PURPOSE:-
The draft Mental Health Bill was published by the Department of Health for consultation on 26th June. The consultation period runs for 12 weeks until 16th September. The Welsh Assembly Government is a consultee. Jane Hutt, the Minister for Health and Social Services, is determined that the consultation in Wales will be as extensive as possible in the timeframe available. To supplement the written consultation procedure she has decided to organise three consultative conferences in Wales to help inform the reply which the Assembly will give to the Department of Health. As one of these three conferences, this event will play an important role in informing the Assembly's formal response to the consultation exercise, alongside the Health and Social Services Committee and Plenary debates and also written responses from stakeholders and Assembly officials in Wales.

ORGANISED BY:-
Centre for Mental Health Services Development (CMHSD) in Wales
Canolfan Datblygu Gwasanaethau Iechyd Meddwl Yng Nghymru
Draft Mental Health Bill Stakeholder Consultation Conference

1. Chair’s introduction (John Sweeney, Welsh Assembly Government)

The Chairman opened the meeting by thanking delegates for attending the event at relatively short notice. He explained that the timing of the Government's consultation period was outwith the Assembly's control and he expressed the Assembly's gratitude to CMHSD for facilitating the three consultation events within such tight time constraints. He apologised that it had not been possible to invite everyone who would have an interest, and explained that this had not been practicable due to constraints at each venue. He was pleased, however, that CMHSD on the Assembly's behalf had been able to ensure as broad representation of interested groups as was possible in all the circumstances.

The Chairman welcomed the Westminster Government's decision to consult on the draft Bill and reiterated that the Welsh Assembly Government's role in the legislative process is that of a consultee. He also reiterated that the events had been arranged to meet the Minister's wish to ensure that the draft Bill is fully and rigorously debated by interested groups throughout Wales. He emphasised that the events were an additional strand of the consultation process and would help inform the Assembly's written response to the Department of Health. He stressed however that it was vital that individuals/organisations also put forward their written responses direct to Department of Health. He advised that these could be copied directly to the Assembly if people preferred, but that the Assembly had already arranged with Department of Health to have sight of all Welsh responses.

2.1 Analysis of the implications of the Bill for service users and professionals in mental health, social care and criminal justice services (Prof. Phil Fennell, Cardiff Law School)

Context of Law Reform

- Homicide Inquiries
- New Primacy of Risk Management
- Human Rights Act 1998
- Cross pollination of Criminal Justice and Psychiatric systems: 'joined-up compulsion'
- National Service Frameworks

The Two Main Policy Goals

- To introduce more effective compulsory community powers than guardianship or supervised discharge to ensure that patients in the community are subject to an effective undertaking to carry on with medication.
- To ensure that dangerous severely personality disordered patients can be subject to detention in the mental health system.
Headlines

• New Human Rights focus on the rights of potential victims rather than rights of service users
• Risk management
• Further convergence between the mental health and criminal justice systems
• Single pathway assessment followed by MHT imposed order authorising treatment in hospital or in the community
  Require doctors and others to give reasons for not using compulsory powers
• Approved Mental Health Professional replaces ASW
• Clinical supervisor replaces responsible medical officer
• Treatability test changed
• Removing the right of the nearest relative to object to compulsory admission for treatment or to discharge a detained patient - replaced with a duty to consult the nominated person.
• Advocacy
• Mental Health Tribunal and Mental Health Appeal Tribunal
• Expert Panel
• Provision for Bournewood (incapacitated) patients: Part V of the Bill.
• Duty to disclose information

Mental Health Bill

• Part 1 Minister must publish Code of Practice which must set out general principles to which a person must have regard in coming to a decision under the Act.

Principles

• Principles must be designed to secure that patients involved in making of decisions which are made fairly and openly and any restrictions imposed on them in the course of their treatment are the minimum necessary to protect their health or safety or other persons.
  but
• Clause 1(4) The Code may provide that one or more of the general principles is not to apply -
  • (a) in circumstances where its application would be impractical or inappropriate,
  • (b) in relation to decisions or persons specified in the Code

Part 1

• Part 1 of the Bill also includes provision for the key institutions: the Mental Health Tribunal, the Mental Health Appeal Tribunal, the Expert Panel and the new definition of mental disorder

Part 2

• Part 2 of the Bill deals with examination, assessment and treatment
• Like Part 2 of the 1983 Act, it deals with compulsory powers and non-offender patients.

**Mental Health Bill**

• New definition of mental disorder - Any disability or disorder of mind or brain, whether permanent or temporary which results in an impairment or disturbance of mental functioning. Clause 2(6)
• approved mental health professional
• Assessment followed by care and treatment order

**Wide definition of mental disorder**

• No particular categories of mental disorder.
• Move away from ‘narrow concept of ‘treatability’ which applies to certain categories of mental disorder.
• Possible removal of exclusions in s 1(3) of the current Act no-one shall be treated as mentally disordered by reason only of sexual deviancy or addiction to alcohol or drugs

**'Risky' patients and others**

• Different criteria for compulsory powers depending on whether use of compulsory powers primarily for patient’s own best interests or to protect others from risk of harm.

**Care and Treatment Order: 'Risky' Patients**

• Suffering from mental disorder
• mental disorder of nature or degree to warrant (specialist White Paper) the provision of medical treatment to him.
• In the case of a person at substantial risk of causing serious harm to other persons that it is necessary for the protection of those persons that treatment be provided to him.

**Care and Treatment Order: All Other Cases**

• Suffering from mental disorder
• mental disorder of nature or degree to warrant ('specialist' in White Paper) the provision of medical treatment to him.
• It is necessary for the health or safety of the patient or the protection of other persons that medical treatment be provided and least restrictive alternative.

**Treatment and Treatability Clause 1(5)**

• Appropriate medical treatment must be available in the patients case:
• Medical treatment means treatment for mental disorder provided under the supervision of an approved clinician
**Treatment and Treatability Clause 1(5)**
Includes:
- (a) nursing;
- (b) care;
- (c) habilitation (including education, and training in work, social and independent living skills); and
- (d) rehabilitation.

**Powers for Non-Offenders**
- Request for assessment may come from any person (clause 9) NHS Trust or PCT must if requested by any person determine whether the relevant conditions are met. Must consult carer of the patient, if practicable - must give reasons for determination.
- If relevant body determines that conditions appear to be met must arrange for patient to be examined by two doctors and AMHP to assess up to 28 days assessment under detention or in the community w. appeal to MHT.

**Examiners**
- Clause 10(1) each examiner must examine patient to determine whether the relevant conditions are met.
- Clause 11 if one examiner determines that not all conditions are met, none of the others may examine the patient, but the examiner must give reasons for determination.

**Reasoned Decisions: Clause 13(2).**
- Within the applicable period, each of the registered medical practitioners must record each of his determinations and the reasons for it, and
- forward that record to an approved mental health professional, and the approved mental health professional must record his own determinations and the reasons for it.

**Reasons for not exercising compulsory powers**
- Professionals will be required to give reasons to those who have a right to request assessment including criminal justice agencies.
- Reasons will have to show why, if there is a risk to an identified individual or individuals from the conduct of the mentally disordered person, the professionals have not taken action within the scope of their powers Osman v United Kingdom
- Proportionality Varbanov v Bulgaria, Litwa v Poland
Feedback - Llandrindod Wells, 13 August 2002

**Assessment**
- Clause 14 AMHP must appoint nominated person as soon as practicable after the patient becomes liable for assessment, and must inform patient and nominated person of
- fact that liable to assessment as resident or non-resident patient
- all determinations and reasons for them
- help available from advocates under Clause 159

**Registration**
- Clause 17 AMHP must within 24 hours of patient becoming liable to assessment register patient with the hospital deemed to be responsible for assessment and treatment
- Clause 18 registration confers authority to take and convey and for managers to admit.

**Clinical supervisor**
- Duty of hospital managers where patient is registered to appoint an approved clinician to act as the patient’s clinical supervisor.
- A person is an approved clinician if he falls within a description specified by the appropriate minister in regulations (Clause 2(8)).

**Care Plan**
- (Clause 26) Within five days the clinical supervisor has to prepare a care plan which must be included in the patient’s records
- In preparing care plan clinical supervisor must consult nominated person and carer
- Must include a description of medical treatment provided and any other information prescribed in regulations

**Appeals**
- Clause 28 Application may be made for discharge of liability to assessment by the patient or by the nominated person
- Tribunal must as soon as practicable inform the clinical supervisor who must forward a copy of the care plan to the tribunal

**MHT powers in applications for discharge of assessment**
- Clause 29 Regulations will determine when hearings must take place
- If MHT determines that not all relevant conditions met must discharge
- If MHT satisfied that all conditions met but that further assessment needed must authorise assessment during assessment period – if all conditions met but no further assessment needed must make a treatment order
Duties of clinical supervisor

- Clause 21 To keep under review question of whether assessment needed as in-patient or out-patient.
- Clause 30 once clinical supervisor determines that all conditions are met and no longer necessary to assess further what medical treatment should be provided, managers must secure that makes an application to the MHT for a care and treatment order.

Care Plan

- Clause 31 Clinical supervisor must review care plan and ensure that includes a description of medical treatment to be provided and include prescribed information on a prescribed form.
- Application for care and treatment order must describe mental disorder, and state reasons for determinations.

Consultation

- Before making an application the clinical supervisor must, if practicable, consult the patient's nominated person and any carer.

Mental Health Tribunal

- Clause 37 If MHT determines that not all conditions are met in the patient's case must discharge or refuse application.
- If determines that all the relevant conditions are met, must make an order or renew.
- Clause 38 Order must state that the care plan included in the order is approved and whether treatment as resident or non-resident patient, and whether clinical supervisor has power to discharge resident patient.

Mental Health Tribunal: Community Treatment

- Clause 38 (7) Order must specify the requirements imposed to secure that the treatment may be provided to the patient or protect his health or safety or the safety of others against the risk by reference to which the tribunal determined the third of the relevant conditions is met in his case.

Mental Health Tribunal Requirements Clause 38(8)

- May include residence at specified place
- Attendance at specified place at specified times
- Makes self available for treatment during specified periods and
- a requirement that the patient does not engage in specified conduct.
Non-Compliance Clause 39

- Making of non-resident treatment order is sufficient authority for the clinical supervisor to require patient to comply with the requirements specified in the order until the non-residency period ends
- If patient fails to comply with requirements or there is a material change in circumstances to determine whether treatment should be provided as a resident.

Application to tribunal for discharge

- Clauses 42-43 If order for medical treatment in force or will be in force for three months or more patient or nominated person may apply to MHT for discharge
- If satisfied that all conditions are met must make order refusing application. Otherwise make an order discharging the patient.
- Clinical supervisor must discharge if not satisfied that all conditions are met (Clause 44) or must apply for discharge (Clause 45)

Expert Panel

- Clause 48 Tribunal must appoint medical adviser member of expert panel who is a registered medical practitioner, and may appoint others to assist.
- Medical adviser must visit and interview and examine patient in private and prepare a report for the tribunal on the merits of the application.

Part 3 patients concerned in criminal proceedings

- Remand on bail or to hospital for mental health reports 57-61.
- Remand and committal for treatment 62-66
- Mental health orders 77-83 and Restriction orders 84-88
- Hospital and limitation directions 89 -91
- Transfer directions 92 et seq.

Part 4 Consent to treatment (Clauses 112-120)

- Special safeguards for psychosurgery and other treatments to be specified by the appropriate minister (section 112 treatments) can be given with consent of capable patient and a second opinion as now, but also will be able to be given to an incapable patient who is unlikely to resist the treatment subject to a second opinion and the approval of the High Court as being in the patient's best interests (Clauses 114-115)

Compulsory medical treatment

- Patients who may be compelled include (Clause 117)
- Resident patients and resident patients on leave
- Non-resident patients who are subject to a requirement to attend hospital and who have complied with that requirement or have been taken and conveyed there
When will consent for ECT or medicine not be required

- Clause 118 ECT and such other descriptions of medical treatment as may be specified in regulations (currently medicine for mental disorder)
- Must be expressly authorised by the mental health tribunal or authorised under the emergency provision (Clause 119)

Patients liable to assessment

- Clause 120 Where clinical supervisor considers that patient should be given ECT or medicines for mental disorder, and a care plan is in force may apply to MHT for order authorising its provision
- Must consult nominated person and carer before making application subject to ascertaining patient’s wishes about consulting carer.
- Tribunal then appoints medical adviser who visits and interviews and examines patient and prepares report for the tribunal.

When will consent for other treatments not be required

- When the patient is liable to assessment and which is described in a care plan in force under cl 26(3)
- Where it is part of the care plan approved by the tribunal, by a criminal court, or by a ministerial transfer direction

Part 5 Informal treatment: Bournewood Patients

- Informal treatment will not be available if conditions in clause 121 met
- Conditions are patient not capable of consenting and he either would resist the treatment if given or is at substantial risk of suicide or causing serious harm to other persons

Informal treatment

- Clause 123(2) trust must assess if requested to do so by any person whether the conditions are met. If the conditions appear to be met, the trust must appoint a clinical supervisor. A patient for whom a clinical supervisor has been appointed is a qualifying patient - qualifying, that is for safeguards

The six conditions Clause 125

- (1) Aged 16 or over
- (2) Suffering from mental disorder
- (3) MD of a nature or degree to warrant provision of medical treatment
- (4) Necessary for the patient to be a resident patient at a hospital for the purpose of providing the treatment
- (5) Patient not capable of consenting to treatment and it is likely to continue to be the case for at least 28 days thereafter
- (6) Treatment can lawfully be provided to the patient without the patient being subject to a care and treatment order

If six conditions met
• Trust notifies local social services authority which must then notify patient of help available from mental health advocates
• Social services must appoint nominated person who must be consulted before medical treatment is commenced and is kept informed while medical treatment continues

**Care plan**
• Must be prepared within 28 days of clinical supervisor being appointed
• Must be forwarded to a medical adviser member of the Expert Panel who visits patient and approves plan or not.
• If not clinical supervisor must apply to MHT for authorisation No ECT or medicines before approval of the care plan for a qualifying patient unless in emergencies (clause 131)
• Must be a review date
• Nominated person may request one review in any twelve months
• Refusals of requests for review must be referred to medical member of the expert panel
• If medical adviser considers review should be carried out clinical supervisor either carries it out or applies to the MHT, which may order him or her to do it.

**Application to MHT for discharge**
• Nominated person or patient may apply once within any 12 months for discharge
• MHT must order discharge if satisfied that patient is unlawfully detained
• Otherwise must refuse the application.

**Nominated persons**
• Clause 148 Patients over 18 - presumption in favour of patient’s choice
• Must appoint patient’s choice unless appointer is unable to ascertain who patient wants or person unwilling to act or person disqualified because themselves incapable by reason of illness or mental disorder, or unsuitable to perform functions, or of a description to be specified in ministerial regulations.

**Nominated persons patients over 18**
• Clause 148 Where the exceptions apply and the patient’s choice is not acceptable, there is a list beginning with the carer followed by husband wife or partner, parent or step parent, adult child or stepchild.

**Nominated persons patients aged 16 and 17**
• Clause 149 Where the exceptions apply and the patient’s choice is not acceptable, there is a list beginning with the carer followed by husband wife or partner, person who has parental responsibility and with whom patient normally resides, any other person with parental responsibility.

**Nominated persons patients under 16**
• Clause 150 Authority may only select a person who has parental responsibility for the patient, is willing to act as the nominated person, and is not disqualified

Functions of nominated persons
• Clause 157 To communicate to person consulting them what appear to be the patient's wishes and feelings about the treatment

Mental Health Advocates (Clause 159)
• Appropriate Minister must to the extent he considers necessary to meet all reasonable requirements for help to be available from mental health advocates to qualifying patients (assessment, care and treatment orders, and informal patients) and their nominated persons.

Mental Health Advocates Clause 159
• Help includes obtaining information about medical treatment being provided, why it is being provided, under what authority, what requirements of the Act apply and what are the patient’s rights.
• Help also includes help by way of representation in exercising those rights.
• Advocates entitled to meet patient in private and access to medical records.

Information Sharing
• RIA Clause 6.1 Consultation Document sets out a proposal that bill include a general duty to co-operate in the supply of information in relation to risk management and risk assessment. There is also a proposal to place a duty on professionals as part of the care planning process, to consider thoroughly whether need to share information.
• RIA Clause 6.2 Further requirement for agencies carrying out functions under the Bill to develop and introduce information-sharing protocols. Lead agencies to be NHS Trusts, the police, probation, local government. Health guidance to be issued in the autumn dealing with health participation in Multi-Agency Public Protection Panels.

Information for victims
• Uncertainty about information which can be given to victims. Propose to extend right to 'basic information about management of the offender under the Criminal Justice and Court Services Act 2000 - to be extended to victims of mentally disordered offenders.
• Will not involve any breach of confidentiality. Basic management issues such as fact that offender no longer detained
• The full draft Bill and consultation documents can be accessed at www.doh.gov.uk

2.2 Question/answer session

Q1 What will happen if a hospital refuses to register a patient?
One of the Conditions of making a care treatment order and assessment is that the treatment is available, i.e. that there is going to be a bed available. It will be necessary for Social Workers, carers and hospital administrators to liaise in order to implement this. If more people fall under the scope of the proposed legislation, then this will increase pressures and may result in a situation where availability is restricted to those who present a risk to themselves and/or others, excluding patients with less severe symptoms from services.

Q2 Who will be accountable for the decisions/reasons for detaining (or not) a patient, and who will have access to the written determinations?

A Patients and nominated persons will be entitled to be given these determinations as soon as possible. There will be a strong element of professional accountability, as doctors will provide written reasons for their decisions. This will make the process more open to judicial review.

3. Plenary – Perspectives on the Draft Bill

3.1 The view of the Mental Health Alliance (Bill Walden Jones, Director, Hafal)

The Mental Health Alliance is a UK-wide consortium of over 50 service users, health professionals, service providers, trade unions and voluntary organisations set up in January 2000 to provide a focus for campaigning on the Government's plans to reform the MHA 1983.

The Alliance has not yet formulated a detailed view on the Government's proposals, but confirmed that it has already put forward a summary position - the more detailed response would be available shortly on the MIND website. It commended the Government for its commitment to reviewing existing MH legislation, but expressed concern that despite representations made by the Alliance and other groups during consultation on the White Paper, the draft Bill showed little change.

Key concerns:
- the draft Bill is likely, in practice, to increase rather than decrease the number of people subject to compulsory treatment either in hospital or community, and would deter people from seeking help from services;
- there is no reciprocal right to services;
- the Bill had become contorted to encompass criminal justice issues, particularly in relation for proposals for detention of sufferers of personality disorders;
- it would increase the stigma associated with mental illness;
- the broader definition of mental disorder;
- the fact that much of the detail of the Bill is unclear - i.e. to be laid down by regulations;
- The Alliance recognises the need for compulsory powers, but advocates strict criteria to ensure these are only used as a last resort where someone is a risk to him/herself and/or others;
- Care and treatment should be the least restrictive and invasive available;
Feedback - Llandrindod Wells, 13 August 2002

- The absence of rights to draw up advance directives/statements which may ease the problem of exercising compulsion.

Positive Aspects:
- Proposals on advocacy services - and if these are extended to voluntary patients this should reduce the need for use of compulsion;
- Compulsion beyond 28 days has to be authorised by new Tribunal;
- Provisions for patients to nominate persons to represent them.

The Alliance urged individuals/organisations to present their views to both the Department of Health and the Assembly, who it feels should have a more central role in shaping legislation which will impact on Welsh policies and MH strategies. The Bill would not sit with the 'empowerment' ethos of the Welsh MH strategies, and would undo much of the progress made since their publication.

[The Chairman clarified that the Assembly had been consulted by Department of Health during the drafting stage of the Bill, but with a view to ensuring that Welsh dimensions were accurately reflected. He also reiterated that the Assembly would see all Welsh consultation responses].

3.2 A service user view - Clive Westwood, user of mental health services and Wales Director of the Manic Depression Fellowship.

Reflecting his own views as well as those members of the Fellowship with whom he has discussed the Bill to date, he stated that they see the Bill as a missed opportunity to improve services. He was concerned that the consultation document only seemed concerned with peripheral issues.

Key Points:
- Proposed legislature focuses on compulsion, coercion and control and is a Criminal Justice Bill dressed as a Health Bill.
- Bill is unworkable and would encourage the stigmatising of Mental Health issues. The service users themselves are fearful and concerned about the new proposals which CW believes would drive people away from seeking help.
- Bill isn't a rights or needs issue but a Bill driven by the Home Office from highly publicised killings. The treatment is based on risk assessment rather than health. The rates of homicides committed by Mentally ill patients are relatively low and are declining. However this Home Office drive is focused on high profile cases such as Michael Stone and Christopher Clunis
- Newspapers and their headlines highlight emotive issues such as ‘the public need protection not Michael Stone’. However, on the other side the Independent on Sunday described the bill as a shameful piece of legislation.
- Bill is incompatible with the principles and ethos of the Welsh MH strategies and rather than being concerned with mental health is more interested in the small section of individuals who are a risk to society.
- According to a survey, 50% of users said that compulsory treatment in the community would reduce the trust between users and the professionals and discourage the users from seeking help. It would also means that choice and negotiation is taken away from the patient.
Feedback - Llandrindod Wells, 13 August 2002

- There is no reference to the right to assessment and treatment.
- Draft discussed the patient's feelings and wishes but not their views. The language/terminology trivialises the patient's views.
- Bill is contrary to the Human Rights Act (HRA) Art 5.

Positive aspects of the Bill:
- The Nominated Person (NP) provisions, but dismay that there were no references to advance directives/statement.
- New Mental Health Tribunals (MHT) but have doubts about the composition with the use of health care professionals.
- He welcomes the suggestions regarding Advocates, but has doubts with regards to their training, recruitment and the costs involved in setting this up.

Suggestions
- Withdrawal of the draft Bill
- Re-visit the Expert Committee's Richards report stating that there are 10 principles that this new legislature needs to follow including the need for: non-discriminatory; consensual care; least restricted alternative; look at patient and respect their autonomy.
- As risk is paramount, this is a regressive and unworkable legislature.
- Responding to the shortfall in services should be central to the new legislature.

3.3 A carer view – Carol Loud

Carol began by expressing her concern that, under the present system, it is often the label of the disorder that gets treatment and not the problem itself. The symptoms of a person's disorder may be given more attention than the causes. She voiced twelve specific concerns:

- There are no indicators as to how the Bill will link in with other recent Strategies Carers Strategy 1995, Children's Act 1989, NSF for Mental Health 2002) which promote user empowerment and reducing stigma.
- There is no mention of the financial ramifications involved, i.e. facilities, staff recruitment etc. There is a reference to manpower, but no outlines on the resources which will be necessary, or where these resources will come from.
- Developing Care in the Community, including assertive outreach, would be a more beneficial use of investment, and would alleviate the need for such a draconian Bill.
- The legal system is overloaded.
- The Bill is very general, and fails to clarify whose views would be taken into account in the Mental Health Tribunals. Losing the views of the Approved Social Workers would change the balance presented.
- The Bill fails to make recommendations as to how care/treatment is explained.
- Prevention/early intervention is not considered, to aid severity and length of the illness.
- The Bill ignores the legislation of treatment and basic human resource issues.
Feedback - Llandrindod Wells, 13 August 2002

- There is no acknowledgement of the closure of care homes.
- Unmet needs in the Care Plan (recorded/rectified).
- The Bill does not consider whether the Local Health Boards have the skills/resources necessary to implement its legislation.
- Treatability - The Bill takes away the obligation for treatment to be aimed at providing therapeutic benefit to the patient

3.4 A service provider view - Prof. Richard Williams, Royal College of Psychiatry Wales

The Royal College's reaction is one of disappointment - its view is that the draft is a missed opportunity. After 10 years campaigning for a change to MH legislation, based on the principle of reciprocity, the draft Bill was not what it had hoped for. The College had also seen the proposed legislation for Scotland, which was quite different, and questioned whether it was equitable and sensible to have such divergence.

Services had come a long way towards changing attitudes/emphasis between users and professionals and the proposed changes would have an adverse impact, as would the language used in the Bill (e.g. examiners rather than RMOs).

Positive Aspects
- Single pathway for compulsion - simplifies;
- Proposals on nominated persons;
- Advocacy services vital and welcome

Key Concerns
- Ethical issues: wide definition of mental disorder; no exclusion or severity test; greater accountability welcome in principle, but the obligation to explain why action has not been taken may prove to have a negative effect. In practice it may be easier for AMHP to justify why they should take action. The intention to give AMHP the power to prevent discharge causes much concern. The Government intends to broaden the use of mental health services towards public order issues.
- Primary or Secondary Legislation: much of the important detail not included in the draft - to be clarified in Code of Practice and secondary legislation which will not be subject to consultation. Scope for a separate Code in Wales noted and positive, but if there is scope regulations diverge not a good basis for legislative reform.
- Criteria for detention - proposed Bill does not give any exclusion criteria
- Severity - there is no severity test mentioned in the Bill so how will they be able to judge proportionate care?
- Who can apply - there is no discretion as to who can apply for an assessment.
- Role of the Nearest Relative - the nearest relative will lose their right to intervene. A patient could go through treatment without meeting their doctor.
- Who’s in charge of personality treatment
- Who can discharge
- Staffing - context of a vacancy rate in psychiatric services of 25% at the moment, many more needed to service tribunals. The demands of the
system will not be deliverable in the short term at least. Retention will prove an issue because of the increased workloads.

- Availability of beds
- Quality of environment of psychiatric inpatient units is already a concern of MHAC, and is likely to suffer due to pressures.
- under new Bill, compulsion in the community could be without duration of time.
- At the moment, children and young people are being detained in adult facilities. The RCPsych believe these numbers will increase if the new Bill is implemented.

The demands of the Bill are not practicable or deliverable, and will not address the issue of improving the quality of a patient's day.

### 3.5 Panel Question/Answer session

**Q1** Will the Act be introduced in Welsh, and will the rights of Welsh-speaking service users be respected?

**A** John Sweeney explained that the Act would be published in English, since it is primary legislation. It will then be the National Assembly’s responsibility to make sure that the Welsh language is accorded its proper status during the implementation process. Phil Fennel added that there is a requirement on the Assembly to be bilingual, in line with the Human Rights Act.

**Q2** Aftercare

**A** The reason there are no definite provisions for aftercare in the Bill is related to the controversy caused by section 117 of the 1983 Act. The House of Lords have ruled that you can’t charge for aftercare services under compulsion. This discriminates against those who enter into care voluntary and therefore need to pay for treatment.

**Q3** From a carer’s perspective, the panel were asked to clarify the changeover from nearest relative to nominated person with reference to confidentiality and consultation. There is a duty to consult the Nominated Person and the carer, but only if consent is granted by the patient. This could prove difficult, since some clients may be hostile towards their carer.

**A** Phil Fennel explained that there will be procedures to enable the refusal of the patient to be overridden (Clause 8) which will allow for some discretion.

**Q4** A member of Dyfed-Powys Police expressed concern at the intention to use police stations as a place of safety.

**A** This is not the ideal situation, but the issue is not as simple as to state that police stations are unsuitable for this function. It is a question of resources, and it is difficult to develop an alternative within health care (Accident and Emergency departments are too fraught). The police have also
proved to have good judgement of mentally disordered patients, and can provide modest security while a person is assessed. Phil Fennel stated that 24hr crisis intervention centres should be established. The proper facilities are needed in order to treat people in medical surrounding and not criminal surroundings.

Q5  If the Mental Health Tribunal does not require the Health Authority to find a bed, is there a risk of people being detained in their own homes?

A  The appropriate medical treatment should be available in each patient’s situation. However, if the appropriate facilities are not available it is a possibility.

Q6:  Is there a method of knowing when there are beds available for treatment? What is the treatment is not available does this mean you can’t make an application for treatment? Can the Courts or MHT have the power to require that the Health Authority should find a bed.

A:  This is one of the reasons this Bill is defective. The budget is driven by the law and not the Health Authorities. There would be problems if the Health Authorities were forced to transfer blocks of need from one sector of society to another. Patients are entitled to expect treatment. There are no provisions in place that say that the courts can make the Health Authorities find a bed. The courts must be satisfied that the appropriate medical treatment is available for each patient’s situation.

4.  Workshops - The key issues for:-

4.1  Service users and carers

Facilitator: Dave Edwards

Attendees: Peter Martin, Welsh Assembly Government; Kelvin Mills, PHMA; Anne James, Gwent Healthcare NHS; Lyndon Lloyd, Ceredigion CHC; Bill Walden-Jones, Hafal; Chris Rudd, PHMA; Jill Dibling, Mid Powys Mind; Lynette Morgan, WWAMH; Barbara Parnell, MDF Wales; Jules Dakin, Abercynon Drug and Alcohol; Andrea Mathews, Association of Welsh CHCs; Sue Evans, Pembs CHC; Julie Cannon, Hafal; John Gillibrand, National Autistic Society; Huw Jones, New Horizons; Steve James, South Wales Police; Sylvia Grau (?); Clive Westwood, MDF Wales; Harold Cookson, Brecon and District Continual Assessment.

The group generally believed that the Bill would lead to an over emphasis on compulsion and lead to fewer people seeking help voluntarily. One person suggested that we might end up with a situation whereby the statutory services equated only to compulsion, with the voluntary services dealing solely with voluntary service users. Main issues/concerns coming out of workshop: -

- Enacting this Bill will discourage people with mental health problems from voluntarily seeking help from statutory services.
• Mental health service users are fearful of being forced into compulsion, as opposed to having choices and being treated on a voluntary basis.
• Resources may be more disproportionately focused towards compulsory treatment, to the detriment of voluntary treatment and services.
• Risk of becoming more hospitalised society rather than more community focused.
• Nothing in the Bill relating to aftercare.
• General perception that the Bill is inconsistent with the adult mental health strategies and NSF for Wales, and is a reverse of the community care policy.
• Legislation for people with dangerous and severe personality disorders should be within the criminal justice system or other legislative framework.
• Police and other agencies may be tempted to use this legislation, and apply it to people with a borderline personality disorder.
• Need to focus on prevention rather than compulsion.

4.2 Regulators and advocates

Facilitator: Phil Fennel, Cardiff Law School

Attendees: Eric J Anscombe, MHRT and CHC; Gruffydd ap Gwent, Dyfed Powys Magistrate Court; Julia Barrell, SW MH Advocacy; Anna Bevan-Jones, Welsh Assembly Official; Huw Bevan-Jones, MHRT; David Coyle, UWCM; Mick Fisher, Health Professions for Wales; Steve Harmes, CPS; Glyn Hughes, Solicitors; Elizabeth Hughes, MHRT; Mervyn Powell, Alzheimer’s representative; Penny Rothwell, MHRT; Daisy Seabourne, WCVA; Cathryn Thomas, All Wales Social Services Unit; and 2 others.

The group identified two positive aspects to the Bill, these being advocacy and the new Mental Health Tribunals (MHT). However, the discussion revealed that they were both fraught with problems. There was also a feeling that their views would not be listened to and that it was a pointless exercise when the drafters seem more interested in the criminal justice position rather than the medical. They hoped that Wales would have some influence on the Bill and modify it to come in line with welsh policy. They also wished to have clarification of the Assembly’s stance on the Bill.

General Issues:

• There should be a formal Independent Inspectorate body such as the Commission for Health Improvement that regularly monitors and inspects the system. This body would bring new ideas and protect mental health patients.
• The money would be better spent in the community rather than on implementing this Bill, thus preventing or reducing the need for a MHT.
• The Bill would not work without the patient’s interest being paramount.
• The public would not understand that Bill like a lawyer would as it is too complex, and in a few years time the Bill will probably be taken in front of the European Court of Human Rights.
• Advance Directives were sadly missed. It was believed that they should be mentioned even if only to explain how they should be regarded and recognised.
• There was a place for patient councils.
• Concerns voices about the amount of secondary legislation proposed. It was believed as much primary legislation as possible should exist from the beginning in order to have a clearer picture. Phil Fennel agreed and used the need to know who would get right of audience in front of the MHT as an example.
• General feeling that the Bill was being hurried along for the Queen’s speech this led to others voicing concerns that shortcuts might be sought in order to get it passed within the deadline.
• What would happen if a decision was made to place a community order where the domestic circumstance were unsuitable? Would there be a chance that a decision could be made on domestic situation rather than on health issues.
• All the paperwork involved may not necessary be productive, and may increase the grounds for judicial review.
• Interested in learning more about the Scottish system where there was an Incapacity Act and the Mental Health Protection Act for offender patients in place before the Bill was considered.
• A representative of the Alzheimer's society stated Some of the key issues that involved Alzheimer's were associated with the Bournewood case and informed consent for people with dementia. Phil informed him that there is an important safeguard in place that enables the NP and Carer to challenge some aspects of the care plan to bring it more in line with the patients wishes.
• With so much money soon to be spent on Health Service restructuring how will this spending be incorporated into the money spent on the Bill. It was also questioned how Wales and England could possibly enact the Bill in the same way. It was explained how in England the Primary Care Trust would be responsible whilst in Wales it would be the locally elected boards.

Advocacy:

• Phil Fennel stated that clarifying what is meant by advocacy is crucial before any other issues. The Durham Report for consultation on advocacy was drawn to the group’s attention. However this was limited to a specific number of patients who could voice a clear opinion.
• Some of the NP’s roles were the same as the advocate’s. It was believed important that the two roles be distinct.
• Phil Fennel indicated the importance of clarifying the advocate’s duties of confidence and whether these duties are the same or higher than those of other health workers?
• Who would manage the advocacy service? The patient or the service
• Concerns that the advocate should have a practical role and not be another person to translate between service user and provider.
• Advocates are brought in too late. If they were present once the patient is admitted to Hospital many problems could be avoided.

Mental Health Tribunals:
• Current Tribunal members were concerned that the medical aspect of the Tribunal was taken out of the equation. Phil Fennel explained that the Richards committee raised concerns about a medical member that examines the patient and then sits on the tribunal. This was found in a Swiss case that was taken to the ECHR stating that Arts of the HRA has been compromised. Thus there may be an expert panel to take the views of the medical member on board. A lay member of the tribunal then questioned where the third member of the tribunal would then come from, with there being a struggle to find people as there is.

• Concerns that if one examiner decided that the patient shouldn’t be discharged then the other two didn’t have any choice in the matter.

• Who would be responsible for the care plan and shoulder any blame if anything went wrong due to the care plan. Phil Fennel stated that there would be many duties that would constantly be under review.

• All agreed that there would be no circumstance when it would be suitable to have a one-person tribunal. It may be suitable should there be cases that were purely legal however, in these matters it was highly unlikely that there would ever be cases that were purely legal with no health matters involved.

4.3 General adult mental health services

**Facilitator:** Peter Fox, CMHSD

**Attendees:** Carolyn Sansom, North Glamorgan NHS Trust; Chris Meadow, Gwent Healthcare NHS; Delyth Alldrick, Cardiff and Vale NHS Trust; Gill Joomaaty, St David’s Hospital; Alan Thomas, Neath Port Talbot Social Services; Richard Lewis, Mid Powys Mind; Phil Lewis, Pontypridd and Rhondda NHS; Mike Hughes; Pat Vogt, Welsh Assembly Government; Jenny Sanger, Monmouthshire LHG; Michelle Forkings, Hazel Centre; Sally Simmonds, Powys Healthcare Trust; David Roberts, Neath Port Talbot LHG; Gill Evans, Powys Social Services; Julie Scullard, Ceredigion Social Services; Mark Evans, Carmarthenshire CC; Vernon King, Bridgend CHC; Barbara Bowness, Bro Morgannwg NHS Trust; Margaret Cresci, Pontypridd and Rhondda NHS; Sandra Cook; Martin Morris, Llanelli CHC; John Barry, Powys NHS Trust; John Lewis, Whitchurch Hospital; Jenny Willmott, Merthyr LHG; Samia Saeed, Rhondda Cynon Taff LHG; Sue Richards, Pembs and Derwen NHS; Jan Nickless, Powys NHS Trust; David Jenkins, Bro Cerwyn CMHT; Jennifer Hood, Powys MH Alliance.

**Main points of discussion:**

**Positive features of the Bill**

The concept of the Nominated Person was thought to be positive, however it would lead to a loss of rights which is not compensated for anywhere else in the Bill. The Nominated Person will not have the right to object, unlike under the 1983 Act.

• Movement towards less use of ECT, by increasing the safeguards for treatment and ways to object to treatment

• Single point of entry
Feedback - Llandrindod Wells, 13 August 2002

• Obligatory Care Plan in 5 days
• Advocacy – but this will need a structure/strategy of its own, and should be extended to include those who are not detained
• Mental Health Commission to replace the Mental Health Act Commission – as a Commission to oversee the Mental Health Act
• Clinical Supervisor – although there is a danger of losing psychologists
• Tribunal proposals

Main concerns

Risk of losing current good practice

• Some sections which work well under the 1983 Act (Section 117 and the provisions for aftercare, for example) will be lost in the new Bill
• Loss of the Approved Social Worker
• Appeals panel – flexibility of section

Confusion between Criminal Justice System and Healthcare system

• The inappropriate title, ‘Mental Health Act’, suggests a sort of social control. The group felt that the legislation would benefit from taking out all reference to offenders and concentrating on the care aspect. It would be more appropriate to develop a separate Bill to address the perceived risk to public order, moving towards reciprocal rights. There should also be a separate Bill to cover assessment.
• Conflict - Is it a Criminal Justice Bill or a Mental Health Bill?

Capacity

• There will be an increased demand on beds and facilities in the community, which will require careful case management.
• Duty to share information – may lead to conflicts around data protection, and could impact on the relationship between the service user and the professional. It also raises questions concerning the sharing of information between health professionals and social workers.
• Administration of changes
• Logistical problem of catering for patients with different mental disorders.
• There will be a requirement to provide some form of treatment for patients who do not comply with a community order (hospital as punishment). The continuous monitoring system will lead to ‘revolving doors’ in the care system.
• The extended definition of mental disorders will lead to an increased number of detained patients. This will cause problems, since there is a lack of low secure services in Wales.

Staffing issues

• Terminology problem - approved mental health professional and other titles. Would the same person have to fulfil many different roles? Raises recruitment and retention issues.
• The way in which the Bill would make individuals accountable for decisions on a patients treatment was deemed unfair.
Feedback - Llandrindod Wells, 13 August 2002

- The discharge of statutory responsibilities raises the issue of skills and expertise. Forcing a change of law on certain groups is philosophically incompatible, and could lead to a loss of skill.
- The timescale for implementing the Bill, if approved, may cause difficulties considering the current lack of psychiatrists (25% vacancies in Wales)

General

- How will the Bill fit in with the Adult Mental Health Strategy and the National Service Framework? The development of these documents has not been well co-ordinated, and the services are not available to implement the suggested changes. The fact that the English NSF is different to the NSF for Welsh services creates cross-border problems. The group also highlighted the fact that England are more advanced in developing their care services. Therefore, England and Wales will be starting the implementation process from different levels, with different resources.

Key Issues for Feedback to the Assembly:

- **Capacity** - how will mental health services cope organisationally, and in training and retaining staff? We need to develop better services for people with mental health problems and ways of managing people with different mental disorders who may or may not have committed a crime
- **Loss of current good practice** - including how will the Bill link in with the Mental Health Strategy and NSF

4.4 High risk groups & mentally disordered offenders

Facilitator: Martin Harper (Caswell Clinic)

Attendees: D Williams, Pembs & Derwen NHS Trust; Sue Hicklin, HMP Parc; Marc Chandler, Llanarth Court Hospital; Trevor Lee, Merthyr Tydfil CMHT; Claire Fife, Gwent NHS Trust; Jane Williams, Cardiff LHG; P Loud; Jane Tilston, Clywd CHC; M Collins; John May, Prison Service; Penny Vaughan, Powys Social Services; Elizabeth Bowring Lossock, Partnerships in Care; Cheryl Hobbs, Newport County Council; Iain Sewell; Andy Walters, South Wales Police; Helen Nethercott, SHSCW; Sue Power, Vale of Glamorgan MH; Frances Rutter, Dyfed Powys Probation; Bob Cotter; Ray Wonnacott, WAG.

The group held a wide-ranging discussion regarding some of the technicalities of the draft Bill, along with the practical implications of the range of proposals with respect to mentally disordered offenders in comparison with current arrangements. It was agreed that the proposals gave effect to no major practical change but that rationalisation for s35, 36 and 37 of the 1983 Act made good sense. There was considerable discussion/clarification on issues surrounding diagnosis and treatment (including availability of specialist facilities) of DSPD persons including suggestion that there should be separate legislation to cover the Government's '3rd way'. Specific Points for feedback were:
• Community treatment in Prisons. There was a huge unmet need for treatment, and while the concept behind the proposals was viewed positively, the group had concerns about the practicalities of compulsory treatment outside of a clinical setting despite in-reach services.
• DSPD - acknowledged that this issue had been subject to separate consultation, and that the draft Bill facilitates those proposals. The group sought to clarify with Phil Fennel that practitioners would not be compelled to detain offenders if they met the criteria, and this was confirmed under the 'availability of treatment' criterion.
• inclusion of AMHPs in the sentencing procedure was seen as potentially a good development depending on the practicalities and guidance that would need to be in the Code of Practice.
• Support for the inclusion of victims of mentally disordered offenders in the information provision proposals, to bring this into line with arrangements in the criminal justice system - general information at key times in the process.
• No real concerns raised regarding the duty to share confidential information on the basis of risk - the group felt that this would help practitioners.

4.5 Services in other divisions of psychiatry

The workshop on “Services in the other divisions of psychiatry” was a small group attended by people either with an interest in CAMHS or in elderly psychiatry. Overall, the group was very opposed to the consultation version of the Bill. The following key issues were raised during discussion:
• Concern about the likely increase in compulsion especially in CAMHS where very few patients are currently subject to compulsion, and the associated impact on relationships with patients.
• Grave concerns about practicality - diversion of resources to expert panel etc will take away from direct care - at a time when there are currently shortages in profession
• General consensus that the draft Bill appears to run counter to the thrust of Welsh MH strategies which emphasise respecting patients etc., whereas this consultation is criminal justice/public protection led.
• Feeling that consultation runs contrary to Welsh strategies with respect to 16-18 year olds. Welsh strategies are moving towards 16-18 being in CAMHS whereas section 3.8 of the consultation document treats them as adults
• Call for much more explicitness in guidance re sharing of information

5. Final Q & A Session

In response to a request to include a greater proportion of service users at the following week's conferences, the Chairman repeated that the Assembly and CMHSD had endeavoured to ensure attendance from across the whole spectrum of interested parties but that time and accommodation constraints had an inevitable impact. He urged delegates to feed back the content to those who could not be invited, through established networks.
6. **Summary and conclusion (John Sweeney)**

The Chairman thanked everybody for their input throughout the course of the day. He said that the notes of the event would be circulated to attendees in bullet point format. He apologised for the non-availability of translation services, and confirmed that these would be present at the Llandudno and Cardiff events the following week.

In response to an earlier question from the floor, the Chairman stated that the Welsh Assembly Government had not yet taken any firm view on how it would respond formally to the consultation. He reiterated that the content of the event would be fed back to the Minister to help to inform. Welsh written responses would also help to inform the Assembly response and he again urged delegates to ensure that they put these forward to Department of Health. He reiterated the need to put forward constructive criticism to Government regarding its proposals.
ANNEX

LIST OF DELEGATES

1. Alldrick Delyth Cardiff and Vale NHS
3. Anscome E J MHRT and CHC
4. Barrell Julia South Wales MH Advocacy
5. Barry John Powys NHS Trust
6. Bevan Jones Anna Welsh Assembly Government
7. Bevan Sue Glanrhyd Hospital
8. Bevan Jones Huw MHRT
9. Bowness Barbara Bro Morgannwg NHS Trust
10. Bowring Lossock Elizabeth Partnerships in Care
11. Brace Phillip Powys NHS Trust
12. Campbell Robert Caswell Clinic
13. Canon Julie NSF
15. Chandler Marc Llanarth Court Hospital
16. Cookson Harold Brecon and District Continual Assessment
17. Cresci Margaret Pontypridd and Rhondda NHS
18. Coyle David UWCM
19. Cowie Celia Powys Agency for MH
20. Dakin Jules Abercynon Drug and Alcohol
21. Davies Gaynor Ceredigion CC
22. Devakumar M N W Wales NHS Trust
23. Dibling Jill Mid Powys Mind
24. Edwards David CMHSD
25. Edwards John Gwilym Healthy Friendships
26. Evans Sue Pembs CHC
27. Evans Gillian Powys Social Services
28. Evans Ivor Pembs LHG
29. Evans Melanie Blaenau Gwent LHG
30. Evans Mark Carmarthenshire CC
31. Fife Claire Gwent NHS Trust
32. Fisher Mick Health Profession for Wales
33. Fox Peter CMHSD
34. Fennell Phil Cardiff Law School
35. Forkings Michelle Hazel Centre
36. Gillibrand John National Autistic Society
37. Gilby Sue Community Legal Services
38. Gregory Ross Caerphilly LHG
39. Harmes S CPS
40. Harris Jane CAMHS
41. Harper Martin Caswell Clinic
42. Harris Lynne Dyfed Powys HA
43. Hession M A MHRT Wales
44. Hicklin Sue HMP Parc
45. Hunter Chris Caswell Clinic
46. Hobbs Cheryl Newport CC
Feedback - Llandrindod Wells, 13 August 2002

47. Hood Jennifer  
   Powys MH Alliance

48. Hughes Elizabeth  
   MHRT Wales

49. Hughes Glyn  
   Solicitors

50. James Anne  
   Gwent Healthcare NHS

51. James Steve  
   South Wales Police

52. Jenkins David  
   Bro Cerwyn CMHT

53. Joomratty Gill  
   St David's Hospital

54. Jones Heulwen  
   CMHSD

55. Jones Huw  
   New Horizons

56. Jones Steve  
   Service User

57. Kaye Helen  
   Powys NHS Trust

58. King Vernon  
   Bridgend CBC

59. Lee Jeff  
   Swansea NHS Trust

60. Lee Trevor  
   Merthyr Tydfil CMHT

61. Lewis Richard  
   Mid Powys Mind

62. Lewis John  
   Whitchurch Hospital

63. Peter Lawler  
   Welsh Assembly Government

64. Lewis Phil  
   Pontypridd and Rhondda NHS

65. Lodge Harriett  
   Voluntary Network MH Org

66. Loud Carol  
   Carer Representative

67. Loud Peter  
   Ceredigion CHC

68. Lloyd Lyndon  
   Association of Welsh CHCs

69. Matthews Andrea  
   Prison Service

70. May John  
   Welsh Assembly Government

71. Martin Peter  
   Gwent Healthcare NHS

72. Meadows Chris  
   PHMA

73. Mills Kevin  
   Llanelli CHC

74. Morris Martin  
   WWAMH

75. Morgan Lynette  
   Mind Cymru

76. Morton Cathie  
   SHSCW

77. Nessman S  
   Powys and Derwen NHS

78. Nethercott Helen  
   MDF Wales

79. Nickless Jan  
   Bryntirion Resource Centre

80. Owen Geraint  
   Gogledd Gwynedd CHC

81. Owen Glanville  
   Carmarthenshire NHS Trust

82. Owen Gwyneth  
   MDF Wales

83. Parnell Barbara  
   Cardiff and Vale NHS

84. Pates Richard  
   Merthyr Crossroads

85. Parfitt Yvonne  
   Brecon and District Continual Assessment

86. Peate N  
   Powys Healthcare NHS

87. Pollock Leslie R  
   Vale of Glamorgan MH

88. Power Sue  
   Powys Agency for MH

89. Richards Mag  
   Pembs and Derwen NHS

90. Richards Sue  
   MDF Wales

91. Rothwell Penny  
   Brecon and District Contact

92. Roberts David  
   Welsh Assembly Government

93. Rowe Miriam  
   CMHSD

94. Robson Elinor  
   Dyfed Powys Probation

95. Rudd Leslie  
   PMHA

96. Saeed Samia  
   Rhondda Cynon Taff LHG
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