community care services, if they appear to be in need. So, it is not just the health service that will be doing the—

[83] **David Melding:** We will drill down to the details during questions.

[84] **Professor Fennel:** In that case, I will just say that there is support from the Law Society for placing duties on health and social services agencies to provide treatment. There is also support for the idea of independent mental health advocacy, as long as that is not seen as a substitute for properly qualified legal representation when it is needed.

[85] **David Melding:** You mentioned assessment immediately. Is that where most lawyers who are interested in mental health would have had some experience—it is fairly serious when somebody is facing compulsion—or are there wider perspectives that lawyers might bring to this?

[86] **Professor Fennel:** A lawyer would become involved if a person were subject to a civil section. That is, they have not committed a criminal offence, but are being sectioned under Part II of the Mental Health Act. A solicitor would not necessarily be involved in that process of compulsory detention, but would become involved if the person sought to challenge the detention by going to a mental health tribunal. The solicitor would come in as an advocate. Very often, solicitors get involved when a person has committed a criminal offence and has ended up in front of a criminal court, and the criminal court has to decide whether to send that person to a psychiatric hospital or to give that person a community order with the condition of psychiatric treatment, or whatever. That would be the first point at which a lawyer would become involved: when somebody is charged with a criminal offence. This is really a type of pre-assessment that you would get if somebody was thinking about detaining you under the Mental Health Act. Solicitors are not generally involved in assessments about sectioning; they do not get involved until later.

[87] **Jenny Randerson:** You referred to the Scottish legislation and particularly to the rights of the service user, the primary carer or the named person to request an assessment. Do you think that the Scottish system of care is a model that Wales could learn from and, if so, what particular aspects do you think we could learn from?

[88] **Professor Fennel:** We do not have enough experience to know how well this duty is working, because the Mental Health (Care and Treatment) (Scotland) Act 2003 has not been in force for long enough. Some of the Scottish practitioners whom I talk to say that they have not heard of the duty. However, that is not a scientific survey; I just phoned up a few people and asked, 'How is this working?' and they said, 'What do you mean?'. So, there are good things in the Scottish system, but the Mental Health (Care and Treatment) (Scotland) Act is very different from the English Mental Health Act 2007. For example, the Scottish Act states that you cannot be detained under its provisions unless you have significantly impaired judgment in relation to the decision to go into hospital. That is not in the English legislation. Scotland has developed a lot of service user involvement, with which we see parallels in Wales. Hafal does amazing work, as does Mind, and, in Scotland, similar organisations do similar, very good work.

[89] The question of a legal duty to provide assessment does not necessarily mean that you will get a great mental health service at the end of it. Service provision and legal duties are linked, but they will not follow like night follows day. Scotland's duty in law is a good thing, but the question is whether we can make that an operational reality in Wales and ensure that it is carried out, so that service users and carers are not left high and dry. I am a carer as well as

a legal academic, so I know how difficult it can be to get an assessment if you do not know your way around the system. To have a clear legal duty placed on the health service and social services departments to carry out an assessment will, in my opinion, be a step forward.

[90] **Jenny Randerson:** Keeping on the same track of who has the right to request an assessment, do you think that that should be put in the amended Order or in a Measure?

[91] **Professor Fennel:** Do I think that it could be left to the Assembly to decide?

[92] **Jenny Randerson:** Do you think that the Order needs amending?

[93] **Professor Fennel:** The Law Society would not like to see the right to request an assessment opened up too widely so that anyone could ask for one. People do things such as get into neighbour disputes and so on, and can act a bit strangely. Therefore, it should be for the relatives or the service users themselves to ask for such an assessment. The police already have the power to do so if someone has committed an offence in a public place, or they can get a warrant if it was in a private place. So, we do not need it to be any wider.

[94] I would trust the National Assembly to follow a line that would keep things limited, and not to open this up too widely so that it could become anti-libertarian in its operation. It would also be based on this philosophy of increasing early access for people with mental health problems. If you have a system that is based too much on compulsion and coercion, the problem is that people will not want to access it until the very last possible minute, because they will be worried about the stigma, about what might happen to them, and that they might end up in hospital. So, we want to this to be accessed by people who are benignly disposed towards the service user, or they are the service users themselves. Limiting the Order would limit the Assembly's freedom to manoeuvre, and that is really a political judgment, which I do not feel qualified to make either way.

10.20 a.m.

[95] **David Melding:** This is an interesting point, given that we are looking at people's right to an assessment well short of the point at which they may need acute treatment in hospital, whether they consent to it or not. It seems to me that the philosophy behind this LCO is to have a more holistic system, particularly when people clearly think that they are in distress or have an illness but who are not so severely ill that they come under the 1983 Act, as amended. Given that, should it just be focused on the request of service users or potential service users? Why allow other people to request an assessment at an earlier stage?

[96] **Professor Fennel:** The answer is because you might need access to services if a person does not have the capacity to seek access in their own right. Many people with a severe psychotic illness do have the mental capacity to make decisions, but you may have somebody who does not. If we are looking at things holistically, we need to remember that mental ill health affects the service user, and, in many cases, the carer. There are thousands of carers of people with mental health problems in Wales, and their job is not just to care physically or mentally for the person—watching for signs of the illness coming back, and things like that—but it is also to play an advocacy role, given that it is often carers who have to claim benefits on behalf of a person, arrange access to services, try to argue the person's case against the use of compulsory powers so that they can remain at home, and make sure that the person takes their prescribed medication. To my mind, it is important to enable carers and family members to access services and to access an assessment, where they think it necessary. I do not think that the system is likely to be swamped by requests of that nature, but just having the back-up of being able to make such a request might be a good thing.

[97] **David Melding:** Thank you. That is very clear. Val is next.

[98] **Val Lloyd:** I think that my questions have been answered.

[99] **David Melding:** Oh, sorry. Have I wandered?

[100] **Val Lloyd:** No, not at all. Both my questions were dealt with earlier.

[101] **David Melding:** Well, you might want to add the point about local authorities' involvement.

[102] **Val Lloyd:** Very well. I was going to focus on who should have the right to assessment and treatment, and you have gone into it in some depth, Professor Fennel. You say in your evidence that it should be placed on local authorities' social services departments and the health service. You have explained why you think it should be restricted, but are there any other bodies that you think it could be placed on?

[103] **Professor Fennel:** The examples given were the police and the employment service, but I do not think so, in those cases. Neither of those bodies exists primarily to provide care and treatment for mentally disordered people. The definition in the Mental Health Act, which I think we will be stuck with in this legislative competence Order, is that medical treatment for mental disorder includes nursing, care, and specialist mental health habilitation and rehabilitation, and those things are provided by the health service and by local authorities' social services departments. It would have to be made clear that this was a joint duty, that the health service must co-operate with social services departments in the duty that they already have, to assess someone's need for community care support. If I have a mental illness and am in the community, and I need some support to, for example, help me with my daily hygiene or to ensure that I do not neglect myself or whatever, I would be entitled to go to social services now and say that I would like some community care support and that I would like it to carry out an assessment. My carer would be entitled to ask for a carer's assessment. Therefore, I think that this should be limited to health and social services. The police have powers already, if they find someone in a public place, to remove them from that place if they think the person is mentally disordered, take them to a place of safety and have them assessed.

[104] I cannot really see where the employment service comes into the picture in terms of providing services that may help people to avoid getting to the stage where they have to go into hospital. If you are in employment, it would be your employer's occupational health service that would be involved, and, if you are not in employment, the time to engage the employment service is when we have decided that the person has reached a stage of recovery where they might be helped into employment. However, at this stage, I do not think that its involvement would be helpful.

[105] **David Melding:** That is very helpful; that is a very clear rationale. Whether we conclude that we need to follow it is another matter, but that was a very clear answer.

[106] **Janice Gregory:** In your written evidence, you state that you agree with the approach of the proposed Order that patients subject to compulsory treatment under the Mental Health Act 1983 should be excluded from future Measures. I think that the reason that you cite for that is that it is a discrete area outside current provisions. The committee has taken evidence that suggests that there should be an integrated system of advocacy, covering voluntary service users and those detained under the 1983 Act. Do you think that the advocacy provision should cover both?

[107] **Professor Fennel:** Assuming that this goes ahead, a person could have three types of advocate. If the person lacks mental capacity and it is proposed to place that person in an institution for more than eight weeks or a hospital for more than 28 days, he or she is entitled

to an independent mental capacity advocate. If the person is going to have a serious treatment and does not have a carer involved, that person will be entitled to an independent mental capacity advocate. If people are detained under the Mental Health Act, from April 2009, they will be entitled to an independent mental health advocate, whose job it will be to give them information about the treatment that they are having and so on. Then there will be these new independent mental health advocates for people who are not subject to compulsion. My question is: what is the role of this advocate envisaged to be? Will the advocate be advocating against the use of compulsory powers, and for the provision of services that enable the person to stay in the community?

[108] One person might have three advocates in the space of six months. You might need some surgery while you are a detained patient in hospital. If you do not have a carer or any relatives who are interested in your wellbeing, you will therefore have an independent mental capacity advocate for that; you will have an independent mental health advocate in relation to your treatment for mental disorder under detention; then, when you come out of hospital, in an effort to avoid your going back into hospital, you will get another independent advocate, perhaps from a different regiment of the advocacy service who will be looking after you there. So, it may make sense to unify these, but currently we have at least two and this will provide a third function. The other question is whether an independent mental health advocacy service should be provided by a non-governmental organisation.

10.30 a.m.

[109] **David Melding:** We will move on to that. That is a very interesting response. You mentioned the different triggers that can give you a right to advocacy, but the fact that there may be different sources in law to provide that right to advocacy would not prevent a unified advocacy service from being developed, would it? The advocates may have different functions at different times, depending on which part of the law they draw on, but the view that we have had from some witnesses is that we could have a parallel system whereby, if you are under compulsion, you have one type of advocacy provision and then if you are no longer under compulsion, it is provided under a different strand. Could the system be unified so that you could potentially have the same advocate moving through the system?

[110] **Professor Fennel:** I imagine that everything is possible, but I am not an administrator.

[111] **David Melding:** The fact that there are different laws covering the field would not make it legally impossible, would it?

[112] **Professor Fennel;** No. As long as the person had someone called an ‘independent mental capacity advocate’ if he or she was being given treatment to which the Mental Capacity Act 2005 applied, and as long as he or she had someone called an independent mental health advocate in relation to their treatment for mental disorder, then the statutory obligations on LHBs in Wales would be discharged. The question then is whether, if the Measure decides to set up another advocacy service to which people would be entitled, they would have to have another advocate who is called an independent mental health advocate. If those roles can be miraculously combined into one person then that would provide the possibility for an ongoing relationship with the service user.

[113] I will say one thing about people’s general experience of the psychiatric service: there is rarely much continuity of contact even with the statutory services. If you have a community psychiatric nurse when you start your treatment, you will be lucky if you still have that same CPN in six or eight months’ time, because the chances are that he or she will have moved to another job. Long-term relationships are very rare. I imagine that advocacy will not be a particularly highly paid occupation, so there will also be a fair degree of fluidity there. So, I

do not see it as a major issue that a person should have one advocate for his or her entire passage through the health system. That is not particularly important as long as people have an advocate, when they are entitled to one, who knows what they are doing in relation to that particular matter.

[114] **David Melding:** Okay. Bethan will introduce this issue of how we define independence in advocacy.

[115] **Bethan Jenkins:** You have already touched upon this, but could you clarify what your opinions are on the fact that the proposed Order as it stands does not place a duty on commissioning or providing independent advocacy on any one body? Do you believe that that should be done through the LCO or at the Measure stage?

[116] **Professor Fennel:** I think that it would be better done at the Measure stage, because the Assembly knows best which bodies in Wales are appropriate to exercise these duties. I am a bit new to this and I sought advice from a colleague of mine who knows a lot about legislative competence Orders. He said that there are various things that you can do: you can draft them broadly so that the Assembly can do more, or draft them narrowly, which means that you might have to go back again quickly to get more powers to do something else that you want to do. I think that this LCO is broad enough—although, looking at it now, I wonder whether it is broad enough.

[117] 'Provision for and in connection with…independent mental health advocacy for persons who are or may be mentally disordered persons'—

[118] I suppose that that would mean that you could, through a Measure, place a statutory duty on whichever body is appropriate.

[119] **Bethan Jenkins:** Do you believe that it would be sufficient to name the organisations or the bodies in the Measure stage, and that the wording is sufficient as it stands?

[120] **Professor Fennel:** It is sufficient as it stands to enable a Measure to be made that includes provision for and in connection with independent mental health advocacy. I would think that that would be wide enough to enable you to put a duty on whichever body you think is appropriate—probably local health boards—or the Assembly Government itself could assume the duty and do it that way.

[121] **Bethan Jenkins:** What role do you see for lawyers in training advocates or taking part in the process? You have mentioned the role that lawyers currently play at the compulsion stage. What enhanced role do you see for lawyers under any new LCO that is made?

[122] **Professor Fennel:** I would expect that lawyers would have a key role in training advocates to ensure that they know how the Mental Health Act 2007 works, and how it will impact upon that client group—the people who are subject to compulsion. As regards those who are not subject to compulsion, I would imagine that lawyers would not have much of a role other than to say, 'Here is what might happen further down the road'. It depends upon the role that you want to give to these advocates: are they supposed to try to keep people out of hospital and in the community, to advocate with health and social services for treatment, or are they supposed to advise people about their legal entitlements? I do not think that that is what is envisaged—I think that what is envisaged is that clients will be befriended by someone who will, in contrast to those people who are telling them what they need, voice their concerns to the authorities, and tell the authorities what the client, or service user, would like.

[123] **Jenny Randerson:** Sticking to the difference between the LCO and any future Measure, do you think that the proposed LCO as drafted will allow future Measures to establish a right to treatment, rather than simply allowing future Measures to place duties on the health service to provide treatment?

10.40 a.m.

[124] **Professor Fennel:** Looking at it in strict legal terms, if the health service in Wales has a duty to provide treatment for mentally disordered persons, if I were a mentally disordered person, I would go and argue—because I am a stroppy lawyer—that I was entitled to treatment. The question then is: what kind of treatment? The Mental Health Act 2007 says that a person cannot be detained in hospital unless appropriate treatment is available for them. 'Appropriate treatment' is defined, helpfully, as treatment that is appropriate in that person's case, taking into account all the relevant circumstances. It then says that treatment is appropriate only if it has the purpose of alleviating the person's mental disorder or one or more of its symptoms. So, we have a clear notion of treatment in the Mental Health Act 2007, and this will be an amendment of that Act. So when we talk about treatment, that is what we are talking about.

[125] We are also talking about appropriate treatment, which could include nursing, care, habilitation and rehabilitation. So, it is very widely defined, and we are not saying that the health service has a duty to provide this or that treatment for mentally disordered persons; we are saying that it is its duty to provide treatment. You might change that to say 'appropriate treatment'. For example, could I use this as it stands to argue that I should see a psychologist because I have a mental disorder and I have been assessed as needing psychological services? We know that those services are very thin on the ground in Wales—in some areas, you cannot get access to a psychologist. Could I say, 'You have a duty to provide me with treatment, and that should include psychological services.'? I do not think that this would give a person that right, but it would give them the right to say, 'You must provide me with some treatment because I am suffering from a mental disorder.'.

[126] **Val Lloyd:** You have suggested in your evidence that the phrase 'may be mentally disordered' is too wide and you suggest the phrase 'who are or who appear to be suffering from a mental disorder'. Can you elaborate on that view?

[127] **Professor Fennel:** Yes. Anyone may be suffering from a mental disorder. If someone has to appear to be suffering from a mental disorder there must be some basis on which that can be said. So, for example, under the NHS and Community Care Act 1990, the duty to assess someone's need for community care services applies if the person appears to the social services authority to be in need of those services. If we placed this duty on health and social services and we say that the person either has to be suffering from a mental disorder or has to appear to be suffering from such a disorder, we would be saying that there must be some factual basis on which we can say that they appear to be suffering from that disorder. The concept that someone may be suffering from a mental disorder is something that I recoil from, as a lawyer, as it is too wide.

[128] **Val Lloyd:** You are saying that the words 'appears to be' would be determined by the health and social services department.

[129] **Professor Fennel:** Yes; it would decide whether it appears that the person is suffering from such a disorder.

[130] In terms of whether we should use the term 'mental disorder', 'mental distress' or something else, 'mental disorder' has a definition in the Mental Health Act 2007, as I am sure you know, which is,

[131] ‘any disorder or disability of the mind’,

[132] which is different from the definition of ‘mental disability’ in the Mental Capacity Act 2005, which is defined as being any disturbance or disability of the mind or the brain. Like the committee, I believe that it is important that we stick with one definition of ‘mental disorder’, which is on a different level to mental distress. If one of my close relatives dies, I will suffer mental distress, but I will not necessarily be suffering from a mental disorder. So, I think that the term,

[133] ‘disorder or disability of the mind’,

[134] is sufficient to cover pretty much everything, even things of a physical origin.

[135] **Val Lloyd:** Where would the phrase ‘mental health problem’ fit into what you have just said?

[136] **Professor Fennel:** I do not like the word ‘problem’, because it suggests that you not only have a mental health problem but that you are a problem in some way. So, I would not like that phraseology. The Mental Health Act uses the term ‘mental disorder’, and if we are going to use something different, we will be making the concept of mental disorder even wider than it already is. At the moment, it includes personality disorder, learning disability, and a disorder or disability acquired by someone because they have been involved in a road accident or have vascular dementia. It would also include a mental disorder caused by someone having a cut that has gone septic and whose system has become toxic and who is in what is called a toxic confusional state. All those things would be covered. The term ‘mental distress’ may help us with regard to issues around using harsh wording, but I do not think that the term ‘mental disorder’ is particularly harsh wording.

[137] **Bethan Jenkins:** I think that the RCN made it clear for me for the first time why this may need to be changed to incorporate mental distress, namely because of the potential for early assessment. Could you clarify why the term ‘mental disorder’ would incorporate people at the front end of the service who perhaps would not have considered themselves to have a mental disorder? Where would those people, who perhaps would not go through the whole care pathway of compulsion, fit in?

[138] **Professor Fennel:** I think that we need to make a distinction between two things here. One is the global public health issue of mental distress, if you want to call it that. For example, one of the major sources of mental distress in the place where I work is workplace stress at various times of the year. That can lead to depression and to people feeling like they are not performing to their best. That is mental distress, and you address that by looking at someone’s workload and by trying to help prevent the distress in a public health way. Basically, what you are then saying is that someone’s mental distress does not amount to a mental disorder. ‘Mental disorder’ is extremely widely defined. The legal definition is wide, and if you pick up one of the international diagnostic manuals you will be amazed by how many different kinds of mental disorder there are, and you could identify many people you know as having some of the features of them. I am not being defensive; I am just saying that, if you look at the diagnostic and statistical manuals of the American Psychiatric Association, that is what you will see. The notion of mental disorder is already very wide.

[139] It is a nice idea that we should have strategies that prevent people from suffering mental distress, which may lead to mental disorder and to their being sectioned, but I think that this Order goes back a stage that is just far enough to make a difference that will be of great importance to many people. I have talked to service-user groups. One famous guy in west Wales, who was in the paper, was supposed to have access to a 24-hour crisis

intervention centre. When it was shut, he broke into it and spilled sugar around the floor in a pattern and then broke out again. That is how he got access to psychiatric services. It was in the newspapers, and I am sure that you will know about that case, Ms Lloyd and Mr Melding, because you were on the committee that heard evidence from that man.

10.50 a.m.

[140] That is where it is really important; it is at that stage that you can go and say, 'Look, I am experiencing mental distress. I do not particularly want to go to hospital, but I need some support at this point to keep me out of the compulsory system.'.

[141] **David Melding:** We have heard evidence that the Assembly might want to legislate on the wellbeing side. Using a more general word, such as 'distress', would enable us to do that. You seem to be concerned that that would divert our attention from those in more need, basically, to the general population—we are all under mental distress to some extent at some point, which is a normal feature of being alive. I am not quite sure that I understand why incorporating a word such as 'distress', which would allow a future Measure, if the Assembly was so minded, to look at promoting mental health, would not be valuable.

[142] **Professor Fennel:** It might well be valuable.

[143] **David Melding:** Is it your feeling that we are trying to include too much?

[144] **Professor Fennel:** This is a legislative competence Order in relation to the Mental Health Act 1983, as amended by the Mental Health Act 2007. The Mental Health Act is not a public health measure; it is a measure that largely provides for treatment under compulsion. It allows people to be admitted voluntarily to a psychiatric hospital, but it is mainly about compulsion. The only bit about service provision is section 117, which places a duty on health and social services to provide aftercare for detained patients. The NHS and Community Care Act 1990 and public health legislation would be the correct vehicles for doing that in my opinion.

[145] **David Melding:** That is very helpful. We are hearing some things that we have not necessarily heard before. Finally, I would like some clarification on one issue. We have heard one witness say that we should use a definition such as 'persons who have any disorder or disability of brain or mind', but I think that you are firmly advising us not to go down that route. Am I right in saying that?

[146] **Professor Fennel:** The definition in the Mental Capacity Act 2005, if I am remembering it correctly, of 'mental disability' is 'any disturbance or disability of the mind or brain'. That is intended to include people who have suffered brain injuries in road accidents in particular who do not necessarily suffer a mental disorder as a result of those injuries, but may be paralysed or unable to communicate decisions. I think that you might find a bit of resistance if you try to use the definition in the Mental Capacity Act in relation to a legislative competence Order that is designed to amend the Mental Health Act, which already has a broad definition that the Government fought extremely hard to maintain in the 2007 Act. It resisted all kinds of attempts to change the definition of 'mental disorder', and it stuck with one that is broad enough to include most, if not all, of the people who might want mental health assessments. That would be my response to that.

[147] **David Melding:** That is very clear, thank you.

[148] We have gone through the list of questions that we wanted to ask you, and we have had a very interesting perspective, which has not always confirmed some of the evidence that we have heard previously—although it has confirmed parts of it. It is very valuable for that

reason. If you feel that you want to bring something to our attention that we have not covered so far, now is your opportunity to do so.

[149] **Professor Fennel:** As a legal academic and not a practising lawyer, I feel that I can say, without being accused of trade unionism, that it is vital that all these new advocacy entitlements are not seen as a substitute for properly qualified legal representation where people are at risk of being deprived of their liberty and of having their physical integrity invaded by treatment that they do not want. Access to legal representation should be maintained, and this should not be seen as a kind of substitute for that in any way. This is additional advocacy and is not to be used instead of properly qualified legal advocacy.

[150] **David Melding:** Thank you very much. We are very grateful for your attendance here this morning. You have certainly given us a lot of evidence to think about. A transcript of the session will be sent to you so that you can check it for accuracy.

10.56 a.m.

## Dyddiad y Cyfarfod Nesaf
## Date of Next Meeting

[151] **David Melding:** All that remains for me to do is to say that we will meet a week today on 20 May, when we will have our second session with the sponsoring Member, Jonathan Morgan AM. With that, I close the meeting. Thank you for your attendance.

*Daeth y cyfarfod i ben am 10.56 a.m.*
*The meeting ended at 10.56 a.m.*