MHB017 – Mind Cymru

Senedd Cymru | Welsh Parliament

Bil arfaethedig – Datblygu'r Bil Safonau Gofal Iechyd Meddwl (Cymru) | Proposed Development of the Mental Health Standards of Care (Wales) Bill

Ymateb gan: Simon Jones, Pennaeth Polisi ac Ymgyrchoedd, Mind Cymru | Evidence from: Simon Jones, Head of Policy & Campaigns, Mind Cymru

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Enshrining overarching principles in legislation

Question 1: Do you think there is a need for this legislation?

Can you provide reasons for your answer.

We agreed with the focus of the principles when they were initially presented in the review of the Mental Health Act and welcome the inclusion in this proposed legislation. Placing these in legislation provides people with the maximum protection under the law.

Being subject to the Act can be a traumatic and challenging experience. It's important to enshrine the principles in legislation to give them the most force possible. In a context where involuntary admission and treatment are authorised by the law, the rights and voice of the patient need to be maximised. Having the principles in law will enable the patient and/or their representative to challenge more effectively poor treatment (in its widest sense).

Embedding the principles in services more widely will benefit people beyond those who are detained including people who are at risk of being sectioned.

Once included in the legislation the principles should be:

- embedded in relevant guidance, practice directions, training and resources provided to tribunal members, including anti-racism training
- taught in curricula for all professionals with duties under the current or future Mental Health Act(s)
- explained in information provided to patients and families
- incorporated into estates guidance, specifically the review of physical requirements of wards recommended by the independent Review
- incorporated into commissioning guidance and service specifications.

Question 2: Do you agree or disagree with the overarching principles that the Bill seeks to enshrine?

The proposed legislation needs to be clear that the principles apply to everyone who is subject to the Act, inside or outside hospital, and they should inform mental health practice beyond the use of the Mental Health Act.

'The person as an individual' should highlight the need to challenge stereotypes of how people with mental health problems are seen, and the fact of being detained influencing how the person is seen. A focus on the individual must not negate the reality of structural inequalities, particularly racism, which affects people as individuals – the person as an individual is the person in their community. This principle needs to translate into tangible improvements for everyone whose individuality is misinterpreted, ignored or discriminated against. It should also be noted that one of the driving purposes behind the reviewing of the Mental Health Act was the disproportionate impact on racialised communities. Adding an equality principle, with reference to race equity, would also help achieve this, although we recognise the reference to the Equality Act (2010) may also provide sufficient coverage of this point.

Specific changes to existing legislation A. Nearest Relative and Nominated Person

Question 3: Do you agree or disagree with the proposal to replace the Nearest Relative (NR) provisions in the Mental Health Act 1983 with a new role of Nominated Person?

Can you provide reasons for your answer.

We welcome the introduction of the nominated person, which will enable people to choose someone who will represent their interests. The current system has no regard for choice and autonomy, which can result in inappropriate people being given what are very serious powers and duties – whether that is relatives who are estranged or abusive, who simply don't know the person very well, or who do not have an interest in supporting them.

At a time when your rights are so restricted it is important that you are able to nominate someone you trust to carry out this role.

B. Changing the criteria for detention, ensuring the prospect for therapeutic benefit

Question 4: Do you agree or disagree with the proposal to change in the criteria for detention to ensure that people can only be detained if they pose a risk of serious harm either to themselves or to others?

Can you provide reasons for your answer.

Mind Cymru agrees with the need to require stronger justification for detention. This must mean substantive justification with a clear, evidenced rationale for what is therapeutic, what constitutes risk, and for the level of harm it is believed would ensue if the person were not detained. If this became law there would be the need for a very clear definition of “serious harm”, as there is already provision within law in terms of the test of proportionality, which seeks to protect people from being detained if this would harm their mental health further. For example whilst detaining someone with mild depression may meet criteria in terms of mental health it would not meet the legal test of proportionality.

The overriding issue people raised with us in engagement for the independent review of the Mental Health Act was for easier and earlier access to services before crisis which would then reduce the need for detention. To make the reforms as effective as possible and to see a sustained reduction in detentions, we need to ensure Part One o of the Mental Health Measure is providing quick access to early support and to see an increase in more culturally appropriate services.

Question 5: Do you agree or disagree with the proposal to change in the criteria that there must be reasonable prospect of therapeutic benefit to the patient?

Can you provide reasons for your answer.

Therapeutic benefit should always be central to the purpose and the outcome of detention in hospital for a mental health problem. We would recommend that “reasonable prospect” is replaced with “clear and convincing evidence” as the former phrase has various definitions and could be left open to interpretation. Altering the terminology here would carry a stronger meaning in law, so enhancing a patients right to challenge a decision.

C. Remote (Virtual) assessment

Question 6: Do you agree or disagree with the proposal to introduce remote

(virtual) assessment under 'specific provisions' relating to Second Opinion Appointed Doctors (SOADs), and Independent Mental Health Advocates (IMHA)?

Can you provide reasons for your answer.

We do not agree that introducing remote assessments would enhance the fulfilment of patients rights to access both advocacy and second opinions. We believe there is little evidence that indicates the quality of the assessment or ability to build a rapport would be equal to face to face contact, with patients indicating it is a negative experience. We are concerned that making this provision will lead to greater use of virtual assessments, limit patient choice and lead to an undermining of the rights that access to a second opinion and advocacy represent.

In considering this proposal we would ask for a better explanation of the issue the use of "remote (virtual) assessments" is trying to solve. Is this to enable a patient to be able to access SOADs quicker than they currently can and if so what is the evidence that underpins this in terms of delays or waits? Is it to increase efficiency in terms of SOADs being able to see more patients due to not travelling to see them face to face? We would expect greater engagement with people with lived experience to understand their views on remote assessments to be undertaken in order to inform whether this provision is appropriate and effective.

When we have spoken to patients about their experiences of remote assessments in England there has been view that remote assessments were second best and each person had experienced different problems, such as technology not working, lack of privacy, finding it much harder to build a rapport which is essential to both the IMHA and SOAD's role. We also have the experience of the use of video hearings at the Mental Health Tribunals, which started to become more common during the pandemic for obvious reasons. Whilst these are much more administratively convenient and cheap, they have received negative feedback from patients. Despite this some remote hearings via video continue even though face to face hearings could be reinstated.

We would want to have a better definition and/or understanding of the "specific provisions" outlined in this proposal. The role of accessing a second opinion via a SOAD is there to protect the rights of the patient with regard to treatment. We would be concerned about any proposal that might reduce the ability of a patient to access this right, either intentionally or unintentionally. The SOAD in particular should be looking at the patient in the context of the ward environment, noise etc, looking at notes and asking staff questions on the spot. The circumstances in which a virtual assessment would be deemed appropriate is key to whether this impinges on the rights of a patient or further protects them. We would also ask who would determine when a remote (virtual) assessment would be appropriate and how the views of the patient would be taken into account so that their needs and method of engagement could still be paramount.

We would also wish to see further clarification of what "remote (virtual) assessment' refers to. Would this be a video call or a telephone assessment? The ability of the patient to be able to feel safe, have their views heard and understood would be paramount to any application of a remote assessment.

Recently Mind intervened in a legal case involving the use of a virtual assessment under the Mental Health Act in order to make a Community Treatment Order, which was successful. The full judgement can be viewed here:

Derbyshire Healthcare NHS Foundation Trust v Secretary of State for Health And Social Care (Rev1) [2023] EWHC 3182 (Admin) (14 December 2023) (bailii.org).

In considering this proposal it is worth reflecting on this statement within the judgement:

"… on the state of the evidence, the claimant cannot show that there is the necessary societal consensus that an examination conducted by telephone or video conferencing will always be of the same high quality as one involving the physical co-location of clinician and patient. As I have sought to explain, Parliament's intention was to demand, as a general matter, an examination of such quality."

The quality of assessments must be paramount. We fully recognise that use of remote technology has become a more regular part of all our lives since the pandemic, but believe that any developments around extending the use of remote assessments needs to be carefully considered and evidenced in terms of patient experience. The outcomes and prevalence of use must be clearly recorded and measured, including feedback from patients as to whether they felt their voices had been heard.

Due to the experience of the patients we have engaged with and the outstanding questions we have, we are not able to support the inclusion of this provision. We would be happy to provide further insight into patients experiences of virtual support if useful.

D. Amendments to the Mental Health (Wales) Measure 2010

Question 7: Do you agree or disagree with the proposal to amend the Measure to ensure that there is no age limit upon those who can request a re-assessment of their mental health?

Can you provide reasons for your answer.

In Mind Cymru's 10-year review of the Measure, we recommended that the Welsh Government "Amend regulations to extend rights under Part 3 to children and young people.", so we welcome this inclusion. The Duty to Review report highlighted how in only applying to people over the age of 18, children and young people are disadvantaged. The report recommended amending regulations to remove this age limit and further extend people's rights under Part 3.

Our review highlighted that over the five years analysed, there were 1,391 requests for an assessment under Part 3 of the Measure each year. Over the same period, an average of 236 (17%) were accepted onto the caseload following an assessment.

Our work raised concerns that the number of requests for rereferral was low compared to the number of people accessing secondary mental health services. There seemed to be a knowledge gap, with many not knowing they could rerefer themselves. Separately, we also called for updated guidance and work with Local Health Boards to ensure Part 3 rights are explained as part of discharge planning from any secondary care service. This would need to be considered as part of the extension to this duty, as well as how it would work for young people who would be at an age whereby they would no longer be eligible for CAMHS, so would be referring back into adult services, potentially for the first time.

Question 8: Do you agree or disagree with the proposal to amend the Measure to extend the ability to request a re-assessment to people specified by the patient?

Can you provide reasons for your answer.

We would support this approach, provided it made provision for a specified 'nominated person' role to ensure that someone was acting on the best interests of the patient and that their rights continued to be safeguarded

General Views

Question 9: Do you have any views about how the impact the proposals would have across different population groups?

Whilst publicly available data in relation to protected characteristics and detention under the Mental Health Act remains limited in Wales, we know that some population groups remain more likely to be subject to the Act than others. The premise of reviewing the legislation was concern for the number and experience of people from racialised communities under the Act. We would expect that this legislation provides an opportunity to address any over representation and negative experiences from unheard and under served populations. This is the reason why we believe a specific principle relating to equity would provide a greater focus on the needs of specific populations.

Question 10: Do you have any views about the impact the proposals would have on children's rights?

Extending the ability to re-refer under the Measure to children and young people resolves a historic children's rights issue in the mental health system, so we welcome the inclusion within the proposal. Being informed and able to access this right when demand on services is high will be the key test as to whether this element of the legislation will enable greater support for children and young people

Question 11: Do you have any general views on the proposal, not covered by any of the previous questions contained in the consultation?

Mind Cymru has called on the Welsh Government to review the legislative landscape for mental health in Wales in order to provide a more streamlined framework in Wales. We recognise that backbench legislation cannot bring together legislation the size of the Mental Health Act (the devolved aspects) and the Mental Health Measure, but we would again urge the Welsh Government to

explore how guidance relating to this proposed legislation and other pieces of mental health legislation can be brought together to provide a seamless overview of what is expected,

We continue to hope that in the future UK Government will bring forward the complete draft Bill around the Mental Health Act as there are many provisions that sit outside what is proposed in this legislation.

We would take this opportunity to highlight elements around Care and Treatment Planning (CTPs) outlined in the draft Mental Health Bill. Whilst we have CTPs in Wales under the Measure, what is proposed within the draft MHA is slightly different.

The draft Bill includes a requirement for detained patients to have a Care and Treatment Plan. Details would be in regulations but the white paper proposals were for the plan to be in place within 7 days of detention and for it to set out:

- the full range of treatment and support available to the patient from health and care organisations
- any care which could be delivered without compulsory treatment
- why the compulsory elements are needed
- what is the least restrictive way in which the care could be delivered
- any areas of unmet need (medical and social)
- planning for discharge
- how specifically the current and past wishes of the patient (and family carers, where appropriate) have informed the plan
- any known cultural needs

The relevant section of the Measure, which provides an outline of what should be considered in a Care and Treatment Plan in Wales is s.18:

18 Functions of the care coordinator

(1)A relevant patient's care coordinator must work with the relevant patient and the patient's mental health service providers–

(a) with a view to agreeing the outcomes which the provision of mental health services for the patient are designed to achieve, including (but not limited to) achievements in one or more of the following areas– (i)finance and money;

(ii)accommodation;

(iii)personal care and physical well-being;

(iv)education and training;

(v)work and occupation;

(vi)parenting or caring relationships;

(vii)social, cultural or spiritual;

(viii)medical and other forms of treatment including psychological interventions

The draft Bill proposes greater focus on patient choice. It sets out why compulsory treatments are needed and focuses on reducing restrictive practices – more so than is currently delivered via the Measure.

We would like to see consideration given within this legislation to including the elements of Care and Treatment Plans outlined in the White Paper into the plans currently required under the Measure.

Finally, we would like to draw attention to the use of restrictive practices within inpatient settings. Whilst the guidance relating to the use of restrictive practices is relatively comprehensive in its approach, we believe its implementation and the data capture around the use of these practices could be strengthened if the guidance was statutory. This may be possible under the “least restriction” principle outlined at the start of this consultation, but we would ask that specific consideration is given to strengthening requirements around the use of restrictive practices.