MHB028 – Welsh NHS Confederation

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: Nesta Lloyd Jones, Cyfarwyddwr Cynorthwyol, Cydffederasiwn GIG Cymru| Evidence from: Nesta Lloyd Jones, Assistant Director, Welsh NHS Confederation

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Introduction

The Welsh NHS Confederation welcomes the opportunity to respond to the consultation into the development of the Mental Health Standards of Care (Wales) Bill.

The Welsh NHS Confederation represents the seven Local Health Boards, three NHS Trusts (Velindre University NHS Trust, Welsh Ambulance Services NHS Trust, and Public Health Wales NHS Trust), and two Special Health Authorities (Digital Health and Care Wales and Health Education and Improvement Wales). The twelve organisations make up our membership. We also host NHS Wales Employers.

Enshrining overarching principles in legislation

**Question 1: Do you think there is a need for this legislation?
Can you provide reasons for your answer.**

Overall, our members support the need for updated legislation to ensure that the legislative framework that health and care professionals are working to are aligned with current practice. However, we recommend that when considering the Bills development and progression, thought should be given to the developments of the Mental Health Bill introduced by the UK Government, reforming the Mental Health Act 1983 and having implications for both England and Wales.

Currently in both Wales and England there is a need to update and review the existing legislation given the original date it was passed. Through updating the mental health legislation, it will take account of the changing and developing landscape, for example the language used in the Mental Health Act 1983 is seen as outdated, disempowering and stigmatising.

The Bill, and the principles within in it, support the United Nations Universal Declaration of Human Rights and the United Nations Convention of the Rights of the Child. In relation to children, young people and families, the Bill has the potential to strengthen the implementation of the NEST/NYTH framework in Wales and supports the Frameworks' core principles, including those of trusted adults, easy access to expertise and no wrong door.

While our members are supportive of the Bill, a potential barrier to some of the potential changes within the Bill is that Wales would no longer align with the legislative frameworks in England, at a time when updated mental health legislation is being considered. There has already been an Independent Review of the Mental Health Act and a subsequent draft Bill and we continue to wait for further information on when this Bill will be introduced.

It is important that there is alignment between England and Wales because the divergence in policy and legislation between the two nations could cause confusion and problems, especially in areas such as area placements and transfers of care. Our members have highlighted that they already experience differences between England and Wales in operational processes and this can cause confusion and complications in cross-border transfers and different codes of practice.

It is key that any changes to legislation is done to improve people's experience and ensure increased consistency of services across Wales. It is also key that through the introduction of new legislation, there is increased parity between mental and physical health services.

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

There is widespread agreement with these overarching principles amongst our members. Ensuring that the individual is at the centre of their own care is pivotal in offering a truly holistic approach and the principles sit well with the therapies principles and model of working. However, our members have provided feedback in areas where improvements could be made.

The Bills principles will further support dignity and respect, choice and influence for individuals and is a positive step in the right direction to improving mental health services. These principles should already be considered in any circumstance when it comes to detention, where detention should be a last resort when no other avenue of support is available. However, it is important to note that where someone is being deprived of their liberty when detained under

the Mental Health Act 1983, this should in no way mean that their views are not considered or listened to. As individuals every person will have a different experience and a different need, and this is something which requires some thought when considering the Bills principles.

While the Bill sets out to establish parity between the treatment of physical and mental health, it has not included social factors which often interface with physical and mental health. The Public Health Wales Social Prescribing Interfaces paper recognises the synergies and distinctions between physical and mental health services, social prescribing, and wellbeing activities and community assets. The paper identifies a series of recommendations, including to recognise and address the interface between social, physical, and mental health and wellbeing in all policies. This integration will place people's holistic needs at the heart of society's effort which may increase quality of life for both current and future generations, and in turn could improve population health.

The Determinants of Health Model demonstrates that there are many factors which contribute to poor social, physical, and mental health and wellbeing. We therefore support the inclusion of 'the person as an individual' principle. However, emphasis should be placed on this principle by ensuring person-centred language is used throughout the Bill e.g. use of the term's individuals and people instead of patient.

Placing an individual at the centre of services which takes a strength-based approach (e.g. a what matters conversation) will help to enshrine the proposed 'person as an individual' principal. Health and wellbeing concern that individuals face are often multi-faceted which require a spectrum of support and therefore recruitment and training implications need to be carefully considered as part of the Bill.

For some, social prescribing may be of benefit when used alongside medical interventions. This involves multiple organisations (statutory health and social care services focused on mental and physical health, social prescribing, and community assets) working together to ensure a coherent and seamless pathway.

Our members also suggest that clinicians or attending staff have a trauma informed response to the individual and their family. We would like to suggest that the Wales Trauma Informed Framework and the evidenced based PACE model are considered, recognising that staff supporting individuals are themselves part of the intervention, at all points of contact. Members have also

highlighted that the Bill could support nursing and therapies professionals to work together in a more joined up way to support individuals.

Our members welcome further information to understand how the delivery of plans could be improved through legislation. Whilst improving the quality of plans would be supported, our members are unsure whether the application of this through legislation is the right vehicle and whether it would lead to the desired change.

Reducing stigma is supported but again there is a question as to whether this is a realistic proposal through legislation alone. It would certainly provide a legal footing and set the tone, but we need to consider the implementation carefully; would a change in legislation lead to the culture change that is required to truly achieve this aim?

Finally, the Bill needs to include clear definitions for terms used e.g. the use of the term “therapeutic benefit” included within the Bill needs to be defined because there is currently no shared understanding across the workforce of what this means.

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 agree with the proposal for people to state a Nominated Person as it gives individuals greater autonomy to choose who can make decisions about their care during periods when they lack capacity. The Nominated Person is positive development because it supports empowering an individual to make choices in relation to those involved in their care, building a positive and supportive network around them. However, it is vital that further consideration is given around protection against exploitation and supporting clinicians to raise any potential concerns relating to risk.

For those experiencing a first episode of mental illness that warrants being admitted for treatment under the Act, or those who have not previously nominated a person, and are assessed as lacking capacity, consideration needs to be given as to when and how Nominated Persons will be identified, and/or

whether clinicians will need to, and be permitted to, revert to the prior Nearest Relatives provision.

Provisions will also need to be made for instances when individuals wish to change their Nominated Person, ensuring clarity of the process to be followed in such instances, be there for a one-off change or multiple changes. This is particularly relevant to long-term secure admissions under Section 3 of the Act.

To ensure that individuals are enabled to nominate a Nominated Person, opportunities should be provided to people who have had previous contact with mental health services to nominate a person during periods of capacity, such as during contact with primary care, community mental health or social care professionals.

It is important that the principles of the Mental Health Capacity Act are adhered to, whereby individuals are assumed to have capacity unless it is established otherwise, decisions are made in the persons best interest and in a way that is least restrictive of a person's rights and freedom of action. Consideration must also be made of any legal documentation in place for Lasting Power of Attorney.

Overall, these changes could be beneficial, but it is important that safeguards are implemented. Consideration must be given as to how easy and accessible it is to just ask a person, especially if the person is in crisis or suffering from a mental disorder, or experiencing an acute episode, as they may not be in a fit state of mind to choose wisely. In addition, further expansion is required on how the Bill will protect against exploitation. A caveat within the Bill may be important e.g. demonstration of the ability to support and ensuring that the clinicians that are involved in individual care are enabled to raise any potential risk concerns.

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.

The detention under the Mental Health Act should always be a last resort, but the criteria would need further consideration as views of what constitutes "risk of serious harm" could be highly subjective. It is vital that the criteria for "risk of serious harm" is clear, that the decision is made by a multi-disciplinary team and the risk to health, both physical and mental health, is considered.

Members agreed that proposals to clarify and strengthen the detention criteria were warranted, particularly the need to make more explicit how serious the harm must be to justify detention and/or treatment or how likely it is that the harm will occur. It is the Mental Health Act assessors who decide whether a person is to be detained and they can exercise significant discretion.

Having clear guidance around what constitutes “serios harm” will be very helpful. For example, from not eating or drinking for a long period of time, is included within this definition. It was felt by some of our members that this proposal could ‘raise the bar’ for detention and that any new standard would need to be widely understood and agreed by stakeholders.

A key part to the role out of this is ensuring that all conversations are multi-disciplinary. Risk assessments should be collaborative to include the individual (whenever appropriate) and informed by the interdisciplinary team and not done in isolation.

If the criteria is strengthened, consideration must also be given to further substantive community services to support those that previously may have been detained. This would need to alleviate a worsening of their mental health and for these people not to be left unsupported until the point of where they would then meet the criteria.

Members also believe community services need to be robust enough to support this change. There must be significant investment in community services to manage patient risks outside the inpatient setting.

Moreover, the evidence for clinical risk assessments being able to predict the immediate/imminent risk of suicide is poor. Raising the threshold to serious risk of harm may inadvertently result in fewer detentions for people at risk of suicide. A full risk assessment of the potential impacts should be considered as a priority action. Overall, these implications need to be considered carefully.

Finally, it must be recognised that detention is not always a negative as it can protect people from harm. It is important that consideration is given to the role that inpatient services play because research suggests that the earlier an individual gets support, improvements can be more significant.

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.

There is general support for the move away from the Mental Health Act being used as a risk-based Act to a treatment-based Act. However, a clear and pragmatic definition of "therapeutic benefit" is required with clarity on timescales and measurable outcomes.

Our members have highlighted the need to consider what constitutes therapeutically beneficial for one person may not be for another. Whilst this would be working in line with treating people as individuals this then means that the therapeutic environment would paradoxically have to be able to support all. Also, further clarity is needed on who will make the determination of probable benefit, including consideration of views from individuals themselves, Nominated Persons or carers and relatives.

Careful consideration must be given to potential scenarios for example, what if someone met the criteria in posing a risk of serious harm to themselves or others but it was felt there was no reasonable prospect of therapeutic benefit in detention? What would be the outcome for them to keep them and others safe from serious harm? We would welcome clarity on the options that would be available in this scenario both for the person and to protect the public. We note that there are justice implications here also.

There is a risk that the current framing could potentially exclude people (particularly people with personality disorder) from mental health care and a risk that access to treatment and care will be determined by a person's level of engagement.

Expansion of the workforce is also needed to enable the role out of changes to ways of working so they are more therapeutic. Staffing capacity across therapies, skills mix and training are key to the embedding of this, whilst also recognising the value of specialisms. It is important that all professions "therapeutic offer" is valued, if it is of benefit to the individual. The Allied Health Professionals workforce is large, although currently makes up a small proportion of the workforce. It is important that all therapies are considered as part of the delivery of care across the pathways, ensuring that a person-centred approach is embedded alongside any of the all Wales strategies.

Processes within mental health are still medically driven and there would need to be a shift in the delivery model to ensure that this works. While members agree that there must be reasonable therapeutic benefit to the patient, they are unsure how the Bill would seek to strengthen this in comparison to current legislation. Therefore, our members want to understand this more fully to enable them to provide further comment.

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.

Overall there is support to the introduction of remote (virtual) assessments, however further details is required to make an informed response and virtual assessments should not become the default or the norm.

While virtual assessments are positive in relation to accessibility and can have some benefits around capacity and time, there is huge value to face to face methods of communication and assessment, including subtilties in body language, emotional responses, scrutiny and personable approach can be missed if virtual assessments were to become a default. This is often what makes up part of the assessment and may be missed over a screen. Remote assessments should not be in replace of face-to-face assessment processes or be a compensatory offer due to capacity issues, and/ or lack of staffing.

While the proposals are in line with the care closer to home strategic priority and increase accessibility, it is an area we would want to understand the application of in detail, to provide informed comment. Theoretically, this could make sense, but a balanced discussion is required to understand practical application and implications as a result. Ultimately, maintaining the principle of 'Choice and Autonomy' will be important in respect to individual preferences for remote or in-person assessments. It is also important to consider the population that NHS bodies serve and how this works for them. Some areas e.g. brain injury may struggle with this method of communication and ability to utilise the assessment process in the way it is meant.

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.

Overall this is a positive proposal as it supports the recognition of choice, management of own care and supporting individuals to take personal responsibility. The proposal could promote equality of access to services and could also help in the planning and delivery of services on an all-age basis. However, some further detail is needed.

Careful consideration is needed in terms of parental responsibility for children and young people, informed consent and Gillick competency. At what age would a parent be unable to request on behalf of a child and what level of individual confidence and assertion would be required? How would potential conflicts between parent/guardian and child be managed? Consideration of whether children under 16 are Gillick competent at the time of requesting a re-assessment and whether their parent/ carer of a young person who is deemed not to be Gillick competent can make a request for reassessment on their behalf.

Finally capacity and resourcing implications for already stretched services will need careful consideration for effective implementation.

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.

Overall we support the proposal to amend the Measure to extend the ability to request a re-assessment to people specified by the patient, especially empowering parents and carers of young people accessing mental health services.

For young people in distress having another person, or trusted adult, who can advocate for them when they are unable to do so for themselves, is important. Any such person would need to have their best interests at heart. Safeguards around this would need to be robust and Advance Directives would further support this to protect against things like cohesion.

We also believe that this would regularly need to be reviewed and updated so that it remained accurate or have an effective clause to determine eligibility at any space in time. Part 3 of the Measure provides opportunity for re-assessment up to 3 years after discharge from specialist mental health services. Who a patient specifies may change over time and an Advance Directive, or similar alternative, might be helpful.

Finally, there needs to be very clear guidance on the management of this proposal. As above, there are resource implications to this that our members would want to consider before providing a full view on the proposal.

General Views

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

The proposed Bill is likely to be a positive move in improving service experiences for people experiencing serious mental illness and their families. However, it is important for this consultation to review whether sufficient responses have been received across a range of demographic groups and/or organisations representing them, particularly those with protected characteristics, those who have had previous contact with mental health service, migrant populations and those living in rural areas to make an informed view about its implications.

We hope the Bill goes someway in improving health equity and reducing inequities in provision and the use of detention under the existing Mental Health Act that are experienced, for example by people from minority ethnic groups. Detention rates for black people under the Mental Health Act are currently around 5 times higher compared with the general population.

In addition, there are cultural implications to be considered in terms of implementation and application. Full Equality and Socio-Economic Impacts would need to be carried out on the Bill. There are also age-appropriate considerations, informed consent and capacity issues that need to be explored further. Careful consideration must also be given to Children and young people, particularly in relation to parental/guardian relationships, confidence, assertiveness etc, people with a personality disorder and those who might be currently at risk of exclusion and older frailty people – particularly the relationship with family and carers.

Accessibility should also be considered, such as digital and health literacy. For example;

- Individuals understanding their own presentation, is able to identify needing support and activating this themselves.
- Self-management.
- Developing knowledge and knowledge of person-centred care as an individual within a service as well as the wider community awareness of this.

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

It would appear to give children greater rights, in terms of accessing assessment of their needs, however, considerations noted above are required.

The Bill would need further consideration around the alignment of CAMHS and adult service to consider transitional work and joined up pathways.

Diversifying practice is addressed in the proposal to amend the Mental Health Act, however if thresholds were different across England and Wales this would be concerning and impact on cross-border working particularly for children and young people where intensive and low secure inpatient care is commissioned in England. How will parental rights be maintained where a parent or guardian is not the child's nominated person? These provisions should particularly address the rights of a person with parental responsibility to consent to treatment of a child detained under the Act and to receive information about their child's treatment and discharge.

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

Overall the proposals appear person and family centred, and this ethos is fully supported. The principles are well intentioned, but we feel that there needs to be further consideration of the application, implications and how it would be monitored and ensured. These are all areas that need further consideration for us to understand whether we support in practice and provide a view supported by evidence.

The overall approach is based on amending and refining provisions to the 1983 Act. However, given the relatively limited scope of the Bill, we would like to understand whether this removes the necessity for a more comprehensive reform of the law (at an England and Wales level) as has been the plan for several years (with a draft Bill published in 2022). We recommend it would be better to have one piece of legislation to cover the broader agenda of reforms needed.

However, if this Bill does go ahead, care will be needed to make sure that it doesn't end up being taken forward at the same time as a broader Bill in the UK Parliament.

In addition, it is key that the Bill aligns with existing strategies in Wales, such as the Mental Health Strategy currently out for consultation, the rehab model etc so that they are weaved into any new standards to ensure consistency, transparency, joint ways of working and shared ways of working.

The language used in relation to 'detention' or 'sectioning' of people under the Mental Health Act is outdated and would benefit from improvement to avoid the Bill repeating/ entrenching stigmatising language. It would be useful to consider less stigmatising language which is more reflective of the supportive nature of 'detention' only for the purposes of safety to self/others and where there is a therapeutic benefit.

Finally, any changes introduced will need to consider training of staff and expectations of staff roles to deliver. Our future workforce is more varied and there are opportunities to broaden current roles.

Other Comments

There is a clear need for this legislation given the changing landscape of mental health services, whether this is Welsh specific or England and Wales through UK Government legislation. There is widespread agreement amongst our members with the overarching principles of the legislation. Legislation which supports dignity and respect, choice and influence for patients is a positive step in the right direction to improving mental health services and providing person centred care.

However, in updating and reviewing existing health legislation, it is important to consider existing health inequalities, which should be seen as a continuous variable, influencing all sectors of society. As highlighted in the Welsh NHS Confederation Health and Wellbeing Alliance briefing, Reducing mental health inequalities, there are many determinants in our lives which influence our mental health: from positive parenting and a safe place to live, to experiencing domestic abuse and neglect, oppression, discrimination, or growing up in poverty. Determinants of mental health interact with inequalities in society, putting some people at a far higher risk of poor mental health than others.

The NHS alone simply doesn't have the levers to make the changes we know are vital to creating the conditions necessary for good health. Meaningful progress will require coherent efforts across all sectors to close the gap and we are calling

for cross-sector and cross-government action to tackle mental health inequalities, including addressing the social determinants of mental health.

Reducing mental health inequalities is key to driving change in mental health services. Inequality has a broad adverse effect on societal wellbeing, as has been demonstrated across a range of measures, including health, life expectancy, crime, and mental health amongst others. Inequality has an impact on society, and not just on discrete disadvantaged groups.

There are many systemic factors which impact mental health services, and it is vital to look through this lens when planning mental health services that are fit for the future. In doing so, this preventative way of working can encompass support for people to not to deteriorate further as well as ensuring they do not become unwell in the first instance.

To improve services to reduce these inequalities it is important that services are co-designed with the people the services are intended to support and they should be universal across all aspects of life. Ultimately, performance measures should be developed focused on reducing inequalities and prevention programmes and services should be prioritised to support people in primary and community care to prevent escalation of needs.